

Developing a training programme for Clinical Associates in South Africa

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History

- 1994: Decision to rely on the Primary Health Care Nurses as a midlevel category of clinician
- The Pick Human Resources Report 2001 recommended training a physician assistant kind of category
- Cabinet and MinMec decision
- Visits arranged to countries such as US, Tanzania, Kenya
- National Task team
 - Scope of Practice, Curriculum, Outcomes, Training resources
 - Research project



Top 10 Conditions: District Hospitals

1	Gastro enteritis
2	Injury, laceration, assault
3	TB
4	Cardiac/vascular disease
5	Resp infection lower
6	Asthma
7	Epilepsy
8	Hypertension
9	Diabetes Mellitus
10	AIDS



History continued

- 2004: Stakeholder consultations
- National Curriculum Workshop
 - The name debate
- 2005: Scope of Practice, Curriculum, National Implementation Plan
- 2006: National Health Council decision
- 2006: HPCSA regulations



History continued

- 2007: Programme coordinators appointed at 3 faculties (Wits, Pretoria, Walter Sisulu Universities)
- Common curriculum outline approved
- January 2008: Training started
- October 2008: First National Conference, Wits
- December 2010: First graduates expected.



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Numbers in training

Intake	2008	2009	2010	2011 (Planned)
WSU	23	24	24	32
UP		51	97	100
Wits		25	32	50



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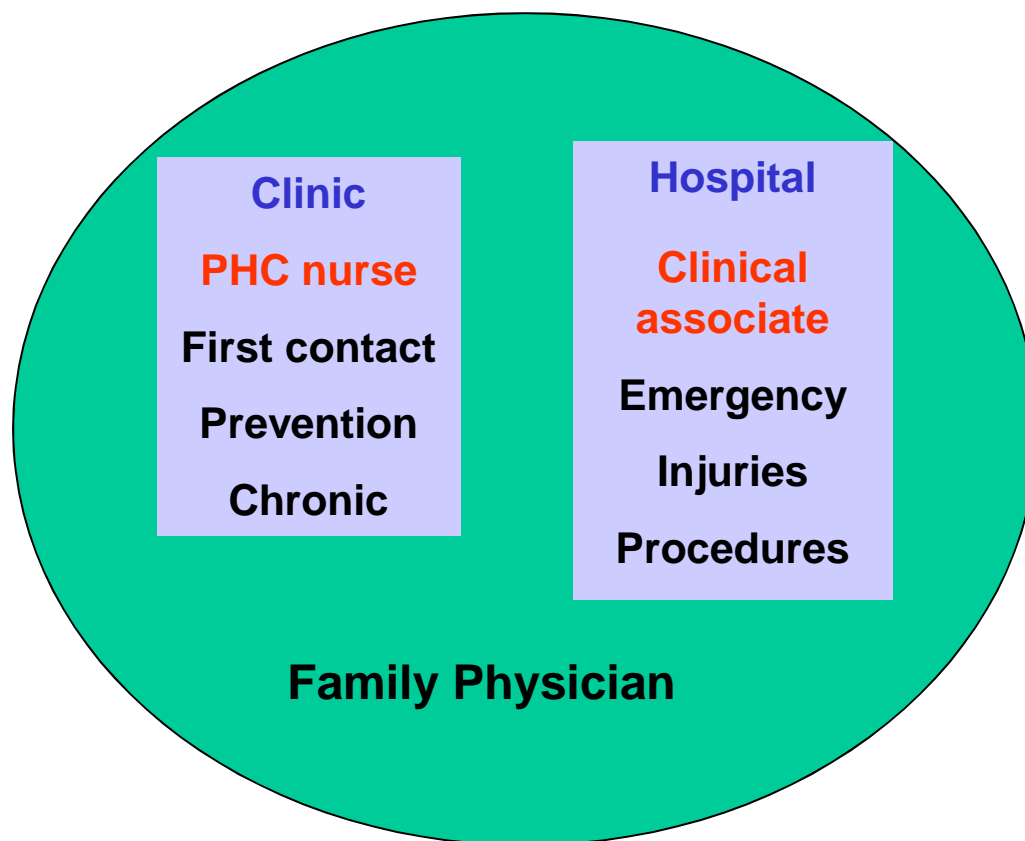


Scope/role

- US vs. Africa
- District Hospital
- Team member
- Assist doctor
- Procedures
- Areas:
 - Emergency unit
 - Theatre
 - Wards



3 Member Clinical Team



District Facilities





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Bachelor of Clinical Medical Practice

= BCMP

- Degree vs. diploma
- Length of study
- Name
- Process of developing a new degree
- Generalist vs. specialist debate



Underlying philosophy

- Curriculum must meet health service needs
- Process of training must address recruitment and retention
 - Which students are selected
 - Where students are trained
- Students must be prepared for the specific role they will play
 - Role definition is critical
- Context is not neutral in education



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Uniqueness

- Integration from outset
- Focus on clinical skills and procedures
- Systems and function approach
- Based in district hospitals
- District training complex concept
 - Lehurutshe example
- Taught by generalists



Context is Critical

- for learning
 - Relevance of curriculum
 - Appropriateness of skills
- for future practice
- for recruitment and retention
- for development of other people in same context



Key issue

- Academic education
 - Must obtain a BCMP degree
- vs.
- Professional training
 - Must have a set of skills and competencies
- Where is it best to achieve these?
 - Context more critical for professional training than academic education



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Local training sites

- Provide context
- Ensure appropriateness, relevance
- Facilitate patient-based learning:
 - Application of academic knowledge



Changing models of medical education

- Traditional medical education
 - Teach students in one context
 - Expect application to all contexts
 - Principles should cover all gaps
 - BUT students learn what they see, not what they hear:
 - Strength of the hidden curriculum



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Changing models of medical education

- New models of medical education
 - Teach students in many contexts
 - Learning by experience
 - Principles developed through application
 - Students learn what they see: exposure to many possibilities



What does this mean for Clin As?

- Specifically being trained to function in a district hospital context, so district hospital is most relevant training site
 - Contextualises learning in the district health system
 - Promotes teamwork
- DOES NOT MEAN NO TIME IN REGIONAL OR TERTIARY CENTRE:
 - Must be used for specific purposes/to address particular gaps



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In conclusion

- Curriculum based on service needs plus pragmatism
- Teaching and learning based on understanding of both educational and human resource (retention) issues
- Scaling up required to make any impact on the health system
- Watch this space ...