INTERNATIONAL HEALTH SCIENCES UNIVERSITY

FACULTY OF MEDICINE

DEPARTMENT OF FAMILY MEDICINE

THE PERSPECTIVES OF HEALTH WORKERS ON THE ROLE OF FAMILY PHYSICIANS.A CASE STUDY OF IHK HEALTH WORKERS.

By

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A research dissertation submitted in partial fulfillment for the award of Master of Family Medicine of International Health Sciences University.

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DECLARATION

I hereby declare that this research was done by myself, Dr Ndahura Duncan under the supervision of Dr Andrew Ssekitooleko (MBChB, MFam.Med) and Teddy Nagaddya (Msc).

Signed:

…….

Dr.Ndahura Duncan Date

APPROVAL

Name of student: Ndahura Duncan

Reg.No:2012-MFM-DR-002

Thesis title: THE PERSPECTIVES OF HEALTH WORKERS ON THE ROLE OF FAMILY PHYSICIANS.A CASE SYUDY OF IHK HEALTH WORKERS.

As research supervisor for the above named student, I certify that I have read Dr. Ndahura Duncan's thesis, titled above, and have approved of the changes required by his examiners. I hereby recommend the thesis to the Faculty of Medicine for acceptance.

Signed: …….. …….

Name of supervisor Signature of supervisor

…….

Date: dd/mm/yy

DEDICATION

I dedicate this work to my family and friends. I will always be grateful for your unconditional support.

ACKNOWLEDGEMENT

I would like to recognize the support I have received throughout this research project from my supervisors Dr Andrew Ssekitooleko and Teddy Nagaddya. It has been a good learning experience.

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God bless you all.

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Operational definitions

In this study, perspectives will mean:

- Opinions of health workers on who family physicians are.
- Skill set of family physicians relevant in health care.

Medical Officer: A doctor that has completed undergraduate medical training and internship but doesn't have any postgraduate training. The term general practitioner (GP) is used interchangeably with medical officer in this study.

List of abbreviations

FM: Family Medicine

FP: Family Physician

GP: General Practitioner

IMF: International Monetary Fund

IHK: International Hospital Kampala

IHSU: International Health Sciences University

NCDs: Non Communicable Diseases

NGO: Non Governmental Organization

NHS: National Health Service

NHI: National Health Insurance

WHO: World Health Organization

WONCA: World Organization of Family Physicians

ABSTRACT

Background

Family medicine is the specialist discipline of primary care with family physicians at the helm. Family physicians in a multidisciplinary team approach can cost-effectively manage most common conditions in the primary care setting [1,2,3] and the strengthening of primary care[4] through incorporating more family medicine in the health care system has been shown to be the best way to address the current glaring health inequities[1].However the role of family physicians is not well articulated by other health workers.

Objectives

The main objective of the study was to understand the perspectives of health workers at IHK on the role of family physicians. Health workers' understanding of a Family Physician and their perceived skill set of Family Physicians made up the specific objectives.

Methods

This was a qualitative study that incorporated key informant interviews and focus group discussions. Twenty six participants took part in the study. They represented the various health cadres working at IHK. Interviews were done with the aid of interview guides and were digitally recorded. Interviews were then transcribed verbatim and thematic content analysis was done manually.

Results

Family physicians were perceived by most health workers to provide comprehensive health care to families, though confusion on the terminology was noted. Clinical, administrative , research and a limited role in policy were mentioned. Attributes of a multidisciplinary practitioner, counselling , communication, interpersonal and leadership skills were ascribed to their skill set.

Benefits of reduced hospital visits, specialist visits, hospital admissions and reduced overall health care costs were attributed to Family Physicians by many respondents.

However Family Physicians were relatively unknown, few in practice and their roles lacked clarity

Conclusion

There needs to be more sensitization of health workers on Family Physicians and Family Medicine. There needs to be clarification of their roles in the health care system.

1.0 CHAPTER ONE: INTRODUCTION

Family physicians play an important role in primary care. They are the entry point of the patient into the health care system, provide continued, comprehensive care and link the patient to other specialists through a collaborative approach. However their role in the health care system is not well articulated by other health workers.

The purpose of this study was to explore the perspectives of health workers at International Hospital Kampala on the role of family physicians.

This chapter presents the background to the study, rationale of the study, problem statement, research questions, objectives and the significance of the study.

1.1 BACKGROUND TO THE STUDY

Family medicine is the specialty discipline of primary care with Family Physicians at its helm. The practice of family medicine is grounded in its core principles: access to care; comprehensiveness of care; continuity of care; collaboration and a contextual approach to patient care [5]. The family physician may assume a number of roles with his or her primary role being that of a clinician tasked with providing holistic care to individuals regardless of age, sex or condition in collaboration with other health cadres or specialists as required[6]. He or she is a consultant and head of the primary health care team, an advocate for the population he or she is responsible for and other under-served communities ,a lifelong scholar involved in research and mentorship as well as administrative and managerial roles[6].These roles will depend on the context in which the physician practices as is evidenced in the well defined gate-keeper role to the health care system in the developed world whereas the African family physician is most often a consultant and leader of the primary care team at the district hospital with the bulk of primary care work being done by other lower level health worker cadres for example nurse practitioners and medical officers [7].

Family physicians bring a unique skill set to health care practiceincluding a patient-centred approach to care, communication skills, interpersonal skills, clinical reasoning, selectivity, professionalism and procedural skills[1]. These skills do not differ much across family medicine practice worldwide but the hallmark of family medicine practice in most of sub-Saharan Africa including Uganda is the need for more surgical and anesthetic skills for effective service in the district hospitals where many family physicians are deployed.

Family medicine is a relatively young specialty in comparison to the more traditional disciplines like internal medicine, general surgery, pediatrics and obstetrics/gynaecology.

It has its roots in general practice in the United Kingdom where as far back as the nineteenth century general practitioners then known as apothecaries provided medical care to communities and referred them for hospital based care where necessary[8,9]. With the formation of the NHS(National Health Service) in 1948 and the government essentially covering the health care costs for its people, the general practitioner became the access point to health care for the entire population[8,9]. All referrals to specialist care were through the general practitioner hence the gate keeper role. A similar initiative in South Africa called the National Health Insurance (NHI) is now currently in its pilot and is aimed at improving access and affordability of care[10]. The Alma Ata declaration of 1978 emphasized the importance of disease prevention and health promotion which became key roles for the general practitioners and later roles in education and research also came up.[8]

Most family medicine training began in the 1960s in the western world and later a specific approach to patient care was adopted i.e a biopsychosocial model which took on a more holistic and patient-centred approach in contrast to the more traditional biomedical or disease-centred model, utilizing doctor –patient communication as an important tool, taking advantage of medical decision making, contextual and comprehensive care of patients in a multidisciplinary primary health care team[11]

South Africa led the way in Africa having had the origins of primary oriented care in the 1940's[11] and t the first family medicine department opening in the University of Pretoria in 1967[12] and other countries followed thereafter. Family medicine was introduced in Uganda at Makerere university in 1989 by a Canadian family physician who was called John Ross with financial support from the Canadian government and it was initially called community health [13]. When he left in 1994, the program nearly collapsed with only one student being trained between 1994 and 1999 with lack of funding , resistance from other specialists and unstable leadership cited as the main causes [13] .With a change in leadership at Makerere University and availing of funding, the program resumed in 1999 and has continued to date[13]. Mbarara university in western Uganda also subsequently started family medicine training with funding from the

German government [13] and most recently in 2012 the International Health Sciences University (IHSU) started a family medicine masters program.

Family medicine in the developed countries like the United States emerged as a response to public dissatisfaction with a shortage of physicians, inaccessibility of health care in rural and urban underserved areas, increased costs of care, depersonalization of medical care and fragmentation of care as a result of increased specialization [14].These problems still persist in many developed countries and more so in the developing world for example in Uganda where health care is characterized by uncoordinated access to hospitals and unrestricted specialist care to those who can afford it[12].This coupled with the perennial underfunding of health budgets by the concerned governments, poor pay resulting in external and internal brain drain of medical talent to developed countries and well paying NGOs respectively, focus on vertical disease programs dictated by the various donors and the generally poor medical infrastructure have resulted in a dysfunctional health system[12]. This is often characterized by glaring inequity with the well off having greater access to health care than the ones who need it the most i.e the poor in rural areas and a poorly structured referral system where patients turn up at specialist clinics without referral and put a heavy workload on the specialists and subsequently increase the health care costs to cover the specialist fees[12].

The WHO report Primary Health Care Now More Than Ever [4] emphasized the need for countries to strengthen their primary health care structures in order to address the inequities in health care delivery and cut down on the ever increasing costs of health care worldwide and family medicine was ear marked as one of the best ways to achieve this [1].

However family medicine still struggles for acceptance in many academic circles. In South Africa which is the torch bearer in family medicine implementation in Africa[15], family medicine was only recognized as a specialty in its' own right in 2007 despite having had the first family medicine department having been set up in 1967 [16].Many leaders and policy makers still struggle to understand what family medicine is and where Family physicians fit into the health care system for example family physicians employed by the government in Uganda serve as public health specialists. This has resulted in role ambiguity and a lack of a clear career pathway which has put off many potential students from taking up this specialty both in the developing [17] and

the developed world [18]. The number of Family Physicians being trained in most African countries can't yet meet the demand for their services for example in 2005 in Uganda a projection was made to train 400 Family Physicians to meet the target of 1 Family physician per 75,000 people but as of 2014 only twenty had been trained [17]and more importantly this number is not sufficient to make the necessary impact especially on policy makers. This is due to a combination of factors among which a poor understanding of what the discipline is about [19], a lack of sustainable funding for family medicine programs and as stated above an unclear career pathway after completion of the masters program have played an important part[17].

For family medicine to be implemented successfully, there needs to be a clarification of the role of the Family Physician. Fellow health workers need to understand where in the health care delivery system family physicians fall and how they can engage with them in providing care to patients. Their perceptions of the roles and skills expected of Family physicians will depend on how exposed they are to Family medicine for example through literature or interaction at the work place if the facility they work incorporates Family Physicians. Unraveling of people's perceptions of a role is a step towards role clarification [20]. This study aims to explore the perspectives of IHK health workers on the role of Family Physicians in health care delivery.

1.2 STATEMENT OF THE PROBLEM

The majority of common health problems can be handled cost-effectively in primary care by Family Physicians in a multidisciplinary team approach with referral to specialists where necessary [1,2,3]. Primary care at IHK is handled mainly by medical officers who are post internship doctors with no specialist training who may not have the time, confidence or necessary skill set to provide the comprehensive and continued care for patients resulting in unnecessary specialist referrals that add on patient frustration, increase specialist workload and increase health care costs.

Family medicine is still to a certain extent plagued by having few numbers of physicians and worse still the few available Family Physicians do not have a well defined role in the health care system. In Uganda they are employed as public health specialists (16) and are often deployed to district hospitals where their roles are also in conflict with those of career medical officers (17).

If other health cadres can understand the role played by Family Physicians in patient care, it will go a long way in clarifying the ambiguity often associated with the discipline of family medicine. The study aim was to find out the perspectives of IHK health workers on the role of Family Physicians.

1.3 Objectives

Main Objective

To understand the perspectives of health workers at IHK on the role of Family Physicians.

Specific Objectives

(i)To assess health workers understanding of Family Physicians at IHK.

(ii)To understand health workers' perceived skill set of Family Physicians at IHK.

1.4 Research questions

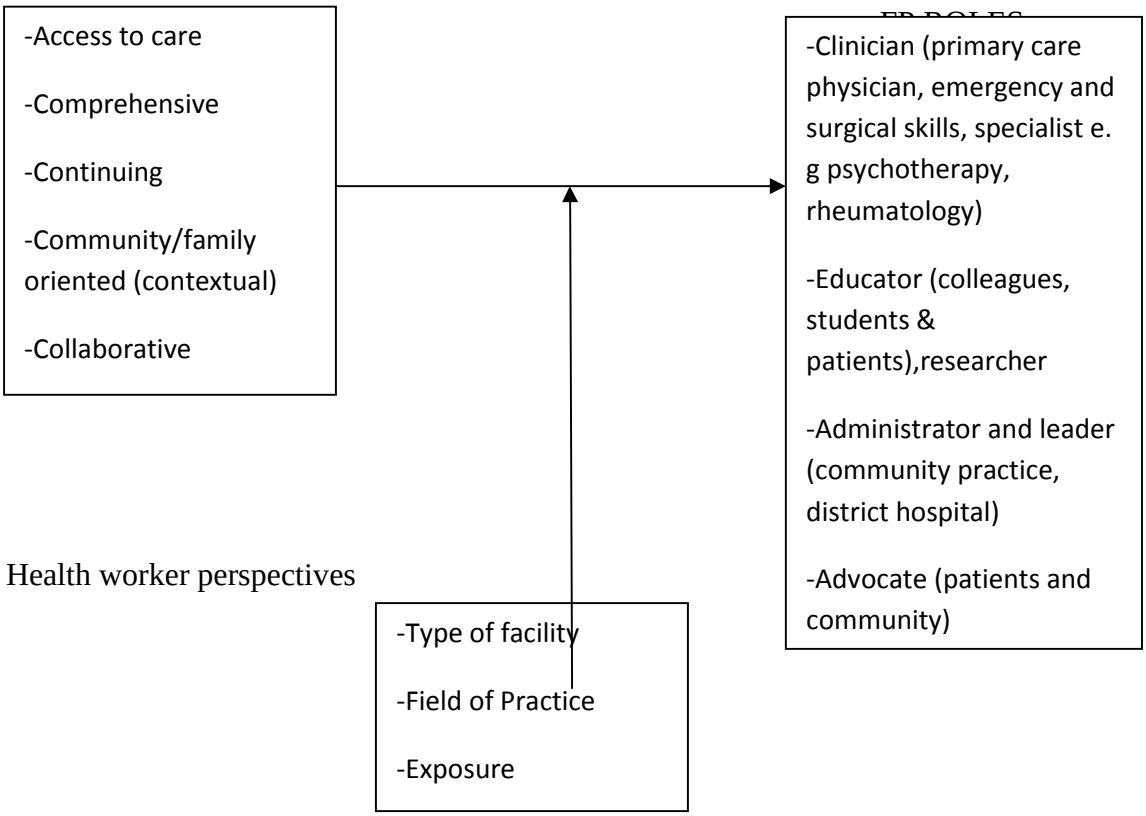
This research project was guided by two key research questions as stated;

- What do health workers at IHK understand by a family physician?
- Whatskill set do health workers at IHK ascribe to Family Physicians?

1.5 Significance of the study

This study was intended to add to the limited research on health worker perspectives on family medicine and the perceived role family physicians play in health care provision and to increase awareness about family medicine as a discipline and possibly encourage more students to take it up as a career which would in turn influence policy makers to avail funding in terms of scholarships for students taking up the course. More meaningful discussions about the place of family physicians in the Ugandan health care structure would also be stimulated.

Conceptual framework



The conceptual framework shows how the core principles of family medicine directly influence on the roles Family physicians play in the health care delivery system with the perceptions other health workers have of them being influenced by the facilities they work in, their field of practice and their relative exposure to family physicians.

CHAPTER TWO: LITERATURE REVIEW

2.0 Introduction

This chapter comprises of literature pertaining to the study problem specifically on who Family Physicians are, their skills and the perceived role they play in health care delivery.

A family physician can be defined as a primary care specialist who provides comprehensive medical care to individuals regardless of age, sex or disease in a multidisciplinary team approach and referring to other specialists where necessary [21]. The definition of a Family Physician needs to incorporate the fundamental principles of family medicine i.e access to care, comprehensive care, continuity of care, contextual care and collaborative care [5].

2.1 Role of the Family Physician

The roles Family Physicians play in health care delivery are based on the fundamental principles of the discipline as described above and context is a critical area in determining this.

Family physicians in the developed world are usually the entry point of the patient to the health care system [8,9,22]. They provide care to the patient and refer to specialists where necessary. This gate keeper role is well defined in countries with strong primary care based systems for example the UK and Canada. In contrast most primary care in the developing world due to a scarcity of doctors in many rural areas is usually done by nurse practitioners and other lower level health cadres. The family physicians usually assume roles of consultants in primary health care teams [6].

As the Delphi consensus process study showed, the core values of the African Family physician did not differ much from those of the western world with the biggest contrast coming from the scope of practice which requires the Family Physician to know major surgical skills to serve at the district hospitals and also to be a consultant, leader, manager and teacher of the primary health care team [7] .This also reverberated in the consensus statement on family medicine in Africa with additional roles of community advocacy and being a lifelong scholar [6].A study of leaders in African higher education institutes and departments of health identified the benefits of a family physician as a clinical all-rounder based at the district hospital, a mentor for team-based care in the community, having a strong leadership role in the district health system and a developer of holistic practice of medicine. However concerns that were noted included the fact that family medicine was unknown or poorly understood, there was a lack of visibility of family

physicians and their roles were not clear as well as policy ambivalence and lack of advocacy for the specialty [23]. A study of South African academic and government leaders also stressed the critical need for family physicians in the district health system though their role was not clear and were seen as a means to fill gaps in district hospitals so as to reduce referrals [24].This role ambiguity has also been noted in other African countries for example in Uganda where family physicians employed by the Ministry of Health are promoted as public health specialists [17]. It is also important to note the emphasis on hospital practice especially at the district level in the African setting where as in the western world emphasis is on clinic and community based practice [6].

Strong primary health care systems with Family physicians at the helm have been shown to improve equity of health care while delivering quality care and improving health outcomes at an affordable cost [1].A study of district managers and chief directors of rural and metropolitan District Health Systems of the Western Cape in South Africa showed that after three years of deploying family physicians into the health system a positive impact on clinical processes in terms of access, coordination, comprehensiveness and efficiency was already evident for HIV/TB, NCDs, mental, maternal and child health [16].

A study of industrialized nations showed that health care costs were lower in countries with a strong primary care based health system compared to those that did not [3].Enhancing primary care particularly family medicine even in areas with high income inequality was shown to reduce all-cause mortality in those areas [1].This study clearly showed the role of family medicine in improving equity in health care. However in Africa more needs to be done because most doctors work in the cities and hospitals where only a small proportion of people and the highest amount of resources are spent in the health care system compared to rural areas and community clinics where the biggest primary care need evidently is. So even with Family physicians being in a unique position to improve equity there needs to be a broader systematic change to improve this situation [24].

The roles of the African family physician may be summarized as a care provider, consultant for primary care services, capacity builder to the primary care team by teaching, mentoring and supporting other practitioners, a supervisor of junior staff and students, a manager of the clinical team and a proponent of community oriented primary care by engaging with the community [10].

2.2 Skill set of a Family Physician

The wide scope of Family Medicine requires that a physician have a unique set of skills relevant to the context of their practice. These could be summarized as patient-centred, communication, interpersonal skills, clinical reasoning, selectivity, professionalism and procedural skills [10, 26]

The patient-physician relationship is the hallmark of family medicine [8,9]. The patient is the focus of the physician in contrast to the traditional medical model where the condition takes precedence. This as well as the holistic approach to care ensures that the patient actively takes part in decisions concerning their health.

Communication is a crucial skill for family physicians given that they are involved in making shared decisions with patients and also impart advice on health promotion and disease prevention which are key aspects in the clinical role of the family physician. Psychosocial issues are very common in primary care and good communication skills are useful in effective counselling of patients.

Interpersonal skills are mandatory in the initial and continued care of patients. Family physicians have to make long lasting relationships with their patients ideally throughout the life cycle. The fact that they also have to work in interdisciplinary teams most of the time also requires that they are able to work in collaboration with other health cadres especially specialists.

Family physicians have to show astute clinical skills given that they work usually under a lot of pressure with the large numbers of patients they have to see, patients presenting with multiple complaints and often see disease in an undifferentiated state. They should be able to recognize acute life threatening conditions which require immediate attention, schedule appointments to deal with less emergent conditions and recognize and refer what is beyond their scope.

Family physicians show a high level of professionalism which is exhibited in how they deal with patients, by treating them with respect, dignity and confidentiality and fellow colleagues too. Maintaining high standards of care through evidenced based practice and a commitment to lifelong learning [6,8,9,10].

The breadth of the discipline of family medicine calls for a wide array of procedural skills that a family physician needs to master [10,26,27]. Context is key in the necessary procedural skills .Clinicians deployed in the district hospitals in often strained conditions in both human and material resources need to have a thorough grasp of surgical and anesthetic skills in addition to

the other medical skills as is evidenced in most African settings [6]. Examples of expected clinical skills include; ability to perform emergency obstetric care, general anaesthesia, primary and secondary surveys of trauma patients, closed reductions, immobilization of fractures, intra-osseous access, fine needle aspiration biopsy, interpretation of radiographs and behavior change counseling [10,27]. In contrast the family physician in the developed world usually practices in the office or ambulatory setting though in the United States many Family Physicians also have mandatory hospital work rotations. [22]

2.3 Perspectives on family medicine

Family medicine from the onset has had to distinguish itself from the other specialties with emphasis on the biopsychosocial model as opposed to the biomedical models favored by the majority of the medical specialties[28], the gate keeper role [8,9] to the health care system which is more evident in the high resource countries than in Africa and the patient-doctor relationship in context of family and community [28]. However the whole idea of family medicine as a specialty contradicts its origins which in part were to address the fragmentation of health care that came with increased specialization and has resulted in a difficulty to clearly define itself in terms of what it is and what it is not.[28].A generalist discipline in the modern highly specialized medical world can be difficult for many to comprehend especially in scope of practice, roles in the health care system and career choices for students. A study in Canada that focused on factors influencing students choosing a career path in family medicine showed that very little exposure to family medicine in the pre-clinical years, negative comments or bad mouthing about family medicine by specialist physicians and sometimes surprisingly from family physicians too played a big role in swaying students away from choosing family medicine as a career [29]. Other factors were the lower prestige accorded to family medicine and the lower pay compared to other specialties and surprisingly the relative ease of getting into a family medicine program [29].This was also shunned upon and has led to many looking at the discipline as one people opt for when they have not been able to match or get into their more preferred programs like surgery, internal medicine etc. Positive aspects of the specialty included the flexibility and shorter length of the program as well as the scope of the practice especially in rural areas that made it very attractive to students [29].A study of first year medical students in Ghana showed a high level of awareness of family medicine as a discipline but majority were not willing to take it up as a specialty due to

inadequate understanding of the course [19]. This is a similar finding to the previous study described whereby not enough exposure for family medicine has been done at the pre-clinical and clinical stages of their medical education where lasting impressions for future career choices are usually made. This study showed that more needed to be done to promote family medicine in undergraduate programs [19].

There is a scarcity of studies addressing the perceptions of health workers on family medicine. A qualitative study involving specialists in Germany showed positive aspects of family physicians including their broad based medical knowledge and knowledge of the patient, gateway function and empathy for patients [30]. However negative aspects like the frustration of family physicians, negative comments from other specialists and the under representation of family medicine in university education as a direct result of specialization [30] were also noted.

2.4 Qualitative research

This may be defined as a research approach that seeks to describe phenomena in their natural settings. It is flexible and iterative. Three philosophical approaches have been identified; understanding (interpretive),critical and postmodern.

Interpretive qualitative research is characterized by the effort to understand situations in their uniqueness, the researcher being the primary instrument for data collection and analysis, data is gathered to build concepts or hypotheses and the results are richly descriptive.[31]

The most common approaches to qualitative research are; basic interpretive, phenomenology, grounded theory, case study, ethnography, narrative analysis, critical and postmodern-post structural. [31]

This study employs a phenomenological approach which seeks to show how complex meanings are built out of units of direct experience. Bracketing is an important aspect in phenomenological research. It requires the researcher to put aside personal attitudes and beliefs about a phenomenon in order to understand an experience. It helps in demonstrating validity of the data collection and analysis and should be initiated all the way from the research proposal stage.[32]

2.5 Conclusion

This literature review has shown that family medicine is a relatively new discipline and is still struggling to gain acceptance in the medical fraternity as well as at the policy level especially in developing countries like Uganda. Family physicians have a unique skill set which enables them to fulfill various roles in health care delivery. Few studies have addressed what other health workers think of family medicine as a discipline and the expected skills of family physicians. This study sought to add more knowledge to this area.

CHAPTER THREE : METHODOLOGY

3.0 Introduction

This section describes the methods that were be used to carry out the study. It describes the study design, sources of data, study population, sampling, data collection techniques and tools, data analysis, quality control and ethical considerations.

3.1 Study design

The study employed an interpretative phenomenological approach to qualitative research. This approach puts into consideration the concept of situated freedom which clearly states that one's subjective experiences are linked to one's social, cultural and political contexts and not necessarily their absolute freedom to choice [33]. In this case, the study focused on describing meanings of the perspectives of health workers on family physicians in terms of who they are and the perceived skill set they require. This approach was considered appropriate to this study because of its sensitivity to one's life world in influencing their experiences which enhances the researcher's deeper understanding of the phenomenal rather than bracketing. [31]

3.2 Study participant recruitment and sampling procedures

Participant recruitment was done from the International Hospital Kampala, a private health facility that has vast specialists and different cadres of health workers. Putting into consideration that the researcher works at the facility, access to health workers was done on a one-to-one interaction. Appointments were made with the selected health workers to seek their consent to participate in the study and also appropriate time for the interviews was scheduled. In instances where scheduling of appointments with the identified health worker was difficult, other health workers who met the inclusion criteria and were available on that particular day, were interviewed. Representation of both male and female health workers was a key consideration in recruitment; however this was based on who could be accessible. The study did not include any health worker who was qualified as a Family Physician for purposes of avoiding biased information.

3.3 Sampling

Participants were purposively selected to include representation from departments of accident & emergency, general ward, maternity ward, antenatal clinic, pediatrics and ICU. Among those selected were; specialists (a general surgeon, an internal medicine physician, a pediatrician, an obstetrician, a dermatologist, a clinical psychologist, a cardiologist, a radiologist, an orthopedic surgeon and an anesthesiologist),a pharmacist, a laboratory technician and nurses (5) and midwives (4) and medical officers (5). The total number of respondents for this study was 26.

3.4 Study population

The parent population was all health workers at International Hospital Kampala, a private for profit hospital offering primary, secondary and tertiary levels of care. It is from this population that study participants were selected to include only those who were 18 years and over, had spent at least one year in practice and were accessible to take part in the interview. The study participants included 16 females and 10 males.

.3.5 Sources of data and collection techniques

Data was collected from health workers using In-depth interviews and focus group discussions. Respondents who were interviewed as key informants were the specialists and heads of departments. This was due to the fact that their positions and experience were assumed to have exposed them to family medicine as a discipline. Interviews with the specialists and departmental heads were conducted from their consultation rooms and private offices respectively, and audio recorded and at the same time notes were taken by the researcher to capture more detailed information during the session. Since the interviews were conducted on an agreed schedule, interruptions from patients were avoided.

The key informants comprised of ten clinical specialists i.e a general surgeon, an internal medicine physician, a pediatrician, an obstetrician, a dermatologist, a clinical psychologist, a cardiologist, a radiologist, an orthopedic surgeon and an anesthesiologist, a laboratory technician ,a nurse in an administrative role and a pharmacist. In total there were 13 key informants. They were selected as key informants because most of them were the heads of their respective departments and were expected to be quite knowledgeable about the research questions. Interviews on average were 15 minutes in duration.

The FGDs consisted of nurses, midwives and medical officers. They were grouped together based on the understanding that their day-to-day professional interaction makes it comfortable for them to engage in the discussion openly. The discussions were conducted in a VIP waiting room which offered a quiet environment and minimal interruption from the on-going hospital activities. Audio recording and notes were taken during the discussions.

In both FGD sessions and during the in-depth interviews, verbal consent for audio recording was sought prior to commencement of the discussion and interviews respectively. .

The focus group discussions comprised of 4 nurses, 4 midwives and 5 medical officers making up a total of 13 participants. These were split to make up 2 focus groups. The nurses and medical officers were from the various departments in the hospital i.e general ward, accident and emergency, paediatrics, obstetrics/maternity ward and ICU. With the exception of the midwives who are strictly for the obstetrics department other health cadres at IHK are rotated within the various departments. The interviews took place during duty days at the lunch breaks and lasted 20 and 35 minutes respectively.

3.6 Data collection tools

An interview guide was developed for both FGD and key informants where questions with questions that would capture responses on the health workers' understanding on the role of Family Physicians in the line care. The FGD and the KI had the following broadly chronological topic guide structure;

Perspectives of Health workers on the role of Family Physicians
• Introduction
• Knowledge on Family medicine
• Source of information about Family Medicine
• State of Family Medicine in Uganda
• Meaning of Family Physician
• Special skills for Family Physicians
• Perceived role of Family Physicians in the healthcare system

Table 1-Interview structure

3.7 Data analysis

The completed audio recorded interviews from in-depth interviews and focus group discussions were transcribed verbatim into a word processing document.Data was manually coded to generate meaningful themes in order to interpret health workers perspectives on the role of family physicians in the line of care..

3.8 Quality control

The researcher deliberately triangulated the sources of data by using focus group discussions and in-depth interviews to allow for comparison of responses from participants and give validity or trustworthiness to the study.

After the interviews respondents were allowed to view the researchers' conclusions to ascertain that these were in fact their opinions and also to check for inconsistencies allowing for respondent validation. This is consistent with the works of Anderson which clearly stipulates openness in research interactions with respondents.[34]

3.9. Plan for dissemination

Results from this study were presented to the IHSU scientific committee and for the health workers who took part in the study reports will be disseminated through the departmental heads and specialists at an appropriate time.

3.9.1 Ethical considerations

3.9.2 Study approval

The proposal was submitted to the International Health Sciences University Research and Ethics Committee for ethical approval. A letter of approval was provided to the researcher and this was presented to the Research Director at IHK who further provided permission for the study to be conducted in the hospital. The entire process was aimed at ensuring that the study participants and the researcher are protected from any harm that may have been associated with the study.

3.9.3 Informed consent procedure

Participants were clearly explained to about the objectives of the study and what was expected of them and written consent was obtained. As part of the interview process, audio taping was to be done and based on this verbal consent was sought from the participants. This helped in building a relationship of trust with the participants.

3.9.4 Confidentiality and Privacy.

For purposes of ensuring confidentiality and privacy of the study participants, interviews were conducted from places they considered comfortable and private for them where minimal interruptions were expected. Furthermore, pseudonyms were used on the transcribed word scripts to avoid linking any information to any respondent.

3.9.5 Limitations of the study

The relatively limited exposure of health workers to family physicians may have resulted in less meaningful data being obtained. On the other hand, putting into consideration that the researcher was known to the respondents, this may have introduced some bias in that respondents may have been tempted to give more socially acceptable answers.

The small number of respondents interviewed could not allow for generalization of the study findings but the study can be replicated in other settings.

CHAPTER 4 RESULTS

4.0 Introduction

In this chapter, findings from the study are presented based on the themes generated from the key informant interviews and the focus group discussions.

4.1 Participants' Profile

The study had a total number of 26 respondents of which 16 were female and 10 male health workers and were within the age range of 25-48yrs and a mean age of 32.7yrs. Of the 26 respondents, 11 of these were specialists who included an Othorpaedic Surgeon, a Radiologist, a Pediatrician, a Cardiologist ,a Dermatologist, a Pharmacist, a Lab Technologist, and a General Surgeon. Majority of the specialists were male though equal numbers of Medical officers were recruited into the study. More male health workers had spent over 9 years in Practice compared to females .Notably nurses and midwives had the longest duration in practice averaging 4 years while medical officers had the least experience averaging at 2 years. Higher level of education as noted in the specialists equated to fewer years in practice and the reverse was true for nurses and midwives who had qualifications at diploma and certificate level.

Table 2: Characteristics of Study Participants

Age range	25-48yrs		
Mean age	32.7yrs		
		Male (n=10)	**Female(n=16)**
Occupation	Specialists	6(23%)	5(19%)
	Medical Officers	3(12%)	3(12%)
	Nurses	1(4%)	4(15%)
	Midwives	0	4(15%)
Level of Education	Postgraduate	6(23%)	6(23%)
	Undergraduate	3(12%)	4(15%)
	Diploma	0	6(23%)
	Certificate	1(4%)	0
Years of Practice	1-2yrs	5(19%)	4(15%)
	3-4yrs	1(4%)	4(15%)
	5-6yrs	0	2(8%)
	7-8yrs	0	3(12%)
	>9yrs	4(15%)	3(12%)

Source: Author, 2015

4.2 Objective 1: Health workers' understanding of who Family Physicians are.

Majority of the respondents had come to learn about Family physicians from their places of work or professional interactions. Notably the specialists and medical doctors emphasized that it's from the medical school that they got to learn of family Physicians. Based on both the Focus group discussions and in-depth interviews the respondents understanding of who a Family

Physicians was expressed under three main themes: a family Physician being a family-centred health worker, providing a broad spectrum of care .and their roles in the health care system.

4.2.1.Family-centred health worker

A family physician was seen by many of the responders as one who handled the health needs of a family. It was assumed that he or she provided the link between the family and the health care system and provided holistic care to the family. This finding cut across the health worker cadres in terms of role, age and duration of practice.

"The family doctor is a doctor responsible for the family's health, goes into detail to know about everyone's health problems, teaches them how to manage their problems, follows them up in hospitals gives them advice accordingly and works in hand with other doctors to manage the family." FGD 2 –Midwife 4

However the terminology associated with the discipline may have been confusing to some respondents and may have had an influence on how they responded.

"… from this discussion I have discovered that probably I do not know so much about Family Medicine. I think the word family is misleading or is it."Key Informant-Pharmacist

Although a few respondents could not distinguish between a family physician and a general physician, they managed to highlight that a family physician is a family's first point of care

"In my opinion I think a Family doctor is more like the center, the first link between a family or society and health. The first responder who responds to the family's needs if they need a general consultation or if they need to be referred." FGD 1-*Medical Officer 2*

4.2.2.Provision of a broad spectrum of care

The broad nature of the work of the Family Physician was noted by many of the respondents predominantly the younger cadres with a relatively shorter duration in practice. The Family physician was seen to handle all types of medical conditions regardless of one's gender or age.

These conditions cut across the sub specialties of paediatrics, gynaecology, surgery and general medicine. They were seen to handle especially non communicable illnesses with the majority of the care given in the out-patient setting.

" A specialized, trained person who handles all types of diseases irrespective of age, sex and who is interested in managing all patients. I can say maybe somebody handling comprehensive medicine irrespective of age, sex and condition." FGD 1-Nurse 1

"…They should be intimately knowledgeable about the specifics pertaining especially to chronic care patients. They should be specifically managing chronic care with the specialists at the top coming in when chronic care becomes complicated or acute exacerbations of chronic conditions. But all chronic care should fall under FPs."Key Informant -Paediatrician

"…… It is outpatient coz I don't think they go into tertiary management. They deal with all age groups and sex.."FGD 1- Midwife 2

4.2.3. Roles

From the health workers understanding of a Family Physician, themes related to the perceived roles they played in the health care system emerged including; the role of a clinician and an administrator as well as mentioning of roles in research and policy.

4.2.3.1 Clinician

All the responders identified the Family Physician with a clinical role but with varying understanding. Many saw him or her as the first point of contact for the patient in the health care system, one who provided continued and follow up care for the patient and referred them on to specialists where necessary. Others saw him or her as a co-ordinator of care for the patient and often collaborated with other specialists, was a specialist in his own right in the out patient department and a health educator.

The majority of the responders saw the Family Physician as a hospital based clinician in the outpatient department with only a handful of responders specifically the key informants who had been serving for the longest duration seeing him or her as a practitioner suited to the community setting.

*"They are specialists as well. I think patients with complicated cases in the primary care can be referred to the family physicians."*FGD 2-Medical Officer 5

*" I do not expect family physicians to be oncologists but they should know how to recognize the basic cancers and educate the patient. I think the biggest part is health care education."*Key Informant-Paediatrician

"……you can go into the communities that would help patients very much if you can get people out there. It is hard for us specialists to go to the community but you people are specialized enough to go out into the community and serve." Key Informant-Cardiologist

4.2.3.2 Administrator

Some respondents saw the Family physician in an administrative role. He or she supervises the clinic and mentors colleagues. It was mainly the key informants/specialists who perceived this role and specifically those that had been practicing for a shorter duration.

*"… I would like us to get to a place where our day to day out-patient department is run by a family physician, our clinics are supervised by family physicians from a clinical point of view and also from the fact that they have done a masters degree in this specialty and have added management experience. They can train junior medical officers."*Key Informant-Pediatrician

A few of the key informants also mentioned roles in research and education for the Family Physicians and only one person also a key informant mentioned a role in health policy

*"…..And of course research, to know details about certain conditions it would be the family physicians we would look to. Family physicians would help us a lot to describe what is on the ground."*Key Informant-Cardiologist

"…..Of course they also have a role in policy and research."Key Informant-Anaesthesiologist

4.3 Objective 2

To understand health workers' perceived skill set of Family Physicians at IHK.

As stated in the previous section, the majority of the respondents had come to know about Family Physicians during their professional interaction and the themes that emerged from their perceived skill set of Family Physicians included; attributes of a multidisciplinary practitioner, interpersonal, communication, counseling and leadership skills.

4.3.1 Attributes of a multidisciplinary practitioner

Many of the respondents perceived the Family Physician as having broad knowledge to encompass the sub-specialties in medicine. He or she is not limited by age, sex or condition. These attributes made him or her a multidisciplinary practitioner or generalist. There was no much variation among the respondents.

*"They must be well rounded. In obstetrics they should be able to conduct normal deliveries, do antenatal care, post natal follow up, vaccinate children, do primary care pediatrics, should do chronic disease clinics. They should be able to do minor surgical procedures, sewing ingrown toe nails, incisions and drainages of abscesses, take out small masses and then refer the more complicated stuff. So their skills should cut across the board…"*Key Informant-Pediatrician

" I think what makes it special is that he can see everyone, sub paediatrician, sub physician, sub gynaecologist, he is comfortable seeing anyone. He sub specializes in all fields, is comfortable with them and is able to relate well with them."FGD 2-Medical Officer 4

4.3.2 Interpersonal skills

The Family Physician was seen by a few of the respondents to have good interpersonal skills as he or she was expected to build good relationships with their patients over time as well as getting along well with other specialists in order to coordinate care for the patient. This was mentioned by health cadres who had been serving for a relatively short duration in practice and no variation among the key informants and the focus groups.

*"…..I don't know how to say that like they should have relationships with their patients as they are the first point of contact so they should be able to build relationships with their patients. Sometimes specialists do not have time or the skills for all that."*Key Informant-Internal medicine physician

4.3.3 Communication

A few respondents mentioned the need for the Family Physician to have very good communication skills given that he or she has to do a lot of health education and health promotion as well as counseling of patients. No variation was seen among the respondents.

"*They should be good communicators, have more time for their patients, be good patient educators, educate patients about illnesses.* "Key Informant-Internal Medicine Physician

4.3.4 Counselling

This was also perceived as a key skill by a few of the respondents predominantly in the focus groups.

*"Family physicians have good counseling skills and go into detail when explaining causes of problems to their patients and they are so social to the clients."*FGD 2-Midwife 3

4.3.5 Leadership

The Family Physician was seen to exhibit leadership skills as the head of the primary care team. He or she was also seen as a mentor for junior colleagues and medical students. This was mentioned by a few of the key informants .

"….They listen , they follow up the patient and I think they are leaders as well."FGD 2-Medical Officer 5

Some negative notions were mentioned during the interviews;

Family Physicians were relatively unknown , very few in practice and there was a need for sensitization about who they were and what they did. There was no variation among respondents on this finding.

*"Family physicians are few, the population ,the lay people don't know much about it. Even in the universities where it is taught the people taking it up as a course are few."*FGD 2-Medical Officer 4.

Family medicine practice was seen by some responders as a lower level specialty and not as popular. It was mainly key informants that made this response with no much variation in age and duration of practice .

*"It's an all round specialty at a lower level than other specialties."*Key Informant-Pediatrician

Some responders thought there was no clear role differentiation for Family Physicians with many seeing no difference between them and medical officers and one actually seeing no role at all for them. This finding cut across the various health cadres.

*"So far what I have seen, they are doing the same role as medical officers."*FGD 1-Midwife 1

*"For me their role in care cannot be at the moment clearly differentiated considering the other specialties available and also the non specificity of what they do in my opinion."*Key Informant-Nurse administrator.

Some benefits of Family Physicians were also mentioned by some responders. They were seen as doctors who could handle most health problems and subsequently reduce hospital visits, reduce hospital admissions, minize specialist visits and health care costs. There was no variation among the responders.

*"I am embracing family medicine because even the queues will become shorter and less costly. Like Midwife 1 said, a patient may see up to 4 specialists in a day from what I've seen. Someone lines up for a physician, a psychologist etc, even time wasting in the hospital. But I think the family physician will be able to cover you at once and then maybe if more specialization is required, he will refer."*FGD 1-Midwife 2

CHAPTER FIVE: DISCUSSION OF RESULTS

5.0 Introduction

This chapter deals with a discussion of the result findings, comparison with previous studies, conclusion as well as study strengths and limitations. The purpose of this study was to find out the perspectives of health workers at IHK on the role of Family Physicians.

Key findings from this study were that Family physicians were seen as providers of comprehensive care to the family and had predominantly clinical and administrative roles. Their skill set included attributes of a multidisciplinary practitioner or generalist, communication, counselling and leadership.

5.1 Discussion

Family centredness was a key feature in the health workers' understanding of a Family Physician. Many of the respondents perceived a family physician as somebody who handled the health needs of a family. He or she was the link between the family and the health care system. This is consistent with the literature which emphasizes the care of patients in the context of family and community as a core value of Family Medicine. [6,8,9] Though the terminology here may have played a role in the participants' understanding and may have been interpreted literally as one respondent noted that the term family was misleading.

The wide scope of practice of the Family Physician was also mentioned by the majority of the respondents .They emphasized the comprehensiveness and holistic nature of care of the physician, he or she could attend to all age groups and gender as well as all medical conditions. This was also noted in the consensus statement on the African Family Physician. [6] Their broad clinical approach was seen by some of the responders to reduce hospital visits, reduce specialist visits and unnecessary admissions as well as overall costs of care. A previous study also indicated the role of family physicians in supporting referrals at the district hospitals and reducing hospital admissions[24].Areas with strong primary care based systems have been demonstrated to have lower health care costs [3] and family physicians have been demonstrated to cost effectively manage conditions in primary care as part of a multidisciplinary team [2].

Most of the respondents identified with the clinical role of the Family Physician though with varying understanding with many seeing him or her as one who did the initial care of the patient, continued and follow up care, coordination of care and collaboration with other specialists. Of note here is that the Family Physician as the first point of care for the patient is a distinct feature of family medicine in the western countries with a lot of the initial contact for patients in Africa being done by nurse practitioners and medical officers[6,8,9]. A few key informants saw him or her as a specialist in his own right mostly handling chronic care in the outpatient department. Health education and promotion were seen as key roles by most of the responders.

The role of the Family Physician in the community setting was only mentioned by a few respondents with the majority being specialists who had been in service for a longer duration. This may have been because they were familiar with the original idea for Family Medicine in Uganda when it was called community health. Family physicians were mostly perceived as hospital based practitioners handling the outpatient departments with only a handful of respondents putting them in the community clinic setting .This was also mentioned by Moosa et al who noted this as a distinct feature of African family medicine [23] .

The role of the Family Physician as an administrator was mentioned by mostly key informants especially those that had been in practice for a shorter duration of time and this may be because of the emphasis on administrative roles for most medical disciplines in the current curriculum. He was seen as the head of the outpatient department, a medical director and a mentor for junior colleagues.

Roles in research were mainly mentioned by a handful of key informants and these were notably of a postgraduate qualification or higher and this may have been due to their familiarity with postgraduate training requirements

The above findings are consistent with the expected roles of the African family physician as noted in the statement of consensus on family medicine in Africa [6] though with limited mentioning of roles in advocacy, health policy and research.

The skill of a generalist was perceived by many of the health workers as a crucial skill for the Family Physician. The fact the he or she has to see all ages and gender and disease conditions.

He or she has to have skills that cut across the board from simple medical consultations and counseling of psychological issues to obstetric emergency operations and anesthesia delivery in theatre. The skills set of the African Family Physician with the need of for comprehensive surgical and anesthetic skills to serve at the district hospitals was also noted in the consensus statement [6].

Good interpersonal skills were noted to be vital for Family Physicians in building the relationships with patients with whom they usually attend to throughout the lifecycle and also in their interactions with other colleagues to coordinate care.

Communication was also seen as a key skill given that Family Physicians were expected to do a lot of health education and promotion as well as counselling of patients.

Leadership was seen by a number of respondents as another key skill. This was mostly mentioned by the key informants/specialists. Family physicians were seen as the heads of the primary care team in the outpatient department and took charge of care for the patient and were also mentors and supervisors for the junior colleagues and students. This finding is consistent with the skill set of the African Family physician as described in the consensus statement [6].

However some negative notions were noted. Family physicians were noted to be few in practice. The specialty was considered to be of a lower level by some of the specialists and there was a lack of clarity on their roles which were perceived to be similar to those of the medical officers. It has been shown that few family physicians are in practice in Uganda and not many new ones being trained either [17] .Clinical exposure has been shown to be critical in demonstrating the positive aspects of family medicine[19,29],negative comments or bad mouthing about family medicine have been demonstrated to negatively influence medical students career choice and the general poor representation at universities have also contributed to the low popularity of family medicine [30].This may explain why some of the respondents mentioned that few students are taking up the discipline in universities.

The study by Swanepoel et al showed that placement of family physicians in district hospitals brought about tension with career medical officers who seemed to fulfill similar tasks and the added costs of hiring family physicians to the health care system were also an issue [16].

Many of the respondents indicated the need for more sensitization about Family Medicine and Family Physicians.

5.2. Limitations of the study

The interviewer was known to the respondents and therefore there was a possible bias towards favorable or more socially acceptable answers.

Exposure to family physicians was very minimal at IHK at the time of the study and therefore meaningful responses may not have been obtained from respondents.

5.3 Conclusion

Health workers at IHK perceived Family Physicians as providers of comprehensive health care to families though the terminology associated with the discipline may have been confusing. They fulfilled clinical, administrative and research roles as well as a limited role in policy. They were perceived to have the skills and attributes of a multidisciplinary practitioner, good interpersonal, communication, counselling and leadership skills.

Benefits of reduced patient hospital visits, reduced specialist referrals, fewer unnecessary admissions and reduced overall costs of health care were attributed to Family Physicians.

However Family Physicians were noted to be few in practice, were generally not well known, the discipline was perceived to be at a lower level by some specialists and their roles were not well fronted with many not being able to differentiate them from medical officers and more sensitization about family physicians was needed.

Recommendations

This study has shown that there needs to be more sensitization of health workers about Family Physicians and Family medicine as a discipline. If more health workers were made aware of their skills and the roles as well as their documented benefit to the health care system then perhaps more health workers may be attracted to the discipline.

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Appendix I: Participant demographics

Date:	**Time:**	**Place:**
Gender:		
Age:		
Specialty/Role:		
Duration in Practice:		

Appendix II: INFORMED CONSENT FORM

Principle Investigator:Ndahura Duncan

Research Project:The Perspectives of Health Workers on the Role of Family Physicians.A Case Study of IHK Health workers.

This form comprises of two sections namely; the information sheet and the certificate of consent.

INFORMATION SHEET.

My name is Dr Ndahura Duncan and I am a student with IHSU currently doing my masters degree in Family Medicine and I would like to invite you to participate in my research project. All information in this form will be clearly explained to you and all your questions regarding your participation will be answered by me.

Purpose of research

To find out what other health workers think of family physicians and what skills they attribute to them.

Participant Selection.

You have been chosen to participate in this research project because you are a health worker serving at IHK and your views on this subject will be important to this research project.Your participation is voluntary and you can choose not to participate at all or stop your participation at any time if you are not comfortable.Your participation or lack of it will not have any implication on your duties at IHK.

Procedures

You will be required to take part in an in-depth interview which will run for about 30-40 minutes and a tape recorder will be utilized to record the interview.If you are not comfortable being recorded on a tape then notes about the interview will be taken during the interview.This information will be kept for the duration of the research project and your responses will be shown to you at a specified time during data analysis to validate your responses and you will also

be informed of the results of the research as needed which will also be disseminated to the research review board.

Risks

There will be no invasive procedures or interventions in this study so no risks are anticipated.

Benefits

There will be no direct benefit to you but your responses will add more knowledge to the research topic.

Reimbursements

No financial reimbursements will be given but refreshments will be provided during the interviews.

Confidentiality

Only the research team will know your identity and your name will not appear anywhere in the research.A unique title or number will be assigned to you for this purpose.

Right to refuse or withdraw

As stated earlier, your participation is voluntary and you can choose not to participate or withdraw at anytime as you may wish to.

This research proposal has been approved by the IHSU IRB and for any further queries the following contacts have been availed;

Dr Samuel KabwiguIHSU-REC Chairperson (0779610100)

Julius Ecuru UNCST contact person (0772595233)

CERTIFICATE OF CONSENT

I_____ agree to voluntarily participate in this study entitled, The Perspectives of Health Workers on the Role of Family Physicians .A case study of IHK health workers by Ndahura Duncan as the Principal investigator. This study is in fulfillment of a masters degree requirement .I will be required to take part in an audio taped interview/focus group discussion lasting about an hour. I will have access to the transcripts and audio recordings as well as the results from this study as needed. No names will be mentioned for the sake of confidentiality. I understand that by signing this form I am agreeing to participate in this study.I have the option to decline participation in this study. This form has been fully explained to me and I understand its contents. I have received a copy of this form.

Name of Participant

Signature of Participant

Date

Signature of Researcher

Date

Appendix III: Key Informant Interview Guide

Interview questions.

1. What do you know about Family Medicine?

2. How did you find out about it?

3. From your perspective, who is a Family Physician?

4 What special skills do Family Physicians have?

5. What role do you think Family Physicians play in the health care system?

6. Is there anything else you would like to add on at this time?

Appendix IV: Focus group discussion guide and questions

Introduction

1. Meeting of discussion moderators with the participants.

2. The purpose of the focus group discussion will be to get respondents (health workers') opinions on family physicians and what role they play in health care delivery.

3.Ground rules for the discussion

- All respondents will be expected to participate in the discussion.
- Time will be given to all participants to give their responses.
- No interrupting of colleagues giving responses.
- Time will be availed at the end of the discussion for questions to the moderators and for clarification of remarks.

4.Consent forms will be provided and signed before commencing the discussion.

Discussion questions

1. What do you know about family medicine?
2. How did you find out about it?
3. How do you think family medicine is fairing in Uganda?
4. In your opinion, who is a family physician?
5. What special skills do family physicians have?
6. What role do you think family physicians play in the health care system?
7. Is there anything else you would like to add on at this time?

Conclusion

- Clarification remarks from participants and verification by the moderators.
- Closing remarks by the moderators.
- Thank you for your kind participation in this focus group discussion.

Appendix V: Budget

The following section shows a breakdown of the research costs. Recorder not included in research costs because it is already available. Additional costs may come in during data analysis.

Item	Cost
Paper (3 reams)	**39,000/**
Pens (2 dozen)	**15,000/**
Note books (10)	**20,000/**
Clip boards (3)	**9,000/**
Refreshments for participants (Sodas and cookies)	**53,000/**
Total	**136,000/**

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P.O. Box 8177 Kampala Uganda
Tel: +256 312 200 400 / +256 414 200 400
email: ihk@img.co.ug

IHK INTERNATIONAL HOSPITAL KAMPALA

PART OF THE INTERNATIONAL MEDICAL GROUP

10.8.2015

Dr. Duncan Ndahura

International Hospital Kampala

Dear Duncan,

Re: Permission to carry out Research entitled "The perspective of Health workers on the role of family Physicians: A case study of IHK health workers"

In reference to your letter dated 7th August 2015 and having noted ethics committee clearance letter, ref IHSU-REC 0007, I am pleased to grant you permission to conduct the study in the stipulated period.

We shall require of you to submit a copy of your final report to this office upon completion.

Sincerely,

Moses Galukande

Associate Professor | Director Surgery, Education & Research
IMG

c.c DMS Dr. Muhame Michael

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P.O. Box 8177 Kampala Uganda
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IHK INTERNATIONAL HOSPITAL KAMPALA

PART OF THE INTERNATIONAL MEDICAL GROUP

10.8.2015

Dr. Duncan Ndahura

International Hospital Kampala

Dear Duncan,

Re: Permission to carry out Research entitled "The perspective of Health workers on the role of family Physicians: A case study of IHK health workers"

In reference to your letter dated 7th August 2015 and having noted ethics committee clearance letter, ref IHSU-REC 0007, I am pleased to grant you permission to conduct the study in the stipulated period.

We shall require of you to submit a copy of your final report to this office upon completion.

Sincerely,

Moses Galukande

Associate Professor | Director Surgery, Education & Research
IMG

c.c DMS Dr. Muhame Michael

Appendix VI: Budget.

The following section shows a breakdown of the research costs. Recorder not included in research costs because it is already available. Additional costs may come in during data analysis.

Item	Cost
Paper (3 reams)	**39,000/**
Pens (2 dozen)	**15,000/**
Note books (10)	**20,000/**
Clip boards (3)	**9,000/**
Refreshments for participants (Sodas and cookies)	**75,000/**
Total	**136,000/**