

SEASON'S GREETINGS AND HAPPY NEW YEAR TO THE WORLDWIDE WONCA FAMILY

WONCA News

An International Forum for Family Doctors



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From the President: Primary Health Care Reform in Finland



GPs Dr Kaisa Nissinen-Paatsalmala, Medical Director, and Dr Ragnar Ulfvens in a typical GP consulting room at the Myllypuro Health Station in East Helsinki

Midwinter is probably not the best time to visit Finland to see the sights. But it is a great time of year to meet with many of our colleagues in family medicine from across the country as they converge on Helsinki for the annual General Practice Finland Conference.

This was my first visit to Finland, a country which has fascinated me since I was five years old and my mother first introduced me to the magical books of Tove Jansen about the Moomins.

Photo: GP Dr Arto Virtanen catching up on his electronic prescription requests at the Nurmijarvi Health Center in rural Finland



Finland has a population of 5.5 million and a reputation for providing

universal health coverage (government-subsidised health care to all citizens regardless of their ability to pay) and a strong track record on the adoption of electronic medical records in general practice to improve

the quality and safety of primary health care.

The Government of Finland has determined that healthcare and social care services will be run by the same government department, which allows for some streamlining of care provision. Finland also has a strong system of general practice run through public clinics, as well as through private services.



Photo: WONCA President with general practice colleagues, researchers and teachers in Helsinki

I was impressed to learn that Finnish general practitioners not only keep all their own medical records on computers but they also have access to full hospital and specialist electronic records and to radiology and pathology results ordered anywhere in the country. This is an achievement which remains beyond the reach of many other developed nations. Finland also has a strong history of embedding clinical guidelines into electronic medical records to assist general practitioners (GPs) in incorporating evidence-based medicine into their daily work with their patients.

There are of course challenges, not least with the funding of public general practice in Finland. Each local government municipality in Finland has responsibility for funding its local health centres, which risks discrepancies between services.

And only 3,500 of the 20,000 doctors in Finland are GPs. This places a huge strain on primary care services. Up to 30% of all Finnish GPs work in rural areas ensuring equitable access to health services for the entire

population, including those living in the northern areas of Lapland.



Photo: Downtown Helsinki with the remarkable wooden "Chapel of Quiet Contemplation"

In Helsinki there are 25 publicly-funded health stations staffed by teams of GPs and primary care nurses. The members of the population are free to choose which health station they will utilize, and can also choose their own personal GP-nurse pair for their continuing health care. The public health stations also include self-treatment areas where patients can take their own blood pressure and monitor other aspects of their own health and fitness. And each health station also includes specialized services in mental health, substance use and oral health, as well as separate maternity and child health clinics. The health clinics are supported by a telephone consultation service, operated by nurses, which triages access to GPs.

There are of course, many challenges. Waiting times for first appointments can be lengthy. Recruiting excellent doctors to work in the public sector GP clinics can be difficult, with many doctors choosing to work in private general practice. And the health system has an over-reliance on specialized care, which has resulted in relative underinvestment in primary care. Postgraduate specialized training in family medicine is available but is not compulsory for those choosing to work in general practice. These are common challenges facing family medicine in many countries.



Photo: Helsinki waterside

Finland also has strong academic family medicine through the Departments of General Practice at each of the nation's five medical schools (in Helsinki, Turku, Tampere, Kuopio and Oulu, in the far north). And every medical graduate in Finland spends up to 9 months immediately after graduation, working as a resident in general practice under the supervision of GPs.

Update on Ebola response

Dr Atai Amaruto, an active member with WONCA's working party on women in family medicine, is set to return home to Uganda after providing many weeks of meritorious voluntary service in Liberia, working alongside colleagues from around the world in helping with the fight against Ebola Virus.

Atai recently drew world media attention to a trend of the wives of some of the healed and discharged men apparently contracted the disease from their husbands and presenting with infection. The World Health Organization recommends that men avoid sexual intercourse for at least seven weeks after recovery, or wear condoms if having sexual intercourse during the first seven weeks after recovery. Ebola is sexually transmissible and this reinforces the need for the use of condoms or abstinence for those who have survived infection.

Michael Kidd
WONCA President

Calidad y Equidad en el Cuidado a la Salud

4^o Congreso Iberoamericano de Medicina Familiar y Comunitaria
WONCA Iberoamericana-CIMF
Hotel Radisson- 18 a 21 de Marzo 2015. Montevideo, Uruguay

Del Presidente: Reforma de la Atención Primaria de Salud en Finlandia



Foto: La médica de familia Dra. Kaisa Nissinen-Paatsalmala, Directora Médica, y el Dr. Ragnar Ulfvens, en la típica sala de consulta de medicina de familia en el Centro de Salud Myllypuro, al este de Helsinki.

Probablemente, la mejor época para visitar los paisajes de Finlandia no sea en pleno invierno, pero es un gran momento del año para encontrarnos con muchos de nuestros colegas médicos de familia de todo el país, a medida que van llegando a Helsinki para la Conferencia Anual de Finlandia sobre Medicina de Familia.

Esta ha sido mi primera visita a Finlandia, un país que me ha fascinado desde que tenía cinco años y que mi madre me presentó por primera vez a través de los libros mágicos de Tove Cansén, acerca de los Moomins.

Foto: El médico de familia Dr. Arto Virtanen, poniéndose al día en sus solicitudes de receta electrónica en el Centro de Salud Nurmiyarvi, en la Finlandia rural.



Finlandia tiene una población de 5,5 millones de habitantes y la reputación de ofrecer cobertura

universal de salud (atención de salud subsidiada por el gobierno para todos los ciudadanos, independientemente de su capacidad de pago), así como un sólido historial en la adopción de registros médicos electrónicos en medicina de familia para mejorar la calidad y seguridad de la atención primaria de salud.

El Gobierno de Finlandia ha determinado que los servicios de salud y de asistencia social se realizarán desde el mismo departamento del Gobierno, lo que permite cierta racionalización en la prestación de la atención. Finlandia también tiene un sistema fuerte en la gestión de la medicina de familia a través de clínicas públicas, así como de servicios privados.



Foto: El Presidente de WONCA con colegas médicos de familia, investigadores y docentes, en Helsinki.

Me quedé impresionado al saber que los médicos generales finlandeses no solo mantienen todos sus registros médicos en los ordenadores, sino que también tienen acceso pleno al hospital y a los registros electrónicos de otros médicos especialistas, con los resultados de radiología y patología ordenados en cualquier parte del país. Este es un logro que queda fuera del alcance de muchos otros países desarrollados. Finlandia también tiene un pasado sólido en la incrustación de las guías clínicas en la historia clínica electrónica, para ayudar a los médicos de familia en la incorporación de la medicina basada en la evidencia a su trabajo diario con sus pacientes.

Hay, por supuesto, dificultades no solo con la financiación de la medicina de familia estatal en Finlandia. Cada municipio del gobierno local en Finlandia tiene la responsabilidad de la

financiación de sus centros de salud locales, que corren el riesgo de las discrepancias entre los servicios.

Y sólo 3.500 de los 20.000 médicos en Finlandia son médicos de familia. Esto supone una enorme presión sobre los servicios de atención primaria. Hasta un 30% de todos los médicos finlandeses trabajan en zonas rurales para garantizar el acceso equitativo a los servicios de salud para toda la población, incluidos los que viven en las zonas del norte de Laponia.



Foto: El centro de Helsinki con la madera extraordinaria de la "Capilla de la contemplación tranquila".

ación tranquila".

En Helsinki hay 25 centros de salud financiados con fondos públicos, que son atendidos por equipos de médicos y enfermeras de atención primaria. La población tiene libertad para elegir el centro de salud que va a utilizar, y también puede seleccionar su propio equipo de médico de familia-enfermera para su cuidado continuado de salud. Los centros de salud públicos también cuentan con sala de auto-tratamiento, donde los pacientes pueden tomarse la presión arterial y controlar otros aspectos de su propia salud y su forma física.

Además, cada centro también incluye servicios especializados en salud mental, en abuso de sustancias y en salud bucodental, así como clínicas separadas de maternidad y salud infantil. Los centros de salud están apoyados por un servicio de consulta telefónica, operado por personal de enfermería, que realizan el triaje para el acceso a los médicos de familia.

Foto: Ribera de Helsinki.

Hay, por supuesto, muchos retos. Los tiempos de espera para las primeras visitas



pueden ser largos. Reclutar excelentes médicos de familia para trabajar en los centros del sector público puede ser difícil, pues muchos médicos se sitúan ante la decisión de trabajar en las consultas privadas. Y el sistema de salud tiene una dependencia excesiva de la atención especializada, lo que ha dado lugar a la falta de inversión relativa en atención primaria. La formación especializada de postgrado en medicina de familia está disponible, pero no es obligatoria para aquellos que eligen trabajar en medicina de familia. Estos son algunos de los desafíos comunes que afronta la medicina de familia en muchos países.

Finlandia también tiene una medicina familiar académica sólida a través de los Departamentos de Medicina General de cada una de las cinco escuelas de medicina del país (en Helsinki, Turku, Tampere, Kuopio y Oulu, en el extremo norte). Y todos los graduados en medicina de Finlandia dedican hasta 9 meses inmediatamente después de su graduación a trabajar como residentes en medicina de familia, bajo la supervisión de médicos de familia.

Actualización sobre la respuesta del Ébola

La Dra. Atai Amaruto, miembro activo con su grupo de trabajo de WONCA sobre mujer en medicina de familia, está lista para volver a casa, a Uganda, después de muchas semanas de voluntariado meritorio en Liberia, en colaboración con colegas de todo el mundo para ayudar a la lucha contra el virus Ébola. Atai ha insistido recientemente a los medios de comunicación mundiales en la tendencia observada en las esposas de algunos de los hombres sanados y dados de alta, que al parecer contrajeron la enfermedad de sus maridos y que presentan infección.

La Organización Mundial de la Salud recomienda a los hombres que eviten las relaciones sexuales durante al menos siete semanas después de la recuperación, o que usen profilácticos si tienen relaciones sexuales durante las primeras siete semanas después de la recuperación. El Ébola es una infección de transmisión sexual y esto refuerza la necesidad del uso de preservativo o la abstinencia para los que han sobrevivido a la infección.

Michael Kidd
Presidente WONCA

Traducción: Eva Tudela, Spanish Society of Family and Community Medicine (semFYC) Director

From the CEO's desk: final 2014 message

The next World Council meeting and Rio world conference

Last month I reported that I would be in Rio de Janeiro, attending a Conference Planning Committee meeting for the WONCA World Conference in 2016. This month let me report back on some of the visits and discussions which took place during my stay in Brazil.

Rio really is a fantastic city, with many beaches right in the heart of the city. The venue for the World Council – the Windsor Hotel in Barra di Tijuca, a suburb of Rio - is across the road from an 18km long beach, which will form an alternative attraction to the events in Council! There are many hotels in the immediate neighbourhood, to suit all pockets. The main meeting within the Windsor Hotel is ample for the Council meeting, and there are plenty of breakout rooms for both Council and for the regional, working party and special interest group meetings which will take place around the same time.

The conference itself is planned for Rio Centro, an excellent congress centre on a really lovely campus, close to what will become the Olympic village for the 2016 Olympics. The Host Organizing Committee for Rio 2016 are working hard to ensure that this is the best WONCA world conference ever, and estimates of up to 6,000 attendees are not unreasonable.

Key dates for the period leading up to the Council and conference include:

- Extra-early bird registration will close on 10th December 2014. This offers great value for money, and even better value for those with WONCA Direct Membership. It's still not too late to apply – go the WONCA website (www.globalfamilydoctor.com) for more details.
- Early bird registration will run until 2nd November 2015.
- Call for abstracts will open on 1st May 2015, through to the end of February 2016. All those who are interested in submitting an abstract should start to work now on their development, so that they are ready for submission.

The other dates for your 2016 diaries are:

- Regional Executive meetings Saturday 29th October
- World Council All day Sunday 30th and Monday 31st October and morning of Tuesday 1st November

- Meetings of Working Parties and SIGs Afternoon of Tue 1st and all day Wed 2nd November
- WONCA World Conference opening on evening of Wednesday 2nd; closing ceremony at lunchtime on Sunday 6th.

For further details and information on the Rio conference you should consult the conference website, which you can access via the [WONCA GFD website](#).



Vasco da Gama Mental Health Group

We've just been notified of the launch of the Vasco da Gama (VdGM) Mental Health Group. The group lead is Ana Luisa Cabrita.

The first project for the new VdGM Mental Health Group is helping plan and get involved in delivery of new doctor sessions at the First International Mental Health Congress taking place in Lille in April 2015. Anyone from the Vasco da Gama Movement with interest in mental health should also ask to join the VdGM Mental Health Group. Further details can be obtained via the VdGM website or Facebook page.

Season's Greetings and Happy New Year from the WONCA Secretariat



The Secretariat team (pictured are Garth Manning with Nongluck Suwisith and Arisa Puissarakij) joins me in sending season's greetings to all our members, in all parts of the world. We wish you all a Happy New Year and look forward to meeting up again in 2015.

Garth Manning
CEO

Policy Bite with Amanda Howe

Honesty with hope – some reflections on maximising our messages

Over the last year, many of you have shared concerns about the progress of family medicine (FM) in your own countries, and worldwide. Evidence of amazing gains by WONCA member organisations are often offset by disappointments – not enough family medicine residents in training; lack of commitment from governments; problems of financial reimbursement; perceptions that we are less respected than other specialists; and constant political change and challenge.

In my own country we have seen an emerging weakness in the FM workforce, in spite of the 'maturity' of general practice within the U.K. health system, which seems surprising. We have representation in all medical schools, strong research and educational capacity, a mandatory specialist postgraduate training, a fascinating and flexible career, and a consistently high satisfaction rating by patients.

Yet young doctors are not choosing to become FM residents – training places are under-filled; many newly qualified are leaving the U.K. workforce after training; and many doctors of my age are retiring at 60, rather than struggle on in the increasingly adverse environment created by lack of investment in primary care, and by increasing workload. The U.K. population is ageing, living longer with more diseases: unemployment impacts on health, especially in the most deprived communities; and the public sector cuts made by the current administration bite ever deeper into the support systems for anyone with health or social problems. So where to go but the local doctor?

Now the big question to you, my dear colleagues and readers, is 'should I be talking about all the problems in family medicine?' Life is surely difficult enough without your President – Elect wading in and admitting that all is not rosy even in the U.K. – how can we give hope and direction to countries with less investment in family medicine, if it isn't working here? I have been living through this

dilemma in my member organisation, the RCGP – we have been running a fantastic campaign led by our Chair Maureen Baker called '[Put Patients First](#)', where we have spelt out the facts about how bad things are in the primary care sector, and why our political leaders really need to take this seriously. Interestingly, while getting huge public support and media attention, we have been accused of causing the problem – people saying that negative talk is leading to anxiety, and doctors feeling they can't safely commit to FM as a career for the future because 'even GPs are saying that things are so difficult!'

So how can we speak the truth while avoid adding to the adverse environment and demotivation? This reminds me of the dilemma with patients with a serious diagnosis – how to tell them the risks and to ensure we act before it is too late, while wanting to empower and support, and give them the choices that may carry them through an uncertain and difficult time. The answer is problem with solution – a clear message that we can make things better, the job is still worth doing, the evidence supports us, and governments need to understand this ([see RCGP news](#)). The personal touch also helps – in a place of uncertainty, an honest but hopeful opinion can make the difference between negative and positive outcomes. Many of you have told me that nothing good is ever easy – that helps me to have hope that things may change if we are persuasive both in our diagnosis and the factors that can alter the prognosis.

And things can change - in the dark nights of our northern winter, I still know that on the other side of the world it is already day.

Amanda Howe
President-elect




WONCA SOUTH ASIA REGIONAL CONFERENCE 2015
13 & 14 FEBRUARY 2015 : DHAKA, BANGLADESH
PRE-CONFERENCE PROGRAMME : 12 FEBRUARY 2015

Fragmentos de política por Amanda Howe

Honestidad y esperanza: algunas reflexiones sobre la maximización de nuestros mensajes

Durante el año pasado, muchos de vosotros habéis compartido preocupaciones sobre el progreso de la medicina de familia (MF) en vuestros propios países y en todo el mundo. Las evidencias de avances increíbles por parte de las organizaciones miembro de WONCA se equilibran a menudo con decepciones: no hay suficientes residentes de medicina familiar en la formación, hay falta de compromiso por parte de los gobiernos, problemas de reembolso financiero, una percepción de que somos menos respetados que otros especialistas y también cambio y desafíos constantes en lo político.

En mi propio país, hemos visto que emerge una debilidad entre la fuerza de trabajo de la MF, a pesar de la "madurez" de la medicina familiar en el sistema de salud del Reino Unido, algo que resulta sorprendente. Tenemos representación en todas las escuelas de medicina, contamos con una fuerte capacidad de investigación y de educación, con una formación obligatoria de especialista de postgrado, con una carrera fascinante y flexible, y con una calificación consistente de alta satisfacción por parte de los pacientes.

Sin embargo, los médicos jóvenes no están eligiendo convertirse en residentes de MF: las plazas de formación no se llenan, muchos recién titulados están abandonando el mercado laboral del Reino Unido después de su capacitación y muchos médicos de mi edad se jubilan a los 60, en lugar de luchar en un entorno cada vez más adverso, creado por la falta de inversión en atención primaria y por el aumento de la carga de trabajo. La población del Reino Unido está envejeciendo, viviendo más con más enfermedades. El desempleo impacta en la salud, especialmente en las comunidades más desfavorecidas, y los recortes en el sector público realizados por la actual administración profundizan la herida cada vez más en los sistemas de apoyo de cualquier persona con problemas de salud o sociales. Entonces, ¿dónde ir, si no es al médico local?

Ahora la gran pregunta para vosotros, mis queridos colegas y lectores, es "¿debería estar hablando de todos los problemas de la medicina de familia?" La vida es sin duda bastante difícil sin que vuestra Presidenta Electa se meta en esto y

admira que no todo es color de rosa, incluso en el Reino Unido. ¿Cómo podemos dar esperanza e indicaciones a los países con menos inversión en medicina familiar, si aquí no está funcionando? He estado viviendo en este dilema en mi organización miembro, el Royal College of General Practitioners, donde hemos estado llevando a cabo una fantástica campaña liderada por nuestra Presidenta, Maureen Baker, llamada '[Pon a los pacientes primero](#)'. En ella hemos explicado los hechos acerca de lo mal que están las cosas en la atención primaria, y por qué nuestros líderes políticos deben tomarse esto verdaderamente en serio. Curiosamente, al obtener un apoyo del público y una enorme atención de los medios de comunicación, hemos sido acusados de causar un problema: la gente mantiene un diálogo interno negativo que conduce a la ansiedad y existe la sensación de que los médicos no pueden comprometerse con seguridad por la MF como una carrera de futuro porque "¡los médicos están diciendo que las cosas son tan difíciles!".

Así pues, ¿cómo podemos hablar sinceramente evitando a la vez un ambiente adverso y desmotivador? Esto me recuerda el dilema con los pacientes ante un diagnóstico serio: cómo decirles los riesgos y asegurar que actuamos antes de que sea demasiado tarde, mientras queremos empoderarles y darles apoyo, así como ofrecerles todas las opciones que pueden conducirles a la incertidumbre y a un momento difícil. La respuesta es un problema con solución: un claro mensaje de que podemos hacer las cosas mejor, todavía vale la pena hacer el trabajo, la evidencia nos apoya y los gobiernos tienen que entender esto ([ver aquí](#)). El toque personal también ayuda... En lugar de incertidumbre, una opinión honesta pero esperanzadora puede marcar la diferencia entre resultados negativos y positivos. Muchos de vosotros me habéis dicho que nada bueno es siempre fácil. Eso me ayuda a tener la esperanza de que las cosas pueden cambiar si somos persuasivos, tanto en nuestro diagnóstico como en los factores que pueden alterar el pronóstico. Y las cosas pueden cambiar: en las noches oscuras de nuestro invierno del norte, todavía sé que en el otro lado del mundo ya se ha hecho de día.

Rural round-up: Dubrovnik - a temptation now and in history

Tanja Pekez- Pavlisko is this month's author of rural round-up. Tanja is president of the Organising Committee of the coming WONCA World Rural Health conference being held in Dubrovnik, Croatia, from April 15-18. Here she reflects on the rich history of Dubrovnik and medicine.



"The vitally important need for health workers in rural areas is universally recognized. There are still enormous rural areas in the world without any proper medical aid, and without any preventive work. Even in the countries which have produced certain important results in public-health work there are still rural districts entirely neglected from the standpoint of health. The distribution of physicians is not made according to the needs of the total population; only a small percentage of them live in rural districts."(1)

These are words spoken by a Croat, a cofounder of the WHO, Andrija Stampar who said them in 1938 at Harvard Medical School. Due to his work, and the work of his colleagues, general practice was introduced as a specialty in the early 1960s in former Yugoslavia, and it was the first of its kind.

The difficulties for Croatian general practice

These days general practice has been neglected by many countries in this part of the world, except in Slovenia and to some degree, Croatia, which is (according to governmental organizations) at the dawn of a primary health care renaissance. Aside from a great number of positive changes happening in Croatia, there are still many difficulties in a GP's work, especially in regards to paperwork, financial fines from insurance companies and lack of acceptance from other colleagues and patients. Colleagues outside of Slovenia and Croatia are also faced with low income and

difficulties in professional development.

The economic crisis and post-war period in the region has led to increased violence (at stadiums, domestic violence) which also translates to general practitioners. Along with verbal abuse, there are plenty of examples of physical violence towards Croatian GPs. Therefore, an open letter was written to members of the Croatian Parliament, Ministries of healthcare and labour, and journalists on problems of violence against medical workers. Our next step is organizing a round table discussion on the problems of violence not just in our practices, but in society as a whole, with the aim to increase awareness of the entire population on this topic.

And, despite all of this general practitioners retain their faith and enthusiasm, and through their work and way of life, try to help their patients in these very difficult times for the entire region. Therefore, a conference in Dubrovnik should renew general practitioners' vigour.

Dubrovnik – a rich history in medicine

The history of these lands, especially Dubrovnik is very old and rich. We would like to introduce you to the tradition of the city with a desire for you to contribute to the city's history.

The medicine of Dubrovnik was never of the local character, nor was it ever isolated from the developments in this field from the rest of the world. It was always aware of the latest achievements in medical science and practice. Many famous physicians lived or were born in Dubrovnik. Furthermore, the citizens of Dubrovnik were aware of the significance of the latest public health and hygienic achievements for the development of their city. (2)

Near the east city gates "vrata od Ploča", there is the building that has the greatest significance for the medical heritage of the old Dubrovnik. The complex of various buildings called "lazareti"



represents the quarantine of Dubrovnik. In the period 1348-1374, many people were dying because of the plague epidemics in Dubrovnik. The solution to this problem was the suspension of trade with other regions especially those in the east from where the plague epidemics usually spread. Such a decision would have been fatal for the economy of the city. In July 1377, a measure was introduced that should have enabled both the protection against the plague epidemics and a free trade with the infested regions: quarantine. (3)

In 1317 at the premises of the Franciscan monastery in Dubrovnik, the first pharmacy was founded. Even today, in the premises of the monastery, there is a public pharmacy that still serves the inhabitants of Dubrovnik. In the 14th century the pharmacy was situated in the lower cloister and was connected by entrances to the street. A part of the inventory of that pharmacy can still be seen on display in the pharmaceutical museum in the monastery. (2) In Dubrovnik, as in the Orient, the preparation of pharmaceutical compounds was in the hands of the pharmacists, not with physicians as it was in the rest of Europe. (2)

Although we don't have precise information we know that the beginnings of a hospital in Dubrovnik date to the period between 1347 and 1352, when it was a Shelter for poor and we

know that in 1420 it had its own pharmacy. From 1540, it operated as a public state hospital inside the city walls until 1888, called Domus Christi. The old hospital of Dubrovnik, by the Senate's conclusions of 1540, had the objective "to bring together poor people, sick of curable sickness and who sometimes die just because there isn't anybody to take care of them or to help them" – "*de faciendo ad cultum Domini Nostri Jesu Christi unum cenochodium seu hospitale pro usum pauperum infirmorum*".(4)

Rural hero

And finally, as we have our pioneer of general and rural practice, Andrija Stampar, so does every country. We would ask you to find among your ranks a colleague who gave a special contribution towards development of rural general practice and share their work at the conference. More on that and other information is available at the [conference website](#).

IMPORTANT DATES

WONCA World Rural Health conference
April 15-18, 2015

Early bird registration closes
February 10, 2015

[References available online](#)

Scholarships for the World Rural Health conference in Dubrovnik

Dear All,

The Croatian Coordination of Family Physicians (KoHOM) as the organizer of the [13th World Rural Health Conference](#) has announced five scholarships (accommodation and registration fee) for the conference.

The criteria to be used to determine the winners by the International Advisory Board are:

- Under 35 years of age
- CV
- Motivation letter
- Recommendation letter from a family physician
- Accepted abstract for the conference

Send your CVs, motivation and recommendation letters by January 10, 2015, by e-mail to: info@conventuscredo.hr

Tanja Pekez Pavlisko, President of the Organising Committee



<http://woncarural2015.com>

Breaking down barriers:
Bringing People Together
15th - 18th April 2015

WONCA and WHO

WONCA's response on Human Resources for Health

In November 2014, WONCA submitted a response to the public consultation to inform the Global Strategy on Human Resources for Health. In that response WONCA stated:

We welcome the call for the investment in multi-disciplinary primary care teams of health workers with a broad skill base in order to achieve the universal health coverage goals, as well as for the delivery of primary health care to be extended beyond the formally trained health workforce through partnership between health professionals and the community. We also welcome the call to improve the evidence-base around the role of mid-level health professionals and community health workers in the delivery of primary care. However in addition to this we feel this strategy must explicitly emphasise that efforts need to be maintained to recruit and retain medical graduates in family medicine.

Examples of recommendations that could be made in the Global Strategy on Human Resources for Health are as follows:

1. National policy should recognise the need to invest in the development of multi-disciplinary primary care teams, which include family doctors, to deliver comprehensive, high quality and sustainable primary care.
2. National policy should recognise family medicine as a medical specialty and emphasise the fundamental role of family medicine in health systems strengthening and in achieving universal health coverage.
3. Every medical school in the world should have an academic department of family medicine / general practice
4. Every medical student in the world should experience family medicine / general practice as early as possible and as often as possible in their training
5. Formal postgraduate training in family medicine leading to specialist recognition as a family doctor should be available and accessible to all medical graduates.
6. An organisation of family doctors should exist in every country to work with government to develop and support family medicine standards and education.
7. Opportunities to upskill any existing unspecialised general practitioner workforce in order to demonstrate competency and attain specialist recognition should be made available, for example through further training, assessment and / or certification
8. Global policy should encourage national governments and international donors to invest in strengthening primary care, for example through targets regarding the percentage funds that should be utilised to strengthen primary care.

Work earlier this year by WHO EMRO and PAHO has led the way in the development of regional strategies to work towards strengthening family medicine within the context of achieving universal health coverage (2, 3, 4). It is essential that this is supported and further developed in the overarching Global Strategy on Human Resources for Health.

Publications including [The Contribution of Family Medicine to Improving Health Systems](#), [Rural Medical Education Guidebook](#), [Family Doctors in the Field](#) and [Integrating Mental Health into Primary Care](#) provide a global perspective on the role of family medicine in health systems. In addition there is significant further work by WONCA on a range of issues relevant to the human resources for health agenda, including topics such as ethical international recruitment, rural workforce and gender equity.

[Read WONCA's response in full here](#)



Interested in an internship at the World Health Organization?

The World Health Organization (WHO) recruits twice a year for interns. Being a WHO intern is a great opportunity for medical students and family doctors in training to develop academic and policymaking skills, as well as to understand how the WHO works.

For (Northern Hemisphere) Summer of 2015 the intake will run from December 1st 2014 to January 31st 2015. Details on the programme from the WHO website are as follows:

What does a WHO Internship offer?

The WHO Internship Programme offers a wide range of opportunities to gain insight in the technical and administrative programmes of WHO. The duration of WHO internships is between six to 12 weeks. Exceptionally, internships may be extended up to a maximum of 24 weeks depending on the needs of the WHO technical unit and your availability. WHO internships are not paid and all costs of travel and accommodation are the responsibility of the intern candidate.

Who is the WHO looking for?

- You are at least twenty years of age on the date of application.
- You are enrolled in a course of study at a university or equivalent institution leading to a formal qualification (graduate or postgraduate) (applicants who apply for an internship within six months of completion of their formal qualification may also qualify for consideration).
- You have completed three years of full-time studies at a university or equivalent institution prior to commencing the assignment.
- You possess a first degree in a public health, medical or social field related to the technical work of WHO or a degree in a management-related or administrative field.
- You are fluent in the working language of the office of assignment.

How can you apply?

- You are invited to complete an application for internship through the WHO. This questionnaire includes providing details about your education and experience. You will be able to indicate the area of work within WHO that you are hoping to intern.
- You will be asked to write about your motivation for applying for a WHO Internship.
- You will find additional information on WHO's Internship Programme and how to apply throughout the website [here](#), additional queries can be addressed to here interns@who.int

REGION NEWS

WONCA EMR president at WHO regional committee



Photo: Dr Tarawneh (3rd from left) with some of the NGO participants during the meeting

WONCA East Mediterranean Region president, Dr Mohammed Tarawneh, was invited to participate in the 61st session of the WHO regional committee for the WHO East Mediterranean region (EMRO) which was held in Tunis from 19-22 October 2014.

All 22 East Mediterranean region countries' representatives (Ministers of the Health or their representatives) participated, in addition to Dr Margret Chan, WHO General Director and various NGOs.

The opening ceremony was held on the evening of October 19, 2014 in the Le Palace Hotel, Tunis, Tunisia

The annual 2013 report of the WHO EMRO focused on the following topics:

- Health systems strengthening towards universal health coverage;
- Maternal and child health;
- Noncommunicable diseases;

- Communicable diseases, particularly health security;
- Emergency preparedness and response;

WONCA statement

The following WONCA statement was delivered by the WONCA EMR president:

The World Organization of Family Doctors (WONCA) is a not-for-profit organization and was founded in 1972 by member organizations in 18 countries. WONCA now has 118 Member Organizations in 130 countries and territories representing 500,000 family doctors and covering more than 90 per cent of the world's population.

On this occasion of 61st WHO-Regional Committee for Eastern Mediterranean meeting, it is my privilege to make WONCA statement on Regional strategy and to highlight the work of WONCA with the WHO EMRO, where our active engagement with the recent mental health and NCD initiatives, and our desire to continue to strengthen our support for WHO EMRO initiatives across the region, to achieve Universal Health Coverage.

WONCA would like to highlight it's desire to work with each nation in the region on supporting the role of family medicine in strengthening their primary health care delivery, and support the training and continuing professional development of family doctors, and the member of primary care team.

WONCA invite involvement of family doctors member organizations, from those countries not already WONCA members, in discussion about membership, with WONCA.

The World Organization of Family Doctors would like to focus on the following recommendations::

- *Every medical school in the world should have an academic department of family*

medicine/general practice, or an equivalent academic focus;

- *Every medical student in the world should experience family medicine/general practice as early as possible and as often as possible during their training*
- *It is urgently needed to invest in training family doctors/general practitioners and design health systems where family doctors/general practitioners are a fundamental and valued part. I am thankful to WHO-EMRO for giving me the opportunity to participate and make a statement at this prestigious gathering.*

The meeting agenda

The agenda of the meeting from October 20-22, 2014 highlighted the following items:

- Eradication of poliomyelitis
- Tobacco free initiatives
- Achievement of the health related millennium development goals and global health goals after 2015
- Regional strategy for health sector response to HIV 2011-2015
- Saving the lives of mothers and children
- Emergency preparedness and response
- Non-communicable diseases: implementation of the political declaration of the UN general assembly and follow up on the UN review meeting in July 2014
- Health system strengthening: progress and prospects 2012-2016
- Reinforcing health information system

The WONCA EMR president emphasized the commitment of WONCA to collaborate with WHO EMRO for better outcomes.

Dr Mohammed Tarawneh
WONCA EMR president



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News from North America region

Fall is a busy time for the North American Region of WONCA. The American Academy of Family Medicine held its Congress and Assembly in October in Washington DC. In an inspiring special address, AAFP member Dr Kent Brantly told of his training as a family physician in Texas, his work in Liberia against Ebola, his personal battle with the disease and subsequent recovery. He challenged all in the audience to support the fight against Ebola financially or by considering directly providing health care in West Africa. [More here.](#)

“Health is Primary” is a new initiative launched by the AAFP in collaboration with several other organizations (www.healthisprimary.org) It is a three-year communications campaign to advocate for the values of family medicine, demonstrate the benefits of primary care, and engage patients in the health-care system. The aim is to build a primary care system that reflects the values of family medicine, puts patients at the center of their care, and improves the health of all Americans.

In November the College of Family Physicians of Canada held its board meeting, Scientific Assembly, and Besroul Conference in Quebec City. Prof Michael Kidd, president of WONCA brought [greetings](#) to the CFPC on the occasion of its 60th anniversary. Take a [look at these links](#) to learn more about the 60th anniversary of the CFPC anniversary and heritage.

The Besroul Conference gathered together international family medicine partners of the 17 Departments of Family Medicine in Canada;

several of the countries represented are not yet members of WONCA, and so the chance for WONCA leadership to interact with them was particularly valuable.



Dr Ruth Wilson, WONCA North America regional president was awarded first Calvin L Gutkin Ambassadorship Award. The award recognizes a dynamic leader in Canadian family medicine distinguished for his or her vision, innovation, and relationship-building with organizations that support and positively influence the ever-changing role of the family physician.

During the Family Medicine Forum, the first face to face meeting of Polaris, the young doctor movement for North America was held. This was an organizational meeting to consider a draft constitution, opportunities for co-operation, and sustainability. [See separate story.](#)

The Caribbean College of Family Physicians will be hosting its [6th triennial conference](#) in Kingston Jamaica February 5-8th with the theme of “*Family Physicians: Integrating Mental Health Care into Practice*”.

Dr Ruth Wilson
WONCA North America region president

Polaris' first executive meeting 2014

News from Polaris - the WONCA North America region movement for young family doctors. Photo shows Polaris members with senior WONCA Leaders (l to r) Steve Hawrylyshyn (Canada), Michael Kidd (WONCA President), Tamra Travers (USA), Aileen Standard Goldson (Jamaica), Ruth Wilson (WONCA North America region president), Victor Ng and Kyle Hoedebecke (USA and Polaris chair)



Polaris has been busy since its launch six months ago on World Family Doctor Day. We are happy to report on Polaris' first executive meeting that recently took place November 12, 2014 during the College of Family

Physicians of Canada (CFPC) annual Family Medicine Forum in Quebec City, Canada.

Polaris was formed in order to better promote family medicine globally, enhance international

collaboration, identify and adopt best practices, and to represent North America's medical students, Family Medicine residents, and junior physicians to the rest of the world. These efforts are led by our executive board composed of three representatives from each college including one young family physician in the first 5 years of practice, one resident, and one medical student, for a total of nine individuals.

At the meeting, Polaris representation from each of the CFPC, American Academy of Family Physicians (AAFP), and Caribbean College of Family Physicians (CCFP) met in person for the first time in person since the launch of our Movement. Additional support came from the AAFP President, Bob Wergin, and WONCA President, Michael Kidd, who were both in attendance. In addition to making final touches on the Polaris constitution and overarching goals, we reviewed and clarified current projects, future plans, and deliverable action items. The work completed during this meeting has allowed us to make the final changes to the constitution prior to ratification at our next meeting in December.

Further positive energy and excitement filled the room as we discussed our multiple collaborations currently taking place in North America and around the world. Polaris has rapidly developed a large social media presence with intense global participation, which we have utilized in order to augment worldwide excitement surrounding our profession. One such project is the newly formed international social media based journal club to discuss current best practices. Additionally we lead an international Balint group that collaborates with both the American Balint Society and the International Balint Federation where meetings are held via videoconference to discuss the multi-faceted issues surrounding patient care using a narrative case-based discussion with an interdisciplinary team and representatives from each WONCA region.



Our team has also created vast amounts of participation and excitement for family medicine through the "1 Word for Family Medicine" initiative (see #1WordforFamilyMedicine on Facebook and Twitter) where unique word clouds (see examples) are created from the combination of individual responses.

Finally, we are all very excited about the Polaris-led three tiered global leader certification called ASPIRE, which is currently being finalized. Currently a small pilot proof-of-concept is being performed and evaluated. When enacted on a global scale, ASPIRE with help students, residents, and junior family physicians solidify their leadership/mentorship skills through international presentations, research, Young Doctor Movement (YDM) participation, and other collaborations. These components will serve to achieve many of the goals set by the WONCA executive as well as augment interest in global health and family medicine as a whole.

Later in the week, we participated in the annual Canadian Global Health Conference that occurred in conjunction with the general CFPC conference. It was an incredible experience allowing access to international leaders in the global health community. During one session, Kyle Hoedebecke (US young family physician), Steve Hawrylyshyn (Canada family medicine resident), Aileen Standard-Goldson (CCFP representative) presented the story behind the creation of Polaris, its goals and objectives, and the current projects underway. We were showered with positive encouragement, support, and general excitement for Polaris and our current endeavors. With our first executive meeting behind us, Polaris' blueprint has been created and its foundation laid. We must now implement our plans and continue construction of this community of collaboration, learning, and friendship.

Tamra Travers (USA),
 Kyle Hoedebecke (USA),
 Steve Hawrylyshyn (Canada),
 Aileen Standard Goldson (Jamaica),

WORKING PARTIES & SPECIAL INTEREST

Pacific Rim Indigenous doctors meet in Taiwan



Dr Tane Taylor, chair of the WONCA Working Party on Indigenous and Minority Groups Health Issues reports on the recent conference of Pacific Rim Indigenous doctors. In the photo he is pictured (right) with Dr Pacidal on a site visit to the Fongbin Indigenous Branch Hospital in Taiwan.

Tena koutou katoa (greetings to you all),

WONCA President Prof Michael Kidd sent a video address to PRIDoC 2014 (Pacific Rim Indigenous Doctors conference) held recently, in Hualien, Taiwan. The address (link at the bottom of this page) was well received. Prof Kidd talked about the importance of the work that WONCA is doing in the indigenous and minority groups health issues .

Last year in Prague, WONCA approved the establishment of the [WONCA Working Party on](#)

[Indigenous and Minority Groups Health Issues.](#)

Prof Kidd invited attendees to join him at the coming [WONCA Asia Pacific region conference](#), being held in March 2015 in Taipei.

At its Council meeting PRIDoC supported the work that WONCA is doing in regards to addressing indigenous health issues. Furthermore, the council acknowledged the Chinese Taipei Association of Family Physicians support for this event by posting it on their website.

Dr Tane Taylor, chair of WONCA Working Party on Indigenous & Minority Groups Health Issues thanked the council for their support. "I look forward to the WONCA Asia Pacific region conference 2015 being held in Taipei, where I am hopeful that the Chinese Taipei Association of Family Physicians will help facilitate and support the work in this important area" – said Dr Taylor.



WONCA World rural health conferences - why not come?



Have you ever considered attending a WONCA World Rural Health conference? The next one is coming up in Dubrovnik, in April. Below find two letters from the chair of WONCA Working Party on Rural Practice, Dr John Wynn-Jones, from Wales, about the outputs of the previous two world rural health conferences and the coming Dubrovnik one.

Dear Colleagues
[Education for Health Vol 27, Issue2, August 2014](#)

I thought that it would be worth passing on this paper that Roger

Strasser and Sue Berry have co-written and follows on from the 2012 WONCA World Rural Health conference held in Thunder Bay, Canada. This was an important event and for those of you who did not come, please read the [Thunder Bay Communique](#).

We see our WONCA World Rural Health conferences are as one of our most important activities. Although they physically fill a short period in a timeline their repercussions and influence go on for many years to come. This is certainly the case with Thunder Bay. The 2014

WONCA World Rural Health conference was held in Gramado, Brazil, and the WONCA Working Party on Rural Health has, at this conference, produced the draft [Gramado Statement on rural health in developing countries](#). The Statement has yet to be approved by WONCA's Executive.

I have no doubt that our coming 2015 rural health conference in Dubrovnik will have a similar impact. There are many groups already working on themes that have a huge impact on rural practice and these discussions will culminate in important themed workshops.

Looking forward to seeing you all in Dubrovnik - [for more information](#)

Regards
 John Wynn-Jones

Dubrovnik prepares for the 2015 WONCA World rural health conference

Dear All

2014 has been a busy and eventful year for me and for other members of the WWPRP. Rather than slowing down after our fantastic conference in Gramado, it seems to have become even busier and we are now hectically organising the programme for Dubrovnik. The WONCA Working Party on Rural Practice Google group has allowed us to prepare for conferences in a different way. Individuals come up with ideas for workshops and themes and small groups get together to plan their activities and submit abstracts accordingly. This is a unique experience for me and it makes conferences more relevant.

So much is happening and it would take me too long to outline all the themes and work plans that are being prepared but rest assured, it will be a great conference and a "not to be missed" moment.

Wherever I go and who ever I speak to, rural practice around the world is struggling to recruit health care professionals and convince the policy makers that rural needs are different to urban ones. The future of rural practice will fall onto the shoulders of the next generation of young doctors. We have to bring more young doctors and medical students into the WONCA Rural Family and I have been working with the Vasco da Gama (VdGM), WONCA's other Young Doctors' Movements and

the International Federation of Medical Students (IFMSA) to develop a young/new doctor and medical student programme in Dubrovnik. We are trying to collect rural video diaries from around the world that will be screened at the conference. Please encourage your colleagues and medical students to help us.

Special thanks to Jo Scott Jones who is also coordinating the "Rural Heroes Gallery". We want to acknowledge rural doctor champions who have made a difference either in their own countries or globally during 20th Century. Please send us your champions. You can find the template on the conference site <http://WONCARural2015.com>

There are too many people to name individually but I want to thank you all for your contributions to WONCA Rural and rural health in 2014. Lets all make 2015 an important year for Rural Health and for WONCA.

I look forward to meeting as many of you as possible in Dubrovnik.

With a final thank you to Tanja, Ennis and the Croatian Dubrovnik team,

Have a great festive season to you all
 John Wynn-Jones

Pledge on Worker's Health - a ten year incubation period

WONCA News has begun a regular feature on the subject of Occupational Health including useful resources for clinical practice. This month we revisit the recent statement on worker's health. Peter Buijs



(left) & Frank van Dijk (right) are the authors - they are Dutch occupational physicians and former family doctors, and for many years active in ICOH.

In the Pledge on Workers' Health (made by WONCA and the International Commission on Occupational Health (ICOH) in Lisbon, in July 2014) both organisations state their intent to start addressing, together with the WHO, "gaps in services, research and policies for the health and safety of workers, and better integrate occupational health in primary care settings, to the benefit of all workers and their families."

[See full story](#) on the WONCA and ICOH statement and pledge on workers and their families.

This Pledge had a long incubation period, and is important for the vast majority of workers worldwide where there is no organised or legislated link between the work /health relationship. The incubation period started at the WONCA Europe Conference, in Kos (2005) where, Peter Buijs (ICOH, and the Dutch Work and Health Research Institute) was invited to present a paper on a kind of 'Blind Spot' in Primary Health Care: lack of attention to work-related health issues. The presentation was based on research by the Dutch Work and Health Research Institute.

In response, the then WONCA President-elect, Chris van Weel spoke on this theme at the ICOH Centennial Congress (Milan, 2006), and met ICOH-president Jorma Rantanen: the first meeting of WONCA and ICOH leaders. They concluded that workers' health could benefit worldwide from better collaboration between GPs and occupations physicians. So they proposed the formation of a joint working party, which was established in Dubrovnik (ICOH, 2007). Igor Svab, as WONCA Europe president, represented WONCA there, and also at the next ICOH World Congress (Capetown, 2009). Meanwhile ICOH was present at the WONCA conferences in Istanbul (2008), Basel (2009) and also in Cancun (2010), where Chris van Weel chaired a Round Table on 'Workers' Health and primary health care'. So gradually mutual trust and understanding grew between two

traditionally separated worlds, with the joint working party playing a connecting role..

It was very important, that the WHO became interested, knowing that only 10-15% of the global workforce has some kind of occupational health care. The rest has none, while often working under the hardest conditions. So, during a WHO expert meeting (Santiago de Chile, 2009), Carol Black (UK) and Peter Buijs proposed the exploration of the potential and willingness of primary health care to pay more attention to workers' health, in collaboration with occupational health professionals. This became the focus of a successful WHO Conference (The Hague, 2011), with representatives from 40 countries worldwide, as well as WONCA and ICOH presidents (Rich Roberts and Kazutaka Kogi).

The [conference outcome](#) changed WHO-strategy towards workers' health: for expanding workers' health coverage, primary health care became essential, having a global coverage of 70-80% (1). During the World Health Assembly 2012, WHO organised a Special Session on this issue with Iona Heath being the WONCA speaker; and later the WHO organised a follow up in Geneva. Finally WHO assigned the conduct of a literature search on Primary Health Care and Workers' Health (2) and supported the development of a website with learning materials for primary health care. www.workershealtheducation.org

These positive developments eventually led to fruitful WONCA-ICOH talks about more collaboration, starting at the WONCA World conference in Prague (2013), with the authors of this page involved, and resulting in the joint Pledge. Meanwhile ICOH has formed a taskforce to proceed further. So hopefully the coming years will show concrete steps forward, supporting primary health care with tools and information – also the aim of this regular workers' health article in *WONCA News* - "to the benefit of all workers and their families."

Peter Buijs and Frank van Dijk,
occupational physicians/former GPs

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1. WHO-director Maria Neira, ICOH World Congress, Cancun, 2012.
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MEMBER ORGANIZATION NEWS

From our El Salvador colleagues



WONCA President, Prof Michael Kidd, recently sent a welcome speech on YouTube, which was translated into Spanish, for the conference of El Salvador colleagues held on October 31 and November 1 this year, in San Salvador (see photo above). Victor Manuel Campos MD, President Asociacion de medicina familiar de el salvador (AMEFAES) wrote to Prof Kidd:

After two days full of different kind of emotions (happiness for the results, tiredness for the effort), I write you to say thanks for the support, in the name of all of members of the Family Medicine Association of El Salvador (AMEFAES). We are very grateful for the courtesy that you showed us. Your speech caused a big impact on the audience: it was the best way to open our Congress. We also had the opportunity to see and hear the words of Dra. Maria Inez Padula Anderson (president of WONCA Iberoamericana region) and Dr Miguel Angel Fernandez, of CIMF. All of us are sure that Family Medicine in our country will grow up with our work, day by day.

In our country we have two schools of family medicine, one in Sonsonate Hospital as part of ISSS (the Salvadorean Institute of Social Security), and the other at Hospital "José Zaldaña", from the Nacional Health System. The first one started in about 1998 and the second one in about 2001. The Association of Family Medicine from El Salvador (AMEFAES) began with a meeting, in May of 2010, with 16 founder members. Under salvadoran law, the Association was constituted on February 21, 2011 and on that day we were 55 family doctors (from an possible number of about 200) working together for the improvement of primary health care.

This recent congress, was our second congress and had the theme: "Chronic diseases and the primary care doctor". (Our first conference on "Health Reform: Development of primary care and

prospective position for family medicine" took advantage of the visit of two colleagues, Dr Fons Mathot and Dr Luc von Bertjin, from The Netherlands, in November 2011).

This time out congress was attended by about 100 physicians - general doctors, family doctors and from other specialities. We had the opportunity of listening to 15 different speakers on a variety of interesting topics like:

- Experiences of family medicine and primary care in Latin America and the World.
- Family doctors in El Salvador: Who we are and what we do
- Prevention and control of smoking
- Management of palliative care
- The suffering of chronic disease
- Chronic conditions in Primary Health Care
- Good clinical practice guide: hypertension and diabetes mellitus 2.
- Updated KDIGO guidelines on chronic kidney disease
- Identification of rheumatic diseases in primary care
- Heart failure in primary care
- current treatment of type 2 diabetes mellitus: about after sulfonylureas and metformin
- Concept terminal patient: how do I approach it?
- Treatment of caregiver syndrome of chronic ill
- Management analgesic in the renal patient
- Chronic pain management
- Operating the terminal delirium
- The joy of being primary care physician

I want to thank to WONCA to providing me the chance to share with everybody these words. It was a great experience, because we had the opportunity of meeting with people who think like us and share our vision; to present our views and tell everyone that WE EXIST AND WE ARE HERE. I'm sure that all in the congress have ended with a smile on his/her face, in realizing what we can do.

FM EXCHANGES

Chloé Perdrix writes: Medicine in the Jungle in Malaysia.

My name is Chloé Perdrix, I'm a 27 year old French GP resident, just ending my last rotation in a health centre in the North-East of New Caledonia. After this last rotation in New Caledonia, I intend to take a sabbatical year travelling around Asia. This is my second story.. [to see others click here.](#)



Final reflections on New Caledonia

The New Caledonia experience is now finished with the balance sheet of this rotation abroad being :

- interesting diagnoses : four cases of syphilis (one secondary and three primary); two hepatic amoebiasis cases; a perforated ulcer; lung cancer, whooping cough; and of course common diagnoses like influenza, gout, boils...(fortunately no Ebola)
- Palliative care, chronic diseases such as diabetes, obesity, hypertension, asthma, COPD, child medicals eg school visits with a large amount of obesity screening (as obesity is exploding in New Caledonia) , home visits...
- A humane and competent medical team, even if it changed a lot during these six months.
- Wonderful persons I met: specially one from Kone who will recognise himself and two patients who became friends and from whom I learnt a lot about kanak culture,
- A personal and work experience which will contribute top my personal and professional lives.
- And last but not least, I feel ready to be a family doctor.

My final reflection about New Caledonian's health system, is about the short turnaround in medical staff. This is a big problem for patients because when they trust in a medical staff member, this person often leaves after several months.

Indeed, the majority of medical staff is from France, since New Caledonia don't have a medical university. Medical staff often come to Pouebo for a new experience but rarely to stay there.

Furthermore, if a local person from New Caledonia wants to do medical studies, they have to go to

France or Australia/New Zealand (if they speak English) which is complicated.

Fortunately, for a few years now, they have a nursing school, but for the moment, most of young nurses prefer staying in urban places like Nouméa, the capital.

It is a real problem for doctor-patient relationship and primary care compliance.

Next country: Malaysia

Now is the next chapter of the trip : sharing primary care experiences in Asia through articles in WONCA's news and thanks to mini Family Medicine 360 exchanges during the coming year.

The Family Medicine 360° Program is a global exchange program for medical doctors training in General Practice and junior General Practitioners (within five years of completing residency training) organised by Vasco da Gamma Movement (VdGM). The VdGM is the WONCA Europe movement for new and future General Practitioners.

I didn't have time to organize a mini FM360 exchange as I have only been in Malaysia for 15 days, but I already have lot of things to share with you.

I joined my brother in Kuala Lumpur, on the 4th of November. We quickly decided to do a four day trek in the oldest jungle of the world: Taman Negara (130 million years). It is situated in the centre of the east coast of Malaysia.

Photo: the Taman Negara



There, we spent a day and a night in an Orang Asli village (pictured on next page). The Orang Asli are native people who live in the rain forest. They have their own concept of health and illness [2] and they use mostly traditional medicine. For instance, they send sick people into the jungle with one other person who will take care of them until they recover. I suppose that this tradition is to avoid epidemics, but that's just a hypothesis.



Another tradition : when people die, the Orang Asli don't bury them. They put them in a hole in a tree, in the jungle to help them in leaving the world.

Medicinal plants are used for various medical problems : from flu, to cancer.

They are the object of lot of scientific research. [1], [3], [4] The plant for leech bites is interesting. (A leech is a very small animal which has hundreds of teeth leeches are very numerous in the jungle.)

When a leech bites someone, it attaches to them for a period and secretes anticoagulants which make its victim bleed a lot, even after the leech has dropped off them. It's not painful, and not dangerous, but it is very annoying because you bleed on your pants, socks and shoes. [5]



To avoid that, the Orang Asli people use a special plant (pictured) that you wet, then rub energetically between hands. A paste appears after 20-30 seconds. If you apply this paste on the leech

bite, the bleeding stops. I used it a lot of times during these four days. It was very effective.

A lot of questions about the Orang Asli people stay without responses, since I only spent 24 hours in their village. How is the children's health? Women's health? I didn't see any old people – where were they?

It seems that the Orang Asli people's health is not so good : they've got more tuberculosis than the state average; leprosy; skin infections such as scabies; and nutritional deficits, especially for women and children. [2]

This experience was very interesting, even if it was very short, and I didn't have the opportunity to discuss more about the Orang Asli medical customs.

To complete my investigation, I decided to visit a health centre in Kuala Tahan, the village next to the entrance to the Taman Negara.

This is a more classic public health centre (pictured) as we see in Europe. Malaysian people pay 1 Ringgit MYR (= 0,238 EUR = 0,298 USD) for a consultation and their medicines. Foreigners pay 50 MYR (12euros, USD15). The nearest hospital is 1 hour by car from the Health centre (Jerantut).



They have one general practitioner who sees all emergencies; nurses, midwives, and paramedicals or medical assistants called "Assistant Medical Officers" that don't exist in France: who are they?

In fact, they work independently or with the limited supervision of a physician to provide healthcare services. They diagnose and treat common ailments, order and interpret tests, counsel on preventive health care, assist in surgery, manage medical/surgical emergencies, manage medical/surgical wards, manage obstetrics & gynaecology, and write prescriptions. They often work in places with no medical officers.

Assistant Medical Officers complete a three and half year Diploma in Medical Assistant (DMA) – an undergraduate program recognised by the Malaysian Qualification Agency.

The students study the human body, how the body systems work, surgery, pharmacology. They work in normal and diseased states and how they relate to medicine. They also learn pre-hospital care, community health, disaster management, orthopaedics, obstetrics and gynaecology. The final year of training involves clinical placement in hospitals and health centres.

So this is what I learnt about primary care in one part of rural Malaysia during these first 15 days.

I hope this story meets your expectations! See You in January for another Asian destination !
Chloé

(Bibliography available online)

A British GP visits Misiones in rural Argentina



*Dr Debbie Hipps is a young British doctor who recently took sabbatical leave and undertook volunteer work in primary care in remote Argentina. Dr Lidia Caballero, the President of the Association of Family Doctors in Misiones, a province in the north-east tip of Argentina kindly offered to host her visit and arranged a multitude of connections to various primary care organisations in the region. Dr Hipps is pictured above (centre) visiting a Primary Health Care Centre (CAPS = Centro Asistencia Primario de Salud) in Alem, a small town east of Posadas, with (right) one of the local GP team Dr Caesar and (left) one of the health promoters. This article details Dr Hipps' experiences and reflections about the sabbatical.**

About the region

Misiones is in the subtropics and the climate is very hot in the summer and generally wet and fertile all year round. The local industries are mate production (a tea-like drink), forestry and tourism (Iguazu Falls and other attractions).



Photo: Typical side street in Posadas

The population lives partly in the cities but is also spread in farmland in the interior. There

are also populations of Guarani, the local indigenous people who were once nomadic but are now more settled in remote villages. Health is heavily influenced, as elsewhere in the world, by the social, economic and political factors in the region. There is much poverty, poor nutrition and dentition and an education system that struggles

to retain children in the cities let alone those in the countryside. The proximity of borders with Paraguay and Brazil and historical migration from Europe into the area results in a population of mixed ethnicities and a certain amount of health tourism as the Argentine system is relatively well organised and free at the point of care.

The public healthcare system provides care to the population via a three layer system – the primary health care hospitals run clinics staffed by generalists and also may have some specialist clinics such as dermatology, cardiology, gynaecology etc. The second level hospitals have an emergency department, surgery and in-patient facilities. Anything complex is sent to the third level hospital in Posadas and failing that to the capital Buenos Aires some 12 hours drive away. There is also an extensive private medical system, as there is a perception that the public health system is second rate. Doctors commonly work for both the private and public systems (or just the private system) partly in order to make ends meet in this country of high inflation and poor public funding.

My activities

I spent most of my time visiting at the first level



public Hospital Dr Pedro Balina, in Posadas (pictured), which was originally built in 1940 as a leprosy

colony, and now has out-patient clinics and a small inpatient building for patients with infectious diseases such as TB and HIV.

Hospital Pedro Balina is a site which is involved in training new generalist doctors and had an education programme which I was able to join and contribute to. I gave a talk (in Spanish) to the maternity hospital staff about how maternity care was organised in the UK – they were most impressed to hear that we had teams of community midwives who could provide care for women wanting home births. This is not available in Argentina and probably partly influenced by this, they have a high caesarean rate of over 30%.



Photo: Patients waiting outside clinic

Other than participating in ward rounds and clinics, I was also able to go out with the health promoters into the surrounding areas, to try to bring vaccinations to children living there (knocking door to door and vaccinating standing in the muddy front yard).

I also visited community clinics in some of the smaller towns and villages outside of the provincial capital where teams of health promoters, nutritionists and GPs run out-reach services for the local populations. The state system encourages families to bring their children to the hospital or community clinics by giving powdered milk to those who have complete health records, with regular height and weight checks and a full immunisation history. (1)

The challenges caused by poor infrastructure are massive and make health improvements hard to achieve – unsealed roads impassable after rain; villages without electricity or even secure water supplies; and housing, often overcrowded, that is constructed of whatever materials a family could find. (Photo shows a single room home for a three generation family of nine).



Poor education and little aspiration lead to high rates of teen pregnancy as young as 12 years old. Although contraception is freely available through the primary health clinics, without education it is too little and too late. The issues of drug misuse, alcoholism and domestic violence are the same around the world and complicate the situation in Misiones as resources to tackle these problems are sparse.

I spent several days with a programme which tries to get children off the streets into day centres where they can access medical care, food, clothing, schooling, sport and social skills. It was heart-warming to see how the children flourished in a more stable and nurturing environment. Another striking experience was a day spent visiting the local prison to see the healthcare provision there. Alongside typical problems of general practice, the visiting Doctor was challenged with high levels of self harm and a unit of mentally unwell adults all on clozapine to keep them calm but with no other psychological input.

Similarities amid the differences

Whilst I was in Posadas I was also able to attend a multidisciplinary congress of all the primary care providers from the three northerly Argentinian provinces and was able to join in a discussion about the management of alcohol misuse. Again the similarity of the challenges facing the programmes in the UK and Argentina were striking and resources to fund the projects a crucial issue.

The visit made me appreciate how much we take for granted in the UK – a joined up service with registered lists of patients and computerised records which help us to provide comprehensive and continuing care. There was much interest throughout my stay in how the NHS worked and the exchange of information and experience was very stimulating.

I return now to my own practice with many new friends across the world and with the intention to look for local opportunities to assist and support those less fortunate than ourselves.

Notes:

(1) Colleagues in Argentina report that: The incentive for mothers to take their children to medical checks is a public policy called "Asignación Universal por Hijo", a universal money benefit for children under 18 years old, where the condition to receive the benefit is to make medical checks, receive the appropriate vaccinations and remain in school. It is a public policy that has improved some health indicators and social inclusion in Argentina.

*the views expressed are personal and based on Dr Hipps' experiences. The descriptions given are not necessarily accurate and do not necessarily reflect the views of WONCA.

Featured Doctor

Dr Marina ALMENAS (Puerto Rico)

What work do you do now?



Over the past 17 years I have been the medical director of two Independent Physician Associations (IPAs), in Puerto Rico, one in the capital city of San Juan and another in Trujillo Alto. The public health system of Puerto Rico serves about 1.6 million of the inhabitants of the island

through these IPA's. These offices group general practitioners and family physicians (the latter have done three years' training in specialist residency programs), as well as paediatricians, internists, obstetricians & gynaecologists, all providing their services in one place. In addition to providing services to patients, my role is to continually improve the services and quality of the entire group of doctors for every audit of insurers and government, so that we can continue to have excellent results in preventing and treating chronic conditions.

I am also the medical director of two Management Service Organizations (MSOs), where with many other doctors, we offer services to 'Medicare patients' (elderly patients) - for prevention and treatment of chronic conditions. I am continually improving the services offered, because in recent years, each month Medicare rates the services provided. We provide ongoing care to these elderly patients for chronic conditions but also implement prevention of other conditions. The care is both outpatient and inpatient. I also offer medical services to patients on private medical plans.

What other interesting activities have you been involved in?

As past president of the Academy of Family Physicians in Puerto Rico and now the Puerto Rico's delegate to the Congress of Delegates of the American Academy of Family Physicians (AAFP) for the past few years, I have set myself big goals for our specialty. Among the goals are: that the payment to our specialty equals other specialties; maintaining the monthly journal Continual Medical Education (CME); organizing an annual convention with more than 20 credits of CME and workshops attended by 500 doctors.



photo: Marina and WONCA North America region president, Dr Ruth Wilson promoting the 2015 Iberoamericana conference and WONCA, at the 2014 AAFP meeting.

I continuously work to ensure that our Association has its own headquarters where we get together monthly and organize activities for our members and for the community. It is where we also work to support our four Residency Programs in Family Medicine.

Working within the community has always been a passion of mine, leading me to be involved in some amazing activities. These include free health clinics to our population; and a poster contest where children and adolescents, of the private and public education system, get to be involved in health education directly. Some of these posters were: "If you love me don't smoke", "For Your Health, MOVE", "Say YES to Your Family Health". Also I was involved in the creation of the Community Award for work, where I had the privilege of working with community entities such as "United Way", "Make a Wish", Youth at Risk and many others. This award recognizes the work of others and serves to promote to our doctors as early as our resident physicians, the idea of combining medicine and community.

What are you interest as a family doctor and also outside work?

My interest as a family doctor is that people should know more of our unique medical specialty. Although we have spent many years educating people about the family doctor, people still do not recognize the importance of having a family doctor. As we say "a family doctor for every family." We created a 30-second video for radio and film, in English and Spanish, to educate the population on this issue. The first video was 10

years ago, and now our new video has been broadcast on our TV channels this year. We have managed to position ourselves at the same level as other specialties in universities, hospitals and insurance companies, but we still have lot of work to do.

Outside of my work I have much to do. I love community work, helping people come together to work for a better future. Besides the Family Medicine Associations in Puerto Rico, a few years ago I began to introduce Puerto Rico to WONCA - CIMF. I started as Vice President of the Mesoamerica Area where I began to educate on the importance of Family Medicine to countries of our region, such as the Dominican Republic, Costa Rica, El Salvador, Nicaragua, which still continue to work and develop family medicine. Afterwards as Honorary Treasurer, I continued to work and support family medicine throughout our region of Latin America in our conferences and summits. Being treasurer is a great responsibility especially in times like this where the economy is difficult, nevertheless we have always succeeded in all our activities.

Then there is my passion for my family. As a wife and mother I work every day for my family alongside my husband, also a doctor. My main triumph is my children; Lorenzo, a third year medical student in the U.S.; Janice, a first year law student; Franceska, a professional stylist and my two smaller children Marimyr and Gabriela, still high school students and future doctors.

Leading several companies and my family is only possible thanks to the support of my parents and in-laws. When we're not working or studying, my family's shared passion is traveling the world and learning about other cultures. As a family we've has the privilege of sharing many stories from exotic cultures like Dubai, Australia, New Zealand and India. I must admit my favorite hobby is taking pictures, it is quite amazing to see the pictures and relive that moment.

What it be like a family doctor in Puerto Rico?

We are an important part of public and private system in our country. The family doctor is a specialist, who still despite all the years as an established specialty, have many goals to achieve. At academic, college, hospital, insurance company and government levels we have achieved a great many things. We still have many more to achieve not only for ourselves, but as advocates for our patients.

To have people understand that it is a specialty, which can provide services to both ambulatory patients and inpatients is one of our main goals. Those who are family doctors in Puerto Rico take great pride and care in our practice even if it is at times hindered - sometimes not being able to practice many of the procedures for which we have so meticulously trained. We are a small island, 100 by 35 miles (160 by 56 km), with many doctors including many medical specialties, and yet, despite that those that choose the path of Family Medicine exercise their practice with great satisfaction.

Resources Added

PEARLS

[446 Self-management effective for chronic obstructive pulmonary disease](#)

[445 Electromagnetic field treatment effective for osteoarthritis pain](#)

[444 Water-based exercise training beneficial in chronic obstructive pulmonary disease](#)

[443 Vitamin D supplementation may reduce mortality in elderly adults](#)

[442 Decision aids helpful for treatment or screening decisions](#)

[441 Fourteen days is ideal treatment duration for Helicobacter pylori eradication](#)

[440 Triclosan/copolymer toothpastes beneficial for oral health](#)

[439 Exercise effective for osteoarthritis of hip](#)

Clinical Resources: Men's Health

[Journal of Men's Health](#)

[The Health of Australia's Males](#)

[The State of Men's Health in Europe](#)

[Asian Men's Health Report](#)

[Trends in Urology and Men's Health](#)

ANNOUNCEMENTS

Mental Health for All - Connecting People and Sharing Experience

Date: April 28-30, 2015

Venue: Lille, France

Website: www.imhclille2015.com

Dear colleagues,

As WONCA is a member and partner of this important conference taking place in Lille France from April 28-30, 2015, we are pleased to inform you

that *Mental Health for All Connecting People and Sharing Experience* has already attracted a great deal of global interest. This is especially important because it will be the platform to launch the Lille Declaration and a global symbol for Dignity in Mental Health.



We very much hope that you will come to Lille and be part of this initiative.

If you have not yet registered to attend please do so by going to [the conference registration page](#)

We are particularly pleased that this event is taking place in Lille (France) because Lille is known for its innovative Mental Health practices, art, cuisine, entertainment and it is a connecting city that symbolises the theme of the congress.

We have already received abstracts from a range of countries including the USA, Spain, UK, Benin, Belgium, Portugal, Brazil, The Netherlands, Canada, Nepal, Taiwan, Cyprus, China, Iran, Australia, Indonesia, Thailand, Slovenia, Ireland, New Zealand, Israel, Lebanon, Switzerland, Germany, Finland, Tunisia and of course France.

We have extended the deadline for submission of abstracts until December 31 2014 so please submit your abstract in French or English so the world can learn from you.

We look forward to seeing you in Lille

Professor Gabriel Ivbijaro, Joint chair Host Organising Committee.

EGPRN conference May 7-10, 2015

European General Practice Research Network (EGPRN) spring conference

Venue: Timisoara, Romania

Dates: May 7-10, 2015

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



EGPRN welcomes posters, oral presentations and one-slide/five minutes' presentations on the theme of the meeting, or on any other relevant research topic.

The theme of this meeting will be: "*Research into new Methods and Techniques in Primary Care*".

There are few researchers among general practitioners/family doctors (GPs/FPs), but all GPs/FPs use the knowledge gained from research papers in their daily practice.

Primary health care practitioners have, in effect, double quality when it comes to research.

First they apply the newest methods after careful assessing the patient and establishing a diagnosis. Second, they know best their community's needs, the main research questions that arise, and the most important areas that need to be researched.

Private practice in Primary Health Care is an ideal platform for studying patients' problems, researching community issues and therefore acknowledging health risks and influencing decision-making regarding community-related, ethical and social issues.

“Research into new methods and techniques in primary care”, the theme of the May 2015 EGPRN Conference, also includes the issue of responsibility towards the population under research.

On the occasion of the May 2015 EGPRN Conference we would like to establish dialogue and communication between clinicians and researchers from the West and the East of Europe, and from the North and the South of Europe regarding:

- New methods and techniques in diagnosis, treatment and follow-up of patients with acute or chronic disease (ultrasound, biomarkers, new lab tests)

- New methods to improve the adherence of patients in managing their chronic disease
 - Ethical dilemmas in the introduction of new methods
 - The challenges of personalized medicine in primary care
 - The educational needs of a GP about new methods
 - New methods in emergency medicine
- Deadline for abstract submission: 15 January 2015 on the [EGPRN website](#):

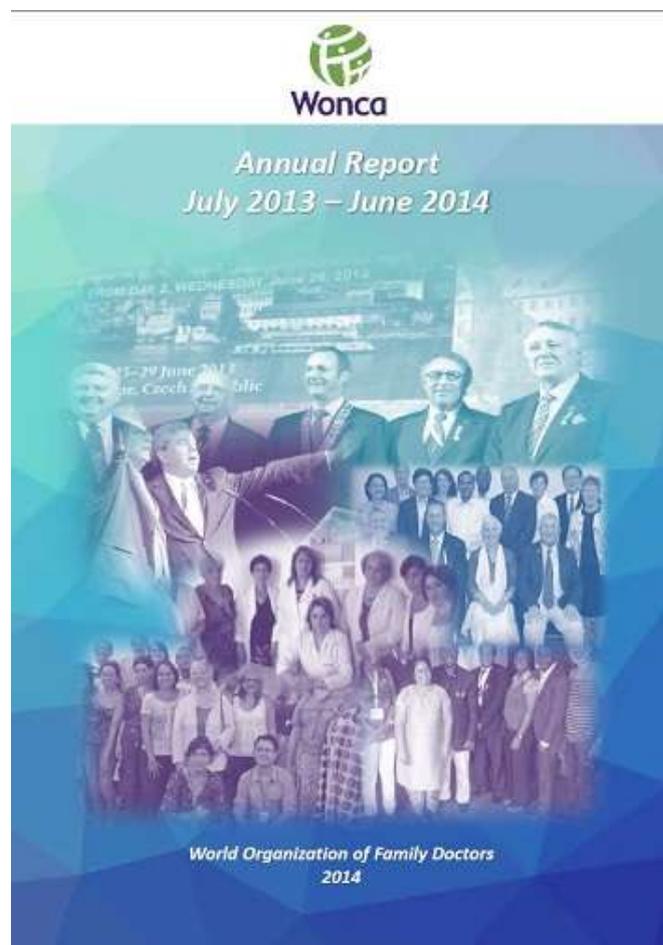
Hanny Prick, EGPRN Executive Manager.
hanny.prick@maastrichtuniversity.nl

WONCA Annual Report 2013-14

WONCA CEO, Dr Garth Manning has announced WONCA's first ever Annual Report covering the period July 2013 to June 2014.

Topics covered by the report are:
President's message
2013-2016 Executive Committee
CEO and Secretariat Update
Finances
Membership
Organizational Equity Committee
Young Doctor Movements
WHO Liaison
News and Media
World Family Doctor Day
WONCA Regional Reports
WONCA Working Parties
WONCA Special Interest Groups
WONCA Conferences
Audit Report of WONCA Trust 2013

[View complete report here](#)



WONCA CONFERENCES 2015

February 13-14, 2015	WONCA South Asia Region conference	Dhaka, BANGLADESH	For more information on these conferences as it comes to hand go to the WONCA website conference page :
February 21-22	Vasco da Gama Movement forum 2015	Dublin IRELAND	
March 5-8, 2015	WONCA Asia Pacific Region Conference	Taipei, TAIWAN	
April 15-18, 2015	WONCA World Rural Health conference	Dubrovnik, CROATIA	
April 30 – May 2, 2015	WONCA East Mediterranean Region conference	Dubai, UAE	
May 6-9, 2015 NEW DATES	WONCA Africa region conference	Accra, GHANA	
October 22-25, 2015	WONCA Europe Region conference	Istanbul, TURKEY	

WONCA CONFERENCES 2016

June 15-18, 2016	WONCA Europe Region conference	Copenhagen, DENMARK	www.woncaeurope2016.com
November 2-6, 2016	WONCA WORLD CONFERENCE	Rio de Janeiro, BRAZIL	www.wonca2016.com

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

Membership for
Individuals and
Organizations



WONCA ENDORSED EVENTS

For more information on WONCA endorsed events go to
<http://www.globalfamilydoctor.com/Conferences/WONCAEndorsedEvents.aspx>

April	Mental Health for All
28-30	Lille, France
2015	

MEMBER ORGANIZATION EVENTS

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

05 Feb - 08 Feb 2015	CCFP Triennial Conference 2015 
	Kingston, Jamaica
06 Mar - 08 Mar 2015	RCGP Global Health Conference 
	London, United Kingdom
25 Apr - 29 Apr 2015	STFM Annual Spring Conference 
	Orlando, Florida, USA
07 May - 10 May 2015	EGPRN Spring meeting 
	Timisoara, Romania
29 May - 30 May 2015	IPCRG scientific meeting 
	Singapore
13 Jun - 14 Jun 2015	6th conference of Japan Primary Care Association 
	Tsukuba, Japan
16 Jun - 18 Jun 2015	19th Nordic Congress of General Practice 
	Gothenburg, Sweden
31 Jul - 02 Aug 2015	RNZCGP conference for general practice 
	Hamilton, New Zealand
21 Sep - 23 Sep 2015	RACGP GP '15 conference 
	Melbourne, Australia
01 Oct - 03 Oct 2015	RCGP annual primary care conference 
	Glasgow, United Kingdom
