



Building Capacity in Family Medicine in Low and Middle Income Countries

An International Strategic Consultation Meeting

on

The Sadok Besrouer Centre
for Innovation in Global Health

November 9 - 11, 2012
Kingbridge Centre
Ontario, Canada

Table of Contents

1. Executive Summary.....	2
2. Background.....	4
3. Understanding the Global Environment.....	6
3.1 Opening Remarks.....	6
3.2 International Family Medicine Partnerships.....	8
4. Creating the Vision.....	16
4.1 Strengthening Family Medicine Globally.....	16
4.2 Mission, Vision, Values.....	18
5. Revised Strategic Directions.....	19
6. Implementation Priorities.....	22
7. Conclusion.....	24

1. Executive Summary

From November 9 to November 12, 2012, Canadian and international delegates convened at the Kingsbridge Conference Centre for a Strategic Consultation Meeting on family medicine capacity building in low and middle income countries (LMIC). Organized by the Global Health Committee of the College of Family Physicians of Canada (CFPC), the purpose of the Consultation Meeting was to develop a mission, vision, and action plan for the Besroure Centre for Innovation in Global Health.

Thanks to the generous support of Dr. Sadok Besroure, the Consultation Meeting was the first of three such annual gatherings of Canadian departments of family medicine and their LMIC partners to collectively develop the role and collective actions of the Besroure Centre.

Participants in this year's Meeting included representatives of the CFPC, faculty from academic departments of family medicine across Canada, and delegates from 10 LMICs at various stages in the development of family medicine. Over the course of the Strategic Consultation Meeting, participants elaborated the following five strategic directions for the Besroure Centre:

- 1. Establish family medicine as an effective, viable and pivotal element of national health systems.**
- 2. Strengthen continuing education and knowledge support for family physicians towards a comprehensive, effective and community responsive scope of practice.**
- 3. Support family medicine accreditation and certification (In collaboration with global community)**
- 4. Enable effective family medicine faculty development**
- 5. Build knowledge for family medicine through scholarship, and evaluating the impact of family medicine on health outcomes.**

The strategic directions were framed by a statement of the vision, mission, and values of the Besroure Centre, which the delegates collaboratively shaped. Through breakout group discussions and broader consultation, the delegates further defined the Besroure Centre's functions by identifying

Vision

A global catalyst for innovative collaborations in Family Medicine towards a healthier world for all.

Mission

The Besroure Centre for Innovation in Global Health will reduce health inequities by enhancing the positive impact of Family Medicine on the health of vulnerable populations at home and around the world through collective learning

In the context of Family Medicine we will:

- Share knowledge to promote high standards of medical education and community based care
- Support training and capacity building
- Encourage scholarship and disseminate knowledge
- Engage with all sectors involved in primary care
- Enable sustainable, multilateral partnerships
- Promote the convergence of primary care and population health.

implementation priorities for the short, medium, and long term, and identified their corresponding key enablers and expected outcomes.

The formal and informal exchanges of ideas, knowledge, and experiences between the delegates were invaluable to the strengthening of global capacity building initiatives in

family medicine. The CFPC Global Health Committee has summarized the proceedings and outcomes of the 2012 Strategic Consultation Meeting in the following report, which will serve as a blueprint for the Besroure Centre for Innovation in Global Health.

Values

- **Equity** – by recognizing the inherent dignity of every human being and the just distribution of resources and access with respect to marginalized and vulnerable groups.
- **Justice** – by ensuring that individuals and groups have fair and impartial access to the benefits of society including the right to health.
- **Excellence** – by striving and adhering to the highest standards of quality, integrity, professionalism, leadership and evidence informed and patient-centered care.
- **Reciprocity** - by promoting the collaborative and multidirectional exchange of experience, knowledge and capacity building between and amongst partners and their communities.
- **Respect** - for each other’s cultures, norms and perspectives.

2. Background

In its 2008 Report, *Primary Health Care: Now more than ever*, the World Health Organization (WHO) reiterated the pivotal role of primary health care in achieving Alma Ata’s goal of Health for All, set 30 years earlier. The WHO’s emphasis on strengthening primary health care, including building capacity in the delivery of community-responsive primary care, reflects the ample and rigorous evidence that health systems anchored in strong primary care and family medicine produce better health outcomes at lower costs with greater equity (Starfield et al. Contribution of Primary Care to Health Systems and Health).

In Canada, family medicine is recognized as a central pillar of our health care system. Internationally, Canadian family physicians are known as being highly trained and skilled practitioners. The College of Family Physicians of Canada (CFPC) has greatly contributed to the current status of the discipline by providing oversight for a process of accreditation and the establishment of standards that underlie the quality of our discipline. Canada’s seventeen academic departments of family medicine have translated the standards of the CFPC into rigorous and innovative programs to train family physicians. They have also greatly enriched the discipline through scholarship and research.

Deeply cognizant of the potential contribution of family medicine to health and equity, and buoyed by a shared commitment to social responsibility, many academic departments of family medicine across Canada have supported the development of family medicine in low and middle income countries through various types of partnerships. Similarly, the CFPC has responded to the request of many around the world for information and support in the development and strengthening of family medicine.

Recognizing the need to deepen Canadian involvement in building family medicine capacity globally, Dr. Sadok Besrouer has generously contributed to the establishment of the Besrouer Centre for Innovation in Global Health. Initial discussions by the CFPC’s Global Health Committee about the specific activities to be undertaken under the Besrouer Centre quickly pointed to a need to consult with Canadian academic departments and their partners working towards the strengthening of family medicine globally.

This initial Strategic Consultation Meeting provided an opportunity to better understand the needs of family medicine capacity building partnerships and to identify concrete strategies through which the CFPC and the Besrouer Centre could support them. The inaugural think tank was understood as the first of three annual meetings to be held for

“This international consultation is intended to strengthen family medicine as a pillar of primary health care in a global context.”

Dr. Sadok Besrouer

the purpose of identifying, refining and establishing collaborative pathways between Canadian academic departments of family medicine and international partners to strengthen family medicine.

By the end of the first annual meeting, participants will have achieved the following:

1. Identify the needs of family medicine with respect to capacity-building in low and mid income countries (LMIC) to inform a strategy for the CFPC to collaborate with them in achieving their objectives;
2. Learn and exchange lessons from mature international family medicine partnership programs and engage with new and emerging partnership programs as each evolves Family Medicine in their respective countries;
3. Confirm a shared vision for the Sadok Besrouer Centre for Innovation in Global Health
4. Identify strategic directions, goals and priority activities for short term (12 to 18 months) and longer term, that will include fertile areas for collaborative projects
5. Build an international community of practice with a shared interest in building capacity in Family Medicine in LMIC.

3. Understanding the Global Environment

3.1 Opening Remarks

Welcome & Introductions

The Chair of the CFPC Global Health Committee, Dr. Katherine Rouleau, welcomed the international and Canadian delegates and thanked the organizers. Dr. Rouleau underscored the importance of striving to keep our patients at the forefront of the discussion.

Dr. Sandy Buchman, the outgoing President of the CFPC, highlighted the critical importance of the Meeting and the significant contributions the CFPC could make to supporting family medicine capacity building in LMICs. He remarked that the Besrou Centre represents an opportunity to demonstrate social responsibility and advocacy as Family Physicians. Dr. Buchman thanked Dr. Sadok Besrou and the CFPC Global Health Committee.

Unfortunately, Dr. Sadok Besrou had to travel urgently to Tunisia and could not attend the Meeting. Dr. Besrou prepared a letter addressed to the delegates describing the Global Health Centre as an opportunity to strengthen family medicine as a pillar of primary health care in a global context.

Setting the Context

Dr. Francine Lemire, incoming CEO and Executive Director, CFPC

Dr. Lemire provided a brief history of the CFPC and explained its current role in Canadian family medicine. Created in 1954 to address the challenges involved in training Canadian family physicians, the CFPC witnessed the establishment of family medicine residency programs in all Canadian medical schools by 1974. Presently, the CFPC has over 27,000 members and operates as the national family medicine accreditation and certification body.

In its role, the CFPC focuses on the following areas: family medicine education; Continued Professional Development (CPD); clinical care; health policy; and advocacy. Through its CPD accreditation program the CFPC promotes and supports the lifelong training of family physicians. The College also serves as a catalyst for capacity building in family medicine research, reflecting its motto “In Study Lies Our Strength.”

Importantly, the CFPC functions as the professional home of family physicians and those who contribute to the discipline. It supports the professional identity and role of family physicians by advocating on their behalf and for the populations they serve.

“The CFPC advocates for family physicians and the populations they serve.”

Dr. Francine Lemire

Following an overview of family medicine’s foundational scholars and documents, Dr. Lemire outlined the lessons learned by the CFPC since its inception. In establishing and strengthening family medicine in Canada, it was important to have a group of champions to articulate the discipline; to develop strategic alliances; to maintain a commitment to educational and scholarly work; and to be active in health policy, advocacy, and policy design.

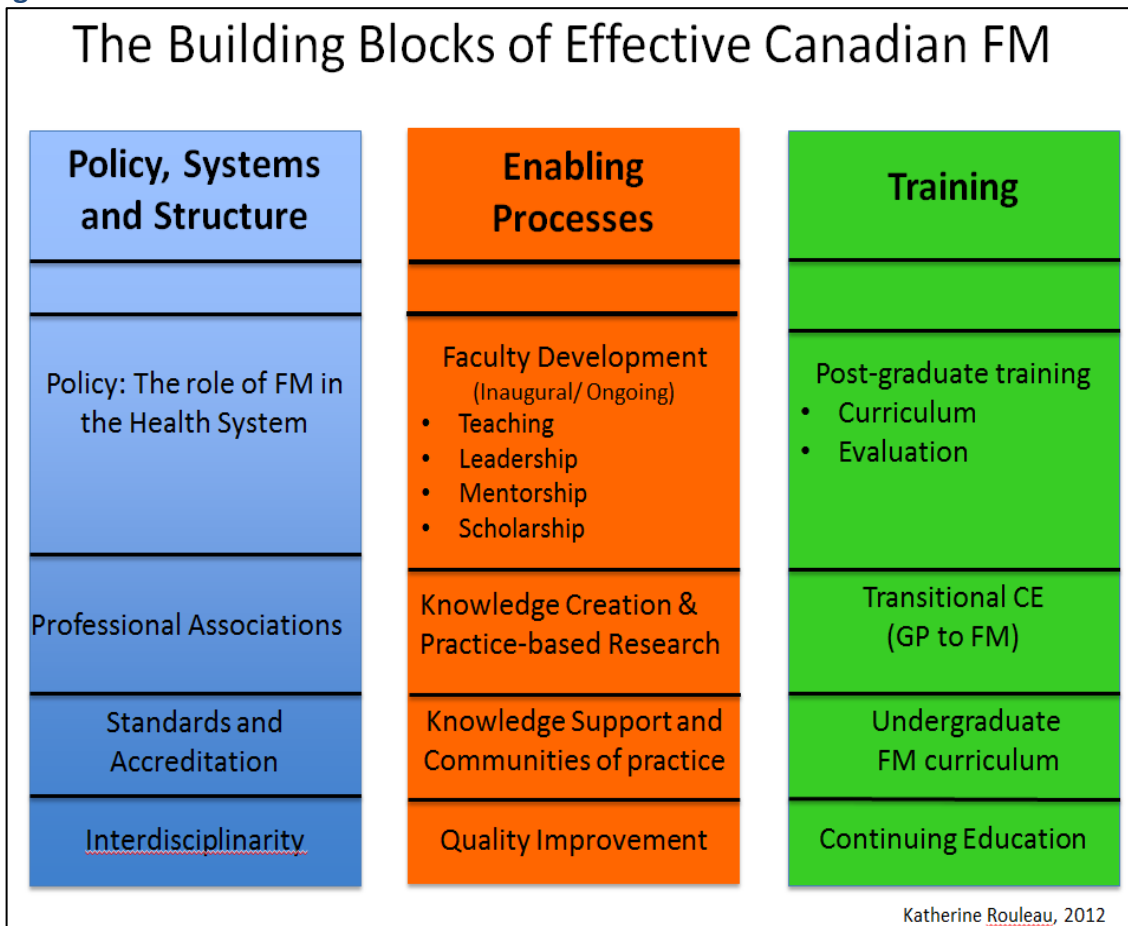
As global health activities in family medicine have increased, the CFPC’s Global Health Committee has discussed the potential for Canadian academic departments and their international partners to collaborate on global family medicine capacity building initiatives. Dr. Lemire challenged the delegates to explore this potential by asking, “is there something bigger that we can do together that we could otherwise not do alone?”

Canada’s Contribution to Family Medicine: A Conceptual Framework

Dr. Katherine Rouleau, Chair, CFPC Global Health Committee

Dr. Rouleau outlined the conceptual building blocks of effective Canadian family medicine (see Figure 1). She encouraged the delegates to modify the framework in order to reflect the realities of their context.

Figure 1



Objectives and Aspirations for this Meeting

Dr. Lemire reinforced that the purpose of the International Consultation Meeting was to develop an initial action plan for the Besroure Centre for Innovation in Global Health. She posed the following questions which were among those that should be discussed during the conference:

- Should the CFPC engage in its areas of strength in other countries?
- How do we achieve synergy among departments of family medicine already engaged in family medicine capacity building in LMIC?
- What are/would be the preparatory steps to adapt Canadian lessons to respond to the needs of other countries?
- What obstacles and challenges are standing in the way of establishing or strengthening family medicine in some LMIC?
- How can the Besroure Centre facilitate the development and strengthening of family medicine in LMIC?
- What might be the priorities of the Besroure Centre in that respect for the next 12-18 months and the longer term?

3.2 International Family Medicine Partnerships

The purpose of the opening panel is to share the successes, challenges, opportunities, and lessons learned from established global family medicine partnerships and to suggest ways in which the Besroure Centre could support these initiatives.

Moderators: Dr. Lynda Redwood-Campbell & Dr. Rosariah Indah

Dr. Lynda Redwood-Campbell of McMaster University and Dr. Rosariah Indah from Aceh, Indonesia, have been engaged in a partnership to develop family medicine in Indonesia. They provided the perspective of the new and emerging family medicine partnership programs who were eager to learn from the lessons and experiences of partnerships with a longer history.

Below are the highlights of four distinct partnership programs.

Mali – University of Sherbrooke

- Dr. François Couturier – University of Sherbrooke; Dr. Mahamane Maïga – Bamako, Mali

Background

- University of Sherbrooke has been involved in training at Community Health Centers (CHC) in Bamako, Mali for the last 15 years. The partnership evolved out of international health electives in Mali for Sherbrooke residents beginning in 1997.
- DECLIC project: Development of Community-based Clinical Teaching. This seven year project has received funding from CIDA to accomplish the following:
 - Assist in the creation of an FM specialty in Mali

<ul style="list-style-type: none"> ○ Support the Mali Health Sciences Institute ○ Develop a network of Academic CHCs (for Malian and Sherbrooke FM residents) ● The Diploma of Specialized Studies in Family Medicine <ul style="list-style-type: none"> ○ rural and urban CHCs are training sites ○ competency-driven ○ clinically oriented ○ community-based ○ embedded in a larger inter-professional training plan ● Academic CHC sites provided infrastructural upgrades and staff professional development ● Educational objectives: Prepare FM residents for primary care work in Mali. Graduates should be more responsive to community health needs and more inclined to practice in non-urban areas.
<p><i>Challenges & Opportunities</i></p> <ul style="list-style-type: none"> ● Lack of community training in medical school creates a lack of preparedness and confidence in primary and community care among MDs
<p><i>Lessons Learned</i></p> <ul style="list-style-type: none"> ● Social accountability: the community is the central stakeholder ● Post-coup (March 2012), it is more important than ever to support primary care in Mali

<p>Lao – Calgary</p> <ul style="list-style-type: none"> ● Dr. Christine Gibson – University of Calgary; Dr. Phetvilay Senavong - Lao
<p><i>Background</i></p> <ul style="list-style-type: none"> ● Goals and strategies: <ul style="list-style-type: none"> ○ Reform undergraduate curriculum ○ Faculty development ○ Develop resources (IT, library, equipment) ○ Improve health for rural populations ● Family medicine competencies developed based on needs assessment <ul style="list-style-type: none"> ○ Competent clinician; community organizer; manages local health services; educator; researcher ○ New family physicians should have the competency and confidence to work in rural Lao ● Family medicine program objectives <ul style="list-style-type: none"> ○ Have knowledge and skills to practice general curative medicine ○ Have knowledge and skills to work in community ○ Specialize in third year for pediatrics, IM, OB, Surgery, ER... (new) ● 3rd year specialization will be mandatory. It is intended to bring FM training to par with other specialties and provide more confidence for working in rural communities

- Principles of training
 - Learning by doing
 - Bedside teaching
 - General skills in all areas
 - Community learning

Challenges & Opportunities

- Maintaining CME, faculty development of rural staff
- Need for FM advocacy, residents unsure of FM, recruitment difficult
- Community supervision challenging, lacking resources
- Annual funding approval by Ministry lacks stability
- Learning resources need improvement

Role of Besroure Centre

- Assist in faculty development
- Provide teaching materials
- Coordinate CME
- Advocate for family medicine

Ethiopia – Toronto

- Dr. Jane Philpott - University of Toronto (UofT); Dr. Dawit Wondimagegn – Addis Ababa University (AAU)

Background

- The family medicine partnership grew out of a broader health sciences collaboration between Addis Ababa University and the University of Toronto (TAAAC).
- The collaboration to establish a family medicine residency program at AAU (TAAAC-FM) began in 2008.
- Activities
 - FM faculty development fellowship for core group of six AAU faculty in Toronto
 - AAU faculty lead identified for FM residency program
 - FM curriculum developed based on epidemiological statistics and data collected through a needs assessment study undertaken jointly by AAU and U of T.
- FM program is supported by a U of T family physician and two additional Canadian family physicians, all of whom are spending a year in Addis Ababa
- Toronto-based faculty will take a few month-long trips to Ethiopia per year to deliver CME events and support resident teaching and supervision
- The residency program is slated to begin in January 2013

Challenges & Opportunities

- Recruitment challenges, conveying understanding of family medicine and its value
- Lack of Ethiopian family physicians in country to role model
- Other international partners involved in the FM initiative
- AAU will be undergoing an undergraduate medical curriculum reform

Lessons Learned

- Collaboration with stakeholders is key to progress
- In-kind contributions have been key to the initiative
- Trust & mutual respect are central to the partnership
- Flexibility and a long-term vision are crucial

Role of Besroure Centre

- Provide resources for CME
- Support the integration of FM into the undergraduate curriculum
- Ultimately, support the establishment of an Ethiopian FM association

The Strengths and Weaknesses of Brazil's Family Health Program

- Sister Monique Bourget, São Paulo, Brazil

Background

- Brazil's public health care system is 20 years old
 - Includes 62,000 primary care centers
 - Primary care is municipally governed
 - Exists parallel to a private system
- Family Health Program (since 1994)
 - 32,000 family health teams in Brazil cover 50% of the population
 - Goal to double number over the next 10 years
 - Team consists of GP or family physician, nurse, assistant nurse, community health agent
 - A family health team serves a population between 2400 and 4000
- The Family Health Program has significantly lowered the infant mortality rate, and resulted in high breastfeeding rates and immunization rates
- Community health agents work in their communities with families and know which inhabitants have what health problems
- Santa Marcelina Hospital in São Paulo has launched a new medical school that emphasizes primary care and family medicine throughout the curriculum
 - The University of Toronto is collaborating to support faculty development for undergraduate preceptors and teachers in family medicine

Challenges & Opportunities

- There is little involvement in primary care at the provincial and federal level
- Geographically-based family health teams means patients have little choice in who their family physician is
- Family health team generalists are often poorly trained
- Preventive medicine is entrenched in the academy and is a barrier to the growth of academic family medicine
- Primary health care and family medicine are not priorities in medical education

Questions from the floor

How do you prepare a health system for FM?

- Lao
 - The gap was identified, and no one else in the health system was performing this service.
- Brazil
 - Primary care in Brazil is still perceived as “poor medicine for the poor” and specialists continue to resist family medicine.
 - With 25,000 GPs working in Family Health Teams, the Ministry of Education needs to implement a policy to mandate family medicine departments in universities.
- Mali
 - The challenge is to get family physicians adequate remuneration
 - CHCs are self-reliant for funding and it is difficult to fund MDs
 - The government and international funders need to invest in CHCs
- Ethiopia
 - Outstanding work in primary care by Ministry in terms of low, mid-level health workers in primary care. However, MD-level primary care is not necessarily part of this vision, even though the MoH has formally supported family medicine
 - Academics and policymakers have worked together in Ontario to reform primary care. We could include Canadian and international policymakers in our next Besroul meeting
 - The challenge is to demonstrate the added value that family physicians would bring to the health system. Continuous advocacy is required at every level

Could the Besroul Centre coordinate the triangulation of partnerships?

- Mali
 - There is no other family medicine development in francophone Africa
 - Brought Burkina Faso faculty to observe field training in Mali, however, the funds and health human resources are lacking to facilitate further exchanges
- Calgary
 - The East Africa FM Initiative brings together local departments of FM to discuss its development
 - We can also look outside of universities for partnership support with NGOs. There could be a role for the Besroul Centre in facilitating these connections

*What are the most serious obstacles encountered with political and economic decision-makers?
Have you faced obstacles with other specialties?*

- Mali
 - Military coup of March 2012. The political situation is volatile. Sherbrooke cancelled its international health fellowships to Mali
 - Internal organization problems as well, including turf wars between specialties

- Strength of project comes from bottom-up approach. It takes time and credibility to convince leadership
- Lao
 - Funding approval from government is year to year, making it very difficult to predict and plan ahead
 - It takes time to educate those outside the initiative

What were key ingredients to initiate the partnerships that made them successful?

Could the Besroul Centre act as a facilitator of new partnerships as well as strengthening existing ones?

- Brazil
 - Emerged from early primary care collaboration involving UofT family physicians in 1990s
 - Brazilian Ministry is much more open to building international partnerships now
- Mali
 - The human focus is fundamental, the partnership began with a relationship between two people
 - First you pursue goals, and reality follows
 - It is important to build alliances and resources
 - CFPC could set guidelines or a framework for partnerships. However, we must be careful not to be too rigid and risk crushing potential collaborations
- Ethiopia
 - A partnership begins with one or two individuals. Individuals have to work within a system
 - Key ingredients include mutual benefit to partners and patience

In a subsequent session on Saturday titled ‘Harmonizing multiple academic Family Medicine partnerships towards a common goal,’ Dr. Neil Arya and Dr. Felix Li presented their perspectives on building and maintaining complex global partnerships.

[Dr. Neil Arya – Global Health Partnerships](#)

Dr. Neil Arya is a family physician and Director of the Office of Global Health at the University of Western Ontario.

- When establishing an Office of Global Health, the University of Western Ontario conducted an environmental scan to identify its strengths, weaknesses, and opportunities for partnerships
- Strategic planning is valuable, taking advantage of opportunities as they develop is also key
- Partnerships can encounter a number of threats and challenges: limited resources, personnel changes, and lack of institutional understanding

- South-South-North and North-North-South partnerships: Important to carefully consider whether collaboration is going to result in a positive and sustainable outcome for all partners.
- Collaborations will not necessarily benefit from a formalized institutional agreement, such as a Memorandum of Understanding (MOU)
- The Canadian Coalition for Global Health Research (CCGHR) has a harmonization project to help coordinate global initiatives.
- The Besrouer Centre could play a coordinating role for FM capacity building activities

Dr. Felix Li - Harmonizing Multiple Academic Family Medicine Partnerships towards a Common Goal: The China Experience

Dr. Felix Li is the Minister Counsellor (Health) at the Canadian Embassy in Beijing, China.

- China has initiated a health care reform in order to provide safe, effective, accessible, and affordable basic health care services to urban and rural residents by 2020, including training 300,000 new general practitioners/family physicians and strengthening primary care
- The China-Canada Family Medicine Symposium took place in March of 2012 and included 9 Canadian departments of family medicine, the CFPC, CIHR and delegates from 25 Chinese provinces. The themes for collaboration that emerged were: the development of a family medicine/GP 'system' (national training and certification standards and scope of practice); University-to-University family medicine/GP faculty development; and Primary Health Care policy development and research.
- The 'train the trainer' model will be much more efficient for such a large-scale project. Canadian universities will be paired with Chinese medical schools and faculty will spend time observing each other's family medicine program to identify needs. Some of the faculty training will take place in China, while some Chinese faculty will undergo training programs in Canada.

In a final context-setting piece, Dr. Jamie Meuser presented on the lessons Canada has learned in the area of Continuing Professional Development for family physicians. Dr. Meuser also commented on progress being made in advancing communication and collaboration locally and globally.

Continuing Professional Development for Family Physicians: Five Lessons Canada Can Share

Dr. Jamie Meuser is the CFPC's Director of Continuing Professional Development

Lesson #1: Don't ignore the obvious

- Family physicians need (and want) to continue learning over their entire career in order to adapt to change and provide optimal care

Lesson #2: Don't forget it's a continuum

- The challenge of distinct motivations to learn as a student or trainee versus as a practitioner is only partially addressed by techniques such as PBL
- Integrate skills and knowledge for lifelong learning into medical training from beginning
- Residents' 'knowledge work' could be integrated into practitioners' learning needs

Lesson #3: Expand your thinking...

- ...about what needs to be taught and learned, using a clear set of competencies and a broad conception of competency in practice
- ...about the audience: primary care is team-based, and the team can practice better together when they learn together.

Lesson #4: Quality of care is the only sensible starting point

- ...For team-focused care, for addressing almost any clinical topic, for identifying previously unperceived learning needs

Lesson #5: Recognize and build on the expertise of practitioners

- Colleagues are the prime source of learning
- Use a virtual platform to allow family physicians to leverage their collective knowledge to answer one another's questions and build a context-specific knowledge base

CFPC's Online Collaborative Knowledge Resource

- Provides immediate access for family physicians to information through the Lookup and Query services and house collaborative spaces

Questions from the floor

- How might this type of community of practice be adapted to an international collaborative context?
 - An online repository of knowledge could be created for partners in LMIC
 - Canadian departments and partners engaged in family medicine capacity-building could share knowledge resources
 - Family physicians can serve as a knowledge resource to other practitioners in a given region, and receive knowledge support from abroad

Conclusions

A number of key themes emerged from the presentations regarding family medicine capacity building partnerships, including the evolution and strengthening of relationships, strategies for socially accountable partnerships, and common challenges faced in the development of family medicine. Furthermore, potential roles for the Besrou Centre were proposed.

4. Creating the Vision

4.1 Strengthening Family Medicine Globally: Collaborative pathways to health for all

Keynote Speaker: Dr. Roger Strasser

Dr. Roger Strasser is a family physician and Dean of the Northern Ontario School of Medicine (NOSM). In addition to being a member of the Wonca Working Party on Rural Practice, Dr. Strasser sits on the boards of NOSM, the Thunder Bay Regional Health Sciences Centre, the Advanced Medical Research Institute of Canada, and the Thunder Bay Regional Research Institute.

Dr. Strasser described family medicine as being based on the '3 Ps' and '3 Cs':

- Primary care; Patient centred care; Preventive care
- Continuing care; Comprehensive care; Community engaged care

Family physicians are highly skilled specialists who occupy a uniquely complex place in the health system. Lessons for strengthening family medicine can be drawn from the experience of rural practitioners, as rural practitioners generally provide a wider range of services and have a higher level of clinical responsibility. They live in the community they serve, which provides an opportunity to assume a greater community health role.

The Northern Ontario School of Medicine (NOSM) was created to improve the health of Northern Ontario populations. NOSM has a strong social accountability mandate, which includes being responsive to the community and committed to the health of the community.

In keeping with its mandate, NOSM's approach is one of 'distributed community engaged learning,' an instructional model that allows widely distributed human and instructional resources to be utilized independent of time and place in community partner locations across the North. The keystone of this model is community engagement. NOSM maintains some 70 training sites and a multitude of interdependent partnerships with communities in Northern Ontario. Active community participation in the learning experience facilitates an understanding of the local social determinants of health, allowing the School to be more responsive to the community's needs.

The benefits of NOSM's model include a very high rate of students choosing family medicine or a generalist specialty, a high rural retention rate, interprofessional cooperation, enhanced access to health care for rural, remote, and underserved populations.

Dr. Strasser concluded with the following statement: "To achieve health equity the world needs family physicians who care for people in their home and community context and who are active in contributing to health systems which are developed through community engagement."

**"Family
medicine is
about the
context."**

Dr. Roger Strasser

Questions and Comments from the Floor

In Tunisia since the revolution, there is a call for health education reform. There is the opportunity to base the health system in the right to health and the needs of communities.

- It is important to distinguish between the wants and needs of a community. It is therefore useful to ground the discussion in health outcomes and involve people actively in the design of benchmarks.

How does one incorporate NOSM's values of community engagement into established urban centers?

- The principles are essentially the same as when engaging rural communities. In more populated areas individuals also belong to a community. Communities are more complex in urban centres, but the principles for engaging with people where they live are the same.

In Aceh, Indonesia, there are initiatives to move towards community-based training. However, this is only a small portion of the training and there are concerns that it may amount to medical tourism. Expanding community-based training is an expensive proposition. How do you overcome the financial obstacles involved in community engaged training?

- The notion of community education started with community oriented (i.e. university based), then evolved into community based, in which the community is a passive recipient, and then into community engaged. In the case of Northern Ontario, a socio-economic impact study of NOSM was conducted. The cost is higher per learner, but the investment was doubled in terms of economic impact in the communities. The communities are also more positive about the future in general. Creative sourcing of funding is also important: local government, development agencies, get communities involved in fundraising.

Canadian family physicians are trained to be ready to practice in any community in Canada. How do we get a cadre of faculty who can teach context-based FM?

- We need to get those in the community working in health to be teachers of future family physicians. These teachers do not need to be family physicians themselves.

The Canadian government has just announced its plans to launch an aggressive new immigration policy. What can we do to address this in health care?

- Individuals have a choice, but higher income countries can help improve the quality of education and services in LMICs to help keep professionals in country.

Dr. Strasser's presentation provided valuable insights on the possibilities of building family medicine programs that are based on and responsive to the needs of the community. Please see the Appendix for the complete presentation and list of references.

4.2 Vision, Mission, and Values Statement Besroure Centre for Innovation in Global Health

Based on the themes that emerged from presentations and discussions during the Meeting, the delegates collectively elaborated the vision, mission, and values that will guide the Besroure Centre.

Vision	A global catalyst for innovative collaborations in Family Medicine towards a healthier world for all.
Mission	<p>The Sadok Besroure Centre for Innovation in Global Health will reduce the inequities and enhance the positive impact of Family Medicine on the health of vulnerable populations at home and across the world through collective learning,</p> <p>In the context of Family Medicine we will:</p> <ul style="list-style-type: none">• Share knowledge to promote high standards of medical education and community based care• Support training and capacity building• Encourage scholarship and disseminate knowledge• Engage with all sectors involved in primary care• Provide support for sustainable, multilateral partnerships• Promote the convergence of primary care and population health.
Values	<ul style="list-style-type: none">• Equity – by recognizing the inherent dignity of every human being and the just distribution of resources and access with respect to marginalized and vulnerable groups.• Justice – by ensuring that individuals and groups have fair and impartial and access to the benefits of society including the right to health.• Excellence – by striving and adhering to the highest standards of quality, integrity, professionalism, leadership and evidence informed and patient-centered care.• Reciprocity - by promoting the collaborative and multidirectional exchange of experience, knowledge and capacity building between and amongst partners and their communities.• Respect - for each other’s cultures, norms and perspectives.

5. Revised Strategic Directions

Over the course of the Meeting, breakout groups met to develop the following five strategic directions for the Besrouer Centre for Innovation in Global Health. Goals and corresponding initiatives were identified for each strategic direction.

Strategic Direction #1:

Establishing family medicine as an effective, viable and pivotal element of national health systems.

Goals	Proposed Initiatives
1.1 Enable/facilitate the definition of the role of family physicians in various international contexts	Short-term Develop a roadmap, including processes and tools to: <ul style="list-style-type: none"> Define the role of FM in a given health systems (Scope of practice, relationships to other primary care providers and other specialists) Outline pathways of access, coordination and continuity Engage the various stakeholders Demonstrate that family medicine is a key avenue to address primary health care needs. (Scholarship Priority) Create and provide educational module to enhance competency in conducting community needs assessment
1.2 Support the process of community needs assessment as a key informant of family medicine implementation in a given setting	
1.3 Support the development of academic departments of Family Medicine	

Strategic Direction #2:

Strengthen continuing education and knowledge support for family physicians towards a comprehensive, effective and community responsive scope of practice.

In the development of family medicine, delegates recognized the need for professional development support for existing practitioners to transition into family medicine. The delegates also identified the need to distinguish family medicine from undifferentiated general practice by clearly defining a context-specific scope of practice and by situating the physician within the primary care team.

Goals	Proposed Initiatives
2.1 Enhance access to pertinent clinical information	Short-term <ul style="list-style-type: none"> Enable practitioners to identify knowledge gaps through various methods

2.2 Enhance competency in reflective practice	<ul style="list-style-type: none"> • Provide Quality Improvement (QI) training
2.3 Support community-responsive continuing medical education and the creation of supportive, community-based learning environment	<ul style="list-style-type: none"> • Develop a train-the-trainer workshop on how to develop quality Continuing Medical Education (CME), in collaboration with various Canadian and international partners • Provide resources and information on website
	<p>Long-term</p> <ul style="list-style-type: none"> • Support the teaching of Evidence-based Medicine (EBM) • Provide resources/information regarding the creation of knowledge locally • Provide resources for knowledge translation • Create "trial" communities of practice using the CFPC WIKI to inform a broader application of this model across emerging FM settings in LMIC

Strategic Direction #3:

Supporting family medicine accreditation and certification (In collaboration with global community)

Housed in the CFPC, the Besroul Centre would be ideally positioned to support the development of family medicine accreditation and certification standards in LMICs. Delegates stressed the importance of creating standards that reflect the local context.

Goals	Proposed Initiatives
3.1 Develop (academic/certification) accreditation standards that are adaptable to the context of different countries	<p>Short-term</p> <ul style="list-style-type: none"> • Participate in ongoing WONCA process and fill gap if needed
3.2 Develop processes for the review of standards in different countries	<ul style="list-style-type: none"> • Develop an "aid" to the development of certification and standards.
3.3 Participate in a global collective to monitor educational and accreditation standards	<p>Long-term</p> <ul style="list-style-type: none"> • Collaborate with other countries in the development of a framework for international review of standards • Develop tool/framework/ resource to develop a locally-relevant certification exam/process • Support the establishment of a professional body to oversee the monitoring of standards

Strategic Direction #4:

Enabling effective family medicine faculty development

A successful family medicine capacity building initiative depends on the creation of a strong local cadre of family medicine faculty. Delegates outlined tools and strategies to attract and support high quality teachers in the discipline.

Goals	Proposed Initiatives
4.1 Enable the identification of faculty development needs	<p>Short-term Develop a faculty development (FD) matrix for family medicine including:</p> <ul style="list-style-type: none"> • FD needs assessment tools • FM Faculty development modular tool kit (virtual and persons) <p>Long-term Develop a faculty development (FD) matrix for family medicine including:</p> <ul style="list-style-type: none"> • A collaborative, national and international FMFD leadership module/workshop • Wiki around FMFD in emerging settings
4.2 Support the development of an adapted faculty development program at a basic and advanced level	
4.3 Provide global opportunities for family medicine faculty development learning (virtual and in person)	
4.4 Identify global experts/resources and have the ability to connect to each other	

Strategic Direction #5:

Building knowledge for family medicine through scholarship, and evaluating the impact of family medicine on health outcomes.

The lack of knowledge and understanding of family medicine often impedes its development in countries where it is not firmly established. Delegates outlined strategies to provide and produce knowledge for the promotion of family medicine in a given context.

This strategy is to be implemented through each of the other four strategies via the following activities:

Goals	Proposed Initiatives
5.1 Promote scholarship to catalyze the development/strengthening of primary care and family medicine at the political/academic interface	<p>Short-term</p> <ul style="list-style-type: none"> • Wiki or web-based community <p>Long-term</p> <ul style="list-style-type: none"> • Explore the establishment of a Besroul Fellowship for a FM leader from a LMIC • Explore the establishment of Besroul fellowship for a Canadian FM leader • Wiki or web-based community • Besroul scholarship collaborative: Research meeting for up to 10 FM researchers from around the world on a specific FM topic every 3-4 years.
5.2 Share resources and knowledge, connect relevant information to specific contexts and needs	
5.3 Identify gaps for research	

6. Implementation Priorities

On the final day of the Meeting, a panel was held to reflect on the vision and strategic directions of the Besroure Centre. The short-term and long-term priorities are identified under section 5 “Revised Strategic Directions”

Moderator: Dr. Ruth Wilson, Queen’s University
Panelists: Dr. Bob Woolard, University of British Columbia
Dr. Mahlet Yigeremu, Addis Ababa University, Ethiopia
Dr. Sihem Safi, Tunisia
Dr. Lynn Wilson, University of Toronto

Dr. Bob Woolard began the session by noting that the Besroure Centre could allow the group to become more than the sum of its parts by helping to create a more coherent and positive impact of family medicine worldwide. He observed that individual relationships were fundamental to the existing partnerships and that the Besroure Centre could facilitate institutional level relationships across borders and systems. Dr. Woolard also mentioned the key role reflective practice has to play in creating an effective and appropriate health care system. He suggested that undergraduate medical education be imbued with the principles of reflective practice, family medicine, service learning, and Continuing Professional Development.

Dr. Mahlet Yigeremu explained that Ethiopia is lacking community-level resources to address health issues. She pointed out that family medicine could bridge the gap between public health and primary clinical care. As family medicine is not clearly understood, the Besroure Centre could support advocacy efforts in Ethiopia. Moreover, the Centre could support ‘train the trainer’ initiatives, as well as efforts to evaluate the impact of primary care on health outcomes.

“Family medicine could bridge the gap between public health and primary clinical care in Ethiopia.”

Dr. Mahlet Yigeremu

Dr. Sihem Safi noted that the Tunisian health system was well structured but no longer responding to the needs of the population. Since the revolution, medical education reform and health care renewal have been initiated. Family Medicine training is underway and continuing education, though established, is not yet standardized. The Besroure Centre could provide support in the assessment and accreditation of teaching sites.

Dr. Lynn Wilson argued that there is currently a global opportunity to strengthen primary care that should not be missed. The Besroure Centre can facilitate the sharing of knowledge and experience and encourage writing activities that focus on learning needs. In this endeavor, the leadership of the CFPC is essential, as it has both national and international credibility. Dr. Wilson suggested that in the first year one or two of the Besroure Centre, key goals be set by partners in LMICs around advancing family medicine.

Discussion

Questions were taken from the moderator and the floor following the panel presentations, prompting the following discussions.

Integrating family medicine into the undergraduate curriculum is a common challenge, as curricula have suffered from specialization and sub-specialization. Space must be created in the curriculum to integrate family medicine. This can potentially be achieved by framing family medicine as generalism, since it is knowledge that all physicians need. It is also useful to create longitudinal family medicine relationships in curricula. At NOSM, students' introduction to intensive specialty education occurs in their fourth year. The first three years focus on family medicine.

Communities tend to organize themselves around primary care. The challenge is to demonstrate the value added of family practice and how it can be adapted for the community. A family physician's scope of practice can go beyond primary care in order to respond to community needs.

A separate point was raised regarding health policy. The suggestion was made for reciprocal engagement in policy, given the wealth of knowledge that partners can learn from each other.

Finally, delegates mentioned that resources within Canada can be leveraged to support LMICs. For instance, PBL faculty development sessions have been provided via videoconference.

7. Conclusion: Stronger Together

By the end of the International Strategic Consultation Meeting, delegates distilled some key messages regarding the proposed Besroure Centre for Innovation in Global Health. Firstly, the Besroure Centre provides a unique opportunity for global family medicine leaders to collaborate around the CFPC's areas of expertise. The delegates emphasized that this initial Meeting is just the first step in a broad, sustainable vision that will involve other interested parties within and beyond the CFPC.

Second, the Besroure Centre represents the prospect of improved global health outcomes through the reinforcement and reinvigoration of family medicine worldwide. Finally, increased collaboration between and within global family medicine partnerships can fuel innovation to address the challenges of delivering primary care in Canada and abroad.

**“We have a
global window
to strengthen
primary care.”**

Dr. Lynn Wilson

The Meeting concluded with remarks from Dr. Francine Lemire, who stressed the need for the shared commitment and responsibility of all the delegates in the establishment of the Besroure Centre. Dr. Lemire reiterated the notion that we are more than the sum of our parts, and summed up the Besroure Centre initiative with the phrase ‘Stronger Together – Plus fort ensemble.’ She noted the high quality of the ideas articulated during the Meeting and reminded delegates that good ideas can find the support they need to flourish.