WONCA News

An International Forum for Family Doctors

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From the President – October 2013

From the President - think global, act local

Family doctors and the Millennium Development Goals

In September I attended the United Nations General Assembly in New York, representing WONCA at a summit called to examine progress in meeting the Millennium Development Goals (MDGs), and to discuss what happens beyond the end of 2015 when the current MDGs conclude.

Image: Millennium Development Goals (source: United Nations)

You are no doubt aware of the MDGs. They are eight aspirational goals, agreed by all the world's countries in 2000, which aim to halve extreme poverty rates by 2015, provide primary school education to all children, empower women, reduce infant and maternal mortality, combat HIV, tuberculosis and malaria, and ensure the sustainability of our environment.

The MDGs have galvanized unprecedented efforts across the globe to meet the needs of the world's poorest people. And progress has been impressive with rates of extreme poverty halved ahead of schedule, and significant reductions in infant and maternal mortality and HIV infection rates in many countries, with millions of lives saved through reductions in preventable deaths. Some of the coordinated partnerships created to achieve these gains have been wonderful.

Examples of successful global programs include the United Nation's Every Woman Every Child initiative, which has been adopted by governments in many countries and includes ensuring access for women and children to quality health care facilities and skilled health workers, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has led to a decline in new HIV infections in many of the countries most affected by the epidemic.

Attendees at the United Nations MDG summit included the Secretary-General of the United Nations, the Director-General of the World Health Organization, the President of the World Bank, presidents and prime ministers of several countries, and representatives of philanthropists and global non-government organisations, such as Oxfam, the Bill and Melinda Gates Foundation, World Vision and WONCA.

Image: Millennium Development Goal Summit, United Nations, New York, September 23, 2013

The summit debated actions needed to further diminish global poverty, improve health worldwide, and achieve sustainability of the environment, and provided recommendations for consideration by the leaders of the nations of the world.

Among the key messages that I took away from the summit was how success has occurred when there has been national and local ownership to give the MDGs traction, and the importance of allowing the local adaptation of the MDGs to target local conditions. And it was no surprise to be reminded that developing countries want capacity, not charity – and that building self-reliance is critical; this is a key role for WONCA in our support through our member organisations for education and training for the members of the family medicine workforce in every nation.

High-level statements and commitments are one part of the solution, but they are meaningless without effective in-country

action. Part of the challenge with the MDGs has been in their, sometimes patchy, implementation. Often initiatives to support the MDGs in a country have failed to engage with the existing primary care workforce, setting up parallel programs that can diminish, rather than strengthen primary care provision.

The MDGs have also come in for some criticism because of what is missing. They don't tackle the need to strengthen the primary care basis of each country's health system, or to tackle chronic disease or mental health, or to address the social determinants of health, or to ensure universal health care access for all people in both rural and urban areas. This is part of the challenge looking beyond 2015. What should be the focus of the next set of global challenges?

As the world debates what happens next, with the clamour of thousands of interest groups and self-interested industries, WONCA needs to ensure the clear voice of family medicine on behalf of our patients and communities continues to be heard during these debates. We need to be clear about our role as family doctors in working with our patients and communities to increase life expectancy and achieve equitable outcomes. And we need to support the focus on the social determinants of health and how we ensure marginalized populations, those groups of people in our communities most at risk of poor health, are not excluded from health care.

A specific focus of this year's United Nations General Assembly was on people with disabilities and how persons with a disability are being excluded from a number of the initiatives set in place to meet the Millennium Development Goals.

People with disabilities make up an estimated 15 % of the world's population, or one billion people. At least 80 % of people with disability live in developing countries and are at greater risk of living in absolute poverty due to their exclusion from equitable access to resources such as education, employment, health care, and social and legal support systems. Think about the challenges which must face a person who is blind or deaf or unable to walk in some of the world's poorest nations.

With the adoption by the United Nations of the Convention on the Rights of Persons with Disabilities in 2006, some progress has been made in improving the situation of many people with disability. However, in spite of such gains, the need for a specific focus on disability remains largely invisible in most mainstream development processes, including the MDGs. The nations of the world attending the United Nations General Assembly were urged to ensure that greater efforts be made.

As family doctors we provide care and are advocates for all our patients, and especially for those who are most marginalized or disadvantaged in our communities. We have a responsibility to ensure that our services are accessible and available to all people in our communities, including those with disabilities.

Following the United Nations Summit I went to San Diego to attend the annual Congress of Delegates of the American Academy of Family Physicians (AAFP).

The AAFP is the largest member organization of WONCA with a membership of over 100,000 family doctors. The Congress is the annual meeting of the AAFP where policy is debated, advocacy is planned, and the leadership for the coming year is confirmed.

This is democracy in action with strong debate about key issues affecting the delivery of primary care to the people of the United States of America. Many topical and important public health issues were being debated including the role of patient-centred medical homes. The top story in the US media that week was about the Affordable Care Act, called "Obamacare" by some, and the attempts of the US President to ensure that affordable health insurance, and so access to health care, is available to all people in the USA.

I attended the presentations by the AAFP members seeking leadership positions as president-elect and as board members. I was impressed by the commitment, eloquence and passion of the members of our professional discipline who put themselves forward for consideration for leadership.

Later in the week the newly installed AAFP President, Dr Reid Blackwelder from Tennessee, addressed the AAFP annual conference. Reid reminded our colleagues that, "regardless of the challenges, family physicians are leading the way in transforming the US health care system."

He spoke how, amid the uncertainty currently surrounding the business of medicine in the USA, family doctors have the opportunity to effect a positive change, that people want patient-centered care, and that people are choosing family medicine because family doctors treat the person, as well as the disease. Reid said, "Family medicine is about making a connection. It's about relationships,

and this ability to make that connection in the moment is what defines us as family physicians. No one does that as well as we do. Our role is unique and it is critical. We're remaking the system into one that's truly about health and caring."

Listening to Reid reinforced for me the role each of us plays as a family doctor, working with our health care team in our local community each day towards achieving the improvements sought by our world's leaders through initiatives like the Millennium Development Goals.

Michael Kidd

WONCA President

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From the CEO's desk : membership matters

Direct members receive discounted WONCA conference registration fees (photo courtesy of Viviana Martinez-Bianchi, MD)

Greetings again from Bangkok. This month I want to talk about the various grades of membership of WONCA, and to highlight the new grade of membership – Life Direct Membership – which was approved by World Council in June.

Most people are members of WONCA through their own Member Organizations – the national associations and college of family medicine/general practice which first gave WONCA its name ("World Organization of National Colleges, Academies and Academic Associations of General Practice/Family Medicine"). However many people also choose to join as Individual Direct Members which, as the promotional material says, " *…..is open to any health professional who has an interest in family medicine/general practice, who supports the vision, mission and goals of WONCA, and who wishes to belong to a worldwide network of family medicine/general practice educators, professionals, caregivers and advocates*."

Direct Membership has normally been available up until now for annual or 3-yearly membership. However World Council, at its June 2013 meeting in Prague, agreed to the proposal to introduce LIFE Individual Direct Membership. Thus for a one-off payment health professionals can now join WONCA for life, with all the benefits and privileges that membership confers.

"The WONCA Life Direct Member category provides the opportunity for individuals to make a special gift to the World Organisation of Family Doctors in return for waiver of annual direct membership renewal requirements. Life Direct Member status is open to any health professional who has an interest in supporting the vision, mission and goals of WONCA. The contribution level required for Life Direct Member status is a minimum of USD750. Life Members receive the same benefits as Individual Direct Members."

In fact as well as getting all the benefits of Direct Membership, including significant discounts on conferences, meetings and publications, Life Direct Members will also be named individually on a roll on the WONCA website, to signify their additional commitment to the Organization. It's also worth pointing out

that Direct Membership is open to all health professionals with an interest in family medicine, and not just doctors.

Academic Membership is another special category of membership of the organization. This is usually of particular interest to academic departments and training programmes who can apply for this form of membership, for a modest annual fee.

Direct Membership will have a simpler pricing structure with effect from January 2014. Further details of Direct Membership and Academic Membership, including how to apply, can be found on the WONCA website membership page.

Until next month.

Dr Garth Manning

CEO

WONCA Policy Bites with Amanda Howe

Professor Amanda Howe, our new President–Elect, said in her speech at the WONCA Council that she would "help with policy messages. In WONCA …. we know what we want to say. I'd work on how we say it – getting accurate clear briefing documents out, so you can adapt them for use in your place". So now we are inviting her to take up that challenge. Here is Amanda's second offering, and she will do this regularly.

We are also inviting you to send us similar material - an important piece of policy from your own organisation or setting that relates to family medicine developments and that might be helpful to others. Please send a summary, a link, and make it short - it's not Twitter, we shall allow up to 500 words! Each piece will be reviewed to check it is appropriate to publish it on the public part of the website - you can also log in to the members' forum to discuss reactions and related issues.

October 2013: Universal Health Coverage

In December 2012, following the publication of the 2010 World Health Report by the World Health Organization (WHO) on *'Health Systems Financing: The Path to Universal Coverage*', a UN resolution was passed encouraging governments to move towards providing universal access to affordable and quality health care services. Most recently the 2013 World Health Report has been published on the subject of *'Research for Universal Health Coverage'*.

What does Universal Health Coverage mean?

In essence Universal health coverage (UHC) aims to ensure everyone has access to needed promotive, preventive, curative, palliative and rehabilitative health services of sufficient quality to be effective without suffering financial hardship as a result. The WHO outlines that:

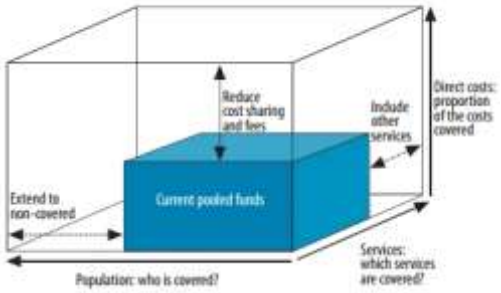
"For a community or country to achieve universal health coverage, several factors must be in place, including:

- *A strong, efficient, well-run health system that meets priority health needs through people-centred integrated care (including services for HIV, tuberculosis, malaria, non-communicable diseases, maternal and child health) by:*
  - *informing and encouraging people to stay healthy and prevent illness;*
  - *detecting health conditions early;*
  - *having the capacity to treat disease; and*
  - *helping patients with rehabilitation.*
- *Affordability – a system for financing health services so people do not suffer financial hardship when using them. This can be achieved in a variety of ways.*
- *Access to essential medicines and technologies to diagnose and treat medical problems.*
- *A sufficient capacity of well-trained, motivated health workers to provide the services to meet patients' needs based on the best available evidence.*

It also requires recognition of the critical role played by all sectors in assuring human health, including transport, education and urban planning."

In order to do this funds need to be collected and pooled (e.g. through taxation or social health insurance), and then used to pay for services, such as primary care, that meet the requirements outlined above. In the provision of health services three key dimensions need to be considered: (1) Who is covered? (2) Which services are offered? (3) What proportion of the costs are covered? (see Fig 1),

Fig 1. **Three dimensions to consider when moving towards universal coverage**



Source: The world health report 2010. Health systems financing: the path to universal coverage. Geneva, World Health Organization, 2010.

The 2013 World Health Report addresses important questions about prevention and treatment, how services can be paid for, their impact on the health of populations and individuals, and how to improve health through interventions both within and beyond the health sector. It uses case studies from around the world to illustrate this and highlights the importance of communicating the evidence-base to change agents, authorities, opinion leaders and innovation champions, all of whom play different roles in policy-making and front line implementation.

Why is this relevant to family doctors?

WHO states that "*a strong primary care system is central to an effective health system*", so we need to be able to communicate the evidence on the value of primary care and use this to support and further develop primary care in all health systems in order to equitably and efficiently achieve UHC. Also, research needs to take place in communities in primary care settings - this is something that WONCA's Working Party on Research is already supporting, and WONCA welcomes case studies from your situation that will illustrate the successes and barriers in strengthening primary care and family medicine.

Send your case study to Prof Amanda Howe, President-Elect amanda.howe@WONCA.net

Or t**o give your views login or join the WONCA forum**

Login to the WONCA forum

Join the forum

Rural Round-up : October 13

This month's rural round-up is written by the secretary of the WONCA Working Party on Rural Practice, A/Prof Bruce Chater of Australia. Find out more about his perspectives and about life as a GP in Queensland.

I am a rural general practitioner and work in a small town 250km from the nearest specialist. I have been a member of the WONCA WP since 1995 and have seen the WONCA Working Party on Rural Practice develop over that time to embrace the needs of the developed and developing world. Our first conference was in Shanghai and in a rural area outside the metropolis in 1996. The thing that struck me at that first conference and since, is that all rural doctor have the similar issues – just different flavours. These issues and suggested solutions were captured in our *Policy on Rural Practice and Rural Health- 2nd edition 2001*.

Much is often made of the poorer health status and standard of living in rural areas – this is true and desperately so in some places but with the provision of public health, good generalist health care and extra job opportunities, rural areas can be wonderful places to live. Rural doctors can be part of the required change to enhance that.

I live in a rural area in Queensland in Australia. If the State of Queensland was a country, it would rank as the 25th largest in the world. The distances are vast, often with hundreds of km between health facilities. I was recently asked by the Health Minister to develop a plan to better utilise Queensland's rural health services. The basis of the report is that public need to know what to expect of its services, that generalist doctors and nurses need to be trained and enabled to staff these facilities and general practices and that they should be supported to provide a wider range of services

such as birthing and chemotherapy, where appropriate, supported by outreach telehealth. The Minister has accepted the plan and we are in the middle of implementing it. (Download plan)

A key element of this is the role of the rural general practitioner that is best suited to the geographic dispersion that characterises Queensland (and many dispersed areas around the world). The recent Health Workforce Australia review outlined this role as rural medical generalists who have skills to:

- Provide unsupervised, un-referred community or primary care of individuals, families and communities
- Work unsupervised to provide in-patient and emergency care in a hospital or related setting such as a remote health centre or multipurpose health service
- Provide extended specialised service in at least one approved medical discipline required to sustain comprehensive health care services in regional, rural and remote communities
- Provide services across the continuum of care in a range of settings and service delivery models including outreach where required
- Apply a population health approach with relevance to the community in which they practice.

This is of international interest and will be the subject of a Summit in Cairns Australia in late October hosted by the Australian College of Rural and Remote Medicine (ACRRM) and supported by the WONCA Working Party on Rural Practice (WWPRP).

The final project of the working party that I would like to mention is the *Guidebook on Rural Medical Education* which is on track for web based publication next year. We have received over 60 chapters about a wide variety of rural medical education subjects and hope that these practical examples will build on and help those of you who seek to implement our policies on rural education and practice.

Rural and urban general practitioners have much in common with and a proud shared tradition. The solutions to providing health care will vary around the world. As one of my colleagues is prone to say "*when you have seen one rural town you have seen one rural town*" - we look forward to our efforts resulting in healthier people leading happier lives in those towns and villages.

Assoc Prof Bruce Chater

Secretary WWPRP

Find out more about the WONCA Working Party on Rural Practice

FEATURE STORIES

WONCA Executive Position Vacant - Junior Doctor Rep Sought!

At the WONCA World Council in Prague in June, Council endorsed the idea of expanding the Executive Committee to include a Junior Doctor representative. This person would represent the views of Young Doctors' movements on Executive as well as the perspective of WONCA's junior doctors generally. The Young Doctors' movements will be responsible for future appointments, but Council has tasked Executive with making this first appointment, in order to get someone in place as quickly as possible.

We're looking for a motivated, energetic and committed young doctor who, at time of appointment, will be undergoing family medicine residency / postgraduate general practice training or will be in the first five years of their professional career after their family medicine residency or post graduate general practice training . They must have reasonable written and spoken English and be available to take part in regular teleconferences and to attend Executive meetings (fully funded by WONCA) every 6 to 8 months in different parts of the world.

For more details of the job description, and how to apply, please click on this link. Closing date for applications is **Friday 11th October 2013.**

WHO survey for primary care providers

The WHO and WONCA want to hear about *your* experiences in providing primary care!

The World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) want to hear about your experiences providing primary care health services. We are looking to learn from both positive and negative experiences from all types of primary care providers in developed, transitional and developing countries, as well as from countries in post conflict or post natural disaster situations.

Responses will be used to inform and potentially be published as narrative stories in the WHO's upcoming strategy on "*High Quality, Integrated People-centred Services*" and may be used for future WHO or WONCA publications.

This is your opportunity to voice your views in this important WHO Strategy!

The survey can be found at the following link: http://surveymonkey.com/s/ZRXKCF5

Deadline for submissions is Friday 8th November 2013

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YOUNG DOCTORS' MOVEMENTS

AFRIWON - African young family doctors' movement

AfriWon Renaissance, the youth movement of the WONCA Africa Region was officially inaugurated on the 27th June, 2013 during the WONCA 20th World Conference in Prague Czech Republic. This forum/movement is for the young (under five years) and trainee Family Physicians in Africa. It is the future of WONCA Africa.

AfriWon Renaissance derived its name from the rejuvenation of Africa WONCA through its youth movement.

Mission and Vision

AfriWon Renaissance has emerged as a uniting force among the young African frontline doctors to address the common health problems of Africa by providing support through:

- Developing Family Medicine and Primary Health Care in Africa in service, training and research amongst young doctors
- Establishing a communication network between African trainee and young family physicians and identifying their concerns, doubts and needs and helping to address them
- Encouraging a global and youthful African perspective, with global exposure and leadership development

Organisational Structure

The executive is responsible for decision making, day to day running and coordination of the activities of the movement. It comprises of three main officers- the Chairman, Secretary and the Treasurer. The AfriWon Renaissance Chairman relates with the other youth movements around the world on behalf of AfriWon Renaissance. He also reports to the WONCA Africa Region President. In addition to the core executive, every member African country has country representatives in the expanded executive.

Chairman - Dr Kayode Alao (Nigeria)
alstacs@yahoo.com

Secretary - Dr Aramide Oteju (Lagos, Nigeria)

WONCA CEO with the WONCA Africa Executive during the AfriWon Launch

Treasurer - Dr Magdelena Petkova (Johannesburg, South Africa)

AfriWon Renaissance has three advisers selected from the major African regions:

West Africa advisor- Dr Dan Abubakar (Nigeria) danex85@yahoo.com

East Africa advisor- Dr Thigiti Joseph (Kenya) jthigiti@yahoo.com

South Africa advisor- Dr Shabir Moosa (South Africa) shabir@drmoosa.co.za

Membership

The countries currently represented include Nigeria, Ghana, Benin Republic, Kenya, Zimbabwe, Malawi, Uganda and South Africa. This is list is however expanding daily.

All young family physicians (under five years), family physicians in training as well as medical students in Africa are encouraged to join and participate fully in the activities of AfriWon Renaissance.

Activities

- Having fun communicating and sharing in a growing circle of African membership
- Reaching out to other African countries who are presently not members of WONCA through their young Family Physicians
- Developing country-based AfriWon membership, structures and activities (in conjunction with WONCA Africa Membership Organisations)
- Working had on exchanges programmes across Africa and internationally
- Planning a 2-day AfriWon pre-conference before the next WONCA Africa Regional Conference in Ghana 2015
- Developing training and research capacity for the young in our countries and collaboratively across Africa
- Engaging internationally with other youth movements and WONCA at Regional and World Conferences. Watch out for AfriWon exhibition at the next Europe Conference in Lisbon, 2014

Contact

Website- WONCAafrica.org

Facebook group- AfriWon Renaissance

Photo: Secretary Shabir Moosa takes a photo of Chairman Kayode Alao

Email- afriwon@WONCAafrica.org

Family Medicine 360 - young doctors' exchanges

What it is:

Family Medicine 360 is a global, international exchange program for Junior Family Doctors and General Practitioners (within five years of completing residency training), who would like to experience Primary Health Care in a different country.

The program is intended to have a high educational value to differentiate itself from other types of exchanges, and will be based on a network that includes all relevant stakeholders needed to support such an initiative.

Why it exists:

The importance of vocational education and training exchanges between different countries has been recognized by several authorities and associations. Intercultural exchanges enable people to come closer and junior family doctors to learn from each other's experiences, problems and solutions.

Furthermore, this initiative also provides senior hosts with a magnificent opportunity to teach their viewpoints for the visitors and to learn from them.

How it is planned to work:

For four weeks, visitors undertake a clinical placement with the host's Primary Health Care setting, to learn from it.

To provide some structure for the visitor's learning experience, there will be learning objectives and outcomes, agreed to by both visitor and host. Participants will also be called upon to discuss their experience before and after the exchange in a final report.

Visitors are expected to cover their own travel and accommodation costs. Hosts are, of course, welcome to assist visitors in finding accommodation.

Background:

On the 27 June 2013, the first meeting for the development of a potential international exchange program took place at the 20th WONCA World Congress, in Prague. The meeting was organized after an open invitation to all the regions of WONCA. The objective was to explore the possibility of establishing a formative Exchange Program at a global level.

The members from the following Junior Family Doctors' Movements were present:

• Julie Wood (AAFP);

• Kayode Alao (AfriWon Renaissance);

• Scott MacLean (First-Five Years in Canada);

• Shin Yoshida (representing the Rajakumar Movement);

• Pramendra Prasad (representing the Spice Route Movement);

• Ana Nunes Barata, Sara Rigon, Raquel Gomez-Bravo, Harris Lygidakis (Vasco da Gama Movement);

• Isabel Mora (representing the Waynakay Movement).

In addition, John Wynn-Jones from the WONCA Working Party on Rural Practice and Per Kallestrup, the founder of the Hippokrates Program, were also present.

Thanks to the great presence of members from all over the world, several topics were raised. All parties agreed that such a program would require high flexibility due to the diversities and inequalities that are observed worldwide. Cultural and linguistic issues may be initial barriers, but all parties agreed to work together with respect and true collaborative spirit in order to agree on a common action plan for the development of this project.

We need your help

Family Medicine 360 is only just starting, and we are always looking for anyone willing to help out with this project. Whether you want to be a host, or have ideas on how to obtain funding, or believe you could assist us in some way, please let us know! The benefits at a professional, personal, community, national and global level are unique and work as triggers for the development of Primary Health Care, which is in agreement with WHO's goal of universal health coverage for all.

• Africa (AfriWon Renaissance) –

Dr Kayode Alao - alstacs@yahoo.com

• Asia-Pacific region (Rajakumar Movement) –

Dr Naomi Harris - drnaomipharris@gmail.com

• Canada (First Five Years in Family Practice Committee) –

Dr Scott MacLean - scott.maclean@ualberta.ca

• Central and South America (Waynakay Movement) –

Dr Isabel Mora - isabelmoram@gmail.com

• Europe (Vasco da Gama Movement) –

Dr Ana Nunes Barata - anunesbarata@gmail.com

• South Asia (Spice Route Movement) –

Dr Raman Kumar - dr_raman@hotmail.com

• USA (American Academy of Family Physicians) –

Dr Julie Wood - jwood@aafp.org

To make suggestions or comments please contact

Dr Ana Nunes Barata

anunesbarata@gmail.com

REGIONAL NEWS

WONCA EMR president in Qatar

WONCA East Mediterranean region president Dr Mohammed Tarawneh, reports that he has just had a good meeting in Doha, Qatar, with Dr Mariam A Abdul Malik, the managing director of Qatar PHC Corporation. The aim of the meeting was to work on them joining WONCA as full member organization.

Dr Mariam arranged a meeting of about 50 family physicians and Dr Tarawneh gave a brief and presentation on WONCA. The audience, after the presentation, had more questions about WONCA and their desire to join WONCA as full member organization and as direct members. Dr Tarawneh is to start working on that with Dr Mariam and his team, as well with Dr Garth Manning, WONCA CEO.

(l to r) Dr Juliet Ibrahim, the executive director of clinical affairs; Dr Zulaikha Mohsen, West Bay HC manager and family medicine manager; Dr Mariam Ali Abdul Malik, Managing director; Dr Moh'd Tarawneh, WONCA EMR president; Dr Mohammed Diab, head of clinical education; Essam Abdul Baqi, family physician consultant; Dr Youssef Noof, family physician consultant

WONCA South Asia Region president attends regional WHO committee

Introduction

The meeting was attended by representatives of all 11 member states of the region, United Nations and other agencies, nongovernmental organizations having official relations with WHO, as well as observers. The joint inauguration of the sixty sixth session of the WHO regional committee for South Asia region and the thirty-first meeting of Ministers of Health of Countries of South East Asia region was held on September 10, 2013. His Excellency Mr Pranab Mukherjee, Honorable President of India, delivered the inaugural address.

Inaugural session

1. In his welcome address, Dr Samlee Plianbanchang, Regional Director, WHO

WONCA South Asia region president, Prof Pratap Prasad, of Nepal, prepares for the meeting.

South East Asia Region, warmly welcomed the Ministers of Health and representatives of the Member States of the WHO South East Region

2. The regional director noted with satisfaction that wild polio virus transmission in the Region had been terminated in 2011 and 90% increase in immunization coverage in the Region, had been achieved. He said that many countries had already reached the MDG targets and agreed on universal coverage as a strategy in the post-2015 development agenda.

3. In her address, Dr Nafsiah Mboi, Honorable Minister of Health of Indonesia and Chairperson of the thirtieth Meeting of Health Ministers, recalled that at the previous Meeting of Health Ministers hosted by the Government of Indonesia, the Yogyakarta Declaration on Ageing and Health had been adopted. The progress made in expansion of universal health coverage and development of a regional framework for non communicable diseases, ensured that equitable, affordable and accessible treatment, care and support was provided through the primary health care.

4. The Director-General of WHO, Dr Margaret Chan termed this year's World Health Day theme as "high blood pressure". Dr Chan noted that the key challenge of public health was to get more people checked early, ideally routinely, and then properly managed. Countries with health systems based on primary health care were on the best position to do this. She encouraged the Ministers of Health to adopt the New Delhi declaration on High Blood Pressure, which calls upon governments to commit to building partnerships among various stakeholders at the national, regional and global level.

5. His Excellency noted that although the countries of WHO South East Asia Region represent a quarter of the global population, and the per capita total expenditure on health was the lowest. To achieve universal health coverage, it will be necessary to strengthen the primary health care systems through prevention and promotion activities and by optimal utilization of scarce resources. Strategic investments in medical education and training would go a long way in enhancing the availability of health care professionals for all communities.

6. Expressing his concern about the health of elderly who are a precious social asset, the Honorable President underscored the need to effectively implement the Yogyakarta Declaration on Ageing and Health 2012. His Excellency stressed the need to define health priorities for the global developmental agenda beyond 2015.

Photo: Prof Pratap Prasad, WONCA South Asia region president (left) with the Minister of Health of Bangladesh

Key agenda and report on the work of WHO

Introduction to the Regional Director's Annual Report on the work of WHO in the South East Asia Region covering the period 1 January to 31 December 2012.

1. Intensified efforts for routine immunisation which started on 2012 were progressing well with all countries achieving at least 90% national coverage. Significant progress had been made in measles immunisation

2. The region is aiming at eliminating HIV infections among children by 2015

3. Tuberculosis (TB) prevalence had reduced by almost 40% between 1990 and 2015

4. The regional director noted that non communicable diseases (NCDs) are the leading cause of death in most member states. More than 60% of all deaths are due to NCDs. Recognition of NCDs as a priority on the public health agenda was increasing and Member states were strengthening national health systems for sustainable NCD prevention and control.

5. Environmental hazards continued to be a major public health challenge in the Region. Around 19% of all cancers are attributed to environmental factors, particularly occupational exposure to chemicals and chemical contamination in the food chain.

Address by the Director General of the World Health Organization

In her address to the Committee, the Director General, Dr Margaret Chan said that universal

health coverage is an important way to address inequalities and inequities in health. Universal health coverage is firmly rooted in primary health care and countries have had a head start in achieving it by staunchly supporting primary health care. She noted that the technical discussions on Universal Health Coverage recommended a phase-wise approach, whereby elimination of inequities and inefficiencies is the initial focus.

Moving towards universal health coverage means increasing access to medicines, vaccines and other interventions. She noted that the South East Asia Region has 60% out of pocket expenditure on health, which is the highest among all WHO regions. Dr Chan asserted that based on the experience of other regions, the ambitious goal of measles and rubella control in South East Asia Region by 2020 is feasible.

Dr Chan said that all the health experts have given cardinal careful attention to the prevention and control of NCDs including the nine voluntary targets by using available data to assess them in the regional context. She said that participations were well aware of the public health problems posed by NCDs. In some countries, a fundamental reorientation of the health system is needed. She concluded that once universal health coverage translates into reality, it will benefit all the citizens and give the poor “a route towards a decent life”.

Statement by Prof Pratap Prasad

Prof Pratap Nayaran Prasad, WONCA South Asia region president was permitted to make a statement about WONCA to the meeting. His words were as follows:

WONCA is a the World Organisation of Family Doctors whose main aim and objective is to serve the unserved people and provide the primary health care in the community under universal health coverage. WONCA South Asia Region is committed to the philosophy of above statement. Under this coverage, I, as the president of WONCA-SAR, would like to make a statement on this gathering to make accountable for South Asia region. On the following point I want to gather attention of WHO/SEARO:

1. Primary Healthcare: to reach the unreached of South Asia Region by family doctors

2. Recognition of role of family physician/GP to achieve the goals of MDG in South Asia Region

In the era of advanced technology and super-specialty, primary health care service is still questionable in this region. Only family physician/GP can cope up with this situation and provide better health care to community. WHO-SEARO must recognise and deliberate importance of the family physician/GP in this region. I look forward to this gathering and request WHO-SEARO to address in those countries where family physicians are not identified as first line consultant doctor. I would like to thank the organisation for allowing me to make a statement in this prestigious gathering.

Twelfth General Programme of Work (GPW) and Proposed Programme Budget 2014-2015

The committee noted that World Health Assembly, in May 2013, had approved the Twelfth General Programme of Work (GPW) , which establishes:

- the overarching health mission, principles and values
- changes to the results-based framework
- six high level health leadership priorities
- six categories of work
- 30 technical programme areas
- the aspiration of results of the Organization for a six year period 2014-2019

The Director General urged the health ministries when planning work to be conducted with the WHO, to focus on a limited set of priorities (between three and five), in order to be able to deliver key health objectives.

Prof Pratap Prasad

WONCA South Asia Region President.

WORKING PARTIES and SIGs

Contribute to stories from environmental family doctors

Open Invitation to WONCA members to contribute to a new book, "*Family Doctors in the Field - stories from environmental family doctors from across the globe*"

Grant Blashki, Alan Abelsohn, Margot Parkes and Karen Flegg are delighted to invite family doctors to contribute to our upcoming book, "*Family Doctors in the Field -Stories from environmental family doctors from across the globe"*, which is to be launched at the WONCA Europe conference in Lisbon, in July 2014.

The aim of the book is to profile ordinary family doctors around the world who are interested or involved in environmental issues. We are looking for contributions of between 500 and 1000 words and a good quality photo of the doctor at their clinic or at work on environmental issues. We are looking for contributions to be submitted before the end of the year.

If you might be interested why not drop an email to A/Prof Grant Blashki, Chair of the Environmental Working Party, and we will send you some more details and a guideline, email Grant at gblashki@unimelb.edu.au. Look forward to hearing from you.

A/ Prof Grant Blashki

Chair WONCA Working Party on the Environment

New WONCA working party under way - WONCA Working Party on Indigenous and Minority Groups Health Issues

He aha te mea nui o te Ao? He tangata! He tangata! He tangata!
What is the most important thing in the world? It is people! It is people! It is people! – Māori proverb

Tena koutou

The first workshop of the WONCA Working Party on Indigenous & Minority Groups Health Issues drew people from around the globe.

There were representatives from Africa, Europe, South East Asia, North and South America and the Pacific. Those people came from Nigeria, Spain, Indonesia, the UK, the USA, Canada, Italy, Australia, New Zealand and Brazil.

Our reasons for participation and what we wanted to get out of the new group brought forth a list of 19 themes to examine and select next steps.

One very clear message was that developed countries should take a different stance on how to help developing countries address their health issues.

Instead of taking the lead, telling developing countries what to do, based on their own standards, developed countries should consider listening, understanding and responding more to what developing countries are saying.

There is strong support and willingness to participate and to take this mahi (work) further.

Themes

1. Identification of indigenous and minority groups (IMG)
- Issues connected IMG in our respective countries, communities and professional organizations.

2. Resources
- Lack, paucity, distribution or quality of resources

3. Culture
- Dominant systems' perspectives a major issue regarding the status of how different systems deal with IMG
- Culture of IMG themselves based on ethnicity, gender, social status, own belief systems, myths. Particularly for Roma (Gypsy) populations which is of more concern in Europe
- Issue of communication and skill-sets with regard to doctors being able to engage with their patients and around lack of skills and understanding of IMG.
- Using culturally appropriate methods rather than one size fits all.

4. Power imbalance
- In all respects, especially with regard to indigenous populations who are, in most cases, dislocated from their rightful place and land, and also for others who have

been dislocated and have never been considered as being part of a particular place.

5. Mobility
- Nomad aspects of certain populations.

6. Research
- Lack of research, and meaningful approach to research, in IMG issues is a significant area that may need to be addressed.
- Acknowledging different world views and this needs to be done through IMG lens.

7. Systems/political regimes
- Some are causing poverty where IMG always find themselves at the bottom of the heap.
- Specific countries could identify some of these concerns, eg:
  - Africa has 35-40% indigenous populations but their health status remains poor: marginalization, HIV and local customs on how you address this
  - In the Amazon, indigenous people are difficult to contact.
  - Mayan people in Mexico are not even counted so they are totally ignored. Acknowledging that their indigenous people do exist is a very important start to see what effects that has on entire system

8. Maternal health
- High maternal morality and anaemia rates, especially in Indonesia and Papua New Guinea.

9. Lateral violence
- Domestic and indigenous group causing harm to their own people.

10. Teenage pregnancy
- High rates in some countries', like Nigeria, minority groups addressing the impact or core family values.

11. Lack of aspiration
- How this leads to despair and people not being motivated to push forward.

12. Equity
- Very strongly felt by all people
- The need to have meaningful health care for IGM, not just throwing money into the system, to help the people with the greatest needs. Which are usually marginalized populations

13. Empowerment
- Not just in health but socially; how communities are engaged and can self-determine their future.

14. Racial issues
- Need for more education to address discrimination.

15. Alcohol abuse
- The significant increase in the use of alcohol and suicide in indigenous populations
- Lack of access to resources, especially in Brazil.

16. Big petroleum company influence
- Countries like Nigeria are rich in oil exploration and water supplies, but the water is polluted and they have the worst population health and minority health outcomes.

17. Prostitution
- Italy raised the problem of Nigerian prostitutes and hardship issues they have

18. Gypsies and homelessness.

19. Anti Islamic practices
- In the UK and increasing divisive across the world.

Next steps

For those people interested in working with us, please consider joining our working party.

We will have an online newsletter in due course that you will also be able to sign up to.

I have set up a Facebook page for the working party to collaborate and share news, ideas, research, sponsorships and developments on a daily or weekly basis online. I encourage your all to like the page so that it flourishes as an informal international forum for our work.

If you are part of the Twitter sphere please do also follow WONCA Indigenous, @WONCAindigenous, tweets, share them and make sure we are following you!

It will be some time no doubt until we can all meet *kanohi ki te kanohi* (face to face) so these "new" online networking tools are an ideal way to build bonds and expand our network.

I am working to raise awareness and secure support from relevant leaders in their fields, and will keep you abreast of any developments on Facebook and through Twitter, and this website. Remember you can direct message me through any of those channels as well.

Naku iti nei

Tane
Dr Tane Taylor (Chair)

WONCA Working Party on Indigenous & Minority Groups Health Issues

Addressing Health Equity - Prague workshop report

Addressing Health Equity was a workshop held at the recent world conference held in Prague, in June 2013.

This workshop sought to explore how a better understanding of the health inequities present in a population can enable the general practitioners to adopt strategies that could improve health outcomes in the delivery of primary health care; it explored the development of a health equity curriculum and opened the discussion of the future and potential impact of health equity training among general practitioners.

As part of the workshop, it was proposed to seek interest in establishing a WONCA special interest group on health equity. There is an indissoluble link between health equity and social justice and our success to make a difference for our patients relies on all frontline doctors and health professionals to advocate for greater socioeconomic equity and the health rewards that would follow.

The workshop was divided into four sections:
1. Welcoming note by Prof Michael Kidd
2. Scope of health equity; and challenges and problems pushing the agenda forward by Prof Iona Heath
3. Brief overview of current initiatives and best practices dealing with health equity in family medicine/ primary care setting by Dr Efrat Shadmi
4. Discussion: regional priorities and challenges in achieving health equity
5. Drafting a proposed curriculum/other business

Here follows a summary of the discussion..

1. Please list three health inequity situations specific to your country that you are aware of (especially if it is related to primary care or your work) and describe how these may impact on health. (From each participants)

Uneven distribution of social determinants of health could systematically affect the distribution of poor health outcomes, such as different life expectancies, and risk behaviours, such as alcohol, domestic violence, smoking, among population of low social economic status (SES). Some common social determinants of health which affect general low SES population include income differences; poor housing; poverty; unemployment; education; access to healthcare services, social support and isolation.

There is a wide income gap between the rich and the poor- it affects people's affordability to healthcare services. In Pakistan, only 30-35% of health care is covered by the public sector. The rest of the patients would go to private practitioners, faith healers, alternate medicine specialists and even quacks. In Brazil, 45% cover is available through public sector; while in Holland, co-payment for secondary care becomes financial barrier to some patients. National cuts in allocation of funding have affected people in socially deprived areas more. Misallocation of resources by central funding body is observed since there is no needs assessments matched with funding.

Income gap could also affect education hence literacy of people. Literacy is only 59% in Pakistan; while in Brazil, literacy is good but not properly exercised.

For countries with urban or rural division, urban areas usually enjoy better healthcare access, whereas healthcare services are extremely limited in rural areas. Pakistan immunization is not possible in remote Pakhtoon areas whereas in Romania, there is a lack of General practitioners in remote areas or rural areas.

For indigenous group or aborigines, cultural differences and expectations could affect their access to healthcare services. Health related policy might be recognised by these groups as cultural Imperialism that serves the purpose of maintaining the cultural hegemony.

Migration is recognised as social determinant of health which might affect migrants' access to healthcare services due to language barriers or unfamiliarity of healthcare systems, which makes their navigation through the healthcare system difficult. One of the examples given was the UK homeless migrant groups.

2. From all of the problems above or mentioned in the presentation, what are the key barriers and facilitators in meeting the health equity agenda (with examples from your own country).

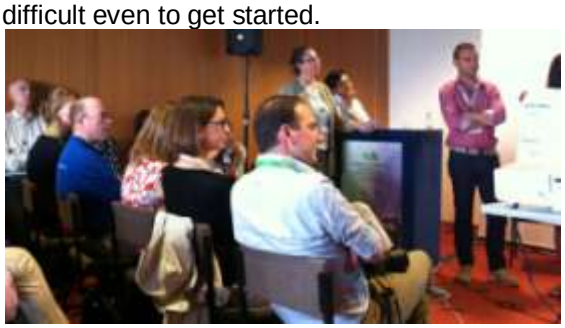
Barriers on the supply side

Health workforce shortage is observed in rural area or primary care which makes health services unavailable to people living in rural area or of low SES. Furthermore, some government doctors might engage in private

practice and reduce the already limited manpower. Efficiency and effectiveness of services will be affected by the lack of coordination and communications between primary and secondary care.

For developing countries, there will be lop-sided priorities; for example, AIDS programs are supported by foreign funding but no attention is paid on safe water supply, immunization and sanitation in Pakistan.

Poorer people/ minorities/ communities with low political equity have little effect on politically driven health policy. Furthermore, there might be a lack of political will, money, and/or knowledge in tackling the problem. Other barriers include the prevalence of corruption feeling that the problem is too big/ difficult even to get started.



Barriers on Demand side

The SES status of patients could affect their utilisation of health services. For those who have no jobs or on low wage, they could not afford health care; for those who have low education, they would have low health literacy. Poverty could have impact on psychology which resulted in low worthiness and expectations. Cultural Norms could also affect people value, perceptions and trust on health services utilisation.

Facilitators

Income gap narrowing and strong democracy over a consistent period can facilitate the health equity agenda. Also policymakers should talk “truth to power”, which they should use medical data by UK lobby groups to support provisions of housing, education, social services and employment, and engage the community. Resources should be focused at departmental level. QUIDS measurements assessed on GP practice IT systems monthly.

General Practitioners could provide patient advocacy locally through media. Health professionals could also empower patients through patient participation groups. Culture of responsibility for health inequities should be borne by the community but not rested on individuals.

Telemedicine for remote areas could be provided to rural area where there is a lack of doctors. Free and comprehensive primary health care could be provided to people in need.

Training on health equity must be provided to the health professionals.

3. How can we as primary are team overcome these barriers with one specific attention to be given to: 1. Health access; 2. Vulnerable groups; and 3. Education and training of health professionals?

Health access

Primary health care should be accessible through family doctors (one doctor for sizable population) like the NHS model.

Practice meetings should be conducted to identify local issues/ problems and it should involve policymakers, general practitioners and nurses. Being aware of what is available locally and getting ideas from other countries may be useful.

Education for patients and public

Signposting for how to navigate healthcare system should be provided to the public and the patients. Community awareness should be promoted in settings that reach out to different groups, such as mosque. Training should be provided to the leaders of vulnerable groups.

Vulnerable groups

Women, minorities, children and people with low social standing should be attended to more comprehensive training of health professionals.

For migrants, ethnic minorities or indigenous groups, signs in different languages should be installed and education about cultural awareness should be provided to staff including general practitioners, or nurses.

Education and training of health professionals

Training in inequity should be provided to medical students as well as general practitioners to improve health equity through primary care. Medical students and doctors should be trained to conduct face-to-face discussions with patients in services to increase understanding. There should be increased exposure with general practitioners for medical students.

More general practitioners should be trained to ensure there are service providers in rural areas.

FEATURED WONCA LEADERS

WYNN-JONES, Dr John

Chair WONCA WP on Rural Practice (UK)

Dr John Wynn-Jones has been a rural GP in Wales for over 30 years. He has now retired from his full time practice but still continues to work part time. He trained at Guy's Hospital London 1969-75 but after finishing his GP training returned to his native Wales to work in a rural practice in Montgomery on the Welsh borders

He soon became aware that the rural GPs lacked any significant support or on-going continuing education. He and a few colleagues formed a local medical society, which provided educational and support for general practitioners and their staff. He went on to found the UK Institute of Rural Health and the Welsh Rural Postgraduate Unit. In 1997 he was instrumental in creating the European Rural and Isolated Practitioner's Association (EURIPA) and remained its president until 2012. Under his presidency the network grew in stature and influence and represents rural practitioners across the continent.

John was one of the founding members of the WONCA Working Party on Rural Practice and took over as chair in Prague this year from Professor Ian Couper. His personal areas of focus for the forthcoming triennium include:

- Renewal of the membership of the Working Party, aiming to ensure that there is gender equity and that younger doctors are represented
- Ensuring relevance to working rural practitioners, through systematically reviewing previous policies and statements of the working party, adopted at conferences over the years, so that they remain relevant and are communicated effectively with rural family doctors.
- Linking more with the broader WONCA family, aiming to work together and combine skills, resources and energies to address the mounting challenges that rural practitioners face over the coming decades.
- Publish the electronic Guidebook on Rural Medical Education, which has been under development for a number of years.

He has held many posts and roles over the years including the position of Medical Advisor to the BBC's Archers, the longest running radio soap in the world. He has spoken at conferences around the world and published on rural issues. He is currently the Senior Lecturer in Rural and Global Health at Keele University.

He worked with his colleagues at the Institute of Rural Health to develop UK's Rural Proofing Tool in 2007 (2nd version was released earlier this year). The rural Proofing process is key to ensuring that rural policy meets the needs of rural populations and used properly can have an impact in promoting equity for rural inhabitants

His passion for rural practice remains unabated and says that despite the success we have much more to do to reduce rural inequalities and improve health outcomes.

John describes himself as *"A catcher of dreams" who believes that we all have the capacity to change the world.*

As Paulo Cohelo says in "The Alchemist" we must listen to the language of the world, look where we started from and take the opportunities when they arise

CHUNG, Ms Yvonne

WONCA Honorary Life Direct member (Singapore)

Administrative Manager, WONCA, 2001 -2012

Yvonne was awarded Honorary Direct Life membership at Prague in 2013 in recognition of her many years of loyal and excellent service to WONCA.

Yvonne Chung was born in Hong Kong. At the age of 3 years, she emmigrated to England with her family. She grew up in Cheltenham where she received her primary and secondary education and went on to the University of London majoring in Social Policy. In 1995 she moved from England to Singapore

with her husband, an international corporate lawyer. They have a 13 year old daughter.

Yvonne gained most of her 18 years of national and international working experience in the areas of research, health and public administration. In Singapore and prior to WONCA, she was a Project Officer at the Nanyang Technological University, Singapore, managing and coordinating a health care research project.

Her interest in medical administration continued in her role as Administrative Manager of the College of Family Physicians, Singapore, where she enjoyed five fruitful years (1996 – 2001) working well with its leadership and staff, with government departments, especially the Ministry of Health, the National University of Singapore, and other related professional bodies to organise and provide vocational training, continuing medical education, and scientific meetings and conferences to enhance and uplift Family Medicine and practice in Singapore.

It was through the international work portfolio at the Singapore College where she began her involvement with WONCA. Her first experience of WONCA was in 1998 where she was part of the Singapore delegation that attended the World Council Meeting in Killarney, Ireland, followed by the World Conference in Dublin. It was also in Ireland that an announcement for a global search for a new WONCA CEO and accompanying World Secretariat was made.

Yvonne was an integral member of the Singapore College team that successfully bid to host the WONCA World Secretariat in Singapore and she is privileged to have been able to contribute to and ensure a seamless transition by being offered the role of Administrative Manager of WONCA in 2001, which she duly accepted and since fulfilled.

During her 12 years at WONCA, Yvonne was responsible for managing, coordinating and maintaining the WONCA World Secretariat operations, and provided a full spectrum of secretariat functions and services to its CEO, Executive, World Council, Member Organizations, committees and Direct Members. She gained tremendous international exposure in this role, enabling her to work well with internal and external stakeholders, with a diverse array of dedicated clinical and academic leaders in Family Medicine, and with other professionals in related industries and global institutions on multiple priorities and across multi-cultural constituencies to project WONCA's work and image globally and to achieve its mission.

She is privileged to have been able to assist and contribute to the Organization's significant developments, including

• incorporation of its status as a legal entity;

• growth in membership when the World Secretariat moved to Singapore in 2001 from 66 member organisations to 126 member organisations in 2012 resulting in the creation of two new regions, East Mediterranean and Iberoamericana-CIMF, to join the existing five regions of Africa, Asia Pacific, Europe, North America and South Asia;

• promotion of new category of Academic Membership for Departments of Family Medicine/ General Practice in universities globally;

• promotion of closer collaborations between WONCA and the World Health Organization (WHO) as an NGO in official relations;

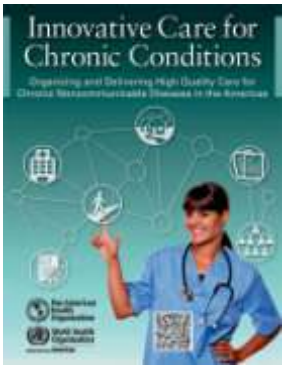
• development and streamlining of its administrative processes to improve the delivery of policy and operational aspects of a growing international medical organization.

Yvonne completed her tenure with WONCA in October 2012 when the then CEO retired and the Secretariat relocated to Thailand under the leadership of a new CEO.

Since WONCA, Yvonne has been keeping herself busy, enjoying her time travelling with her family to countries in South East Asia, spending time with her parents and siblings in England, catching up with old friends, making new friends, enhancing her cooking skills, widening her repertoire of western and Asian cuisines, and keeping fit through regular morning runs and exercise classes.

RESOURCES ADDED

PAHO/WHO report, Innovative care for chronic conditions:



A new report from the Pan American Health Organization/World Health Organization (PAHO/WHO) advances a new model for integrated care of noncommunicable diseases such as heart disease, diabetes, cancer and chronic obstructive pulmonary disease, among others.

Noncommunicable diseases (NCDs) are a growing problem in the Americas, where they cause nearly 4 million deaths each year. Research shows that globally, the vast majority of those affected by NCDs do not receive adequate care. Only about half of people suffering from NCDs are diagnosed, only half of them receive medical care, and only 1 in 10 is treated successfully.

The new PAHO/WHO report, *Innovative care for chronic conditions: Organizing and delivering high quality care for chronic noncommunicable diseases in the Americas,* proposes an integrated Chronic Care Model for addressing NCDs in the context of primary health care. The report also provides practical guidance for health care program managers, policymakers, and those involved in planning and delivery of services for patients and people with NCD risk factors.

The publication discusses key implications of integrated management of NCDs at the policy level, including financial and legislative aspects of on health care and human resources development. It lists examples of effective intervention for each component of the Chronic Care Model and highlights country-based examples of good practices in NCD care.

The report argues that it is critical to integrate primary health care–based chronic care into existing services and programs and to consider chronic diseases not in isolation, but rather as one part of the health status of individuals, who may be susceptible to many other health risks.

Improving the health of chronic disease patients requires a change from essentially reactive health-care systems, primarily focused on treating people are already sick, to proactive systems that are focused on keeping people as healthy as possible, the report says.

Care should be integrated across time, place, and conditions, and members of health-care team should collaborate with one another as well as with patients and their families to develop treatment goals, plans, and implementation strategies that are centered on patient needs, values, and preferences.

The report makes 10 recommendations for organizing and delivering high-quality care for NCDs in the Americas:

1. Implement the Chronic Care Model in its entirety.
2. Ensure a patient-centered approach.
3. Create (or review existing) multisectoral policies for NCD management including universal access to care, aligning payment systems to support best practice.
4. Create (or improve existing) clinical information system including monitoring, evaluation and quality improvement strategies as integral parts of the health system.
5. Introduce systematic patient self-management support.
6. Orient care toward preventive and population care, reinforced by health promotion strategies and community participation.
7. Change (or maintain) health system structures to better support NCD management and control.
8. Create primary health care–led networks of care supporting continuity of care.
9. Reorient health services creating a chronic care culture including evidence-based proactive care and quality improvement strategies.
10. Reorganize health workers into multidisciplinary teams, ensuring continuous training in NCD management.

The report concludes that there is no single formula for developing efficient health systems. However, these 10 recommendations are useful for any health system that seeks to improve integrated care for chronic noncommunicable diseases.

Download document

Health 2020: A European policy framework and strategy

Health 2020 is a policy framework aimed at providing European politicians and policy-makers key strategic advice to support action for improving health, well-being and health equity, in a way that is sensitive to each country's situation, political and organisational circumstances.

The report puts emphasis on political commitment, as well as professional expertise and the engagement of civil society.

It identifies four priority areas which include

(1) Investing in health through a life-course approach and empowering people

(2) Tackling Europe's major health challenges: non-communicable and communicable diseases

(3) Strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and

(4) Creating resilient communities and supportive environments. Within the third priority it highlights:

"*Health 2020* remains committed to a primary health care approach as a cornerstone of health systems in the 21st century. Primary health care can respond to today's needs by fostering an enabling environment for partnerships to thrive, and encouraging people to participate in new ways in their treatment and take better care of their own health, making full use of 21st-century tools and innovations such as communications technology – digital records, telemedicine and e-health – and social media can contribute to better and more cost-effective care. Recognizing patients as a resource and as partners and being accountable for patient outcome are important principles"

Health 2020: a European policy framework supporting action across government and society for health and well-being

2013, 180 pages

ISBN 978 92 890 0279 0

Available in English, Français, Deutsch, Русский

PEARLS

396 Psychosocial interventions reduce antipsychotic medications in residential care homes

397 Face-to-face interventions not shown to impact on immunisation status

398 Many pharmacological interventions effective for smoking cessation

399 Multimedia educational interventions about prescribed and over-the-counter medications effective for consumers

400 Insufficient evidence for effectiveness of interventions for complex regional pain syndrome

401 Limited evidence for benefits of non-steroidal anti-inflammatory drugs for tennis elbow

ESPAÑOL

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

Del Presidente - octubre 2013

Pensar globalmente, actuar localmente: los médicos de familia y los Objetivos de Desarrollo del Milenio

En septiembre asistí a la Asamblea General de las Naciones Unidas en Nueva York, en representación de WONCA, una cumbre convocada para examinar los progresos en el cumplimiento de los Objetivos de Desarrollo del Milenio (ODM) y para discutir lo que pasará más allá del final de 2015, cuando los ODM actuales concluyan.

Sin duda, conoces los ODM. Son ocho objetivos aspiracionales, acordados por todos los países del mundo en el año 2000, cuyo objetivo es reducir a la mitad la pobreza extrema para el año 2015, proporcionar educación primaria a todos los niños, autonomía a las mujeres, reducir la mortalidad infantil y materna, combatir el VIH, la tuberculosis y la malaria, y garantizar la sostenibilidad de nuestro medio ambiente.

Imagen: Objetivos de Desarrollo del Milenio (Fuente: Naciones Unidas)

Los ODM han galvanizado esfuerzos sin precedentes en todo el mundo para satisfacer las necesidades de las personas más pobres del mundo. Y el progreso ha sido impresionante, con índices de pobreza extrema reducidos a la mitad antes de lo previsto y reducciones significativas en la mortalidad infantil y materna, en las tasas de infección por el VIH en muchos países, y millones de vidas salvadas a través de las reducciones en las muertes prevenibles. Algunas de las colaboraciones coordinadas, creadas para alcanzar estos logros, han sido maravillosas.

Ejemplo de programa global de éxito es la iniciativa de las Naciones Unidas “Cada mujer, cada niño”, que ha sido adoptada por los gobiernos de muchos países e incluye asegurar el acceso de las mujeres y los niños a los servicios de salud de calidad y a trabajadores de salud cualificados, así como el Fondo Mundial de Lucha contra el SIDA, la Tuberculosis y la Malaria, que ha llevado a una disminución de nuevas infecciones de VIH en muchos de los países más afectados por la epidemia.

Entre los asistentes a la cumbre de los ODM de las Naciones Unidas estuvieron presentes el Secretario General de las Naciones Unidas, el Director General de la Organización Mundial de la Salud, el Presidente del Banco Mundial, los presidentes y primeros ministros de varios países, así como representantes de los filántropos y de organizaciones no gubernamentales mundiales, como Oxfam, la Fundación Bill y Melinda Gates, World Vision y WONCA.

Imagen: Cumbre del Milenio, los Objetivos de Desarrollo, Naciones Unidas, Nueva York, 23 de septiembre de 2013.

En la cumbre se debatieron las acciones necesarias para reducir aún más la pobreza global, mejorar la salud en todo el mundo y lograr la sostenibilidad del medio ambiente, y se formularon recomendaciones para que sean examinadas por los líderes de las naciones del mundo.

Entre los asuntos clave que me llevé de la cumbre estaba el conocer cómo se ha producido el éxito cuando ha habido una asunción nacional y local para dar empuje a los ODM, y la importancia de permitir la adaptación local de los ODM al afrontar las condiciones locales. Y no fue una sorpresa que se recordara que los países en desarrollo quieren la capacidad, no la caridad, y que la construcción de la autonomía es fundamental, algo que es una función clave de WONCA con nuestro apoyo a través de nuestras organizaciones miembro a la educación y la formación de miembros de la familia de trabajadores médicos en todas las naciones.

Las declaraciones y los compromisos de alto nivel son una parte de la solución, pero no tienen sentido sin una acción eficaz en el país. Parte del desafío de los ODM ha estado en su, a veces, irregular implementación. A menudo, las iniciativas de apoyo a los ODM en el país no han podido colaborar con el personal de atención primaria existente y la creación de programas paralelos pudiera disminuir, en lugar de fortalecer, la prestación de atención primaria.

Los ODM también han sido objeto de algunas críticas por sus carencias. No hacen frente a la necesidad de fortalecer la base de la atención primaria del sistema de salud de cada país, no abordan las enfermedades crónicas o la salud mental, los determinantes sociales de salud, o el garantizar el acceso universal a servicios de salud para todas las personas, tanto en las zonas rurales como en las zonas urbanas. Esto es parte del desafío si miramos más allá de 2015. ¿Cuál debería ser el centro de la siguiente serie de retos globales?

A medida que el mundo debate lo que sucederá después, con el clamor de miles de grupos de interés e industrias con intereses propios, WONCA debe garantizar la voz clara de la medicina familiar en beneficio de nuestros pacientes y comunidades para que siga escuchándose durante estos debates. Tenemos que tener claro nuestro papel de médicos de familia en el trabajo con los pacientes y las comunidades para aumentar su esperanza de vida y lograr resultados equitativos. Y tenemos que apoyar el enfoque de los determinantes sociales de la salud y cómo podemos asegurar que las poblaciones marginadas, los grupos de personas en nuestras comunidades con mayor riesgo **de problemas de salud, no estén excluidos de la atención sanitaria.**

Un aspecto específico de la Asamblea General de las Naciones Unidas de este año versó sobre las personas con discapacidad y cómo están siendo excluidas de una serie de iniciativas puestas en marcha para cumplir con los Objetivos de Desarrollo del Milenio.

Las personas con discapacidad representan aproximadamente el 15% de la población mundial, o mil millones de personas. Al menos el 80% de las personas con discapacidad vive en países en desarrollo y tienen un mayor riesgo de vivir en la pobreza absoluta debido a su exclusión del acceso equitativo a recursos como la educación, el empleo, la atención sanitaria y los sistemas de apoyo social y legal. Pensad acerca de los desafíos que debe enfrentar una persona que es ciega o sorda o incapaz de caminar en algunas de las naciones más pobres del mundo.

Con la adopción por las Naciones Unidas de la Convención sobre los Derechos de las Personas con Discapacidad en 2006, se han logrado algunos avances en la mejora de la situación de muchas de estas personas. Sin embargo, a pesar de estos logros, la necesidad de un enfoque específico sobre la discapacidad sigue siendo en gran medida invisible en los procesos de desarrollo más convencionales, incluidos los ODM. Se instó a las naciones del mundo que asistieron a la Asamblea General de las Naciones Unidas a asegurar que se hagan mayores esfuerzos.

Como médicos de familia, proporcionamos atención y abogamos por todos nuestros pacientes, y especialmente por aquellos que están más marginados o desfavorecidos en nuestras comunidades. Tenemos la responsabilidad de asegurar que nuestros servicios sean accesibles y disponibles para todas las personas de nuestras comunidades, incluyendo aquellos con discapacidades.

Después de la Cumbre de las Naciones Unidas fui a San Diego para asistir al Congreso Anual de Delegados de la Academia Americana de Médicos de Familia (AAFP).

La AAFP es la mayor organización miembro de WONCA, con una masa social de más de 100.000 médicos de familia. El Congreso es la reunión anual de la AAFP, donde se debaten las políticas, se planifica la promoción y se confirma el liderazgo para el próximo año.

Esta es una democracia en acción, con un fuerte debate acerca de los problemas clave que afectan a la prestación de atención

primaria para la población de los Estados Unidos de América. Muchos de los problemas de salud pública importantes en la actualidad se debaten incluyendo el papel de las residencias médicas centradas en el paciente. Las noticias más importantes en los medios de EE.UU. esa semana fueron la Ley de Asistencia Asequible, llamada "Obamacare" por algunos, y los intentos del presidente de EE.UU. para garantizar el seguro de salud asequible, y así, que el acceso a la atención de la salud esté a disposición de todas las personas en los EE.UU.

Asistí a las presentaciones de los miembros de la AAFP que buscaban posiciones de liderazgo como presidente electo y como miembros de la junta. Me quedé impresionado por el compromiso, la elocuencia y la pasión de los miembros de nuestra disciplina profesional que se propusieron para ser valorados como líderes.

Más tarde, en aquella semana, el Presidente de la AAFP recién elegido, el Dr. Reid Blackwelder, de Tennessee, se dirigió a la asamblea anual de la AAFP. Reid recordó a los colegas que, "a pesar de los desafíos, los médicos de familia están a la vanguardia en la transformación del sistema de atención de salud de EE.UU". Habló de cómo, en medio de la incertidumbre que rodea actualmente el negocio de la medicina en los EE.UU, los médicos de familia tienen la oportunidad de efectuar un cambio positivo, habló de que la gente quiere atención centrada en el paciente y de cómo las personas están optando por la medicina de familia, porque los médicos de familia tratan a la persona además de la enfermedad. Reid dijo: "La medicina de familia trata sobre conectar. Se trata de las relaciones y de esa capacidad de conectar en ese momento, que es lo que nos define como médicos de familia. Nadie lo hace tan bien como nosotros. Nuestro papel es único y es fundamental. Estamos reconvirtiendo el sistema en uno que trata realmente acerca de la salud y el cuidado".

Escuchar a Reid me ha reforzado el papel que cada uno de nosotros desempeña como médico de familia, con el trabajo en nuestro equipo de atención a la salud de nuestra comunidad local cada día, hacia el logro de las mejoras solicitadas por los líderes de nuestro mundo a través de iniciativas como los Objetivos de Desarrollo del Milenio.

Michael Kidd

Presidente

Organización Mundial de Médicos de Familia (WONCA)

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

WONCA Fragmentos de política con Amanda Howe – octubre 2013- Cobertura Universal de Salud

La Profesora Amanda Howe, nuestra nueva presidenta electa, afirmó en su discurso en el Consejo WONCA que iba a "ayudar con mensajes políticos. En WONCA… sabemos lo que queremos decir. Me gustaría trabajar en cómo lo decimos, conseguir documentos de información clara, precisa, para que puedas adaptarla al uso en tu entorno." Así que ahora invitamos a Amanda a afrontar ese reto. Aquí está la segunda propuesta de Amanda, que va a ir ofreciéndolas de forma regular.

También os invitamos a que nos enviéis material similar: un elemento importante de la política de vuestra propia organización o un marco que se refiera a la evolución de la medicina de familia y que pueda ser útil a los demás. Por favor envía un resumen, un enlace, y hazlo breve (no es Twitter, vamos a permitir que un máximo de 500 palabras!). Cada pieza se revisará para comprobar que es apropiada para aparecer en la parte pública de la página web (también se puede acceder al foro de los miembros para discutir las reacciones y los problemas relacionados).

En diciembre de 2012, tras la publicación del Informe sobre la Salud Mundial de 2010 por la Organización Mundial de la Salud (OMS) sobre "Financiación de los Sistemas de Salud: El camino hacia la cobertura universal", se aprobó una resolución de la ONU para alentar a los gobiernos a avanzar hacia el acceso universal a servicios asequibles y servicios de

atención de salud de calidad. Más recientemente, fue publicado el Informe Mundial de la Salud 2013 sobre la "Investigación para la Cobertura Universal de Salud".

¿Qué es la cobertura universal de salud?

En esencia, la Cobertura Universal de Salud (CUS) tiene como objetivo asegurar que todas las personas tengan acceso a la necesaria promoción, prevención, tratamiento curativo, paliativo y de los servicios de salud de rehabilitación de calidad suficientes para que sean efectivos, sin que se sufran dificultades financieras como resultado. La OMS destaca que:

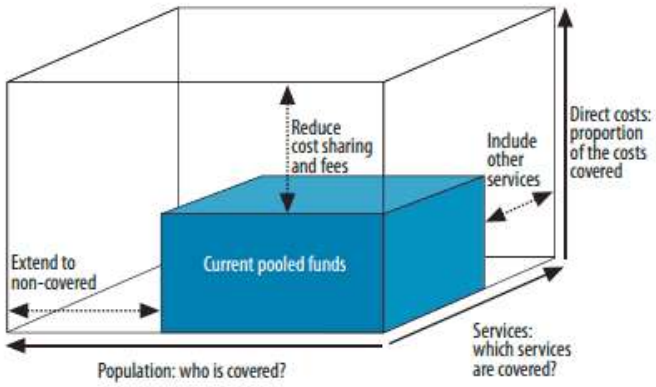
"Para que una comunidad o un país pueda lograr la Cobertura Universal de Salud, varios factores deben estar en su lugar, incluyendo:

- *Un sistema de salud fuerte, eficiente, bien dirigido, que responda a las necesidades prioritarias de salud, a través de la atención integral y centrada en las personas (incluidos los servicios para el VIH, la tuberculosis, el paludismo, las enfermedades no transmisibles, la salud materna e infantil), teniendo en cuenta que es necesario lo siguiente:*
  - *o informar y alentar a las personas a mantenerse saludables y prevenir enfermedades;*
  - *o la detección temprana de los problemas de salud;*
  - *o tener la capacidad de tratar la enfermedad;*
  - *o ayudar a los pacientes con la rehabilitación.*
- *Asequibilidad - un sistema de financiación de los servicios de salud para que las personas no sufran dificultades financieras al utilizarlos. Esto se puede lograr de distintas maneras.*
- *El acceso a los medicamentos esenciales y tecnologías para diagnosticar y tratar problemas médicos.*
- *Una capacidad suficiente de trabajadores del ámbito de la salud motivados y capacitados para prestar los servicios y satisfacer las necesidades de los pacientes sobre la base de la mejor evidencia disponible.*

También requiere el reconocimiento del papel fundamental desempeñado por todos los sectores en el aseguramiento de la salud humana, incluyendo el transporte, la educación y la planificación urbana."

Con el fin de lograr todo esto, deben conseguirse fondos y juntarlos (por ejemplo, a través de impuestos o un seguro social de salud), y luego usarlos para pagar servicios como la atención primaria, que cumplan con

Fig. 1. **Three dimensions to consider when moving towards universal coverage**



los requisitos antes mencionados. En la prestación de servicios de salud deben ser consideradas tres dimensiones clave: (1) ¿Quién está cubierto? (2) ¿Qué servicios se ofrecen? (3) ¿Qué proporción de los costes están cubiertos? (véase la Fig. 1).

Figura 1: Tres dimensiones que deben ser consideradas cuando se va hacia la cobertura universal. Fuente: "Informe sobre la salud mundial 2010. Sistemas de financiación de la salud: el camino hacia la cobertura universal". Ginebra, Organización Mundial de la Salud, 2010.

El Informe Mundial de la Salud 2013 aborda cuestiones importantes sobre la prevención y el tratamiento: cómo los servicios pueden ser de pago, su impacto en la salud de las poblaciones y los individuos y la forma de mejorar la salud a través de intervenciones, tanto dentro como fuera del sector salud. Se utilizan estudios de casos de todo el mundo para ilustrar todo esto y se pone de relieve la importancia de comunicar la base de evidencia y provocar cambios en agentes, autoridades, líderes de opinión y líderes de innovación, todos los cuales desempeñan diferentes papeles en la formulación de políticas y su ejecución en primera línea.

¿Por qué es esto importante para los médicos de familia?

La OMS afirma que "un sistema de atención primaria fuerte es fundamental para un sistema de salud eficaz", así que tenemos que ser capaces de comunicar los datos sobre el valor de la atención primaria y usar esto para apoyar y seguir desarrollando la atención primaria en todos los sistemas de salud, de forma que logremos de manera equitativa y eficiente la CUS. Además, la investigación de atención primaria en las comunidades debe llevarse a cabo. Esto es algo que el Grupo de Trabajo sobre Investigación de WONCA ya está apoyando y WONCA anima a que envíes tus estudios de casos de situación para ilustrar los éxitos y los obstáculos en el fortalecimiento de la atención primaria y la medicina familiar.

Ahí tienes el argumento: ¿se aplica en tu entorno?

Envía tu estudio de caso a la Prof. Amanda Howe, presidenta electa de WONCA a la dirección: amanda.howe@WONCA.net

O para dar tus puntos de vista, entra o únete al foro de WONCA:

Entra en el foro WONCA

Regístrate en el foro

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

WONCA Fragmentos de política con Amanda Howe – septiembre 2013

Aquí está la primera propuesta de Amanda.

La política

El Médico de Familia y General 2022 - una visión para la Medicina General en el futuro NHS (Londres; RCGP: 20131).

El problema

- La medicina de familia tiene que hacer más, porque la gente está viviendo más tiempo, con más problemas de salud, más tratamiento y más opciones de cuidado de salud que tenemos que gestionar de forma eficaz.
- El dinero y los recursos son inferiores a las necesidades y, a menudo, los más pobres reciben el peor trato.

Para hacer la medicina de familia deseable para el gobierno y los pacientes, en 2022, tenemos que ofrecer:

- Una medicina familiar y una fuerza de trabajo en Atención Primaria profesional, amplia, hábil, resistente y adaptable.
- Una experiencia positiva para los pacientes, los cuidadores y las familias: los pacientes y los cuidadores necesitan sentirse respetados como personas y ser incluidos en las decisiones.
- Un servicio de salud de alta calidad, integral, accesible a todas las comunidades.
- La inversión en locales adecuados situados en la comunidad para la prestación de asistencia, docencia, formación e investigación.
- Un mayor uso de la información y la tecnología para mejorar la salud y el cuidado.

Esto debe resultar en:

- Una coordinación y colaboración de la atención a las personas con menos fragmentación.
- Una reducción de las desigualdades en salud y una mayor autosuficiencia de la Comunidad.
- Una mejora de la comprensión y el manejo de la variabilidad inadecuada en la calidad.
- Más investigación, desarrollo y mejora de la calidad dirigidos por la comunidad.

Para ello tenemos que:

- Observar la expansión de la fuerza de trabajo de la medicina de familia para satisfacer las necesidades de la población y las necesidades de servicio.
- Promover una mayor comprensión del valor de la atención generalista y demostrar su valor para el servicio nacional de salud.
- Desarrollar nuevos servicios generalistas dirigidos por atención primaria que ofrezcan atención personalizada y coste-eficiente.
- Mejorar las habilidades y la flexibilidad de la fuerza de trabajo de los profesionales

generalistas para proporcionar atención compleja.

- Apoyar el desarrollo de la organización en las prácticas basadas en la comunidad, los equipos y las redes.
- Aumentar la actividad académica basada en la comunidad para mejorar la eficacia, la investigación y la calidad.

Nuestras expectativas sobre los demás:

Para lograr estos objetivos será necesario un desplazamiento de recursos dentro del servicio de salud y que la medicina de familia se valore como un recurso central de cualquier sistema rentable de atención médica.

En concreto, se necesita una inversión para permitir la expansión de la capacidad de la medicina de familia y su fuerza laboral dentro de la comunidad; mejorar la formación generalista de los médicos y otros profesionales de la salud que esperan trabajar en la comunidad, y la inversión en la infraestructura de servicios e instalaciones, tecnología y recursos para prestar esa atención.

Referencias

1. Esta es una adaptación del *2022 Informe de la visión* - Con agradecimiento, a Clare Gerada, Nigel Mathers et al.

Puedes leer el documento completo en Inglés en las páginas de política del Royal College of GPs.

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

Salud Mental y Atención Primaria

Discurso de apertura de la Conferencia Temática de la Asociación Mundial de Psiquiatría sobre "*Salud Mental y Enfermedad Mental: Centrándonos en Eurasia*".

Gracias por la oportunidad de participar aquí en Ereván en esta conferencia temática. Y mis felicitaciones a la *Asociación Mundial de Psiquiatría (WPA)* por su gran trabajo en el fortalecimiento de la atención de salud mental para las personas de todo el mundo. La *Organización Mundial de Médicos de Familia (WONCA)* y la WPA tienen una larga historia de trabajo en común para la promoción y apoyo del acceso universal a la atención de la salud mental, y tengo la intención de continuar nuestra colaboración durante mis tres años como presidente de WONCA.

Tenemos la capacidad de tratar con éxito los trastornos de salud mental, sin embargo, en muchas partes del mundo, sólo una pequeña minoría de personas con enfermedades mentales tiene acceso a un tratamiento eficaz.

En esta presentación me centraré en la integración de la salud mental en la atención primaria y voy a argumentar que la integración de la salud mental en atención primaria es la forma más viable para cerrar la brecha en el tratamiento y asegurarse de que las personas tengan acceso a la atención de salud mental que necesitan. Voy a aprovechar la labor que la *Organización Mundial de la Salud (OMS)* y la *Organización Mundial de Médicos de Familia (WONCA)* han realizado en todo el mundo durante los últimos años y a seguir con algunos de los problemas y desafíos clave para Eurasia.

Soy médico de familia. En Australia, se me llama médico general, que, como en el Reino Unido, indica que he realizado formación académica de postgrado y obtenido títulos académicos en la especialidad reconocida de la práctica generalista.

Las palabras que usamos para describirnos a nosotros mismos como médicos que trabajan en la comunidad pueden ser confusas: tanto si nos llamamos a nosotros mismos médico general, médico de cabecera, médico de familia o médico de atención primaria. En esta charla voy a utilizar el término médico de familia. El lenguaje que usamos para describir lo que somos, no importa. Lo que importa es el trabajo en común que hacemos, la visión que compartimos, los resultados que obtenemos.

Estoy compartiendo con ustedes algunas imágenes de médicos de familia que me han permitido visitar con ellos sus consultas en diferentes partes del mundo. Ayer me reuní con la **Dra. Armine Tadevosyan**, que trabaja en la aldea rural de Agarak, en el norte de Armenia. Esta es la Dra. Armine en su clínica con su pequeño equipo de enfermeras y matronas, que en conjunto proporcionan servicios de atención primaria en medicina de familia a más de 3.500 niños y adultos en su población y en la región circundante.

Me gustaría empezar contando algunas cosas sobre WONCA. WONCA se fundó hace 40

años, con un pequeño grupo de colegios y academias de medicina de familia, que se unieron para crear un organismo mundial que comparte un ideal de formación y educación en medicina familiar y altos estándares de atención clínica en todas las naciones del mundo.

Ahora, WONCA y sus organizaciones miembro representan a más de 500.000 médicos de familia en más de 130 países y territorios de todo el mundo. Cada año, los 500.000 médicos de familia representados por WONCA tenemos más de dos mil millones de consultas con nuestros pacientes. Dos mil millones. Ese es el alcance de nuestro trabajo actual y nuestra influencia.

Pero necesitamos hacer más. Necesitamos trabajar para que cada médico de familia, cada médico general, todos los médicos de atención primaria se unan a nosotros en nuestro compromiso de ofrecer una atención primaria de alta calidad a nuestros pacientes y comunidades. Necesitamos ampliar nuestro compromiso con la educación y la formación de los médicos de familia, la atención de calidad y la investigación en atención primaria, a las 80 naciones del mundo donde WONCA aún no tiene presencia. Y tenemos que asegurarnos de que la atención que ofrecemos incluye la salud mental, igual que tratamos los problemas de salud física.

Así que vamos a hablar de la salud mental y la atención primaria. Hay varias maneras en las que sé, como un médico de familia, si he tenido un buen día de trabajo en mi consulta. He aquí una de ellas:

"*No he tenido un buen día como médico de familia, si al menos una persona no ha llorado en mi consulta*."

Esto puede sonar mezquino, pero hay que entender el contexto.

En mi práctica, veo a muchas personas con enfermedades crónicas, en especial con VIH / SIDA. Sé que muchos de mis pacientes están en riesgo de depresión como comorbilidad. También sé que, como médico de familia, tengo que estar alerta para tratar de detectar a los pacientes con depresión no diagnosticada. Sé que muchas personas que se suicidan en mi país se han presentado en un centro de salud en busca de ayuda en los días antes de suicidarse. Por lo tanto, la detección de la depresión no diagnosticada entre mis pacientes es una emergencia médica.

También sé que muchos de mis pacientes no vienen a decir "*estoy deprimido*". Pueden venir con síntomas físicos como dolor de cabeza o dolor de espalda y dolor de estómago, o el deseo de hablar de sus problemas en casa o en el trabajo o con su niños, o se quejan de dificultad para dormir, o preocupación excesiva, o pérdida de peso, o falta de concentración, o simplemente, no se sienten bien. Es solo cuando recojo las señales y hago las preguntas correctas, cuando las lágrimas comienzan a fluir. Y puedo trabajar para hacer un diagnóstico. Y trabajar para ayudar a mis pacientes en el camino hacia el manejo de su depresión.

Los médicos de familia, como los psiquiatras, notamos la relación que hay entre la salud física y el bienestar de nuestros pacientes así como la de su salud mental y su bienestar.

La belleza de la medicina de familia, como en la psiquiatría, es que hemos puesto a nuestro paciente en el centro de la atención y tenemos un enfoque en la persona, en lugar de en las enfermedades individuales.

En palabras del académico canadiense de medicina de familia, Ian McWhinney, uno de los gigantes de nuestra profesión, que falleció el año pasado: "*El médico de familia se compromete con la persona más que con un conjunto de conocimientos, grupo de enfermedades, o una técnica especial."* Este es nuestro ideal generalista.

Ian McWhinney también nos aconseja que "*lo ideal es que los médicos de familia compartan el mismo hábitat que sus pacientes*". Esto nos permite entender mejor el contexto social de la vida de nuestros pacientes.

Los problemas de salud mental constituyen una parte sustancial de la carga de enfermedad de los pacientes en la comunidad y son un motivo habitual para el contacto con un médico de familia. De hecho, los problemas de salud mental son parte de las experiencias diarias de los pacientes y sus familias, por lo que es vital que los médicos de familia afronten este tipo de problemas.

Tú y yo sabemos que la gente es más que una colección de partes desconectadas. La mujer con antecedentes de infarto de miocardio puede estar deprimida porque ya no puede cuidar a su anciana madre y la depresión puede ponerla en riesgo de otro ataque al corazón. El hombre que utiliza el alcohol para controlar sus síntomas de ansiedad crónica y desarrolla pancreatitis puede entonces preocuparse obsesivamente por estar condenado a una vida de dolor crónico, lo que agrava aún más su ansiedad.

Somos conscientes de las consecuencias de la mala salud física en la salud mental de muchos de nuestros pacientes. La depresión, en particular, es una comorbilidad común para muchas personas con enfermedades crónicas como el cáncer, las enfermedades del corazón, la diabetes, el VIH y la tuberculosis. También somos conscientes del impacto que la mala salud mental puede tener en el bienestar físico de nuestros pacientes. Esto afecta especialmente a nuestros pacientes con discapacidad intelectual y problemas de salud mental crónicos.

Probablemente fue siempre así, pero vivimos en tiempos preocupantes. En una época de cambios rápidos, de malestar social y conflictos en muchas partes del mundo. La medicina de familia ofrece cierto consuelo a nuestros pacientes, a nuestras comunidades y a nuestras naciones.

Podemos proporcionar consuelo porque estamos acostumbrados a tratar con la complejidad y la incertidumbre.

Ofrecemos consuelo en un momento en que la incertidumbre es cada vez mayor para los pacientes que se enfrentan a un aluvión de elecciones y opciones y una gran cantidad de información errónea, gracias a Internet.

Ofrecemos consuelo a nuestros países, que se enfrentan a la incertidumbre sobre su capacidad de proporcionar servicios de salud a todas las personas y saben que deben mantener a la gente fuera de los caros hospitales, pero no están seguros de cómo hacerlo.

En estos momentos de incertidumbre sobre el futuro de la asistencia sanitaria, el papel del médico de familia sigue creciendo. Y esta necesidad de consuelo mueve a nuestra organización global a un papel cada vez más estratégico con la Organización Mundial de la Salud y otras organizaciones mundiales de salud, como la Asociación Mundial de Psiquiatría.

La integración de la salud mental en la atención primaria es una parte esencial de este trabajo, y juntas, WONCA y la Organización Mundial de la Salud han estado trabajando para fortalecer la prestación de asistencia sanitaria mental a través de la atención primaria. Esto nos condujo a nuestra publicación conjunta de 2008 sobre la integración de la Salud Mental en Atención Primaria, que algunos de ustedes también contribuyeron a hacer posible. Con esta publicación, la OMS ha hecho una declaración de gran alcance en el sentido de que la salud mental es un componente básico de la medicina familiar y la atención primaria.

Las habilidades y competencias específicas no solo son necesarias para evaluar la eficacia, diagnóstico, tratamiento y apoyo, y para dar servicios de referencia a las personas con trastornos mentales, sino que es esencial que los trabajadores de atención primaria estén adecuadamente preparados y apoyados en su trabajo con la salud mental.

Todos los estudiantes de medicina necesitan educación acerca de la salud mental, todos los alumnos de medicina de familia necesitan capacitación en salud mental, todos los médicos de familia cualificados deben continuar su desarrollo profesional en la salud mental. El acceso a las terapias apropiadas, a los medicamentos y servicios de referencia son esenciales. La investigación debe llevarse a cabo en las tasas de problemas de salud mental de las comunidades y en el diagnóstico y tratamiento de problemas de salud mental en la atención primaria.

Ha sido excelente este mes poder ver el nuevo Informe Mundial de la Salud de la OMS, que se centra en la investigación necesaria para la cobertura universal de salud. Cuenta con importantes mensajes para la medicina de familia y la psiquiatría.

La **Dra. Margaret Chan**, Directora General de la Organización Mundial de la Salud, ha dicho que "*la salud mental es esencial para lograr una atención primaria centrada en la persona y su salud integral*".

La Dra. Chan tiene razón. Debemos crear conciencia y cambiar la percepción pública de la salud mental. Tenemos que sensibilizar a la opinión pública sobre las cuestiones de salud mental y voy a compartir con ustedes algunas formas de hacerlo.

Soy miembro de la junta de una organización en Australia llamada *Beyondblue*, financiada por el Gobierno de Australia, y que se ha comprometido a sensibilizar a los profesionales de la salud y al público en general acerca de la salud mental, la lucha contra el estigma y la discriminación, así como en apoyar a la gente de nuestro país para buscar la ayuda que necesitan. Este es un ejemplo de una de nuestras campañas de educación pública: este anuncio se emite en la televisión nacional y en los cines.

En cada país, hay que destacar el papel de los líderes clínicos entre los médicos de atención primaria y especializada, que abogarán por la necesidad de gestionar tanto las necesidades

de salud física como mental de cada uno de nuestros pacientes.

Tenemos que reforzar la necesidad de un gobierno activo y del apoyo empresarial, incluida la reforma de la financiación, para garantizar que la atención de los problemas de salud mental se integra con la atención de problemas de salud física de las personas que asisten a los centros de atención médica de primaria y especializada.

Durante demasiado tiempo, los trastornos de salud mental han sido pasados por alto, en gran medida, como parte del fortalecimiento de la atención primaria. La salud mental es fundamental en los valores y principios de la Declaración de Alma Ata: la atención integral no se logrará hasta que la salud mental se integre plenamente en la atención primaria.

Los malentendidos comunes acerca de la naturaleza de los trastornos de salud mental y su tratamiento han contribuido a su abandono. Por ejemplo, muchas personas piensan que los trastornos mentales afectan sólo a un pequeño subgrupo de la población, pero de hecho, un gran número de personas que asisten a las consultas de atención primaria pueden tener un trastorno mental diagnosticable. Otros piensan que los trastornos de salud mental no se pueden tratar, pero sabemos que existen tratamientos efectivos y que se pueden ofrecer con éxito a través de la atención primaria. Algunos creen que las personas con trastornos de salud mental son violentas o inestables, y por lo tanto deben ser encerradas, cuando todos sabemos que la gran mayoría de los individuos afectados no son violentos y son capaces de vivir de manera productiva en sus comunidades.

La gente tiene que ser capaz de acceder a los servicios de salud mental más cercanos a sus hogares, cosa que permite mantener unidas a sus familias y seguir con sus actividades diarias. Además, se evitan los costes indirectos asociados con la búsqueda de atención especializada en lugares distantes.

Los servicios de salud mental prestados en la atención primaria tienen el potencial de reducir el estigma y la discriminación y eliminan el riesgo de violaciones de derechos humanos que a veces ocurren en los hospitales e instituciones de algunas partes del mundo. Y, como muestra nuestro informe, la integración de servicios de salud mental en la atención primaria genera buenos resultados de salud a un coste razonable. No obstante, los sistemas de atención primaria deben fortalecerse antes de poder esperar que la integración de la salud mental florezca razonablemente.

Nuestra humanidad nos obliga a respetar la aspiración universal de las personas de tener una vida mejor y a apoyar su objetivo de un estado de completo bienestar físico, mental y social, y no solamente la ausencia de afecciones o enfermedades. Con la atención primaria integrada, la carga global sustancial de los trastornos mentales no tratados puede reducirse, mejorando así potencialmente la calidad de vida de cientos de millones de personas y sus familias. Todo esto es parte de la cobertura de salud universal.

El Informe Mundial de la Salud de 2013 examina la base de investigación para la cobertura de salud universal. La cobertura de salud universal ha sido parte de la Carta de las Naciones Unidas desde 1948. Y no significa satisfacer las necesidades de 80 % de la población: significa garantizar que la atención médica está disponible para todos.

A raíz de Alma-Ata tuvimos "*Salud para todos en el año 2000*". Es evidente que esto no se logró y, como consecuencia, en 2000, las Naciones Unidas acordaron los Objetivos de Desarrollo del Milenio (los ODM), 8 objetivos con hitos que deben alcanzarse en 2015, 8 metas "*dirigidas a las personas en situación de pobreza extrema y privaciones múltiples*".

Lamentablemente el progreso en los ODM relacionados con la salud, los números 4, 5 y 6, no es tan importante como nos gustaría observar, aunque hemos visto millones de vidas salvadas a través del descenso de muertes prevenibles.

Los ODM también han sido objeto de algunas críticas por lo que se está perdiendo. No hacer frente a la necesidad de fortalecer la atención primaria o a la salud mental y las enfermedades crónicas, o no abordar los determinantes sociales de salud, o no garantizar la cobertura universal de las personas, tanto en zonas rurales como urbanas.

Las Naciones Unidas están iniciando los debates acerca de su enfoque después de 2015, la era posterior a los ODM. Por encima del clamor de miles de grupos de interés y sectores con intereses propios, durante estos debates se oye que nuestras organizaciones mundiales deben unirse para garantizar la atención a la salud mental, en beneficio de nuestros pacientes y comunidades, y esto se incluye en lo que sea que vaya a salir de la ONU en 2015.

Me gustaría centrarme en algunas de las áreas específicas que requieren atención:

Niños y salud mental de los adolescentes. Muchos niños sufren de un trastorno de salud mental. Trastornos vistos regularmente en la atención primaria incluyen el trastorno de atención con hiperactividad (TDAH), el trastorno de conducta, el delirio, el trastorno de ansiedad generalizada, el trastorno depresivo, el trastorno de estrés postraumático (TEPT) y el trastorno de ansiedad por separación. La depresión en adolescentes a menudo continúa sin disminuir en la edad adulta, y supone un riesgo de suicidio entre los jóvenes.

La salud mental en las personas mayores. La población mundial está envejeciendo rápidamente. Por supuesto, las personas mayores tienen más probabilidades de tener enfermedades crónicas y necesidad de los servicios de salud. Su salud mental se ve influida por el acceso a los servicios de salud, la educación, el empleo, la vivienda, los servicios sociales y la justicia, y por la libertad contra el abuso y la discriminación.

Algunos éxitos en la detección y tratamiento de los trastornos de salud mental. En algunos países, el tratamiento de los trastornos mentales en atención primaria ha ido en constante aumento. Varios factores parecen explicar el aumento, incluidos la educación basada en la comunidad y su defensa, el aumento de la demanda del consumidor, una mejor formación de los trabajadores sanitarios de atención primaria, el desarrollo y aplicación de directrices basadas en la evidencia, y servicios más accesibles. Esta tendencia, aún no es evidente en la mayor parte del mundo, especialmente en los países de bajos y medianos ingresos.

El nuevo problema de mal uso o abuso de los tratamientos de salud mental. En ocasiones, los trabajadores de atención primaria recomiendan tratamientos de salud mental para personas que no los necesitan. Aunque claramente no es tan frecuente como la subdetección y el tratamiento deficiente, el uso excesivo desperdicia recursos escasos y puede ser peligroso para los pacientes. El uso excesivo puede ser el resultado de técnicas de diagnóstico y tratamiento pobres, a menudo relacionados con una educación y formación inadecuadas. Por ejemplo, en algunos países, los trabajadores de la atención primaria de salud cada vez recetan más antidepresivos y ansiolíticos para las personas que están pasando por etapas de infelicidad, pero no cumplen el umbral para un trastorno de salud mental. Los medicamentos psicotrópicos a veces son usados en exceso, en lugar de otras modalidades de tratamiento basadas en la evidencia como la psicoterapia. Y la promoción de la industria farmacéutica puede ser un arma de doble filo: con una mayor conciencia de enfermedades como la depresión, puede haber una tendencia a sobrediagnosticar y sobretratar.

El reto de la adherencia al tratamiento a largo plazo también es importante. La tasa media de adhesión para el uso de medicamentos a largo plazo en atención primaria es un poco más del 50 % en los países de altos ingresos, y se cree que pueda ser aún menor en los países de ingresos bajos y medios. A los pacientes se les culpa cuando no se sigue el tratamiento prescrito, a pesar de la evidencia de que los trabajadores de salud y los sistemas de salud pueden influir en gran medida en la adherencia de los pacientes. En realidad, la adhesión al tratamiento con medicamentos a largo plazo es un desafío multifacético que requiere la consideración y mejora de varios factores, entre ellos, una relación de confianza entre el trabajador de la salud y el paciente, un plan de tratamiento negociado, la educación del paciente sobre las consecuencias de una buena o mala adherencia, el reclutamiento de apoyo familiar y comunitario, la simplificación del régimen de tratamiento, medir la capacidad del paciente para pagar el tratamiento y el manejo de los efectos secundarios de la pauta de tratamiento.

Una pregunta que surge es si los médicos de familia tienen un papel que desempeñar en la gestión de las condiciones de salud mental en los países de bajos y medianos ingresos. Hay quienes dicen que la medicina de familia no tiene un verdadero papel que desempeñar en los países de ingresos bajos y medios. Bueno, hemos volado por los aires esa teoría. La nueva edición de la Guía de WONCA sobre el papel de la medicina familiar en la mejora de los sistemas de salud fue presentada en junio de este año por la Dra. Margaret Chan, e incluye contribuciones de la OMS que muestran la investigación en medicina de familia y el impacto que está teniendo en la mejora de los resultados de salud en muchos países de ingresos medios como Brasil, China, Tailandia y países de la región del Mediterráneo Oriental. Además, hay un capítulo que esbozó la labor extraordinaria que está en marcha a través de África para fortalecer la medicina de familia, especialmente, implicando a las organizaciones miembro de WONCA en

África, que apoyan la evolución de las naciones vecinas.

Lo que estos acontecimientos demuestran es la necesidad de fortalecer a toda la fuerza laboral de profesionales de la salud, incluidos los médicos de familia, enfermeras comunitarias, trabajadores comunitarios de la salud y matronas y el apoyo al trabajo en conjunto para ofrecer una atención adecuada a todas las personas. Las personas de países con bajos ingresos todavía quieren y merecen tener acceso a servicios de salud, incluida la salud mental, el acceso a los médicos asistenciales y el acceso a medicamentos que salvan vidas.

También tenemos que aceptar el concepto de innovación inversa. ¿Qué pueden hacer los sistemas de salud de los países de altos ingresos para aprender de los sistemas de salud de los países de bajos ingresos? Es algo que las personas que pasan tiempo trabajando en otro sistema de salud en un país diferente aprenden muy rápidamente.

La Dra. Margaret Chan ha señalado que la atención primaria no es barata y no debe ser una "*serie B*" de la asistencia sanitaria.

Si vamos a ofrecer una cobertura universal, tenemos que frenar los costes de la atención de la salud, y podemos hacerlo aumentando la inversión en los servicios de salud basados en la comunidad y reduciendo la cantidad gastada en los hospitales. Al mismo tiempo, debe haber un movimiento de financiación de los hospitales hacia la comunidad, en lugar de esperar a una atención más basada en la comunidad para que se entreguen, sin haber aumentado los recursos.

El mismo modelo de atención no va a funcionar para cada comunidad. Es por eso que la medicina de familia y nuestro modelo generalista es tan importante. Nos adaptamos a las necesidades de la comunidad.

El mundo digital también ofrece una gran cantidad de desafíos. En nuestro mundo asíncrono, ¿cómo lograr la continuidad de la atención? Pero también traerá beneficios. Estamos empezando a aprender que las teleconsultas pueden permitirnos visitas domiciliarias a pacientes a distancia, y esto ha sido especialmente exitoso en muchas partes del mundo con la telepsiquiatría, con médicos de familia y psiquiatras consultores que trabajan juntos a grandes distancias para proporcionar un óptimo cuidado del paciente.

Así pues, ¿**cómo integrar la salud mental en la atención primaria**? Bueno, aquí tenéis diez maneras:

1. La planificación y las políticas requieren incorporar la atención primaria a la salud mental. Necesitamos el compromiso formal por parte de nuestros gobiernos de una atención de salud mental integrada. La integración puede ser facilitada no solo por una política de salud mental, sino también por una política general de salud que haga hincapié en los servicios de salud mental en atención primaria.

2. Se requiere promoción para cambiar las actitudes y el comportamiento. El tiempo y el esfuerzo son necesarios para sensibilizar a los líderes políticos, a las autoridades de salud y a los trabajadores de atención primaria acerca de la importancia de la integración de la salud mental.

3. Es necesaria una formación adecuada de los trabajadores de atención primaria. Esto incluye la formación de los estudiantes de medicina y recién licenciados, y también la de los médicos de familia con experiencia. Modelos de atención colaborativos o compartidos, en los cuales las consultas conjuntas y las intervenciones se lleven a cabo entre los trabajadores de atención primaria y los especialistas en salud mental son una forma especialmente prometedora de brindar capacitación y apoyo permanente.

4. Las tareas de atención primaria deben ser limitadas y realizables. Inicialmente, cada sistema de salud tiene que ver la capacidad de su personal de atención primaria y sus funciones se pueden ir ampliando con el tiempo, a medida que los profesionales van adquiriendo habilidades y confianza.

5. Los profesionales de salud mental especializados y las instalaciones deben estar disponibles para apoyar a la atención primaria. La integración de los servicios de salud mental en la atención primaria debe ir acompañada de servicios complementarios, componentes de atención especial secundaria a las que los trabajadores de atención primaria pueden acudir para obtener referencias, apoyo y, en caso necesario, supervisión.

6. Los pacientes deben tener acceso a medicamentos psicotrópicos esenciales en la atención primaria. Para ello es necesario que los países distribuyan directamente medicamentos psicotrópicos a las instalaciones de atención primaria en lugar de a través de los hospitales psiquiátricos. Los países deben revisar y actualizar la legislación

y los reglamentos para que los trabajadores de atención primaria puedan prescribir y dispensar medicamentos psicotrópicos, en particular donde los especialistas y médicos de salud mental son escasos.

7. La integración es un proceso, no un evento. Incluso cuando existe una política, la integración requiere tiempo y por lo general implica una serie de desarrollos, incluyendo la formación y contratación de personal apropiado y una financiación adecuada.

8. El coordinador de servicios de salud mental es crucial. Los problemas inesperados, a veces, pueden poner en peligro los resultados de un programa o incluso su supervivencia. Los coordinadores de salud mental son fundamentales en la dirección de programas en torno a estos retos inesperados, así como en impulsar el proceso de integración.

9. Es necesaria la colaboración con otros sectores del gobierno no dedicados a la salud, con organizaciones no gubernamentales, con la población y la comunidad de trabajadores de salud y voluntarios. Estas organizaciones pueden desempeñar un papel importante en el apoyo a la atención primaria de salud mental. Población y trabajadores comunitarios de la salud pueden ser especialmente valiosos en la identificación, y al referenciar a las personas con trastornos de salud mental a los centros de atención primaria, las organizaciones no gubernamentales de base comunitaria pueden proporcionar un gran apoyo auxiliar a las personas con problemas de salud mental.

10. Se necesitan recursos financieros y humanos. A pesar de que la atención primaria de salud mental es rentable, se necesitan recursos económicos para establecer y mantener un servicio. Los gastos de formación deben ser cubiertos y podrían ser necesarios más trabajadores de salud primaria y comunitaria, así como especialistas en salud mental adicionales para proporcionar apoyo, supervisión y consulta especializada. A medida que conozcamos mejor las necesidades de salud mental, la demanda de servicios se incrementará y no puede ser que se cuente con los servicios ya existentes para hacer frente a la creciente demanda.

Finalmente, unas palabras sobre nuestra propia salud mental, médicos. Una de las principales lecciones de la vida que tenemos que aprender como médicos es encontrar el equilibrio en nuestras vidas: el equilibrio entre el cuidado de nuestros pacientes y el cuidado de nosotros mismos. Si no nos ocupamos de nosotros mismos, no vamos a tener la capacidad ni la resistencia para proporcionar atención continua de alta calidad a nuestros pacientes y a nuestras comunidades.

Tenemos que asegurar que nos mantenemos física y mentalmente tan bien como sea posible. Y tenemos que cuidar de los demás. En palabras de Sir William Osler: "*Un médico que se trata a sí mismo, tiene a un tonto por paciente*".

Cada médico necesita a su propio médico, alguien en quien podemos confiar para nuestro propio cuidado médico y consejo. Si vamos a prevenir nuestros propios problemas de salud física y mental, tenemos que tener nuestro propio médico de confianza. Como médicos, merecemos tener acceso a la misma atención médica de alta calidad que ofrecemos a cada uno de nuestros pacientes. Y nuestras familias también merecen ese nivel de atención. Así que, por favor, y esto se aplica a todo el mundo en esta sala, si no tienes tu propio médico de familia, encuentra uno.

Cuida tu propia salud mental. Una forma de hacer esto es encontrar el significado en nuestro trabajo diario, y al hacerlo, descubrir y redescubrir cada día de tu vida la alegría y el privilegio de ser médico.

Michael Kidd

Presidente de la Organización Mundial de Médicos de Familia (WONCA)

Ereván, 30 de agosto 2013

Esta publicación incluye algún contenido publicado previamente en la publicación conjunta de 2008 de la Organización Mundial de la Salud (OMS) y la Organización Mundial de Médicos de Familia (WONCA) sobre Integración de la Salud Mental en Atención Primaria, así como la publicación de MR. Kidd y P. Coker sobre el rol de los médicos de primaria y especializada en el Informe del Día Mundial de la Salud Mental de la Federación Mundial de Salud Mental, La Enfermedad Mental y la Enfermedad Física Crónica: la necesidad de cuidado continuo e integral.

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

Declaración de Yerevan

El 13 de Agosto de 2013, en Yerevan, la capital de la República de Armenia, el presidente de la Organización Mundial de Médicos de Familia (WONCA), firmó la ”declaración de Yerevan” junto con los dirigentes de la Asociación de Psiquiatría Mundial y otras tres asociaciones profesionales mundiales de Salud Mental. Supone un compromiso de nuestras organización es mundiales para promover la mejora continuada de la salud mental de todos los habitantes del planeta.

DECLARACIÓN DE EREVÁN en español

Dr Gustavo Gusso en Perú

La sociedad peruana de medicina familiar, tiene el agrado de anunciar que el Dr Gustavo Gusso, medico familiar, profesor de la universidad de Sao Paulo, past president de la SBMFYC y editor del Tratado brasileño de medicina familiar y comunitaria; dará una conferencia Titulada: conceptos de prevención y prevención cuaternaria

Lugar: Colegio Medico del Peru Miraflores

Fecha y hora: 31 de octubre 6:00PM

WONCA CONFERENCES 2014

May 21 – 24, 2014	WONCA Asia Pacific Regional Conference	Sarawak MALAYSIA	Nurturing Tomorrow's Family Doctor www.WONCA2014kuching.com.my
May 21 – 24, 2014	WONCA World Rural Health Conference	Gramado BRAZIL	Rural health, an emerging need http://www.sbmfc.org.br/WONCArural/
July 2 – 5, 2014	WONCA Europe Regional Conference	Lisbon PORTUGAL	New Routes for General Practice and Family Medicine http://www.WONCAeurope2014.org/

WONCA Direct Members enjoy *lower* conference registration fees. See WONCA Website www.globalfamilydoctor.com for updates & membership information

MEMBER ORGANIZATION MEETINGS

RACGP GP '13 conference

Host: The Royal Australian College of GPs

Date: October 17-19, 2012

Venue: Darwin, Northern Territory, Australia

Web: www.gp13.com.au/

Wonca APR and Fiji College GPs research conference

Host: Fiji College of GPs

Date: October 18-20

Web: http://www.fijigp.org

2013 Family Medicine Global Health

Host: American Academy of Family Physicians (AAFP)

Date: October 10-12, 2013

Venue: Baltimore, Maryland, USA

Web: www.aafp.org/intl/workshop

Email: Rebecca Janssen or Alex Ivanov

Family Medicine Forum 2012

Host: The College of Family Physicians of Canada.

Date: November 7-9, 2013

Venue: Vancouver, Canada

Web: http://fmf.cfpc.ca

The Network: Towards Unity for Health annual conference

Host: TUFH

Theme: Rural and Community Based Health Care

Date: November 16-20, 2013

Venue: Ayutthaya, Thailand

Web: http://www.the-networktufh.org/conferences/upcoming

EGPRN Spring meeting

Theme: Preventive Activities in Primary Care; an approach from clinical and health services research

Date: May 8-11,2014

Venue; Barcelona, Spain

We: www.egprn.org

XXXIV Congreso de la semFYC

Host: SemFYC

Theme: Dejando huella

Date: June 12-14 2014

Gran Canaria, Spain

Date: Junio 12-14, 2014

Note: this conference is in Spanish.

Web: http://www.semfyc2014.com