

Understanding of family medicine in Africa:

a qualitative study of leaders' views

Abstract

Background

The World Health Organization encourages comprehensive primary care within an ongoing personalised relationship, including family physicians in the primary healthcare team, but family medicine is new in Africa, with doctors mostly being hospital based. African family physicians are trying to define family medicine in Africa, however, there is little clarity on the views of African country leadership and their understanding of family medicine and its place in Africa.

Aim

To understand leaders' views on family medicine in Africa.

Design and setting

Qualitative study with in-depth interviews in nine sub-Saharan African countries.

Method

Key academic and government leaders were purposively selected. In-depth interviews were conducted using an interview guide, and thematically analysed.

Results

Twenty-seven interviews were conducted with government and academic leaders. Responders saw considerable benefits but also had concerns regarding family medicine in Africa. The benefits mentioned were: having a clinically skilled all-rounder at the district hospital; mentoring team-based care in the community; a strong role in leadership and even management in the district healthcare system; and developing a holistic practice of medicine. The concerns were that family medicine is: unknown or poorly understood by broader leadership; poorly recognised by officials; and struggling with policy ambivalence, requiring policy advocacy championed by family medicine itself.

Conclusion

The strong district-level clinical and leadership expectations of family physicians are consistent with African research and consensus. However, leaders' understanding of family medicine is couched in terms of specialties and hospital care. African family physicians should be concerned by high expectations without adequate human resource and implementation policies.

Keywords

Africa; definition; family practice; healthcare systems.

INTRODUCTION

The World Health Organization argued that primary care service delivery needs reform,¹ principally shifting towards comprehensive primary care within ongoing relationships between patients and providers, whether providing care as individuals or as teams. The primary care team is also expected to take responsibility for the health of a defined population and not just the patients presenting at facilities.

Internationally, family medicine promotes this person-centred and community-orientated approach; however, much of the international primary care system is based on doctors delivering first-contact care. There is a worldwide trend to team-based care (including nurses, family physicians and community health workers), owing to spiralling health costs. This is supported by the World Health Assembly.²

While strong primary health care is essential to provide efficient and effective health care in both resource-rich and resource-poor countries,³ the role of family medicine cannot be assumed to be the same everywhere. There have been renewed efforts globally to define the principles and practice of family medicine,⁴ for example, the European definition of general practice in 2002, the future of family medicine in the US in 2004, and the future

of general practice in the UK in 2007, as well as operational definitions of attributes of primary health care in Canada.⁵⁻⁸ African primary care systems are poorly resourced and hence rely considerably on the primary healthcare team, usually led by non-doctors. Generalist doctors are expected to staff district hospitals, to bring hospital care closer to the community.

Most generalist doctors, including private GPs in the small private sector, function with only their undergraduate training. Postgraduate training in family medicine has only emerged in six countries (Kenya, Ghana, Nigeria, South Africa, Tanzania, and Uganda) over the past 20 years. This has only become substantial recently; for example, the specialty has only been fully recognised in South Africa since 2007. This success has emerged mostly from responding to public service needs, especially in district hospitals. Family physicians have felt the need for surgical, anaesthetic, and procedural skills to provide services at the district hospital, as well as skills in mentoring and teaching frontline primary care workers.^{9,10} These skills are reflected in training that is different from European or North American models.¹¹

African family physicians have felt the need to clearly define family medicine in Africa, in the light of global trends in family

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How this fits in

African leaders are positive about the contribution that family medicine can make to health systems in Africa, but are unclear as to exactly what the role of the family physician is, or should be. There are high expectations of the discipline, some of which are unrealistic in the absence of comprehensive plans. Family medicine in Africa needs to advocate for context-appropriate human resource policies and implementation plans that appropriately include family physicians in the primary healthcare team.

medicine and experiences in Africa. One study has defined the principles of family medicine in Africa from the perspective of family physicians.⁹ A second study explored grassroots views on the role of the generalist doctor in Africa.¹⁰ The 2nd African Regional World Organisation of Family Doctors (WONCA) Conference also reached a consensus statement in 2009 that articulates what family medicine has to offer in an African context.¹² This academic discourse and growing consensus is being used to engage various leaders in sub-Saharan Africa on implementation of family medicine. The aim of this study was to understand the views of key leaders in sub-Saharan Africa, in order to engage effectively. Key areas explored were how leaders understood the discipline of family medicine, and their views on implementation challenges and human resource issues.

METHOD

Study design

This was a qualitative study, using in-depth interviews of leaders across the setting of nine countries in southern, eastern, and western Africa. Members of the study population were leaders in higher education institutions or the department of health in various countries. Partners in the PRIMAFAMED Africa Network of departments of family medicine in 16 African countries were asked to purposively identify four key leaders in each country, who were seen by them as influential to the development of family medicine, two in a government department of health and two in an academic institution. Those with postgraduate education in family medicine were excluded.

Data collection

The authors, and key people in the

PRIMAFAMED Africa Network, who were all briefed and trained in qualitative interviewing and orientated towards the study objectives, performed the interviews. Written informed consent was obtained before a 30–60 minute interview. A standard operating procedure and interview guide were used to explore the viewpoint of interviewees. Questions asked were:

1. Can you tell us about family medicine?
2. What are your thoughts on the role of family medicine in your country?
3. What do you think are the issues in implementing the discipline of family medicine?
4. What are critical human resource issues to establishing family medicine?
5. Do you have anything else to add?

Interviews were recorded digitally and conducted in English, except in the Democratic Republic of the Congo (DRC) where they were conducted in French and translated into English by the interviewer. The interviewers transcribed digital recordings verbatim. The transcriptions were separately validated against digital recordings.

Data analysis

Qualitative data analysis followed the framework method.¹³ All authors familiarised themselves with the data. The six authors met in November 2011, identified major and minor themes from the initial 12 transcripts, and developed a thematic index. The text from all transcripts was then systematically coded according to the thematic index by one author, using NVivo 9, and supervised by another author. These index-coded themes and transcripts were then presented to the research team. The six authors met in February 2012 to interpret these and develop key findings.

RESULTS

A total of 27 interviews were conducted in nine countries (Table 1). These were conducted from June to December 2011, when it was decided that there were sufficient data for analysis. Attempts to interview the other identified leaders had not been successful. The responders were mostly at the level of head of department, director, and deputy director in ministries of health, and vice-chancellor, dean, vice-dean, and principals in medical schools, and college presidents. Any further detail would identify them.

Table 1. List of responders per country and sector

Country	Number from government	Number from academic institutions
Botswana	1	0
Democratic Republic of the Congo	3	1
Ghana	2	2
Kenya	2	2
Malawi	1	2
Nigeria	1	0
Rwanda	2	2
South Africa	3	1
Uganda	1	1
Total	16	11

Responders described numerous potential benefits, as well as concerns, regarding family medicine (Box 1).

There were no clear differences between academic and government leaders' views. In the quotations, responders are labelled by country, as either government (G) or academic (A), and interview number.

Benefits

Benefits were linked to the wide range of roles that stakeholders saw for family medicine, especially in filling gaps in their health systems:

'I am looking at the gaps that exist in our healthcare delivery system. The family physician must fill those deficiencies ...' (Malawi G3)

A clinically skilled all-rounder based at the district hospital. Family physicians were viewed as 'all-round specialists', who could care for the most common presentations, conditions, and emergencies at district hospitals. This was often conceptualised as an integration of four traditional hospital-based disciplines; medicine, surgery, obstetrics, and paediatrics. The scope was considered wider and higher than for the usual doctor:

'A family medicine practitioner is able to do many of the things that it would take three or four different specialists to do.' (Nigeria G1)

'... [family physicians will have] the competences to practise across a broad range of specialties in a non-specialist way.' (Nigeria G1)

Because of this broad clinical expertise, many responders commented positively that family medicine would reduce referrals to central hospitals:

'I think family medicine, for me, it's like a link between health systems, because we have the referral hospitals, we have district hospitals, and we have health centres and we have communities.' (Rwanda A1)

'Family medicine could reduce noticeably referrals to hospitals.' (Kenya A1)

'We are looking at improved skills available closer to the people and this will lead to reduced referrals to central hospitals, which are already overstretched in terms of human resources.' (Malawi G3)

This impact on referrals was also because of the expected rural location of family physicians:

'It could help in rural area where we could not find all specialties, it could reduce number of transfer from rural hospital to town hospital.' (DRC A4)

Mentoring team-based care in the community. There was a strong sense that family physicians should be involved with supervision and mentoring of medical officers, nurses, clinical officers, and allied healthcare workers. Family physicians were expected to lead clinical governance, outreach support, and task shifting with these cadres in district facilities, linking them to the specialists. The capacity for research, critical thinking, and evidence-based medicine was seen as crucial to maintaining and developing the quality of the team:

'The family physician would be the ... main person at the district hospital ... who can supervise the medical officers there.' (Rwanda A3)

'[The family physician would be] a mentor and supporter of people around clinical governance in primary health care at the

Box 1. Key themes identified

Benefits	Concerns
<ul style="list-style-type: none"> • A clinically skilled all-rounder based at the district hospital • Mentoring team-based care in the community • A strong leadership role in the district health system • Developing holistic practice of medicine 	<ul style="list-style-type: none"> • Family medicine is unknown or poorly understood • Poor recognition, visibility, and role clarity • Struggling with policy ambivalence and needs advocacy

district and sub-district level.' (South Africa G2)

Family physicians were seen as key to training the full team:

'They can be the resource providers in terms of training for the other cadres.' (Malawi A1)

'They are also expected to train the middle level and lower cadres to build effective teams for the improvement of primary healthcare services.' (Malawi G3)

The family physician was seen as working deep in the community, in charge of a health centre, and consequently the community around it. They were expected to undertake community diagnoses, take charge of priority health programmes, and strive for improvement in population-based health:

'He will look at the causes of these problems and the community impact and try[to] also go beyond and try to resolve those causes.' (Rwanda A1)

'They've done well and transcend the health centre [going] to CHPS [the smaller clinics].' (Ghana G4)

A strong leadership role in the district health system. Many responders saw family physicians providing strong leadership and even management of the district healthcare system. They were seen as crucial to the organisation of the primary healthcare system, including community health workers, owing to their experience as clinicians. The proposed role for family physicians varied, from being the 'chief' of the health district, to being a 'consultant to district medical practice':

'Family physicians could help to organise [the] primary health care system.' (DRC A4)

'These people are team leaders for the district as a whole.' (Malawi G3)

'I think that having a specialist who should be a leader of quality around the whole gamut of primary health care is a good thing.' (South Africa G2)

They were also expected to be involved in the district management team. It was felt that they needed management skills:

'These are the kind of doctors that should take charge of the programmes and again

they are the ones who should be involved in strategic planning development and managing of primary healthcare services, and beyond this they should be the ones who are doing some kind of monitoring or evaluating the quality of healthcare services.' (Kenya A2)

'It would be desirable that these team leaders should also be trained in this area to encompass people management, resource management, as well as to be able to critically analyse the delivery of health care in the district as a whole.' (Malawi G3)

Developing holistic practice of medicine.

It was felt that family medicine in Africa should be holistic. Family physicians are expected to see the patient as a whole, thinking broadly and not in specialties. Providing care was seen not only as giving drugs, but also as exploring psychosocial issues in a family and community context:

'Family medicine is a holistic medicine, which treat[s] patient[s] but not disease.' (DRC A1)

'The challenge was ... specialties, they go away with this knowledge in boxes ... we should produce a person who thinks holistically.' (Kenya A1)

Prevention, health promotion, and public health considerations were seen as important:

'[A family physician should be] a kind of generalist who can really take care of the whole family, but not only the curative part but also preventive.' (Rwanda A1)

A few stakeholders considered continuity as important:

'[It is important] that patients and the doctor are all the time linked ... to meet the expectations of the family ... as Malawi is developing.' (Malawi A2)

Concerns

Family medicine is unknown or poorly understood.

A strong theme was that the broader community of policymakers have not yet conceptualised the contribution that family medicine can make to their health systems. Many responders felt that family medicine was an unknown discipline with no clear explanations about what it has to offer in Africa:

'It will not be easy to implement it since people don't know it.' (Rwanda G2)

'There is no clear explanation about family medicine.' (DRC G3)

'So you are kind of the super GPs.' (South Africa G3)

In some settings, misunderstandings about the training of family physicians also hindered policy commitment. One responder reported the confusion of a minister of health:

'Now you're going to train this person who is 10 specialties. I will need 20 years to train them.' (Kenya A1)

Poor recognition, visibility, and role clarity.

Responders stated that the recognition of family medicine was another issue of concern. They felt that family medicine is seen as inferior to other disciplines and not accepted by other specialists as a fully-fledged specialist programme. Responders were also concerned about the integration of family medicine into the academic system:

'The fact that the discipline is relatively new practice, it means that it is not fully institutionalised ... not fully mainstreamed ... not fully acceptable by the existing practices.' (Kenya G4)

'Up till recently, the specialisation was not valued as it should have been. General practice is not regarded as a specialisation.' (Nigeria G1)

South African responders felt that family physicians could be challenged by high expectations, as clinically skilled all-rounders at the district hospital. They recommended strong training of family physicians, with awareness of their limitations and possible sub-specialties in family medicine, such as palliative care.

The case for family medicine is also weakened by the lack of African evidence for its contribution where it has been implemented. The small numbers of family physicians also make it difficult to demonstrate an impact. In some instances, the few family physicians that are in the system have been inappropriately placed, some becoming administrators in large hospitals:

'They are not playing as visible and important a role as they should be and they are not, obviously they are not, in such numbers that they can make an impact on society.' (Nigeria G1)

'They have been shunted into jobs that are

not designed to show off their training to best ... You know, they get put into jobs like CEOs [chief executive officers] of hospitals or things like that.' (South Africa G2)

The creation of a new specialty inevitably creates tension with existing cadres, especially when their respective roles potentially overlap. The confusion between family medicine and public health medicine was mentioned several times. There was also confusion between family medicine and internal medicine. The supervision of mid-level healthcare workers such as clinical officers may also need to be renegotiated if family physicians are available.

South African responders commented that, with the growing role of family physicians, their clinical governance role appeared similar to that of chief medical officers, who have been in the system for a while. This was seen as a source of conflict:

'The threats are recognition by your peers ... mutual respect ... and support from other disciplines.' (Ghana A2)

'It might well be a recipe for some contestation and fought with difficulty until the rules of the game become clearer.' (South Africa G2)

There was acceptance that administrative responsibilities came with seniority and a leadership role in the district, but there was caution, especially in South Africa, that the role of the family physician should remain primarily clinical:

'[They should] stay with the clinical role.' (South Africa G3)

Struggling with policy ambivalence and needs advocacy. A concern was raised that family medicine is not clearly defined from an African perspective, and that funders and international bodies, as well as faith-based organisations in some countries, inappropriately shift the development of family medicine to serve their own agendas. The lack of local trainers also leads to the use of foreign-trained family physicians, with the potential for inappropriate models and poor sustainability.

A lack of recognition with medical councils, a lack of local professors, the low priority given to family medicine training, and a lack of budget, hinder policy commitment to family medicine:

'Family medicine is not yet seen as a priority area of investment.' (Rwanda A3)

'Family medicine does not have support from DRC political and academic leaders.' (DRC A1)

There appears to be policy ambivalence in some countries. Although family physicians are being trained and appointed into posts, national strategic human resource planning has yet to mention family physicians clearly within them:

'Although the ministry has not finalised its human resource strategic document for the next 5 years, the need for family physicians is clear in the documentation.' (Ghana A1)

'We've been talking a lot about family medicine and the implementation of all these issues, but we haven't had a detailed human resource plan to support this.' (South Africa A1)

Responders felt that strong advocacy was required by family medicine itself, with stronger associations, the development of academic departments, and engagement with leaders:

'I think that you have a lot of advocacy to do ... make the move and we will support you.' (Ghana A1)

The following statement sums up this sentiment:

'A lot of people are not knowing what role they may play and if we are not careful the policy makers may not be able to provide the required resources to support the implementation of this programme. The shortage of people in this particular area may not be able to show the kind of impact that the programme is having. We need to create awareness on the need of this programme and especially with policy makers and experts.' (Kenya A2)

DISCUSSION

Summary

Responders were both positive and encouraging about family medicine making a difference to fragile and uncoordinated health services, particularly in underserved areas. The primary role of the family physician was seen as the 'all-round specialist' at smaller hospitals, in the absence of other specialists. The strongest motivation appeared to be reducing referrals to overburdened central hospitals. Some responders identified the district hospital and the community health centre as the primary sites of practice of the

family physician. The principal clinical role was balanced by a number of non-clinical roles such as supervision, mentoring, leadership, and improvement of the quality of care and health systems; all these roles were held to be important. The responders also expect family medicine to improve the supervision and mentoring of mid-level staff, enhance teamwork, enhance a holistic approach to patient care, and improve the quality of primary care. Each of these roles is consistent with African family physicians' views as expressed in the consensus statement,¹² but different from family medicine in other parts of the world. The large extent of hospital-based practice versus office- or clinic-based practice appears to be one distinct feature of family medicine in Africa. African family physicians see hospital care as an essential part of comprehensive primary health care, and their current role as a phase in the development of comprehensive primary health care in Africa.

However, the conceptualisation of family medicine is underdeveloped in Africa, with a wide variety of understandings as well as a general lack of clarity. The discourse on family medicine by these leaders appears to be couched in specialist- and hospital-centric terms. It is defined in terms of how it combines aspects of established specialties and helps to reduce the workload of specialists at central hospitals. Many responders saw family medicine as merely a combination of four major clinical specialties, or even as a stepping stone to later specialisation, rather than a positive career option in its own right. While some leaders saw family medicine as an extension of the GP role as practised in high-income countries, most saw the family physician in Africa as largely a hospital specialist. The concept of personal care of individuals and their families over time, as with general practice or family medicine as understood and practised in high-income countries, was mentioned but seen as a distant goal. In addition, the significant role in clinical governance, management, teaching, and research is not adequately quantified and appears dependent on local circumstances. Responders did urge greater clarity and advocacy from family medicine. There were no clear differences between academic and government leaders' views.

Strengths and limitations

The strengths of this study lie in its broad reach across nine countries in southern, eastern and western Africa, encompassing the views of influential informants who are directly

concerned with family medicine. Despite the limitation of using multiple interviewers, with the possible lack of adherence to the interview guide and communication skills, there was sufficient convergence to extract common, relevant themes. It is possible that additional viewpoints and themes might have emerged if additional countries or leaders unsupportive to family medicine had been included in the study. The findings cannot be generalised to Africa as a whole, but give a useful insight to the viewpoints of leaders in multiple settings, which should certainly be considered when discussing the development of family medicine in an African context.

Comparison with existing literature

In terms of the global typology of primary care organisational development, these leaders' views of family medicine in Africa appear mired in a grey area between the hospital (with its divided specialist-orientated structure and processes, and focus on individual patient outcomes), and the district health system (with its generalist, primary care, public health, and population-orientated approach).¹⁴

Leaders lack a strong positive understanding of the generalist paradigm and have a tendency to define family medicine in terms of deficiencies in the system: a discipline to 'fill gaps' without an overarching conceptual framework of the unique and specific contribution of well-trained generalists. There is also a concern that the expectations of the family physician to fill all the gaps are unrealistic, if they are seen as just one 'super GP' fulfilling all the expected clinical, surgical, community, and administrative roles. Fulfilling all these roles will require the presence of other types of well-trained health workers, such

as community health workers, clinical officers, clinical nurse practitioners, and managers, as well as an adequate number of family physicians per facility or district. Family physicians must also be given clear authority to fulfil their expected responsibilities and be held accountable. This concern echoes that of Kenyan family physicians, who often felt overwhelmed by their workload.¹⁵ While family physicians aspire to a personalised family-based and community-oriented primary care (COPC) approach in Africa,^{9,16} there is little evidence of this in action and little explicit policy support for the development of family medicine in a COPC approach. As noted by African family physicians⁹ and generalist clinicians,¹⁰ and confirmed by Kenyan family physicians,¹⁵ 'the closest they got to the community was the door of the outpatient unit'. Advocacy is compromised when the desired service or role that is being promoted is unclear.

Implications for practice and research

The parallel processes of policy formation and the building of consensus among policymakers that is based on evidence¹⁷ is crucial to the development of the discipline. The ideal balance of clinical, educational, managerial, and community-oriented roles of the family physician in the African context needs further evaluation to make the task of family physicians feasible and effective. In the process, the case for family medicine needs to be made in a more unified and consistent manner, as well as advocated more widely, to overcome current misconceptions and lack of awareness. There needs to be a clearer articulation of human resource policies and implementation strategies, by family physicians themselves.

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Ethical approval

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Provenance

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Competing interests

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