



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.

Results. During the 2.5 years of the Primafamed project, all partner universities made progress in the development of their family medicine training programmes. The SWOT analysis showed that at both national and international levels, the time is ripe to train medical doctors in family medicine and to integrate the specialty into health-care systems, although many barriers, including little awareness, lack of funding, low support from other specialists and reserved support from policymakers, are still present.

Conclusions. Family medicine can play an important role in health-care systems in sub-Saharan Africa; however, developing a new discipline is challenging. Advocacy, local ownership, action research and support from governments are necessary to develop family medicine and increase its impact. The Primafamed project showed that development of sustainable family medicine training programmes is a feasible but slow process. The South–South cooperation between the ten partners and the South African departments of family medicine strengthened confidence at both national and international levels.

Key words: Continuing medical education (CME), faculty development, family health, graduate medical education/fellowship training, international health.

Introduction

Health systems based on primary health care (PHC) distribute health care more equitably, are more cost effective and have better overall health outcomes and impact than health systems based on specialist care (1). This is the foundation of the 'Health for All' concept of Alma-Ata, adopted by the World Health Organization (WHO) in 1978 (2) and reiterated in the World Health Report 2008 (3). Worldwide, authorities have recognized that the health and well-being of a population is highly dependent on a quality PHC system that is equitable, easily accessible and affordable for all members of the community (4) and that emphasizes universal coverage (5).

The concept of the postgraduate-trained family physician qualified to deliver equitable, high-quality PHC closer to the community is now accepted in many countries around the world. However, in sub-Saharan Africa, family medicine is still a relatively new concept. In this article, we analyse the development of family medicine in Anglophone sub-Saharan Africa in the recent years based on the experiences of the Primafamed (Primary Health Care and Family Medicine Education) project (6).

Primary health care and family medicine in Africa

Lower-resource countries in sub-Saharan Africa face enormous health challenges and pervasive poverty. Despite the work of governments and nongovernmental organizations (NGOs), the majority of people still do not have easy access to affordable quality health care. The 'inverse care law' (7), noting that the fewest health-care professionals are found where they are needed the most and vice versa, is still very much applicable in most African countries. The poor are not only more prone to illnesses but are also unable to cope with diseases because health care is hard to access. With continuous population growth and a rather slow economic development, the number of people living in poverty in sub-Saharan Africa has also increased, with 20.6% living on less than US\$1.25 a day in 2008 (8).

The Alma Ata Declaration was the first international statement underlining the importance of PHC. It defined PHC as part of a strategy to attain the goal of 'health for all by the year 2000' (2). It is the first level of contact of a continuing health-care process bringing health care as close as possible to where people live and work (9). PHC responds to the immense challenges that African countries are facing in their health systems by providing accessible, high-quality services that offer comprehensive and continuous care (preventive, curative, rehabilitative and palliative) at the local level, through interdisciplinary teams integrating vertical disease-oriented programmes. Family physicians together with PHC nurses (and in some countries, mid-level care workers) act as the clinical practitioners of the PHC team. In 2009, the 62nd World Health Assembly urged its member states

to train and retain adequate numbers of health workers, including family physicians, and to encourage the implementation of vertical programmes in the context of integrated PHC (10).

In 1968, the University of Pretoria was the first university in South Africa to start training specialized PHC physicians, now referred to as 'African family physicians' (11). This was followed by the other seven Health Science faculties in South Africa. In 1997, these eight departments of family medicine formed a network for communication and consultation, FaMEC (Family Medicine Educational Consortium), to share and exchange expertise, form a core curriculum and standardize examinations and develop appropriate assessment systems (12). In August 2007, the South African government officially recognized family medicine as a specialty (13).

The concept of the African family physician in other Anglophone African countries is even more recent. Only in the 21st century did universities in Anglophone countries in sub-Saharan Africa start family medicine training programmes, and the recently graduated African family physicians are beginning to find their place in the health systems of their respective countries. Family medicine departments are struggling for recognition as health systems are still dominated by centralized specialist services and vertical disease-oriented approaches. Several countries, such as Namibia and Botswana, did not have medical schools until very recently (14). Furthermore, many countries, such as the Democratic Republic of Congo (DR Congo), are emerging from conflict and need to rebuild both state and infrastructure. At the WONCA (World Organisation of Family Doctors) Africa Conference in 2009, the Statement of Consensus on Family Medicine in Africa was agreed upon. This consensus statement defined the contribution of family medicine to equity, quality and PHC within an African context, as well as the role and training requirements of the African family physician (15). Due to the low number of trained doctors per capita and the high burden of disease, African family physicians work in their specific context, mainly in district hospitals with outreach to health centres, in PHC teams that address the problems of the community in a comprehensive, holistic and patient-centred way whereby specific skills like surgery and district management often are essential due to the lack of other specialists. The consensus illustrates the ownership of the development of family medicine by African universities, one of the key points from the Paris Declaration (2005) and the Accra Agenda for Action (2008) (16).

Objectives

The aim of this article is to explore the extent to which the Primafamed South-South cooperative project contributed to the development of family medicine in sub-Saharan Africa. The specific objectives are the following:

1. The implementation of the Primafamed project;
2. The outcomes of the Primafamed project;
3. The development of family medicine training in sub-Saharan Africa from the viewpoint of the Primafamed partners.

Methods

A process analysis of the Primafamed project between 2008 and 2011 is presented to discuss the implementation of the programme and the development of the network of 10 universities and associated partners in Anglophone sub-Saharan Africa. The outcomes and conclusions of the project after 2.5 years are described. Finally, a SWOT analysis is detailed to explore the positive and negative dynamics that partners faced during the project.

The Primafamed Edulink project

In 2007, a call for proposals under the name Edulink was launched by the Secretariat of the African, Caribbean and Pacific (ACP) Group of States (17). Together with 10 universities in eight countries in sub-Saharan Africa (Sudan, Ghana, Nigeria, DR Congo, Rwanda, Uganda, Kenya and Tanzania), Figure 1, the Department of Family Medicine and PHC at Ghent University in Belgium developed the Primafamed project proposal with a focus on developing family medicine training in sub-Saharan Africa. The objectives of the project are described in Box 1. The aim of the Primafamed project was to establish an institutional network between new and established departments of family medicine in universities in sub-Saharan Africa, within a framework of South–South cooperation (18). The WHO World Health Report 2006, ‘Working together for

health’, emphasized the need for PHC training in the local community in order to deal with the brain drain from ACP states (19). Training medical doctors in the field of family medicine, thus providing PHC at the district level, responds to this call.

The Primafamed partners

The partnering universities in the Primafamed project were University of Goma (DR Congo), Moi University (Kenya), National University of Rwanda, Aga Khan University (Tanzania), University of Lagos (Nigeria), Makerere University (Uganda), Mbarara University (Uganda), Ahfad University for Women (Sudan), Gezira University (Sudan) and University of Ghana. The South–South network connecting these 10 universities worked together with the eight departments of family medicine in South Africa and accordingly formed a forum to share knowledge, experiences and resources.

Outcomes of the Primafamed project

Each of the 10 partner universities hired a local coordinator to oversee the implementation of the project, coordinate the activities and actively communicate with all partners. Partners worked independently, integrating the Primafamed objectives and the output for the project into the already existing structures and work plan at their universities. Because African family physicians work mainly in district hospitals with outreach to the health centres, this is where the bulk of family medicine training takes place. The Primafamed project consequently stimulated all partners to develop training complexes (mainly district hospitals, several of which are located in rural areas) for family medicine residents and to support the supply

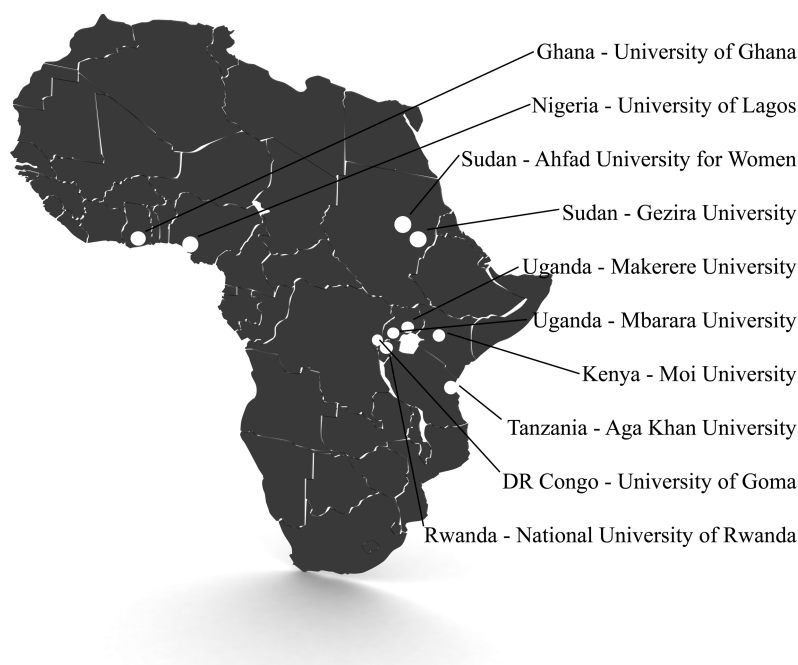


Figure 1. The Primafamed partners. Adapted from Shutterstock.

Box 1. Objectives of the Primafamed project

The objectives of the Primafamed project were formulated as follows:

1. To contribute to the health of communities through accessible, responsive and quality health systems in sub-Saharan countries by educating and training family physicians who provide interdisciplinary PHC services, oriented towards the needs of individuals, their families and the communities in which they live.
2. To plan, develop and strengthen academic departments or units of family medicine that offer family medicine training at the undergraduate and postgraduate levels.

The specific objectives were as follows:

1. To develop a comprehensive vision and strategy, within the specific context of sub-Saharan countries, that delineates the integral contribution of family medicine and the PHC team to an equitable and quality PHC system;
2. To establish a specific institutional network between departments and units of family medicine.

The expected results of the Primafamed project were the following:

1. An improved institutional and administrative functioning in terms of policy, management, planning and administrative capacity building of the participating departments and units of family medicine.
2. Improved relevance of family medicine in undergraduate and postgraduate training in the regional context.
3. Research output with respect to curriculum development in family medicine.

of these training complexes with the needed equipment. To further strengthen family medicine residents' education, training sessions by professors from South African universities and other associated Primafamed partners were held. A yearly conference for partners, associates and stakeholders was organized with the goal of offering trainings, sharing ideas and experiences, and strengthening the network. At the 2008 conference in Kampala, the *African Journal of Primary Health Care and Family Medicine* (20) was launched. This new open-access online journal has since published various articles related to the development of family medicine on the African continent, and researchers in the field of PHC have written numerous articles on operational research and community-oriented primary care (COPC) projects (21).

To monitor and evaluate our project, a progress scale was developed (Box 2). This four-level scale shows the progress that

Box 2. Progress scale for development of the Primafamed partners

Level 1:

- Structural implementation of the training programme and the department is in preparation

Level 2:

- Department/unit of family medicine exists or is part of other departments (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.

took place during the 2.5-year period in which Primafamed supported the partners. The first level corresponds to the institution being at a preparatory stage in the development of a postgraduate family medicine training programme. The fourth level reflects that the institution has started a postgraduate family medicine training programme with an existing curriculum by an organized department at well-organized training complexes and, most importantly, that family medicine has been accepted by the Ministry of Health as a specialization and that graduated family physicians are integrated into the existing health system. Undeniably, the fourth level is not the end stage because, in our opinion, the ultimate objective would be to have an equitable and high-quality PHC system with a central role for family physicians.

All 10 Primafamed partners made progress during the 2.5 years that the project provided funding and support (Table 1). At the start of the project, all of them had a unit or department of family medicine under development or in place, yet only three had officially started postgraduate family medicine training. At the end of the project, eight had started postgraduate training, with family medicine residents located in properly equipped training hospitals.

Table 1. Progress scale for development of the Primafamed partners

	January 2008, start of the Primafamed project	July 2010, end of the Primafamed project
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.

The integration of family medicine into the local health systems has been a slower process. In many countries, policymakers have adopted a somewhat conservative attitude, with health systems mainly based on hospital/specialist care and on vertical programmes, which are often stimulated by donor programmes. A critical mass of well-trained family physicians is needed to demonstrate the effectiveness of family medicine training programmes. Because all but one partner universities train only a limited number of family medicine residents simultaneously due to limited capacity, reaching that critical mass takes time. However, as the example of Gezira University (Sudan) has shown, it is possible to create a large pool of well-trained family physicians who can make a difference, in a short time. In this particular situation, because there was a vital need, policymakers and local authorities worked closely together with Gezira University in development of the training (Example 1).

In 2012, African family physicians came together at the WONCA Africa Conference and the Primafamed Network Workshop in Victoria Falls, Zimbabwe, and reaffirmed the importance of reaching that critical mass and therefore scaling up of family medicine, particularly in the African context, in which poverty is very prevalent, where rural–urban gaps remain, and where many of the Millennium Development Goals (MDGs) will not be reached, including those related to child survival, maternal death and accessibility to antiretroviral drugs (22).

SWOT analysis

In 2010, all Primafamed local coordinators contributed to a SWOT (strengths, weaknesses, opportunities and threats) analysis on the development of family medicine training programmes and of family medicine as a new discipline within the health systems of their countries (Box 3). The main findings are presented

Box 3. SWOT analysis of family medicine training in the Primafamed partnering countries

Strengths

- Strong partnerships and collaboration with universities and professional bodies abroad is present
- The South African departments of family medicine have substantial experience in the family medicine training programmes: they can assist in training *via* South–South cooperation and these cooperative steps can be seen as exemplary models and ‘good practices’
- The Primafamed project and Edulink ACP-EU funding strengthens the development of family medicine training and is seen as the motor for the family medicine training development
- Individuals working in the family medicine departments are very motivated, proactive and willing to advocate for the cause
- Family physicians working as faculty are highly experienced and well qualified
- The chosen district hospitals and health centres are ready for the training programmes
- In several of the countries (Sudan, Kenya and Ghana), a high commitment from the Ministry of Health, the National Council and leaders is existing
- Family medicine is responsive to the needs of the communities, especially in the rural areas where the majority of Africans live

Weaknesses

- Family medicine is not yet part of undergraduate medical training, therefore medical students are not exposed to the concept of family medicine and its principles
- Poor quality of intake and recruitment of family medicine residents for the family medicine training
- The lack of family physicians and local teachers. Many of the departments of family medicine depend on family physicians coming from non-African countries (mainly, Western Europe and United States)
- Due to work overload, family medicine residents are continuously working in the hospital setting and have insufficient time to focus on the training in other aspects of family medicine, such as disease prevention and health promotion, community medicine, outpatient/continuity of care and research
- The existing health systems are still weak in several countries; plagued by poor support, weak referral systems, poor communication, poor funding and poor coordination between health centres, district hospitals and referral hospitals

- Dropping out of family medicine residents during the training sometimes happens in countries like DR Congo because family medicine residents lose faith in their career opportunities
- There is a lack of didactic materials
- Capacity is still too limited
- There is poor guidance for the present faculty
- There is a lack of awareness and knowledge of family medicine by medical graduates, specialists and the community
- There is lack of adequate infrastructure in some countries, such as DR Congo and Ghana
- There is poor communication with policymakers and little support from the government in countries like Tanzania and Rwandaⁱ
- Standardization of training and examinations between faculties and countries is presently not existing, although there is a strong need for accreditation and quality assurance
- There is insufficient financial support for the family medicine residents in postgraduate training
- The position of family physicians in the different health systems is unclear (What is the career perspective of graduated family physicians?)

Opportunities

- There is international support for the concept of family medicine: In the World Health Report 2008 'Primary Health Care: Now more than ever', the WHO advocated for the importance of moving health care out of tertiary hospitals into the community and from vertical to horizontal care, in order to respond to the needs of the community
- Family medicine training is growing in the whole African continent, and there is support in the surrounding countries. The Primafamed project has been linking these different countries, in order to fight for the cause together
- Existing health systems in several countries are weak (poor coordination, poor referral systems, poor communication and little funding). Family medicine can be used as a technique to strengthen these health systems
- Internet connection is present in several of the training centres (and this is rapidly expanding); e-learning is a very useful didactic tool for the family medicine residents
- A yearly conference is organized by the Primafamed network to strengthen the network and to share ideas and exchange experiences
- Woncaⁱⁱ Africa is organizing three yearly conferences and has been expanding in terms of number of members in the recent years

- There are many existing links with organizations and universities in the North for financial and didactic support
- IUCEAⁱⁱⁱ and WACP^{iv} can assist in accreditation and quality assurance
- Several very useful books on African family medicine have been published recently and can be used as training material
- The new *African Journal of Primary Health Care and Family Medicine* gives more opportunities for registrars to publish research
- Health-care workers and policymakers are becoming increasingly aware of the importance of the basic principles of PHC and family medicine such as patient-centred care, non-communicable diseases (NCDs), interdisciplinary care, and continuity of care
- Many African ministries of health are working on health-system reforms
- Research in the field of family medicine is done by the registrars during the training
- The Primafamed network has been looking into expanding to Francophone Africa: Mali and Benin will participate in a VLIR UOS-funded project starting 2012, and the *African Journal of Primary Health Care and Family Medicine* will be published in English and French from 2012 onwards

Threats

- Other specialities see family medicine as a threat
- Family medicine is a new concept and not yet part of the health system in most of the partnering countries
- Overload of work for doctors leads to little time for training
- Lack of career opportunities for family medicine physicians in countries where family medicine is not supported by the government
- There is little or no funding for family medicine within the existing systems
- Substantial decrease in funding for further development of the family medicine training after ending of the Primafamed project funding from Edulink ACP-EU
- Migration of graduates to private practice, NGOs, management positions or public health (internal brain drain) or migration of graduates to other countries (external brain drain)^v
- War and political instability (e.g. DR Congo, Sudan and Nigeria); in some countries, there is a high turnover of government and with this, there often is a change of policies
- Increasing commercialization and privatization of health-care provision

- Worldwide economic crisis, which is decreasing the funding for health care and is putting health systems under pressure
 - Fragmentation of care through vertical disease-oriented programmes, not only for infectious diseases, but increasingly for NCDs (23).
- i. When the SWOT analysis was done in 2010, the Rwandan Ministry of Health was supportive of the new discipline and family medicine was accepted by the government as one of the specialist MMed trainings from the National University of Rwanda. However, at the time of writing this article, the Ministry of Health in Rwanda has changed its vision and family medicine is not seen as a priority. Recently, financial support for the training was reduced.
 - ii. World Organisation of Family Physicians
 - iii. Inter-University Council of East Africa
 - iv. West African College of Physicians
 - v. Especially in Sudan, this is a problem as a large percentage of medical graduates move to Saudi Arabia for more job opportunities, better salaries or family reasons

Adopted from the Primafamed Edulink ACP EU project

and categorized into the following levels: local/university level, national level, regional/African level and international level.

At the local/university level, the availability of resources plays an important role. From a human resources perspective, family physicians (in most cases from abroad) are needed to form the faculty, train family medicine residents and develop teaching materials. Other local professors and specialists willing to train family medicine residents in the different disciplines are important to the strengthening of both the training and the interdisciplinary network; however, several partners noted a low level of support from other specialists because family medicine is often not well understood and is often seen as a threat. Adequate motivation of faculty and family medicine residents is important and is influenced by many other factors such as financial backing, career opportunities and support at the local, national and international levels. The availability of training sites, especially at district hospitals and health centres, is crucial, including having access to physicians to train and mentor the family medicine residents and stimulating teamwork with other health-care workers such as the local nurses. Well-written curricula (often developed based on sample curricula from family medicine training programmes in other African universities) and training materials are essential to create a high-quality training atmosphere. Access to the Internet and to didactic materials and equipment (such as ultrasound machines or health education materials) are important to strengthen the actual training. Lack of diagnostic or therapeutic equipments or insufficient

availability of essential drugs in the training hospitals influences the way the doctors learn and hinders implementation of evidence-based medicine. Ensuring that there is a place for family medicine training in undergraduate curricula plays a crucial role in raising awareness and recruiting newly trained medical doctors.

At the national level, policymakers play a pivotal role. In several countries, decision-makers accept family medicine as an official specialization that is starting to take its place in the health-care system, with Kenya, Sudan and Ghana as examples (see Examples 1, 2 and 3). Several other countries have had more difficulties with the Ministry of Health accepting family medicine, including Tanzania and Rwanda. This influences career safety prospects for family physicians and therefore renders recruitment more difficult. Continuous communication and advocacy to create awareness and understanding are important. Research on the positive outcomes of family medicine on health-care provision plays a significant role in advocating and strengthening awareness. A negative factor at the national level is political instability and war, as seen in Eastern Congo.

At the regional/African level, the importance of strong partnerships and collaboration with universities and professional bodies abroad is noted. South African universities have excellent curricula and knowledgeable professors with extensive experience that can be leveraged *via* South–South cooperation. Moreover, conferences organized by Primafamed and WONCA Africa support the development of African family medicine. Networks are created to support each other and to start joint research. The establishment of the *African Journal of Primary Health Care and Family Medicine* is a great opportunity for young researchers to learn from others' work and to publish their own articles.

At the international level, a key point is the funding and support from institutes in the North. Secondly, global recognition of the importance of training health-care workers in PHC (World Health Report 2006 and 2008) is vital to the development of African family medicine. However, fragmentation of care undermines the importance of comprehensive PHC (23).

Conclusions

The ultimate goal of health care is to reverse the 'inverse care law' through achieving universal coverage and by providing equitable and high-quality health care through well-trained health-care workers to every individual. This is what health systems based on PHC can provide. Training doctors who work closer to communities, where they are most needed, is an important step towards improving the health outcomes of the African population. However, developing a new discipline that has not yet been defined in the national health systems is a challenging task.

The Primafamed project showed that developing sustainable family medicine training programmes is a feasible but slow

process with many obstacles. The South–South cooperation between the Primafamed partners and the South African family medicine departments strengthened confidence in the project and reinforced the principal need for well-trained African family physicians. Local ownership is of utmost importance, although, with no local family physicians as role models, this can be a difficult task. Support from key figures at the level of policymakers and academicians is necessary to create this new discipline and give it a place in health systems. Without the integration of family medicine into national health policy, it is very difficult to recruit new doctors for the training programmes because the uncertainty in career prospects negatively influences a potential candidate's decision to join these programmes. Continuous advocacy for the discipline and for strengthening the role of the African family physician are crucial. Exposure to family medicine and community health in the undergraduate medical curriculum is required to create awareness among new medical doctors. Action research, such as COPC (24), in the African setting is needed to demonstrate significant outcomes and the positive influence of the discipline at the individual, community and national levels. Recruitment, training and retention of doctors in family medicine need to be adopted in the health system of each of the African countries. This requires increased investment of resources in PHC, both from governments and from donor organizations.

The Primafamed Network that was created during the 2008–10 project continues to endeavour to make these action points a reality. In November 2012, during the WONCA Africa Conference, representatives from many African family medicine departments came together and discussed steps forward in creating a strong family medicine and PHC-oriented health-care system in various African countries. This led to the 'Statement of the Primafamed Network: Scaling up family medicine and primary health care in Africa'. Concrete action for scaling up is needed, including convincing ministries and leadership of medical schools to integrate family medicine and PHC into the undergraduate curriculum and to train a significant proportion of medical school graduates (between 40% and 60%) in family medicine and PHC. Essential conditions include having accredited under- and postgraduate curricula; well-equipped training centres for transformative learning with well-trained trainers; national and international support networks; a sufficient number of funded posts for family medicine residents/registrars with appropriate remuneration; and continuous advocacy at the population and government levels (25).

Continuous interaction with key players at the policymaking level and support from the government are necessary to scale up family medicine and to develop it into an essential part of the health-care systems, in order to provide equitable, high-quality

health care for communities and, ultimately, to improve overall health in sub-Saharan Africa.

Example 1. Sudanese family physicians

Gezira University is a public university based in central Sudan, in the city of Wad Madani. When the Primafamed project started, family medicine did not yet exist in Sudan. In many health centres, community physicians and medical officers were in charge of patient care. Together with policymakers, district health officers and representatives from the Ministry of Health identified the need for further training for medical doctors in Primary Health Care. Gezira University decided to develop a 1-year diploma and a 2-year in-service Master of Science (MSc) in family medicine. Both are accepted by the Sudan National Medical Specialisation Board. With the help of the Primafamed project, a coordinator for this development was financed, a curriculum was developed and training sites were identified and equipped with the needed material. In 2009–10, the first 10 medical doctors were trained in the 1-year course. In 2010, 120 candidates were selected for the 2-year in-service MSc in family medicine. In the fall of 2012, these 120 Sudanese family physicians graduated with comprehensive knowledge in district primary health care. In 2013, 200 new candidates were selected. The University of Gezira can be seen as a perfect example of how working together with policymakers is essential for the development of family medicine. Adopted from the Primafamed Edulink ACP EU final report.

Example 2. Family medicine training at Moi University, Eldoret, Kenya

In 2005, Moi University started the first family medicine training programme in Anglophone Eastern Africa, outside South Africa, Nigeria and Ghana, leading to the degree of Master of Medicine in Family Health. The development of this residency programme was a triangular effort from Moi University, Infa-Med (Institute of Family Medicine, a faith-based NGO, aiming to introduce family medicine in Kenya) and the Kenyan Ministry of Health (MoH). Moi University provided central facilities, academic leadership and long-term vision. Infa-Med contributed financial support, expatriate family medicine faculty and well-established training hospitals; and the MoH provided political support to the new specialty as well as scholarships to medical doctors entering the residency programme (26). A national policy (the Kenyan Family Medicine Policy) was developed (27) and in August 2009, this was adopted by the Kenyan government. In 2008, the first registrars finalized the family medicine programme at Moi University. Most of these registrars are now working in connection with the department to further develop the curriculum and the training sites.

A study in 2011 on the challenges of family physicians after placement showed that the ministry's posting policy needs to be improved to ensure that family physicians have a chance to perform their intended roles (28). In 2011, one of the first-graduated Kenyan family physicians, Dr Patrick Chege, became the Head of Department. The department of family medicine has strongly been focussing on the development of research. In 2009, a review of the present family medicine curriculum was started to improve the curriculum with a focus on the needs of the hospitals where the family physicians will be based. Many external experts from Primafamed partners and associates were consulted in this process. In January 2012, the revised curriculum was approved by the Moi University Senate.

Example 3. Family medicine in Ghana

The West African College of Physicians (WACP) accepted family medicine in 1985 (29) and it extended to the subregion outside Nigeria in 1991 (29). In Ghana, postgraduate training began in March 1999 with three family medicine residents under the auspices of the Faculty of Family Medicine (then General Medical Practice) of the WACP. This was a hospital-based training programme with the initial group of trainers being private general practitioners who were elected into fellowship by the College in the early 1990s. It started as a 4-year programme leading to Membership after the initial 2 years and Fellowship after a further training for 2 years. Currently, one trains for 3 years for Membership. The first graduate fellow completed training in April 2005. That same year, the Ghana College of Physicians and Surgeons also started another programme in family medicine to run alongside the one conducted by WACP. The Ministry of Health provides sponsorship for the programmes and accords graduates of family medicine equal status and remuneration as graduates from other specialties. In January 2008, the undergraduate programme began in the University of Ghana Medical School with the first two fellowship graduates appointed as lecturers. The undergraduate unit is currently part of the Department of Community Health. These local efforts at promoting the specialty in Ghana received a major boost with two significant collaborations: first with the Primafamed Edulink ACP-EU project in 2007, a North–South–South cooperation, and second, with the Department of Family Medicine, University of Michigan Health Systems in 2008, a North–South cooperation. These collaborations focussed on curriculum development, faculty development, teaching of students and family medicine residents, development of training complexes and research. Currently, there are two well-established postgraduate training complexes in Accra (Korle-Bu Teaching Hospital) and Kumasi (Komfo-Anokye Teaching Hospital) with 35 family medicine residents at various levels of membership and fellowship training (30).

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