

WONCA News

An International Forum for Family Doctors/



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From the President: Perspectives on Iran



Photo: WONCA president with group of health volunteers at Torab primary health care centre in Tehran

Dr Samira Pouryosefi is a family doctor working in the Zar nan rural health centre in the Islamic Republic of Iran. As the head of her local primary health care team, Samira is responsible for the health and well being of over 4,700 people living in her rural town and the surrounding region. Samira also works with the community health workers, called behvarz, who run the small health clinics, called health houses, in the surrounding rural villages.



Photo: Family doctor, Dr Samira Pouryosefi (right) in her clinic at the Zar nan rural health centre in the Islamic Republic of Iran (with WHO Iran lead and family doctor, Dr Jihane Tawilah)

I was visiting Iran as a member of a mission for the World Health Organization (WHO) examining the integration of health services with medical education across the country. As part of the mission I had the opportunity to visit the capital city of Tehran, in the north of the country and

dominated by the Alborz Mountains, the city of Mashhad, built on an oasis on the former Silk Road and most famous for the tomb of Imam Reza, visited each year by millions of pilgrims, the former royal city of Isfahan, former capital of Persia, designated by UNESCO as a World Heritage Site for its outstanding examples of Iranian and Islamic architecture, including palaces and mosques and bridges, and a number of rural towns and villages.



Photo: Inside the Imam Reza mosque complex in Mashhad

Iran has a population of 78 million people, with 12.5 million people living in the capital city, Tehran. It is the 18th largest country in the world and one of the world's most mountainous countries. 30% of the population lives in rural areas.

The success of primary health care in Iran is world-renowned. Iran is one of the country's that has successfully tackled universal health coverage through the training and support of a nationwide network of community health workers, known in Persian (Farsi) as behvarz. The behvarz are people from rural communities who work to link their population to the doctors and nurses working in local health units. Each behvarz operates from a small clinic, called a Health House, based in their local village. There are 14,000 Health Houses across the country. Some behvarz work alone, others in pairs, often a husband and wife team. Their work is especially focused on maternal and child health, vaccination programs, prevention of infectious diseases, sanitation, first aid and family planning. The behvarz know everybody in their local community, conduct home visits for the newborn, the elderly and those with disability, and keep records on a chart in each

Health House, known as a Health Horoscope, which provides a quick and easily updated summary of the health status of all the people in each community. Between 1984 and 2000 Iran was able to halve its infant mortality rate, raise immunization rates from 20% to over 95%, and implement a highly successful program of family planning. Public primary care services are provided free of charge.



Photo: Behrvarz Samantha Amir-Torbati and behrvarz Mohammad Eahgh, in their rural health house outside the city of Mashhad (note Health Horoscope on the wall behind)

To extend the work of the behrvarz in rural areas, the government of Iran has also created a program of urban-based health volunteers, mainly women, called Davtaleb Salamat (the Farsi term for Health Bridge). The health volunteers work with the members of their local communities, based out of urban primary care centres.

Iran is also famous for the integration of medical education and public health services. In 1985 the nation created a single Ministry of Health and Medical Education. The Chancellor of each University of Medical Sciences in the country is responsible not only for the education of health professionals and medical research, but also for the clinical services delivered through public hospitals and primary health care services within their assigned geographic region. This allows far greater integration between the functions of universities and health services, than exists in many other countries. Some of the Chancellors are responsible for the health care services provided to over 5,000,000 people.

As health care measures have improved, Iran has recognized the need to strengthen primary care through the creation of the specialty of family medicine, and WONCA is providing support to the country to develop formal training for the family medicine workforce. The lack of a recognised specialty of family medicine has meant that most

medical graduates have been training to become hospital-based specialists and sub-specialists. High public demand for health services in teaching hospitals, and self-referral, has led to excessive demand for hospital-based clinical services, lengthy waiting lists and rising health care costs. At the same time the prevention and management of chronic health conditions has been less than optimal. As in many countries, family medicine is recognised as the solution to these common health system challenges. President-elect, Professor Amanda Howe, has recently visited Iran, again with the WHO, to assist with the development of postgraduate family medicine training. Iran is not yet a member of WONCA but we look forward to welcoming our colleagues from Iran into the WONCA family.



Photo: WONCA president receiving membership application from Dr Faramarz Rafiee from the Iranian Society of General Practitioners, with Dr Saeed Taammali, general practitioner advisor to the Iranian Minister of Health and Medical Education

This was an interesting time to be in Iran, with the United Nations having recently announced a nuclear accord that could lead to the lifting of long-standing sanctions. I admit that I was a little nervous about visiting Iran, especially when told that I would have to undertake advanced security training through the United Nations. Once in Iran, I felt welcome and safe. The people I met were welcoming, friendly and very hospitable. The cities were clean and green. The cultural heritage is remarkable and I enjoyed learning about the country's history. It took me two days to realise that my group was accompanied by a discrete security detail of two military-trained paramedic officers driving their ambulance behind us as we moved around the country.

Michael Kidd
WONCA President

From the CEO's Desk - WONCA's Global Reach

WONCA truly is a global organization, representing over 500,000 members in more than 140 countries and territories in all continents. We take our role, as the global voice of family medicine, very seriously, and we know from feedback that our members regard this global representation as one of the most important functions of WONCA. A lot has been happening over the past few months, and many more activities are ongoing, so I thought it important to report back to you all on what we have been doing, on your behalf, on the world stage.



Sustainable Development Goals

I've written on this in past months but, as a reminder to everyone, the Millennium Development Goals (MDGs), formulated by the UN in 2000, have now expired, to be replaced by the Sustainable Development Goals (SDGs), which will run until 2030.

The SDGs were launched with a fanfare at the end of September in a ceremony presided over by Angela Merkel, Bill Gates and Dr Margaret Chan, and I'm pleased to say that our President, Professor Michael Kidd, was invited as the representative of family medicine. Michael will report more fully on the event elsewhere, but we regard it as vital that family medicine continues to be represented at significant events such as this, to make sure that the critical role of family doctors and family medicine and primary health care is always at the forefront of planners' minds.

The MDGs had eight goals, of which three had a health focus. The SDGs have 17 goals and 169 targets with only one goal focusing directly on health. SDG3 states "Ensure health lives, and promote well-being for all, at all ages". Universal Health Coverage (UHC) – the ability to access health care regardless of ability to pay – is only one of the sub-goals and yet we regard this as central to achieving the SDGs. No-one should be kept in, or pushed into, poverty due to out-of-pocket expenditure, yet the World Bank reports that over 100 million people are pushed into poverty annually as a result of out-of-pocket expenditure on health care. That is why WONCA strongly supports the concept of health equity - that those who needed most resources received

most help – and we work through our Special Interest Group on Health Equity to promote and support this.

Primary Health Care Performance Indicators

Of course of paramount importance will be how to monitor and evaluate progress in achieving the SDGs, and there have been many discussions in recent months about how to develop robust and relevant Primary Health Care Performance Indicators. Again, WONCA has been part of those discussions represented by our President, and he has been reminding everyone that WONCA has already developed relevant tools, in the form of a PHC coding system - the International Classification of Primary Care (ICPC) - developed and updated over the years by our WONCA International Classification Committee (WICC).

ICD-11 Development

WONCA is also now actively engaged with WHO in the development of the primary care elements of ICD-11. Discussions had been going on for some considerable time, but progress had stalled until fairly recently. However WHO has now acknowledged – prompted by a number of our Member Organizations writing directly to WHO to express concerns - that greater input is required from primary health care if ICD-11 is to be fit for purpose. Again it is our colleagues in WICC, with the WONCA ICPC coding, who are leading on this, most particularly Kees van Boven and Thomas Kuehlelein. Kees recently represented us at a meeting of the Joint Linearization of Morbidity and Mortality Group, and further work with WHO is ongoing.

Other WHO representation

We also respond to many calls from WHO for inputs into meetings and consultation documents, and we are fortunate to have as our WONCA-WHO Liaison Dr Luisa Pettigrew, who does a fantastic job on our behalf. Recent responses have been submitted on the WHO Global Strategy for Human Resources for Health 2030 and the Global Coordination Mechanism for NCDs, and we will be represented later this month at meetings in Geneva on cardiovascular disease and on the global strategy and plan of action on ageing and health. Finally we are invited to be represented at most WHO Regional Council meetings. Professors Job Metsemakers and Anna Stavdal attended the WHO EURO Council meeting in Lithuania recently, whilst Dr Mohammed Tarawneh will attend the WHO EMRO meeting in Kuwait. We also hope to

be represented at WHO AFRICA in Chad and WHO WPRO (Western Pacific) in Guam.

I hope you will agree that you are all being well represented by your leaders on the international stage, but we will continue to report from time to time on further inputs and activities. Meantime the

WONCA Executive will meet face to face for two days in October, in Istanbul, and next month I'll report back on some of the issues which were debated and discussed.

Dr Garth Manning
CEO

Policy Bite: What gets measured gets managed?



Prof Amanda Howe is on holidays, so this month's Policy Bite is written by guest author Dr Luisa Pettigrew. Luisa is a member of WONCA Executive and our liaison person with the WHO.

The cliché is that “if it is not measured it is not managed” - or simply may not be done. Whilst there are numerous pitfalls associated with wanting to measure things that cannot or should not be measured, there is also some underlying truth in this saying. The biggest challenge is therefore measuring what matters, and coming up with feasible and appropriate ways of doing so.

The health and well-being of patients and populations are the most important end-point measures for any health system, but health outcomes are often long-term and based on numerous different factors. Structure and process measures, which measure how care is delivered, are also important as indicators of the quality of service and its consistency with evidence. These are particularly relevant to primary care, where evidence suggests that if condition-specific outcome targets are used to direct health services this can be to the detriment of other conditions, holistic care and to health system strengthening. This is particularly relevant when resources are limited and the appeal of vertical programmes for funders is strong.

In August the WONCA executive therefore published a [letter in The Lancet](#) underlining the [need for global primary care development indicators](#). The letter stressed that there is a need

to try to measure the distinctive dimensions that evidence suggests make primary care effective. These include coordination, comprehensiveness and continuity of care, as well as measures of quality of care and integration into the health system. It is also important to be able to measure government expenditure on primary care, financial accessibility to primary care and workforce development.

We acknowledge that many of these dimensions are currently very challenging to measure in a large part of the world as the resources and mechanisms to collect the data are not yet there. However examples exist of how it can be done, and although these are principally from higher income country settings they provides a basis from which to start (1,2).

The United Nations have set 17 ambitious [Sustainable Development Goals](#) to be achieved by 2030. Good quality comprehensive primary care is essential to meet not only the main health related goal, but it can also make a significant contribution across the other goals.

We therefore need to be ambitious about measuring what matters, and primary care matters.

1. Johns Hopkins Primary Care Policy Centre. Primary care assessment tools. www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/pca_tools.html.
2. Dionne S. Kringos, Wienke G.W. Boerma, Allen Hutchinson, Richard B. Saltman. Building primary care in a changing Europe. European Observatory on Health Systems and Policies & NIVEL. www.euro.who.int/en/about-us/partners/observatory/publications/studies/building-primary-care-in-a-changing-europe

Rural Round-up: a Tokunoshima after party



the National Rural Health Alliance conference in Darwin.

Rural people the world over have barriers to access to care, be it the great distances in Australia, the remote islands of Japan, or the ravages of war in Croatia.

What Manabu saw in Australia

Emerald is a rural town 1000 kilometres from Brisbane, the capital of Queensland, and 300 kilometres from the nearest tertiary hospital. Like many rural towns in Australia it is

a focus point for industry, cattle, agriculture, coal and cotton. It is a hub for education and 'School of the Air', healthcare and administration.

What sets Emerald apart is that it is also a young and vibrant community with many children, as evidenced by the 400 births a year at the local hospital. This is very different from the ageing and dying communities out west, and a challenge that was to be also found in the Japanese Islands as young people move to the city.



Google maps show the remote locations of the home towns of Ewen from Emerald in Australia and Manabu from Tokunoshima Island in Japan.

It is my belief that one important contribution to a vibrant community is access to excellent care and good General Practitioners (GPs) and nurses that people trust.



日本語

Ewen McPhee writes of an exchange of ideas between rural doctors from Queensland, Australia, and rural doctors in Tokunoshima Island, Japan, after a chance meeting at the WONCA rural conference.

Dubrovnik

A chance encounter between colleagues thousands of kilometres from home, one seeking answers to challenges in his country, another looking outwards to share experiences.

It was April in Croatia, the WONCA World rural health conference was in full swing at a convention centre in Dubrovnik, and where I first met Dr Manabu Saito (pictured).



Manabu, an Emergency Physician, now General Practitioner, had sought his own training in gastroenterology and home care medicine, was travelling the world learning from other health systems.

Australians are a rowdy bunch yet Manabu was brave, coming out with us to have a meal. It was there that we sealed a deal, Manabu would visit Emerald (in Queensland, Australia) on his way to

Emerald has experienced its own trials, with obstetric service closures, reliance on locums to deliver care in the absence of a local medical workforce, and reliance on retrieval services. From 2000 to 2014, I was the only local GP obstetrician.



Photo: Ewen teaching obstetrics (see below) watched by new friend Manabu (far right)

A global question is how to improve the health of rural people. Even in Australia rural people suffer more from preventable diseases such as Coronary Artery Disease, pneumonia and Chronic Obstructive Airways Disease. Suicide remains a major killer of country people and the health of our indigenous people does not equal that of the broader Australian community.

Encouraging young people to invest in training to be rural doctors, nurses and other health professionals, is a conundrum that challenges Japanese communities, as it has Australia. This is the holy grail that Manabu came searching for answers to.

In Queensland there is a new professional, the Rural Generalist (RG). A specialist in a wide range of clinical skills that support rural and isolated practice. The model nurtures rural school students into medicine, creating a premium pathway, that delivers an attractive quality experience. These young clinicians are taught an advanced skill of a procedural or non procedural nature, such as obstetrics, anaesthetics, surgery, population or Aboriginal health.

What has resulted from the program has been an enthusiastic, highly trained and complementary health team with the expertise to look after rural people as close to home as possible, living and working in the communities they serve. Manabu was able to see this in action in Emerald, joining training sessions and speaking with young Rural

Generalists about their role in primary care as GPs, and their advanced practice.

Later Manabu met the architect of the Queensland Rural Generalist Program (QRGP), Dr Denis Lennox, and Prof Tarun Sen Gupta of James Cook University. The Rural Generalist system is the outcome of contributions from the generalist colleges, government, the medical schools, rural hospitals and GPs.

The Australian College of Rural and Remote Medicine (ACRRM) sets the training standards for the QRGP and the preferred qualification is Fellowship of ACRRM. Registrars may also elect to meet the standards through training for Fellowship of the Royal Australian College of General Practice (RACGP) and their Fellowship of Advanced Rural General Practice (FARGP).

Through the program, Emerald has seen a reinvigoration of birthing with three more GP obstetricians to assist me - young highly professional women GPs. A Rural Generalist surgeon performs common operations and gastroenterological examinations ably supported by six GP anaesthetists. Each and every one of these young specialists also works in primary care as a GP.

Central Australia and the National Rural Health Alliance conference were introduced to a passionate crusader for rural medicine in Manabu's subsequent travels in Australia.



Photo: in Japan, the helicopter is used often

A reciprocal visit

So four months later, I am sitting in the back of a Kawasaki BK 117 flying to Fukuoka to start the trip home from Japan. In the last five days, I have shared the message of rural generalist training, the importance of a primary care workforce and the challenges that only well trained GPs and

nurses can meet of an ageing population and the epidemic of chronic disease.

A Rural Generalist Fellow, and Royal Flying Doctor Service (RFDS) medico, Dr David Morgan has shared the challenges of remote care with a number of audiences. His stories of the use of fixed wing aircraft is news to Japanese clinicians who almost universally rely on helicopters for retrieval; a great challenge for very remote island communities. Telehealth care is something that Japan is also yet to discover as a means of providing specialist support to rural doctors in decision making in emergency, and for routine care.

Alison Kirby, a GP Anaesthetist and rural generalist registrar shared her passion for rural medicine and her commitment to rural Australia. Alison lives on a cattle station the same size as our final destination Tokunoshima, with as many cattle as the famed home of bull fighting. She is a true rural doctor, having grown up in 'the bush' then trained to return as a skilled doctor. Alison's enthusiasm was greeted with intense interest from the Munakata Medical Association and students from ten universities in the Kyushu area (including medical, nursing and pharmacy).



Photo: Alison and David in small group teaching

Alison, David and I have been treated to a fantastic opportunity to immerse ourselves in the rich culture of Japan. In Fukuoka we challenged clinicians by presenting a workshop, showcasing some of the many skills required of rural generalists. We were impressed by the passion of medical students, doctors and in particular the community of Tokunoshima for change.

The health system in Japan is quite different. Tokunoshima itself has three separate hospitals, including a 200 bed psychiatric hospital. The

specialist led units see employment of two obstetricians for 200 deliveries yearly, quite the opposite of Emerald where generalists take on multiple roles. Opportunities to broaden the skill set of doctors and reduce the costs of needing to supply multiple specialists to small communities exist by application of a generalist model of care.

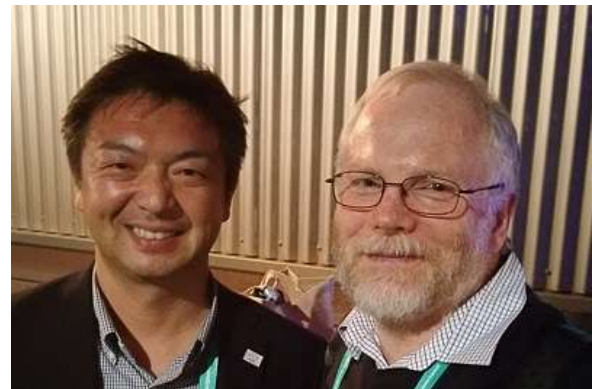
My lasting memory will be of a young midwife at our last gathering. With a tear in her eye she asked what was the most important thing in our lives. Universally we agreed that looking after our



communities and training those that came behind us was our passion. I think that Manabu and all the Japanese clinicians we met feel the same way too.

Ewen McPhee (*pictured being interviewed in Japan*)
Emerald, Queensland, Australia

Editor's note: Manabu has now made another trip



to Australia and was seen in September with Ewen at the Royal Australian College of GPs annual conference in Melbourne (photo below)

WONCA's international partnerships

WONCA PRESS RELEASE

WONCA and International Health Terminology Standards Development Organisation deliver collaborative products

Close coordination will facilitate adoption of standards-based healthcare implementation internationally

Bangkok, Thailand; Copenhagen, Denmark – 30 September 2015.

The World Organization of Family Doctors (WONCA) and International Health Terminology Standards Development Organisation (IHTSDO) are pleased to announce the release of the General Practitioner/ Family Practitioner Reasons for Encounter/ Health Issues (GP/FP) subset and the map from the GP/FP subset to the International Classification of Primary Care (ICPC-2). WONCA and IHTSDO signed an agreement to collaborate in 2009 to promote cooperation between the two organizations. The agreement contained a commitment to map relevant content in SNOMED CT to the ICPC-2 for the benefit of users worldwide.

The GP/FP Subset and ICPC-2 map were developed between 2010 and 2013 by the International Family Practice/General Practice Special Interest Group (SIG), and the subsets were first released for review in April 2014. Changes to the structure of the subsets were made following feedback, and we are now pleased to announce that the SNOMED CT subset is being released along with the map to ICPC-2. The GP/FP Subset and map to ICPC-2 will be updated with each release of the SNOMED CT International Release.

The GP/FP subset contains SNOMED CT concepts focused on reasons for encounter and health issues. This increases the usefulness of SNOMED CT for General Practitioners and Family Practitioners because it targets high usage concepts from electronic records. ICPC-2 is a classification designed for use in general/family practice around the world. ICPC-2 is developed and maintained by the WONCA International Classification Committee (WICC), representing members from almost 30 countries.

SNOMED CT, a multidisciplinary international healthcare terminology, is designed to support the entry and retrieval of clinical concepts in electronic

record systems and the safe, accurate, and effective exchange of health information.

Access

Access within IHTSDO member countries is provided by the Member National Release Centre in each country, via the relevant Member web page. Affiliates of IHTSDO in non- member countries can access the release files through their MLDS account (Member Licensing and Distribution Service) – www.mlds.ihtsdotools.org. Please contact info@ihtsdo.org for more information if required.

About WONCA

The World Organization of Family Doctors (WONCA) is a not-for-profit organization and was founded in 1972 by member organizations in 18 countries. WONCA now has 131 Member Organizations in over 140 countries and territories with membership of about 500,000 family doctors and more than 90 per cent of the world's population. WONCA represents and acts as an advocate for its constituent members at an international level where it interacts with world bodies such as the World Health Organization.

About IHTSDO

The IHTSDO (International Health Terminology Standards Development Organisation) and its Members seek to improve the health of humankind by fostering the development and use of suitable standardized clinical terminologies, notably SNOMED CT, in order to support the safe, accurate, and effective exchange of health information. The IHTSDO is an international organization, established as a Danish not-for-profit association. (www.ihtsdo.org).

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Social Justice Position Statement

The WONCA Executive Committee has endorsed and supported the World Psychiatric Association (WPA) Social Justice Position Statement and the call for a FAIR DEAL. The WPA plan to release these on September 4 - "Mind Matters Day". These papers tackle stigma and discrimination against people with mental health concerns, and call for a FAIR DEAL.

WPA WORLD MIND MATTERS DAY :
FAIR DEAL FOR MENTAL HEALTH

Fairness and equity in funding, resources, outcomes and research

Accessibility to effective services

Integrating physical and mental health

Reducing discrimination and stigma

Disparities at all levels to be demolished

Education of public and stakeholders

Alliances and advocacy with patients and carers

Links with organisations and across specialities

All of these areas are inter-linked. Equity and fairness in funding, research will lead to better

outcomes and greater patient and carer satisfaction. Advocacy of our patients will produce equitable access and better recovery. Tackling discrimination will improve access and engagement.

The campaign includes public mental health agenda as well as campaign for social justice for those with mental illness. Three Steps:

Achieving a Fair Deal: awareness: The campaign will involve a programme of public education and communications work to raise awareness of the eight priorities .

Achieving a Fair Deal: action: The WPA will undertake key projects and actions to address each of the eight priorities, including partnership work with other organisations..

Achieving a Fair Deal: involvement: The Fair Deal campaign will involve psychiatrists, patients, carers and policy makers.

Get involved, sign up and spread the word.

[see WPA Position Statement On Social Justice For Persons With Mental Illness \(Mental Disability\)](#)

WONCA and WHO

Global Strategy and Action Plan on Ageing and Health: consultation

WHO is in the process of developing a Global Strategy and Action Plan on Ageing and Health which will be submitted to the World Health Assembly next May for endorsement.. The strategy will guide action and specify commitments by countries around the world over the next five years, hopefully leading to a Decade of Healthy Ageing from 2020 to 2030.

As well as the face-to-face consultation, a web consultation on Draft Zero of the Strategy is now live. The full draft zero strategy document will soon be also available in French, Spanish and Arabic and will be placed on the site as soon as the translations are complete. Please note this is VERY preliminary draft, as WHO is looking for external inputs to help shape the contents.

WHO is keen to have as many contributions as possible from individuals and organizations, and welcomes feedback on the strategy using the electronic survey at this site. There is also an

email address to collect additional comments, if some people prefer (HealthyAgeing@who.int). Maximum input is crucial if WHO is to develop a balanced Global Strategy that reflects the needs, concerns and aspirations of older people around the world.

The draft zero proposes the following 5 strategic objectives. You may comment on each section in turn.

1. Committing to foster healthy ageing in every country
2. Aligning health systems to the needs of older populations
3. Developing long-term care systems
4. Creating age-friendly environments
5. Improving measuring, monitoring and understanding

[Go to Draft Strategy](#)

WHO/UNAIDS Global Standards for quality health care services for adolescents is launched

The recently published *WHO/UNAIDS Global Standards for quality health care services for adolescents* aims to assist policy-makers and health service planners in improving the quality of health-care services so that adolescents find it easier to obtain the health services that they need to promote, protect and improve their health and well-being.



Global initiatives are urging countries to prioritize quality as a way of reinforcing human rights-based

approaches to health. Yet evidence from both high- and low-income countries shows that services for adolescents are highly fragmented, poorly coordinated and uneven in quality. Pockets of excellent practice exist, but, overall, services need significant improvement and should be brought into conformity with existing guidelines.

[Document accessed here](#)

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Feature Stories

Chloé Perdrix writes: the final leg of a journey

Chloé Perdrix is a young French GP who has taken a sabbatical year travelling around Asia. In order to stay in touch with the medical network, she has tried to meet general practitioners during this journey. This is her final article - over the past year we have read her fascinating stories and felt the warmth of the welcome she has received from colleagues. Next month she heads to the WONCA Europe conference in Istanbul. If you missed her earlier stories [click here](#).



Primary care in Mongolia and Russia and reflections about my future in family medicine.

Time is going so fast! In few days, it will have been one year since my first article was edited in WONCA news. Do you remember? It was about Malaysia and traditional medicine in Orang Asli people who live in the jungle.

During this long journey, some people asked me: Aren't you scared to have forgotten everything in medicine?

To be honest, I'm more stressed than scared. I imagine my 'go back to work' day like the first day in a new medical rotation in a new place. Like when I was a resident. But no, better than that. I trust in my brain. I won't forget 10 years of studying as easily.

Furthermore, I have kept my medical knowledge up to date, by reading medical articles on internet,

medical periodicals, and by going to medical congresses like next WONCA Europe Conference in Istanbul. I also practised medicine during my travel, and realized that reflexes I learned were still in my brain: I diagnosed an alcoholic coma in a man who was supposed to board a plane in few minutes and provided him the initial care before the airport medical team took charge of him; I took care of an infected sunburn; I found medication to treat a gout crisis in the Laos countryside; I diagnosed scabies and helped the person to find treatment in China; and I advised many travellers and local people who had questions about their health.

When you are a Family Doctor, you never stop being a family doctor, wherever you are.



My most recent professional experience was in Mongolia. Our parents had joined us for 15 days. As we were hiking on a steppe and walking next to a “Ger”/ “Yurt”, local people invited us to have a break. They offered us tea and oiled-fried pancakes with milk (typical food in Mongolia). They told us that one of the men had injured his right calf in the morning when he was mowing the lawn (don’t ask me why he did it since there is grass for kilometres on the steppes... Maybe to prepare food for animals during winter?).

I examined the injury. My first impression was that it was not so bad. The wound was not bleeding anymore and the skin was in a good state. But when I looked more closely, I discovered a 1cm deep injury. I felt the foot pulse but the neurologic exam was not good. Sensation was modified and asymmetric. A nerve was probably affected. I advised him to go to the nearest hospital as soon as possible. (He had been injured for more than eight hours). They called family in Oulan Bataar to get him with their car. He would go to the emergency room the next day. It was the quickest solution.

I advised him on how to heal his wound, gave him some paracetamol and disinfectant spray and really insisted on the importance of going to a hospital in order to explore the wound surgically and to vaccinate him against tetanus.

As I gave him advice, I guessed how his next day would be: a very long day of waiting. Indeed, I had already had a discussion with Mongol people who explained to me how health care is organised in Mongolia.

Each salaried person pays 7% of their salary to fund a public health system which provides a large assortment of medical care for free. But these people told me that when Mongol people can afford it, they subscribe in addition to a private insurance to have access to private clinics. They thought it was better “because medical staff were often better” and “mostly because the waiting time was shorter”. Public hospitals and health centres are overbooked and people have to wait, for

example, two or three hours for a General Practice consultation.

In the opinion of these people, level of the public medical school was not very good, and Mongol medical students have to study

medicine abroad. South Korea and Turkey are the main countries where Mongol medical students go.



Photo: Medicinal Flowers used as infusion for stomachaches, Like eidelweiss for headaches, Mongolia

In Russia, I had the opportunity to visit two health centres. As in Mongolia, since the days of the Soviet Union, each district has a public medical centre where people can receive medical care for free. But because of the population growth, these public health centres don’t manage to take care of everyone, and the government’s funds provided to create more public health centres are not high enough.

Consequently, some “half-public/half-private” health centres are being developed with the help of public funds. The second health centre I visited was one of them. It was built two years ago in a very new area of Moscow where a lot of young people and families settled.

Photo: St Basil's Moscow.

In Russia, the main topic which interested me was doctors’



salary (all specialties included) in public health centres or hospitals.

Some doctors told me their salary was no more than USD200 per month.

I made inquiries because I couldn't believe it and found that in Russia, "medical doctors are included on the list of lowest-paid professions in the country". The average salary of a doctor in Russia is approximately 28,000 roubles a month (= 367 Euros ; USD 414). Many Russian doctors make even less than that. (1)(2)

"The doctors' profession hasn't left the top-10 least paid professions in the country for a few recent years (worse positions include only medical nurses, salespeople, secretaries and street cleaners). To get more, doctors have to work 1.5-2 times more than full-time, have additional jobs etc. Russian doctors have no time left for further training or self-education because of increased work loads. »(1)



Photo: The Kremlin, Moscow.

Based on data from the Russian Bureau of Statistics, the minimum wage in Russia is RUR 13,200 (=173 Euros ; USD 195) (against the

average wage of RUR 18,300 nationwide (= 240 Euros ; USD 270) and RUR 35,600 (466 Euros ; USD 526) in Moscow). Currently, 1 euro = 75 RUR and 1 USD = 67,700 RUB.(1)

I talked to a Russian patient who was aware of this problem. She told me that her government considers professions who take care of people (like medical professionals or teachers etc) as "people who work for charity", so they don't pay them properly.

This Russian patient also told me about consequences of this professional under-consideration: Russian doctors leave Russia to work in another country where they can earn enough money. The second option is to work for pharmaceutical laboratories. Indeed, my patient said laboratories pay proportionally to the number of prescriptions they do that include their products. Knowing that, my new friend didn't trust in any doctor and preferred taking care of her health by herself, as far as she could.

In conclusion, and to finish with more positive words, this break in my professional life made me understand and confirm how much I loved my job.

I can't deny that our work is hard sometimes, requires long working hours, a lot of patience, and faces injustices. But we also must keep in mind that injustice is everywhere and can touch any kind of job. In that state of mind, I prefer having a job like ours which is mostly noble, useful, close to people, interesting in an intellectual and social way... the list is still long.

This wonderful adventure is reaching its end. Soon, I will come back to my French life. How will it be? Maybe difficult, maybe not... All I know is that I will never regret this life experience. It was the dream of my life and I fulfilled it. Now, I need to find another one ;-)

But before going back to France, Istanbul!
Chloé

Photo: Gobi desert, Mongolia (below)



How students can change realities?

I will tell a brief history from some different students from south of Brazil. It is merged with my history. I am a medical student and like most students I have had a lot of concerns.

In 2010 in my first year at the Medical School I was disappointed. The University was not exactly what I expected: "a place to change lives and where I could practice my humanity". It was very biological with biochemistry, physiology, anatomy, etc. However, once each week I had the chance to experience the routine of a Health Basic Unit in the Brazilian Health System, the place for community based Primary Care in Brazil. Maybe this was a place that would prove to be exciting? Sadly, after one semester, it was just disappointing. Once, coming back from the university campus in the bus I discovered that I was not alone. My colleague was disappointed as well. To exemplify our experiences in a few words: the doctor said to the patient to do something (like eat less salt), the patient did not do it, so the doctor gave the instructions again, the patient did not listen again, and at the end of the consultation, doctor and patient were both frustrated.

We needed to plan a project that would enable us to find what we were missing in the community. We decided that we would like to go to the community to listen and learn (and maybe share and exchange something). So, in August of 2010, we started the Health Education League. An initiative of the junior medical students of the Universidade Federal do Rio Grande in the very south of Brazil. We wrote the project and structured our ideas in a week (we used all our time and energy for that). To get more people to participate in the project we stood after a biochemistry class to invite others to participate in a project that would go into the community, not to impose our knowledge, but with the aim of learning different realities. As you can imagine no one raised a hand. Anyway, we believed in the project, so we talked and convinced a few close friends that it was a good idea. After a while, we found a Family Medicine professor who decided to guide the project.

We decided to start with heavy theoretical meetings to discuss popular education, health promotion, health education history and community approach. We wanted to change the paradigms of our medical education, once, a student said: "our minds are like boxes that just store content: in the first year they put in Guyton,

Netter [medical books]; in the second year Bates(...). I wouldn't like to be a box anymore".

After one month, we started the practical activities with a meeting in the school of the Carreiros community with a Youth and Adult Education class. We decided to sit like a wheel and mix some students with community. We brought some brown paper and marker pens. We introduced ourselves and ask for them introduce themselves.



Photo: Students and Community

We started with a question: "What is health?" that we wrote on the brown paper. They started to say: "It is take vaccines", "It is have a good head" (referring to mental health), "It is take medicines", "do activities", "do not use drugs", etc. In the end, we have generally the same concept as the WHO of what health is, however it was not imposed, it was a construction.

The problem started when we did the second question of the day: "Why I do not go to the doctor". We wanted to do this question to address one of our anxieties about patient adhesion. It was almost a shot in the foot when we opened it for the community.

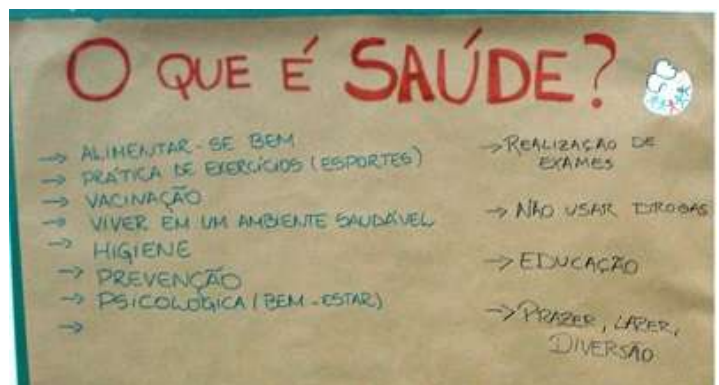


Photo: What is health?

The first reaction was anger. A man stood up and with his finger pointing at me asked: “are you here for money?”

I was totally in shocked, but I managed to react to say that I was there because I liked people. They started to say that doctors liked coffee more than people, that they do not care, that doctors do not look into the eyes of the patient, and a range of other disappointments. It was half-frustrating and half-encouraging. In the end, they had the power to choose what a “Health Education League” could offer them and we organized the project for the year.

The project grew and this is just the beginning of the history. We worked in communities in the very south of Brazil trying to empower them (and us) using Freire’s Popular Education. It was a great learning process.

Just to tell another achievement (and probably another long text to read) was the empowerment of a fishing community, more isolated from the city centre, and a community that almost do not have primary health care. After less than a year of the Health Education League working with them they decided to organize themselves to advocate for their right to health, for the implementation of a Health Basic Unit with a Brazilian Health Strategy.

I could write a book with all a range of histories ... actually, we wrote a book, community and students together, it is in Portuguese and it is called: “The Quilt: experiences of Health Education League” (A colcha de retalhos: vivências da Liga de Educação em Saúde) [available in Portuguese here](#):

Since beginning the project we changed the way that we understand medicine, medical education, empowerment and health communication. We used our creativity to create group dynamics and a constructive process of learning where “no one knew more than other, we just know differently” – like Freire said. We constructed ways that go from how to explain and share knowledge about hypertension to how discuss health rights.

In the beginning I got tired of listening “you are a dreamer” or “it will not work”. Now more than 100 students have experienced it and we have changed realities together with (and not for) community and students.

Photo above: Image from a dynamic made by a junior student to explain health communication



and medical relationship at the Health Education League Space.

The First Family Medicine Café

Also, in the coming days I am organizing the first Family Medicine Café. It will be an informal meeting on Google hangouts to chat about themes related to Family Medicine focusing on Rural Family Medicine. It will be a space to discuss and spread ideas of global FM. The idea is to put together practitioners from all around the world to talk about selected themes. The estimated duration will one hour and it will have

around five experts discussing the selected theme. The first meeting will be with me, Sarah Strasser, Amber Wheatley and Veronika Rasik.

Please check more information on [this link](#)

Mayara Floss
5th year medical student
Universidade Federal do Rio Grande, Brazil
[Blog](#) (Portuguese):
Twitter: @mayafloss

Conference news

WONCA Europe Istanbul programme announced

Scientific Program

Accreditation application for the CME credits are underway with The College of Family Physicians of Canada and EACCME.

22 October 2015

23 October 2015

24 October 2015

25 October 2015

[Click here for detailed program at a glance](#)

[Click here for detailed program](#)

	21 October 2015 Wednesday	22 October 2015 Thursday	23 October 2015 Friday	24 October 2015 Saturday	25 October 2015 Sunday
09:00-10:15	VdGM Pre-Conference PDE Courses	VdGM Pre-Conference	Symposia / Panel Brite / Workshops Oral Presentations Coffee Break	Symposia / Panel Brite / Workshops Oral Presentations Coffee Break	Symposia / Panel Brite / Workshops Oral Presentations Coffee Break
10:30-11:00		PDE Courses	Keynote Lecture Coffee Break	Keynote Lecture Coffee Break	Keynote Lecture Coffee Break
11:15-12:30			Symposia / Panel Brite / Workshops Oral Presentations	Symposia / Panel Brite / Workshops Oral Presentations	Symposia / Panel Brite / Workshops Oral Presentations
12:30-14:00		Registration	Lunch & Satellite Symposia	Lunch & Satellite Symposia	Awards & Closing
14:00-15:15		Workshops Oral Presentations Coffee Break	Symposia / Panel Brite / Workshops Oral Presentations Coffee Break	Symposia / Panel Brite / Workshops Oral Presentations Coffee Break	
15:30-16:45		Opening Panel	Grand Sessions Coffee Break	Grand Sessions Coffee Break	
17:00-18:15		Opening Ceremony	Symposia / Panel Brite / Workshops Oral Presentations	Symposia / Panel Brite / Workshops Oral Presentations	
18:15-20:00		Welcome Cocktail			

WONCA Europe conference is coming soon to Istanbul Download the full program [here](#)

Courses at the conference

There will be 13 different courses October 22nd between 09:00-12:30.

You can register one of the courses by sending email to wonca2015@k2-events.com

Due the capacity of the courses registration needs to be confirmed by the registration team.

You can see list of the courses [here](#)

Meet the speakers

Opening Panel

Future projections of general practice/family medicine in the context of health policies

Moderator: Prof. Dr. Job Metsemakers

October 22nd, 15:30 - 16:45, Halic Auditorium

Keynote Speaker - Prof. Amanda Howe

The tree bends when it is young - The value of flexibility and adaptability for the development of family medicine

October 23th, 10:30-11:00, Halic Auditorium

Keynote Speaker - Prof. Emin Kansu

Role of academia, science, ethics and mentor for the future of medicine

October 24th, 10:30-11:00, Halic Auditorium

Keynote Speaker - Prof. Jan De Maeseneer

What has changed in the role of family physician and general practitioner

October 25th, 10:30-11:00, Halic Auditorium

Istanbul program relevant to migrant care, international health and travel medicine

A few days ago we received the program for the WONCA Europe conference Oct 22-25 in Istanbul. As you know we will as the WONCA World Special Interest Group on migrant care, international health and travel medicine present two workshops there, on the health of refugee children and on migrant children. These will take place Friday 23 at 11.15 and Saturday 24 at 17.00. You can find this, and all other sessions that have a focus on migrant care in the information below.

I hope I will meet many of you there!

Best regards,

Maria

Dr. Maria E.T.C. van den Muijsenbergh
Convener WONCA SIG on migrant care,
international health and travel medicine

WONCA Europe 2015, Program relevant to migrant care, international health and travel medicine

Red means organised by SIG on migrant care, international health and travel medicine

Blue means very relevant

Thursday Oct 22nd

14:00–15:15 SYMPOSIUM - 51 SADABAT HALL
Indigenous and minority groups Issues and Health Outcomes
Tane Taylor

Friday Oct 23rd

09:00-10:15 SYMPOSIUM CONFERENCE - 1776 HALIC AUDITORIUM
The Future of Family Medicine - a Contextual View
50 Years From Now
Carl Steylaerts

09:00-10:15 CONFERENCE– 66

Issues, Challenges and way forward for Primary Care Research: A global Perspective
Waris Qidwai

09:00-10:15 BRITE KASIMPASA ROOM 1
Socio Economic Situations and Health Care
Veronica Rasic, Elle Mall Keevallik , Alexandra Georgious Tsipou, Emily Clark

09:00-10:15 WORKSHOP - 1695 CIBALI ROOM 2
WONCA Conflict and Catastrophe Special Interest Group
Rich Withnall, Tanja Pekez-Pavliško

11:15–12:30 SYMPOSIUM - 1775 HALIC AUDITORIUM

Making a World Book of Family Medicine
Carl Steylaerts, Mehmet Ungan

11:15–12:30 WORKSHOP - 220 MARMARA ROOM

European Forum for Primary Care (EFPC)
Workshop on Interprofessional Collaboration (IpC):
Communication and Language
Diederik Aarendonk, Kathryn Hoffmann, Jan De Maeseneer, Mehmet Akman

11:15–12:30 WORKSHOP -333 HASKOY ROOM WONCA SIG on Migrant care and international health

Health and Health Care for Refugee Children
Maria Van Den Muijsenbergh, Suzanne Gagnon, Anne Meynard, Pinar Doner, Rebecca Farrington

15:30–16:45 GRAND SESSION TOPHANE HALL

Patient centeredness and community centeredness: How to deal with diversity
Moderator: Andree Rochfort
Speakers: Thomas Freeman, Tina Eriksson

17:00–18:15 WORKSHOP - 22 BALAT ROOM

Primary care as a strategy to tackle health inequity in Europe
William Wong, Sara Willems, David Blane, Patrick O'Donnell

Saturday 24th Oct

09:00–10:15 WORKSHOP - 2272 BALAT ROOM
Health Literacy: Finding the right words for better health
Fatma Gökşin Cihan, Dursun Çadırcı, Didem Kafadar

11:15–12:30 WORKSHOP - 676 MARMARA ROOM

Equip
Health inequalities related to socio-economic status: how primary care may reduce them
Hector Falcoff, Sara Willems, Piet Vande Bussche, Isabelle Dupie

15:30–16:45 GRAND SESSION EYUP HALL

War, Immigrants and Ethnicity: Effects on Primary Care
Moderator: Niels Kristian Kjær
Speakers: Oana Sever-Cristian, John Yaphe

17:00–18:15 WORKSHOP - 676 KASIMPASA ROOM 5
Health inequalities related to socio-economic status: how primary care may reduce them
Hector Falcoff, Sara Willems, Piet Vande Bussche, Isabelle Dupie

17:00–18:15 WORKSHOP - 332 HASKOY ROOM
Migrant Care
Migration-related health disparities in immigrant children; the need for community oriented primary care and the role of the GP
Maria Van Den Muijsenbergh, Anne Meynard, Rebecca Farrington, Viviane Martinez Bianchi, Marwa Achmed, Guus Busser, Eldine Oosterberg

Sunday Oct 25th, 2015

09:00–10:15 SYMPOSIUM - 485 HALIC AUDITORIUM
How to implement guidelines and training initiatives in practice: learning from the RESTORE project
Christopher Dowrick, Christos Lionis, Erik Teunissen

11:15–12:30 PANEL – 2162 SADABAT HALL
Vaccination of the migrant child - a challenge
Sandra Adalgiza Alexiu, Daniela Ștefănescu, Dorica Sănduțu, Cristina Barbu, Gindrovel Dumitra, Dana Ștefana Popescu, Raluca Zoițanu, Anca Deleanu, Maria Lup

11:15–12:30 WORKSHOP - 93 KASIMPASA ROOM 3
Euract
Learning needs for cultural competence in family medicine, so to develop a teaching curriculum in culturally responsive healthcare for medical education in Europe
Jachym Bednar, Ruth Kalda, Elena Frolova, Francesco Carelli

11:15–12:30 WORKSHOP - 126 HASKOY ROOM
Dealing with intimate partner violence from a family perspective in different cultural contexts
Lodewijk Pas, Amanda Barnard, Lorraine Bacchus, Carmen Fernandez Alonso, Sylvie Lo Fo Wong, Nena Kopcovar, Joyce Kenkre, Tanja Pekez Pavlisko, Angela Taft, Abimbola Silva, Omneya El Sharif

SIG on Complexities in Health activities in Istanbul

The WONCA Special Interest Group on Complexities in Health will run three workshops at this year's WONCA Europe conference in Istanbul. Building on our successful previous workshops we invite this year's WONCA attendees to join our workshops on improved health delivery frameworks and primary care education conducted by Joachim Sturmberg, Bruno Kissling, Jim Price and Rick Botelho.

Come early to the workshops – our Lisbon workshop on Multimorbidity attracted so much interest that we had to turn people away. This workshop, to the great surprise of the presenters and participants, was also showcased at the daily conference review.

Workshops

October 22nd, 2015 09:00-12:30 COURSE - 1346 Kasimpasa room 3
Lead the Next Health Movement (Part 1 - 2): Become Health Coaching Buddies
Rick Botelho
Relevant links: [Part 1](#) and [Part 2](#)

October 22nd, 2015 14:00–15:15 WORKSHOP - 1298 Marmara room
Innovation for primary care. The development of an Optimal Care Delivery framework

Joachim Sturmberg, Bruno Kissling, Rick Botelho

October 23th, 2015 09:00-10:15 WORKSHOP - 319 Cibali room 1
Curiosity & Complexity in Primary Care and Health Education. A Complexity SIG workshop
Joachim Sturmberg, Carmel Martin, Jim Price, Bruno Kissling

SIG meeting

The SIG on Complexities in Health will hold a working group meeting - Thursday 23-Oct-2015, 12.45pm-1.45pm, Mamara Room. All interested participants are invited to join.

Agenda Items for SIG Discussion

1. Publish a Primer on Complexity Concepts for Health and Healthcare as a WONCA Publication
2. Use LINKED-IN as a social media platform to create a SIG learning community
3. Submit a series of submission on Complexity in Health for the 2016 World WONCA conferences in Brazil
4. Your ideas

Joachim P Sturmberg – Co-convenor of the SIG on Complexities in Health

WONCA Europe Conference 2016 newsletter



Europe is experiencing a humanitarian tragedy. Thousands of refugees and migrants are trying to escape war, fear and a ruined future. They have scars on soul and body and they need good family medicine. At the same time, European countries have fragile or socially deprived groups of citizens that are in high need for basic and comprehensive care by family doctors. Even more, some health care systems are in such a shortage of resources and funding that it threatens the delivery of fundamental health care for children and elderly people.

In addition, the WONCA Europe 2016 Conference welcomes abstracts for sessions that have this specific topic about inequality in health and [specific patient groups'](#) need for family medicine.

Now you have the possibility to register for WONCA Europe 2016 - please [click here](#) for registration

Abstract submission is also open, and please do not hesitate to submit your abstract - start submission [here](#)



The conference in Copenhagen 15-18 June 2016 will integrate the networks and special interest groups (SIGs) into the program, and we expect that many SIGs and networks are interested in playing a significant role in providing a valuable content. For more information about this special invitation to SIGs

and networks - please click [here](#)

The European general practitioners/family doctors all have a huge responsibility to support and be available for people in receiving basic medical care. Nobody else than these generalists know how to provide bio-psycho-social and high medical quality to the groups in most need. Still, how can we do that? How do we fill in appropriately and accountably this role as European family doctors?

Visit us in Copenhagen 15 - 18 June 2016

The WONCA Europe 2016 Conference in Copenhagen is proud to be able to enlighten this area with keynotes by Bernadette Kumar and Katherine Rouleau. We want to focus on the possible risk of increasing inequality in health and access to health care in Europe.



Please share WONCA Europe 2016 on Facebook with all your colleagues and friends. During this summer and autumn there will be even more to share, as we will be delighted to present our seven keynote speakers (inclusive Michael Kidd) and the main themes for our conference "*Family Doctors with heads and hearts*".

We wish you all a great summer.

(Sign up for our WONCA Europe 2016 newsletter [here](#))



Peter Vedsted
President of Scientific Committee

Roar Maagaard
President of Host Organising Committee



WONCA World conference 2016 call for abstract submissions - www.wonca2016.com



WONCA
2016 RIO
Family Medicine
Now, more than ever!
November 2 - 6, 2016
Riocentro - Rio de Janeiro, Brazil



OPEN SUBMISSIONS
Check the rules and schedule at:
www.wonca2016.com

We have three types:

Deadline: November 01, 2015

Scientific activities as workshops and round tables

Deadline: February 01, 2016

Oral presentations and posters
Cultural activities



WONCA
21st WONCA World
Conference of
Family Doctors
November 2 - 6, 2016
Riocentro - Rio de Janeiro, Brazil
Family Medicine
Now, more than ever!

Organized by



WONCA SBMEC

East Mediterranean Region News Feature

WONCA EMR workshop in Egypt

Date: September, 3, 2015

Venue: Center of Educational System International Cairo – Egypt

In close collaboration with Egyptian family medicine association, WONCA EMR president Dr Mohammed Tarawneh and WONCA EMR treasurer Dr Oraib Alsmadi participated in a workshop under the title “Support the role of specialized federation for health system improvement NGOs in the field of family medicine”



This workshop aimed to strengthen the role of civil societies in supporting family medicine specialty in Egypt, in addition to the MOH and Universities support, the workshop started with welcome speech by Dr Taghreed Farhat EFMA president , then Prof Wajidah Anwar the president of the specialized federation for health system improvement ,both addressed in their speech the importance of involving the large number of civil societies(thousands) exists in Egypt and working in different fields such as health and other fields to strengthen and increase the community involvement in health issues, they emphasized on the role of some health NGOs on universal health coverage education such as Egyptian society for

quality control, Egypt health society, integrated services society , Egyptian environmental society , where most of them belongs to the Ministry of social support.

The participants in the workshop represent different organizations such as government, individuals, civil societies, private sector and others. Dr Tarawneh addressed in his speech the role of WONCA in supporting such activities related to education and training. In addition Al-Razi Young Family Doctors president Dr Nagwa Nashat, demonstrate the movement objectives too.

The workshop also highlighted the importance of integrating the family medicine programs in undergraduate and postgraduate training programs, in addition to explain the role and activities conducted by the civil societies.



Mohammed Ibrahim Tarawneh (pictured speaking at the meeting), WONCA East Mediterranean Region (EMR) President



Al-Razi young doctors movement annual report

This annual report on activities to August 31, 2015, is provided by the convenor, Dr Nagwa Nashat (seated second front left in photo), for the Al Razi young doctors' movement of the WONCA East Mediterranean Region

Among the EMR region

It started with three countries (Egypt, Iraq And Kuwait) and six members and reached seven countries (Egypt, Iraq, Jordan, Kuwait, Lebanon, Palestine And UAE) with nearly 42 members.

The main group activities were:

- A monthly Skype meeting
- Member recruitment
- Al-Razi Bylaws developed and under revision and finalization
- A research about community acceptance to family physician treating mental illness is going on by Dr Mohamed Mosa by Dr Nagwa Nashat (pilot study has been done and validation of the questionnaire is done in the current time)
- Facilitate communication and present group themes through social media by creation of a [facebook group](#) and a twitter account @Alrazimovement

Egypt liaison activities:

Research methodology workshop:

It was conducted on 9/9/2014 by Egypt coordinator Marwa Mohaseb under the supervision of Al Razi convenor Nagwa Nashat and EFMA CEO Prof Taghreed Farahat. 25 young family physicians were recruited by addressing Menofiya health Director. An orientation about YDMs and Al Razi movement was presented, then an introduction to medical research lecture was made. After that they were divided into five small groups to work among family health care problems, how to prioritize and how to use research to solve it.

Celebration of the WONCA family doctor day:

It was done in collaboration with family medicine department and



Egyptian family medicine association (EFMA) by orientation session to the community about the role of family medicine in community and their importance.

Collaboration With MSSA

Based on Dr Garth Manning's input on collaboration with IFMSA, a contact had been made to Menofia students' scientific association (MSSA) which is part of the IFMSA to seek methods for collaboration through Mr Ibrahim Kandeel MSSA-Menofia president (2014-2015).

Workshops

Two workshops were held with score research team of MSSA for:

Quality indicators' workshop:

On Sunday 9th of August 2015 a workshop for MSSA undergraduate students in collaboration with the family medicine department and Egyptian family medicine association (EFMA) for quality indicators in primary health care where they had an introduction to quality. The lecturer was Dr Mohamed Fouda (a family practice quality specialist in the ministry of health and population). it was organized by Marwa Mohaseb and Nagwa Nashat



Research Workshop:

On Wednesday 26th of August a workshop for MSSA undergraduate students in collaboration with family medicine department and Egyptian family medicine association (EFMA) was held. It was about the basic medical research. A subsequent follow-up workshop will be held on Sunday 6th of September 2015

Internationally:

- Attending the YDM leads meeting
- Sharing in FM360 program

- Collaboration with other movements e.g:
 - Polaris in Balint 0.2 and #1WordforFamilyMedicine (creation of images for Egypt , Jordan and Palestine - see below)
 - Afriwon in a [research paper](#).



WONCA EMR 2016 call for abstracts



THIRD
Wonca FAMILY
EAST MEDITERRANEAN MEDICINE
CONGRESS

17 - 19 MARCH 2016
DUBAI | UNITED ARAB EMIRATES

Exciting opportunity to showcase your Research and be part of the Scientific Program at WONCA EMR 2016

The scientific committee of 3rd WONCA East Mediterranean Region Family Medicine Congress 2016 invites presenters worldwide to submit abstracts to be presented as Oral or Poster presentation at WONCA EMR 2016 being held on 17 – 19 March 2016 in Dubai, United Arab Emirates.

Abstract Topics Include:

- Health Policies and Management
- Ethical Issues
- Continuous Medical Education
- Research in family Medicine
- Quality and Accreditation
- Nursing in PHC
- Non-Communicable Diseases
- Communicable Diseases
- Mother and Child Care
- Geriatric Care
- Preventative Care and Health Promotion
- Women and Men's Health
- Palliative Care
- Abuse and Violence
- Musculoskeletal Health
- Clinical Audit
- Evidence Based Medicine
- Age Related Screening
- Undifferentiated Illness

[Submit abstract](#)

[Conference homepage](#)

WONCA Working Parties and SIGs

WONCA SIG on Health Equity news

Welcome to the WONCA Special Interest Group on Health Equity news. In this edition we would like to share with you our excitement towards the upcoming WONCA Europe conference where we have been invited to host a Health Equity workshop. In addition to this, our convener shares with us some interesting and related experiences this summer.

Save the date: SIG Health Equity Workshop in Istanbul

In the upcoming WONCA Europe Conference in Istanbul, due to take place on the 22nd-25th October, 2015, we will be conducting a Health Equity workshop. Here, we will assess the use of Primary care as strategy to tackle health inequities in Europe.

This workshop will enable the participants to:

- Understand trends in health inequity across Europe and European primary care systems;
- Reflect on the role of primary care in reducing health inequity;
- Consider specific actions that can be taken to improve health equity, based on experience in different countries.

We will be sending out details later regarding schedules and location. Keep a look out through our mailing list and blogs. We look forward to seeing you and hearing about all the different experiences and ideas.

As always we welcome contributions from anyone who shares the same interest in us in the strive for health equity. If there you have any interesting experience, or materials you would like to share, or you are interested in subscribing to our mailing list, feel free to direct your emails to: SIGhealthequity@wonca.net

Reflection: UCL Summer School on Social Determinants of Health (29/6- 3/7/2015)

During this summer, our convener was invited to UCL Social Determinants of Health Summer School run by Prof Marmot's Centre on Health Equity in London, which attracted 48 delegates from across the world including the USA, Europe and Asia. The summer school was opened with Sir Michael Marmot himself with presentations and discussions into the various aspects of social determinants of health.

Through interactive discussions the summer school highlighted the vast expanse of health equity right from biological and social foundations all the way to macro-level of global governance and health policies. Topics included a focus on health inequity of psychological stress, early childhood development, but also health equity in disability, and within gender and health.

"It was certainly very informative and stimulating. This summer school was very useful for me as the Convener of Health Equity Special Interest Group." - Dr William Wong

Image: Dr William Wong (Centre), with other members of the Summer School

Food for thought Discrimination and Health Equity

Our world, becoming ever more globalised brings about continuously changing dynamics between and within countries; shifts in cultural and societal dynamics are inevitable. Much evidence has shown that discrimination can be to disruptive psychological well-being (Schmitt et al 2014). Yet Williams et al, back in 2003 pointed out



a relationship between discrimination, specifically ethnic discrimination, on health: “Subjective experience of racial bias may be a neglected determinant of health and a contributor to racial disparities in health”

Their study, interestingly also highlight the lack of tools used to study racial discrimination. Linking this to clinical practise, Meeuwesen et al (2006) found that even in clinical practise, there were differences between consultations of Dutch doctors to Dutch and non-Dutch patients of ethnic minorities. Hence discrimination presents an important aspect which can impact health equity all over the world in local and contextual ways.

Meeuwesen et al.. (2006). Do Dutch doctors communicate differently with immigrant patients than with Dutch patients?. *Social Science & Medicine*, 63(), 2407–2417.

Schmitt et al.. (2014). The Consequences of Perceived Discrimination for Psychological Well-Being: A Meta-Analytic Review. *American Psychological Association*, 140(4), 921-948.

Williams, D. .R, Neighbors, H. .W & Jackson, J. .S. (2003). Racial/Ethnic Discrimination and Health: Findings From Community Studies. *American Journal of Public Health*, 93(2), 200-208.

Viewpoint

Gender and global health: evidence, policy, and inconvenient truths. Sarah Hawkes, Kent Buse

Gender is missing from, misunderstood in, and only sometimes mainstreamed into global health policies and programmes. In this Viewpoint, we survey the evidence for the role of gender in health status, analyse responses to gender by key global health actors, and propose strategies for mainstreaming gender-related evidence into policies and programmes...

...The exact contributions that sex and gender make to health status are often hard to disentangle and quantify, and “biological influences and social influences do not operate independently”. Moreover, they often interact with other social determinants of health...

...Drawing on the work of Lim and colleagues, who analysed the effects of 67 risk factors and clusters of risk factors for their disease burden and found the top 10 all to be more common in men, 13 we review two high burden risks (alcohol and unsafe sex)...

> [Download pdf version with more on upcoming events](#)

Featured Doctors

A/Prof Roar MAAGAARD

Denmark : President HOC, WONCA Europe conference Copenhagen 2016



Roar Maagaard from Denmark is president of the Host Organising Committee for the [2016 WONCA Europe conference](#) coming to Copenhagen in June. Next month he will talk about his hopes for the conference - here we find out more about him.

What work do you do currently?

Come October, I have been working as a GP for 27 years - and all years in my “second home” - the GP Practice in Skødstrup which is situated 15 km

north of the centre of Aarhus, Denmark. Aarhus is the second city in Denmark (after Copenhagen) and first of all Aarhus is the home of a very big and respected university - and also known to be the city of green wind technology.

Compared to Danish standards our practice is a bit unusual regarding the size of the practice: we have 12,000 patients on our list and we are eight GP partners, two trainee doctors and a staff of 11 people (nurses, clinical assistants/secretaries and a dietician) - the norm in Denmark is 1-4 doctors in a practice. In Denmark, a GP typically works in his practice for all active years as a GP - so the 27 years are in no way unusual. And the practice is my second home!

What is your philosophy regarding your practice situation?

You spend so many of your waking hours in the clinic, so it is very important to have good working conditions: cooperation with your colleagues should be good; the working environment physically/socially/psychologically must be good for all working in the clinic; and the premises should be spacious, nice, letting lots of light come into the premises! In this way the clinic gives good conditions for our patients and for all working in the clinic. The premises are owned by the doctors and we have prioritised these characteristics of good premises - and so it should be when it is your second home, I think.

Over the years, I have had other commitments as well as my daily work in the practice - but still, the most important part of my working life is the daily contact and continuity with my patients in Skødstrup. A perhaps slightly adopted quotation of Gandhi expresses it very well: "A patient is the most important person in our hospital. He is not an interruption to our work. He is the purpose of it. He is not an outsider in our hospital, he is part of it. We are not doing him a favour by serving him, he is doing us a favour by giving us an opportunity to do so." This is the motto for Bombay Hospital - but it also should go for every GP practice. And I think Gandhi also added: "the patients are our bread and butter".

The broad spectrum of reasons for the clinical encounter has my interest - and the continuity with patients I have known for all 27 years. And on top of that I have a special interest in palliative and terminal care. This interest began during my training in general practice where two charismatic tutors demonstrated their commitment to these important tasks for a GP - it was a huge inspiration to the young trainee doctor! I think dedicated help to palliative and dying patients is an essential task for us GPs. It can mean so much for the patients, for their relatives and it is also rewarding for the doctor himself. At least to me, it holds more meaning than minor changes to medication for hypertensive patients... not saying that this is not an important task, too. In Denmark, we have recently launched a new clinical guideline on palliative care in GP - and later this autumn an App for your mobile device should be ready on palliative care.

What other interesting activities that you have been involved in?

For 25 years I have been involved in medical education. The work has been on all aspects of medical education: from student education, to GP specialist training and to CME/CPD for GPs. I am a trainer in our GP practice but also responsible for training on a regional and national level. Much

inspiration has come from colleagues abroad too - especially through the European organisation for teachers in GP, EURACT. I have enjoyed being active in EURACT for many years and am still participating in the work, including ongoing developmental work on assessment of teachers funded as an EU (Leonardo da Vinci) project. I sometimes have fierce discussion with colleagues who talk about the "art of medicine". I do not like the word "art" in combination with our discipline! As a GP trainer I think the specialty of GP/FM can be taught, one must be trained - and after many years of practising, you might become a very good and skilful GP for your patients - but there is nothing artistic about it! To my opinion artists have some native artistic competencies - and you can bet that I do not have any artistic genes!

In Denmark, you have to be specifically trained to be a GP trainer. We emphasise to trainers how important the feedback is to the trainees on their clinical work - and that they should be aware of the fact that the trainers will be seen as role models. All surveys show what a great effect it has when a young doctor experiences a dedicated senior doctor/trainer. Good role models are the principal recruitment instrument for our specialty.

What are your interests as a family physician and also outside work?

I have explained some of my interests already, especially the educational work, but I also have had an interest in medical organisation matters. I was the chair of The Danish College for GPs (DSAM) for six years and experienced significant challenges in this work. I think cooperation among all medical specialties is very important (I don't see GPs as "we" and the other specialists as "them"), so I am on the board for the umbrella organisation for all Danish specialist doctors. On the international level I am now part of the Executive Board of WONCA Europe - and this gives me a good insight into the conditions that GPs face across Europe - and very few are as privileged as we are in Denmark.

Despite there being so little time outside my work interests, top priority is of course my family. When my children were smaller my wife and I tried to show them many places on the globe, and in that allow them understand that living conditions vary a lot around the world and hopefully also give them humility regarding the privileged conditions we have in northern Europe, and awareness about how we have to cooperate with all people on the globe. My children are now older and our first grandchild, Sigrid, arrived six months ago so she is now the top-top priority :) - she is surely the 'icing on the cake'.

Prof Rich WITHNALL

UK : Convener SIG Conflict & Catastrophe Medicine



Professor Rich Withnall MD MA MSc FRCGP CMgr is the convener of the newly formed WONCA Special Interest Group on Conflict and Catastrophe Medicine. Find out more about their [proposed activities here](#).

What work do you do currently?

I am currently the UK Defence Professor of General Practice & Primary Care. Having qualified in London (MBBS 1992), I now hold an MSc in Primary Care from the University of Birmingham, and an MA and Doctorate of Medicine from King's College London. I lead the Academic Department of Military General Practice at the Royal Centre for Defence Medicine, Birmingham, UK. My Department is embedded within the University of Birmingham, so my excellent team of Lecturers, Academic Research Fellows, Academic General Practice Specialty Trainees and Administrators benefit from collaborating with other military and civilian Professorial departments, especially nursing, anaesthetics & critical care, emergency medicine, surgery and trauma & orthopedics. My role is to sustain innovation and excellence in military General Practice (Family Medicine) in order to optimize medical support to deployed operations, maximize the number of UK Service personnel fit to undertake their jobs, and provide the best possible quality of advice to Commanders. We deliver this innovation through research, the development of new concepts and processes, exploitation of new technologies and the development of new curricula and guidelines. Although I love Academic General Practice, I still really enjoy my clinical sessions too!

What are the other interesting activities that you have been involved in?

I'm a Fellow of the UK Royal College of General Practitioners (RCGP) and a Chartered Manager; a member of RCGP Council; the RCGP Medical Director for International Accreditation and Training; the RCGP Lead for Non-NHS Revalidation (a 5-yearly process for all doctors registered the UK General Medical Council) and

an Academy of Medical Royal Colleges GP Specialty Advisor. I've been a GP Trainer since 2002, and an Examiner in the MRCGP examination (the UK licensing examination for all GP trainees, and one of the biggest Family Medicine examinations in the world) since 2005. I am on the Core Group for the MRCGP Clinical Skills Assessment, and have a particular interest in examination psychometrics and working with the Role Players.

How did you come to be the leader of the WONCA SIG on conflict and catastrophe medicine?

I've been lucky enough to work in over 20 countries, including remote and rural locations in the Balkans, Canada, the Middle East, Scandinavia, South America, the South Atlantic and West Africa. It's a huge privilege to learn from others' practices and cultures, but also sometimes humbling and saddening to see the 'Inverse Care Law' is still so prevalent in times of conflict and catastrophe.

The World Health Organisation, United Nations and individual Governments and Administrations have long advocated the global use of primary health care to raise the levels of health in deprived populations by acting upon social, economic and political causes of ill health. Despite wide-ranging initiatives (including: Health for All (2000); the Eight Millennium Goals (2000); the Crisp Report (2007); Health is Global (2008); Primary Care Now More Than Ever (2008); and the Tallinn Charter (2008)), I believe this ambition remains as important today as when it was crafted at Alma-Ata in 1978.

Population deprivation and health inequality may result from or be exacerbated by wars, revolutions and civil uprisings, terrorism, natural disasters and other humanitarian crises. Having been involved in global analyses of strategic trends that anticipated conditions that could widen global health inequality, I became more convinced than ever that coordinated General Practice/Family Medicine efforts in times of conflict and catastrophe are hugely important, as evidenced by the 2004 Tsunami, the 2005 Kashmir earthquake, the 2007 flooding in Central Africa, and the recent Ebola outbreak in West Africa and earthquake in Nepal.

After discussions with WONCA delegates in Basel and Prague, and fantastic support for my proposal

from Prof Michael Kidd, Prof Amanda Howe, Dr Garth Manning and the wider WONCA Executive, approval was granted for the establishment of the Special Interest Group in Conflict & Catastrophe Medicine (SIG C&CM). I am delighted that we now have engagement from General Practitioners/Family Medicine Doctors in 15 countries spanning all WONCA regions, but new SIG C&CM members are always welcome... [click here to join.](#)

What are your interests outside work?

Family time is very important. I am lucky to have a supportive wife who is Matron at King's St Albans School, Worcester. We are blessed with a daughter and a son. I used to do a lot of sport, mainly swimming and rugby. Although my mind is still willing, my body is less so! Instead, I have

season tickets at Kingsholm, home to the Premiership side 'Gloucester Rugby' where one of my General Practitioner friends is a club doctor. I really enjoy spending Saturday afternoons with my son watching 'the Cherry and Whites' at one of the most atmospheric rugby grounds in England, then Sunday mornings watching him play for Bredon Star Rugby Club. My daughter is an accomplished rider, so we spend a lot of family time at the stables, or proudly watching her compete in One Day Events with her horse, Pedro. In the quieter moments, I enjoy fly-fishing, although I'm usually outwitted by brown trout. I also like music. I'm a reasonable pianist, but progress in trying to teach myself the guitar is disappointingly slow!

RESOURCES

CFPC releases "Fundamental Teaching Activities in Family Medicine: A Framework for Faculty Development"

Dear Colleagues:

It is with great pride that the College of Family Physicians of Canada (CFPC) releases its latest resource: *Fundamental Teaching Activities in Family Medicine™: A Framework for Faculty Development (FTA Framework)*.

The FTA Framework was designed to support clinical teachers while they provide quality family medicine education in Canada. Authored by the Working Group on Faculty Development, a subcommittee of the Section of Teachers, and chaired by Dr Allyn Walsh, the FTA Framework:

- Describes the roles and responsibilities of teachers in family medicine
- Acts as a road map to guide self-reflection and continuing professional development
- Assists programs, departments, and faculty members in developing curricula for faculty development
- Serves as an organizational framework for family medicine faculty development materials, tools, and strategies, both locally and nationally

Intuitive in its language and practical in its approach, the FTA Framework describes what teachers actually do and helps them to consider ways to expand and enhance their teaching activities. With the implementation of the Triple C Competency-based Curriculum and other undergraduate, postgraduate, and continuing professional development educational initiatives, the CFPC recognizes that supporting clinical teachers is a priority for the organization. It is the CFPC's hope that *Fundamental Teaching Activities in Family Medicine: A Framework for Faculty Development* will become an essential resource for all who have a role in family medicine education. If useful for your own organization, we would be pleased to discuss ways to adapt it for your own context.

You can read and download the FTA Framework at www.cfpc.ca/FTA. Please share this link and the document widely with your colleagues. If you have specific inquiries, please contact us via email at fta@cfpc.ca

Sincerely, Garey Mazowita, Francine Lemire, Allyn Walsh
- [See more](#) [français](#)

Español

Del Presidente Octubre 2015: perspectivas sobre Irán



Foto: El presidente de WONCA con un grupo de voluntarios de asistencia en salud en el centro de Asistencia Primaria de Torab, en el centro de Teherán.

La doctora Samira Pouryosefi es un médico de familia que trabaja en el centro de salud rural Zarnan en la República Islámica de Irán. Como jefe de su equipo local de Atención Primaria de salud, Samira es responsable de la salud y el bienestar de más de 4.700 personas que viven en su pueblo rural y la región circundante. Samira también trabaja con los profesionales de la salud comunitarios, llamados behvarz, que dirigen las pequeñas clínicas, también llamadas casas de salud, en los pueblos rurales de los alrededores.



Foto: Médico de familia, Doctora Samira Pouryosefi (derecha) en su clínica en el centro rural de salud de Zarnan en la República Islámica

de Irán (con el médico de familia y representante de la OMS de Irán, Dr Jihane Tawilah).

Me encontraba en Irán como miembro de una misión de la Organización Mundial de la Salud (OMS), examinando la integración de los servicios de asistencia con la educación médica en todo el país. Como parte de la misión tuve la oportunidad de visitar la capital Teherán, en el norte de Irán y rodeada por los montes Elburz, la ciudad de Mashhad, construida sobre una parada en el camino de la Ruta de la Seda y muy conocido por

la tumba del Imam Reza, visitada cada año por millones de peregrinos, la antigua ciudad de Isfahan, capital de Persia en el pasado, designada por la UNESCO como Patrimonio Mundial a causa de sus espectaculares ejemplos de arquitectura iraní e islámica con palacios, mezquitas y puentes y un buen número de poblaciones rurales a su alrededor.



Foto: Interior de la mezquita de Imam Reza en Mashhad

Irán tiene una población de 78 millones de personas, con unos 12 y medio que viven en la capital Teherán. Es el decimoctavo país más grande del mundo y uno de los países más

montañosos. Un 30% de la población vive en las áreas rurales.

El éxito de la cobertura de Atención Primaria en Irán es muy conocido a nivel mundial. Irán es uno de los países que ha abordado con éxito la cobertura universal de salud por medio de la formación y el apoyo de una red nacional de profesionales en comunitaria, conocidos en la lengua persa como behvarz. Los behvarz provienen de las comunidades cuyo trabajo principal es el de hacer de enlace entre la población y los médicos y enfermeras que trabajan en los pequeños centros de salud local. Cada behvarz trabaja desde una pequeña clínica llamada Casa de Salud que se encuentra en los pueblos de reducido tamaño. Hay 14.000 Casas de Salud en el país.

Algunos de ellos trabajan solos, otros en parejas, a menudo son equipos de marido y mujer. Su trabajo se focaliza especialmente en la salud materna e infantil, programas de vacunación, prevención de enfermedades infecciosas, saneamiento, primeros auxilios y planificación familiar. Los behvarz conocen a todo el mundo de su comunidad local, llevan a cabo visitas en las casas para ver a los recién nacidos, los ancianos y los discapacitados, y registran los casos en el registro que guardan en cada Casa de Salud, conocido como El Horóscopo de la Salud, que proporciona una descripción rápida, actualizada y fácilmente actualizable del estatus sanitario de todas las personas de cada comunidad. Entre los años 1984 y 2000 Irán consiguió reducir a la mitad su mortalidad infantil, aumentar las tasas de inmunización de un 20% hasta más de un 95% e implementar un programa muy efectivo de planificación familiar. Los servicios sanitarios públicos son gratuitos. Para extender el trabajo de los behvarz a las áreas rurales, el gobierno de Irán ha creado un programa de voluntarios de la salud en sitios urbanos, la mayoría de ellos mujeres, llamados Davtalab Salamat (el término Farsi persa por Puente de Salud). Los voluntarios trabajan con los miembros de las comunidades locales, situadas fuera de los centros de salud urbanos.

Irán también es famoso por haber integrado la educación médica con el sistema de salud pública. En 1985 el país creó un único Ministerio de Salud y Educación Médica. El Rector de cada universidad de ciencias médicas del país es el responsable no solo de la educación de profesionales de la salud y de investigación médica sino que también lo es de los servicios de asistencia de la región que le ha sido designada. Esto permite una mayor integración entre las funciones de las universidades y los servicios

sanitarios, comparada con la que existe en muchos otros países. Algunos de los rectores son responsables de los servicios de asistencia sanitaria proporcionados a más de 5 millones de personas.



Foto: La Behrvarz Samantha Amir-Torbati y el behrvarz Mohammad Eahgh, en su casa de salud rural a las afueras de la ciudad de Mashhad (ver el Horóscopo de Salud en el muro de detrás).

A medida que las medidas de asistencia de la salud han crecido, Irán ha reconocido la necesidad de fortalecer la Asistencia Primaria mediante la creación de la especialidad de Medicina de Familia, y WONCA está proporcionando asesoramiento al país para que desarrolle una formación adecuada para el personal de medicina de familia. La ausencia de una especialidad reconocida en Medicina de Familia ha significado que la mayoría de graduados en medicina se han estado formando para convertirse en especialistas hospitalarios y sub-especialistas. La alta demanda de servicios de salud en los hospitales de enseñanza, y la propia auto-referencia, ha llevado a una excesiva demanda a los servicios clínicos hospitalarios, largas listas de espera y creciente costes de salud pública. Al mismo tiempo la prevención y el manejo de las condiciones de salud crónicas no ha sido la óptima. Al igual que en muchos países, la Medicina de Familia es reconocida como la solución a estos desafíos del sistema de salud público. La presidenta electa, Amanda Howe, visitado recientemente Irán, también con la OMS, para colaborar con el desarrollo de la formación de postgrado en Medicina de Familia. Irán aún no es un miembro de WONCA pero estaremos encantados de dar la bienvenida a nuestros colegas de Irán a la familia.

Ha sido interesante estar en Irán justo cuando las Naciones Unidas han anunciado un acuerdo nuclear que podría ser el primer paso al levantamiento de las sanciones impuestas ya hace mucho tiempo. Reconozco que estaba un

poco nervioso al visitar Irán, especialmente cuando me comentaron que tendría que disponer de un entrenamiento avanzado de seguridad de la Naciones Unidas. Una vez en Irán, me sentí bienvenido y a salvo. La gente que conocí fue muy hospitalaria, amistosa y amable. Las ciudades estaban limpias y verdes. La herencia cultural es remarcable y disfruté mucho aprendiendo sobre la historia del país. Tardé dos días en darme cuenta que mi grupo iba acompañado de un discreto equipo de seguridad formado por una pareja de oficiales militares paramédicos que nos seguían siempre en una ambulancia mientras nosotros cruzábamos el país.

Foto: El presidente de WONCA recibiendo el formulario de inscripción del doctor Faramarz Rafiee de la Sociedad Iraniana de Médicos de Familia con el doctor Saeed Taammali, asesor general del Ministerio Iraniano de salud y Educación Médica.



Michael Kidd
WONCA President

Traducción: Pere Vilanova, Spanish Society of Family and Community Medicine (semFYC) - Periodismo y comunicación

Del Presidente Setiembre 2015: WONCA y los nuevos objetivos de las Naciones Unidas para el Desarrollo Sostenible

"Con el fin de promover la salud física y mental, y el bienestar, así como para aumentar la esperanza de vida de todos, tenemos que lograr la cobertura universal de salud y el acceso a una atención sanitaria de calidad."

Organización de Naciones Unidas. La transformación de nuestro mundo: la Agenda 2030 para el Desarrollo Sostenible

Recientemente he estado en Natal, en el noreste de Brasil, reuniéndome con los miembros la Sociedad Brasileña de Medicina Familiar y Comunitaria, miembro de WONCA, y hablando en el 13 Congreso Nacional de la Sociedad.

Estos últimos años he visitado frecuentemente Brasil y otros países de Centro y Sudamérica, estoy muy impresionado con el trabajo que nuestras organizaciones miembros de WONCA están haciendo en esta parte del mundo, sobre todo para garantizar la calidad y la equidad en la medicina de familia para las poblaciones de estos países.

La cobertura universal no significa satisfacer las necesidades del 60% o 80% o 90% de la población, sino que significa hacer frente al desafío de asegurar que la asistencia sanitaria está disponible para todos. Brasil es uno de los

países líderes del mundo en el fortalecimiento de la Medicina de Familia asegurando que la asistencia sanitaria está disponible para todas las personas. Brasil se ha convertido en un importante líder mundial en la oferta de cobertura universal de salud a través del conocido modelo de los equipos compuestos por profesionales de la Medicina de Familia, enfermeras y trabajadores de la salud de la comunidad. Cada uno de ellos presta una atención en equipo completa basada en la clínica y en el hogar para una población específicamente definida.

En la actualidad hay cerca de 40.000 equipos de Medicina de Familia en funcionamiento en la globalidad de Brasil. Es un modelo impresionante la cualidad del cual espero que muchos de nuestros colegas de todo el mundo sean capaces de comprobar cuando asistan en noviembre del próximo año a nuestra conferencia mundial WONCA que tendrá lugar en Río de Janeiro.

Creo que hay esperanza para la salud mundial viendo que países de todo el mundo, al igual que Brasil, han tomado conciencia de la importancia de fortalecer la Atención Primaria y del papel del Médico de Familia. Tanto tú como y yo sabemos que la medicina de familia tiene el poder de transformar la conformación de las sociedades.

Foto: El presidente de WONCA con los jóvenes médicos de familia miembros de la Sociedad Brasileña de Medicina de Familia y Comunitaria

2015 es un año clave en la salud mundial ya que representa el final del periodo de cumplimiento de los Objetivos de Desarrollo del Milenio. En septiembre de 2015, a las Naciones Unidas se les pedirá que adopten los 17 nuevos Objetivos de Desarrollo Sostenible. Solo hay un objetivo específico respecto a la salud, el número 3:

"Asegurar una vida sana y promover el bienestar para todo el mundo en todas las edades." Pero cada uno de estos 17 objetivos tiene un impacto en la salud mundial, en sus individuos y en sus comunidades

El documento que se ha mandado a Naciones Unidas para su aprobación en septiembre se llama Transformando nuestro mundo: la Agenda 2030 para el Desarrollo Sostenible. En el preámbulo de dicho documento se puede leer:

"Este Programa es un plan de acción para las personas, el planeta y la prosperidad. Asimismo, se pretende fortalecer la paz universal en una mayor libertad. Reconocemos que la erradicación de la pobreza en todas sus formas y dimensiones, incluyendo la pobreza extrema, es el mayor desafío mundial y una condición indispensable para el desarrollo sostenible.

Todos los países y todas las partes interesadas, actuando en asociación colaborativa, implementarán este plan. Estamos decididos a liberar a la raza humana de la tiranía de la pobreza y la necesidad, y a sanar y proteger nuestro planeta. Estamos decididos a tomar las medidas audaces y transformadoras necesarias con urgencia para cambiar el rumbo del mundo hacia una senda sostenible y resistente. Al embarcarnos en este viaje colectivo, prometemos no dejar a nadie detrás.

Los 17 Objetivos de Desarrollo Sostenible y los 169 propósitos demuestran el tamaño y la ambición de esta nueva agenda universal. Con ellos se trata de construir sobre la base de los Objetivos de Desarrollo del Milenio y completar así lo que éstos no alcanzaron. Tratan de hacer realidad los derechos humanos de todos y lograr la igualdad de género y el empoderamiento de las



mujeres y las niñas. Son integradores e indivisibles y ejercen como fuerzas equilibradoras de las tres dimensiones del desarrollo sostenible: la económica, la social y la ambiental."

El documento de las Naciones Unidas se centra en las personas, el planeta, la prosperidad, la paz y la colaboración. Afirma que, "Pretendemos un mundo libre de pobreza y hambre, de enfermedades y necesidad, donde toda vida pueda prosperar, un mundo libre de miedo y violencia. Un mundo con la alfabetización universal. Un mundo con acceso universal y equitativo a una educación de calidad a todos los niveles, a la atención sanitaria y a la protección social, en que el bienestar físico, psicológico y social esté asegurado. Un mundo en el que reafirmamos nuestros compromisos con respecto al derecho humano al agua potable y al saneamiento y donde se mejore la higiene; y donde la comida sea suficiente, segura, asequible y nutritiva. Un mundo donde los hábitats humanos son seguros, resistentes y sostenibles y donde hay un acceso universal a la energía asequible, responsable y sostenible."

Quiero compartir con ustedes los elementos de esta nueva estrategia de las Naciones Unidas que se centran en la salud. El documento reconoce que "las amenazas globales de salud, la previsión de mayores y más intensos desastres naturales, los conflictos cíclicos del extremismo violento, el terrorismo y las crisis humanitarias que comporta y el desplazamiento forzado de personas amenazan con revertir muchos de los avances de desarrollo en las últimas décadas."



Llamada de las Naciones Unidas para el Desarrollo Sostenible

Así mismo, reconoce que con los Objetivos de Desarrollo del Milenio "el progreso ha sido desigual, especialmente en África, en los países menos desarrollados, en aquellos que se encuentran en desarrollo pero carecen de salida al mar, de igual forma que en los pequeños estados insulares en vías de desarrollo. Además, algunos de los Objetivos de Desarrollo del Milenio siguen sin cumplirse, en particular aquellos relacionados con la salud materna, la de los recién nacidos y la salud infantil y reproductiva."

Concretamente, en lo que a la salud respeta, el documento afirma que, "Para promover la salud física y mental y el bienestar, y para prolongar la esperanza de vida para todos, tenemos que lograr la cobertura universal de salud y el acceso a una atención sanitaria de calidad. Nadie puede ser dejado atrás. Nos comprometemos a acelerar los progresos realizados hasta la fecha en la reducción de la mortalidad materna, infantil y de los recién nacidos poniendo fin a todas esas muertes evitables antes de 2030. Estamos comprometidos a garantizar el acceso universal a servicios de salud sexual y reproductiva, incluyendo la planificación familiar, información y educación. Del mismo modo, vamos a acelerar el ritmo de los progresos realizados en la lucha contra la malaria, el VIH / SIDA, la tuberculosis, la hepatitis, el ébola y otras enfermedades y epidemias contagiosas, abordando la creciente resistencia a los antibióticos y al problema de las enfermedades desatendidas que afectan a países en desarrollo. Estamos comprometidos con la prevención y el tratamiento de las enfermedades no transmisibles, como los trastornos de comportamiento, de desarrollo y neurológicos, que constituyen un gran desafío para el desarrollo sostenible." Estos compromisos sólo podrán realizarse mediante la implementación fuertes sistemas de atención primaria en todos los países.

El documento también identifica con precisión la importancia del medio ambiente en la salud humana y el bienestar, y pone el énfasis en la necesidad de "reducir los impactos negativos de las actividades urbanas y de los productos

químicos que son peligrosos para la salud humana y el medio ambiente, en particular mediante la gestión ambientalmente racional y segura de los productos químicos, la reducción y el reciclaje de los residuos y el uso más eficiente del agua y la energía".

Y es necesario recordar que no podemos tener prosperidad sin "tener una fuerza de trabajo saludable y bien educada con el conocimiento y las habilidades necesarias para el trabajo productivo y gratificante y la plena participación en la sociedad."

El documento incluso identifica al deporte como "un importante factor de desarrollo sostenible. Reconocemos la creciente contribución del deporte a la realización del desarrollo y la paz en su promoción de la tolerancia y el respeto y la contribución que hace a la autonomía de la mujer y de los jóvenes, las personas y las comunidades, así como la salud, la educación y los objetivos de inclusión social."

Estas son las ambiciones atrevidas, y como ciudadanos del mundo, los médicos de familia debemos desempeñar nuestro papel en la implementación de los Objetivos de Desarrollo Sostenible. La asistencia centrada en la persona es un componente básico de la cobertura universal de salud, y la Medicina de Familia tendrá un peso cada vez mayor en los próximos años en cada país para asegurar que esto suceda. Este movimiento global proporcionará oportunidades muy bienvenidas que fortalecerán el papel de la Medicina de Familia y la Atención Primaria en todos los países, y el importante trabajo que hacemos como médicos de familia que apoyan la salud y el bienestar de nuestros pacientes, sus familias y nuestras comunidades.

Michael Kidd
Presidente de WONCA

Traducción: Pere Vilanova, Spanish Society of Family and Community Medicine (semFYC) - Periodismo y comunicación

Fragmentos de política de Amanda Howe Setiembre 2015: Género y salud – una agenda más equitativa



Este mes me ha llegado una publicación de los compañeros de Holanda y me ha recordado los motivos por los cuales me involucré en WONCA en los años 90. La publicación hace hincapié en algunas áreas importantes que representan retos clínicos comunes para los médicos de familia – pacientes que son víctimas de maltratos físicos y psicológicos, problemas de salud mental, y múltiples síntomas que carecen de explicación – así como principios generales de estilos de vida y promoción de la salud, cardiopatías, tratamientos de drogodependencia, diabetes, sexualidad y violencia doméstica. La sección 2 me ha parecido una actualización muy interesante puesto que me ha recordado las distintas epidemiologías y necesidades de los hombres y mujeres en sus etapas vitales. Sería una fuente fantástica para los miembros que necesitan hechos claros, ya que en ella se expone también la evidencia, y intenta llenar los huecos en las investigaciones.



La profesora Toine Lagro-Janssen (foto), que ha desarrollado un trabajo erudito excepcional y ha defendido durante toda su carrera las cuestiones de género tanto en la salud como en el trabajo, colega académico del profesor Chris van Weel, nuestro último presidente, es quien

suscitó mi interés en la publicación. Le pedí a Toine que hiciera comentarios sobre el informe y sus implicaciones para nuestros miembros a nivel internacional. Ella comenta que "Esta Agenda de Género y Comprensión ha sido elaborada en nombre de la alianza de Género y Salud en colaboración con un gran número de expertos profesionales de la salud y con el mundo académico, así como con la contribución significativa de los médicos relacionados con los Estudios de la Mujer del Departamento de Atención Primaria en Nijmegen.

Explorando las diferencias entre hombres y mujeres en materia de salud, siendo cada vez más efectivos en el tratamiento de la enfermedad, podemos aumentar el potencial para mejorar la

calidad de vida y al mismo tiempo reducir los costes innecesarios en salud. Un enfoque biopsicosocial, tan común en la práctica general y la medicina personalizada, será beneficioso para los logros alcanzados en la medicina con perspectiva de género. Los datos de la investigación con perspectiva de género confirman lo importante que es mantener la búsqueda de la igualdad para optimizar los resultados de la investigación en salud. Como resultado de la equidad deberían aplicarse tratamientos distintos para mujeres y hombres. "

WONCA se ha organizado para examinar y cuestiones de primer orden en el campo del género y la salud - el Grupo de Trabajo WONCA sobre la Mujer y Medicina de Familia (WWPWFM) ha trabajado en esto, y el Comité de Equidad Organizacional aspira a hacer un trabajo de introspección con el fin de determinar nuestro nivel de concienciación en cuestiones de equidad, incluidas las cuestiones de género. Tenemos muchos colegas académicos que estarán interesados en las conclusiones acerca de las prioridades necesarias en investigación. También tenemos el SIG en Desigualdades en Salud, que seguro que encontrará este informe muy relevante desde el punto de vista del paciente. Hemos vinculado el informe como una fuente de información en nuestro sitio web.

Pero para aquellos de ustedes que no dispongan del tiempo para poder leerlo intentaré identificar los puntos que me parecen más importantes. Como generalistas y médicos de familia nos enorgullecemos de ser capaces de atender a las personas de todas las edades y con diferentes necesidades de salud. Sin embargo, nosotros mismos estamos influenciados por nuestras preferencias, experiencias y contextos socio-culturales. Este informe es un recordatorio oportuno de algunas áreas clínicas clave y presenta cual es la prevalencia del género en éstas. Debería poner al corriente nuestras actividades clínicas, académicas y políticas. ¡Leed y aprended!

Amanda Howe
Organización Mundial de Médicos de Familia

Fragmentos de Política de Amanda Howe Agosto 2015: El personal moderno de Atención Primaria



Recientemente he participado en una comisión independiente para hacer recomendaciones acerca del personal que trabaja en Atención Primaria en Inglaterra. Para aquellos que no estén familiarizados con esta manera de trabajar, se trata de solicitar a un grupo de expertos a que analicen y evalúen pruebas y luego informen a los llamados 'comisionados' – generalmente a un departamento gubernamental o a un organismo profesional. Ésta es una manera de conseguir una opinión independiente enfocada en la estrategia de conseguir nuevas ideas mediante las cuales las opiniones entran en conflicto. En concreto, esta comisión se creó en respuesta a las crecientes preocupaciones sobre la desinversión en medicina de familia y la contratación de personal e infraestructuras... El informe dice que La inversión en la Atención Primaria ha caído muy por debajo de la inversión en los hospitales, a pesar de las expectativas de demanda laboral que van a tener que cubrirse en la AP. Entre 2003 y 2013 el número de consultas en el hospital aumentó un 48% mientras que la contratación de médicos aumentó solo en un 14%. En realidad el número de médicos en relación con la población ha ido disminuyendo desde 2009, con el aumento de los problemas de contratación y retención.

El trabajar en la comisión supuso una gran cantidad de esfuerzo y tiempo, pero resultó muy interesante el hecho de dejar examinar las propias ideas por parte de otros colegas con otras áreas igual de críticos e inteligentes (enfermeros, farmacéuticos, profesionales de salud pública y diseñadores de políticas). Reunimos y leímos pruebas, tuvimos personas que hablaron de su experiencia y contestaron preguntas, y se hicieron visitas en toda Inglaterra. El informe consta de más de 50 recomendaciones detalladas y se publicará oficialmente en septiembre. Las áreas clave que creo que serán interesantes para los colegas de WONCA son, en primer lugar, la declaración política de que es necesario que haya suficiente personal con una preparación adecuada para realizar el trabajo necesario en Atención Primaria y que los miembros de este personal han de tener las habilidades para evaluar las distintas tareas que se realizan y tienen que sentirse respaldados para mejorar los sistemas en los que trabajan.

Aun así, no se llegó a decir cuántos médicos, enfermeros o otros asistentes en salud y

administración son realmente necesarios por persona, porque sabemos que de algunas prácticas hay una demanda mucho mayor que de otras, y también que la configuración de las plantillas es muy diferente en función de los distintos contextos. Por ejemplo, en un interesante viaje que recientemente he realizado a Irán, vi el excelente servicio prestado a las comunidades rurales por el grupo de trabajadores de la salud conocidos como behvarz, que son contratados a nivel local y combinan una serie de funciones preventivas, educativas y exigentes tareas de diagnóstico. En una de nuestras visitas al Reino Unido, vimos una práctica en que las enfermeras dirigían a los médicos, estos últimos solamente trataban a los pacientes que ellas les derivaban: pero también vimos una asistencia comunitaria importante por parte de doctores que hacían todas las primeras evaluaciones de los pacientes (tras una conversación telefónica o un correo electrónico) a los miembros del equipo de acuerdo con la relevancia y la preferencia.

Aconsejamos que todos los equipos de Atención Primaria fueran susceptibles de beneficiarse de las siguientes categorías del personal:

- Medicina de Familia, Médicos de Cabecera con posgrado y formados
- Enfermeras de Atención Primaria
- Asistentes de salud (formación básica, pero capaz de hacer tareas específicas y ayudar a otros miembros del personal)
- Administrativa y personal directivo
- Y fuertes vínculos locales con otras personas que puedan ayudar a nuestro trabajo de asistencia en urgencia y emergencia ("paramédicos"): los cuidados paliativos a nivel de la comunidad: los farmacéuticos que dan servicios específicos para la revisión de los medicamentos a los pacientes con necesidades complejas, y a nivel de intervenciones de atención social y comunitaria.

También nos preocupa mucho la falta de una estructura de carrera para el personal de Asistencia Primaria. La diversidad de marcos no

debería significar que el desarrollo profesional y el apropiado respaldo y preparación se deje de lado en el entorno de la Atención Primaria, sea pública o privada. Muchos trabajadores nos comentaron que una de las razones por las cuales un buen número de médicos o de profesionales de otras especialidades son reacios a trabajar en Atención Primaria es porque no podían estar seguros del desarrollo de sus roles, de estar actualizados con regularidad y de su desarrollo personal en un futuro. La atención a CPD y a los estándares educativos de WONCA cobra aquí una especial importancia, en la medida que más y más países desarrollan sus plantillas de AP.

El otro “gran tema” trataba sobre la redimensión y “seguridad y cifras”. Muchos equipos comprobaron que, cuando se podía colaborar con una comunidad, se conseguía una mayor revitalización y flexibilidad – conversaciones con colegas, compartir guardias, cubrir vacaciones, y organizar formación a veces recibían el apoyo entre clínicas. Además, en los nuevos servicios, miembros del personal sénior compartían a través de prácticas y se intercambiaban las responsabilidades de supervisión con los estudiantes, los residentes y aquellos recién llegados a la zona. Este hecho parece estar ayudando la contratación y el

desarrollo educacional. Algunos de estos intercambios se hicieron mediante correo electrónico o Skype, especialmente en las áreas rurales. El viejo dicho una carga compartida es la mitad de una carga parece haber sido de ayuda. Así que debemos pensar con quien podemos trabajar y pedir asesoramiento, y así reducir el aislamiento profesional y las demandas prácticas.

Espero que cuando se haga público el informe completo sus conclusiones van a dar más en lo que pensar. Mientras tanto – pensad en grande: explicad a vuestros gobiernos que la inversión en Atención Primaria les va a ser útil y será buena para el bienestar de la gente – y si aún no trabajáis en equipos consideradlo. Todos los países lo están debatiendo y espero esto va a estimular y aportar información a vuestros propios debates.

Amanda Howe,
Organización Mundial de Médicos de Familia
(World Organization of Family Doctors, WONCA)

Traducción: Pere Vilanova, Spanish Society of Family and Community Medicine (semFYC) - Periodismo y comunicación

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