

# RCGP *International Newsletter*

June 2004

Issue 31

## A postcard from Oman

**Dr Roger Neighbour FRCGP**



*MRCGP[INT] award ceremony in Oman, March 2004*

In March I flew out to Oman with David Haslam to award certificates to several dozen doctors who had been successful in the MRCGP[INT] exam, joining other College Fellows Adrian Freeman, Cameron Lockie, Mike Jeffries and Rob Caird, who had all contributed to the Oman programme. On our arrival at Muscat airport in the early evening, the first thing that struck us was the heat. The second was the warmth – of the local and ex-pat staff; the students of the medical school at Sultan Qaboos University; of our chief contact Shirley McIlvenny and her colleagues; and the Omani people themselves.

One of the good things about being President is that you get to hear what people think about primary care in general and the College in particular. This is always interesting and sometimes chastening; but every now and then you get a sense of what esteem the College is held in, and how appreciative people are of what we offer.

At an outdoor presentation ceremony, David and I found ourselves, begowned and applauded – the British Ambassador in the front row, with palm trees and the sound of the Arabian Sea as our backdrop.

We did – quite literally – pinch each other.

Earlier in the day we had an audience with the Omani Minister of Health, explaining how investing in primary care improves health outcomes better than secondary. During a session on the nature of generalism, I found many of the issues the group wanted to discuss had a degree of familiarity: work-life balance; recruitment and retention; the feminisation of the profession; why hospital doctors looked down on general practice.

The previous week one of the visiting MRCGP examiners, Adrian Freeman, had suffered a heart attack and was recovering in the enviably well-equipped public hospital. Angiograms were planned for the following day, and two precautionary units of blood had been ordered from the blood bank.

The deal with patients in Oman is 'if you take blood out of the bank, you get it replaced'... before long the College Chairman and President had plasters over the punctures in our antecubital fossae, and receipts for our donations were on their way to Adrian's ward. (He's fine, by the way). But now, if any sceptic ever asks what they get for their membership fee, the answer is easy: 'You want blood? We do blood!'

**Dr Roger Neighbour FRCGP**  
**RCGP President**  
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## Editorial

This issue of the RCGP International Newsletter once again has articles from all over the world, reflecting the involvement of doctors in many different societies and cultures with the common and universal goal of providing good Primary Care.

The accreditation for MRCGP[INT] is creating much interest throughout the world, as it is the only recognition of a standard in Primary Care which exists. The purpose behind it is not to create an examination identical to the MRCGP(UK) but to recognise an equivalent standard in other countries. Many countries and departments have expressed an interest in acquiring MRCGP[INT] and it might be helpful to give a brief outline of the process involved. The International Committee appoints an International Development Adviser (IDA) to assist the Host Examining Body (HEB) in achieving standards of assessment which are reliable and valid, and to establish a process where these may be applied. When this is in place, two Exam Development Assessors (EDAs) observe the conduct of the HEB examination and report their recommendations to the International Committee, which then may award recognition. The IDAs and EDAs are experienced assessors drawn from the Panel of Examiners at the College in London. The standard set so far by Family and Community Medicine Department (FAMCO) in Oman and by Brunei will be the yardstick which others will have to meet, and it is gratifying to see that this objective has been influential in raising standards in so many other training programmes.

In this issue we have an article from Dr Roger Neighbour, President of the RCGP on the award of the MRCGP[INT] to its first recipient, the FAMCO, Sultan Qaboos University, Oman. Roger and the Chairman of Council, Dr David Haslam, together with the IDA, EDAs and Oman Fellow were at the splendid ceremony in Oman when the first graduates were awarded their diplomas.

If this represents the "end point" of achieving good Primary Care, then read about others who are starting and travelling along the way: in Uganda a huge challenge presents itself but it is obvious from Dr Ruth Taylor's experience that enthusiasm is infectious and that enabling health workers to learn for themselves has a cascading effect. This is borne out both in Afghanistan and in Kosovo, two countries recently torn by the destruction of war, where great progress is being made, and example set, by dedicated teachers whose experiences are described here.

International Travel Scholarships (ITS) are awarded twice a year by the RCGP with the intention of fostering the development of Primary Care. Many applicants use these to spend time in the UK, seeing how the systems both of health care delivery and education in General Practice are carried out and we include one doctor's experience here. Perhaps it will stimulate others to apply for an ITS, or even to submit an article for this Newsletter, which we would welcome.

**Dr Rob Caird FRCGP**  
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## Medecins sans Frontieres in Afghanistan

**Dr Jonathon Tomlinson MRCGP**

Since November 2003 I have been working for Medecins sans Frontieres (MSF) in Kushk-e-Kohna district in the north West of Afghanistan near the Turkmenistan border. I have been training staff in a village clinic. There are approximately 60,000 people in the district, the majority of whom are farmers. The main health problems are lack of potable water, food and education. The main morbidities are diarrhoeal diseases, acute respiratory infections, dyspepsia, malaria and tuberculosis. There are only 3 clinics in the entire district but there are pharmacies in many villages.

In 2002 there were 4000 doctors in Afghanistan. Half of these were working in Kabul. Almost all are men. There were about 7000 medical students. There are far less trained CHW (Community Health Workers) and TBA (Traditional Birth Attendants) than doctors. The primary care pyramid has been turned on its head, which is to say that most people in villages should be seen by a CHW or TBA and referred to a doctor if necessary. As a result, the majority of people have no access to any formal healthcare. Patients usually consult local traditional doctors, some of whom run the pharmacies as well, or (less commonly) they visit the village mullah, who will say prayers or for example, give a bottle of water with a prayer inside to be drunk like a medicine. Most of the pharmacists in the villages seem to be unqualified, the drugs are of dubious quality and the amount of medication prescribed has more to do with the amount the patient is willing to pay than the illness. Maternal mortality is 1700/100,000, the second highest in the world. Women may be seen by a male doctor but usually only if accompanied by a male relative and occasionally their husbands refuse to let them attend a male doctor. Usually they bring a child to the clinic to validate their own consultation. Life expectancy is 46 and between 1 in 5 and 1 in 3 children die before they are 5 years old. The vast majority of these deaths could be prevented with doctors or drugs.

Afghanistan is over medicated and underfed, over studied and undereducated, like most of the developing world. There are ambitious plans to rebuild the national health infrastructure, but the security in

many parts of the country is still very poor and there is a desperate lack of trained health workers.

I have been writing a diary every week and I have edited some of the descriptions to give an impression of the problems people face and the work I've been doing.

### November 14 2003

Dr Wazir Ahmad [the clinic doctor] has started bossing the patients around in a way that I am far too soft and too culturally distinct to do. His first victims are dummies. He explains to the women that they are lazy, and that the crying is because the child is hungry and he instructs them to breastfeed. Most days we come across children who have become sick and having appeared to be disinterested in feeding had not been fed. Most breastfeeding mothers with healthy children only seem to feed 3 or 4 times a day so those that survive are incredibly resilient. And thin.



*'GP consultation, Afghanistan'*

How long can MSF provide food to malnourished children before the crops and livestock recover and people can get a fair price for their wheat, before mothers feed their children appropriately and can choose the size of their families, before people can afford new seeds and equipment and.... the rest.

### December 20

It suddenly occurred to me yesterday, as we bumped and slithered our way over the rock-strewn, flooded tracks from Kushk to Herat that my patient, labouring and bleeding beneath her burkha, might actually deliver underneath her modesty sack and not tell me. I was accompanying her back to the hospital because the bleeding and contracting had been going on irregularly for the last 2 days. She was covered for the duration of the 4 hour trip except for a couple of brief occasions when she came up for air. This was her eleventh pregnancy, so it was not at all unlikely that

the baby might just pop out with a big bump or even a little cough. Somehow she held the baby in, a compliment to her pelvic floor after such a journey, and she was delivered with child in utero much to the relief of all concerned.

### February 16

"This is from the burning wife", he said handing me a piece of gauze with what appeared to be a small piece of flesh nestling in the middle of the plump, white, sterile pad. Next door to the vaccination room was a woman with a swollen, purple face, like Verucca Salt, surrounded by curious onlookers. I had seen her a few minutes earlier, a burn victim of a pressure cooker explosion and a cosmetic victim of her husband's generous administrations with Gentian Violet. The nursing assistants who set about carefully cleaning her wounds, were burly bearded men who double, indeed treble and quadruple as guards, vaccinators, administrators, cooks, cleaners and occasionally nurses. With calm, efficient professionalism they thoroughly cleaned the wounds, removed the dead skin and very gently dressed the wounds while the children scream and struggle.

### December 30

The sex education class was already well underway by the time I showed them the 20cm long wooden penis so that everyone could practice putting on a condom. We discussed HIV/AIDS and 'streetwalkers' and I reassured them – with some difficulty – that masturbation did not make you blind, or daft, or give you a humpback or hairy palms. We wondered why there was no information about HIV in Afghanistan.

On Wednesday June 3rd, 5 of our colleagues and friends; Bezmillah, Fazil Ahmad, Pim Kwint, Egil Tynaes, and Helene De Bier, were shot and killed whilst travelling in Badghis province, only about 4 hours drive from Kushk-e-khona. MSF Holland in Afghanistan has suspended all operations until we can properly assess the possibility for continuing safely. Further threats have been made to NGOs and other foreigners in the western region since their murders. We are all terribly shocked and our friends and colleagues are greatly missed.

**Dr Jonathon Tomlinson**

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# UNDERSTANDING MUTUAL AGENDAS

**Dr Pierre Mallia**

With the MRCGP[INT], the RCGP is not only extending a specialist-recognized qualification abroad but it is using the opportunity to enhance cooperation and dialogue between itself and other countries. Each country may have a reason why it would want to import the MRCGP[INT], but would probably say that they wanted to raise the standard of care for patients and the quality of primary care. This is a broad statement which may not suffice for a better understanding between colleges; to illustrate, my path is to take as an example my own country – Malta.

Malta has a population of less than half a million. We have one University and within it one medical school. To specialize in any area, doctors must go abroad. Traditionally we have been an 'MRCP-culture'; doctors go to the UK to obtain the membership of colleges representing the speciality they wish to enter. This necessitates, in most cases, spending time in the UK.

This has not applied to Family Medicine. Of course one can go to the UK and work towards the MRCGP(UK). But this qualification caters for the British scene. When doctors in Malta have a constitutional right to practice, spending years abroad is unnecessary and one can start investing in private practice – the mainstay of family medicine in Malta. With the introduction of Vocational Training (VT) things may change. It is still unclear whether our government intends to insist that only doctors working in community government health centres have completed VT, or whether the view should be that of the Malta College of Family Doctors (MCFD), that *all* doctors wishing to do primary care should have this qualification.

This is the agenda of the MCFD for the future. To increase the standard of care we are introducing further CME, which will lead to the membership of our college (MMCFD). We need incentives for those who

would qualify for a "grandfather clause". Here is where the MRCGP[INT] may be involved: if by obtaining the former one qualifies for the latter, we would be attaining our goal of being inclusive and having all primary care physicians as members. Having a qualification, which is equivalent to MRCGP(UK), would indeed give the necessary impetus to doctors and the necessary respect from other specialist colleagues. College memberships have traditionally been recognized by our University as legitimate post-graduate qualifications.

The understanding of our agenda on the part of the RCGP is therefore very important to us. We expect the RCGP to recognize what we feel should be the requisites for our own membership, given our culture and traditions without, of course, compromising standards. This would be the job of the International Development Adviser (IDA).

We wish to see the RCGP set the standards for family medicine in dialogue with us. This is especially true within the European Community, as it is inevitable that Europe will move towards a common standard of care. The MCFD in Malta will validate VT, thereby having considerable influence over standards. The MCFD intends to work on a Diploma in Family Health (DFH) in addition to VT. This, combined with clinical skills and practice assessment – to be worked out in collaboration with the IDA – should lead to MRCGP[INT].

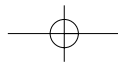
The challenge of the twenty-first century is dialogue in an atmosphere of diverging cultures on one hand and multiculturalism on the other. In a world where force may give you power, benevolence gives you authority. MRCGP[INT] is a sign of this benevolence to doctors wishing to ascertain their higher standard of proficiency; it may also be a sign of the times – globalization.

**Dr Pierre Mallia**  
**President, Malta College of Family Doctors**  
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## International Visits

The College regularly hosts delegates from around the world who wish to learn more about the College's activities and the UK Primary Health Care System. Among others this year, we have received visitors from the United Arab Emirates, China, India, Dubai and Brazil, and plan to welcome parties from Ethiopia, Bangladesh, Thailand, Pakistan and Turkey before the end of 2004.

Contact the International Department (details on page 12) for more information.



# Country Profile

## MALTA

Where: Malta  
 Population: \*393,000  
 Population Growth: \*0.7  
 Capital City: Valletta  
 Area: \*316 sq km  
 (120.08 sq miles)

Source: \*World Health Organisation 2000



# Health Profile\*

Life expectancy at birth:	Males 75.9 Females 80.3
Total fertility rate:	1.8
Infant mortality (per 1,000)	Males 7 Females 6
Adult mortality (per 1,000)	Males 87 Females 51
Total expenditure on health per capita (US\$)(2001):	813
Total health expenditure as % of GDP(2001):	8.8%
Public health expenditure as % of total health expenditure	68.5
Public health expenditure as % of general government expenditure:	12.8%

## RCGP International Travel Scholarships

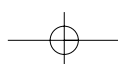
- Fully qualified and trained GP or Family Physician?
- Interested in conducting research into an aspect of primary healthcare?
- Looking to travel overseas?

**The International Travel Scholarship** assist any general practitioner or family doctor in the world to undertake personal study of an aspect of primary health care in an international context.

**The awards are open to** members and non-members from the UK and overseas. They enable GPs travelling to or from the UK to study an aspect of primary health care internationally, which is relevant to their country's needs, or to help develop systems of primary care.

Application forms can be downloaded from the RCGP website [http://www.rcgp.org.uk/international/its\\_info.asp](http://www.rcgp.org.uk/international/its_info.asp) or by contacting the International Department (see contact details on page 12).

**Closing dates** Friday 13 August 2004  
 Friday 14 January 2005



# RCGP INTERNATIONAL DEVELOPMENT

**IRAQ:** The College is represented by Dr Mary Polkinhorn on the Iraq Working Subgroup of the Department of Trade and Industry. Meetings have been held with Iraqi officials about developing College-accredited training programmes, though the ongoing tensions in the region preclude any more active inputs for the time being.

**KOSOVO:** Dr Graham Rawlinson has begun a series of visits to Kosovo with a view to accrediting the local exam for the award of MRCGP[INT].

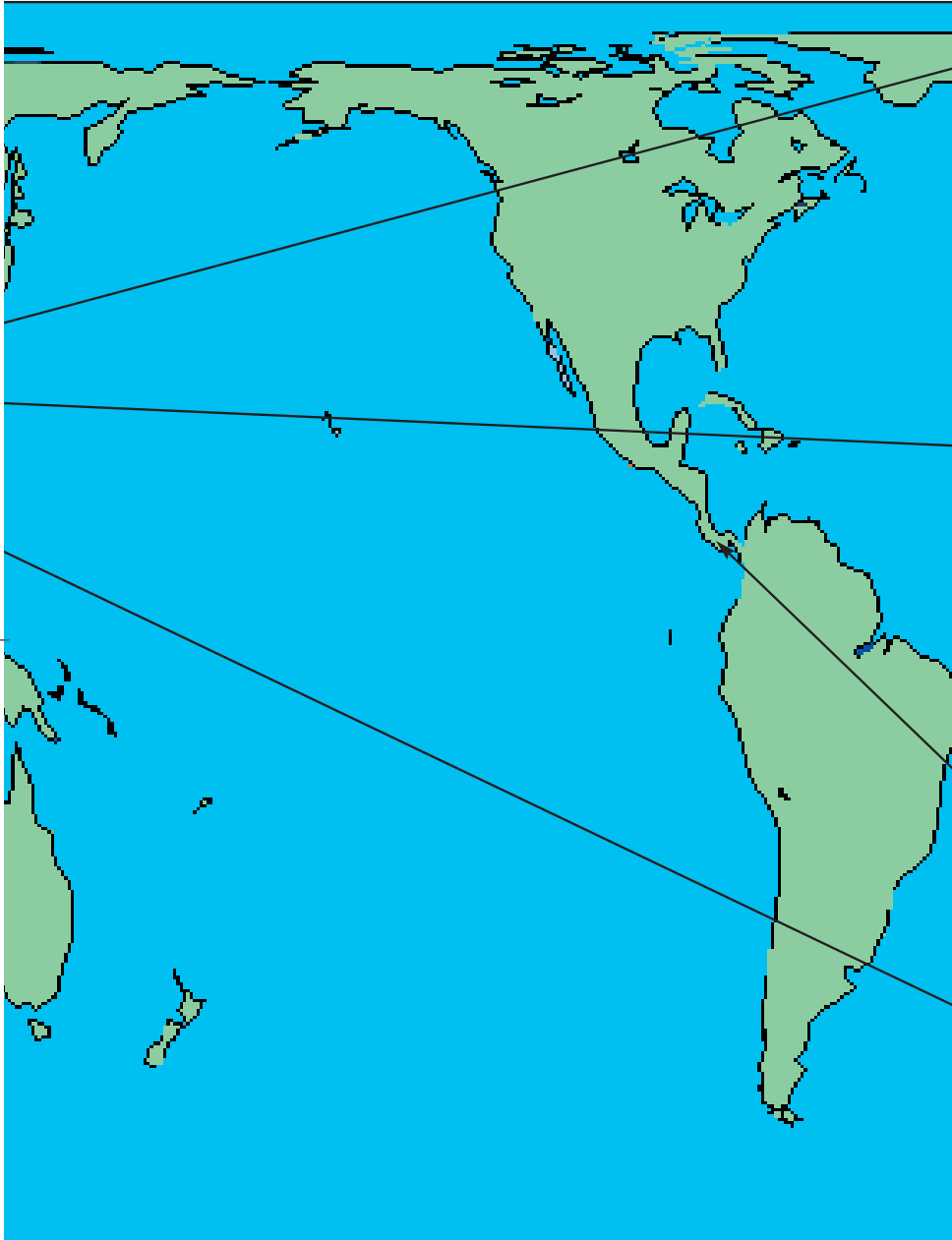
**CHINA:** An inward mission of Chinese health professionals, sponsored by Department of Health International, was hosted by Dr Sunil Bhanot at RCGP in mid-May. As a direct result of this Dr Garth Manning will take part in a Ministerial Visit to China in early June, to have discussions with the Chinese about possible collaboration on a number of ventures.

**CYPRUS:** RCGP is assisting the Cyprus College and Ministry of Health Cyprus to develop accreditation processes for family doctors. The second module of the "Excellence in General Practice" teaching programme was delivered in March 2004 and we are in discussions about providing further support to developments in Cyprus.



**SOUTH ASIA:** Development of the MRCGP[Int] process for South Asia continues. Representatives from Bangladesh, Nepal, Pakistan and Sri Lanka met at Aga Khan University Karachi in late March to participate in an Examiners' Workshop run by Professor Val Wass and Dr David Sales and facilitated by Professor Riaz Qureshi and Dr Garth Manning. A further workshop will be held in Karachi in February 2005, to coincide with the next AKU-organised Regional Family Medicine Conference. It is hoped that the written component of the first MRCGP[Int] Examination for South Asia can be held in November 2005 (in a number of centres) with the practical exams (for those successful in the written papers) scheduled for Dhaka in February 2006.

# INTERNATIONAL PROGRAMME:



**INDIA:** RCGP's long term collaboration with the Apollo Hospitals Group is just about to enter its fifth year. Dr Jim Cox will make his last visit in June and we are in the process of confirming his successor as IDA. We have also been in discussions with the Lutheran University about developing training programmes for Indian doctors who are seeking a career within the NHS and which would be accredited by RCGP. PMETB, JCPTGP and BMA have all been represented in the discussions.

**BANGLADESH:** Continues to host the MRCGP[Int] Secretariat for South Asia led by Professor Falahuzzaman and to be one of the five lead countries in the MRCGP[Int] initiative. The Bangladesh College of Physicians and Surgeons (BCPS) has just agreed a three-year post-graduate training programme in family medicine and RCGP has had the chance to input into this. The Executive Officers from BCPS will visit RCGP later in the year for further discussions on collaboration.

**PANAMA:** Following an inward visit by Panamanian officials last September Dr Garth Manning has now been invited to present at a PHC seminar in Panama in August.

**THAILAND:** Our collaboration with Thammasat University Bangkok, National University of Laos and University of Maastricht got under way with an inception mission in February. Dr Mei Ling Denney and Professor Rosslynne Freeman have been appointed as the College IDAs for this programme, which will involve training of trainers and developing curricula for CPD programmes.

## where in the world are we?

**Dr Garth Manning FRCGP, Medical Director,  
International Development Programme  
gmanning@rcgp.org.uk**

# Building Family Medicine in Kosovo

**Dr Tom Garrett FRCGP**

## Primary care post-conflict

Eastern Europe has been host to many members and fellows of the College since the fall of communism in 1989. Some of us have been working in Kosovo with the European Agency for Reconstruction under the leadership of Dr Bob Hedley. He has worked with the Dean of the Medical School and colleagues in the Ministry of Health such as Dr Arben Cami, to develop medical training for Family Medicine. An integrated health service for the returning people of this mountain bound province of ex-Yugoslavia is now assured with primary care as its keystone.

The estimated population of 2,000,000 needs 700 family physicians (FPs) and so there is more human and personal building to be done. As with many communities in the south-east of Europe life-expectancy is low: less than age 50 for males at age 15 and less than 60 for females. Diseases of circulation are the commonest (particularly stroke) with lung cancer and other diseases of smoking.

There has been rapid and enthusiastic progress in the implementation of Family Medicine to replace the communist system of basic general practice and specialisation in polyclinics. Patients have taken a liking to this form of health delivery. The energy of newly-trained family doctors and nurses is matched only by that going into the building in and outside the capital Pristina of large new family homes!



*Dr Bob Hedley and staff outside the new building for the Centre for the Development of Family Medicine, Pristina*

## From signpost to gatekeeper

The status of family physicians had been very low

prior to the implementation of the new form of health care; this is now changing markedly. Some 300 family physicians have been trained through a fast-track two-year course to become specialists in their own right, equipped with good communication skills, professional development and revised generalist knowledge. Those doctors with more than 10 years practice were offered a year's professional development through the support of WHO.

Dr Genc Yverhalili heads the centre for development of Family Medicine working in Pristina and the eight administrative municipalities. The next phase of development includes vocational training for specialisation preceded by an undergraduate curriculum and foundation training. All doctors will receive a foundation in our discipline based in the eight main family medicine teaching centres. When a dozen or so doctors have completed their Masters research-based studies later this year a full Department of Family Medicine is planned. Final year students are showing great interest in the orientation talks given by staff and there will be no lack of doctors intending to train in this attractive new speciality. The capacity is building high and the door is now open.

## Training the trainers

It was an adventure for me in 2001 to teach the first module of acute medical emergencies and trauma to the first two-year group. We struggled with the cultural shift from didactic teaching to problem-based learning in which each participant became as authoritative (if not more so!) as the teacher.

Returning 21 months later I found many of the group are fully established and expert trainers. They hugely enjoy bringing on a new cohort and feel fulfilled.

In the final two weeks of the current phase of the project (May 2004) we will be facilitating a selected group of trainers as they train 30 new trainers. As usual in the past year I will be working with Huw Morgan, like me a retired Bristol GP and ex-VTS course organiser. Also visiting will be another member of our old VTS team, Graham Rawlinson, the newly-appointed MRCGP[INT] IDA for Kosovo. From foundational training for capacity into assessment for quality; so the building is nearing completion.

As the adage goes: "If you can't, then teach and if you can't teach, then teach teachers!"

**Dr Tom Garrett**  
**International Development Adviser**  
**Email: tgarrett@cix.co.uk**

# Family Medicine in Bangladesh

**Dr Md Shams-UI-Alam**

In Bangladesh, General Practice/Family Medicine is still in its primitive stage. Practice is individual doctor based, and after graduation, there is a lack of any GP training. GPs do not have any opportunity to get any vocational or refresher training, even if they have practiced for thirty years or more. There is no accredited course or training program for the GPs in Bangladesh. No referral system or follow up is established in general practice. Patients usually visit a doctor when their disease becomes intolerable. Medical audit or clinical governance is unknown to the GPs of Bangladesh.

Under these circumstances, I am working to establishing GP/FP as an internationally acceptable accredited service in Bangladesh. In April 2001 and in March 2002 I attended the International Courses for Teaching of General Practice "Promoting Excellence in Teaching General Practice" in Aga Khan University, Karachi, Pakistan facilitated by Professor Rosslyne Freeman of the RCGP London.

Under this RCGP International Travel Scholarship programme of "Orientation on Family Medicine" I got the opportunity to visit London from 12 February to 08 March 2002. I visited the following centres and institutions to meet with the individuals working there, to understand the objectives and activities of their programmes:

- (i) The Albion Health Centre, East London;
- (ii) The Hurley's Surgery, Ebenezer House, Kennington Lane;
- (iii) The Vauxhall Surgery;
- (iv) The Lambeth Walk Surgery;
- (v) The Royal London Hospital;
- (vi) The Department of General Practice and Family Medicine, King's College – guided and facilitated by Dr. Cynthia Yiu GP;
- (vii) Guy's Medical School – guided and facilitated by Dr. Cynthia Yiu GP;
- (viii) The Department of Social Services, London Borough of Hackney;
- (ix) RCGP – guided and facilitated by Dr. Garth Manning, Director International Development Programme.

I learnt many new things from this visit. Among the important lessons for me to take back to Bangladesh are:

- General Practitioners group practice.
- Multidisciplinary team approach to service delivery.
- Practice management issues.
- The systems of training for general practice at both undergraduate and post-graduate level, and the links between universities and practices.
- Intermediary care by a team of GPs in the community care centre.
- Computerized lab services and General Practice use of software developed by NHS.
- Links between primary health care and social services.
- Guidelines for patients and practitioners to decide diagnosis and management of different diseases developed by local GPs, health professionals and patients.
- Clinical governance to ensure standard of treatment followed by GPs

I intend to share my experiences in Bangladesh among GPs and the associated organizations to develop FP/GP as an accredited professional entity. Working closely with the Directorate of Medical Education of the Government of Bangladesh; Bangladesh College of Physicians and Surgeons; Academy for Family Physicians; RCGP, my organization is trying to achieve the objectives of (i) developing FP/GP as an accredited professional entity in Bangladesh, and (ii) starting the undergraduate and the postgraduate FM/GP curriculum in medical colleges.

My visit was very interesting and I enjoyed every minute of it. I particularly enjoyed the integrated curative, preventive and domiciliary service delivery package of surgery; clinical governance and service delivery protocol for the diagnosis and treatment of different diseases; computerized surgery; GPs link with the medical schools and Royal London Hospital; GPs research; vocational and continued medical education programmes; medical student's communication skill curriculum; medical student's placement in surgery; health and social services joint community care action plan.

**Dr Md Shams-UI-Alam**  
**National Adviser, Nicare/The British Council**

# The International Department

## Jenny Stock

Emails, phone calls and letters pass back and forth across continents between the RCGP International team and our colleagues and friends overseas. It is so rare that we get to meet the people we correspond with and vice versa, we thought it was time that we introduced ourselves.

Claire, International Manager, steers the department, represents it externally, writes the reports to Council, and pays the bills!

Jenny, International Officer, administers the International Committee, the International Travel Scholarship (ITS) awards, the International Teachers Course, and the International Family Medicine Development Programmes. The RCGP is Secretariat for the Royal Colleges' International Forum (RCIF) and Jenny is responsible for organising and running these meetings. The department is often asked to arrange programmes for International visitors and senior official delegates, to which everyone in the Department contributes.



*The International team out to lunch with one of the ITS winners from 2003 (from left to right: Mercedes Arechaga, Claire Burden, Jenny Stock, Rosemary Rodgers and Sarah Bland)*

Rosemary is the part time International Officer and takes charge of MRCGP[INT], liaising with overseas partners and the UK based International Development Adviser (IDAs) and Exam Development Assessors (EDAs). On top of this she is also the "General Enquiries Guru".

Last but not least, Sarah is the International Projects Co-ordinator. Sarah works with the team on a part-time basis and is responsible for the International website, researching useful information and she plays a huge part in producing this Newsletter!

The team are lead and guided by Dr John Howard, Chairman of the International Committee and MRCGP[INT] Board, Dr Rob Caird, Vice-Chairman of International Committee and Editor of the Newsletter, and Dr Garth Manning, Medical Director of the International Family Medicine Development Programme.

None of this work could be done, however, without the invaluable support and effort of our Members who welcome visitors to their homes and practices, or spend time preparing for courses and visits. The department has friends and colleagues all over the world and we would like to thank them for all the time and effort they put into making the programmes and schemes run so smoothly and successfully.

**Jenny Stock**  
**International Officer, RCGP**  
**Email: [jstock@rcgp.org.uk](mailto:jstock@rcgp.org.uk)**



## Wonca 2004 17th World Conference of Family Doctors

will be held October 13–17, 2004, in Orlando, Florida, USA. Wonca 2004 is your premier chance to learn the latest medical techniques, explore new avenues in global family medicine and meet with colleagues from around the world. Plan to save US\$100 on your registration fee by registering before July 14, 2004. Visit <http://www.wonca2004.org> to register now and to learn more about this exciting conference!

# Report on 'Working In Uganda' A Volunteer's Viewpoint Of Working With Health Care Workers and Undergraduates in Mbarara

**Dr Ruth Taylor MRCGP**

Mbarara University Teaching Hospital (MUTH) was built in the late 1980's and it has a well-developed and well-run Community Medicine department. The department is largely responsible for the fourth year of the medical undergraduate curriculum. During this year the students have teaching on Ethics, Family Planning, Maternal Child Health, Community Medicine, Palliative Care, and Communication Skills as well as attachments with specialty subjects.

My time has been split working in various hospital departments, as and when my expertise was required: designing and implementing the family planning section of the fourth years' curriculum, teaching on the BSc Nursing course, designing and implementing the nutrition section of the internal medicine course, delivering the ethics lectures, running an HIV clinic and finally facilitating in a community workshop.

I was allocated three afternoon sessions to teach family planning to the fourth year medical students. With 54 in the year this was indeed a challenge. My colleagues in the UK were kind enough to send me some demonstration IUD's, diaphragms, condoms and femidoms. Apart from helping to inject a considerable amount of humour, these visual aids were invaluable to my lectures, not least because many of the students hadn't seen them before.

My most exciting and rewarding work in family planning and community health came from an unexpected quarter. A colleague doing work with community leaders in Kabale had wanted to run a workshop on maternal health. In two and a half days we packed in discussions on 'women's role in the home', family planning, complications of pregnancy, childbirth and post partum problems. We facilitated role-plays, group work and problem trees. It was remarkably enjoyable and productive and took some key messages right to the heart of the rural communities.

Another aim was to empower women in Uganda to take responsibility for their own sexual health. This was achieved through the education of the medical

students and more directly through the community workshop. In both settings I emphasized cultural and social issues. In the community workshop I explored in depth some of the myths and cultural beliefs surrounding contraception. The community leaders demonstrated wonderfully their understanding of some of the benefits of contraception in the role-plays at the end. The participants then re-enact these role-plays in their communities to spread the information.

Hospice Mbarara is mainly a nurse led organization with only one medical officer. The hospice offers home based palliative care. Patients who are well enough attend hospice for treatment and counselling, others send a relative to collect medications and others we visit in their homes. The nurses make most of the clinical assessments and decide on the need for drugs as appropriate. Hospice Uganda currently has a central role in training healthcare workers of all descriptions in the use of morphine for palliative care.



*A workshop group acting out their role-play. (A couple are attending their local family planning clinic and are being counselled by the health care worker)*

The fourth years were not allocated any time for a visit to hospice to have a 'hands on experience' of palliative care. Within the limitations of my position, I managed to squeeze in a day's visit for each student after many letters and negotiations with other clinical departments. The changes that I have facilitated at Hospice with regards to education and clinical practice

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have been supported, and in some cases initiated by the Nurse Supervisor, Martha. In terms of family planning, I have left all the resources I used in the department for future years.

I have learnt an enormous amount from my year in Mbarara. I have taught a diverse mixture of subjects to an even more diverse audience using many different media. I have often felt the constraints of working in a resource-poor environment and I have endeavoured to make the most of what is available.

My work at Hospice has been the most rewarding. They truly practice holistic care, offering not only medication but counselling and spiritual support. Home visits have taken on a new context. Twice a month the hospice does an outreach clinic in two towns about 60km away. It takes all morning to reach these towns because en route various patients or their representatives are standing at the roadside at pre-determined points to meet the hospice team, discuss any new problems and get their next months supply of medicine. Teamwork is critical in any healthcare setting and I hope my experiences with Hospice will carry me forward in General Practice on my return to the UK.



*Patient consultation en route to Ibanda*

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