LETTER TO THE EDITOR

Family Medicine may be helpful in improving health care delivery in sub-Saharan Africa

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Abstract: Efforts to introduce and integrate the discipline of family medicine in sub-Saharan Africa have remained slow due to failure to understand what role and benefit such physicians can play in the existing health care systems in the region. An attempt is made here to explain reasons for this trend and suggest ways to overcome it.

Introduction: Despite recent enhanced efforts to expand the discipline of family medicine/General practice in Uganda and throughout sub-Saharan Africa, debate remains as to its role and benefit to the healthcare systems in the region.

Although the discipline has been existent in South Africa for a longer period, in East and Central Africa it was first introduced as a post-graduate specialty at Uganda’s Makerere University in 1989, and has since been bogged down by uncertainty of survival, sustainability, enrollment disinterest, resistance from the major specialties and haphazard deployment of the few graduates of the struggling academic departments from the region.

Why the interest? Sub-Saharan Africa remains one of the world’s poorest regions, with immense poverty and preventable infectious diseases killing millions of people each year, particularly women and children. Most of the 42 countries that contribute 90% of the all under-5 childhood deaths in the world are in this region. Despite embracing the Alma Ata declaration in 1978, implementation of the PHC concept has not been as successful as hoped.

It has been shown that healthcare systems based on effective primary care with highly trained generalist physicians practicing in the community provide both more cost-effective and more clinically effective care than those with a low primary care orientation.

Why the scepticism? Unlike in the western world where primary care physicians are usually the point of first clinical contact in the healthcare system, in areas of the world where doctor-patient ratios are so low, the healthcare systems rely more on the traditional healers, nurse aides, nurses and bachelor-level ‘medical officers,’ not higher trained physicians as first clinical contact. So the benefit of this higher level generalist physicians has been questioned in these areas since in the foreseeable future, this cadre of physicians is not going to be able to replace the present scenario of primary care delivery.

Suggestions for integration: The above scenario means that family physicians/general practitioners in healthcare systems in the developing world cannot be integrated as first line care providers as is the case in the developed world, but as the next level of care-givers to those cadres outlined above. This group of higher trained physicians is particularly required in the ongoing process of decentralization of health service delivery for not only do they provide supervisory and consultative roles to health workers in the health sub-districts, but also much needed leadership in the implementation of PHC services. They may also be a solution to the congestion in referral hospitals, as their presence at district hospitals shall mean only complicated clinical cases are referred for specialist care in referral health centers. Thus positions for family physicians should be created at district and health center IV levels and their training sped up to catch up with the urgent need in districts.

To date, only South Africa and to a lesser extent Nigeria, have been able to successfully integrate family physicians into their healthcare system. These countries have done it not only through sustained commitment on the part of all stakeholders but also introducing the discipline to undergraduate students early in their medical training. It has been shown that this contributes to choice of specialty training choice later.

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