THE NEED, TRAINING AND ASSESSMENT OF PUBLIC HEALTH MEDICINE SPECIALISTS IN NIGERIA, WEST AFRICA.

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Order of Presentation

• Preambles
• Introduction: Early medical education in Nigeria
• Colonial medical and health services in Nigeria
• Post-colonial development of PH in Nigeria
• The NPMCN and the FPH training & services
• Recent improvements in the programme
• University PH training for doctors and others
• Efforts at improved understanding, CE & field practice of CM&H
• The need for African and developing countries active cooperation in CM&H; Conclusions.
Preambles

• Gratitude for our presence here and its genesis
• Our experiences and knowledge regarding the validity and important differences and relations between public health, preventive medicine, social medicine, preventive & social medicine, community medicine, community health, primary (medical) care, primary health care and lately also, public health medicine.
• My discussion to be on professional public health and community medicine otherwise also simply called community medicine; but not necessarily so in a PG medical college.
• Explanation for my emphasis and balancing
Introduction: Early medical education in Nigeria

• Early medical doctors in Nigeria were trained and/or resourced from the UK; USA/NA also, later
• Earliest medical education in Nigeria was for British West Africa, an MB,BS (London) degree
• MB,BS (Ibadan) from 1963 & very differently
• Residency programme in Nigeria from the 1970s
• Now 12 specialties in medicine and 2 in dentistry
• Public health as one of those; & a foundation faculty
• Was intentionally professional/statutory PH & CM
Colonial medical and health services in Nigeria

• Clinical medicine, surgery and PH all clearly established in the colonial period
• PH limited to vertical, legalistic, sanitary, urban health & DPH/MPH university-trained doctors but not of the full professional, whole community, bottom-up developmental paradigm
• My 1984 national situation analysis & needs assessment study showed only 41 MOHs out of the 141 minimum LGAs/needed at that time
• The residency programmes were not serving the staffing needs nationally
Post-colonial development of PH in Nigeria

• Community medicine & health never developed in Nigeria right up to Alma-Ata and beyond

• Wrong development of C/PHC in Nigeria in the late 1980s from our very enthusiastic and very powerful but vertical PH & preventive medicine experts

• Greater need today than ever before for authentic professional and statutory PH & CM in Nigeria/WA

• Ever more new age ‘community’ medical and health “professions” and quasi-professions arising

• Very poor or non true professionalizations; & need to develop the inter-disciplinary $2^0$ & $3^0$ PH also
The NPMCN and the FPH training & services

• The FMCPH from the outset intended professional & comprehensive PH & CM

• A 3 exams-based, minimum of 4 and maximum of 6 years training expected; with only 1 certification for only those who fully complete the programme in the few places approved for these

• 10 subspecialties; 3 theoretical, teaching-only or subsidiary practice subject areas; and 2 field practice applications expected for the part I exams

• Limited subspecialty excursions and dissertation expected of the senior residency

• Dissertation of MPhil/PhD level at part II (and “community project” also in the 1st 10 years)
Recent improvements in the programme

• Recent curriculum improvements under the present faculty leadership by self & others
• Training to be more truly competency-based, actively monitored, recorded and immediately countersigned by both technical and professional trainers all along the way.
• Log books introduced now also for the part II
• Other aspects of professional development encouraged and to be recorded and evaluated for each exam stage
• More sub-specialty & university based training and certification to be encouraged – up to 2 as possible
• Subspecialty certification in O&EM from now & why
• Case book/community project & certification for part I, & separate DMCPH programme for purely civil service intending specialists on the discussion table
University PH training for doctors and others

• University DPH/MPH have always been limited in curriculum, just enough to earn the credit units prescribed for the degree, as long as epidemiology & biostatistics are covered

• However, from the mid-70s in Lagos and early 90s following our 1984 study and pressures from other WA countries in Ibadan, comprehensive MPH covering all PH theories and why

• Currently 11 MPHs & 2 PGDs in PH in Ibadan, 4 MScs and 10 other MPH/MCHs in 10 other Nigerian universities, even one with no medical or professional health science school at all!
Efforts at improved understanding, CE & field practice of CM&H

• The continuing problem with CM training and services in the persistence of a wrong and unchanging, community-undermining PH system and inexperience in statutory/professional CM/H practice by most Nigerians including health staff!

• CE and professional development promotion in CM/H by and for Nigerian PH/C physicians – NPMCN, APHPN, AMOHN, departments of CM

• Zonal association meetings, etc, and AGM/SC sessions on state of CM/H & practice in Nigeria and the way forward
Plate 1: Mobile clinic service in Ankpa LGA 1978
Plate 4. Pictures of community health day at a village in the Fiji Islands.
Plate 3: Pictures of community health day at a village in the Fiji Islands II.
Plate 4: Pictures of community health day at a village in the Fiji Islands III
The need for African and DC active cooperation in CM&H; Conclusions

• Why professional/statutory PH & CM is needed in a special way in Africa and the DCs and not really so in the other countries
• The truly developing countries may also not need these as much and so might do with only PHM
• CN/M as the most desperately needed and why – see all countries at the time they did this – Sweden, SA?!
• PMC/SGMP/FM needs this also, whether in combined location with CM/PHC or of the primary specialty and nucleus of SHC in its full right.
• Policies, PH legislations, programmes of training and services that worked, etc, for sharing; and efforts to get the politicians to develop our countries and peoples too!
THANK U!