Primafamed Meeting 18-19 October 2022

Programme and abstracts

Day 1

08h30-10h00 Chair: Martha Makwero

Welcome from Vice-Chancellor: 08h30-08h45

Introduction to the meeting and programme – Martha Makwero: 08h45-09h00

Education for Primary Health Care in Africa – talk on the theme of the meeting, including an overview of the PRICE project who are funding the meeting- Thomas Mildestvedt/ Martha Makwero/ Joseph Zulu: 09h00-10h00

10h00-10h30 Tea and coffee

10h30-12h30 Parallel sessions on capacity building for education and training

Room: Nkhwazi 1 **Thomas Mildestvedt & Emma Thompson**	**Room: Nkhwazi 2** **Christian Lokotola & Charlotte Scheerens**	**Room: Gallery** **Sunanda Ray & Farai Madzimbamuto**
How to train the clinical trainer and improve workplace based assessment	How to embed planetary health into training of primary care providers	Creating a regional college for training and assessment of family physicians

12h30-13h30 Lunch

13h30-15h30 Parallel sessions sharing educational research and educational innovations from across Primafamed – oral presentations

Room: Nkhwazi 1 **Educational research/ innovations – track1** **Mpundu Makasa**	**Room: Nkhwazi 2** **Educational research/ innovations – track2** **Innocent Besigye**	**Room: Gallery** **Educational research/ innovations – track3** **Vincent Setlhare**
6 presentations in 20 minute slots	6 presentations in 20 minute slots	6 presentations in 20 minute slots

15h30-16h00 Tea-coffee

16h00-18h00 Wonca Women – Women as clinical trainers and teachers – Martha Makwero

16h00-19h00 Networking, recreational visits and activities - Jesse Mbamba

Day 2

08h00-09h30 Chair :Edward Chagonda

Accreditation of postgraduate education and the work of the Wonca Working Party on Education – Akye Essuman

Plenary address on Educating the whole PHC team – Innocent Besigye

09h30-10h30 Interactive poster presentations sharing educational research and innovations. Chair: Bob Mash

10h30-11h00 Tea and coffee

11h00-13h00 Parallel sessions on capacity building for educational research

Room: Nkhwazi 1 **Anna Galle**	**Room: Nkhwazi 2** **Akye Essuman**	**Room: Gallery** **Bob Mash**
Creating WHO CC in PHC in Africa	Benchmarking postgraduate programmes against the Wonca accreditation standards	Creating an educational research agenda and collaborative research projects

13h00-14h00 Lunch

14h00-15h20 Strategic partners. Chair: Zelra Malan

Update on the AfriWon Research Collaboration – Pius Ameh

Update on the Ghent University WHO collaborating centre initiative – Anna Galle

Update on the Primary Health Care Research Consortium initiative – Bob Mash

Update on the CliMigHealth network and TEAM grant – Charlotte Scheerens

Update on Wonca Africa and AfroPHC – Innocent Besigye

15h20-15h45 Tea and coffee

15h45-17h15 Annual planning: Facilitator: Martha Makwero

Overview of PRIMAFAMED's goals and achievements in 2020/21 – Bob Mash

Feedback and discussion

Annual planning process for 2023

17h15-17h30 Closure and final business

Abstracts for workshops

Day 1

Workshop 1 (Day1): Clinical Teaching and Workplace Based Assessments

Dr Emma Thomson. Ag. Director Teaching and Learning Development Centre (TLDC), Kamuzu University, Malawi

Associated Professor PI Thomas Mildestvedt, Department of Family Medicine University of Bergen, Norway

The aim of this workshop is to increase awareness and knowledge on why you should and how you could practice teaching and assessment in a clinical setting in a LMIC country setting

Learning and assessing in a clinical setting is at the very top of Miller´s pyramid. Even though this most sited publication in medical education has been acknowledged for more than three decades, many faculty still struggle to put this into practice. We will share and discuss some central theories and possible methods for teaching in a clinical setting. Examples are how to teach clinical reasoning and the One Minute Preceptor as a useful tool in postgraduate training.

In the second part we will focus on assessment with focusing the question: How can we use assessment to improve students' performance?

The presentations will focus on aspects of particular interest to the participants. To focus the presentations participants will be invited to share their own experiences and reflect on strengths, challenges and possible developments within this topic.

Workshop 2 (Day 1): Planetary Health Education and Family Doctors in Africa.

Dr Charlotte Scheerens, Climate Change, Migration and Health network and University of Ghent

Dr Christian L. Lokotola, Climate Change, Migration and Health network and Stellenbosch University

The global environmental crisis is impacting health and health services across Africa. The study of these effects has been termed planetary health. The crisis is made up of many ecological drivers such as climate change, biodiversity loss, changes in land use and pollution. Climate change impacts the social and environmental determinants of health such as clean water, secure shelter, food production, security

and safety, and clean air. The impact of the environmental crisis is felt first in primary health care through changes in the burden of disease and via extreme weather events. Health facilities and services must develop resilience to face the current and future challenges. Likewise, health systems must develop in environmentally sustainable ways.

Primary care providers on the frontline need to understand more about planetary health in order to prepare for, respond to, and recover from these challenges. They may also need to advocate for the health of their communities to policy makers. Responding to the environmental determinants and risks may become a key focus of community-orientated primary care.

This workshop would like to identify ways in which undergraduate, postgraduate and in-service training of family doctors or primary care providers can incorporate planetary health.

Workshop 3 (Day 1): Proposal to set up a College of Family Medicine in East, Central and Southern Africa

Sunanda Ray, Department of Medical Education, Faculty of Medicine, University of Botswana, Gaborone, Botswana

Farai Madzimbamuto, Department of Anaesthetics and Critical Care, Faculty of Medicine, University of Botswana, Gaborone, Botswana

Family Medicine training in Africa is constrained by limited postgraduate educational resources and opportunities. Specialist training programmes in surgery, anaesthetics, internal medicine, paediatrics and others have developed a range of trainers and assessors through colleges across East, Central and Southern Africa (ECSA).

Each college has a single curriculum with standardised training and assessment in designated institutions, which run alongside and in collaboration with the Master's in Medicine programmes in universities. Partnerships between colleges in Britain, Ireland and Canada and national specialist associations have led to joint training-of-trainer courses, e-learning platforms, improved regional coordination, better educational networking and research opportunities through regional conferences and joint publications.

We propose the establishment of a regional college for specialist training of family physicians, similar to other specialist colleges in ECSA. Partnerships with family medicine programmes in South Africa, Canada and Australia, with support from international institutions such as the Primary Care and Family Medicine Network for

Sub-Saharan Africa (PRIMAFAMED) and the World Organisation of Family Doctors (WONCA Africa), would be essential for its success.

Improved health outcomes have been demonstrated with strong primary care systems and related to the number of family physicians in communities. A single regional college would make better use of resources available for training, assessment and accreditation and strengthen international and regional partnerships. Family medicine training in Africa could benefit from the experience of specialist colleges in the ECSA region to accelerate training of a critical mass of family physicians. This will raise the profile of family medicine in Africa and contribute to improved quality of primary care and clinical services in district hospitals.

The proposal will be discussed further in the workshop and can be read beforehand at: Ray S, Madzimbamuto FD. Proposal to set up a College of Family Medicine in East, Central and Southern Africa. Afr J Prm Health Care Fam Med. 2022;14(1), a3612. https://doi.org/10.4102/ phcfm.v14i1.3612

Day 2

Workshop 1 (Day 2): Strengthening primary health care by a South-South-North Collaboration

Dr Anna Galle,

WHO Collaborating Centre (WHO-CC) is a title granted to research institutes due to their contribution to the World Health Organization's programmes at large. Globally, most WHO-CCs for Family Medicine (FM) and Primary Care (PC) are located in high-income countries (4 in Europe, 4 in North America and 5 in Asia), with no representation from the African region.

Our project aims to set up a new collaboration of the tandem UGent-Stellenbosch University with two Sub-Saharan African institutions with expertise on PC and FM and enable these institutes to become WHO-CCs. The prestige of becoming a WHO-CC will put these Sub-Saharan institutions in better positions to influence the global agenda of health priorities and challenges.

A joint trajectory involving research, education and policy translation will be drawn with all institutions around three central themes: interdisciplinary working in primary care, health systems thinking and translating knowledge into policy. Ghent University will offer advanced online courses, research projects, calls for small research grants, internships and dissemination events. Stellenbosch University will link with the African Doctoral Academy for courses for the partnering institutions. The WHO head office and WHO AFRO will be involved in all steps to guarantee the activities can evolve into sustainable collaborations.

This workshop will explain the project to all eligible institutions and how you can apply to become part of this project. If your institution is selected for the project you will be able to follow a two year trajectory of joint education and research and eventually apply to become a WHO-Collaborating Centre.

IMPORTANT!

Due to the rules of the funding organization only a limited number of countries can apply: Benin, Burundi, DR Congo, Ethiopia, Kenya, Rwanda, South Africa and Uganda.

Workshop 2 (Day 2): Assessment of Family Medicine Postgraduate Programmes in Sub-Saharan Africa using the Wonca Global Standards.

Akye Essuman, Faculty of Family Medicine, Ghana College of Physicians & Surgeons, Ghana / Wonca Working Party on Education

Background: Family medicine training programmes globally, exhibit significant variability in content and skill acquisition depending on the given setting.

Wonca World Council approved the Wonca Global Standards for Postgraduate Family Medicine Education in June 2013. The aim is to enhance family medicine education globally, facilitate training programmes to share expertise and learn from each other, and to promote Family Medicine as a discipline. These standards were developed by family medicine experts from across the globe who discussed the critical elements in educating physicians to become family doctors/general practitioners. The Wonca Working Party on Education (WWPE) has been accrediting family medicine programmes across the globe using these standards. Assessment of existing or developing training programmes using these standards can provide insight into the degree of variability, and gaps within the training programmes.

Objective: The workshop aims to assess postgraduate family medicine programmes in sub-Saharan Africa using the Wonca Global Standards for Postgraduate Family Medicine Education.

Methods: After a brief overview of the pre-visit checklist of the WONCA Global Standards for Postgraduate Family Medicine Education, participants will break out into smaller groupings. Each group will have a participant presenting his/her postgraduate FM programme and other participants completing the checklist. Discussion will focus on strengths and areas of improvement for the programmes assessed, as well as the positive attributes of the standards and the areas for possible improvement.

IMPORTANT!

Participants will be required to provide either soft or hard copies of their respective programmes.

Expected Outcome: The workshop presents an excellent opportunity for participants to have a hands-on experience of the Wonca pre-accreditation process. Participants will have the opportunity to assess a family medicine postgraduate programme and/or have their programmes assessed using the Wonca standards. This could be a prelude for requesting a formal Wonca accreditation.

Workshop 3 (Day 2): Creating an educational research agenda and collaborative research projects

Bob Mash, Division of Family Medicine and Primary Care, Stellenbosch University and Editor-in-Chief, African journal of Primary Health Care and Family Medicine

Sunanda Ray, Department of Medical Education, Faculty of Medicine, University of Botswana, Gaborone, Botswana and Assistant Editor, African journal of Primary Health Care and Family Medicine

Musa Dankyau, Department of Family Medicine, Bingham University, New Karu, Nigeriaand Assistant Editor, African journal of Primary Health Care and Family Medicine

Innocent Besigye, Department of Family Medicine, Makerere University and Assistant Editor, African journal of Primary Health Care and Family Medicine

This workshop aims to help people conceptualise and/or develop educational research proposals in the field of family medicine or primary health care. After a brief presentation on the different types of research questions and methods that might be appropriate, the workshop will help participants with their research ideas. This presentation will draw on the work presented in the new Wonca book:

Bob Mash and Jan de Maeseneer. How to develop critical mass and ensure primary care educational innovations and initiatives are evidence-based in Akman M, Wass V, Goodyear-Smith F (Eds) How to do primary care educational research. London" CRC Press, 2021.

The editorial team from the PHCFM journal will facilitate the small group work. Participants may also find opportunities to collaborate on research projects with similar aims and objectives.

Day 1: Abstracts for oral presentations

Track 1: Undergraduate educational research/ innovations. Chair: Mpundu Makasa

Presentation 1: Experience of SNAPPS in Addis Ababa University, Department of Family Medicine

Nitsuh Ephrem, University of Addis Ababa

Medical clinical education teaching suffers with issues like long and unstructured presentations inclusive of a lot of historical information and time constraints due to increasing workload. A six-step pneumonic SNAPPS, a learner-centered model modifies the learning encounter by condensing the reporting of facts while encouraging clinical reasoning. SNAPPS links learner initiation and preceptor facilitation in an active learning conversation.

This learner-centered model for case presentations follows a mnemonic called SNAPPS consisting of six steps:

- Summarize briefly the history and findings
- Narrow the differential to two or three relevant possibilities
- Analyze the differential by comparing and contrasting the possibilities
- Probe the preceptor by asking questions about uncertainties, difficulties, or alternative approaches
- Plan management for the patient's medical issues
- Select a case-related issue for self-directed learning

With the use of SNAPPS model our department has benefited in so many ways such as change in the preceptor perception of teaching, faculty development and learner development as companions in clinincal education. Guided by the SNAPPS technique, students summarized patient findings concisely while maintaining the same degree of thoroughness as in traditional case presentations. They also are clearer about their diagnostic hypothesis, compared and contrasted their differential and initiated patient management discussion.

Out of experience we can conclude that SNAPPS a learner centered technique for case presentations facilitated the expression of clinical diagnostic reasoning and case based uncertainties without extending the unusual length of the student case presentations. We as a department use SNAPPS in our clinical patient encounter both outpatient and inpatient round teaching, bedside teaching and case presentation thus it has paved our way to an enhanced self-directed active learning.

Presentation 2: Students' Perspectives of a Community-Based Medical Education Programme in a Rural District Hospital

Mathew Benedict, Free State University, South Africa

Background: Students are the consumers of medical education and are, thus, the ideal evaluators of the efficacy of their own course and learning environment. To evaluate the quality of the CoBME community-based medical education programme in Botshabelo District Hospital (BDH), this study investigated student's perceptions of their experience during their CoBME training. In addition, suggestions on how to enrich students' experience during the CoBME posting were obtained.

Methods: This research was designed as a qualitative (ethnographic) study that used a structured self-administered questionnaire to obtain written statements from 120 fourth-year undergraduate medical students, describing their experience during their CoBME training at BDH.

Results: 84 out of the 120 questionnaires were returned (i.e. 70.0% response rate). When asked to indicate what they liked or disliked about their CoBME training, 'Good educators/staff' and the 'Poor attitude of some doctors' were the themes that scored highly (25.1% and 19.4%) in the 'likes' and 'dislikes' category, respectively. Some of the challenges faced during the CoBME training

Included: exposure to new learning environment (14.2%), clinical practice context (12.6%), and language barrier (7.2%). They gained knowledge of how to perform certain clinical procedures and acquired core clinical skills. The students feel increasing the duration of CoBME training may enrich their experience.

Conclusion: Findings by this study reveal that CoBME is a valuable pedagogical tool to enhance learning in undergraduate medical education and that more work is required to improve the quality of CoBME training in BDH. We believe that the findings by this study will inform future planning of CoBME training programmes in BDH. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6859681/

Presentation 3: Impact of research training for undergraduate students in primary health care

Titus Kahiga, Kenyatta University, Kenya

Background: The Health-Professional Education Partnership Initiative (HEPI)-Kenya is a grant awarded to the University of Nairobi in partnership with 3 other local universities and 2 USA universities. The aims of the program are to increase the pipeline of young Kenyan researchers by offering an innovative 10-week research elective that targets medicine, nursing, and pharmacy students undergoing clinical undergraduate degrees. This report aims to report the impact on primary health care

where the research and mentorship were carried out by Kenyatta university students.

Methods: The students were selected from the 3 disciplines of pharmacy, medicine, and nursing through a competitive process. They undergo a 5-day workshop on introduction to health research in week 1. This is followed by 8 weeks of integrated clinical rotation and mentored research, including proposal approval by the Kenyatta University Ethics Review Committee.

Results: For the past three years, Kenyatta University has trained 139 undergraduate students in a one-week didactic research cycle process and supported 55 students to carry out research projects during their elective terms. Among the deliverable from this support were journal publications, 3 manuscripts undergoing review at different stages, and several conference presentations. Some primary care facilities have improved their outcomes as a result of the recommendations given.

Conclusion: The program has generated evidence that has changed the practice and clinical outcomes and recommends that it should be expanded and integrated in curriculums in health-related disciplines

Presentation 4: How much PHC is in your curriculum?

Bernhard Gaede, University of KwaZulu-Natal, South Africa

Introduction: The international literature notes wide support for strengthening PHC in health professions education to train fit-for-purpose graduates that are responsive to the health needs of populations. The WHO calls on ministries of health in many countries to re-orientate the health professions training to PHC. However, in the discussion regarding what a 'PHC curriculum' is, it became evident that 'PHC' was a vague and unclear term.

Method: A tool has been developed at UKZN to gauge the extent to which PHC is being taught in the curriculum. The tool drew on a range of policy documents to develop a working definition of PHC for health professions education.

Findings: It was noted that the definitions that were being offered fell into a number of broad categories, namely PHC principles, PHC values, PHC components and levels of care. A number of indicators for each of these categories were developed to form the basis of an assessment tool to review the curriculum. The tool that was developed is divided into 2 sections and each of the categories and is assessed for each section. The first covering the 'breadth' of PHC in the curriculum, namely whether PHC was being taught, how it is taught, whether activities were included and how PHC was assessed. The second section of the tool assesses the depth of PHC content in the curriculum, using Miller's pyramid.

Conclusion: The application of the tool to assess PHC in a health professions curriculum assisted in the process toward curricular review.

Presentation 5: Electronic Distance Based Clinical Skills training: Namibia

Zelra Malan, University of Namibia

Background: As part of family medicine training, 3rd - and 4th year medical students are expected to live and work in a rural facility and community for 4 weeks as part of Community Based Education. The focus of the placement is the practical implementation of clinical skills and knowledge in a primary care context. Clinical skills were previously assessed by collecting signatures in logbooks from supervisors.

Objectives: 1.To improve direct observation of medical students who deal with actual patients in real workplace for increased performance-based assessment. 2.To involve more members of the primary health care team in assessment. 3.To improve constructive feedback on performance. 4.To reduce carbon footprint and move to an electronic paperless system

Methods: Three tools were introduced to the students and clinical supervisors to assess performance in procedural, consultation and counselling skills.

Two of the most frequently used assessment tools that measure the trainees' performance in workplace is the mini-Clinical Evaluation Exercise (mini-CEX) and the Direct Observation of Procedural Skills (DOPS), in which an assessor observes and rates the actual performance of trainees. Assessors can be anyone with expertise in the procedure, including nurses, doctors as appropriate.

Primary care providers should be competent in brief behaviour change counselling (BBCC). The ABC tool is sufficiently reliable for the assessment of BBCC. Students have completed the online course training in BBCC and were asked to peer review performance using the ABC tool.

Results: Students are now assessed with the tools and are electronically submitting the proof of clinical learning in an online electronic portfolio.

Presentation 6: Reflective learning and assessment through portfolios for undergraduate medical education in family medicine and public health, University of Zimbabwe

Sunanda Ray, University of Botswana

Introduction: Medical students at the University of Zimbabwe carry out community-based education (CBE) attachments at rural district hospitals and urban city health clinics during each of the five years of their training. They learn about the health system from a primary care perspective, the interface with communities, the socio-economic background of their patients, their illness experience, treatment and care.

Aim: Learning through reflective writing by medical students during their CBE attachments is explored.

Innovation: The portfolio as a new method of learning and assessment during CBE attachments was introduced in 2018 for years 3, 4 and 5. Students were taught Gibbs Reflective Writing techniques to write narratives of cases, to include key points from their peer discussions of these cases. Each activity conducted during CBE was written with a reflection on it. The narratives provided an objective basis during supervisions for group discussion with evidence of exposure to appropriate cases.

Lessons learnt: Review of the portfolios revealed the scope and depth of students' learning during these attachments. The narratives demonstrated meaningful application of knowledge and skills, how the students built on them and integrated their experiential learning with theory. Supervisors commended the improvement in students' writing skills as preparation for written exams and future publications.

Conclusions: The positive impact of reflective writing on student learning includes enhanced retention of information and deep learning, which is most effective when faculty feedback is regular and focused. The practical and experiential basis of this learning, makes it a useful method for teaching family medicine and public health.

Track 2: Postgraduate educational research/ innovations. Chair: Innocent Besigye

Presentation 1: Tracking Family Medicine in Zambia

Mpundu Makasa, MD, University of Zambia

Primary Health care is the cornerstone to achieving Universal Health Care (1), and delivering high-quality care remains one of the three essential pillars, including empowered and engaged communities and multi and intersectoral action for health. The six characteristics of high-performing primary care systems include primary care systems that act as people's first contact and that are comprehensive, coordinated, people-centred, continuous and accessible (2). Family medicine is premised on these principles and therefore is key to improving care in the primary health care setting.

Tracking Family Medicine in Zambia using the cycle of change theory by Prochaska and DiClemente (3), Zambia has evolved through various phases. Its trajectory extends from the early nineties, in action phase, after commencing its first Master of Medicine programme in District Health. This was a specialist training programme for primary care physicians under university of Zambia to address the country's primary health care needs. Challenges included uncertainties among trainees for career progression upon the graduation and concern over the name of the programme, suggesting that these physicians would only work in a District hospital, giving rise to a notion that it is an inferior speciality. Apprehension and lowered confidence among trainees, resulted in it's collapse. The lessons learnt have helped shape the current MMed Family Medicine programme, which now is moving to maintenance phase. Partner support has been instrumental. To track the progress, we reflect on challenges and successes and share aspirations and future direction to ensure sustainability.

Presentation 2: Primary health care strengthening through family medicine training in Tanzania

Eric Aghan, Muhimbili University of Health and Allied Science, Tanzania

Background: Tanzanian health indicators have steadily improved over last decade and continue to improve albeit with a slow pace. The government through its 2007 - 2017 Primary Health Services Development Programme (PHSDP) identified 6 barriers to access quality care. Human resource both in quality and quantity was prioritized as a crisis and thus deserved emergent action (1).

Vision: Aim is to achieve quality universal health care and access at all PHC facilities throughout Tanzania

Objectives: To establish a standardized FM Training program in public universities. To develop a national standardized curriculum.

Methods: Modified Delphi method for decision making to obtain consensus among experts and stakeholders was used: Skill set 1: Leadership, governance and lifelong learning. Skill set 2: Clinical acumen and surgical skills. Skill set 3: Community oriented primary care and researcher. Skill set 4: Educator/mentor. Skill set 5: Professionalism. Skill set 6: Surgical skills. Skill set 7: Behavioral and mental health. Skill set 8: Obstetrics and gynecology. Skill set 9: Pediatrics

Results: 9 Skill sets with 123 competencies. Send to 7 experts and 35 stakeholders. Response rate: 71% & 54%. Consensus on 7 out of 9 skills sets achieved >80% agreement. Skill set 6 & 8; 52% and 55% agree, 27% & 22% ambivalent and 21% & 23% disagree.

Conclusion: 80% of the standardized National Curriculum agreed, residents' responses skewed scale towards disagreement on the 6 and 8 skill sets.

Presentation 3: Family Medicine program at Makerere University Kampala Uganda

Innocent K. Besigye, Makerere University, Uganda

Introduction: Family medicine is a relatively new medical specialty in Sub Saharan Africa. Despite the well-known contributions of family medicine in strengthening health systems, there are still low numbers of family physicians in many Low and Middle Income Countries. This results from weak training programs with poor visibility in medical schools coupled with negative perceptions towards family medicine among undergraduate medical students.

Aim: To describe the development and strengthening of the Family Medicine programme at Makerere University Kampala Uganda.

Innovation: Several activities had to be undertaken to develop and strengthen the family medicine programme. Identification and effective engagement of non-family medicine specialist champions. Advocating for family medicine inclusion in the undergraduate curriculum. Developing a family medicine off campus training programme in a rural district. Selecting and mentoring young and committed family physicians as future leaders. Targeted faculty development to strengthen pedagogical skills and research capacity. Partnering with local authorities.

All these have resulted into the increase in the family medicine visibility and number of trainees. The department of family medicine at Makerere University has moved from no student admitted in the years 2005-2008 to 13 registrars admitted in a single year of 2022.

Lessons learnt: Understanding of context is important in planning activities to advocate and develop family medicine. Networking both within and outside the country is important. It takes a long time to mentor competent and effective family medicine leaders and this should be deliberately and strategically done.

Conclusion: Family medicine is a relevant discipline and has support among stakeholders but requires committed teams of champions to sustainably lead the process of change.

Presentation 4: An alternative online learning platform with minimal technical or financial barriers to deployment.

John Lotz, Walter Sisulu University, South Africa

Introduction: Online platforms facilitate distance learning programmes, and Walter Sisulu University's decentralised Family Medicine registrar programme is one such example. Multiple software packages exist, with varying functionality and financial implications. When a problematic transition between two platforms threatened to interrupt the learning experience of registrars, an interim solution was sought by WSU's Department of Family Medicine and Rural Health.

Aim: Our faculty aim was to seek an urgent interim online teaching and learning platform, that allowed for rapid orientation of facilitators and learners, and was financially accessible at short notice.

Innovation: Google's Classroom software provided a simple and functional platform that enabled facilitators to easily upload and effectively present content, including discussions and assessments. There were no licensing costs involved.

Lessons Learnt: While other online learning platforms may offer different functionality, they require more time and expertise for set up and support, and usually with significant cost implications to the institution. Google Classroom provided a suitable interim solution through its user-friendly interface, requiring very little time and expertise for facilitators to deploy curricula without requiring expert support, and for learners to understand how to engage meaningfully with online resources and assessment activities. The software provided for an excellent learning experience, with potential for use in a wide variety of learning settings.

Conclusions: In our experience using this alternative online learning platform, we foresee that the ability to provide a fruitful learning experience with minimal technical or financial barriers to deployment and engagement may present excellent utility for use in a variety of learning environments throughout Africa.

Presentation 5: Coaching future clinical leaders: a revised approach to delivering a leadership and governance module for family medicine registrars

Klaus von Pressentin, Angela de Sa, Paddy Pampallis, Tasleem Ras, University of Cape Town

Introduction: Family physicians are seen as leaders of interventions aimed at strengthening the health service within their sphere of influence by working within clinical teams. Interviews with district managers highlighted the need for family physicians to develop their leadership qualities, build resilience and become change agents able to shape their context. The updated programmatic learning outcomes for the training of South African family physicians were published in 2021 and provided an opportunity for curriculum review at the University of Cape Town's Division of Family Medicine. A review of the leadership and governance module in the third

year of registrar training showed that the sessions were content-heavy with insufficient opportunities for reflection.

Aim: The module convenors plan to evaluate a revised module implemented in 2022 that aims to support registrars in their emerging understanding of their roles as leaders tasked with strengthening primary care teams and services.

Innovation: The module convenors collaborated in the design and delivery of a revised module blueprinted on the updated national learning outcomes. The module is presented over a longer period and incorporates a group coaching style to increase self-awareness among registrars on how best to manage themselves and their team.

Lessons learnt: This presentation will share preliminary insights from the revised module in its developmental phase, to inform a formal evaluation.

Conclusion: Family physicians should add value through their leadership ability across all their roles. Efforts should focus on how best to create formal and informal learning opportunities aimed at facilitating their growth as leaders.

Presentation 6: Educational Evaluation of GOPD-based Learning and Assessment

Pius Ameh, Department of Family Medicine, FMC Keffi, Nasarawa State.

Problem Statement: Assessment is a critical component of postgraduate medical education with workplace-based assessment (WPBA) preferred as a formative assessment tool. However, there is sub-optimal quality of clinical teaching and learning in the GOPD clinic of the FMC Keffi. This is evident by the virtual lack of use of the recommended workplace-based assessment (WPBA) tools during clinic sessions. In the light of recent changes in the postgraduate college curriculums, high trainee turnover and recent faculty appointments within the department, there is a need to identify areas where GOPD-based clinical assessment and feedback can be improved and to ensure trainees effectively meet their learning outcomes.

Aim: To conduct an Educational Evaluation of the Family Medicine GOPD experience to explore training needs, gaps and challenges to teaching and learning in the GOPD clinic in order to implement the appropriate WPBA tools.

Methods: Proposed key informant interviews, document reviews of summative assessments and stakeholder surveys using the Integrated Program Evaluation Model (Dubrowski and Morin, 2011) as an evaluation framework over a six-month period.

Results/Conclusions: The Educational Evaluation could increase reliability of training methods in the GOPD as factors behind faculty variability should be revealed. Improved confidence/and competence of residents should result in higher quality of

patient care. Identification of suboptimal training methods leading to better training and learning techniques. Opportunity for faculty development to ensure involvement in WPBA tools

Track 3: Educational research/ innovations. Chair: Vincent Setlhare

Presentation 1: HEPI-TUITAH Micro-Research Approach to HIV Training in Uganda

Dr. Vincent Mubangizi, Mbarara University, Uganda

Introduction: Traditionally training of health professionals in Uganda has focused on clinical skills acquisition with less emphasis on research yet health professionals engage in research as collaborators, drivers or partners but have limited resources and training. Mbarara University of Science and Technology (MUST) received a five-year grant from the Fogarty International Center of the United States National Institutes of Health to support the HEPI-TUITAH (Health Professions Education Partnership Initiative - Transforming Ugandan Institutions Training Against HIV/AIDS) to support interdisciplinary undergraduate students team with micro research grant seeds among other activities. The activities took place at MUST and her partner institutions (Bishop Stuart University – BSU and Lira University – LU in Uganda) in collaboration with Massachusetts General Hospital – MGH in the US.

Aim: To develop the capacity of undergraduate health professions students to conduct locally relevant research in HIV/AIDS

Innovation: Inter-professional education approach was used to train interdisciplinary teams of undergraduate health professional students who are more likely to become collaborative health professionals. The training was guided by an adapted micro-research model whereby grant recipient teams are selected using a multi-step process from partner institutions.

Lessons learnt: It was acceptable, appropriate, and feasible for health professions undergraduate students to undergo this program in that it promoted peer mentorship, teamwork, and academic collaboration.

Conclusion: With the support, health professional students are able to conduct publishable research. So far out of 54 teams supported, 23 have published their research in peer-reviewed journals have been achieved.

Presentation 2: Participatory action research to improve the quality of assessments in the MMED training (Family medicine) at the University of Witwatersrand

OB Omole[1], D Pretorius[1], N Erumeda[1] M Torlutter[1], C Lion-Cachet[1], A George[2]

[1]Division of Family medicine, Department of Family medicine and primary care, University of the Witwatersrand, Johannesburg, South Africa. [2]Centre for Health Sciences Education, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa.

Background: Assessments conducted on our district-based MMED training in 2013 revealed poor standardization and supervision, perceptions of unfair assessments, and a low pass rate at the exit examination. A team consisting of the MMed coordinator, trainers and a health sciences education researcher utilized a participatory action research (PAR) methodology to better align the training to national outcomes, standardize it across districts, and develop a blended learning programme that incorporated an online resource platform. However, significant inter-trainer variability is still observed during academic and clinical assessments, warranting further intervention.

Aim: To improve the quality of clinical and academic assessments using video recordings and feedback to examiners.

Methods: As part of the ongoing design-based research project to improve the quality of training, videos on aspects of the clinical encounter will be recorded and used as assessment training tools for the trainers. Trainers will be asked to assess videos using standardized and validated tools during interactive training sessions. The PAR team will then evaluate the trainers' assessments and provide feedback in recorded sessions. A national panel of academic family physicians will then view the recordings, cross-validate the PAR team's assessment, and provide feedback while exploring the perception and competency of trainers to assess the multi-faceted elements of the clinical encounter. Focus groups will be used to explore the trainers' acceptability and utility of the assessment program.

Discussion: This project can potentially reduce the inter- and intra-trainer variability in assessments and promote the acceptability and utility of the process.

Presentation 3: Teaching for improving health outcomes at PHC level

Vincent Setlhare, University of Botswana

Improving health outcomes may be best achieved by paying attention to the initial interaction between doctor/healthcare worker and patient in a PHC clinic. We must pay attention to the consultation. This we do in both undergraduate and registrar/residency programs. However, we need to move from a theoretical teaching of the consultation to a pragmatic discussion of the consultation that addresses what we see in our health systems.

We should teach what a successful consultation looks like and what it is built on. A successful consultation is based on a good doctor patient relationship. It is built on

several factors such as student admission factors, patient related factors, doctor/health care worker related factors, PHC facility related factors, and health system related factors.

Medical student admission should ensure recruitment of students who are suitable to be trained as doctors. Psychometric measures and other criteria that address the needs of our communities should be used.

Patient related factors include queuing for many hours, their expectations, communication skills, and their social skills.

Doctor related factors include social skills, communication skills, clinical skills, and contextual congruency.

PHC facility factors include management of processes, clinic layout, equipment and medicine management, task shifting, information technology, and general management.

Health system factors include provision of adequate resources for health, provision of enough clinics, provision and maintenance of adequate equipment, medicines, and reagents, provision of adequate health education (health promotion, disease prevention, treatment, and rehabilitation).

Teaching the consultation should be realistic.

Presentation 4: Osteoarthritis management mixed onsite, virtual facilitation and clinical decision supportive training

Riaz Ratansi, Aga Khan University, Tanzania. Eric Aghan, Kamran Hameed, Nancy Matillya, Nadeem Kassam, Mwanaarab Sibuma

Tthe rationale for the initiative: In Tanzania and other sub Saharan countries, limited testing and surveillance capabilities makes it difficult to assess how widely COVID-19 pandemic has spread. This lack of clear pattern of spread has scared patients with chronic medical conditions such as osteoarthritis, chronic lower back pain, hypertension, diabetes etc. away from their routine care and follow up and so are not attending their appointments for fear of contracting COVID-19 at the hospitals. This fear compounds the already existing low thresh hold from the clinicians to suspect and identify patients with osteoarthritis. Poorly managed osteoarthritis leads to disability and low quality life. The family medicine department in conjunction with internal medicine department have undertaken to train primary care clinicians working at the over 20 Aga Khan Primary and Outreach centres spread out across Tanzania. The training involves a mix of small group and online sessions via Virtual Learning Environment (VLE) and the ZOOM platform to ensure that the Medical Officers working in these centres receive continuing training and supportive supervision. Diagnosis and management of rheumatologically conditions remain

immensely underdeveloped in Tanzania and East Africa in general. The number of rheumatologists and Primary care trained clinicians remain very low in this region. Thus to be able to reach the rural and less privileged communities the transmission of knowledge and skills to the lower cadre is of immense significance to enable task shifting and improved care.

The concept of a virtual classroom is relatively new and requires appropriate skills and in-depth understanding to ensure that the delivery of curriculum content meets the intent learning outcome. The relative lack of rheumatologists and the few family physicians requires escalation of efforts and establishment of short courses to patch up the knowledge gap in management of rheumatological conditions and pain management optimisation. In this course use of actual and simulated patients will provide adequate case mix for the trainees to acquire the anticipated skills and knowledge.

Presentation 5: Medical Assistant & Clinical officer training in Malawi: Primary health care under microscope?

John Kuyokwa, Malawi College of Health Sciences

The Malawi college of health sciences (MCHS) is an autonomous parastatal organization established through a government order of 21st June, 1996. MCHS was formed by a merger of the Lilongwe School of Health Sciences (LSHS) in Lilongwe, the Medical Assistants Training School (MATS) in Blantyre and Zomba School of Nursing (ZSN) in Zomba. The Lilongwe School of Health Sciences, School, was built in 1976. The school opened its doors on 12 July, 1976. Blantyre became operational in the 1960s. Present structure was built in 1996 The Zomba School of Nursing which opened in 1930 is the oldest institution. The current structure was built in 1990.

Mandated to train health workers that form a vital component of government plan to improve the health of the Malawians. It is the vision of the Malawi College of Health Sciences to be a leading and dynamic middle level health training institution in sub-Saharan Africa Intention of offering quality training to relevant, multidisciplinary, frontline mid-level health care professionals, conduct research and consultancies and engage in community outreach.

Lessons and innovations: Coordinated efforts -revamp the training and become relevant. We are still important for the ministry of health and Malawi. We have to explore new ways of offering our programs like online & block teaching. BSc programs- urgent. We need support from relevant stakeholders including MoH & KUHes. Meaningful collaborations- teaching, research & consultancy.

Presentation 6: Entrustable professional activities and workplace based assessment

Bob Mash, Stellenbosch University, South Africa

Postgraduate family medicine training in South Africa has developed a national set of learning outcomes, a national licencing examination and a nationally shared portfolio of learning for registrars in training. Currently the portfolio documents workplace based learning, which each university uses for their own internal assessments. A satisfactory portfolio is a requirement for entry to the national licencing examination.

Currently the portfolio contains a logbook of over 200 skills, which the registrar is meant to become competent in. The supervisor and registrar regularly grade competence to assess progress.

In future, the national licencing examination will include workplace-based assessment as the main approach to assessing competence and not just an entry requirement. This requires a more formal and reliable approach to assessing the portfolio. There is also the intention to introduce the new concept of approximately 40 entrustable professional activities instead of the skills list. These EPAs are currently being developed along with ideas on how workplace based assessment will develop in future.

Day 2: Abstracts for poster presentations

Poster 1: Community Oriented Primary Care (COPC) Training: A community-Based Model for Primary Healthcare (PHC) Training in Rural Western Kenya.

James A. Amisi[1], Dan N. Tran[2], Daria Szkwarko[3], James Kamadi[4], Simon Kisaka[5], Jeremiah Laktabai[1], Sonak Pastakia[6]

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Introduction: Since 2016, the Moi University Family Medicine Department (MUFMD) through stakeholder engagement, developed an Innovative COPC model with a rural community in Western Kenya consisting of approximately 15,000 people. The model, Bridging-Income-Generation with grouP-Integrated-Care BIGPIC-Jami,i delivers portable healthcare as well as economic enhancement activities aimed at addressing social determinants of health (SDOH). COPC is a core component in the training of PHC workers and Family Physicians. However, implementation of the COPC curriculum content faces many challenges. The health system as currently designed lacks Primary-care-Networks. Therefore, our MUFMD aims to meet the gap in COPC training with the model.

Aim: To describe the approach to COPC training using a community-based-care delivery model to address SDOH and comprehensive primary care delivery.

Innovation: A COPC site was established; the model was piloted and implemented in Bungoma County, western Kenya. This model delivers healthcare incorporating SDOH making it uniquely practical for the training of PHC workers and FM residents. The residents are trained on point of care ultrasound and electrocardiography. Faculty and students review patients together during clinical encounters. The residents also use the site for their comprehensive healthcare clinical cases and quality improvement projects. The Partnership has resulted in mutual benefit for the community and the trainees.

Lessons Learnt: The trainee: A trainer to other PHC trainees. The unique model has led to better Community engagement. Sustainability challenges: External funding.

Conclusion: COPC training of primary care providers is feasible using an innovative model like BIGPIC Jamii.

Poster 2: The off-site and External Rotations- Lessons learnt so far

Amos Mailosi MBBS; Charles Hassan MBBS; Anna McDonald MD, MPH; Jacob Nettleton MD

Family medicine is still a newly established department at Kamuzu University of Health Science(KUHeS) in Malawi. The program aims to produce doctors that are very competent to work in Malawi rural areas where they are needed most, while at the same time be relevant and able to compete at international and global level. Over the few years the curriculum has been changing; this is expected for a young and developing faculty. It is important to recommend the components of the curriculum that have proved to be useful and criticize the ones that need to be changed.

In this report we will discuss the lessons learnt from off-site and external rotations. Currently the faculty has a relationship with providence health; the senior registrars are required to have a 6-week rotation in Seattle, USA. All registrars that have graduated and the current senior registrars have gone through this rotation. Recently the faculty has formed a relationship with the family medicine faculties of other countries in the region. These countries include Zambia, South Africa(SA) and Kenya, just to mention a few. This year 2 registrars have had a 3-weeks rotation in SA. In 2021, Partners in Hope-Neno district became the off-site 4-weeks training place for health system management; now 6 registrars have gone through the Neno rotation.

While the offsite and external rotations are very important to the program there is a need to reflect on what is working and what could be maintained or discarded as we continue develop the specialty into the most relevant specialty in Malawi and the region.

Poster 3: Use of webinars to coordinate training of students

Jean-Pierre Fina Lubaki, Department of Family Medicine and Primary Heatlh Care, Protestant University of Congo, Kinshasa, Congo

Introduction: The Protestant University in Congo organises family medicine teaching in approved hospitals in several provinces of the Democratic Republic of Congo. Harmonising the teaching conditions and succeeding in constituting a homogeneous group has always been a challenge because the hospitals are in different contexts, and the involvement and quality of the mentors varied. The COVID-19 epidemic has

prompted the adoption of distance learning and an e-learning programme has been introduced.

Aim: To reduce differences in teaching family medicine concepts and modules between family medicine training sites in the Democratic Republic of Congo.

Innovation: Weekly webinar teaching of up to 5-6 hours in length supported by on-site supervision motivated by identified problems.

Success: Conducting distance learning in the context of the pandemic with the content of family medicine modules and the approach to common health issues. Supervision of data collection at the level of health facilities (health centres, hospitals, health district office) on health problems and management. Identification of learning issues. Ownership of the sessions by the residents. Sharing and discussing local health problems with broader audiences

Challenges: Creation of digital campuses at training sites. Internet connectivity.

Conclusion: The webinars overcame the restrictions of COVID-19 and beyond that, help on creating a homogeneous group. They are a channel to be perpetuated and developed in our training system.

Poster 4: Family medicine development in Sudan

Dr.Abdelhaleem Elmamoun Mohamed Taha, Sudan

Introduction: In Sudan, the specialty started in 2002 at the Sudan Medical Specialization Board (SMSB), and was called "General Practice". It was a 4-year MD at hospital training program. The training aimed to graduate health team leaders who practice at a rural hospital, rather than a personal family doctor this is similar to the models used in some other African countries including South Africa. In 2010 for the SMSB training program to be both PHC based and hospital based , the curriculum was updated to meet the standards of FAMILY MEDICINE international curricula .

Aim: The aim of this poster is to describe the development of family medicine in Sudan in a relatively short time and on an up to date educationally based curriculum.

Innovation: In 2010 the Gezira Family Medicine Project (GFMP) was initiated in Gezira state, Sudan, designed as an in-service training model. The project is a collaboration project between the University of Gezira, which aims to provide a 2-year MASTER`S program in family medicine for practicing doctors, and the Ministry of Health, which facilitates service provision and funds the training program.

Just after the start of the Gezira Family Medicine Project (GFMP). The staff of the GFMP were enrolled in the national family medicine board of the Sudan medical specialization board (SMSB) and participated in the curriculum refiguring workshop. The MD curriculum has been changed to be similar more or less to the European model (personal doctor), and the specialty is now called "FAMILY MEDICINE".

The preference of the (personal doctor) model in Sudan is attributed to the relatively big number of graduated doctors in Sudan compared with other African countries (Over 30 medical schools in Sudan) and the high number of health centers compared to the number of rural hospitals. Family physicians are also needed in cities to organize the health system and alleviate the work load on urban hospitals.

After switching to FAMILY MEDICINE (rather than GP) curriculum by SMSB the number of the annually enrolled training residents is in progressive increase .

Lessons learnt: Switching to FAMILY MEDICINE (rather than GP) curriculum by SMSB encouraged huge number of junior doctors to enroll in the training program and it also inspired many universities to adopt FAMILY MEDICINE master programs

Conclusions: In spite of its relatively short implementation period FAMILY MEDICE training program in Sudan graduated large numbers of competent, skillful and knowledgeable graduates from both Sudan medical specialization board (MD) and different universities (MSc).

Poster 5: Tech that facilitates communities of learning

Owen Eales, University of Pretoria, South Africa

Introduction: During 2020-2022 more than 800 medical students were taught the application of Family Medicine principles in PHC. The teaching happened in groups of approximately 80 using Zoom as an online platform for 5 days. This was followed up with practical work-based training in PHC clinics for 3 weeks.

Aim: Various platforms were tested to enhance students learning and engagement. To create communities of learning.

Innovation: A mixture of various digital platforms were used, some more traditional like Zoom and google drive, as well as some newer applications. Padlet, Mentimeter, Kahoot, Podcasts, video teaching, Tik Tok and Linktree were used.

Lessons learnt: Most medical students are tech savy and engage on technology platforms. Interactive Apps can facilitate engagement and enhance the learning process. Use of Synchronous technology tends to leave those behind with less Technology skills and infrastructure like stable internet connection and fast internet.

The use of Asynchronous technology (Not in real time) gives everyone an opportunity to engage.

Conclusion: The use of technology and applications to engage with students are valuable. Make sure you understand your students' tech capabilities before you expect them to engage.

Poster 6: Revision and restructuring of the Family Medicine training curriculum in Lesotho

Dr. Radiance Ogundipe, Dr. Jill Sanders, Dr. Sebaka Malope, Family Medicine Specialty Training Program, Lesotho Boston Health Alliance

Introduction: The Family Medicine training program under the aegis of the Lesotho Boston Health Alliance is the first and only accredited postgraduate medical training program in Lesotho. As part of the requisites for re-accreditation by the Lesotho Council of Higher Education (CHE), the training program had to revise and restructure the curriculum into a modular format in line with the specifications of the Lesotho Qualification Framework (LQF). This essential step is expected to help with the development of credit accumulation and transfer criteria that will facilitate vertical and horizontal articulation of training requisites in the country.

Background: The Family Medicine Specialty Training Program (FMSTP) commenced in January 2008. Candidates are recruited after completion of medical school and internship. The training is full-time through week-long contact sessions, supervised rotations, and supervised research. Presently the program has a faculty of three: Dr. Sebaka Malope a family physician and program director, Dr. Jill Sanders a pediatrician and HIV clinician, and Dr. Radiance Ogundipe a family physician.

Restructuring: The training curriculum was revised into Eight core Family Medicine modules with 480 total credits delivered over four years. In addition, the trainees undergo clinical rotations in Child Health, Women's Health, Adult Medicine, Surgery, Orthopedics, Anesthesia, Ophthalmology, ENT, and electives in any clinical rotation of their choice. In all, the training requires 262 credit hours.

Conclusion: We are hopeful that the restructuring and revision of our Family Medicine training curriculum in line with the Lesotho Qualification Framework will help to align the training program in Lesotho with the regional standards, paving the way for a mutually accreditable regional Family Medicine training program in Lesotho.

Poster 7: Exploring Zambia's readiness to integrate Family Physicians in its health Care system: Advocacy for Family Medicine and important milestones

Mpundu Makasa, Phillip Mubanga, Joseph Zulu, University of Zambia

The Human Resources for Health (HRH) crisis remains unresolved in Zambia. This is despite efforts to ensure an adequate Health Worker Force (HWF). This is partly due to inadequate institutional capacity, under-investment in human capital development, low HWF outputs and uncoordinated partnerships (1). In 2017, Zambia's Physicians, Nurses and Midwives per 1,000 population ratio was 1.2, compared to the prescribed World Health Organization (WHO) standard of 2.3 per 1,000 population, while the physician density is 0.16 physicians/1,000 population. The gap is greatest in rural areas, with 1.12 Health Care Workers per 1,000 people compared to 1.87 per 1,000, in urban areas (2).

Zambia is a signatory to several international protocols and agreements, such as the Abuja Declaration of 2001, to improve the health sector; the 2015 Sustainable Development Goals, the 2016 Global Strategy for Human Resources: Workforce 2030 and the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa (2009) for Health Systems strengthening. A HWF of adequate size and skills and fit for purpose is critical to the attainment of national and global health goals (3). Family Physicians are integral to Primary Health Care and well posed to contributing to attaining Universal Health Coverage (4,5).

With Zambia now prioritizing Family Medicine in the National Training Operational Plan, there is need to explore the Ministry's vision and readiness to integrate the specialists in the establishment. And as its first graduates are produced, there is need to reflect on the successes and challenges and to track its graduates.

Poster 8: Post Graduate Family Medicine Training in Zimbabwe

Edward Chagonda, University of Zimbabwe

Background: The need for post graduate training in Zimbabwe cannot be over-emphasized. As such two medical schools, have embarked on a four year post graduate Masters in Family Medicine training at their institutions.

Current Status: The National University of Science and Technology's Medical school began training of family medicine registrars three years ago and have two registrars who are in third year. This was followed by the University of Zimbabwe (UZ) a year later. The UZ has one registrar in the second year and four registrars in the first year of training. Both institutions have advertised for the 2023 academic year intake. The course consists of academic modules and clinical modules. The academic modules are delivered remotely via online learning. With regards to the clinical modules,

registrars train from their primary care institutions and use the various training facilities in the country. We have two qualified Family Medicine lecturers (local) and one external lecturer who are responsible for the programs at the two intuitions.

Challenges; (i) There is a huge attrition rate at both institutions and maybe attributable to the general economic state currently prevailing in Zimbabwe. (ii) There are no designated family medicine teaching facilities yet. (iii) There are too few lecturers and there is an urgent need to recruit new lecturers.

Way forward; There is need to address the above challenges and foster local , regional and international linkages so as to upscale post graduate Family Medicine training in Zimbabwe.

Poster 9: The Contribution of Family Medicine to the Health System in Somaliland

Mubarik Magan, Amoud University, Somaliland

Abdiqadir Omer Rabile, Mohamed Ahmed Abdillahi, Mohamoud Hashi Abdi, Rahma Ismail Yasin, Tim Fader.

Somaliland's first specialty training programme for physicians is a master's degree in Family Medicine that began at Amoud University in 2012. A survey of the 24 Family Medicine graduates working in Somaliland demonstrates their clinical and leadership impact on the health system and their contribution to higher education. The specialists directly contribute to the health and education priorities of the government of Somaliland.