Family Medicine and Primary Care at the Crossroads of Societal Change: Perspectives for 2030.

Prof. Jan De Maeseneer, MD, PhD, (Hon)FRCGP

International Member NAM

DEPARTMENT OF PUBLIC HEALTH AND PRIMARY CARE

WHO Collaborating Centre
Family Medicine and Primary Health Care

GHENT UNIVERSITY

Jan De Maeseneer

Family Medicine and Primary Care

At the Crossroads of Societal Change

LANNOO CAMPUS

Introduction:

° Family Medicine and Primary Care have been severely affected by the Covid-19 pandemic.

° Whilst at the individual level, it became clear that especially for vulnerable patients, hospitals could make a difference, at the population level, it was obvious that Family Medicine and Primary Care, working together with public health and social services, are essential to "win the battle".

° In this presentation we describe the main lessons learned in Family Medicine and Primary Care and formulate conclusions for further developments in practice, research and advocacy for policy change, in the perspective of broader international cooperation.

Table 1. Core Attributes of Primary Care, Definitions, and Examples

Attribute	Definition	Examples of AHRQ Resources to Guide Research
Person and family centeredness	Person and family centeredness entails caring for people in the context of their lived family, social, and community experiences. It refers to being "respectful of and responsive to individual patient preferences, needs and values."[3,6]	*Chartbook on Person- and Family-Centered Care*[7]
Community centeredness	Primary care practices should play an integral role in improving and promoting the health of the communities they serve by engaging with community organizations with a shared mission.	*Clinical-Community Relationships Measures Atlas*[8]
Primary care centeredness	Primary care is the foundation for all other health care. All individuals would have access to and receive comprehensive, longitudinal, and coordinated, high-quality primary care.	*Redefining Primary Care for the 21st Century*[9]
Advancing health equity	Primary care has a critical role in eliminating pervasive, structural, and long-standing inequities in access, quality, and outcomes of care.	*A Call to Action to Achieve Health Equity*[10]
Digital health solutions	Ongoing advancements in health information technology and the development of digital health solutions designed specifically to support primary care.	*AHRQ's Digital Solutions to Support Care Transitions Challenge*[11]
Aligning payment	Fundamental transformation of primary care is not possible without equally fundamental changes in the allocation of resources to primary care.	*New Models of Primary Care Workforce and Financing*[12]
Workforce development	Primary care teams are designed to allow all team members to practice at the "top of their license," and can continuously work to improve patient care, while reducing individual workloads and burnout.	*Creating Patient-Centered Team-Based Primary Care*[13]

AHRQ = Agency for Healthcare Research and Quality.

Quintuple Aim

Improving care as perceived by the individual

Improving health status at population level

Ensuring that professionals in care and welfare can do their work in a good and sustainable way.

With the resources deployed, realising more 'value' for the person needing care and support in the field of care and welfare

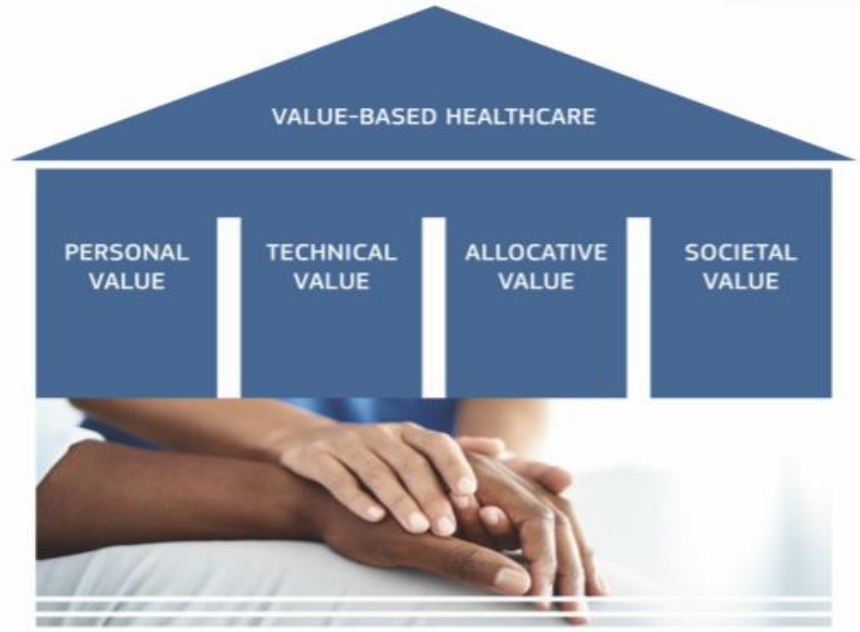
To achieve the same for everyone, extra efforts will need to be made for the most vulnerable.

Michael Matheny, Sonoo Thadaney Israni, Mahnoor Ahmed, and Danielle Whicher, Editors. 2019. Artificial Intelligence in Health Care: The Hope, the Hype, the Promise, the Peril. NAM Special Publication. Washington, DC: National Academy of Medicine. Translated, adapted, and reproduced with permission from the National Academy of Sciences, Courtesy of the National Academies Press, Washington, D.C.

VIVEL

Vlaanderen

European Commission



DEFINING VALUE IN "VALUE-BASED HEALTHCARE"

Report of the

Expert Panel on effective ways of investing in Health (EXPH)

Frank Vandenbroucke

Vice-eersteminister en minister van Sociale zaken en Volksgezondheid

01 Wetenschap en solidariteit

- wetenschap = vaccin
- solidariteit = vaccinatiecampagne

°science = vaccine
°solidarity = vaccinationcampaign

"... reframing our health systems with a **primary healthcare lens** is not just a choice; it's a moral obligation, a prerequisite to the kind of society in which we all aspire to live – a society grounded in **trust** and **empathy**, where health and happiness flourish for all"

HANS KLUGE

WHO Regional Director for Europe

Most important lessons learned

°There are other ways to contact patients than direct interaction in consultations and home visits: within a few weeks: tele-consultation became standard practice in primary care. Moreover the need for testing, contact-tracing, support of quarantine, was a 'natural driver' for more interprofessional cooperation in teams of family physicians, nurses, social workers, psychologists, community health workers, public health professionals,…

°A perspective-shift from individual reactive care towards pro-active interventions focusing on population health took place in a context of "learning by doing". Sharing of data, taking into account privacy requirements, contributed to the formulation of a 'community diagnosis' and integration of public health activities in family medicine practice. Data were not be constrained to bio-medical information, but include SES, data on ethnicity, …

°The paradigm-shift from a disease-oriented approach towards a 'goal-oriented' approach, starting the care process with exploring what really matters to the patient, is of utmost importance, especially in frail elderly people with multi-morbidity (e.g. advanced care planning).

From: 'What is the matter with Mr. Johnson?'

To: 'What matters to Mr. Johnson?'

Special Article

Goal-Oriented Medical Care

James W. Mold, MD; Gregory H. Blake, MD; Lorne A. Becker, MD

ABSTRACT

The problem-oriented model upon which much of modern medical care is based has resulted in tremendous advancements in the diagnosis and treatment of many illnesses. Unfortunately, it is less well suited to the management of a number of modern health care problems, including chronic incurable illnesses, health promotion and disease prevention, and normal life events such as pregnancy, well-child care, and death and dying. It is not particularly conducive to an interdisciplinary team approach and tends to shift control of health away from the patient and toward the physician. Since when using this approach the enemies are disease and death, defeat is inevitable.

Proposed here is a goal-oriented approach that is well suited to a greater variety of health care issues, is more compatible with a team approach, and places a greater emphasis on physician-patient collaboration. Each individual is encouraged to achieve the highest possible level of health as defined by that individual. Characterized by a greater emphasis on individual strengths and resources, this approach represents a more positive approach to health care. The enemy, not disease or death but inhumanity, can almost always be averted.

(Fam Med 1991; 23:46-51)

1. There exists an ideal "health" state which each person should strive to achieve and maintain. Any significant deviation from this state represents a problem (disease, disorder, syndrome, etc.).
2. Each problem can be shown to have one or more potentially identifiable causes, the correction or removal of which will result in resolution of the problem and restoration of health.
3. Physicians, by virtue of their scientific understanding of the human organism and its afflictions, are generally the best judges of their patients' fit with or deviation from the healthy state and are in the best position to determine the causes and appropriate treatment of identified problems.
4. Patients are generally expected to concur with their physicians' assessments and comply with their advice.
5. A physician's success is measured primarily by the degree to which the patients' problems have been accurately and efficiently identified and labeled and appropriate medical techniques and technologies have been expertly applied in an effort to eradicate those problems.

This conceptual model is ideally suited to the understanding and management of acute and curable illnesses. It has

Challenges in patients with multimorbidity

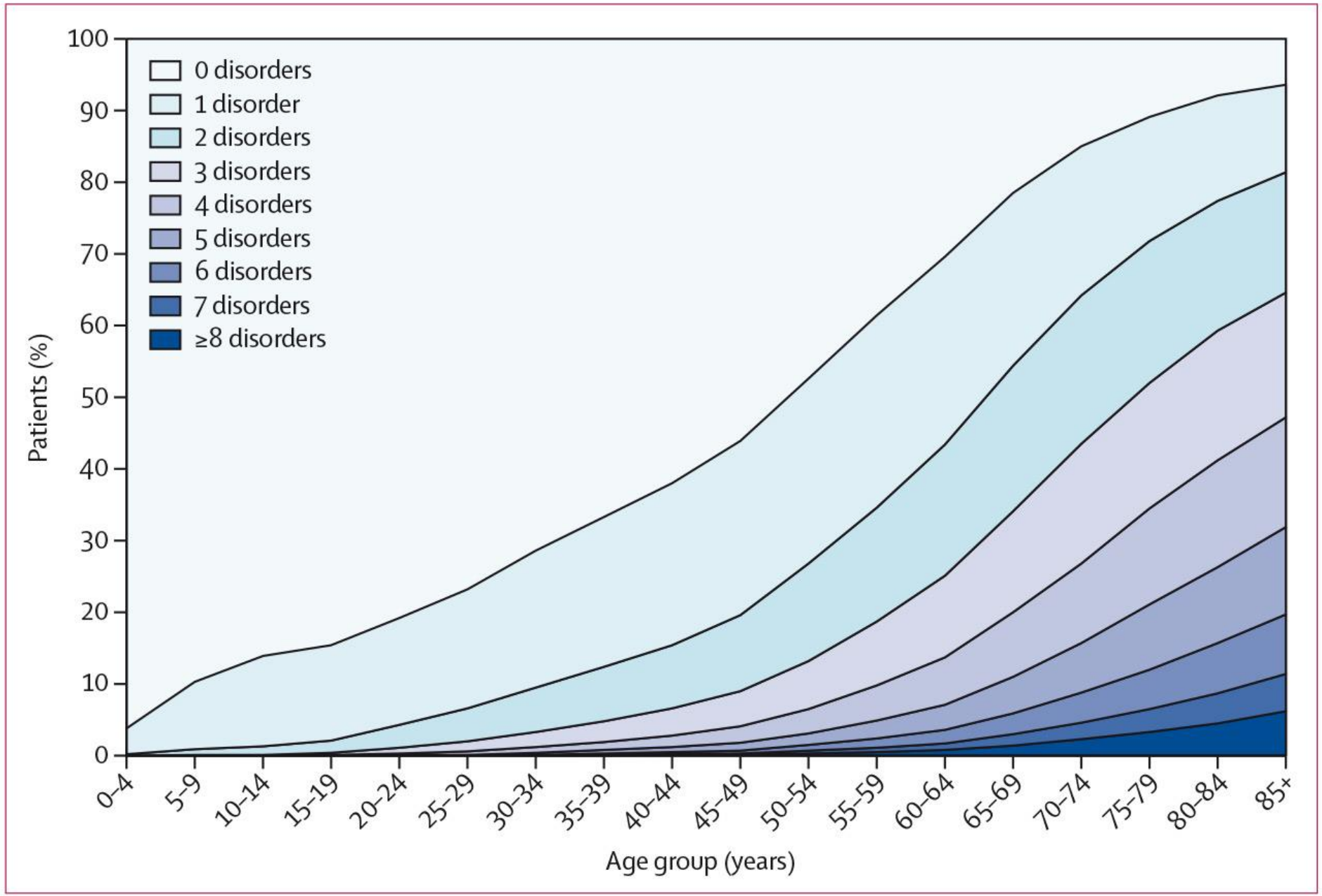
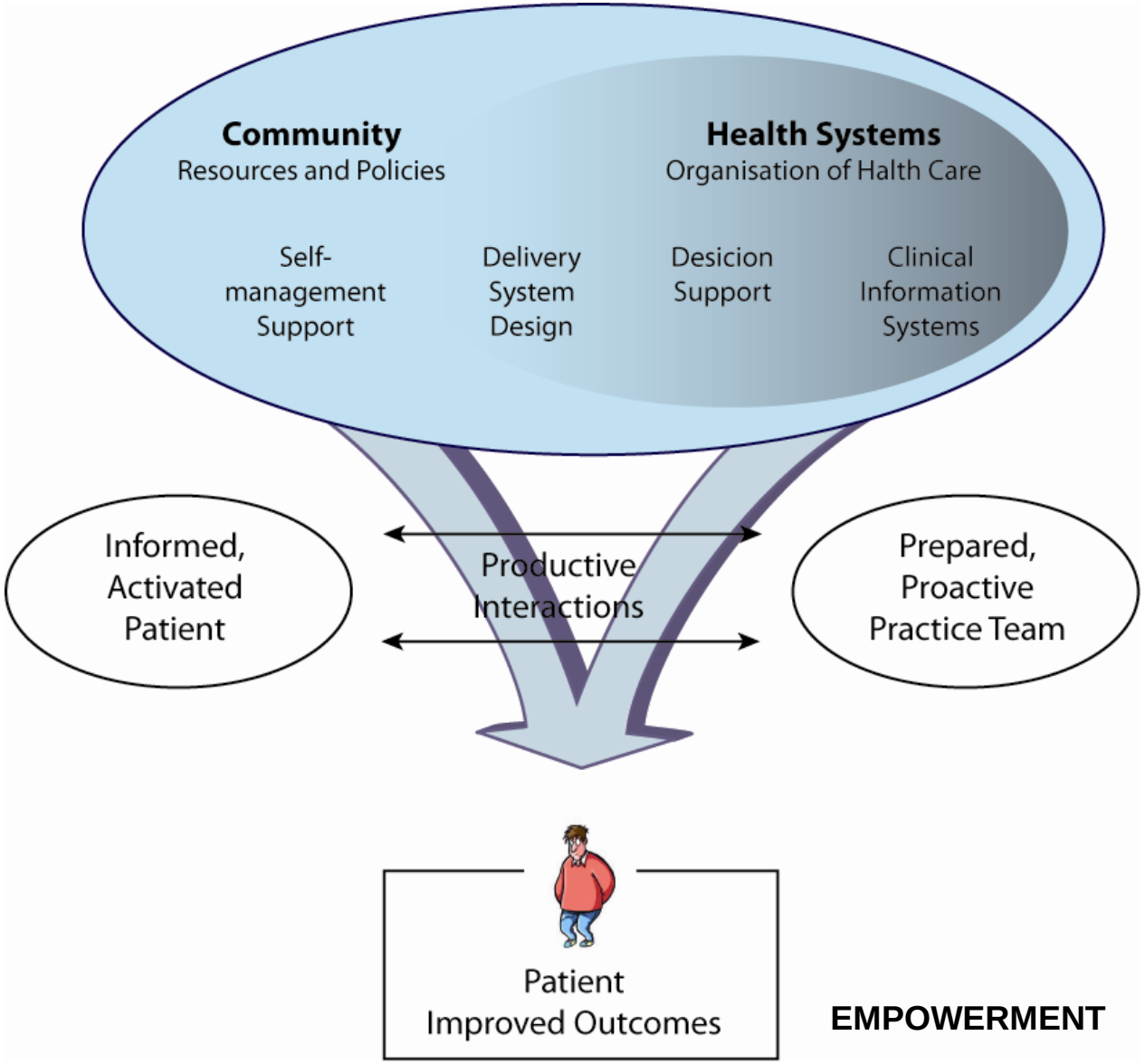
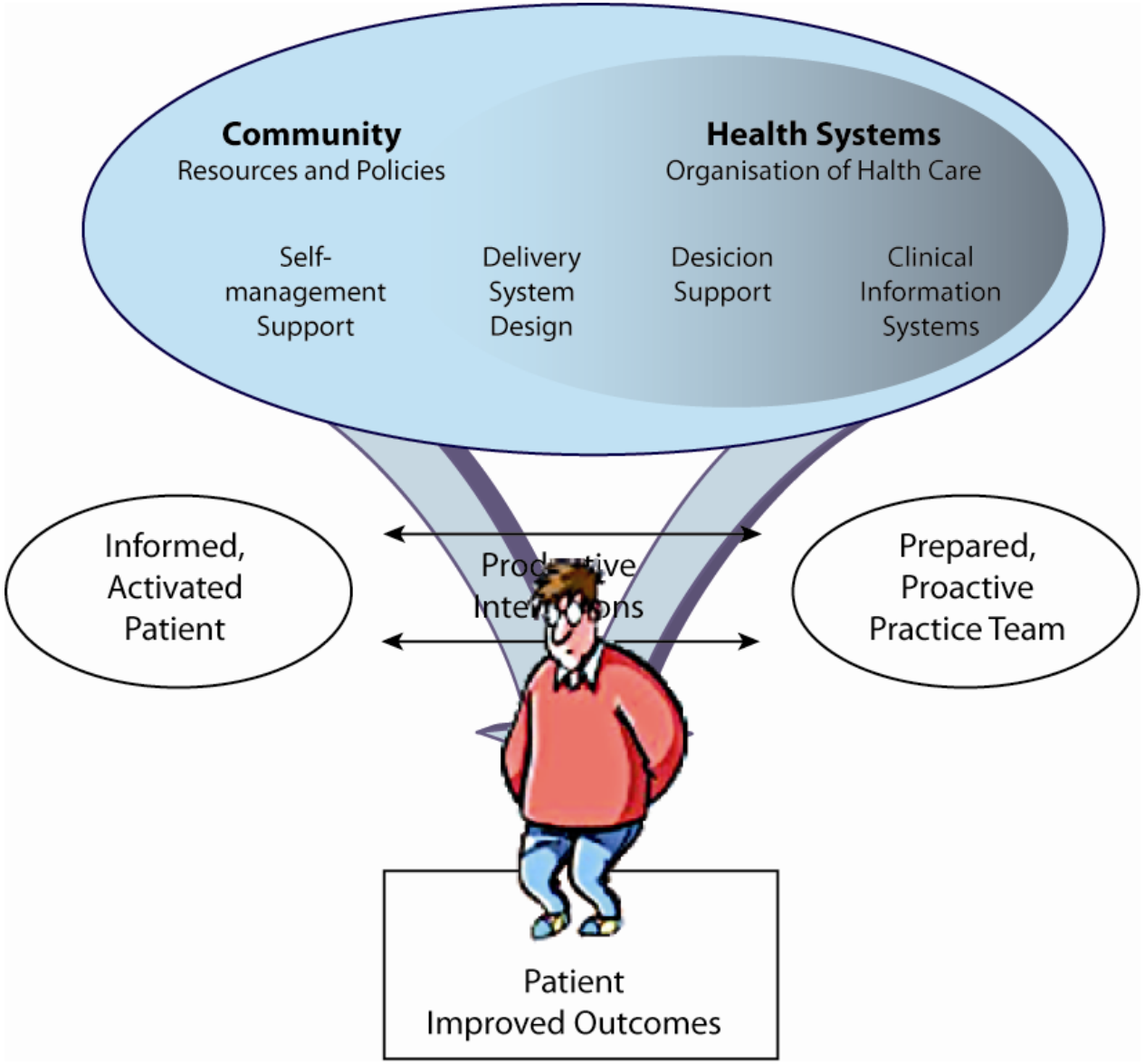


Figure 1: **Number of chronic disorders by age-group**


Community
Resources and Policies
Health Systems
Organisation of Halth Care
Self-management Support
Delivery System Design
Desicion Support
Clinical Information Systems
Informed, Activated Patient
Productive Interactions
Prepared, Proactive Practice Team
Patient Improved Outcomes
EMPOWERMENT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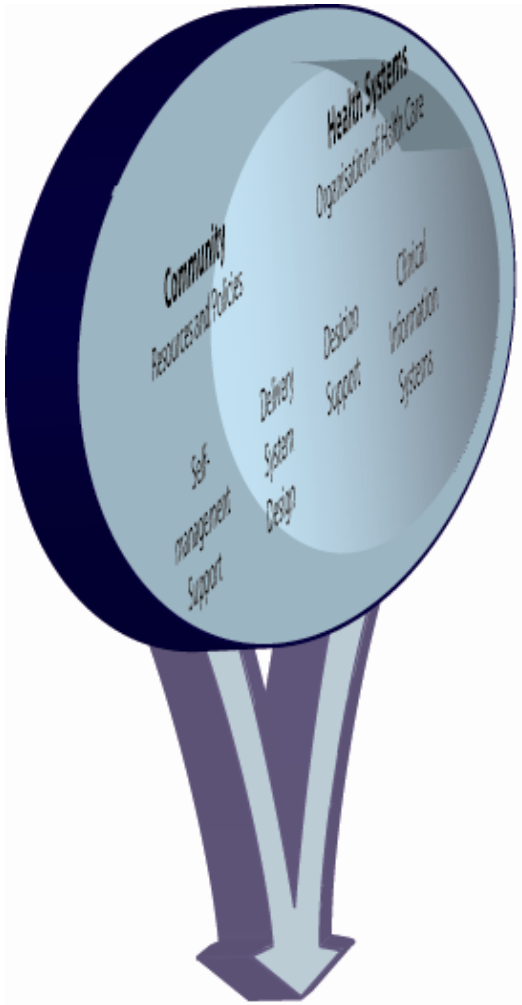
But…


Health Systems
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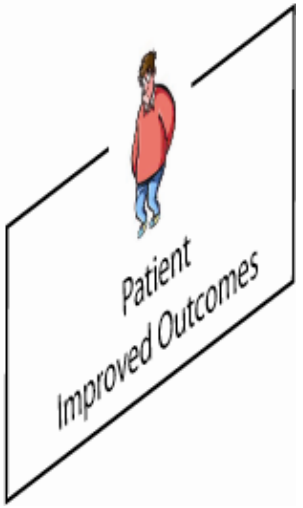
management
Support


Patient
Improved Outcomes

Debate & Analysis

James Mackenzie Lecture 2011:

multimorbidity, goal-oriented care, and equity

INTRODUCTION

Today we face an important demographic and epidemiological transition, confronting us with the challenge of non-communicable diseases (NCDs), which occur more and more in the context of multimorbidity. In the next decade, multimorbidity will become the rule, no longer the exception: 50% of the those aged ≥65 years have at least three chronic conditions, whereas 20% of the ≥65-year group have at least five chronic conditions.[1] In the case of COPD, for example, more than half of the patients have at least one comorbid disease.[2]

HOW DO WE ADDRESS PATIENTS WITH MULTIMORBIDITY TODAY?

work in a situation of multimorbidity"?

Let us illustrate this with a patient from our general practice, we call her 'Jennifer' (Box 1).

According to the actual guidelines, Jennifer is faced with a lot of tasks[4]: joint protection, aerobic exercise, muscle strengthening, a range of motion exercising, self-monitoring of blood glucose, avoiding environmental exposure that might exacerbate COPD, wearing appropriate foot wear, limiting intake of alcohol, maintaining body weight. Her medication schedule includes 11 different drugs, with a total of 20 administrations a day. The clinical tasks for the GP include vaccination, blood pressure control at all clinical visits, evaluation of self-monitoring of blood glucose, foot examination, and laboratory tests. Moreover, referrals are needed to physiotherapy, for ophthalmologic examination, and pulmonary rehabilitation. So, Jennifer's reaction is not unexpected.

Jennifer's case clearly illustrates the need for a paradigm-shift for chronic care: from problem-oriented to goal-oriented care. In 1991, Mold and Blake[5] recognised that the problem-oriented model, focusing on the eradication of disease and the prevention of death, is not well suited to the management of a number of chronic illnesses. Therefore they proposed a goal-oriented approach that encourages each individual to achieve the highest possible level of health as defined by that individual. Goal-oriented care assists an individual in achieving their maximum individual health potential in line with their individually defined goals. The evaluator of success is the patient, not the physician. And what really matters for patients is their ability to function (functional status), and social participation. So, certainly in the context of multimorbidity, there is a need for a shift from 'chronic disease management' towards 'participatory patient management', with the patient at the centre of the process. For many people, giving meaning to the chronic illness process they are going through, is of the utmost importance. Safety and avoiding side-effects (not having to suffer more from the treatment than from the disease) is very important. Patients expect comprehensiveness in their care instead of fragmentation.

A recent survey of 'chronic disease management' in 10 European countries[6] illustrated that most of the programmes use a vertical disease-oriented approach. Although much has been learnt from vertical disease-oriented programmes, evidence suggests that better outcomes occur by addressing diseases through an integrated approach in a strong primary care system. Vertical disease-oriented programmes for HIV/AIDS, malaria, tuberculosis, and other infectious diseases foster duplication and the inefficient use of resources, produce gaps in the care of patients with multimorbidity, and

Jennifer is 75 years old. Fifteen years ago she lost her husband. She is a patient in the practice for 15 years now. During these last 15 years she has been through a laborious medical history: operation for coxarthrosis with a hip prothesis, hypertension, diabetes type 2, COPD and osteoartritis. Moreover there is osteoporosis. She lives independently at her home, with some help from her youngest daughter Elisabeth. I visit her regularly and each time she starts saying: “Doctor, you must help me”. Then follows a succession of complaints and unwell feeling: sometimes it has to do with the heart, another time with the lungs, then the hip, …

Each time I suggest – according to the guidelines - all sorts of examinations that did not improve her condition. Her requests become more and more explicit, my feelings of powerlessness, insufficiency and spite, increase. Moreover, I have to cope with guidelines that are contradictory: for COPD she sometimes needs corticosteroids, which worsens her glycemic control.

The adaptation of the medication for the blood pressure (at one time too high, at another time too low), cannot meet with her approval, as does my interest in her HbA1C and lung function test-results.

After so many contacts Jennifer says: “Doctor, I want to tell you what really matters for me. On Tuesday and Thursday, I want to visit my friends in the neighbourhood and play cards with them. On Saturday, I want to go to the Supermarket with my daughter. And for the rest, I want to be left in peace, I don’t want to change continually the therapy anymore, … especially not having to do this and to do that”.

In the conversation that followed it became clear to me how Jennifer had formulated the goals for her life. And at the same time I felt challenged how the guidelines could contribute to the achievement of Jennifer’s goals. I visit Jennifer again with pleasure ever since: I know what she wants, and how much I can (merely) contribute to her life.

Sum of the guidelines

Patient tasks

- Joint protection
- Energy conservation
- Self monitoring of blood glucose
- Exercise
- Non weight-bearing if severe foot disease is present and weight bearing for osteoporosis
- Aerobic exercise for 30 min on most days
- Muscle strenghtening
- Range of motion
- Avoid environmental exposures that might exacerbate COPD
- Wear appropriate footwear
- Limit intake of alcohol
- Maintain normal body weight

R

- F
- Ophta
- Pul

Time	Medications
7:00 AM	Ipratropium dose inhaler Alendronate 70 mg/wk
8:00 AM	Calcium 500 mg Vit D 200 IU Lisinopril 40mg Glyburide 10mg Aspirin 81mg Metformin 850 mg Naproxen 250 mg Omeprazol 20mg
1:00 PM	Ipratropium dose inhaler Calcium 500 mg Vit D 200 IU
7:00 PM	Ipratropium dose inhaler Metformin 850 mg Calcium 500 mg Vit D 200 IU Lovastatin 40 mg Naproxen 250 mg
11:00 PM	Ipratropium dose inhaler
As needed	Albuterol dose inhaler Paracetamol 1g

Clinical tasks

- Administer vaccine
- Pneumonia
- Influenza annually
- Check blood pressure at all clinical visits and
- sometimes at home
- Evaluate self monitoring of blood glucose
- Foot examination
- Laboratory tests
- Microalbuminuria annually if not present
- Creatinine and electrolytes at least 1-2 times a year
- Cholesterol levels annually
- Liver function biannually
- HbA1C biannually to quarterly

Patient education

- Foot care
- Oeseoartritis
- COPD medication and delivery system training
- Diabetes

Boyd et al. JAMA, 2005

Special Article

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“Problem-oriented versus goal-oriented care”

	Problem-oriented	**Goal-oriented**
Definition of Health	Absence of disease as defined by the health care system	Maximum desirable and achievable quality and/or quantity of life as defined by each individual

“Problem-oriented versus goal-oriented care”

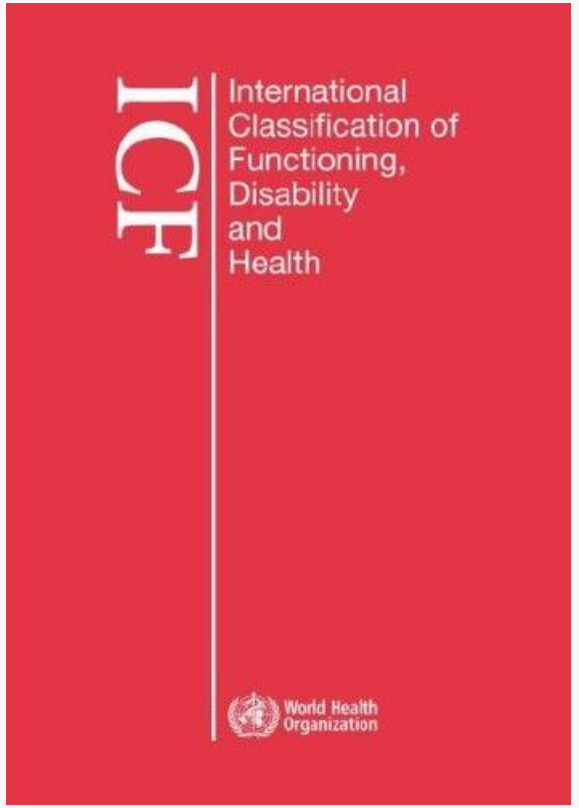
	Problem-oriented	**Goal-oriented**
Measures of success	Accuracy of diagnosis, appropriateness of treatment, eradication of disease, prevention of death	Achievement of individual life-goals

“Problem-oriented versus goal-oriented care”

	Problem-oriented	**Goal-oriented**
Evaluator of success	Physician	Patient

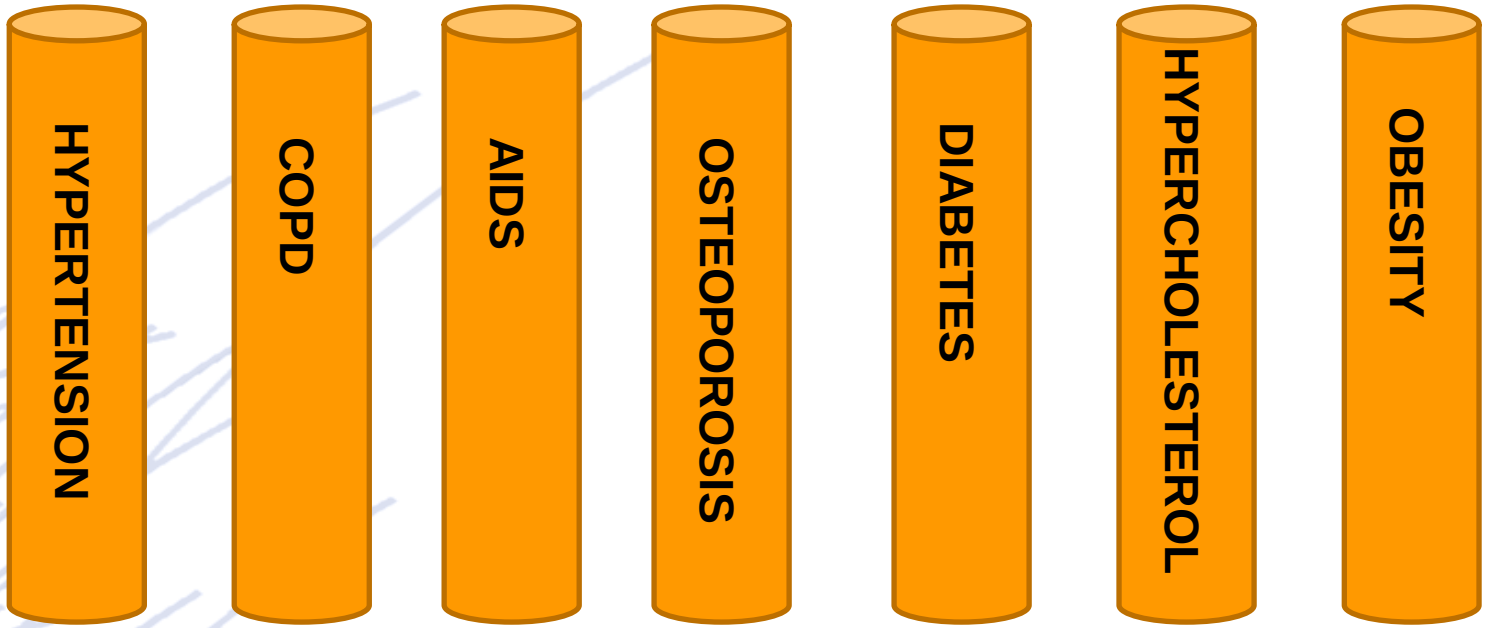
What really matters for patients is

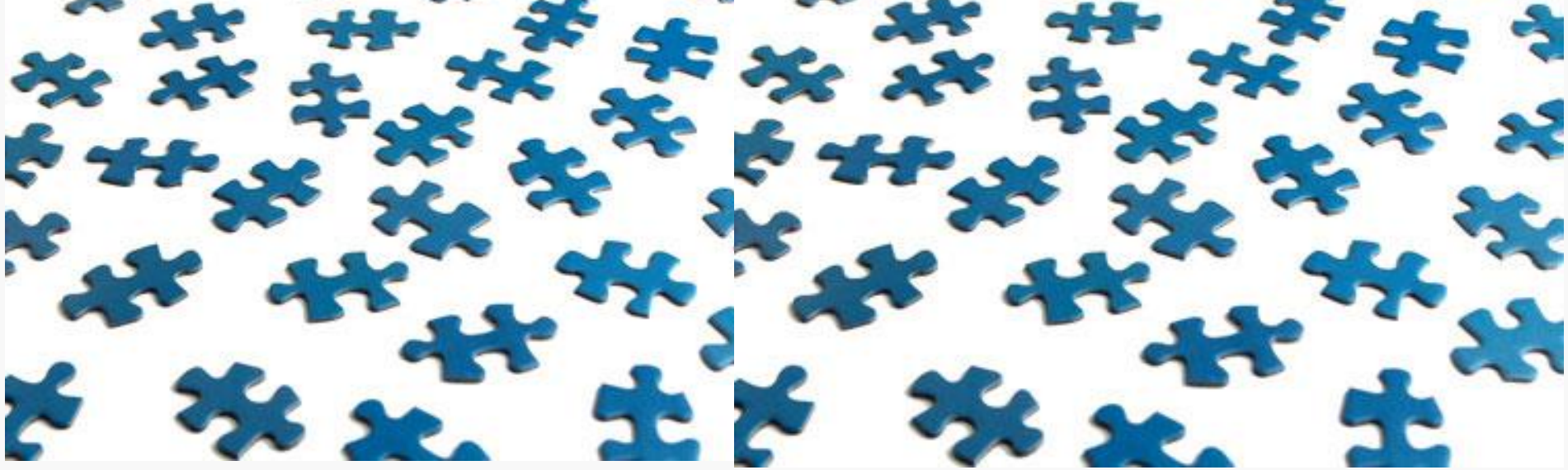
- Functional status
- Social participation



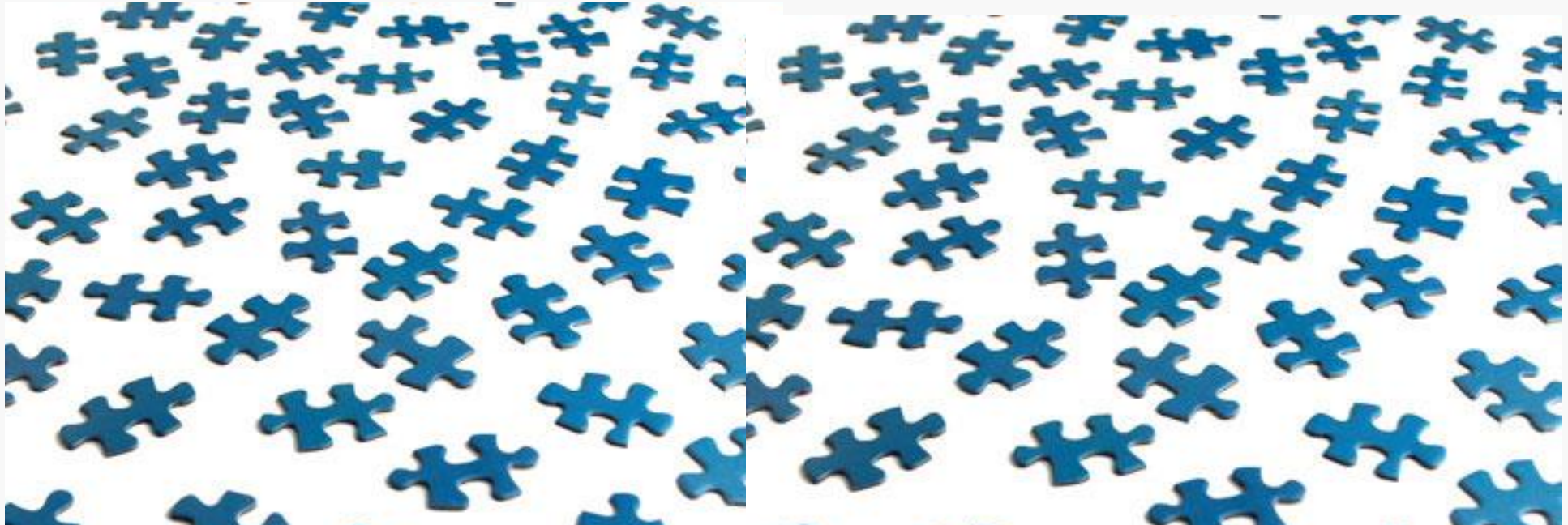
Vertical Disease Oriented Approach

- Mono-disease-programs? Or…
- Integration in comprehensive PHC





FRAGMENTATION



The challenge: vertical disease- oriented programs and multi-morbidity

- Create duplication
- Lead to inefficient facility utilization
- May lead to gaps in patients with multiple co-morbidities
- Lead to inequity between patients: “inequity by disease”

Campaign: www.30by2030.net

Nowadays hundreds of primary care providers have been trained in goal-oriented care in Flanders (Belgium)

European Journal of General Practice

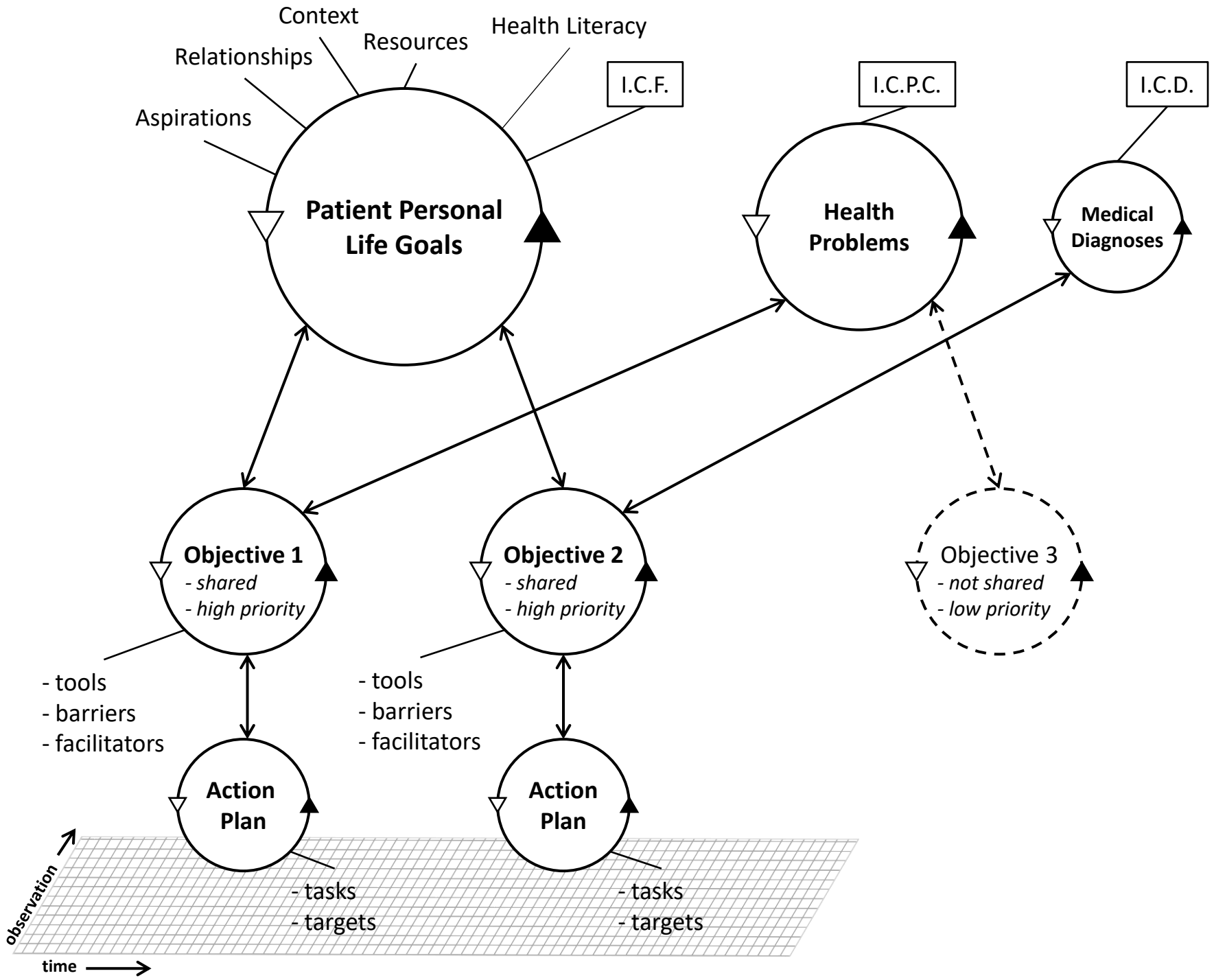
ISSN: 1381-4788 (Print) 1751-1402 (Online) Journal homepage: http://www.tandfonline.com/loi/igen20

Towards an overarching model for electronic medical-record systems, including problem-oriented, goal-oriented, and other approaches

Huibert Tange, Zsolt Nagykaldi & Jan De Maeseneer

To cite this article: Huibert Tange, Zsolt Nagykaldi & Jan De Maeseneer (2017) Towards an overarching model for electronic medical-record systems, including problem-oriented, goal-oriented, and other approaches, European Journal of General Practice, 23:1, 257-260, DOI: 10.1080/13814788.2017.1374367

To link to this article: https://doi.org/10.1080/13814788.2017.1374367


Context
Relationships
Resources
Health Literacy
Aspirations
I.C.F.
I.C.P.C.
I.C.D.
Patient Personal Life Goals
Health Problems
Medical Diagnoses
Objective 1
- shared
- high priority
Objective 2
- shared
- high priority
Objective 3
- not shared
- low priority
- tools
- barriers
- facilitators
- tools
- barriers
- facilitators
Action Plan
Action Plan
- tasks
- targets
- tasks
- targets
observation
time

- As both the Covid disease and the containment-measures had impact on people's mental health and wellbeing, the need for psychological support and community-based interventions for rehabilitation (e.g. in case of "long covid"), became very clear and care organizations had to adapt to new challenges.
- The need to address the wellbeing of health care providers stimulated initiatives focusing on strengthening resilience if individual professionals and health systems.
- The limits of traditional financing systems, developed for reactive care (e.g. fee-for-service), became clear and new ways of integrated population-oriented payment systems were explored.

THE ORGANISATION OF RESILIENT HEALTH AND SOCIAL CARE FOLLOWING THE COVID-19 PANDEMIC

Opinion of the

Expert Panel on effective ways of investing in Health (EXPH)

EUROPEAN SOLIDARITY IN PUBLIC HEALTH EMERGENCIES

Opinion of the

Expert Panel on effective ways of investing in health (EXPH)

SUPPORTING MENTAL HEALTH OF HEALTH WORKFORCE AND OTHER ESSENTIAL WORKERS

Opinion of the

Expert Panel on effective ways of investing in Health (EXPH)

THE ORGANISATION OF RESILIENT HEALTH AND SOCIAL CARE FOLLOWING THE COVID-19 PANDEMIC

Opinion of the
Expert Panel on effective ways of investing in Health (EXPH)

"Strong primary care and mental health systems should form the foundation of any emergency and/or preparedness response. All Member States should re-assess their investments in primary care and mental health and strengthen the integration of these systems with public health at population level"

OECD

TACKLING CORONAVIRUS (COVID-19):
CONTRIBUTING TO A GLOBAL EFFORT

oecd.org/coronavirus

Strengthening the frontline: How primary health care helps health systems adapt during the COVID-19 pandemic

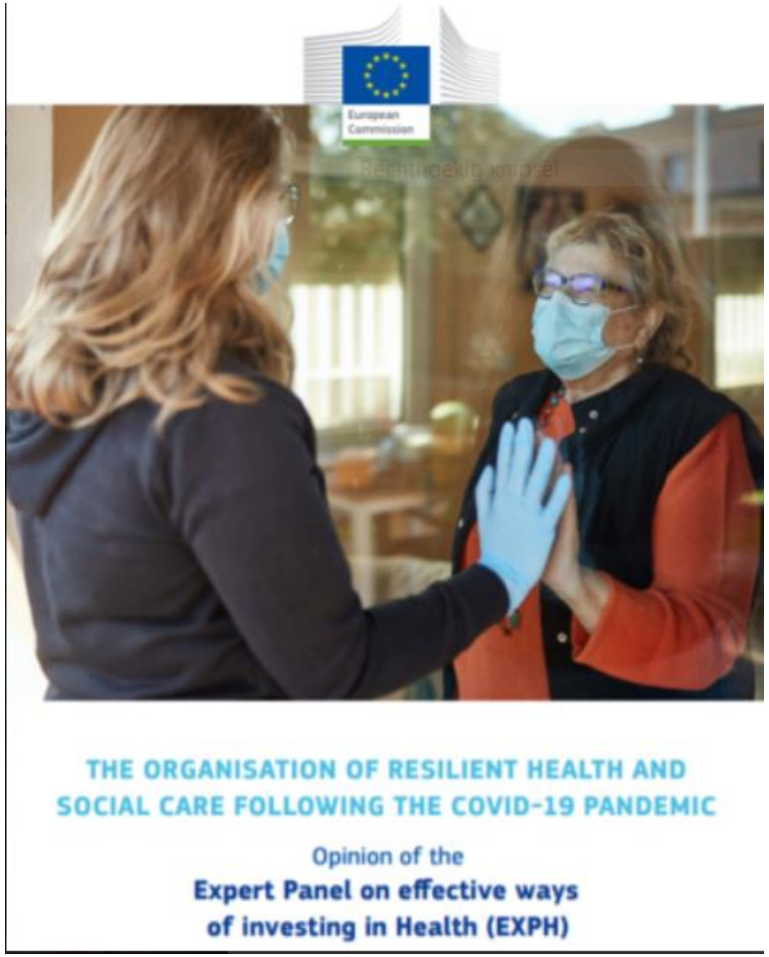
10 February 2021

"Strong primary health care – organized in multi-disciplinary teams and with innovative roles for health professionals, integrated with community health services, equipped with digital technology, and working with well-designed incentives – helps deliver a successful health system response. The innovations introduced in response to the pandemic need to be maintained to make health systems more resilient and able to meet the challenges of ageing societies and the growing burden of chronic conditions."

Focus on strengthening Primary Health Care.

WHO Director-General's opening remarks at the 150th session of the Executive Board — 24 January 2022

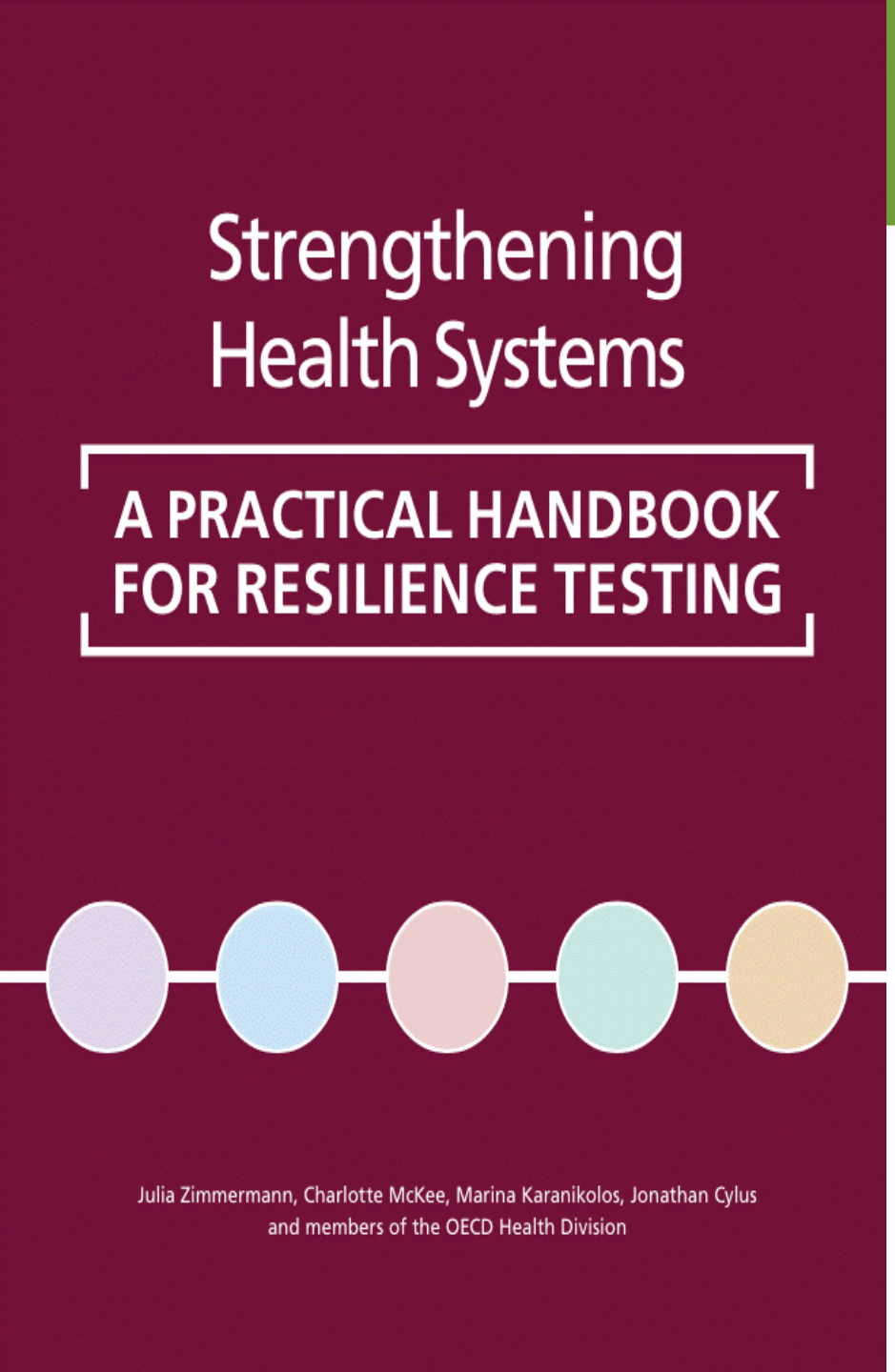
“The second priority is to support a radical reorientation of health systems towards primary health care, as the foundation of universal health coverage. That means restoring, expanding and sustaining access to essential health services, especially for health promotion and disease prevention, and reducing out-of-pocket spending”



°How to test the health system's **resilience?**

° "The capacity of a health system to (a) proactively foresee, (b) absorb, and (c) adapt to shocks and structural changes in a way that allows it to (i) sustain required operations, (ii) resume optimal performance as quickly as possible, (iii) transform its structure and functions to strengthen the system, and (possibly) (iv) reduce its vulnerability to similar shocks and structural changes in the future." (HSPA)

°Covid19 raises questions on improved preparedness, on how to strengthen primary care, on how to reinforce the resilience of hospitals, looking for solutions that also involve long-term structural challenges in public health structures.



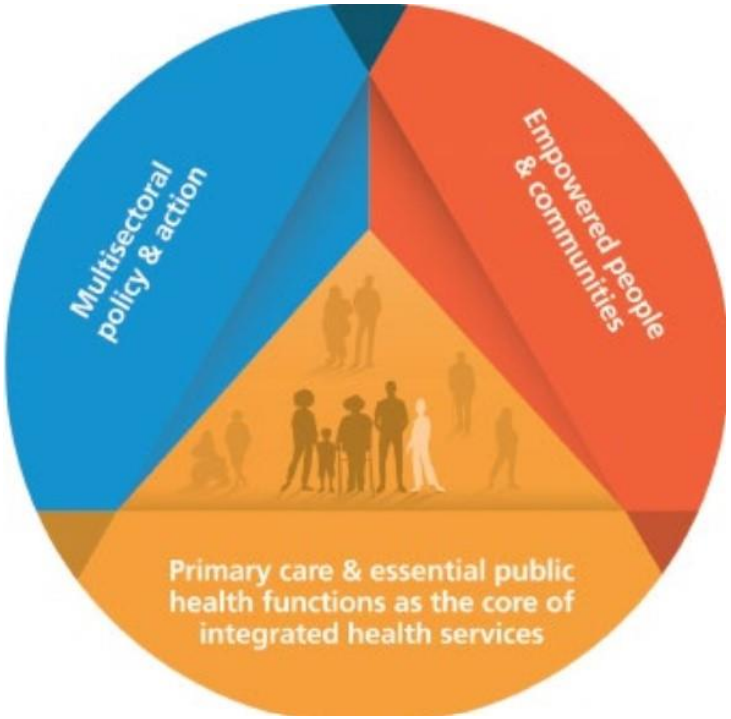
European Commission

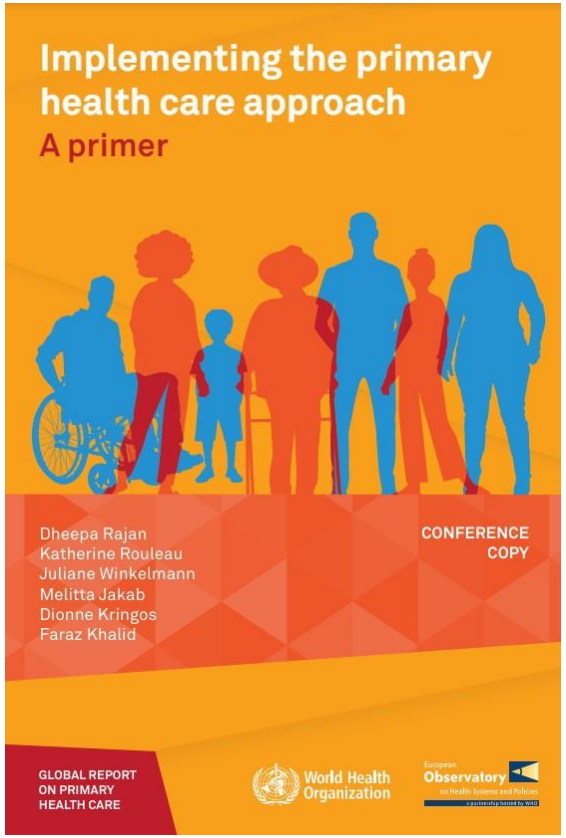
An Example Outcome of the Resilience Test

Sample Scorecard for a Resilience Test of a Health System

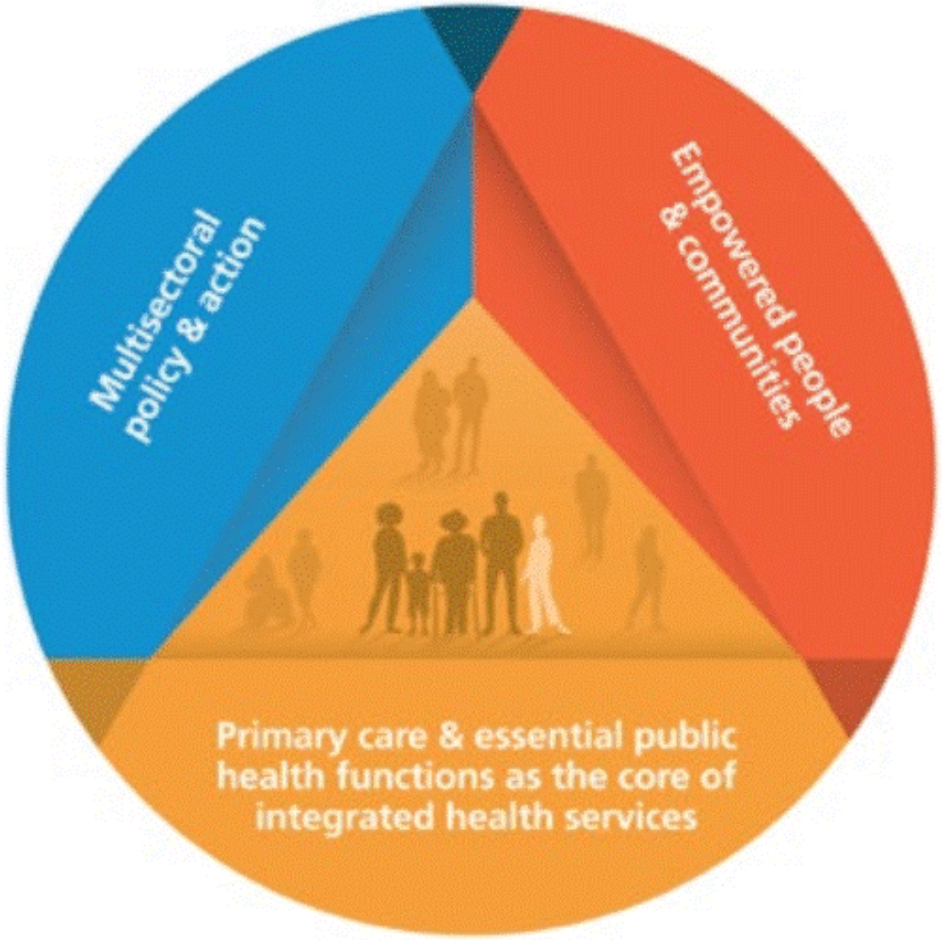
Health Workforce	Community Carers	Medicines	Infrastructure	Information Systems	Governance	Financing	Health Services	Health Promotion
CONDITION: Normal								
CONDITION: Scenario 1 – Super-bug								
CONDITION: Scenario 2 – Budget cut resulting from financial crisis								

- Global evidence: strategies to enhance PHC
  - strengthen **care integration**
  - **incorporate public health** tasks into PHC
  - **re-skill health workforce** for PHC
  - **re-design financing** mechanisms





https://eurohealthobservatory.who.int/publications/i/implementing-the-primary-health-care-approach-a-primer



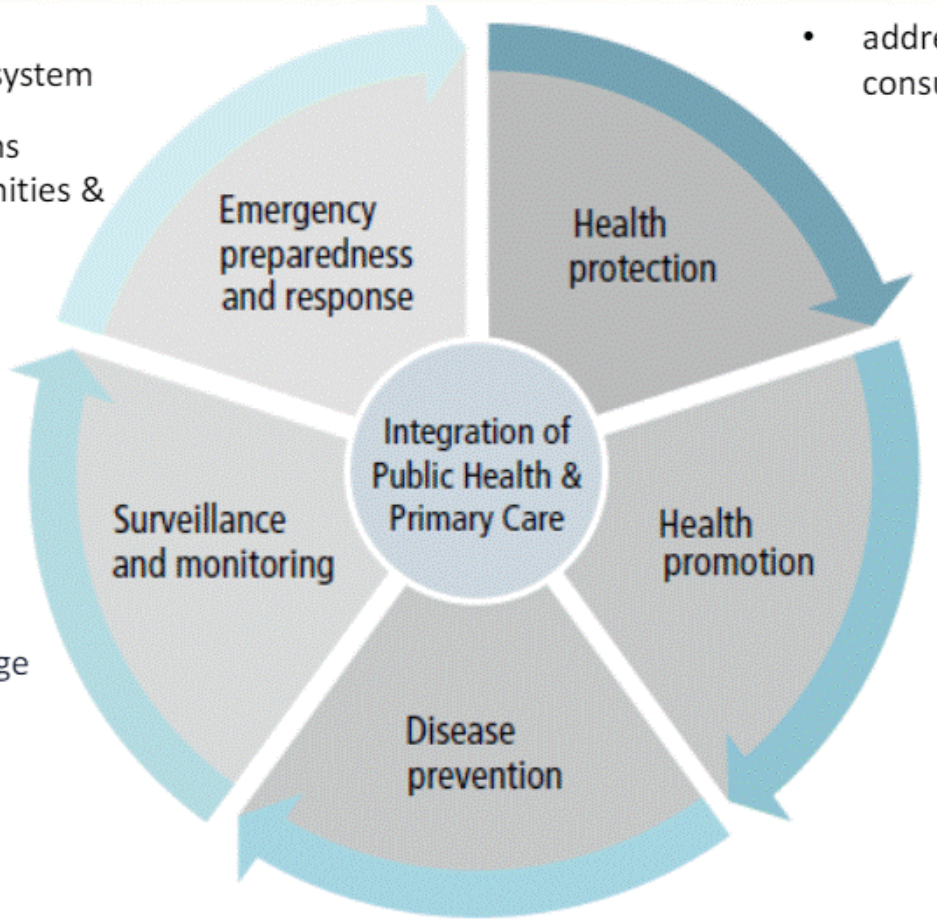
- **Strengthen care integration** – primary care, public health, community care, secondary care, social care…
- **Incorporate public health** tasks in PHC with a focus on health determinants
- **Re-skill the health workforce** for PHC -- generalist skills, community-facing roles for outreach/addressing determinants, public health tasks…
- **Re-design financing mechanisms** – PHC funding, payment systems to incentivize PHC performance

Incorporating public health into PHC with a focus on health determinants

- respond to emergencies
- serve as an early warning system

- prepare community-level emergency plans
- provide training and guidance to communities & policy-makers
- plan services for emerging needs

- address individual risk factors (tobacco, alcohol consumption, infectious agents)
- monitor & act on the immediate causes of disease (sources of infection) & upstream causes (commercial and political structures that enable them)



- provide individualized advice & support
- where possible, support changes to individual's living conditions, for example by liaising with social services.

- provide data elements from individual services

- epidemiology/biostatistics and data linkage
- build population profiles
- design surveillance systems
- report findings to the public and policy-makers

- assess health of the population, including targeted analyses for underserved populations

- chronic disease management
- vaccinations
- risk factor management (hypertension…)

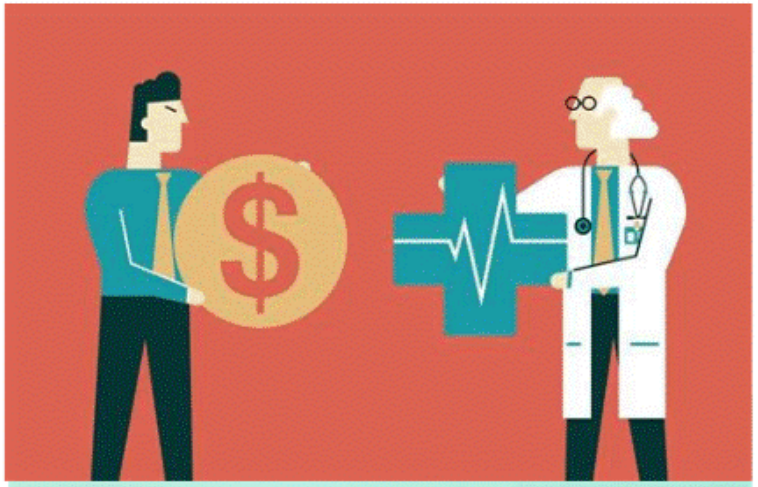
- identify patterns,
- support outreach
- manage outbreaks
- reduces disparities, working with many sectors

Pinto et al. 2023

Redesigning financing: funding flows to PHC

- Reduce OOP to increase access
  - pooled public financing
  - budgetary means to direct resources to PHC
  - user charges - not an effective instrument to direct people to efficient health service use
- Reduce fragmentation of funding
  - providers receive funding from separate sources to address multiple, interlinked health conditions

  → difficult for integration of care
- Needs-based resource allocation mechanisms
  - equal resources for equal need
  - including citizens & communities → accountability, better understanding of their needs



World Health Report 2010; Brundlandt 2022; Hanson et al. 2022; OECD 2020

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Social Cohesion and Primary Care

1. A central concept in this overview is "Social Cohesion/Connectedness":
Social Cohesion is a structural determinant of health

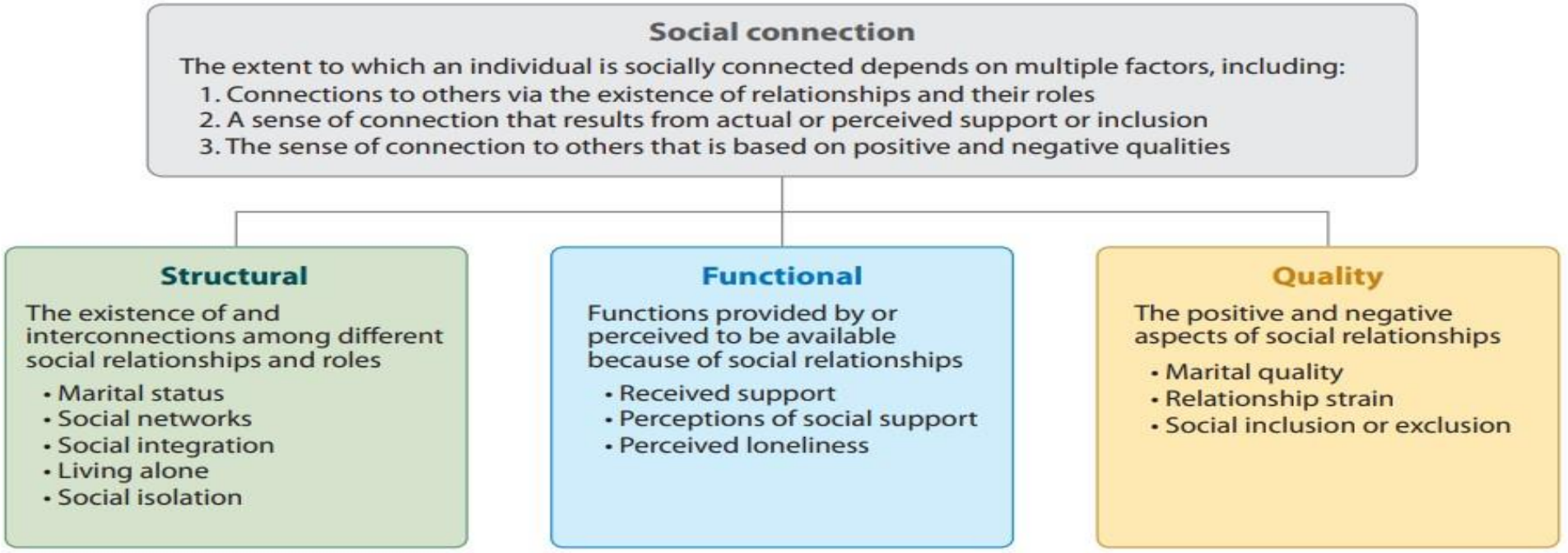


Figure 1

Social connection as a multifactorial construct including structural, functional, and quality components.

{Holt-Lunstad J. Social Connection as a Public Health Issue: The Evidence and a Systemic Framework for Prioritizing the "Social" in Social Determinants of Health. Annu. Rev. Public Health 2022.43:193-213. https://doi.org/10.1146/annurcv-publhealth-052020-110732 }

Social Connection/Cohesion as a Causal Determinant of Health

Table 1 Bradford Hill guidelines and summary of supporting evidence for social connection

Bradford Hill criteria		Summary of supporting evidence
Strength	How large is the association?	Effect size is comparable to or exceeds that of other clinical and mortality risk factors
Consistency	Is there consistency or replicability across varying types of studies and populations?	Ten meta-analyses, 276-plus studies using a variety of locations, populations, and methods
Specificity	Does exposure give rise to only a single outcome?	Exposure gives rise to multiple health-related outcomes Some evidence of mechanistic specificity
Temporality	Does exposure precede the outcome?	Prospective epidemiological studies
Biological gradient	Is there evidence of a dose–response curve?	Demonstrated in nationally representative samples across development stages
Plausibility	Are there plausible biological mechanisms?	Several plausible biological mechanisms have been documented
Coherence	Is there parallel evidence? Does it fit within what is known?	Fits within the framework of social determinants of health
Experiment	Is there experimental evidence?	Nonhuman animal studies of isolation Human social RCT interventions Laboratory manipulations of social situations
Analogy	Is the evidence consistent across measurement types?	Consistency across multiple conceptualizations and measurement approaches

Abbreviation: RCT, randomized controlled trial.

Table adapted from Reference 39 (copyright 2021 Sage Publications).

{Holt-Lunstad J. o.c. }

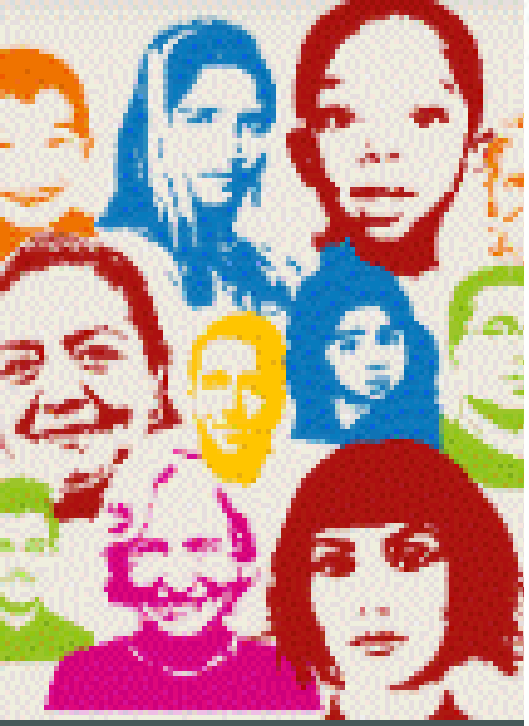
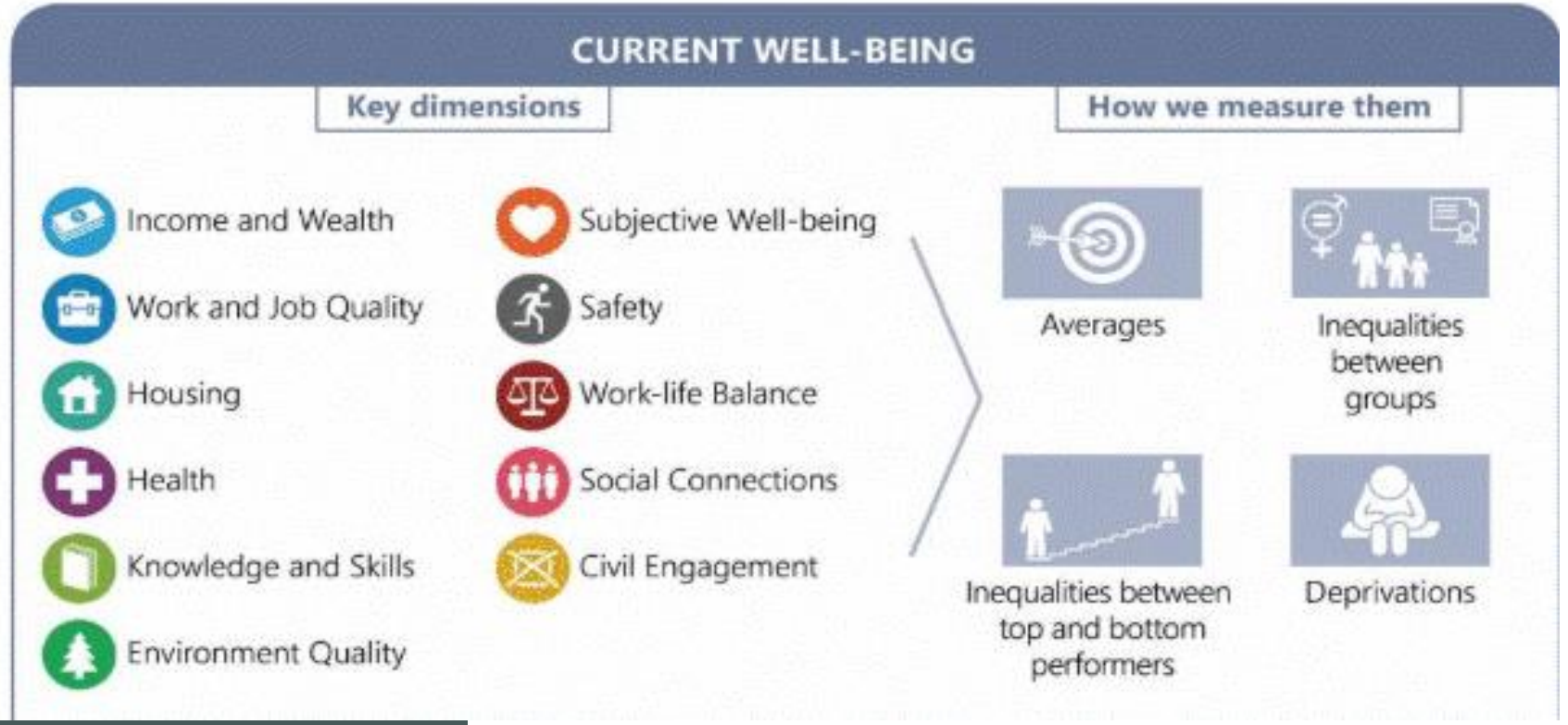


Figure 1. The OECD Well-being Framework



The need for operationalisation of Social Cohesion/Connectedness

Social Connections

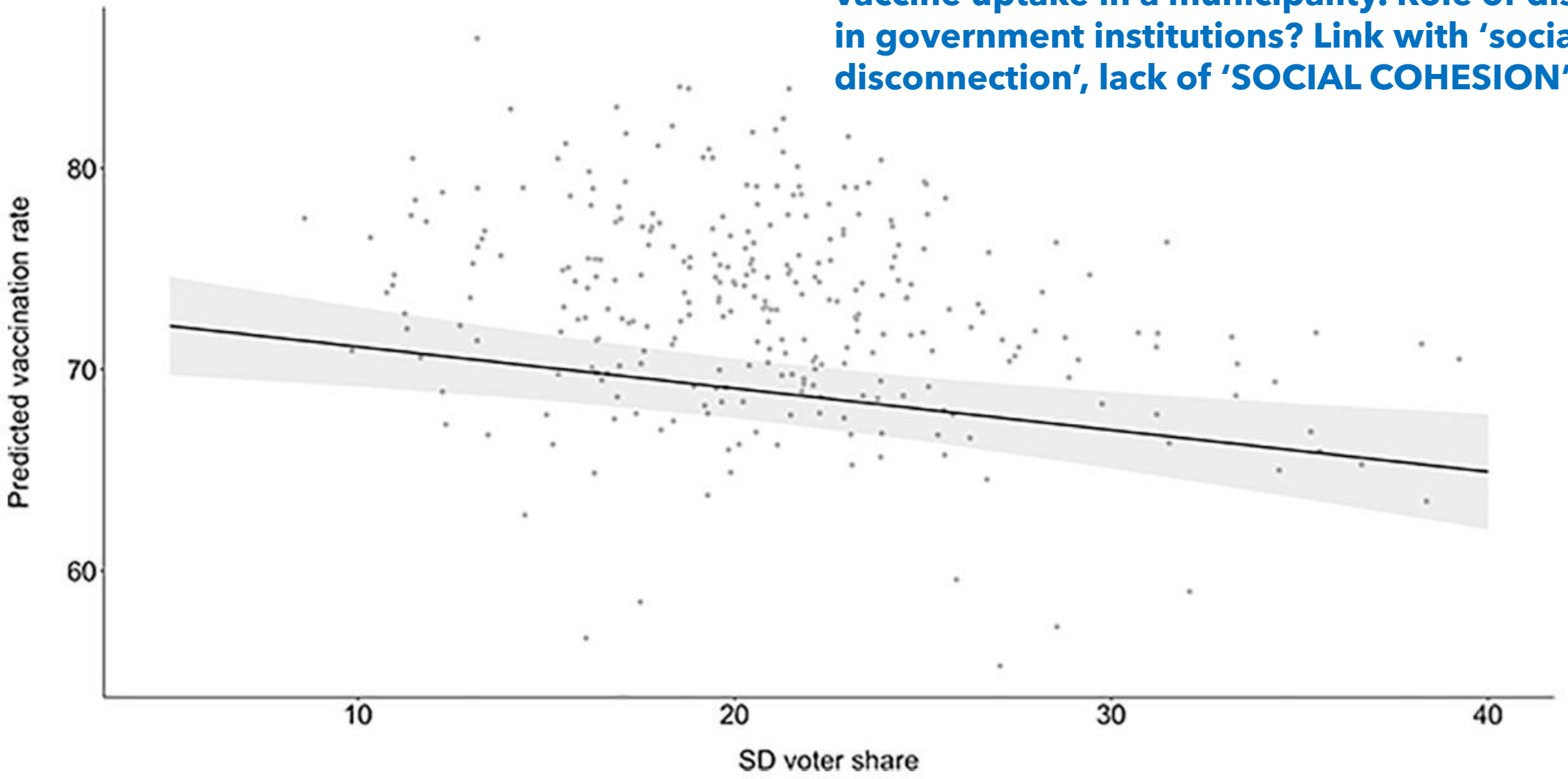
- **Social Support**
- **Social interactions**
- **Satisfaction with personal relationships**
- **Loneliness**

Fig 2

POLITICAL CONTEXT

Predicted vaccination rates for municipalities with various levels of support for the SD.

Gray dots are observed values.



The SD ("Sweden Democrats") are an anti-establishment (radical right) party: the higher the voter share for SD, the lower the Covid-19 vaccine uptake in a municipality. Role of distrust in government institutions? Link with 'social disconnection', lack of 'SOCIAL COHESION'?

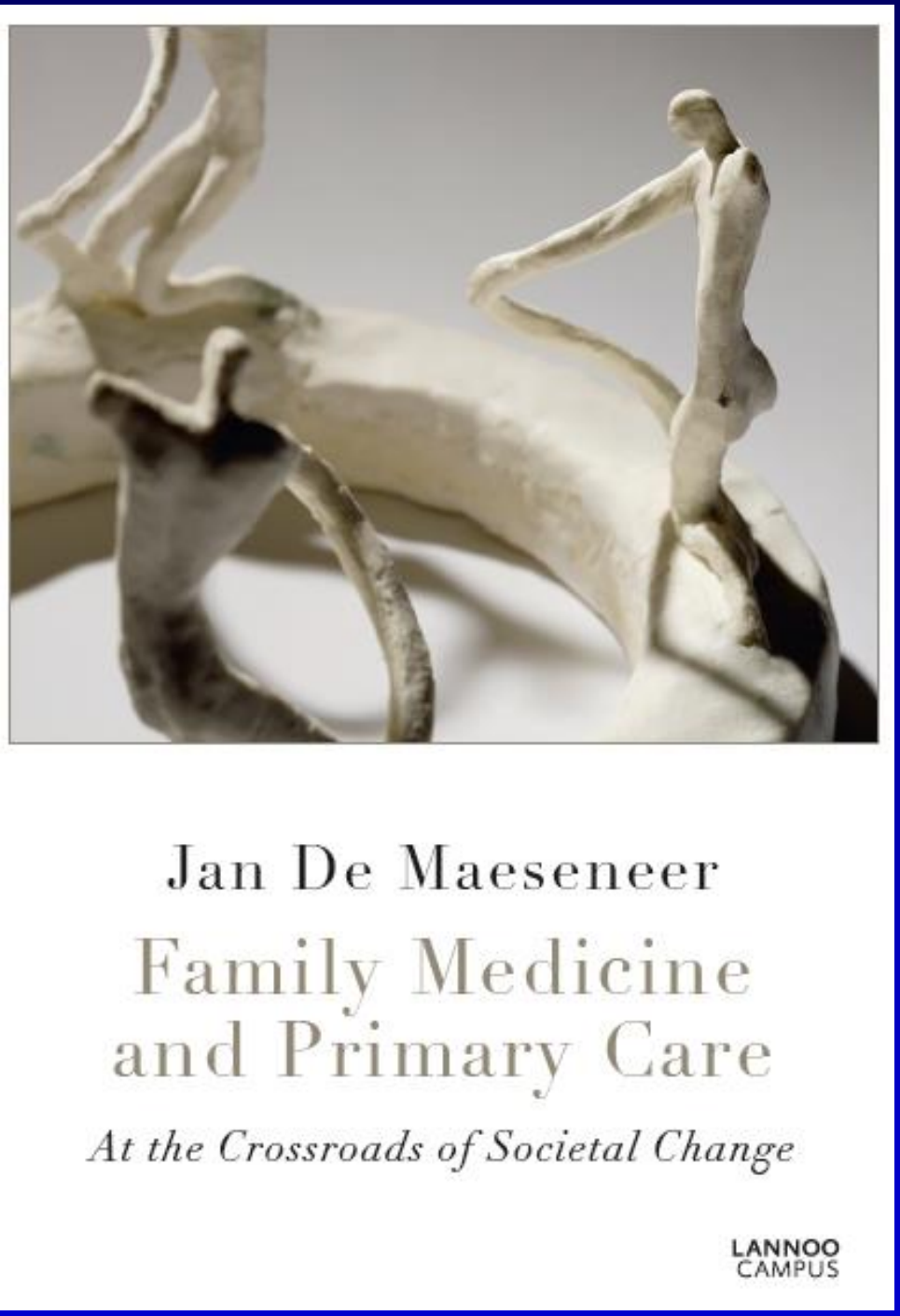
doi: https://doi.org/10.1371/journal.pgph.0001204.g002

Conclusion : the recent experiences in addressing Covid-19 could inspire international cooperation at the level of development of interdisciplinary practices with family physicians and other care providers in primary care, with a strong data-driven component focusing on public health and using an integrated 'goal-oriented' health record .

Moreover a new research agenda is needed integrating research on individual care processes with addressing upstream causes (e.g. equity and social determinants of health) at population level. We also learned from Covid that there is a need for rapid scientific response to new diagnostic and therapeutic challenges, using clinical trials in the community.

Finally the renewed attention for family medicine and primary care, invites us to engage in advocacy campaigns to invest in primary care locally and globally, and support campaigns to shift resources from vertical disease-oriented programs towards comprehensive primary care (see www.30by2030.net). For this advocacy, cooperation between Africa, Europe and other continents can make change happen. What are the opportunities ?


Canada
Hudson Bay
Labrador Sea
United States
Gulf of Mexico
Cuba
Puerto Rico
Caribbean Sea
Guatemala
Nicaragua
Venezuela
Guyana
Suriname
Colombia
Ecuador
Peru
Brazil
Bolivia
Paraguay
Chile
Uruguay
Argentina
South Pacific Ocean
North Atlantic Ocean
South Atlantic Ocean
Ireland
Poland
Italy
Romania
Turkey
Portugal
Tunisia
Morocco
Algeria
Libya
Egypt
Western Sahara
Mauritania
Mali
Niger
Chad
Guinea
Gulf of Guinea
Gabon
DRC
Tanzania
Angola
Zambia
Mozambique
Madagascar
Kazakhstan
Mongolia
Kyrgyzstan
Turkmenistan
Afghanistan
Iran
Iraq
Syria
Saudi Arabia
Yemen
Oman
Gulf of Aden
Arabian Sea
Ethiopia
Somalia
India
Myanmar (Burma)
Thailand
Vietnam
China
South Korea
Japan
Sea of Okhotsk
Sea of Japan
East China Sea
South China Sea
Philippine Sea
Bay of Bengal
Laccadive Sea
Indonesia
Banda Sea
Arafura Sea
Papua New Guinea
Coral Sea
Australia
Great Australian Bight
Tasman Sea
New Zealand
Indian Ocean



https://www.perlego.com/book/3052938/family-medicine-and-primary-care-at-the-crossroads-of-societal-change-pdf

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DARE TO THINK

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