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Primafamed Conference 2022: Reflecting on the Family Medicine Role in Malawi

O. Bates, B. O'Shea

Discipline of Public Health and Primary Care, Trinity College Dublin.

The 2022 Primafamed Conference was scheduled in Mangochi, in rural Malawi in October. Cancelled for the preceding 2 years, this was a welcomed and well attended educational and research conference for Primary Care and Family Medicine, mainly involving Academics and GP Trainees from Sub Saharan Africa (SSA), with representatives also from Belgium, Norway and Ireland. Established c. 10 years previously, with critical support from Norway (University of Bergen), Belgium (University of Ghent and Maastricht) and South Africa (Universities of Stellenbosch, and Walter Sislu), the objectives of Primafamed include strengthening training and service delivery for Primary Care in SSA, with particular but not exclusive emphasis on Family Medicine. Several SSA States now have well established Masters in Family Medicine Programs for example, and the practice of higher specialty training for family physicians is beginning to produce a growing output of Family Physicians, typically on completing a 4 years Masters Program.

That the conference was held in Malawi was of particular interest. Previous collaborations involved the Gorey Malawi Collaboration, GP Trainee Placements at the Billy Riordan Clinic and the Standing Voice collaboration involving community clinics in Malawi and Tanzania underline a significant strand of collaboration. With a view to building on this, the ICGP participated in sending 2 delegates to Primafamed 2022.

The objective of the Primafamed network is to build capacity in primary care and family medicine in central, eastern, and southern African states[1]. The population of Malawi is approximately 20 million and the physician to population ratio is roughly 1.9 physicians to 100,000 of the population. The average life expectancy for a woman in Malawi is 66 years, and 61 years for men[2]. Most people in Malawi access health care at district level – either at a health centre or district hospital level. There are 28 districts in Malawi, organised into four zones (North, Central, South East and South West). The expectation is that district hospitals will be increasingly staffed by family physicians who, in addition to family medicine, are also trained to carry out a number of tasks ordinarily carried out by specialists, up to and including appendicectomies and caesarean sections. This arrangement is typical for much of rural Africa and in other African states.

Our goal in attending the conference was to foster a collaborative relationship between the ICGP GH SIG/Kildare Faculty of the ICGP and the Family Medicine faculties in SSA. The Primafamed conference provided an excellent opportunity to perform a needs assessment of the key areas in which collaborative educational, research and clinical projects might benefit the provision of healthcare in SSA. At present some promising areas of collaboration emerging from the conference include work in the realm of community palliative care, Non-Communicable Diseases (NCDs), physician burnout and postnatal care. In order to establish truly reciprocal, equitable and mutually beneficial collaborations it was crucial to engage with stakeholders and institutions within SSA.

Also essential to our aim was the development of a deeper understanding of SSA healthcare systems. In contrast to our definition of family medicine in the northern hemisphere, in certain respects the responsibilities of the family medicine doctor are much broader in Malawi. They are working as doctors whose skillset is informed by their context, expected to perform a wide number of services for their communities - from chronic HIV and TB management to emergency caesarean section. Family medicine practitioners are expected to be 'multi-skilled providers' who are "socially accountable to the health needs of the population"[3].

In considering the work being done in the SSA States, it is useful to acknowledge the learnings that our health system might take from the delivery of family medicine in Malawi. Although the additional responsibilities within family medicine practice are borne of necessity, their role also has a functionality; it is a means of reducing the burden on tertiary care services, and in reducing the need for specialist referral options.

Corresponding Author:
Oisín Brady Bates,
Trinity College Dublin/Health Service Executive Specialist training programme,
Discipline of Public Health and Primary Care,
Institute of Population Health,
Russell Building,
Tallaght Cross,
Dublin 24.
E-Mail: oisinbb@gmail.com

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