WONCANews

Vol 42, Number 7 : August 2016

www.globalfamilydoctor.com

Contents

WONCA President
Prof Michael Kidd AM
Faculty of Health Sciences, Flinders University
GPO Box 2100, Adelaide SA 5001, Australia
Tel: +61 8 8201 3909
Fax: +61 8 8201 3905
Mob: +61 414 573 065
Email: President@WONCA.net
Twitter @WONCApresident
LinkedIn WONCA president
Facebook Michael Kidd - WONCA president

WONCA Chief Executive Officer
Dr Garth Manning

WONCA World Secretariat
World Organization of Family Doctors
12A-05 Chartered Square Building,
152 North Sathon Road,
Silom, Bangrak, Bangkok 10500, THAILAND
Phone: +66 2 637 9010
Fax: +66 2 637 9011
Email: admin@WONCA.net

President-Elect
Prof Amanda Howe (United Kingdom)

Executive Member at Large & Honorary Treasurer Dr Donald Li (Hong Kong, China

Executive Member at Large & WHO Liaison Person
Dr Luisa Pettigrew (United Kingdom)

Executive Member at Large
Dr Karen Flegg (Australia)

Regional President, WONCA Africa
Dr Matie Obazee (Nigeria)

Regional President, WONCA Asia Pacific
Prof Jungkwon Lee (South Korea)

Regional President, WONCA East Mediterranean
Mohammed Tarawneh (Jordan)

Regional President, WONCA Europe
Prof Job FM Metsemakers (Netherlands)

Regional President, WONCA Iberoamericana-CIMF
A/Prof Inez Padula (Brazil)

Regional President, WONCA North America
Prof Ruth Wilson (Canada)

Regional President, WONCA South Asia
Prof Pratap Prasad (Nepal)

Young Doctor Representative
Dr Raman Kumar (India)

Editor, WONCA News & Editorial Office
Dr Karen M Flegg
PO Box 3161
Manuka 2603 ACT Australia
Email editor@WONCA.net

From the President : Singapore and the Sustainable Development Goals

Photo: WONCA president with family medicine residents and Associate Professor Tan Boon Yeow during a recent visit to Singapore

I recently visited Singapore and had the opportunity to meet with members of the College of Family Physicians Singapore, our WONCA member organization. The college was established in 1971, rapidly became a member of WONCA, and has hosted our World Conference in 1983 and again in 2007.

Singapore is a small city-state, with its population of 5.5 million people receiving excellent health care and enjoying some of the best life expectancy rates in the world.

I was reminded by college president, Associate Professor Lee Kheng Hock, that family medicine is not yet recognized as a medical specialty in Singapore. The good news is that the Academy of Medicine Singapore, the umbrella organization of all specialist disciplines in the country, has agreed to set up a chapter of family medicine physicians, and this has been approved by the Ministry of Health. Our colleagues in Singapore now need to advocate to ensure the specialty of family medicine is recognized by law in the Medical Registration Act.

The recognition of family medicine as a specialty matters. We need the brightest and the best of each nation's medical students to see community-based primary care as a viable and exciting and worthwhile career choice, and to join us in a career in family medicine. We want our medical graduates to become family doctors by choice, not by accident.

Primary health care services are provided in Singapore by family doctors and community-based nurses, working either in one of the 1,500 private medical practitioner clinics, or in one of the network of 18 government polyclinics. The polyclinics are described as "one stop" comprehensive primary health care centres, and provide medical treatment, health screening and immunization, and health education services to the members of their local community.

This network of private and government clinics across Singapore ensures that primary health care services are accessible and affordable for all members of the population.

This focus on accessibility is part of the aim of the United Nations' Sustainable Development Goals. In September 2015, the United Nations adopted 17 goals to ensure a more equitable world. Only one of the 17 goals is specifically about health, but all 17 have an impact on the health and well-being of humanity, and many will only be successful if nations invest in ensuring the health and well being of their populations.

The single health goal is about "ensuring healthy lives and promoting well being for all people at all ages". This is the goal of universal health coverage, ensuring that every person and every family in every country of the world has access to health care.

Primary care provides the answer to universal health coverage, and health systems founded on strong primary care are critical "to ensuring healthy lives and promoting well-being for all at all ages". We need an unambiguous commitment by the United Nations and other stakeholders to the development of high quality, comprehensive integrated primary health care in each country of the world.

If we are going to achieve universal health coverage across the world, then the way many of our nations invest in health care is going to have to change. We need to invest more in health promotion and preventive care, keeping people as well as possible for as long as possible. We will need to invest in early detection and community-based management of chronic diseases. And we will need to address the mental health concerns that affect so many people.

If health care is going to be accessible for all then our nations are going to have to make sacrifices. We need to work with our governments to determine what each nation needs to sacrifice to ensure that health care remains affordable and attains universal health coverage. That means fewer new shiny hospitals for politicians to open, and more well resourced community-based clinics with well-supported family health care teams of family doctors and community nurses.

This was the basis of WONCA's statement on *Health in the 2030 Agenda for Sustainable Development*, which I delivered at the World Health Assembly in Geneva in May. Here is the content of our statement:

Primary care teams worldwide provide examples, from their daily practice, that illustrate their contribution across the Sustainable Development Goals (SDGs). This includes helping to improve people's life chances and reduce health inequities; advocating for healthy lifestyles and environments; and promoting health in communities. When integrated into a nation's health system, family doctors are trained to care for all aspects of peoples' health including health promotion, disease prevention, acute, chronic, rehabilitative and palliative care. Family doctors provide this care to people over the life-course, within the community they serve, and in collaboration with other health professionals.

National governments, and other stakeholders, need to be ambitious in measuring and monitoring progress towards strengthening primary health care to meet the SDGs. This monitoring includes the use of indicators that capture the principles of equity, community participation, prevention, use of appropriate technology, and inter-sectoral collaboration. Evidence is clear that this monitoring needs to measure the elements that make primary care services successful: first contact care, continuity, comprehensiveness, coordination, and care that is person-centred with family and community orientation.

Health financing indicators need to track government expenditure in primary care, and provide information on the economic accessibility of primary care services. Indicators on the make-up and distribution of the primary care workforce are crucial.

Primary health care integrates many of the SDGs. However in order to realise the full potential of the contribution of primary health care to sustainable development, and indeed universal health coverage, a strong interdisciplinary primary health care workforce, including family doctors, is needed in all countries.

Michael Kidd
WONCA President

Del Presidente : Singapur y los Objetivosde Crecimiento Sostenible

Foto: El Presidente de WONCA con los Residentes de Medicina de Familia y el Profesor Asociado Tan Boon Yeow durante la reciente visita a Singapur

Recientemente visité Singapur y tuve la oportunidad de encontrarme con miembros del Colegio de Médicos de Familia de Singapur, nuestra organización miembro de WONCA, y que tanto en 1983 como en 2007 fue la sede de nuestra Congreso Mundial WONCA.

Singapur es una pequeña ciudad-estado, con una población de 5,5 millones de personas que reciben una asistencia sanitaria excelente y gozan de uno de los mayores índices de esperanza de vida de todo el Mundo.

El colega Presidente y Profesor Asociado, Lee Kheng Hock, me recordó que la Medicina Familiar todavía no es una especialidad médica reconocida en Singapur. Las buenas noticias son que la Academia de Medicina de Singapur – organización paraguas de todas las especialidades en el país, ha acordado abrir una sección para los Médicos de Familia, iniciativa que ha sido aprobada por parte del Ministerio de Sanidad. Ahora lo que hace falta es que nuestros colegas de Singapur defiendan la especialidad para que ésta sea reconocida oficialmente en el Registro Médico.

El hecho de reconocer la Medicina de Familia como una especialidad es importante. Es necesario que los mejores estudiantes de Medicina y los más brillantes de todos los países perciban la Atención Primaria y la asistencia Comunitaria como una carrera estimulante y que vale la pena, y que se nos unan en la especialidad Familiar y Comunitaria. Queremos que nuestros graduados quieran ser Médicos y Médicas de Familia por propia voluntad, no por causas circunstanciales.

Los Médicos de Familia y los profesionales de enfermería que trabajan en el ámbito comunitario, son los encargados de ofrecer los servicios de asistencia de Atención Primaria, ya sea trabajando en una de las 1.500 clínicas privadas o en una de las 18 policlínicas que forman la red del Gobierno. Las policlínicas se definen como Centros de Salud de Atención Primaria con asistencia completa, y ofrecen tratamiento médico, revisión en salud e inmunización, así como servicios sanitarios educativos a los miembros de la comunidad local.

Esta red de clínicas privadas y públicas que se extiende por todo Singapur garantiza que los servicios de asistencia de Atención Primaria son accesibles y asequibles por parte de toda la población.

Esta focalización en la accesibilidad es parte de la voluntad de los Objetivos para el Desarrollo Sostenible de las Naciones Unidas. En septiembre de 2015, las Naciones Unidas adoptaron 17 objetivos para asegurar un mundo más equitativo. Solamente uno de los 17 objetivos está especialmente dirigido al ámbito de la salud, pero todos y cada uno de los 17 tienen un impacto sobre la salud y el bienestar de la humanidad, y muchos de ellos solamente podrán tener éxito si todos los países invierten en asegurar la salud y el bienestar de sus conciudadanos.

El único objetivo sanitario está dirigido a “garantizar vidas saludables y promover el bienestar de toda la población en todas sus franjas de edad”. Este es el objetivo de la cobertura universal de salud, que asegura que todas las personas y todas las familias en todos los países del mundo tienen acceso a la asistencia sanitaria.

La Atención Primaria da respuesta a la cobertura sanitaria universal, y los sistemas sanitarios basados en una Atención Primaria fuerte son cruciales “en la garantía de vidas saludables y la promoción del bienestar en todas las franjas de edad”. Es necesario un compromiso inequívoco por parte de las Naciones Unidas y otros inversores para el desarrollo de una Atención Primaria de alta calidad y completamente integrada en todos los países del mundo.

Si lo que queremos es conseguir la cobertura sanitaria universal en todo el mundo, entonces la forma de invertir que ahora mismo están aplicando muchos de nuestros países deberá cambiar. Es necesario que se invierta más en la promoción sanitaria y en la asistencia preventiva, con el fin de mantener a la población tan bien cómo sea posible durante el mayor periodo de tiempo posible. Vamos a tener que invertir en la detección precoz y en el manejo de las enfermedades crónicas. Y va a hacernos falta abordar los problemas derivados de la salud mental que afectan a tanta gente.

Si la asistencia sanitaria tiene que ser accesible para todos y todas, nuestros países deberán hacer más sacrificios. Debemos trabajar con nuestros gobiernos para determinar en qué puede sacrificarse cada país a la hora de garantizar que la asistencia sanitaria sigue siendo asequible y tiende a lograr la cobertura sanitaria universal. Esto significa menos hospitales relucientes inaugurados por políticos y más y mejores Centros de Salud bien financiados y apoyados por equipos de profesionales especializados en Medicina de Familia y Comunitaria y profesionales de Enfermería comunitarios.

Esta fue la base de la declaración de WONCA Salud en la Agenda 2030 para los Objetivos para el Desarrollo Sostenible, que presenté en la Asamblea de Ginebra del pasado mes de mayo. Este es el contenido de nuestra declaración:

Los equipos de Atención Primaria de todo el mundo ofrecen ejemplos, a través de su práctica diaria, que ilustran su contribución a los Objetivos para el Desarrollo Sostenible (Sustainable Development Goals, SDGs). Esto incluye ayudar a mejorar las opciones de vida y reducir las desigualdades en salud; abogando por estilos de vida y entornos saludables y promoviendo la salud en las comunidades. Una vez integrados en el sistema sanitario de sus respectivos países, los Médicos y las Médicas de Familia tienen la formación para dar asistencia a todos los aspectos en salud de la población incluyendo la promoción sanitaria, necesaria para prevenir las enfermedades agudas, crónicas y que necesitan de rehabilitación y cuidados paliativos. Los Médicos y las Médicas de Familia ofrecen esta asistencia a la población a lo largo de toda su vida, dentro de la Comunidad en la que ejercen y en colaboración con otros profesionales sanitarios.

Los Gobiernos y todo el resto de inversores, deben ser ambiciosos a la hora de medir y supervisar los progresos en el fortalecimiento de la Atención Primaria para conseguir hacer realidad los Objetivos para el Desarrollo Sostenible. Esta supervisión incluye el hecho de usar indicadores que fijen los principios de equidad, participación comunitaria, prevención, uso de la tecnología apropiada y la colaboración intersectorial. Está claro que para realizar esta supervisión es necesario contabilizar los elementos que hacen que los servicios de Atención Primaria tengan éxito: en un primer lugar, el contacto con la asistencia, la continuidad, la exhaustividad, la coordinación y la asistencia centrada en la persona con una orientación familiar y comunitaria.

Los indicadores de financiación de la Salud deben ir en la misma dirección que el gasto gubernamental en Atención Primaria, y proveer la información económica necesaria acerca de la accesibilidad a los servicios de la AP. Los indicadores acerca de la constitución y la distribución del personal de Atención Primaria son fundamentales.

La Atención Primaria incorpora muchos de los Objetivos para el Desarrollo Sostenible. A pesar de ello, con el fin de conseguir el máximo potencial en la contribución de la Atención Primaria para un desarrollo sostenible, y por supuesto también para la cobertura sanitaria universal, un personal de Atención Primaria interdisciplinario, que incluya Médicos de Familia, es necesario en todos los países.

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

Du président: Singapour et les Objectifs du Développement Durable

Photo: Le président de WONCA en compagnie de résidents en médecine familiale et Tan Boon Yeow, professeur associé, pendant une visite récente à Singapour

J'ai récemment visité Singapour où j'ai eu l'occasion de rencontrer des membres du Collège des médecins de famille de Singapour, organisation membre de WONCA. Le collège a été fondé en 1971 et est très vite devenu membre de WONCA. Le collège a accueilli notre conférence mondiale en 1983 et à nouveau en 2007.

Singapour est une ville-état de petite taille dont la population de 5.5 millions d'habitants bénéficie d'excellents services de soins de santé et de l'un des meilleurs taux d'espérance de vie du monde.

Lee Kheng Hock, professeur agrégé et président du collège, a rappelé que la médecine familiale n'est pas encore reconnue comme spécialité médicale à Singapour. La bonne nouvelle est que l'Académie de Médecine de Singapour, organisation cadre de toutes les disciplines spécialistes du pays, a convenu de mettre en place un chapitre des médecins en médecine familiale et ceci a été approuvé par le ministère de la santé. Nos collègues à Singapour doivent désormais maintenir leur engagement pour garantir que la spécialité de la médecine familiale soit reconnue par la loi sous le Medical Registration Act.

Cette identification de la médecine familiale comme spécialité est importante. Nous devons montrer aux meilleurs étudiants en médecine de toute nation que les soins de santé primaires au niveau de la communauté sont un choix de carrière viable et louable et nous devons les encourager à nous joindre dans cette carrière. Nous voulons que nos diplômés en médecine deviennent médecins de famille par choix et non pas par accident.

Les services de soins de santé primaires sont fournis à Singapour par les médecins de famille et les infirmières communautaires qui travaillent soit dans l'une des 1 500 cliniques médicales privées soit dans l'une des 18 polycliniques publiques. Les polycliniques sont décrites comme centres primaires complets de santé intégrés fournissant traitements médicaux, dépistages de santé, services de vaccinations et services d'éducation sanitaire aux membres de leur communauté locale.

Ce réseau de cliniques privées et publiques dans tout Singapour garantit que les services de soins de santé primaires sont accessibles et abordables pour tous les membres de la population.

L'accent mis sur l'accès fait partie du but des « Objectifs de développement durable des Nations Unies ». En septembre 2015, les Nations Unies ont adopté 17 objectifs pour assurer un monde plus équitable. Seul l'un des 17 objectifs concerne la santé, mais chacun des 17 objectifs a un impact sur la santé et le bien-être de l'humanité et bon nombre d'entre eux ne seront atteints que si les nations s'investissent dans la santé et le bien-être de leurs populations.

L'unique objectif de santé concerne « l'assurance de vies saines et la promotion du bien-être pour toutes les personnes à tous les âges ». Ceci est l'objectif de l'assurance santé universelle qui garantit que toute personne et toute famille en tout pays du monde ait accès aux soins de santé.

Les soins primaires sont la réponse à l'assurance santé universelle et les systèmes de santé fondés sur des soins primaires forts sont cruciaux « pour garantir des vies saines

et pour promouvoir le bien-être pour tous à tous les âges ». Un engagement non ambigu par les Nations Unies et autres parties prenantes est essentiel au développement de soins de santé primaires de qualité, complets et intégrés, dans tous les pays du monde.

Pour parvenir à mettre en place une assurance santé universelle à travers le monde, la manière dont de nombreuses nations investissent dans la santé va devoir changer. Nous devons investir davantage dans la promotion de la santé et dans les soins préventifs afin de préserver la santé des gens aussi bien et aussi longtemps que possible. Il nous faudra investir dans le dépistage et dans la gestion des maladies chroniques au niveau de la communauté. Et nous devrons répondre aux préoccupations touchant la santé mentale qui affecte tant de personnes.

Pour que les soins de santé soient accessibles à tous, nos nations vont devoir faire des sacrifices. Nous devons collaborer avec nos gouvernements afin de déterminer les sacrifices nécessaires par chaque nation pour s'assurer que les soins de santé demeurent abordables et pour réaliser l'assurance santé universelle. Cela veut dire que les politiciens auront moins d'hôpitaux flambant neufs à ouvrir et que davantage de cliniques communautaires seront bien équipées et auront des équipes de médecins de famille et d'infirmières communautaires bien soutenues.

Ceci formait la base du rapport de WONCA sur la santé dans le programme du développement durable pour 2030 que j'ai livré à l'Assemblée mondiale de santé à Genève en mai. Voici la teneur de notre rapport :

Les équipes de soins de santé primaires du monde entier fournissent des exemples dans leur pratique quotidienne qui illustrent leur contribution en respect des objectifs de développement durables (ODD). Ceci inclut les efforts pour améliorer l'espérance de vie des personnes et pour réduire les injustices d'accès à la santé, l'encouragement pour l'adoption de styles de vie et d'environnements sains, et la promotion de la santé dans les communautés. Une fois intégrés dans le système des services de santé d'une nation, les médecins de famille sont formés pour prendre en charge tous les aspects santé de la population, y compris la promotion des soins de santé, la prévention des maladies, les soins aigus, chroniques, de réhabilitation et les soins palliatifs. Les médecins de famille fournissent ces soins aux patients tout au long de leur vie, au sein de la communauté qu'ils servent et en collaboration avec d'autres professionnels de la santé.

Les gouvernements nationaux et autres intervenants se doivent d'être ambitieux dans la mesure et la surveillance des progrès vers le renforcement des soins de santé primaires afin de réaliser les ODD. Cette observation inclut l'utilisation d'indicateurs qui capturent les principes de l'équité, de la participation communautaire, de la prévention, de l'utilisation de technologie appropriée et de la collaboration inter-sectorielle. Il est évident que cette observation doit mesurer les éléments qui permettent le succès des services de soins primaires: premiers soins, continuité, globalité, coordination et soins centrés sur la personne avec orientation sur la famille et la communauté.

Les indicateurs de financement de la santé doivent suivre les dépenses publiques en soins primaires et fournir des informations sur l'accessibilité économique des services de soins de santé primaires. Les indicateurs sur la composition et la distribution du personnel en soins de santé primaires sont cruciaux.

Les soins de santé primaires comprennent de nombreux ODD. Cependant, afin de réaliser la pleine capacité de la contribution des soins de santé primaires au développement durable, et effectivement à l'assurance santé universelle, un personnel de soins primaires interdisciplinaire, y compris des médecins de famille, est nécessaire dans tous les pays.

Michael Kidd
Président de WONCA

Traduit par Josette Liebeck
Traductrice professionnelle anglais-français
Accréditation NAATI No 75800

From the CEO: Important things repeated

Hello again from Bangkok. As I mentioned last month, we have entered into a fairly quiet spell in terms of extra activities, though the Secretariat has been very busy of late dealing with WONCA Awards and with nominations for WONCA officer positions, with preparing the Annual Report (of which more in a moment) and with getting papers and logistics ready for the Rio Council and conference.

Rio Timetable

We published the timetable for Rio some time ago, but it's worth repeating to try to ensure that everyone has a clear idea of the schedule for the various meetings around the time of the World Council. Just prior to Council our Regional Executives meet, whist between Council and conference most of our Working Parties and Special Interest Groups meet, and we have already been in contact with all of these groups regarding logistics arrangements.

Those attending regional executive meetings will need to be at the Windsor Hotel in Barra di Tijuca, Rio de Janeiro, by the evening of Friday 28th October, ready to start on Saturday 29th. All other Council delegates need to be at Windsor Hotel by evening of Saturday 29th October – when there will be an informal welcome reception – ready to begin the work of Council on Sunday morning, October 30th.

Please note that the opening ceremony of the conference will be at 6pm on Wednesday 2nd November. We hope that Dr Carissa Etienne, Director of PAHO – the Pan American Health Organization (WHO for the Americas) – will deliver a keynote speech, as will our President, Professor Michael Kidd. The closing ceremony will be late afternoon on Saturday 5th November. There will still be some conference sessions on Sunday 6th, but these will be especially geared towards our Iberoamericana colleagues and will be in Spanish and Portuguese.

A particular date for your diary is Friday 4th November at 11.15, when the WONCA Awards ceremony will be held, followed by the Presidential handover from Michael Kidd to Amanda Howe.

That timetable in full:

Dates	Event
Monday 24th and Tuesday 25th October	Executive travel to Paraty for meeting
Wednesday 26th to lunchtime Friday 28th October	Executive meeting Paraty.
early afternoon Fri 28th October	Executive travel back to Rio
Saturday 29th October	Regional meetings in Windsor Hotel, Barra da Tijuca Evening welcome reception for Council delegates
Sunday 30th October to lunchtime Tuesday 1st November	WONCA World Council, Windsor Hotel, Barra di Tijuca, Rio de Janeiro
Tuesday 1st November afternoon	Meeting of new WONCA Executive; some WPs and SIGs meet
Wednesday 2nd November Breakfast meeting (0730 – 0900)	new Executive, together with new Chairs of WONCA WPs and SIGs
Afternoon of Tuesday 1st and all day Wednesday 2nd	Meetings of WONCA WPs and SIGs at conference venue (RioCentro)

Wednesday 2nd November	WONCA WPs and SIGs meet at RioCentro (the conference centre)
Evening of Wednesday 2nd November 6pm	Opening ceremony and welcome reception of WONCA World Conference – RioCentro
Thursday 3rd to Sunday 6th November	WONCA World Conference Sunday 6th will have an Iberoamericana theme
Saturday 5th late afternoon	closing ceremony
Sunday 6th	Additional sessions in Spanish and Portuguese.

Full details of the conference, and also the hotels, social activities and tours being arranged, can be found on the conference website (www.wonca2016.com.br) or you can always access full details through the WONCA website (www.globalfamilydoctor.com).

Zika Virus
I included this update ion the Zika virus in my column last month, but it's worth repeating, in order to reassure people about the very low risks posed by travel to Brazil. We continue to keep a close eye on WHO's advice regarding the Zika virus. In its latest bulletin, dated 31st May, WHO continues to advise that, based on available evidence, it has issued no general restrictions on travel to countries, areas and/or territories with Zika virus transmission. However, WHO is advising pregnant women not to travel to areas with ongoing Zika virus outbreaks. This advice is based on the increased risk of microcephaly and other congenital malformations in babies born to pregnant women infected with Zika virus. This advice is summarised on our website.

WHO offers general advice to travellers to help to prevent mosquito bites. This and other information on Zika can be found on the WHO website.

WONCA Annual Report
Finally for this month, work is well advanced on the latest Annual Report, covering the period from July 2015 to June 2016. Most work is now completed, but if any of the WONCA Regions, WPs, SIGs or YDMs have yet to submit an article then there is JUST time, as long as I get it by the end of the first week of August. (email to manager@wonca.net). It's a great way to promote the activities in your region or group, and to let members know what is happening, so we hope very much that every group will contribute.

Until next month.
Dr Garth Manning
CEO

Policy Bite: What is, or is not, Family Medicine? Definitions, models and limits

Amanda Howe, President Elect writes:

Many lectures and curricula begin with a definition – one commonly used in WONCA is:

- A doctor who is trained to deal with people across all life stages
- A medical generalist who can deal with all types of health problem at point of first contact in a community setting, and
- Offering a service that is comprehensive, accessible, focuses on a specific community, allows continuity over time, and is centred on the care of people - not specific parts of their body or diseases.[1]

I have seen three broad models of Family Medicine worldwide:-
- Single handed practitioner, with a list of patients who may or may not live locally: there may be one other member of staff supporting the doctor. The personal link over time can be strong, as this doctor is solely responsible for their patients.
- A group practice, with several doctors, often also with nurses and health care assistants.
- A 'department' or other institutional setting, in a hospital alongside other specialist services.

But, whichever model exists, within that we also need to look at the following variables:

1. Scope of practice- many family doctors are not using the full scope of the discipline in their particular setting or practice. For example, in U.K. family doctors are trained to see adults and children, also to do routine gynaecological and women's and men's health work – but in some countries family doctors only see adults, or do not do contraception or cervical cytology checks.

2. Relation to a population – some systems do not incentivise registration or continuity with a family doctor. Patients can switch providers frequently, or bypass primary care and go straight to hospital specialists. In some countries, family doctors may keep a registered 'list', but this may not be geographically based. A clinic which does not have continuity with its patients over time cannot easily implement preventive intervention programmes, nor identify unmet health needs and follow up on chronic disease management. And a clinic list which is not geographically based makes working with other agencies (e.g. community leaders, day care services) difficult.

Does this matter?

I think it does, at least at the level of the 'system'. While individual circumstances and opportunities may vary, a health care system that does not implement the full scope of family medicine is likely to be less cost-effective. A doctor who cannot make a first assessment of most types of problems will not be able to supervise family medicine residents who need to learn to see a full breadth of patients. Individual doctors may choose a specific role in the course of a career which looks 'less' like family medicine. But we do need to be able to show the full range of our discipline in each country to allow it to be fully understood and utilised.

For countries 'in transition', where this is not yet possible, it is important both to be able to show some pilot schemes where there is 'real' Family Medicine (as in the definition at the beginning of this article), and to be able to discuss honestly and analytically how things would look different if the full ideal of family medicine was implemented across the system. At least in this way we can compare our current reality to a stronger future. It is also important to be clear about this when governments or funders propose a change in the system. Will it increase our ability to combine health promotion, prevention, screening, acute and chronic care for a group of patients over time? Or will the change proposed increase fragmentation and reduce the scope of our practice?

We need constantly to defend family medicine principles and to ensure that we work to enhance these over time.

[1] http://www.woncaeurope.org/sites/default/files/documents/Definition%20EURACTshort%20version.pdf

Fragmentos de política: ¿Qué es y qué no es la Medicina de Familia?

Muchas conferencias y currículums comienzan con una definición – entre las utilizadas frecuentemente en WONCA encontramos:

- Un Médico especializado en tratar con la población a lo largo de toda su vida.
- Un Médico generalista que puede tratar todo tipo de problemas de salud en el momento en el marco comunitario
- Ofrece un servicio completo, accesible, focalizado en una Comunidad específica que permite continuidad a lo largo del tiempo y una asistencia centrada en la persona – no solamente en los campos específicos de una parte del cuerpo o de enfermedades concretas. [1]

En todo el Mundo, he visto tres amplios modelos de Medicina Familiar:

- El médico que ejerce de forma individual, con una lista de pacientes que no necesariamente viven cerca de la consulta (en esos casos suele haber otro miembro del personal que le apoya). La relación personal con los pacientes y su dedicación en el tiempo tiende a ser fuerte, dado que este médico es el único responsable de sus pacientes.

- Un grupo de trabajo, que consta de varios médicos, entre los que suele haber enfermeras y profesionales de asistencia sanitaria.

- Un "departamento" u otro tipo de organismo institucional en un hospital junto con otros servicios especializados.

Pero, sea el que sea el modelo que haya, dentro de este debemos analizar las siguientes variables:

1. Ámbito de práctica – Muchos Médicos de Familia no están utilizando todos los conocimientos de su especialidad en su marco de trabajo o en su práctica médica. Por ejemplo, en el Reino Unido, los Médicos de Familia están formados para visitar a adultos y a niños, también para realizar rutinas ginecológicas y para tratar problemas de salud de los hombres y las mujeres – sin embargo, en algunos países los Médicos de Familia solo visitan a adultos, o no se dedican a la contracepción ni hacen chequeos con citologías cervicales.

2. En proporción con una población – Algunos sistemas no incentivan el registro o la continuidad con el Médico de Familia. Los pacientes suelen cambiar de proveedores frecuentemente, o evitan la Atención Primaria para ir directamente al especialista hospitalario. En algunos países, puede ser que los Médicos de Familia vayan manteniendo un registro, pero este no tiene por qué estar en relación con su localización geográfica. Una Práctica Clínica que no tiene continuidad con sus pacientes a lo largo del tiempo no puede fácilmente aplicar programas preventivos ni identificar necesidades en salud no satisfechas o realizar un buen seguimiento de enfermedades crónicas. Además, una lista de pacientes que no esté ceñida a un ámbito geográfico hace difícil el trabajo con otras entidades (líderes comunitarios, servicios sociales, etc.).

¿Esto importa?

Yo creo que sí, al menos a nivel del "sistema". Mientras que las circunstancias individuales y las oportunidades pueden variar, un sistema sanitario que no implementa todo el ámbito de la Medicina de Familia es probable que sea menos coste-efectivo. Un médico que no pueda hacer una primera valoración ante la mayor parte de las dolencias no podrá supervisar a los Residentes de Medicina Familiar que necesitan aprender a ver una gran variedad de pacientes.

Los médicos que trabajan por su cuenta pueden elegir realizar una labor específica en un trabajo que tiende a aparecerse menos a la Medicina Familiar. Pero tampoco hace falta que seamos capaces de exponer toda la gama de contrastes de nuestra disciplina en cada país para pedir que sea globalmente entendida y totalmente utilizada.

Para aquellos países "en vías de desarrollo", en los que esto todavía no es posible, es importante tanto ser capaces de mostrar modelos piloto a los que seguir en los que se aplica una Medicina de Familia real (como en el caso de la definición del principio de este artículo), como poder analizar honestamente y de forma analítica cómo serían las cosas si el global de la ideología de la Medicina Familiar se implementara totalmente en el sistema. Al menos de esta forma podremos comparar nuestra realidad actual con la de un futuro mejor. También es importante dejar todo esto bien claro cuando los gobiernos o inversores proponen cambios en el sistema. ¿Aumentará nuestra habilidad para combinar promoción en salud, prevención, chequeo y la crucial asistencia crónica a ciertos grupos de pacientes a lo largo de su vida?, o, más bien, ¿estas propuestas de cambio provocarán una mayor fragmentación y reducirán el ámbito de nuestra práctica?

Debemos defender constantemente los principios de la Medicina de Familia y asegurarnos de que siempre trabajamos para mejorarlos.

Amanda Howe
Presidenta Electa de WONCA

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

Rio Conference News

Cultural exhibitions and contests for Rio close August 31

Deadline for entries August 31.
As part of the cultural calendar for the WONCA World conference 2016 in Rio, our colleagues in the Brazilian Society of Family and Community Medicine have launched a call for two exhibitions and three contests of cultural material. The two exhibitions call for video and photograph submissions, whilst the three contests are seeking short story, music and poetry submissions. More details are available via the conference website through your restricted area.

More information on each competition is available at the links below.

Photo Exhibition of Family Health

Video Exhibition of Family Health

Family Health Short Story Contest

Family Health Music Contest

Family Health Poetry Contest

Young doctor bursaries for Rio close August 15

The Brazilian Society of Family and Community Medicine (SBMFC) as official organizer of the RIO WONCA 2016 conference will offer 30 bursaries to provide the opportunity for young family physicians/general practitioners from around the world to attend the event. These bursaries will be available for family physicians/general practitioners from the countries listed on the conference website (see "more information"). The bursaries cover registration and provide 500 Reals towards expenses.

CLOSING DATE EXTENDED TO AUGUST 15TH

More information

WHO Information for travellers visiting Zika affected countries

As the WONCA World conference in Rio approaches, you may be interested in the latest WHO advice relating to the Zika virus. The information below is the latest for travellers, but there is more comprehensive information on the WHO website.

Source:
http://www.who.int/csr/disease/zika/information-for-travelers/en/

Updated 31 May 2016

Based on available evidence, WHO has issued no general restrictions on travel or trade with countries, areas and/or territories with Zika virus transmission.

However, WHO is advising pregnant women not to travel to areas with ongoing Zika virus outbreaks. This advice is based on the increased risk of microcephaly and other congenital malformations in babies born to pregnant women infected with Zika virus. Microcephaly is a condition where a baby is born with a small head or the head stops growing after birth.

As a precautionary measure, some national governments may make public health and travel recommendations to their own populations, based on their assessment of the available evidence and local risk factors.

Zika virus is primarily transmitted to people through the bite of an infected Aedes mosquito. Zika virus can also be transmitted through sex.

• Read "Prevention of sexual transmission of Zika virus"

Before travelling to Zika affected areas
Travellers to areas with Zika virus outbreaks should seek up-to-date advice on potential risks and appropriate measures to reduce the possibility of exposure to mosquito bites and sexual transmission of Zika.

While in Zika-affected areas

Men and women should practice safer sex (including the consistent use of condoms) or abstinence to prevent Zika virus infection, human immunodeficiency virus (HIV), other sexually transmitted infections, and unwanted pregnancies.

Prevent mosquito bites during the trip by following these measures:
• wear clothing - preferably light coloured - that covers as much of the body as possible;
• use insect repellent: repellents may be applied to exposed skin or to clothing, and should contain DEET, (diethyltoluamide) or IR 3535 or Icaridin. Repellents must be used in strict accordance with the label instructions;
• use physical barriers such as regular or mesh screens or insecticide treated netting materials on doors and windows , or closing doors and windows; and
• sleep under mosquito nets, especially during the day, when Aedes mosquitoes are most active.

Upon return home
To prevent the onward transmission of Zika and adverse pregnancy and fetal outcomes, all returning travellers should practice safer sex, including through the correct and consistent use of condoms, or abstaining from sex for at least 8 weeks. If men experience symptoms (rash, fever, arthralgia, myalgia or conjunctivitis) then they should adopt safer sexual practices or consider abstaining for at least 6 months.

Sexual partners of pregnant women should practice safer sex or abstain for at least the duration of the pregnancy.

WHO Zika Virus comprehensive factsheet
The Zika virus fact sheet is available in the following languages
• Portuguese
• Arabic
• Chinese
• French
• Russian
• Spanish

Region News

WONCA Europe 2016 report - keynotes online




Dear WONCA Europe Conference participants,

Did you realise that we all just had a fantastic conference in Copenhagen? That is what we hear.

We hope that you all had enjoyable stays in Denmark and Copenhagen – and hopefully many of you got the opportunity to travel to some of the other Nordic countries as well.

We want to thank you for the brilliant contributions you all made. Whether it was scientific, clinical or as an interested clinician, everyone made the WONCA Europe Conference 2016 a memorable conference.

Many of you have also contributed through the evaluation questionnaire, and we have received more than 400 very useful comments, which will be forwarded to the organisers of the two coming WONCA Europe conferences. Below just a few figures (scores from 1-5 with 5 as highest score);

- Relevance of the keynote sessions: 4.48
- Relevance of the non-keynote sessions: 4.02
- Overall organisation of the conference: 4.47

On our website you will find small videos with testimonials from each keynote speaker, videos of each keynote presentation as well as the PowerPoint slides from all keynotes speakers.

Go to Keynote videos and presentations
Picture gallery

WONCA Europe Conference 2016 with the theme "Family Doctors with heads and hearts" and WONCA Europe have made a joint statement: "The Copenhagen Legacy Document" encapsulating some of the achievements of the conference.
See legacy document

Now we look forward to meet many of you in Prague in 2017 . Please also remember that the Nordic Congress for General Practice in 2017 is held in Iceland.

We thank you all again.

Peter Vedsted & Roar Maagaard

Karen Flegg - A very Danish practice experience.

Photo: Danish colleagues, Gobind Kalsi and Kristian Müller in Gobind's "paper free" office

The recent WONCA Europe conference provided an opportunity for attendees to undertake a visit to the practice of Danish colleagues. I was welcomed by Dr Gobind Kalsi and Dr Kristian Müller at their practice in Vesterbro, Copenhagen. Vesterbro is a suburban area of people who are mostly well established in large houses, or young and trendy enjoying the proximity to the city centre.

The practice is on the fifth floor of a building that conveniently houses what I consider to be a community health centre providing free services such as a weight loss centre for obese children and a centre for patients with chronic diseases such as diabetes, COPD, and heart disease which provides access to patient education courses (for example for diabetes and quit smoking).

The first thing I notice in the sleek, custom designed clinic is the patient entering and swiping his health entitlement card through a machine which not only tells reception that he has arrived but also sets up the capacity for automatic billing to the Government for the coming consultation. The practice is paid on a mixed basis with some capitated payment for the practice population and then fee for service payment.

A young man walks down the hall calling a patient in – is he a doctor? – he is wearing shorts and a T-shirt. Actually this is the practice "intern" Dr Kristoffer Vinding. He is a young doctor who has been accepted into the specialist training program for family medicine. The practice hosts young doctors at all levels of their training and sometimes they have more than one at any point in time. Kristoffer is able to ask for assistance at any time – while I was there he asks about the same sort of things our registrars in Australia ask about – a skin rash and managing antihypertensive medication when someone is not controlled on multiple medications. Gobind and Kristian deliver half an hour of teaching daily.

Gobind and his patients allow me to sit in on a few consultations. We are both amused that the first patient who has an English sounding name, but turns out to be Australian. The next is Danish, and the next Pakistani. The team includes a nurse who is well utilised by the doctor – today she teaches peak flow technique, does an INR, wound care and advises about coming investigations. Not only does the practice do point-of-care INRs they also do their own urine cultures for antibiotic sensitivity – an idea I'm keen to take home to Australia.

Photo: Kristian and Gobind at left and Kristoffer at right with the practice team and some interesting Danish design.

As well as consulting rooms for doctors and nurse there is a small laboratory and also a consulting room for a physio (he is wearing shorts just like the intern but no shoes – this approach is fine in trendy Copenhagen!). Next door are specialist rheumatologists and a plastic surgeon as well as a chiropractor. The practice is very well equipped – electronic eye charts, electronic beds and of course electronic computer records.

We all aspire to be paper free but this practice really is paper free! I was surprised to see very little paper - one small stack in Gobind's room. Danish GPs seem to have mastered something most of us struggle with.

My hosts were kind enough to provide a traditional Danish open sandwich lunch. We compared our health systems finding more similarities than differences. It seems the government pays about the same per consultation in both our countries - however in Australia we can charge more than the Government payment. Access is thus likely better in Denmark. Access brought talk of remote practices and comparisons of remote Australia to Greenland where Kristoffer had worked. Comparisons of lack of doctors, distance and time to help, poorer health statistics of residents in remote places.

GP life seemed so similar - if it weren't for the need to speak Danish, I felt that I might almost be able to work in this system without too many challenges and that Gobind and Kristian could walk into my practice in small town Australia and fit in perfectly! All in all we agreed we were all lucky to be working in countries where there is good access to health care and systems in place to provide services to patients which in other places they cannot afford.

Always a fabulous experience to be so far from home and yet find so many similarities and a warm welcome from colleagues who you've never met before. My sincere thanks to Gobind, Kristian and their team for the warm welcome and an insight into a wonderful general practice by any country's standards! On behalf of all colleagues who visited practices as part of this initiative by the Copenhagen conference committee, our gratitude to all host practices and our Danish colleagues for the warm welcome we received.

Karen Flegg
WONCA Editor

WONCA Africa news

Some useful news from WONCA Africa:

WONCA is having its World Conference in Rio 2-6th Nov 2016 and you must be there. WONCA Africa will be having its Regional Council Meeting on the morning of Saturday 30th October so join if you can.

The South African Academy of Family Physicians (SAAFP) will be having its 19th Annual Conference in Cape Town 12-14th August 2016. Keep tabs on this link as the SAAFP will be hosting WONCA Africa's next Regional Conference in Pretoria, South Africa on 17-20th August 2017 - book the dates!

Don't forget to look at the African Journal of Primary Health Care and Family Medicine!

Do you mind having a look at a draft of the South African Community Acquired Pneumonia Guidelines and follow instructions to give comment to me at shabir@drmoosa.co.za

Have a look at the brochure for Stellenbosch University's Post Graduate Diploma in Family Medicine, a new concept in South Africa. There are other universities also doing this so enquire at your nearest Family Medicine Department.

regards
Shabir Moosa
Secretary
on behalf of the WONCA Africa Executive Committee
shabir@drmoosa.co.za

Working Parties and Special Interest Groups

Rural Round-up: Ewen Mc Phee's masterclass on social media & medicine

This month's rural round up is a presentation given in April by Ewen Mc Phee "Masterclass on Social Media and Medicine" (Luxembourg). You can read the transcript below or alternatively click on the image above and watch it on YouTube.

Hi my name is Ewen McPhee

Before I start I wish to pay my respects to you all and recognize Raquel and Harris for their kind invitation to be with you today.

I am a rural doctor in Central Queensland Australia. I am a family medicine practitioner and a GP Obstetrician. I have lived in my town for the last 27 years. My town of Emerald has a population of about 16,000 people. It is a center for Coal Mining as well as Cattle and Agricultural Industries.

I work in a busy training practice where registrars in family medicine study towards fellowship of the Australian College of Rural and Remote Medicine or the Royal Australian College of General Practitioners.

Family Medicine is very strong in Australia with over 30,000 clinicians in primary care. Most rural GP's have special skills in addition to primary care including skin cancer medicine, mental health, palliative care, and procedural specialties like obstetrics. GP's are the gatekeepers for referral to Hospital and to Specialists, they look after patients from cradle to grave.

Australia is a big country. It takes over 6 hours to fly from one end to the other and cross three time zones from Cairns to Perth (one of the most isolated cities in the world). There are over 6 million Australians living in rural and remote areas. These Australians have poorer health outcomes than their city cousins.

You can understand then that isolation is a significant part of the existence of rural Australians and even more so the Health professionals that deliver care to them. This is where my interest in Social Media has grown from.

Most Australians have access to social media even where access to the internet is poor, through the use of wireless and satellite technologies. Social media has been a rapidly growing medium for connecting clinicians, sharing their experiences and medical knowledge.

In my presentation today I will talk about one mode of social media that I use, the benefits that I see from engaging in this space and the utility of same in medical education and medical politics.

Like many older people I discovered Social Media through the activities of younger people in my case Medical Students. In 2010 I was appointed as President of Rural Doctors in Queensland and started to use Twitter.

Twitter has been the main platform for my engagement with Social Media since that time. My experience of Social Media has been a rich one, and one of significant personal growth.

I have to say though at this point that you should take some time to think about your handle. I'm @Fly_texan, why? Because the


Texan was the aeroplane I learned to fly in.

The power of Twitter is the ability to rapidly update yourself on the news across the world, to touch friends and followers and to disseminate updates about things you're interested in.

Twitter is a powerful medium for connecting with people. I have friends who live and work in isolated and difficult circumstance, and having a means of reaching out at times of difficulty or distress cannot be underestimated.

Have you ever had a bad day and wanted to share your concerns? In Australia the nearest clinician could be a thousand kilometers away. I recall one young doctor who had a difficult couple of obstetric cases, she had been criticized by a specialist in the city, that she needed to debrief. With a comment on twitter she was able to contact and confide in three senior rural doctors. She still relates this story and how it made her feel safer and more secure knowing that help and support was just a few clicks away.

Twitter is a way for educating yourself and for sharing the message across the world. I first met Harris and Raquel through a Tweet chat #HCSMANZ, a regular online conversation that has seen us partner on two occasions now internationally.
http://www.hcsmanz.com.au/

I use Twitter to tweet short summaries and links to references when I attend conferences, as a way to make "notes" and to also share the conversation more broadly. This last week I attended #Ottawa2016 an international conference for the education of medical humanities. I was able to join over 500 other Twits in sharing the messages from that conference to over 4 million accounts.

Twitter can also be stored and recalled for future reference. An America innovation called the Healthcare Hashtags project is something I would encourage you to explore. By Registering a Hashtag, you can advertise your conference, keep of a record of the participant's conversation and retrieve useful analytics about the breadth of interaction that occurred. http://www.symplur.com/healthcare-hashtags/

There is a new conversation called #FOAMed or free open access medical education. Twitter has become a media for asking a clinical question and rapidly receiving an answer from experts in the field. Twitter is a means of sharing your research, sharing discoveries or useful facts with your followers, be they colleagues or students.
http://lifeinthefastlane.com/foam/

The Rural Doctor Movement in Europe, Africa, the Americas and the Pacific strongly relies on social media to connect and share important rural health messages to isolated clinicians everywhere. Through twitter I am aware of the work of many young doctors across the world. I follow the Vasco da Gama and Euripa movements actively on social media and I must shout out to people like Ulrik Kirk, Kyle Hoedebecke (of Wonca Polaris North America) and others for their work on #SOMEambasadors and @FMchangemakers https://twitter.com/FMChangemakers and https://sites.google.com/site/someambassadors/

I must applaud the work of a young Brazilian Medical Student Ms Mayara Floss who has been one of the main instigators and a driving force behind the Rural Medicine Café Project, a collaboration of young health professionals around the world who use social media to connect for regular Google Hangout sessions, with Twitter and Facebook interactions to

share and discuss important World Health priorities

Twitter as a tool for change cannot be underestimated. In Australia at least many Journalists and media outlets follow opinion leaders. Politicians staff actively monitor the ebb and flow of information. As the President of a Rural Advocacy Group this is a powerful way of sharing your message, links to interviews Press releases and the like.

However, to quote Uncle Ben from Spider-man, "With Great Power comes Great responsibility". Nowhere is discretion and Judgement more called for than in Social Media. As a professional you must conduct yourself as you would with your patients, be polite, be diligent and be respectful.

A good rule of thumb to follow is to ask yourself whether you would be happy to say something on Social media that you wouldn't say in a crowded elevator, or on the front page of the local newspaper.

Follow those people whom you value and like, not just Justin Bieber or Madonna. Interact and share as you would with your friends in real life and you will receive great rewards.

So in conclusion I hope you have enjoyed my brief snapshot of one aspect of Social Media, the use and utility of Twitter in connecting, sharing, educating and advocating. Twitter is just one aspect of a universe of rich opportunities for meaningful relationships across the world. The best experiences come from caring and sharing just as you do now.

See you online soon…
Ewen McPhee

WONCA Policy on eHealth

WONCA has launched its new policy statement on eHealth developed by the WONCA Working Party on eHealth

The new WONCA Policy Statement on eHealth calls for information technology that supports the family doctor in providing patient-centered care that has high quality and is safe. Patients should have access to their records and control over who can access their data, and they should be able to enter data into personal health records which they can share with their care providers. Information technology should support patients' self-management, shared decision-making and easy communication with their care providers. One patient should have one record across all levels of health care that contains essential data about their problems, medications, procedures, measurements, and test results, as well as a care plan, all in coded format. The family doctor should have tools that allow care coordination of the individual, as well as the care of the whole population by identifying people that would benefit most from appropriate care. Secondary use of the data is encouraged for the creation of new knowledge and for quality improvement. Governments are responsible for ensuring interoperability of all health data and making continuously updated medical knowledge available for family doctors and patients.

The policy statement was developed during two years by members of the WONCA Working Party on eHealth and EQuiP delegates. A workshop was arranged during the WONCA Europe Conference in Copenhagen where Danish patients commented on what kinds of eHealth services they would benefit from and how family doctors could collaborate with their patients in developing those services.

Ilkka Kunnamo
Chair, WONCA Working Party on eHealth

View full policy document

WONCA Policy Statement on eHealth 2016

1. The primary aims of Health Information Systems (HIS) should be to empower patients and health professionals by - supporting patients' self-management, shared decision-making, easy communication with the primary care provider, and data entry into personal health records which patients can share with their care providers; - supporting professionals in delivering care that has high quality and is safe. Health Information Systems should also provide patients with reliable information on health, disease and relevant care.

2. Each patient should have one record containing essential coded data including, as a minimum: problems, medication list, test and examination results, procedures and management plans; across all levels of health care and social care when needed, in order to promote continuity, patient-centeredness, team work, integrated care, and care coordination by the family doctor. Patients should have access to their records and control over who can access their data.

3. Family doctors and patients should have the right to use information technology tools that are tailored to their needs. This can be accomplished by making the data interoperable and shareable by different tools, including mobile applications.

4. Health Information Systems should enable and facilitate the coding of high-quality data in a standardized manner so as to allow processing by computer, clinical decision support, personalised medicine, automation of tasks, and patient-oriented service provision.

5. Health Information Systems should enable the family doctor to analyse the health data of the whole population for which he or she is responsible, in order to identify care gaps in people who would benefit from health care interventions, and to serve the people with the greatest health care needs.

6. Health Information Systems developers should engage family doctors and patients in the development of tools that support the care of people with multiple morbidities and polypharmacy; facilitate care coordination and promote evidence-based practice, while preventing fragmentation of care, overdiagnosis, overtreatment and medicalization.

7. Health Information Systems should help primary care providers to learn from every patient, every intervention and its outcome. Health Information Systems should enable the capture of coded data from electronic health records and personal health records in a standardised manner, and the deposit of such coded data into repositories controlled by the primary care unit that has generated the data, for use at the unit, and for sharing standardised data reports for quality improvement and benchmarking.

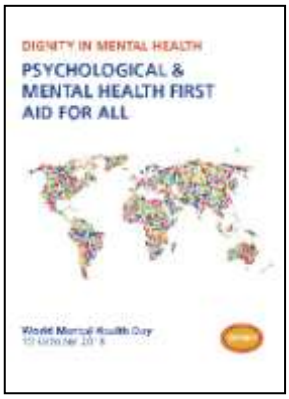
8. Health Information Systems should enable the sharing of anonymised or encrypted data through safely maintained and publicly controlled repositories for the generation of new knowledge via research and big data analysis. The primary care units should make their participation in data sharing known to patients, and patients should be granted the choice to opt out from sharing their data or to pose restrictions on the ways in which their shared data can be used.

9. Governments, in close collaboration with health care professionals, should endorse and implement eHealth strategies and infrastructures that include standardisation and interoperability, and develop their regulations to facilitate the use of data for research, development and innovation in a secure and safe manner, so as to guarantee the rights of the individual.

10. Governments should ensure access for professionals and patients to the best available health information systems and continuously updated clinical knowledge in primary care, education and training in health literacy and in the use of IT tools. Governments should also ensure the availability of aggregated data for decision making and management.

WONCA Working Party on eHealth April 2016

World Mental Health Day (October 10) educational material



Dear All

I am delighted to share with you the 2016 World Mental Health Day educational/promotional material. This year's theme is very close to our hearts as family doctors and I am very grateful for the support given to us by members of WONCA, particularly our President, President Elect, CEO, Members of the WONCA Working Party on Mental Health, and Karen Flegg (WONCA editor).

Please begin the promotion to all your contacts, colleagues and friends down load the materials from www.wfmh.org

World Mental Health Day

World Mental Health Day (10 October) is a day for global mental health education, awareness and advocacy. It was first celebrated in 1992 at the initiative of the World Federation for Mental Health, a global mental health organization with members and contacts in many countries. On this day, each October, thousands of supporters observe an annual awareness program to bring attention to Mental Illness and its major effects on people's lives worldwide. In some countries this day is part of an awareness week, such as Mental Illness Awareness Week in the US and Mental Health Week in Australia.

This year's theme '*Dignity in Mental Health-Psychological & Mental Health First Aid for All*' will enable us to contribute to the goal of taking mental health out of the shadows so that people in general feel more confident in tackling the stigma, isolation and discrimination that continues to plague people with mental health conditions, their families and carers.

You can download the report by clicking on the image. Also please make it available on your website.

I have already sent a blog to the Huffington post.
Together we can make a difference
Gabby

Professor Gabriel Ivbijaro MBE, JP
President WFMH (World Federation for Mental Health)
Chair, The World Dignity Project

New Special Interest Group on Genetics - Why?

Genomics and family practice
"The study of genomics 'addresses all genes and their inter relationships, in order to identify their combined influence on the growth and development of the organism'."
The World Health Organization definition of genomics

A newly formed WONCA Specialist Interest Group on Genetics has been set up and we hope the topics and themes discussed in this short paper will interest WONCA members (and we look forward to having new members join!).

Most of us recognise the importance of taking a good and accurate family history which helps us in our decision making – for example, to consider the risk of cancer or heart disease when managing the individual and family in front of us. As we all know, in family practice environmental and behavioral influences are very important, as in the management of obesity and diabetes. One of our tasks in the future is to understand when we should be using genomic information appropriately.

World – wide research and collaboration into

genomics is gathering pace, based on sequencing technology which through speed and greater accuracy is leading to the discovery and analysis of potentially causal gene variants in disease. For example, in England there is a large translational research project called the 100,000 Genome Project being led by Genomics England Ltd. Patients with cancer, rare diseases and infectious diseases are having their genome 'sequenced'. Whole genome sequencing involves coverage of non-coding and coding DNA which goes beyond just focusing on whole exome sequencing i.e the coding section of DNA (or classical genetics study).

Research findings use publically available genomic databases to allow researchers and clinicians to evaluate whether identified new gene variants are pathogenic (i.e. associated with disease). This publically available information has also been used by commercial companies to provide private genomic testing. This use is premature, as there is still much research that is necessary around the clinical utility and validity of using genome tests to inform clinical practice. Also of importance are the ethical and social considerations around the use of genomic data in clinical practice. For example, when is it appropriate to test children?

When should genomic information be shared with relatives? When should individuals carrying high risk genes be offered prophylactic surgery (e.g. BRCA gene in females giving a high risk of breast and ovarian cancer [1])? What about the use of targeted genomic tests tailored to certain populations (e.g. haemoglobinopathies)? What pre-test counselling should be available, and how should follow up care be financed?

A particular example where all these considerations are needed is the use of circulating fetal DNA in the maternal circulation in testing for Downs's syndrome. This has been going through rigorous evaluation internationally, and there has been consideration of harms and benefits and limitations of testing. The duty of care provided after testing is crucial, and the key principles around autonomy, beneficence, non-beneficence and justice must apply to the new genomics – otherwise mandatory testing at high costs to those at risk might be a future possibility. For example, in some health systems, female relatives of those with BCRA positive tumours will be offered testing – but then could in future find themselves excluded from some types of life and health insurance, unless a country takes action to agree that test results should not affect insurance [2].

The work around genomics and the need to integrate this into day to day practice will be challenging. As family practitioners we have a wide skill-set including how to manage new information that will need to be applied to patients in their ongoing management of complex conditions. We need to ensure that genomic information is validated for clinical use for the benefit of our patients and their families. There are many examples such as in cancers (e.g. tumour status) and inherited cardiac conditions (e.g. long QT syndromes) where genomic information is powerful and can influence treatment and management. This requires us in family practice medicine to be aware and be ready to apply this new knowledge.

Key points
Family doctors need to know enough about the new genomics to help their patients to make good evidence based choices about tests that could predict their own and their family's risks.

We need to know what tests are valid and reliable for diagnostics in our own population, and to avoid use of tests which are not yet accurate. If patients present with the results of such tests, we need to help them to understand the implications.

We need to also to advocate for patients who may risk psychological and financial harm if tests are carried out without guarantees of appropriate care if the risk is positive.

Imran Rafi
Convenor WONCA SIG Genetics

Join the WONCA SIG on Genetics
References online

Member Organization news

STFM Foundation International Scholarship

The Society of Teachers of Family Medicine (STFM) Foundation supports the sharing of expertise among those who want to advance the family medicine model throughout the world. The Foundation offers the International Scholarship Program to advance family medicine worldwide by fostering relationships between STFM members and international family medicine educators leading to enhanced information exchange and sustained professional relationships. One scholarship recipient is selected each year and receives funding to attend the STFM Annual Spring Conference.

"It was an honor for me to receive the 2008 International Scholarship. The Annual Spring Conference was intellectually stimulating and I was able to network with many STFM members. I was impressed by the climate of collaboration, respect, and support among participants. After the conference I visited Tufts University to learn the details of competency-based curriculum development, AAFP to learn how to develop CME programs, and KU Medical Center to learn about inpatient care. Finally, I visited the University of Arizona, where I was able to start my qualitative research project for my master's degree in higher education. This experience has been one of the richest and most stimulating of my career."
—Augustina Piñero, MD
School of Medical Sciences, National University of Cordoba, Argentina

Program Goals
o Foster relationships between STFM members and international family medicine educators
o Collaborate with colleagues globally for growth in family medicine education
o Facilitate the development of outstanding future family medicine leaders globally
o Learn about international primary care models and tools, and disseminate promising elements

The program rotates its world region of focus from year to year: eastern Europe and former Soviet Socialist Republics in 2017, Africa in 2018, and Asia in 2019.

The nominee selected receives an award of up to $3,500 (US dollars) to support travel expenses to attend the STFM Annual Spring Conference. If feasible, the awardee spends additional time in the United States visiting family medicine programs and the offices of the American Academy of Family Physicians and STFM in Leawood, Kansas.

There is one award available, and a limit of two nominees per country.

Eligibility Requirements
o Must be in the first 5-10 years of first faculty appointment
o Must be fluent in English
o Must have the support of the country's family/general practice organization
o Must have a US sponsor to help coordinate the visit
o Must have completed advanced training, such as a residency in family medicine or general practice
o Must have the potential of becoming future leader in family medicine
o Must be willing to develop and maintain a relationship with a US collaborator(s)
o Be willing to report on progress made on implementing a new program or initiative in his/her home country based upon the information learned during the US visit
o Must be a first-time STFM conference attendee

Selection Criteria
o Personal potential for contributing to the development of family medicine in his/her home country
o Strength of proposed activities during the US visit
o Strength of proposed activities upon returning to the home country
o Strength of strategies proposed for maintaining communications with the US collaborator
o Regional needs and potential for family medicine development

Application Requirements
Individuals who are interested in the program should submit the following:

o Letter expressing why you wish to receive the award
o A proposal describing the program or initiative to be implemented in the home country
o Letter of support from your home institution
o Letter of support from your country's family/general practice organization addressing the potential for family medicine development in your country
o Letter of support from US sponsor
o Copy of current curriculum vitae

International scholars will be expected to submit a brief written report on their activities during their US visit.
Applications must be submitted electronically by September 30 to Pat Lodge plodge@stfm.org. If you have questions, please contact Pat on 800-274-7928, ext 5402. Notification of selection is made in November.

More about the STFM foundation

Amanda Howe visits Taiwan & the TAFM Action Plan

Report from Prof Howe regarding her visit to Taipei, Taiwan, Asia Pacific Region, July 8-11 2016.

Occasion: Taiwan Association of Family Medicine (TAFM) National Conference and 30th Anniversary.

Funder: TAFM.

Activities: keynote at conference, press conference, young doctor presentations and panel, clinic visit to Taichung Hospital, and meeting with 12 residents there.

Rationale for attendance: to acknowledge important work of the TAFM over many years: and to establish relationship with Prof Meng Chih Lee who is President of TAFM and will be Asia Pacific President from November 2016. Conference also attended by Prof. Donald Li and Dr Gene Tsoi (Hong Kong) and colleagues from Shanghai, Beijing, and Shenzhen as China Mainland delegation invited by the TAFM.

Support for members and family doctors – this was well attended (2000+), had a real buzz, and as far as I could tell from a national programme was what family doctors wanted. Run on a Sunday, with mainly clinical topics, doctors had come from all over the country to attend. There was a prominent but professional exhibitors space, which included some non-pharmacological stands such as kiwi fruit promoters and complementary therapies (which are part of the Taiwanese insurance package.) The local organisers would be best placed to give objective evaluation. The celebratory atmosphere of the event led me to describe it to friends as 'like going to a wedding or a party': I think this emphasis on years of effort and evidence of success will have boosted morale.

Profile of family doctors in Taiwan – there were a number of non – family doctors, leads from some collaborating countries, a large and well attended press conference, a wonderful historical photomontage of the TAFM, and an interest in international speakers. In my research about the meeting, I found a number of published articles about the development of FM in Taiwan, showing objective evidence of outputs over the three decades.

Health care system - Taiwan has a strong health system where family medicine is already playing a major role. From reviewing the literature before this visit I remembered that Taiwan introduced a National Health Insurance (NHRI) model more than 20 years ago, which continues to fulfil the government's commitment to universal health coverage, and has proved both popular and cost effective [1]. They also have a well established national training for family residents, which again has existed for 30 years, and was written up by Meng Chih Lee and colleagues more than 10 years ago [2]. Recently the NHRI has considered incentivisation of registration of the population with a family doctor, which is great news.
References available online

The TAIWAN Action Plan
Dr Donald Li (WONCA Treasurer) and Dr Meng-Chih Lee (TAFM) report that during a press conference attended by Prof Amanda Howe, the Taiwan Association of Family Medicine made the following declaration:

Vision: Establishing a person-centered, system-based integrated health care system to meet the needs of an aged society.

Goal: Building Taiwan into the world paradigm of "Every family a family doctor" by 2020.

The TAIWAN Action Plan

T: Developing a uniquely Taiwanese family physicians system fully capable of delivering quality person-centered, family-based, and community-oriented healthcare services;

A: Enhancing Accountability of care and empowering citizens to enhance self-care;

I: Providing Integrated people-centered health services and enforcing bi-directional referral to ensure coordination and continuity between the three tiers of health care;

W: Providing family physicians with payment incentives to support reasonable increase in national health expenditure, thereby building up a World leading model of sustainability;

A: Upgrading the ability of family physicians in providing preventive health care to reinforce Assurance of quality care;

N: Constructing Networks of community health support by recruiting and training volunteers for health education, and self-care.

Euripa rural health forum coming in Marseille

The 6th Euripa Rural Health Forum, to be held in Marseille 23-24 September 2016, will address the full scope of research and educational questions facing rural family doctors of all ages, through presentations, workshops, and poster sessions.

Website : www.euripaforum2016.eu/

INVITATION TO YOUNG DOCTORS

Invitation to join the VdGM/St Exupery Movement Exchange Programme, during the 6th EURIPA Rural Health Forum in Marseille.

The Organising Committee, the Faculty of Medicine of the University of Marseille, the Marseille Association of Graduates, the Saint Exupery Movement are pleased **to invite 10 young trainees or doctors to spend two days in a surgery close to Marseille** before the Rural Forum begins.

What form will it take?

On Tuesday September 20th, late afternoon, all the participants will meet with their French counterpart at the Faculty of Medicine. Each of them will be hosted by a French trainee and will spend the two following days (Wednesday 21st and Thursday 22nd) in a general practice. They will learn about the French health system, the organisation of internships and the relationship between trainee-trainer-patient.
During the 6th EURIPA Rural Health Forum, the Exchange Group will provide a report to be presented on Saturday.

To be a candidate for the Exchange Programme, you have to:

- be a graduate, a post graduate or a young doctor (less than five year licensed.)
- be interested in rural practice
- write a cover letter, with a short CV and agree to help to organise an exchange in your country in the future.
- be registered at the 6th EURIPA Rural Health Forum with a special fee of €50.

Housing will be provided by your host until the end of the EURIPA Forum.

For more information, please contact Dr Ludovic Casanova ludovic.CASANOVA@univ-amu.fr

Looking forward to welcoming you in Marseille!

Featured Doctors

Dr Raluca ZOIȚANU : Romania : VDGM rep on WONCA Europe executive

What is it like to be a young family doctor in Romania?

It is not easy to be a family doctor in Romania, young or not. There are many disparities in Romania and especially health disparities. As family doctors we have the opportunity to be there for almost all patients in need, especially in rural areas where no other specialist is available and the emergency services can't always reach patients in time. Unfortunately, due to bad decisions taken by the Government regarding financing of healthcare services provided through the National Health Insurance System, and lack of involvement of local authorities in supporting healthcare professionals in the community, health disparities are still very much a reality in Romania.

We mostly work alone, with just one nurse, and both doctor and nurse act as office secretary as well, answering phone calls and doing paperwork. It is not easy and not rewarding so it is no surprise that many family doctors are leaving the country. But we are constantly working to fix things, to make them better for our patients and ourselves. What governments often don't seem to understand when they, hypocritically, say "we always put patients first!" is that when doctors suffer, their patients will suffer as well. A doctor in burnout, a doctor who can't meet his own needs, will not be a very efficient doctor for his patients.

As a medical student I volunteered in projects designed to help patients in need and increase health literacy and education while also improving practical skills of medical students. I continued to do so later as a Family Medicine trainee when I also decided to join the Family Doctors' Association in Bucharest (AMFB), my hometown and place of work. AMFB is organized as an NGO with voluntary membership and it is the professional association of family doctors in Bucharest and the surrounding area, Ilfov county. It is a member of the national professional association, called the Romanian National Society of Family Doctors (SNMF), a proud WONCA member since 1994.

How did you get involved with the VDGM?

Early on I realized that as family doctors we need to be more than just doctors. We need to accept our roles as leaders in the community and advocates for family medicine and for our patients. In 2010, with a lot of enthusiasm I accepted the role to lead the trainees department of AMFB - this gave me the opportunity in 2011, to meet with WONCA leaders of the time including, WONCA Europe President, Tony Mathie, and WONCA President, Prof Richard Roberts.

It was an eye opening experience which quickly helped me decide to apply for the position of National Delegate to the Vasco da Gama Movement Council and thus to become involved in family medicine projects on a European level. Back home that same year, following the mantra "think globally, act locally", I created the Young Family Doctors' Group as part of SNMF, a group which five years later has 400 members and a core group of regional coordinators of nine young family doctors. Last year I stepped down as the VdGM Council country delegate.

When I joined VdGM it was a time of change in leadership, with a completely new Executive Group starting its term. In my first year in Council, Harris Lygidakis was just starting his Executive role as Image Liaison, a position I took over from him the next year, when Harris was elected President of VdGM. Big shoes to fill, because Harris had done so much in the Image Group in just one year, but with a great team around me we managed to do it.

It was such an amazing time to work together for a few years in the Executive with Raquel Gomez Bravo, Martin Sattler, Sara Rigon and

many other young, dedicated, enthusiastic family doctors from all over Europe.

VdGM grew during our mandate over the 1000 members mark, organized a World Preconference in Europe, then its first Forum. Now, many of the young family doctors who helped VdGM grow are active members of WONCA Europe and the Member Organizations, working as hard as they did for VdGM. I see them every year in the WONCA Europe Council as representatives of their National Colleges, Organizations and Academies but also in the Networks – EGPRN, EQuiP, EURACT, EURIPA, Europrev. What a journey! And at the VdGM preconference in Copenhagen I saw many new faces of young family doctors who I am sure will grow into future leaders.

What is your current involvement in WONCA?

Last year in October in Istanbul I joined the WONCA Europe Executive Board as representative of VdGM. It is an exciting duty for me personally and a great acknowledgement for the Vasco da Gama Movement, which, eleven years after its birth, was last year accepted as a Member of WONCA Europe with a seat on the Executive Board.

In 2013 I was appointed by WONCA Europe to be the regional representative on the WONCA Organizational Equity Committee (OEC). A fantastic experience and the opportunity to work together with many great WONCA leaders from all regions. The Committee is working towards ensuring WONCA is a transparent and equitable organization for its members.

It is a very exciting time to be an active part of WONCA and in particular WONCA Europe. The organization is growing now in the direction of working with other healthcare organizations to provide better healthcare to our patients and improved working conditions and education to family doctors. The link with WHO is becoming stronger every year due to the big efforts and commitment of WONCA and WONCA Europe leaders. My home country WONCA Member Organization, SNMF, which every year since 2013, has run immunization awareness campaigns together with the WHO Country Office in Romania during the WHO European Immunization Week.

Every form of collaboration helps towards the goal of developing our specialty. For a few years between 2013-2016, I coordinated the e-health working group of SNMF and leading the creation of a position paper on the development and implementation of the Electronic Health Record in Romania. The position paper was given to policy makers in Romania in an effort made by SNMF to support a better legal framework for EHRs.

Another collaboration worth mentioning is the Social Media Compass guide, a collaboration between VdGM and EQuiP, which was shared by WONCA President Michael Kidd with the United Nations High Level Panel on Health Technologies earlier this year. I am a strong believer in the fact that by being proactive and using every appropriate opportunity we can push family medicine forward and improve the care we provide to patients. WONCA is the perfect place to collaborate and share our experiences.

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

My family doctor work in the office, caring for patients, takes half of my work time. I'm currently a part time family doctor in Bucharest and part time "activist" for doctors and patients in family medicine organizations. Last month I volunteered, as delegate of SNMF, to assist the current Health minister of Romania in improving the legal framework and financing for healthcare in general and primary care in particular.

So I would say my interests are health services organization, e-health, family medicine training, quality improvement. I am also interested in the doctor-patient relationship and how privatization of health systems is influencing this relationship. Too many managers and CEOs and too few doctors! Who do patients need the most?

Outside work I try to find time to enjoy nature and be physically active outdoors, because all my work keeps me mostly indoors and sedentary. Lately I haven't been very successful but I keep on trying! I enjoy reading, travelling, spending quality time with close friends and family, learning from experiences and life stories. Guess I picked the right medical specialty then, as we always get to know our patients' life stories as their family doctors.

Dr Claire Marie THOMAS
UK - VDGM president elect

Claire Marie Thomas (UK) is President elect of the Vasco da Gama Movement (VDGM) for European young doctors

What work do you do now?

I am a qualified General Practitioner (MRCGP 2014) passionate about global health, primary care, medical leadership and social justice. I have always strived to focus my attention internationally as well as locally, engaging in student and professional activities that have taken me across Europe and around the Globe, giving me a breadth of insight into different cultures and health systems. Currently I am completing a year of volunteering as a family physician in rural Uganda at Bwindi Community Hospital. My work here has combined clinical in-patient and out-patient activities with quality improvement, education and capacity building. In August I will be returning to the UK to work as a locum/salaried GP in Bristol, where I plan to engage with a local GP practice that serves the refugee/asylum seeker and homeless populations.

Other interesting things you have done (in brief)?

As an undergraduate I founded and chaired the Board of Trustees for the UK registered charity Students for Kids International Projects, in 2002. SKIP supports multi-professional teams of students to collaborate with local NGOs in resource poor settings. The aim is to empower communities to improve the health, welfare and education of vulnerable children, whilst simultaneously enhancing the personal and professional development of our student volunteers. After setting up our first project in Zambia, I spent 12 years working with a team of inspirational motivated individuals, building SKIP into a member-led democratic voluntary organisation, driven by seven core values of sustainability, working in partnership, respect for culture and traditions, empowerment, development, fun and enthusiasm. SKIP now has over 10 active projects in countries around the world. I retired from SKIP in 2014 and was honoured to later be elected as a lifelong patron.

My interest in global health led to me undertake a Diploma in Tropical Medicine and Hygiene. I have subsequently volunteered in rural hospitals in Nepal (2011) and Uganda, where I am due to complete a year of service this July. This work has combined frontline family medicine with teaching, mentoring and capacity building local staff and leading projects to develop services for key primary care challenges such family planning, chronic disease and gender based violence. Whilst undertaking this work I have developed a keen interest in Gender Equity and undertaken further studies in Sexual and Reproductive Health. I lecture on request on the topic of Global Health Careers, a talk that is now an annual feature of the Keele Medical School Global Health Special Study Module.

Outside of global health I have gained further leadership, team working and advocacy experience within the International Federation of Medical Students Associations, the British Medical Association and the Faculty of Medical Leadership and Management. I am a qualified life coach and have a Diploma in Neuro Linguistic Programming, enabling me to offer high quality mentoring and coaching.

In 2008, I co-founded Zero Generation, a non-profit foundation delivering regular training events to foster leadership and management skills amongst students and young professionals around the globe. Recently I also had the pleasure of working with Humans of Health as a trainer at their Healthcare Leadership Summer School, where amongst other things I focused on teaching the art of

utilizing narrative as a tool for leadership, sharing values and motivating others to act.

And the Vasco da Gama Movement?

I have been an enthusiastic contributor to VdGM activities since first discovering the movement in 2012, facilitating pre-conference workshops, attending exchanges, engaging in various Working Parties and Theme Groups, presenting at Forums and WONCA Conferences, kick starting the #FMChangeMakers initiative, organising Flash Mobs and most recently being invited to act as European Co-Liaison for the ASPIRE Global Leader Program.

It was not until I first joined a VdGM preconference in 2012 in Vienna that I found what I had been looking for: A place full of like-minded individuals, whose dreams and ideals mirrored my own.

I see the role of President is not only to coordinate and promote the activities of VdGM, but also to embody it's spirit. It is to inspire those around you to be their best version of themselves and to work with heart on the issues that matter to them. It is to dream big whilst delivering tangible outcomes and to approach VdGM as we would approach our patient care: with collaboration, empathy and passion.

I prefer instead to focus on the true essence of the Presidency which is the real reason we were all drawn to the Vasco Da Gama Movement and WONCA in the first instance: the heart, the narrative, the soul.

What are your interests outside work?

Outside of work I am a keen traveller and enjoy exploring the world with my husband Stuart, who works as a psychiatrist. We enjoy skiing, surfing, hiking and diving whenever we get the opportunity, rare as that may be in busy lives. In my spare time I play the ukulele (badly), read avidly and try my hand at cooking international cuisine (much to my husband's delight and despair).

Obituary

Dr Fons SIPS : 1940 - 2016

Vasco da Gama Movement founder

It is with great sadness that we today learned of the death on 22nd July 2016 of our great friend, colleague and one of the Founding Fathers of the Vasco da Gama Movement, Fons Sips.

Alphons Jacobus Ignatius Sips, known as Fons Sips, was born on 11th August 1940 in Heerlen, the Netherlands. Following his studies in medicine and psychology at the University of Nijmegen, in 1972, Fons settled as a single handed Family Doctor in the village of Vught, where he practiced until his retirement in 2006. Fons was also a Senior Lecturer at the University of Maastricht and a GP Trainer on the vocational training scheme and served as Secretary of the Dutch Board of GP/FM from 1987 – 1994.

In the early 1980s, Fons began his journey of involvement in European Family Medicine. From 1987 he served on the Board of SIMG, subsequently becoming Vice-President and then President. In the late 1980s and early 1990s, Fons was instrumental in the amalgamation of SIMG and WONCA. This culminated on 5th October 1995 with the inaugural conference of WONCA Europe; the celebration of an umbrella European structure including the National Colleges and the European Network Organisations (EURACT, EGPRN and EQuiP) took place in the meeting room of

the European Parliament in Strasbourg.

It is however, as one of the Founding Fathers of the Vasco da Gama Movement that we, in this, his Family, most fondly remember Fons. The foundations of our VdGM Family stretch back to 2002 during preparations for the 2004 WONCA Europe Amsterdam Conference. Along with representatives from EURACT and a small enthusiastic working party of trainees from the Netherlands, Fons was instrumental in developing a project; a preconference meeting for six international groups each involving students with EURACT Teachers as guides. This initiative was the effective birth of the Vasco da Gama Movement.

VdGM is a Family in which many new and future GPs / Family Doctors have, and continue to find, support and inspiration. It is a Family to which we are all proud to belong ... a Family that was created by Fons Sips! While VdGM has now become firmly established among the Networks of WONCA Europe and has grown immeasurably in its activities and collaborations, the passing of Fons Sips serves to remind us of the importance of ensuring that our culture, heritage, history and origins are never forgotten.

As a tribute to the vision and fortitude of Fons Sips, to mark his death and celebrate his life, and in recognising and expressing deep appreciation for his contribution and commitment to making VdGM the successful and vibrant organization it is today, we are proud to announce the creation of the “Fons Sips Outstanding Achievement Award”; the inaugural award will be made at WONCA Prague in June 2017.

Finally, to Aneke, Herman, Bernadette and Jacqueline on behalf of everyone in the VdGM Family, we offer sincere condolences and warmest best wishes at this time. While we have lost one of our Founding Fathers, you have lost your Father. We hope you will take solace in knowing the deep regard with which he was held in VdGM.

Dr Peter A Sloane
President, Vasco da Gama Movement
On Behalf of the entire Vasco da Gama Movement

See WONCA Europe obituary by Carl Steylaerts

http://vdgm.woncaeurope.org/3rdforumvdgm/welcome-message

WONCA CONFERENCES 2016

September 14-16, 2016	3rd Vasco da Gama forum	Jerusalem, ISRAEL	3rdforumvdgm
November 2-6, 2016	WONCA WORLD CONFERENCE	Rio de Janeiro, BRAZIL	www.wonca2016.com

- WONCA Direct Members enjoy *lower* conference registration fees.
- To join WONCA go to: http://www.globalfamilydoctor.com/AboutWONCA/Membership1.aspx

WONCA CONFERENCES 2017

March 23 – 25, 2017	WONCA East Mediterranean region conference	Abu Dhabi, UAE	Save the dates!
April 30 – May 3, 2017	WONCA World Rural Health conference	Cairns, AUSTRALIA	Save the dates!
June 28 – July 1, 2017	WONCA Europe Region conference	Prague, CZECH REPUBLIC	Save the dates!
August 17-20, 2017	WONCA Africa region conference	Pretoria, SOUTH AFRICA	Save the dates!
August 23-26, 2017	WONCA Iberoamericana-CIMF region conference	Lima, PERU	Save the dates!
November 1-4, 2017	WONCA Asia Pacific Region conference	Pattaya City, THAILAND	Save the dates!
November 25-26, 2017	WONCA South Asia region conference	Kathmandu, NEPAL	Save the dates!

WONCA ENDORSED EVENTS

08 Apr - 12 Apr 2017 **World Summit on Social Accountability** Hammamet, Tunisia

MEMBER ORGANIZATION EVENTS

For more information on Member Organization events go to
http://www.globalfamilydoctor.com/Conferences/MemberOrganizationEvents.aspx

04 Sep - 06 Sep 2016	**European Forum for Primary Care conference**	Riga, Latvia
07 Sep - 10 Sep 2016	**EACH 14th International Conference on Communication in Healthcare**	Heidelberg, Germany
08 Sep - 10 Sep 2016	**EURACT Educational conference in Dublin**	Dublin, Ireland
20 Sep - 24 Sep 2016	**AAFP Family Medicine Experience**	Orlando, Florida, USA
23 Sep - 24 Sep 2016	**6th EURIPA Rural Health forum**	6th EURIPA Rural Health forum
29 Sep - 01 Oct 2016	**RACGP GP 16 conference**	Perth, Australia
05 Oct - 08 Oct 2016	**11th JSFM conference for family medicine**	Amman, Jordan
06 Oct - 08 Oct 2016	**RCGP annual primary care conference**	Harrogate, United Kingdom
13 Oct - 16 Oct 2016	**EGPRN meeting**	Leipzig, Germany
20 Oct - 22 Oct 2016	**Rural Medicine Australia 2016**	Canberra, Australia
09 Nov - 12 Nov 2016	**Family Medicine Forum / Forum en médicine familiale**	Vancouver, Canada
30 Mar - 01 Apr 2017	**11th Congress of General Practice France**	Paris, France
05 May - 09 May 2017	**STFM Spring conference**	San Diego, California