

Summary report on the

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Regional consultation on development of the bridge programme for capacity-building of general practitioners in the Eastern Mediterranean Region

Cairo, Egypt
10–11 May 2016



World Health
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Regional Office for the Eastern Mediterranean

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Contents

1.	Introduction.....	1
2.	Summary of discussions	3
3.	Points for action	10

1. Introduction

A preliminary assessment of primary health care in the 22 countries of the World Health Organization (WHO) Eastern Mediterranean Region shows that 90% of primary health care facilities are managed by physicians who are certified to work without further specialized training after graduating from medical schools. It was therefore agreed that Member States should advocate for establishing, strengthening and expanding sustained and effective refresher course(s) for general practitioners (GPs) working in public/private sectors to strengthen/update their knowledge and skills to improve the quality of health services provided at primary health care level.

In this regard, through a joint effort with the Department of Family Medicine at the American University of Beirut (AUB) Medical Center, WHO has developed a short online course to orient GPs on principles and elements of primary care services, including clinical management of common diseases.

The training modules are an appropriate blend of theoretical knowledge and practical skills, based on global best practices. They have an online component along with elements of face-to-face training in which GPs can readily participate. The training curriculum covers the main competencies that a GP/family physician has to master including: primary care management, person-centred care, specific problem-solving skills, comprehensive approach, community orientation and holistic approach.

The short course includes two main modules: module I on family medicine core concepts, and module II on clinical updates of specific medical conditions. Selection of topics for module II was based on the most common medical problems seen in primary care settings, as

reported in literature and from the results of assessment a of GPs learning needs conducted by AUB.

The outcomes of the joint collaboration with AUB discussed in two-day regional consultation with representatives from health ministries, higher education ministries and GP syndicates/associations from Egypt, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Sudan and Tunisia.

Objectives

- Share regional situation of the family practice programme: challenges and priorities.
- Present the contents and curriculum of the online training course for GPs to the key focal points/institutions responsible for continuing medical education programmes in selected countries of the Eastern Mediterranean Region.
- Seek perception of key stakeholders who may intend to adapt/adopt the bridging programme in their respective countries.
- Agree on practical steps for rolling out the bridging programme, building local capacities and its institutionalization in countries of the Region.
- Consensus on scaling up production of family medicine specialists and enhancing system capacity to attract family physicians in the Region.

Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean, highlighted in his opening address that the shortage of family physicians is felt worldwide. However, the situation in the WHO Eastern Mediterranean Region is acute and requires urgent action. Although Member States should do their best to strengthen family medicine departments in teaching institutions, the huge shortage of family

physicians will not be overcome solely by the establishment of more academic departments. Other factors, including issues related to service delivery, must also be addressed based on local capacities and needs.

The Regional Director stressed that the most important challenge is the shortage of family physicians. The current annual output of trained family physicians in the Region is around 681, against identified needs of almost 21 000 family physicians. According to a situation analysis carried out in late 2014, in collaboration with the World Organization of Family Doctors (WONCA) and Aga Khan University in Karachi, Pakistan, only 20% of all medical schools in the Region have functional family medicine departments.

2. Summary of discussions

Family practice status in countries of the Region

WHO undertook an assessment of implementation of the family practice programme in the Region in 2014, which was updated in 2015. According to the assessment, 16 countries have included family practice in their national health policy and plans, and established a unit or appointed a focal point responsible for the programme. Thirteen countries have expansion plans for the family practice programme. The proportion of primary health care facilities fully implementing family practice and the number of family physicians varies tremendously between the three groups of countries¹ in the Region, and even between countries within each group.

¹Group 1: Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates; Group 2: Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic and Tunisia; Group 3: Afghanistan, Djibouti, Pakistan, Somalia, Sudan and Yemen.

In Group 1 countries, primary health care facilities fully implementing family practice range between 100% in Bahrain and Qatar and 14% in Oman. The density of family physicians varies from 2.12 per 10 000 population in Bahrain to 0.04 in the United Arab Emirates. Density in Group 2 countries varies between 0.18 per 10 000 population in Lebanon to 0.01 in Palestine. Despite reasonably good political support for the family practice programme in Egypt, the Islamic Republic of Iran and Iraq, the density of family physicians is less than 0.08 per 10 000 population.

Ten countries reported staff availability in primary health care facilities sufficient to deliver the essential package of health services, while the remainder experience shortages and disparities between rural and urban areas. Patient registration of over 80% of the catchment population exists in 6 out of 22 countries while Bahrain, Kuwait and the United Arab Emirates assign physicians for a specific number of families. In the other countries, families may see a different physician on each visit except in Jordan, Iran and Pakistan (only in primary health care facilities where the programme is being implemented).

All the countries in the Eastern Mediterranean Region have developed an essential package of health services, although full implementation exists in only 14 countries; in the other eight countries implementation is partial or nonexistent. All countries have developed an essential drug list. Seventeen countries have reported the availability of these drugs in primary health care facilities; however, their full availability at all times in all primary health care facilities needs to be further assessed in the 17 countries.

Despite the existence of academic institutes with family medicine departments in 13 countries, all countries, without exception, still face major difficulties due to a shortage of family medicine specialists. To

improve their technical capacities, 11 countries have developed short-term training programmes over the past decade. The duration of these programmes varies from country to country: Kuwait and Saudi Arabia have established 24-day programmes, followed by 16 days in Oman, 50 hours in Bahrain and 5 days in Jordan. The Islamic Republic of Iran has developed distance training programmes through user-friendly multimedia comprising PowerPoint slides, audios, videos, and text files.

The assessment shows that 17 countries do not have a functioning referral system despite the availability of guidelines. Family/individual health folders are available in 14 countries, however the huge variations between and within countries should be noted. An electronic information system in primary health care facilities is fully implemented in three countries, and partially in eight. Disaggregated data at primary health care level is available in 13 countries.

A key challenge for implementation of the family practice programme in primary health care facilities is a weak or fragmented health system structure with limited managerial support. A recent study by WHO shows that 33% of family physician key informants reported a low level of readiness in the Region's health systems to absorb family physicians. Thus, it is recognized that health systems may need to be strengthened/reshaped to absorb the family practice approach.

From GP to family medicine specialist: the importance of global capacity-building for strong primary care

Although doctors often work for many years serving the local community/patients who are happy with the care provided, they may have lacked investment in their professional education or clinical services. These doctors may therefore need significant knowledge updating, and also a much broader awareness of how to be proactive

(for example, for prevention and management of noncommunicable diseases) rather than giving reactive care. Another issue to address is modern orientation to appropriate primary care: many GPs did their training in medical schools, which is taught in hospital settings, and recommend tests and drugs that may not be relevant or useful in first-contact care. Finally, many doctors have had a partial case mix (only adults, children or women, etc.) and in order to give good general medical care in a primary care team they may need to revise some areas of clinical practice.

Many countries are already looking to the future by training family medicine specialists who can provide first-line clinical care for any condition at any stage of life, and unite health education, prevention, early intervention, acute diagnosis, chronic/ongoing illness management, palliative and end-of-life care. Family physicians work with individuals and communities over time, to “prevent where possible, cure if they can, and care always”, and also act on a level with the population. However, up-skilling of doctors already working in the community has the potential advantage of retaining their links with a locality, and possibly being quicker and cheaper. However, it may be less easy to “unlearn” old ways than learn new ones, and they will need both infrastructure investment (into premises, team support and essential technical equipment) and to adjust their practice; patients will also have to adjust their expectations and accept their “new” doctor’s ways.

Up-skilling GPs will not work unless all parts of the health care system understand why these broad, integrative, person-centred skills are needed. A clear timeline, resource plan and support for ongoing practice and skill retention are required. This investment will only be cost-effective if other parts of the system – financing models, hospital sector, other primary health care staff and patients – use the services appropriately. Existing and upcoming family medicine specialists need

a clear role and interface with their GP colleagues who are learning new skills – perhaps mutual mentorship, supervision and even referrals. Both groups will need to develop as team leaders, data analysts, service developers and evidence-based practitioners. They will need to understand the application of values that work with their individual patients and communities to analyse and address health needs, empower and support, and manage risk and resources.

WONCA can help by sharing expertise, curriculum standards, advice, accreditation and expert consultancy. There are many people in all regions that have already started this journey. WONCA note that countries in the Eastern Mediterranean Region, with WHO support, are taking a strong lead in transitioning towards the family practice approach. Countries are encouraged to evaluate their progress, demonstrate the outcomes and use WONCA as an expert resource (www.globalfamilydoctor.com).

Overview of the training course to improve knowledge and skills of GPs on service delivery

It was noted that the United States of America has past experience in transitioning from GPs to family physicians. A comparable initiative is soon to be launched in Lebanon, which highlights the importance of governing laws and political support.

A step-by-step description of the training course content was provided. The course covers the main competencies and characteristics of the discipline of family medicine as determined by WONCA. It targets GPs who have not received any vocational training prior to entering practice in order to complement their experience, refocus on the principles of the family medicine model and institutionalize the concept of continuous professional development.

The training course will be delivered in a blended format and covers 48 topics, including the management of common medical problems in primary care and family medicine core concepts. It runs over 24 weeks and is divided into four main blocks, starting with an orientation session and ending with final examinations. Each block spans a 5-week period, whereby the first 4 weeks are delivered online and the fifth week includes a 6-hour face-to-face session or live review.

Participants were briefed on the evaluation tools, highlighting components of the formative and summative assessments. This was followed by a description of the management of the course and its set-up on Moodle or other course management systems. Finally, a demonstration of the contents of the course was given on Moodle. The presented course model can be considered as a basic skeleton that each country can add and adapt to their needs and resources.

Assessment of learning needs of GPs

The Department of Family Medicine at AUB Medical Center conducted an assessment of GPs' learning needs in the 22 countries of the Eastern Mediterranean Region. This was a crucial step before the development of the training course, as education programmes based on needs assessment have been found to be more effective in changing the behaviour of physicians and improving the quality of health care.

The survey targeted two groups: health experts and stakeholders, and GPs in the countries. Two different online questionnaires were sent to the groups through LymeSurvey. The response rate was 48% for health experts, whereas for GPs it was very low at only 11%. The top 20 medical topics that GPs are interested in learning about were identified, with management of common noncommunicable diseases being top of the list. Both groups preferred a blended type of learning and English

was identified as an acceptable training language. Both groups were in favour of additional training of GPs in family medicine, either in the form of a 1-year diploma or 2-year master's programme.

Scaling up production of family medicine specialists and enhancing system capacity to attract family physicians

Participants were briefed on the current situation and challenges associated with the production and absorption of family physicians in the Region. Short-term, medium-term and long-term strategies were recommended for the three groups of countries within the Region.

Almost 80% of medical schools in countries of the Region have no department for family medicine, and the situation is worse among newly emerging private medical schools. Family medicine as a specialty is less attractive to medical graduates compared to other specialties. It is not well recognized by the public or other health professionals and offers lesser pay and incentives in some countries, especially in group 2 and 3 countries of the Region.

Lack of recognition of the important role family physicians play in dealing with more than 85% of the population's health and health care needs is an important factor in influencing training capacity and service re-designs. Recent assessments conducted by WHO have demonstrated the enormous gap between training capacity and service needs in the Region.

There are many reasons for the severe shortage of family physicians. Lack of central workforce planning is a key issue in many Member States, along with lack of coordination between ministries of health, ministries of higher education and academic institutes. Increasing the capacity of family medicine departments for producing more family

physicians is not a practical option in the short term. Countries need a transitional period to move from GPs to family physicians, based on their family medicine training capacity and duration of the recommended training programme to cover all eligible GPs. The online training course is a first step to introduce GPs working in public health facilities to family medicine.

Taking into account the differences between the three groups of countries in the Region in terms of health status, health system financing and organization, training capacity and public expectations, there is no one solution that fits all. Learning from countries' successful experiences in developed their health systems based on family practice, an integrated approach to develop family practice is essential comprising three main pillars: (i) strengthening medical schools undergraduate education; (ii) strengthening specialty training through national programmes; (iii) and strengthening health systems based on primary care.

Eleven countries requested to conduct the training course in 2016, as a first step to introduce GPs working in public health facilities to family medicine. The participants agreed on two main topics as an outcome of the consultation, with action points as follows.

3. Points for action

Actions to enhance the bridge programme for capacity-building of GPs

- Participants from Egypt, Islamic Republic of Iran, Jordan, Kuwait, Lebanon, Morocco, Oman, Pakistan, Saudi Arabia, Sudan and Tunisia agreed on the need for the online capacity-building

programme for GPs and will endeavour to raise political commitment of ministers of health.

- WHO to work with an expert group to develop a 2-page policy brief for high-level policy-makers by end of June 2016, covering: reasons for choosing a family practice approach; challenges in service delivery through family practice approach; main contents of the bridge programme; beneficiaries of the programme; how the programme will impact service delivery improvement; continuation and sustainability of the programme; and political support needed to enhance the programme.
- WHO in collaboration with AUB to organize two rounds of training of trainers on using the bridge programme in August and November 2016; noting, Jordan, Morocco and Tunisia offered hosting the training.
- Ministers of health to take the lead in a joint effort with ministers of higher education and medical associations/syndicates to nominate a maximum of four potential trainers (preferably among family physicians, or other specialists if no family physicians are available) to attend the training of trainers courses.
- Committees to be established at the country level to review the training course contents and oversee adaptation/revision of curriculum and implementation of the programme, based on local needs and capacities.
- Country training activities to be mentored/coached by the national trainers.
- AUB and WHO to work on programme evaluation, to identify measurable outcome indicators and incorporate an evaluation kit (pre- and post-test) into the course curriculum.
- AUB to elaborate on course methodology and develop mentorship/trainers' guide/manual to facilitate organizing the course at country level.

- Countries to consider incentives for candidates entering the family medicine specialty or enrolling in the bridge programme, such as career path incentives or entering the postgraduate course on family medicine in local universities/fellowships with the 6-month online course as credit.
- WHO to work on advocacy, networking and marketing of the bridge programme.
- Online course to be usability tested in Lebanon in a small cohort and results shared with countries of the Region.
- WHO to work with AUB to ensure the online course is user-friendly and easy to operate. An information technology specialist from each country may attend the last day of the training of trainers to be back-up support for trainers at the country level.
- Countries to be assisted to develop risk assessment, and identify gaps in management of the training programme with clear contingency plans.

Actions for countries to enhance health system capacity to implement family practice

- Linkage of the family practice approach with national health policies, Sustainable Development Goals and other development plans.
- Allocation of funds to enhance the family practice programme at national level.
- Update the essential package of health services based on community needs and ensure its implementation at all primary health care facilities on gradual basis (based on countries' capacities and availability of health workforce).
- Review laws/regulations and standards of service delivery based on family practice approach.

- Strengthen partnerships (with other service providers, private sector, nongovernmental organizations) through contracting out of services, covering family practice by insurance organizations, etc.
- Establish/strengthen family medicine departments; capacity of intake of residency programmes to be increased.
- Organize transitional period training activities for countries to move from GPs to family physicians.
- Strengthen family medicine departments and incentives to ensure a certain percentage of medical doctors enter a family practitioner residency.
- Involve/train other health workforce cadres (paramedics, nurses, midwives) on family practice approach.
- Medical and nursing school curriculum to be amended to be more community-oriented, problem-based and in line with family practice approach in order that undergraduate students become more familiar with the concept of primary care and family medicine after graduation.
- Incorporate family medicine in medical, nursing and other health professional education and curriculum (undergraduate courses) along with appropriate clinical training in primary care settings.
- Sustainable funding for expansion of the family practice programme.
- Strategic purchasing, costing of essential package of health services and capacity for contracting out.
- Collaborate with health insurance organizations for family practice implementation.
- Introduce appropriate incentives for family practice teams to enable them to perform as expected.
- Measure service delivery performance and improvement.
- Define catchment population per primary health care facility, identify patient rostering, family/individual folders and registration of individuals with primary health care facilities.

- Integrate noncommunicable diseases as a priority in primary health care; strengthen referral channels; improve logistics; monitoring and evaluation; home health care; team work; and ensure equity in access to services for rural, urban and poor population.
- Encourage a team approach in family practice, involving multidisciplinary teams including nurses, midwives and other health professionals as needed, and ensure an enabling working environment for them to practice as a family practice team.
- Countries to be encouraged to strengthen and engage private practitioners in service delivery through family practice approach.
- Implement WHO quality standards/indicators framework.
- Enforce accreditation programme.
- Establish community health boards, engage in awareness building on benefits of family practice and engage in local planning.
- Strengthen staff communication skills with the community.



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