Family medicine's commitment to the MDGs

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Although there are still 5 years to go, there are clear indications that the Millennium Development Goals (MDGs) will not be met by 2015. All regions lag on at least some of the goals and south Asia and sub-Saharan Africa lag on almost all of them. In these regions, most countries are making insufficient progress to reduce child mortality and maternal mortality.

In many countries, much more needs to be done to reach people who are poor with development programmes.[1] Reductions in the incidence of and better outcomes for HIV and non-communicable diseases in low-income countries can greatly enhance progress in the health-related MDGs.[2] Action is needed to address these challenges and WHO has responded by calling for the renewal of primary health care.[3,4]

The World Organization of Family Doctors (Wonca) has built its 19th World Conference (to be held in Cancun, Mexico, on May 19–23, 2010) on the contribution of family medicine to the MDGs. Wonca wants to take the World Health Assembly resolution[4] as the guideline for its further development. Across the world, family physicians work in interdisciplinary teams in the community. In health centres and district health hospitals in townships in Africa, in rural and remote areas in Latin America and Australia, in mega-cities like Shanghai, or in medical homes (multidisciplinary primary care teams providing patient-centred co-ordinated comprehensive care) in the USA, initiatives are developing to integrate responsive primary care and provide a wide range of services.

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These innovative approaches depend on community-based professionals (nurses, midwives, and allied health professionals in primary health care, and family physicians[4]) possessing the special skills that integrate general medical, social, psychological, and managerial competencies. The vital role of primary health care for the MDGs stresses an important fact: the professional competencies can only be gained and further developed in the multidisciplinary setting of primary health care. Primary health care requires multidisciplinary training in the community setting, which is where research and innovation in care should also occur.

Wonca has invested in combining generalist medical care with community-based interventions that cross traditional borders of health care.[5] Family medicine has become a discipline that puts people at the centre of health care through continuity of care, including health promotion, disease prevention, and curative, palliative, and rehabilitative care. Moreover, family physicians act as advocates for their patients and communities and as navigators by referring, when appropriate, through increasingly complex health-care systems.

Crucial for the success of the primary-health-care response to the MDGs is to ensure that family physicians and other professionals in primary health care continue to work in the communities of the world. Training efforts are wasted if the trained subsequently drift to other functions or places—their expertise needs to be retained.[4] Primary health care is facing the problem of internal, international, and intercontinental brain-drain. In many (developing) countries, there is a brain-drain from generalist disciplines towards specialist care, from rural to urban areas, from poorer to richer populations. Only investment in community-based training of family physicians, nurses, midwives and others might stop this attrition. Therefore Wonca has helped the development of African national colleges and international support for training of family physicians through the Primafamed-network.[6,7] South Africa, Kenya, Rwanda, and the Democratic Republic of the Congo have recognised family medicine as a specialisation and train family physicians who are adjusted to the needs of the local community, with use of a holistic approach. South African departments of family medicine are involved in a South-South strategy, twinning with training complexes in Namibia, Botswana,

Swaziland, Lesotho, Malawi, and Mozambique for the training of family physicians.[8] There is an urgent need for medical faculties to join this effort and Wonca therefore cooperates with the Network: Towards Unity for Health, which will convene in Kathmandu, Nepal (Nov 13–17, 2010) in a meeting entitled Advancing Quality through Partnerships of Health Professions Education and Health Services Institutions.[9]

To make health care more effective, disease-specific vertical programmes should be implemented in the context of integrated primary health care.[10] When maternal, newborn, and child health care operates within primary health care, quality and continuity of care are improved. Wonca was one of the lead organisations that launched the 15by2015 campaign,[11] asking major international donors to assign 15% of their budgets by 2015 to strengthening horizontal primary-health-care systems to combat fragmentation.[12] Family physicians can play an important role to increase synergy between programmes.

The Cancun conference will mark the transformation of family physicians from individual providers, looking at the individual needs of individual patients, into a medical team-member focused on the needs of the community, working together with other community health workers while integrating personal and community health care. There is strong evidence that countries with a robust primary-health-care system have better outcomes in terms of relevance, equity, quality, and cost-effectiveness of the health system.[13] The time has come to put this evidence into practice.

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Smokeless tobacco—proposals for regulation

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In 2006, the International Agency for Research on Cancer (IARC) concluded that smokeless tobacco is carcinogenic in human beings, causing cancer of the oral cavity and pancreas.[1] IARC noted wide variability between geographic regions in the type and extent of disease caused by use of smokeless tobacco, and that the disease dissimilarities were accompanied by large differences in the concentrations of carcinogens in the tobacco used in different regions.

Smokeless tobacco as used in Sweden does not increase the risk of oral cancer although there is an association with pancreatic cancer.[1] In the USA, smokeless tobacco causes oral cancer.[2] In India and parts of Africa, the risk of oral cancer in smokeless tobacco users is dramatically higher than that in the USA.[1,3] The preparation (moist snuff or Snus) used in Sweden is produced to a standard that results in a low nitrosamine content. In the USA, there are traditional products with high levels of nitrosamines. Very high concentrations of nitrosamines and polycyclic aromatic hydrocarbons have been found in some smokeless products from Asia and Africa.[1,4–6]

Smokeless tobacco has recently been considered by WHO's Study Group on Tobacco Product Regulation