From Alma Ata to Astana

Family Medicine is at the centre of the progress that has been made in developing primary health care in sub-Saharan Africa

Delegates during the morning session at the Global Conference on Primary Health Care in Astana, Kazakhstan

In 1978, in Alma Ata, Kazakhstan, the WHO Declaration on Primary Health Care proclaimed PHC the main focus a country's health system. It stated:

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and a country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.[1]

Rarely has more vision and wisdom been contained in a few lines! However, the immediate response to this declaration in Africa was rather limited as countries were suffering from socio-economic and political hardship and neo-colonialism was omnipresent. In 2008, the World Health Report, *Primary Health Care: Now more than ever!* had more impact as it was recognised by PHC teams as a supportive invitation to look at people-centred care from a comprehensive eco-bio-psycho-social perspective, integrating strategies to address social determinants of health in daily practice and focusing on universal health coverage (UHC).[2] On 25 October 2018, the Global Conference on Primary Health Care formulated the new Astana Declaration on PHC, re-emphasising that 'Strengthening PHC is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that PHC is a cornerstone of a sustainable health system for universal Health Coverage (UHC) and health-related Sustainable Development Goals (SDGs).'[3]

In this article we analyse what progress has been made in practice and in education with respect to the development of PHC in sub-Saharan Africa.

Starting in the community

In most African countries, the districts represent the decentralised system of government. Increasingly, it is at this level that PHC policy development and governance is situated. Here is where providers and organisations are accountable for providing access to quality primary care for the whole community.[4] In the district, PHC centres or Community Health Centres (CHCs) provide comprehensive care by inter-professional teams that might include nurses, family physicians, community health workers (CHWs), social workers, health promoters and nutritionists. The centres are surrounded by clinics where nurses and CHWs provide first (front-line)

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contact care and support and refer patients to the centres when necessary. Family physicians may 'outreach' to the clinics (e.g. once a week) to support the work of the nurses and CHWs and advise on complex problems. With their person-centred training and competencies, family physicians can play a key role in quality PHC delivery.[5] However, this is often not the case: owing to a lack of human resources and a limited availability of specialists (obstetricians-gynecologists, anesthesiologists, surgeons), family physicians are forced to substitute for specialist functions in the district hospital (and sometimes even in the regional hospital), reducing their opportunity to provide PHC and to work in the community with ambulatory patients.

A second challenge for providing integrated comprehensive care at the level of PHC centres and CHCs comes from vertical disease-oriented programmes. The advent of HIV/AIDS in the 1980s and 1990s led to a fragmented approach, due to earmarked donor funding, specific staff and treatment for patients with a specific condition. Such 'selective PHC'[6] hindered the development of integrated, comprehensive PHC and created 'inequity by disease' as access to services was restricted according to diagnosis.[7] This was completely the opposite of the broad generalist approach that characterises PHC. Presently, we see a similar development in the field of chronic conditions, with vertical programmes for diabetes, hypertension, Chronic Obstructive Pulmonary Disease, cancer, etc. In 2008 the 15by2015 campaign tried to reverse this trend, asking donors that financed vertical disease-oriented programmes to invest by 2015 15% of the resources needed for strengthening comprehensive PHC.[8] The intellectual and moral support for this campaign was strong, but it took a decade before change started to happen in practice.

An opportunity for PHC in Africa is undoubtedly

Box 1: CHCs in South Africa, Malawi and Belgium

In **South Africa**, Chiawelo Community Practice (CCP) was set up in 2013, in a small section of Chiawelo CHC (one of five CHCs within Soweto, Johannesburg) as a model to reclaim COPC and the true CHC model. It serves a community of around 22,000 people and is staffed by a part-time family physician, a clinical associate, two intern doctors rotating weekly, and 20 CHWs who work under the guidance of a junior nurse team leader. The CCP team delivers people-centred care. Promising outcomes have been documented: lower waiting times than at the general CHC; reduced rates of avoidable utilisation; high satisfaction rates among patients; and a high compliance rate (83%) with national standards of chronic care. Drawing from local data, local stakeholders are highly engaged in supporting a growing inter-sectoral health promotion programme. The centre's CHWs have set up five health clubs in the community with ±150 elderly chronic patients involved in daily exercise, diet, and social sessions to combat social isolation. CCP has renewed COPC in South Africa. Students rotating through CCP are motivated to reconsider some negative perceptions of primary care and family medicine, and CCP is also influencing national policy: COPC is being explored as the core model in design of the new PHC capitation contract under South Africa's National Health Insurance System.(11)

In Nkhoma Mission Hospital in **Malawi**, COPC has been practised for many years. In order to become familiar with the concept, post-graduate Family Medicine registrars 'adopt' several health centres during their training. The registrars make monthly visit to these health centres. During their visits, registrars discuss referrals and complicated cases with health centre staff. Several times a year, village chiefs and representatives from local NGOs gather in the health centre, in the presence of the registrar, to discuss any health issues in the community. The registrars and health centre team try to find public health responses to tackle these issues. Through these processes, we have noted that collaboration and communication has greatly improved between health centre and mission hospital, and with the surrounding communities. It has been a great learning opportunity for all.

In **Belgium**, CHC Botermarkt was established in 1978, in Ghent's Ledeberg neighbourhood, one of the most impoverished in the city at that time. The CHC initiated consultations and home visits by inter-professional teams to address psycho-social needs. In the mid-1980s, the CHC's family physicians, nurses and social workers put poverty as a core determinant of health on the agenda of local authorities. They convened a multi-sector partnership within the neighbourhood that included primary care providers, schools, police, social welfare institutions, informal care givers, and civil society organisations to address the upstream causes of ill health. The CHC used a COPC-approach, analysing anonymised health and social data collected from primary care visits and encoded with the International Classification of Primary Care to arrive at 'community diagnoses'. Core health challenges – including poor the physical condition of young people, lack of traffic safety, epidemics of lice and scabies, poor oral health, and multi-morbidity – were all addressed by re-prioritising health care services and cooperating across agencies for inter-sectoral action.(12)

Engaging and giving 'a voice' to diverse groups and residents in the community has become increasingly important. Over the past 20 years, the population of 6,200 people served by CHC Botermarkt has diversified from some 30 to 107 nationalities of origin. Partly this illustrated the impact of migration and the arrival of refugees. CHCs are responding to these developments by investing in appropriate care for refugees and respect for human rights. In this global context, it is more important than ever to build strong, community-oriented responses at the level of primary care leading to increased connectedness and social cohesion.(13)

Examples from by the International Federation of Community Health Centres (www.IFCHC.org)

the development of Community Oriented Primary Care (COPC), first developed in South Africa in the 1940s.[9]

> COPC is defined as the systematic assessment of health care needs in a practice population, identification of community health problems, implementation of systematic interventions involving target population (e.g. modification of practice procedures, improvement of living conditions) and monitoring the effect of changes to ensure that health services are improved and congruent with community needs. COPC teams design specific interventions to address priority health problems. The team, consisting of primary care workers and community members, assesses resources and develops strategic plans to deal with problems that have been identified. COPC integrates individual and population-based care, blending clinical skills of practitioners with epidemiology, preventive medicine, and health promotion, minimising the separation between public health and individual health care.[10]

Box 1 documents examples of COPC implementation in CHCs, illustrating the global relevance of this approach.

These examples illustrate that strong PHC has the potential to provide integrated person- and people-centred care, and to address the social determinants of health through inter-sectoral action, underpinning a global 'health-in-all-policies' strategy. So the ambition for PHC should go far beyond UHC, but contributes to a transformational societal process.

The discipline of family medicine

Building the capacity of health care professionals with an appropriate mix of skills for PHC is a continuing challenge in Africa. This certainly also applies to the discipline of family medicine. Family medicine has been practised and taught in South Africa since the mid previous century, though it was only accepted as a specialty in 2007, and official training of family physicians commenced in 2008.[5,12–14] In Kenya, specialised training in family medicine was first mooted in 1998 and formally started in 2005.[4] The most recent programme started in Malawi in 2016.[15] In Nigeria, the first family medicine training programme started in 1981, while in Ghana the family medicine residency programme was launched in 2005.[7,16] Uganda started a family medicine programme, originally called Community Practice, in 1989, while Sudan launched one in 2010.[8,17,18]

At the 2010 conference of WONCA Africa (the Africa region of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians), a comprehensive definition of family medicine in Africa was formulated, emphasising that:

> The family physician in Africa operates according to the principles of comprehensive person-centred care, with a family and community orientation, responding to undifferentiated illness and acting as the medical discipline in the primary health care team. The role of the family physician involves a comprehensive set of skills adapted to the circumstances, local needs, available resources, facilities and the competency and limitations of the practitioner. The family physician has a commitment and responsibility to a defined population to whom they are accountable through its representative structure.[14]

Since 1997, the Primafamed-Network (which started as the Family Medicine Education Consortium in South Africa – FaMEC) has supported the development of the training of family physicians in an increasing number of countries in SSA (today almost 20: see primafamed.ugent.be). The strategy focused on exchange of recruitment methods, curriculum design and content, establishing training complexes, exchanging programmes, staff and international external examiners and holding an annual Primafamed workshop.[15] Flinkenflögel et al. assessed the impact of the Primafamed Project looking at the developmental progress at the level of the participating departments of family medicine and PHC in the period 2008–2011. All departments made considerable progress, and the 'strengths, weaknesses, opportunities and threats analysis' illustrated that support from local authorities for the departments is of utmost importance. Training of family physicians is a slow process, but South–South cooperation is an effective strategy.[15]

There is still a lot of debate about how family physicians can best define their future roles. According to some authors the future for the discipline of family medicine is in a community-oriented, primary care perspective:

> We need to recapture our focus on primary care. We need to reconsider how we can train family doctors for primary care better. ….We also need to move away from our current hierarchical model and incorporate primary health care nurses and clinical associates into the PHC team, and to include them as genuine partners in the organisations and training. We need to look at how we relate to public health medicine, and work more closely with our community medicine colleagues, for the sake of communities. … We believe it is not too late for us to change direction and to find the right way forward for the sake of health care.[18]

Policy measures to strengthen PHC

Educational efforts are very important but may not be successful without the necessary political reforms. More money should be invested in health in Africa (according to Abuja Declaration, at least 15% of GDP) and at least a quarter of the health budget should go to PHC. The investment in PHC should not only focus on CHWs but also on well-trained nurses and family physicians. Of all the investments in African health care, PHC will have the highest return on investment.

PHC teams should be financed according to a list-based 'risk-adjusted integrated capitation system'.[19] This may help to shift from cure to prevention, stimulate self-reliance, and increase competency-sharing and task-shifting. This strategy of financing PHC teams enables governments to have a common approach to public, private, NGO and faith-based teams. PHC teams should have a gate-keeping function, providing appropriate referrals to secondary care.

A major effort is needed to change undergraduate and post-graduate training in all disciplines (nursing, medicine, social workers, nutritionists), with an emphasis on generalism and inter-professional cooperation. CHWs should be appropriately recruited, trained and remunerated. At least 40% of the medical graduates should be trained for family medicine,[20] and those

candidates should be exempted from compulsory community service. All kinds of brain drain (from rural to urban, generalist care to vertical donor-funded programmes, from family medicine to specialist care, from central to southern Africa, from Africa to the West), should be addressed, for instance by an international regulation that every Western country that integrates a health-care provider from a developing country into its health system should reimburse the country of origin with the full training cost of that professional in the Western country.

Delegates from East Africa at the Global Conference on Primary Health Care in Astana, Kazakhstan

Finally, strategies should be put in place to address social determinants of health, turmoil and war, to strengthen respect for human rights and address corruption at all levels.

Conclusion

The Astana Declaration makes clear that a new effort is needed to strengthen PHC in Africa. We describe what could be done at different levels, and how PHC should be ambitious, not only in terms of creating UHC, but by an inter-professional and inter-sectoral investment in care based on relevance, equity, quality, people-centredness, cost-effectiveness, sustainability, innovation, and the principle of leaving no one behind. In order to make that happen integration of PHC and social care and of primary care and public health is of utmost importance. Inter-professional PHC teams, operating in health centres with surrounding clinics and a district hospital, may be the way forward.

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