Letters

Family medicine is coming of age in sub-Saharan Africa

To the Editor: Recently I had the privilege of visiting Botswana and Malawi and discussing the development of family medicine training programmes in these two countries. The outcome is encouraging for the discipline of family medicine, but more importantly for the development of district health services in these countries.

Botswana

Figure 1: Prof Bob Mash, Dr Oathokwa Nkomazana and Prof Sam Fehrsen with staff of a new district hospital in Molepolole, Botswana

Botswana has historically trained its undergraduate and postgraduate medical students in other countries; however, only about 15% of doctors return to the country.[1] In primary care, out of 150 doctors only one is actually from Botswana. Therefore, despite the relatively small numbers of doctors needed for a population of 1.85 million it will be more cost-effective for Botswana to train their own doctors in the country.

Botswana currently has 3 referral hospitals, 7 district hospitals and 16 primary hospitals. Of the 7 district hospitals 4 are newly built, large 350-bed facilities that currently do not have the available expertise to offer comprehensive services. The government is now appointing foreign specialists to run these new hospitals. Another challenge is that the hospitals are run by the Ministry of Health and the primary care clinics by the Ministry of Local Government, although district hospitals and primary hospitals differ only in terms of size. There is thus a need for greater collaboration and joint planning. Currently there are no qualified family physicians in Botswana's public sector, although there are a number of students currently enrolled in South African training programmes. There is an awareness that the services offered by the district and primary hospitals, as well as in primary care, could be enhanced by employing specialist family physicians.

In 2009 the University of Botswana's new Faculty of Health Sciences intends to introduce an undergraduate MBChB programme and, at the same time, launch key postgraduate MMed programmes. One of the programmes identified is Family Medicine. The local Health Professions Council has already created a new category for family physicians.

Malawi

Malawi has a population of 13.6 million and 28 health districts. Unlike Botswana, Malawi has an established medical school and is currently increasing its output from 20 to 60 doctors annually. At present, most of the doctors that remain in the country are employed by the central hospitals, private practice or development agencies that can offer higher salaries. Forty per cent of health care is delivered by the non-governmental Christian Health Association of Malawi. The author visited a regional hospital in Zomba where none of the specialists are actually Malawian.

Malawi, like Botswana, has recently invested in the building of several new district hospitals but is also struggling to offer comprehensive quality services due to the absence of doctors. Primary care services are generally delivered by medical assistants who have a two-year diploma and the district hospitals are largely run by clinical officers who are mid-level health workers with a four-year diploma. The only doctor at the 350-bed district hospital visited was the District Health Officer, who mainly has public health and managerial responsibilities. The vacancy figures show a clear trend: only 72% of medical assistants, 64% of clinical officers, 43% of medical officers and 23% of specialist posts were filled during 2007.

In the past, family medicine was perceived as an unrealistic idea as it was seen in terms of the UK system of general practice. More recently, however, academics and managers of the health system have begun to realise that a specialist family physician who is trained to work independently at the district hospital and in primary care could be a useful addition to the medical staff. The human resources plan already includes the possibility of creating four specialist posts at most of the district hospitals. The Medical Council already has a category for Family Medicine. The Medical Council already has a category for Family Medicine and there is currently one person on the register. The College of Medicine is therefore hoping to develop a curriculum for the training of family physicians as part of an MMed programme, and to commence with training as early as 2009. Such an initiative would of course require support from the Ministry of Health and the Health Council. Further incentives may be required to attract and retain family physicians in the more remote district hospitals.

Primafamed Conference

In November 2008 people representing 13 different countries in Sub-Saharan Africa (Democratic Republic Congo, Ethiopia, Ghana, Kenya, Lesotho, Mozambique, Nigeria, Rwanda, South Africa, Sudan, Tanzania, Uganda and Zambia) came together in Kampala to discuss improving the quality of family medicine training. Interest in developing family medicine was higher than expected and international participants also included family physicians from Afghanistan, Australia, Belgium, Canada, Netherlands, United Kingdom and United States. The conference (www.primafamed.ugent.be) welcomed the recent World Health Report "Primary Health care: Now More Than Ever" which emphasizes people-centred primary care and is synergistic with the key values and principles of family medicine. The conference also launched a new on-line journal for the region entitled the African Journal of Primary Health Care and Family Medicine (www.phcfm.org). The conference supported the campaign for donor organizations to allocate 15% of their budgets to strengthening the primary care system as a whole, and not just specific disease programmes, by 2015 (www.15by2015.org). A new initiative to twin South African departments of family medicine with emerging departments in the region was also discussed and, in addition to the countries mentioned above, will lead to support for family medicine in Botswana, Malawi, Namibia and Swaziland.

Conclusion

It is clear that politicians, health managers and academics are

beginning to realize the potential contribution of family medicine to district health systems in sub-Saharan Africa. This is in part due to the modeling of family medicine as a cornerstone of the district health system in South Africa and the emergence of established postgraduate training programmes in other countries such as Nigeria and Kenya. The emergence of a clearer definition of family medicine in the region and a recognition that while core values may be shared the organizational aspects and scope of practice are not the same as in Europe or America has also been important.(2)

In October 2009 South Africa will host a WONCA Africa Congress, which is expected to lead to a more formal publication of a regional definition of family medicine.

Although family medicine in South Africa has moved further along the development pathway than most other sub-Saharan countries, the contribution to district health systems will only be fully realized and evaluated over the next decade. In South Africa we have a responsibility to not only fulfill this potential but also to offer support to those countries that wish to walk the same path to better district health care.

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