



Peter Manschot Fonds

*Fondsenwerving ter ondersteuning van de
Family Medicine Training in Low Resource Countries*

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aan De Stichting Dioraphte
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onderwerp Bijdrage aan 'Family Medicine' Training in Low Resource countries.

Geacht bestuur,

Enige weken terug heb ik telefonisch contact gehad met Dhr van Stokkom over de onderliggende aanvraag, waarna ik deze nu indien. Het Peter Manschotfonds bevindt zich in een cruciale fase, waarin succes bij stimuleren van training in Family Medicine aan post- en undergraduates tot gevolg heeft dat onze kas nagenoeg leeg is. Ondanks stimulerende bijdragen van particulieren, die inzamelingen hebben gehouden, vormen die bedragen slechts een gering aandeel in de benodigde bedragen. Opleiden is duur en de resultaten zijn lange termijn. Het PM-fonds dankt veel aan de inzet van de support groep van de WHIG (Werkgroep Huisartsgeneeskunde en Internationale Gezondheidszorg). Dat netwerk in verschillende landen heeft een stroom aanvragen tot gevolg, die u terugvindt in het projectplan. We moeten hen nu allemaal teleurstellen. Onze hoop is dan ook gevestigd op een donor, die onze visie en commitment deelt rond het promoten van FM in LRC en die op basis van vertrouwen en rekenschap dit netwerk wil ondersteunen in de verdere realisatie van onze ambitieuze projecten t.b.v. meer generalistische zorg aan meer mensen, vooral ook in rurale gebieden. Een aanvraag voor het CBF is ingediend en een afspraak voor accreditatie wordt gemaakt.

Met vriendelijke groet,

Fons Mathot, voorzitter
Pieter van den Hombergh, vicevoorzitter
Adam Lagro, secretaris
Freke Manschot, Penningmeester

Supporting Undergraduate & Post Graduate Family Medicine Training of Physicians & Staff in Low Resource Countries



Building Capacity for Primary Care Family Physicians in LRCs

Project number WHIG/2016/01

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Kenyan Family Practitioners (FPs) meeting in Eldoret 2011

1. List of Abbreviations

CME	Continuous Medical Education
DM	Diabetes Mellitus
DRC	Democratic Republic of Congo
FAMCO	Family and Community Medicine
FHC	Family Health Care
FM	Family Medicine
FMS	Family Medicine Specialist
FMP	Family Medicine Physician
FP	Family Practice / Physician
GP	General Practitioner
HoD	Head of Department
HIS	Health Information System
HR	Human Resources
LRC	Low Resource Country
IH	International Health
KAFP	Kenyan Association of Family Physicians
MoF	Ministry of Finance
MoH	Ministry of Health
NGO	Non-Governmental Organisation
MUNDO	Maastricht University Development Organisation
NUR	National University of Rwanda
NVTG	Nederlandse Vereniging voor Tropische Geneeskunde; Dutch Society for Tropical Medicine & IH
PCP	Primary Care Physicians
PHC	Primary Health Care
PM-fund	Peter Manschot Fund
SA	South-Africa
SSA	Sub-Saharan Africa
TOR	Terms of Reference
ToT	Training of Trainers
UN	United Nations
WHIG	(Dutch) Working Party for FM and International Health
WHO	World Health Organisation
WONCA	World Organisation of National Colleges & Associations of Family Medicine

2. Introduction

This is a project plan of the Working Party for Family Medicine and International Health (WHIG). The project plan hopes to raise money for the ambitions of the WHIG in promoting Family Medicine. A support (of FM-training) team in connection with a Fund (Peter Manschot-fund) enable the promotion of Family Medicine (FM)-training and principles in Low Resource Countries (LRCs) and support training of Family Medicine helping in undergraduate and postgraduate training programs. The WHIG is the umbrella organisation. For the justification and background of the promotion of Family Medicine in addressing the health care needs in LRCs we refer to Annex 2 and www.whig.nl. In Table 1 you find a core information on Family Medicine in Low Resource Countries, WHIG and PM-fund.

Table 1: Core information on Family Medicine in LRCs and the PM-fund

See also <http://whig.nl/whig-international/family-medicine-in-low-resource-countries/>

The vision, mission and core values of Family Medicine are:

Vision for the Family Physician: envisions a community where individuals and families have efficient promotive, preventive and curative health care;

Mission: to provide high quality, affordable, sustainable, health services to all and provide leadership and coordination in health education and research

Core Values: equity, quality, relevance, cost-effectiveness, comprehensiveness, community focus (context), patient centeredness, continuity of care & lifelong learning.

The WHIG (Working Party for Family Medicine and International Health)

Its aspirations are:

1. Being a platform for those FPs who are active in the exchange of expertise and are willing to contribute to this.
2. Offering expertise on FM for capacity building in FM-training sites. Presently WHIG supports FM-training in Moi University, Eldoret, Kenya, in Rwanda and Uganda.
3. Facilitate the exchange of young doctors. We help Dutch trainees in FM and GPs to increase their knowledge on global diseases (import diseases).
4. Contribute to the FM-orientation of those doctors who want to work in a LRCs.
5. Contribute to the FM-orientation of those doctors/ MO's who have to do compulsory service in their country, in order to raise interest for rural and emergency medicine.
6. Contribute in research and publication on the above subjects.

The PM-fund aims to promote Family Medicine training programs in LRCs. The focus is on capacity building through support of students in meeting tuition fees, through help with staff/ faculty for the training, help with organizing training courses and stimulating research. The FM-training requires a continuous input of means for the students and the trainers (fees, books, living) as well as for materials, transport and cost of overhead/ ICT. <http://whig.nl/whig-international/peter-manschot-fund/>

Lately the development of Family Medicine has gained momentum in Low Resource Countries (LRCs), more so because Non-Communicable Diseases (NCDs) are quickly becoming the main health problem and because there is a vast need to be met in rural areas especially in emergency medicine. The support group tried to effectively promote FM-principles wherever possible and in various ways. In the period 2004-2010 Dutch FPs/ former tropical doctors helped in setting up the FM-training in Moi University, Eldoret. Later 4 other Kenyan universities also started departments of FM.

Later activities were 'paying tuition' and thus facilitate enrolment, building a training center, training staff on the spot. In Europe we support undergraduate training programs that involve a community health approach and made a promotion film. (Table 2)

Financial support was first provided by MUNDO with money from DoenDenkers (Dioraphte) (€ 100.000,-), Innovation foundation of the Dutch Health Insurers (€ 112,000,-), The Jan Ivo Fund and the Tejchevé fund (€ 30.000,-) but from 2013 the PM-fund depended mostly on private gifts and the reserves exhausted with just ± € 10.000,- left to finish projects. The support group and PM-fund working within the WHIG have the ambition to continue being an effective network for implementation of FM. Presently the PM-fund has not the capacity to start new projects, since its financial situation only secures a descend finalization of the current projects.

Through the WHIG new collaborations can be initiated to support FM trainings in LRCs, but that requires funding and that is why this project plan is crucial for continuation.

Some ongoing activities



Left: First KAFP Western Chapter CME-meeting (2011).

Right: Pit Latrine and shower as promoted by the community nurses in Naitiri, the community health training centre for FM-registrars. Emphasis is on hand washing after using the latrine.

Table 2: Accomplishments in Family Medicine training in LRCs + its future scope

Accomplishments of the Peter Manschot Fund 2007 – 2016

Eldoret

Since 2005, over 30 Family Physicians (FPs) graduated in Eldoret and a FM-training to become specialist in FM has since started in 5 universities in Kenya. Both the curriculum and the FM-department in Eldoret is developed and accomplished with the expertise of the support group and the means of the PM-fund. All the trained FPs work in rural district & sub-district hospitals, health centres or have become faculty staff in FM-training departments in both Eldoret and other universities. FPs also have a key role in health care through implementing a Family Medicine approach. None of the FPs has left the country so far. They started their own College and Association and are in close contact using social media (e.g. Whatsapp). CME and research have taken off and FPs are in high demand for senior positions in the counties.

An achievement was that Family Medicine has been acknowledged as a specialism by the Kenyan MoH including equal salary levels compared to other specialists.

Documentary film

A documentary film was made to stimulate Family Medicine. In addition to the full version (30’), a Youtube (3’) version was developed. The film received a warm welcome during the first FM-conference in Nairobi.

(<https://www.youtube.com/watch?v=6FJKWizd-qI&feature=youtu.be>).

Rwanda, Uganda, Indonesia

The Peter Manschot-fund also contributed to the Family Medicine training in Rwanda (both post- and undergraduate program) and in Uganda (training course for the HoD of the Makerere FM-training program) and Indonesia (Training of Trainers). They also collaborate with FM-training departments in SA and Malawi.

Exchange in teaching has been realized between Rwanda, Uganda & Kenya (Eldoret).

Scope

Primary Care\ Family Physicians must be able to address a wide range of primary care problems particularly emergency care. They have the competence to practice for all people both in urban and rural areas. Emergency care competence is paramount.

The Primary Care Physicians Programmes aim to prepare competent, caring, compassionate doctors equal to Family Physicians committed to serving their community by providing leadership in their communities, in addressing the broad range of health needs, rendering comprehensive clinical services (“from ‘womb’ to ‘tomb’”) . Family Medicine is becoming an accepted specialism, that does not replace Community Medicine or Public Health, but adds a more person-directed approach.

It takes many years for countries to reach a sufficient knowledge body & culture of FM. Countries with the ambition to offer universal health coverage will need will need Family Physicians. We also must prepare the next generation of Family Physicians by introducing primary care & emergency/ rural care in (under)graduate programs.

3. Project proposal

3.1 Problem analysis and challenges in supporting Family Medicine training

- 1) *Startup of Family Medicine departments, getting staff/ faculty, expertise and means.*
Training FPs is expensive as it requires a department with high quality trainers as well as non-productive time of trainees. Training starts already in the undergraduate curriculum. As a result the whole continuum is rather expensive. Although there is extensive knowledge on what sort of curriculum could be offered, curricula still vary considerably. Experienced teachers or trainers are hardly available for specific FM-fields like person centered care\ communication, palliative care, research, chronic care, organisation & quality improvement, etc. Providing such staff in the startup could help and keep costs low.

Currently Malawi, Rwanda & Kenya (Eldoret) are providing under- & post-graduate training (Rwanda stopped the postgraduate training, but has a chance to restart under the new minister of Health). More countries in East Africa have started or consider starting a FM-training programmes (Indonesia, Uganda, Ethiopia, South Sudan). WHIG is faced with a challenge to contribute when progress is blocked, due to lack of expertise and/or finances. This asks for local connections and mutual trust. We state upfront that the FM-training has to be self-sufficient.

A curriculum matching the needs of people: Family Medicine & Emergency Medicine
FM is responsive to the needs of the people in their context. In rural areas this means extra competence in emergency/acute care. It determines the clinical effectiveness of the Family Physician. Next to person centered care this competence is key to success.

3.2 Objectives

The aim of this project is: Support WHIG to assist in (setting up) FM-training in LRCs, more specifically WHIG will:

- 1) consider calls for support for training from all LRC countries;
- 2) assist in the process to get FM recognized as a specialism on a par with other specialists in that specific country;
- 3) support the process to get FM-principles integrated in the Health Care System
- 4) strive towards establishing affordable, attractive under- & postgraduate training and job perspective for FPs

3.3 Planned results

The WHIG identifies needs for support and helps to meet the demand in FM-training. Our activities cover three narrowly connected fields:

- 1) *Training of Trainers program, linking expertise between FM-trainings departments.*
In the last 20 years Primafamed in Belgium (Prof. Jan de Maeseneer) has built an extensive network with FM-training departments in Africa (Botswana, Mali, Benin, Ghana, Sudan, Uganda, Kenya, Rwanda, Democratic Republic of Congo (DRC), Nigeria, Tanzania) <http://www.primafamed.ugent.be/>.

A Dutch branch was started in close contact with the WHIG and Steven van de Vijver has agreed with funder Jan de Maeseneer to be the contact person. As such he became chairman of the Dutch Support Committee for FM-training in 2016.

<http://whig.nl/whig-international/dutch-support-committee-of-fm-training/>

His first assignment is to link experts in FM-fields to FM-training in LRCs with identified needs for such expertise. Priority will be given to Train-the-trainer-courses in various university departments. Steven presented these plans during the yearly WONCA Africa Conference in Ghana and several universities applied already for support. (Ghana, Rwanda, Malawi). In 2017 the network hopes to be operational, if this project could be funded in conjunction with Primafamed.

- 2) *Supporting a course for FM-trainees and staff of a FM-department interested in FM.*
Utrecht and Maastricht Universities are co-developing a Family Medicine summer course for FM-trainees and trainers from abroad, aiming to learn from the Dutch Primary Health Care system, Quality Assurance and our FM-training methods. (see annex 4: Quality Management in Training and Patient Care in General Practice)
A first course was planned in summer 2016, but cancelled due to difficulty with costs for travel and stay. There was sufficient interest and assisting in meeting the difference with money from this project could help to reach an important lot of people that exchange views and ideas. (see annex 4: Quality Management in Training and Patient Care in General Practice).
- 3) *Boosting under- & post-graduate FM-training; assisting when needed in:*
 - a. staffing Departments of FM (Rwanda); Starting and staffing training sites for FM-trainees which satisfy the requirements for teaching and are role models for primary care (e.g. Webuye, Naitiri, Iten, and Kagundo are such sites we are already involved in). Rwanda has a problem keeping up a department of FM.
 - b. opening up tools for FM-training using databases from international FM-training material (Hamilton, Calgary, Rily program, WHIG-website)
 - c. grooming PhD-students by helping them in with the necessary training courses.
 - d. increase attraction for MOs for the FM-training by offering tuition fees in rural areas or by creating awareness through campaigns and other PR activities.
 - e. boosting professional Colleges/ Associations and help them organise CME and disseminating the principles of FM.
 - f. the setup of a prospective/ retrospective study to evaluate the contribution of FM care (of these FPs) compared to usual care at the district level.

In 2017 this support translates per country into:

For Kenya:

- Continuation of courses “The clinician as a teacher”, “Palliative care” and “Communication skills (yearly)
- Support for a PhD student in Palliative care
- Support in organizing a (yearly) meeting of the college + CME
- Helping to have a relevant number of FPs in Kenya by 2020;
- Support a comparative prospective study between FM-care and usual care

For Rwanda

- A reopened Family (and Community) Medicine Master program & department at the University of Rwanda supported by the MoH before 2020.
- Recognition of the value of FM & the specialism in the Rwandan health system.
- Support of the Master program by the MoH through scholarships to residents.
- Medical (undergraduate) students getting yearly a training in FM & Community Health (\pm 700 students/ year)

For Malawi, Ethiopia and Uganda

- Start of one PhD-study in 2017 in each country.

For Indonesia

- Collaboration with the Maastricht & Utrecht university FM-training departments.

4. Monitoring and Evaluation

In general

The PM-fund is accountable to the donor for the allocated money. Project plans applying for support by the PM-fund need to be SMART and clear about their contribution to FM-training and how they fit in the bigger picture of institutional and government support. Reporting of results and financial accountability (when and how) should be specified per project. Reporting will be published on the website. Project progress will be documented both quarterly and annually in progress reports to be assembled by the project supervisor(s) (in NL a member of both the support group and the PM-fund). Quarterly the project supervisor(s) will monitor the progress and assist in overcoming obstacles to project implementation.

A two year final project evaluation is done together with the project supervisor. Project proposals will also have to meet a set of criteria already in use by the PM-fund. The support committee in collaboration with the PM-fund (on behalf of the WHIG) will see to it that recommendations made in progress- and internal evaluation reports are followed up in further implementation of the project. The board of the WHIG can only dis- or approve of our activities and helps by donating income out of their teaching activities. Funds will be allocated quarterly or yearly on the basis of results.

Project Management

Tasks will be divided between members of the support committee and the Head of Department (HoD) in the FM-training site, that has asked for support:

- Project supervisor - overall and final responsibility for the project
- Members of the support committee are project owners per country
- The head of Department Family Health is:
 - responsible for the day to day management of the project,
 - assisting the local accountant with the financial management of the project (i.e. processing funding requests for project activities, follow-up & accounting)
 - reporting internally

Assumptions

The 1st assumption is that in each country the MoH & donors will continue to invest in the training of Family Physicians and CME courses and support the FPs in the field.

The 2nd is that MoH budget allocation to Family Medicine is not further tightened.

5. Workplan

The activities planned are organized and coordinated in collaboration with the support group. Before money is allocated by the PM-fund a SMART project plan has to be submitted, that specifies the contribution to the planned results. A breakdown of the costs and copayments is required.

5.1 Project planning

3.2	Planned Results WHIG/2016/01	2016		2017												2018	
	Activities	11	12	1	2	3	4	5	6	7	8	9	10	11	12		
a	Making the projects SMART and get approval of support group																
b	Finalization project proposal																
c	Search for external financial support																
1.a	Train-the-trainers program, linking expertise between FM-trainings deps.																
2.a	Organisation of the Course for FM-teaching in Utrecht																
3	Boosting under- & post-graduate FM-training																
3.a	Starting and staffing Deps of FM-training & training sites																
3.b	Opening up tools for FM-training Proposal in Jan. Start sept.																
3.c	Stimulating PhD-students offering training courses			?													
3.d	Increase attraction for MOs for FM-training and PR			?													
3.e	Boosting colleges/ associations of FM and help them organises CME			?													
3.f	Several FPs per county by 2020.																
3.g	The setup of a prospective study for evaluation of FM-care vs usual care																

Annex 1 – Budget

Budget						
Project number:		WHIG/2016/01				
Report		2017				
Project name:		Supporting Family Medicine in Undergraduate and Post Graduate Training of Physicians & staff in LRCs.				
Project Results		Activity	Specified Inputs	Budget		
2017	activity code		Description of inputs:	Quantity	fee/price	Total Budget in EUROS
	1.a	Train-the-trainers program, linking expertise between FM-trainings deps.	5 experts ~€ 2000,-	5	2000	10.000
	2.a	Organisation of the Course for FM-teaching in Utrecht	10 participants/ yr, each supported with ~ € 1000,-	20	1000	20.000
	3	Boosting under- & post-graduate FM-training				
	3.a	Starting and staffing Deps of FM-training & training sites	Support for HoD and training in Rwanda			50.000
	3.b	Opening up tools for FM-training	Student project			3000
	3.c	Stimulating PhD-students offering training courses	4 PhD students	4	10.000	40.000
	3.d	Increase attraction for Mos for FM-training and PR	On demand			10.000
	3.e	Boosting colleges/ associations of FM and help them organise CME	5000 per college	2		10.000
2018	3.f	Target of ± several FPs per county in Kenya by 2018.	Assisting in Tuition € 2000,-	25		50.000
	3.g	The setup of a prospective study for evaluation of FM by these FPs	Study coordinated from Kabarak (Bruce Dahlman)			10.000
Total		2017-2018				203.000
		Income generated by the Support group, gifts of individuals				-20.000
Funding		2017-2018				183.000

- The WHIG hopes to generate 20.000,- with promotion and through gifts.

Annex 2. THE DISCIPLINE AND SPECIALTY OF FM (WONCA 2011)

General practice / family medicine is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care.

Characteristics of the discipline of general practice/family medicine:

- a) It is normally the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned.
- b) It makes efficient use of health care resources through coordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialties taking an advocacy role for the patient when needed.
- c) It develops a person-centred approach, orientated to the individual, his/her family and their community
- d) It promotes patient empowerment
- e) It has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient
- f) It is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient.
- g) It has a specific decision making process determined by the prevalence and incidence of illness in the community.
- h) It manages simultaneously acute & chronic health problems of individual patients.
- i) It manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.
- j) It promotes health and well being both by appropriate and effective intervention.
- k) It has a specific responsibility for the health of the community.
- l) It deals with health problems in their physical, psychological, social, cultural and existential dimensions.

The Specialty of General Practice / Family Medicine

General Physicians/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilizing the knowledge and trust engendered by repeated contacts. General Physicians/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care, or palliation and promoting patient empowerment and self-management.

This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care. Like other medical professionals, they must take

Responsibility for continuously monitoring, maintaining and if necessary improving clinical aspects, services and organisation, patient safety and patient satisfaction of the care they provide.

STATEMENT OF CONSENSUS

Countries that still develop a Family Health care a consensus on the contribution of FM to equity was reached on the African Regional WONCA in Rustenburg, SA 2009.

The contribution of Family Medicine to equity in health care

1. Family Medicine, a core contributor to primary health care, is critical to the achievement of equitable health outcomes for all.
2. All people should have equal access to health care. In particular, access should not be limited by the inability to pay, or the lack of health care providers or facilities. Care should be focused on people and not specific diseases, as is the situation with regard to the funding of vertical health programs. Access should not be limited by geography, culture, gender, religion, administration, policy or disability.
3. In order to deliver better health outcomes for all, the principles of Family Medicine should be shared by the whole primary health care team. They include the FP, the GP, the clinical nurse practitioner, the midwife, mid-level workers (including clinical/medical officers & assistants) and community-based health workers.
4. Training institutions should be socially accountable in adequately preparing health workers with the Correct knowledge, attitudes and competencies, so that they are able to play their part in the primary care team.
5. FM should advocate for social and health policies that promote equitable health care. For example, health funding should be allocated according to the health needs of the population and incentives should be provided to attract health workers to underserved communities in order to improve the quality of care.
6. FM should advocate for the resolution of conflicts and promote peace as a fundamental prerequisite for the provision of equitable health care.
7. FM should practice cost-effective care in order to attain maximum value from limited resources.
8. FM should contribute to quality care that is not threatened by commercialization, or by weak services in the public sector.
9. FM should empower people in communities to tackle social determinants of ill health.

WONCA Rio Statement on the Contribution of FPs to Universal Health Coverage 2016:

The World Organization of Family Doctors (WONCA) calls for all countries to increase the number of family doctors in order to achieve high quality comprehensive primary care and universal health coverage.

Effective strategies include: improving the skills of doctors already working in the community; recognizing Family Medicine as a specialty and enhancing the academic basis of the discipline; strengthening the family medicine experience of all medical students; actively recruiting more medical graduates into more postgraduate family medicine training programs; giving all family doctors and members of their teams the resources to carry out their work, recognizing their contribution, and ensuring their retention in the workforce – all in order to deliver excellent integrated cost-effective people-centered care

Annex 3: Plan to restart Family Medicine in Rwanda

Why Rwanda needs Family Medicine

The place of Family Medicine in the Rwandan health system

Introduction

Despite tremendous achievements in healthcare, Rwanda still carries a high burden of disease with infections the leading cause of death, and chronic non-communicable diseases constituting 25% of the disease burden. It is particularly Rwandans in rural areas and poor communities that are at greatest risk.

More than 90% of all Rwandan outpatient visits happen in health centers, yet most nurses at health centres are not trained holistically in preventive primary care. The shortage of well-trained primary care providers is one of the biggest challenges facing the Rwandan health system. This overburdens secondary and tertiary care and hinders Rwanda's efforts to establish a sustainable, quality and self-reliant health system.

Thus, there is a need to strengthen the primary health care (PHC) system. While community health workers constitute an important step, we believe further steps are needed to ensure appropriate care on the entire health system frontline. We suggest Family Medicine (FM) has an essential role to play in organizing, coordinating and supporting district, sub district and PHC services.

What is Family Medicine?

FM is a clinical discipline specialized in the provision of continuous, comprehensive, coordinated and contextualized PHC for individuals, families and communities.

FM incorporates prevention and health education with clinical care. It considers biological, psychological, socio-economic, cultural and spiritual parameters and is not limited by age, gender, organ, system or disease.

Family physicians are experts in team-based care as well as clinical training. They may ensure quality of care by coordinating teaching and mentorship efforts for providers in the frontline addressing the complex health challenges at community level.

The Statement of Consensus on Family Medicine in Africa, 2009 asserts that in an African context, the family physician is a clinical leader and consultant in the PHC team, ensuring continuing, comprehensive, holistic and personalized care. The African family physician is a specialist in the common medical problems, thus trained in the most common surgical procedures (including orthopaedic and abdominal surgery), obstetric care, paediatric care, internal medicine and in particular chronic care. They operate according to the principles of comprehensive person-centred care, with a person, family and community orientation rather than simply focusing on a disease.

Family Medicine is a critical part of health systems of many countries, including many African countries like South Africa, Kenya, Uganda, Nigeria, Ethiopia, Ghana, Botswana, and Namibia. WONCA, the World Organization of Family Doctors, officially collaborates with the World Health Organization (WHO) and represents 500,000 doctors in 130 countries. FM is consistently shown to be efficient and cost effective. Building capacity at the frontline not only saves lives, but also resources at higher health system levels through prevention, early diagnosis and by minimizing unnecessary transfers to secondary and tertiary institutions.

Brief history of Family Medicine in Rwanda

Planning of a FM postgraduate program in Rwanda started in 2006. At that time the country was restructuring PHC around health centers and a network of community health workers. The objective of this new program was to train community-oriented doctors capable of providing quality health care at a district level, ready to support PHC teams.

A 4-year Master program was developed under the Department of Family and Community Medicine (FAMCO) at the National University of Rwanda (NUR) with the assistance of Moi University (Kenya), Makerere University (Uganda) and the University of Colorado (US). This MMed (Master in Medicine) program provided by NUR was approved by Cabinet in 2007. In 2008 the Ministry of Health accepted and supported it, and the first cohort of 7 residents was enrolled the same year.

When the HRH program was developed, Family Medicine was considered a backbone and CHAI leveraged this knowledge and support to build the HRH plan. The training was based on development of specific competencies, not simply rotation through specialties. It focused on common health problems of Rwanda and the region, and management within the district hospital framework, as well as collaboration with community health centers with emphasis on disease prevention health promotion at individual and community level.

Eighty percent of training was in assigned district training hospitals (Kabgayi, Musanze and Rwinkwavu), 20% in central training hospitals (CHUK and CHUB) and other selected district hospitals. Residents were trained by qualified family physicians and existing specialists at district training hospitals. Initially CDC, Tulane University, Colorado University and a small fund from PrimaFamed in Europe, funded the program. In 2010 Partners In Health (PIH) started also to support the program.

In 2009, in collaboration with the Ministry of Health, the Faculty of Medicine at NUR organized a workshop to discuss the role of FM in Rwanda. The following agreed resolutions were taken:

- Family Medicine is a relevant and necessary element of the Rwandan health system, and should form an integral part of the Health Sector Strategic plan.
- The primary role of the Family Physician is the delivery of high quality PHC, at the district level, although they are able to function at all levels of the Health System
- Family Medicine is recognized as a specialty, equal to other MMed specialties

Therefore it was decided that the program should be retained, strengthened, and expanded.

In 2011, The Ministry of Health published the 2011-2016 HRH Strategic Plan where Family Medicine was at the center of district hospitals. However, in 2012 the Ministry of Health suspended its support for new intakes just as the first cohort of residents were graduating. The explanation provided was reprioritization though no official documentation of this decision was provided. Only 2 cohorts of students graduated. The country currently has only 9 specialists in Family Medicine. Some are practicing in district hospitals (DH); two are directors of DHs (Shyira and Bushenge DHs) and one is a faculty at the University of Rwanda where he is conducting a PhD research project in capacity building of PHC providers. Are these good places for them? Are they able to do what they do best?

However, to get future doctors to believe in this specialty, early 2012 an undergraduate program in social medicine and community health has started by the FAMCO department and the curriculum for all years was later developed. Since 2012 hundreds of medical students are trained. Unfortunately the HoD left recently and the financing of her position is not any longer supported by PIH due to cuttings in their budget. Also the University of

Rwanda is not able to support the position financially. Just mid-2016 a change in leadership at the MOH took place that would make a restart of Family Medicine training possible.

Why should we invest again in Family Medicine in Rwanda?

And what could be achieved and is measurable?

The Rwandan health system has medical specialists in referral hospitals, while non-specialized general practitioners run the district hospitals. Yet, if disease is caught and managed early by well-trained district or sub district clinicians:

- Less referrals for expensive care by specialists at tertiary hospitals are needed
- Patients recover faster to re-enter the work force and as a resource rather than a burden in the family and community
- Patients recover with less complications, thus less likely to require expensive chronic treatment and specialized care

This alone would save the health system important financial resources.

WHO is emphasizing PHC (now more than ever) as the pillar of the health system with team-based care models and social accountability of health professionals. The broad training of family physicians makes them well suited to any emerging need for care.

In Rwanda the role and scope of FM is dynamic over time and depends on the changing health needs of the community. Family physicians are trained for flexibility to practice in any setting and at all levels. While family physicians are even found at specialized tertiary hospitals, their most ideal place is at the district or even subdistrict level.

Achievements in future for Rwanda

- **Reaching Universal Coverage** with quality services at district level will require a different approach. The 2011-2016 HRH plan called for at least 2 Family Health Physicians along with other specialists. It has been challenging to consistently staff and retain specialists in all district hospitals as there are many issues that prevent this from happening.
- **Family Physicians training specifically to be staffed at district hospitals**, it is by design and vocation that they are supposed to work there and retention would be much less of an issue.
- **In District Hospitals, they would ensure continuity of care for patients.**
- **They would also be uniquely positioned to supervise and coordinate with health center staff to ensure timely and appropriate referral and counter-referral.**

In addition they would provide teaching to medical students, nurses, general practitioners and other health workers in the district. The National HRH plan calls for at least 2 Family Doctors per hospital, but considering the challenges with getting more specialists and the patient volume, 4 is probably a minimum.

In many countries, Family Physicians are the center point for care coordination, referrals and managing patients in their entirety. This would be particularly well suited for Rwanda with a central core of specialist in tertiary centers and a strong referral network managed at district level by FPs using modern methods (e.g. telemedicine, telediagnosics)

- **Family Medicine would answer a key need for the population by bringing quality services to where most patients are.**

Decentralized strong Primary Care is a cost-effective, quality and proven approach to build a sustainable system. It would bring Rwanda closer to Universal Coverage and make the

population healthier. We hope the Ministry of Health will share the same vision as in the HRH strategic plan and support the program.

- **We also need to get our doctors to believe in this specialty, which is why it is important to introduce it in undergraduate training**

through already-existing modules, albeit insufficiently supported. Several partners have already expressed an interest in funding the program again, if the MoH agrees to resume it. This is a unique opportunity and we hope Rwanda will be a leader in establishing a strong Primary Care system based on multidisciplinary teams coordinated by Family Physicians.

Potential competences of family physicians in Rwanda:

- ▶ Expert management of 50 most common health problems in Rwandan communities
- ▶ Improve organization of chronic disease care and care continuity
- ▶ Improve organization of triage, discharge and referrals
- ▶ Clinical training and CPD coordinator at district level
- ▶ Deliver surgical care at district hospital level
- ▶ Coordinate mentorship and capacity building of health centre nurses

In conclusion

To reopen a Family (and Community) Medicine Master program the University of Rwanda needs support from the Ministry of Health. This should start with the recognition of the value of FM in the Rwandan health system. As the Ministry of Health is committed to develop strong and effective PHC we believe it should consider supporting this Master program especially by providing scholarships to residents. Starting Family and Community Medicine postgraduate training would help to meet the country's healthcare needs in a cost-effective way and ultimately, improve the health of every Rwandan.

Therefore in 2017 a HoD position at the University of Rwanda is needed

1. To continue the undergraduate training program at the University (year 1,2 and 4)
2. To advocate for and start of a Family Medicine and Community Health postgraduate program September 2017

Budget: € 50,000,-/year for HoD position; 25,000 euro may be covered by other donors.

Resource Persons:

Prof Phil Cotton, Specialist in Family Medicine, Vice Chancellor, University of Rwanda (the only UR funded FM faculty)

Dr Vincent K. Cubaka, Specialist in Family and Community Medicine, PhD student, Rwanda and Denmark (funded by PhD scholarship though soon to have employment at NUR through an external fund)

Dr Eleazar Ndabarora, PhD, Specialist in Community Health, Nurse, Rwanda (funded by Partners in Health for the fifth year medical students training in social medicine & community health, though gives a day a week to UR)

Assoc Prof Mieke Visser, Specialist in FM, The Netherlands and Rwanda (funded part-time by Partners in Health)

Dr Eva Arvidsson, Specialist in Family Medicine, Sweden and Rwanda (self-funded)

Dr Djordje Gikic, Specialist in Family Medicine, Rwanda (self-funded)

Annex 4: Training course for Family Medicine Trainers and staff ***“Quality Management in Training and Patient Care in General Practice”***

Family Medicine in the Netherlands has developed a well-established and highly valued program for quality management, both in patient care and in professional specialty training for general practice. In a 2 week summer course we want to share our experiences with you.

The course covers the essentials you need to know about the development and assessment of high quality health care in general practice and the training of competent primary care doctors.

In the 1st week of this course we will address important issues related to the development of a high quality academic training program for general practice. Principles of teaching and training, the content of a solid curriculum, aspects of student assessment and quality assurance within educational organizations will be discussed. You are provided with knowledge to draft the 'optimal' specialty training program for general practice in your country. The 2nd week will focus on different aspects of quality assessment in primary health care: the impact of professional guidelines, quality management programs, development of indicators and visitation. You are challenged to perform a ‘real life’ quality of care assessment in a primary care practice on site.

The multi-cultural background of the participants provides a unique opportunity to learn about the universal and country-specific characteristics of teaching, training and quality of care assessment in general practice.

COURSE AIM

The aim of the course is to make primary care physicians and trainees in general practice familiar with the basic issues related to development of high quality primary health care. We will raise your awareness on principles of specialty training for doctors to become general practitioners and give insight in the Dutch quality management and assessment systems in primary care.

TARGET GROUP

International audience of primary care physicians (GPs, family physicians) and trainees in general practice with sufficient proficiency in English reading and writing.

STUDY LOAD

Two full weeks of daily lectures, workshops and group assignments, including an excursion to a primary care practice in Utrecht.

PERIOD: 04 July-15 July 2016

CREDITS: 3.0 ECTS credits

FEE: € 1295 (Course + course materials + housing), Early bird discount €145,-, group discount 30% if > 1 person

COURSE LEADERS: Prof. Roger Damoiseaux (MD,PhD), prof. Niek de Wit (MD,PhD) and Saskia van Vugt (MD,PhD)

MORE INFORMATION: medicine.summerschool@umcutrecht.nl, +31 887553488