

WONCANews

An International Forum for Family Doctors



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FROM THE WONCA PRESIDENT:

AN ANCIENT DISEASE: A NEW GLOBAL THREAT?

“The drug resistance that we are seeing now is without doubt the most alarming TB situation on the continent since World War II, and our message to European Union leaders is: Wake up. Do not delay.”

Markku Niskala
Secretary-General
International Federation of Red
Cross and Red Crescent Societies
October 2006

The infective agent appears to have been around since before man evolved on earth. Its clinical expression became a scourge in Europe as the disease reached epidemic proportions when the crowded cities of the Middle Ages and later the industrial revolution provided the environment for its spread. It was spread to ‘the colonies’ by European empire building and colonisation. It was late in coming to the Pacific Islands and Africa. In 1882, Robert Koch identified the organism as the bacillus responsible for tuberculosis. Now it is the killer of millions annually in the African continent, made worse by its deadly close cohabitation in individuals infected by the HIV virus. But now, like a pendulum that has just paused at the end of its periodic swing, it appears about to swing back with a vengeance in the developed industrial countries where it began. It is a new phase in the evolution of bacillus that could change the nature and burden of disease in family doctors’ practices globally.

This was highlighted for me in a few weeks ago when I attended an urgent meeting in Johannesburg on

XDR-TB, the abbreviation for *extensively (or extremely) drug-resistant tuberculosis*. A few days before that, there had been an emergency summit in Johannesburg attended by WHO, CDC, other global health agencies and health ministries in the African sub-continent to discuss an emerging threat to the region. Data presented at the XVI International AIDS Conference in Toronto had indicated the high mortality associated with XDR-TB - of 536 patients with TB in a rural district in KwaZulu Natal, South Africa, 221 had Multi-drug-resistant TB (MDR-TB), and 53 of these were defined as XDR-TB, 43 of whom were co-infected with HIV. The tragedy was that 52 of these 53 patients had died. Since then XDR-TB has been isolated in 28 hospitals in South Africa.

MDR-TB, defined as resistance to at least isoniazid and rifampicin, requires the use of second-line drugs that are less effective, more expensive, and more toxic than first-line regimens based on isoniazid and rifampicin. Recognised earlier this year, XDR-TB is MDR-TB that is also resistant to three or more of the six classes of second-line drugs. Of 17,690 TB isolates taken internationally between 2000 and 2004, 20% were MDR and 2% were XDR. XDR-TB has now been identified in all regions of the world but is most prevalent in Asia and in Eastern Europe. Since WHO guidelines recommend the use of at least four drugs for those with MDR-TB, XDR-TB is untreatable to international standards.

How much of a threat is it to Europe and other developed countries? MDR-TB in itself is a major problem. “Drug-resistant strains of the disease are lurking just beyond the European Union’s borders, in countries where AIDS blossomed following the collapse of the Soviet Union”, say U.N. and Red

Cross health officials. Of the 20 countries in the world with the highest rates of multi-drug resistant tuberculosis, 14 are in “the European region,” according to a recent global survey by the WHO and the U.S. Centers for Disease Control and Prevention. In Europe, 50 people get sick with TB and eight people die of the disease every hour, reports Pierpaolo de Colombani, a WHO tuberculosis expert.

Recent reports from the CDC and WHO on data from 2000-2004 indicate that of MDR-TB cases 19% in Latvia, 15% in South Korea and 4% in USA, met the criteria for XDR-TB. In industrial countries, including USA, the rate of XDR-TB has risen from 3% to 11% of MDR-TB in the 5 year period. It is suggested that failure to act now to contain the threat posed by XDR-TB will have devastating consequences for patients with TB, particularly those co-infected with HIV/AIDS.

There are many contributing factors to the development of MDR-TB and XDR-TB, including delayed diagnosis; inadequate investigation and poor management; shortage of drugs; poor compliance by patients; poor understanding of the gravity of the condition by patients, families and communities; failure of the elements of the DOTS (Directly Observed Treatment Short Course) programmes; and poor monitoring, follow-up and surveillance.

Primary care doctors globally, especially those working in community clinics and hospital-based ambulatory services are to be encouraged to exercise extra diligence and care in TB management. International travel has made the problem a reality for all primary care practitioners, who should maintain a watchful vigilance for possible TB patients.

There is also a major role for University departments of family medicine, Colleges and Academies to offer training and refresher courses, and assistance with audit and quality assurance programmes. There should be special emphasis on prevention, early detection, diagnosis and appropriate treatment, monitoring, contact tracing and follow-up. Those who do not respond to treatment must be adequately investigated for resistance and managed appropriately. Support for patients and family members is of paramount importance especially when patients with XDR-TB are 'incarcerated' in isolation facilities for long periods of time. Of concern to me is that such long term admissions could have inhibitory effects on self-reporting by patients with undiagnosed TB. Illegal immigrants face a particular problem when presenting for care, since once they enter the health care system their anonymity is not guaranteed, and expulsion of them and their families is more likely.

I encourage all member organisations and individual members of Wonca to heed the call to be vigilant and assist in the global programmes being developed and disseminated over the next few months. This is a serious threat. MDR-TB has become a daily consideration for us working in Africa. In the early 90's we were faced with the beginnings of MDR-TB which has now reached pandemic proportions. When will XDR-TB reach a similar global coverage?

A useful website for frequently asked questions about XDR-TB is: <http://www.who.int/tb/xdr/faqs/en/index.html> To read the entire Report from the Expert Consultation on Drug-Resistant Tuberculosis, go to:

http://www.who.int/tb/xdr/johannesburg_report/en/index.html

Paul Sommerfeld of TB Alert, has said: "XDR-TB is very serious - we are potentially getting close to a bacteria that we have no tools, no weapons against. What this means for the people in southern Africa, who are now becoming susceptible to this where it is appearing, is a likely death sentence. For the world as a whole it is potentially extremely worrying that this kind of resistance is appearing."

Professor Bruce Sparks
President
World Organization of Family Doctors

FROM THE CEO'S DESK:

HIGHLIGHTS FROM THE BUENOS AIRES WONCA EXECUTIVE MEETING

The Wonca Executive met for two-and-half days in Buenos Aires from Sunday, 8th Oct to Tuesday, 10th Oct 2006 in conjunction with the of the Iberoamericana-CIMF Regional Conference.

This First-ever Wonca Iberoamericana-CIMF Regional Conference was successfully held at the Sheraton Hotel and Convention Centre in the district of San Martin, Buenos Aires, Argentina. The Conference was hosted by the Argentine Federation of Family and General Medicine from 11th – 14th November 2006. There were over 2000 registrants for the Conference with a vast majority of delegates from the Region itself. Over 1000 paper submissions were received by the Host Organizing Committee for

presentation. The Argentine Minister of Health graced the opening of the Conference followed by a special Plenary Lecture by Dr Barbara Starfield.

The attendances at the plenary and workshop sessions were very good and demonstrated the degree on interest and commitment to health system improvement, quality practice, research and continuing education by the family doctors of the Region.

The agenda for this Executive Meeting was, as was in the case with past Executive Meetings, very full. But the new approach in the organizing of the Agenda Items and Papers allowed Executive to navigate through the agenda with sufficient time to deliberate adequately on the key issues. I will highlight some of the interesting and key issues below

Wonca Africa Region

Wonca Executive welcomed Prof Khaya Mfenyana, the newly elected Regional President for Wonca Africa, to his first Executive Meeting. Prof Mfenyana assumed office in May 2006 after the resignation of Dr Abra Fransch. In his report, Prof Mfenyana highlighted the many existing challenges facing his Region in terms of the distances between members and member organizations and the existing communication difficulties and scarcity of resources.

Despite these difficulties, he was pleased to report on the FaMEC (Family Medicine Educational Consortium) Meeting that had recently taken place on 15th – 16th June 2006 in Kampala, Uganda which resulted in the inauguration of the FaMEC Africa Project would last for three years to April 2009. The aim of the project is to contribute to the health of

communities through assessable, responsive and quality health care systems in Eastern and Southern Africa with the education and training of family doctors. The overall academic objective would be the planning, development and strengthening of academic departments or units of family medicine that offer structured training at undergraduate, postgraduate and continuing professional development levels.

Wonca North America Region

Wonca Executive approved the new name of the Wonca North America Region to replace the Wonca Americas Region to better reflect the region that now has member organizations from the United States, Canada and the non-Spanish speaking Caribbean Islands. The newly named Wonca North America Region will also help distinguish this region from the recently established sixth Wonca region, Iberoamericana-CIMF, which includes member organizations from Central and South America.

Wonca Middle East and South Asia (MESA) Regions

There has been a rapid increase in the interest to join Wonca by family medicine organizations in the countries of the Middle East these past months. This has led to the possibility that a new Wonca Middle East Arab Region may be formed out of the MESA Region. Current Wonca members are from Bahrain, Iraq, Jordan, Lebanon, Saudi Arabia and the United Arab Emirates.

Executive discussed this exciting development and felt that the new region could be formed if there are eight or more member organizations to make up the new region.

There is currently an expression of interest by a family medicine organization in Egypt and if this is approved, there will be only one more member organization needed to initiate the formation of the new and Seventh Wonca Region.

Five New Wonca Member Organizations Admitted

At this Executive Meeting, the following were admitted as members of Wonca subject to some having to fulfill certain required admission criteria:

1. Section of Teachers and Section of Researchers, College of Family Physicians, Canada – admitted to Associate Membership
2. Nicaraguan Association of Family Medicine – admitted to Full Membership.
3. Cuban Society of Family Medicine – admitted to Full Membership.
4. Romanian National Center for Studies in Family Medicine – admitted to Associate Membership.
5. Serbia Medical Association, Section of General Practice – admitted to Full Membership.

The admission of the above organizations would bring the total Wonca Membership to 112 organizations (including 10 Organizations in Collaborative Relations) in 93 countries globally.

Wonca Website (www.Globalfamilydoctor.com)

This item was discussed at great length by Executive. The consensus was that the website would play a key role in the broader strategic plan of Wonca in the future.

Executive also felt the need to make Wonca more relevant to its member organizations by putting website information on the local markets through encouraging translations to the languages dominant in each Wonca Region (eg, Spanish for the Iberoamericana-CIMF Region).

Executive also accepted the plans for the hand-over of office of GFD Chief Medical Editor from Prof Wes Fabb to Dr Jim Vause. This will be formally done at the Wonca World Council in Singapore in July 2007

Timing of World and Regional Conference in the Same Year

The issue of how best to time the interval between a Wonca World Conference and a Regional Conference in the same year has been discussed in several past Wonca Executive Meetings. Prof Igor Svab, the Regional President for Wonca Europe was tasked at the Kyoto Executive Meeting in 2005 to study this issue in consultation with the other Regional Presidents and the CEO.

At this Executive Meeting, Prof Svab's recommendation that there be an interval period of at least four months between a World Conference and a Regional Conference was accepted. It was also agreed by Executive that the World Conference will have priority in setting its date which will be informed to the CEO who will in turn ensure that the Regional Conference be held at least four months earlier or later.

Gender Equity

Wonca Executive studied and had extensive discussions on the submissions of the Wonca Working

Party on Women and Family Medicine (WWPWFM) and The *Hamilton Equity Recommendations* (HER) Statement that was issued following the WWPWF meeting in Hamilton, Ontario. Executive was very appreciative of the efforts of the WWPWF to foster gender equity in Wonca and supported the principles enunciated in the (HER) Statement. Wonca Executive will work with WWPWF to promote gender equity through all Wonca activities including Bylaws changes where appropriate.

Special Interest Group to Working Party

The submission by the Wonca Special Interest Group on Psychiatry and Neurology to have its status changed to that of a working party was accepted by Wonca Executive at this meeting. Executive was impressed with the amount of work done by the SIG in the short span of three years and with its collaboration with the Mental Health Division of WHO.

In the conversion to a Wonca Working Party, Executive felt it best to have the new entity called The Wonca Working Party on Mental Health. We congratulate all participants of the SIG who now go on to be members of the new Wonca Working Party.

Dr Alfred Loh
Chief Executive Officer
World Organization of Family Doctors

FROM THE EDITOR:

FAMILY DOCTORS GATHER AND LOOK FORWARD TO SINGAPORE

This issue of Wonca News reports on important gatherings of Wonca's Regions, Working Parties and Member Organizations in the year leading up to the 18th Wonca World Conference in Singapore from July 24-27, 2007.

In June, family doctors from the College of Family Physicians of Canada gathered at Niagara Falls, Ontario to better understand the evolution of our discipline and make their organization more relevant and meaningful. In August, the Wonca Working Party on Women and Family Medicine hosted family doctors from 16 countries at McMaster University in Hamilton, Ontario, Canada to further their discussions and activities on gender issues affecting physicians and patients.

In September, the Wonca Working Party on Rural Health hosted family doctors from 20 countries at the 7th Wonca World Rural Health Conference in Seattle, Washington and a post-conference in Alaska. In October, the Wonca World Executive met in Buenos Aires, Argentina, site of the first Wonca Iberoamericana-CIMF Regional Conference in the days that followed. In this issue, Wonca CEO Dr Alfred Loh reports on the highlights of the Wonca World Executive meeting in Buenos Aires.

Subsequent issues of Wonca News will report on recent and upcoming important family doctor gatherings at Wonca Regional Conferences for Wonca Europe held in Florence, Italy; for Wonca Asia-Pacific held in Bangkok, Thailand; and for Wonca Iberoamericana-CIMF held in Buenos Aires, Argentina.

These and many other family doctor gatherings crescendo towards the triennial meeting of all meetings – the 18th Wonca World Conference in Singapore. This issue reports that online registration is open at www.Wonca2007.com and the deadline for submitting abstracts is December 31, 2006. Look forward to seeing you in Singapore!

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FEATURE STORIES

WONCA 7TH RURAL HEALTH CONFERENCE A SUCCESS

The 7th Wonca World Rural Health Conference was held in Seattle, Washington, USA from September 8-13, 2006, and a post-conference was held in Anchorage and Talkeetna, Alaska, USA from September 14-16. The Seattle portion of the conference was divided into a section on education, policy and research for rural practice and a second section of continuing medical education for clinical aspects of rural practice.

Since Seattle and the University of Washington School of Medicine are the home of the WWAMI medical education program (WWAMI stands for Washington, Wyoming, Alaska, Montana, Idaho), we established the conference theme of “Transforming Rural Practice Through Education”. Over 200 family physicians from more than 20 countries attended the Seattle meetings, and 40 of the physicians went on to the Alaska sessions.



Sessions were held on the campus of the University of Washington attended by over 200 rural family physicians from over 20 countries

The Seattle meetings were held on the campus of the University of Washington School of medicine. In keeping with the cultural themes of prior Rural Wonca meetings, the

opening ceremonies included traditional dances by Native Americans and a ceremonial blessing by a Native elder.



Yakima Native American Dance Club members performing traditional dances during the opening session

Three sets of plenary sessions were presented, with each session focusing on a specific theme. The opening plenary was oriented toward overarching issues that impact rural family medicine. Speakers and topics included the following:

- “Building Rural Systems of Care” by Mary Selecky – Secretary of Health, Washington State Department of Health
- “Impact of Violence and Social Turmoil on Rural Health” by Steve Gloyd, MD, Director of International Health Program, University of Washington
- “The Global Initiatives in Rural Health – What is the Role of Family Physicians?” by James Litch, MD, DTMH, Maternal, Newborn and Child Health Specialist, PATH
- “Impact of Social and Economic Disparities on the Health of Rural Populations” by Victor Inem, MBBS, MPh, College of Medicine, University of Lagos, Nigeria

Plenary sessions for the next two days focused on addressing worldwide shortages of rural family physicians and creating new, rurally leaning medical schools:

- “Attracting Future Rural Practitioners to Health Care: The Experience on Two Continents”

by Roger Strasser, MD, Northern Ontario Medical School

- “The Disturbing Evidence From the U.S.” by Robert Bowman, MD, University of Nebraska
- “An African Perspective” by Ian Couper, MD, University of Witwatersrand, South Africa
- “The European Story – Networks” by Christos Lionis, MD, Department of Social Medicine, University of Crete
- “The Asian Experience” by Fortunato Cristobal, MD, Zamboanga Medical School, Phillipines
- “The Australian Experience” by Paul Worley, MBBS, Flinders University Rural Clinical School, Adelaide, Australia
- “The Canadian Experience” by James Rourke, MD, Dean of Medicine Memorial University of Newfoundland, Canada

Slides from the plenary sessions will be posted on the conference website within the next month for those who are interested in these topics.

A highlight of the meeting was the conference banquet that was held on an island in Puget Sound. Guests traveled by boat to the dinner for a traditional northwest native meal of salmon and fresh vegetables. The view of the Seattle skyline from the boat was impressive.



Seattle skyline as seen by the rural Wonca banquet guests

Following the policy, education, and research portion of the

conference, the guests attended two days of clinical continuing medical education as part of the 36th annual Family Practice Update at the University of Washington. At the conclusion of the CME program, forty physicians and guests traveled to Alaska for an outstanding “post-conference” that included tours of the Alaska Native Medical Center, the Sunshine Clinic (a rural community health center), and a stay at the Talkeetna Lodge, near Denali National Park. Activities included enjoying the scenery and jetboat tours on the Susitna River.



Denali National Park

Overall, the meetings were successful and were enjoyed by the rural family doctors who attended.

Tom E. Norris, MD
 Chair, Host Organizing Committee
 Wonca 7th Rural Health Conference
 tnorris@u.washington.edu

Register and Submit Abstracts Online for Wonca World 2007 in Singapore

Singapore beckons! As we gear up in our preparations for the 18th Wonca World Conference from 24-27 July, 2007, Singapore promises a host of exciting attractions and activities. Besides getting updates on the latest advances that genomics and biomedical sciences

have to offer, the scientific program also promises a whole new paradigm in delivery of lectures and plenary sessions.

The deadline for submitting abstracts is December 31, 2006. Please submit your abstracts online at www.Wonca2007.com Also, please register for the online at www.Wonca2007.com.

Officially opened on 30 August 1995, Suntec Singapore is a world-renowned, international venue that has the perfect location for meetings, conventions and exhibitions. Suntec Singapore is situated in the Central Business District, only 20 minutes’ drive from Changi International Airport. Suntec Singapore is in the heart of a self-contained, totally integrated events infrastructure. In addition to its first-class facilities, Suntec Singapore offers direct access to 5,200 hotel rooms, 1,000 retail stores, 300 restaurants and the region’s new centre for the performing arts, Esplanade – Theatres on the Bay.

The medical technology exhibition will also provide a unique business matching opportunity for all family physicians and medical groups wanting to scale up their practice profiles and offer an improved and vastly increased range of point of care testing services for their patients.

In addition to work and academic schedules, the organizing committee also promises to host a dazzling array of social programs for your partners and family members. Thinking of bringing along your loved ones? Fret not, as arrangements have been made for the more than 100 nurseries and child care centers to take care of your kids daily so that you can attend all of our programs and social activities with complete freedom from worries

of caring for the needs of your young ones.

Shop till you drop, feast on some of the greatest culinary delights as well as attend world class performances at our latest state of the art architectural marvel, the Esplanade. You will never have a dull moment in Singapore, the city that never sleeps!

So, stay tuned and make a date with Singapore for the Wonca 2007 World Conference, 24 to 27 July 2007!

Dr Tan See Leng
 Chairman
 Host Organizing Committee
 Wonca World Conference 2007
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 Website: www.wonca2007.com

Historic Wonca Working Party on Women and Family Medicine Meeting Held in Hamilton

Members of the Wonca Working Party on Women and Family Medicine (WWPWFM) met in August 2006 at McMaster University in Hamilton, Ontario, Canada to further their discussions and activities on gender issues affecting both physicians and patients. The 25 participants came from 16 different countries (Antigua and Barbuda, Australia, Austria, Canada, Colombia, Ecuador, Nepal, Nigeria, Netherlands Antilles, Pakistan, Philippines, Sri Lanka, Thailand, Uganda, United States of America, and Venezuela), representing all six Wonca regions. The group included two university vice-chancellors, a dean of a Faculty of Health Science, current and former associate deans, chairs of departments of family medicine, presidents of local organizations and associations, as well as authors of several books on aspects of family medicine, all of whom

brought a wealth of clinical, academic, research and organizational experience.

The meeting was supported by generous grants from Wonca, McMaster University, the American Academy of Family Physicians, the College of Family Physicians of Canada, the Royal College of General Practitioners (UK) and a number of academic departments of family medicine in the United States and Canada. During this remarkable four-day gathering, the participants thrived in the camaraderie and collegiality, as well as the wonderful hospitality of the group's chair, Dr. Cheryl Levitt.



The 25 women family doctors at McMaster University in Hamilton Ontario:
Fourth Row: Susana Alvear, Ecuador; Anne D Atai-Omoruto, Republic of Uganda; Flor Ledesma, Venezuela; Zorayda Leopando, Philippines;

Third Row: Jan Coles, Australia; Dorothy Pietersz-Janga, Neth. Antilles; Liliana Arias-Castillo, Colombia; Ilse Hellemann, Austria; Sue Smith, Nepal; Marlene Joseph, Antigua and Barbuda; Kymm Feldman, Canada;

Second Row: Cheryl Levitt, Canada; Lucy Candib, USA; May Cohen, Canada; Michelle Howard, Canada; Barbara Lent, Canada; Sheila Dunn, Canada; Kate Anteyi, Nigeria;

First Row: Sarah Strasser, Canada; Betsy Garrett, USA; Ruth Stewart, Australia; Linda French, USA; Marie Andrades, Pakistan; Somjit Prueksaritanond, Thailand; Nandani de Silva, Sri Lanka

The participants reviewed Wonca's previous endorsements of both the Beijing Platform for Action and the Millennium Development Goals in 2001. These documents recognize that the elimination of gender inequality (as well as other violations of universal human rights) is an important prerequisite for human development, including the improvement and achievement of optimal health. The support for these documents as well as the formal recognition of the group as an official Wonca Working Party provide

evidence that Wonca is ready to move forward toward gender equity in policy and program. The group's work in Hamilton furthered these goals.

The group accomplished several tasks fundamental to its strategic plan developed at the last Wonca Triennial meeting in Orlando in 2004.

First, the group finalized the Working Party's recommendations for gender equity amendments to Wonca's bylaws and regulations, following several months of intense deliberation and legal consultation. The WWPWFM will be proposing these amendments to the core Executive Council in Buenos Aires in October 2006.

Second, the group developed a proposal for a "Women's Track" for the Wonca Singapore 2007 meeting. Such an important international meeting provides concrete opportunities for the development of leaders and the advancement of women general practitioners/family physicians in Wonca. We plan to offer a smorgasbord of activities including a WWPWFM pre-conference, symposia and leadership workshops.

Third, the group made significant progress in developing a statement urging Wonca to promote awareness of the vital effects of gender as a determinant of health.

Finally, the group put together a policy statement on gender equity for Wonca's endorsement: *The Hamilton Equity Recommendations* (The HER Statement). We have forwarded a signed copy of that statement to the Wonca Executive for their consideration.

The members of WWPWFM look forward to working with family physician colleagues in the ongoing efforts to integrate gender equity into clinical practice, medical education, research development, and organizational activities. The WWPWFM will have an active presence at the upcoming Wonca meetings (Buenos Aires in October 2006, Singapore in 2007, and Cancun in 2010).

Further information can be found at the group's website at www.womenandfamilymedicine.com, where the group's numerous documents are posted. We encourage those interested in subscribing to the group's listserve to send a message to its co-ordinator, Dr. Lucy Candib (at lcandib@massmed.org).

Cheryl Levitt MBBCh, Chair of the WWPWFM
Lucy Candib MD
Barbara Lent MD

WONCA REGIONAL NEWS

THREE YEAR FAMEC AFRICA PROJECT INITIATED DURING KAMPALA UGANDA MEETING

The leadership of the Family Medicine Education Consortium (FaMEC) project in Kampala, Uganda from 15th-16th June 2006 to inaugurate the FaMEC Africa project and introduce it to the participating countries and institutions. The main purpose of the FaMEC Project is to develop and strengthen training in Family Medicine/Primary Health Care in Southern and Eastern Africa, in order to contribute to the realisation of quality and equitable health care in the region. The countries involved in the project are: South Africa, Tanzania, Kenya, Uganda, Democratic Republic of Congo, and Rwanda.

The project duration is three years: from 01 April 2006 to 31 March 2009. Four major results are expected in a period of 3 years:

1. A definition of the concept of Family Medicine within an African context including the vision and strategy for implementation;
2. The development of strategies that are necessary to obtain more horizontal integration of vertical programmes involving the community;
3. The formation of a strong, high quality Family Medicine training programme through sharing of experiences and resources with the participating institutions;
4. The creation of a Family Medicine education consortium for Africa, with clearly identified membership and links to organisations with complementary missions.

The aim of the FaMEC Project is to contribute to the health of communities provided by accessible responsive and quality health care systems in Eastern and Southern Africa through the education and training of family physicians who contribute to interdisciplinary primary health care services, oriented towards the needs of individuals, their families and the communities in which they live. Research, capacity building and extension are needed to realise this objective. Research will try to define a comprehensive framework and definition for family medicine/primary health care in an African context. This will involve all stakeholders utilising a DELPHI-procedure. Moreover, documentation

about field experiences will underpin specific strategies of community oriented primary care, community based education and service, and service-learning. Capacity building is a main objective, focusing on the establishment of training complexes, and making available through South-South cooperation expertise in the format of E-learning, training programmes, workshops on "training the trainers". Finally in order to make the intervention sustainable networking will be essential, exploring the possibilities for further funding in a wider framework (EU-EDULINK-programme).

The overall developmental objective of the project is to contribute to the health of communities through accessible, responsive and quality health care systems in Eastern and Southern Africa through the education and training of family physicians who contribute to interdisciplinary, primary health care systems, oriented towards the needs of individuals, their families and the communities in which they live.

The academic overall objective is the planning, development and strengthening of academic departments or units of family medicine that offer family medicine training at the undergraduate, postgraduate and continuing professional development levels.

The meeting was attended by representatives from 7 Departments of Family Medicine in South Africa (Walter Sisulu University, Stellenbosch University, University of Pretoria, University of Limpopo, University of Free State, University of Cape Town, University of Witwatersrand), Makerere and Mbarara Universities in Uganda, University of Goma in DRC, Moi University in Kenya, Ghent University in Belgium, Ghets, Inter-University Council for East Africa, FaMEC Regional Coordinators for Southern and Eastern Africa, and President of Wonca Africa. The partner institutions in full are:

- Department of Family Medicine, Walter Sisulu University, Mthatha, South Africa
- Department of Family Medicine, University of Pretoria, South Africa
- Department of Family Medicine, Aga Khan University, Tanzania
- Department of Family Medicine, University of Free State, Bloemfontein, South-Africa
- Department of Family Medicine, Mbarara University, Uganda
- Department of Family Medicine and Primary Health Care, University of Limpopo, South Africa
- Département de Médecine Générale, Centre Universitaire de Goma, DRC
- Department of Family Medicine, Stellenbosch University, South-Africa

- Department of Family Medicine, University of Kwa Zulu Natal, Durban, South Africa
- Department of Family Medicine, University of Witwatersrand, Johannesburg, South-Africa
- Department of Family Medicine, University of Cape Town, South Africa
- Department of Family Health, Division of Medicine, Moi University, Kenya
- Global Health Through Education Training and Service
- Department of Family Medicine and Primary Health Care, Ghent University, Belgium

Envisaged links are with the Wonca Africa Region, the Inter University Council for East Africa (IUCEA), Towards Unity for Health (TUFH), and World Health Organisation (WHO).

Academically, the project aims to establish a specific institutional network between departments and units of family medicine and primary health care to:

- Define the discipline and specialty of Family Medicine academically within the African context
- Enhance the quality of programme content, training and educational methods, including community based education programs and service-learning within training complexes
- Encourage research collaboration
- Foster high quality and locally relevant continuing professional development
- Introduce a unified system of quality assurance of training.

The idea of a Wonca Africa Working Group on Education and Research has been triggered by the FaMEC Africa project. The project activities and meetings as outlined above place this group in an ideal situation to be a working group that will generate educational issues and research projects for the whole of Africa. The African countries that are not members of this group will be invited to attend meetings and make contributions. This idea was put forward to this group and has been accepted with enthusiasm.

All the efforts of the FaMEC Africa project, both educational and research work can be shared openly in a conference and also published in peer reviewed journals. Educational issues can be shared at workshops and research work can be shared in posters and papers. The FaMEC Africa project participants believe that a Wonca Africa conference will be the best way to share what has been achieved. There is no better way to end the funded life span of the project than showing the results concretely in this way.

I look forward to receiving any communication from those Wonca member organizations and individual family doctors with an interest or experience working with family medicine development in Africa. Updates from the FaMEC Africa projects will be periodically shared through Wonca News.

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HEALTH AND HEALTH SYSTEM NEWS

PRIMARY CARE IN THE USA CONTRIBUTES TO HEALTH SYSTEM AND HEALTH IMPROVEMENT

(Editor's Note: Dr Barbara Starfield, a world renowned health services researcher, has published and spoken extensively on the contribution of primary care to health system and health improvement. Dr Starfield and Dr Shi published a landmark article in this field entitled "Primary Care Contributions to Health Systems and Health" in the Milbank Quarterly (Volume 83, Number 3, 2005), a highly respected multidisciplinary journal of population health and health policy). The first excerpt of this article, published with the permission of Dr Starfield and the Milbank Quarterly, focuses on her research in the United States, where Dr Starfield lives. The second excerpt, to be published in a future issue of Wonca News, will focus on international comparisons. The entire Milbank Quarterly article and references, as well as additional related resources, may be downloaded from the Wonca Global Resource Directory at www.GlobalFamilyDoctor.com).

Evidence on the health-promoting influence of primary care has been accumulating ever since research has distinguished primary care as a special part of health services. This evidence shows a positive impact of primary care on prevention of illness and death. Evidence demonstrates that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in

populations, a finding that is robust in cross-national studies and within countries. The mechanisms by which primary care improves health have been elucidated, thus suggesting ways to improve overall levels of health and reduce systematic differences in health across major population subgroups.

The term “primary care” is thought to date back to about 1920, when the Dawson Report was released in the United Kingdom. That official report mentioned “primary health care centres” which were intended as the hub of regionalized services in that country. Although primary care came to be the cornerstone of the health services system in the UK as well as in many other countries, no comparable focus developed in the United States. The formation of one after another specialty board in the early decades of the 20th century signaled the increasing specialization of the US physician workforce. The GI Bill of Rights, which supported further training of those returning from services in World War II, fueled a further increase in specialization of physicians, many of whom had been general practitioners (generalists) before the war. At that time, physicians who were general practitioners lacked additional training after graduation from medical school apart from a short clinical internship.



Professor Barbara Starfield

Concern that the survival of generalist physicians would be threatened by the disproportionate increase in the supply of specialists in the United States, family physicians in the 1950s and 1960s, working with international colleagues, developed standards for credentialing the new “specialty” of family practice. In the 1970s, longer postgraduate training became part of preparation for the practice of generalist physicians. Recognition of a “specialty” of primary care in the United States resulted in two reports from the US Institute of Medicine. These reports defined primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community”. This definition is consistent with international reports from Wonca and the World Health Organization and has been used to develop instruments to measure four main features of primary care services: first contact access for each new need; long-term person (not disease) focused care; comprehensiveness in dealing with most needs for health services; and coordination of care when it must be sought elsewhere. Primary care is assessed as “good” based on the degree of attainment of these four main features. For some purposes, an orientation towards family and community are also included.

Research on the beneficial effects of primary care on health can be demonstrated from three types of studies: studies of the supply of primary care physicians, studies of people who identify a primary care physician as their regular source of care, and studies linking the receipt of high quality primary care services with health status. These three lines of evidence represent a pro-

gressively stronger demonstration that primary care improves health; first by showing that health is better in areas with more primary care physicians, second by showing that people who receive care from primary care physicians have better health, and third by showing that the characteristics that constitute primary care are associated with better health.

More Primary Care Physicians are Associated with Better Health

These studies, as a group, cover a variety of health outcomes: total and cause-specific mortality, low birth weight, and self reported health. They examined the relationship between primary care physician supply and health at different levels of geographic aggregation (state, county, metropolitan and non-metropolitan regions); after controlling for a variety of population characteristics (such as income, education, and racial distribution); and used a variety of analytic approaches (standard regressions, path analyses) in both individual years (cross-sectional) as well as over time (longitudinal).

The number of primary care physicians per 10,000 population is the measure of “supply”. In the United States, Primary care physicians in the US include family and general practitioners, general internists, and general pediatricians. These three types of physicians constitute the primary care physician workforce and have been shown to provide the highest levels of primary care characteristics in their practices.

Studies in the early 1990s showed that US states with higher primary care physician to population ratios had better health outcomes,

including lower rates of all-cause mortality; mortality from heart disease, cancer, or stroke, infant mortality, low birth weight, and poor self-reported health, even after controlling for sociodemographic measures (% elderly, % urban, % minority, education, income, unemployment, pollution) and lifestyle factors (seatbelt use, obesity, and smoking). Vogel and Ackerman subsequently showed that the supply of primary care physicians is associated with an increase in life span and with reduced low birth weight rates.

Additional studies examined the influence of primary care physician supply at the state level while also taking into account specialist physician supply. These analyses found that primary care physician supply was significantly associated with lower all-cause mortality whereas greater specialty physician supply was associated with higher mortality. When primary care physician supply was disaggregated into its components (family physicians, general internists, and pediatricians), only family physician supply showed significant relationships with lower mortality.

Studies of health according to people's relationship with primary care facilities and providers

Because an increased number of primary care physicians does not necessarily mean that all people in the area have greater access to or receipt of primary care services, analyses that consider people's relationships or experiences with a primary care practitioner are helpful in examining the primary care-health outcome association. Thus the second line of evidence for a positive impact of primary care on health comes from comparisons of

the health of people who do or do not have a primary care physician as their regular source of primary care.

A nationally representative survey showed that adult US respondents who reported a primary care physician rather than a specialist as their regular source of care had lower subsequent 5-year mortality, after controlling for initial differences in health status, demographic characteristics, health insurance status, health perceptions, reported diagnoses, and smoking status. That is, people who go to a primary care physician as their regular source of care have subsequent better health regardless of their initial health or various demographic characteristics.

Studies of health according to the primary care characteristics

As noted in the introduction, until recently primary care could be assessed only by determining the type of physician who provided it: family physicians, general internists, and general pediatricians in the US, and family physicians or general practitioners in most other industrialized countries. The intensive examination of criteria for the designation of "primary care" in the most recent half century encouraged the development of tools to assess the adequacy of those health delivery characteristics which, in combination, define the practice of primary care. This development made it possible to examine the extent to which receipt of better primary care is associated with better health.

Using these new methods, several studies have demonstrated a positive association between the adequacy of the features of primary care and provision of preventive services. In a cross-sectional study of patients in the state of Ohio, the

four primary care attributes were evaluated for their relationship with delivery of preventive services. After controlling for patient age, race, health, and insurance in the hierarchical linear regression model, each of the measured primary care attributes was significantly associated with patients being up to date on screening, immunization, and health habit counseling services. In another study, adolescents with the same regular source of care for preventive and illness care (one indication that the source is focused on providing primary care) are much more likely to receive indicated preventive care and less likely to seek care in emergency rooms.

The positive impact of primary care also was shown by comparing the self-assessed health of those who actually experienced better primary care (as assessed by the health delivery characteristics of primary care) with those who reported less adequate primary care. Among those who reported better primary care, greater than 5% fewer people reported poor health and 6% fewer reported depression than was the case for people experiencing less adequate primary care. Just considering those who reported the best primary care experiences, 8% fewer reported poor health and more than 10% fewer reported feeling depressed as compared with those with less adequate primary care.

In summary, these studies in the US are consistent in showing a relationship between more or better primary care and most health outcomes studied. Primary care is associated with improved health outcomes as measured by all cause mortality, heart disease mortality, stroke mortality, infant mortality, low birth weight, life expectancy, and self rated health. The effect is also found for cancer mortality in all but a few studies. In addition, studies of the

impact of actually receiving care from a primary care source are consistent in showing benefits on a variety of health and health-related outcomes. The results of these studies suggest that as many as 127,617 deaths per year in the US could potentially be averted through such an increase in the number of primary care physicians,

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WOMEN FAMILY DOCTORS AND THE DOCTOR-PATIENT RELATIONSHIP

(Editor's Note: This article is one of a series done by the authors on behalf of the Wonca Working Party on Women and Family Medicine (WWPWFM) published in Wonca News over the past few months. Please see www.womenandfamilymedicine.com for the full monograph, literature review, summary and annotated bibliography on women family physicians and the doctor-patient relationship.)

Given the increasing numbers of women in the medical profession and the important role that building and nurturing relationships play in the socialization of women, one might expect the gender of the physician to be influential in the doctor-patient relationship. Enhanced communication skills should also be beneficial in providing more personal and

humanized medicine. Sensitive and empathetic doctor-patient relationships might help overcome imbalances associated with expert power and gender power. Nevertheless, critics have expressed concern about how the changing gender distribution of the medical profession will have a negative impact on health care and on the status of the profession. To shed further light on these issues, we have prepared a short article, based on our review of the literature (limited by it being mostly from North America and Europe) on how the gender of the physician influences practice patterns and communication styles.

Research demonstrates that women family physicians are more likely to provide more health education and/or counseling to their patients than men physicians. Women physicians are also more likely to offer more preventive services, particularly, but not exclusively, for gender-specific procedures. Such studies raise the question as to whether women physicians are more prevention-oriented; whether prevention-oriented patients seek out women physicians more; whether women physicians are more comfortable providing female specific preventative services than men; whether women are more risk averse and therefore counsel more for prevention; or whether women see prevention as part of care-giving role out of experience of mothering.

In North America, women patients often seek out women family doctors more than men family doctors, preferring women for obstetrical-gynecological and for behavioral and emotional health concerns; this gender preference does not extend to other non-female-specific health concerns. However, it is unclear whether these

preferences reflect real differences in physicians' attitudes and communication styles, or patients' stereotyping of physicians, or patients' past experiences with men and women physicians. Cultural and/or religious factors are also important influences on patients' choices with respect to physician gender.

Studies on the practice patterns and activity levels of women family physicians have raised questions regarding the relative productivity of women versus men physicians. One Canadian study showed that women family physicians billed more per patient seen and provided fewer services than men. These findings might partly be explained by the increased likelihood of more counseling and length of encounter offered by women physicians, as data are based on payment per encounter rather than quality and extent of the encounter. Comparisons of the productivity and behavior of men and women physicians can be further complicated because women physicians in these studies were on average younger than men physicians. Younger family physicians differ from older physicians in scope of practice and in the number and proportion of women patients seen per week.

In the area of doctor-patient communication, research has shown that women family doctors are more likely to engage in more patient-centered communication (e.g. positive talk, partnership building, psychosocial counseling and question asking, and emotionally focused talk) than men doctors. In addition, women are more likely to conduct longer visits, offer more support to their patients and possess a higher awareness of the impact of psychosocial factors in patient care. Interestingly, physician

gender may also affect patient behavior in the encounter, with the patients of women doctors speaking more, disclosing more biomedical and psychosocial information, and making more positive statements to their physicians than patients of men doctors. The impact of these communication differences on patient outcomes is as yet unknown.

Women's communication styles may partly explain the high patient satisfaction, compliance and some patient health outcomes observed in some studies. In one study, patients were significantly more satisfied with women physicians than men physicians. In another, higher levels of satisfaction were found among women patients of women physicians than women patients of men physicians. However, in contrast, another study reported men doctors being preferred to women doctors. Both men and women patients examined by younger physicians, especially younger women physicians, tend to be less satisfied, especially when younger women physicians examine men patients. This finding suggests attitudes, values and expectations may influence patients' reactions to physicians' gender.

The doctor-patient relationship is fraught with power imbalances. Some researchers have suggested that a feminist analysis of these imbalances might help all doctors, regardless of gender, to remedy the impact of these imbalances in clinical encounters. The high degree of expert, esoteric knowledge possessed by the physician allows the physician to dominate the medical encounter through either validating or disregarding the patient's own understanding of his or her health problem. This is particularly problematic for women patients who are exposed not only to expert power but gender power

as well. Enhancing the patient's ability to care for him/herself requires a range of skills: recognition of the oppression felt by the patient, empathy, respect for the person as a person, responding to the patient's changing abilities, exploring and understanding the patient's own understanding of her illness, respecting and maintaining the patient's sense of control over her life, and providing the patient with the tools and information required to maintain optimal health.

Physician and patient gender are also influential in the establishment and maintenance of appropriate boundaries in clinical care. Sexual abuse of patients is the most serious boundary violation, and typically occurs when men physicians engage in sexual abuse of women patients. Conversely, women physicians may be at greater risk of sexual harassment in clinical encounters with men patients. On the other hand, women physicians can potentially blur the boundaries between personal and professional relationships by disclosing more personal information as a way of enhancing their relationships with patients.

Patients choose physicians for a myriad of non-clinical reasons, such as life experience, comfort, stereotyping, culture and religion. Understanding the differences between women and men physicians will allow us to comprehend patients' expectations more fully. From the vantage point of each gender, we can reflect carefully on our own clinical encounters, as we strive to provide our patients with exemplary clinical care in the context of their families and communities.

Barbara Lent MD
Lucy Candib MD
Michelle Howard MSc
Cheryl Levitt MBBCh

MEMBER AND ORGANIZATIONAL NEWS

WONCA APPROVES SIX NEW MEMBER ORGANIZATION APPLICATIONS

We continue to receive many enquiries about membership in Wonca as well as completed applications. After the Core Executive in Singapore, Wonca represented 107 member organizations from 90 countries. This includes nine Associate Members and ten members in Collaborative Relationships.

During the Wonca Executive in Buenos Aires, the following membership applications were reviewed and approved:

- The Sections of Teachers and Researchers of the College of Family Physicians of Canada was approved for Associate Membership.
- The Nicaraguan Association of Family Medicine was approved for full membership. This is contingent upon receipt of their financial records and the dues payment.
- The Cuban Society of Family Medicine was approved for full membership. This is contingent upon receiving their dues payment.
- The Romanian National Centre for Studies in Family Medicine (NCSFM) is approved for Associate Membership, subject to payment of dues.
- The Serbia Medical Association, Section of General Practice is approved for full membership. This was approved contingent upon receipt of their financial

records, payment of the dues and submission of its membership list.

Subsequent to these actions by the Wonca Executive in Buenos Aires, Wonca now represents 112 member organization from 93 different countries comprising 85% of the world's population.

Professor Warren Heffron
Chair, Membership Committee

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA HOLDS SUMMIT

Niagara Falls, Ontario was the backdrop for the CFPC Summit in June 2006. Focused on making our organization relevant and meaningful for all family physicians in Canada, approximately 100 members participated in activities to help us better understand the evolution of our discipline. Over a three-day period, we explored the needs of specific member groups such as francophones, international medical graduates and women. We examined how well the College

addresses member needs through education, training, continuing professional development and advocacy. We considered issues surrounding focused practices. We discussed a possible time-limited alternative route to certification (without examination) for our non-certificant members. As a result of our summit, on Sunday, June 4th, a motion to acknowledge that Family Medicine is a specialty with its own body of knowledge, attitude and skills was approved in principle by the CFPC Board of Directors.

Our President, Dr. Louise Nasmith, goes into more detail in her report on the summit in the August issue of CFPC News. Her full message can be read at www.cfpc.ca under the eNews heading.



Lynda Redwood-Campbell, Sarah Beer Delaney, Katherine Rouleau, Kevin Pottie and Veronic Ouellette pictured above at the Family Medicine Forum 2006 in Vancouver, British Columbia

In February 2006, The College of Family Physicians of Canada held the first meeting of its International Health Committee. Its mandate is to promote the global development of family practice and to support CFPC members meeting health needs worldwide. Our initial focus has been the very significant overlap between international health and global health, specifically its impact on our ability to care properly for some populations at risk within Canada. Our chair is Lynda Redwood-Campbell of McMaster University. The committee is comprised of Veronic Ouellette, Kevin Pottie, and Katherine Rouleau. Dr. Francine Lemire, Associate Executive Director of Professional Affairs and Sarah Beer Delaney, Manager of Member and Chapter Relations, are the CFPC liaisons to this committee.

RESOURCES FOR THE FAMILY DOCTOR

IMPROVING HEALTH SYSTEMS: THE CONTRIBUTION OF FAMILY MEDICINE – THE WONCA-WHO GUIDEBOOK

Why is family medicine emerging in almost every health system of the world? How can Wonca member organizations and their family doctors become involved in improving health systems with family medicine?

Health systems everywhere achieve better outcomes at lower costs when based on a strong foundation of primary health care (PHC). Community based PHC teams

are able to deliver PHC most effectively; team members can share responsibilities to provide continuous access, comprehensive coverage, and coordinate referrals with others in the health system as needed. When family doctors are appropriately prepared and available to provide comprehensive care based on local needs and resources, they can enhance both the scope and quality of PHC teams.

Recognizing the fundamental importance of PHC in all health systems and the critical role of family doctors in PHC teams, the World Health Organization (WHO) and the World Organization of Family Doctors (Wonca) produced a guidebook, *Improving Health Systems: the Contribution of Family Medicine*, that was published in 2002. The guidebook is intended to help countries establish or strengthen family medicine.

The guidebook is the result of many years of collaboration between the WHO and Wonca. As early as 1963 an expert committee of the WHO emphasized the need for family doctors in every country. In 1978 the Alma Ata conference on Primary Health Care urged all governments to establish PHC as a vehicle to provide health for all. Family medicine/general practice post-graduate training programs began in Europe and North America in the late 60s. Wonca was established in 1972 and now includes members from more than 60 countries. In 1993 representatives of WHO and Wonca began meeting to identify common goals and strategies for strengthening medical education, family medicine and PHC delivery; the guidebook emerged from this process.

The guidebook was prepared by co-authors Charles Boelen, Cynthia Haq, Vincent Hunt, Marc Rivo and Edward Shahady, with guidance from a steering committee sponsored by the WHO and Wonca. More than seventy individuals from six continents contributed to describe the similarities and differences in family medicine in different regions of the world.

The book is divided into five chapters. Chapter 1 describes the features of responsive and sustainable health care systems and the critical importance of balancing conflicting priorities among those who contribute to health care. Chapter 2 describes the enormous challenges facing health systems and the importance of PHC. Chapter 3 explains how family doctors can make significant contributions to PHC. It describes the attributes of family doctors, their roles and responsibilities, and the quality and cost-effectiveness of their work. Chapter 4 outlines the continuum of training for family doctors that begins in medical school, extends through specialty training, and is sustained through a process of continuing medical education. Chapter 5 calls for unified efforts among policy-makers, health managers, health professionals, academic institutions, and community representatives to create a supportive environment for family practice. This environment is sustained through dedicated leadership, institutional commitment, strategic policy development, and appropriate resources. A Resource Directory lists key organizations and contacts to assist those interested in considering development of family medicine programs.

The Wonca-WHO Guidebook has been widely distributed, discussed and debated. It has been discussed at Wonca executive and regional meetings throughout the world. More than 2000 copies of the Wonca-WHO Guidebook have been distributed to Wonca member organizations and to WHO regional offices.

A Thai translation of the Wonca-WHO Guidebook has been completed under a Wonca Agreement with Asst. Prof. Dr. Nitaya Wongsangiem Tanuwong with of Faculty of Medicine, Thammasat University (nitaya@alpha.tu.ac.th).

A planned Greek translation of the Wonca-WHO Guidebook was initiated through an agreement between Wonca and Dr Christos Lionis (lionis@galinos.med.uoc.gr), Associate Professor Clinic of Social and Family Medicine, University of Crete and the Greek Academy of Family Physicians, an affiliate of the Greek Association of General Practitioners.

A planned Turkish translation of the Wonca-WHO Guidebook was initiated through an agreement between Wonca and Prof Dr Nazan BILGEL (communication via Dr Hakan OZDEMIR hozdemir@uludag.edu.tr), Director of Uludag University School of Medicine Department of Family Medicine in Bursa, Turkey.

A planned Lao translation of the Wonca-WHO Guidebook was initiated through an agreement between Wonca and Dr Sing Menorath (menorath_s@yahoo.com), Vice Dean of the Faculty of Medical Sciences, at the National University of Laos.

A planned Korean translation of the Wonca-WHO Guidebook was initiated through an agreement between Wonca and Professor Hyun Rim Choi (fmdr@dreamwiz.com), Senior Director at

The Wonca-WHO guidebook may be ordered from Ms. Yvonne Chung, Administrative Manager, World Organization of Family Doctors (Wonca), by emailing admin@wonca.com.sg. It costs US\$15 for Wonca members, US\$20 for non-members by airmail. In the future the guidebook will be available on the Wonca website at <http://www.GlobalFamilyDoctor.com>. Those interested in translating the Wonca-WHO Guidebook into their country's language may also contact Yvonne Chung for additional information and directions to complete an agreement with Wonca.

FACULTY DEVELOPMENT PROGRAM AT THE UNIVERSITY OF TORONTO

The program, "Teaching & Learning in the Health Professions", will be offered May 7-11, 2007 at the University of Toronto. It is based on the well regarded Clinical Teacher Certificate courses established in the Department of Family and Community Medicine over the past ten years by Dr Helen Batty, last year's national

Canadian ACFM award winning faculty developer.
The registration and brochure is at
<http://www.cme.utoronto.ca/phso602.html>

Interested persons may also wish to register for the full Clinical Teacher Certificate program which has an additional field practicum that can be completed in the home location, and a selective course such as our online Teaching Evidence Based Medicine which can also be completed in the future without traveling to Toronto. The full Clinical Teacher Certificate program can be seen at: <http://dfcm.utoronto.ca/GradStudies/ProgramInformation/ClinicalTeacherCertificate.asp>

Toronto is a welcoming multicultural city with many interesting attractions. May is the beginning of our lovely cool Spring season. There are good reasonable accommodations in the area close to the program location and the city streets are safe to walk. Restaurants of many different special ethnic and cultural varieties are nearby.

We hope local, national and international colleagues from many health professions will seriously consider joining us on campus in Toronto for this innovative program. Graduate degree credits may also be available for participants already enrolled in a Master's or PhD degree.

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WONCA CONFERENCES 2006 – 2011 AT A GLANCE

 Information correct as of October 2006.
 May be subject to change.

**Wonca Direct Members enjoy lower conference registration fees

 See Wonca Website www.GlobalFamilyDoctor.com for updates & membership information

2006	Region	Venue	Theme
11 – 14 Oct	Iberoamericana - CIMF Regional Conference	Buenos Aires ARGENTINA	Building a Primary Care-Based Health System: the Role of the Family Doctor
5 – 9 Nov	Asia Pacific Regional Conference	Bangkok THAILAND	Happy and Healthy Family
2007			
24 – 27 July	18th WONCA WORLD CONFERENCE	SINGAPORE	Genomics and Family Medicine
17 – 21 Oct	European Regional Conference	Paris FRANCE	Re-Thinking Primary Care in the European Context: A New Challenge for General Practice
2008			
September	Europe Regional Conference	Istanbul TURKEY	Theme to be confirmed
1 – 5 Oct	Asia Pacific Regional Conference	Melbourne AUSTRALIA	A Celebration of Diversity
2009			
5 – 8 June	Asia Pacific Regional Conference	Hong Kong	Building Bridges
Date to be confirmed	Europe Regional Conference	Basel SWITZERLAND	Theme to be confirmed
2010			
19 – 23 May	19 th WONCA World Conference	Cancun MEXICO	Millennium Development Goals: the Contribution of Family Medicine
Date to confirmed	Europe Regional Conference	SPAIN	Theme to be confirmed
2011			
February 2011	Asia Pacific Regional Conference	Cebu PHILIPPINES	Paradigms of Family Medicine: Bridging Old Traditions with New Concepts

GLOBAL MEETINGS FOR THE FAMILY DOCTOR

WONCA WORLD AND REGIONAL CONFERENCE CALENDAR

18th Wonca World Conference, Singapore 2007

Host: College of Family Physicians, Singapore
Theme: Genomics and Family Medicine
Date: 24-28 July, 2007
Venue: Singapore International Convention and Exhibition Centre
Contact: Dr Tan See Leng, Chairman, Host Organizing Committee College of Family Physicians, Singapore College of Medicine Building 16 College Road #01-02 Singapore 169854
Tel: 65 6223 0606
Fax: 65 6222 0204
Email: cfps@pacific.net.sg
Web: www.wonca2007.com

Wonca Europe Regional Conference, Paris, 2007

Host: French National College of Teachers in General Practice
Theme: Rethinking Primary Care in the European Context
Date: 17-20 October, 2007
Venue: Palais des Congres Paris, France
Contact: French National College of Teachers in General Practice 6 rue des Deux Communes 94300 Vincennes, France
Tel: 33-153 669 180
Email: cnge@cnge.fr
Web: www.cnge.fr

8th Wonca Rural Health Conference, Nigeria 2008

Host : National Post-Graduate Medical College of Nigeria
Theme: Frontline Medicine – From Natural Disasters to Daily Care
Date: 20th – 23rd February 2008
Venue: Calabar , Cross River State, Nigeria
Contact: Dr Ndifreke Udonwa Chair Local Organizing Committee C/O Office of C.M.A.C University of Calabar Teaching Hospital, GPO Box 147, Calabar 54001, Cross River State, Nigeria.
Tel : 234 (0) 803 341 6810
Fax: 234 (0) 87 232 053
Email: nudonwa@yahoo.com

19th Wonca World Conference, Cancun 2010

Host: Mexican College of Family Medicine
Theme: Millennium Develop Goals: The Contribution of Family Medicine
Date: 19-23 May, 2010
Venue: Cancun Conventions and Exhibition Center, Cancun Mexico
Contact: Mexican College of Family Medicine Anahuac #60 Colonia Roma Sur 06760 Mexico, D.F.
Tel: 52-55 5574
Fax: 52-55 5387
Email: javier.dominguez@unfpa.org.mx

MEMBER ORGANIZATION AND RELATED MEETINGS

College of Family Physicians of Canada (CFPC)
 Family Medicine Forum, Manitoba 2006
Date: November 2 - 4, 2006
Venue: Quebec City Convention Centre Quebec City, Quebec
Contact: Joanne Langevin; Meetings Manager Cheryl Selig, Registration Coordinator 2630 Skymark Avenue Mississauga, Ontario, Canada L4W 5A4
Tel: (905) 629-0900 / 1-800-387-6197
Fax: (905) 629-0893
Email: info@cfpc.ca
Web: www.cfpc.ca

Invitación VII Congreso Venezolano de Medicina Familiar, Lecherías Venezuela 2006

Date: 7 -11 Nov, 2006
Venue: Maremare Hotel Marina & Spa Lecherías, Anzoategui. Venezuela
Host: Sociedad Venezolana de Medicina Familiar (SOVEMEFA)
Contact: Congrex of Venezuela SOVEMEFA
Phone: 58212 - 2639733
Fax: 58212 - 9762681
Email: info@congrex.com.ve
Web: www.sovemefa.net

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Disease Alerts – the latest disease outbreaks from WHO and CDC

Travel Alerts – advice for you to give to your traveling patients

Online CME – interactive programs, some with CME credits

Clinical Nutrition Updates – a new topic is presented every three weeks

POEMs – Patient-Oriented Evidence that Matters – a new POEM is posted twice a week

POEMs em Portugu s – a new one is posted twice a week

eMedicine – a weekly clinical case for you to solve, with a visual cue: photo, ECG, radiograph

EBMsources – an appraisal of two evidence based medicine websites is posted every month

Cutting Edge – an interesting series about the latest medical hypotheses, posted weekly

Educational Resource Centre – a repository of educational materials for family doctors

Research – the latest on Wonca's research activities, and opportunities for research

Conference updates – details of Wonca and other conferences

Publications – details of Wonca publications and Wonca News

Wonca Websites – addresses of Member Organization and other Wonca websites

Global Resource Directory – where you can record you international projects, and view others

Medical Mirth – humor with a medical angle to lighten your day

Quotable Quotes – quotes you can use, many with a medical slant

Latest News – of coming meetings, conferences and events

Patient education – resources you can use to inform your patients

About Wonca – details of the Wonca organization, office bearers and Direct Members

Wonca Groups – details of Wonca's committees and working groups

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