Editorial

Global health

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Citizenship and Immigration Canada data indicate that Canada receives approximately 25 000 refugees each year.[1] Although these refugees undergo certain medical examinations in their countries of origin, their health statuses upon arrival in Canada are not clear. The 2-part article entitled "Health Status of Newly Arrived Refugees in Toronto, Ont" in this month's issue (**pages e303** and **e310**) is highly instructive.[2,3] It describes a study conducted by Redditt et al that examined data for 1063 refugees who consulted a specialized health clinic for refugees in Toronto between December 1, 2011, and June 23, 2014. These data reveal that the refugees had high rates of infectious and chronic disease. The prevalence rates of HIV, hepatitis B, and hepatitis C infection were 2%, 4%, and approximately 1%, respectively. Many of the refugees who came to the clinic presented with parasitic diseases such as schistosomiasis and strongyloidiasis. In addition, they presented with high rates of certain chronic diseases; 11% of children younger than 15 years and 25% of women older than 15 years had anemia. Overall, 30% of adults had high blood pressure and 8% had abnormal blood sugar levels. In addition, 11% of female patients had abnormal cervical cytology results.

These results are cause for concern, and we have to wonder about the health status of other refugees—those who do not find refuge in Canada. If this is the health status of refugees who make it to Toronto and who consult a specialized health clinic, what about those who cannot come or are not accepted? What about those who are trapped in countries ravaged by war, conflict, and bloodshed? What about the health of populations held hostage by war and conflict? Never mind access to medications; what about access to the most basic necessities of life? It is highly likely that the health status of these populations, forgotten or abandoned, is even worse.

What can be done? We can donate to the Red Cross and to volunteer and charitable organizations. We can sign up with Doctors Without Borders. What else? What can family physicians specifically do to improve global health?

Canadian Family Physician will attempt to answer this question in a new series on family medicine around the world called "The Besrour Papers." The first such paper, published in this month's issue (**page 596**), is entitled "Developing the evidentiary basis for family medicine in the global context."[4] It is an overview of the important methodologic challenges in finding definitive evidence of the positive effects of family medicine and family medicine training on a global scale. Future papers will focus on proposed methodologies to overcome these challenges, as well as emerging evidence from Canadian partners in low- and middle-income countries. Over this series of papers, we hope to add a further platform in crafting a more robust evidentiary framework.

Can family medicine play a role in improving global health? Barbara Starfield's research is often quoted in response to this question. Dr Starfield found that "primary care improves health by showing, first, that health is better in areas with more primary care physicians; second, that people who receive care from primary care physicians are healthier; and, third, that the characteristics of primary care are associated with better health."[5] However, as the authors in our series point out, determining the effects of family medicine is more difficult in other parts of the world (ie, in low- and middle-income countries).

To what extent can family medicine change the health status of the planet's most impoverished inhabitants? That is the real question. What we can say, at this point, is that while access to a physician (or the equivalent) is desirable for populations ravaged by war, misery, and famine, the determinants of health are more likely to start with access to life's bare necessities: food, water, a livelihood, and a safe place to live. Where basic well-being is concerned, access to a family physician is perhaps only one piece of the puzzle.

References

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5. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005;83(3):457-502.

Cet article se trouve aussi en français à la **page 577.**