Walter Sisulu University

PROFESSORIAL INAUGURAL LECTURE

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Topic: Towards Medical Education that is Responsive to Community Needs, while Recognising Community Assets and Capabilities

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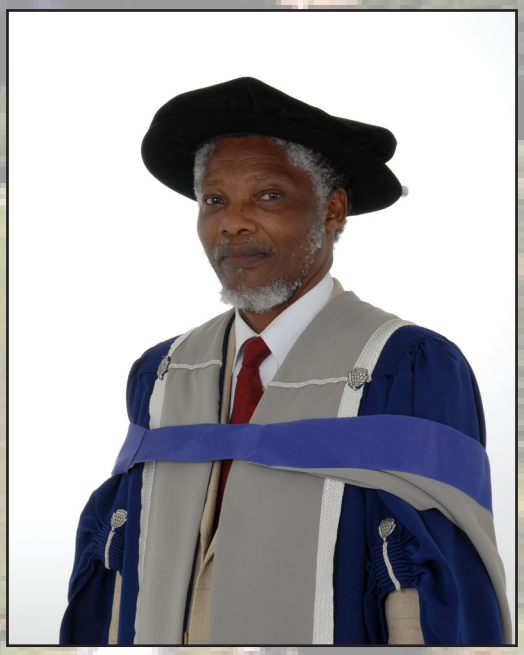

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WALTER SISULU UNIVERSITY
PROFESSOR OF FAMILY MEDICINE
FACULTY OF HEALTH SCIENCES

TOPIC
TOWARDS MEDICAL EDUCATION THAT IS RESPONSIVE TO COMMUNITY NEEDS, WHILE RECOGNISING COMMUNITY ASSETS AND CAPABILITIES

BY
K MFENYANA

DATE: 07 OCTOBER 2010

VENUE: WSU AUDITORIUM

1. WHO AM I?

I am an African, a Black South African born in a Rural Village in the former Transkei called Lady Frere. This is in the Eastern Cape Province of South Africa, the second largest, one of the most poor and one of the most rural. I went to a rural school next to my home up to Standard 6, and then left home to study in a more modern high school called Lovedale, next to the University of Fort Hare but still in the Eastern Cape, from 1958 to 1962. I then studied at Fort Hare from 1965 (after two years of non-schooling) and completed a Teachers Diploma and a 1st Bachelor's Degree (B Sc), before proceeding to do Medicine at the University of Natal, Black Section, in 1971. My studies were interrupted by a year of teaching in Cofimvaba, still in the former Transkei in 1967, before completing the B Sc Degree in 1970. After completing medicine in 1977, I worked at Mthatha General Hospital, then at Mount Frere, Cala and the Medical University of Southern Africa (Medunsa) in Pretoria, before coming back to Mthatha, this time to be part of the Faculty of Health Sciences at the then University of Transkei, now Walter Sisulu University, in 1989. All the places I have worked in are rural or serving mainly rural populations including Medunsa and Walter Sisulu University (WSU). Most people in the rural settings happen to be Black South Africans. Walter Sisulu University is about 220 Kilometres from the rural village from where I was born.

I failed Matric (Standard 10) at Lovedale in 1962. The main reason is that Afrikaans was introduced at this school and some of us were forced to do it as one of the major languages. The year 1962 was a very difficult year for some of us and it was punctuated by strikes all the year round because of Afrikaans. I was sitting at home in 1963&1964 and was lucky to be at University in 1965. The year 1967 was a very good year for me when I was a high school teacher. I learnt a lot about life and decided to go back to school. The years 1968 to 1970 sharpened my interest to further education, and as a result I went for medicine in 1971. I was a mature student by then and I have good and bad memories about the educational exposure at this university during my 6 Years of study.

When I completed my medical studies in 1977, I did internship at Mthatha General Hospital. I loved each and every discipline I went through and at the end I was not able to choose an area of specialization, although I wanted to specialise. Also, when I moved from one discipline to another, I did not stop practicing what I learnt from previous disciplines, despite resistance from my colleagues and nurses. I was a nuisance, creating more work for my colleagues and nurses, instead of referring patients to where they "belong". My confusion was cleared in 1980 by Prof Sam Fehrsen, who was busy recruiting doctors from the Eastern Cape, especially Mthatha, to become Family Physicians. At that time I knew nothing about Family Medicine, but when he explained what a Family Physician does, it became clear in my mind that Family Medicine is the specialty for me. I may just add, to some disappointment from one of my fellow country men, one of the few educated persons in my village who is not a doctor, who thought, after I explained to him what Family Physicians do, that Family Physicians are not real specialists. I understood him very well. You see, a Family Physician is a relatively new medical specialty that is different from others in a big way. It is a specialty in breadth which is very unusual. I then enrolled for the Masters Degree in Family Medicine at Medunsa under Prof Fehrsen and completed my studies in 1984. Prof Fehrsen did not end there but persuaded me to join Medunsa as a teacher on a part-time basis until I joined full-time as a Senior Lecturer from 1987 to 1988. His mentoring did a lot to

me and as a result, I was recruited by Prof Dan Ncayiyana, who was the Acting Dean of the Faculty of Health Sciences at the then University of Transkei (now Walter Sisulu University), to take up the post of Full Professor and Head of Department of Family Medicine from 1989 till I formally relinquished the position at the end of 2007, to be Executive Dean of the Faculty of Health Sciences at Walter Sisulu University (WSU) as from January 2008. While Prof Fehrsen to me is the Father of Family Medicine in South Africa, Prof Ncayiyana is the Father of Problem-Based Learning and Community-Based Education at Walter Sisulu University. These two gentlemen are my mentors. These two gentlemen have contributed to what I am today in the field of Family Medicine and Medical Education. The late Prof Harris Kakaza, who took over Deanship from Prof Ncayiyana, further allowed me to pursue my interests in Medical Education and Education in general and this led to my W.K. Kellogg Fellowship that enabled me to spend some time in an educational environment at Michigan State University from 1994 to 1996. I ended up with a Masters in Educational Administration after completing the whole course work towards a PhD in Educational Administration, because I had to come back home without doing the dissertation. Subsequently, I enrolled for a PhD Degree under the University of Natal, now University of KwaZulu-Natal, again completed the whole coursework on Service- Learning but could not have time for my dissertation. I still need time to complete this work, even after my retirement, because it is close to my heart. I was awarded a Fellowship of the College of Family Physicians (FCFP) by peer review by the Colleges of Medicine of South Africa in 2009. My home, family and friends, my rural background and my educational exposure have all contributed to what I am today. I have been a full professor for the past 21 years and in a way, this inaugural is long overdue. On the other hand, I am very happy to be giving it at this time of my development. I am now able to look back and see where I am coming from and where I am going. My reflections will attempt to show my journey towards assisting not just in the production of doctors but in the production of doctors and other health professionals that are responsive to health needs of the community. Further, my hope is also to share my thoughts on what still needs to be done.

2. INTRODUCTION

Medical education today is under severe tension between “maintenance of standards” and “relevance to the needs of the population served”. A standard is a level of excellence and conventional schools tend to separate “standards” from “relevance” whereas innovative schools do not. This battle has been going on for sometime and in many places including South Africa. de Klerk (1979) warns that South African doctors should not allow the medical standards they have set for themselves to deteriorate because of the pragmatic problems encountered in attempting to attain the primary health care ideal. Daubenton (1990), on the other hand, states that one is excellent only if one is relevant. According to Daubenton, medical education can only be considered excellent if it is responsive and relevant to local needs.

3. STATEMENT OF THE PROBLEM

According to a community survey that was conducted by Stats SA in February 2007, South Africa had an estimated population of over 48.5 million, of which 79.6% were Africans, 9.1% White, 8.9% Coloured and 2.5% Indian. The population is either urban or rural and the majority of the rural population is African. Although classified as a middle income country with an estimated GDP per capita of US $5659.74 in 2006 and spending

8.7% of GDP on health care, South Africa has major disparities and inequalities largely resulting from the previous policies which ensured racial, gender as well as regional disparities. South Africa is therefore referred to as both a first and a third world country. A large population of South Africa, especially the Africans and the rural communities, still has inadequate access to basic services including health, clean water, and basic sanitation. "Further, the proportion of people who live in poverty is high and so is the unemployment rate. About fifteen (15) years ago, seventy five percent (75%) of the poor were reported to be living in the rural areas as compared to 53% of the general population (Department of Health, June 1995, p. 1). This percentage was reported to have shifted to 65% in 2004 due to urban migration (www.sarpn.org.za). Is this not because the rural areas are neglected?

A Community Health Assessment for Mthatha Health District was conducted in 1998. This was a huge community survey that I conducted with my colleagues on behalf of this University and the Department of Family Medicine, in partnership with the Department of Health (the then Mthatha Health District that consisted of Mthatha and Ngcobo) as the Service Provider and the Community. The sample size was 4293 households of which 2637 were from the 34 Mthatha Administrative Areas and 1656 households were from the Ngcobo 64 Administrative Areas. We did the study with 70 volunteers of which 40 were from Mthatha and 30 from Ngcobo. The data analysis took a bit of time to be initiated until we were assisted by the University College London in 2002. The data analysis was finally completed in 2004 and a research article from this was published in 2006 (Mfenyana et al 2006). This study did show us the extent to which the rural and underserved were lagging behind in terms of basic needs and services, especially in this part of South Africa. This study also convinced me even more about the importance of assessing the health needs of people that are being served, in partnership with the people themselves.

Table 1: Health Statistics derived from Stats SA 1996 for all the provinces of South Africa and the average for South Africa, also Compared with a Community Health Assessment for Mthatha Health District in 1998.

	Mthatha	EC	FS	GP	KZN	LP	MP	NC	NW	WC	ZA
1	36.7	53.5	94.0	96.0	66.3	-	82.2	91.2	81.4	96.8	79.8
2	18.6	23.2	42.0	79.9	45.8	19.5	35.6	52.4	33.8	76.5	47.1
3	44-0	29.1	8.8	2.5	15.2	21.1	8.7	10.7	6.3	5.4	12.4

1 = % of households with access to piped water
2. = % of households using electricity for cooking
3 = % of households with no toilets

Mthatha = Community Health Assessment for Mthatha Health District
(This consisted of Mthatha & Ngcobo at that time)
EC = Eastern Cape; FS = Free State, GP = Gauteng; KZN = KwaZulu-Natal; LP = Limpopo; MP = Mpumalanga; NC = Northern Cape; NW = North West; WC = Western Cape; ZA = South Africa

The above table 1 shows huge disparities in health statistics form stats SA 1996, with the Eastern Cape and Limpopo Provinces on one side of the scale, and Western Cape and Gauteng on the one side. The percentage of households with access to piped water in the Eastern Cape is 53.5 (no available statistics for Mpumalanga), the percentage of households using electricity for cooking is 23.2 in the Eastern Cape and 19.5 in Limpopo and the percentage of households with no toilets in the Eastern Cape is 29.1 and 21.1 in Limpopo. This table further reflects huge disparities between the Eastern Cape as a province and Mthatha as a Health District within this province. Mthatha is in the former Transkei Homeland and the main campus of Walter Sisulu University is in Mthatha.

Table 2: Health Statistics derived from Stats SA Community Survey 2007

	EC	FS	GP	KZN	LP	MP	NC	NW	WC	ZA
1	70.8	97.3	97.9	79.3	83.6	91.1	94.4	89.9	98.9	88.7
2	45.3	75.2	81.3	61.0	41.3	55.7	77.2	65.8	88.8	66.4
3	23.5	3.2	1.6	10.4	12.4	8.0	6.9	5.8	3.8	8.3
4	60.3	56.0	35.3	60.0	36.2	50.8	33.4	42.6	25.3	46.1
5	17.9	22.3	22.5	26.1	12.3	21.8	11.6	20.6	9.0	18.6
6	29.4	31.6	30.6	38.7	20.4	34.6	16.6	30.7	15.3	29.4
7	47.6	32.8	20.8	39.3	47.1	37.2	24.3	38.0	16.7	33.4
8	50.0	38.1	36.3	45.8	57.0	41.9	39.4	46.1	22.9	41.2
9	61.2	24.2	2.8	54.0	86.7	58.7	17.3	58.2	9.6	42.5
10	2183	1722	12246	5707	1196	1149	432	962	7288	34324
11	13.5	5.7	21.5	21.2	10.8	7.5	2.2	6.7	10.9	100
12	6.5m	2.8m	10.5m	10.3m	5.2m	3.6m	1.1m	3.3m	5.3m	48.6m
13	0.3	0.6	1.2	0.6	0.2	0.3	0.3	0.3	1.4	0.7
14	1/3333	1/1666	1/833	1/1666	1/5000	1/3333	1/3333	1/3333	1/714	1/1428

1 = % of households with access to piped water

2. = % of households using electricity for cooking

3 = % of households with no toilets

4 = Infant Mortality Rate (Deaths under 1 year per 1000 live births)

5 = HIV Prevalence – Age 15-49

6 = HIV Prevalence – Antenatal

7 = Poverty Prevalence – 2001 census indicators (Proportion of people/households living in poverty)

8 = Unemployment Rate in 2004 - expanded definition (The official definition of the unemployed is that they are those people within the economically active population who:

a) did not work during the 7 days prior to the interview,

b) want to work and are available to work within a week of the interview, and

c) have taken active steps to look for work or to start some form of self-employment in the 4 weeks prior to the interview.

Note that the expanded definition excludes criterion (c).

9 = % living in rural areas in 2003 (Rural areas include commercial farms, small settlements, rural villages and other areas which are further away from towns and cities).

10 = Number of registered medical practitioners with HPCSA

11 = % Population by Province

12 = Total Population by Province

13 = Number of registered medical practitioners/1000 population

14 = Doctor/Patient Ratio

Table 2 further shows the persistent disparities in 2007 with Eastern Cape still at the receiving end in terms of access to piped water, electricity for cooking and toilet facilities.. This table further shows a challenging picture for the Eastern Cape regarding Infant Mortality Rate, Poverty Prevalence and Unemployment Rate. The Doctor/Patient Rate shows huge disparities between the Eastern Cape, Limpopo, Mpumalanga and North West on one side and Gauteng and Western Cape on the other side. The percentage of the population living in rural areas is high in the Eastern Cape and Limpopo. On the whole, it is therefore clear from the above statistics that the most affected provinces are those that are mostly rural. It is therefore clear that there is a great need to produce not just more doctors in South Africa but doctors who will be committed to improve the health status of the community, especially the rural and underserved.

The training of physicians in South Africa is still conducted mainly in tertiary care centres that are attached to universities with schools of medicine, and these centres happen to be situated mainly in metropolitan areas. A tertiary care centre is a hospital with specialist care services and thus provides expertise in complicated and fascinating but not necessarily common medical conditions, including heart transplants. These tertiary care centres, therefore, have facilities that are not available elsewhere in the country, and certainly not available in areas where most students are supposed to practice after graduation. Very little time is spent on training of physicians in primary health care and therefore in primary health care settings, although the majority of the population of South Africa needs primary health care as it is in most parts of the world. Primary health care settings include the home, the community, clinics, community health centres, old age homes hospices and district hospitals. Figure 1 below shows that out of a thousand (1000) adults, seven hundred and fifty (750) report an illness, two hundred and fifty (250) consult a doctor, nine (9) are admitted in a general hospital and only one (1) is admitted in a tertiary hospital, in a normal working referral system with adequate facilities and appropriate personnel (White et al, 1961).

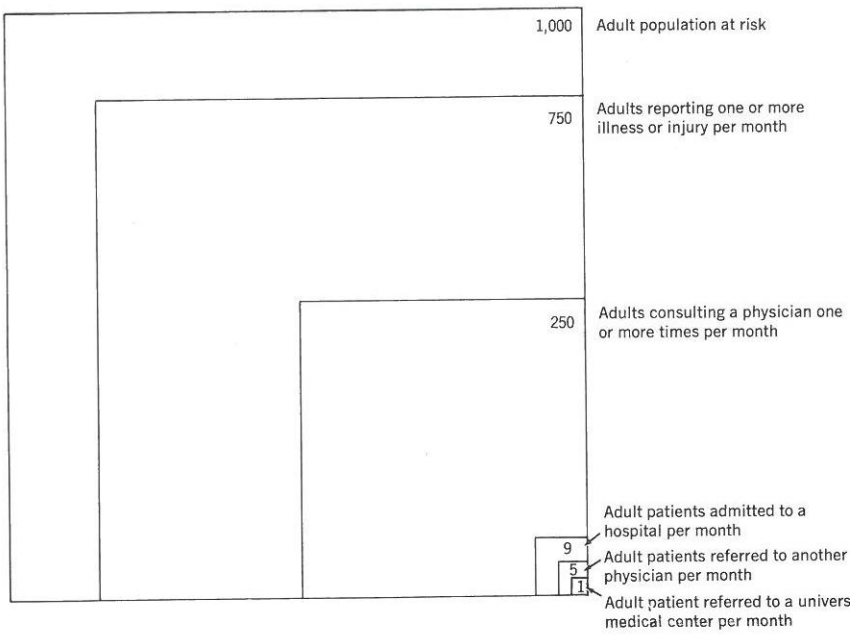

Figure 1: Prevalence of illness among 1000 adults in the United States and Great Britain (White et al, 1961).

This scenario was revisited by Green et al in 2001 with a similar result. A study conducted in Mthatha by the Department of Family Medicine of which I was part, together with the University College London in 2001 and 2002, was to determine the spectrum of clinical problems encountered at a clinic, community health centre and a district hospital in order to make sure that what we teach is appropriate for the community we serve. This study was published in 2010 (Brueton et al, 2010) and will now show in the first Chapter of the 3rd Edition of the Handbook of Family Medicine, edited by Bob Mash (see table 3 below).

Table 3: The 10 most common diagnoses by site in Mthatha, South Africa

Rank	ICPC Code	Frequency (Total)	%	Clinic (Total)	%	Health Centre (Total)	%	Hospital (Total)	%	Diagnoses
1	A98	383	12.60	18	6.64	309	18.23	56	5.21	Health maintenance and prevention
2	K86	221	7.27	8	2.95	166	.79	47	4.38	Hypertension
3	S72	176	5.79	43	5.87	117	6.90	16	1.49	Scabies and other acariases
4	R74	158	5.20	1	0.37	58	3.42	99	9.22	URTI acute
5	R80	156	5.13	62	22.88	90	5.31	4	0.37	Influenza
6	R83	118	3.88	1	0.37	78	4.60	39	3.63	Resp. infection other
7	N88	110	3.62	5	1.85	69	4.07	36	3.35	Epilepsy
8	A70	95	3.13	2	0.74	23	1.36	70	6.52	TB
9	X99	78	2.57	10	3.69	47	2.77	21	1.96	Genital disease, other
10	D96	77	2.53	18	6.64	41	2.42	18	1.68	Worms, other parasites
Other	-	1468	48.30	103	38.00	697	41.10	668	62.1	Other
Total	-	3040	100.0	271	100.0	1695	100.0	1074	100.0	-

This study showed a spectrum of common problems that patients present with at clinic level, community health centre level and at district hospital level around Mthatha in the Eastern Cape Province of South Africa. The most common health problems included respiratory tract infections, hypertension, pregnancy, asthma and injuries, in addition to seeking assistance in health maintainance and prevention. These results are in line with the four (4) broad groups that cause the greatest burden of disease in South Africa. These groups are HIV and AIDS related diseases (e.g. respiratory), chronic non-communicable (e.g. hypertension and asthma) violence and trauma (e.g. injuries) and maternal and child health (e.g. pregnancy).

According to Schmidt et. al. (1991), the network of community-oriented educational institutions for the health sciences was established in 1979 at the instigation of the World Health Organization (WHO). Schmidt et. al. states that at that time, it was felt that medical education was no longer responsive to the health needs of larger segments of the population, both in the industrialized and in the developing world. According to Schmidt et. al., two different but related problems were identified. The first problem was felt most deeply in rural areas in Africa and Southeast Asia but was also felt in medically underserved areas such as New Mexico and Northern Canada, and in the inner-city slums of large metropolitan areas. It is the problem of unequal access to health

care. There were inadequate medical services in these areas in terms of both manpower and health facilities. The second problem has to do with the training of physicians itself. The clinical training takes place at tertiary health care hospitals that have facilities not available elsewhere in the country and certainly not available in the places where students are supposed to practice after graduation. Hence students generally have serious trouble adapting to environments alien to those in which they were trained. Schmidt et. al. also state that the population of patients seen in the academic tertiary care hospitals by no means resemble the population normally seen by physicians. People who are referred to an academic tertiary care hospital tend to be more seriously ill, suffer from more uncommon diseases, and show more atypical symptoms as compared with the normal population of patients. Roger & Gal (1989) also endorse the fact that most physicians are trained in academic medical centres although most of their future patients live in non-academic communities and will receive care in non-academic settings.

In view of the fact that training of physicians in South Africa is conducted mainly in tertiary care centres whilst the majority of the people need primary health care, the training is inappropriate for the needs of the majority of the people served. Any curriculum that does not emphasise the disease burden of the country does not address the needs of society. “It is now recognized that there is a need for a major shift from the view that Academic Medicine was based predominantly at the tertiary level and accept their role in the provision of a wide range of services from basic primary health care activities to the more sophisticated specialist services (Department of Health, June 1995, p.).” The Department of Health further suggests that the curricula should be revised to place greater emphasis on the needs of communities in line with primary health care principles, and that the training should therefore take place at various levels of health care to enhance benefits to communities. This is a powerful statement of what South Africa needs, and what is left now is to explore means of achieving that. . This will also address the question of access to health care, and thus lead to improved health status of all the people of South Africa. How should we go about doing what we want to do?

The Medical and Dental Professions Board of the Health Professions Council of South Africa (September 1999) came up with guidelines for undergraduate medical education and training. The background to these guidelines was triggered by major changes in medical education worldwide. These changes include the Edinburgh Declaration (1988) of the World Federation for Medical Education, which emphasised that medical education should be adapted to the needs of society. The Yaounde Declaration (1994) identified responding to community needs as one of the attributes that should be enhanced in medical students. The Cape Town Declaration (1995) stated that medical education should be responsive to community needs and at the same time meet global standards. One of the recommendations of the Medical and Dental Professions Board of the Health Professions Council of South Africa (September 1999) is that “undergraduate education and training must make provision for and be sensitive to both academic demands and the unique needs of the South African society”. The Medical and Dental Professions Board goes on to say that “relevance of the curriculum is a key criterion”. Another recommendation is that “community-based education and training should be emphasised and students should be introduced to community work at an early stage”. According to the Health Professions Council of South Africa, therefore, community-based education is central to the education and training of community responsive physicians.

4. COMMUNITY-ORIENTED CURRICULUM

A community-oriented medical curriculum is a programme whose content takes into account the major health problems afflicting the population served by the programme graduates (Schmidt et. al., 1991). These problems could be anything from infectious diseases and malnutrition to coronary heart disease and obesity. According to these authors, this definition implies several things. First, curriculum content is no longer determined by the internal structures of the disciplines contributing to it. Rather, these disciplines are relevant to the curriculum and they, therefore, contribute to a deeper understanding of the problems that define the curriculum. Secondly, the programmes differ from each other, depending on the specific nature of the priority health problems in particular populations. Thirdly, these curricula are highly adaptive to changes in the environment, because problems of today may be different from tomorrow's.

Although this notion of community-oriented medical education is a big shift from the highly fixed and standardized conventional curricula that is determined independently by the various academic disciplines, it is not considered sufficient. Clinical training of physicians in only tertiary care hospitals provides medical students with a distorted perspective on the nature of the problems encountered later in professional life and also on the facilities available for diagnosis and treatment. The technological facilities available at these academic tertiary care hospitals are different from what is available at regional hospitals, let alone primary health care levels. Schmidt et. al., therefore, argue that students should actually be exposed to the realities of health care in the community as soon as they enter medical school. This exposure in the community should not be brief and transient, but should be an important part of the curriculum. This means that a medical curriculum should be community based.

5. COMMUNITY-BASED EDUCATION

"Community-based education is a means of achieving educational relevance to community needs ..... It consists of learning activities that use the community extensively as a learning environment, in which not only students but also teachers, members of the community, and representatives of other sectors are actively engaged throughout the educational experience (WHO, 1987, p. 8)."

"A community-based learning activity is one that takes place within a community or in any of a variety of health service settings at the primary or secondary care level (WHO, 1987, p. 9)." According to this working definition, therefore, learning activities conducted in specialized medical care facilities such as tertiary care settings, cannot be considered as community based activities.

An ideal community-based medical education programme model should therefore be characterized by an appropriate number of learning activities in a balanced variety of educational settings, and that the community based learning activities should be distributed throughout the duration of the curriculum (WHO, 1987, Schmidt et. al., 1991). In other words, learning activities in the community settings should not be conducted for a token two week period, and these activities should be distributed throughout the learning period from year one to the last year of the medical programme. These two characteristics contribute towards the formulation of the basic concepts of community- based medical education.

The notion of community-based medical education represents an important trend in current methods of education as a whole (WHO, 1987). It involves the integration of education and productive work within the learning process and the participation of all those involved in the actual work. It is a product of evolving educational methods in general. At the same time it is a source of relatively new ideas in the fields of educational policy, organization of education and design of curricula, and methods of education. A great deal of experience in community-based education has accumulated and has been described in literature. Community-based education is associated with efforts to involve students and educational institutions in national development.

According to the WHO, (1987), for a community-based medical education programme to be effective, it must fulfil certain conditions and conform to certain guiding principles:

a) The student's activities should relate to planned educational goals, and these goals should be clearly understood by all those involved in the programme, including the students.
b) The activities should be introduced very early in the educational programme.
c) The activities must continue throughout the educational programme.
d) The student's work during training must be "real work" that is related to their educational needs, and also form part of the requirements for obtaining a degree.
e) The students are fully exposed to the social and cultural environment and thus come to understand the important elements of community life and the relationship of these elements to health-related factors and activities.
f) The programme must be of clear benefit to both the students and the community, and this implies that the community must be actively involved in the educational programme.

The WHO, (1987) has further developed qualitative criteria for determining the extent to which a programme is community-based. These criteria include the following:

1. The degree to which educational planning has been carried out in coordination with the health services;
2. How well inter-sectoral linkages are functioning;
3. The mechanisms that exist for ensuring community involvement;
4. The importance given to encouraging the health team approach;
5. The extent to which competency-based education is used;
6. The extent to which problem-based learning is used;
7. The extent to which performance of students is measured in a valid way.

The guiding principles described by the WHO, together with the qualitative criteria for determining the extent to which a programme is community-based, add to the characteristics of community-based medical education in providing some basic concepts of community-based medical education.

The World Federation of Medical Education (WFME) also supports community-based medical education (CBME). In its conference in 1988 at Edinburgh, Scotland, a document known as the Edinburgh Declaration was passed. The document reported that medical students couldn't be prepared for a role in community-

oriented primary care (COPC) if their training programmes are based almost exclusively in tertiary care hospitals (Metcalfe, 1989). According to Smilkstein (1990), the recommended actions, from the Edinburgh conference that should be taken by medical educators, include an enlargement of the range of settings in which educational programmes are conducted to include all health resources of the community, not hospitals alone.

Smilkstein (1990) states that community-based medical education is central to the training of community responsive physicians, and he further suggests some features for this programme, which extend from medical student recruitment to graduate physician support systems. His model features include: the recruitment of students who have demonstrated commitment to community service; a continuity of community experience through four years of medical school; a research requirement for medical students that is related to community-oriented primary care; and a coordinated programme that brings together medical students and resident physicians with role models of primary care practitioners who are dedicated to community health care. Smilkstein suggests the following strategies for implementing the above set of decisions: participation in community service to be used as a positive attribute during the selection process for medical students; integration of community experiences into the students' curriculum to be practiced; community-oriented research to be done as projects by the students; medical students to work in community clinics. Smilkstein's model adds more information to the characteristics of community-based medical education already mentioned, the guiding principles by the WHO, and the qualitative criteria for determining the extent to which a programme is community-based.

Richards (1993) did a study of community partnerships in health professions education, an integral part of health programming of the W. K. Kellogg foundation. This initiative was established in 1991 with the purpose of increasing the number of primary care practitioners, physicians included. The idea was to redirect the educational programme of health professionals by creating community-based non-hospital teaching centres that address primary health care, education, and research, using a multidisciplinary approach. Seven model partnerships in the USA were established at that time. The educational experiences in these community partnership models are: multidisciplinary (involving professions other than medicine); integrated (bring together learning in ambulatory care paediatrics, medicine, and family practice, for example); longitudinal (occur through the four years); a significant component of the curriculum.

In summary, therefore, characteristics of community-based medical education, guiding principles, qualitative criteria, Smilkstein's model, and the programme elements of community partnerships, all contribute towards the formulation of basic concepts of community-based medical education. What did the WHO do in an attempt to make medical education responsive to the health needs of larger segments of the population?
In summary, therefore, community-based medical education, is advocated not only for the undeserved areas where access is still a problem, but also for the developed countries because the population of patients seen in academic tertiary care hospitals by no means resemble the population normally seen by physicians. Access is addressed at least by making available students and more physicians during the process of training, which may be continued indefinitely if the programme is sustainable. A more ambitious expectation concerning access is to hope for more physicians serving institutions in disadvantaged areas after community-based training and thus reduce the flow of physicians to cities and to other countries. Couper et

al (2007) showed that one of the facilitating factors for doctors to practice in rural areas is the "exposure to rural practice during training". Appropriate training is addressed, firstly, by appropriate use of technology in diagnosis and management of patient problems. Secondly, community-based medical education helps the physician in training to manage problems commonly seen by physicians in a normal population.

6. SERVICE-LEARNING

Community-based learning emphasises learning in the community, while Service-Learning equally emphasise learning and service.

Three (3) complementary definitions of service-learning are the following:

- Service-learning can be defined as a "course-based, credit-bearing educational experience in which students (a) participate in an organized service activity that meet identified community needs and (b) reflect on the service activity in such a way as to gain further understanding of course content, a broader appreciation of the discipline, and an enhanced sense of civic responsibility" (Bringle and Hatcher, 1995, p. 112).

- Service-learning appears to be an approach to experiential learning, an expression of values – service to others, community development and empowerment, reciprocal learning – which determines the purpose, nature and process of social and educational exchange between learners (students) and the people they serve, and between experiential educational programs and the community organizations with which they work (Stanton, 1987).

- Service-learning can be defined as a thoughtfully organised and reflective service-oriented pedagogy focused on the development priorities of communities through the interaction between and application of knowledge, skills & experience in partnership between community, academics, students and service providers within the community for the benefit of all participants . (Joint Education Trust, 2000).

Service-Learning characteristics therefore include: being course/module-based and credit-bearing; a thoughtfully organised service activity, being of equal importance as the learning component and also meeting identified community needs or developmental priorities; a reflective service-oriented pedagogy; community development & empowerment, and reciprocal learning as core values; a partnership between community, university & service providers.

From the above characteristics, it can then be noted that service-learning also focuses on meeting identified community needs in partnership with community, university and service providers. Service-Learning is therefore another pedagogical strategy that enables students to respond to community needs. Service-learning reconnects higher education to society by making its programmes relevant and responsive to identified development priorities.

7. SOCIAL ACCOUNTABILITY

Community-based education and service-learning within the partnership philosophy instill a sense of Social Accountability. WHO (1995) defined Social Accountability of Medical Schools as "the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public."

The Principles of Social Accountability are:

- Building partnerships between university, community & service providers
- Recruitment & selection of students from communities with greatest need
- Developing an appropriate curriculum that is guided by identified community needs
- Developing a student support programme that ensures access for success
- Recruitment & development of teaching staff with passion for community engagement
- Developing appropriate learning sites in the community
- Providing tangible, sustainable & integrated service, based on relevance, equity, quality & cost effectiveness

8. THE FACULTY OF HEALTH SCIENCE MODEL

The Faculty of Health Sciences committed itself to Community-Based Medical Education in 1989 but the programme was put into action in 1991.

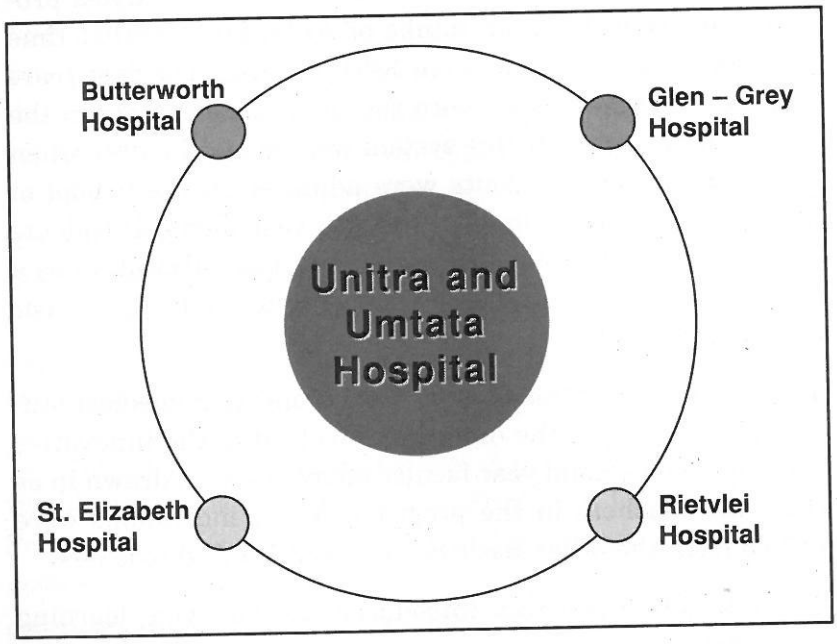

Figure 2: The Original Faculty of Health Science Model

The Faculty of Health Sciences at this stage committed itself to use Umtata General Hospital and four (4) district hospitals (Butterworth, Glen Grey, St Elizabeth and Rietvlei Hospitals) as its teaching platform as shown in Figure 2. Although there was thinking of using clinics and community health centres, the problem was that there no community health centres nearby and the existing clinics were in a very poor shape and therefore not suitable for teaching purposes. In 1991, the Unitra Community Health Partnership Project (UCHPP) of the Faculty of Health Sciences, of which I was Director, was born. This was a project that was funded by the WK Kellogg Foundation for the purpose of establishing "Models of Academic Community-Based Primary Health Care Centres" around Mthatha. This project helped the Faculty of Health Sciences realize its dream of teaching in community health centres. The medical model was extended to be a health science model as not only medical students but also nursing and health promotion students went out to the community health centres. The original Unitra Medical Model was expanded as shown in Figure 3 below.

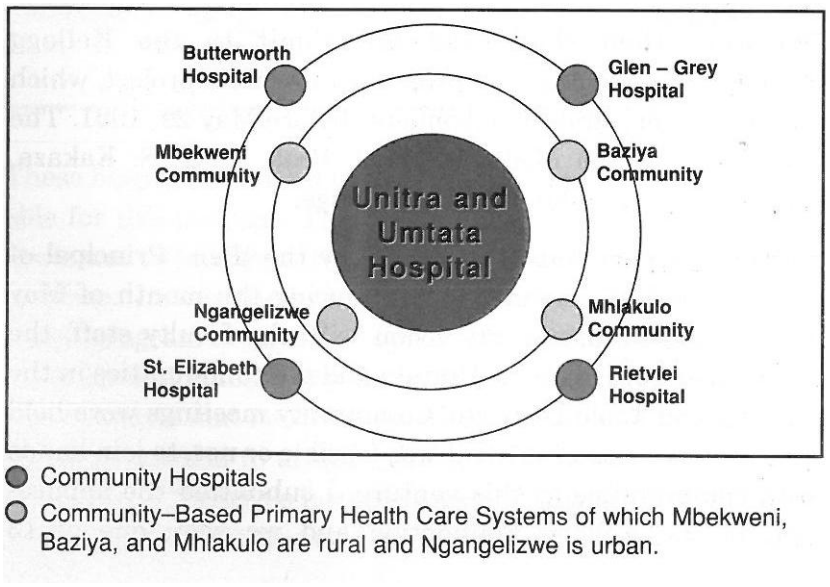

Figure 3: The Expanded Faculty of Health Science Model

The UCHPP added the partnership component in the community-based education model of the Faculty of Health Sciences. The partnership was established between the University of Transkei (the Academic Institution), four (4) local communities (Baziya, Mbekweni, Ngangelizwe and Mhlakulo) and two (2) service providers (the Eastern Cape Department of Health and Umtata Municipality). The shared vision of the UCHPP was " An improved health status and quality of life for the underserved communities in the Eastern Cape Province of South Africa, through education, research and community service". This project was externally evaluated by the School of Health Systems and Public Health, University of Pretoria, in January 2000. Major achievements included: the establishment of a "real partnership" between the university, community and service providers; the establishment of four (4) community health centres; more organized community-based education by the university; the movement of the whole Department of Family Medicine from being hospital-based to the community health centres (i.e. community-based) substantial improvements to primary health care services in the areas served by the partnership.

In 1999, the Unitra Community Health Partnership Project (UCHPP) gave birth to the Community Higher Education Service Partnership (CHESP), again under my Directorship. Community-Based Education therefore progressed to Service-Learning, where learning and service are given equal importance in the education of health science students as already discussed above. This expansion of UCHPP as seen in the comparison table 4 below.

Table 4: UCHPP vs CHESP

	UCHPP	CHESP
Faculties	Health Sciences only	All University Faculties
Service Providers	Health Focus	Wide range of departments (Government, NGOs & Private)
Institutionalisation	A Project, funded outside the university	A Programme, funded outside and inside the university
Educational Strategy	Community-Based Education	Service-Learning

Later on, the Faculty added more community health centres and hospitals to the model with a resultant of seven (7) community health centres and about fifteen (15) district hospitals as shown in figure 4 below.

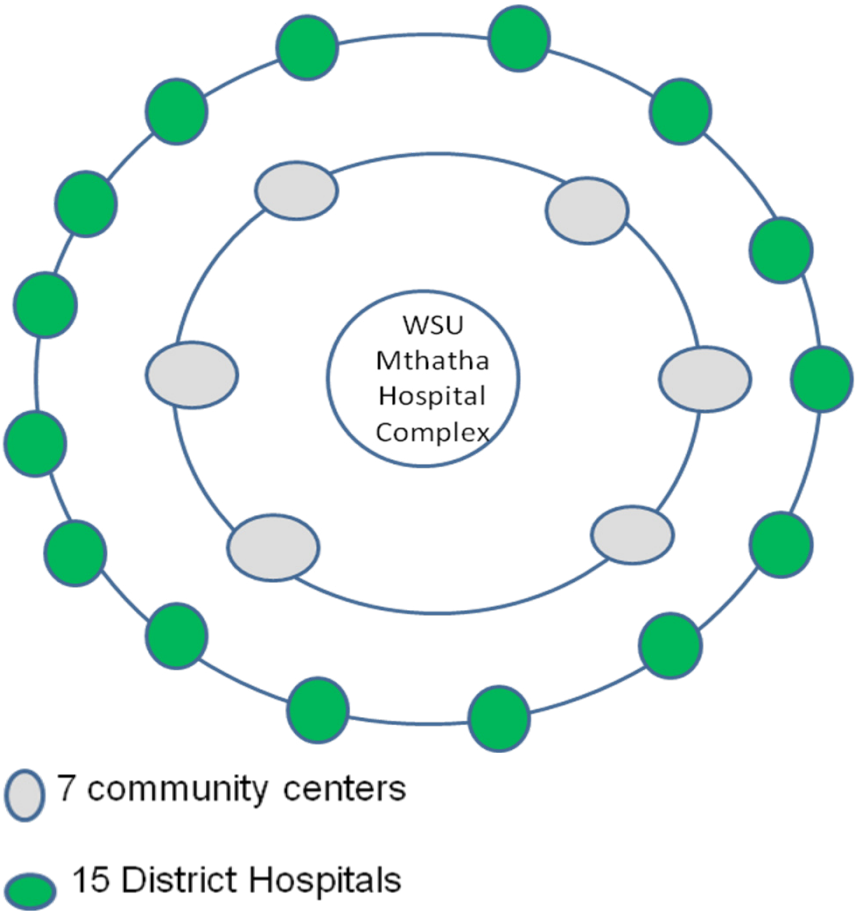

Figure 4: The Current Faculty of Health Science Model

The Faculty still intends to expand this model to include the other two (2) hospital complexes in this province, that is, East London and Port Elizabeth Hospital Complexes with their community health centres and district hospitals as shown in figure 5 below. An increase in the teaching platform will lead to an increased intake of students in this Faculty.

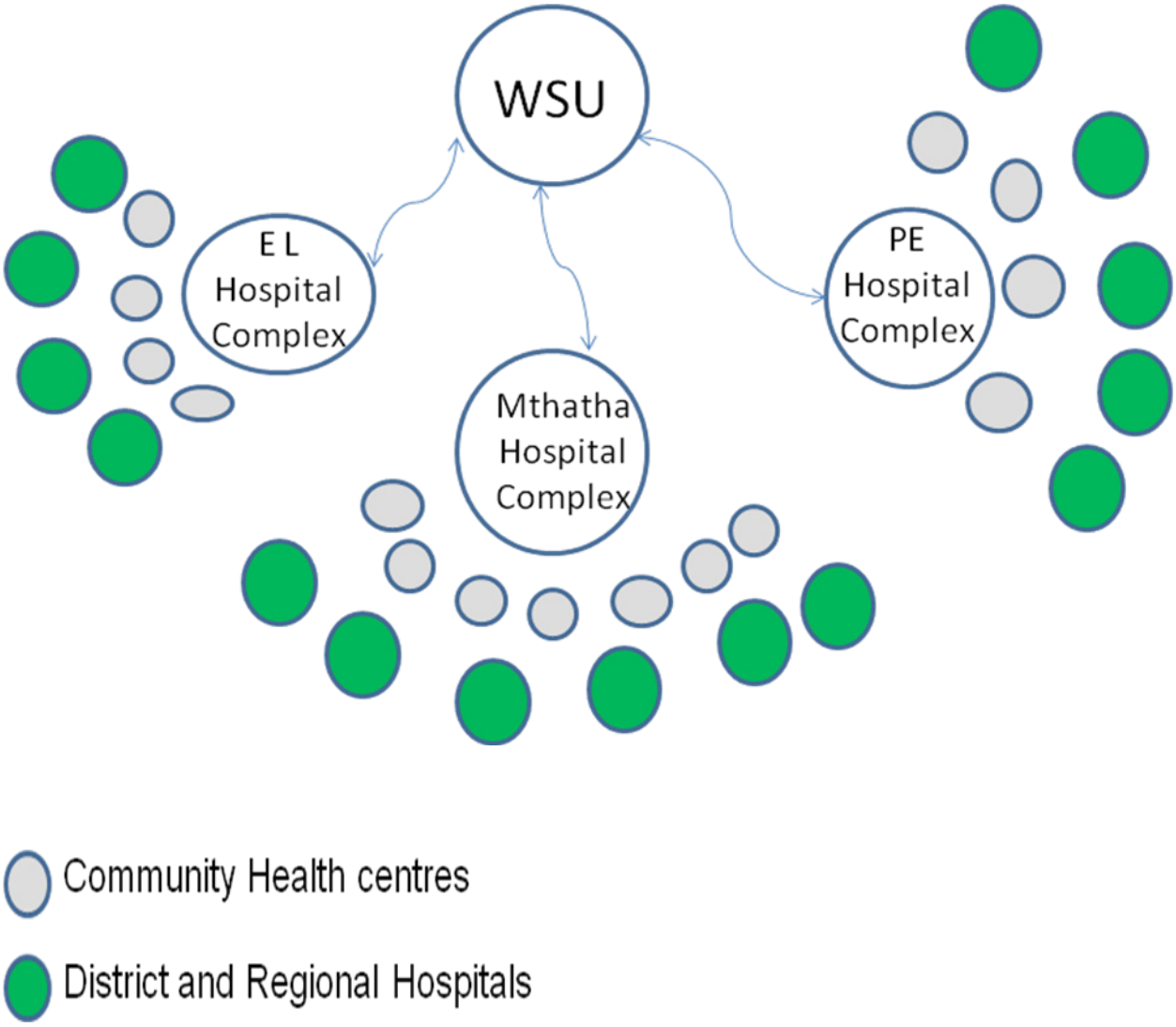

Figure 5: The Future Faculty of Health Sciences Model

9. FAMILY MEDICINE

In addition to the Faculty Model that emphasises Community-Based Learning, Family Medicine brings in an additional dimension of Patient-Centred Care and Holistic Care as a way of paying attention to patient's needs. We know the importance of attending to the disease and we have described how to attend to the community as part of the context. We should also know that the patient has a family and lives in an environment that can influence disease. The context therefore (family, community and environment) is also very important. What is easily forgotten is the person/patient himself/herself. The person has thoughts, feelings, and expectations. Figure 6 shows the interaction between the person, the disease, and the context.

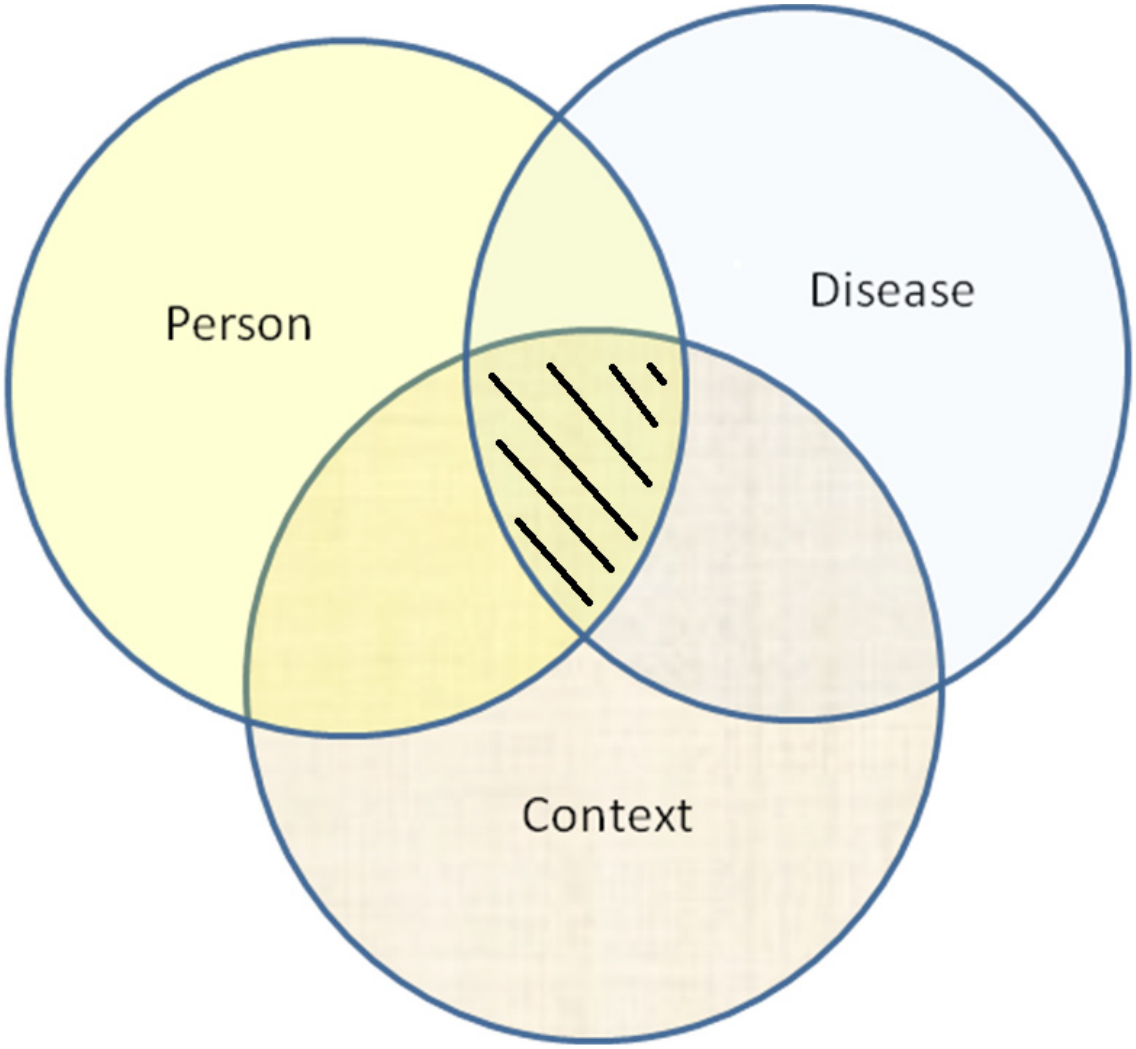

Figure 6: The Person, the Disease and the Context

When I was a 4th year medical student, I was challenged by a patient during a ward round. This was a big ward round with many consultants, medical officers, registrars, medical students and nurses in a surgical ward. As usual, the whole team was moving from bed to bed, discussing patients and their problems. The Chief Consultant spent more time at some beds and discussed "the so called interesting issues", but move away quickly from some beds where there was not much to be discussed. There was a corner bed where the team just moved quickly passed without saying much. The patient was a young woman. She called me and asked a question, using the local language. "Hini nivele nidlule nje ningabuzanga nokuba ndinjani?" that is, "Why do you just pass without finding out how am I?" Before I could answer, she had a follow-up question. " Nenziwa yintoba ndinuka?" that is, " Is it because I am smelling?" This lady had a breast cancer that was too advanced, "fungating" and smelly. The smell was indeed unbearable. I had to sit down next to her bed and talk to her. That was quite an experience for a 4th Year medical student. That is an experience I will never forget as long as I still live and practice medicine. I learnt a lot from that patient. I learnt that patients have needs that should be addressed, no matter what the diagnosis or prognosis. Health professionals have to respond to those needs, and, to be able to respond to those needs appropriately, health professionals need to find out from the patients

themselves what those needs are. That was when I first realised that patients are not machines or objects to be used for our learning, but are human beings that have feelings, thoughts and expectations. My consultants did not teach me that. Reflecting on that experience 35 years ago, a simple: "How are you? What can I do for you today?" would have been sufficient to show that we were caring health professionals. This seems like common sense but common sense is not always common. Doctors have to address the needs of their patients, no matter what they are. If the need is too big, there are other health professionals who can address that. Those were the days when there was no teaching in Family Medicine and no teaching in Palliative Care.

As a general practitioner at Mount Frere I did some research work from 1980-1982, towards partial fulfillment of requirements for the Masters Degree in Family Medicine. My study was focused in understand the needs of my patients and how medical education had played a role in influencing behaviour of our patients. I was puzzled by the way we as general practitioners were prescribing treatment for our patients. There was a common understanding that each and every adult patient that visited a doctor should be given at least one injection, two or three packets of tablets and a bottle of medicine. I then conducted a study to verify this perception. I found out that some patients indeed expect an injection but a good number of patients would prefer treatment without an injection. In fact, during this study, some patients stated clearly that they do not want an injection. This assumption that all patients want an injection when they visit a private doctor has made doctors to inject patients with Vitamin B Complex, when there is no indication for a specific injection. This is not necessary, as patients would normally understand when you explain to them the appropriate treatment for what they are suffering from. This also goes for drugs like antibiotics that are prescribed even in conditions that do not require them. The danger of overprescribing antibiotics is resistance. Doctors also would find it difficult to tell a patient that has diarrhoea that oral rehydration is all that is needed. Doctors need to address the patients needs and this cannot be done without talking to the patients themselves. Partnership is the key.

Family Medicine has expanded the role of the doctor from the individual (patient-centred care) through the family (family-oriented care) to the community (community-oriented primary care - hence the perceived overlap between Family and Community Medicine. We focus on the patient irrespective of the disease, and also we look at the patient holistically. We therefore do not use the Medical Model, which focuses on biomedical problems only, but the Bio-Psychosocial model, that looks at holistic care. This brings-in the importance of medical psychology, medical sociology and medical anthropology in medicine. Family Medicine therefore focuses on common problems and also life-threatning problems that should not be missed across all clinical disciplines, community-oriented primary care and psychosocial problems. Family Medicine is therefore a specialty in breadth that runs across all clinical disciples and also human behavioral sciences like medical psychology, medical sociology and medical anthropology (see Figure 7).

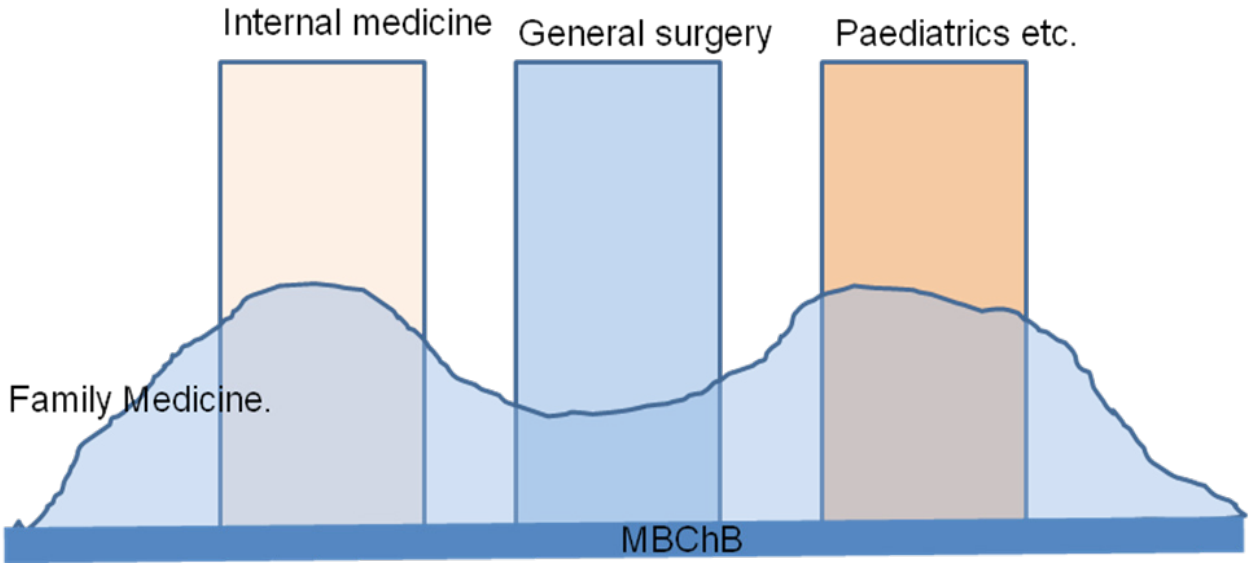

Figure 7: Family Medicine, Internal Medicine, General Surgery, Paediatrics etc.

Family Physicians are best described by the principles that govern their actions. According to McWhinney (1997), known as the "Father of Family Medicine", the nine (9) Principles of Family Medicine are as follows:

- Commitment to **the Person, not the Disease,** i.e. not limited by the type of health problem, age or sex of the patient
- **Understanding the Context** of the illness, i.e. beyond the Biomedical Model
- Using every contact with patient as **an opportunity for Prevention** or Health Education
- Viewing of **the Practice as a Population at Risk,** i.e. interest in the health needs and priorities of the practice population
- **Being part of a Community-wide Network** of supportive and health care agencies, i.e. understanding and using available resources in the area
- **Sharing of the same Habitat** with patients, rather than being a commuting doctor
- **Seeing patients in their Homes,** in addition to seeing them at the clinic, practice or hospital
- Attaching of importance to **the Subjective aspects of Medicine,** i.e. both his/hers and the patient's subjective experiences, rather than being dominated by a strictly objective and positivistic approach to health problems
- Being **a Manager of Resources,** including who has to be admitted in hospital and what treatment is to be given

In the Handbook of Family Medicine that is edited by Bob Mash (2006), a tenth (10) principle has been added as follows:

- Being a **Lifelong Learner**, especially due to the challenge of "best practice" and the fact that Family Medicine is a specialty in breadth. Hugo and Allan (2008) further endorse these ten (10) principles with examples from the South African context.

I would like to make a point that these, to me, are principles of good practice, not necessarily principles of Family Medicine. Who on Earth in the field of medicine these days would not see that these principles should be applicable across all disciplines that deal with medical education and beyond, especially in undergraduate education and training? Why can't we teach our students, irrespective of discipline, to look at the whole person rather than focus on a body of knowledge or particular disease or special technique? Why can't we all talk holistic care? Why can't we all look beyond the biomedical model into the bio-psychosocial model? Why can't we use every opportunity that avails itself for prevention or health promotion during our encounters with patients? Why can't we look beyond the presenting patients into the population at risk and address the needs of the population as teams, through the available community-wide network of health professionals and beyond? Is there any debate about teaching all health professionals to be good managers of resources? Which discipline or profession does not need lifelong learners? Walter Sisulu University as a whole talks about lifelong learning. The only challenging principles for every health professional are those that refer to sharing the same habitat and seeing patients at home. This happens easily in other countries like Cuba but not in South Africa. The infrastructure in rural areas is just too difficult for people who have a choice to stay elsewhere. The crime situation is also too challenging for people to do home visits at night. Adherence to these principles is a major contribution towards training health professionals to be responsive to health needs of the community.

10. CONCLUSION

Community responsive medical education at the Faculty of Health Sciences at Walter Sisulu University was strengthened early in its existence by:

- The establishment of a Department of Family Medicine
- The establishment of a Department of Community Medicine
- Being the first Medical School in South Africa to implement Community-Based Education and Problem-Based Learning
- Doing a needs assessment so as to inform the curriculum
- One of the first Medical Schools in South Africa to form meaningful partnerships with Community and Service Providers through the Unitra Community Health Partnership Project (UCHPP) that led to the establishment of Community Health Centres of Baziya, Mbekweni, Mhlakulo and Ngangelizwe. This is a project that was funded by the WK Kellogg Foundation from 1991 to 2001
- One of the first Medical Schools in South Africa to form a Community Higher Education Service Partnership (CHESP) extend the partnership philosophy beyond Faculties of Health Science and other service providers in addition to health departments from 1999 to date

I have been involved in all the above as I was the first Professor and Head of Department of Family and Community Medicine, before the two departments were separated. I was the Leader of the UCHPP and later the Leader of CHESP. Now I am trying to instill the principles of Social Accountability as agreed by the Training for Health Equity Network (THEnet), of which the Faculty of Health Sciences at Walter Sisulu University is a member. THEnet is a Global Network of Socially Accountable Medical Schools that are particularly committed to eliminating Health Disparities towards achieving better health for all. Walter Sisulu University is one of eight (8) Medical Schools in this network, the only one in Africa.

Taking all the above into consideration, community responsive medical education at Walter Sisulu University is already bound by the following principles:

- An **established partnership** between the university, service providers and the community that jointly identifies health needs of the community, region and nation;
- A recruitment strategy that takes into consideration applicants coming from **rural and underserved and also committed to community service** as this is the area of greatest need;
- A community-based medical education programme that has been **properly planned** with clear goals that are understood by all the stakeholders
- Training of students in this programme that **integrates learning with service** in the community with clear benefits or reciprocal learning to both students and the community;
- Training of students that has a **research requirement related to community-oriented primary care** as an intervention strategy and service to the community;
- Twelve and half percent (12.5%) of **community learning activities that are spread throughout the duration of the curriculum;**

  What still needs to be improved/introduced are the following:
- A **longitudinal integrated clerkship** that will place students in the community for a period of one year during the 5th year of training from year 2014, and thus increase community learning activities to twenty five percent (25%);
- The training programme that encourages **team work and multi-professional learning** with role models of Primary Health Care as teachers;
- The training programme that has evidence of **reflective practice and integrated assessment** of student performance throughout the period of community learning;
- Adoption of the Principles of Family Medicine to be **Principles of Medical Education** in general;
- Introduction of an **integrated clinical examination** at the end of the longitudinal integrated clerkship and at the end of the final year, where students are examined on three or four patients by examiners from various disciplines, as long as there is a wide spread of patients with different problems;
- Introduction of **community learning throughout the Academic Health Service Complex of the Eastern Cape Province** (in addition to those falling under Mthatha Hospital Complex) to include East London and Port Elizabeth Hospital Complexes with 15 – 20 District Hospitals and Community Health Centres around them, so as to increase the intake and production of doctors at Walter Sisulu University by fifty percent (50%) in response to the national call;
- Appointment of at least two (2) **Specialist Family Physicians** at each district hospital where training of medical students is taking place by 2014.

The Faculty of Health Sciences at Walter Sisulu University therefore committed itself to community-based education, which was later strengthened by the partnership philosophy, service-learning and social accountability. To be responsive is to be socially accountable.

I thank you

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ACKNOWLEDGEMENTS

Mr Vice-Chancellor, Sir, I would like to sincerely express my gratitude to all those who have made me who I am today. First, the Almighty God, who has not just made me who I am, but also made this day what it is. May I then thank the Executive Management of Walter Sisulu University under the leadership of Prof Balintulo for the support given in all my endevours. Prof Balintulo, you have been very inspirational to me. You are down to earth, very focused in your thinking and very encouraging to those who work under you. You have installed the spirit of team work within your management team. I have therefore learnt a lot from you as a leader. Prof Obi, as my immediate supervisor, I salute you. You have tried by all means to lift the academic standards and research outputs in this university. The policies you have championed together with your insistence on staff incentives will definitely take this university to a higher level. Thank you for your support and thank you for your understanding when difficult matters are put on the table. Prof Ekosse, you were flexible enough to accommodate my requests for this inaugural address. Things have not been easy but you stood firm and made it the success it is today. Mr Nyakenye and your team at the Mthatha Health Resource Centre, you availed your help at the time I needed it most. Thanks for helping in the preparation of this presentation.

My Faculty Management is a pleasure to work with. The regular meetings, team work and frank talk has put us where we are. To the Faculty of Health Sciences as a whole, my message is similar to what I have just said about Faculty Management. We are working as one big family. The commitment you have shown to this university and our Faculty is unbelievable. What I like most is that although we say things as they are at meetings, sometimes very hashly especially to a listening outsider, we remain being good friends after the meeting. There are usually no hidden agendas. It is not about us, but about the faculty and the university. If you do your bit, and I mean all of you, I will be able to do mine. Team work will always take us through. I am therefore proud to be the leader of this faculty. Thank you very much colleagues, for the dedication you have shown to this faculty and university as a whole.

I have many friends. People like me. To all my friends, especially those present here today, I say thank you. Dr Mvuyo Tom and your family, I treasure our friendship. We have shared very good moments and also we have supported each other even during difficult times in this country. Let our friendship survive. Our friendship has also been strengthened by the fact that we are in the same medical field as Family Physicians, and also about what people say regarding our facial similarities. My other Friends, Aunt Laura Mpahlwa, I learnt a lot from you as a community developer and later on as a fellow worker within UCHPP. Your wisdom, patience and understanding has contributed a lot to the development of this faculty. The honorary doctorate the university gave you as a community developer is well deserved. When talking about Aunt laura, the picture is not complete without mentioned Prof Rachel Gumbi. Prof Gumbi stood by me all the time when the going was tough, in and outside the university. She helped the faculty break the divide between nurses and doctors. Thanks RV for being a true friend. To my mentors and friends, Prof Sam Fehrsen and Prof Dan Ncayiyana, you know what role you played in my development. I can now stand firm as an academic anywhere in the world, because of you.

To my family, I am very grateful. When I failed matric, I forgot about education. I stayed at home for two years,

enjoying the country life and fields with no clear purpose in life. My father was instrumental in my getting back to school as he spoke to the then Principal of Freemantle High School, Mr Rix, who agreed to support me. My father is late now but my mother is still alive. She is 96 years of age and is still my inspiration. She is very well for her age, thanks God for that. My sisters are very supportive to me. To all of you, I say thanks very much for your understanding. I am not able to take up my role sometimes in family matters because of work commitments. You have not complained, but instead, you have thanked me for the time I have managed to be there. My sisters include my sisters in law. Thanks very much. Similarly, at home we do not make a distinction between brothers and brothers in law. They are all my brothers. Without them, I am telling you all, I would not have survived. We are literally sticking together at all times. For this I am very greatful. To my big brother, Prof Maqashalala, I want to say thank you. You nurtured me at Fort Hare when I was struggling to find my area of interest. You are still my confidante even now in times of need. Our friendship and relationship cannot be faulted. Thanks very much bhuti. I have acquired a new brother and sister by the names of Dr and Mrs Peter and Kenny Boshigo, through my son and daugher in law. These two people have fitted in our family like gloves. When talking to them I am talking to real brother and sister. Thanks very much guys for your support all the time.

Very importantly, I would like to thank my wife's family for handing over to me the wife I have. Thanks Thandie on behalf of the Zitumane family. You are also a sister to me. This family accepted me as I am and for that I will forever be greatful. Lastly, I would like to thank very sincerely my wife and kids for all the support and understanding they have given me. My wife has allowed to move up and down without interference. You know, moving from Mthatha to Mount Frere, Cala, Pretoria and back to Mthatha has all been determined by me. She has been following without complaints. This compromised her career as she had to adapt to whatever environment and context I wanted to be in. One of my kids asked me one time, where is home? Thank you guys. Really and truelly, without your support I would not have achieved what I have achieved today.

Mr Vice Chancellor, Sir, I would like to thank everybody who has made this event possible, starting from preparations, setting of the hall, machinery, performance and attendance. The attendees are local, national and international. To all of you I say thank you. For those who would be returning home either this evening, tomorrow or later, I wish you happy travelling. God bless all of you. God bless Africa.

CITATION

Prof Khaya Mfenyana was born in the Eastern Cape at Lady Frere (near Queenstown) at Macibini Administrative Area to Mordecai Nceba and Winnifred Dorcas Mfenyana. He is the only son and has three (3) sisters. He is married to Nomlindelo Edith Mfenyana, nee Zitumane, and has four (4) children and two (2) grandchildren.

He did his matric at the then Lovedale High School in Alice in 1962 but completed it privately in 1964. He then did the then South African Teachers Diploma at the University of Fort Hare from 1965 – 1966 and taught at the then Rhoda High School in Cofimvaba in 1967. He went back to Fort Hare and did a B Sc Degree from 1968 – 1970. He then proceeded to the then University of Natal for MB ChB Degree from 1971 – 1977.

He did his internship at Umtata General Hospital in 1978 and after working as a Medical Officer for two (2) months at the same hospital in 1979, he proceeded to Mount Frere and worked as a Private General Practitioner and a Part-Time Medical Officer at Mary Terese Hospital from March 1979 to February 1982. He proceeded to Cala where he worked as a Private General Practitioner and a Part-Time Medical Officer at Cala Hospital from March 1982 to December 1986.

He enrolled for a Masters Degree in Family Medicine under the Medical University of Southern Africa (Medunsa) in 1980 under Prof Sam Fehrsen and completed this degree in 1984. He continued to be attached to Medunsa as a Part-Time Lecturer in Family Medicine from 1985 – 1986 and then joined Medunsa and Ra-Rankuwa Hospital on a Full-Time basis as a Senior Lecturer and Principal Medical Officer from 1987 – 1988. He was then recruited to join the then University of Transkei (now part of Walter Sisulu University) and Umtata General Hospital (now part of Mthatha Hospital Complex) as a Full Professor and Chief Family Physician from 1989 to date. He was also made the 1st Head of Department of Family and Community Medicine. These two (2) departments were soon separated and Prof Mfenyana then became the 1st Head of Department of Family Medicine.

Prof Mfenyana joined the University of Transkei when the 1st class of MB ChB students was to enter the 5th year of study in a 6-year traditional medical programme. He then developed the programme and teaching material for the 5th year class together with programmes for 2nd to 4th year classes. In other words, 1989 was the year Family Medicine was introduced in the Faculty of Health Sciences for the 1st time. The 2nd years were introduced to Clinical Skills for the 1st time from April 1989, following implementation of the Problem-Based learning and Community-Based Curriculum at that time.

Prof Mfenyana was fortunate to be introduced to Problem-Based Learning and Community-Based Education by Prof Sam Fehrsen in 1988, that is prior to joining the University of Transkei (Unitra) in 1989, through workshops that were organized by the National Medical and Dental Association (NAMDA), a revolutionary medical organization that was opposed to the Medical Association of South Africa (MASA) before the days of the unified South African Medical Association (SAMA). At the beginning of 1989, Prof Mfenyana was even more fortunate to be one of five (5) academics who conducted a study tour for a period of about four (4) weeks, visiting overseas universities that were known as leaders in Problem-Based Learning (PBL) and Community-

Based Education (CBE). These universities included New Mexico in the United States of America, Mc Master in Canada and Beer Sheva in Israel. The traditional Mc Gill university in Canada was visited as a control. The PBL and CBE curriculum at this university was developed by informed colleagues from international experience but the curriculum that emerged was a Unitra curriculum. Prof Mfenyana visited other innovative university including some in Africa like Suez Canal University in Egypt and Moi University in Kenya. All this information helped to refine the curriculum to the Unitra and Mthatha context.

In 1991, Prof Mfenyana established the Unitra Community Health Partnership Project (UCHPP) and as a Leader of this project, he formed a core team of five (5) of which Aunt Laura Mpahlwa and Mawethu Bam were community representatives, while Prof Rachel Gumbi and Prof Dan Mkize were university representatives. There was also a consultative committee of twenty two (22) consisting of representatives from three (3) stakeholders: the university, the community and department of health as a service provider. This initiative led to the establishment of four (4) Community Health Centres around Mthatha namely: Baziya, Mbekweni, Mhlakulo and Ngangelizwe Community Health Centres, under the sponsorship of the WK Kellogg Foundation. In 1992, Prof Mfenyana became the Vice-Dean of the Faculty of Health Sciences, in addition to being the Head of the Department of Family Medicine. At the beginning of the same year, Prof Mfenyana introduced a Masters Degree in Family Medicine at this university with assistance from Medunsa, again under the leadership and support of Prof Fehresen. Initially the students registered with Medunsa with Medunsa colleagues coming to teach these students at Mthatha. Among the Medunsa staff, I would like to single out Prof Ron Henbest and Prof Jannie Hugo, in addition to Prof Fehrsen.

In 1993, the work of the Unitra Community Health Partnership Project (UCHPP) led to the establishment of the Health Personnel Education (HPE) Unit in this faculty and Prof Mfenyana was further requested to be its 1st Director, again this was added to his other duties of being the Head of Department of Family Medicine, Vice-Dean of the Faculty of Health Sciences and Co-Director of UCHPP together with Aunt Laura Mpahlwa. He also became the Acting Dean of the Faculty of Health Sciences from January to March 1992 and from June to August 1994. He was awarded a 2-year Fellowship by the WK Kellogg Foundation to study overseas from August 1994 to July 1996. This time was spent at Michigan State University in the United States of America, where he registered for a Master of Arts in Educational Administration. When he realized that he would be able to complete this programme way before July 1996, he negotiated for an upgrade to a PhD, with the aim of doing just the PhD Coursework before going back home. This request was granted with difficulty as the College of Education at this university had doubts that the request was achievable. Prof Mfenyana did not just complete the coursework with almost all Grade 4s, but also wrote and passed the required PhD Comprehensive Examination in May 1996. Unfortunately, no other time was available for him to complete the PhD Dissertation as he had to come back home.

In 1999, Prof Mfenyana upgraded the Unitra Community Health Partnership Project (UCHPP) to Community Higher Education Service Partnership (CHESP). UCHPP supported Community-Based Education for the Faculty of Health Sciences, while CHESP introduced Service-Learning for the whole university. Prof Mfenyana was again appointed as Director of CHESP. He also enrolled for a PhD in Community Higher Education Service Partnership at the University of Natal and completed the coursework for this qualification at the end of 2002. In the midst of all these academic endevours, he became Acting Vice-Chancellor of Unitra from May to August 2002. There was not even a Deputy Vice-Chancellor at that time. He, however, persisted with his PhD work beyond 2002 by preparing and submitting a Research Protocol at the University of Natal at the end of 2004, but could not take the project further due to heavy commitments at Unitra and later on at Walter Sisulu University. He even cancelled the study leave that was already approved by Senate from July to December 2005.

At the beginning of 2005, he was made Deputy Vice-Chancellor of Unitra and then Interim Vice-Principal for Academic Support of a newly established Walter Sisulu University from July 2005 to December 2007. Prof Mfenyana was appointed as the 1st Executive Dean of the faculty of Health Sciences from January 2008 to date. He was awarded a Fellowship of the College of Family Physicians of South Africa by Peer Review in October 2008. He is still planning to complete his PhD even after retirement, if the university commitments do not allow.

Prof Mfenyana has earned several awards including a prize while at Medunsa for the 1st Best Research Paper, a Scherag Writer's Award for the Best Original Article written by a Family Physician in the South African Family Practice Journal, a WK Kellogg Fellowship Award and the Ernest and Aurora Melby Scholarship Award at Michigan State University. He was the 1st Honorary President of the Rural Doctors Association in South Africa. He is a Member of the College of Family Practice within the Colleges of Medicine in South Africa, Vice-President of the South African Academy of Family Physicians and the current Chairperson of the Committee of Medical Deans in South Africa. He has been the President of the World Organisation of Family Doctors (Wonca) for Africa region and a Member of the Wonca World Executive for the past four (4) years up to May 2010. He is an inspector for the accreditation of hospitals for Internship Training in South Africa on behalf of the Health Professions Council of South Africa (HPCSA). He has been a member of the sub-committee for undergraduate medical education and training of the HPCSA from 1997 to date. In this regard, he was involved in the development of accreditation guidelines for undergraduate medical education and training in South Africa. He has been a member of the accreditation panel of experts since the inception of the accreditation visits in 2001. To date, he has been part of seventeen (17) accreditation visits of which he chaired nine (9). He is one of only two academics who are currently used by the sub-committee for undergraduate education and training to chair these accreditation visits. He was also part of an accreditation panel of experts that visited the national University of Rwanda in July 2008 and was the only external from South Africa. He has participated in the University Audits that are conducted by the Higher Education Quality Committee (HEQC).

He has been a Guest Lecturer in many universities in South Africa and abroad including University of Cape Town, University of Liverpool in the United Kingdom, University College London and Royal Free Hospital also in the United Kingdom and University of Illinois and Rush University, both in the United States of America. He has been an external examiner many times in five (5) of the seven (7) medical schools in South Africa.

Prof Mfenyana has produced twenty (20) Specialists in the field of Family Medicine and thus has supervised twenty (20) research projects in this field. He has published in peer reviewed journal both in South Africa and abroad including publishing in the British Medical Journal. The thrust of his publications is medical education and health inequalities in South Africa. He has presented numerous papers and posters at national and international conferences, mostly on invitation. He has also contributed a chapter in both editions of the Handbook of Family Medicine in South Africa, currently working on the same chapter for the 3rd edition. His research interest currently is Community-Based Education and Service-Learning.

Prof Mfenyana has been the Chairperson of the Hospice Association of Transkei from 1996 to date, the Chairperson of the Mthatha Wellness Village Board, a Trustee of the Health Systems Trust, a Trustee of the Rural Health Initiative in South Africa and the Chairperson of the Fred Hollows Foundation of South Africa.

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