

Closing remarks of Prof. Jan De Maeseneer, Primafamed - promoter, at the end of the Conference.

The Conference "Improving training in Family Medicine in Sub-Saharan Africa" has been a very special gathering of people who are characterised by their commitment for the health of the populations they serve in their local communities and through their involvement in training and education of future family physicians.

During this week Africa has explored the concept of family medicine and developed strategies to improve training and capacity building for family medicine operating in the framework of a Primary Health Care (PHC) System. It has become clear that Family Physicians need to be excellent clinicians, that they are responsible for a defined population (in Africa most of the time the population will be defined geographically), that they are community based (although in the African context there will be a need to also provide services in district hospitals, apart from the work in primary health care centres and the supervision of clinics) and that for family physicians the doctor/patient relationship is central.

Family medicine will respond to the challenges described in the World Health Report 2008: "PHC more now than ever" and contribute to care that puts people first as described in chapter 3 of this very important document.

Moreover Family Physicians will have to face to the important challenges of the social inequalities in health. Two weeks ago, at the conference: "Closing the gap in a generation" in London the Commission on Social Determinants of Health of WHO has stated that Health Care Systems have better outcomes when built on PHC, emphasizing locally appropriate action across the range of social determinants and an emphasis on the primary level of care with adequate referral to higher levels of care.

Accessible PHC, without user fees, is very important, as demonstrated here in Uganda by the positive effect that abolishing user fees had on health care utilisation in the Kisoro

district in 2000. Family medicine in the PHC-team is able to address social determinants of health through empowerment of individuals and communities and through the contribution to social cohesion. The model of Community Oriented Primary Care (COPC) may be an inspiring concept.

The growing number of departments of family medicine and primary health care in Africa have demonstrated during this conference their commitment to a high quality and socially accountable training of family physicians. But to make that happen, some essential conditions should be fulfilled.

In the undergraduate curriculum, there is a need for appropriate exposure of students to family medicine and primary health care, and to focus on patient-centredness and the importance of context in health. The internship should have an obligatory rotation in PHC/FM.

We should reflect on the position of community service in the career: the question arises if it could not be organised in a more didactic context or even integrated in the training of family physicians.

A fundamental prerequisite for recruitment of candidates for post-graduate training in family medicine is that registrars are adequately paid by the Ministry of Health during their training, as they make an important contribution to service delivery.

There is an urgent need to increase capacity and the number of trainees in family medicine. This will only be possible if career-perspectives for family physicians improve. To pay family physicians at the same level as other specialists (as proposed in the document on Family Medicine of the Kenyan Minister of Health) seems to be an appropriate strategy in order to improve attractiveness of the career.

One of the problems for the development of primary health care in Africa is that actually a lot of the care is organised through vertical disease-oriented programs that focus on one disease (HIV/Aids, TB, Malaria). These programmes are very often sponsored by donor-organisations e.g. PEPFAR, Goba Fund, Bill and Melinda Gates Foundation,...

There is now evidence that these programs are very often not efficient, because they lack a comprehensive approach and that their efficiency could be improved through integration in a PHC-approach.

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 136 million US\$, the PEPFAR (President's Emergency Plan for Aids Relief) provided the country with an HIV targeted budget of 150 million US\$.

A consequence is that on the one hand HIV positive patients receive free care, whereas others with more routine disease receive poor care and still have to pay themselves. This creates a new form of inequity, inequity by disease.

Salaries of health care providers working for donor-funded vertical programmes are often more than double or even triple than 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 "international brain drain". But it is the underfunded primary care clinics and health centers that care for all diseases, including common illnesses such as diarrhea, malnutrition and respiratory tract infections, which take many more lives than HIV, tuberculosis and malaria.

Therefore a campaign is launched: the 15 by 2015 campaign.

This campaign calls for major international donors to assign 15% of their vertical budgets by 2015 to strengthening horizontal primary health care systems so that all diseases can be prevented and treated in a systematic and comprehensive way.

The problem is what will happen with donors and government aid now that there is financial turmoil and crisis?

My view is that this crisis is both a challenge and an opportunity. When we look at history, we see that the 2 decades that showed the most social progress in the 20th century were the periods between 1910-20 and 1940-50.

People reflected about the future and e.g. in 1942 the British Social System was designed.

I think the actual challenge for his world could help us to make progress provided the financial restoration is complemented by an ecological and a social restoration. Time has come to rethink fundamentally how we will be able to organise a caring society that creates opportunities for personal and collective development, based on social justice worldwide.

And there, the family physician is back in the picture: continuity, longitudinality, prevention of unnecessary interventions and comprehensiveness are key. Finally, it was for me a privilege to be here and to learn from Africans' wisdom, hopes, creativity optimism and commitment. Because we know, if we work together: yes, we can! We can make a difference where it really matters!

Kampala, 21.11.2008.