Group A

5mins presentation and 2 minutes Q&A

Keshena Naidoo

Scaling up Postgrad Education for Family Medicine at SMU, SA

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INTRODUCTION

There is a concern that focusing only on undergraduate training and ignoring postgraduate education was unsuitable for the South African higher education system This strong connection between the two means that focus on one without consideration of the other could lead to ineffectiveness [1].

Research studies highlighted some of the challenges that delay registrars in developing and completing their research studies [2,3]. For example:

- Inadequate learner-centered research education strategies that can better develop research competence [1,2,3].

SMU Family Medicine registrars are also experiencing the same challenges

INTERVENTION

Three pillars encapsulate Academic Experience at SMU are:

- Learning and teaching
- **Research**
- Community Engagement

At SMU Family Medicine department we adopted the ff to improve **research output:**

- Compulsory online training and assessment for the first-year registrars on research methodology (REME).
- Compulsory rotation of first year registrars at a nearby research centre (MRC).
- Engaging with our provincial health office to support and approve dedicated research time.

DISCUSSION

- All first-year registrars developed their research protocol within three months of their registration with the university.
- At the end of their rotation at the research centre, registrars are ready to write up their COPC assignment.

CONCLUSION

- There is also a need to look at and improve the supervisors' expertise in guiding their registrars with the research process.
- Over and above improving the research output, we are also improving the registrars academic experience and further increasing the registrar posts in our region (Tshwane district of SA).

REFERENCES

1. Saidi A, Promoting access to, and success in postgraduate education in South Africa: A synthesis of emerging issues. South African Journal of Higher Education. Vol 38 | Number 1 | March 2024 | pages 1–27. https://dx.doi.org/10.20853/38-1-6304
2. Louw E, Mash RJ. Registrars' experience in Family medicine training programs in South Africa. S Afr Fam Pract (2004). 2024 Apr 10;66(10:5907
3. Moxley K. The development of research competence among specialist registrars in South Africa: Challenges and opportunities for research education and capacity development. AJHPE. June 2022, Vol 14, No 2

THE AGA KHAN UNIVERSITY

Accreditation Council for Graduate Medical Education (ACGME)

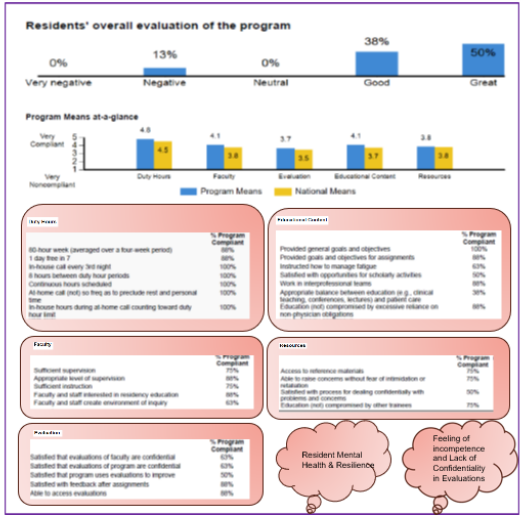
A Strategy to Scale Up Post Graduate Training in Family Medicine at AKU

Dr Jacob Shabani, Prof Gulnaz Mohamoud, Dr Norah Obungu, Dr Elizabeth Chege

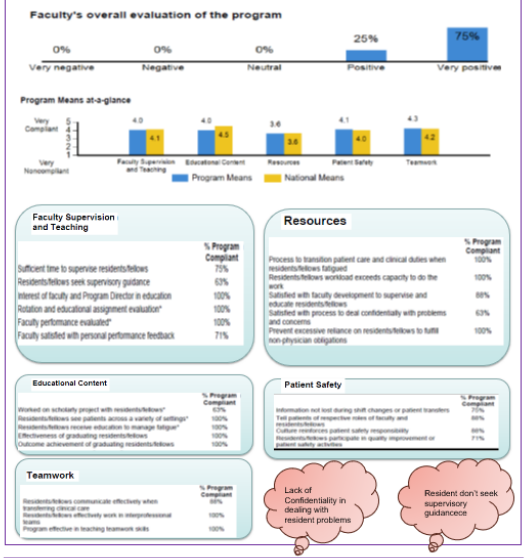
ACGME- I - An Introducution

- ACGME-I accredited residency programs in Family Medicine prepare residents to provide comprehensive primary care to diverse individuals and families within the context of a personal doctor-patient relationship.
- ACGME-I accredited programs educate residents to provide care throughout life and to appreciate the individual, family, and community connection to health.

Resident Assessment of the Program



Faculty Assessment of the Program



Clinical Competency Committee and Program Evaluation Committees

- CEC – Meets twice a year and helps to develop individual learning plans. Led by faculty who are non-departmental. Advisory to program director
- PEC - evaluates the program quality annually.

What have we done

Threats to Resident Health	Interventions
Feelings of incompetence	• Early and regular check-ins by chief residents, program directors, and /or mentors. • Early, frequent, and skilled feedback by senior residents and supervising faculty. • Reminders to residents that they are not expected to know everything at the start of training; that they are there to learn, and their knowledge, skills, and confidence will grow over time. • Start continuity clinics from 1 year and follow up the same patient in the 4-year journey
Isolation	• Social gatherings • Team-building exercises
Stigma and reluctance to use mental health services and resident support	• Early communication about how to access mental health resources and encouragement to use these resources. • Opt-out mental health appointments • Teaching faculty, residents, and staff basic principles of psychological first aid and ensure that all know how mental health resources are accessed
Mistreatment , bias and lack of confidentiality	• Anonymous reporting system for reporting inappropriate behavior by residents, faculty, or staff. (Safe disclosure) • Training of faculty residents, and staff on implicit bias and microaggressions. • Out of station psychological assessments
Burn-Out	• Incorporation of the Maslach Burn Out Inventory periodically during resident assessments and health seeking opportunities. • Adoption of the 'Milestones' Assessment that individualize resident progress and support

OUTCOMES

- No resident attrition in the first year
- Career progression certainty and Options – Enhances Retention
- In the Last two years we have had graduating classes that are at full complement.

MODULAR FAMILY MEDICINE PROGRAMME IN GHANA

Prof Henry Lawson, Ghana.

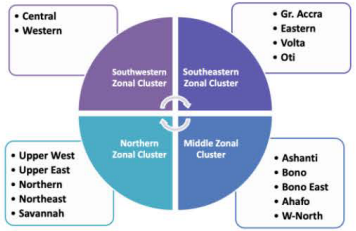
Introduction

Family Medicine training in Ghana is a 5-year programme divided into a 3-year Membership and a 2-year Fellowship programme. Applicants must undergo a selection interview after passing an entrance examination popularly called Primaries. Upon selection, the applicant is assigned a Training Centre. IN Ghana, there are currently 7 training centre – Korle Bu Teaching Hospital, Komfo Anokye Teaching Hospital, Cape Coast Teaching Hospital, Ho Teaching Hospital, Greater Accra Regional Hospital, St. Dominics Catholic Hospital, KNUST Hospital and Nyaho Medical Centre (a private medical facility). The selected resident re-locates from their institution of work to be close to the training centre for training to occur. This process disenfranchises a lot of medical practitioners who are sole doctors in district health facilities or are owners of private health facilities who would like to undergo postgraduate training in Family Medicine.

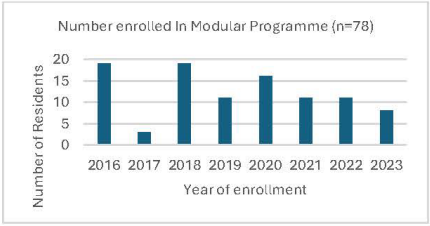
The Faculty of Family Medicine of the Ghana College of Physicians and Surgeons designed the Modular Family Medicine Training programme to improve the opportunity of doctors in the categories described above to enroll in training. Secondly, the faculty needed to improve on the number of family physicians being churned out at the College and this strategy was seen as a tool to expand the number of graduands.

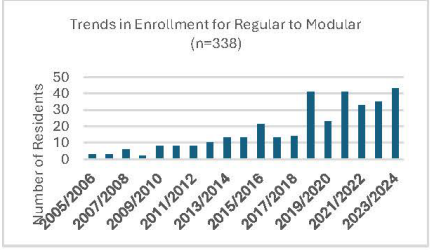
Year	Regular Programme	Modular Programme	Modules
Year 1	Rotations in Clinical Disciplines	Modules 1-4/ plus Rotations in Clinical Disciplines	Module 1 – Principles Of Family Medicine Module 2 – Adult Medicine Module 3 – Women's Health Module 4 – Pharmacology Of Prescriptions Drugs
Year 2	Rotations in Clinical Disciplines	Modules 5-8 plus Rotations in Clinical Disciplines	Module 5 – Adolescent and Child Health Module 6 – Mental Health Module 7 – General Surgery & Anaesthesia Module 8 – Surgical Specials
Year 3	Rotations in Clinical Disciplines	Modules 9-12 plus Rotations in Clinical Disciplines	Module 9 – Diagnostics (Laboratory Medicine) Module10 – Orthopaedics, Accidents and Emergencies Module 11 – Diagnostics (Radiology & Oncology) Module 12 – Community-Oriented Primary Care
Year 4	-	Modules 13 & 14 plus Rotations in Clinical Disciplines	Module 13 – Special Interest Areas Module 14 – Medical Jurisprudence, Ethics, Quality, Health Administration & Management

Each module is a 5-day in-person session from Monday to Friday. The first session of Day 1, apart from the first module, is used for the Module Assessment of the previous completed module lectures. Lectures are held centrally at the Ghana College of Physicians and Surgeons. However, since 2021, some virtual lectures have been included for convenience of both lecturers and residents. There are 11 weeks between module lectures which are used to complete clinical rotations. The clinical rotations are conducted in facilities which have been accredited by the faculty in the clusters where the residents are based. Each resident designs their rotations for up to 3 days per week so that they continue to provide services to their primary medical facilities. This allows service delivery to continue whole the resident is training. Supervising teams from the College visit the residents in the various clusters across the country on schedule and sometimes at random. These centers are separate from the 7 training centers listed above.

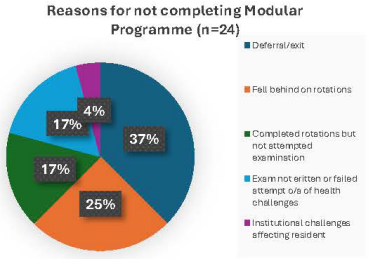


Enrollment





Outcomes



Discussion/Conclusion

A total of 369 residents have been enrolled in the Family Medicine membership training programme since the inception of the College in 2003. Of these residents, 264 were enrolled between 2016 and 2024. The Modular programme enrolled 98(37%) residents. Modular residents have contributed 49 (21%) of the 233 graduating membership residents of the Ghana College of Physicians and Surgeons from 2016 to 2024. This data confirms the crucial role modular training has contributed to training of Family Medicine residents in Ghana. The mode of delivery of 5-day in-person lectures for the 14 modules is very attractive and there have been suggestions from residents enrolled in the regular programme who covet this method. Non-Family Medicine trainers are recruited to support the programme. The programme design allows trainees/residents to continue to provide service to their parent institutions. This creates a win-win situation for patients, hospitals and residents alike. The overall enrolment of residents for family medicine training in the GCPS have also appreciated over the 7-year period. These gains have however not been chalked without challenges. Of the enrolled modular residents, 9 have deferred or exited the programme, 6 fell behind on their rotations, 4 completed rotations but have not attempted the examinations, another 4 have withdrawn for health reasons and 1 resident withdrew due to challenges with his parent healthcare facility. There have also been logistic challenges to support supervision of clusters and zones. There are also challenges with residents completing their rotations within their clusters because they may have to move to other clusters for specific training.

Family Medicine Postgraduate Education at UNZA - strategies & Innovations

Mpundu Makasa[1], Phillip Mubanga[2]

1 University of Zambia, 2 Lusaka Adventist Hospital

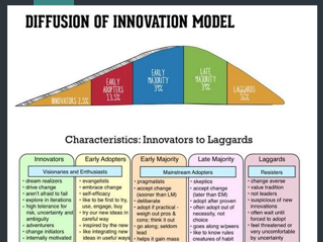
Introduction

University of Zambia has been running a Family Medicine (FM) postgraduate program for five year

In line with the WHO building blocks for systems health strengthening – human resource is one of the important elements for ensuring quality healthcare provision

FM well aligns to Ministry of Health's vision is to provide equitable access to cost-effective quality healthcare as close to the families as possible

PHC is the vehicle to achieve this vision. The overall goal is to provide UHC to all & leaving no one behind



Phase 1

UNZA recognized the unique role that family physicians could play at PHC level

To respond to the needs of the country, UNZA introduced a graduate program In the early 1990s, leading to the enrolment of the first cohort

The aim was to train Primary Health Care Physicians and impart both clinical and management skills

Envisioned that these would work in the periphery of the health care system

This initial attempt was brief

Phase 2

In 2012/13, UNZA revisited the idea of training Family Physicians

In response to the growing population and increasing disease burden

Coupled with the shortage of human resources for health, and the PHC being worse affected

The development of the program took up to 5 years

Included extensive advocacy work leading to buy in of key stakeholders i.e. MoH

Evidenced by the inclusion of FM in the National

Challenges

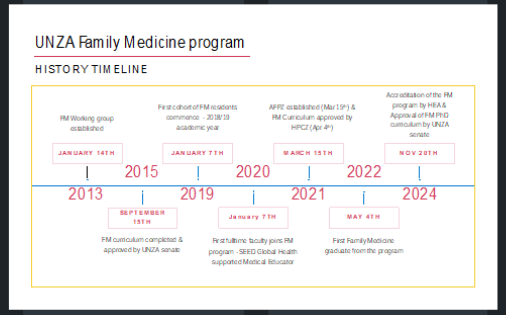
In the initial phase the specialty was not yet recognized by MoH

Career aspects were unclear under the MoH the main employer

The uncertainty in career progression, led to attrition and subsequently the collapse of the program

There were also no linkages with the international programs of family medicine

Main challenges in phase 2 have been inadequate number of educators to meet the demand for the program



Strategies & Innovations

Partnership – Seed Global Health – support of Educators, vison to wean off, RICE project – student scholarships –Master & PhD– helped boost numbers of registrars at inception

Primafamed network - Strong support system, mentorship, training from developmental stage to date

MoH - Partnering with MoH consultants – Payment of honorarium with support from partners

Faculty development –5/6 graduates now parttime faculty, advocating for full time positions, involved in grant applications for funding for program & PhDs – to ensure sustainability

Way forward

Strengthen the faculty development – formal fellowship to ensure sustainability
active involvement of registrars in various leadership roles – coordination, chief resident

Identify strengths of registrars and new graduates and develop them with view of strengthening the program

Collaborate regionally/internationally and active involvement in ECSACFP to learn best practices and foster growth

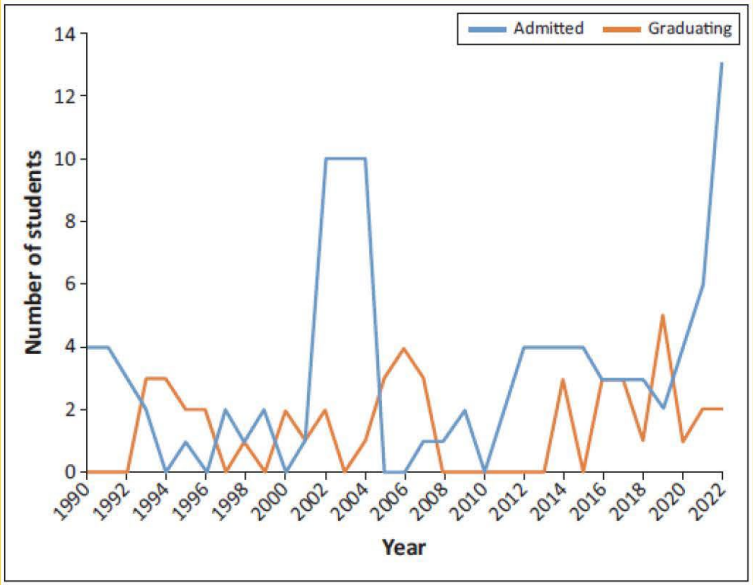
Resource mobilization

Introduction of undergraduate family medicine for scaling up postgraduate training

Context: Since the 1960s, family medicine has been steadily developing in sub–Saharan Africa. In Uganda, family medicine training was introduced at Makerere University in 1989 & later Mbarara University of Science and Technology in 1996. These postgraduate programs were started in absence of family medicine in undergraduate curricula. As a result, medical students would graduate as medical doctors without any exposure to family medicine. This made family medicine largely unknown among medical doctors who are the potential trainees.

What was done?

In 2011, Makerere University College of Health Sciences undertook a major curriculum review for the Bachelor of Medicine and Bachelor of Surgery program. This created an opportunity for making a case for inclusion of family medicine in the undergraduate curriculum. Faculty in the department of family medicine at Makerere University developed and presented a case for family medicine to the School of Medicine curriculum development and review committee. Family medicine was then included as an 8-week clinical course in the 4th year of study



Lessons learnt

Family medicine is now known among medical students and health professionals. This has resulted in the number of family medicine postgraduate applicants to increase steadily since the introduction of family medicine in the undergraduate program

Conclusion: The scaling up of family medicine postgraduate training is closely related to the presence of family medicine in the undergraduate curriculum

Authors: Innocent K. Besigye and Namatovu Jane, Department of Family Medicine, School of Medicine, Makerere University Kampala Uganda

INNOVATIONS TO INCREASE RECRUITMENT: FAMILY MEDICINE ADVOCACY TALKS AT DISTRICT HOSPITALS IN MALAWI

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3. Senior Clinical lecturer, School of Medicine and Oral Health, Kamuzu University of Health Sciences.

INTRODUCTION

- Kamuzu university of health sciences (KUHeS) introduced the Family medicine (FM) postgraduate training in 2015
- However, enrolment was low due to novelty of specialty in Malawi
- The department put recruitment efforts into action
- Coordinated efforts of faculty, registrars and partners to introduce FM advocacy talks

APPROACH TAKEN

Advocacy talks: Online and in-person

Lead persons
- Senior registrars
- Faculty

Focus areas
- What is FM?
- Impact in Sub Saharan Africa?
- FM in Malawi
- Postgraduate training and opportunities
- Q&A, Interactions

Focus Population
- Medical officers at district hospitals
- Interns at central Hospital

Fig1: Online advert for FM advocacy talk


Fig2: Advocacy talks; Phalombe District Hospital


Fig 3: Advocacy talks; Balaka District Hospital


Fig 4: Advocacy talks; Zomba Central Hospital


Fig 5: Some registrars motivated by advocacy talks

RESULTS

- Attendance beyond the target population
- District Leadership interested to be FM training sites, "we need FM program at our hospital" said the DMO of Kasungu district.
- New trainees indicate advocacy talks influenced decision to join the FM residency

CONCLUSION

- Involving registrars creates a friendly platform for interaction
- Targeted advocacy talks improves recruitment of trainees

Acknowledgements

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Scaling Registrar Success Through Co-Creation: Faculty-Registrar Partnership in Curriculum Design

Division of Family Medicine, Department of Family, Community and Emergency Care (FaCE), University of Cape Town

Background

The University of Cape Town's Family Medicine training programme traditionally relied on **registrar-led biweekly contact sessions and site visits**. These sessions aimed to integrate theoretical knowledge with practical skills, using journal clubs, clinical care discussions, pharmacology, and formative assessments. However, variability in presentation quality and evolving registrar needs prompted a shift.

A culture of feedback and registrar agency laid the foundation for a **co-creation strategy**, enabling curriculum revisions that better aligned with **real-world practice** and **examination preparation**.

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FACULTY OF HEALTH SCIENCES

FaCE
Department of Family, Community and Emergency Care

Innovation

Co-Creation Strategy Highlights

- **Collaborative academic planning:** Registrars co-develop academic schedules, select topics, and invite guest lecturers.
- **Integrated exam preparation:** Includes registrar-led study groups, mock consultations, and peer teaching.
- **Competency-based design:** Aligned with Entrustable Professional Activities (EPAs).
- **Dynamic feedback loops:** Continuous adaptation based on registrar input.

Impact

Survey: 10 responses from a total of 16 registrars

- Increased **registrar ownership, engagement, and satisfaction**.
- Improved **retention, throughput, and exam success**.
- Fostered a **sense of belonging and identity** within the **family medicine community**.

Registrar Voices

"The academic day reminds me why I'm doing this —it makes me feel part of a team."
"I benefit from my colleagues' perspectives —they challenge the structure in meaningful ways."
"Learning to speak up and take charge of my learning."

PRIMAFAMED
Primary Care and Family Medicine Network for sub-Saharan Africa

Lusaka, Zambia: 24 – 25 June 2025

Reflection and sharing

Scalability Enablers

- Low-cost, high-engagement model.
- Minimal structural change required.
- Adaptable across institutions and specialities.
- Builds a culture of academic ownership and responsibility.

Challenges

- Time management and session pacing.
- Need for more structure in EBM sessions.

Lessons Learned

- **Co-creation empowers** registrars and enhances learning.
- **Adult learning models** foster deeper engagement.
- **Feedback-driven design** ensures relevance and responsiveness.

Take-Home Message

Empowering registrars through **co-creation** is a **scalable strategy** that enhances learning, strengthens academic identity, and supports the **development of competent, confident family physicians**.

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