"Twenty years of Primafamed-Networking: looking back at the future"

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Chairman Expert Panel on Effective Ways of Investing in Health (EC)

Gent, 15.12.2017

Twenty years of Primafamed-Networking: looking back at the future

1. The sustainable development goals and the new societal context
2. Looking back: Alma Ata, Selective PHC, Primafamed
3. The future?
4. Conclusion

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Primary health care and the Sustainable Development Goals

After the eight Millennium Development Goals that have shaped progress in the past 15 years, 17 Sustainable Development Goals (SDGs) were adopted by governments at the UN General Assembly in September, 2015. SDG3 explicitly relates to health—to "Ensure healthy lives and promote well-being for all at all ages". This goal is translated into 13 targets: three relate to reproductive and child health; three to communicable diseases, non-communicable diseases, and addiction; two to environmental health; and one to achieving universal health coverage (UHC). Four further targets relate to tobacco control, vaccines and medicines, health financing and workforce, and global health risk preparedness.

When supported by strong public health policies and with aligned efforts across social, economic, and political domains, primary health care has a central role in achievement of sustainable development. Although differences are inevitable between countries in the organisation of primary health care and the human resources available, many of the challenges outlined in SDG3—related to reproductive and child health, communicable diseases, chronic illnesses (including multimorbidity), addiction, and other mental health problems—can be addressed through a person-centred and population-based approach to primary health care.[1,2] Delivery of vaccines and drugs needs a functioning
m. Well integrated and prepared has a key role in health emergency it is essential for the achievement of ost-effectively.[3,4]

y health care can contribute to f many of the 16 other SDGs; for addressing the social determinants fined in the report Closing the Gap rimary care teams worldwide can om daily practice that illustrate their the SDGs, including helping to end utrition, provide health education g learning, empower individuals and luce inequities and promote justice, fe water and sanitation, encourage sustainable employment, foster e for healthy and sustainable living promote peaceful communities.

in realising the full potential of primary health care still seems elusive to many governments, policy makers, funders, and health-care providers. Therefore, 7 years after the World Health Report and *The Lancet* Series on primary health care, and 37 years since the Alma-Ata declaration, the absence of reference to primary health care in the SDGs and their targets seems a serious oversight. Two conclusions could be drawn: first, that primary health care is dispensable and peripheral to achieving sustainable development; or, second, that primary health care is so integral to the path towards the SDGs that reference in a goal or target would undermine its cross-cutting role.

We opt for the second conclusion, yet do so with apprehension, because one of the contributing factors to the documented failure of primary health care in many settings since the Alma-Ata declaration was "the scarcity of a proposed strategy for implementation and its monitoring for accountability and scale-up purposes".[5] This issue needs to be addressed in the development of implementation strategies for the SDGs. If the agenda is not explicit about how health systems with good-quality comprehensive primary care can be achieved, or how to measure progress towards this goal, we risk repeating the failures of the past.

National governments and other stakeholders need to be ambitious in measuring progress towards delivery of primary health care that will address the SDGs. This monitoring includes the use of indicators that can capture the principles of equity, community participation,

For **Sustainable Development Goals (SDGs)** see https://sustainabledevelopment.un.org/topics

For the **World Health Report and *The Lancet* Series on primary health care** see http://www.thelancet.com/series/alma-ata-rebirth-and-revision

For the report **Closing the Gap in a Generation** see http://www.who.int/social_determinants/thecommission/finalreport/en/

*Luisa M Pettigrew, Jan De Maeseneer, Maria-Inez Padula Anderson, Akye Essuman, Michael R Kidd, Andy Haines
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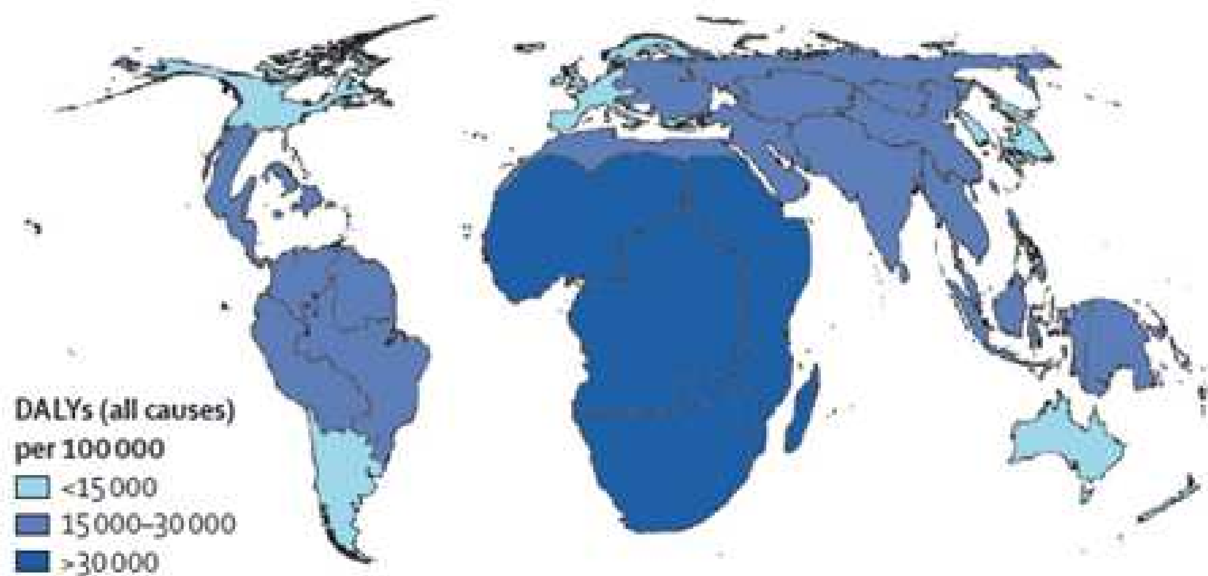
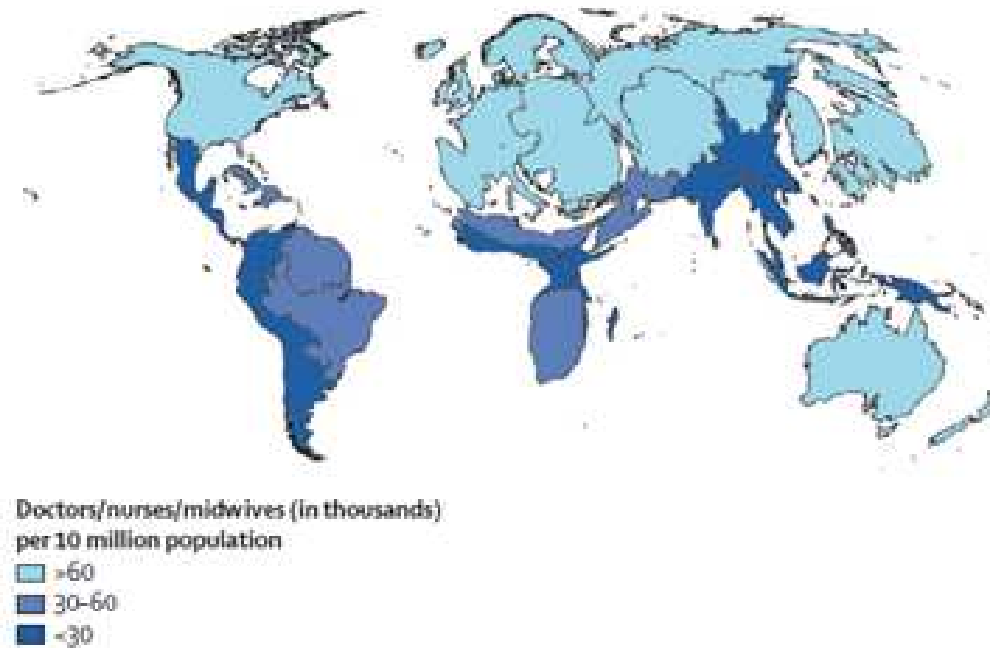
luisa.pettigrew@lshtm.ac.uk

Source: Frenk et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet 2010; 376: 1923–58



Source: Frenk et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet 2010; 376: 1923–58



"Inverse (Primary) Health Care Staffing law"

Source: Frenk et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet 2010; 376: 1923–58

Willcox *et al. Human Resources for Health* (2015) 13:76
DOI 10.1186/s12960-015-0073-8

HUMAN RESOURCES FOR HEALTH

REVIEW

Open Access

Human resources for primary health care in sub-Saharan Africa: progress or stagnation?

Merlin L Willcox[1*], Wim Peersman[2], Pierre Daou[4], Chiaka Diakité[5], Francis Bajunirwe[3], Vincent Mubangizi[3], Eman Hassan Mahmoud[6], Shabir Moosa[7], Nthabiseng Phaladze[8], Oathokwa Nkomazana[9], Mustafa Khogali[6], Drissa Diallo[4,5], Jan De Maeseneer[2] and David Mant[1]

Abstract

Background: The World Health Organization defines a "critical shortage" of health workers as being fewer than 2.28 health workers per 1000 population and failing to attain 80% coverage for deliveries by skilled birth attendants. We aimed to quantify the number of health workers in five African countries and the proportion of these currently working in primary health care facilities, to compare this to estimates of numbers needed and to assess how the situation has changed in recent years.

Methods: This study is a review of published and unpublished "grey" literature on human resources for health in five disparate countries: Mali, Sudan, Uganda, Botswana and South Africa.

Results: Health worker density has increased steadily since 2000 in South Africa and Botswana which already meet WHO targets but has not significantly increased since 2004 in Sudan, Mali and Uganda which have a critical shortage of health workers. In all five countries, a minority of doctors, nurses and midwives are working in primary health care, and shortages of qualified staff are greatest in rural areas. In Uganda, shortages are greater in primary health care settings than at higher levels. In Mali, few community health centres have a midwife or a doctor. Even South Africa has a shortage of doctors in primary health care in poorer districts. Although most countries recognize village health workers, traditional healers and traditional birth attendants, there are insufficient data on their numbers.

Conclusion: There is an "inverse primary health care law" in the countries studied: staffing is inversely related to poverty and level of need, and health worker density is not increasing in the lowest income countries. Unless there is money to recruit and retain staff in these areas, training programmes will not improve health worker density because the trained staff will simply leave to work elsewhere. Information systems need to be improved in a way that informs policy on the health workforce. It may be possible to use existing resources more cost-effectively by involving skilled staff to supervise and support lower level health care workers who currently provide the front line of primary health care in most of Africa.

Keywords: Human resources for health, Primary health care, Review, Sudan, Mali, Uganda, Botswana, South Africa

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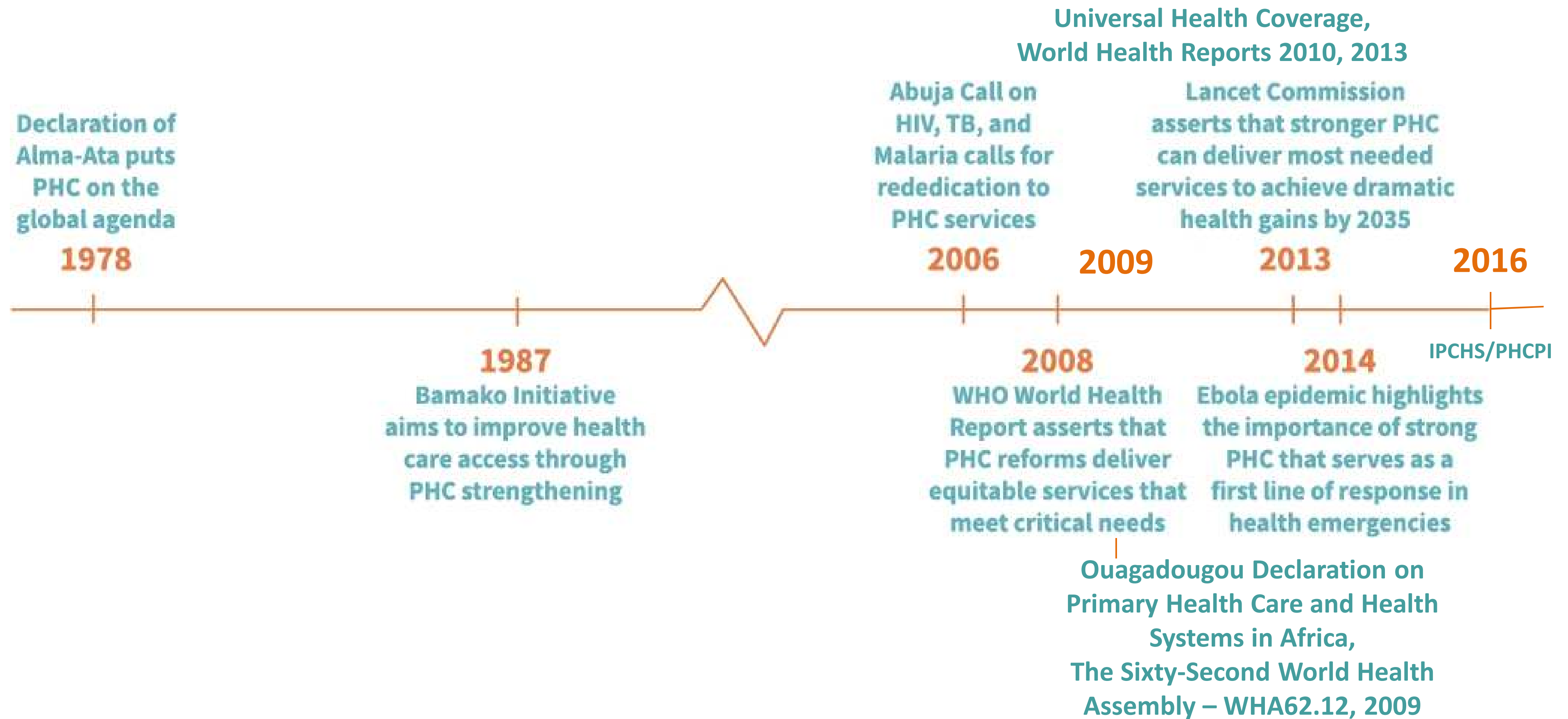
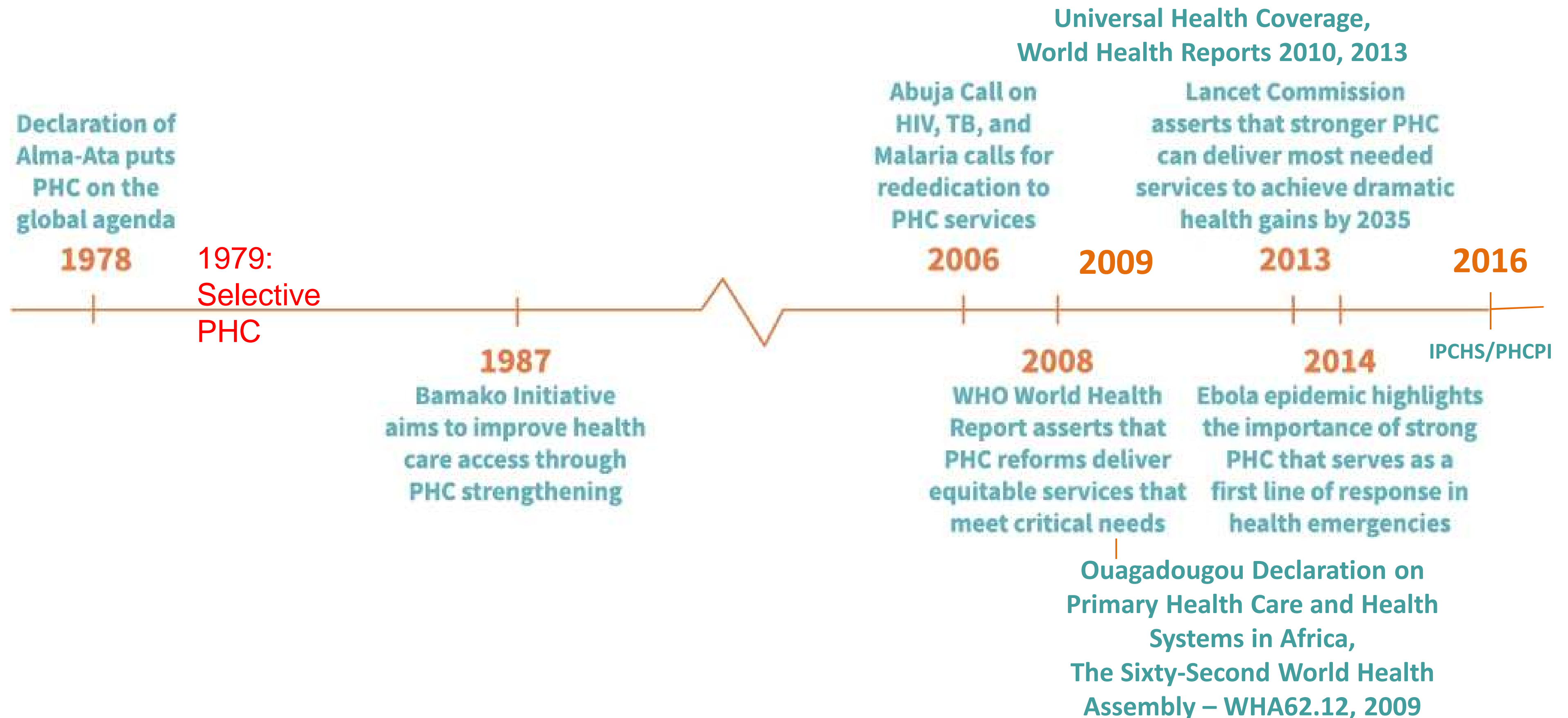
Historical Perspective



Historical Perspective



Jan De Maeseneer

Family Medicine and Primary Care

At the Crossroads of Societal Change

LANNOO CAMPUS

10 SEPTEMBER 2017

Selective vs. comprehensive Health Care

- 1978: Alma Ata Declaration (WHO): comprehensive primary health care: improving health requires, in addition to access to health care, changes in economic, social and political structures. Health and health care are basic human rights that require community participation (horizontal programming).

Selective Primary Health Care

Shortly after its publication the Alma-Ata Declaration was criticised for being too broad and idealistic and having an unrealistic time table, especially in the slogan "Health for All by 2000". In 1979 the Rockefeller Foundation sponsored a conference "Health and Population in Development" in Bellagio (Italy). Important stakeholders attended the meeting, e.g. Robert S. McNamara, President of the World Bank. He promoted business management methods and clear sets of goals, advocating poverty reduction approaches. The conference discussed the paper "Selective Primary Health Care, an Interim Strategy for Disease Control in Developing Countries".[7] In that paper a strategy based on "basic health services" was presented. Selective primary health care was introduced as the name of the new perspective. The term meant a package of low-cost technical interventions to tackle the main disease problems of poor countries. These interventions were summarised in the acronym GOBI-FFF (Growth monitoring, Oral rehydration techniques, Breast-feeding, Immunisation, Food supplementation, Female literacy, Family planning). Selective primary health care quickly attracted the support of donors, scholars, and agencies.

De Maeseneer J. Family Medicine and Primary Care, 2017

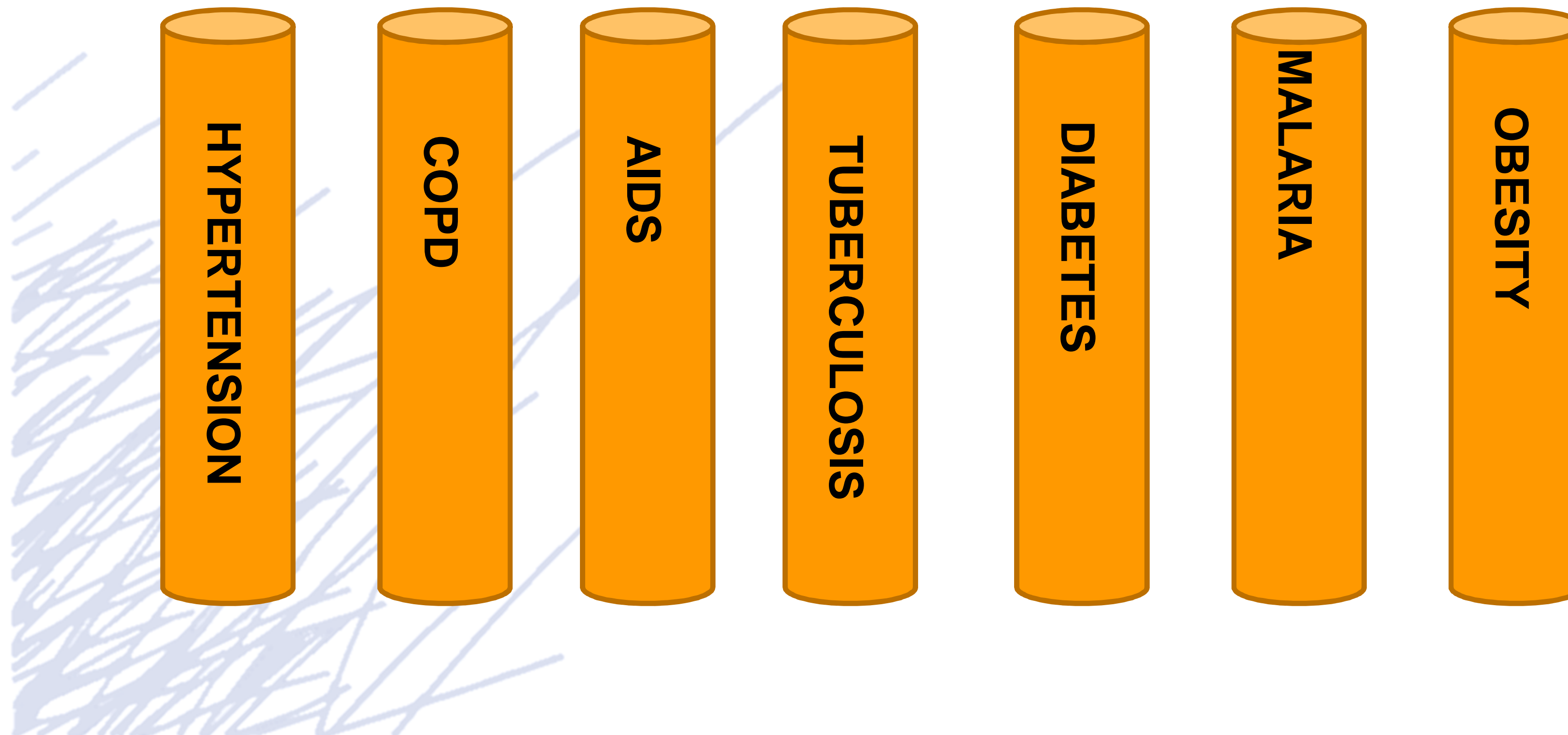
Selective vs. comprehensive Health Care

- 1978: Alma Ata Declaration (WHO): comprehensive primary health care: improving health requires, in addition to access to health care, changes in economic, social and political structures. Health and health care are basic human rights that require community participation (horizontal programming).
- Selective health care: targets specific diseases (vertical programming). Alma Ata concepts are unattainable. A more selective approach, addressing the greatest disease burden in the community, will have a better chance of improving health in less developed countries.

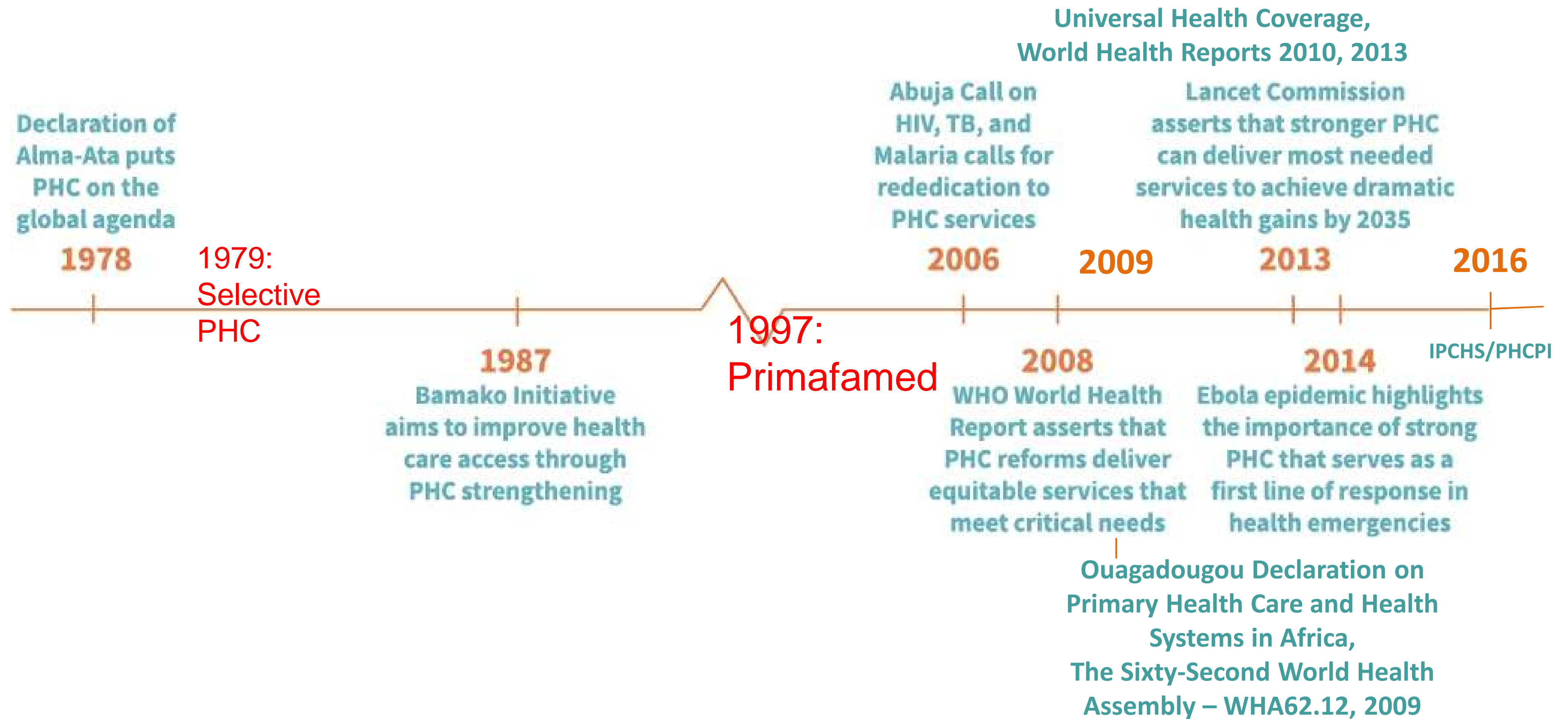
The AIDS-epidemic of the late 1970's and the early 1980's generated a strong impetus to develop vertical programs and this selective strategy has been favourably received by international agencies such as World Bank, Unicef, academic institutions and research centres, bilateral aid-agencies and private institutions

Vertical Disease Oriented Approach

- Mono-disease-programs? Or…
- Integration in comprehensive PHC



Historical Perspective



1995: Prof. Baqwa (UCT, +) invites Prof. Jan De Maeseneer for a Study Visit to South-Africa, in order to look at the "coalface" of Primary Care

TRAINING IN FAMILY MEDICINE

AND

PRIMARY HEALTH CARE

IN SOUTH AFRICA AND FLANDERS

REPORT OF A STUDY VISIT (16-25/09/97)

Centrum voor Huisartsgeneeskunde - Universitaire Instelling Antwerpen
Academisch Centrum voor Huisartsgeneeskunde - Vrije Universiteit Brussel
Vakgroep Huisartsgeneeskunde en Eerstelijnsgezondheidszorg - Universiteit Gent
Academisch Centrum voor Huisartsgeneeskunde- Katholieke Universiteit Leuven

Verslag van het projectnr. ZA.96.11
Gefinancierd door het Ministerie
van de Vlaamse Gemeenschap
Departement Onderwijs

SAM

Family Medicine Education Consortium: a national network in South-Africa

- 1997:

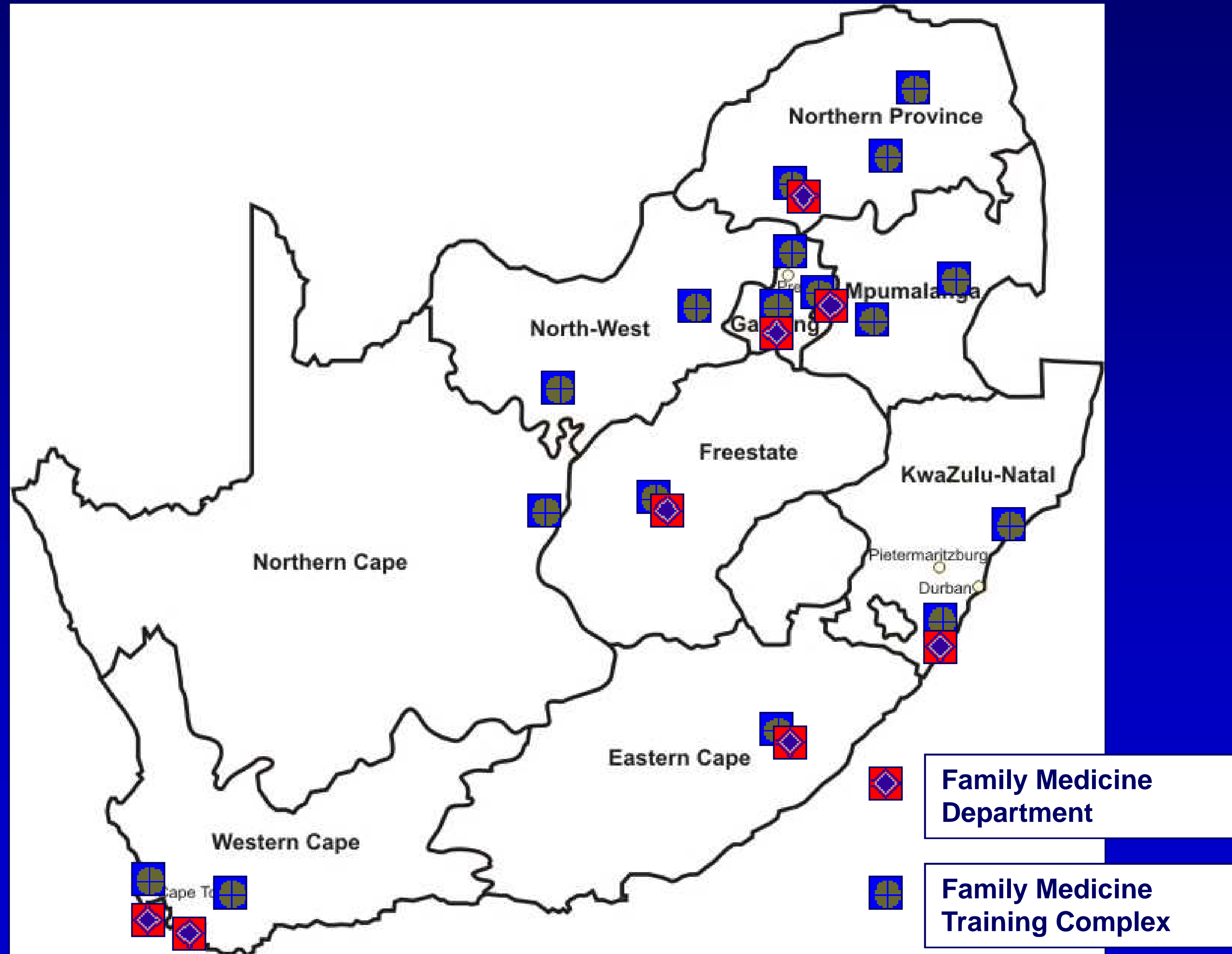
  8 departments of Family Medicine and Primary Health Care start FAMEC

- Objectives:

  - Development of a ‘core curriculum’
  - Sharing learning tools
  - National examination
  - Shifting family medicine towards needs of the population

- VLIR-Own Initiatives-project [ZEIN 2003 PR290]

17 Family Medicine Training Complexes in South-Africa



VLIR-Own Initiatives 2006-2009
VLIR ZEIN 2006 PR 320

- Development of training in family medicine/primary health care in Southern and Eastern Africa:

- A contribution to the realisation of quality and equitable healthcare through a South-South Network

Training sites

- Improving the infrastructure of training complexes
- New training complexes appointed
- Rural and remote areas, townships

Training session University of Ghana

A set of 3rd undergraduate students having a tutorial just before their clinical exposure in family in medicine in the department's conference room (Makerere University College of Health Sciences)

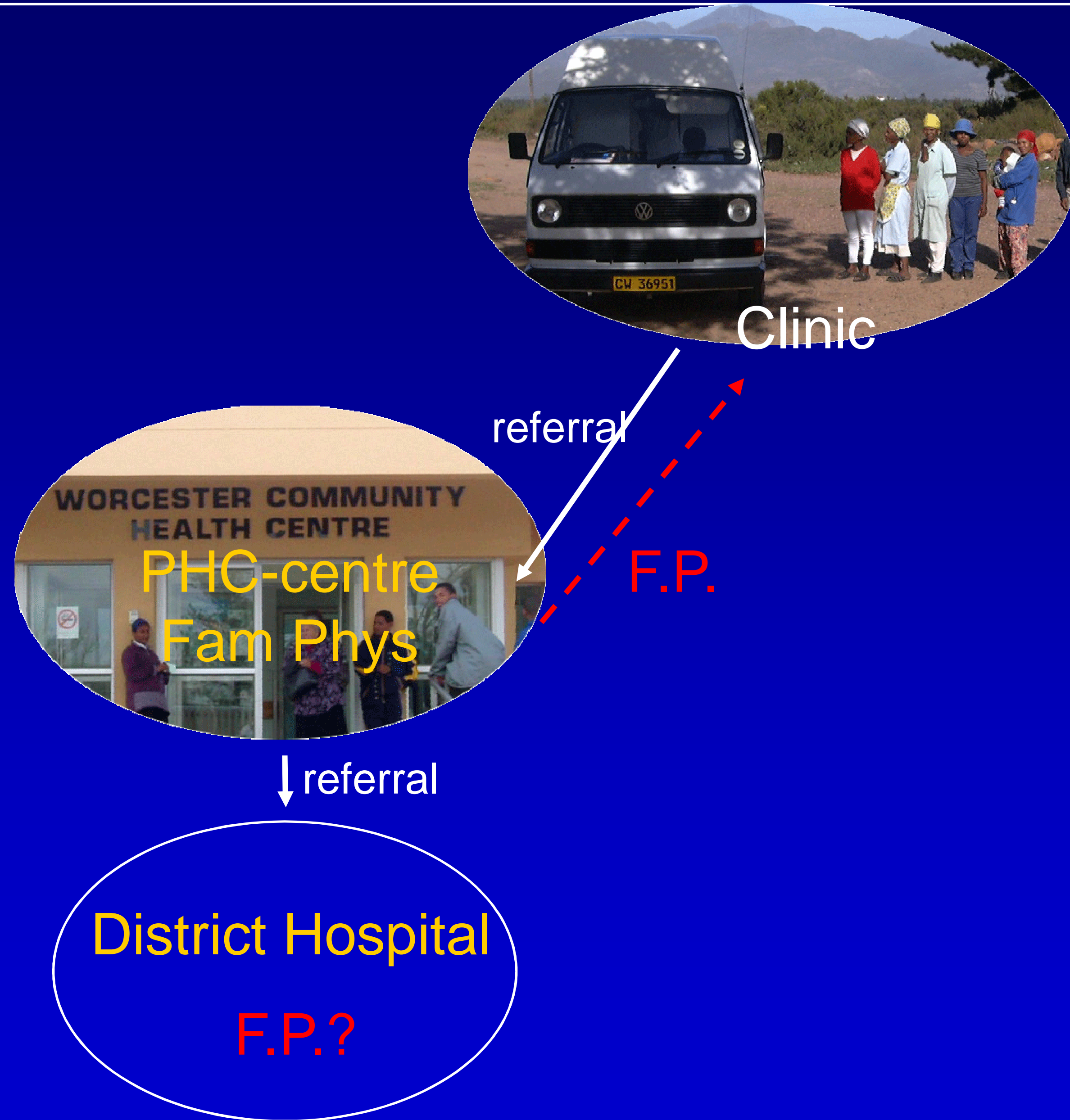
The Delphi-study:

"African family physician"

- Mash R, Couper I, Hugo J. Building consensus on clinical procedural skills for South African family medicine training using the Delphi technique. SAFamPract 2006;48(10):14-14e

- Mash R, Downing R, Moosa S, De Maeseneer J. Exploring the key principles of family medicine in Sub-Saharan Africa: international Delphi consensus process. SAFamPract 2008;50(3):62-67

The position of family physicians



Primary health care in Africa: do family physicians fit in?

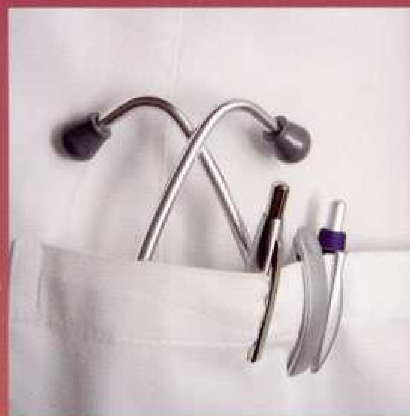
Jan De Maeseneer and Maaike Flinkenflögel

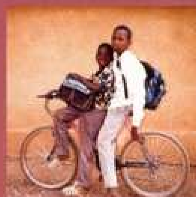
INTRODUCTION

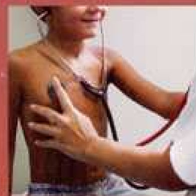
Family medicine or 'general practice' is a very recent discipline in medicine, if you look at it in terms of academic recognition. In 1963 the University of Edinburgh appointed Richard Scott as the first professor of family medicine in the world.[1] Family medicine was a concept, mainly developed in western countries, starting with postgraduate training in the 1960s. In the 1970s and 1980s, the discipline developed a specific approach to patients and health problems: a biopsychosocial frame of family medicine were medical practitioners who were highly motivated to contribute to the welfare of the poor through a community-oriented approach, the main focus in the early years of family medicine was on the relationship of the physician with the individual patient and his/her family. It was mainly public health programmes that looked at the broader societal context and tried to act at that level.

The World Health Organization (WHO) Alma-Ata Declaration on primary health care which stated 'health for all by the year 2000' did not mention the discipline of family medicine.[2] In the last 30 years, all over the world, primary health care has developed and, increasingly, the awareness has grown that there is need for a specific medical clinical discipline in primary health care: the GP/family physician. In Africa, the term 'family physician' is used, as a GP in Africa is most of the time a 'medical officer' working in private or public practice without any further training after the undergraduate medical curriculum. The question is, what should be the profile of a family physician in Africa, in order to be responsive to the needs of the local population? This lecture explores this further and will look at the following three questions:

DOCTORS FOR TOMORROW



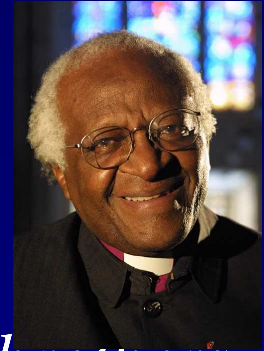




Family Medicine in South Africa

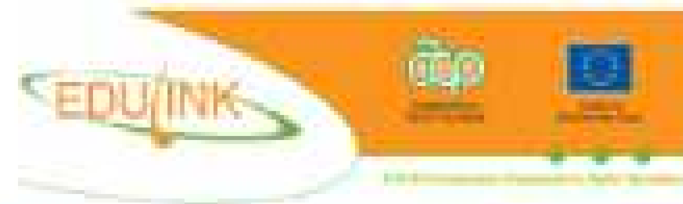
Jannie Hugo & Lucie Allan

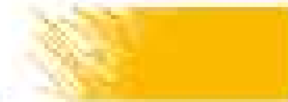
Preface:
A message of hope



This hope is not only for South Africa, but also for our brothers and sisters in the rest of the continent and the rest of the world. If the family medicine movement can play that role, let us join hands and realise that dream.

Archbishop Emeritus Desmond Tutu
Johannesburg, 2007



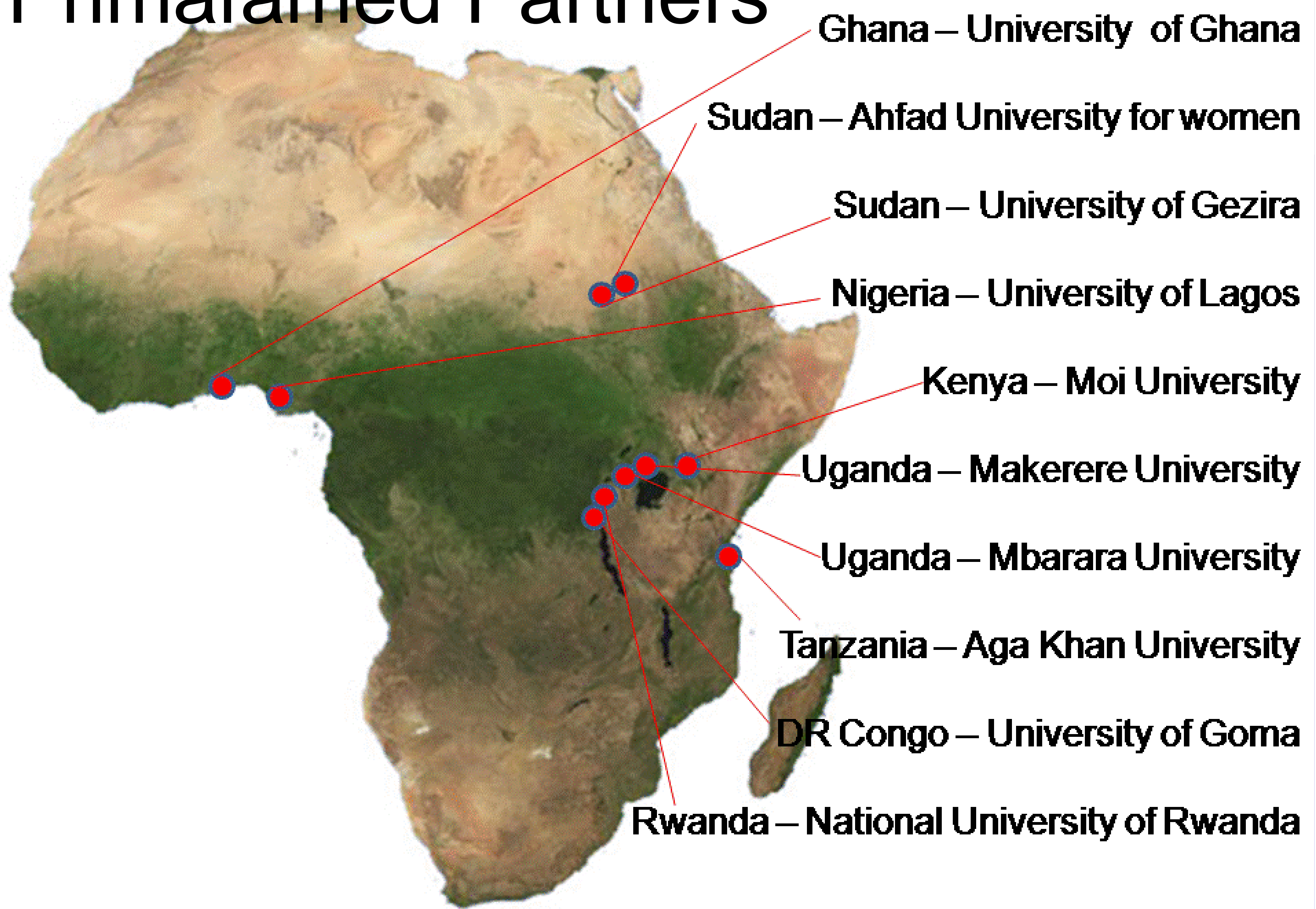


Primary Health Care Family Medicine Education Network

Family medicine in Sub-Saharan Africa

www.primafamed.ugent.be

Primafamed Partners



Conference Primafamed

"Improving the Quality of Family Medicine Training in Sub-Saharan Africa"

- 17-21 November 2008
- Kampala Uganda
- www.primafamed.ugent.be

ICHO

Quality Of Family Medicin
Saharan Africa'
Nov. 2008.

PRIMAFAMED CONFERENCE

Improving The Quality Of Family Medicine Training
in Sub-Saharan Africa'
Kampala, 17-22 Nov. 2008.
Cassia lodge
The best View in Kampala

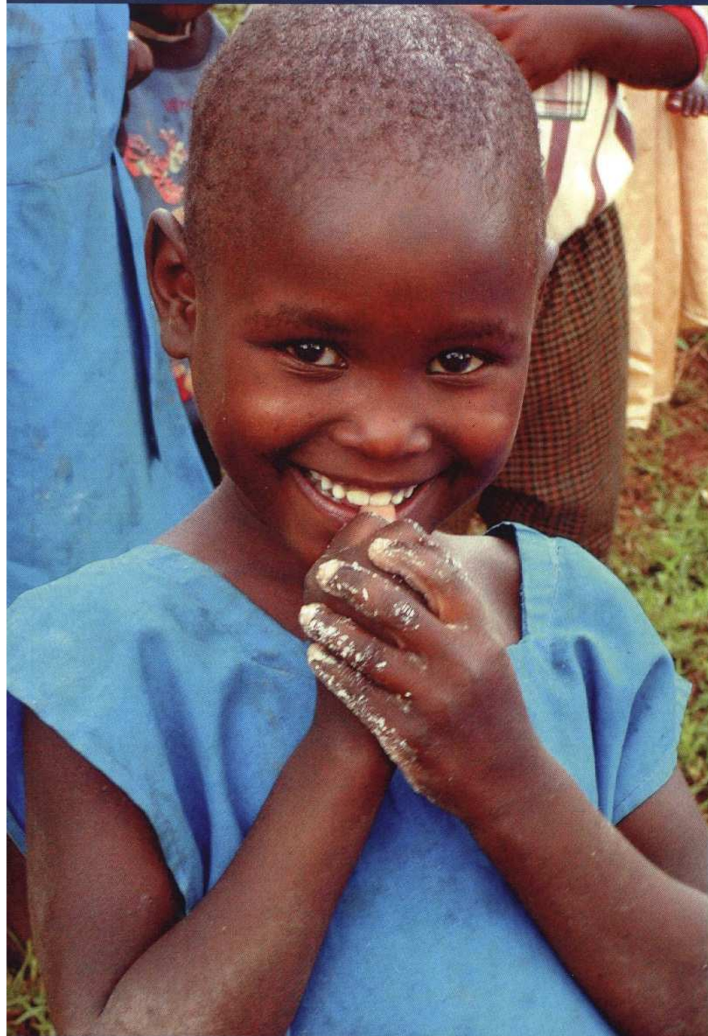
Defining
FAMILY
Medicine
& PHC
In Africa

PHCFM

Vlaamse Interuniversitaire Raad
VLIR UOS University Development Cooperation

African Journal of Primary Health Care & Family Medicine

ISSN: 2071-2928



Stigma, medication adherence and coping mechanism among people living with HIV attending General Hospital, Lagos Island, Nigeria
Adekemi O. Sekoni, Obinna R. Obidike, Mobolanle R. Balogun

Potential for the specialty of Family Medicine in Botswana: A discussion paper
Luise Parsons, Taatske Rijken, Deogratias O. Mbuka, Oathokwa Nkomozana

Determinants of patient satisfaction with outpatient health services at public and private hospitals in Addis Ababa, Ethiopia
Tayue Tateke, Mirkuzie Woldie, Shimeles Ololo

Knowledge, attitude and practice study of HIV in female adolescents presenting for contraceptive services in a rural health district in the north-east of Namibia
Alexis Ntumba, Vera Scott, Ehimario Igumbor

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Vol. 4 No. 1 2012

VLIR ZEIN 2009 PR 361: Twinning Project

South-South Cooperation in health professional education: A literature review

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[1] *Centre for Rural Health, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa*

[2] *Ukwanda Centre for Rural Health, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa*

[3] *Department of Family Medicine and Primary Health Care, Faculty of Medicine and Health Sciences, Ghent University, Belgium*

Corresponding author: *I Couper (icouper@sun.ac.za)*

In the literature on the evolution of funding approaches there is criticism of traditional funding strategies and the promotion of inclusive models, such as South-South Cooperation (SSC) and triangular models. The latter are felt to have a number of advantages. This article has four broad objectives: (*i*) to present a literature review on the evolution of Southern approaches to development co-operation; (*ii*) to indicate examples of current co-operative programmes in health and health professional education in Africa; (*iii*) to assess the advantages and disadvantages of these models; and (*iv*) to mention some emerging issues in monitoring and evaluation. The Boolean logic approach was used to search for applicable literature within three topic layers. Searches were conducted using PubMed, PLoS and other accessible databases. An initial draft of the article was presented to a group of academics and researchers at the Flemish Inter-University Council (VLIR-UOS) Primafamed annual workshop held in August 2010 in Swaziland. Comments and suggestions from the group were included in later versions of the article. It is important to note that the existence of various funding models implemented by a variety of actors makes it difficult to measure their effects. In health and health professional education, however, SSC and triangular models of aid provide conditions for more effective programming through their focus on participation and long-term involvement. With an eye towards evaluating programmes, a number of salient issues are emerging. The importance of context is highlighted.

The emergence of family medicine in Africa

Shabir Moosa

Promotor: Prof. dr. Anselme Derese
Copromotor: dr. Wim Peersman

Ghent, 28 October 2015

Family Practice Advance Access published May 23, 2014

Family Practice, 2014, Vol. 00, No. 00, 1–10
doi:10.1093/fampra/cmu014

Family medicine training in sub-Saharan Africa: South–South cooperation in the Primafamed project as strategy for development

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Abstract

Background. Health-care systems based on primary health care (PHC) are more equitable and cost effective. Family medicine trains medical doctors in comprehensive PHC with knowledge and skills that are needed to increase quality of care. Family medicine is a relatively new specialty in sub-Saharan Africa.

Objective. To explore the extent to which the Primafamed South–South cooperative project contributed to the development of family medicine in sub-Saharan Africa.

Methods. The Primafamed (Primary Health Care and Family Medicine Education) project worked together with 10 partner universities in sub-Saharan Africa to develop family medicine training programmes over a period of 2.5 years. A SWOT (strengths, weaknesses, opportunities and threats) analysis was done and the training development from 2008 to 2010 in the different partner universities was analysed.

Downloaded from http://fampra.oxfordjournals.org/ at Ghent University on July 8

Huraprim
Ghent University Centre

3. Strategies for change

Progress scale for development of the Primafamed partners	
Level 1	• Structural implementation of the training and department is in preparation
Level 2	• Department/unit of family medicine exists or is part of other department (community medicine) • Training complexes are under development • Family medicine is part of undergraduate training
Level 3	• Department/unit of family medicine exists • Training complexes are in place • Curriculum is written • Postgraduate training has started
Level 4	• Department/unit of family medicine exists • Training complexes are in place • Curriculum is written • Postgraduate training has started • The ministry of health has accepted family medicine as a specialization and graduated family physicians are part of the health care system

Adopted from the Primafamed Edulink ACP EU project. M Flinkenflögel, et al.

3. Strategies for change

Progress of the Primafamed partners 2008 - 2010		
University of Goma, DRC	Level 2	Level 4
Moi University, Kenya	Level 3	Level 4
National University of Rwanda	Level 2	Level 4
Aga Khan University, Tanzania	Level 2	Level 3
University of Lagos, Nigeria	Level 1	Level 2
Makerere University, Uganda	Level 3	Level 3
Mbarara University, Uganda	Level 2	Level 3
Ahfad University for Women, Sudan	Level 1	Level 2
Gezira University, Sudan	Level 1	Level 4
University of Ghana	Level 3	Level 4

Adopted from the Primafamed Edulink ACP EU project. M Flinkenflögel, et al.

Twenty years of Primafamed-Networking: looking back at the future

1. The sustainable development goals and the new societal context
2. Looking back: Alma Ata, Selective PHC, Primafamed
3. The future? OUR ASSETS
4. Conclusion

Strategies for change

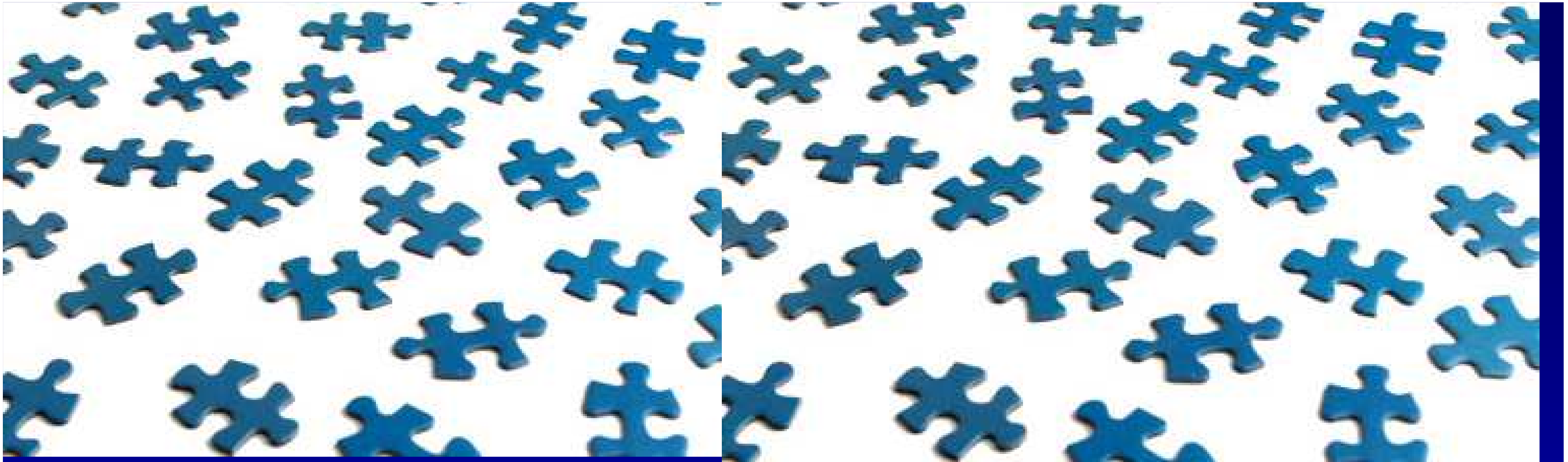
Political action: local, national, international

Important factors in African Family Medicine:

- Acceptance of Ministry: as part of the health care system of the country
- Influence political decision-making
- Addressing vertical disease-oriented programs

Vertical programs

- Create duplication
- Lead to inefficient facility utilization
- May lead to gaps in patients with multiple co-morbidities
- Undermine government capacity
- Lead to inequity between patients
- Lead to internal brain-drain



FRAGMENTATION

Zambia: HIV prevalence rate: 16,5 %

Distribution of MUST* Alumni

Currently in Uganda	687 (88%)
Work for: Government NGO or Private	 270 (35%) 510 (65%)
HIV related NGO	383 (51%)
Effort dedicated to HIV None Less than 50% Over 50%	 119 (15.8%) 317 (42.2%) 314 (42.0%)
Donor program not HIV	169 (22.5)

*Faculty of Medicine n=790

“Inequity by disease” becomes an increasing problem both in developed and developing countries

[see www.15by2015.org

Code of best practice for disease control programs to avoid damaging health care services in developing countries[1].

“Disease control activities should be integrated in health centers, which offer patient-centered care and should be designed and operated to strenghten health systems”.[2]

Source: [1] Unger JP, De Paepe P, Green A. A code of best practice for disease control programmes to avoid damaging health care services in developing countries. Int J Health Plann Manage 2003;18:S27-S39

[2] Meads G, Wild A, Griffiths F, Iwami M, Moore P. The management of new primary care organisations: an international perspective. Health Serv Manage Res 2006;19:166-73

Fifteen by 2015: strengthening primary health care in developing countries

Prof. J. De Maeseneer, MD, PhD; Prof. C. van Weel, MD, PhD; Prof. D. Egilman, MD, PhD; Prof. K. Mfenyana, MD; Prof. A. Kaufman, MD; Prof. N. Sewankambo, MD, PhD

WONCA, World Conference

Singapore, 25.07.07

Funding for primary health care in developing countries

Money from disease specific projects could be used to strengthen primary care

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The World Health Organization's World Health Report 2007 deals with access to primary health care as an essential prerequisite for health.[1] It acknowledges the importance of the Alma-Ata declaration of 1978, which called for integrated primary health care as a way to deal with major health problems in communities and for access to care as part of a comprehensive national health system. Yet the mission of Alma-Ata—to provide accessible, affordable, and sustainable primary health care for all—has been implemented only partially in developing countries.[2] We have therefore instigated the "15by2015" campaign (www.15by2015.org), which proposes a funding mechanism for strengthening primary health care in developing countries.

In the accompanying analysis article, Gillam notes that most developing countries have failed to provide even basic primary healthcare packages. Weaknesses in primary healthcare services often result from a variety of forces, including economic crises and market reforms, which limit the range and coverage of services and thus their effect on health.[3 4] On the positive side, between 1997 and 2002, financial support to improve health care in developing countries increased by about 26%, from $6.4bn (£3.3m; €4.4m) to $8.1bn.[5] However, most aid was allocated to disease specific projects (termed "vertical programming") rather than to broad based investments in health infrastructure, human resources, and community oriented primary healthcare services ("horizontal programming").[6]

An example of vertical programming is the enormous donor response to the HIV epidemic. In 2006, although Zambia's entire Ministry of Health budget was only $136m, the President's Emergency Plan for AIDS Relief provided the country with an HIV targeted budget of $150m. This unbalanced distribution of health funding occurs across sub-Saharan Africa. Thus, although HIV positive patients receive free care, others with more routine diseases receive poor care and still have to pay. Salaries of healthcare providers working for donor funded vertical programmes are often more than double those of equally trained government workers in the fragile public health sector. This lures government workers to the higher paying vertical programmes and creates an internal "brain drain." But it is the underfunded primary care clinics and health centres that care for all diseases, including common illnesses such as diarrhoea, malnutrition, and respiratory tract infections, which take many more lives than HIV, tuberculosis, and malaria.

A new global strategy is needed to reinforce community focused primary health care in developing countries. This will require cooperation between ministries, universities, non-governmental organisations, and donors working on health to overcome severe resource constraints, including insufficient numbers of doctors, pharmacists, and other health personnel. Four international organisations—the World Organization of Family Doctors (www.globalfamilydoctor.com); Global Health through Education, Training and Service (www.ghets.org); the Network: Towards Unity for Health (www.the-networktufh.org); and the European Forum for Primary Care (www.euprimarycare.org)—have therefore set up the 15by2015 campaign to foster a better balance between vertical and horizontal aid. This campaign calls for major international donors to assign 15% of their vertical budgets by 2015 to strengthening horizontal primary healthcare systems so that all diseases can

REVIEW

The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control

Regien G Biesma,[1]* Ruairí Brugha,[1,2] Andrew Harmer,[2] Aisling Walsh,[1] Neil Spicer[2] and Gill Walt[2]

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This paper reviews country-level evidence about the impact of global health initiatives (GHIs), which have had profound effects on recipient country health systems in middle and low income countries. We have selected three initiatives that account for an estimated two-thirds of external funding earmarked for HIV/AIDS control in resource-poor countries: the Global Fund to Fight AIDS, TB and Malaria, the World Bank Multi-country AIDS Program (MAP) and the US President's Emergency Plan for AIDS Relief (PEPFAR). This paper draws on 31 original country-specific and cross-country articles and reports, based on country-level fieldwork conducted between 2002 and 2007. Positive effects have included a rapid scale-up in HIV/AIDS service delivery, greater stakeholder participation, and channelling of funds to non-governmental stakeholders, mainly NGOs and faith-based bodies. Negative effects include distortion of recipient countries' national policies, notably through distracting governments from coordinated efforts to strengthen health systems and re-verticalization of planning, management and monitoring and evaluation systems. Sub-national and district studies are needed to assess the degree to which GHIs are learning to align with and build the capacities of countries to respond to HIV/AIDS; whether marginalized populations access and benefit from GHI-funded programmes; and about the cost-effectiveness and long-term sustainability of the HIV and AIDS programmes funded by the GHIs. Three multi-country sets of evaluations, which will be reporting in 2009, will answer some of these questions.

Keywords Global health initiatives, HIV/AIDS, health system strengthening, aid

Conclusions: negative effects

- Distortion of recipient countries' national policies
- Distracting governments from coordinated efforts to strengthen health systems
- Re-verticalisation of planning, management and monitoring and evaluation systems

Source: Health Policy and Planning 2009;24:239-252

Resolution WHA62.12
“Primary Health Care, including health systems strengthening”

The World Health Assembly, urges member states: … (6) to encourage that vertical programs, including disease-specific programs, are developed, integrated and implemented in the context of integrated primary health care.

Kenya: Government is involved

MINISTRY OF HEALTH

KENYAN FAMILY MEDICINE STRATEGY

September 2007

TANZANIA: DIALOGUE WITH GOVERNMENT AND OTHER STAKEHOLDERS 2017

THE PROPOSED ROLE OF FAMILY MEDICINE IN TANZANIA:

A DRAFT CONCEPT NOTE

BACKGROUND:

The postgraduate Family Medicine programme at the Aga Khan University, Tanzania was initiated in 2004. This is a 4 year programme leading to a Master of Medicine (MMED) degree in Family Medicine. Most of the graduates from this programme are working in private and private not for profit organizations as there are no positions in the public sector for those specializing in Family Medicine. After discussions and consultations with respected colleagues at the Ministry of Health, Community Development, Gender, Elderly and Children it was agreed that a concept paper should be developed on the potential role of Family Medicine in strengthening Primary Health Care (PHC) particularly in the district health service in Tanzania. If agreed in principle, we would follow up with a more detailed plan for the training of Family Physicians in the context of the needs of the health care system in Tanzania. The detailed plan would be developed in collaboration with MOHCDEC representatives.

Salary scale for primary health care professionals, Uganda 2012

Grade	Monthly salary (UGX)	Monthly Salary (Euro)
Medical officer special grade	UGX 633,333	€ 182.52
Medical officer	UGX 541,667	€ 156.10
Nursing officer grade 1	UGX 270,833	€ 78.05
Nursing officer grade 2	UGX 233,333	€ 67.24
Enrolled nurse	UGX 208,333	€ 60.04
Enrolled midwife	UGX 208,333	€ 60.04

Uganda: MPs Disagree over Health Budget

"Many MPs initially insisted they would not pass the national budget if the Government did not reverse its plan to reduce health expenditure".

"According to the 2012/13 National Budget framework paper, the health ministry's budget reduced from sh 852b to sh 800b".

(Source: httm://allafrica.com/stories/printable/201209300370.html)

Why Uganda needs to increase its health budget: A briefing for MPs

Too many mothers and children are dying in Uganda

In 2000, the United Nations agreed upon the Millennium Development Goals (MDGs), which include the reduction of under-five mortality by two-thirds and reduction of the maternal mortality ratio (MMR) by three-quarters between 1990 and 2015[1]. Although progress is being made towards achieving these goals, child and maternal mortality remain unacceptably high in Uganda. According to the Uganda Demographic and Health Survey 2011, for every 1000 babies born alive, 90 died before their fifth birthday. This is a 52% reduction since 1990, but the target is to reduce it to 62 child deaths per 1000 live births by 2015. This target is now within reach, and every effort should be made to achieve it.

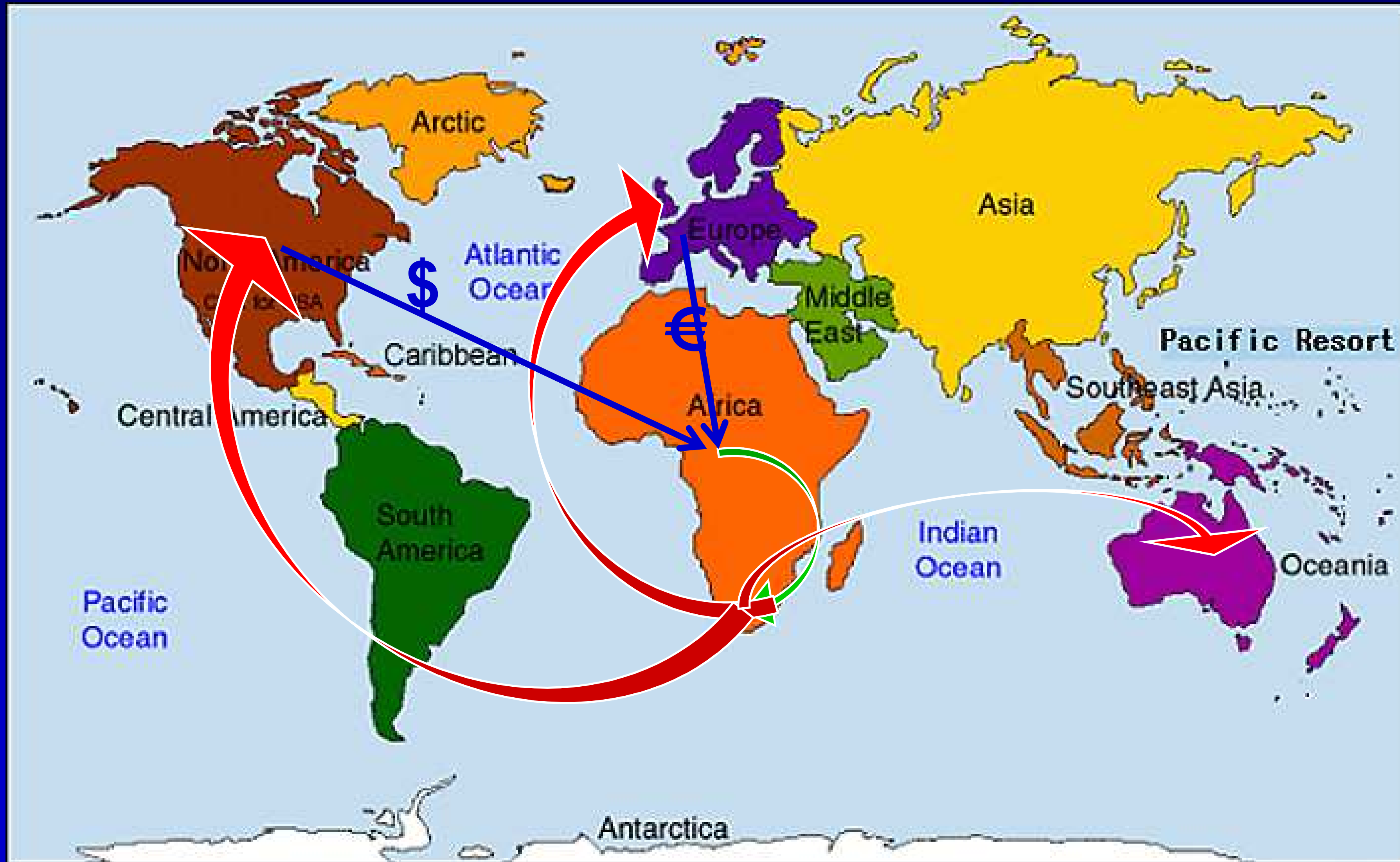
Uganda: MPs Disagree over Health Budget (2)

“On Wednesday the Government announced that it would double monthly pay for doctors in health centres IV level form sh 1,2m to sh 2,5m”.

“They would also spend sh 49,5b to recruit 6,172 health workers, of which sh 6,5b was released immediately”.

(Source: httm://allafrica.com/stories/printable/201209300370.html)

Reverse the deadly carrousel of brain-drain



Political action at the international level:

Every Western country should reimburse the country that trained the physicians and nurses they receive in their health system, with the full cost of training in the receiving country

Twenty years of Primafamed-Networking: looking back at the future

1. The sustainable development goals and the new societal context
2. Looking back: Alma Ata, Selective PHC, Primafamed
3. The future? NEW OPPORTUNITIES?
4. Conclusion

Primafamed-Network: opportunities for the future ?

1. Projects that create opportunities for funding of the Network: EuropeAid, Huraprim, ITN
2. Taking advantage of broad based funding: MEPI. Quid USA - Trump?
3. Ex Oriente Lux?
4. Gates Foundation?
5. Your suggestions?

Institutions in the North committed to support Primafamed

- Ghent University (B)
- University of Amsterdam (NL) + WHIG
- University of Aarhus (DK)
- University of Birmingham (UK)

Primafamed-Network: opportunities for the future

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MEPI- COUNTRIES

Overlap MEPI- and PRIMAFAMED-countries

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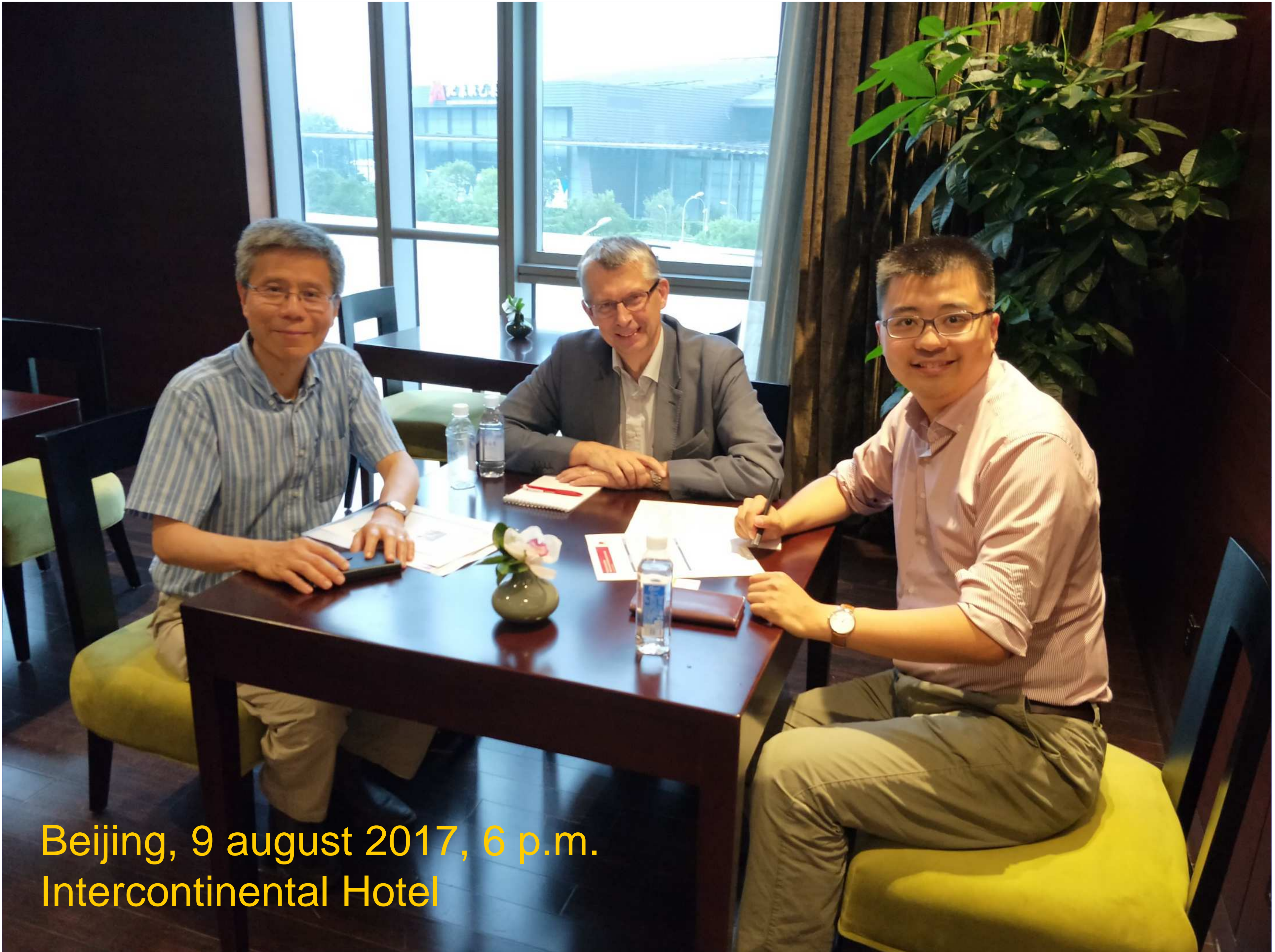
Beijing, 9 august 2017, 6 p.m.
Intercontinental Hotel

Primafamed-Network: opportunities for the future

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"Hear arguments about vertical and horizontal health care. The horizontal piece is the most important piece."

Bill Gates, at launch of PHCPI, 26.09.15

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Scaling up Family Medicine and Primary Health Care in Africa: Statement of the Primafamed network, Victoria Falls, Zimbabwe

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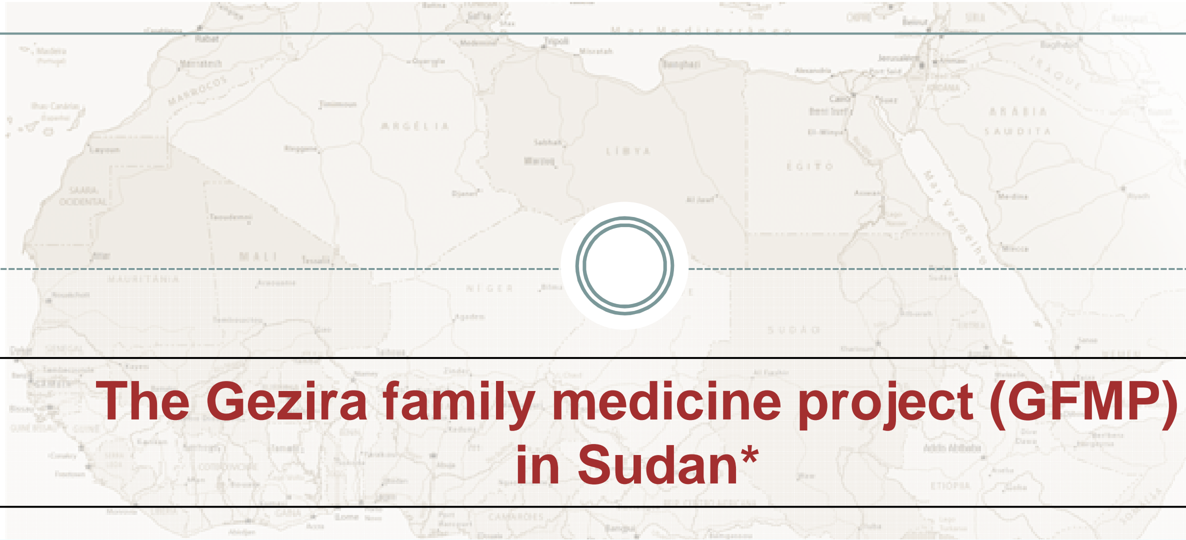
From 21 to 23 of November 2012, participants from 20 countries convened at the Fifth Annual Primafamed Conference (www.primafamed.ugent.be) at Victoria Falls, Zimbabwe. The participants want to support fully the realisation of the World Health Assembly (WHA) resolution 62.12[1], by contributing:

> … to train and retain adequate numbers of health workers, with appropriate skill-mix, including primary health care nurses, midwives, allied health professionals and family physicians, able to work in a multidisciplinary context, in cooperation with non-professional community health workers in order to respond effectively to people's health needs.

The participants recognise the importance of the worldwide demographic and epidemiological transitions and the impact of the global economic crisis on health and that these phenomena give rise to new challenges for healthcare providers in Africa. Moreover, the participants stress the need for an integrated approach to comprehensive PHC in order to address the fragmentation of care and health systems as a consequence of vertical disease-oriented programmes (HIV, malaria, COPD, diabetes, etc.). They confirm their commitment to the realisation of the WHA resolution 62.12:[1]

> … to encourage that vertical programmes, including disease-specific programmes, are developed, integrated and implemented in the context of integrated primary health care,

the WHO Global Health Workforce Strategy[2] and the WHA resolution 59.23: 'Rapid Scaling Up of Health Workforce.'[3]



The Gezira family medicine project (GFMP) in Sudan*

**With special thanks to Dr. Khalid Mohamed*

The Gezira family medicine project (GFMP) in Sudan

Gezira state:

- 25,549 km² with 3,7 M. Pop.in the middle part of Sudan.
- 80% are living in rural areas

GFMP-project:

- start 2010
- Partnership: MOH & FMUG
- Recruited 207 doctors in rural and urban areas
- 2 years Master in Family Medicine as ”in service training”

Challenges in teaching and clinical supervision

With special thanks to Dr. Khalid Mohamed

The Gezira family medicine project (GFMP) in Sudan

Components of the project:

1. The **training** component (UoG)

2. **Service** presentation component (MoH)

3. **Telecommunication and information technology** component to facilitate both training and service presentation

With special thanks to Dr. Khalid Mohamed

Huraprim
Ghent University Centre

1. **Training:**

- Master program principles

- a 2-years integrated primary care – university – hospital program:
  1. University teaching, evaluation and exams
  2. Hospital training in relevant clinical departments, based on a specified set of objectives (log book) for family medicine skills training
  3. Primary care work (in field service) training should constitute at least 70% of the time
  4. Paid training positions; salary and patient fees. Public investments in buildings and equipment. 75 new lab technicians

2. Service presentation:

- Before the program there were 116 primary care doctors in Gezira in 78 health centres
- The program recruited 207 salary paid Master student doctors which are spread in 162 centers all over the state
- 84 of the centers had no doctor before the program started
- More equipment and staff (Role of F.P.)

*With special thanks to Dr. Khalid Mohamed

3. ICT: Telemedicine

3. ICT: Electronic filing system

3. ICT: Distance education

The Gezira family medicine project (GFMP) in Sudan

Outcomes:

1. Doubling of doctors in the rural areas
2. More qualified doctors
3. More equipment and more staff
4. Reports from the Ministry of Health show:
   - Less hospital congestion
   - Less maternal mortality

*With special thanks to Dr. Khalid Mohamed

THE TIME FOR CHANGE IS NOW : YES WE CAN!

Thank you…

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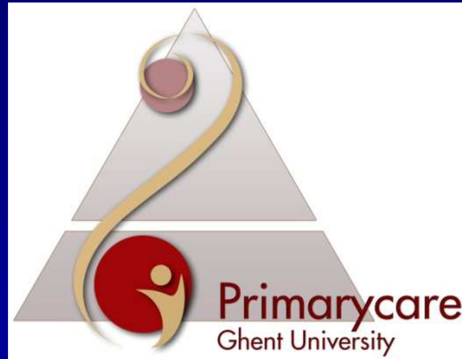
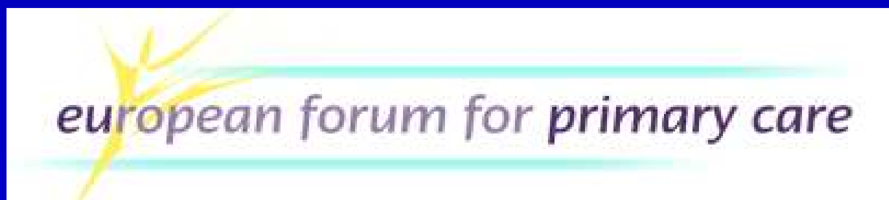
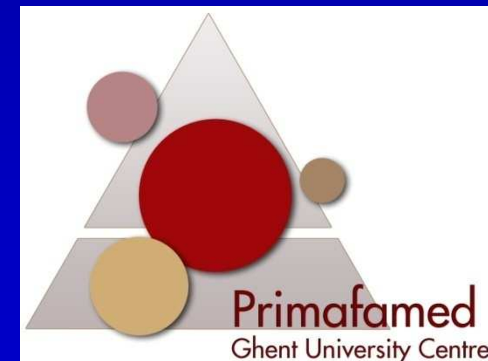


WHO
Collaborating
Centre on PHC





FACULTEIT GENEESKUNDE EN
GEZONDHEIDSWETENSCHAPPEN

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