The current state and future of family medicine in Africa

Innocent Kabahena Besigye and Robert James Mash give us an insight into the growth of Family Medicine in Africa and its role in Primary Health Care.

Africa is the last continent to embrace family medicine as a discipline and specialist family physicians as a key component of their health workforce. Given the scarcity of health workers, including doctors, most countries have focused on deploying specialists in central and referral hospitals. Some countries look to Europe and the United States, where doctors provide first contact care, and say we can never afford that, and it would not be feasible here. There is a need to argue for and demonstrate the value proposition for family physicians in a fit-for-purpose model of care.

Despite global and governmental political commitments to primary health care this has not yet fully translated into high quality primary care, multisectoral action on health or community participation in a meaningful way[1]. Primary care services have historically developed a very selective approach to the package of care. After Alma-Ata countries transformed the broad vision of 'health for all' into a strategy for child survival based on the GOBI-FFF package of care (Growth monitoring, Oral rehydration, Breast feeding, Immunisations, Family planning, Food supplementation, Female education). These services were offered by health care workers with little or basic training in primary care, such as community health workers or nurses. Subsequently, many countries developed verticalized disease programmes, often with donor funding, to tackle priority diseases such as HIV, TB or malaria.

The development of high-quality primary care requires a commitment to first contact access, comprehensiveness, continuity, coordination and person-centredness, as well as essential public health functions[2]. Health systems that deliver on such an integrated and comprehensive approach will need doctors trained in family medicine as part of their primary care teams[1]. On the one hand community health workers can expand coverage, disease prevention and health promotion in a community-orientated approach[3]. While on the other hand, family physicians can add value to the primary care team and closely linked primary hospital. The majority of first contact primary care will remain with nurses or clinical officers.

Family physicians bring more advanced clinical skills to the team which enables them to better manage multimorbidity, chronic conditions and complexity[4]. They also bring more procedural skills closer to the community, particularly filling skills gaps in the primary hospital in areas such as maternity care, surgery and anaesthetics. They act as consultants and capacity builders to improve the competency and performance of their clinical teams. Increasingly they also act as clinical trainers for medical students, interns and registrars. Family physicians also have a key role in improving patient safety and quality of care through leadership of clinical governance activities.

In Africa, the need for family physicians is high. Over the years, there have been efforts to scale up family medicine education in the continent but with limited success[5]. The current training programmes cannot meet the existing need unless innovative scale up approaches are instituted. Such approaches will include inclusion of family medicine in the undergraduate curriculum coupled with early clinical exposure to practicing family physicians to serve as role models[6]. The establishment of the East, Central and Southern African College of Family Physicians is expected to significantly contribute to the scale-up of training across 11 countries[7]. Scale up will require political commitment and deliberate investment by our governments for training opportunities and family physician posts. This is something they have already committed to in the WHO resolution on "Accelerating action on the global health and care workforce by 2030". In this resolution there is a "special focus on the primary healthcare workforce in remote or otherwise vulnerable health settings in order to accelerate progress towards universal health coverage"[8].

Like any other medical speciality, family medicine strives to develop following the three domains of training, practice and research. Training ensures the lifeline of the speciality by increasing and replenishing the pool of specialists, practice demonstrates the clinical value of the specialty while research increases the body of knowledge and evidence for improvement in training and practice. Table 1 summarises the status of family medicine in Africa and the proposed future within the framework of the three domains.

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Table 1: Summary of the current and proposed future of family medicine in Africa.

Current	Future
Training	
Family medicine training does not happen in all countries and even within countries, not in all medical schools	Scale up family medicine postgraduate training opportunities and registrar posts in all countries and medical schools, including rural areas.
Limited or absent family medicine exposure in undergraduate curricula	Inclusion of family medicine in all undergraduate curricula
Postgraduate training is mainly university-based in east, central and southern Africa. In west Africa, training is college-based	Combination of university and college training opportunities for family physicians, such as development of ECSA-CFP.
Training of family physicians is done by non-family physicians in some countries or medical schools	Ensure that family physician training happens in appropriate settings and primarily by family physicians
Undergraduate and postgraduate family medicine training content is heterogeneous across the continent	Harmonised family medicine training content and outcomes across the continent
Family medicine not included in internship training in most countries.	Family medicine included as mandatory component of internship training
Lack of expert teachers of family medicine, especially in new training programmes	Faculty development, South-South-North collaboration, and training of clinical trainers
Practice	
Family physicians deployed to fill gaps at referral hospitals or as managers within the health system	Family physicians deployed in primary care and primary hospitals as clinicians leading clinical teams
Family physicians not accounted for in human resources for health policy	Countries report on the numbers of family physicians and have clear policy goals
Family physicians not recognised or remunerated appropriately	Family physicians recognised as specialists and appropriately remunerated in the public and private sectors
Family practice is not based on empanelment and services to defined populations or communities	Family physicians leading team-based care empanelled to defined populations and communities.
Family physicians are more likely to be found in metropolitan areas and primary hospitals	Posts are created in rural areas and primary care facilities or subdistricts
Research	
Low numbers of established family medicine researchers who are unevenly distributed	Development of a researcher training pipeline from emerging, to early career and established researchers across the region
Primary care research agenda not well developed despite the widespread research gaps in the region.	A well-developed regional primary care research agenda to generate evidence for family medicine and primary care advocacy
Research training capacity is limited, as many family medicine programmes lack capacity for doctoral training	Availability of research capacity with most family medicine programmes able to offer doctoral training
Most studies in family medicine and primary care are descriptive with inability to generate higher level evidence to inform policy and practice.[9]	Family medicine research includes more observational analytical studies and clinical trials, as well as multi-centre interdisciplinary collaborative research projects, and practice-based networks.
Research lacks a focus on children, palliative care, older adults, rehabilitation, continuity and coordination.[9]	Family medicine research is more comprehensive across the life course, continuum of care and core functions of primary care



Africa humanitarian aid doctor taking care of patient
***Source**: Freepic*
***Available from**: https://tinyurl.com/mr2cudwt*

How the current state of family medicine in Africa was achieved

Since the 1960s, when family medicine training and practice started in South Africa and Nigeria, its development has been progressive, albeit slow. The more rapid growth of family medicine occurred in the last ten years with new programmes starting in countries such as Zimbabwe, Zambia, Angola, Somaliland among others[5]. The Primary Care and Family Medicine (PRIMAFAMED) network, a network of academic departments across more than 25 countries in sub-Saharan Africa, has provided a platform for working together and capacity building through annual physical meetings, monthly educational and research online workshops as well as collaborative research projects.[10] Other organisations like the World Organisation of Family Doctors (WONCA) have played a supportive role in the development of family medicine in Africa. Biennial regional and world conferences help in development of collaborations and networks for working and learning together in scaling up family medicine in Africa.

In many African countries, family medicine is a recognised specialty. In such countries, family physicians are employed by governments as medical specialists. However, in other countries like Somaliland and Eswatini, family medicine is not a recognised specialty with no provision for registration of specialist family physicians. There is also a differentiated approach between English-, French- and Portuguese-speaking countries. Family medicine appears to be less developed in French-speaking African countries and this may be partly explained by the different colonial histories[11]. Angola, a Portuguese speaking country, has recently implemented family medicine at scale with support from Cuba and Brazil.

Many family physicians work in the private sector alongside doctors with no postgraduate vocational training. In most countries the medical insurance companies do not acknowledge the specialist training and extended scope of practice and do not remunerate specialist family physicians any differently.

The African Journal of Primary Health Care and Family Medicine, the official journal of WONCA Africa that was initiated by PRIMAFAMED, provides opportunities for family medicine research capacity development. Most African family physicians have their first publication in this journal and peer reviewing helps them to develop confidence and skills in research methods and scientific writing. The journal's African focus and scope provide opportunities for publishing context-specific articles which otherwise would not have been published in journals from other regions and high-income settings.

Achieving the future

The envisioned future of family medicine in Africa will be achieved through adapting the current initiatives to the dynamics of a rapidly changing world. Such changes are ecological (e.g. climate change and pollution), geopolitical (e.g. changing donor landscape), technological (e.g. emergence of artificial intelligence and digital transformation) and socio-economic (e.g. increasing migration, urbanisation). These changes impact the health needs of communities and the model of primary care and should influence the planning of future family medicine and primary care services.

We call on governments to invest in family physicians as an essential component of high-quality primary care and primary hospital care, as leaders of multidisciplinary teams. To go to scale there needs to be a commitment to expanding training programmes and opportunities as well as ensuring a high standard of training and assessment. Family physicians should be trained by family physicians and in settings where family medicine is practiced. Support for the East, Central and Southern African College of Family Physicians will be important.

Training should keep the need for health equity in mind and ensure training programmes are also located in rural areas. This will ensure availability of a variety of family physicians with ability to meet the diverse needs of the different populations and communities. This will also ensure equity and improved social accountability of the family medicine speciality.

In future all primary care teams should have access to a family physician and all primary hospitals should have family physicians. Family physicians should be in health centres and larger primary care facilities and provide outreach to smaller clinics and health posts. Human resources for health policy should set feasible goals and countries should track progress. All communities deserve high quality primary care that is accessible, comprehensive, ongoing, coordinated and person-centred. Health systems need family physicians as part of their multidisciplinary teams to achieve this. WONCA will need to support evidence-based advocacy in many countries, and the WHO Afro region should advise governments accordingly.

Africa faces unique health challenges that can only be answered by context-specific research studies. Family medicine and primary care research should be based on priority research questions identified by the different stakeholders, who include researchers, practitioners, users and patients, and policy makers. The WHO's PHC measurement framework can provide a useful map,2 and research should address both clinical issues as well as health systems and services strengthening. To answer these questions, we will need a broader menu of methodological approaches, a growing body of established researchers and a functional developmental pipeline from emerging (e.g. Masters and Doctoral students), to early career (e.g. post-doctoral students) and established researchers. Funders should support more family medicine and primary care research from the African region, where all health sciences research currently makes up around 1-2% of global outputs[12].

Conclusion

The current state of family medicine training, practice and research in Africa cannot meet the health needs of communities. There is a need to deliver on primary health care as a whole of society approach and high-quality primary care that embodies the five core functions. Implementing family medicine and deploying family physicians at scale is essential to achieve these goals. Deliberate efforts include scaling -up family medicine training models, embedding the need for family physicians in policy, and building capacity for context-relevant research. Strong advocacy from WHO and WONCA will be needed to achieve this vision.

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