4th Annual Besrour Global Health Conference

Family Medicine at the Heart of Health Systems: Reaching for evidence

Final Report

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RESEARCH AND EDUCATION FOUNDATION
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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

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PLANÈTE EN SANTÉ ET EN PAIX

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Executive Summary

The Besrour Centre is a hub of collaboration that brings together Canadian and international family medicine experts, academics, communities, patients, and key stakeholders to advance the discipline of family medicine as a pathway to health equity around the world.

The 4th annual Besrour Global Health Conference (Besrour Conference) in 2015 was an opportunity for the Besrour community to unite and explore ways to advance family medicine on a regional and a global scale. The conference brought together approximately 100 delegates from almost all university departments of family medicine across Canada and international partners from 14 countries. The theme of the conference was "Family Medicine at the Heart of Health Systems: Reaching for Evidence." With a goal of informing and influencing policy, participants highlighted the key role of research and the types of evidence required to develop an effective discipline of family medicine. Participants also identified research foci and strategies to direct Besrour partners in collecting data to capture the growth of family medicine from local and collective perspectives.

Over the course of the 3-day event, participants posed incisive questions and explored ways to establish family medicine as an effective element of health systems around the world. Conference activities included a variety of interactive sessions, small group discussions, a deans' round table, a world café exercise, and presentations from Besrour partners and special guests.

Delegates discussed the contributions of family medicine to health systems by offering their reflections on what constitutes impactful evidence in support of family medicine and how to gather it. In doing so, several research priority areas were identified, including the impact of family medicine on population health and on the health care workforce, and family medicine as a pillar of patient-centred care—accessible, comprehensive, coordinated, cost-effective, quality care. Delegates also identified various types of qualitative and quantitative data at both the patient and system level, and underscored the usefulness of process and outcome indicators.

Delegates explored how the Besrour Centre could help gather, synthesize, and apply this evidence to effectively influence global policy. Drawing upon local and collective experiences of the Besrour community, various methods were suggested, including the use of case studies as comparative evidence on models of care, a consensus methodology to demonstrate the effect and impact of family medicine, cost-analysis studies, a participatory rural action approach, and an appreciative inquiry approach. It was suggested the Besrour Centre could play a role in supporting this process and promoting its application by taking part in the generation of knowledge; increasing primary care research capacity; synthesizing information; assisting in branding family medicine in different contexts; disseminating knowledge through local and global partnerships; and advocating for family medicine to key stakeholders.

The Besrour Centre will develop a more detailed Besrour Research Plan over the coming months based on the input collected from Besrour partners during the 4th annual Besrour Conference and throughout the year. The Besrour Centre will also ensure its priorities continue to be aligned with the Besrour community through the continued efforts of its working groups and through its strategic plan. The conference concluded with participants collectively voting to hold the 5th annual Besrour Conference in Rio de Janeiro, Brazil, immediately prior to the 2016 WONCA World Conference of Family Doctors in November.

Day One: Thursday, November 12, 2015

Dr Katherine Rouleau, Director of the Besrour Centre, opened the conference by inviting delegates to explore the integral role family medicine plays in health systems around the world and how members of the Besrour Centre community can engage with one another and key stakeholders to begin to develop the necessary evidence base to advance family medicine globally. With an emphasis on informing and influencing policy, the goals of the 2015 Besrour Conference were:

- To highlight the key role of research and inquiry in the development of an effective discipline of family medicine
- To discuss the types of inquiry and evidence needed to advance family medicine globally and to begin to identify indicators to measure and guide the progress of Besrour-related activities
- To identify key steps and strategies to enable Besrour partners to begin collecting data that are useful to the development of effective family medicine in their specific contexts
- To identify research questions and foci around which to develop an international research network in emerging family medicine over the next 3–10 years

Working Group Reports

Moderator: Dr Christine Gibson

The first day of the conference began with updates from the five Besrour Centre working groups. Each working group summarized working group goals, their achievements, and next steps.

Narratives and Family Medicine Mapping Working Group

Leads: Drs Christine Gibson and Robert Woollard

The Narratives and Family Medicine Mapping Working Group, led by Drs Christine Gibson and Robert Woollard, has been working toward three main objectives: 1) to gather and discover positive stories related to family medicine worldwide; 2) to analyze these stories for themes; and 3) to present these stories for the group and others to share knowledge.

Since the inception of this working group, narratives from 14 international partners have been collected, edited, and showcased in bilingual brochures and on the Besrour website of the College of Family Physicians of Canada. The group has also written a paper for publication in the journal *Canadian Family Physician*.

The working group members plan to continue exploring and re-framing the narratives collected to date through additional thematic analyses. Dr Christine Gibson also expressed the desire to develop a methodology to gather more narratives in order to continue mapping family medicine around the globe. The pursuance of more narratives will likely raise new questions for the working group and Besrour community to answer, such as whether to collect narratives outside Canadian partner institutes and countries. The Narratives and Family Medicine Mapping Working Group also wishes to explore ways in which the Besrour website can become an ongoing "living document."

Faculty Development Resources Working Group

Leads: Drs Clayton Dyck, Ryan McKee, Lynda Redwood-Campbell

The goal of the Faculty Development Resources Working Group is to foster inter-partner collaboration on faculty development activities and scholarly work to the benefit the Besrour Centre's global partners in their endeavours to develop family medicine.

Over the past year, the Faculty Development Resources Working Group has been advancing this goal through a variety of activities: the development and implementation of a 2-day capacity-building workshop on family medicine in Shantou, China; a research workshop in Aceh, Indonesia, spanning eight different research topics; the development of capacity-building workshop template materials for the Besrour community to access on the Igloo website; and the development of a "lessons learned" paper, currently in progress.

Moving forward, the Faculty Development Resources Working Group aims to integrate rigour and scholarly activities into its activities (eg, focus group); refine and expand existing workshops/faculty development activities in Shantou, China, and Aceh, Indonesia; and to submit a "lessons learned" workshop to the 2016 WONCA World Conference for discussion among primary care and family medicine researchers from around the world.

Continuing Medical Education Working Group

Leads: Drs Jamie Meuser, Eva Purkey, Nicolas Barticevic Lantadilla

The Continuing Medical Education Working Group had two goals for the past year: 1) to explore, describe, and share options for supporting the knowledge and skills of practising generalist physicians for optimal patient care and system function; and 2) to support the augmentation of generalist physicians' knowledge and skills to the level of residency-trained family physicians.

In endeavouring to achieve these goals, the working group completed a comprehensive literature review on current practices in continuing professional development (CPD) for generalist physicians in low- and medium-resource settings. Five themes were extracted from a literature review: 1) how CPD can serve health system needs; 2) barriers and incentives for learning; 3) upskilling current generalist physicians; 4) examples of effective interventions; and 5) systems for developing, validating, and delivering CPD.

In identifying next steps, the working group leads expressed the desire to validate their literature review findings through consultations with Besrour partners as well as with other methods used to probe areas with little current evidence, such as grey literature, surveys, etc. Beyond this, the working group is also considering other areas of activity for 2016, such as the creation of a needs and skills inventory for faculty development of teachers in CPD activities; pilot activities around the use of communications technology and enhanced country-to-country collaborations; and exploration of practice-eligible/CPD-supported routes to family medicine certification for existing generalist physicians.

Advocacy, Community Engagement, and Ethics Working Group

Lead: Dr François Couturier

The Advocacy, Community Engagement, and Ethics Working Group had three goals for the past year: 1) to define an ethical framework for the development of academic partnerships; 2) to support community engagement; and 3) to build an advocacy strategy focused on high-level decision-makers.

Over the course of 2015, the working group moved its advocacy agenda forward by identifying and securing academic and institutional leaders as keynote listeners and speakers at the 2015 Besrour Conference, and by identifying potential Besrour partners. The Canadian medical community has largely been the focus of the working group's community engagement activities, with a particular focus on the College of Family Physician of Canada's 35,000 members, medical students in both Canada and partner countries, faculties of medicine and health sciences, and departments of family medicine. The working group is also developing a conceptual framework on ethical considerations related to the Besrour Centre and global health activities taking place in the respective family medicine departments of the Besrour community. In the spirit of advancing this framework, the working group invited 2015 Besrour Conference delegates to a workshop to further explore and reflect on this aspect of the group's work.

The working group's intention is to validate current findings, prioritize objectives, define a road map for action, and continue to seek out opportunities to grow in the coming year.

Group discussion

- Negative or misguided perceptions toward family medicine must be considered as important contextual information when promoting family medicine in settings that are not particularly receptive to family medicine, such as sub-Saharan Africa. This is especially important when the pool of doctors for general practice is very limited, such as in Ethiopia.—*Dr Dawit Wondimagegn, Addis Ababa University, Ethiopia*
- Robust evidence is of paramount importance, especially in settings where there is significant prejudice against family medicine, such as Uganda. If a model of family medicine and family physicians is being promoted, evidence is required to prove that family medicine makes a difference—that is to say, evidence that demonstrates differences in care between generalists without graduate training and doctors with family medicine training. This also underscores the need for generalists to have access to CPD programs. The message that care provided by family medicine practitioners is as valuable as care provided by other specialists is often eschewed by policy-makers.—*Dr Innocent Besigye, Makerere University, Uganda*
- Other participants critiqued the comparison being made between general practitioners and family physicians, as they are essentially natural allies. Instead, it is important to demonstrate the value of primary care family medicine in health systems.
- The most important aspect of family medicine is to understand its impact on the population it serves, in the profession's ongoing commitment to social accountability.—*Dr Ahmed Maherzi, University of Tunis, Tunisia*

Besrour Papers and Research Working Group

Moderator: Dr David Ponka

The Besrour Papers and Research Working Group lead, Dr David Ponka, described Besrour papers as vehicles for everyone's work.

One of the working group's goals was to develop a series of papers to define the major obstacles in synthesizing data on family medicine globally. During the discussion, Dr Ponka emphasized the importance of finding ways to effectively engage colleagues from around the world despite language and time zone barriers, and he encouraged delegates to reflect on ways to help the group capture the rich work coming from all Besrour partners.

Another goal of the Besrour Papers and Research Working Group was to begin to delineate methods to overcome the identified obstacles to synthesizing global data on family medicine. Dr Ponka reflected upon the need for a framework to guide us in asking the right questions, a methodology for collating and gathering evidence, and ways to overcome obstacles. Similarly, Dr Ponka encouraged the Besrour delegates to reflect on these questions. The Besrour Papers and Research Working Group is striving to develop an evidentiary basis for a family medicine paper. Family medicine is diverse and implemented in various ways in different contexts, and one the challenges lies in the ability to collate and synthesize diverse evidence while ensuring methodological rigour.

As of November 2015, the working group has had two papers published in *Canadian Family Physician*, one paper is in press, and five papers are in progress. The working group looks forward to developing its series of papers further, and to act as a vehicle for the other Besrour working groups to converge and reflect on lessons learned as Besrour Centre efforts progress.

Group discussion

In response to Dr David Ponka's presentation and invitation for input, Besrour delegates offered their reflections on what evidence is needed to support the development of family medicine, and how to gather it. In doing so, delegates explored the rhetoric of family medicine, the generation of evidence, methods to generate this evidence, and ways in which to position family medicine on the global stage.

The rhetoric of family medicine:

- **Diversity in family medicine:** The role of family doctors is broad and expansive, and is contextual to their environments. Family physicians in Indonesia, Ethiopia, and Canada will have different practices. How can family doctors respond to the needs of specific communities, such as the rural poor or marginalized communities in sub-Saharan Africa? There is no one-size-fits-all approach to family medicine.
- **Family medicine versus generalism:** What is the added value of family medicine over generalism? And what is generalism, when in many countries doctors who are generalists are not trained to treat a wide array of medical conditions, but rather operate according to an antiquated model that perceives medicine as disease-oriented and acute care–focused?—*Dr François Couturier, University of Sherbrooke, Canada*
- **Link between family medicine and primary care:** From a Malian perspective, for donors to move the family medicine agenda forward it is important to define "What is the added value of family medicine and what gaps in primary health care will it fill?" Regional bodies and international organizations that can leverage health system reform are of particular importance and can make adjustments in the health system for better career development for family medicine practitioners.—*Dr Seydou Doumbia, University of Bamako, Mali*
- **Population health:** From a sub-Saharan African perspective, it is also important to underscore the value of family medicine in reducing the burden of disease and mortality in low-income countries.—*Dr Seydou Doumbia, University of Bamako, Mali*
- **Value for money:** Ultimately, family medicine is about resource allocation. "It's all about money."—*Dr Janusz Kaczorowski, University of Montreal, Canada*
- **Link between family medicine and universal health coverage:** Participants noted that while family medicine physicians believe that family medicine is essential to improving equity and quality of care, the average citizen is not convinced of this fact. In developing countries most individuals prefer seeking care

from other specialists. The challenge is to transmit the message that effectively articulates the family medicine value proposition to the population and to demonstrate that family medicine is an important part of the development of universal health coverage.

- **Family physicians as the quarterbacks of health systems:** Dr Woollard shared the history of the concept and practice of "triage," which dates back to the Napoleonic wars of the late 18th century. The idea behind triaging was to ensure the least experienced practitioners were not being sent to the front lines. As family doctors, "our job, whether it's in Mali or Manitoba, is to be the best we can be at the front lines." Dr Woollard suggested that perhaps the research focus should not be about how various needs are identified and met, but how family medicine as a collective discipline is responding to these needs. The problems confronting patients are poverty, violence, and infectious diseases. The family medicine physician is in essence a quarterback; this quarterback is not simply a gatekeeper for secondary/tertiary care, but someone coordinating resources and ensuring the patient is seen by the health care provider with the most appropriate skill set.—*Dr Robert Woollard, University of British Columbia, Canada*

Evidence to support the establishment and strengthening of family medicine:

- **Population health impact:** Participants underscored the need for data demonstrating that more patients survive when the methodology shifts from general practice to family medicine.
- **Economic models and decision aids:** Evidence is not the only thing that will move decision-making. Generating research takes time, and generating rigorous research takes even more time. We are dealing with very heterogeneous contexts. A focus on secondary data that exist in Canada and elsewhere was suggested, and perhaps developing a series of decision aids and economic models for decision-makers that show the implications of resource allocation decisions. Use the best data and supplement with local context data to demonstrate the pros and cons of different models.—*Dr Janusz Kaczorowski, University of Montreal, Canada*
- **Process indicators:** Family medicine is not simply about collecting hard figures on mortality rates; it is ultimately about the quality of care and should consider using multiple parameters to measure equity. How do we build feedback loops that show we are getting where we want to go? There is no golden measure that will show us we are getting closer to our desired results.
- **A family medicine-centred system:** Dr Steini Brown, Director of the Institute of Health Policy, Management and Evaluation at the University of Toronto in Canada, encourages the Besrour Centre to focus its attention on defining what a family medicine-centred system is, as opposed to simply defining the discipline of family medicine.—*Dr Katherine Rouleau, Besrour Centre*

Methods to collect family medicine evidence:

- **Appreciative inquiry lens:** The adoption of a narrative and appreciative inquiry approach to gathering family medicine evidence lends itself to the challenge of developing the concept of family medicine in a manner that acknowledges its diversity in each country and within the global context. The role of family doctors is to provide for communities that are diverse.—*Dr Robert Woollard, University of British Columbia, Canada)*
- **Develop networks:** How can family doctors influence policy change? Dr Lynn Wilson suggested this can be done through the creation of a network involving the Besrour community, public health researchers, education researchers, and chairs of departments.—*Dr Lynn Wilson, University of Toronto, Canada*
- **Report card for the Besrour Centre:** How could the Besrour Centre solicit feedback from global partners on whether it is meeting the needs of the Besrour community? One way to do this is to develop a report card and highlight priority areas for scoring. Additionally, for countries that do not yet have family medicine, how could the Besrour Centre be a resource?—*Dr David Ponka, University of Ottawa, Canada*

Global positioning of family medicine:

- **Leverage the Sustainable Development Goals:** Participants noted that much of the global health evidence is related to the United Nations' Sustainable Development Goals (SDGs), of which goal No. 3 pertains to health. This SDG includes targets for the prevention and treatment of non-communicable diseases and substance abuse, which are essentially family medicine domains. Participants emphasized that there is a real opportunity to use data that are already being collected.
- **Branding family medicine:**
    - While the Besrour Centre and its partners would like to grow family medicine and include GPs who are currently providing primary care, the challenge remains to define the unique contribution of the family physician to primary care and in strengthening health systems.—*Dr Ruth Wilson, Queen's University, Canada*
    - The Besrour Centre and its partners collectively need a strong clarion call: What is the contribution of family doctors to primary care?—*Dr Lynn Wilson, University of Toronto, Canada*

Anchoring Family Medicine as an Academic Discipline, Part I

What kind of evidence? Evidence for what?

Moderator: Dr David Ponka

Dr David Ponka moderated this session and noted that strong primary care is the foundation of healthy communities. Dr Ponka noted the quest for generating evidence to advance family medicine is often confronted by challenges in collecting data and evidence in low- and middle-income countries (LMICs).

Group discussion

- Low-income countries (LICs) and middle-income countries are converging in terms of their health care burdens. Many LMICs face a growing demand for health services in the areas of chronic disease management, hypertension, and diabetes. There is an increasing need for preventive care and management of chronic conditions. Furthermore, in many countries there is a misalignment between health care supply and demand. Many health care systems are designed to manage acute episodic care as opposed to chronic conditions. Family medicine can address the growing burden of disease that demands care for patients with complex co-morbidities.—*Dr Janusz Kaczorowski, University of Montreal, Canada*
- Conducting research to strengthen family medicine requires a different set of skills than those traditionally possessed by physicians. Generating research necessitates methodological training in qualitative and quantitative methods and an ability to formulate and test research hypotheses. Increasingly, mixed methods are being used to provide both quantitative data to illustrate trends and relationships and qualitative data to provide narratives that demonstrate why and how phenomena transpire as they do in family medicine.—*Dr Janusz Kaczorowski, University of Montreal, Canada*
- Can the Besrour group develop a template that will enable cross-country comparisons in terms of gaps in family medicine? What kind of information is needed to tell a story? If the objective is to persuade decision-makers and governments to strengthen and invest in family medicine, we need both hard quantitative data and compelling stories that illustrate how resource allocation decisions have crucial consequences for the health of populations. The motivation for investing in family medicine was framed as one that has a clear policy objective, as family medicine has the ability to create a health system that is accessible and provides quality care with continuity and coordination.—*Dr Janusz Kaczorowski, University of Montreal, Canada*
- Given the financial constraints experienced by both high-income countries (HICs) and LICs, investing in specialist care and technology is not a means to curtailing health care costs. The United States was highlighted as the country with the highest investment in health care, yet the poorest outcomes compared with other HICs. It's not how much you are spending, but where you are spending it. Data show time and

again that if you spend on primary care and family medicine you will have better outcomes at a population level.—*Dr Janusz Kaczorowski, University of Montreal, Canada*

What evidence is needed to inform policy?

Speaker: Dr Dawit Wondimagegn

Dr Wondimagegn began by first describing the context and challenges faced in establishing family medicine in Ethiopia. Initially, many levels of resistance emerged: a conceptual level of resistance emerged when novel ideas and ways of practice were introduced; there was resistance to the notion of implementing Westerns models in a Southern context; there was resistance at the policy level; there was resistance at the implementation level; and there was resistance as at the community level. Given these challenges, the salient question was how to align family medicine within the existing primary health care system of the country, including one with a system highly focused on other specialists.

Drawing lessons from the Ethiopian context, Dr Wondimagegn highlighted that it wasn't evidence demonstrating the cost-effectiveness of family medicine that led to its implementation in Ethiopia. Dr Wondimagegn cautioned participants about assuming a linear relationship between research and policy, and highlighted that a strong evidence base cannot be assumed to automatically penetrate policy-making processes. Rather, Dr Wondimagegn urged the Besrour community to consider how polices are formulated and to understand the actors involved in the policy-making processes. In Ethiopia, advocacy was a critical factor in advancing family medicine, which was largely based on an understanding of the Ethiopian context. Dr Wondimagegn further underlined how relationship-building with the minister of health was crucial for mobilizing efforts toward implementing family medicine.

Translating evidence into health systems innovation: The Rio experiment

Speaker: Dr José Carlos Prado

Dr José Carlos Prado, the Vice Secretary of Health in Rio de Janeiro, Brazil, noted that when primary health care reforms were implemented in Rio de Janeiro in 2009, only 3.5% of the population in Rio (or 150,000 people) had access to primary health care. Now, more than 3 million people are covered and it is expected that by the end of the next year, 4 million people will be covered (70% coverage). Dr Prado noted that in Rio, the team drew on robust evidence from around the world and adopted evidence-based models and practices to inform the implementation of family medicine in the Brazilian context. Dr Prado further noted the team aimed to adopt Dr Barbara Starfield's definition of family medicine in its implementation efforts. The use of effective techniques and approaches were used to call policy-makers into action with respect to primary health care. For example, visiting other contexts with strong primary health care systems and seeing the positive impact on populations first-hand is a powerful way to do this. In Rio, family medicine is implemented using a team-based approach. The current challenge is integrating primary care with secondary-level facilities, such as hospitals.

Group discussion

- Besrour delegates were curious to know how teachers were recruited for this initiative. Dr Prado explained that the program was able to attract qualified family physicians by offering salaries of R$30,000 (Brazilian real). At the beginning of the reforms, there were only 14 family doctors in the city. Now there are 150 family doctors in Rio de Janeiro. Dr Prado said the implementation of primary care in Rio started with 18 clinics, and over the course of 5 years many more were established.

A perspective: What I've seen and learned as a Canadian family medicine researcher

Speaker: Dr Tara Kiran

Dr Tara Kiran shared an experience of implementing family medicine from the Canadian context. Dr Kiran noted that in Canada, more than a decade ago governments implemented reforms to strengthen family medicine and improve patient care. In looking at these reforms retrospectively, it is important to ask: Did they deliver what was intended? Dr Kiran observed that the reforms were based more on theory than evidence. She highlighted how the push in Canada for a pay-for-performance funding model, which had gained prominence in the United States, was based on the tenuous assumption that such a payment scheme would improve quality of care. Dr Kiran cited the example of using pay-for-performance bonuses in cancer screening and noted the initiative failed to increase screening rates for the population because it targeted physicians who were already more likely to screen. The perceived improvement in cancer screening was not due to an actual improvement, but rather an artifact of better data collection. Dr Kiran further underscored that having an electronic medical record is not a prerequisite for collecting meaningful data, and basic data gathering such as chart audits can also provide useful data.

Table discussion: What evidence do we need? Evidence for what?

The two questions examined during the table discussions were:

1. What types of evidence do we need?
2. What enablers currently support (or could support) efforts to generate evidence in your context?

Table 1: Concept harvest – What types of evidence?

Priority areas—what should be measured and why	• **Accessibility*** in order to better understand integrated care • **Effectiveness** • **Coordination*** in the health system • **Comprehensiveness*** • **Cost-effectiveness** • **Population health** **Note*: *According to the PHCIP framework, these are service delivery measures for people-centred care.*
Level of evidence	• **Patient-level data** • **System-level data**
What aspect of care should be assessed?	• **Process of care** • **Outcomes of care**

Type of evidence	• **Qualitative:**
	  ○ Pathways to care; ie, map the patient journey through the health system and the role and/or intersection of family medicine. This will help establish the value of family medicine at the patient level, especially where new programs are being built. This will also help answer the question: Are primary care initiatives reaching the right people? It can also help to incentivize patients to seek family medicine instead of care from other specialists.
	  ○ Patient satisfaction feedback
	  ○ Healing (the human experience)
	  ○ Narratives about why people chose one care path versus another; ie, stories with impact
	  ○ Data that answer the question: How do family physicians adapt care to the context of their patients and communities?
	• **Quantitative:** Participants noted that policy-makers and ministries of health

	often demand quantitative data to make resource allocation decisions regarding implementation of health care programs. ○ Baseline data on the impact of family medicine training; this can contribute to the PHCPI ○ Population served; ie, universal health care ○ Screening targets and barriers to achieving those targets ○ Cost-analysis data ○ Data on underserved populations

Participants also explored methods to obtain data:

- **Natural experiments:** Use case studies to compare similar contexts to determine models that work; eg, look to other countries with adequate family physician care. Evidence generated from natural experiments could be used to demonstrate family physician training as a way of meeting the needs of a population, and more generally could act as a mechanism to influence decision-makers to invest in health. Participants cautioned against the exact replication of a model from one country to another. Research findings must be contextualized—there is variability in the numbers and abilities of health care workers and health care ecosystems from one context to the next, and these factors will influence how family medicine is implemented. Participants reflected on the Brazilian experience:
    - The primary health care reform in Rio de Janeiro, Brazil, referenced the work of Dr Barbara Starfield and Prof. James Macinko
    - There was a clear identification of health problems in the population, based on health indicators (baseline)
    - Visits to other cities (London, Barcelona, Lisbon) were conducted with the mayor of Rio de Janeiro
    - The Primary Care Assessment Tool and a questionnaire to evaluate health professionals and the users of the system were employed
- **Examination of the existing literature:** This can help to identify how health care burdens in different counties can be effectively addressed. What strategies can address health outcomes? The World Health Organization (WHO) has published a number of studies maintaining that improving health access and equity requires a robust family medicine strategy. Similarly, Dr Starfield's research demonstrated that improving health outcomes demands strong primary care.
- **Consensus methodology**
- **Cost-analysis and cost-efficiency studies** to support a health system shift. Currently in Latin America, the Caribbean, and sub-Saharan Africa, family doctors are considered an expense. Cost-efficiency data in support of family medicine would help to dispel this notion.
- **Randomized controlled trials**
- **Evaluation studies**

Participants also commented on how the generation of evidence can help to:

- Advocate for the establishment of family medicine–centred health systems; participants noted the need to measure what family medicine has achieved thus far before advocating for how it can add value
- Frame family medicine as a solution to a problem
- Brand the discipline of family medicine

Concept harvest – What enablers currently support (or could support) efforts to generate evidence in your context?

Participants identified the following as enablers to support the generation of evidence in their respective settings:

- Using electronic medical records
- Building capacity for primary care research. Some ways in which to do this include:
    - Building the knowledge of residents in epidemiology and statistics
    - Supporting the teaching of research methods
    - Encouraging scholarly activity in new family medicine programs
    - Sensitizing health care providers to the realities of poverty and how it can affect people and their health-seeking behaviours
- Building networks
- Recognizing the need for strong leadership and political will
- Having sufficient resources

Enablers in the Brazilian context:

- Having the minister of health support 40% to 50% of the local budget
- Calling for proposals to allow for funding of research projects, supported by SUS (unified health system)
- Having a primary care information system that generates health indicators

Anchoring Family Medicine as an Academic Discipline, Part II: The Privileged Role of Deans

Moderator: Dr Paul Grand'Maison

Mapping family medicine research around the world

Speakers: Drs Frank Sullivan and John Parks

How can the strength of research in family medicine be assessed? Drs Sullivan and Parks noted that research on family medicine has increased significantly in the last decade. One way to assess the current research strength in family medicine is through the conceptual lens of the Donabedian model—a framework for examining health services and assessing the quality of health care. This paradigm suggests information about the quality of care can be drawn from three categories: structure, process, and outcomes.

Deans' round-table discussion: How could/should academic institutions influence health and education policies?

Dr Paul Grand'Maison opened the session by recognizing the privileged role medical deans play in anchoring family medicine as an academic discipline. There is a need for evidence, but there is also a need for leadership, commitment, and concrete actions in implementing family medicine. Deans establish an important link between policy-makers, the public, governments, and health care institutions, both formal and informal. The discussion that follows is an exploration of what anglophone and francophone deans from around the world view as factors of their success and a commentary on anchoring family medicine in their respective settings.

- **Memorial University of Newfoundland/Government of Nunavut partnership—Dr Jim Rourke**

  Dean Rourke discussed the implementation of a family medicine rotation in Nunavut. He described how Nunavut—a large, sparsely populated territory in northern Canada—was confronted with the challenge of recruiting and retaining family physicians to meet the demands of its population, and highlighted that the majority of doctors working there were locums. In describing the partnership between Memorial University and the Government of Nunavut, Dean Rourke described several key enablers, including the federal government's commitment to serving rural and remote populations and the importance of identifying individual champions in Nunavut to carry out the goals of the partnership. Dean Rourke described his role as dean of Memorial University's medical school as that of a conductor, highlighting the coordination, facilitation, and leadership roles of his position.

- **University of Bamako, Mali/Sherbrooke University partnership—Dr Seydou Doumbia**

  Like Dean Rourke, Dean Doumbia highlighted the importance of partnerships and leadership in the development of family medicine in Mali. He described the progressive nature of activities that have been developed with Sherbrooke University in Quebec that have strengthened family medicine training at the University of Bamako. He highlighted the importance of the expertise his university's Canadian partners provided in developing a competency-based curriculum and faculty training program in family medicine in Mali. Dean Doumbia noted the important role of high-level stakeholders, including institutions such as the International Monetary Fund, in promoting the decentralization of services, the empowerment of communities, and the engagement of various governmental sectors in enabling the establishment of family medicine.

- **Addis Ababa University, Ethiopia/University of Toronto partnership—Dr Dawit Wondimagegn**

  Associate Dean Wondimagegn identified two key enablers in the success of establishing family medicine in Ethiopia: namely, the ability to develop partnerships between Addis Ababa University and international collaborators to support family medicine education, and the successful recruitment of an initial cohort of family medicine residents. He also highlighted the importance of educating colleagues from other specialties and fostering their support to bolster the family medicine program. He described how some of the early champions of the program were physicians from other specialties, including himself. He pointed to the importance of a rigorous curriculum that responds to community needs, including training in research. In a bold statement, Dean Wondimagegn pointed out the Addis Ababa University experience illustrates how one need not wait for a formal policy endorsement by government before moving toward the establishment of family medicine, and instead highlights the importance of bridging the needs of the community and academic institutions with the broad policy vision of the government.

- **Faculty of Medicine of Tunis, Tunisia/University of Montreal partnership—Dr Ahmed Maherzi**

  Dean Maherzi noted that while the Faculty of Medicine of Tunis is 50 years old and offers a program deeply steeped in teaching and research, there have been no studies to date about its impact on the health and well-being of Tunisian people. Dean Maherzi reported that general medicine in Tunisia is often a default choice for those who are not successful in applying to specialty training. Since 2006,

Tunisia's four family medicine programs have expanded their efforts to grow family medicine and guide students toward choosing a medical practice that addresses the needs of the population. National efforts to harmonize family medicine training in Tunisia were launched in 2011, and Dean Maherzi described the key role of broad consultation among decision-makers, deans, and medical faculty in developing the family medicine curriculum. He highlighted the importance of training teachers in collaboration with the Faculty of Medicine at the University of Montreal and the development of family medicine faculty as key enablers in the creation of the discipline in Tunisia. Echoing other comments about the importance of partnerships, Dean Maherzi emphasized the importance of selecting credible partners and cautioned against the use of a blueprint approach to establishing family medicine because of the importance of adapting family medicine to local contexts and communities.

- **Syiah Kuala University, Indonesia/McMaster University partnership—Dr Gazali Syahrul**
  Dean Syahrul of Syiah Kuala University described a chronic shortage of primary care providers in Indonesia. He noted the 2004 tsunami in the Indian Ocean led to an opportunity to engage with Dr Lynda Redwood-Campbell from McMaster University in Hamilton, and the relationship has since developed into a partnership between both institutions with ongoing efforts to establish family medicine training at Syiah Kuala University.

- **University of Antananarivo, Madagascar/Laval University partnership—Dr Luc Hervé Samison**
  Dean Samison of the University of Antananarivo identified an international conference of French-speaking faculties of medicine as the setting of a catalytic conversation for recognizing the need to train more family physicians in Madagascar to meet the needs of the country's population. He described the importance of physicians who are required to spend their early years of practice in rural areas and highlighted the need for incentives to encourage physicians to practise in remote communities. Dean Samison noted the importance of aligning the priorities of family medicine faculties and family medicine training programs with those of the Ministry of Health, as the minister decides medical curriculum content, pointing to the importance of deans being part of the curriculum development process. Dean Samison also reported on a Commission of Reflection on Medical Training created by the minister of education to examine different issues and to identify goals for the minister of health. The conference mission identified an important opportunity for deans to reflect on their social responsibility.

- **Northern Ontario School of Medicine experience—Dr Roger Strasser**
  Dean Strasser noted the role of mentors and teachers has emerged as a key theme in the narratives shared by the other deans. He highlighted the powerful impact of teaching by example, noting that most recent graduates choose specialties in part because their own role models have come from those specialties, including family medicine. The clerkship year for Northern Ontario School of Medicine (NOSM) students is anchored in family practice, and during that year students are immersed in communities. Dean Strasser reported that thanks to this model, the majority of the school's graduates choose a career in rural family medicine. Expanding on the previously discussed interface between policy and family medicine, Dean Strasser discussed the role deans could potentially play throughout the Besrour collective. He asked how policy windows could be exploited, such as in the political environment in Tunisia and Madagascar. Building on the strong community engagement at the core of

NOSM's medical school, he urged other medical schools to engage not only with their communities, but also with politicians and bureaucrats, as political levers were foundational to the establishment of his medical school.

Group discussion

1. **In sub-Saharan African countries, deans are not family physicians. How do you go about developing curricula and training competent family physicians when deans are not family physicians?**
   Dr Dawit Wondimagegn offered his response from the Ethiopian perspective. In Ethiopia, the curriculum was developed with partners from the University of Toronto and Addis Abba University. A needs assessment study was done by the University of Toronto. Dr Wondimagegn said the objective of the training program determines what content a curriculum should have. Dr Wondimagegn further explained that in Ethiopia, uncertainty is the norm, not the exception. The context affords an opportunity to develop a different set of skills and to manage uncertainties. Physicians know the system is unpredictable, so they learn how to be leaders in such a system.

2. **How important is accreditation?**
   Dr Seydou Doumbia offered his perspective from the Malian context. In Mali, all medical schools need to be accredited by 2023, and there is an urgency to work toward accreditation. All francophone countries are obliged to meet accreditation requirements.

   Canadian participants noted the accreditation process is quite onerous and focuses on details that do not influence the desired outcome of having better physicians who meet the needs of the community. We are trying to transform accreditation system in Canada. The process is extremely time-consuming and measures the wrong thing at this point in time, and we are consciously choosing change. Accreditation is an opportunity for us to change.

   Dr Maherzi, the dean from Tunisia, noted that for francophone faculties of medicine, accreditation is seen as aspect of social responsibility. Dr Maherzi noted there are three important factors in advancing family medicine: 1) autonomy of universities and deans; 2) family medicine projects; and 3) international partnerships.

Day Two: Friday, November 13, 2015

Besrour Conference participants were encouraged to attend FMF 2015 activities and to build time into their day to meet with their respective Besrour Centre working groups. Besrour participants were also invited to attend the following Besrour Centre consultative sessions:

- Faculty Development Focus Group Survey (Dr Lynda Redwood-Campbell)
- Continuing Medical Education Working Group (Dr Jamie Meuser)
- Ethics workshop (Drs Janie Giard and Katherine Rouleau)
- Narratives workshop (Drs Christine Gibson and Robert Woollard)

Day Three: Saturday, November 14, 2015

Primary Health Care Performance Initiative

Speaker: Federica Secci

Federica Secci, a health specialist with the World Bank Group (WBG), presented on the Primary Health Care Performance Initiative (PHCPI), a new partnership between the WBG, the Bill & Melinda Gates Foundation, and the WHO that brings together policy-makers, health system managers, practitioners, advocates, and other development partners to catalyze improvements in primary health care in LMICs through better measurement and knowledge sharing. Ms Secci posed the question: Why is there a need for a PHCIP initiative? As we work to meet the United Nations' Sustainable Development Goals (SDGs) and countries progress toward providing universal health coverage, primary health care becomes more important than ever. Ms Secci pointed out there is a "black box" in primary care service delivery that needs to be understood. PHCPI will help countries track key performance indicators for their primary health care systems, identifying strengths and weaknesses. This will enhance accountability and provide decision-makers with essential information to drive improvements. Ms Secci emphasized that to make data actionable, this partnership will also provide a platform for countries to share lessons and best practices.

Table 2: The four streams of the Primary Health Care Performance Initiative

1. Strengthen Performance Measurement:
PHCPI will use existing and emerging data to monitor and report on primary health care performance, promote accountability, and guide country improvement efforts. The PHC Vital Signs Indicators on the PHCPI website provide a snapshot of primary health care performance. PHCPI will also work with countries to expand data availability and develop additional indicators that pinpoint underlying challenges.
2. Generate and Share Knowledge:
PHCPI will extract lessons from effective primary health care delivery models and provide countries with guidance on how to improve their own systems.
3. Promote Country-Level Improvement:
PHCPI will support countries in making improvements by working with the Joint Learning Network for Universal Health Coverage and other global partner networks to develop practical tools collaboratively for primary health care system improvements. PHCPI will support countries in using these tools to take meaningful steps in strengthening their primary health care systems.
4. Engage Partners to Build Momentum:
PHCPI will elevate primary health care as a global priority by bringing together a network of committed country-level policy-makers, advocates, and other development partners.

Source: PHCPI, 2015.

PHC Vital Signs Indicators: PHCPI involves benchmarking with 25 PHC Vital Signs Indicators. The indicators assess whether primary health care is prioritized in a health care system. Are there sufficient facilities and supplies for the system to produce results? The impetus behind the indicators is to understand what is causing weaknesses within a primary health care system. Ms Secci mentioned that only nine countries were able to report on all 25 indicators. She further noted the WBG has been approached by a number of countries for help; the WBG will be working with Argentina in the area of non-communicable diseases, for example. Ms

Secci noted PHCPI cannot be fully comprehensive; the goal is to coordinate and harmonize efforts and reduce duplication and fragmentation.

Group discussion

Participants posed a number of questions:

1. **Where does training fit into this equation? Education and training of the health work force are key elements of a primary health care system.**
   Ms Secci noted the PHCPI is not specifically focusing on training but rather on the availability and absenteeism of health care workers.

2. **Others raised questions regarding the sources of data informing the PHCPI. Are data coming from governments and/or NGOs? What strategies are in place to check for the quality of data, especially from governments?**
   Ms Secci noted the PHCPI uses a number of different sources, including national health accounts. Data quality is checked. Consolidated Health Informatics (CHI) a United States government initiative designed to promote the adoption of health information standards, CHI worked with the PHCPI to ensure the comparability and validity of the data.

3. **What are the PHCPI's funding mechanisms? For universities starting family programs and needing infrastructure and strategic development, what are the mechanisms for financing?**Ms Secci noted that while the PHCPI is not currently providing funding opportunities, there might be opportunities in the future.

4. **Three out of five outcome measures are mortality measures. From the perspective of primary care physicians, how much of a focus will be on access to quality care? Should cost-effectiveness and patient satisfaction be included? Which of the indicators can the Besrour Centre help address in regard to the PHCPI?**
   Ms Secci agreed that the PHCPI needs to push further than using only infant mortality as the main indicator of health system performance, which is the conventional approach.

5. **Dr Anne Andermann of McGill University in Montreal shared an important finding from her research team—that front-line health workers play a pivotal role in assessing the socio-economic status of people with ill health. Access to food, security, and shelter are all intricately interwoven with health status. With the potential to align PHCPI with other initiatives on constructing indices for universal health coverage, capturing the multidimensional factors that affect health status is important.**
   Ms Secci noted the team struggled a lot on the definition of primary care. While endeavouring to explain the principles of a good primary care system, the PHCPI team tried to develop the most comprehensive definition possible.

6. **How can the Besrour Centre and the PHCPI work together?**
   The main components of a collaboration between the PHCPI and the Besrour Centre would be advocacy and working toward the same goal, using different angles. Ms Secci said it would be helpful if the Besrour Centre would consider using the conceptual framework underpinning the PHCPI and passing the same message to different types of stakeholders, faculties of medicine, and ministries of health, as we need to be as consistent as possible. The PHCPI team would welcome participants taking on the development of any of the data sets or indicators. Ms Secci noted there is a scarcity of data for some of the health system indicators. It would be useful to have a discussion on which indicators require concerted efforts for reporting.

7. **How will the PHCPI work to get more robust data for health indicators?**
   Indicator around health care workforce.

8. **Could the PHCPI also examine the quality of care provided?**
   Ms Secci said the WBG invests significant efforts and resources in primary care. The PHCPI requires data that are reliable and comparable across countries.

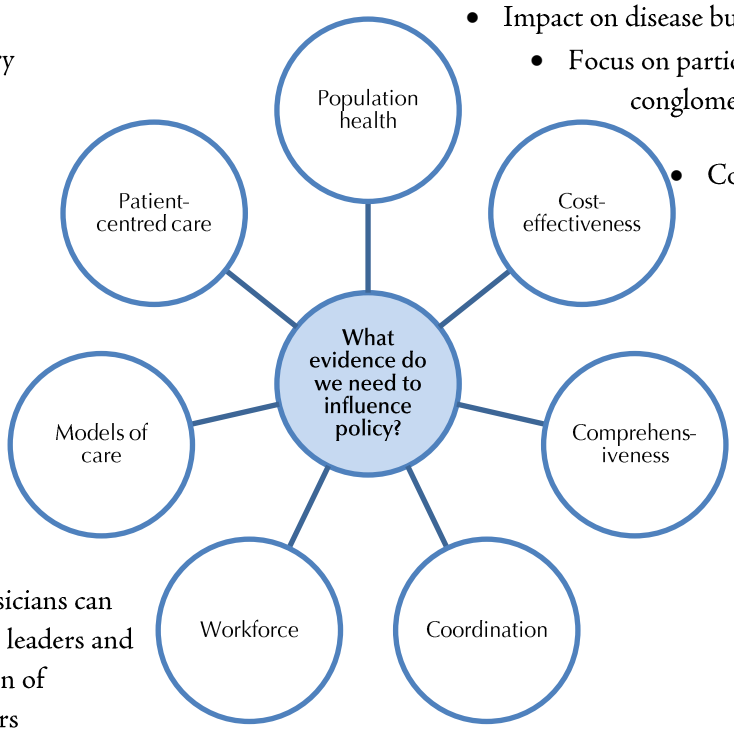
9. **The PHCPI looks specifically at the numbers of community health workers, nurses, and midwives relative to a country's population size, but includes no mention of physicians. Physicians should be treated as an indicator of quality of care. Participants urged to have this feedback taken back to the WBG.**
   Ms Secci noted the PHCPI is attempting to understand situations where the first point of contact in health care does not take place with a doctor, but with a pharmacist, for example. The goal is to understand whether people are seeking care from trained health care providers. In LMICs, the first point of contact for many patients is often not a doctor.

World Café Exercise: Translating Research into Policy

The World Café exercise involved a creative process for leading collaborative dialogues, sharing knowledge, and creating possibilities for action in small groups. Participants engaged in small group discussions and held a series of conversational rounds lasting 20 minutes about the following questions: 1) What evidence do we need to influence policy? 2) How do we inject this evidence into policy-making? 3) How can the Besrour Centre help make this happen? The results of the discussion are described below.

Figure 1: Concept harvest – What evidence do we need to influence policy?

- Evidence to persuade patients to choose primary care
- Map the patient journey/experience
- Map the patient's out-of-pocket expenses
- Patient satisfaction data
- Comparative evidence on models of care: family medicine versus primary care versus specialized care
- Evidence that family physicians can act as a family health care leaders and contribute to the retention of community health workers

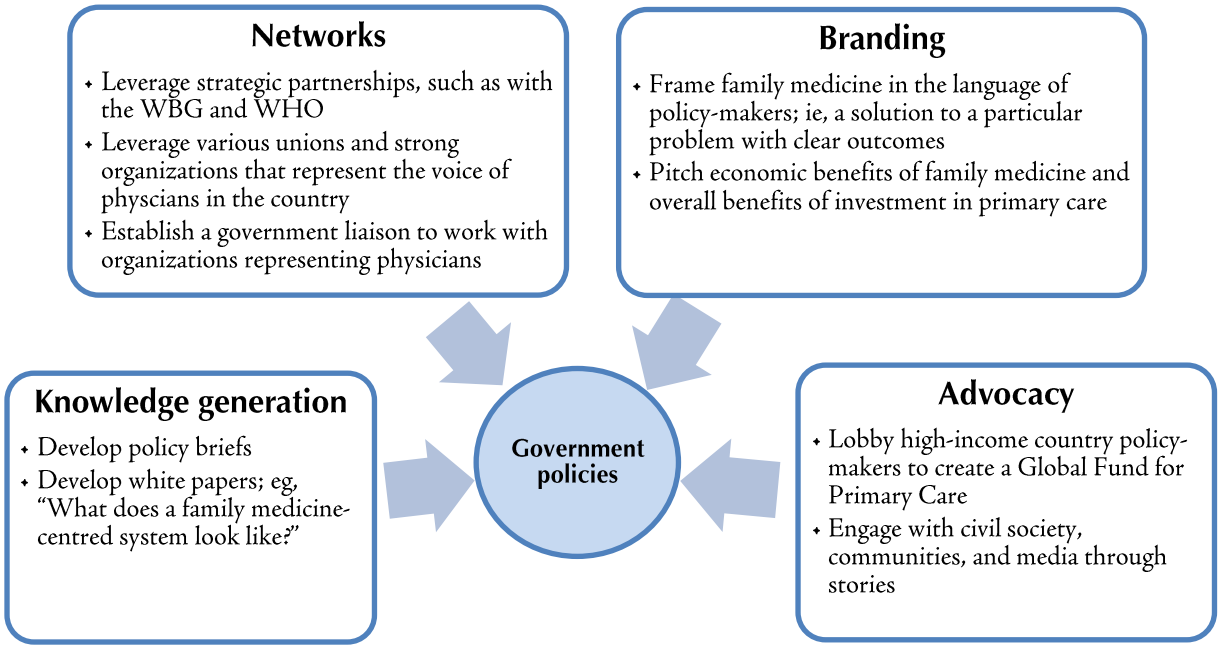


- Impact on disease burden and mortality rate
- Focus on particular health problems or a conglomeration of health problems
- Cost effectiveness of family medicine versus general practice
- Scope of practice
- Efficiency of care

Methodologies to generate these data include:

- Rich, in-depth qualitative case studies; eg, primary care reform in Rio de Janeiro, Brazil
- Family medicine narratives
- Participatory Rural Action approach

Figure 2: Concept harvest – How do we inject this evidence into policy-making?



How can the Besrour Centre help make this happen?

- **Dissemination of knowledge**
  - Share experiences: successes and failures. What has worked in different countries? How were challenges tackled?
  - Develop a series of policy briefs: eg, Rio dengue experience
  - Provide comparative evidence
  - Develop tailored approaches for different types of policy-makers
  - Use Besrour papers as part of communications strategy
  - Generate policy bites and punchy YouTube videos
- **Capacity building**
  - Equip physicians to be policy advocates
  - Organize workshops that target advocacy initiatives
  - Apply Canadian experience to international problems
- **Knowledge generation**
  - Centralize evidence and foster the generation of new evidence and support for colleagues looking to create evidence for their own programs
  - Use website to collect ideas and to share what is occurring with working groups
  - Identify leads rather than working groups per se
- **Branding**
  - Develop clarity of definition of family medicine and family physician

    - Obtain assistance from the Besrour Centre in developing consistent messages targeted to different stakeholders: health leaders, patients, and policy-makers
    - Support branding of family medicine in different countries with policy-makers and civil society
- **Advocacy**
    - Identify target audience
    - Target decision-makers and opinion-makers

What I Like, What I Wonder, What I Suggest

Key listeners: Drs Ruth Wilson and Enis Baris

Exploring the nexus between family medicine and policy-making: Dr Enis Baris, Sector Manager for Health, Nutrition and Population, Europe and Central Asia at the WBG, offered some incisive insights and reflections on the themes and questions raised by participants during the conference. Dr Baris noted the three overarching questions for the session resonated with him because they contain the pivotal word "policy." Dr Baris mentioned that while there are many skilled practitioners, the question is whether they can relate to policy-makers. Dr Baris further observed a change in the discourse and analysis at the Besrour Conference compared with previous conferences. He commended the Besrour Centre for shifting from a narrower focus on family medicine to linkages between family medicine evidence, policy, decision-makers, and financing. He further underscored that the Besrour Centre is dedicating its efforts to exploring a critical issue: how family medicine can change things on the ground.

Defining constitutive components of family medicine: Dr Baris mentioned this is an opportune time in history for strengthening family medicine given the strong alignment between the WHO and the WBG in advancing universal health coverage. The synergy between these multilateral institutions helps in implementing primary care. However, Dr Baris noted that while many countries are moving toward universal health coverage, implementation is uneven with health care institutions in many countries lacking qualified doctors. He highlighted that the discussion has now shifted to the goal of "effective coverage." Dr Baris advocated for focusing on family medicine as a part of primary care. How is family medicine within primary care being defined? Does family medicine entail providing people with comprehensive, coordinated, and continuous care that also recognizes how socio-economic status influences health? Dr Baris emphasized that family medicine is ultimately about providing quality care to people. He noted that family medicine is about more than service provision as it also involves linkages with organizations such as hospitals and home-based care. Family medicine is part of the health care delivery system with a central role for family physicians.

Explaining the value of the Besrour Centre and the Canadian primary care model: Dr Baris pressed the Besrour Centre to consider what its "value add" represents. Why should institutions want to work with the Besrour Centre? What do partners gain in partnering with the Besrour Centre? Dr Baris highlighted that the Besrour Group is based in Canada, a country that has established an evidence base and success story in family medicine. The Besrour Centre could disseminate the Canadian experience in the WBG's focal countries and help promote the mission of family medicine and primary health care. The WBG has been investing in primary health care for decades and has invested $1 billion in primary health care. Ms Secci said the Besrour Centre is uniquely positioned to bring the Canadian experience to discussions about family medicine, and to help define the unique identity of family doctors and how this relates to patient satisfaction and patient perspective. Dr Ruth Wilson referenced Dr Margaret Chan, Director-General of the WHO, who maintains that universal health coverage is the most effective public health intervention countries can make. Universal health coverage is the bedrock of primary care. The Besrour Centre could help develop the capacity of national associations and academies of family medicine as these are areas in which Canada has significant capacity. Participants noted the

strengths of the College of Family Physicians of Canada are in teaching, research, and policy development. Such strengths can be leveraged to advance the family medicine agenda in LMICs.

Advancing family medicine requires more than cost-effectiveness data: Dr Baris said he has never been asked by a ministry of finance about the cost-effectiveness of family medicine. The questions ministries of finance often grapple with are: "Can I afford this? How am I going to convince existing specialists and hospital associations that I want to change health care gatekeeping in the country? Am I going to lose any credibility? Is there a risk to my reputation? There is an election 2 years down the line." Dr Baris emphasized that the task is not about providing cost-effectiveness data, but about demonstrating why family medicine should be implemented even if it necessitates short-term pain for long-term gain. Does the Besrour Centre have success stories from countries around the world that can be disseminated? Cost-effectiveness data should be made available, but such evidence on its own is not compelling. Dr Baris observed that it is important to contextualize the notion of cost-effectiveness and to consider how persuasive such data would be for policy-makers in decision-making. Some participants noted that cost-effectiveness is a reductionist concept.

Identifying the "tipping point" in family medicine: Dr Baris further encouraged participants to consider the "tipping point" in family medicine. Dr Baris shared his experience of visiting with the minister of health in Belarus. The mission involved the construction of a new health information system. Dr Baris said the minister's chief concern was to address the negative health impact of the Chernobyl nuclear disaster on the population. The minister's motivation came from a place of emotional and cognitive empathy, not from a position of cost-effectiveness. Dr Baris highlighted the importance of understanding the motivations and mission of policy-makers and of connecting with policy-makers as people. Dr Wilson posed the question: How do you convince policy-makers to invest in primary care and family medicine?

Adopting a multidimensional lens to understand family medicine: Some critiqued the PHCPI for essentially adopting a vertically oriented approach in which vertical health interventions are considered stand-alone interventions but get slotted together under the umbrella of primary health care. Participants raised concerns about assuming primary health care is the "sum of its parts." Participants emphasized that primary care is holistic, and this is a message that needs to be strongly articulated by the Besrour Centre. Participants also noted the need to consider the kind of family medicine being promoted. There is often a parochial focus on the biomedical aspects of medicine and a lack of attention paid to the psychosocial aspects of medicine. How can family medicine take a community-oriented approach to primary care and not merely a biomedical one?

Dr Baris mentioned the WBG is focusing on "integrated care" in Eastern Europe. He said many people have multiple and complex morbidities, which require an integrated approach as the current systems in most countries cannot respond to patients with complex co-morbidities in a holistic manner. Dr Baris encouraged the group to think about integrated care at both a conceptual and practical level. The WHO, for example, is focused on person-centred and integrated care. Dr Baris noted the development of health systems in countries is also shaped by path dependencies; once countries adopt a particular approach or system, it is difficult to transform the embedded system.

Group discussion

- Dr Bob Woollard noted family physicians are particularly influential due to their clinical credibility.
- Ms Secci encouraged the Besrour group to consider the role of family physicians in contexts where the private sector plays a role, and often a significant one, in resource-constrained settings.

Next Steps

Moderator: Dr Katherine Rouleau

Dr Rouleau concluded the conference proceedings and noted the next steps for the Besrour Centre will involve determining how the group can engage in rigorous research, both qualitative and quantitative, through a unified Besrour Research Plan.

Participants discussed how the Besrour Centre will focus its work. Several foci emerged from the discussions that will help frame the Besrour Research Plan and ultimately contribute to the future of family medicine.

Potential research foci for the Besrour Centre include:

Research capacity building: Capacity building emerged as a predominant theme throughout the conference. Capacity building in LMICs was discussed, and international partners were solicited on how the Besrour Centre could help fulfill their local needs and mandates. Dr Innocent Besigye (Uganda) underscored that in Uganda, capacity building is an area in need of much support. Although there is a need for data collection, there remains the challenge of insufficient capacity to collect these data and evidence. It was also noted that given its history, NOSM has an important role to play in building capacity and advancing education in family medicine.

Effectiveness of models of care: Using models of care to demonstrate the "value add" of family medicine was discussed at length throughout the conference proceedings. Dr Rouleau noted Canada models family medicine effectively and that such a model could be promoted globally, along with other demonstrated models of care around the world.

Knowledge generation: Delegates clearly articulated that the Besrour community must examine how it may contribute to the generation of knowledge, ultimately contributing to the advancement of the discipline of family medicine. Potential areas to examine include:

- What does a family medicine-centred system look like?
- Continuing professional development: What is the efficacy of CPD for a cohort of generalists? How effective is the application of CPD across settings? Could the Besrour community Centre generate comparative CPD evidence?
- Identification of five to six priority indicators from the PHCPI framework
- Community engagement through the potential creation of another Besrour (sub) working group
- Particular clinical areas or themes
- Patient and community perspectives
- Social determinants of health
- Role of health workers

The issue of data collection was also addressed. Dr Basia Siedlecki (NOSM) suggested WONCA could be leveraged as a means for collecting data through focus groups and a forum to present research. WONCA attracts family doctors from around the world and affords the Besrour Centre a ready audience. Other suggestions supported data collection through patients and researchers.

Knowledge translation strategy: A recurrent theme expressed by delegates was the importance of knowledge translation throughout the Besrour process. How can the Besrour Centre use a knowledge translation strategy to disseminate key messages? Some participants suggested examining the patient experience in LMICs, which is often a powerful means for incorporating patients' voices and perspectives in accessing family medicine.

Dr Katherine Rouleau shared a suggestion from Dr Steini Brown (University of Toronto) that the Besrour Centre needs to incorporate marketing into its knowledge translation strategy.

Knowledge-sharing platform: Delegates expressed the need for the Besrour Centre to provide a collaboration platform to advance knowledge sharing among partners and stakeholders. How do we as the Besrour Centre provide a process and hub to advance knowledge sharing? Southern partners emphasized the need for context-specific and country-specific evidence that can be leveraged in their discussions and negotiations with policy-makers. The Besrour Centre could provide a menu of options from which countries could select various types of evidence, such as case studies, community or families' behaviour as a microcosm, health outcomes, cost-effectiveness, and patient satisfaction.

While the Besrour Centre works to create a structure to connect various groups across the globe, an initial approach might include focusing on areas relevant to multiple partners, as the Besrour Centre is unable to address individual needs. A significant aspect of the coordination and communication occurs through working group leads. It may be necessary to identify sub-leads of working groups in the future.

Fund-seeking resource: Exploration of the potential role of the Besrour Centre as fund-seeking resource was initiated by Dr Anne Andermann (McGill University), who asked whether it would be possible to make available micro grants for programs to pursue projects. Could a "speed dating"-like portal be developed and implemented locally whereby Besrour participants could pitch projects to different audiences? The portal could match up programs and allow them to apply for funding. Participants noted the difficulty in securing funding while conducting health systems research.

Advocacy: Delegates also explored tools and strategies that could be developed by the Besrour Centre to advocate for family medicine to policy-makers. Conducting a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of programs and approaches for persuading policy-makers was suggested as a potential tool.

Workforce development and medical education research: Delegates expressed the need to consider CPD research as a key component of the Besrour Research Plan and as a way to engage medical graduates. Delegates noted the importance of following medical students and residents who choose family medicine. Once you train family medicine graduates, what do they do and where they end up are often questions posed by policy-makers. The Besrour Centre must be part of answering this question.

Moving Forward

A more detailed Besrour Research Plan will be developed over the coming months based on the collective input Besrour partners provided at the 2015 Besrour Conference and throughout the year. The Besrour Research Plan will serve as a guide for the Besrour Centre's contributions to family medicine and primary care research.

The Besrour Centre will also ensure its priorities and initiatives are reflective of the Besrour community in both the global North and South, through the continued work of the Besrour working groups and through a refresh of the Besrour Strategic Plan.

The conference concluded with participants collectively voting to hold the 5th annual Besrour Conference in Rio de Janeiro, Brazil, upon invitation from the Besrour Centre's Brazilian partners, immediately prior to the WONCA World Conference in November 2016.