

**MOI UNIVERSITY**  
**SCHOOL OF MEDICINE**

**MMed in FAMILY MEDICINE**

# STRUCTURE

The curriculum is organized into two parts:

- Part 1 is covered during the first academic year.
  - Courses are in **epidemiology, biostats, and research methods**
  - **Clinical work** begins in out-patient and in-patient services
  - A **research proposal** is submitted, and must be approved by IRB *before* taking Part I Exam.
- Part 2 normally covers two academic years
  - Block courses for **management and community leadership**
  - Longitudinal **clinical** experiences continues
  - Focused clinical rotations build **competencies** where needed
  - **Research** data collection and analysis, report writing, and presentation; must defend thesis *before* taking Part II Exam.

# Curriculum

## COURSE STRUCTURE

Course Code	Course Title	Units
<b>Part I</b>		
MMB 801	Epidemiology and Biostatistics	4
MMC 810	Medical Ethics and Physicianship	2
MMR 801	Medical Research and Proposal Writing	7
FHC 810	Family Health <b>Clinical</b> Care I	<u>27</u>
	Total	40
<b>Part II</b>		
CHM 803	Health Services <b>Management</b> and Health Policy	4
FHC 820	Symptom-based <b>Learning</b>	6
FHC 822	The Art of Family Health	8
FHC 830	Family Health <b>Clinical</b> Care II	36
FHC 832	Individual and Family <b>Counselling</b>	2
FHE 836	Elective Period	6
FHL 820	Clinician as <b>Teacher</b>	8
FHL 830	<b>Community</b> Leadership	2
MMR 899	Research Project Implementation	<u>8</u>
	Total	80

NB: Highlighted words point to 5 areas of competencies: 1) Clinical, 2) Management, 3) Behavioural, 4) Community, 5) Teaching and Learning

# In practice...

- First Year: Mostly clinical, inpatient
- Second Year: More outpatient, though still hospital based
- Third Year: Management, Community Health, Health Centre rotation (1-2 months), Behavioural Science
- **Throughout:** Research project/ thesis writing

In the curriculum: **“Clinical Care”** (FHC 810 + FHC 830 + FHC 820 + FHE 836) = **63%** of units  
**“Community Leadership”** = **< 2%**

**Why the emphasis on clinical care and  
apparent neglect of Community Health?**

# Primary Health Care in Kenya

- Kenya fully embraces PHC, and has given responsibility for their Community Strategy and PHC to the District Medical Officer of Health: an MO, increasingly with an MPH.
- Clinical work at health centres (level 3) is at present done by Clinical Officers;
- Clinical work at district hospitals (level 4) is by intern-trained Medical Officers, and some consultants.

# Where Might Family Medicine Fit in Kenya?

- Function as or with DMOH
  - “FP will contribute to strengthened DHMT [and] at level 3... provide community leadership.” Kenya FM Policy Document
- Improve clinical care at Health Centres, reducing the referral *to* hospitals
  - “At level 3, provide... clinical care” Kenya FM Policy Document
- Improve clinical care at district hospitals, the place of first referral *from* Health Centres
  - “At level 4, ... provide clinical care” Kenya FM Policy Document

# The Present

- Kenya has chosen Family Medicine to be primarily clinical, to be practiced *at present* in district hospitals and large health centers.
- This plan has not been tested: our first class is only just now graduating, with placements beginning in 2009.

# Future Proposals

- At present, only students who have completed internship and at least two years of work, preferably rural, are admitted.
- Some have proposed that we
  - Admit students directly after internship
  - Increase the program length to 4 years
- Curriculum review is scheduled for April, 2009. We will likely increase to 4 years, the additional year to focus on non-clinical areas.