

WONCA News

An International Forum for Family Doctors



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From the President: The World Bank, Romania & ICPC... read on

Dr Sandra Alexiu is a family doctor in Romania, and a member of WONCA's working party on rural practice. Sandra practices in a small community called Jilava, outside the capital city of Bucharest. Sandra works in partnership with a primary care nurse, and together they provide care to a population of 2,500 people.



Photo: Rural family doctor, Sandra Alexiu (left), at her family practice clinic in the small rural community of Jilava in Romania

In Romania family medicine is a recognized specialty, with three years of required postgraduate training and formal assessment at the end of training. Like several other countries in Eastern Europe, Romania reformed its health care system, based on family medicine and strong primary health care, about 20 years ago, in order to ensure that all people have access to high quality community-based health care.

More than 45% of Romania's population of 20,000,000 live in rural areas, and, as in many other parts of the world, it is family doctors like Sandra who are usually the only doctors serving rural communities.



Photo: Romanian Health Minister Nico Baniciou meets WONCA President, Professor Michael Kidd, and World Psychiatric Association leaders including President Dinesh Bhugra

I was in Romania in June to deliver the opening address at the 2015 World Psychiatric Association Congress, held in Bucharest. The conference had a special focus on the integration of mental health into primary care. A copy of my address is [available here](#).

The visit provided me with the opportunity to meet with Sandra and other family medicine colleagues in Romania and to discuss some of the challenges facing family medicine and the delivery of universal health coverage. Dr Rodica Tanasescu, president of WONCA's member organization in Romania, the National Society of Family Medicine, told me that there is a continuing challenge to define the role of the family doctor, and the required postgraduate training curriculum, in the face of what feels like endless rounds of health system reform. I was advised that Romania has had 24 health ministers in the 25 years since the end of Communism, each with their own ideas on health reform and the place of family medicine. In the meantime the nation's dedicated family doctors continue to deal with the challenges and uncertainty, and provide the best care they can, often with inadequate support and resources.

Photo: Dr Rodica Tanasescu and other leaders of Romania's National Society of Family Medicine at the Society's offices in Bucharest



Romania, like most countries, is seeking to strengthen the nation's primary health care system in order to best meet the needs of their population and ensure universal health coverage. The delivery of universal health coverage will receive global

attention in September 2015, when the United Nations adopts the new Sustainable Development Goals for 2015-2030. Nations will be looking for ways to measure whether they are meeting these new global development goals.

The World Bank, the Bill and Melinda Gates Foundation, and the World Health Organization (WHO) have established the new Primary Health Care Performance Initiative (PHCPI) to encourage countries, especially low and middle income countries, to achieve universal health coverage, by supporting improvements in each nation's primary health care system, through better measurement, knowledge-sharing of best practices, and the provision of practical tools to manage and improve delivery of essential health services.



Photo: Palace of the Parliament, Bucharest, Romania

WONCA has been asked to assist the World Bank, the Gates Foundation and the WHO in the development of these measures of primary care effectiveness. In June I was invited, as president of WONCA, to contribute to a meeting about the new Primary Health Care Performance Initiative, held at the World Bank Headquarters in Washington DC.

It is clear that to date attention appears to have been on "what we can measure, rather than on what we should be measuring". I see this as the fundamental challenge that will determine whether this initiative delivers real improvements in global primary health care. We should not be limited by current data sets as these largely focus on vertical program delivery.

Part of the challenge facing this Initiative is that the funders describe primary care as a "Black Box". A "Black Box" is something that can be viewed in terms of its inputs and outputs without any knowledge of its internal workings. I am troubled that our work in primary care is seen as a "Black Box". The work we do may seem impenetrable to health care policy makers and statisticians who haven't engaged closely with us,

but those of us working inside the "Black Box" see everyday the benefits of the work that we do with our patients and with our communities, and we understand the workings very well.

Primary care is a complex system, just like hospital-based health care, and is no more a "Black Box" than hospital-based health care. But what makes primary care more difficult to understand and measure are the added challenges of care delivery being distributed, rather than centralized, of being delivered by multiple types of health care providers, often with a mix of private and publicly-funded services with patients moving between providers, and with a lack of standardized ways to capture data about what we actually do.

WONCA recognized many years ago that we would not see the improvements we wanted to see in primary care unless we could measure what was happening in our clinics, and this required a standard system of coding and classification. This led to the development of WONCA's International Classification of Primary Care (ICPC), now part of the World Health Organization's Family of International Classifications. ICPC is used in many countries, including low and middle-income nations. Importantly ICPC does not just record the diagnoses made in primary care, but also allows us to record the Reasons for Encounter, the reasons why someone has presented to our clinic, and so allow us to capture details of our patients' symptoms and signs and allow us to examine health-seeking behaviours in different contexts. ICPC also allows us to record what happens following a consultation, through referrals to consultant specialist services, ordering of investigations and ordering of medications, which allows measurement of flow-on costs throughout the rest of the health system, and the targeting of education to support the efficient and effective use of limited health resources.

I am pleased to see that the vital sign indicators of new Primary Health Care Performance Initiative do not just include vertical disease-focused measurements, but also include important health system indicators that provide some indication of how well a nation's primary health care system is working. This includes measures of primary health care expenditure as a proportion of a nation's total health expenditure. This needs to be expanded to measure appropriate spending, especially on those activities that genuinely knit primary health care interventions together.

The new Primary Health Care Performance Initiative also includes a number of condition-

specific health outcome measures and, while these are important indicators of specific health improvements, the risk of focusing on these alone is that policy makers and funders will continue to pursue vertically-oriented approaches to health care, rather than focus on much needed health system strengthening measures.

I was asked by the World Bank and Gates Foundation to outline the sorts of measures that can demonstrate how well we integrate vertical programs into existing health systems to create primary care-led health systems.

For example, it is important to be able to measure where our primary care clinics are based, compared to the population. And particularly to measure whether we are meeting the needs of those communities in greatest need, including people who are poor or otherwise disadvantaged and marginalised, and especially those based in rural and remote locations.



Photo: Typical pharmacy in Romania

Similarly measuring the staffing profile in primary care is important and needs to include family doctors as well as community health workers, primary care nurses, midwives and birthing attendants. It is a mistake to think that people in low and middle-income nation don't want and deserve access to caring and competent primary care doctors. The presence of a doctor can turn around unfavourable local community attitudes towards a community health service and improve the quality and range of services on offer.

We need measures of the percentage of the graduating output of the nursing schools and medical schools in each country who are destined to work in the community in primary care. For doctors, WONCA believes this needs to be around 50% of all medical graduates if health systems are

going to be sustainable and equitable. Too many countries are training too many hospital-based medical specialists at the expense of strengthening their primary care medical workforce, with the attendant diversion of health spending away from the community where it is most needed.

We also need measures of whether a country values health care professionals who work in primary care. Is family medicine recognized as a medical specialty? Do doctors require supervised postgraduate training before being released to work in primary care? Do we send our most experienced doctors and nurses to work in the most challenging health care settings, in remote rural locations and with disadvantaged communities, or do we send recent medical and nursing graduates with no clinical experience and inadequate supervision? Are there opportunities for career advancement for those working in primary care? Are suitable clinic facilities provided to allow clinicians to use their skills and training to deliver the best quality care? And do nurses and doctors working in primary care, especially in remote rural areas, receive higher incomes than nurses and doctors working in hospitals? I use an index to compare countries called the "Health Minister's Salary Index". Does a family doctor working in a remote rural area receive a higher salary than the nation's Minister of Health? It seems to me that if a nation is paying its health care professionals working in the most challenging circumstances more than their politicians, they are probably on the right track.

One of the great challenges of universal health coverage is how do we adopt true person-centredness into our health services. We need to be able to measure person-centredness through indicators such as patient satisfaction, access to care after hours, access to home-based care, measures of continuity of care, access to interpreters, physical access to our clinics and services for those with a disability, and the integration of preventive care and health promotion services into primary care services. We also need to include measures of quality and safety in primary care, such as infection control, vaccine cold chain compliance, and our preparedness for epidemics of infectious diseases.

The so-called gatekeeper role of primary care providers is also important. Do people need to attend primary care before they can access expensive specialist consultant services and investigations? The gatekeeper role is an effective way to contain a nation's health care costs,

prevent unnecessary expenses for patients and their families, and tackle the challenges of overinvestigation and overmedication and potential iatrogenic harm.

These are all measures that indicate whether or not a nation values primary care and whether each nation genuinely sees primary care as the best way to ensure universal health coverage and improve the health and well being of their entire population.

Whether we like indicators or not, the Primary Health Care Performance Initiative of the World Bank and the Gates Foundation will be an important part of global primary health care development over the years ahead. It also provides a real opportunity for WONCA to work with other major global organisations to improve the quality of life of the peoples of the world through fostering high standards of care in family medicine.

Michael Kidd
WONCA President



Photo: A stork resting on a typical small church in a village in Romania's Danube Delta region

Foto: Una cigüeña en una pequeña iglesia típica de la región del Delta del Danubio de Rumanía

Del Presidente: El Banco Mundial, Rumanía y el ICPC... sigue leyendo

La Doctora Sandra Alexiu es una médica de familia en Rumanía, y también forma parte de la sección de trabajo en práctica rural de WONCA. Sandra ejerce en una pequeña localidad llamada Jilava, a las afueras de la capital Bucarest donde trabaja conjuntamente con una enfermera de Atención Primaria, y juntas dan asistencia a una población de 2.500 personas.



Foto: La médica de familia rural, Sandra Alexiu (izquierda), en su centro de medicina de familia en la pequeña comunidad rura de Jilava en Rumanía

En Rumanía la medicina de familia es una especialidad reconocida para la que se requiere formación post universitaria y una evaluación formal al final de ésta. Igual que en un buen número de países del este de Europa, Rumanía también reformó su sistema sanitario hace unos 20 años basándolo en la familia de medicina y fortaleciendo la asistencia primaria con el fin de asegurar el acceso de todo el mundo a un servicio sanitario de alta calidad.

En Rumanía, más de un 45% de un total de población de 20 millones, vive en áreas rurales y, como en muchos otros sitios del mundo, son los médicos de familia como Sandra los únicos que atienden a estas comunidades.

El pasado junio estuve en Rumanía para pronunciar el discurso de bienvenida del Congreso de 2015 de la Asociación Mundial de Psiquiatría, que tuvo lugar en Bucarest. La conferencia puso el foco en la integración de la

salud mental en la Atención Primaria. Mi discurso íntegro puede leerse aquí:

<http://www.globalfamilydoctor.com/AboutWONCA/PresidentsBlog/MentalHealthPrimaryCareandtheChallengeofUniversalHealthCare.aspx>



Foto: El ministro de Salud de Rumania Nico Baniciou se reúne con el presidente de WONCA, el profesor Michael Kidd, y los líderes de la Asociación Mundial de Psiquiatría incluyendo al presidente Dinesh Bhugra

La visita me dio la oportunidad de conocer a Sandra y a otros colegas médicos de familia en el país y pudimos conversar sobre los retos de la medicina de familia y la cobertura sanitaria universal. La doctora Rodica Tanasescu, Presidenta de la Sociedad Nacional de Medicina de Familia de Rumanía (organización que forma parte de WONCA) me explicó que se encuentran en un constante desafío con respecto a la definición del rol del médico de familia y la formación realmente necesaria tras los estudios universitarios para poder encarar las reformas del sistema. Me informaron de que Rumanía había tenido 24 ministros de sanidad distintos durante los 25 años después del comunismo, cada uno con sus propias ideas sobre las reformas del sistema de sanidad y el lugar de la medicina de familia. Mientras tanto el país ha dejado que los médicos de familia se enfrentasen solos a sus retos e incertidumbres y dieran la mejor asistencia posible, a menudo con recursos y apoyos insuficientes.

Foto: Doctora Rodica Tanasescu y otros líderes de la Sociedad Nacional de Rumanía de Medicina de Familia en las oficinas de la sociedad de Bucarest

Rumanía, igual que muchos de los países, busca fortalecer el sistema de asistencia de atención primaria con el fin de identificar las necesidades de su población y asegurar la cobertura universal.



Precisamente este debate recibirá atención global el próximo septiembre de 2015, cuando las Naciones Unidas adoptarán los nuevos objetivos de Desarrollo Sostenible 2015-2030. Los países debatirán sobre formas de cuantificar si se logran o no los objetivos fijados.

El Banco Mundial, la Fundación de Bill y Melinda Gates y la Organización Mundial de la Salud han creado la nueva Iniciativa de Acción en Asistencia Primaria (OMS) para incentivar a los países, especialmente aquellos con índices de riqueza medios y bajos, a que consigan la cobertura sanitaria universal, apoyando las mejoras de sus sistemas sanitarios mediante un mejor dimensionamiento, conocimiento y compartición de las buenas prácticas, así como la provisión de herramientas para gestionar y mejorar la asistencia de servicios de salud esenciales.

Se le ha pedido a WONCA que asesore tanto al Banco Mundial como a la Fundación Gates y a la OMS en el desarrollo de estas medidas de efectividad de la Atención Primaria. En junio fui invitado, como presidente de WONCA, a colaborar en un encuentro sobre la nueva Iniciativa de Acción en Asistencia Primaria que tuvo lugar en la sede del Banco Mundial en Washington DC.

Parece claro que hasta la fecha se ha puesto la atención en “aquello que podemos medir, más que en lo que deberíamos estar midiendo”. Este hecho me parece el reto fundamental que determinará si esta iniciativa podrá ofrecer mejoras reales en el sistema de atención primaria global. No debemos sentirnos tan limitados por las situaciones actuales como por las de una visión a largo plazo.

Parte del reto al que se va a enfrentar esta iniciativa es que los inversores describen la atención primaria como la “caja negra”. Una caja negra es algo que puede ser descrito en términos de evaluar los cambios que se producen tras la entrada y la salida en ella pero desconociendo el funcionamiento interno. Me preocupa que nuestro trabajo en Asistencia Primaria sea visto como una caja negra. El trabajo que hacemos puede parecer impenetrable para los redactores de pólizas de seguros o los estadistas que nunca se nos hayan unido, pero aquellos que sí han trabajado con nosotros dentro de la caja negra ven cada día los beneficios de lo que hacemos con nuestros pacientes y

con nuestras comunidades, y entienden cómo



funciona.

Foto: Palacio del Parlamento, Bucarest, Rumanía

La Atención Primaria es un sistema complejo, igual que la asistencia sanitaria de un hospital, y no es una caja más negra que la de un hospital. Pero lo que la hace más difícil de entender y cuantificar es que, en vez de centralizarse, se repartan los retos añadidos entre múltiples clases de proveedores de salud, a veces con una mezcla de servicios privados y semipúblicos con los pacientes moviéndose entre los proveedores médicos, y con una falta de formas estandarizadas de recogida de datos que cuantifiquen qué se les está haciendo en cada momento.

WONCA reconoció hace algunos años que sin poderse medir lo que pasa en nuestras clínicas no era posible ver las mejoras que queríamos que se produjeran en la Atención Primaria. Para poder hacerlo debíamos acordar un sistema de calificación y cuantificación. El departamento de Calificación Internacional de la Atención Primaria (ICPC en sus siglas en inglés) desarrolló el sistema, que ahora está integrado en el departamento de Calificaciones Internacionales de la OMS. El ICPC se utiliza en bastantes países, también en los de rentas medias y medio-bajas. El ICPC no solo recopila los diagnósticos hechos en Atención Primaria, sino que también nos permite recoger las "Razones de la Visita", razones por las cuales los pacientes van a la consulta, y nos permite dejar constancia de los síntomas de estos y de sus rasgos, haciendo posible el examen de los distintos aspectos por los cuales se acude al médico. El ICPC nos permite dejar constancia de lo que pasa tras la consulta, mediante el registro de las distintas derivaciones a otras especialidades, la prescripción de pruebas y de medicación – facilitando así el cálculo de los costes en el global del sistema sanitario – y, finalmente, los objetivos en educación para apoyar el uso eficiente y efectivo de los limitados recursos de los sistemas de asistencia.

Me complace ver que los indicadores vitales de la nueva Iniciativa de Acción en Atención Primaria no solo incluyen datos de enfermedades, sino que también recogen indicadores del sistema de salud que permiten saber hasta qué punto funciona bien la Atención Primaria de un país. Esto incluye los datos de gasto en inversión en Atención Primaria en proporción al gasto global en salud de un país. Es necesario saber el gasto total para poder medir si la inversión es la apropiada, especialmente en aquellas actividades que unen genuinamente distintas intervenciones.

La nueva Iniciativa de Acción en Atención Primaria incluye también una cifra de medición de resultados específica y, mientras estos indicadores de mejora de la salud son importantes, el riesgo de focalizar toda la atención solamente en estos es que las compañías aseguradoras y los inversores van a mantener una visión vertical a la asistencia en salud, en vez de tener en cuenta las medidas de ámbito más general tan necesarias para el fortalecimiento del sistema.

Desde el Banco Mundial y la Fundación Gates se me pidió que explicase la clase de medidas que permiten demostrar como integramos los programas verticales en los sistemas de salud ya existentes con el fin de enfocarlos a la orientación de la salud centrada en la persona.

Por ejemplo, es importante ser capaces de medir dónde se localizan nuestros centros de atención primaria, comparados con la población. Y, especialmente, ver si estamos cubriendo las necesidades de aquellos grupos sociales con más necesidades, incluyendo la gente pobre o en situación de exclusión social, poniendo el énfasis en aquellos que viven en zonas rurales y aisladas.

Del mismo modo la medición del perfil del personal en la atención primaria es importante y debe incluir a los médicos de familia, así como a los trabajadores de salud comunitarios, a las enfermeras, a las matronas y a los asistentes de parto. Es un error pensar que la gente de un país con una tasa de ingresos bajos y medianos no quiera ni merezca el acceso a los médicos de atención primaria que cuiden y que sean competentes. La presencia de un médico puede cambiar las actitudes de la comunidad local en entornos desfavorables y convertirlas en positivas hacia un servicio de salud que se preocupe de esa comunidad y mejore su calidad de vida y la variedad de servicios que se ofrecen.

Necesitamos saber cuáles son los porcentajes de graduados en enfermería y en escuelas de medicina de cada país destinados a trabajar en Atención Primaria. En el caso de los médicos, WONCA estimó que el porcentaje debía ser de alrededor de un 50% de todos los médicos graduados si se quiere que un sistema de salud sea sostenible y equitativo. Hay un número demasiado alto de países que está formando demasiados médicos especialistas hospitalarios a expensas de fortalecer su fuerza de trabajo médico de atención primaria, con un notable desvío asistencial de la inversión en salud respecto la comunidad que más lo necesita.



Foto: Típica farmacia de Rumanía

También necesitamos medidas para saber si un país valora los profesionales de la salud que trabajan en Atención Primaria. Es la medicina de familia reconocida como una especialidad médica? ¿Requieren los médicos de supervisión y formación tras la universidad para trabajar en Atención Primaria? ¿Se están realmente mandando los médicos y las enfermeras con más experiencia a trabajar a los centros de atención de salud que presentan más complicaciones, en zonas rurales remotas y con las comunidades desfavorecidas, o más bien estamos mandando a los recién graduados de medicina y enfermería sin experiencia clínica y con una supervisión inadecuada e insuficiente? ¿Hay oportunidades para la promoción profesional de las personas que trabajan en la atención primaria? ¿Son las instalaciones clínicas que proporcionamos a los profesionales las más adecuadas para permitir que los médicos a utilicen sus habilidades y preparación y ofrezcan la mejor calidad en la atención? ¿Y reciben las enfermeras y los médicos que trabajan en las zonas rurales remotas mayores ingresos que las enfermeras y los médicos que trabajan en los hospitales? Yo consulto un índice para comparar los países llamado el "Índice Salarial del Ministro de Salud". ¿Tiene un médico de familia que trabaja en una

remota zona rural un salario más alto que el del Ministro de Salud del país? Me parece que si un país paga más a sus profesionales sanitarios que trabajan en circunstancias difíciles que a sus políticos está en la dirección correcta.

Uno de los grandes retos de la cobertura universal de salud es ¿cómo adoptar un servicio centrado verdaderamente en la persona? Tenemos que ser capaces de medir esta característica a través de indicadores como la satisfacción del paciente, horas necesarias para el acceso a la atención, acceso a la atención domiciliaria, medidas de continuidad de la atención, acceso a intérpretes, acceso físico a nuestras clínicas y servicios para las personas con una discapacidad, y integración de los servicios de atención y promoción de la salud preventiva en los servicios de Atención Primaria. También tenemos que incluir medidas de calidad y seguridad, como el control de la infección, el cumplimiento del calendario de vacunaciones, y nuestra preparación para epidemias de enfermedades infecciosas.

La llamada función de guarda de los proveedores de atención primaria es también importante. ¿Las personas tienen que asistir a la Atención Primaria antes de poder acceder a los servicios más caros de especialistas y pruebas de diagnósticos? El papel de guarda es una manera eficaz para contener los costes del cuidado de la salud de un país, evitar gastos innecesarios para los pacientes y sus familias, y hacer frente a los riesgos de un sobrediagnóstico y una sobremedicación con el potencial daño iatrogénico.

Estas son todas las medidas que indican si un país valora o no la Atención Primaria como la mejor manera de garantizar la cobertura universal de salud y de mejorar la calidad de vida y el bienestar de toda su población.

Nos gusten o no los indicadores, la Iniciativa de Acción en Atención Primaria de Salud del Banco Mundial y la Fundación Gates será una parte importante del desarrollo mundial de Atención Primaria de salud en los próximos años. También proporcionará una oportunidad real para WONCA de trabajar con otras grandes organizaciones mundiales con el fin de mejorar la calidad de vida de los pueblos del mundo a través del fomento de altos estándares de atención en la Medicina de Familia.

Michael Kidd

Presidente de WONCA

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

From the CEO's desk: looking forward to Rio & Istanbul

Hello again

August already – where does time go to? Those of you in the northern hemisphere will be thinking of holidays, whilst many in the southern hemisphere are having to cope with the winter cold. That being said, I'm just back from Brazil where it was a very pleasant 32 degrees in Natal and around 30 degrees in Rio de Janeiro – it makes me wonder how hot it will be by November next year, as their summer approaches and when we hold our next WONCA world conference!

Brazil

As I mentioned last month, the latest meeting of the WONCA 2016 World Conference Planning Committee (CPC) took place in Brazil on 12th and 13th July, with Dr Dan Ostergaard and I staying on for additional meetings until 16th July. We, together with Professor Michael Kidd and Dr Bohumil Seifert, had been invited to attend the national conference of the Brazilian Society of Family and Community Medicine (SBFMC) in Natal, a three hour flight north of Rio and it was terrific to meet up with many friends and colleagues from all over Iberoamericana and not just Brazil. There was a great turnout of young doctors from the [Waynakay Movement](#) too.

The two days of the CPC meeting were really useful, as we heard from Dr Gustavo Gusso (Chair of the Rio Host Organizing Committee - HOC) about HOC activities since our last visit in October last year. Whilst there is still much to be done, huge progress has been made, and plans for abstract submission are almost complete. There will be up to eight plenaries throughout the conference, with careful attention to gender and geographical equity, and we look forward to presentations from colleagues such as Amanda Howe (UK), Katherine Rouleau (Canada) and Peter Gotzsche (Denmark). The remaining keynote speakers have been chosen, but have not yet confirmed their availability, but they will all bring something special to the conference. We also hope to have senior WHO representatives present, further strengthening the collaboration between our organizations.

Early bird registration continues to November this year, so it's a fantastic opportunity to register for a bargain price. In addition, the Rio HOC are offering particularly generous discounts for all WONCA Direct Members, so if you haven't already signed up for Direct Membership then there is now an extra incentive. [Click here](#) for more details of WONCA Direct Membership.

For further details of the conference, and also the hotels, social activities and tours being arranged, keep an eye on the [conference website](#) or you can always access full details through the [WONCA website](#).

I also thought it might be helpful to give you all some dates for your diaries around Rio conference time. The diary is starting to look like this:

Monday 24th & Tuesday 25th October 2016	WONCA Executive gather in Rio de Janeiro and travel to Paraty.
Wednesday 26th to lunchtime Friday 28th October	WONCA Executive meeting in Paraty
Saturday 29th October	WONCA Regional meetings at Windsor Hotel, Barra di Tijuca, Rio de Janeiro



	Evening welcome reception for Council delegates
Sunday 30th October to Tuesday 1st November lunchtime	WONCA World Council at Windsor Hotel, Barra di Tijuca, Rio de Janeiro
Tuesday 1st November afternoon	New WONCA Executive meets at Windsor Hotel. Some WPs and SIGs may also arrange to meet.
Wednesday 2nd November	WONCA WPs and SIGs meet at RioCentro (the conference centre)
Wednesday 2nd November	Conference opening ceremony at 6pm, followed by welcome reception.
Thursday 3rd to Sunday 6th November	WONCA World Conference at RioCentro. Closing ceremony at lunchtime on Sunday 6th.

Istanbul

Of course we still have the WONCA Europe conference to look forward to in Istanbul from 22nd to 25th October. It's particularly exciting that we are managing to bring together the leads of all seven of our young doctor movements, to take part in the Vasco da Gama pre-conference and also to meet with the WONCA leaders. More details about the Istanbul conference are available at www.wonca2015.org.

2016 regional conferences

And as well as looking forward to Rio in November 2016, before that we have a number of regional conferences to look forward to in 2016:

- South Asia Region conference in Colombo, Sri Lanka, on 13th and 14th February. See www.woncasar2016.com for further details.
- Eastern Mediterranean Region conference in March in Dubai (dates to be confirmed)
- Iberoamericana-CIMF Summit in Costa Rica on 11th and 12th April, with Mesoamerican Conference 14th to 17th April
- Europe Region conference in Copenhagen, Denmark, from 15th to 18th June. See www.woncaeurope2016.com for more details.

WONCA Annual Report

I mentioned the WONCA Annual Report in my column last month, but I just want to send out a brief reminder to all Regional Presidents, and Chairs of WONCA Working Parties and Special Interest Groups, to get their contributions to us as soon as they can. 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 to be inundated with contributions.

Until next month.

Dr Garth Manning
CEO



20th
Wonca Europe
Conference 2015
istanbul

October 22-25, 2015

Halic Congress Center
Istanbul / TURKEY

www.wonca2015.org



Policy bite: The modern primary care workforce



Prof Amanda Howe, President-elect, writes:

I have recently been a member of an independent 'Commission' to make recommendations about the primary care workforce in England. For those unfamiliar with

this model of working, a group of experts can be requested to gather and evaluate evidence and then feed back to the 'commissioners' – usually a government department, or a professional body. It is a way of getting independent advice fed into strategy where there is a need for new ideas, or where opinions may conflict.

This one was set up in response to the increasing concerns about disinvestment in family medicine and its supporting staff and infrastructure.. As the report said *"Investment in primary care has fallen well behind investment in hospitals, despite increasing expectations of the work that should be done in primary care. Between 2003 and 2013, the number of hospital consultants increased by 48 per cent while GP numbers increased by only 14 per cent. Indeed, the number of GPs per head of population has declined since 2009, with major problems of recruitment and retention. Nursing is another area of serious concern, with an ageing workforce in general practice nursing and similar problems of recruitment and retention."*

It was a lot of time and effort, but very interesting to put one's own ideas to scrutiny by equally intelligent and critical peers from other backgrounds (nursing, pharmacists, public health, and policy makers). We gathered and read evidence, had people attend to give witness and answer questions, and made site visits across England. The report makes more than 50 detailed recommendations, and is to be formally launched in September. The key areas that I think will be of interest to WONCA colleagues are, first, the fundamental policy statement that *"there need to be sufficient staff with appropriate training to do the work that is needed in primary care, and individual staff members need to have the skills to evaluate what they are doing and be empowered to improve the systems in which they are working"*.

But we stopped short of saying exactly how many doctors, nurses, or other health care and administrative assistants are needed per head of population, because we know that some practices are much 'higher demand' than others, and also

that different workforce configuration work for different settings. For example, in my very interesting trip to Iran recently, I saw the excellent service delivered to rural communities by the cadre of village health workers known as *behvarz*, who are locally recruited and combine a number of preventive, educational and acute assessment functions. In one of our UK visits, we saw a practice with nurse-led clinics and doctors taking only their referrals: but also a large community service with doctors doing *all* front line assessment and signposting patients (after email or telephone discussion) to different members of the team according to need and preference.

We recommended that all primary care teams are likely to benefit from the following categories of staff –

- FM / GP postgraduate trained doctors
 - primary care nurses
 - health care assistants (basic training but able to do specific tasks and assist other staff)
 - administrative and managerial staff;
 - and local strong links with others who can do assist our work in urgent and emergency care ('paramedics'): community level palliative care: pharmacists who give specific services for review of medications and patients with complex needs: and social and community level care interventions.
- We also were very concerned about the relative lack of career structure for staff in primary care. The diversity of settings should not mean that professional development and proper support and training is neglected in the primary care setting, whether public or private. Many staff said that one of the reasons that doctors and others were reluctant to enter primary care and community careers was because they could not see how they could be secure in their roles, get regular updates, and develop themselves over time. WONCA's attention to CPD and educational standards is really important here, as more countries develop their primary workforce.

The other 'headline' was about upscaling and 'safety in numbers'. Many teams found that, where they could collaborate across a community, they had better refreshment and resilience – discussions with colleagues, sharing on call and holiday cover, and organising training often seemed to be helped by networking between clinics. Also, new services, more senior staff shared across practices, and sharing supervision of students, residents, and those new to the area, seemed to help recruitment and education thrive.

Some of this was being done through email and Skype, especially in rural areas. But the old adage 'a burden shared is a burden halved' seemed to help. So we should think about who we can work with and seek help from, in order to reduce professional isolation and practical demands.

I hope when the full report is made public that it will provide more food for thought. In the

meantime – think big: tell your governments that investment in primary care will serve them and the people well – and if you are not already working in teams, consider it. All countries are having these discussions and I hope this will stimulate and inform your own debates.

Fragmentos de política: médicos de familia – a qué nos referimos realmente? Julio 2015

Este ha sido un mes especial para algunos. Desde un punto de vista personal, para mí la gran noticia es que he visto el nacimiento de mi primer nieto, y nuestra amiga y colega la doctora Luisa Pettigrew (miembro histórico del departamento ejecutivo de WONCA Ejecutivo) ha tenido su segundo hijo. Esto me ha hecho reflexionar sobre la palabra y el significado de la familia: "aquellos a quienes estamos unidos por la sangre (1), en lugar de la fe, la raza, la comunidad o los intereses comunes."

Pero los médicos de familia son definidos claramente como aquellos que no tratan a su propia familia – en realidad, en el Reino Unido se desaconseja específicamente que sea así, a causa de factores como un exceso de implicación emocional y el hecho de sobrepasar los límites al debatir posibles riesgos personales (2). Así pues, ¿qué significa ese profundo compromiso con la "familia" de nuestro nombre? De noche, últimamente, cuando tras el nacimiento me encontraba sentada en una sala de hospital, pensé:

Testimonio: Vemos la vida de los demás, intentamos ayudar, reconfortar y aconsejar, pero no controlar.

Observar y esperar: Por muy duro que trabajemos, los cambios en la salud y la enfermedad están rodeados de incertidumbre, de esperanza y desesperanza, de vida y de muerte. A diferencia de muchas disciplinas médicas, nosotros reconocemos la inevitabilidad de algunos malos resultados, sabemos que la biología puede jugar malas pasadas y nos esforzamos para evitar la intervención y el heroísmo excesivos. Vemos cambiar los síntomas, vemos curarse las heridas y hacemos uso del tiempo para revelar diagnósticos y tratamientos adecuados.

Cuestionarse – porque en un sistema de salud fuerte, todos los días y todas las noches, a cada

paciente, en todos sus altibajos, un médico de familia dice hola y nos trata como si fuéramos de la suya, dándonos una atención de alta calidad constante seamos como seamos, pequeños o grandes, blancos o negros, enfermos o sanos, viejos o jóvenes, altos o bajos, y hay algunos que incluso nos sonrían y nos abrazan, y sentimos al otro como a un aliado en un mundo difícil.

Hacer frente a los traumas y dificultades de abrazar la humanidad es, sin duda, un gran desafío – pocos pueden hacerlo tanto tiempo. También debemos dormir, desconectar, entregarnos y apoyarnos en los demás. Así como los padres necesitan respaldo, reconocimiento y renovación, los médicos de familia también los necesitamos, aunque a veces los obtenemos con el acto de la educación. Y por eso ahora soy nuevamente consciente de que aquí es donde está la grandeza de los profesionales de la salud, especialmente aquellos de la medicina de familia. Nos entregamos a los sucesos vitales y a las transiciones – las vidas se viven a través nuestro, y nos implicamos con las vidas de nuestros pacientes y comunidades. Me emocionó mucho escuchar que cuando Michael me excusó en el encuentro regional africano de Ghana, la gente aplaudió las razones por las que me quedé en casa ("La presidenta electa está enclaustrada esperando la inminente llegada de su nieto"). Así que luchemos para hacer lo mejor por nuestros pacientes – como si se trataran de nosotros mismos.

Amanda Howe

1. [source accessed here](#)
2. www.gmc-uk.org/guidance/10247.asp

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

Feature stories from around the world

Rural Round-up: a rural practice in Southern Italy

An example of continuity of care across two generations of family doctors.



In this month's rural round-up, Dr Ferdinando Petrazzuoli describes his rural practice in Ruviano, Province of Caserta, Regione Campania in Southern Italy

I am a middle aged Italian family doctor who lives and works in a rural

village in Southern Italy. My rural home village is called Ruviano in the province of Caserta, Campania region. It has less than 2000 inhabitants, and is about a one hour drive from Naples. I work in a solo doctor practice and my surgery is in a wing of my own house. This is quite unusual and considered barely legal nowadays, but is tolerated as I started my practice long ago.



Photo: My house - my practice is in the right side.

Living and working in the same building has its advantages and disadvantages. You save time and money but are on call all the time. My patient list consists of nearly 1500 patients. Over 35% of my patients are over the age of 65. (Children under six years are cared for by the local health district paediatrician.) Many patients are farmers.

I have been working as a family doctor since 1989. To be honest this was not my initial choice but the result of the lack of prospects in another field: cardiology.

Map: where is Ruviano?



I have a diploma in cardiology and another in cardiac surgery and used to work at the University Department of Cardiology and Cardiac surgery of the University "Federico II" in Naples. Unfortunately in 1989 my father, who was also a family doctor in my home village, died so I decided to take over. It was not an easy decision for me at that time, but one I will never regret.

My patients know me not only as a doctor but as a person and I know most of my patients just as well. Usually I don't have to ask for a family medical history - I already know their family medical history. Many of my patients used to be my father's patients and some elderly people with early cognitive problems tend to get confused and speak to me as I were my father, often reminding me gratefully of the good old times when I saved their lives in the late fifties!!!

In Italy patients are free to access their family doctor whenever they require medical attention. In my area family doctors usually see patients without appointments.

Although this system has some advantages in terms of access, nothing can be done to stop patients from attending at all hours for minor diseases and the phenomenon of "frequent attenders" is widespread.

Family doctors also perform home visits as required. I perform at least 35 home visits per week, especially for patients who aren't mobile. Most of the elderly remain in their own homes and their caregivers are often middle aged ladies coming from Eastern Europe.

The family doctor service officially runs on a 12-hour basis, five days a week. Between 8pm and 8am on weekdays, and from Saturday 10am to Monday 8am patients are supposed to refer to an "on call service" but many rural patients rely heavily on their local GP. Emergencies are dealt with by an emergency system called 118 (actually 118 is the phone number of this service!)



Photo: My surgery

Some of us are accredited for Vocational Training for GPs, and already teach medical students during their clinical GP attachments.

I usually deal with serious ailments and chronic diseases but my work is also bureaucratic: repeat prescriptions and transcriptions of specialists' prescriptions, what feels like hundreds of certificates and so on, fortunately my secretary gives me a hand.

In Italy, continuity of care is provided through patient registration and most family doctors have electronic patient records. Private primary care is practically non-existent – especially in poor rural areas. Family doctors are paid according to a capitation system: they have a fixed list of patients and are paid according to the number and age of patients on that list.

Public secondary care usually works with an appointment system, but patients have to be referred by their own GP who holds a gate keeper role.

Secondary and tertiary care can be accessed through a completely private service that is expensive and not very popular or through two different types of public hospitals to which patients can be referred free of charge. These free

services are provided in state owned and non-state-owned clinics and hospitals.

There are often long waiting lists for state owned centres but fortunately not for the non-state owned centres and most patients are referred into this part of the service.

This creates some ill-feeling from time to time. Health authorities are often complaining and accusing family doctors of being affected by some sort of illegal pressure from the non-state owned clinics!!

Primary care in Italy is well organised and it has succeeded in promoting and providing satisfactory preventive and curative health services. The basic health needs of my patients are met.

What is lacking is the provision of rehabilitation services. Domiciliary health services for the elderly and disabled people are almost non-existent except for some basic community nursing.

A weak point is that family doctors in Italy don't have the rights and working conditions that most of our hospital colleagues have. For example, unlike them we have to pay for locums if we need to take sick leave, study leave or when we decide to go on holiday.



Photo: Ruviano

I enjoy being part of WONCA.

I started attending the WONCA Europe Conferences in 2001 in Tampere Finland, and since then I have never missed one. In 2002, I started attending the European General Practice Research Network (EGPRN) Conferences in Avignon, France, and in 2008, I became the Italian national representative of EGPRN. In 2010, I was elected as a member of the EGPRN executive board. Now I am still on the EGPRN executive board and I am the chair of the Education Committee.

I joined EURIPA, in 2006, and I have been involved in many initiatives, sometimes joint EGPRN-EURIPA activities, over the past five years. Recently I have been nominated as chair of the EURIPA research committee, a position that was held by the late and never forgotten Claudio Carosino.

That's just a small insight into the working life and interests of an Italian rural family doctor.

If you would like to contact Ferdinando e-mail: ferdinando.petrazzuoli@gmail.com

Chloé Perdrix writes:

India and Kyrgystan - two very different countries, two very different experiences of primary care.



Photo - Himalaya, 5200m high!

My name is Chloé Perdrix, I'm a 27 year old French GP resident. I am taking a sabbatical year travelling around Asia. In order to stay in touch with the medical network, I intend to meet general practitioners during this journey. I proposed to WONCA and the Vasco da Gama Movement (VdGM), to write an article each two months in order to share my discoveries, my questions and my reflections about this experience. This is my sixth story.. to see others [click here](#).

India

India's Family medicine residency and health system compared to France. In New Delhi, I had the pleasure to present the Family Medicine (FM) residency organization in France to some Indian residents. Then, we compared my country's family residency and health system with the Indian ones.

I learned that there is no public health insurance in India. All health expenses are chargeable to patients. Private health insurances do exist.

In France, it is different. The French system of Social Security is financed largely by contributions based on the wages of employees. (5) These contributions are managed by the « Sécurité sociale » (French public health insurance) which distributes this money to partially refund people

who need health care. French health system is based on solidarity - for example, the public insurance refunds 70% of the price of a GP consultation. What is left is chargeable to the patient who

often contributes to an additional private insurance to be totally refunded. (a GP consultation is 23 euros in France).

I also learned that Family Medicine residency in India is not mandatory, but has been available since 2009. The residency lasts two years and ends with a very difficult exam which evaluates students on a very large number of competencies which go beyond family medicine ones. For example, they have to learn how to perform an appendectomy (appendectomy).

But studying for this difficult exam doesn't seem to be enough for residents to feel ready to work in primary care after finishing their studies. Indeed, according to what I was told during this meeting, a lot of them prefer working one or two more years in hospitals to improve their practice.

In France, residents feel the same at the end of their studies – they fight to change rotation schedule so that as Family Medicine residents they feel ready to work as General Practitioners at the end of their studies. To achieve this aim, we asked for more rotations in primary care centres. Indeed, our education and training is mostly in hospital based. We only have six mandatory months in general practitioners' clinics during our three years of specialisation training.



Photo - cows are holy in India, so they can stay in the middle of a road without being scared for their life.

In India, I think this problem is the same. FM Residents don't have any mandatory rotations in primary care centres during their residency. How can they feel ready to be a general practitioner if they have never faced real primary care situations?

During this meeting, I met Dr Raman Kumar, Chairman of Academy of Family Physicians of India (AFPI) and WONCA World executive member, and Dr Bhavna Matta, President of The Spice Route Movement for young doctors in the WONCA South Asia Region. I am always very honoured to meet and spend time with such active general practitioners. I thank them again for their availability and hope that Bhavna passed her exam successfully.

Indian castes and human rights

In India, Romain and I noticed with sadness that caste discrimination still remains despite of government efforts.

Dalit, meaning "oppressed" in Marathi, is the self-chosen political name of the castes who were formerly considered "untouchable" according to the Hindu varna system. (1) Their official name is « Scheduled Castes ».

Dalits are 'outcastes' falling outside the traditional four-fold caste system consisting of the hereditary Brahmin, Kshatriya, Vaishya, and Shudra classes. Indian culture still considers them as impure. They are therefore physically and socially excluded and isolated from the rest of Indian society.

During our journey in India, we witnessed men, women and children who were extremely under-nourished, begging on the street, collecting empty

bottles of water to sell them. One day, in the train I saw one person being insulted by another from an upper caste because he dared to touch him. The most difficult thing for me was to walk on the street and see dozens lying on the ground like animals, without any covers or pillows. Just laying, sometimes in the middle of the street, and trying to survive.

Dalits represent a community of 170 millions of people in India, constituting 17% of the population. Dalits regularly face discrimination and violence which prevent them from enjoying the basic human rights and dignity.(2)

Discrimination remains in things like education, healthcare or politics. According to a survey undertaken in 565 villages in 11 major states of India led by « National campaign on Dalit human rights », medical field workers do not visit 65% of Dalit settlements, 47% of Dalits are not allowed to enter into ration depots.

In a large number of state schools, Dalit students are requested to sit in the back of the classroom, and are forbidden from touching mid-day meals. They are required to sit separately at lunch or are required to eat with specially marked plates. (1)

To finish this section on a positive note, the Indian government, since its independence in 1947, has provided jobs and educational opportunities for Dalits.

To prevent harassment, assault, discrimination and other criminal acts on scheduled castes and scheduled tribes, the Indian government also enacted the Prevention of Atrocity (POA) act on March 31, 1995. The Act denoted specific crimes against Scheduled Castes and Scheduled Tribes as "atrocities" and created corresponding punishments.(3) Furthermore, the 17th Article of the 3rd part of Indian constitution abolished untouchability. (4)

Photo: on a train in India



But there is still a long way to go for these people to get basic human rights, as this discrimination towards them has existed for many centuries.

If you want to know more about this population and its story, read the links in the bibliography.

Kyrgystan and its national drinks

Our primary care experience in Kyrgystan was almost all about traditional medicine and national drinks.

We discovered «Kymys», which is alcoholised horse milk fermented in a sheep skin. (see picture of Romain, my brother, carrying this recipe). The taste is very special but we had to get used of drinking it because all the Kyrgyz people we met offered us several cups of it.

Photo - Romain carrying a sheep skin where Kymys ferments several days

Kymys is known to be good for digestion (ulcer prevention), blood, and fertility.

We also discovered «Maksym», named «Jarma» in the Naryn Region and «Shoro» in the Bishkek region. It is a drink based on wheat, water and oil, all fermented together for several days before being drunk. It helps digestion, has good nutritional value, and prevents blood conditions such as anaemia.

Finally, there is vodka, imported due to the Russian influence (Kyrgystan used to be a Russian colony, until its independence in 1991). Of course, I won't advertise vodka's health qualities because it would be against my medical ethics. ;)

Some Kyrgyst people drink it from the morning to the evening to give them strength, and to help them to work in the cold mountains. We can imagine the health consequences about that ...

Nevertheless, thanks to vodka and the kyrgyst legendary hospitality, we made good friends like Altynbek, Timur, Jourzu, Nadirbek, Nyrlan and Tilek. And I also had a lot of marriage proposals (which I politely declined)!!



Photo - Yourts and landscape in Kyrgystan

Kyrgystan is a very beautiful country, with almost universally, a rural life. Landscapes are made of mountains covered by grass, lakes, horses and yourts.

Kyrgyz people are nomads and practice mostly the Muslim religion. Religious practices are however adapted to fit with the nomadic way of life.

And last but not least, this is the only country where we could drink water directly from the river without needing any purification! This is so rare!

Our stay in Kyrgystan was a real breath of fresh air!

See you next time for my last article about Mongolia and Russia! And hope to meet some of you to the VdGM preconference and the WONCA Europe conference in Istanbul in October!

Photo: Kyrgyz people

My best regards,

Chloé Perdrix

Bibliography online:



Occupational Health - China and Thailand

WONCA News has begun a regular feature on the subject of Occupational Health including useful resources for clinical practice. Peter Buijs (right) & Frank van Dijk (left) are the promoters and main authors. They are Dutch occupational physicians and former family doctors, and for many years active in ICOH (1).

In their last contribution, they dealt with their review, commissioned by the WHO, on interventions in Primary Health Care regarding the health of workers. In this edition, they tell about two good practices, described in the report, where PHC is paying more attention to work issues, coming from two newly industrialized countries: China and Thailand.

The first publication by Chen et al. (2010) describes the stepwise integration of so called 'basic occupational health services' (BOHS) in the primary health care (PHC) system, in the Chinese province of Baoan. Capacity building, training and education have had the aim to realize surveillance of workplaces and of workers' health, risk assessment, control and evaluation activities.

This model provides essential occupational health care, especially to underserved workers like migrants and those who work in the 'informal economy' and in small- and medium-sized enterprises. The authors conclude that the 'Baoan model' has proved to be effective and also cost-effective. The care for workers' health is integrated in PHC, supported by government, employers and employees. In 2006, 3,700 factories had BOHS-coverage and 610,000 workers received health surveillance. In 2008, these figures were about tripled: respectively 9,200 factories and 1.9 million workers. The coverage rate for factories increased from 35% to 82%, and for workers from 29% to 81%. Chen and colleagues conclude "This strategy might be a feasible and effective way of protecting the health of workers confronted with occupational hazards."

As in many other developing or newly industrialized countries, in Thailand most work is still agricultural, informal or self-employed, without access to occupational health provisions. In their publication 'Basic Occupational Health Services (BOHS) and the National Program for Farmers' (2011) Chanchaoren and colleagues state that it is crucial to include (parts of) OHS in primary health care, because PHC is close to informal workers in the communities. They are mostly working in agriculture and small industries, or offering services, and are often exposed to serious

occupational risks. Income losses of this group are seldom covered by social security schemes in the case of occupational diseases, work accidents or work disability.



In 2008, a pilot project started to integrate OHS into 16 primary care units by capacity building, training and supervision. In 2010, the units were able to provide essential services for workers' health (BOHS) including health examinations and interviews of workers with occupational diseases or injuries. Risk assessments showed that infectious diseases were the highest occupational risk - and not NCDs (2) - since most farmers worked in contaminated areas, often with animals. The project demonstrated that BOHS can be included in primary care, offering not only secondary and tertiary prevention activities such as screening of occupational diseases, health examinations and treatment of such diseases and injuries; but also primary prevention. This includes walk-through surveys at workplaces with an observation checklist and risk assessment. Collaboration with the local authority and health volunteers in the community was very important.

In 2010, 156,975 workers accessed the services (72% of them farmers). They mostly worked in poor postures, and in environments with a high risk for biological (63%), noise (49%) and chemical exposure (43%). Farmers had been injured from sharp tools or equipment (30%), slipping (21%), chemical splashes (13%) and electricity (11%). The most common health problems were pesticide poisoning, muscular pain and occupational injuries.

In 2011, the Public Health Ministry decided that primary care units in high-risk areas will provide BOHS, including risk interviews, health examinations, screening tests for pesticide poisoning, risk communication and training of health volunteers. The goal: reaching 800,000 farmers through 1,000 Primary Care Units. Overall conclusion and 'take home message'

Experiences in Thailand and China show, that with a programmatic approach, it is very feasible – at least in newly industrialized countries – to “... integrate occupational health in the primary care setting, to the benefit of all workers and their families.” (WONCA ICOH Pledge, Lisbon, 5-7-15)

Notes and references online:

South American Happy Audit II

The aim of Happy Audit II is to determine the factors associated with prescription of antibiotics in patients with suspected respiratory tract infection I South-America. This is the second report on progress.

Appropriate use of antibiotics is crucial to contain the increase of resistant strains.

172 doctors working at primary care level in six regions in South America [Corrientes (Capital), Misiones y Rafaela (Santa Fe) de Argentina, La Paz (Bolivia), Depto. Itapúa (Paraguay) y Uruguay] are participating in a quality improvement project about use of antibiotics in patients with respiratory tract infection.

The first registration of respiratory tract infections took place from 16 June to 16 August 2014.

Follow-up and research evaluation meetings were held in the different regions during March 2015: 7 March in Posadas (Misiones), Argentina; 10 March in Rafaela (Santa Fe), Argentina; 13 March in Encarnación (Paraguay); 16 March in Montevideo (Uruguay); 25 March in La Paz (Bolivia).

The doctors participated in a four hour meeting in which they received a personal report about use of antibiotics and participated in a focus group about

Happy Audit II Sudamérica

El objetivo es determinar los factores que influyen en la decisión de prescribir antibióticos en pacientes con sospecha de infección del tracto respiratorio en Suramérica.

El uso apropiado de antibióticos es decisivo para contener el incremento de la resistencia bacteriana.

El primer registro de las infecciones respiratorias se realizó desde el 16 de Junio al 16 de Agosto de 2014 durante 3 semanas.

En la auditoría participaron 172 médicos y 11.398 pacientes de 6 redes de investigación en Sudamérica: Corrientes (Capital), Misiones y Rafaela (Santa Fe) de Argentina, La Paz (Bolivia), Depto. Itapúa (Paraguay) y Uruguay.

Se realizó la reunión de seguimiento y evaluación del estudio en las distintas regiones participantes: 07/03/15 en Posadas (Misiones), Argentina; 10/03/15 en Rafaela (Santa Fe), Argentina; 13/03/15 en Encarnación (Paraguay); 16/03/15 en

the use of indicators to help them to improve the quality of their prescriptions.

The results of the first audit showed great variation in antibiotic use within each network and between research networks. This variation means we cannot assess the quality of antibiotic use just focusing on the average usage by research network, but the challenge is to improve the use of antibiotics as a group. It means, the reduction of inappropriate use of antibiotics should be accompanied by a homogenization of clinical practice within each network and between networks.

Doctors were asked about the importance of working with quality indicators considering the large group variation when evaluating the prescription of antibiotics, all agreed on the importance of including these indicators: Acute Otitis, acute sinusitis, acute bronchitis and antibiotic use in viral infections, which will be considered in the second register to be carried out from 16 June to 16 August 2015.

The first results and future work was presented at the Ibero-American Congress of Family Medicine in Montevideo (Uruguay) on 20 March 2015.

You are welcome to contact:/ Invitados a contactar:

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Montevideo (Uruguay); 25/03/15 en La Paz (Bolivia).

Cada médico recibió un resumen de su desempeño junto al reporte general a fin de evaluar la calidad de atención de cada uno de ellos.

Los resultados de esta primera auditoría muestran gran variación en el uso de antibióticos dentro de cada red y entre las redes de investigación.

Esta variación significa que no podemos evaluar la calidad del uso de antibióticos sólo enfocándonos en el promedio de uso por red de investigación, sino que el reto está en mejorar el uso de antibióticos como grupo; es decir, que la disminución del uso inapropiado de antibióticos debe ir acompañada de una homogenización de la práctica clínica dentro de cada red y entre las redes.

La variación en los porcentajes de indicadores de calidad entre las redes así como las diferencias organizacionales, pone de manifiesto la necesidad de diseñar estrategias de mejora de la calidad que se ajusten al contexto. Se preguntó a los médicos sobre la importancia de trabajar con indicadores de calidad considerando la gran variación grupal al

momento de evaluar la prescripción de antibióticos en cada una de las regiones participantes. Todos coincidieron en la importancia de incorporar estos indicadores: Otitis aguda, Sinusitis aguda, Bronquitis aguda y uso de antibióticos en infecciones virales, los que serán considerados en el segundo registro que se hará del 16/06 al 16/08/15.

El Proyecto fue presentado en el Congreso Iberoamericano de Medicina Familiar en Montevideo (Uruguay) el día 20/03/15 donde se expusieron los resultados obtenidos hasta ahora y los pasos a seguir.

WHO news

Public consultation on the WHO's 'Global Strategy on Human Resources for Health: Workforce 2030'

All WONCA members and member organizations are urged to respond to the online public consultation towards the development of a Global Strategy on Human Resources for Health. In May 2014, the 67th World Health Assembly requested the development of a new global strategy on human resources for health to be considered by the 69th World Health Assembly in May 2016. The draft strategy is now open for consultation until 31 August 2015.

It represents a critical component of the WHO strategic vision towards universal health coverage (UHC) in the framework of the post 2015 health development agenda. The draft will also be discussed at various global health events as well as a number of WHO regional technical consultations. This global dialogue will inform the continuing improvement of the draft and a final version to be submitted to the WHO Executive Board in January 2016.

It is vital that the role of family doctors and multidisciplinary primary care teams are

highlighted in this strategy, we therefore urge all



WONCA members to respond to the consultation.

[HEALTH WORKFORCE 2030 A Global strategy on human resources for health brochure](#)

To access the online consultation, please [visit this link](#).

DEADLINE: 31 August 2015

Conference news



WONCA South Asia Region Conference 2016
Colombo, Sri Lanka

Reaching across the shores to strengthen primary care
13-14 February 2016
(Pre-conference 11-12 February 2016)

WONCA World Health Network Caring for people

College of General Practitioners of Sri Lanka

woncasar2016.org

WONCA South Asia to meet in Colombo 2016

Prof Antoinette Perera, President of the College of General Practitioners of Sri Lanka is interviewed by the WONCA Editor about her hopes for the conference. Antoinette is also a WONCA Featured doctor this month. To find out more about Antoinette [click here](#).



Needless to say, we are planning a memorable event.

My hopes are to do it in a grand style so that everyone will appreciate the abilities of our members and also develop skills of good family practice for those in primary care.

We have booked the main international conference hall in Colombo, as it can accommodate many participants. My dream is to get 500 participants, so I hope there will be good participation. I have the support of the former WONCA SAR President Dr Preethi Wijegoonawardene, who is leading the Organising committee.

I also hope to get those doctors working in isolation in the remote areas in our country to attend and develop skills of good family practice as well as make connections with the CGPSL. To this end I have written a proposal to the Ministry of Health asking for funds to support these doctors to attend the conference.

I also hope to entertain foreign guests in the Sri Lankan style and introduce a little of Sri Lankan culture and hospitality for foreign participants to enjoy. I hope that many members from the South Asian Region, as well as from all over the world will attend and also see the beautiful spots in the

country. We have a reputable travel company to give us good packages and a vibrant social committee to attend to these affairs.

I sincerely hope we network and make strong connections with the others from SAR and all over the world so that the younger ones coming into the field of family medicine will benefit and carry out the work we have begun. I also hope to convince the policy makers whom I will invite to the conference, the necessity of improving the primary care curative services to all people of Sri Lanka specially for the poor in our country.

Antoinette Perera's welcome to the conference

Welcome to the WONCASAR 2016 in Sri Lanka from February 12-14 (with pre-conferences 11-12).

The theme of the conference is "*Reaching across the shores to strengthen primary care*". This conference is an effort to bring together the different stake holders locally and from abroad to promote patient centered approach in caring for patients and seek new practical ways for universal coverage of health care through a strong primary care based system of health services. We aim to provide a platform to exchange ideas and success stories from both the East and the West and to motivate introduction of family practice in South Asia. So let us join in February 2016 to promote better patient care for our people.

Sri Lanka also has much to offer with its scenic beauty, its superrich wild life and being a small island could be toured in a very short time. I am sure it would be a memorable stay for those of you from abroad.

Welcome from Dr Preethi Wijegoonawardene, Chairperson – HOC

It is my great pleasure to announce the WONCA – SAR Regional Conference 2016 in Colombo from 12th – 14th February 2016.



As you all are aware, the WONCA South Asian regional members have worked hard to ensure that the Family Physicians are a strong force to reckon with, as a “Pivot” on a Primary Health Care team in each of our countries, and to this end our theme for the Conference is APT and it is the duty of all family Physicians in the South Asian Countries, and all other regions of WONCA-World to join us to fortify our mission to enhance the quality of the

delivery of Primary Care by Family Physicians. A Scientific Programme addressing the current needs of the Primary Care Family Doctors is being meticulously planned.

An additional social programme, where you will experience the wonderful hospitality of the smiling Sri Lankan people and the exotic Holiday Resorts in this beautiful country will be provided to you for a special package.

I wish you will spread this message to and all to make this event in February 2016 in Colombo “A One Of A Kind”.

[more about the conference](#)

Vasco da Gama young doctors to meet before WONCA Istanbul



The VdGM Pre-Conference 2015 will take place in Istanbul, Turkey, between 21-22 October 2015.

As the Pre-Conference Istanbul 2015 Team, we invite you to the Pre-Conference 2015 Istanbul to share special moments in the amazing city, Istanbul with us. You will be surprised with an excellent scientific programme which is gilded with amazing social programme.

Information about the registration is available here and on the [WONCA Europe Conference 2015 Istanbul website](#)

VdGM PreConference - Europe Council Members* or Discussion Groups Participants**
21-22 October 2015
70,00 Euros

* If you are the National Delegate of your country to the Europe Council this is the registration you need - [National Delegates page](#)

** If you are a GP trainee or GP in the first 5 years after qualification as a GP and want to participate

in the discussion groups of the Preconference this is the registration you need.

Social Event for VdGM Pre-Conference - Bosphorus Boat Tour with Guide and Dinner
(Registration can only be made with VdGM Pre-Conference Registration).
21 October 2015
20,00 Euros

To register, click on Registration on the www.wonca2015.org website and follow the instructions. Credit card, bank transfer and money order payments available.

To learn more about the Pre-Conference, don't forget to check this page and the WONCA Europe Conference 2015 Istanbul website regularly! We will be honoured with your participation.

Please don't hesitate to contact us for any questions by e-mail: preconference@vdgm.eu

Grants to attend the WONCA Europe Conference, for new and future GPs/FPs

A total of 195 grants are made available by the Turkish organisers of the WONCA Europe Conference starting September 22nd 2014. For more information please [visit this link](#)

VdGM also offers bursaries to new and future GPs/FPs through the VdGM Fund. Details are available on the [dedicated page](#)

Accommodation options

The document [attached](#) guides you to options that you can select hostels, apartments and hotels during your stay in Istanbul.



EGPRN Edirne, Turkey meeting

Immediately preceding the [WONCA Europe 2015 conference in Istanbul](#)

Theme: Research on Active Ageing in Family Medicine/General Practice

Registration deadline: October 3, 2015

Web: <http://www.egprn.org/>

Dear doctors, researchers, and colleagues,

Population around the world is rapidly ageing. With the increase in life expectancy people not only want to live longer, they also want to have a high quality of life. The age to be considered older has variations and changes from country to country. According to WHO people over 60 years of age and over are considered "older people". Aging has challenges and opportunities. To meet these challenges and turning them into opportunities will help to improve the quality in active ageing. Elderly population in Edirne is about 9% and rapidly increasing putting the city in the third row in ageing. Researchers from Trakya

University Department of Family Medicine are conducting a project to establish an Active Aging



Center which includes medical, rehabilitation and social facilities to improve health related quality of life among elderly inhabitants. This will be an important opportunity for the participants to contribute this center's early outputs and vision.

- Patient safety
- Chronic diseases and elderly
- Mental Health
- Substance abuse in elderly
- Elderly abuse and neglect
- Multimorbidity in elderly
- Prevention in elderly
- Integrated care for elderly
- Communication with elderly
- Ethical aspects in care for elderly
- Epidemiological issues
- Social Determinants in Active Aging



XXth World Congress of The World Federation for Mental Health

Theme: 'Mental health in times of crisis- Building comprehensive health care systems.'

Venue: Intercontinental Citystars Cairo Egypt

Date: 16-19 October 2015

Dear Friends,

We are counting down to the XXth World Congress of The World Federation for Mental Health (WFMH) which is being held at the Intercontinental Citystars, Cairo Egypt from 16th-19th October 2015.

On October 16th-19th 2015 mental health advocates, service users, carers and professionals from around the world will gather in Cairo to voice a message of harmony at this congress entitled 'Mental health in times of crisis- building comprehensive health care systems.'

The first World Congress in 1948, held in London just after the end of the Second World War faced the issue of 'Mental health and world citizenship' posing the question: 'Can the peoples of the world learn to co-operate for the good of all?'

Nearly seven decades later we are faced with another global crisis of identity, social injustice and discrimination which has an even more profound effect on people with mental health conditions and their families.

The XXth World Congress of the WFMH provides us with an opportunity to address the question; what is the role of advocates, service users, carers and professionals in providing a culture of care and harmony for future generations?

Cairo has gone through many transitions and is finally emerging into a buzzing metropolis that offers the visitor a sense of vibrant presence. People who care about mental health should to come and support this congress in Cairo, so that the needs of those who face mental health challenges are highlighted and addressed.

The XXth World Federation for Mental Health World Congress has local and international support including the Behman Hospital and the Egyptian Society for the Rights of People with Mental Illness as hosts and the World Psychiatric Association, the Royal College of Psychiatrists and the World Association for Psychosocial Rehabilitation who are co-sponsors.

This Congress promises to deliver a unique experience for collaborative work and the list of Distinguished Speakers who care about mental health keeps growing. Mrs. J Sadat, Dr I. Serag Eldin, Dr Z. Hawas will talk about Egypt's heritage in the field of development. Prominent names in the field of Mental Health include Prof Dinesh Bhugra CBE, Prof Sir Simon Wesley, Prof Susan McDaniel, Prof Michelle Riba and many others.

The XXth WFMH World Congress will also see the 41st WFMH President Professor George Christodoulou after his successful two year tenure handing over to the 42nd WFMH President Professor Gabriel Ivbijaro MBE who has promised to make Dignity and Mental Health parity the theme of his two year Presidency. Please come to Cairo and be part of the transition.

The social program is an example of Egyptian hospitality, with a Welcome Reception hosted by The Minister of Tourism, an evening at The Sound and Light Show by the Pyramids and an evening at The Cairo Opera House.

So please come to join us. Submit your abstracts or register to attend. Visit www.wfmh2015.com

Remember that symptoms are not a barrier to recovery, attitude is. Please play your part to make a difference.

Gabriel Ivbijaro MBE
President Elect WFMH



WONCA Europe
region conference
2016

Copenhagen,
Denmark
Jun 15-18, 2016



Member Organization News

Bangladesh Family Medicine Diploma exams

The Bangladesh Institute of Family Medicine & Research [BIFMR] is an Institute of the University of Science & Technology Chittagong [USTC]. BIFMR has been an 'Academic Member of WONCA' from the beginning of that membership category. The Institute is running a one-year long 'Family Medicine Diploma [FMD]' course from 1 July to 30 June of the following year. Students from all over Bangladesh have joined the course and benefitted. In fact this is the only university to run a course in family medicine in Bangladesh. More than 200 lectures are arranged and delivered on Fridays only. Some key clinical examinations, patient handling techniques, instrument handling, etc. are also taught on Fridays.

Photo - a student faces the examiners



Students are attached to family

medicine teachers at their respective localities, where they keep records and submit a log-book as proof of their work. At the last part of the course, students attend compact hospital training programmes. A very competent full-time faculty of the family medicine discipline teaches the students. Teachers from other specialties are also invited to deliver lectures.

In the month of June, final evaluations are done in five categories. They are: 1] Written examinations in 2 papers, 2] Log-book consisting of 25 illustrative cases, 3] Objective structured practical examinations [OSPE] in 20 stations, 4] Clinical examinations of one long case and two short cases, and 5] Viva examination. Students have to pass all the sections separately. The University issues certificates and mark-sheets to all the successful students. They usually attend convocation and receive certificates from the Hon'ble President of Bangladesh, who is the Chancellor of the University.

Family Medicine Diploma examination 2015

The recent course started on 1 July 2014 and continued until 30 June 2015. Total 36 students were admitted into the course. From them, 30 students attended the examinations.

The examinations of the 'Family Medicine Diploma' of June 2015 were held on 12, 13, 24 & 25 June 2015. Written Examinations of Paper-I and Paper-II were held on 12 June 2015 at BSU, Dhaka. Written questions consisted of short questions and problem oriented questions. All the clinical problems encountered by the family physicians were presented. In OSPE section x-rays, pathology reports, ECG, specimens, photographs, instruments, etc. were given. There were 20 stations for 20 exhibits. Students attended all the stations and answered the relevant questions. In clinical examinations, students were given two short cases and one long case. For each of the short cases 10 minutes was

allotted. For a long case, 20 minutes was given for history taking, examinations and making diagnosis and 10 minutes for defending. Students faced one viva board where they were evaluated critically. They also defended their log-books here. Three teachers, including one external teacher assessed their depth of knowledge.

Mr M H Mohsin, CEO of the BIFMR has tabulated the results while Prof Firoz Ahmed helped him. The Controller of Examinations of the USTC is publishing the result. Of the 30 students who were enrolled as candidates and 26 students passed the examination successfully. All the successful students will be given a testimonial from the Institute. They will be issued certificates and mark sheets by the Controller of Examinations of the university. The students usually attend convocation for receiving certificates.

[Download full report and photos](#)

Prof Kanu Bala MBBS, PhD, FRCP
Chief Examiner

Photo - Prof Bala at left discussing candidates with an external examiner



Canada- Prof Ruth Wilson receives civil honour

Prof Ruth Wilson is the WONCA North America region president. WONCA congratulates her on receiving the award of Member of the Order of Canada.



Family medicine professor named to Order of Canada

Health-care leader Ruth Wilson earns prestigious national honour, following in the footsteps of her mother Lois Wilson.

Ruth Wilson, a professor in the Department of Family Medicine at Queen's, was named today as a Member of the Order of Canada by His Excellency the Right Honourable David Johnston (Law'66), Governor General of Canada, for her contributions to improving primary care in Ontario and for her leadership in family medicine.

Dr Wilson follows in the footsteps of her mother Lois Wilson, a Companion of the Order of Canada, the first female moderator of the United Church of Canada and former member of the Canadian Senate.

"I am very honoured to be receiving the Order of Canada," says Dr Wilson. "I love the motto of the Order of Canada: 'They desire a better country.' I do the work that I do because of my desire for a better country. This award is also significant because it extends beyond the world of medicine." Ruth Wilson has been named to the Order of Canada.

A leader in the Canadian medical field, Dr Wilson joined the Queen's in 1989 and served as Department of Family Medicine head from 1991 to 2001. She is currently vice-president of medical and academic programs for Providence Care, where her leadership has advanced the organization's reputation as a leading provider of integrated services in the areas of mental health, aging and rehabilitative care.

"The Order of Canada recognizes outstanding achievement and dedication to the community and to Canada," says Principal Daniel Woolf. "As a leader in the field of health care, Dr Wilson is deserving of this award for the enrichment she has

brought to the lives of others which extends to the Queen's community and our students."

In addition to her research work, Dr Wilson is a family physician with the Queen's Family Health Team. She also has more than a decade of experience practicing family medicine in remote areas of Canada. From 2001-2004, she served as chair of the Ontario Family Health Network, which was responsible for implementing primary care reform in the province. She has also contributed internationally to the development of primary health-care systems in areas of need.

"What I love about my work is I'm able to bridge the continuum between caring for patients, leading change in the medical system in Canada, developing policy, and teaching the next generation," says Dr Wilson. "I'm a generalist. I want to join policy, patients and learners."

In 2013, Dr Wilson was elected president of the North American region of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA), which works to foster high standards of care in family medicine globally. In 2010, WONCA awarded Dr Wilson a Five Star Doctor Award, one of two triennial awards for excellence in health care, citing her excellence as a care provider, a decision maker, a communicator, a community leader and a team member.

Also in 2010, Canada's Women's Executive Network named her one of the country's Top 100 Most Powerful Women.

"Dr Wilson is highly respected within her community, her department, throughout the Faculty of Health Sciences and, indeed, throughout the university," says Glenn Brown, Head, Department of Family Medicine. "She has provided leadership in many important and sensitive areas, always demonstrating deep knowledge, respect and sound judgement."

For more information about the Order of Canada, visit the Governor General's [website](#).

This article is reproduced with permission of the Queen's University "Queen's Gazette" and was written by Anne Craig, Communications Officer.

RCGP launches International Affiliate membership

The Royal College of General Practitioners (RCGP) has recently launched a new membership grade, International Affiliate membership. The RCGP is the professional membership body and guardian of standards for family doctors in the UK, working to promote excellence in primary healthcare.



Royal College of
General Practitioners



International Affiliate membership is designed to provide comprehensive support and resources to medical students, trainees in Family Medicine and family doctors based outside of the United Kingdom, who we cordially invite to join the RCGP as an International Affiliate member.

The wide range of benefits available to International Affiliate members includes unrestricted access to the RCGP's Online Learning Environment which comprises of hundreds of hours worth of RCGP accredited training materials.

In addition to this, membership also comes with an online subscription to the British Journal of General Practice (BJGP). The BJGP is an international journal publishing research, debate and analysis, and clinical guidance for family practitioners and primary care researchers worldwide. It is the leading primary care journal in Europe and one of the most highly cited primary care journals in the world.

International Affiliate membership compliments MRCGP[INT], our full international membership category. MRCGP[INT] is available to doctors who have taken and passed a MRCGP[INT] exam at one of our accredited sites.

For more information about International Affiliate membership including fees, how to join and our full range of benefits please visit here – www.rcgp.org.uk/intaff.



Why become an International Affiliate member?

By joining our network of international doctors, you gain access to our extensive benefits which include:

- Subscription to the British Journal of General Practice online
- Online Learning Environment (OLE)
- RCGP updates including a quarterly membership ebulletins
- Continuing professional development event discounts, including the RCGP Annual Conference

IPCRG - Asthma Research Priorities

The International Primary Care Respiratory Group (IPCRG), a Special Interest Group of WONCA Europe, research subcommittee chair Prof Mike Thomas of the UK, asks family doctors to complete a survey about asthma research...

Dear colleague

The IPCRG has been closely involved with this European project called [EARIP](#) to define the priorities for asthma research funding by the European Union.

We encourage you to ensure primary care's voice is heard. Please complete the survey and also circulate it to colleagues including your national group. Details are below. Please note closing date 3 August 2015. We have circulated to all colleagues, not just those in Europe, because the questions are relevant for all.

Many thanks

Mike Thomas

Chair of IPCRG Research sub-committee

Professor of Primary Care Research

University of Southampton, UK

Calling all asthma professionals: what topics should future research focus on?

A European Union-funded project is creating a new action plan to outline research priorities in the field of asthma.

The European Asthma Research and Innovation Partnership (EARIP) will produce the action plan to inform the European Commission about which areas require urgent funding. The project is calling on all healthcare professionals working in the asthma field to share their insights on a range of areas including services, diagnosis, monitoring, treatment, prevention and policy.

Complete the survey to share your thoughts:

English – <https://www.surveymonkey.com/r/EARIP>

French – <https://fr.surveymonkey.com/r/EARIP2-FR>

Spanish – <https://es.surveymonkey.com/r/survey-2-ES>

Russian – <https://ru.surveymonkey.com/r/EARIP2-RU>

German – <https://de.surveymonkey.com/r/EARIP2-DE>

If you have any questions, contact Sarah Masefield (sarah.masefield@europeanlung.org).

[More about IPCRG](#)

RESOURCES ADDED

PEARLS

[464 Short courses of systemic steroids effective in severe chronic obstructive pulmonary disease](#)

[463 Some evidence for effectiveness of electronic cigarettes](#)

[462 Exercise effective for osteoarthritis of the knee](#)

[461 Minimal benefits from neuraminidase inhibitors in influenza](#)

[460 Calcium channel blockers minimally effective for Raynaud's phenomenon](#)

[459 No evidence for routine systemic antibiotics for venous leg ulcers](#)

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[457 Vitamin D alone ineffective for preventing fractures](#)

[456 Short-term psychodynamic psychotherapies can benefit common mental disorders](#)

Featured Doctor

Prof Antoinette PERERA

Sri Lanka: SAR conference president

Antoinette is President of the College of General Practitioners of Sri Lanka (CGPSL) and president of the organising committee for the WONCA South Asia region conference being held in February 2016, in Colombo in Sri Lanka.

What work are you doing now?

At present I am working as Emeritus Professor and consultant to the department of Family Medicine, Faculty of Medical Sciences, University of Sri Jayawardenepura Sri Lanka. It is situated about 12 km south of the capital city of Colombo. I teach undergraduate medical students but I also take part in training nursing students and pharmacy students at the university Family Practice Centre established in 1997, a model centre for training, service and research which I helped to establish and sustain. We have a large clientele of patients from in and around the village and also from different parts of the country. I also have trainees undertaking the Diploma courses in Family Medicine or Geriatric Medicine, trainees following the MD in family medicine those sitting for MRCGP (international) exam.

I continue to see my patients most of whom I have followed over the last 17 years. I see patients on two days of the week. And I am on call if any problem arises.

I was elected the President of the College of General Practitioners of Sri Lanka (CGPSL) in April 2015, and ceremonially inducted on the 13 June - the day of the feast of St Anthony, one of my favorite saints. This position has added to my responsibilities. However I have been a council member for many years and was the Vice President of the CGPSL for the last two years and am familiar with the work.

I am also heavily involved in the Sri Lanka Association of Geriatric Medicine launched last year and am a council member. I actually am a "mother" to the young physicians who launched the association.



Since July, I have been involved in the election campaign of my husband Srinath Perera a President's Counsel (Queens Counsel to you). He is contesting for parliamentary elections in Sri Lanka from Colombo district!

Other interesting things you have done?

My original medical interest was in Dermatology as I was posted as house officer to a large General Hospital in the hill country, where I was sent to work with the dermatologist. I seem to be able to remember skin lesions without any effort. However, after I selected Family Medicine as a career I have never looked back. I continued with my interest in dermatology and have worked with the Dermatologists for nearly 42 years.

Among the interesting things I have done which I enjoyed hugely has been organising international conferences, conducted by the Sri Lanka Association of Dermatologists (SLAD) which later became a College. I have played many roles in organising their conferences for example as the social activities Chair and later as the Publications Chair.

My research published in index journals also was on many dermatological problems. I have been the main research author on the epidemiology of skin problems in Sri Lanka for the eighth community survey done in the world. I am also very interested in herbs and the practices of Ayurvedic medicine and carry out research in the use of these, especially for skin problems.

I have been the Chair of the Community based medical learning programme in which we carry out a residential programme for 150 students, where they reside in a purpose built training centre in a rural area and visit the primary care hospitals. One of the interesting things that I have done is organising a day with the villagers in the area, to have face to face chats and find out about the villagers' backgrounds, beliefs and practices. On the whole I have enjoyed these programmes and I was also able to identify the poorly resourced hospitals and start medical laboratory services by getting funds from the provincial council and the provincial Directorate.

One of best activities I enjoyed was being the senior treasurer of the nature and photography



A TEACHER FOR ALL SEASONS

A teacher is like Spring,
Who nurtures new green sprouts
Encourages and leads them,
Whenever they have doubts.

A teacher is like Summer,
Whose sunny temperament
Makes studying a pleasure,
Preventing discontent.

A teacher is like Fall,
With methods crisp & clear,
Lessons of bright colours
And a happy atmosphere.

A teacher is like Winter
While it's snowing hard outside
Keeping students comfortable,
As a warm & helpful guide.

Teacher, you do all these things,
With a pleasant attitude;
You're a teacher for all seasons,
And you have my gratitude!

20th Batch

club at the Faculty for many years and going about with the students on their visits to jungle areas. I wish I could go with them more but I am getting older and cannot do the activities that the young ones enjoy. I am now a life member of the club.

What are your interests and passions in medicine and outside medicine?

I love teaching and patient care and I have attached one of the latest tributes I got from my undergrad students for you to see.

I have trained 20 batches of medical students and many post graduates. In them, I have tried to instill the necessity for the introduction of family practice approach in patient care. My students are now consultants in different disciplines but they tell me that they practice what I taught and many are in primary care hospitals in the state sector, trying to upgrade them into model practices. I am so proud of them all. I am very passionate about teaching and was the language activity leader in the faculty and set up a language activity lab together with a committed team to improve English and Tamil (for Sinhala students) and Sinhala (for Tamil students).

My passion in Medicine is to try and at least initiate a proper family practice system in the country and bring recognition to a discipline which should take top priority in a country. To achieve this I have worked with the Ministry of Health (MOH) for around 7-8 years. And have very staunch helpers in the Ministry who are as convinced as I am that we need a proper primary care curative system so that all people of the country will have a primary care doctor on whom they can rely on in sickness and in health. This is real uphill work and we need the policy makers' support. To this end, I support my husband in his political career as he too gave up a distinguished career in the Attorney General's Department of Sri Lanka.

I love dancing and have now gone out of practice and hoping to start again!

I also garden and love growing orchids and try out various methods. Unfortunately I have a very small garden and little time as, even though I retired in December 2013, I am reemployed at my Faculty and now taken up the Presidency of the CGPSL.

[Read about Antoinette's hopes](#) for the February 2016 South Asia region conference coming to Colombo. [See more about the WONCA SAR conference](#)

Dr Jyoti PAREKH

India: family doctor



Dr Jyoti Ramnik Parekh, M.B.B.S., D.G.O., F.C.G.P. [Hon] and her husband, Ramnik (pictured at right) are leaders of family medicine in India and WONCA life direct members.

How did Jyoti start out as a family doctor?

About half a century ago in 1966, Mumbai in India was destined to get a Family Doctor called Jyoti Parekh, to begin her practice with her equally enterprising husband Ramnik Parekh.

At a time when some medical specialists with highly lucrative practices could not think of a fully air-conditioned, opulent and well appointed office, the office of Dr s Jyoti and Ramnik Parekh could and did - it was considered path-breaking in a number of ways. Their joint practice maintained paper medical records of all the families, immunisation records of children and designed a unique postal reminder system for repeat doses of vaccines and booster shots. They had probably arrived before their time. After Ramnik Parekh changed his career to occupational health in 1982, Jyoti carried the baton to become an iconic and a most popular family physician in South Mumbai.

Although she was also qualified in Obstetrics and Gynaecology Jyoti's first and only choice was Family Medicine and Paediatric practice. She started and managed Mumbai's first private immunisation centre, where smallpox, triple, polio, MMR, typhoid and anti rabies immunisations were administered. When she retired after about 45 years of practice she had immunised three generations of children, a total of about 5,000!

Along with immunisation, she imparted guidance about child care to mothers. She was also the first family doctor to use a computer in her practice, in

1982. Another first for her practice was the "Child Guidance Clinic" – together with a team comprising of a child psychologist, a counsellor and a psychiatrist. A modest pathology lab and physiotherapy service were added during her last two decades of practice.

What have been Jyoti's other interests?

On the academic side, Jyoti presented a number of scientific papers at national and international conferences (see photo). She held the post of the president of the General Practitioners' Association of Greater Mumbai where she was a founding member. She also pioneered activities of the IMA College of General Practice, Mumbai as the first Honorary Secretary. She also was past-President and an office-bearer of the Bombay D Ward Medical Association.



Jyoti was also teaching in the Sophia College Polytechnic and SNDT University for training medical secretaries. She has been contributing a medical column regularly in "Good Housekeeping" magazine for many years.

Looking back?

Jyoti unhesitatingly claims that she enjoyed every moment of her family practice career and would not have given up for anything. Several young

family physicians worked as interns under her tutelage.

"I instinctively chose Family Medicine because of my natural love to be close to human beings; and I believe that each patient is a holistic organism with feelings with an inherent need to be cared for. I always believed in being easily accessible and intimate with a patient and made him or her participate in treatment and decision making. Very often I was assertive, but always in the patient's interest. My long career was most fulfilling."

In retirement?

Jyoti, a lifelong Direct Member of WONCA, and Ramnik Parekh were instrumental in starting The Spice Route Movement for Young Family Physicians of South Asia. Both of them are now Direct Life Members of WONCA and have founded the "Ramnik & Jyoti Parekh Scholarship" with an annual grant of Rs100,000 for the Spice Route members. The Bangladesh Academy of Family Physicians' "Friends of Young Physicians" Award to this duo during WONCA South Asia region conference in February, 2014 did not come as a surprise!

After her reluctant retirement from family practice in 2011, Jyoti has been teaching science, history, geography etc. to street children through Vatsalya- (an NGO); looks after Healthcare initiatives for the disadvantaged section of society on behalf of Maharashtra State Women's Council; and continues writing her health column. Along with Dr Ramnik Parekh she is a Trustee for Antim Samskar Seva, a community service for dignified funeral and cremation of the departed. They both coach family physicians on art, culture, and music etc under the banner of 'Culture Club'. Jyoti's hidden talents in i-Phone photography were revealed during "Worldscapes" - a joint exhibition of photographs on canvas, with Ramnik in Mumbai's prestigious Jehangir Art Gallery in 2012.

Jyoti's advice to young doctors.

"With the world moving towards universal coverage and resurgence of faith in primary care as the basis of accessible and affordable healthcare delivery, young generation of young physicians will do well to look at Primary Care or Family Practice as a first choice. This career has unlimited range of possibilities."

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November 2-6, 2016	WONCA WORLD CONFERENCE	Rio de Janeiro, BRAZIL	www.wonca2016.com

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| 21 Sep
- 23 Sep
2015 | RACGP GP '15 conference  |
| | Melbourne, Australia |
| 29 Sep
- 03 Oct
2015 | AAFP Family Medicine Experience  |
| | Denver, Colorado, USA |
| 01 Oct
- 03 Oct
2015 | RCGP annual primary care conference  |
| | Glasgow, United Kingdom |
| 02 Oct
- 04 Oct
2015 | AAFP Family Medicine Global Health Workshop  |
| | Denver, Colorado, USA |
| 17 Oct
- 20 Oct
2015 | EGPRN Edirne meeting  |
| | Edirne, Turkey |
| 19 Nov
- 22 Nov
2015 | 2nd National Conference FMPC 2015  |
| | IHC New Delhi, India |
| 21 Nov
- 22 Nov
2015 | Family Medicine & Primary Care India 2015  |
| | New Delhi, India |
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- 04 May
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