The definition of family medicine in sub-Saharan Africa

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Introduction

At a recent presentation of the study, *Exploring the key principles of family medicine in Sub-Saharan Africa*,[1] one of the audience challenged me by saying "So, where is the definition?" This editorial is an attempt to answer this question in the spirit of eliciting further dialogue and debate.

Family medicine is an emerging discipline in sub-Saharan Africa. In a few countries, such as South Africa, family medicine has established itself as a speciality and gained recognition. In many countries, however, the emphasis is still on building central referral hospitals and running vertical disease-orientated programmes. In these countries, family medicine departments, if they exist at all, are poorly resourced and struggling for recognition. Family physicians are few and may not be registered as specialists by the relevant health professions council. These same countries often struggle to provide quality care at the district level through primary care nurses, medical assistants or clinical officers and even when doctors are available they may not be appropriately trained.

Some countries, such as Botswana, Uganda and Kenya, however, are beginning to explore the possibility that training and employing family physicians at the district level could improve the quality of care in the services closest to communities. Internationally there is a body of research showing that stronger primary care services are linked to better health outcomes and lower overall costs. The number of family physicians in a community has also been linked to decreased mortality.[2]

When stakeholders such as ministries of health, local government, universities and regulatory councils start to engage with this issue, they often look to international experts or literature on general practice and family medicine. In doing this, there is a risk that experience with the organisation, role and scope of the practice of family medicine in other contexts, such as the USA or Europe, is assumed to hold true in the African context. In order to engage in a more relevant and clear dialogue about the contribution of family medicine to health systems in sub-Saharan Africa, it is necessary to have a regional definition. I hope that the World Organization of National Colleges and Academics (WONCA) Africa will take up this challenge.

The definition given below is based on a research project in which a regional panel of experts reached a consensus on the key principles of family medicine.[1] The definition is also shaped by the experience of the authors and discussions between family medicine departments in South and East Africa.[3]

In writing this definition we have divided it into three sections. In the first section are the core values of family medicine. If family medicine is a truly global discipline one would expect it to share these core values and for this section to have the greatest similarity to other regional definitions. This is followed by a section on the organisational principles of family medicine. The way in which the values of family medicine are expressed in the organisation of family practice will clearly differ between regions and countries, as well as between the public and private sectors. How the values of family medicine are best expressed in organisational terms is also affected by the demographics of the region, the burden of disease, the resources available and government policy. These organisational principles therefore represent a blend of current reality as well as realistic goals for the future. Finally, the role of the family physician is described, and once again regional variation would be expected due to different burdens of disease, health systems and availability of other specialists.

The core values of the discipline of family medicine are that it is:

1. **Comprehensive**: Deals with all issues related to health care, in all ages and sexes, regardless of the presenting problem, the organ system involved or the disease.
2. **Competent**: Cares competently for the majority of health problems in a specific community.
3. **Holistic**: Provides a holistic assessment of the patient that includes biomedical, psychological, social and environmental factors.
4. **Person-centred**: Cares for a person in his/her totality and not just for a specific illness, disease or organ system. Attempts to understand the person's perspective, which may include reasons for consulting, illness experience, ideas, beliefs, concerns, emotions, reactions and expectations.
5. **Relational**: Care requires a provider-patient relationship that may have therapeutic properties. This relationship is characterised by good communication skills, collaboration, patient participation, trust and confidentiality.
6. **Open-ended**: Is open-ended in its duration and not limited to any specific episode of illness.
7. **Family-orientated**: Cares for people in the context of their significant others, household members and family. Sometimes the provider engages with the whole family or other groups such as couples.

8. **Preventative**: Concerned with health promotion, patient empowerment and disease prevention.
9. **Community-oriented**: Connects the experience of individual patients with the broader public health issues in the health district. Practitioners are able to work with community groups, leaders and other government sectors to develop interventions that improve public health.

The key organisational principles of the discipline of family medicine are that:

1. It includes the primary care facilities *and* hospitals within the district health system.
2. It includes the family physician, clinical nurse practitioner and mid-level practitioner.
3. First-contact care is usually offered by clinical nurse practitioners or other mid-level practitioners who can refer patients to the family physician or other doctors.
4. It is delivered by a well-functioning clinical team that includes the clinical nurse practitioner, family physician, other doctors (such as interns and registrars) and mid-level practitioners.
5. It requires a broader multi-disciplinary team that includes professionals from other disciplines, such as nurses, pharmacists, administrative staff and social workers.
6. It engages with the broad network of local community resources and agencies that can assist with helping people.
7. It uses resources by decision making that is evidence based, ethical and sensitive to the personal needs of the patient, as well as equitable and fair to the community and health system.
8. Services are integrated horizontally within the health centre or clinic.
9. It is the gateway to accessing services at secondary and tertiary levels of care.
10. It is accessible to the community that is served and access is not limited by disability, geography, culture, race, language, religion, socio-economic status or administrative processes.
11. It is responsible for people living within a defined geographical area.
12. It is committed to co-ordinating the care of patients horizontally within the district health system, as well as vertically within secondary and tertiary levels of care.
13. It organises care to maximise the potential for continuity between consultations. Relational continuity with one provider usually is not possible and continuity is more often with the clinical team or at least the clinical information.
14. It actively attempts to involve representatives of the community in planning and improving their health care.
15. Community-based services such as home visiting are rarely offered by the clinical team, but may be possible through community health workers or other community-based agencies.

The role of the African family physician

In relation to the six core characteristics of primary care identified by Starfield,[2] the African family physician usually will not be engaged with first-contact care and may struggle to implement longitudinal and coordinated care in current health systems. Comprehensive care is a reality and a family orientation often is possible. Community-orientated care is relevant, but not yet an established characteristic. At present the key roles of the African family physician are:

1. **Care-provider**: The most senior practitioner in the district health system and able to care for the majority of illnesses in the community that is served. The scope of practice is tailored to the needs of the community and the availability of other specialist resources. Works as a consultant at the primary care level and is able to perform most of the common procedures and operations appropriate to the district hospital.
2. **Capacity-builder**: Mentors, teaches and supports other members of the clinical team, and provides leadership.
3. **Consultant**: Acts as a consultant to the rest of the clinical team and receives referrals from them (second-contact care).
4. **Supervisor**: Supervises other members of the clinical team, such as interns or registrars, during training.
5. **Manager**: Contributes to the management of facilities and the district, particularly through a focus on clinical governance and improving quality of care.
6. **Community leader**: Engages with important public health issues that arise from the community that is served. This may involve engaging with community leaders, nongovernmental organisations, public health specialists and other governmental sectors.

Conclusion

African family medicine shares many of the values as its global counterparts, but differs significantly in the way these values are expressed in the organisation of district health services, the extent to which they are a current reality and in the role of the family physician.

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