Conceptual and strategic approach to family practice

Towards universal health coverage through family practice in the Eastern Mediterranean Region

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Contents

Executive summary

Countries of the WHO Eastern Mediterranean Region face many challenges that are generally cross-cutting in nature and apply to most countries irrespective of socioeconomic and health development. Addressing these challenges is key to the achievement of universal health coverage. The need for high-level political will and commitment to move towards universal health coverage with high-quality health care is the predominant challenge in many countries.

The path to universal health coverage brings attention to various barriers in access to health services linked to significant shortage in resources, fragmentation of health care systems and lack of comprehensiveness and people-centredness. Improving access to high-quality health care services is one of the seven priorities for health system strengthening in the Eastern Mediterranean Region. In October 2012, the 59th session of the Regional Committee for the Eastern Mediterranean in resolution EM/RC59/R.3 urged Member States and WHO to develop an essential package of health services at the primary care level and explore different options for its implementation including family practice programmes.

Experience from across the world has shown that the family practice approach can increase households' access to a defined package of services at an affordable cost, through trained and motivated family practice teams who can ensure high-quality, continuing and comprehensive primary care services for the individual and family across all ages and both sexes.

The document sheds light on three main aspects—the concept, principles and the policy imperative for establishing family practice programmes; strategic guidance to operationalize family practice programmes; and the current situation, challenges and opportunities for family practice programmes in countries of the Eastern Mediterranean Region. Detailed operational guidelines for the establishment of family practice programmes are being developed in a separate document.

The purpose of this document is to provide insight to policy-makers and managers on what it takes to introduce or strengthen family practice programmes as the principal approach for the delivery of quality and effective health care services and to help realize commitments made in national health policies and strategies for moving towards universal health coverage.

The first part of the document discusses the conceptual framework of a family practice programme including its characteristics and good practices from selected countries across the world. The importance of national commitment, community awareness and engagement, and family practice financing are among major components of the first part.

The key operational elements of a family practice programme are described briefly in the second part of the document that is divided into: population, family health centre and management elements. The Regional Office for the Eastern Mediterranean will develop a detailed package covering all operational aspects of the programme.

The third part of the document contains a rapid assessment of the situation of family practice programmes in countries of the Region based on a strategic approach and operational elements of family practice programmes.

Introduction

Although family practice programmes around the world have much in common, the actual scope of services can vary significantly within countries and communities, depending on many factors. The distinctive economic, political, social and cultural characteristics of a country, its burden of disease and distinctive epidemiology are important dynamics to develop appropriate health care strategies and to establish the resources. For this reason, family practices vary from country to country [1]. The fundamental characteristics of family practice and its derivative attributes allow the family physician to contribute substantially to health care systems in all countries despite differences in the way these systems are planned, organized and managed.

In all circumstances, the family physician is expected to serve as an adviser and advocate for individual patients as well as for the health of the community [2]. Despite these differences, the core elements of family practice around the world are similar. These elements provide the foundation necessary to care for the majority of people's health needs and integrate individual and community health systems with the roles of other health professionals. Family practice principles and core elements are more or less the same but their implementation can be substantially different. The principles include two main outlines: patient-centredness and comprehensiveness of care.

Family practice is already operational in many countries of the Region although there is some diversity in the approach to implementation. Family practice is more likely to succeed when based on careful consideration of a country's local conditions. This document is not intended to outline rigid criteria for family practice but rather to draw attention, based on international experience, to priorities to be considered in the design and implementation of the family practice model.

Countries of the Region should commit to and implement family practice as the principal means for the delivery of primary health care services. Many countries of the Region are making efforts to establish family practice programmes as the principal vehicle for delivering primary care. Many have already adopted family practice and are at different stages of implementation. Countries have yet to evolve workable family practice models due to such challenges as the lack of trained family practitioners, inability to register families and establish a system of family folders, lack of integration of prevention and care of noncommunicable diseases and mental health, and weak information and surveillance systems.

The purpose of this document is to provide insight to policy-makers and managers of what it takes to introduce or strengthen family practice programmes as the principal approach for the delivery of high-quality and effective primary care services. The document aims realize commitments made in national health policies and strategies for moving towards universal health coverage.

1. Rationale of family practice in universal health coverage

1.1 Universal health coverage and family practice

Universal health coverage means that all people have the access they need to promotive, preventive, curative, rehabilitation and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the users to financial hardship [3] The path to universal health coverage has three fundamental key elements: countries must raise sufficient funds; reduce reliance on direct payment to finance services; and improve efficiency and provide high-quality health services. This document presents why family practice is the approach best suited to providing good quality and effective primary care services, which are essential elements for progress towards universal health coverage.

According to the World Organization of Family Doctors (WONCA), family practice is defined as the "health care services provided by family doctors; characterized by comprehensive, continuous, coordinated, collaborative, personal, family- and community-oriented services; comprehensive medical care with a particular emphasis on the family unit; known as general practice in some countries" [2].

Box 1. Thailand's experience in universal health coverage through a people-centred family medicine model

Universal coverage implies not only financial risk protection but also primary care networks that provide people-centred services. Thailand introduced comprehensive universal coverage reforms in 2001. People pay a flat rate of 30 baht (less than US$1) per disease episode or hospitalization. Any remaining cost is covered by existing financing systems and supplementary funds. In addition, primary care is the first point of contact within the Thai health system. When the political movement for universal coverage resulted in national reforms, the people-centred family medicine model was already tried, tested and known, and was therefore adopted as the means of delivering health care to all. Since 2007, to reduce financial barriers, especially for the poor, the service has been free at the point of service.

More on Thailand's experiences in Boxes 5 and 7.

The main principles of family practice are developing and strengthening primary care delivery with continuous education, encouraging physicians and other health employees, and concentrating on preventive health services by considering an individual's family health and social requirements. Materializing these principles will prevent patient accumulation at secondary or tertiary level and ensure that there is enough time for the patients who actually need to be treated at the secondary and tertiary level. Providing primary care efficiently lessens society's disease burden and gives an opportunity to secondary and tertiary level institutions to provide better health services and health education.

Family practice and family medicine have been interchangeably used in the literature. The latter is defined as the "specialty of medicine concerned with providing comprehensive care to the individuals and families and integrating biomedical, behavioural and social sciences; an academic medical discipline that includes comprehensive health care services, education and research" [2]. While adhering to the principles of family medicine, the term "family practice" has been preferred in this document as it has wider application and encourages those countries of the Region to participate which currently may not be in a position to produce family medicine specialists.

The purpose of this document is to provide insight to policy-makers and managers of what it takes to introduce or strengthen family practice programmes as the principal approach for the delivery of high-quality and effective primary care services and to help realize commitments made in national health policies and strategies for moving towards universal health coverage.

1.2 Why family practice?

Family practice is person-focused, not disease-focused—the rationale for the discipline is based on the health of individual persons and populations, not organ pathology or the one-by-one counting of diseases, their diagnosis and management [4]. The family practice team, which is led by a family physician, knows the community where it provides service by being geographically close to family members and familiar with their relationships, their community, their environment and their occupations. The family practice team is a group of health care providers who have the best knowledge of the health and life conditions of all members of a family; therefore, the team best knows how to apply preventive health interventions including health education and other promotive, preventive, curative, rehabilitative and palliative health services.

The WONCA guidebook *Improving health systems: the contribution of family medicine* [2] identified the following major elements as benefits of implementing family practice: meeting people's health needs, unifying resources to improve health care delivery, the comprehensive role of the family physician, the proper training of the family physician team and the creation of a supportive environment for implementation of family practice.

1.3 Evolution of family practice

In nearly every country where family practice is established, the concept of family medicine started from a model of general practitioners without further specialized training following medical school. Around 1970, formal post-medical school training in family medicine was established in Australia, Canada, the Netherlands, New Zealand, the United Kingdom, the United States of America and former Yugoslavia. These programmes recognized the need for specific training of family physicians and paved the way for education in family medicine to become a formal part of medical education at all levels [1]. By 1995, at least 56 countries had developed specialty training programmes in primary care, and many more have followed suit [5]. Many family practice training programmes have been established through partnerships with medical schools, community hospitals and practising physicians [6,7]. Yet in many countries of the world, family medicine is still not recognized or established as a distinct medical specialty.

The distinctive economic, political, social and cultural characteristics of a country, its burden of disease and distinctive epidemiology are important dynamics for developing appropriate health care strategies and to establish resources. For this reason, family practices vary from country to country. The fundamental characteristics of family practice and its derivative attributes allow the family physician to contribute substantially to health care systems in all countries despite differences in the way these systems are planned, organized and managed.

1.4 Characteristics and attributes of family practice

Family practice has several key attributes [2].

- *General.* Family practice addresses the unselected health problems of the whole population.

- *Continuous.* Family practice ensures continuing care of individuals such as children, pregnant mothers and patients suffering from chronic diseases and ensures patients receive specialized and hospital care throughout their lives.
- *Comprehensive.* Family practice provides integrated health promotion, disease prevention, curative care, rehabilitation, and physical, psychological and social support to individuals. Family physicians can provide independent care for 85%–90% of problems encountered in daily practice.
- *Coordinated.* Family practice can deal with many of the health problems presented by individuals at their first contact with their family physician team but, whenever necessary, the family physician should ensure appropriate and timely referral of the patient to specialist services.
- *Collaborative.* A family practice team should be prepared to work with other medical, health and social care providers, delegating to them the care of their patients whenever appropriate, with due regard to the competence of other disciplines. Family physicians have traditionally served as the patient's first contact and point of entry into the health care system.
- *Family-oriented.* Family practice addresses the health problems of individuals in the context of their family circumstances, their social and cultural networks and the circumstances in which they live and work.
- *Community-oriented.* The patient's problems should be seen in the context of his or her life in the local community, ensuring community engagement in decision-making about the health and well-being of its members and awareness of the processes of care delivery through a family practice approach.

Box 2. The effectiveness of Brazil's family practice [8]

Family health is now public policy in Brazil and is high on the agenda of unified health system managers. There are 33 420 family health teams (covering 55% of the population), 256 847 community health workers (covering 65% of the population), oral health teams and 1250 family support core units operating nationwide. Each family health team is ideally responsible for between 3000 and 4000 people, according to the socioeconomic profile of the population, or fewer where the population is more socially vulnerable.

Brazil family health has three main characteristics that differentiate it from primary health care systems in other countries [9]:

1. multidisciplinary teams are responsible for geographical areas and their populations, with the task of identifying operational, organizational or social problems in an appropriate manner
2. the presence of community health workers
3. the inclusion of oral health in the public health system.

The positive results noted in a number of studies on family health take into consideration a range of factors such as evaluations by patients, managers and health professionals, the choice of health interventions offered and access to and use of health services, the reduction in infant mortality, the reduction in the number of hospital admissions for conditions treatable at the primary care level, and the improvement in the socioeconomic indicators of the population [10].

1.5 Family practice and its link with people-centred integrated care

There is no standard or single "model" of family practice with predefined elements that can be used as a reference. Countries have different elements developed based on specific needs for family practice implementation. Family practice is more likely to succeed when based on careful consideration of the country's local conditions. This document is not intended to outline rigid criteria for family practice but rather to draw attention, based on international experience, to priorities to be considered in the design and implementation of the family practice model.

Family practice is distinguished by two main characteristics that make it unique: its holistic approach and being people-centred. This has led WONCA to maintain that every family in the world should have access to a family doctor; a family doctor for every community [11].

Holistic approach Care delivered by family physician team should be bio-psychosocial (sometimes named holistic) [12]. The above three dimensions of care – biomedical, psychological and social – should be integrated implying that not only should care be delivered with bio-medical, social and psychological elements but that decisions made in one of these domains should explicitly be influenced giving due consideration to the features belonging to the two others.

People-centred People are free to seek their health care services from any physician they prefer, but in order to create a balance between the catchment population of each family physician team, people must be educated about the advantages of selecting their own family physician to ensure continuity of care [13,14]. Table 1 below presents the difference between conventional care and people-centred care.

Table 1. Distinguishing features of conventional care and people-centred care

Conventional care	People-centred care
Focus on illness and cure	Focus on health needs
Relationship is limited to the moment of consultation	Enduring personal relationship
Episodic curative care	Comprehensive, continuous and person-centred care
Responsibility limited to effective and safe advice to the patient at the moment of consultation	Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health
Users are consumers of the care they purchase	People are partners in managing their own health and that of their community

Source: *World health report 2008*. Geneva, World Health Organization, 2008.

Box 3. Malaysia's experience in people-centred care [15]

In Malaysia, a country of 27 million people with limited resources for health, principles of people-centred care have been incorporated into national health policies. A "person focus" is included among Malaysia's national health service goals. National policies and strategies do not carry the explicit label of people-centredness, but are fully consistent with the ideals and principles of people-centred care. These include a focus on wellness, a commitment to the provision of accurate and timely information, empowerment of people for self-management of their health, tailored health services provided close to people's homes and integrated services throughout the life course. Importantly, primary care services are accessible to all people and almost free of charge. Each patient is charged a nominal fee of 1 ringgit (equivalent to US$ 0.30) for each outpatient visit.

Box 4. People prefer approaching family doctors in Cuba [16]

All Cubans are covered by health care services which are provided free of charge. Health care services are provided by more than 68 000 doctors, 32 000 of which serve as family doctors all around the country, including all rural areas.

Family doctors have major tasks: providing rehabilitative services and preventive health care such as vaccination and encouraging a healthy life style. Specialist physicians visit the offices of family doctors on a regular basis where they meet the demand for consultation requests and provide continual training.

Patients can directly visit family doctors, polyclinics and hospitals in order to use health care services. Each geographical area hosts a polyclinic in which family physicians work among local people. Although patients have the right to consult a hospital, most patients consult family doctors. Besides attending their patients in their offices, doctors often make home visits and follow up on pregnant women, children and patients in need of continuous care.

1.6 Developing a family practice team led by family physician

The family physician is the one to whom the patients entrust their health, from whom they receive consultancy and whom they contact first as a physician for the preservation of their health and for the removal of their health problems.

Even in countries with middle and high incomes, there are problems in practice and perception of family practice as a medical discipline. For this reason, the setting cannot always be provided to encourage the medical graduate physicians to prefer family medicine as a specialty field. The duties and responsibilities of family physicians working in primary care services often involve the following:

- administering the family health facility, supervising the practice team and providing its in-service training
- contributing to local health planning, working in cooperation with the district health administration
- informing the community health centre and district health administration about the situations relating to public and environmental health met during daily medical practices
- providing person-based counselling and health-promotive and preventive services; in this context, providing mother and child health care and family planning and periodic examinations (such as cervical screening or smoking cessation advice)
- assessing the health situation of the families/individuals during the first visit and while families are registered with the health facility
- providing primary diagnostic, therapeutic and rehabilitative services in the family health facility or through home visits
- referring the patients who need to be diagnosed or treated at a more advanced level of the health care system; evaluating the examination, investigation, diagnosis, treatment and hospitalization information of the patients referred; coordinating with secondary and tertiary therapeutic and rehabilitative services; and providing home health care whenever is needed
- providing access to basic laboratorial services
- sending the records and notifications related to family medicine practices to the relevant local authorities
- where appropriate, providing first aid and emergency intervention services.

1.7 National commitment and policies to support family practice approach

Reforming primary care services into a family practice programme is not easy to execute. Empirical evidence from recent years suggests that many countries went through initial implementation struggles before family practice eventually took off, such as preparing treatment protocols, developing an essential package for health services and essential medicine list, making family folders for the families etc. It was only when the health policy objective became achieving universal coverage, including primary care reform, that the multi-disciplinary family care approach proved successful. The interpretation and local adaptation of family practice varies from one country to another in the Eastern Mediterranean Region [17].

Egypt, Bahrain, Jordan and Islamic Republic of Iran are typical examples. In 1999 in Egypt, the family health model was adopted as an integral part of health sector reform. Family practice in Bahrain has a high level of commitment: the family practice programme is well established and included in the national health plan. In Jordan the first family medicine training programme was adopted in 1989 at the Ministry of Health, and in 1994 family practice training was established at Jordan University. The Islamic Republic of Iran in 2006 started reforming health service delivery and finance, which was designed through implementing a family physician programme and universal health insurance respectively [18]. In 2012 the 59th session of the Regional Committee for the Eastern Mediterranean requested WHO to provide technical support to its Member States in moving towards universal health coverage [19]. WHO is committed to providing continued technical support to its Member States in adopting a strategic approach, standards and elements for implementation of family practice that is a tool to improve service delivery in line with universal health coverage. WHO also facilitates the exchange of experience in family practice and documents achievements and lessons learnt that will be used to streamline delivery of quality and comprehensive health care in towards universal health coverage.

Box 5. Thailand's experience in developing political support [15]

Political will was developed strategically by organizing demonstration visits to family practice health centres. These visits provided a clear vision of what people-centred family practice could achieve. Visits were organized for politicians (the Minister of Health, the Deputy Governor of Bangkok, senators and members of parliament), high officials (the permanent secretaries of the ministries of health and interior), representatives of civil society and consumer organizations, and students and health workers. Collectively, these visits helped convince a wide range of leaders, within and beyond the health sector, that a people-centred family medicine approach was both feasible and useful.

A key lesson from the Thai experience is that both technical field work and political pressure are important in facilitating change. The Thai people-centred family medicine model was developed over ten years before becoming part of the national strategy for universal coverage. During that time, the approach was refined, tools and guidelines were developed and, most important, the model's visibility was enhanced among political and health leaders.

Box 6. Political commitment a key to success of family practice in Viet Nam [20]

Viet Nam has a solid organizational structure for meeting the health care needs across the country, but there is a lack of physician providers and minimal patient confidence in the primary health care system, particularly in rural areas. In 2004 the country established a new paradigm for the delivery of primary care with the following outlines: establish and maintain departments of family medicine, complete curriculum development, upgrade community training sites, conduct faculty development, link US and Vietnamese family medicine departments, establish a national oversight committee, develop and administer entrance examinations, implement a two-year training programme, develop and administer certifying examinations and evaluate the transition to community-based practice.

1.8 Community awareness and engagement in family practice

The *World health report 2008* suggests four sets of policy directions that will reorient health systems towards a primary health care approach, along with moving towards universal health coverage, health-for-all policies and more inclusive governance.

WHO recommends reorganizing health services around people's needs and expectations. To improve health and social outcomes, health systems must put people first. They must respond to people's needs and expectations. Health care should focus on the whole person, adjusting its response to the specificities of local communities, families and individual lives. To become more relevant, services also have to do more to meet the needs of the entire population, while at the same time addressing the specific needs of some population subgroups. Therefore, a successful family practice programme depends on the degree of households' awareness about the benefits and processes of family practice and their active engagement in assisting health care providers to implement the programme.

People should recognize the advantages of receiving timely health care services through a family practice approach; for example: better quality health care without long waiting hours, availability of a follow-up and referral mechanism, availability to obtain an essential package of services and medicine without financial hardship at the point of delivery, and availability of comprehensive and effective care accessible easily to the entire population. In summary, the health care services must meet availability, affordability, accessibility, comprehensiveness, quality, efficiency, non-discrimination and age-responsiveness.

Box 7. Family medicine and community orientation as a new approach of high-quality primary care in Thailand [21]

Universal health coverage was achieved in 2002 in Thailand. In other words, by 2009, 99.36% of Thai people had access to a comprehensive package of health services through the Universal Coverage Scheme (75% of the population), the Civil Servant Medical Benefit Scheme (15%) and the Social Security Scheme (10%).

Thailand had an extensive network of health facilities before achieving universal coverage: at least one referral hospital in each district (for 30 000 to 100 000 people) and one health centre in each subdistrict (for an average of 5000 people) [22]. The experience of the demonstration health centres has been considered as the cornerstone of the universal coverage policy in setting up criteria for primary care units. Family medicine is considered as an academic based innovation that support primary care at the health centre level.

Under the Universal Coverage Scheme, known as the 30 baht scheme, patients have to register with a contracted primary care unit. They are then eligible to use the health centre where they have registered or the outpatient department of the hospital belonging to the same contracting unit for primary care. To access the service, people initially had to pay a flat rate of 30 baht (about US$ 1) co-payment per episode of illness including hospitalization. Since 2007, to decrease financial barriers, especially for the poor, the service has been free at the point of service.

Contracting units for primary care: in order to reinforce integrated health care systems, health care providers must be organized as a contracting unit for primary care to get funding. Health services providing primary care must fulfil some criteria to be recognized as a contracting unit for primary care, particularly in relation to human resources: they must have a doctor (in favour of at least 1:10 000 population, flexibility is possible up to not more than 1:30 000 population; each contracting unit for primary care must have a doctor for at least one primary care unit, a pharmacist (preferably at least 1:20 000 population, flexibility is possible up to not more than 1:30 000 population), a dentist (preferably at least 1:20 000 population, flexibility is possible up to not more than 1:40 000 population). Personnel employed by a contracting unit for primary care must be present more than 75% of their working time, services have to be available at least 56 hours per week and a laboratory system for investigations must be available as well as vehicle(s) for transferring patients. The following are major impacts of family medicine in Thailand.

- An increase in the use of primary care units, a better pathway of patients from primary care units to referral hospitals and vice versa as an outcome of the universal coverage policy [23]. In this regard, the proportion of patients of hospital outpatient departments/primary care units, by numbers of all visits who directly access hospital outpatient departments, has reduced from 1.2 in 2003 to 0.7 in 2011.
- In terms of patient experience and patient satisfaction, family practice has been systematically rated better than non–family practice. [24,25].
- The incidence of catastrophic health expenditure has fallen from 6.8% in 1996 to 2.8% in 2008 [26].

All medical services should cover both physical and mental health, including the provision of equal and timely access to basic promotive, preventive, curative, rehabilitative and palliative health services and health education, regular screening programmes and appropriate treatment of illnesses and disabilities. Further, health care services should be coordinated with the provision of social support services, including, when necessary, the provision of basic essentials such as food, shelter and safety. Community-based family practice programmes should incorporate the following general principles.

1. All health care centre staff should receive basic training in family practice, age-, sex- and culturally sensitive practices that address the required knowledge, attitude and skills to communicate with their catchment population.

2. Health care centres should provide age, sex and culturally appropriate education and information on health promotion, disease management and medications for all groups of patients, in particular vulnerable groups, of the community such as mothers, children, people suffering from communicable and noncommunicable diseases and the elderly.
3. Health care centres should make every effort to adapt their administrative procedures to the special needs of their catchment population, for example people with disabilities, chronic patients, older persons with low educational levels or with cognitive impairments.
4. Health care centre systems should be cost-sensitive in order to facilitate access to needed care by low-income persons.
5. Health care centres should adopt systems that support a continuum of care both within the community level and between the community and secondary and tertiary care levels.
6. Health care centres should train volunteers and use them in follow up of defaulters, provide simple health care services at the door steps of the community, etc.
7. All record-keeping systems in health care centres should support continuity of care by keeping records on care as well as facilitating access of the households to social services for their clients through intersectoral collaboration.
8. Individual patients, families and other groups within the community should be part of participatory decision-making mechanisms regarding the organization of the family practice services.
9. The physical environment of the health care facilities should be acceptable and matched with culture of the clients; simple and easily readable signage should be posted throughout the health care centre in order to locate easily recognized available services.
10. Key health care staff should be easily identifiable using name badges and name boards.
11. The health care centre should be equipped with good lighting, non-slip floor surfaces, stable furniture and clear walkways.
12. The health care centre facilities, including waiting areas, should be clean and comfortable throughout.

These general principles can be adapted to each health care centre and provider setting in order to ensure responsiveness and sensitivity to the community served.

1.9 Scaling up of training programmes (postgraduate and on-the-job training)

All countries of the Region have a major shortage of family physicians. In addition to the long years of study to qualify as a certified family physician, there are other factors that contribute to this shortcoming such as [27] lack of effective coordination between ministries of health and higher education institutions, limited institutional capacity to provide large-scale training for family physicians, as well as to adapt the existing surplus cadre of general practitioners to family physicians through customized programmes, and the inability to establish family medicine as an attractive career path for fresh graduates [28,29]. There is also a lack of uniformity in the curricula and duration of family practice training programmes across the Region.

Box 8. Family medicine trainees are improving the quality of care in South Africa [30]

Medunsa University in South Africa provides opportunities for physicians in government clinics and hospitals or private practice to complete family medicine specialty training through distance learning. Participants complete 12 learning tasks related to their clinical practice, a master's dissertation, and a final examination.

One of the learning tasks is to complete a quality improvement project. Trainees are expected to find and weigh clinical evidence, to measure, analyse, reflect on and change a specific practice.

Through one such project, a trainee and his local health team identified a problem of a high mortality rate during weekend and night shifts in a rural community hospital. By developing a new on-call and reporting arrangement, mortality was reduced by nearly 20% over a period of four months. The trainee not only learnt important lessons about quality improvement but also contributed to improvements in patient care.

Rolling out a family practice programme cannot rely only on the limited annual production of certified family medicine physicians. Family physicians need at least two years to obtain their degrees in family medicine (depending on the educational rules and regulations of each country), which varies between fellowship, masters and board training. Family medicine residency programmes in the Arab countries are estimated at 31 core curriculums graduating just about 182 residents per year [31]. This number does not meet the minimum regional market needs, which increase exponentially every year. This situation will most certainly limit countries' plans to expand family practice.

There is a pressing need to develop short-term on-the-job training programmes to improve general practitioners' technical skills in family medicine. Such programmes will help in providing a flow of family medicine–oriented physicians to many primary health care facilities. As an example, in Turkey, family practice was accepted as a field of specialization in 1984. However, the number of family physicians available is around 1300 while the number of family physicians needed would be around 20 000. Turkey developed a two-year training programme in the past decade for general practitioners, in line with European Union and WONCA requirements, to increase the number of family physicians [32].

1.10 Financing of family practice programmes

Ministries of health in the Eastern Mediterranean Region finance family practice programmes on the same lines as they do the health sector: the level of family practice team remuneration is relatively low, and morale may be adversely affected. Furthermore, in a fixed salary system, family physicians do not receive additional payment for exceeding the required patient load. This can undermine the efficiency and functioning of the system, particularly if the physician has the capacity to earn more in the private sector [33].

There is limited experience in the Region of strategic purchasing of services and adoption of different payment methods. In Egypt, the Family Health Fund introduced mechanisms for the purchase of health services from public or private health facilities based on capitation methods (payment based on per capita) that met predefined service quality standards. In Islamic Republic of Iran, as a plan of universal health coverage with family practice services through public and private providers, the Ministry of Health and Medical Education in 2012 assigned one physician for each 500 families in Shiraz (around 1.5 million inhabitants) and purchased the services of family physicians for the provision of a defined package of services by offering an annual contract with the public and private sectors.

Box 9. Dutch health care reforms [34]

- Introduction of compulsory private insurance based on the principles of primary care–led health care and including all citizens irrespective of their financial, employment or health status.
- Introduction of primary care collaborative for out-of-hours services and chronic disease management.
- Primary care team-building, including practice nurses.

These innovations were introduced on top of a strong primary care tradition of family practices with defined populations based on patient panels, practice-based research, evidence-based medicine, large-scale computerization and strong primary care health informatics.

Out-of-pocket payment as a percentage of total country health expenditure in the Region may reach up to 69%. All essential health services delivered in family practice should aim to be delivered equitably and free at the point of delivery. There is no best single method for compensating family physicians to encourage them to provide every facet of continuing high-quality primary care delivery. Family physicians may be best funded when they are supported as a component of comprehensive primary care services, through a combination of capitation or salaried payment plus targeted incentives to encourage specific services, for example, to reach over 98% immunization coverage. There are several benefits of capitation payment systems for family physicians. This method of funding requires registration of patients with a specific family physician or group and as a consequence, patient registries linked with capitation systems offer family physicians a principal role in caring for the patients' common health problems in coordination with secondary and tertiary care [2].

Box 10. Family practice structure in Denmark [1]

In Denmark, there is a universal health insurance system, within which there are two different groups of health insurance.

In the first group of insurance, which covers 97% of population, persons have to choose one particular family physician. They do not pay the family doctor, nor the specialist, nor the hospital upon referral from the family doctor. Patients have the right to change the family doctor after six months.

In the second group of health insurance, persons pay a portion of the health care service fee. They are free to choose or change their family doctors without restriction. They can directly consult any family doctor or specialist. In case of consulting a specialist, there is no need to be referred by a family doctor. But they have to pay an extra charge, charged by the specialist and the doctor receives the fee-per-unit of service from the insurance company.

In Denmark, every family doctor is responsible for the continuing health care and follow-up of an average of 1600 patients. Services such as follow-up of mothers and children, routine examinations, vaccination of children and prescription filling when needed are performed in both office and home visits. In Denmark, there are around 3300 family doctors.

Average family doctors see each of their patients six times per year. It is preferred that patients choose a doctor in their own neighbourhood. However, in case of discord with the doctor, the patient may choose a more distant doctor. Although it is generally stipulated that doctors would not register more than 2066 patients, this limit is exceeded in locations with shortages of doctors. If the number of persons under the coverage of the first group of health insurance is more than 1306 per family doctor, another family doctor is allowed to work in that area.

In Denmark, there are also doctors who work outside the health insurance system. However, the patients who consult them have to pay the whole fee. A family doctor is also responsible for providing emergency health care services out of office hours. To maintain this, there is an out-of-hours duty system in which family doctors in the same area equally share that responsibility.

2. Elements for implementation of family practice

Although family practice programmes around the world have much in common, the actual scope of services can vary significantly within countries and communities, depending on many factors. The services provided by family physicians depend on the local prevalence of diseases and health problems, the availability of resources (such as diagnostic equipment and supplies), the extent of their training, the organization and funding of health services, and the roles, responsibilities and availability of other health professionals. In some countries, patients may receive their primary care from community workers, with consultation and assistance from the family physician. In other countries, the family physician is trained to provide coordination and hospital care when necessary, to deliver babies and perform minor surgical procedures when indicated. In all circumstances, the family physician is expected to serve as an adviser and advocate for individual patients as well as for the health of the community [2]. Despite these differences, the core elements of family practice around the world are similar. These elements provide the foundation necessary to care for the majority of people's health needs and integrate individual and community health systems in concert with the roles of other health professionals. Family practice principles and core elements are more or less the same but their implementation can be substantially different. The principles include two main outlines: patient-centredness and comprehensiveness of care.

As stated earlier, WHO does not have standard norms or guidelines for implementing family practice programmes. There is no one-size-fits-all family practice model; rather every country will need to adapt to its own requirements. The recommended family practice elements in this chapter reflect the authors' experiences with challenges facing countries of the Region in their primary health care programmes. Bearing in mind the range of clinical practice methods in countries of the Region, the essence of a family practice programme is a flexible approach. This chapter advocates implementing options that are consistent with a country's specific health needs, resources and cultural expectations.

From the implementation perspective, this document assumes the family health centre as the first-level contact of the health system. Based on burden of diseases and epidemiological needs of the population, an essential health services package has to be identified. The defined package of services will be available at the family health centre to a defined population. Estimation of the annual number of visits per capita per primary health care facility and per staff will assist in the identification of workload at the facility level. When the types of services and staff required are clear, then we can identify the training requirements and the technology needed, such as equipment, medicine and supplies. This chapter will show this flow of thinking and enable countries to arrive at a feasible and relevant well thought-through decision on developing their own programmes of family practice.

The WHO Regional Office for the Eastern Mediterranean, in collaboration with Member States, will work over the next two years on developing family practice norms, standards, patterns and manuals. These deliverables will lead to the integration of service provision around individuals and families, restructuring today's fragmented facilities into a system of community-focused family health providers. Again, the produced deliverables over the coming period will contribute to the implementation process rather than covering the theoretical aspect of family practice. In addition, documenting countries' experience with the recommended family practice components will help enable the implementation of family practice programmes in the Region.

There are number of prerequisites for successful implementation of family practice:

- a high level of political commitment and continuity
- addressing the population's health needs
- government partnership with nongovernmental providers
- recognizing the incremental nature of programme development
- implementing measurable processes with a proper feedback loop.

The following are the recommended elements needed for implementation of family practice.

Elements related to awareness of the community in the catchment area

1. registration of catchment population and development of family folder
2. development family physician roster
3. community engagement.

Elements related to the family health centre

4. essential health services package
5. essential medicine list
6. staff pattern based on family practice with updated job descriptions
7. family health centre facility with standard set of medical equipment and furniture

Elements related to management

8. training programmes based on the new job descriptions
9. short-term on-the-job training for general practitioners
10. treatment protocols
11. referral system
12. primary health care information system for family practice
13. quality and accreditation programme.

2.1 Registration of catchment population and development of family folders

The family folder is an effective tool used for monitoring family's social and health status and for watching over an individual's health conditions from birth and during the whole course of life.

Each family member in the catchment area and registered with the family health centre will have a health folder that contains all his/her medical information. The patient's health folder moves from one family health centre to another when the family moves its residence. It contains all information about family health status, immunization status and history of antenatal, postnatal, child and other continuum care. The referral letters, replies from hospital and laboratory results are also kept in the family folder. There are number of important notes in developing family folders.

- Each individual's folder contains biographical data for members of the family (name, date of birth, national identification number, educational status, marriage status, permanent address, profession, work address, telephone number, blood group, Rhesus factor and allergies). It also contains data on an individual's health status (history in addition to any other health issues, chronic diseases, surgical operations, injuries, etc.).
- Each individual's folder contains complete medical examination data and all the procedures carried out on him/her.
- Vaccination records for vaccine preventable diseases added to an individual's folder for children under the age of five and pregnant mothers, in addition to monitoring the children's nutrition through the visits form and growth monitoring.

- Chronic diseases and disabilities are to be followed up through the visits form and a distinguishing mark to be put on an individual's folder, noting that these chronic diseases and disabilities are to be mentioned on the cover sheet of the family folder.
- The family folder should also contain information about the environmental status of the household, including access to water and sanitation, number of rooms, places for keeping animals if any, etc.

2.2 Patient rostering in family practice

Patient rostering in family practice is a process by which patients register with a family practice, family physician or team. Patient rostering facilitates accountability by defining the population for which the primary care organization or provider is responsible and facilitates an ongoing relationship between the patient and provider. Patient rostering helps to improve the practice through defining the patient population, provides better access to information about each patient, supports optimal scheduling of visits, facilitates preventive care, enhances chronic disease management and strengthens the patient–family physician team relationship [35].

Family physicians get to know their patients well through long-term continuous relationships. A wealth of unique knowledge is accumulated from these interactions. This knowledge is an invaluable aid in making accurate diagnoses and determining how rapidly to respond with interventions. Close follow-up provides the opportunity for an experienced family physician to consider differential diagnoses while watching the patient closely for developments suggesting a need for more active intervention. In this way, high-quality care is provided without expensive or unnecessary diagnostic testing, many problems are clarified or resolved spontaneously, trust is established, costs are reduced and iatrogenic risks are diminished.

To develop a family physician roster the total population in the primary health care catchment area must be identified and a plan developed for registration of families for each working family physician. The number of families per family physician team is based on the following averages.

- The average number of visits per family physician is 24–27 per day. The calculation here is based on quality standards that estimate the average time required for patient examination to be 10–15 minutes. The suggested average time and number of visits per family physician may vary from country to country based on several factors, such as staff technical competency, availability of diagnostic equipment and medical records, etc.
- Average annual number of outpatient visits for each family member (at the national level) is 0.9 per year (as an example).
- Average size of the family is 5.9 (as an example).
- Average annual working days per physician is 250 (excluding weekends and annual leave).
- Average number of visits per physician per day = average annual number of outpatient visits for each family member × average size of the family × number of families registered per physician ÷ average annual working days per physician.

These numbers are just examples of the calculations for a family physician roster. Each country may have different family sizes, number of outpatient visits and working days.

2.3 Community engagement

Community engagement is the process of involving the community by promoting dialogue with and empowering communities to identify their own needs and provide solutions for them. Participation of the community in improving primary care has been seen in most countries

through the formation of community health committees, village health committees and health centre or area health committees and the selection of community health workers for training. Furthermore, community representatives have to be included in family health centre board and intersectoral management structures such as district health boards, district development committees and hospital management boards.

A major challenge with community participation has been the capacity of the community representatives and relevant national structures to support it. Some countries responded by developing guidelines on what was expected of the communities and committed to train and support the communities. Nonetheless, community involvement, beyond paying for services and providing labour for work carried out at health facilities, has been one of the most challenging and difficult aspects of primary care implementation.

There is limited evidence of community involvement in most in countries of the Region, which leads to a lack of awareness and engagement on the part of the population to be served.

Experience from different countries of the Region has shown that organized and aware communities are able to significantly improve health indicators, especially related to immunization coverage, access to water and sanitation, mother and child health, tuberculosis and malaria control and healthy lifestyles. The following major strategies will be considered in the community engagement process:

- community empowerment for local needs assessment, prioritization and empowering the community in planning and management of local health action
- address the needs of women, children and young people and other vulnerable groups of the community
- strengthen access of the poor to the essential health package including preventive health care services, nutrition and environment
- target the poor and underprivileged
- encourage networking and partnership.

2.4 Essential health services package

The essential health services package is the core set of health services delivered at the primary care facility. The contents of the essential health services package will reflect other primary health care services delivery including level of referral, training programmes, contents of the essential medicine list, technical skills required from primary care physicians, standards equipment and furniture and many other relevant issues. In this context, the contents of the essential health services package represent the range of services that the family health centre can offer. Services outside the essential health services package will need referral.

Since the 1993 *World development report*, many middle- and low-income countries have adapted the essential health services package plan to their own situation. In some countries, this has led to direct implementation, while in others, it is more of a statement of principle.. Essential health services packages obviously include different interventions in different countries, reflecting in variation in models of care and economic, epidemiological and social conditions [36].

There are number of services that are common in essential health services packages across many countries: immunization, antenatal care, safe delivery, postnatal care, family planning services, child growth monitoring, acute respiratory infection, first aid, health education, access to essential laboratory and dental services.

Ministries of health must revisit the essential health services package for primary care facilities. This package has to be delivered under optimal quality standards to ensure that it meets community needs and epidemiological trends of diseases.

Box 11. Iraq basic health services package [37]

1. Maternal and newborn health
2. Child health and immunization
3. Communicable diseases treatment and control
4. Nutrition
5. Immunization
6. Noncommunicable disease treatment and prevention
7. Mental health
8. Emergency care
9. Food safety, environmental health and school health
10. Health education

For more information on the Iraq basic health services package, see http://www.emro.who.int/irq/iraq-news/ministry-of-health-of-iraqwho-launch-global-report-on-disability.html.

All patients conditions should be covered by one of the interventions included in the essential health services package and will receive the appropriate care as described in the treatment protocols. Such standardized benefit plans can ensure a minimum level of coverage, improve efficiency and identify the resources needed to maintain the quality standards of the services delivery.

There are three approaches for defining the essential package:

- first, specify a list of services (based on burden of diseases) that ought to be available under any form of health care system)
- second, look at the medical benefits and seek to develop an essential package out of known efficacious treatments (the problem of this approach is that an essential package of services is defined independently of resources, and households cannot bear the costs for all types of interventions which may have medical benefit)
- third, determine what the average person would want with respect to medical care and use that as a standard for determining what is essential care (this approach also defines essential services independently of resources, and the care wanted may have no medical benefit) [38].

Box 12. Bahrain's package of health services

- Child health care including immunization, growth monitoring and child development, preschool screening and periodic school screening and dental hygiene programmes
- Women's health including premarital counselling, family practice, antenatal and postnatal care and periodic screening of women including mammography
- Young adult and adult health including prevention, screening and diagnosis of communicable and noncommunicable diseases, management of ear, nose and throat problems and fever, emergency service management, minor ambulatory surgery, opportunistic screening, social counselling, health education, antismoking, nutrition clinic and home visit services.
- Occupational health including: pre-employment screening, periodic examination and disability assessment
- Dental care services including general dental treatment, root canal treatment, orthodontic treatment, paedo-dental care and dental hygiene services

To decide on the health services included in essential health services package for a country, the following five criteria have to be considered [39,40]:

- essential services are the core set of interventions to be provided through family health centres at the primary care level and should be as comprehensive as possible depending on the level of resources. Top health needs of the population according to sex and age groups are priority
- severity of illnesses and diseases afflicting the population
- services that reduce the major causes of mortality and morbidity
- the cost-effectiveness of interventions to treat or cure those illnesses/diseases and attain the most health value for money spent.

Successful implementation of the essential health services package requires the following prerequisites:

- development and implementation of management and treatment protocols
- upgrading of technical skills of primary care physicians and other family practice team members
- implement referral policy
- implement quality assurance and accreditation measures.

It is difficult to predict the cost of a basic benefit package because of the complexity of its design. Several elements for consideration in the costing process including: inadequate or conflicting pricing data; increased use of health care because coverage becomes available; the effect of managed health care; and trends over time in use, and population demographics. Defining and fully characterizing the target population is critical in determining a basic benefit package. Several issues have to be considered during the costing of the package [41].

- cost of human resource, which may different from that of the previous primary health care staff
- cost of training programmes
- cost of the newly developed essential medicine list
- new standard equipment and furniture list
- depreciation cost of the newly designed family health centre
- cost of utilities.

The concept of an essential package of interventions has been accepted by policy-makers and researchers, but there are few cases where the policy is implemented, probably because of the following problems [42]. First, there is a lack of guaranteed and sustainable sources of financing. In some poor countries there seem to be insufficient resources to finance the package of interventions. Experience shows that sufficient and sustainable financing is the most important factor that determines the successful implementation of the package. Second, the willingness to implement an essential package and its success depend on the strength of government policy. The usual case in low- and middle-income countries is that the government directs public resources more to the needs of a powerful elite, rather than adopting the implementation of the package as a system-wide policy. Third, there exists a technical problem. Because of limitations of data and technical capacity, the package is often determined by estimates about the effectiveness of interventions and social judgment about reasonableness, rather than by evidence that results from systematic and scientific investigation. The outcome is that resources may not be reallocated in an economically desirable way [43]. Last, the lack of a capable and sustainable provision system and quality

assurance programme may hinder the implementation and effectiveness of the essential package.

2.5 Essential medicine list

According to the World Health Organization's definition, essential medicines are those that meet the health care needs of the majority of the population and thus should be easily available in adequate quantities and in suitable dosage forms [44].

The essential medicine list is simply a list of medicine supplies, with generic names, that are needed to deliver treatment based on the essential health services package. Any changes in the essential health services package will be directly reflected in the contents of the essential medicine list. In other words, the essential medicine list is required by the family health centre in order to fulfil its ability to deliver the necessary services at its level of care within the essential health services package. The medicines selected should be from those specified in the treatment guidelines or the standard treatment protocols.

The regular provision of adequate amounts of appropriate medicines is crucial if health services are to be effective and credible. A large number of problems are associated with the provision and use of therapeutic medicines in developing countries: inequitable access to cost-effective safe medicines; escalating medicine costs; inefficient procurement, distribution and management; and irrational prescription and consumption [45].

Most of ministries of health have already developed essential medicine lists for primary health care facilities. Countries are in need to review and update essential medicine list's contents to fit with the essential health service package. Maintaining the availability of the contents of the list is crucial for primary health facilities.

The main objective of the essential medicine list is to increase the availability and accessibility of cost-effective medicines to populations whose basic health needs have not been met by the existing supply system. A survey conducted by WHO showed that 70% of the population in 23% of the low- and middle-income countries had no access to essential medicines [46], reflecting the rationale for the establishment of and ensuring the accessibility to such a list. The second objective, which is less explicitly stated, is to decrease the use of less cost-effective medicines.

Box 13. Introduction of an essential medicine list in Sudan and Yemen

According to the literature review by le Grand [47], a randomized control study in Yemen showed that after the introduction of an essential medicine list, doctors' knowledge of the rational use of medicines increased significantly, and improvement of medicine-prescribing behaviour was observed: there was an increase in use of essential medicines, a reduction in injections, and a decrease in inappropriate use of antibiotics. Likewise, in Sudan, significant improvements were noted in the use of essential medicines in all health facilities after introduction of the essential medicine list.

2.6 Staff patterns for family health facilities and job descriptions

Effective health care systems require a mixture of providers and facilities designed to deliver essential preventive and clinical services based on local needs, available resources and affordable costs. This includes health professionals who have been adequately trained, who

have the necessary facilities for accurate diagnoses and therapy, and who are geographically distributed to meet the needs of the population. Investments in health workers, which may consume up to two-thirds of a national health budget, need to ensure the correct number, type and distribution of health professional necessary to provide the desired spectrum of individual and public health services [48].

Health professionals do not work in a vacuum. They require a system that encourages and supports their efforts and provides adequate facilities with good working conditions. If teams are well composed, each member understands and depends on the skills of the others to create a functional whole that accomplishes the best outcome.

This document assumes that a family health centre is the first level of care and the entry to the family health system of care. A family health centre will have a number of family physicians based on the population of the catchment area. The family health centre will provide the entire basic curative and preventive outpatient services described in the essential health services package.

Patients who need basic inpatient services will be referred to the nearest district hospital with capacity to provide these services. Other referrals coming out of the essential health services package will be referred to specialist hospitals. Families will initially be assigned to the nearest family health centre (area-based assignment). It should be taken into consideration that an individual family member may prefer to be seen by a different health professional in the same clinic or in another clinic.

Box 14. Egypt staff pattern for a family health centre with a catchment area of 5000 population

1) Family physician: 1
2) Nurse: 1
3) Assistant pharmacist: 1
4) Laboratory technician (assistant): 1
5) Nurse for child health: 1
6) (immunization)
7) Medical records officer: 1
8) Births and deaths officer: 1
9) Sanitarian (1/10 000 population): 1
10) Front office: 1
11) Assistant admin/finance: 1
12) Social worker: 1
13) Janitor: 2

Total: 14

There is a need to develop national standard staff patterns for family health centres. Shortages in human resources should be fulfilled according to the staff pattern developed. Detailed job descriptions should be developed, and discrepancies between “theoretical” job descriptions and “real” work profiles should be identified and rectified if necessary. The training programmes for each staff category will fit with the developed job descriptions.

The number and staff categories working at family health facilities may differ from the proposed pattern, based on specific needs for each country. The suggested staff pattern presents the initial optimal number of working staff; again this number may increase with the rise in the use rate. The number of registered families per physician may decrease if the use rate is above 24 visits per day per family physician.

For implementing the family health practice, there are three factors for determining the number of family physicians and other staff in each family health facility. These factors are:

- the population of the catchment area and the planned percentage of coverage through the public facilities
- the expected number of daily visits, which is based on the number of visits per year per family member
- the size of the health facility, which may vary between one and three clinics according to availability of space.

Based on these criteria, the staffing at the may vary from 21 people in a facility with one clinic up to 49 people for facilities with six clinics.

2.7 Family health centre facility with standard set of medical equipment and furniture

The scope of services at the family health centre will encompass preventive and curative outpatient services, public health services including public health programmes, health information, education and communication activities, and environmental health. Support services, such as laboratory, pharmacy, health information systems and training are part of the services. The essential health services package has been determined for family health centres within this scope of services.

Assessment of primary health care facilities in Iraq and Libya shows that there is no clear infrastructure—no standard equipment or furniture for primary care. There is a significant difference in the equipment lists between primary care facilities.

National equipment and furniture standards should be developed for primary health care delivery facility. The standard contents are based on the minimum level of equipment and furniture needed to perform the services listed in the basic health services package. Other services outside the essential health services package (e.g. health office) may need to be included because it is the ministry of health's policy to offer such services at primary health care facilities. We may need to add equipment and furniture for any training centre, if the family health centre will provide training.

Several factors have to be considered in developing a standard primary health care facility:

- availability of space at the facility
- total population of the catchment area
- existence of other primary health care facilities in the catchment area
- urban versus rural factors
- current and expected number of visits.

2.8 Training programmes based on the new job descriptions

Assessment of 52 primary health care facilities in Iraq showed that one in five of facility directors and staff did not participate in any training during the year prior to the assessment. Training programmes in general do not reflect what is needed to improve the primary health care staff's technical and managerial capacities. The recommended training will have a major impact in enhancing not only the staff's technical skills but also the staff's working behaviour; it is they who will lead the implementation process inside family health centres.

There is a need to develop training programmes for each staff category that reflect the real need to perform their jobs conforming to the best quality standards. It is expected that the

training programmes improve the technical skill and behaviours of the staff, establish patient satisfaction and improve staff morale and motivation.

Box 15. Establishing family practice training in the Eastern Mediterranean Region [1,49]

The Arab Board of Medical Specialties was established in 1978 to support improving health systems and residency training through establishment of regional standards. The Arab Board of Family and Community Medicine was later established and plays a strong role in setting standards for family medicine training and provides certification for graduates. While it is not required to have certification in order to be licensed, it is considered valuable often resulting in better job opportunities and compensation, and Arab Board certification is seen as a must in some academic settings.

There are two types of training programme for family health centre staff: general training for all staff and specific training for each staff category. The general training includes the following.

- Orientation on the family practice programme principles and outlines. The training covers the nature of family practice and its link with people-centred and integrated care, the six attributes of family practice, the main principles of family practice in strengthening primary health care, the fundamental characteristics of family practice and its derivative attributes.
- Quality and accreditation. The training programme includes quality assurance strategy, quality concepts, quality tools and techniques, accreditation criteria and how to achieve it, steps for accrediting family health facility, accreditation survey measures (eight categories) and survey instruments for accreditation of family health facilities (record review, interview and observation).

Specific training is envisaged for specific cadres such as laboratory services, public health, health education, communication, family folders, clinical information system and basic computing, dental services and pharmacy services.

2.9 Short-term on-the-job training for general practitioners

All countries of the Eastern Mediterranean Region face a major shortage of family physicians. In addition to the long years of study to qualify as a certified family physician, there are several other factors that contribute to this shortcoming [7]. Among these factors are financing issues, including the level of payment of family doctors compared to hospital specialists, and health system structures which do not discourage patients from accessing hospital specialists for non-emergency care without first consulting with their family doctor. The negative attitudes towards family practice often start at medical school due to a lack of understanding of the role of and lack of exposure to family practice as a medical student, limited leadership and role models in family practice and lack of investment in continuing professional development opportunities. The current shortage will not be overcome simply through the establishment of more academic departments of family practice., All the factors contributing to the shortage must be addressed as well.

Rolling out family practice cannot rely only on the limited annual production of certified family medicine physicians. As noted earlier, family physicians need between three and six years to obtain their degrees in family medicine in addition to their MD degree, which varies between fellowship, masters and board training. This situation will most certainly limit countries' plans to expand family practice.

Providing general practitioners with a short term on-the-job training programmes to improve technical skills in family medicine will increase the number of family medicine-oriented physicians.

The Regional Office for the Eastern Mediterranean will start developing a training curriculum in cooperation with academic institutes in Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan and Lebanon. Such programmes will help in providing a flow of family medicine-oriented physicians to many family health facilities.

Global Standards for Postgraduate Family Medicine Education developed by the WONCA Working Party on Education highlight that:

- Every medical school in the world should have an academic department of family medicine/general practice, or an equivalent academic focus.
- Every medical student in the world should experience family medicine and general practice as early as possible and as often as possible in their training.

2.10 Management and treatment protocols

Clinical or treatment protocols are the guidelines that physicians follow in order to have an acceptable clinical outcome. The protocol would provide the caregiver with specific treatment options or steps when faced with a particular set of clinical symptoms or signs or laboratory data. Clinical guidelines are systematically developed statements designed to help practitioners and patients make decisions about appropriate treatment options for specific circumstances/cases.

Although guidelines and protocols have a role, they can be less useful in patients with multiple morbidities and the evidence to support their use in complex patients is limited. The implementation of guidelines is justified by the fact that there are many medical education institutes and a large variation in medical practice for the same health conditions across geographical areas and among physicians. This suggests the possibility of inappropriate provision of health care, which may cause an unnecessary increase in health care expenditure without bringing about improvements in health. Wennberg et al. have argued that exposing clinicians to scientific evidence about medical interventions and information on the extent and effects of variations will reduce variations and improve providers' behaviour, and thus improve the cost-effectiveness of health care [50].

The nature of practice in primary care brings particular difficulties, as well as opportunities. Family physicians have the advantage of continuous care over time, but usually work under considerable time pressure for consultation, and have to deal with the full range of physical and psychological aspects of medical care. Preliminary assessment for availability essential health services package treatment protocols in Iraq shows that there are no standard treatment procedures among primary health care physicians there. In addition, there is a lack of key protocols, for example for the management of diarrhoea, malaria and childbirth. Good clinical guidelines can maintain good quality of health care service delivery. Essential health services package treatment protocols are needed for the following reasons:

- to ensure the availability of standards to all components of the essential health service package
- to unify standards for management of common diseases and delivery of health care services

- to compile the available material from all programmes in an integrated format that suit the family health centre setting
- to provide the basis for development of competency-based training material
- and to better assess and evaluate the programme/functioning of the centre or team.

Box 16. Medical guidelines in the United Kingdom, Netherlands, Finland, France and United States [43]

Medical guidelines are increasingly used in many countries. In the United Kingdom, guidelines based on consensus conferences and expert opinions have existed for decades, but the rigorous design of guidelines based on scientific evidence is a phenomenon of recent years. Professional bodies produce guidelines to be used by providers to improve quality of care and by purchasers to guide contracting. In the Netherlands, the Dutch College of General Practice has produced guidelines since 1987. At present, more than 70 rigorously developed guidelines are used by medical practitioners. Finland has issued more than 700 guidelines since 1989. A programme of evidence-based guidelines development has been started recently. In France, there are 100 guidelines based on consensus conferences or modified from guidelines in other countries. In New Zealand, the implementation of guidelines is national policy. Guidelines are intensively used to restrict less cost-effective services at the point of service. In the United States, the idea of practice guidelines is not new. By 1980, eight medical societies in the United States were developing practice guidelines of their own. In 1990, more than 26 physician organizations had developed guidelines, and approximately a dozen more societies had plans to do so. In total, these societies have produced more than 700 practice guidelines.

The guidelines are usually prepared as a support to health service providers for performance improvement to provide better quality of care. The outcome is health promotion, disease prevention and cost-effective medical care. Outlined below are key principles for developing essential health services package clinical guidelines [51]:

- the guidelines provide quality improvement strategies that are valid, important and applicable to the family health centre setting
- these guidelines are more than clinical practice guidelines; they cover all the components of the essential health services package and consider the bio-psycho-social approach to health promotion and preventive and curative care
- the guidelines address technical/clinical aspects of family practice
- the guidelines address the specific needs of the family physician; what to do and when to refer
- the contents are presented in a user-friendly format
- guidelines are subjected to continuous review and updating to conform to the most recent evidence-based/best practices as they change with time
- compilation of the sections allow for multiple users for the different sections at the same time, and for easy review and replacement of parts, or all of a section.

Guidelines help health care providers in performing their work but do not replace basic knowledge and skills. The guidelines provides a user-friendly resource that address the needs of the family health centre staff and support them in providing evidence-based best practices in their daily work. The guidelines thus serve as service standards, as the basis for developing training material and as a tool for on-the-job training through supportive supervision for performance improvement and to maintain the quality of the work.

2.11 Referral system

A fundamental principle for the family health model is the close relationship between all levels of the health care system, starting at the community extending upward to family health centre and district hospital and beyond. Each patient is therefore connected through a seamless continuum of services and should arrive at the appropriate level capable of giving optimal health care for any given problem. This assures that the most common and often important measures are available near the household's residence. Through a smoothly functioning referral system, the patient can arrive at higher levels where more specialized medical professionals as well as diagnostic and therapeutic tools are available. Thus the referral system is an integral part of family health centres' daily work.

The weakest part of this communication is generally the back referral from the hospital to primary health care delivery facility. This communication not only assures proper patient care and follow up, but importantly provides continuing education to the family physician [52].

Data analysis for 52 primary health care facilities in Iraq showed that as many as 38% of primary health care patients were referred to hospitals. There was no clear level of referral, and no referral back system existed. In addition, most patients bypassed primary health care facilities and sought care directly at hospitals for illnesses that could have been easily treated at a primary health care facility. This can overburden hospitals, and is often more expensive for the hospitals and the health care system.

Developing and implementing referral guidelines between primary health care facilities and hospitals will maintain integration of health services. Every patient referred from a primary health care facility will be accompanied by a written record of the findings, any treatment given and specific reasons for referral. Based on countries' experience and the results of implementation of referral system, the following obstacles were observed [53,54,55]:

- dissatisfaction of the community once the referral system was initiated because the community would not have direct access to hospitals except for emergency cases
- insufficient medication available at the family health centres, while available at hospitals
- deficiency in the referral form data
- deficiency in completing, collecting and returning the referral forms
- non-availability of clear instructions covering the referral path
- the hospital receives referral cases which could be treated at the family health centre
- the family physician lacks information and medical skills to refer patients to the appropriate level
- non-efficiency in data reading and calculating the indications.

2.12 Primary health care information system for family practice

Information systems at most primary health care facilities lack systematic patient registration, and at many facilities the information system is underdeveloped or absent. The format and content of a patient record is not defined. As a result the data collected are not effectively used for analysis, feedback or planning.

Confidentiality and trust are vital in the clinician–patient relationship. Often clear regulations and guidance need to be in place to ensure information is used and shared appropriately. A good

family practice electronic health records system can be used for population health surveillance, health service planning, resource allocation, bench-marking, quality reviews, health research and of course to support individual patient care. WONCA has developed and supports the use of the International Classification of Primary Care (ICPC). Developed by family doctors and recognized by the WHO, the ICPC allows the coding of encounters from a primary care perspective and easily maps to hospital-oriented classification systems.

There is a need for flexible, compliant and easily adaptable primary health care information system. The system should fulfil the family physicians' requirements and reflect the contents of the family folders. The family health centre information system will collect the right clinical data and connect patient registration, family physician clinic, laboratory and pharmacy. In addition to the routine surveillance indicators, the system produces weekly reports that contain at least the following data:

- number of visits per physician
- number of visits by age group
- list of prescribed medicines
- number of cases for a specific diagnosis
- number of laboratory investigations
- number of X-ray investigations
- number of referral cases.

The system will be designed to produce the following data upon request:

- number of registered families per clinic
- number of patients by name and date of visits
- number of children and specific age group.

2.13 Quality and accreditation programme

Accreditation is the external assessment of the quality of healthcare services delivered by reference to compliance with a set of predetermined standards. It is not only a process to screen facilities and include those with optimal levels of care in the implementation process, but a great tool to set the ground for introducing a performance-based reimbursement system. Accreditation also plays an important role in strengthening the regulatory role of the ministries of health.

Client/patient satisfaction represents an outcome indicator of the perceived quality of care. It has become a top priority in number of countries of the Region including Saudi Arabia, United Arab Emirates, Bahrain and Kuwait. The ministries of health of these countries have begun a systematic pursuit of methods and mechanisms for the continuous monitoring and documentation of quality improvement interventions. The performance improvement of the services delivered through accreditation and certification is being explored in many countries, especially among members of the Gulf Cooperation Council, Egypt, Islamic Republic of Iran and Jordan [56].

Preliminary assessment of primary health care facilities in several countries of the Region shows that implementation of complete quality standards and accreditation programmes is very limited.

The development of accreditation programmes is crucial to maintain the optimal standards of service delivery in family health centres. Family practice accreditation will be voluntary or obligatory to family health centres according to the availability of resources. Accreditation survey measures should be used that focus on key processes, activities and outcomes that each facility should achieve. Implementation of a family practice accreditation programme should be based on at least eight quality measures: patient rights, patient care, patient safety, management of the facility, management of support services, management of information, quality improvement programme and family practice. There are two main principles of the accreditation process.

- The accreditation programme has to be designed to support the existing regulations of the ministry of health. These regulations provide a strong framework for the accreditation programme since they clearly define standards for compliance as well as monitoring methods and approaches.
- The accreditation programme will coordinate with supervisory systems available at the governorate level. In this context, the accreditation process is not planned to replace existing supervisory systems. Accreditation rather aims to strengthen existing systems.

2.14 Key messages

- National commitment and policies to support family practice are prerequisites for effective country programme implementation. These can be materialized through allocation of required funds, making family practice an overarching strategy for health care delivery, building health infrastructure in line with the family practice approach and ensuring all family practice elements are in place.
- Family practice must respond to peoples' needs and expectations. A successful family practice programme depends on the degree of awareness among households about the benefits and processes of family practice and their active engagement.
- There is no standard or single "model" of family practice with predefined elements that can be used as a reference. Countries have developed different elements for family practice implementation based on specific needs.
- There is urgent need to develop short-term on-the-job training programmes to improve health professions' technical skills in performing as family practitioners.
- Reforming the entire health system in a manner to ensure access to quality health services, streamlining health care delivery through the family practice approach and access to medicines and technologies, are as important as reforming the financing system if universal health coverage is to be achieved.
- Engagement with the private sector is critical for progressing towards universal health coverage. This should be done in an evenhanded manner that allows for regulating the private sector and whenever possible incentivizing it. The family practice approach encourages public–private partnership.
- Countries need to give more attention to the quality and safety of care in order for the population to have more trust in the delivery system. This can be done through accreditation programmes or improving clinical governance or both. Universal health coverage is unlikely to be achieved while service quality remains poor.

3. Family practice programmes in countries of the Eastern Mediterranean Region

1.1 The regional context and challenges

Many countries of the Eastern Mediterranean Region face health system challenges including inequities in health, rising exposure to health risks, increasing health care costs and unacceptably low levels of accessibility to high-quality health care [19]. Despite the building of extensive modern networks of health infrastructure, increasing the skilled health workforce and wide deployment of medical technologies over recent decades, the gains are not shared evenly across the Region. Among the challenges facing countries of the Region is the need for governments to develop a clear vision for health reform and build a sustainable health system and financing strategy that ensures equitable access to essential health services.

Strengthening health systems in the Region is based on and guided by the values and principles of primary health care [57], the four reform areas outlined in the *World health report 2008* [58] and the Qatar Declaration on Primary Health Care[1]. Underpinning these guiding documents and declarations is the adoption of family practice as the principal approach for the delivery of essential health services, thereby making progress towards the achievement of universal health coverage.

What follows is a brief overview of family practice programmes in countries of the Region; the current status of family practice programmes including challenges and opportunities; and lessons learnt for instituting family practice as the principal approach for the delivery of primary health care services in the Region.

1.2 Commitment to family practice in countries of the Eastern Mediterranean Region

The Eastern Mediterranean Region comprises 23 countries that span from Morocco to Pakistan and covers a population of 630 million. The commitment of the countries to the adoption of family practice is variable and can be considered across the three subgroups of countries of the Region.

- The six Gulf Cooperation Council countries[2] have made high levels of commitment to adopting family practice and are in the process of implementing different components of it as the fundamental approach to the delivery of primary health care services. These countries nevertheless face capacity challenges and rely on expertise and experience, especially from economically developed countries, for shaping their national family practice programmes.
- Among the ten middle-income countries in the Region[3] most have expressed commitment to family practice; however, implementation is patchy and piecemeal, and there are significant capacity challenges related to human resources, financing and organizational aspects of family practice programmes. Countries that have demonstrated governmental commitments include Islamic Republic of Iran, Iraq, Egypt and Jordan. The subsequent sections provide an update on progress made and bottlenecks faced.

[1] The Qatar Declaration on Primary Health Care was adopted by all Eastern Mediterranean Region countries at an international conference held in Doha in 2008.
[2] Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates.
[3] Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic, Tunisia.

There is insufficient commitment and capacity to establish family practice programmes in the seven low-income countries of the Region,[4] most of which are also among the least developed and which together account for more than 50% of the Region's population. Family medicine organizations in Pakistan are all working to promote family medicine and improve training and continuing medical education in the face of limited engagement and political will from various governments.

- Sudan stands out as the only country that has demonstrable vision and commitment to establishing a family practice programme in Gezira state. A further challenge in these countries is to determine whether the globally recognized model of family practice centred on a family physician will be realistic, or alternative models for family practice need to be considered in such settings.
- Finally, many countries of the Region continue to be in a state of conflict and protracted emergency. This puts additional pressures on already stretched health systems. Establishing or strengthening family practice programmes poses a much greater challenge in these situations than under normal circumstances.

1.3 Situation analysis of family practice in the Eastern Mediterranean Region

There is no standard or clear definition of the family practice in most of countries of the Region. Some have family medicine as a specialty with well defined training programmes, but there is no clear framework of service provision that ensures the quality of health services [59]. The assessment of family practice in 19 countries of the Region shows that over recent decades most of these countries have developed departments of family medicine that offer training programmes [59]. Few countries have developed family practice strategies as a core for improving primary health care. Additionally, the assessment revealed that family physicians are the least available specialty in all the countries assessed. The private sector is not an attractive career for family physicians, and there is an absence of attractive career path in the public sector with few continuing medical education programmes for family physicians. At the same time, there is insufficient awareness of the basic concepts and role of the family physician in the community.

3.3.1 Family practice essential elements

A rapid assessment of the situation of family practice programmes in selected countries of the Region was undertaken by the Regional Office in early 2013. This was based on two sets of criteria.

- The first related to the broad and more strategic approach to family practice in countries and included: national policy and commitment; community perception; the establishment and scaling-up of training programmes (postgraduate and on-the-job training); the existence of family practice accreditation; and financing schemes for family practice programmes.
- The second set of criteria related to the operational aspects of family practice programmes and focused on: implementation of a health service essential package, essential medicines list, standard equipment list and existence of clinical guidelines and protocols; staffing pattern; existence of functioning referral systems; extent of registration of population and adoption of family folders; and a health information system geared to support family practice programmes.

[4] Afghanistan, Djibouti, Pakistan, Somalia, South Sudan, Sudan, Yemen.

The countries that provided information were Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Sudan and Tunisia and also UNWRA. The last in this list is the United Nations agency that provides services to 5 million Palestinian refugees living in Jordan, Lebanon, Syrian Arab Republic, West Bank and Gaza.

3.3.2 Strategic aspects of family practice programmes

National policy and political commitment to family practice

Among the countries reviewed, Bahrain, Islamic Republic of Iran and Egypt have incorporated family practice as the principal approach for the delivery of primary health care services. In the case of Islamic Republic of Iran, family practice has been included in several five-year development plans starting in 1995 and had been expanded to all provinces by 2012. The national policy for family practice in the case of Bahrain is supported by a strategic mission, guidelines and well developed strategies. In Egypt, family practice is the principle that underpins the national policy for improving health care delivery.

Some of the factors that have encouraged countries to commit to establishing family practice programmes are the following. The changing epidemiologic and demographic profile in countries of the Region has created demands for services that provide continuity of care; there is increasing emphasis on providing a package of services that fulfils promotive and preventive aspects of care; accumulating evidence from several countries, both developed and developing, demonstrates the success of the family practice approach; and the message of the *World health report 2008* that puts patients at the centre of care.

The inclusion of family practice in a national policy or strategy document does not necessarily imply unequivocal commitment to its adoption and subsequent implementation. Although not part of their national health policy or strategic framework, Iraq, Jordan and Sudan have shown an increasing commitment to family practice. The commitment of Bahrain and Islamic Republic of Iran has been translated into inclusion of family practice in national plans and allocation of resources for its implementation. Egypt committed to family practice as early as 1999, which was supported by a multi-donor–funded health sector reform project. This commitment has not translated into allocation of adequate funds from national sources. Although a framework for the development of family medicine was approved in 2008 in Tunisia, the family practice programme is not yet functioning.

Community perception/acceptance of family practice programmes

Given the different levels of development, the perception and acceptance of family practice programmes varies among countries. There is greater community engagement in Bahrain, Islamic Republic of Iran and Gezira state in Sudan. For instance in the Islamic Republic of Iran, community representatives (*shura*) have a major role in the planning and problem-solving of health services, and households are free to register with any of the recognized family physicians within their area of residence. In Egypt, the Ministry of Health and Population has developed and implemented a marketing strategy to improve community perceptions regarding family practice. In Iraq, Jordan and Tunisia, additional efforts are needed to raise the level of awareness and to better define the roles of communities.

Training programmes for family physicians and practitioners

The training programme for family practice in Islamic Republic of Iran lasts six years. In addition, there is a continuing medical education programme for family practitioners with five-year intervals between relicensing, which represents an important step in maintaining standards of care provided by family practitioners. Many physicians from the Arab countries take the Arab Board in Family Medicine, which is a four-year programme. Others have developed their national programmes. For instance, the Egyptian Fellowship Board is offered over three years. In Bahrain, almost 230 family physicians had graduated up to 2012. This is complemented by regular in-service training of family physicians working in health facilities. Jordan and Lebanon also have well developed postgraduate training programmes in family medicine. In Gezira, Sudan, the University of Medical Sciences and Technology offers a one-year diploma in family medicine. Tunisia has developed postgraduate and continuing service training courses for family practice. A specific curriculum for family medicine was introduced in 2012.

Despite the existence of the above as well as other family medicine training programmes in the Region, their scope remains limited and the numbers produced are far fewer than the requirements of national programmes. Underlying factors include: the lack of effective coordination between ministries of health and higher education institutions; limited institutional capacity to provide large-scale training for family physicians, as well as for converting the existing cadre of general practitioners to family physicians through customized programmes; and the inability to establish family medicine as an attractive career path for fresh graduates [29] There is also a lack of uniformity in the curricula and duration of family practice training programmes across the Region.

Accreditation of family practice programmes

Many schemes to accredit family practice programmes exist and are described as primary health care accreditation programmes in some countries. The family practice programme in Bahrain has been accredited for some years by Accreditation Canada. Jordan also has a similar programme for primary care facilities accredited by its own Health Care Accreditation Council. Accreditation programmes in the Islamic Republic of Iran and Egypt do exist but need to be strengthened and institutionalized, as many of the accreditation requirements at health care facilities are only partially met. These function under the administrative authority of the respective health ministries and lack the independence required of such programmes. Iraq, Jordan, Lebanon, Sudan and Tunisia have developed accreditation programmes which are not fully functioning.

Financing of family practice programmes

Family practice programmes are generally financed on the same lines as the health sector. In the case of Bahrain, the family practice programme is entirely financed out of public sector revenue but only for its citizens. The expatriate population has to rely on private insurance schemes for receiving similar services. In the Islamic Republic of Iran the public sector is largely responsible for financing family practice programmes. In Sudan, the programme in Gezira state is jointly funded by the state ministry of health, a health insurance agency and other partners. The national health sector strategy 2012–2016 of Sudan proposes a scaling up with financing from national resources and the support of international partners. In Egypt, the donor financed family health fund used to the major source of financing for family practice programmes, but since its abolition the sustainability of the programme has been questioned due to low revenue

and lack of funds from national resources. The government of Tunisia has not allocated special funding for its family practice programme.

There is limited experience in the Region in strategic purchasing of services and adoption of different payment methods. In Egypt, the family health fund introduced mechanisms for the purchase of health services from public or private health facilities based on capitation methods that met predefined service quality standards. In the Islamic Republic of Iran, the Ministry of Cooperatives, Labour and Social Welfare purchases the services of family physicians for the provision of a defined package of services by offering an annual contract.

3.3.3 Family practice components: operational aspects

Essential health services package, essential medicine list, treatment protocols and essential technology

In general most countries included in the review have an essential or a basic package of health services. The major challenge is the inclusion of promotive and preventive interventions and the implementation of the essential health services package itself. Recent assessments conducted by the Regional Office in early 2013 for health services provided at primary health care facilities in a number of countries of the Region show remarkable differences in the available health services among primary health care facilities. There is no agreement on the services delivered at country primary health care facilities. For example, some facilities may provide family planning, others may not; it is the same with perinatal care. Emergency services and laboratory investigations are different from one primary health care facility to another. Referral protocols, which provide guidelines for referral, are not available in most primary health care facilities.

According to WHO, up to 100 million citizens of the Region lack regular access to essential medicines [60,61]. Assessment of the availability of essential medicines at primary health care facilities in a number of countries of the Region show that many key essential medicines are either totally missing or in short supply. Primary health care facilities have experienced delays in receiving medicines that varies from one month in about half the facilities to more than three months. Such poor availability of these essential medicines renders the facility ineffective and unable to save lives. It also reduces use and leads to poor client satisfaction.

Bahrain has developed and introduced the essential health services package and essential medicines list, and treatment protocols for common chronic diseases are available in all health care facilities. In the case of the Islamic Republic of Iran a package of services for each level of care comprising preventive, screening, diagnostic, treatment, referrals and rehabilitative health services has been developed. The essential medicines list is accessible at all health facilities, as are treatment protocols for most prevalent diseases. Moreover, the guidelines and essential equipment are in line with the package of services to be delivered. In Egypt, the essential health services package includes preventive and curative health services that target the whole population, while the programme is implemented with special emphasis on the poor. In addition, treatment protocols are fully developed and standard equipment/ furniture and building designs have been developed to upgrade facilities. In Iraq, the essential health services package and essential medicines list have been developed since 2009 but not fully implemented. The treatment protocols in Iraq are only available for those problems that are covered under vertical programmes such as diseases involving diarrhoea, diabetes and hypertension. The essential health services package and essential medicines list are available in Sudan, but implemented only in Gezira state. The treatment protocols are developed only for some prevalent diseases in Sudan. Jordan has also developed an essential health services package and list of essential

medicines but has not implemented them. Treatment protocols are also available for some vertical programme related diseases in Jordan. Tunisia has not yet implemented an essential health services package. However, the terms of reference for family physicians has been defined.

Staffing patterns

Given the limited capacity of family practice training programmes in the Region, staffing of facilities by qualified family physicians, family practice nurses and other workers is the single most important challenge. Despite acceptable health worker-to-population ratios in many countries, these are by and large general physicians and general nurses and not qualified family health practitioners. Bahrain may be among the few countries in the Region where two-thirds of the primary care physicians in government health centres are trained family physicians, and the majority of these are Bahraini nationals. In Egypt, standardized staffing patterns exist and post descriptions for family physicians are available, but there is a shortage of trained family practitioners. In Iraq, the number of qualified physicians is limited, there is lack of a clear job description for family physicians along with the absence of trained paramedical staff in family medicine. Jordan has developed norms for family physicians but has not implemented these yet. The staffing pattern has not been identified in Sudan and Tunisia.

Referral system

The lack of a well functioning referral system in support of family practice programmes is a recalcitrant problem faced by most countries. With the exception of Bahrain, where the referral system is operational, the Islamic Republic of Iran, Egypt, Jordan and Sudan are all in some ways struggling to make it functional. In the Islamic Republic of Iran, the weakness in the referral chain is less from health houses[5] to the rural health centres than from the latter to the hospitals. In Sudan and Tunisia, the referral system has yet to be properly designed.

Registration of catchment area population and development of family folders

Four demographic elements are important for the development of a family health centre programme: identifying the catchment population in the vicinity of the facility; registration of all members of households at the health facility with the choice given to the family for selection of a family physician in their area of residence; development of the family physician roster (number of families assigned to each family physician); and the existence and use of a system of family folders to ensure continuity of care. These functions can be undertaken manually by staff, be semi-automated or be recorded electronically. Bahrain, Egypt, Jordan and Islamic Republic of Iran are the only countries that are more or less implementing all four elements. In the Islamic Republic of Iran, women health volunteers function as a bridge between households and health facilities to follow up the defaulters. In Egypt, most of the health facilities register their catchment populations and family folders do exist but are implemented only partially. In the pilot area of Gezira state, Sudan, the catchment population for each facility is defined and is registered in an electronic database. Family registers have been designed, and their completion is the responsibility of the family physician. There is no defined catchment area at the moment in Tunisia.

[5] The health house is the most peripheral health facility in the Iranian rural setting providing primary health care services to a defined population of 1500 by trained community health workers.

Family practice information system

The health information system in most countries is by and large not geared to support a robust family practice programme. Once again, it is functional and automated in the case of Bahrain. In the Islamic Republic of Iran and Egypt key health indicators related to the defined catchment area have to be reported on a regular basis to the higher level based on defined health information system tools and guidelines. The health information system for the family practice programme in Egypt requires further strengthening. In Jordan, key information is collected and reported by the health facilities to the higher level, which is done on a manual basis. In 2013 Jordan started an electronic health information system. Although a health information system is lacking in primary health care in Tunisia, it is planned to develop an epidemiological surveillance programme followed by identifying risk factors.

3.4 Case studies on family practice from the Eastern Mediterranean Region

The following section presents case studies that provide insight into the development of the family practice programme in three different contexts. It highlights many challenges faced as well as achievements in reconfiguring existing primary care delivery programmes into family practice programmes.

3.4.1 Establishing a family practice programme in UNRWA refugee camps, Jordan [62]

UNRWA, established in 1949, has now expanded to provide health and social services to 5 million Palestinian refugees living in camps in Jordan, Lebanon, Syrian Arab Republic, West Bank and Gaza Strip. In 2010, a study carried out by WHO in Nuzha and Baqa'a camps in Jordan, embracing a population of 200 000 Palestinians, revealed that primary health care services delivered in these two camps focused on maternal and child health,[6] family planning and communicable disease prevention according to defined standards and procedures. Subsequently, UNRWA made efforts to integrate management of noncommunicable diseases, introduce a screening programme for the detection of diabetes and hypertension in adults, and prevent micronutrient deficiencies. Health centres located in the camp areas introduced a home visit system for high-risk clients. Outpatient care, dental care, rehabilitation of physically disabled persons, laboratory and radiological facilities and provision of medical supplies were strengthened to deliver an expanded package of services in these camps. All registered Palestinian refugees, irrespective of their income, social status or sex were considered eligible to receive UNRWA health services. "Healthy family" files were maintained in the health centres that contained the medical history of each family member to make the UNRWA's health programmes family focused.

The UNRWA's health department has also adopted the integrated community-based action framework as a bottom-up approach to socioeconomic development. It aims to reduce poverty, improve health and environmental conditions, achieving better quality of life through active community involvement. A camp health committee including representatives from the health centre, community members, camp administration, local leaders and police has been established to ensure that community members are involved in the planning, monitoring and evaluation of primary health care services. Monitoring of primary health care services

[6] Antenatal and post natal care, family planning, immunization, growth monitoring, promotion of breastfeeding, oral rehydration, food supplementation and iron supplementation.

implementation is carried out through a systematic assessment based on measurable indicators through regular visits to the field.

The programme has contributed to increasing immunization coverage among infants to 99.3%, deliveries assisted by skilled health personnel to 100%, the contraceptive prevalence rate to 53%, access to safe drinking-water to 99.3%, as well as reducing the infant mortality rate to 22.6 per 1000 live births and the maternal mortality ratio to 22.4 per 100 000 live births.

3.4.2 Family practice in the Islamic Republic of Iran: political commitment and intersectional action are essential elements for a successful family practice programme

During the past two decades, the Islamic Republic of Iran has made significant improvements in health indices, which have been achieved mostly through the establishment of a primary health care network system. However, the need to concurrently establish family practice and universal health insurance programmes as part of health sector reform has been recognized for some time. The family practice programme aims to improve continuity of care, especially for noncommunicable diseases, in a way that reduces referrals to higher levels, and improves and sustains the quality of primary care services.

Family practice programmes inevitably are embedded within the primary health care framework. Family practice teams are the first contact at the primary care level and cover a well defined population. The teams get involved in public health functions including screening, surveillance, health promotion, health education and preventive measures. At present, more than 5500 physicians and 2500 midwives and nurses provide primary health care services for almost 23 million rural dwellers. Primary health care in rural areas works more efficiently with higher coverage rates compared to service delivery in urban areas. The primary health care network system has three major components: health houses established in a village where a group of nearby villages with an average defined population can be served; local (one male and one female) community health workers (*behvarz*) who are trained over two years on delivery of primary health care services and are recruited by the government to serve in the same community; and simple and effective health information systems. Health houses serve approximately 1500 people living in the main and satellite villages with no more than one hour's walking distance. *Behvarz* are committed to stay in the same village for at least four years after "graduation" till they become eligible for continuing their education as health technicians in the universities. Health houses provide primary health care services to their defined catchment population, actively follow up defaulters, collect health data and produce monthly reports to the nearest health facilities that are run by family practice teams. *Behvarz* are part of the family practice team in rural areas. The introduction of this system has helped to greatly improve the national health indictors within a short period of ten years after the programme was introduced.

The current fifth five-year plan for economic, social, and cultural development obligates the Ministry of Health and Medical Education and the Ministry of Cooperatives, Labour and Social Welfare to extend their services (universal health insurance and family physicians) to urban areas. Currently, the necessary groundwork for expansion of the programmes to urban areas and establishment of the electronic health information system is being done, and the implementation phase has just started in all provinces. Due consideration is being given to aspects related its organization, human resources, financing and payment mechanisms, capacity-building, and health information system. At this early stage several implementation challenges are being faced for each of these components.

3.4.3 Family health model: Egyptian health sector reform programme [63]

The aim of the Egyptian was twofold: first, to introduce a high-quality essential package of primary health care services, contribute to the establishment of a decentralized (district) service system and improve the availability and use of health services; second, to introduce institutional reforms based on the concept of purchaser–provider split and strengthening the regulatory functions of the Ministry of Health and Population. Egypt has adopted the family health model as its principal strategy for the promotion of primary health care services in the country. The Ministry of Health and Population emphasized five key interventions while implementing the health sector reform programme and the family health model: facility architectural design and equipment; basic benefits package, staff capacity building and continuing training; quality and accreditation; and establishment of a family health fund.

Currently, 2078 primary health care facilities (50%) have been upgraded to work as family health units. The upgrading includes physical infrastructure, development of family health folders and updating of the family health operational manuals. In addition, health care providers at the primary health care level have been extensively trained to assume their new role as family health care providers. The ongoing plan is to accredit the upgraded primary health care facilities [59].

A study comparing user satisfaction between accredited and non-accredited family health units was done in 2005. The result showed high levels of satisfaction in accredited family health units due to positive attitudes of family physicians and community nurses, cleanliness, and short waiting lists. The family health fund was established in 2001 to act as a purchaser of health care services on behalf of its beneficiaries, the Egyptian population. It was intended to be a financially independent body established as an insurance unit to put into effect separation of service provision from financing. The role of the family health fund was to purchase curative and preventive primary health care services, to be extended to secondary care in the future, by contracting health service providers in both governmental and nongovernmental sectors, paving the way for competition and improved access and efficiency.

Since the closure of the health sector reform programme in 2005, it has been difficult to sustain the quality of health services. Lack of motivation of patients to use family practice services, weak referral systems, a high turnover rate among family physicians and inadequate health systems financing mechanisms are now among major challenges for sustainability of the family practice programme in Egypt.

3.5 Integrated district health system based on the family practice approach: a regional initiative

The Regional Office for the Eastern Mediterranean launched in 2011 an initiative called “Integrated District Health System based on the Family Practice Approach” (IDHS-FPA). The initiative was launched in four districts of Iraq and one of Jordan, and the assessment phase has been successfully completed. The IDHS-FPA project proposes the following interventions for the establishment of a family practice model: mapping of available health facilities at the district level; development of an essential service package and essential medicines list; financing modalities, including payment methods, to improve access at district level; public–private partnership: contractual and noncontractual arrangements; decentralization of health service management; enhanced health system monitoring and evaluation; workforce capacity-building and human resource management; financial, administration, logistics and maintenance management system; improved information system: information collection, processing,

analysis, and use of information for health service planning and management; community ownership in local health development; and sustained intersectoral collaboration [64].

3.6 Conclusions and lessons learnt

The establishment of family practice in countries of the Eastern Mediterranean Region is at a relatively early level of development. In most countries addressed in this study the complete family practice programme does not exist and in many only a few components are being implemented. Despite these shortcomings a reasonable beginning has been made and this needs to be sustained over the next decade. Family practice programmes, if implemented well, constitute an essential step on the way to achieving universal health coverage. The lessons learnt from these programmes are not unique but rather reinforce the lessons learnt from other regions. These lessons have been summarized below.

- Sustained political commitment is critical for acquiring a vision, evolving strategies and implementing family practice programmes. This political commitment should translate into provision of financial resources as well as organizational support to programme implementers.
- There is no perfect family practice model, and every country has to come up with its own model that best suits its requirements and resource availability. Nevertheless every family practice model, sophisticated or otherwise, should adhere to the fundamental elements of family practice that include, among others, patient-centredness, continuity of care, whole-person orientation and the promotion of equity, quality and safety.
- Developing a qualified and well trained workforce of family physicians supported by well trained family practice teams is critical to the success of any family practice programme. This requires establishing and scaling up competency-based long-term as well as short-term training programmes, especially to convert the cadre of existing general practitioners into family physicians.
- Family practice programmes will be successful only when they gain the acceptance and active participation of the community. This is essential as communities will only register with and use family practice facilities if they are involved in their planning, appreciate the quality of services provided and trust the functionality of the referral system for more serious ailments.
- Piloting of family practice programmes may provide opportunities to adapt and refine a family practice model that best suits the context. It can help minimize costly errors prior to pursuing a policy of scaling up.
- The implementation of the family practice model through private sector facilities, of which there is limited experience in the Region, should be explored. Engaging contractually with private providers that meet the eligibility criteria to deliver an essential package of publicly financed services based on a specified payment method requires new sets of skills and capacities for the provider as well as the purchaser;
- More research and, equally important, good quality documentation are needed among countries of the Region to share and disseminate positive as well as negative experience on all aspects of family practice programmes.

Glossary

Continuity of care: a term used to indicate one or more of the following attributes of care: (i) the provision of services that are coordinated across levels of care – primary care and referral facilities, across settings and providers; (ii) the provision of care throughout the life cycle; (iii) care that continues uninterrupted until the resolution of an episode of disease or risk; (iv) the degree to which a series of discrete health care events are experienced by people as coherent and interconnected over time, and are consistent with their health needs and preferences.

Comprehensiveness of care: the extent to which the spectrum of care and range of resources made available responds to the full range of health problems in a given community. Comprehensive care encompasses health promotion and prevention interventions as well as diagnosis and treatment or referral and palliation. It includes chronic or long-term home care, and, in some models, social services [58].

Family doctor: a medical practitioner who is a specialist trained to provide health care services for all individuals regardless of age, sex, or type of health problem; provides primary and continuing care for entire families within their communities; addresses physical, psychological, and social problems; coordinates comprehensive health care services with other specialists as needed; may also be known as a family physician or a general practitioner in some countries [65].

Family medicine: specialty of medicine concerned with providing comprehensive care to individuals and families and integrating biomedical, behavioral, and social sciences; an academic medical discipline that includes comprehensive health care services, education, and research; known as general practice in some countries.

Family practice: the health care services provided by family doctors and often supported by a multidisciplinary team; characterized by comprehensive, continuous, coordinated, collaborative, personal, family and community oriented services; comprehensive medical care with a particular emphasis on the family unit [2].

Family physician: see family doctor.

General practice: see family practice.

General practitioner: see family doctor.

Health service: *any* service (*not* limited to medical or clinical services) aimed at contributing to improved health or to the diagnosis, treatment and rehabilitation of people [66].

Health system: 1) all the activities the primary purpose of which is to promote, restore, and/or maintain health; 2) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they service, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities the primary intent of which is to improve health; 3) the ensemble of all public and private organizations, institutions, and resources mandated to improve, maintain, or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental, and economic determinants of health [67].

People-centred care: WHO defines people-centred care as "care that is focused and organized around the health needs and expectations of people and communities rather than on diseases. People-centred care extends the concept of patient-centred care to individuals,

families, communities and society. Whereas patient-centred care is commonly understood as focusing on the individual seeking care (the patient), people-centred care encompasses these clinical encounters and also includes attention to the health of people in their communities and their crucial role in shaping health policy and health services" [68].

Primary care: often used interchangeably with *first level of care*. 1) The part of a health services system that assures person focused care over time to a defined population, accessibility to facilitate receipt of care when it is first needed, comprehensiveness of care in the sense that only rare or unusual manifestations of ill health are referred elsewhere, and coordination of care such that all facets of care (wherever received) are integrated. Quality features of primary care include effectiveness, safety, people-centredness, comprehensiveness, continuity and integration [58,69]. 2) The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care need, developing a sustained partnership with patients, and practicing in the context of family and community [70].

Primary health care: a health reform movement launched at Alma-Ata in 1978 to move towards health for all. In 1978 it called for essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country could afford to maintain at every stage of their development in the spirit of self-reliance and self- determination. It formed an integral part of both a country's health system, of which it was the central function and the main focus, and of the overall social and economic development of the community [71]. In the 1980s it became the set of activities outlined in the Declaration of Alma-Ata: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential medicines. In the 1990s it was a level of care that was the point of entry to the health services system (see primary care). More recently (2008) it was a set of policy orientations and reforms needed to move towards health for all: moving towards universal coverage; shifting service delivery to people-centred primary care; ensuring health in all policies; and promoting inclusive leadership and governance [58].

Universal coverage or **universal health coverage**: ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, services of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship [72].

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Annex 1

Overview of the status of family practice programmes countries of the Eastern Mediterranean

Table 1. Group 1 countries

Elements of family practice programmes	Bahrain	Kuwait	Oman	Qatar	Saudi Arabia	United Arab Emirates
National policy and commitment to family practice	High level of commitment, included in national health plans, family practice programme well established	Available and evolving of political support	No separate national policy for family practice, it is part of PHC strategy. There is a good political commitment	Family physician concept is part of the National Strategy for the Health Sector	Available as part of PHC country strategy with good political support	Good political commitment
Community perception about family practice	High level of community awareness; limited active participation	Increasing community perception for family practice (e.g. through mass media, personal feedback, satisfaction studies)	Weak community perception for family practice	In process of developing community perception for family practice	In process of developing community perception for family practice	One of the major challenges facing family practice
Training programmes for family physicians	Residency programme for family physicians exists; most are certified by the Arab Board and the Royal College of Surgeons in Ireland	Well accredited post-graduate family medicine residency training programme. In service training on-going but not well structured	4-year training programme under the Oman Medical Specialty Board In-service training available	4 years family practice Board) In-service training available Continuous medical education programme available 18% of PHC physicians have a degree in family medicine	4 years –KSA medical specialty Board family practice One year diploma In-service training available	3 years Arab Board. 60% of physicians working in family medicine are nationals and 40% are expatriate
Accreditation schemes for family practice programmes	PHC facilities have been accredited by Accreditation Canada	Pending for accreditation (preparation ongoing)	Not available	Available, in the piloting phase	Available, in the piloting phase (in 100 PHC centres)	Not available
Financing of family practice programmes	Public sector financing; for expatriates private health insurance schemes	Majority within Ministry of Health budget	Within Ministry of Health budget	Within PHC budget	Within Ministry of Health budget	
Existence of EHSP, EDL,	EHSP developed and	BHSP and EDL are available and	BHSP, EDL and treatment	Available and	BHSP and EDL are available	All are available and

Elements of family practice programmes	Bahrain	Kuwait	Oman	Qatar	Saudi Arabia	United Arab Emirates
treatment protocols and essential technology	being implemented; EDL and guidelines available at all PHC facilities	implemented Treatment protocols are Available but not comprehensive , partially implemented	protocols are available and implemented	implemented	and implemented 4 protocols are available and distributed. In process of developing 16 protocols CPG for 45 diseases are in process	implemented
Staff pattern in family practice facilities	Staff pattern standardized; two-thirds of PHC facilities have trained family physicians	Available, not implemented	Available and implemented	Available and implemented	Available fully implemented	Not available
Functioning referral system to support family practice programmes	Referral system in support of family practice functions reasonably well	Available and implemented	Available and implemented with several challenges	Good referral system but referral feedback is weak	Available fully implemented	Good referral system but referral feedback is weak
Registration of population and development of family folder	Catchment area defined, population registered and can choose its provider, system family folders functional	Defined area for health centres. Electronic medical records	Well defined area No family folder	Catchment urban areas Family folders are available	Catchment areas are defined Family folders are available	The patients are distributed geographically through the health centres Family physician is responsible for 4000 inhabitants
HIS geared towards family practice programmes	Electronic health information system fully supports family practice programme	Full computerized information system	Full computerized information system	Computerized information system, partially implemented	Computerized information system, partially implemented	Available and implemented

PHC Primary health care
EHSP Essential health services package
EDL Essential medicine list
HIS Health information system

Table 2. Group 2 countries

Elements of family practice programmes	Libya	Morocco	Palestine	Syrian Arab Republic	Tunisia
National policy and commitment to family practice	New PHC oriented strategy introduced family practice as the pillar of a re-engineered health system	"Adopting workable models of family practice for the delivery of primary care services" is one of the country health priorities	There is a good political support. No family practice national policy	No family practice national policy	No national policy as yet for family practice. Increasing commitment
Community perception about family practice	No community perception about family practice	No community perception about family practice	Very limited community awareness	Very limited community awareness	Limited community awareness
Training programmes for family physicians	There is no explicit policy on human resource development	Lack of adequately trained family physicians is a major challenge facing family practice	El Nagah University postgraduate sutday4 yeas. 20 graduates in 2013	4 years post graduate family medicine study	Post-graduate and continuing service training courses available
Accreditation schemes for family practice programmes	There is an accreditation programme but not functioning	Accreditation programme is not fully functioning	Not available	Only on a pilot phase.	Not implemented
Financing of family practice programmes	No specific fund allocated to family practice	No specific fund for family practice	No specific fund for family practice	No specific fund for family practice	No earmarked funds
Existence of EHSP, EDL, treatment protocols and essential technology	Not available	"Package of Minimum Care" exist and is well-defined EDL is available	EHSP at EDL (updated recently)are available implemented	EHSP at EDL are available but not implemented	Not available
Staff pattern in family practice facilities	No staff pattern is implemented.	Not fully implemented	Inconsistently implemented	Not implemented	Staffing pattern not standardized, most staff are not family practitioners
Functioning referral system to support family practice programmes	It is one of the country health strategy but not functioning	Not functioning	Not fully functioning	Not functioning	Referral system in support of family practice not well functioning; bypass phenomenon common
Registration of population and development of family folder	There is an ongoing vital registration system in which every family has in its possession a book "the family book"	Not mandatory	Not available	Not available	Catchment population identified, not registered; family folders do not exist in general

Elements of family practice programmes	Libya	Morocco	Palestine	Syrian Arab Republic	Tunisia
HIS geared towards family practice programmes	Health information system not upgraded to support family practice	Health information system not to support family practice	There is a primary health care HIS	Not available	Health information system not upgraded to support family practice programme

Table 3. Group 2 countries (continued)

Elements of family practice programmes	Egypt	Islamic Republic of Iran	Iraq	Jordan	Lebanon
National policy and commitment to family practice	Included in national policies since 1995 under the health sector reform programme; funding commitment to family practice variable	High level of commitment, included in national plans since 1995; emphasis on family practice programme in urban areas	Increasing commitment; not included in national policy as yet	Increasing commitment; included in national policy for five governorates	No family practice national policy
Community perception about family practice	Limited community awareness; Ministry of Health and Population has a 'marketing' strategy	High especially in rural areas; community leaders involved in planning and management	Limited community awareness	Limited community awareness	Improved over the past few years
Training programmes for family physicians	Egyptian Fellowship Board Programme offered over 3 years; supported by internships and fellowships in family medicine	family practice training programme of 6 years' duration; system of continuing education with re-licensing every five years	Pre- as well as in-service family practice training programmes not developed	Pre- as well as in-service family practice training programmes	Two postgraduate programmes: one at AUB (4 years) one at USJ (3 years) A CME system is established with the Order of Physicians
Accreditation schemes for family practice programmes	In initial stages, needs further strengthening; oversight and management by the Ministry of Health and Population	In initial stages; oversight and management by the Ministry of Health and Medical Education	None	PHC facilities accredited by Health Care Accreditation Council	A PHC accreditation programme was piloted in 2010–2012 for 26 PHC centres, the programme will expand to 174 PHC centres in next three years
Financing of family practice programmes	Initially financed by the donor; currently financing is a challenge	Public sector financed including Ministry of Health and Medical Education; Ministry of Social	Public sector financing; modalities not adequately worked out	Public sector financing from government revenues and social health insurance	As part of Ministry of Public Health budget

Elements of family practice programmes	Egypt	Islamic Republic of Iran	Iraq	Jordan	Lebanon
		Welfare and Social Security			
Existence of EHSP, EDL, treatment protocols and essential technology	EHSP developed and being implemented; EDL and guidelines available at all PHC facilities	EHSP developed and being implemented; EDL and guidelines available at all PHC facilities	EHSP developed since 2009, not implemented	EHSP developed and partially implemented	EHSP is developed and introduced in the PHC network The Ministry of Public Health has an EDL that is updated every 2 years The Society of Family Medicine has developed a guidebook on management of the 30 most common cases and conditions seen at PHC centres
Staff pattern in family practice facilities	Health workforce to population ratios are adequate; accredited PHC facilities have trained family physicians	Health workforce to population ratios are adequate; most are not trained family physicians or practitioners	Initial piloting being done to define staffing patterns, most staff are not family practitioners	Staffing pattern not standardized, most staff are not family practitioners	Most PHC centres have general practitionerss and specialists and registered nurses
Functioning referral system to support family practice programmes	Referral system in support of family practice is not well functioning and bypass phenomenon is common	Functions better at the level of health house and PHC facility; inadequate functionality from PHC facility to hospitals	Referral system in support of family practice not well functioning; bypass phenomenon common	Referral system in support of family practice not well functioning; bypass phenomenon common	Not functioning. Two pilot sites at Wadi Khaled and Nabatieh
Registration of population and development of family folder	Catchment population registered, family folders exist but not fully implemented	Households registered with health facilities, family folders exist and women health volunteers function as a bridge between households and health facilities	Catchment population identified, not registered; family folders do not exist	Catchment population identified, not registered; family folders do not exist in general	The family folder is adopted at some centres There is no catchment area defined for PHC centres
HIS geared towards family practice programmes	Health information system not upgraded to support family practice programme	Currently being upgraded and automated to meet requirements of family practice programme	Health information system not upgraded to support family practice programme	Health information system upgraded to support family practice programme	Not fully functioning

Table 4. Group 3 countries

Elements of family practice programmes	Afghanistan	Djibouti	Pakistan	Somalia	Sudan[Gezira State]	Yemen
National policy and commitment to family practice	No family practice national policy	No family practice national policy	No national policy on family practice	No family practice national policy	Increasing commitment; not included in national policy as yet	No family practice national policy
Community perception about family practice	Very limited community awareness	Very limited community awareness	Community perception of family practice is missing	No community awareness	Community awareness satisfactory, but not active participation	No community awareness
Training programmes for family physicians	Training programme for Family physicians does not exist	No training for the concept of family practice in the curricula at the university or at the field	Since the early 1990s there are four institutions has developed family medicine programmes	No data	Diploma in family practice offered by Gezira University	In the process of establishing family medicine especially at Hadramout University
Accreditation schemes for family practice programmes	Not available	Not available	Not available	Not available	None	In process of developing guidelines
Financing of family practice programmes	No specific fund for family practice	No specific fund for family practice	family practice training programmes in public institutions (CPSP and KEMU) are funded	No specific fund for family practice	Funded by state Ministry of Health, health insurance agency and partners	No specific fund for family practice
Existence of EHSP, EDL, treatment protocols and essential technology	EHSP and EDL are available and implemented	Outdated EHSP at EDL are available but not implemented	EHSP at EDL are available but not generally implemented Treatment protocols and guidelines are available for number of diseases	EHSP is available but not implemented. EDL is available in many PHC facilities. There is standard treatment protocols that will be updated in 2013	EHSP and EDL are available, but implemented only in Gezira State	EHSP and EDL are available and implemented in a limited scale
Staff pattern in family practice facilities	Not implemented	Not implemented No family practice facilities	Not applicable as there are no family practice facilities	It is available, implemented in 20% of PHC facilities	Initial piloting being done to define staffing patterns, most staff are not family practitioners	Available, but not implemented
Functioning referral system to support family	Not functioning	Not functioning	The referral system is in place but	Not well functioning	Referral system in support of	Very limited implementation

Elements of family practice programmes	Afghanistan	Djibouti	Pakistan	Somalia	Sudan[Gezira State]	Yemen
practice programmes			generally not		family practice not well functioning; bypass phenomenon common	
Registration of population and development of family folder	Not available (annual catchment area census is conducted by all health facilities)	Not available	Not available	Not available	Catchment population registered, family folders exist but not fully implemented	Not available
HIS geared towards family practice programmes	Not available	Not available	Not available	Not available	Health information system not upgraded to support family practice programme	Not available

Improving access to high-quality health care is one of the seven priorities for health system strengthening in the Eastern Mediterranean Region. Experience from across the world has shown that the family practice approach can increase household's access to a defined package of quality health services at an affordable cost. The purpose of this document is to provide insight to public health policy-makers and managers of what it takes to introduce or strengthen family practice programmes as the principal approach for the delivery of quality and effective health care services and to help realize commitments made in national health policies and strategies for moving towards universal health coverage.

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