Chapter 2.1.6

SETTING UP DELTA STATE UNIVERSITY MEDICAL SCHOOL, NIGERIA

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Introduction

The move for a medical education that will train doctors in Africa who are aware of the socio-cultural attitudes of their patients and impacts of their environment started after the World Conference on Medical Education held in Edinburgh in 1988. This event was immediately followed by the implementation of a National Health Policy in Nigeria that saw primary health care become the cornerstone of the country's health system.

In August of 1989 the African Ministers for Health and Education met in Abuja, Nigeria, to fashion an agenda for change in medical education. At that meeting the then-Minister for Health for Nigeria, the late Prof Olikoye Ransome Kuti, mentioned inter alia that 'we cannot continue to train doctors to solve the health problems of other countries other than our own … We cannot continue to seek international recognition for our medical graduates which only permits them to emigrate at the earliest opportunity'. And the then-Minister of Education in Nigeria, Prof Jubril Aminu, noted that 'medical education has more strings attached to it than a dancing marionette ... Because of the large number of entrenched interest groups that contribute to or influence it' (1).

These guiding principles were to become the benchmark for setting up medical schools and the direction of medical education in Africa.

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A medical school in Abraka

It is within this context that the Delta State University, Abraka and its anticipated medical school was established three years later on 28 April 1992. This arose out of the metamorphosis of the Abraka campus of the defunct Bendel State University Ekpoma into a full-fledged university, following the splitting of the then-Bendel State into Edo and Delta States.

From the outset the university was designed to operate a completely rural multi-campus system. The infrastructure and equipment on all campuses were neither originally intended nor designed for university education, however, having been converted from a non-degree awarding college of education. This partly explains the level and dimensions of inadequacies in this rurally-based university – and the need to evolve a master plan that would guide the growth and development of a proper university became obvious.

The first curriculum development meetings took place from September to December 2004 – with the task of reviewing and developing an appropriate curriculum for the medical school that had started in the summer of 2002. Students were earlier admitted without having fulfilled accreditation requirements of both the Medical and Dental council and the National University Commission. There was a great and urgent need to correct this anomalous situation.

Fifty academics from traditional medical schools of Lagos, Ibadan, Benin, and two from Ilorin and Ife (where community-based experience and services (COBES) was already being implemented) worked under the leadership of Prof Austin Efe Ohwovoriole from the University of Lagos' College of Medicine, who was also chairman of the powerful Nigerian Medical and Dental Council committee on accreditation and medical education. It was agreed that the programme would compromise a traditional/ conventional medical school - with all the new concepts and innovations in medical education incorporated as relevant, at the different levels and in the different component programmes as possible; namely problem-based, student-centered, integrated, community-based, community-oriented, small group, self-directed learning programme.

The programmes were to run as pre-clinical and clinical blocks, with clinical introduced as early as possible even within the pre-clinical school. Most of the students were to be recruited from local communities without compromising the standards of Joint Admission Matriculation Board[2] . Levels would be as for the rest of the university with the medical programme running from the 200 level to the 600 level

Community-based medical education

The Delta State University College of Health Sciences Abraka resolved to produce doctors that are sensitive to the community health needs of the majority of the populace. The College established the community-based experience and services (COBES) programme as an innovative medical education, partly to assuage the feelings of those who felt strongly that the College should depart from the conventional model and forge a new integrated community-based path.

As part of this innovation, a professor of family medicine was appointed to drive this reform. To complement the COBES programme he developed a unit of rural, remote and riverine medicine which comprised integrated clinical experiential training with the intention to produce doctors who will live in these areas to manage the health problems occurring there.

In line with the commitment to innovation mentioned above, the curriculum is student-centred, community-based and problem-solving. During COBES, medical students are expected to be posted in the communities for experiential immersion at the 200, 300, 500 and 600 levels with specific learning objectives.

Challenges

Given the volatile nature of the local politics of the Niger Delta (that have had international implications) there have been some reversals in the establishing of these programmes. Students and faculty[3] are reluctant to stay in the remote communities for more than two weeks.

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2 This required five credit scores in English and mathematics and in the sciences of chemistry, biology, physics at the O levels and high scores at the matriculation exams, or three A-levels, or a Bachelors degree in Sciences.

3 'Faculty' is another term for members of academic staff.

Following Professor Jubril's caution in 1989 that 'medical education reforms are initiated by medical educators …The most militant advocates are among them ... so are also the most obstinate opponents', some influential and enlightened community members continue to insist that the medical school be run along traditional lines to meet international standards.

Accreditation of the clinical components of the programme from the National University Commission and the Medical Dental Council has also posed further challenge for implementing the programme.

Practice pearls

What to do

Generally:
- Purposely choose a rural location
- Ensure that there is support from state government
- get faculty from local medical school to help

Particularly in Nigeria:
- address NUC issues
- involve the Medical and Dental Council of Nigeria (MDCN)
- set up a curriculum development summit

What not to do

- Allow stakeholders unfounded excitement for Rural Medical Education to be the dominant driver of the initiative
- Agree to over-specialisation of care
- Compromise on research

In summary

Starting a new medical school in a rural location does not guarantee a change in medical education from the conventional and traditional curricula. At best, a mixture of curriculum can be envisaged.

References

1. *Medical education for Africa: Agenda for change. Highlight of an African ministerial consultation*. Abuja, Nigeria. p2-4. http://whqlibdoc.who.int/whf/1990/vol11-no3/WHF_1990_11(3)_p265-268.pdf (accessed 25 January 2014).

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