Narratives in

Global Family Medicine

A Working Group of the Besrour Centre
Overview

The Besrour Centre for Innovation in Global Health is a project of the College of Family Physicians of Canada (CFPC) and is funded via the Research and Education Foundation (REF). It has hosted a global health conference twice, once in 2012 and again in 2013. The Besrour 2013 conference began to uncover the fundamental needs in projects that the Centre could be involved with, and thus four working groups were formed.

The Narrative Working Group was tasked with the collection and synthesis of qualitative accounts of successes in the implementation of family medicine in the context of ten defined international partners. These partners consist of Tunisia, Indonesia, Laos, Ethiopia, Tanzania, Palestine, Uganda, Brazil, Mali, and Nepal.

We have been working together to better understand the rich diversity of initiatives around the world that are building innovative family medicine programs. To do this we asked southern partners of Canadian universities to provide a brief perspective on what is happening in their country. The objective was an effective understanding by all of us as to how we can work together to have a major impact on the health of all of our citizens.

View of Laos, one of our participating countries.
Tunisian Family Medicine

The public health care system in Tunisia has been successful in improving the health of its 11 million inhabitants. However, there are wide disparities between regions and a growing but weakly regulated private sector.

Family medicine is yet undervalued, being seen as second-tier to specialist training. As such, the Faculties of Medicine of Tunisia (FMT) are working towards developing well-rounded medical education that will place greater value on generalism. Enhancement of family medicine will occur by directing the training curriculum of students to priority health needs of the country based on a common core of major health problems of the population as defined by the department of family medicine (eg, maternal and child health, emergencies, chronic disease, mental health).

To address regional disparities, hospital infrastructure will be evaluated for efficiency. Access to quality care will occur through improving the coordination, continuing education, and delivery of care in the health system. Family medicine will serve as frontline care, working in close collaboration with various partners.

Acehnese (Indonesian) Family Medicine

Located in western Indonesia within the island archipelago of Sumatra, the province of Aceh has seen its share of turmoil in the recent past. It was particularly devastated by the tsunami of 2004, and was also hit by the financial crisis of 1998.

In 1969, the Indonesian government introduced public primary care clinics called Pukesmas. There is at least one in every subdistrict, and they focus on a number of primary care initiatives, including maternal and child health, family planning, nutrition, environment, public health, and mental health. They function for health promotion, disease prevention, healing, and rehabilitation.

Unfortunately, after the 1998 financial crisis, citizens began circumventing these clinics, favouring specialist care. This was addressed in 2010, when the Jaminan Kesehatan Aceh (JKA), a provincial health care coverage program, was introduced. Since then, variola has been eradicated, and maternal/infant mortality rates have decreased substantially. Family medicine is successfully re-emerging in full force here.
**Tanzanian Family Medicine**

With a population of about 45 million, almost half of the Tanzanian population is under the age of 15, and 80% live rurally. Maternal and child mortality remain high, and the HIV epidemic is growing. There is no continuity of care, and health care workers have very little training or competency.

In 2004, Aga Khan University launched the first family medicine program, which remains the sole postgraduate program nationally. It prepares trainees for office-based practice, and also for community practice via the community-oriented primary care (COPC) principles launched in 2012. Success has been achieved through a strong, contextual curriculum that produces qualified physicians who function efficiently in the public-private health care system.

**Ethiopian Family Medicine**

A total of 83% of the 90 million people living in Ethiopia live in rural or remote areas, making equitable health care quite difficult. It is also seriously limited by economics, ranking 174th of 187 on the Human Development Index. There is less than one physician per 30,000 people, which is less than a third of World Health Organization minimum values.

Half of Ethiopian physicians are general practitioners (GPs), though this is usually due to inability to secure specialist training. In 2013, the first family medicine program in the country was formed at Addis Ababa University in cooperation with the University of Toronto and Cuso International. This program will help to elevate competency in, and respect of, generalist medical practice to more optimal levels.

**Nepali Family Medicine**

As the third poorest country in Asia, Nepal has a population of 27.5 million. Almost 1 in 20 infants younger than 5 years of age die, and the maternal mortality rate is 0.23%. Life expectancy is 67 years, but in the remote far western district, it is much lower, at 49 years for men and 39 years for women.

Postgraduate generalist training was initiated in 1982 between the Institute of Medicine at Tribhuvan University and the University of Calgary. By 1991, this program was entirely based in Nepal. Since then, two more postgraduate family medicine training programs have been initiated. Family medicine is more valued, and senior Nepali GPs now take part in government health planning.
Palestinian Family Medicine

Palestine, currently a set of territories yet to receive full statehood, has a population of more than 4 million. Health rights of the people residing there are poor due to continued military occupation by Israel and much subsequent violence. Unemployment remains high, and more than a quarter of the population lives below the poverty line. The population is young, and fertility is high (4.1 births per woman).

Juzoor for Health and Social Development, a Palestinian non-governmental organization, is using an innovative, sustainable program to promote health as a basic human right. It recently engaged with the United Nations Relief and Works Agency (UNRWA) to shift towards family health teams (FHTs). Juzoor is also collaborating to develop a continuing medical education program to support the transition.

Strategic partnership development and national dialogue have proven to be effective in the furthering of generalist practice in Palestine. Initial pilot FHTs have shown positive results in 2012. The community is being engaged and encouraged to actively take part, so as to relatively guarantee relevance.

Malian Family Medicine

 Ranked 176th of 187 countries, Mali’s population of 14.5 million is extremely poor. 70% of the population lives rurally, and only 49% of births are attended by skilled personnel. Infant mortality is 9.6%, and maternal mortality is 0.46%. Since 1992, Mali has created about 800 health care cooperatives (CHCs), but less than 10% of these CHCs have a doctor.

To address the massive deficit in professional resources, the Policy on Developing Human Resources for Health (PDHRS) and the Ten-Year Programme in Health and Social Development (PRODESS) were developed.

A specialized medical program in family medicine was developed for medical graduates, called the Diploma of Specialized Studies (DES) in family medicine/community medicine (FM/CM). This program is run at the University of Bamako in cooperation with the consortium consisting of the Université de Sherbrooke, Cégep de St-Jérôme, and CCISD. Five teaching campuses were also initialized, and the consortium also supports training for other health care workers via the National Training Institute of Health Sciences (INFSS).
Ugandan Family Medicine

With a population of 35 million, approximately 72% live within 5 km of a health facility. However, these facilities lack qualified staff, and the referral system is far from streamlined. For example, only 38% of childbirths are attended by a skilled health care worker.

To date, approximately 50 family physicians have been trained via the three existing family medicine programs across the country. These individuals tend to be high-level administrators, and so the objective has not yet been realized. The number of trainees is steadily increasing, however, and thus the future outlook is positive.

Brazilian Family Medicine

Over the past 30 to 40 years, Brazil has seen marked improvement in health care indicators, as well as the social determinants of health. As such, demographics have shifted towards a more elderly population that requires care for more chronic diseases. This is where primary care becomes absolutely essential.

The Sistema Unico de Sauda (SUS), a unified health system administered by the Ministry of Health, was formed with the understanding that access to health care is a fundamental right. SUS led to the development of the Family Health Program (PSF) and Strategy (ESF), and subsequently, to the Primary Care Policy of 2006, mandating greater primary care commitment and spending. Some evidence of success has already been observed.

Laotian Family Medicine

Of the 6.5 million population of Laos, 25% live below the poverty line. Four in five of those under the line live in rural areas serviced by district hospitals, and access is especially poor during the annual rains. Education is low (average is 4.5 years per citizen), and Laos ranks at 138th of 187 on the Human Development Index. Most medical graduates are sent to practise immediately, without formal training.

The Lao government has partnered with the University of Calgary to create a family medicine program that attracts and retains medical school graduates to the district hospitals. This has led to greater competence of primary care physicians in rural scenarios and has proved to be quite successful.
The challenges to the development of family practice are very real and run the gamut from simple awareness of the concept, through developing appropriate curricula and attracting excited students, to creating a system that can employ trained graduates instead of seeing them emigrate to other countries where they can practise their hard-won skills. However, the narrative project seeks to explore the many successful ways in which the individual schools, the partnerships, and the networks have worked to thrive in spite of (perhaps because of?) the remarkably difficult work involved. The Besrour initiative seeks to understand and build upon the rich array of experiences such that Canadian and overseas partners become “more than the sum of their parts.” The narrative project is a living website that will grow as schools increasingly share their successes and we continue to refine the themes that arise from those accomplishments. The current thematic analysis is a platform on which to build the collective capacity to use ideas and passion, rather than slogging strife, to build the global future of family medicine.

Themes such as **Advocacy** arise in low resource areas such as Mali and Nepal; **Stakeholder Engagement** and **Linkage With Public Health Initiatives** are evident in conditions of both advanced integrated national health plans such as in Brazil and emerging conflict and post-conflict areas such as Tunisia, Ache, and Palestine. Many countries have helpful **Health Systems Policies** and **International Partnerships**, but effective **Interdisciplinary Partnerships**, while frequently talked about, seem less commonly achieved outside of Palestine. **Curriculum Development/Transformation, Undergraduate Education**, and **Community or Rural-Based Education** are more regular themes, while actual **Rural Outreach** is less common. **Competency-Based Education** and formal responsibility for Continuing Professional Development are even less common. **Local Champions** seem particularly important in such low resource situations as Ache, Palestine, and Uganda. **Key Challenges, Social Responsibility**, and **Measuring Outcomes** are undoubtedly significant to all the work but are less universally formally acknowledged.

It is likely that the process of reviewing both the narratives and the themes will provide clarity and accuracy in the reports but, more importantly, will provide an exercise in “reflective practice” as each of the existing and new partnerships learn from one another’s stories and experiences.

In the initial phase of identifying the themes, three faculty members reviewed the descriptions sent to the template designed to organize a narrative picture of developments in each country. The separate lists were then explored and a consensus reached on the themes, their definitions, and the schools exemplifying the themes. This is intended to form the foundation upon which further narratives and new themes can be built so that the Besrour initiative can become more than the sum of the individual relationships—it can become a “learning organization” to collectively advance family medicine throughout the world and across Canada.
Collaboration

In the spirit of networking and collaboration through this process, we were delighted to discover parallel initiatives, such as the work of Dr John Parks, who has done extensive work in creating a database detailing the landscape of family medicine around the world. Our synergistic efforts provide a micro and macro lens to the scope and breadth of family medicine while being enriched with local voice and perspective. If you would like to know more about the John Parks project, please contact him at johnticeparks@gmail.com. For any questions or feedback on the Besrour narratives project, please contact us at the email below.

Contact Us

This document presents an introduction to our work and we endeavour to enrich it with your contributions and suggestions. Through this work, we recognize that there are incredible and inspired champions of family medicine all over the world. Please contact us to add your voice and share the narrative of how you are promoting the development and implementation of family medicine in your country. We invite and encourage contributions to this collection of narratives.

Global family medicine story information

Visit our website for our evolving database of extensive narratives and a detailed thematic analysis:

global.cfpc.ca/narratives

For further information, please contact us at

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We wish to recognize the contributions of Innocent Besigye, Katrina Butterworth, Christine Gibson, Videsh Kapoor, Andy Shillingford, and Robert Woollard.

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