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THE EIGHTH ANNUAL BESROUR FORUM REPORT

FAMILY MEDICINE: LEADING THE FUTURE OF GLOBAL HEALTH

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Contact us:
www.cfpc.ca/The_Besrour_Centre

besrourcentre@cfpc.ca

twitter.com/CFPCBesrour

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The Eighth Annual Besrour Forum, organized around the theme "Family Medicine: Leading the future in global health," was held over one and a half days in Vancouver, British Columbia, Canada. Fifty participants attended the various sessions in person and 18 attended online, with representation from 12 countries. The Forum included six sessions, ranging from gathering medical school deans' perspectives on community engagement strategies at their institutions to highlighting a successful Besrour Centre consultation partnership in Argentina. At all sessions time was allotted for small-group discussions and reporting, which offered participants the opportunity to grapple with the various topics in their own contexts and share experiences and learnings with their groups.

A unique aspect of this year's conference was a live demonstration of the Besrour Café, a regularly scheduled, synchronous online discussion designed to foster capacity building in family medicine education globally. Following the Besrour Café live demonstration, participants' feedback included the importance of keeping these co-learning spaces solution focused. Others suggested that recording the sessions will allow for asynchronous participation, extending the benefit to those who were unable to join the live events. Also, participants acknowledged that technology can serve only to support, not replace, the relationships we build that allow for meaningful engagement and co-learning to occur.

- 68 participants representing 12 countries
- First live demonstration of the Besrour Café
- Strong shared values of co-learning, collaboration, innovation, and sustainabilit emerged

The Besrour Forum Scientific Committee hosted the annual poster session, encouraging scholarly dialogue, collaboration, and exchange among participants. Notably, this year's poster session winners were Amanda Marcinowska, Dr. Tibor Schuster, Dr. Yves Bergevin, and Dr. Isabelle Vedel from McGill University; and Dr. Alex Cassenote from the Santa Marcelina Primary Health Care Network, Sao Paulo, Brazil, for research titled "Identifying primary health care research priorities in underserved regions of Sao Paulo, Brazil."

Finally, the hour-long interactive Strategic Planning Session included 25 participants (19 in person and six attending via Zoom technology) from nine countries: Argentina, Brazil, Canada, Haiti, Indonesia, Kenya, Nigeria, Rwanda, and Uganda. Using Slido technology, the session focused on participant input centred on three key questions:

1. Imagine the Besrour Centre three to five years from now. What are three specific words that could be used to describe its success? How should we evaluate our success?
2. What are the changing needs of our community and stakeholders, and are there opportunities that we should be leveraging?
3. Given our community needs and strengths, where should we focus over the next three to five years?

Shared values emerged from both the online and in-person participants, with key themes including co-learning, collaboration, innovation, and sustainability.

Dr. Sadok Besrour provided the closing remarks for the 2019 Besrour Forum, expressing that he felt hopeful as he anticipates moving forward with this momentum.

BACKGROUND: THE BESROUR CENTRE

The Besrour Centre is housed within the College of Family Physicians of Canada (CFPC). The Besrour Centre's mission is to promote health equity around the world by cultivating collaborations in global health that enable the establishment of family medicine as the foundation of health systems. Officially launched in 2015, the Besrour Centre grew from an invitation from Dr. Sadok Besrour (Canada) to the CFPC. The combination of Dr. Besrour's experience in his native Tunisia and the CFPC's 60-year history enabled an exploration of how to advance family medicine globally as a pathway to health equity. In the years since, the Besrour Centre has gathered collaborators from 22 low- and middle-income countries (LMICs) worldwide, flexibly supporting a diverse set of emerging family medicine systems.

VISION	Leading the way in creating a world where all have access to high-quality primary care
MISSION	To foster collaboration to advance family medicine globally
VALUES	Equity, justice, excellence, reciprocity, respect

STRATEGIC PRIORITIES

Advocacy, partnerships, and community engagement

The Besrour Centre engages Canadian and international stakeholders to advocate for robust family medicine and primary care worldwide.

Medical education and training

The Besrour Centre supports educational innovation to train effective primary care providers and family physicians in LMICs.

Research, scholarship, and quality improvement

The Besrour Centre shares knowledge to strengthen health systems globally and leads the development of a mutually relevant international family medicine and primary care research agenda, with a focus on the creation of evidence to improve access to high-quality family medicine and primary care in LMICs.

FAMILY MEDICINE: LEADING THE FUTURE IN GLOBAL HEALTH

The Eighth Annual Besrour Forum, organized around the theme "Family Medicine: Leading the future in global health," was held over one and a half days in Vancouver, British Columbia, Canada. Fifty participants attended the various sessions in person and 18 attended online, with representation from 12 countries.

REPORTING PROCESS

All sessions involved active participant involvement and discussion. Formal presentations were often followed by smaller discussion groups and question-and-answer periods.

An external report writer attended the Besrour Forum, recorded audio and took notes during all sessions, and worked with Besrour Centre staff to compile this report. The report is organized into summaries of each session in the order of occurrence.

COMMUNITY-BASED MEDICAL EDUCATION: THE DEANS' PERSPECTIVES

Ahmed Maherzi, MD; and Alain Pavilanis, MD CM, CCFP, FCFP

More and more, community engagement is at the heart of the strategies of academic institutions and public health organizations around the world. It is also an essential step in improving health equity because it influences action on the social determinants of health. In this context, medical schools must gear their educational, research, and service activities in such a way as to respond to the top concerns of the communities they serve, according to their missions of social responsibility. In this session a panel of Canadian and international deans discussed community engagement strategies developed in their respective institutions to fulfill their missions of social responsibility to underserved populations. Six deans and academic leaders, representing six medical schools in five countries, formed the panel. Four panelists presented in person and two panelists joined via video-conference technology. In addition to the 50 participants in the room, 18 participants from around the world joined the session online.

1. What strategy enabled you to overcome barriers to ensuring community engagement and the promotion of social accountability in your faculty?
2. How do you prioritize community-identified issues in your faculty?

Dr. Preston Smith, Dean of Medicine, Faculty of Medicine, University of Saskatchewan, Canada, highlighted the University of Saskatchewan's approach that "sets out to lead with social accountability." The approach involves engaging authentically with communities through education and research. Several key programs that highlight social accountability at the institution include Making the Links, SWITCH (Student Wellness Initiative Toward Community Health), SEARCH (Student Energy in Action for Regina Community Health), and St. Mary's Wellness and Education Centre. In addition, at the University of Saskatchewan the College of Medicine's Division of Social Accountability works to administer some of these programs and to facilitate community-centred curriculum development and a community reciprocity fund. This fund serves to work toward reconciling the imbalance in power, time, and resources that often occur between academic institutions and community organizations.

Dr. Rado Ramanampamonjy, Vice Dean, Faculty of Medicine, University of Antananarivo, Madagascar, spoke of community-based medical education in the Madagascar context. Madagascar is a sizable island with a large proportion of the population living in rural areas. Madagascar has six faculties of medicine from which approximately 250 family physicians graduate each year. Over the past few years, Madagascar has worked with UNICEF and the World Bank to identify issues in its community health system. These consultations identified policy and institutional barriers, including insufficient resources for health and community health (health accounts for eight per cent of the government budget) as well as fragmented coordination between health and community programs.
A lack of health services is attributed to both a shortage of health professionals and inequity in the distribution of health professionals. Identified solutions include financial and non-financial incentives for health care workers, along with clearly articulated community health priorities.

Dr. Khaled Al Kattan, Dean of Medicine, Alfaisal University, Saudi Arabia, (online) spoke to his institution's three-level plan to transform the health sector in Saudi Arabia and improve primary care. First, at the level of medical education, the aim is to encourage students to learn in community contexts to foster community-based interests and skills. Second, at the medical residency level, they are working to increase the number of residency placements in family medicine as well as to incentivize family medicine placements. Third, at the faculty level, they are working to assign faculty to community-based initiatives with students to increase faculty interest in community-based settings. Furthermore, Dr. Al Kattan recognized the need for a culture shift in terms of how care is sought, so that the population first seeks primary care before seeking secondary or tertiary care.

1. What strategy enabled you to overcome barriers to ensuring community engagement and the promotion of social accountability in your faculty?
2. How do you prioritize community-identified issues in your faculty?

Dr. Hélène Boisjoly, Dean, Faculty of Medicine, University of Montreal, Canada, described the geographic setting of her school: The university is in Montreal, with a campus located about 100 kilometres outside of Montreal and a patient population of about 4 million. Primary care was an identified priority for the population and, as such, the institution has 18 clinics spread over the geographical area that the school covers. More than 55 per cent of graduates choose to go into family practice. The university has a program during medical school clerkship for an in-community rotation (e.g., prison or street rotation). This is seen as an important program to develop an awareness and responsiveness to societal needs and priorities. The Faculty of Medicine is currently working with the local Indigenous population and organizing a community forum to identify community priorities in an Indigenous context.

Dr. Safrizal Rahman, Vice Dean of Syiah Kuala University, Indonesia, acknowledged health and education as key issues in Indonesia—a country with more than 250 million people. The school's strategy for community-based medical education includes overcoming a weak community health system by developing a family medicine curriculum and opportunities to participate in community health programs for medical school students. The inaugural Family Medicine Forum (not affiliated with the CFPC's conference of the same name) was held in Indonesia this year, which was a key step toward strengthening primary care in the country. Next steps include establishing a family medicine residency training program in Indonesia.

Dr. Sarita Verma, Dean, Northern Ontario School of Medicine (NOSM), Canada, shared NOSM's mission and values of social accountability. The inception of the school was, itself, a social accountability strategy. The school was created to address the health needs of Northern Ontario with a focus on rural, remote, francophone, and Indigenous populations. Medical education is embedded in the community, with community-orientated, community-based, and community-designed medical education. To date, NOSM has produced 655 physicians. Of the physicians who completed their residencies in Northern Ontario, 94 per cent stayed to work in the region after graduation. Key enablers of the success of NOSM's partnership with communities are the qualities of patience and tolerance and the ability to adapt to the communities' needs.

Following the panel discussion, attendees were invited to ask questions and contribute to an open talk about community-based medical education. Comments acknowledged the challenges both locally (in Canada) and worldwide to address barriers—recognized to be largely political—in valuing and advancing family physicians' role in the health system. There was a brief discussion about Canada's Patient's Medical Home initiative, with some participants seeing it as an opportunity for family medicine trainees overseas. Others worried that the initiative may be too urban focused.
A delegate from Indonesia commented on the value of gleaning lessons learned from Canada in the development of a health system and bypassing some of the growing pains Canada experienced by applying what works well to the Indonesian context. In summary, attendees showed enthusiasm and expressed hope about the progress being made toward community-based medicine and community-based education.

THE BESROUR CAFÉ: MAKING REAL-TIME CONNECTIONS IN GLOBAL FAMILY MEDICINE

Françoise Guigné, MD, CCFP; Kenneth Yakubu, MPhil (Family Medicine), FWACP (Family Medicine); and Clayton Dyck, MD, CCFP, FCFP

In collaboration with its partners, the Besrour Centre is developing the Besrour Café, a regularly scheduled, synchronous online discussion forum, to foster capacity building in family medicine education globally. This communication tool may be used to promote collaboration between partners in different geographical contexts. The Besrour Café was demonstrated live, featuring a discussion on challenges and experiences faced by family medicine trainees undertaking a research or quality improvement project. Using technology and online resources, the Besrour Café aims to engage participants in creating a safe space for co-learning and capacity building, with an end goal of strengthening family medicine education globally. Co-learning comes from a place of mutual trust and respect, with a responsibility to engage in order to achieve equity. An evaluation form was disseminated to participants both online and in person; the results of the evaluation will be discussed at the next forum.

Besrour Café

50 in-person participants

18 online participants

20-minute live demonstration

12 countries represented

4 continents represented

Participants were asked: For family medicine trainees undertaking research or quality improvement, what are some challenges or experiences?

- A participant from the Democratic Republic of the Congo responded to the question above by sharing that in his experience, barriers include a lack of skilled human resources. For example, there are often too many students per preceptor in training settings, resulting in competing demands for time. Also, residents often struggle to identify research topics of value to family medicine.
- A participant from Kenya observed that in their setting, not all faculty members who are appointed as research advisers necessarily have research experience or expertise; therefore, training faculty in research is an area that requires more attention. A lack of financial resources and time were also identified as challenges that limited research.
- A participant from Nigeria spoke of the challenge of maintaining trainee interest in local work and research, as many prefer to travel abroad.
- A participant from Brazil also commented on the lack of time residents have for research as well as the lack of research expertise among faculty advisers.

- A participant from Haiti shared that their family medicine programs experience many of the same barriers that others mentioned. One approach to overcoming some of these barriers has been the creation of a research training course and the addition of a research rotation in their medical training. This ensured protected time for research. This initiative is in its second year and, so far, seems to be successful. They are now working on increasing access to more software for research, such as Stata (statistical software).

Participants were asked for feedback after the live Besrour Café demonstration. Several participants voiced the need to keep these co-learning spaces solution focused. This could be done by taking an appreciative inquiry approach to these discussions. One participant suggested summarizing and disseminating what was discussed at the end of each call. Another participant suggested that sharing some resources prior to the session, including relevant literature on the question of interest, may serve to increase understanding on the discussion topics. Others suggested that recording the sessions is important to ensure that those who are unable to join the live event can still benefit from the discussions. Furthermore, a moderator was identified as important to ensuring the discussions are smooth and productive. Reliable Internet availability will remain a challenge for some participants; however, how to address this is being explored. Finally, it was acknowledged that technology can serve only to support, not replace, the relationships we build that allow for meaningful engagement and co-learning to occur. Several participants commented on the sense of community the Besrour Café provided and said this is a positive step toward increased innovation and co-learning.

Key learnings from the Besrour Café:

- Remain solution focused
- Summarize and disseminate discussions
- Prepare and share relevant resources prior to the discussion
- Record the sessions
- Appoint a moderator

COMPETENCIES FOR COLLABORATIVE INNOVATION WITHIN THE GLOBAL PRIMARY CARE WORKFORCE

Kenneth Yakubu, MPhil (Family Medicine), FWACP

Previous efforts have demonstrated the value of collaboration in building global family medicine and primary care systems. However, a common theme has been the need to use sensitivity and respect when established family medicine programs (in the Global North) support emerging ones (in the Global South). We observe that the mutual exchange of innovation, learning, and information within the global primary care workforce is essential, not just for promoting authentic and reciprocal partnerships, but also for addressing emerging threats to global health security and ensuring quality improvement takes place in our clinical practices (e.g., choosing diagnostic tests wisely, strengthening clinical skills). More important, there is a need to ensure that the future global primary care workforce acquires the competencies necessary for collaborative innovation.

Why collaborative innovation?

Family practice is becoming more complex. The health equity gap is expanding and as globalization increases, so does the diversity within a population. Apart from our need for innovative approaches to primary care delivery, we need to equip both the current and future primary care workforce with the skills to achieve this quickly.

Participants broke into three discussion groups (two in English and one in French) to discuss these questions:

- Who in your family medicine program should have the relevant competencies required to foster collaborative innovation between your program and its global partners?
- What would those competencies entail?
- Where should they be addressed in their training?
- What gaps and challenges exist in your country/context's family medicine competency framework?
- Predict readiness and suggest creative options for integrating these competencies into your family medicine competency framework.

Group one

Concerning collaborative innovation, it was recognized that the focus should be on defining competencies for the collective primary care workforce, as well as ensuring that they are developed in an inter-professional manner. This should include the right mix of knowledge, skills, and attitudes. Humility, the ability to identify opportunities for complementary learning, and a commitment to co-learning were identified as important competencies for achieving collaborative innovation. The importance of recognizing a compatible fit when working in partnerships was likened to dating before marriage, where some level of familiarity and compatibility should be determined before committing to a partnership.

The group questioned how to instill and develop these competencies in trainees, and how to appropriately understand a partner's local context. Further, participants agreed that trainees in family medicine and primary care need to acquire these collaborative innovation competencies early during the course of their training.

Group two

This group did not think interprofessional training should be the priority for family medicine training programs but recognized the importance of partnerships for achieving a better understanding of varying contexts.

Group three

Several concepts around collaboration emerged, including recognizing that teaching these competencies to students may not be enough, and that training and supporting educators in achieving these competencies are also important. Bi-directional learning between partners was recognized as being key to collaboration. In addition, this group discussed the value of interprofessional teams and that the development of collaboration among interprofessional teams should be encouraged early on. Qualities of partnership should encompass humility, relationship building, and communication.

GOING GLOBAL: A CONSULTATION ON FAMILY MEDICINE AND PRIMARY CARE IN ARGENTINA

Marcelo Garcia Dieguez, MD; Nancy Fowler, MD, CCFP, FCFP;
and Clayton Dyck, MD, CCFP, FCFP

With the recent adoption of the Declaration of Astana,* countries around the world have made the commitment to build primary care–oriented health care systems for their people. Argentina is one of these countries. At the core of Argentina's primary health care reform is the strengthening of its family medicine programs. Through a World Bank–funded consultation, the Besrour Centre worked with family medicine experts in Argentina to identify levers for change and support the design of a comprehensive education and training proposal in family medicine to successfully implement primary health care reform. Through this technical exchange, the Canadian and global family medicine communities have learned more about the synergy between educational reform and national health systems and about how designing robust family medicine programs can optimize health systems to ensure good health and well-being are accessible to all.

Argentinian context

Argentina has large disparities between provinces in both health care outcomes and expenditures. Three identified focus areas for enhancement that will improve access to health care include digital health, family and community health, and coverage expansion. Currently there are large discrepancies in the numbers of family medicine residents in each province. This is due, in part, to the way incentives are structured and to desirability, resulting in a workforce distribution that does not meet population health needs. Family medicine is not a preferred choice for medical school graduates, leaving many family medicine residency positions unfilled. Short-term human resource strategies to combat this shortage include increased mentorship opportunities for medical students in family medicine as well as long-term training improvements such as scholarships and other incentives.

Besrour consultation details

The objective of the consultation was to identify levers for change and support the design of a comprehensive education and training proposal in family medicine in Argentina. Reflections on the process identified supportive university involvement as a strength of the partnership. An identified barrier to the process included a lack of buy-in from provincial leads, as the family medicine program in Argentina is financed by the national government, with provincial support necessary for ongoing success. A novel aspect of this partnership was that the World Bank forged the connection between individuals at the national level in Argentina and the CFPC.

To succeed, the team needed to be attuned to potential factors such as funder priorities (World Bank), timing (federal elections occurring within the year), and change agents (accreditation process). Learnings from Canada regarding linking education to primary care reform served to inform the process in Argentina.

* The Declaration of Astana, unanimously endorsed by all WHO Member States in October 2018, makes pledges in four key areas: to make bold political choices for health across all sectors; to build sustainable primary health care; to empower individuals and communities; and to align stakeholder support to national policies, strategies, and plans. The Declaration of Astana reaffirms the historic 1978 Declaration of Alma-Ata, the first time world leaders committed to primary health care.

Pre-visit consultation planning included understanding the context and goals of the consultation, conducting concentrated work with the host team, building a competency framework, building a professional profile for the family doctor of the future, and engaging accreditation bodies to entrench change within the system. Challenges included time constraints, the language capacity of the teams, and a lack of certainty around future funding. Successes included the Argentinian participants taking the lead on the work and flexibility and adaptability among the teams. All members of the Argentinian team were committed to the process and keen to learn from the Canadian experience.

A fruitful large-group discussion followed the presentation. One participant shared an experience from Tunisia, where change was met with resistance, and they asked whether this had been encountered in the Argentinian example. Working with natural champions of the change you are trying to bring about was identified as an important strategy for overcoming potential resistance. In the Argentinian example, universities selected for the pilot were institutions that already had a higher number of students who spent time in family medicine. Another participant asked how the team accessed World Bank funding for this work. This project was not an isolated request but came after a longer historical relationship with the World Bank. In addition, the goals and objectives aligned with World Bank priorities. Another participant noted it was important that the request for the consultation came from the Argentinian team, rather than being put forward by Canadian experts.

> "Once we started working, we realized that our two countries are not so different, and we can learn from one another."

MOVING FROM SELECTIVE TO COMPREHENSIVE PRIMARY HEALTH CARE: THE BESROUR CENTRE WORKSHOP FOR RESEARCH TO PROMOTE PRIMARY CARE DEVELOPMENT IN LMICs

Adelson Guaraci Jantsch, MD; General Director of the Family Medicine Residency Program of the Rio de Janeiro Secretary of Health and a Besrour Centre member

Many LMICs share a recent history of public policies aiming to strengthen primary health care and promote access to universal health care. Despite the growing recognition that family medicine is the medical specialty that should deliver primary care, LMICs face many difficulties in translating public policies into real change in primary health care.

Capacity building and workforce development for primary care delivery, especially in family medicine training, are among the main hurdles for LMICs, along with structural and organizational issues. Several ongoing global initiatives that support countries in their journeys toward having strong primary health care include developing tools to measure the performance of their health systems. While not disagreeing with this aim, the Besrour Centre believes that assessing the development of primary health care with a more qualitative approach would be more appropriate than strictly measuring performance with quantitative methods. Quantitative information (how much/many) is important in health system assessment, but as family physicians, we highly value what stories and experiences can bring to the discussion, showing the reasons (how, who, when, in what way) that an initiative was successful. Measuring the development of primary health care in LMICs is a good opportunity to combine quantitative and qualitative information in a mixed-methods research initiative.

Confounders: Strong primary health care systems should lead to good health outcomes that are also measurable. However, this relationship is not linear in the sense that there are many confounding variables that affect both primary health care and health outcomes. These confounding variables may include social development, political stability, education, employment, and wealth.

Storytelling: When trying to answer “why” questions, we must include storytelling to find meaning in the numbers. Numbers must be fleshed out with contextual information including why, how, where, and by whom.

Shared goals: Developing shared goals necessitates defining objectives. For example, developing a comprehensive primary health care system necessitates establishing a shared definition of “comprehensive.”

Dr. Jantsch facilitated small-group discussions in which participants were asked to envision possible stages of development for primary health care in the context of their working environments. Participants then shared their ideas with colleagues and thoughtful discussion ensued. These preliminary talks have created the groundwork for research that will seek to understand some of the complexities of primary health care development. Notes from the discussion will be analyzed. Participants shared feedback on their experiences in the small-group discussions and commented on the importance of diversity in each small group, highlighting that having alternative points of view was an important component of the conversation.

ENCOURAGING SCHOLARLY DIALOGUE, COLLABORATION, AND KNOWLEDGE EXCHANGE: THE BESROUR POSTER SESSION

The Besrour Forum Scientific Committee hosted the annual poster forum, encouraging scholarly dialogue, collaboration, and exchange among participants. Criteria for submission included a North–South research collaboration and research following sound scientific process. The committee received 21 high-quality submissions this year, ranging in topics from addressing skilled health care worker shortages in LMICs, to identifying primary health care research priorities in underserved regions, to analyzing the cost-effectiveness of residency training in family medicine to promote better access to health care.

2019 Besrour Poster Session Winner:

"Identifying primary health care research priorities in underserved regions of Sao Paulo, Brazil"

Congratulations to Amanda Marcinowska, Dr. Tibor Schuster, Dr. Yves Bergevin, and Dr. Isabelle Vedel of McGill University; and to Dr. Alex Cassenote of Santa Marcelina Primary Health Care Network, Sao Paulo, Brazil.

Notably, this year's poster winner was selected by the Besrour Forum Scientific Committee and was chosen for the Delegates' Choice Award. The research systematically identified top research priorities in underserved areas of eastern Sao Paulo based on experts' knowledge of and experience in child and maternal health, communicable diseases, non-communicable diseases, mental health, urgent and emergency care, patient safety, and care coordination in the region. The research team will present their work at the 2020 Besrour Forum.

2018 Besrour Poster Session Winner

"Attitudes, barriers, and enablers towards conducting primary care research in Banda Aceh, Indonesia: A qualitative research study"

Dr. Ichsan of Syiah Kuala University, Indonesia

Dr. Ichsan and his team were the Besrour poster award winners in 2018 and received support from the Besrour Centre to present their investigation on conducting primary care research in Banda Aceh, Indonesia. Dr. Ichsan traced the story of his partnership with McMaster University back to 2012.

Since then, the partnership has continually developed and led to this research study. Research was identified as a necessary means to engage policy-makers in strengthening primary health care systems in Indonesia. This study was designed to identify the research experience held by current primary care faculty members at Syiah Kuala University, Indonesia, and to identify facilitators and barriers to promoting research in their institution.

Methodology
Qualitative descriptive approach
In total, 29 out of 32 faculty members participated in 10 focus group discussions (three groups conducted in English and seven in Bahasa Indonesia).

Results
Most participants recognized that their university had set research as a priority. Most participants had previous experience conducting research and were themselves currently conducting research. Personal motivation emerged as an important enabler of increasing research activities. Barriers to conducting research included weak research policy, a lack of research funding and infrastructure, a complicated research bureaucracy and administration process, and time constraints. Recommendations included allocating research time for faculty.

A notable outcome from the research was the inaugural Family Medicine Forum (not affiliated with the CFPC's conference of the same name) hosted by Syiah Kuala University in Indonesia (October 9 to 10, 2019). Peer-reviewed publications about research in family medicine were identified as drivers for the momentum that culminated in this inaugural conference. This forum provided an opportunity for participants to advocate for the national regulation of family medicine residency programs by the Indonesia Medical Council. This forum also marked the end of historical conflicts between various medical associations in the country and signalled the beginning of a way forward for family medicine in Indonesia.

BESROUR CENTRE STRATEGIC PLANNING SESSION

The Strategic Planning Session was an hour-long collaborative session with 25 participants (19 in person and six via Zoom technology) representing nine countries (Argentina, Brazil, Canada, Haiti, Indonesia, Kenya, Nigeria, Rwanda, and Uganda). Using Slido technology, the session focused on participant input around three key questions. The questions and summaries of the ensuing discussions are provided below.

QUESTION ONE:

Imagine a robust, productive Besrour Centre three to five years from now. What are three specific words that could be used to describe its success? How should we evaluate our success?

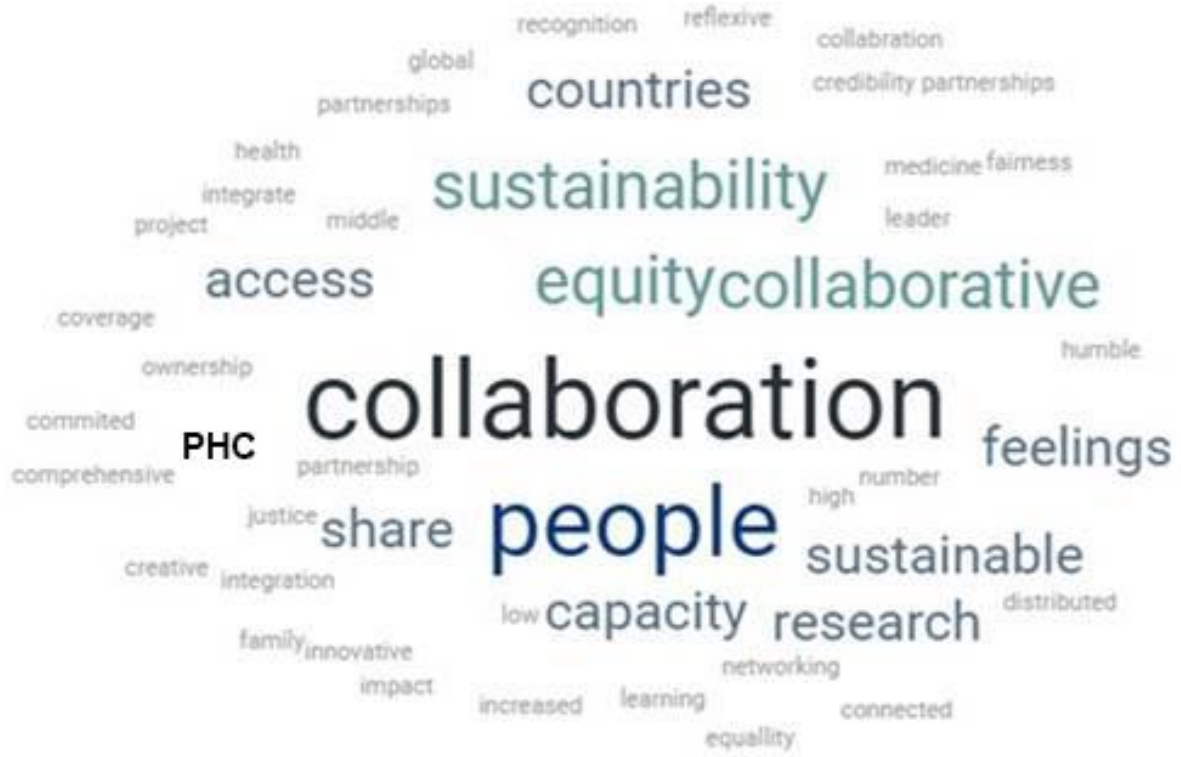

Figure 1. Word cloud of responses to question one, generated from Slido

BESROUR CENTRE STRATEGIC PLANNING SESSION

Key themes that emerged from the online and in-person discussion included co-learning, collaboration, innovation, and sustainability. The group recognized that there are shared values among participants in terms of where the collective sees the Besrour Centre going in the future. Some participants wondered if the Besrour Center's aim to improve primary health care globally should include work with other developed countries, such as those in Europe. Participants had mixed opinions on this topic, with some suggesting that other developed countries require less support from a group such as the Besrour Centre than do LMICs; other participants acknowledged that regardless of where inequity occurs, it is part of our responsibility as fellow human beings to work to reduce it. Another participant acknowledged the importance of humility, recognizing that we in Canada are not a beacon on a hill, and we have a long way to go to improve family medicine; however, part of this journey is to highlight and share what is working well.

QUESTION TWO:
What are the changing needs of our community and stakeholders, and are there opportunities—currently and forecasted—that we should be leveraging?

Participants acknowledged the strength in focusing on two to three opportunities to ensure we do those well. One participant commented that it will be important to understand the group's skills and experience and to use those to determine opportunities the Besrour Centre should pursue. Another participant commented that the Besrour Centre could play a connecting role where members do not have the appropriate expertise and to avoid duplication of work being done elsewhere. As the Besrour Centre keeps evolving, the group is committed to continuing to share lessons learned. However, our expertise will continue to evolve to meet the current needs of partners and the populations we serve.

Participant responses:

- Equity
- Access to care regardless of setting
- Increased technology
- Reducing health inequity
- Open mind
- Health as a human need and right
- Integration
- Expanding network; different cultures
- Climate health
- Important contributions of family doctors
- Enhancing research capacity
- New academies and medical education in LMICs
- More health care professions other than family medicine

QUESTION THREE:
Given our community needs and strengths and the strengths of the College of Family Physicians of Canada, where should we focus over the next three to five years?

Participants articulated the importance of collaboration in understanding how the Besrour Centre can make a difference. Participants said they hoped the vision that emerges is not only a Canadian vision of how to make a difference, but that this question would be viewed through a collaborative lens. The Besrour Centre needs to remain well-connected globally for co-learning to occur. One participant added that "it is not just exporting our vision—we are not doing so much of a great thing here in Canada—but that we can learn from innovation in delivering primary health care elsewhere as well, especially from the community."

Participant responses:

- Capacity building for primary care
- Supporting family medicine development politically
- Research collaboration among Besrour partnerships
- Promotion of family medicine
- Scope of practice
- More regular capacity building
- A real-time system that identifies Canadian and Besrour partners
- Family health care research project
- Child technology and diseases
- Learning from all partners and bringing that learning together
- The evolving role of primary care

To another participant, the Besrour Centre is all about bringing together partnerships. As a bilingual country we have a unique opportunity to strengthen primary care in francophone countries, thinking specifically of Haiti and West and Central Africa. There is also much Canadians can learn from other places in the world—places that are quite remote, where there is no access to care. The most important thing is to identify what is happening and see how the Besrour Centre can contribute.

Dr. Besrour provided closing remarks for this final session of the 2019 Besrour Forum, commenting that he felt hopeful and looks forward to progressing with this momentum.

"We are all in this room because we think leadership in family medicine is a good way of solving deficiencies in access and equity."

STRATEGIC SUMMARY

- The shared values and vision of co-learning, collaboration, innovation, and sustainability emerged strongly from the group discussions.
- The Besrour Centre needs to remain well-connected globally for co-learning to occur.
- The Besrour Centre has the potential to play a connecting role where members do not have the appropriate expertise and to avoid the duplication of work being done elsewhere.
- The Besrour Centre has a recognized, unique ability to interact with francophone countries due to Canada's bilingualism.

2019 Besrour Forum participants
Vancouver, British Columbia