WONCANews

An International Forum for Family Doctors

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From the President: Something wonderful in the state of Denmark

Dr Thomas Drivsholm is a Danish family doctor working in Copenhagen. Thomas has a list of patients who rely on him for their medical care and advice.

Photo: Danish family doctor, Dr Thomas Drivsholm, at work in his clinic (with role-playing patient)

Denmark is a country with an enviable system of health care, based on strong family medicine and providing universal health coverage. I was invited to visit Denmark to speak at the annual meeting of the Danish College of General Practitioners (DSAM) and I was keen to learn more about the successes and also the challenges facing Danish general practice.

The Danish population of 5.5 million people is served by 3,600 general practitioners. All citizens are covered by the national insurance scheme and have free access to general practice services, regardless of their ability to pay. While general practices are privately owned businesses, health care is entirely publicly funded. Each general practitioner has a list of patients and serves as a gatekeeper to specialist medical services and many allied health services. Each fulltime GP provides care to an average of 1600 people. Government funding is 25% capitation and 75% fee for service. Danish GPs provide over 36,000,000 consultations each year, an average of seven consultations for each citizen.

Danish general practice is also a world leader in the use of health care technology and has embraced electronic medical records, using WONCA's classification system, ICPC (International Classification of Primary Care), to code diagnoses. ICPC allows Danish GPs to analyse the content of their medical record systems to their own activity and to better understand the health needs of their patient population. Data from Danish general practices is transferred automatically from the electronic medical record systems to the Danish General Practice Database allowing primary care researchers in Denmark to investigate the health status of the whole community, analyse the quality of care being delivered, provide feedback to each GP about their own patient population, and make national recommendations for continuing improvements to health care delivery.

Photo: Typical green spires of Copenhagen

Yet Danish general practice faces challenges, including ensuring the provision of care to people living in the more sparsely populated areas of Denmark and the remote autonomous territories of Greenland and the Faroe Islands. As the population ages, Danish GPs, in common with colleagues in many other countries, are being asked to do more chronic disease management and preventive care activities without additional resourcing and support. One-third of Danish GPs work in solo practices, often in rooms within old apartment buildings, with little opportunity for merger or expansion. While many general practices employ nurses, this is not yet universal. And the Danish GP workforce is ageing, with an average age of 54 years.

Fortunately there is strong enthusiasm for general practice among many recent medical graduates and medical students in the nation's four medical schools. General practice specialty training is for six years following graduation from medical school, the same as for other medical specialties. And general practice research in Denmark is very strong, as is the case in many of the countries of Northern Europe, and makes a major contribution to the global primary care evidence base.

I was very impressed with the work of the WONCA's member organization in Denmark, the Danish College of General Practitioners, and the commitment of the college to education, research and quality care. And, as is so common around the world, the energy and enthusiasm of young GPs in Denmark was infectious. WONCA members will have the opportunity to experience Danish general practice when the Nordic member of WONCA host the WONCA Europe conference in Copenhagen in June 2016.

Before heading to Denmark, I spent three days in Cairo in Egypt at a meeting of the Eastern Mediterranean Region Office of the World Health Organization (WHO). I was joined in Cairo by members of the WONCA working party in mental health, Dr Gabriel Ivbijaro and Dr Abdullah Al-Khathami.

Photo: World Health Organization campaign to raise awareness of the devastating effects of disasters and wars on the mental health of the people of affected populations

The WHO is working with the nations of the Eastern Mediterranean region to strengthen mental health care and WONCA is supporting the WHO on ways to better integrate mental health into primary care and improving the training of all health care workers in mental health.

The Eastern Mediterranean Region covers nations from Morocco to Somalia in Northern Africa, and from Lebanon to Pakistan in the Middle East and South Asia. It includes many nations where people are experiencing serious armed conflict and war, including Libya, Syria, Iraq and Afghanistan, and nations with large numbers of refugees including Jordan. It was sobering to hear representatives of nations speaking about the impact of these serious conflicts on the health and well being of their population and especially the impact on the mental health of children experiencing the horrors of war.

WONCA is working closely with the WHO on a number of global mental health initiatives to assist people affected by disasters and war. I recommend the following WHO resources to you:

Preventing Suicide – a global imperative
This report, released in September by the WHO, provides details of suicide statistics for all nations and recommendations that nations can implement to support suicide prevention.

Building Back Better – sustainable mental health care after emergencies
This is a wonderful report on how creating sustainable mental health systems must be part of any long-term recovery in the aftermath of emergencies, including natural disasters, armed conflicts and civil wars, and technological failures, such as nuclear disasters. It outlines how emergencies can provide the opportunity to build better mental health care, and includes valuable insights on programs in Afghanistan, Burundi, Iraq, Jordan, Kosovo, Somalia, Sri Lanka, West Bank and Gaza Strip, Indonesia (Aceh) and Timor-Leste.

Mental Health Action Plan 2013-2020
This is the WHO's global plan, endorsed by all member nations, and outlining strategies and targets to improve mental health care provision to the people of the world.

Integrating mental health into primary health care
This is an important joint publication from WONCA and WHO. It was released in 2008 and continues to form the basis for the global work WONCA is doing strengthening the delivery of mental health services through family medicine around the world.

Finally I want to again highlight the continuing Ebola crisis in nations in West Africa. While it provides some hope to see recent activity by some world leaders to assist local health care workers in tackling this serious health crisis, the situation is still extreme. I urge you to provide financial support, through agencies like Médecins Sans Frontières (Doctors Without Borders) and the International Red Cross/Red Crescent, to support our colleagues working with these organizations in their work on the ground assisting our colleagues in West Africa. And I urge you to advocate to your own government to increase aid and support. The epidemic continues to spread,

taking the lives of many people, including many of our colleagues in West Africa, who have had inadequate access to protective equipment and life-saving treatments, and who have died while providing care to the people of their local communities.

Michael Kidd
President
World Organization of Family Doctors (WONCA)

Del Presidente: Algo maravilloso en Dinamarca

Foto: Agujas verdes típicas de Copenhague.

El Dr. Thomas Drivsholm es un médico de familia danés que trabaja en Copenhague. Thomas tiene una lista de pacientes que dependen de él para su cuidado médico y su consejo.

Foto: El médico de familia danés, Dr. Thomas Drivsholm, trabajando en su clínica (con personas desempeñando el rol de pacientes).

Dinamarca es un país con un sistema envidiable de atención de salud, basado en una medicina familiar fuerte y una oferta de cobertura de salud universal. Fui invitado a visitar Dinamarca para hablar en el Congreso Anual del Colegio Danés de Médicos de Familia (DSAM) y tenía muchas ganas de aprender más sobre los éxitos y también los desafíos que enfrenta la práctica de la medicina de familia danesa.

La población danesa de 5,5 millones de personas es atendida por 3.600 médicos de familia. Todos los ciudadanos están cubiertos por el sistema nacional salud y tienen el acceso gratuito a los servicios de medicina de familia, independientemente de su capacidad de pago. Mientras que las consultas de medicina de familia son un negocio de propiedad privada, la atención de salud está completamente financiada públicamente. Cada médico de cabecera tiene una lista de pacientes y sirve como puerta de entrada a los servicios médicos especializados y a muchos servicios de salud relacionados. Cada médico de familia a tiempo completo atiende a un promedio de 1.600 personas. La financiación del gobierno es del 25% y la cuota de capitación es del 75% para el servicio. Los médicos daneses ofrecen más de 36 millones de consultas cada año, con un promedio de 7 consultas por cada ciudadano al año.

El médico de familia danés es también un líder mundial en el uso de la tecnología del cuidado de la salud y ha acogido la historia clínica electrónica, utilizando el sistema de clasificación de la WONCA, CIAP (Clasificación Internacional de Atención Primaria), para codificar los diagnósticos. La CIAP permite a los médicos daneses analizar el contenido de sus sistemas de registros médicos para su propia actividad y comprender mejor las necesidades de salud de su población de pacientes. Los datos de los médicos de familia daneses se transfieren automáticamente a partir de los sistemas de registros médicos electrónicos a la base de datos general, permitiendo a los investigadores de atención primaria en Dinamarca investigar el estado de salud de toda la comunidad, analizar la calidad de la atención que se ofrece, proporcionar retroalimentación a cada médico de familia sobre su propia población de pacientes y hacer recomendaciones nacionales para continuar con la mejora de la prestación de atención de salud.

Sin embargo, la práctica de la medicina de familia en Dinamarca se enfrenta a retos, entre ellos garantizar la prestación de la atención a personas que viven en las zonas menos pobladas de Dinamarca y en los territorios autónomos remotos de Groenlandia y las Islas Feroe. Como la población envejece, a los médicos daneses, igual que a los colegas de muchos otros países, se les pide hacer más gestión de la enfermedad crónica y actividades de atención preventiva, sin recursos ni apoyo adicional. Un tercio de los médicos daneses trabajan en consultas en solitario, a menudo en habitaciones dentro de edificios de apartamentos viejos, con pocas oportunidades de fusión o de expansión. Si bien muchos de los médicos de familia emplean enfermeras, esto todavía no es universal. Y la fuerza de trabajo de la medicina de familia danesa está envejeciendo, con una edad media de 54 años.

Afortunadamente hay un fuerte entusiasmo por la práctica de la medicina de familia entre muchos médicos graduados recientes y entre los estudiantes de medicina en las cuatro escuelas de medicina del país. La formación para obtener la especialidad de medicina de familia es de seis años, después de la graduación en la escuela de medicina, igual que para otras especialidades médicas. Y la investigación en Medicina de Familia en Dinamarca es muy fuerte, como ocurre en muchos de los países del norte de Europa, que hacen una importante contribución a la base mundial de datos de atención primaria.

Me quedé muy impresionado con el trabajo de la organización miembro de la WONCA en Dinamarca, el Colegio de Médicos Generales de Dinamarca, y el compromiso de la universidad con la educación, la investigación y la atención de calidad. Y, como es tan común en todo el mundo, la energía y el entusiasmo de los médicos jóvenes en Dinamarca fue contagioso. Los miembros de WONCA tendrán la oportunidad de experimentar la práctica de la medicina de familia danesa cuando el miembro nórdico de WONCA acoja el Congreso WONCA Europa en Copenhague, en junio de 2016.

Antes de dirigirme a Dinamarca, me pasé tres días en El Cairo, en Egipto, en una reunión de la Oficina de la Región del Mediterráneo Oriental de la Organización Mundial de la Salud (OMS). Me uní en El Cairo a miembros del grupo de trabajo WONCA en salud mental, el Dr. Gabriel Ivbijaro y el Dr. Abdullah Al-Khathami.

La OMS está trabajando con las naciones de la región del Mediterráneo Oriental para fortalecer la atención de salud mental y WONCA está apoyando a la OMS sobre la manera de integrar mejor la salud mental en la atención primaria y mejorar la formación de todos los trabajadores de salud en materia de salud mental.

La Región del Mediterráneo Oriental abarca a los países desde Marruecos hasta Somalia, en África del Norte, y desde el Líbano hasta Pakistán, en Oriente Medio y Asia del Sur. Incluye muchos estados donde la gente está experimentando graves conflictos armados y guerras, como Libia, Siria, Irak y Afganistán, y países con un gran número de refugiados, como Jordania. Fue aleccionador escuchar a representantes de distintos estados hablar sobre el impacto de estos graves conflictos en la salud y el bienestar de su población y, especialmente, el impacto en la salud mental de los niños que sufren los horrores de la guerra.

Foto: Campaña de la Organización Mundial de la Salud para crear conciencia de los efectos devastadores de los desastres y las guerras en la salud mental de las personas de las poblaciones afectadas.

WONCA está trabajando estrechamente con la OMS en una serie de iniciativas de salud mental a nivel mundial para ayudar a las personas afectadas por los desastres y la guerra. Recomiendo los siguientes recursos de la OMS:

Prevención del suicidio: un imperativo mundial
Este informe, publicado en septiembre por la OMS, proporciona detalles de las estadísticas de suicidio para todas las naciones y recomendaciones que los países pueden implementar para apoyar la prevención del suicidio.

Reconstruir mejor: atención de salud mental sostenible después de las emergencias
Este es un informe maravilloso que explica que crear sistemas sostenibles de salud mental debe ser parte de cualquier recuperación a largo plazo para las emergencias, incluidos los desastres naturales, los conflictos armados y las guerras civiles, así como fallos tecnológicos y desastres nucleares. Asimismo, señala cómo las emergencias pueden ofrecer la oportunidad de construir una mejor atención de salud mental, e incluye información valiosa sobre los programas en Afganistán, Burundi, Iraq, Jordania, Kosovo,

Somalia, Sri Lanka, Cisjordania y la Franja de Gaza, Indonesia (Aceh) y Timor Oriental.

Plan de Acción de Salud Mental 2013-2020
Este es el plan global de la OMS, aprobado por todos los países miembros y que delinea las estrategias y metas para mejorar la prestación de atención de salud mental para las personas del mundo.

La integración de la salud mental en la atención primaria de salud
Esta es una publicación conjunta importante de WONCA y la OMS. Fue lanzada en 2008 y sigue siendo la base para el trabajo mundial que WONCA está haciendo en el fortalecimiento de la prestación de servicios de salud mental a través de la medicina de familia en todo el mundo.

Por último, quiero destacar de nuevo la persistente crisis del ébola en los países del África occidental. A pesar de que ofrece algo de esperanza ver la actividad reciente de algunos líderes del mundo para ayudar a los trabajadores sanitarios locales en la lucha contra esta grave crisis de salud, la situación sigue siendo extrema.

Os insto a que proporcionéis apoyo financiero a través de agencias como Médicos Sin Fronteras y la Cruz Roja Internacional / Media Luna Roja, para apoyar a nuestros colegas que trabajan con estas organizaciones en su labor sobre el terreno, para ayudar a nuestros colegas en el África occidental. Y os insto a defender esta postura ante vuestro propio gobierno para aumentar la ayuda y el apoyo. La epidemia sigue propagándose, llevándose las vidas de muchas personas, incluyendo a muchos de nuestros colegas en el África occidental, que han tenido un acceso inadecuado a los equipos de protección y a los tratamientos que salvan vidas, y que han muerto mientras ofrecían su atención a las personas de sus comunidades locales.

Michael Kidd
Presidente
Organización Mundial de Médicos de Familia (WONCA)

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

From the CEO's desk: awards, conferences, resources.

Hello again from Bangkok. This month I want to concentrate on WONCA awards, WONCA conferences and WONCA resources.

WONCA Awards
Two sets of awards are currently available for WONCA members. The Montegut Scholarship awards provide support for one doctor from each of the seven WONCA regions to attend their regional conference annually. The Taiwan Family Medicine Research awards are available to three young researchers, to present their research at the Asia Pacific conference in Taipei next March.

Montegut Scholarships
The Montegut Global Scholars Program, established by the American Board of Family Medicine Foundation (ABFM-F) in 2010, will provide a USD2,250 scholarship for one family physician selected from each of the seven WONCA regions to attend their respective regional WONCA meetings in 2015. If there is no meeting planned for a region in 2015 then it will be permissible for the nominee from that region to use the scholarship to attend a meeting in another region. Further details are available from the WONCA Secretariat (manager@wonca.net) or on the WONCA website.

Taiwan Family Medicine Research Award
As the result of a generous donation from the Chinese Taipei Association of Family Medicine WONCA is pleased to seek applications for the Taiwan Family Medicine Research Award for new primary care researchers. Three awards will be given, each of $1,000, to support three junior and emerging researchers to travel to Taipei, Taiwan, to present his or her paper at the WONCA Asia Pacific Region conference, being held in Taipei from 4th to 8th March 2015. Further details are available on the WONCA website. Closing date for applications is Friday 28th November.

WONCA Conferences 2015
South Asia in Chennai in August was the last conference of 2014. However there's a really busy schedule of meetings and conferences, so make sure you get the dates into your diary now.

- South Asia Region Dhaka, Bangladesh 13-14 February

- Africa Region Accra, Ghana 18-21 February
- Asia Pacific Region Taipei, Taiwan 4-8 March
- Iberoamericana-CIMF Montevideo, Uruguay 18-21 March
- Rural Health conference Dubrovnik, Croatia 15-18 April
- Eastern Med Region Dubai, UAE 30 April-2 May
- Europe Region Istanbul, Turkey 22-25 October

more information on all WONCA conferences

WONCA Resources
Finally for this month, a special offer on some WONCA resources. Many resources are freely available on the WONCA website, but for the remaining three months of 2014 we are offering a discount to anyone purchasing both the WONCA Guidebook: "*The Contribution of Family Medicine to Improving Health Systems*" and the WONCA Mental Health book: "*Integrating Mental Health into Primary Care*".

The guidebook sells for $65 whilst the mental health book is priced at $45. However for the rest of this year we are offering the two books together for $90. Orders should be sent to Arisa at admin@wonca.net

At the end of October I will take part in a Conference Planning Committee meeting in Rio, as part of the preparations for the 2016 World Conference. Drs Bohumil Seifert and Dan Ostergaard will join me as we meet with our Brazilian colleagues over 2 days of discussion and visits and I'll write more on this in a future column. Over the coming weeks we will also be sending out a questionnaire to all Member Organizations asking for feedback on a number of issues, so I hope very much that we can encourage a good response.

Good wishes to all WONCA members globally.

Dr Garth Manning
CEO

Policy Bite: What do we mean by 'integrated care' – and how can we test its integrity?

Amanda Howe writes:

What do we mean by 'integrated care' – and how can we test its integrity?

'Integration' has become the latest buzzword on the health policy agenda – WHOi, the King's Fundii, and the Nuffield Trustiii all have major programmes of work on this topic, and in the UK the pre-election political party manifestos are awash with the need for 'integrated' care. But there are many definitions and models being debated, and these tend to depend on the nature of the health system and the level of integration envisaged.

For example, the UK RCGP has used the 'horizontal integration' definition of '*Patient-centred, primary care led, delivered by multi-professional teams, where each profession retains their professional autonomy but works across professional and organisational boundaries to deliver the best possible health outcomes' iv*, but the USA model of an integrated care organisation defines itself as "a formal or virtual vertically integrated organisation from primary to acute service levels, often serving a defined population". The differences may be profound, with family medicine working to a hospital provider, rather than across a community – but the main thing is whether the integration of care works for patients. Our UK member organisation, the Royal College of General Practitioners, has recently published 'Five tests of integration' in a manifesto to go to all political partiesv. These tests help us to know whether the integration is primary care – oriented: they say that,

"Proposed models of integrated care should:

(1). Ensure community-based services are led by community-based clinicians with a person-centred perspective.
(2). Underpin safe patient care by ensuring that GPs [family physicians] can continue to act as independent advocates for their patients - with their emphasis on the person not the institution.
(3). Avoid over-medicalization and the perpetuation of clinical treatments that are over-

reliant on the perspective of condition-specific specialists.

Proposed models of integrated care must not:

(4). Lead to major top down structural reorganisation, which would lead to the setting up of new bureaucratic structures and divert millions of pounds away from patient care.
(5). Lead to the diversion of NHS funding to plug the social care gap." (This is about residential care of older dependent people – a concern that health service funding will be 'lost').

This may seem very abstract and high – level when you are seeing your fortieth patient in an overcrowded clinic, and the electric power has just gone off. But every day leaders of family medicine are having to discuss service delivery in their locality, or region or nation – and are trying to make a difference to the choices made by policymakers, who will be more conscious of the big corporate models than the community-oriented ones. An affordable service which brings good comprehensive care close to home, and where different parts of the clinical and social support team can liaise to make the best of their contact time with patients, will be both cost-effective and popular. A patient who has to make multiple visits to different clinics and different hospitals (costly in time and money) for the different bits of their body and mind will either not attend or become exhausted and confused in the process – as will their friends and family.

So when you find someone in your network is talking about 'integrated care' – make the tests, and talk up horizontal integration – you will have WHO policy and WONCA to back you up!

Amanda Howe
President elect

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vi All downloaded 27/9/14.

Fragmentos de política, por Amanda Howe: ¿Qué entendemos por "atención integrada" y cómo podemos comprobar su integración?

"Integración" se ha convertido en la palabra de moda en la agenda política de la Salud: la OMS[i], la Fundación King[ii], y el Nuffield Trust[iii] tienen todos ellos grandes programas de trabajo sobre este tema y en el Reino Unido los manifiestos preelectorales de los partidos políticos están inundados de la necesidad de la atención "integrada". Pero hay muchas definiciones de modelo que se están debatiendo, y estas tienden a depender de la naturaleza del sistema de salud y el nivel de integración previsto. Por ejemplo, el RCGP del Reino Unido ha utilizado la definición de "integración horizontal" como "centrada en el paciente, liderada por la atención primaria, a cargo de los equipos multiprofesionales, donde cada profesión conserva su autonomía profesional, pero funciona a través de fronteras profesionales y de organización para ofrecer los mejores resultados de salud posibles[iv], pero el modelo de EE.UU. de organización de atención integrada se define como "una organización formal o virtual integrada verticalmente desde la primaria hasta los niveles de servicio de agudos, a menudo sirviendo a una población definida". Las diferencias pueden ser profundas, con una medicina de familia que trabaja para un proveedor hospitalario, en lugar de a través de una comunidad, pero lo más importante es si la integración de la atención se enfoca a los pacientes. Nuestra organización miembro del Reino Unido, el Royal College of General Practitioners, ha publicado recientemente 'Cinco pruebas de integración' en un manifiesto con el que dirigirse a todos los partidos políticos[v]. Estas pruebas nos ayudan a saber si la integración está orientada hacia la atención primaria y dicen que:

"Los modelos propuestos para la atención integral deben:

(i). Asegurarse de que los servicios situados en la comunidad son dirigidos por médicos de esa comunidad con una perspectiva centrada en la persona.

(ii). Sustentar una atención segura del paciente, asegurando que [los médicos de familia] pueden seguir actuando como defensores independientes de sus pacientes, con énfasis en la persona, no en la institución.

(iii). Evitar el exceso de medicalización y la perpetuación de los tratamientos clínicos que dependen excesivamente de la perspectiva de los especialistas en patologías específicas.

Los modelos propuestos para la atención integral no deben:

(iv). Producir una importante reorganización estructural de arriba hacia abajo, lo que llevaría a la creación de nuevas estructuras burocráticas y apartar millones de libras de la atención al paciente.
(v). Conducir a la desviación de la financiación del NHS para tapar la brecha de la atención social. (*Esto se refiere a la atención residencial de personas mayores dependientes y es la preocupación de que la financiación de servicios de salud se pierda*)."
Esto puede parecer muy abstracto y a muy de alto nivel cuando estás viendo al paciente número 40 en una consulta desbordada y cuando la energía eléctrica acaba de irse. Pero cada día, los líderes de la medicina de familia se ven obligados a discutir la prestación de servicios en su localidad de su región o país y están tratando de marcar una diferencia en las decisiones tomadas por los políticos, quienes serán más conscientes de los grandes modelos corporativos que de los orientados a la comunidad. Un servicio que aporta un buen cuidado cercano e integral en casa, y donde las diferentes partes del equipo de apoyo clínico y social se coordinen para sacar lo mejor de su tiempo en contacto con los pacientes, será a la vez coste-eficiente y popular. Un paciente que tiene que hacer varias visitas a diferentes consultas y hospitales diferentes (costosas en tiempo y dinero) para cada uno de los distintos fragmentos de su cuerpo y la mente, no asistirá o llegará agotado y confundido en el proceso, como lo harán sus amigos y familiares. Así que cuando encuentres a alguien en tu red que esté hablando de la "atención integral", haced las pruebas, y hablad hasta la integración horizontal, que tendrás las políticas de la OMS y de la WONCA apoyándote!

Referencias:
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[v] http://www.rcgp.org.uk/policy/~/media/Files/Policy/RCGP-Election-manifesto-2015-web.ashx

[vi] Todas descargadas el 27/9/14.

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

13th WONCA Rural health conference 2015 – Dubrovnik, Croatia

More information

Rural round-up

Being Rural - exploring sustainable solutions for remote and rural healthcare.

RCGP Scotland Policy Paper written by the Rural Strategy Group Scotland[i]

Dr Miles Mack, RCGP Scotland Chair-elect writes:

Scotland is by no means unusual in having difficulties in recruiting to remote and rural posts. At present there are many isolated mainland and island practices that are unable to recruit and in many places the Health Boards have been forced to employ short term locums or even take over the running of practices to ensure patients are provided with the care they need[ii].

What is perhaps unusual about Scotland is that we have a long history of acknowledging and successfully overcoming such problems. In 1912 the UK government set up the "Dewar Committee[iii]" that travelled the length and breadth of the Scottish Highlands & Islands to enquire about the state of medical services. What they found was truly shocking. In Ross-shire 40% of deaths went without a medical certificate as patients did not even have access to a doctor for their final illness. Many communities had no medical or nursing provision and the proposed National Insurance Scheme was unworkable in the crafting* communities. The result was the setting up in 1913 of the Highlands & Islands Medical Service[iv] (HIMS), the first state funded health service in the world. It was startlingly successful and was, in fact, the only model of care quoted in the 1944 National Health Service white paper[v].

In 2012 the North of Scotland Faculty of the Royal College of General Practitioners took advantage of the centenary of the report and the HIMS to research and share its history[vi]. We were struck by the similarities to problems facing rural communities now, except things have moved on. In the Dewar Report they advocated better use of technology. Then it was the telephone and internal combustion engine, now it is broadband and mobile phone access. This has led us to develop a mind-map[vii] defining the problem and this has been core to reports by NHS Education for Scotland[viii] and NHS Highland[ix]. The RCGP Scotland "Being Rural" report goes further than these two documents and has defined core problems and solutions across seven areas: -

- Connectivity (mobile phone/broadband)
- Transport
- Fragility of support services
- Workload (including the 24 hour commitment)
- Professional development
- Education and training
- Professional and social isolation, including
- Adverse effects on family life

RCGP Scotland is now committed to working with others to begin to tackle these problems. We have already had meetings with Scottish Government on issue of connectivity and are beginning to discuss changes in the selection and training of medical personnel in line with the WHO Global Policy Recommendations[x]. As a result of concerted effort across different agencies across Scotland there is clear evidence of a different mood in remote and rural health. In addition, many of the issues in this paper will be important to non-rural areas too. The model of closely integrated health & social care with effective decision support for expert generalists holds a great deal of promise in tackling increasing multi-morbidity in an ageing population.

Dr Miles Mack
Chair-elect, RCGP Scotland

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** Crofting is a system of rural agriculture peculiar to the Highlands of Scotland. It was developed to overcome difficulties in land ownership in the late 19th century and continues as a system of smallholder type agriculture with particular legal rights to this day. It arose from the ashes of the "clearances" when so many highlanders headed for other parts of the empire…*

Rural and Remote Health reviews Rural Medical Education Guidebook.

LINK to *Rural Medical Education Guidebook*

WONCA launched its *Rural Medical Education Guidebook*(RMEG) at the 12th WONCA World Rural Health Conference, Gramado, Brazil, in April 2014. The project has been proudly supported by WONCA through the WONCA Working Party on Rural Practice, the Northern Ontario School of Medicine, Memorial University of Newfoundland (MUN), and the Rockefeller Foundation.

The RMEG Consisting of 71 chapters written by 74 authors, it represents a unique collaboration, with contributions from every continent. It is intended to be a free resource for doctors, educators and others wanting to obtain practical ideas on implementing aspects of rural medical education and to learn from the experience of colleagues in different contexts.

This week, *Rural and Remote Health* the international electronic journal of Rural and Remote Health research education and practice policy has published a review by Dr John Wootton of the *WONCA Rural Medical Education Guidebook (RMEG).*

John Wootton, MD, CM, from Shawville, Quebec, Canada, in his review writes:

"*… It is an encyclopaedia, a smorgasbord, a feast of insights and information about rural practice, rural education, rural life, and rural society, writ large. Although purporting (by its title) to be primarily a tool for rural educators and about rural education, it is in fact much more than this. Not only a text for preceptors and programs, but also a compendium of what we know and where we would like to go. Clearly education is where it all starts, but rural community is where it ends, and there is no shortage of stories that span this spectrum.*

The editors have identified five themes, into which they have slotted the essays in logical clusters. Readers are free of course to follow the order of the essays as they are presented, but they may also dip in at will where they recognize a name or a theme with particular resonance. Either strategy invariably yields a pearl: from an historical description of surgery in remote Newfoundland, to an inside look at the challenges faced by women in rural practice, both written by those who have 'been there, done that'."'

Dr Wootton continues *"The 'elephant in the room' is the question: has this intimate knowledge of the history, dynamics, and social structures underlying the inequities in distribution of health and healthcare to rural populations begun to improve the situation? For surely this is the fundamental reason for this effort, and for the creation of this tool. Undoubtedly in some places things have improved. Equally as sure is the fact that in many it has not. This collection of wisdom and insight and energy must therefore not be a static thing, but rather a process which invites new contributions as new practitioners bring their experience to bear on the problem."*

If you have not yet looked at the WONCA Rural Medical Education Guidebook now is the time.

Link to full text of review article
Citation: Wootton J. Rural Medical Education Guidebook. Rural and Remote Health 14: 3277. (Online) 2014. Available: http://www.rrh.org.au

Region news

WONCA at the WHO South Asia regional committee

Photo: Prof Pratap Prasad, WONCA SAR president with all members of the host organizing committee of WONCA SAR conference coming in 2015 at Dhaka

The 67th Session of the World Health Organization's (WHO) Regional committee for South East Asia (SEAR) was held in Dhaka, Bangladesh from September 9-12, 2014. It was attended by representatives of all 11 member states of the region, the United Nations and other agencies, as well as non-governmental organizations in official relations with WHO, including WONCA. WONCA was represented by Professor Pratap Narayan Prasad, WONCA South Asia region (SAR) president.

The Honorable Prime Minister of Bangladesh, Her Excellency Sheikh Hasina, delivered the inaugural address at the joint inauguration of the 67th annual regional committee meeting and the 32nd meeting of Ministers of Health. Dr Margaret Chang, WHO Director General and Dr Poona K Singh, Regional Director WHO SEAR, delivered the Regional committees' opening address. Dr Chang focused her speech on Universal Global Health coverage and Ebola Virus. Dr Singh spoke of a four pronged strategy to address the persisting and emerging epidemiological and demographic challenges; advance universal health coverage and robust health systems; strengthen emergency risk management for sustainable development; and developing a strong regional agenda within the global health agenda in South East Asia.

A key agenda item during the meeting was discussion on the 'Regional strategy or strengthening health workforce education and training' during which Prof Prasad emphasised that every medical school should run an undergraduate and postgraduate course in family medicine in order to strengthen health services in the region. During the meeting resolutions were passed on the subjects of nutrition and food safety; health emergency fund; polio, injury prevention; immunization programs; HIV; research and development; mental health and NCDs.

This WHO regional meeting provided an opportunity for the WONCA region president to personally discuss with Ministers of Health and WHO country representatives, the role of Family Medicine in strengthening health systems, and WONCA's fundamental role in supporting this. Of note, the Minister of Health and Family Welfare for India expressed his interest in strengthening Family medicine, in India. Similarly interested were the Ministers and Secretaries of Health for the Maldives, Bhutan and Myanmar who invited further contribution from WONCA South Asia to help achieve this.

Photo: Prof Prasad (second from left) with IFMSA representatives Dr Bronwyn Jones, Yameen Hamid,Wonyun Lee

Links with the International Federation of Medical Students' Associations (IFMSA) in the region were also strengthened during the meeting. In addition being in Dhaka provided an opportunity to meet with the WONCA SAR 2015 conference committee, who look forward to representation of the IFMSA at WONCA SAR conference being held in Dhaka, in 2015, as well as greater participation by WHO leadership from South East Asia.

Prof Pratap Prasad
WONCA SAR president

EMR Meeting on Noncommunicable Diseases in Primary Health Care

WONCA EMR president, Dr Mohammed Tarawneh, and Dr Oraib Alsmadi, WONCA EMR honorary treasurer, were invited as temporary advisors to attend the WHO EMR meeting on strengthening the integration and management of noncommunicable diseases in primary health care, held in Cairo, 8-10 September 2014.

The meeting considered diabetes, CVD, chronic lung diseases, and cancers and the main four interventions of their common risk factors ie tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol.

Representative from Ministries of Health / PHC directorates / NCDs departments from all member states of the region, WHO advisors and experts, other experts from other WHO regions, and some NGOs like UNRWA, IDF and WONCA were present at this event.

WHO EMRO classified member states in three groups according their income: the first group is composed of GCC countries (KSA, Kuwait, Bahrain, UAE, Qatar and Oman); the second group is composed of Egypt , Lebanon, Jordan , Iran and Iraq; and the third group is composed of Pakistan, Afghanistan, Somalia, Sudan, Djibouti, Yemen, Tunis, Morocco and Palestine.

All agreed to adopt the family practice approach, as the best model to be applied in PHC settings where NCDs should be integrated.

Many challenges are facing this approach such as political commitment (mainly in the second and third category of governments in the region), lack of resources, shortages of family physicians, shortages of workforce training programs, task shifting, lack of research, referral systems through the levels of health systems, lack of monitoring system, lack of accreditation and other obstacles such as the community itself not wanting to accept some procedures due to local culture and beliefs.

We emphasised that WONCA can strongly assist and provide technical support through regional or other regions' experts.

Mohammed Tarawneh
WONCA EMR president

WONCA East Mediterranean meets Tunisian family doctors

Photo: meeting participants

WONCA EMR executives, Dr Mohammed Tarawneh (WONCA EMR president) and Dr Oraib Alsmadi (WONCA EMR treasurer) conducted a visit to Tunisia from 4th-7th September. Last June, Professor Amanda Howe (WONCA president-elect) linked Dr Tarawneh with Dr Mundher Ltaief, from Tunis (WHO), and Dr Mundher, in turn has introduced WONCA EMR executives to several colleagues from Tunisia.

A meeting was held on Sep 6 with five Tunisian family medicine societies (located in Tunis city, Sousse, Monastir, Sfax , Mahdia , and the Tunisian GP society from Tunis city), and four academic medical schools belonging to the following universities - Tunis city, Sousse, Monastir, and Sfax. The meeting agenda included informative speeches (presentations) of ten Tunisian colleagues introducing his/her organization.

Dr Tarawneh shared with colleagues an informative presentation followed by discussion.

The moderator was Dr Zied Ben Lamine , president of Tunis FM society in the city of Tunis. Dr Oraib Alsmadi also shared in the presentation and discussion.

The universities do not have family medicine residency programs, however starting from 2015 in Sosa University they will have the first graduates of a two year Master degree family medicine.

As regard the societies of family medicine, they only have the name of family medicine with no content of family medicine specialty and no Bylaws - the societies considering any doctor as a family doctor with no specific certificates.

Long discussions ensued about the situation and how improvement could take place. As WONCA we advised them to have one unified national society as a first step and then submit an application to join WONCA as member Organization.

In addition WONCA offers a technical support to advocate for Academic / family medicine departments and programs. We encouraged the academia / departments of family medicine to join WONCA as academic members.

After this meeting the Tunisian family medicine societies ,Tunisian GP society, and academic medical school conducted a meeting where all Tunisian organizations representatives are present, and they agreed to work to overcome the main challenges and have a plan within six months - this was the first time for them to have such meeting and organize their work.

Mohammed Tarawneh
WONCA EMR president

Working Parties and Special Interest news

Mental Health Gap Action Programme Forum 2014

Photo: Dr Gabriel Ivbijaro (former WWPMH chair), Dr Shekhar Saxena (WHO); and Dr Luis Galvez (chair WWPMH)

WHO has developed a plan to address the mental health of the citizens of this planet: *"Mental Health Action Plan, 2013-2020".*

We know that mental health is an important part of the WHO health definition, that is why this plan is so important. Four major objectives are set forth:
- More effective leadership and governance for mental health
- The provision of comprehensive, integrated mental health and social care services in community-based settings.
- Implementation of strategies for promotion and prevention.
- Strengthened information systems, evidence and research.

One way to achieve these objectives set by WHO, is the annual Mental Health Gap Action Program (mhGAP) meeting, which this year took place September 4-5 at the World Health Organization premises, Geneva. It is a way to get in touch the secretariat of WHO, with member states, and international partners. (WONCA is one of those international partners).

This scientific association was represented by Dr Luis Gálvez and Dr Abdullah Al-Khatami (pictured below with Natalie Drewer Bold), chair and co-chair of WONCA Working Party on Mental Health (WWPMH), and Dr Gabriel Ivbijaro, president-elect of the World Federation on Mental Health (WFMH) and past-chair of WWPMH.

Integrating mental health services into primary care can generate good quality cost-effective

outcomes. It is an essential way to close the treatment gap and ensure that people have access to the care they need, close to home.

WONCA has a strong history of collaboration with WHO in mental health issues:
- The international classification of primary care (ICPC).
- Integrating mental health into primary care; A global perspective, offering examples in good practices in low, middle and high income countries and highlighting 10 common principles for the successful integration of mental health into primary care.
- Companion to Primary Care Mental Health, that include the work of an international group of family doctors and other professionals of mental health
- The Yerevan Declaration (link on this page), about the importance of integrating mental health into primary care

The meeting lasted two days, and after appropriate presentations, four working groups were established, one for each of the main objectives of the WHO action plan. These informal meetings allowed us to share information about the activities of our organizations in order to achieve the objectives of the plan.

The World Suicide Report (the first report from WHO dedicated to suicide prevention) was presented at the conference.

The WHO document titled "Preventing suicide. A global imperative" (ISBN 978 92 4 156477 9) was presented and that was followed by the comments of the ambassadors from different countries that showed their interest and could collaborate with the solution of this important health problem.

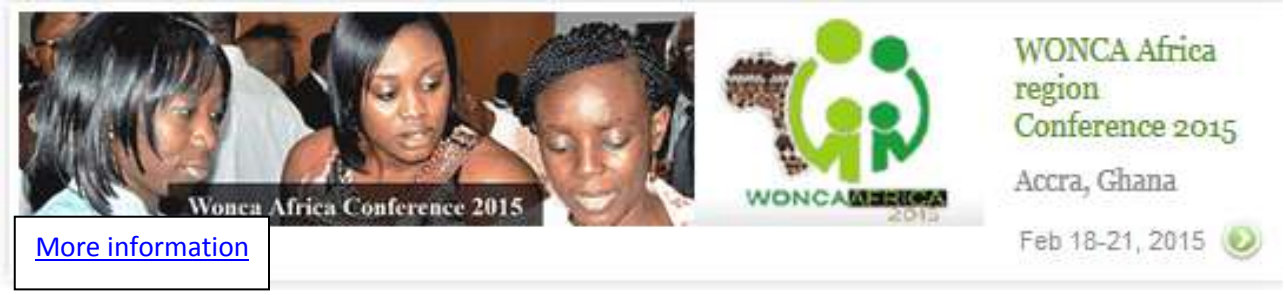
I participated in the first informal working group, moderated by Michelle Funk and Natalie Drew. I gave them a list with some ways that WONCA can collaborate in order to maximize the integration of primary and mental health within the mhGAP framework.

WONCA can offer international consultancies in primary care mental health to low and middle income countries and our consultancies include:
• Policy: development and implementation of primary mental health care services at national and regional levels;
• Education and training: creation, delivery and evaluation of primary mental health care programmes for qualified and trainee primary care staff;
• Research: advice on identification of primary mental health care research priorities and funding opportunities; collaboration on implementation and evaluation of research projects.
And the project will be coordinated by Prof Christopher Dowrick.

The mhGAP gave me the opportunity to talk to Gabriel Ivbijaro (president-elect of World Federation on Mental Health) and Dinesh Bughra (president-elect of World Psychiatric Association) about the third thematic conference of "Mental Health and Primary Care Working Together" that will be held in Granada, Spain, in 2016. The conference will be organized by WONCA, WPA and WFMH.

I spoke to Gabby Ivbijaro about the "Mental Health for all" conference in Lille, France next year: where WWPMH members take an active part of that congress.

Luis Gálvez-Alcaraz, MD, PhD.
luisgalvez@semfyc.es
Chair WONCA Working Party on Mental Health (WWPMH)



Primary Health Care & Workers' Health

In coming months, WONCA News will feature regular articles on the subject of Occupational Health including useful resources for clinical practice. This month we revisit the recent statement on worker's health.

Joint WONCA-ICOH Statement on workers' health

This joint statement of WONCA and the International Commission on Occupational Health (ICOH) – the first one ever made together – was released on July 3, 2014, during the WONCA Europe conference in Lisbon, Portugal. It was presented by Prof Michael Kidd, WONCA President, in his keynote speech and included the pledge that follows.

See full story on WONCA and ICOH statement and pledge on workers and their families

Pledge

The World Organization of Family Doctors (WONCA) and the International Commission on Occupational Health (ICOH) pledge to work with our partner organizations (including WHO and ILO) to address the gaps in services, research, and policies for the health and safety of workers and to better integrate occupational health in the primary care setting, to the benefit of all workers and their families

.

This is an important statement, because not only the health of individual workers is at stake: in each country working people are the backbone of the economy. So their health is of great importance for themselves and their families – often depending on the earnings – as well as for the country's prosperity and for provisions like food production, health care, social security and education.

This Statement also revitalises one of the phrases of the famous 1978 WHO Declaration of Alma Ata on Primary Health Care, aiming at "*bringing health care as close as possible to where people live and work*." Yet, as the WONCA-ICOH Joint Statement says: *"the health and safety of people at work are too often addressed separately from their health outside of work*."

Moreover, for many years not more than about 10-15 % of the global workforce has some kind of specific occupational health care (mostly workers in the more prosperous parts of the world) while the poorest workers and those most in need, with the most precarious working conditions, often have no work-related care at all.

The coverage of primary health care is, as we all know, about 70-80 % of the world's population. Among them are many workers far out of reach of occupational care, like rural and migrant workers, and workers in the informal economies. But, it is also well known that many family doctors and other primary health care professionals have a kind of 'blind spot' for work-related health problems. On the other hand, in almost all countries with a social security system, workers have to visit their family doctor or another treating physician during sick leave, in order to get a sick note. So those professionals have to investigate the fitness for work under specific working conditions.

The WONCA-ICOH Joint Statement says: "*to better integrate occupational health in the primary care setting, to the benefit of all workers and their families*". Such action will create great new opportunities: when primary care professionals pay more attention to the work related health problems of their patients, many more workers could be reached with a kind of basic occupational health care than the 10-15 % mentioned before!

That will also mean that family physicians will have to reflect systematically on questions like: Are these health problems work-related? If so, is that relationship causal, which means that work causes occupational and work-related diseases such as chronic low back pain or aggravates existing health problems like COPD? Or is the health condition causal? What are the consequences of a disease or treatment (for e.g. asthma, myocardial infarction or diabetes) for the patient's work? Can the working conditions be adapted to the limited capabilities of a worker with multiple sclerosis or a worker who survived cancer but is still having complaints? Where can I get reliable occupational health information on effects of pesticides or on risk factors for epicondylitis? To which clinic can I refer my patient with a chronic contact dermatitis or presumed latex allergy related to work?

In the coming editions of the *WONCA News* we will try to address these kinds of questions. The next time however we will first write about developments and events from the last decade, leading to this Joint WONCA-ICOH Pledge.

Peter Buijs & Frank van Dijk
(are Dutch occupational physicians and former family doctors, and for many years active in ICOH)

Young Doctors' Movements

The VDGM 10th Anniversary Preconference

see more photos on Flickr photo album

So the ship eventually returns to its port; to bring back the experiences of a journey, to look back at the moments that defined it, whether they were good, bad, passionate, exciting, imperfect, thought-provoking or irrational, and to build upon them. A circle has been completed, so much more to discover!

The astonishing city of Lisbon was the host of the 10th anniversary preconference of the Vasco da Gama Movement (VDGM), which was held on 1st and 2nd July 2014, and was made possible thanks to the enduring effort and passion of the preconference organising team, which was led by Catarina Matias, and included Ana Nunes Barata, Pedro Azevedo, Nuno Cardoso Jacinto, Rita Lopes, and Ana Margarida Cruz, and the unconditional support of the Portuguese Association of Family Medicine (APMGF).

Just two days before the main event kicked off, an exchange programme was organised for participants coming across Europe, who had the opportunity to attend a brief presentation of the Portuguese Primary Care system, and to visit Portuguese practices.

The theme of this year's preconference was "New Routes for General Practice and Family Medicine"; on this topic, two leaders of Family Medicine were invited to convey reflections and inspiration to the participants with their visionary speeches.

Dr João Sequeira Carlos, the president of the 19th WONCA Europe conference and past chair of our movement, kick-started the works of the preconference with an insightful journey to the past. His speech, entitled "VdGM - through seas never sailed before", carried the values and the passion of the founders of our movement, which have proven to be indelible through time.

In his lecture, Dr Per Kallestrup, the 'father' of the Hippokrates Exchange Programme, encouraged the audience to reflect on their aspirations and passions, and invited them to realise their potential to make the world a better place and our profession stronger.

This year's theme functioned as an inspirational pretext that brought together nearly 150 new and future General Practitioners / Family Physicians coming from different parts of the world, and enabled them to share, reflect and dream. The participants were divided in small working groups and were given the task to discuss innovation in primary care as seen through the eyes of the new generation of family doctors, before presenting them in the final plenary session. As expected, they soon started talking about their own lives, about how they became interested in Family Medicine, about the problems they faced back home, but also about their aspirations and that endless desire to make change happen.

Photo: ideas ideas ideas.

A broad spectrum of common problems was emphasized, including the healthcare inequities, the bureaucracy and workload, and the struggle to balance professional and personal life. A variety of solution paths were discussed and focused on areas such as the undergraduate Family Medicine education, the professional training and continuous medical education, the evidence-based medicine and the lurking danger of 'godlines' (a play of words, between guidelines and god - meaning that we should not follow guidelines as a religion, as our god), the communication skills and the patient education.

Three additional points were frequently mentioned in the discussions and outcomes of the working groups:
• The patients who are in real need of care, the universal healthcare;
• Advocacy, the necessity to improve our image and encourage the establishment of the pillars for an efficient, bilateral, cross-professional, interdisciplinary and cross-generational interactive communication;
• Innovation, technology and communication that can function as a supplement to a broader strategy that aims at empowering patients, caregivers and communities, even in the most rural areas of the world.

Creativity shone, as the attendees found surprising ways to present their conclusions, such as the launch of a new group, the #VdGMChangeMakers, that would collate resources and develop materials to help new and future GPs/FPs to address common Family Medicine challenges in their countries.

Finally, during the preconference, the governmental body of the VdGM, the Europe Council, held a productive meeting to assess the past year and evaluate new strategies. Leaders from other peer movements around the world honoured us with their presence, including Dr Raman Kumar, Dr Scott MacLean, Dr Victor Ng, Dr Kayode Alao and Dr Kyle Hoedebecke; their attendance strengthened our relationship in the ever-expanding global WONCA family. Finally, during this meeting, the VdGM bid farewell to Dr Sara Rigon, Dr Raquel Gomez Bravo, Dr Zuzana Svadlenkova, and Dr Tobias Freund, expressing wholeheartedly its gratitude, and welcomed Dr Peter Sloane, Dr Berk Geroglu, Dr Rosa Avino, Dr Ivana Babic and Dr Enrique Alvarez Porta as new members of the Executive Group.

The VdGM 10th Anniversary Book

The epitome of the anniversary celebrations was the presentation of the “The Vasco da Gama Movement Anniversary Book: 10 years sailing, much more to discover” during a special ceremony on Wednesday 2nd July 2014.

The book was a fantastic example of a bottom-up initiative inside VdGM, which was led by the vision of Catarina Matias, Rita Lopes, Patrícia Amaral and Zelal Akbayin, and became reality thanks to the generous sponsorship and support of the Portuguese Association of Family Medicine (APMGF).

Stories narrated by the founders and leaders of our movement where gathered and contributions from different nations were collected to provide a quick look at the diversity of the European context.

In her opening letter in the book, Catarina Matias (pictured with the book) says: *“It is with great pleasure that we present this book, which aims to tell the story of the first 10 years of the Vasco da Gama Movement (VdGM). From an idea into a project, passing to the execution, it maintains nowadays a continuum of more ideas and projects. This continuing and intense activity contributes to the Family Medicine / General Practice development and maintains the enthusiasm of European trainees and young Family Doctors / General Practitioners. Like a virus, it attempts to spread around the globe, encouraging and supporting the creation of similar movements in other continents – this is the true Vasco da Gama spirit!”*

The WONCA leaders, Prof Job Metsemakers and Prof Michael Kidd, honoured us with their presence at the presentation of the book, which was carried out on the second day of the preconference. Perhaps the most emotional quote was made by one of the founders of our Movement , Dr Fons Sips:*“If happiness is when your fantasies become reality...I'm happy!”*

Harris Lygidakis
Immediate past president VDGM

The Spice Route Movement report on Chennai 2014

Photo - Pre conference dinner

Reported by Dr Raman Kumar, Dr Sonia Mehra, Dr Pramendra Prasad, Dr Bhavna Matta, Dr Jigyasu Singh, Dr Kunal Doshi, Dr Md Zakiur Rahman

WONCA South Asia region conference 2014

Over 600 delegates attended the magnificent WONCA SAR 2014 conference at Hotel Green Park, Chennai, on August 16-17, 2014, jointly organized and hosted by Indian GP organizations, IMA CGP, AFPI and FFPAI. The theme of this conference was *Hope, Healing and Healthy nation through Family Medicine.*

The Spice Route pre-conference dinner

The conference was preceded by a pre-conference dinner on 15th August 2014 at Hotel Maurya International. The theme of the evening was to introduce The Spice Route movement for young and future South Asia family practitioners to the attendees. The presence of Dr Raman Kumar, Dr Sonia Chery and Dr Pramendra Prasad marked the evening. Dr Raman Kumar introduced The Spice Route movement following which he elaborated the aims and objectives of same. Dr Sonia Chery described the inception of this movement in 2010 and briefed about the developments so far. Dr Pramendra Prasad shared his experience at different International WONCA conferences.

This was followed by open discussion on Family Medicine education and training at different institutes all over India. There were attendees from New Delhi, Mumbai, Kolkata, Bangalore, Kerala and Chennai. The diversity of attendees facilitated healthy discussions regarding the current status and future strategies and also how we can contribute towards future development of "The Spice Route Movement" as future health professionals.

The Spice Route workshop

The Spice Route movement is a WONCA forum for young, new and establishing family medicine doctors in the South Asia Region. It includes medical students, residents, trainees and recently qualified Family Medicine doctors within first five years of practice. The workshop was chaired by world leaders of Family Medicine namely, Professor Michael Kidd, WONCA World President; Dr Garth Manning, CEO WONCA; Dr Pratap Narayan Prasad, President WONCA South Asia region; Dr Ramnik Parikh, honorary secretary WONCA South Asia region; and Dr Raman Kumar, young doctor representative on WONCA Executive.

The workshop commenced with a presentation by Dr Bhavna Matta who introduced the seven WONCA Young Doctor Movements.

This was followed by introduction of The Spice Route movement presented by Dr Kunal Doshi and Dr Jigyasu Singh collectively. Dr Sonia Mehra introduced to the audience "FM 360- Global Exchange Program". This was the highlight of the workshop and attracted many residents and young family practitioners to participate in the event. Dr Pramendra Prasad very beautifully described regional exchange opportunities in Nepal. This was followed by Dr Md Zakiur Rahman's invitation to "Spice Route Dhaka 2015". Dr K M Abul Hasan spoke about the *All India Convention of Young Doctors*.

Following this was a group discussion and group presentations where groups were lead by Spice Route Representatives, namely Dr Sonia Mehra, Dr Bhavna Matta, Dr Jigyasu Singh and Dr Kunal Doshi.

The objectives of the Group activity were as follows:
- To involve the delegates in structure formation of "The Spice Route"
- To outline membership details
- To identify potential future leaders
- To understand their viewpoints and expectations from the movement
- To motivate them to actively participate in future Spice Route activities
- To bring them altogether on common platform to discuss challenges faced by them at different institutions

Photo collage: The Spice Route workshop

At the end of the group activity it was proposed that delegates could enrol with "The Spice Route" through their official representatives or WONCA member organization of their respective countries. In India, membership with Academy of Family Physicians of India (AFPI) automatically confers Spice Route membership to the eligible family physicians.

The interactive session allowed delegates to broaden their interest and knowledge in different aspects of Family Medicine training. Activities related to education and training, career development, research and publications, Image and social media etc were identified as key areas where team activities needed to be facilitated through formation of regional committees. This way most of the young physicians could get the opportunity to actively participate and contribute towards development of "The Spice Route".

Consultations were conducted with key stake holders regarding future leadership, governance and structure of Spice Route. Dr Bhavna Matta was elected the new chairperson of the Spice Route Movement. Constitution of a formal Spice Route council is currently under process and it is proposed that each of the member countries from SAR will nominate three council members. Nominations from India (Dr Bhavna Matta, Dr Jigyasu Singh and Dr Kunal Doshi) and Bangladesh (Dr Md Zakiur Rahman, Dr Md Nurul Islam Bhuiyan, Dr Md Abdul Quayum) is already complete.

We have deserving candidates but formal nomination from Pakistan, Nepal and Sri Lanka is awaited. Bhutan shall be represented by only available member Dr Chhabi Lal Adhikari. We expect to complete this process soon. Development of constitution is underway.

We shall be meeting in Dhaka Feb 2015 for WONCA SAR conference to for the meeting of a formal Spice Route council, selection of coordinators of other regional committees and adoption of a formal constitution.

The Spice Route Movement has a new chair - Dr Bhavna Matta. Find out more about her here and elsewhere in this newsletter.

VdGM meets the world through AAFP Workshop

From September 11-13, 2014, the American Academy of Family Physicians (AAFP) Global Health Workshop was held in San Diego.

For three days participants shared their experiences and initiatives in global health. From medical students to senior doctors, it was quite astounding to make contact with so many interesting people and their experiences from all over the world!

Attendees were actively promoting global health, as they presented the results of their projects from all over the world. It was also incredible to learn how global health initiatives are already being included in curricula at some universities in the USA, be they in the form of voluntary work or meeting sessions.

During this workshop, the WONCA North America region movement for young family doctors, Polaris, was also in the spotlight. Many initiatives of the newly-born movement were presented on a background of excitement and optimism. It was very well received and generated great interest from attendees, be it due to the initiative itself, but also regarding its collaboration with the "Family Medicine 360º" program.

A Vasco da Gama Movement (VdGM) team, of Ana Nunes Barata, Lisa Gambhir and Harris Lygidakis, had the great opportunity to participate in this workshop. After presenting the latest activities from the WONCA Europe Region and the VdGM during the AAFP Global Health board meeting, the team also contributed with a breakout session and a poster at the workshop.

In the session titled *Exploring Global Family Medicine through an Exchange Program*, the VdGM team shared their practice exchange experience and tried to motivate attendees for the value of exchanges.

In order to give some examples, prior to the workshop, the VdGM team asked both hosts and visitors who already participated in exchange programs (either through the*Hippokrates program* or the global *Family Medicine 360º* program) to answer some questions on a video, sharing their experience. The inputs were very inspiring and they were collated into two short videos – one covering the visitors' points of view and the other the hosts'.

Some quotes from the videos:
"I think exchanges are a way of putting us out of our comfort zone."
"Regardless of the country and the population, the Family Doctor is always a reference."
"People in the UK as in Uruguay have the same reasons to ask for GP care."
"I decided to become a host to be able to provide to young colleagues the same opportunities that I once received during my training."
"Personally, I find it very motivating to meet with young, eager and enthusiastic colleagues, who ask questions about patient care or the organisation of our healthcare system."
"They make me reflect on things that already take for granted and inspire me to think of different solutions to a problem."

Link to the videos:
- Exchanges in Family Medicine – Meet the Participants
- Exchanges in Family Medicine – Meet the Hosts

In the end of the session, participants were asked to share their answers on the question "How do you see someone who participated in exchanges, in ten years time?". From "*acquiring a world-wide view", "leadership skills"* and *"becoming a better clinician";* ideas soared.

The VdGM poster presented the conclusions that were gathered at the World Café on Global Health that happened last February, at the first VdGM Forum, in Barcelona.

As the VdGM team, we hope to have motivated attendees to value the importance of having Junior Doctors Movements, especially in their region. We also hope to have raised the interest in global health, as it not only contributes to professional and personal development but also to the development of Primary Care.

It was a very dynamic workshop, with lots of networking possibilities and fun.

We wish to extend our gratitude to Alexander Ivanov and Julie Wood, of the AAFP, for welcoming us and making this experience possible for us.

Ana Nunes Barata (speaking in photo)
Harris Lygidakis
Lisa Gambhir

Member Organization news

SemFYC annual meeting report

More than 2,500 specialists in Family and Community Medicine attended the XXXIV semFYC annual meeting

SemFYC Junta Directiva (executive Board) with some of the VIP guests also present.

More than 2,500 specialists in Family and Community Medicine attended the semFYC XXXIV Congress, from June 12-14. Of the attendees, 35% were residents and young family and community physicians.

During the conference, 80 scientific activities were offered (clinical sessions, over 25 workshops, and meetings held with the experts...). Two thousand abstracts were submitted and 1,350 of them were accepted.

All these activities covered topics of interest to specialists in Family and Community Medicine, with presentations by experts, as well as members of the various working groups and semFYC's programs. The consequences of the economic crisis in the health system and in primary care consultations with the dangerous effects of the application of Royal Decree 16/2012 are two more issues which appeared in many conference panels. In addition, studies on the health of the Spanish population were presented and various activities were conducted with community.

An international congress

The XXXIV semFYC Annual Meeting had a strong international flavour through the Vasco da Gama Movement (VdGM), which conducted its own conference. Some of the attendees were prestigious speakers - led by the president of the VdGM, Harris Lygidakis. The Editorial Register of the *British Medical Journal (BMJ*), Tiago Villanueva, as well as Luisa Pettigrew, (WONCA Executive Board member and WONCA liaison with the WHO) were two of the most outstanding speakers. This panel was moderated by Raquel Gómez Bravo, who was at her last conference as a representative of the VdGM in Spain. A month later, during the 19th Congress of WONCA Europe, she left the position and received a tribute from her colleagues. She is succeeded by Enrique Álvarez, from Spain.

The conference dealt with innovation and survival in times of crisis and was structured in two parts: a preview of short talks on the individual experiences of each of the speakers in three different areas and a second group working on issues that they raised.

In addition, Luisa Pettigrew attended a meeting of the SemFYC Executive Board while visiting us.

For further information about the contents of SemFYC Annual Meeting click on these two links:
http://www.comunicacionescongresosemfyc.com
http://www.semfyc2014.com/modules.php?name=webstructure&idwebstructure=448

4° Congreso Iberoamericano de Medicina Familiar y Comunitaria

Theme: "Calidad y Equidad en el Cuidado a la Salud"

Venue: Hotel Radisson, Montevideo, Uruguay

Date: - 18 a 21 de Marzo 2015.

Web: www.montevideo2015wonca-cimf.org

Featured Doctors

Chloé Perdrix - a French GP travels Asia

My name is Chloé Perdrix, I'm a 27 year old French GP resident, just ending my last rotation in a health centre in the North-East of New Caledonia, a French island in the Pacific, next to Australia.

I'm the French exchange coordinator in the Vasco da Gama Movement, (WONCA Europe's young doctors' movement), and used to be the manager of international relationships in the French young GP's Union, ISNAR-IMG for 18 months from January 2013 to June 2014.

After this last rotation in New Caledonia, I intend to take a sabbatical year travelling around Asia, with my brother, who just finished business school.

In order to stay in touch with the medical network, I intend to meet general practitioners during this journey. I proposed to WONCA and the Vasco da Gama Movement (VdGM), to write an article each two months in order to share my discoveries, my questions and my reflections about this experience. I thank them very warmly in accepting my request. (*WONCA editor note: we welcome such innovation*)

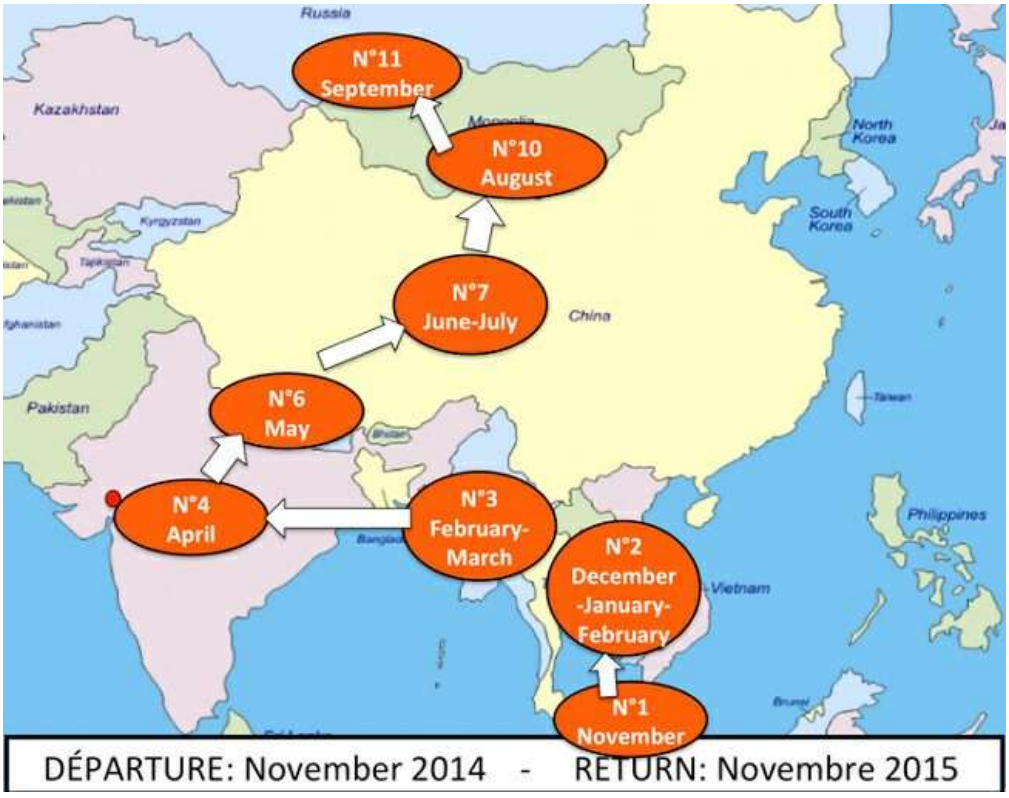
I see this opportunity very simply : I won't do a "double-blinded-multicentric, randomised control" study . I only want to share my experience about medicine and primary care in Asia through these articles.

Even if it's a modest thing, sharing my reflections with GP readers from all over the world is very important to me. It gives a greater purpose to my trip : it will not only be a personal and selfish journey but also a collective one.

To give you an idea, our proposed itinerary is shown below. Of course, this might change during the journey. I can't guarantee 100% that it will really be exactly this itinerary.

I hope this experience will interest you.
Chloé

If you want to share your thoughts with Chloé why not join the discussion just started on the WONCA Forum
Login to the WONCA discussion forum
Join the WONCA discussion forum



Chloé Perdrix article 1: New Caledonia

First step of the trip :

New Caledonia : a French Pacific Island where independence will be voted on, in 2018, by referendum.

Nowadays, French residents can come to practice in New Caledonians hospitals and medical centers.

GP residency lasts three years in France. My residency in Paris had been a very good experience, but I didn't want to practice in such a big city. As a lover of travel, I wanted to combine a rural experience and travelling.

That's why I choose a health center in the North-East of New Caledonia for my last six months as a GP resident. The village's name is Pouebo. It is a very authentic place where nature and Kanak culture are omnipresent.

The people I care for, are almost all Kanaks - the people who lived here before British and French colonization.

Medical practice is, surprisingly, the same as in France for a lot of cases - chronic diseases, pediatrics, gynecology, oncology, palliative care, traumatology - except that there are more infectious/tropical diseases, even though New Caledonia is spared from some severe tropical diseases like malaria. The main tropical disease is listeriosis, and a big screening campaign is organized by the government to detect it early.

I also observed many emergency cases. That's probably because the medical center is 1 ½ hours from nearest hospital.

What is very different and interesting in working here is the Kanak culture, which is very rich.

For instance, ways of communication are different. Kanaks speak French like their mother tongue, so there are no language barriers, but they have some communication peculiarities.

Photo: Health center, Pouebo, New Caledonia.

To give you an example, instead of saying "oui" ("yes"), they put up there eyebrow without saying anything. In the beginning, I thought they didn't want to answer me. When I understood this peculiarity, it was easier to communicate. It also encouraged me to ask open-ended questions without yes/no answers,

which is a good exercise in general practice.

Kanaks live in strong communities. Everything is shared (money, houses, pets, nature). Society is organized into tribes and in Pouebo there are 16 of these.

Each tribe is comprised of two to four clans, which in turn, are comprised of two to four families. There is a chieftain for each level (family, clans, tribe). The title of "chieftain" is mostly given from father to son, like a patrilineal monarchy.

Photo: Typical Chieftain house (Lifou)

In each tribe, there is a healer. When a person is sick, they often go to see him first, to be treated with plant medicine - one for flu, one for wounds, one for insect bite. When plants do not work, patients go to the medical center.

When a severe disease is diagnosed, and the patient must go to hospital, they have to let the chieftain know about the situation, and have his approval.

For a sick kid, parents also have to consult his "uterus uncle" (the mother's brother) and have his approval to go to medical center or hospital. The "uterus uncle" has a big place in family and is as important as the father.

I've been in Pouebo for four months now. I want to share with you an intense experience : a delivery.

The medical team is comprised of two doctors, one GP resident, and three nurses who are in the medical center, seven days a week.

Normally, every pregnant women in Pouebo is hospitalized in the nearest maternity unit, one month before the expected delivery date. Unfortunately (or not), one of the pregnant women refused to be hospitalized.

Marie is one of the Pouebo's medical center doctors. She is young GP in her first five years. We both feared that this resistant woman would give birth during our on-call time. Consequently, we made a deal : if the woman came during either of our on-call shifts, we could call each other to ask for help.

It was on a Saturday morning, at 6 o'clock that I got a phone call from the nurse on-duty and Marie. The woman in question was in medical center, and she was in labor. Tachycardia (mine). Here was the moment that we feared.

When I arrived, the patient was having one contraction every 10 minutes, with a fully dilated cervix. I touched the amniotic sac. We didn't have the time to transfer the patient to hospital.

Fortunately, I had already helped to deliver several times during my gynecology internship, five years ago, and it all came back very quickly, like when you haven't cycled for a long time.

I remembered that I had to break the sac. I mustn't have the good technique because all the water splashed on me. (We laughed a lot remembering this moment). The baby arrived . I saw the head crown, asked to the mum to push, the baby's head was out!

I was in tachycardia again, what to do now? Looked at the mum: " It's not finished, push! push! push!"

With a last scream (no epidurals here) she pushed, and the baby slid out.

There was a 3,310 grams boy in my hands crying. Marie cut the umbilical cord . After a little moment in mum's arms, Marie and Audrey put the baby in the incubator.

We waited after the delivery for 30 minutes, but the placenta didn't come. The hospital nurse on the phone said : "It's time to do an examination of uterus, you must do an artificial delivery". Neither Marie, nor I had experience in that, but we didn't have any choice. The complete placenta arrived after two uterine exams.

We finally transfered Mum and baby (named Doui) to hospital, both in good health. Mum didn't even have a vagina tear! We were proud.

It had lasted for two hours.

After that, the team had lunch and discussed this amazing experience. We had done it!! And we were not afraid anymore! This experience was amazing, and magic.

Mum and Doui came back to the health center several times for their postnatal care.

I love general practice specialty for that: we have a real patient following.

Thank you for reading my first story. Next stop : Malaysia!

Chloé

Photo: It's difficult to take a bad photo in New Caledonia (Isle Ouen, South of New Caledonia)

If you want to share your thoughts with Chloé why not join the discussion just started on the WONCA Forum
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Prof Phil Cotton: UK/Rwanda – family doctor

What work do you do now?
Currently Principal of the College of Medicine and Health Sciences in the University of Rwanda (UR). UR was formed from the seven public higher learning institutions in September 2013. The College is one of six in the University and has 11 campuses around the country. We train almost all of the health care professionals in the country from prosthetists to doctors. Last year we opened the first ever dental school and next year we will begin the first clinical speciality Masters in Nursing. We aim to be one of the most recognisable Universities in Africa.

What other interesting activities that you have been involved in?
I was the founding chair of a fair and ethical trade organisation in Scotland. Every day is packed with interesting activities. Students are my greatest source of inspiration and they have almost certainly led me to the projects and causes that have given me the greatest interest. Once you look into the sea of faces in the lecture room you realise that the talent pool is almost overwhelming - special people doing special things.

What are your interests as a GP and also outside work?
As a GP I worked in one of the poorest electoral wards in Scotland. Hugely influenced by Prof Graham Watt and his Deep End Project*.

I imagine I will return to the same part of Glasgow to work. I also worked with an organisation called Freedom from Torture which helped me to understand others better.

I recently published a book on empathy with my friend Prof Stewart Mercer. He is a great GP academic who articulates perfectly the values that underpin our lives as primary care doctors. In recent years most of my time has been spent in medical education with the wonderful GP educationalist Prof Jill Morrison.

Every few years I return to my love of oil painting. I enjoy cooking and gardening and for several reasons don't do either in Kigali. I love music from Emeli Sande to Bach - and find listening restorative. I find time to attend Church at least once a week and am keen to get to 'the last thing on Friday' service.

What are you doing to help the development of family medicine in Rwanda?.

Photos: community outreach: Phil and students

We have a postgraduate training program in family medicine and some superb trainees. The department of family and community medicine in the School is led by incredible individuals who have established a program that is very highly evaluated by students. We are increasing the amount of curriculum time in social and community medicine and have two sites for placements - Kabgayi and Rwinkwavu which is supported by Partners in Health.

There is a Minister of State for Primary Care and Public Health and both he and the Honorable Minister are committed to primary health care through an incredible network of health centres.

* *Deep End is a collective of GPs working in the poorest electoral wards in Scotland and building the evidence and experience base to change policy for fair and just delivery of primary care to some of the most challenged general practices*.

Dr Bhavna Matta - new chair of the Spice Route Movement

Dr Bhavna Matta is a Medical Council of India (MCI) and Educational Commission for Foreign Medical Graduates (ECFMG) certified physician who is currently pursuing Family Medicine Residency (PGY2) in New Delhi.

She graduated from University of Seychelles American Institute of Medicine (USAIM) in 2009, and completed her internship at a government hospital, Lokmanya Tilak Municipal Medical College and Hospital, in Mumbai. This further nurtured her clinical skills and practice of medicine through its huge outpatient inflow of over six hundred thousand per year. To gain experience in the corporate sector, she worked as a Resident Medical Officer at Sterling Wockhardt Hospital, Mumbai.

During her internship and residency, she actively volunteered and organized community camps, construction site camps and health checkups. She conducted a research study on knowledge, attitude and practice study regarding HIV among construction site workers. She proactively initiated and was involved in educating construction site workers and corporate office employees regarding safe sexual practices and life style modifications to prevent non communicable diseases. She also had an opportunity to spend a month in rural clinic at Vaitarna, Maharashtra, which gave her insights into practicing medicine with minimal medical resources. After having diverse experience in different sectors of the society, Dr Bhavna Matta is one of the pioneers in the country who voluntarily opted for Family Medicine residency.

Her area of interest is towards development of training of Family Medicine Residency in India and to establish collaborations with International Organizations to support the cause. Simultaneously, her interest in holistic healing, led her to GMCKS Pranic healing and Arhatic yoga workshops, which give her a whole picture of disease conditions and healing techniques when it comes to practice of medicine.

Dr Bhavna Matta is determined to set forth on this journey to bring about transformation in education and training for Family Medicine in the entire South Asia Region starting from her home country, India.

Dhaka Bangladesh

Dates: February 13-14, 2015 with preconference on February 12

Announcements

Montegut Scholarships to 2015 WONCA conferences

The Montegut Global Scholar Program (MGSP) was established by the American Board of Family Medicine Foundation (ABFM-F) in 2010. The MGSP will provide a USD2,250 scholarship for one family physician selected from each of the seven WONCA regions, to attend their respective regional WONCA meetings in 2015. If there is no meeting planned for a region in 2015 then it will be permissible for the nominee from that region to use the scholarship to attend a meeting in another region.

Brief details below. Full details available on the Montegut Scholar page

Eligibility
Criteria for all applicants
- Must be a family physician/general practitioner in good professional standing
- It is suggested that the selectee be a physician involved with education, research and/or committed to improving the quality of family medical care in his/her region.
- The selectee chosen should be a person whom under ordinary circumstances would not have the financial means to attend the referenced meetings
- The selectee shall not be part of the WONCA leadership in his/her region.
- The selectee possesses proper documents/credentials for international travel

Additional criteria for North America applicants
- The nominee from the North American region should come from the Caribbean College of Family Physicians
- Should be approved by the North American President

Deadlines for submissions for 2015 conferences

- **31 October 2014** - South Asia region conference AND Africa region conference
- **30 November 2014** - Asia Pacific region conference AND Congreso Iberoamericano
- **31 December 2014** - East Mediterranean region conference
- **Early 2015** (exact date to be advised) - Europe region conference

Further details are available from the WONCA Secretariat (manager@wonca.net) or on the WONCA website.

Family Medicine Research Award - Call for Applications

On behalf of the Host Organizing Committee of the 2015 Asia Pacific Region Conference in Taipei we advise you of the Call for Applications for the Taiwan Family Medicine Research Award.

This Research Award is made possible by a generous donation from the Chinese Taipei Association of Family Medicine to WONCA. Three Awards, each of $1,000, will be given to support three junior and emerging researchers to travel to Taipei, Taiwan, to present his/her paper at the 2015 WONCA Asia Pacific Region Conference, to be held in Taipei from March 4-8.

As the result of a generous donation from the Chinese Taipei Association of Family Medicine WONCA is pleased to seek applications for the Taiwan Family Medicine Research Award for new primary care researchers. Three awards will be given, each of $1,000, to support three junior and emerging researchers to travel to Taipei, Taiwan, to present his or her paper at the WONCA Asia Pacific Region conference, being held in Taipei from March 4-8, 2015.

Criteria
1. A junior researcher is defined as a person with no more than 5 peer-reviewed publications.
2. The researcher should be a clinical family physician.
3. The research topic should be on primary care.
4. The applicant needs to submit a full paper for the award. The paper may have been submitted for publication, but not yet published.

Selection will be based on scientific merit and potential impact of the findings on patients. Note: applications are not restricted to those from the Asia Pacific region.

Application
Applications must be submitted by e-mail to the WONCA Secretariat (manager@wonca.net) . The application must consist of the research paper and

a covering letter demonstrating that the applicant meets the award criteria.

Deadline for Submission
Applications must be received by the WONCA Secretariat in Bangkok no later than Friday November 28, 2014.
Results of Applications
The results of the Research Award applications will be made known by Thursday December 31, 2014

Contact Details
Contact details for the WONCA Secretariat are
Email: manager@wonca.net
12A-05 Chartered Square Building, 152 North Sathon Road,
Silom, Bangrak, 10500 Bangkok, Thailand
Tel: +66 2 637 9010
Fax: +66 2 637 9011

AFMC Charles Boelen international social accountability award

The Association of Faculties of Medicine of Canada (AFMC) has announced a new award - the AFMC Charles Boelen International Social Accountability Award. Named after Dr Charles Boelen, a world leader in Social Accountability, it aims to celebrate people or organizations whose professional accomplishments are an example of the principles of social accountability implemented as defined in the Global Consensus for Social Accountability of Medical Schools (www.healthsocialaccountability.org) and in internationally recognized references.

It is with great pride that the AFMC is joining forces with Dr Charles Boelen to create this new international award and reach out to our colleagues from around the world. Social Accountability is a major focus for our association and we look forward to collaborating with you and hopefully awarding this inaugural prize to someone within your organization at next year's Canadian Conference on Medical Education in Vancouver, Canada.

Nomination process
Nominations may be proposed by an individual or by an organization and must be submitted before the closing date for nominations, on October 31.

The following documentation must be provided for each nomination: name and affiliation, a resume if the nominee is an individual or a description of the mission if a team, a department, an establishment or an organization is nominated, a description of the works corresponding to the criteria enumerated above, as well as a recommendation letter no longer than 1000 words.

You can read more about the AFMC – Charles Boelen International Social Accountability Award on the AFMC's website or see the attached flyer.

About Dr Charles Boelen
Charles Boelen is a Belgian born physician, specialized in public health, health system management and medical education, with a large experience in international health, namely as staff member of the WHO for 30 years. His work focusses on partnership in health, social accountability of academic institutions and the development of health professions. The concept of the "5-star doctor" was an initiative of Charles' which WONCA continues in its 5-star doctor awards

Resources added

International Journal for Equity in health
http://www.equityhealthj.com/

PEARLS

438 Yoga may be beneficial for primary prevention of cardiovascular disease

437 Uncertain effectiveness of physical conditioning to reduce sickness absence for back pain
436 Early surgical dressing removal may be beneficial
435 Stroke unit care effective
434 Nursing interventions effective for smoking cessation

WONCA CONFERENCES 2015

February 13-14, 2015	WONCA South Asia Region conference	Dhaka, BANGLADESH	For more information on these conferences as it comes to hand go to the WONCA website conference page:
February 18-21, 2015	WONCA Africa region conference	Accra, GHANA	
March 5-8, 2015	WONCA Asia Pacific Region Conference	Taipei, TAIWAN	
April 15-18, 2015	WONCA World Rural Health conference	Dubrovnik, CROATIA	
October 22-25, 2015	WONCA Europe Region conference	Istanbul, TURKEY	

WONCA CONFERENCES 2016

November 2-6, 2016	WONCA WORLD CONFERENCE	Rio de Janeiro, BRAZIL	www.wonca2016.com **ULTRA EARLY BIRD Registration ends November 3 2014**

Early bird registration closing soon

CLOSING OCTOBER 31; Taipei, TAIWAN – conference March 5-8, 2015

CLOSING NOVEMBER 3: WONCA WORLD CONFERENCE Rio de Janeiro, Brazil. November 2-6, 2016

CLOSING DECEMBER 31: Dhaka, BANGLADESH conference February 13-14

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

WONCA ENDORSED EVENTS

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

April
28-30
2015

Mental Health for All

Lille, France

MEMBER ORGANIZATION EVENTS

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

09 Oct - 11 Oct 2014	RACGP GP '14 conference	Adelaide, Australia
21 Oct - 25 Oct 2014	AAFP annual scientific assembly	Washington DC, USA
23 Oct - 26 Oct 2014	EGPRN Autumn meeting	Heraklion, Crete, Greece
13 Nov - 15 Nov 2014	Family Medicine Forum / Forum en médicine familiale	Québec, Canada
19 Nov - 23 Nov 2014	The Network: Towards Unity for Health conference	Fortaleza, brazil
25 Apr - 29 Apr 2015	STFM Annual Spring Conference	Orlando, Florida, USA
07 May - 10 May 2015	EGPRN Spring meeting	Timisoara, Romania
20 May - 22 May 2015	The 1st International Congress (COPOC)	Tel Aviv, Israel
29 May - 30 May 2015	IPCRG scientific meeting	Singapore
16 Jun - 18 Jun 2015	19th Nordic Congress of General Practice	Gothenburg, Sweden
26 Jun - 28 Jun 2015	Fiji College of General Practitioners conference	Nadi, Fiji