The 5th Annual Besrour Global Health Conference

Harnessing Family Medicine for SDG3

Final Report

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Executive summary

The Fifth Annual Besrour Global Health Conference, held last November in Rio de Janeiro, Brazil, brought together 75 family doctors, academic leaders, and family medicine professionals from over 20 different countries. The conference goal was to leverage global family medicine toward achieving Sustainable Development Goal 3 to "ensure healthy lives and promote well-being for all at all ages." The conference dovetailed with the 2016 WONCA World Conference of Family Doctors, where the Besrour Centre was able to lead a conversation about equity, social accountability, inclusion, and strategy. It also explored how a family medicine approach can provide the needed practical, intellectual, and moral backbone for a robust primary health care system.

The Besrour Conference focused on four objectives: measurement, knowledge generation, partnerships, and medical education.

Delegates explored frameworks for measuring primary health care and family medicine systems at the macro level by looking at the Primary Health Care Performance Initiative's Vital Signs indicators, and seeded a Besrour network comparative study focused on identifying relevant measures from the ground level perspective of family doctors. As well, clinic level measurement tools and frameworks were explored, such as the cumulative patient profile.

During workshops about knowledge generation, participants grappled with how the Besrour Centre can assess local research capacity and facilitate research and quality improvement activities within the Besrour community. Proposed solutions prioritized the development needs of the Besrour Centre's international partners. They included continuing to leverage the Besrour network, adopting online social networking tools, and developing tool kits, supports, and training opportunities to enable research and constructive enquiry among family and resident doctors in a way that fully engages those in low-resource settings.

Participants explored the work in medical education, focusing on identifying local education needs and designing country-specific strategies to address them. Strides were made in developing further supports in faculty and curriculum development as well as continuing medical education for practising doctors. This year's conference introduced a discussion about certifying family doctors and accrediting family medicine residency programs.

Throughout the conference, the Besrour Centre's holistic approach to understanding and developing primary health care systems—by focusing on the relationships between the system's constituents—provided valuable insights for delegates from diverse backgrounds and contexts. The conference made space for a deeper discussion about developing a code of ethics for socially responsible partnerships. In addition, at the Besrour and WONCA conferences, the Besrour Storybooth Project captured personal narrative interviews of 130 family doctors from 50 different countries, for advocacy purposes as well as for systematic analysis.

Conference delegates articulated a clear need for a dynamic online social platform and necessary infrastructure to facilitate year-round collaboration and exchange in all aspects of Besrour community initiatives.

The Brazilian delegation played a central role in the conference, graciously hosting the proceedings, taking the opportunity to showcase Rio de Janeiro's innovative and robust expansion of family medicine and rolling up of sleeves to push ahead.

The conference welcomed participation by Dr Hernan Montenegro (WHO) and outgoing WONCA president Dr Michael Kidd (Australia). It also hosted the signing of a memorandum of understanding (MOU) between the College of Family Physicians of Canada (CFPC), the Brazilian Society of Family and Community Medicine, and the University of Toronto Department of Family and Community Medicine. This support from and synergy with the greater international community grew from a shared understanding that family medicine offers a much needed path toward our global ambitions and is a necessary ingredient for achieving Sustainable Development Goal 3.

Introduction

The Fifth Annual Besrour Global Health Conference, titled "Harnessing Family Medicine for SDG3," brought together 75 family doctors, academic leaders, and family medicine professionals from over 20 different countries. The conference goal was to leverage global family medicine toward achieving Sustainable Development Goal 3 (SDG3) to "ensure healthy lives and promote well-being for all at all ages."

The conference focused on four objectives:

1. Knowledge generation: Build family medicine research capacity through the identification and development of tools and strategies to advance:
    a) research-ready practices and practice-based research networks in low-resource settings
    b) research skills for practising physicians
    c) quality improvement activities
2. Medical education: Identify strategies and activities for the Besrour Centre to support partner-informed family medicine education needs through continuing medical education and family medicine program accreditation
3. Measurement: Capture family medicine's contribution to primary health care through identifying family medicine-specific measurement tools and indicators
4. Partnerships: Identify guiding principles and tools to begin and strengthen country and institutional partnerships

This multipart focus sparked a vibrant discussion of the many and diverse ways that a family medicine approach can provide the needed practical, intellectual, and moral backbone for a robust primary health care system.

The conference marked a new chapter in collaboration by inviting the Besrour community to Brazil—a world innovator in capacity building and family medicine, and a long term partner of the Besrour Centre. Rio de Janeiro was also the meeting place for the global family medicine community, which gathered for the 2016 WONCA World Conference of Family Doctors, November 2nd to 6th, 2016. The first two days of the Besrour conference were held in historic Copacabana, and the latter part at the WONCA World Conference site, where Besrour delegates had the unique opportunity to engage with WONCA delegates from around the world.

Some interesting details about conference attendees:

- Almost half were new; newly-participating countries included Nigeria, Myanmar, Algeria, and the Kingdom of Saudi Arabia
- More than half were from Brazil, Asia, Africa, the Middle East, and the Caribbean; the rest were from Canada

- Approximately one-third were female; about one-quarter were francophone; translation in French and English was offered

Throughout the conference, delegates expressed an ever-deepening confidence, trust, and affinity with the evolving Besrour family.

Besrour Centre background

The Besrour Centre is housed within the College of Family Physicians of Canada (CFPC). The 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 privileged pathway to health equity. In the years since, the Besrour Centre has gathered collaborators from 22 low- and middle-income countries worldwide, flexibly supporting a diverse set of emerging family medicine systems.

The WONCA definition states, "general practice/family medicine is an academic and scientific discipline with its own educational content, research, evidence base, and clinical activity and a clinical speciality orientated to primary care." Within the global community of family medicine, the Besrour Centre aims to lead a progressive conversation among leaders about equity, social accountability, inclusion, and strategy in the global struggle to bring quality primary health care to all.

The Besrour Centre's strategic priorities for improving health globally are:

- Engage partners and stakeholders to improve global health through family medicine
- Advocate for family medicine in health systems globally
- Advance family medicine education, training, and certification
- Strengthen family medicine scholarship and quality improvement
- Secure operational sustainability and accountability of the Besrour Centre

Conference reporting process

Based on feedback from previous conferences, the 2016 conference involved active participation, sharing, discussion, and contribution from all delegates. Formal presentations were usually followed by Q&A sessions and small group discussions. While the conference agenda remained flexible, accommodating changes until the last moments, the sessions were kept on schedule and focus on objectives was maintained.

Among the conference attendees were a small team of Brazilian family doctor residents and an external report writer who took notes during the presentations and discussions to be compiled later to create this report.

Conference presenters and moderators led the larger conference group in a series of interrelated sessions, and discussions often traversed thematic boundaries. In this report, the session discussions are organized into the broad categories of measurement, knowledge generation, partnerships, and medical education, and therefore are not necessarily presented in the sequence they occurred. A list of conference events has been included for reference in Appendix A.

In each session, presenters began by stating any possible conflicts of interest, a formality that underscored the shared value of transparency and showed, without exception, that presenters were free from compromising influences.

Set the stage: Focus on SDG3

As the global community sets out to meet the challenges of the SDGs, it is clear that in order to ensure healthy lives and promote well-being for all at all ages, the world's population must move beyond focusing on vertical funding of single diseases, narrow populations, and hospital-based care. Instead, there is a need to strengthen health systems and invest in evidence-based horizontal (integrated and patient-centered) funding strategies that have proven more efficient. Family medicine can play an important role in informing and supporting our global health efforts.

At the conference, the Besrour community explored how its collective efforts and collaborations to advance family medicine globally align with and inform the targets set forth by the SDGs, through the lens of social accountability. The social accountability framework provides the opportunity for family medicine to offer its unique perspective for responding to and proactively meeting the needs of society and achieving the global ambitions of the SDGs.

The conference opened with a brief welcome address by Besrour Centre director Dr Katherine Rouleau (Canada), and Besrour Centre founder Dr Sadok Besrour (Canada), who introduced the keynote speaker, Dr Ahmed Maherzi (Tunisia), Dean of the Faculty of Medicine at the University of Tunis.

In his keynote address, Dr Maherzi spoke of SDG3, formally adopted by a UN resolution in 2015. He then connected the dots between global declarations in health, culture, science, and business to articulate a compelling synthesis of the central role for family medicine in the struggle toward global equity.

Dr Maherzi emphasized the need for medical schools to institutionalize an ethos of social accountability, drawing attention to the Global Consensus for the Social Accountability of Medical Schools, and the Francophone project on social accountability, involving 56 medical schools in 18 countries. Dr Maherzi offered examples drawn from his own multifaceted work at the University of Tunis about the need to strike a balance between the pressing demands of undertaking proactive research in primary health care and disseminating and implementing already-established best-practice models. This concern with different modes of research emerged as central theme of the conference in the days that followed.

By clearly articulating a goal of quality health care for all and making the case for the central role of social accountability in medical education and practice, Dr Maherzi set up delegates to focus on the practical challenges laid out in the conference objectives.

Objective: Measurement

The conference set out to explore various frameworks for measuring and assessing the impact, strength, and progress of primary care and family medicine. Delegates sought to identify metrics and information that might contribute to more meaningful assessment and measurement of the impact and quality of primary care and family medicine in their diverse settings. They also tried to find possible common activities within the Besrour network to advance this discussion.

Primary Health Care Performance Initiative and the Vital Signs indicators

On the second day of the conference, delegates explored the usefulness of a key global primary health care improvement monitoring framework, the Primary Health Care Performance Initiative (PHCPI). Ms Chelsea Taylor (USA) from Results for Development (R4D) led the discussion.

Building on the discussion about the PHCPI from the 2015 Besrour conference, Ms Taylor reiterated the primary focus of the PHCPI: to strengthen primary health care systems by providing a snapshot of primary health care performance, using 25 Vital Signs indicators. The indicators have been categorized into five groups: system, inputs, service delivery, outputs, and outcomes. Ms Taylor highlighted the difficulties of measuring the "black box" of service delivery and suggested this was an area to which the Besrour community could contribute.

In the group discussion following Ms Taylor's presentation, delegates explored ways in which the Besrour Centre might contribute to the PHCPI's work-in-progress by helping to add a family medicine perspective and some family medicine-centred data points. Additionally, the PHCPI project served as a jumping-off point for a discussion about how the Besrour Centre could create a comparable tool for measuring family medicine health systems.

Small group discussions explored the PHCPI Vital Signs indicators from clinical, regional, and global perspectives. One group mapped out the information flow where regional/national data informs global analysis, which in turn informs local practice. The intended audience for PHCPI Vital Signs indicators was questioned; the indicators appear geared more toward macro policy-level decisions. Will the measures be fair for accountability when family practitioners cannot control many of the factors? Are they better suited, at a local level, to quality improvement? Dr Joshua Tepper (Canada) suggested there might be a role for the Besrour Centre in helping navigate this healthy tension between accountability and quality improvement. Dr Kenneth Yakubu (Nigeria) suggested that the Primary Care Assessment Tools (PCAT) surveys, designed to measure a system's performance, offer a more relevant tool on a clinical level.

Ms Taylor clarified that PHCPI focuses on available data and has tried to avoid asking countries to collect new data for the purpose of the framework. The idea that the Besrour Centre could play a

role in collecting data needed to measure family medicine systems was discussed. Dr Janusz Kaczorowski (Canada) suggested better inclusion of the patient's perspective in the indicators.

On a global level, it was recognized that the PHCPI Vital Signs indicators can serve as a rubric to identify which country models are worth replicating and to support advocacy for equity and information sharing. By strengthening health systems, the indicators will help reduce infectious disease occurrence and monitor the long-term impacts of non-communicable diseases. On a regional and national level, the indicators support needs assessments, offer standardized measures for research, and provide a platform for comparison and networking.

However, delegates questioned whether the 25 indicators were in fact the best measures. Do we need something more specific to family medicine? How many family doctors are there per country? How many community health workers are there per 1,000 people? Questions were raised about how to capture the rural/urban divide, how to go beyond absolute numbers, and how to create meaningful feedback loops.

Policy-makers, it was noted, will likely grab what is easy to measure. Delegates suggested a more complex, holistic model: Dr Robert Woollard (Canada) offered a 3-D graph as a visualization of the PHCPI data. The *x*-axis showed structural-functional outcomes, the *y*-axis indicated the doctor-patient relationship, and the *z*-axis showed continuity and comprehensiveness of access.

The PHCPI strategy overall offers a compelling model for how to compare family medicine systems in different countries. Dr Rouleau offered the metaphor of the Besrour Centre and PHCPI as neighbours in adjacent houses, exchanging ideas, cooperating, and staying aware of each other's activities.

The cumulative patient profile survey

Approaching the systematization of knowledge on a different scale, Dr David Ponka (Canada) presented the cumulative patient profile (CPP) as a potential tool to capture the dimensions of continuity, comprehensiveness, and so on, in the context of primary care delivery and ultimately demonstrate the impact of family medicine on the efficacy of health systems globally. The CPP, a clinic-level tool, is a concise, cumulative summary of a patient's health status, medical history, and personal circumstances. Dr Ponka shared the results of a survey of Besrour delegates, asking about the use (if at all) and composition of a CPP-like document in their practice. Of the Canadian respondents, 10 of 12 said they used a CPP, compared with 5 of 11 international respondents.

This survey and interest in CPPs was in part inspired by Dr Atul Gawande's book *The Checklist Manifesto* (2011), which advocates using checklists to improve human performance in systems. The checklist has been embraced in aviation but remains optional in medicine. Dr Gawande is a surgeon but the logic of the checklist extends to primary care.

Dr Tepper pointed out that, based on the book, checklists had been regulated for use in surgery in Ontario, Canada, and subsequent research had found no improvement in outcomes. The suggestion

was that the checklist itself was not enough—it needed to be supported by a cultural shift within the system, aimed at improving outcomes.

Dr Woollard made the point that most of medicine is complex, like raising a child, but not complicated, like landing a rocket on the moon. What is most essential is developing feedback loops and quality relationships.

Dr Aboi Madaki (Nigeria) said that he has 4 minutes and 8 seconds to see a patient and that he cannot implement a checklist. There was discussion about over-documentation in the UK and the danger of turning doctors into data entry clerks. Dr Ponka suggested that nurses could play a role in collecting the CPP data.

Dr Rouleau described her dentist, who sends an email the day before an appointment inquiring about any changes to health status or personal data. She also shared her experience asking patients about their socio-economic status, their initial reluctance to share the information, and how an explanation of her interest in the social determinants of health transformed the conversations.

Dr Maherzi expressed interest in piloting the idea. Dr Ponka invited any others with interest to also join.

Research idea—Measuring with primary health care models

On the second morning of the conference, Dr Adelson Guaraci Jantsch (Brazil) led a workshop to explore other ways in which family medicine can measure the impact and progress of global primary care frameworks by surveying participants' experiences of primary health care and family medicine strategies in their national contexts. These were addressed at three levels:

- One group looked at the big picture, discussing national approaches in terms of governance, policies, universities, incentives, partnerships, structures, and asking what is missing.
- Another group looked at strategies for professionalization, in terms of residency programs, workforce development, and incentives for primary care providers, asking what kind of professionals are working in a given country's primary health care.
- A third group looked at whether family physicians have all they need in their clinics to deliver a good quality service, with efficiency and equity in health. Can they diagnose and manage the most prevalent health problems in their communities (acute diseases, mental health, maternal and child health, health promotion, and preventive care)? How many patients is a family physician responsible for? What is still needed in order to move from selective to comprehensive primary health care?

Afterwards, Dr Jantsch explained that this is a research starting point to better understanding family medicine's potential contribution to strengthening health systems through better measurement and information sharing. A comparative analysis of the evolution of primary care in different countries

and contexts within the Besrour network has already begun to show the diversity and contrasts, and can serve as the beginning of a multicentre study to further explore this research question.

Coordinating efforts with the WHO

Dr Hernan Montenegro (WHO) reiterated the crucial role of family medicine in the global shift to re-engineer health services in a more integrated and people-centred manner as a means of improving access, equity, affordability, quality, and responsiveness. Using as a lens the WHO's framework of Integrated People-Centred Health Services (IPCHS), Dr Montenegro pointed out how family medicine can deliver on this vision by playing a crucial role in coordinating complex care across settings. Furthermore, the IPCHS framework has identified the re-orientation of models of care toward family and community practice models as one of its core tenets. Dr Montenegro's remarks highlighted the importance of family medicine and robust primary care as the cornerstones of any strong health system and to the various global frameworks such as the IPCHS and the SDGs.

Next steps

Identifying measurement as a priority distinct from research and knowledge generation recognizes that these overarching frameworks structure how we interpret and make sense of the data we collect. This macro perspective, coupled with an ability to see the implications of macro frameworks for ground-level health care systems, positions the Besrour Centre to play a special role in this high-level conversation. Going forward, the Besrour Centre will continue to examine, engage with, and contribute to the development of framework tools that effectively capture and help support family medicine and primary health care systems. The IPCHS framework is a welcome innovation and will continue to be explored, along with other frameworks, as necessary and imperfect sense-making structures. The Besrour Centre remains committed to a strategy of maximum impact toward SDG3.

Objective: Knowledge generation

Knowledge generation capacity within the Besrour community

Parallel to the Besrour effort to develop tools for measuring and assessing health systems that incorporate the family medicine perspective, the Besrour Conference participants explored research, knowledge generation, and the spectrum of techniques available.

Guest presenters were invited from the University of Toronto Practice-Based Research Network (UTOPIAN) and Health Quality Ontario. Dr Ponka, Besrour Papers and Research Working Group lead, presented his research capacity development project, which is based in Guyana. Dr Jantsch led a workshop session, to seed the idea for a multicentre research project comparing family medicine systems and strategies across countries.

Delegates explored: the capacity within the Besrour network to carry out research; the diverging aims of formal research and quality improvement; the possibilities of multicentre knowledge generation projects; and the supports needed to conduct research, data collection, and analysis in low-resource settings. Developing capacity for research and quality improvement initiatives within the Besrour community emerged as a clear priority, as did implementing a modified practice-based research network.

Research skills development in family medicine

On the first day of the conference, Dr Ponka led a series of sessions about capacity-building research skills in family medicine. He explained that research is essential for developing any academic discipline. In a field as big as family medicine, research likely requires coordinated partnerships. He noted that while practically all current research in family medicine focuses on the experiences of industrialized countries such as Canada, family medicine in emerging settings often looks very different.

Developing the capacity for research is not an easy or a straightforward process. For practising physicians in low-resource settings, it requires time to conduct the research, a passionate interest in the research question, teamwork, and strategic targets. He noted that this approach has been highlighted by the WHO; in 2008, the WHO called for sustainable community health research and online supports do exist.

UTOPIAN—An exemplary practice-based research network

Ms. Aashka Bhatt (Canada) presented the University of Toronto Practice-Based Research Network, called UTOPIAN, where she is a practice coordinator. They conduct research in 14 teaching hospital

sites and 400 practices, involving 1,400 faculty members and as many as 1 million patients. Ms. Bhatt described UTOPIAN as a living lab for primary care, where groups of primary care clinicians work together to answer community-based health care questions and translate research findings into practice. They support investigators from idea-inception through planning, finding practice-based partners, implementation, analysis, and presentation, tackling both small, low-cost pilots and larger, funded studies. UTOPIAN has adapted for their own use for self-accreditation the UK RCGP Research Ready® program.

UTOPIAN runs an annual six-day training course for researchers, supports the course faculty, and funds pilot projects. UTOPIAN itself is funded by core investment from government, participating sites, and non-profit foundations. Their model taps the research cycle to develop a more accessible research culture. For participating family doctors, UTOPIAN offers improved systems, a model of community-based research, and enhancement of their own professional profile.

Pilot research capacity project in Guyana, strategies from Brazil

Dr Ponka and Dr Jantsch presented their work in Guyana and Brazil, respectively.

The ongoing Family Medicine for Guyana project is built on collaborations over the past five years between universities in Canada and the West Indies, the Pan-American Health Organization, the Canadian government, the colleges of family physicians in Canada and in the Caribbean, and more recently on a formal partnership with the University of Ottawa with support from Academics Without Borders. In 2015, Guyana launched its national family medicine program.

The Family Medicine for Guyana Program aims to develop Guyana's clinical capacity by offering a series of modules for the Guyanese medical residents designed to support them as they develop their own self-directed research projects. Chosen topics of research include teen pregnancy and contraception, personal hygiene practices, road accidents, HIV, and diabetic foot infections. The larger goal of the project is to improve doctors' confidence by supporting them as they develop research projects focused on improving the processes of care.

The need for this type of proactive learning is highlighted by the fact that at the beginning of the project, several participating residents were unaware of the data sources available in their own region. The feedback from participating residents has been enthusiastic.

Dr Ponka and his colleagues want to develop the Guyanese faculty partners' capacity for delivering the modules independently. They are also working on developing a unified research agenda. Dr Ponka is interested in adapting these modules and the project approach for Besrour partners.

Dr Jantsch presented recent developments in Brazil. Local universities have introduced a new Masters in Primary Care for doctors, including those from other disciplines. They have a program to train preceptors to develop their communication and research skills to better pass on the needed

knowledge. He has 70 to 80 students per year enrolled in the program, each required to produce a research thesis.

Quality improvement approach

Dr Tepper made a short presentation about quality improvement (QI), which he described as a "path to better." He suggested that QI is an important focus for emerging systems that have an opportunity to embed QI into their culture. He highlighted the Institute of Medicine's six domains of health care quality: safe, effective, patient-centred, timely, efficient, and equitable.

QI is not the same thing as research. While it is true that both represent a disciplined approach to a problem, each uses a different set of tools and they have different goals. Research can be seen as the production of generalizable knowledge, with special consideration to minimizing bias. In research, the improvement in care is a secondary concern. QI, in contrast, is a systematic method of making things better. The primary purpose is improvement of care with a focus on contextualized, applicable knowledge.

Dr Tepper suggests that QI is a journey from information to knowledge to change, which he describes like this: You do not need a huge data set, you can have great data in just one Excel spreadsheet. Patients offer a great source of information—with five people and some coffee, you can learn a lot about what is or is not being done well. Creating a safe and neutral space for this feedback is key. QI is a skill set and a tool box for working with information and data. Even a two-day course can develop capacity. People should be familiar with a PDSA cycle (plan, do, study, act) and a run chart.

Beyond collecting and analysing data, change and improvement through QI requires leadership. It requires someone who believes in the project. Failure is an important possibility to factor in, because often QI does not work. Committing to better is not necessarily a formula for instant success. Dr Tepper suggested four ways to get started: create an aim statement; create a QI plan; conduct training in QI; connect with people who know how to do it through networking tools, like Facebook and Skype.

Research, QI skills, and the way forward

Midway through the series of presentations about research, delegates broke into small groups to brainstorm about the kinds of supports that might allow for building research and QI capacity, and for research and QI activities to be carried out. Ideas emerged along a variety of themes.

Delegates noted that the requirements for conducting QI or research activities are a team, tools, dedicated time, remuneration, dedicated resources, skills development, organizational support, patient involvement, networking, development of a community of practice, and access to existing data. QI, in particular, requires having the autonomy to incorporate identified changes, and both research and QI require the space for critical observation and reflection.

Delegates suggested that the Besrour Centre could offer hands-on writing workshops and workshops in research methods and techniques at the next conference, if not before. There was also strong interest in what would likely be a parallel stream of hands-on workshops in QI methodologies and techniques. These workshops could be built around concrete proposals for studies and based on ideas generated either by workshop applicants or a more formal needs assessment and research agenda-setting process.

Additionally, the Besrour Centre could support translating ideas into projects. Several delegates expressed interest in accessing mentorship opportunities to help generate proposals, and with actual research or QI processes. There was discussion about leveraging academics as potential collaborators, of facilitating an understanding within academia of the family medicine lens, and promoting interdisciplinary collaboration with family medicine research. Participants recommended focusing on reaching out to junior faculty.

Other suggestions for the Besrour Centre included:

- Identify scholarships to PhD programs to develop formal research capacity within emerging family medicine systems, and to try to stimulate interest in research and QI at the level of medical training and residency programs
- Identify and connect the community with existing research. This could be a part of the process of identifying a research agenda geared to help health systems and communities. The Besrour Centre could review members' abstracts and/or papers for language and content. Eventually, there would be a need to help disseminate findings.
- Form a project incubator that could offers small grants to support research and QI projects including travel grants to support multicentre research, funding at the pre-proposal stage, and seed funds for research partnerships
- Advocate for including QI as part of certification and certification maintenance requirements and the possibility that the Besrour Centre could be a certifying body for these QI requirements

Building the Besrour research network

Stepping back from this storm of ideas, many delegates recognized that essentially what was being described was an enhanced Besrour research network, perhaps adapting aspects of the practice-based research network redesigned to meet the unique needs of the international Besrour community. There was a shared desire to find ways to continue collaborating as a network between meetings and a sense of urgency to getting started. Organizational challenges were identified, such as record-keeping, governance, planning, identifying and developing partnerships, identifying a research agenda, and establishing a research culture and standards of quality. These all become more challenging with limited time and funding, and with competing priorities. Understanding the relationship between data, knowledge, and change is essential, as are setting benchmarks, building relationships, and celebrating research and QI successes among partners through specific examples.

One useful approach could be iterative, focused on developing the needed infrastructure and adding courses and projects case by case.

Leverage technology

Throughout this discussion, delegates suggested ways that communication technology could be incorporated into the ongoing Besrour process, to advance the work of the Besrour Centre between conferences and to ensure continuous engagement year-round. This could involve a dedicated social network, such as the commercial Slack, or the open-source Mattermost or Rocket.Chat tools.

It was envisioned that these tools could allow members to find out what others are doing, to share articles and information, and to get quick answers to questions.

Other technology-based ideas involved delivering online training, courses, and webinars in research or QI, identifying existing courses and coordinating participation, and identifying and sharing other online resources. There was a suggestion to explore the idea of pre-publishing for family medicine research (modeled after arXiv.org, Cornell University's health and science e-print library).

There was also an idea about somehow sifting through the mass of new research (more than a million articles in medicine each year) to identify key articles relevant for family medicine and the Besrour community.

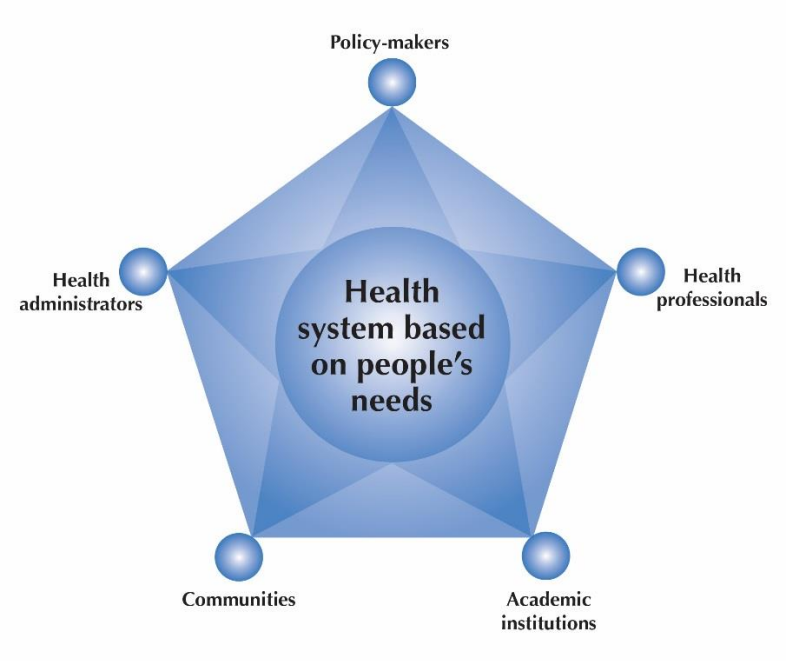
Next steps

Based on feedback, the Besrour Centre will continue to develop a research plan and network, considering partner research needs, alignment with local research efforts, meaningful metrics, and a focus on building engagement, skills, and culture. The Besrour community will begin with practical tools to support this collective process, such as using communications technology and creating practical research and QI workshops for delivery at the following Besrour conference. Practice-based research networks and their adaptation to local settings will be explored further.

Objective: Partnerships

The pentagon framework

On the third day of the conference, Dr Woollard, co-lead of the Besrour Narratives and Family Medicine Mapping Working Group, led a panel presentation for a wider WONCA audience. The Pentagram Partner Workshop offered insight into the Besrour approach. The presentation explored the pentagon framework as an effective tool for analyzing the functioning of health systems of all sizes, from cities to countries to the global context. It identified the five key constituencies in a health system as policy-makers, health professionals, academic institutions, communities, and health administrators.



The framework posits that while the system itself must aim at meeting people's needs, the system functioning is best understood by analyzing the relationships between these key constituencies. According to Dr Woollard, a sense of social responsibility here is both the foundation and the fruit of a well-functioning system.

Innovation seen through the pentagon framework

Dr Jose Carlos Prado (Brazil), Vice-Secretary of Primary Health Care in Rio de Janeiro, gave a presentation detailing the rapid expansion of Rio de Janeiro's primary health care system, which has grown from serving just 3.5% of the city's total population in 2009 to 50% in 2015. Dr Prado described early challenges managing the interplay between a community with little concept of primary health care, policy-makers, and academic institutions.

Clinics piloted in Rio de Janeiro as early as 1998 were well received by communities. Later, community dialogue with policy-makers, together with the compelling economic efficiency of the family medicine model, convinced key players in government that this approach could work in Rio de Janeiro. Team-building with doctors focused on nurturing an ethos of social responsibility among young doctors, combined with offering adequate salaries and stimulating development within medical schools, have all been important aspects of the program's success so far.

Next, Dr Samantha Franca (Brazil) described her experience among the first cohort of family doctor residents in 2009 in Rio de Janeiro's then-nascent family medicine program. At this early stage, residency positions were scarce. The few existing family medicine teams were isolated from each other and pay was low. Hospital emergency rooms were overburdened, inefficient, and relied on other specialists. Faced with the obstacle that existing training hospitals would not or could not create the needed residency spaces for graduating family medicine doctors, the city stepped in to create a massive residency program that continues to fill this need.

The story of Rio de Janeiro's innovative approach to capacity-building told through these two perspectives, with a focus on the relationships between key constituencies, clearly demonstrated the relevance of the pentagon framework. Rio de Janeiro's family medicine system stands as a testament to the positive change that is possible under inspired leadership. As well, it remains a test case to watch about the resilience of emerging health systems as political leadership changes.

A Canadian pentagon framework perspective

Dr Jamie Meuser, Besrour co-lead of the Continuing Medical Education Working Group, reflected on the pentagon framework through the lens of identity. Family doctors, he explained, tend to be good at empathy, they are good collaborators, and they are driven by the positive regard of their patients. They are also people who are compelled to see the trees as well as the forest, always balancing individual and collective concerns. He described their role at academic institutions as the workhorses who get things done. He spoke about the natural alliance between family medicine and health policies shaped by a concern for the social determinants of health. He emphasized that while it was important to take a moment to self-congratulate, it was also important to continue to push ourselves.

Doctors as patients and the pentagon framework

Dr Woollard asked the doctors and health professionals present to reflect on their other role—a patient of health systems. People spoke about the importance of the development of trust between doctors and patients, the sense in family medicine that doctors will treat each patient with the same concern they would show to a member of their own family, and the importance of competent and consistent care, and professionalism.

Others noted that it is important for patients to understand the pentagon framework and to be aware of the functioning of the health system as a whole. The possibility of an unequal pentagon was discussed, along with the crucial role of government as shown both by Rio de Janeiro's example and,

conversely, by the example of Rwanda where family medicine was sidelined for the entire term of an unsupportive government. Dr Woollard noted that one needs to get all five corners of the pentagon in the room. It was suggested that, in Mali, donors should be considered a sixth corner on the diagram.

Dr Maherzi emphasized that patients need to remain the focus, with the whole system being designed toward delivering primary health care that is effective and socially accountable. Dr Kyaw Thu (Myanmar) remarked that the pentagon framework usefully underscores the challenges facing Myanmar, where few if any of these five constituencies are familiar with the family medicine model. Dr Woollard concluded by noting that for change to happen, people need two beliefs: that the proposed change is doable, and that it is desirable.

Socially responsible partnerships

On the third day of the conference Dr Janie Giard (Canada), lead of Besrour's Ethics sub-working group, invited Dr Beatrice Godard (Canada), a medical ethics professor from the University of Montreal, to lead a session aimed at developing a Besrour Centre code of ethics for responsible international partnerships. The code would be a set of guiding principles used by people from different institutions trying to work together toward common goals, so that all can share in the risks and benefits in transparent and equitable partnerships. The envisioned ethical framework tool is both a code of ethics that members can aspire to implement, as well as a set of operational standards that can act as a set of norms representing the minimal goals of the organization. It would be a tool to guide in deciphering the right thing to do and also act as a public declaration of shared values.

This was a continuation of an initiative started at the 2015 Besrour Conference to explore the kinds of partnerships the Besrour Centre aims to create, and to develop the tools needed to support these. Dr Godard's initial presentation quickly cut to the heart of the issues involved in forging international partnerships, such as power and equity, while highlighting the need for institutions to find ways to work together. She pointed to the Canadian Council for International Co-operation's Code of Ethics and Operational Standards as one example of the kind of document we are trying to create.

After a primer about the issues involved with cross-cultural partnerships that bridge economic and power inequity, the group split for discussion to spend 15 to 20 minutes on each of three questions:

- What goes into the decision whether or not to partner (including essential factors, no-goes, and other considerations)?
- How does one develop partnerships (including essential elements and pitfalls to avoid)?
- How can we concretely initiate a partnership?

To summarize, the essential factors are mutual interest, respect, engagement, the possibility of mutual advantage, an equitable balance of power, commitment (individual and institutional), a willingness to pursue and invest in the project, and continuity. Transparency, shared objectives, shared ethics, adequate time, and the right timing are all essential, as are adaptability and safety

considerations. Other considerations include the historical context of each country and institution, linguistic and cultural barriers, the reputations of the organizations, and finances.

Networking—between people and institutions, through participation in workshops and conferences—is important for learning how to develop partnerships. There is a need for honest, transparent, and frank dialogue. Leadership and project champions, feedback loops, and familiarity with the terrain (both with the shared work and the process of partnering) are all key.

Writing a paper together can be an excellent early step in developing a partnership, as can collaborating on a pilot project, especially one that focuses on low-hanging fruit and that can lead to a successful outcome; celebrating success is seen as essential. Alternatively, a localized trial has the advantage that it can successfully identify failure as well as opportunity, as opposed to pilots that are geared more toward success and tend to be abandoned when they fail.

Some potential pitfalls in the partnership-building process are: relying on only one person; poor planning; poor, or lack of, communication; unclear expectations; hidden agendas, deliberate or subconscious; excessive rigidity; and a lack of recognition and awareness of the ongoing influences of colonialism, racism, and sexism.

The SWOT (strength, weaknesses, opportunities, threats) analysis technique was described as a potential pitfall by some in that it focuses on threats and weakness and leads to blaming, but defended by other participants as useful. Similarly, a memorandum of understanding (MOU) was cited as a tool that is sometimes misused in that it can codify dysfunction. On the positive side, an MOU can document and formalize communication and commitments, thereby supporting continuity and accountability. One compromise is that an MOU is best preceded by an expression of interest and best undertaken at a latter stage in the process. However, there was no final consensus about the best approach to formalizing partnerships or at what stage this should happen.

Initiating a partnership begins through networking and the expression of an interest or need. Listening well is key, as is a basic sense of self-possession ('Let them come to us.'). The process involves identifying an appropriate partner with common interests, establishing human-to-human contact, building trust at both a personal and an institutional level, doing due diligence, identifying champions, identifying and connecting with people who get things done, looking for allies, developing a strategy, possibly formalizing this through an agreement of some kind, conducting evaluations, and managing conflict.

Narratives—The Storybooth Project

One of the unique features of the Besrour Centre approach is the Narratives and Family Medicine Mapping Working Group. This link between narrative and mapping may not be immediately obvious, but the combination offers a powerful insight. Personal narratives are particular human stories. On the spectrum of knowledge, scientific research occupies one end that is generalizable and unbiased, and quality improvement occupies a middle section, scientific and systematic but more focused on local context and application. Personal narratives complete the spectrum, offering personal, anecdotal,

situated knowledge that is no less rational or less true than scientific knowledge, but which is experienced as refreshingly specific, colourful, and immediate. Combined with the ecosystem mapping approach of the pentagon framework, people's narratives offer insight into what the health system looks like from where they stand.

Throughout the Besrour and WONCA conferences, the Storybooth Project—led by the Narratives and Family Medicine Mapping Working Group co-head, Dr Christine Gibson—captured the personal stories of 130 family doctors from 50 different countries. In a short video clip participants answered one of three questions:

- What led you to choose family medicine as a profession?
- What is the impact of family medicine in your community?
- What are the best traits you share with other family medicine doctors around the world?

The initiative is part community engagement, part exploratory research, part advocacy, and a celebration of the social responsibility at the core of the family medicine systems. Like the movement toward more formal research, this nascent initiative responds to a perceived need and opportunity.

Since the conference, a poster and slideshow of portraits with the #globalfamilymed hashtag has been created and transcriptions are under way for possible systematic analysis.

Next steps

The Besrour Ethics Sub-Working Group will build from these latest discussions by structuring its data collection technique, using the Delphi method to hone in on the important elements of an international ethical framework and to present a formalized Besrour ethical framework at the next Besrour conference.

The Storybooth will continue to explore the collection of transcriptions for adaptation into possible systematic analyses and future workshops.

Objective: Medical education

Besrour Centre education work

A core Besrour mission is supporting emerging family medicine systems around the world. An early and ongoing need is helping develop the capacity to provide medical education. Currently, this work is divided between two working groups—Continuing Medical Education and Faculty Development.

An added element at this year's conference was a presentation about accreditation and certification, highlighting the relationship between health administrators, policy-makers, and universities. While a presentation about the Canadian approach is often a starting point for conversations, much of the learning occurs from sharing the experiences of family medicine proponents from a variety of emerging contexts. These fresh perspectives and solutions also serve to deepen and invigorate the Canadian understanding of the ever-evolving mechanisms of family medicine.

From the perspective of the education working groups, the 2016 conference was an opportunity to forge ahead with the work in progress, to check in about partner country needs, and to set new goals for the work ahead.

International continuing professional development

On the first morning of the Besrour conference, Dr Clayton Dyck (Canada), co-head of the Working Group on Faculty Development, introduced a panel discussion with Dr Patrick Chege (Kenya), Dr Aileen Standard-Goldson (Jamaica), and Dr Meuser (co-head of the Continuing Medical Education (CME) Working Group), about the role of continuing professional development in supporting generalist doctors internationally.

The session began with a presentation by Dr Meuser about an informal literature review conducted by the Besrour CME working group exploring international models of CME, looking at incentives and disincentives for physician participation, delivery modalities, decision making, and funding. The literature survey also sought connections, if any, that exist between CME for generalists and the licensing and accrediting bodies, universities, medical schools, and training programs in the context of functioning health systems.

Dr Meuser laid out the case for continuing professional development. Generalists arrive in the profession with varying degrees of preparation and tend to have limited incentives and opportunities to augment their basic skills and training. Additionally, doctors require ongoing supports to respond to changes in scientific knowledge, population needs, and system priorities. Such advances in scientific knowledge and needed skills could, if taken up, allow for improved patient care and improved efficiency of the overall health system.

CME can provide a route for existing generalist physicians to acquire the skills and knowledge to be prepared for certification as family physicians. It can enhance the connections between existing and

newly trained doctors. And, significantly, the organization around continuing education has historically been a starting point for collaborating to meet other professional and system needs

Dr Meuser asked the other panelists to speak about the opportunities and barriers in their own settings, and about the roles for information technology, universities and training programs, governments, and family physician organizations, and about any role the Besrour Centre could play. The main ideas put forward can be summarized as follows:

Describing the situation in the West Indies, Dr Standard-Goldson explained that implementing a system for continuing training has been a slow process. Doctors in Jamaica are certified after undergraduate medical studies plus one year, so the fact that specialized training in family medicine is not required is a barrier to improving quality. The Caribbean College of Family Physicians offers continuing education, driven by a mandated one day of training each month for doctors practising in the public system. Continuing education remains a challenge and she is looking toward collaborations between universities and government.

Dr Chege explained that Kenyan doctors get five to six years of medical education plus a year-long internship before beginning a practice. Those in the public sector may find opportunities for continuing education, but most doctors practise in the private sector and they have remained on their own, largely forgotten by government regulators until recently. Five years ago, the government introduced a regulation mandating some training, creating a gap that is often filled by drug companies. In Kenya, as described by Dr Chege, generalist doctors are not trusted by the public and experience pressure from insurance companies to seek educational opportunities. He is currently proposing to offer CME, leading to both increased knowledge and certification, designed so that it does not disrupt a doctor's practice, and that is financially supported by insurance funds. He also noted that in several countries, the biggest fight has been between the emerging family medicine system and existing specialist doctors who feel threatened by the new emphasis on a family medicine approach.

Asked about technology, Dr Standard-Goldson explained that, in her Caribbean context, they use IT for communication among resident doctors. The Ministry of Health is seeking to partner with universities to extend this support to rural doctors. Dr Chege also saw technology as a means to reach rural doctors by telephone and internet. Kenyan doctors tried using the McMaster Modules, from Canada, but struggled to access hard copies of the manual and to afford expected subscriptions.

In the group discussion that followed, Dr Assegid Geleta Tucho (Ethiopia) spoke about the difficulties changing the existing health system, of retaining doctors in the public sector, needing to learn from our past experiences, and finding ways to grow family medicine faster. Dr Madaki said that Nigeria was considering instituting mandatory CME, but noted that mandatory CME did not necessarily translate to improving knowledge. He also flagged the scarcity of training opportunities and the difficulty of accessing the Internet—and even electricity—in some rural settings. Dr Standard-Goldson said that mandatory CME has worked in the West Indies but that a professional body is needed to regulate quality and standards for CME to avoid self-serving offerings by the pharmaceutical industry. Dr Meuser noted that in Canada, it has only been in the last 10 years that

attention has been paid to the quality of CME. The CFPC now has doctors make a five-year learning plan for themselves on which the College can advise and track.

Faculty development and results from the 2015 focus groups

Dr Lynda Redwood-Campbell (Canada), co-lead of the Faculty Development Working Group, presented the results of a focus group study conducted at the 2015 Besrour conference to identify the status, needs, gaps, opportunities, and next steps for faculty development for family medicine in low- and middle-income countries. Participants came from 10 countries. Open-ended, in-depth discussions were recorded and formally analyzed to identify the themes presented along with animating quotes.

Overall, the study found strong commonalities in family medicine faculty development needs across low- and middle-income countries, where the faculties tend to lack formal structures, organization, and needed resources. The study highlighted the issue of specialist faculty being called on to teach family medicine and pointed to a need to form a network and develop a tool kit to support faculty development across country contexts.

Training about the basic concepts, techniques, and principles of family medicine is needed for other specialists called on to teach family medicine. Additionally, faculties need further support to develop competency-based curriculum, including surgical and obstetric skills as well as family medicine clinical competencies, professional behaviours, and research skills. Teaching skills are also needed, such as marking, grading, evaluation, behaviour management, and communication skills.

It was felt that the Besrour Centre could play a role in setting guidelines, frameworks and standards to support faculty development and teaching methodologies across country contexts. The Besrour Centre could provide informational support online, but participants also stated the need for human resources. Participants emphasized that training should happen in their own countries and be geared toward their specific contexts. They suggested a tool box that might include a template for a lecture week or a structure for a training retreat.

Participants suggested creating a network, affiliated with a college, that focuses on faculty development and that meets at least once a year to provide continuity. The network could provide mentorship, direction, and consultancy, help with decisions related to technology and with career development, and provide support for engaging with current and potential faculty and with government.

The 2015 study participants suggested setting clear goals and conducting focused workshops at the next Besrour Conference to develop the needed network and tool kit and to push these plans forward.

Faculty development workshop

The Faculty Development Workshop involved 18 participants and opened with presentations by Dr Clayton Dyck and Dr Lynda Redwood-Campbell. They provided a brief overview of faculty development and its overlap and synergies with continued professional development, as well as the similarities and differences with faculty development in varying global contexts. They reported about a capacity building workshop that was developed by the Besrour Faculty Development Working Group and presented in Indonesia, China, and Ethiopia, as well as lessons learned from delivering the workshop.

The second half of this workshop was devoted to small group work aimed at helping participants identify concrete objectives for their family medicine faculty development program, determine activities to meet these objectives, and identify challenges, barriers, and strategies for sharing resources.

The participant feedback from the workshop was consistent with the 2015 focus group findings. Identified barriers and challenges ranged from geographical separation to a lack of funds, expertise, experience, and time, and from a lack of inter-university affiliations to a lack of governmental commitment to family medicine and primary health care.

Objectives, while consistent with the 2015 findings, began here to assume a more defined shape. Discussions about teaching skills and curriculum development skills linked to a discussion about objective structured clinical examinations, SMART goals, continuous quality improvement, and performance-based assessment. Strategies for developing an understanding of family medicine among new university deans and within undergrad programs, pushing for mandatory attendance for faculty development courses, and recruiting and engaging qualified trainers were discussed. Other objectives identified were developing networks and mentorship relationships, developing or accessing online resources, and securing funding for faculty development.

Roles for the Besrour Centre identified were:

- Forming the needed faculty development support network
- Conducting a needs assessment of online resources and developing an online mentoring tool kit and a mentor database
- Advocating for resources and support for regular faculty development workshops, including bringing in outside experts and developing modules
- Linking the community with research that strengthens the case for family medicine

Participants in this workshop also saw potential for a Besrour-led research network.

Accreditation and certification

Accreditation

Dr Ric Almond (CFPC) presented Canada's process of accreditation. He stressed that accreditation in Canada is not a test, but rather a peer review process of continuous quality improvement and feedback, with a focus on maintaining a standard of quality across each of Canada's 17 family medicine schools.

The report, compiled by the surveyors from their visits, is submitted to the CFPC's Accreditation Committee. Approval sets off a process of feedback and reporting between the university and the committee. He described CanRac, a trilateral partnership formed to develop a new accreditation system for Canadian residency education.

Certification

Residency programs in Canada last two years, compared to three or four in the US. Certification exams in Canada involve two parts. The computer-based Short Answer Management Problem (SAMP) involves 40 to 50 topics, is key-feature based, and is given in two 3-hour sections (http://www.cfpc.ca/SAMPs/). The Simulated Office Oral (SOO) is an interview-based oral component involving five 15-minute interviews where the examiner role-plays the patient (http://www.cfpc.ca/SOOs/).

Discussion

Following Dr Almond's presentation, participants at each table discussed either accreditation or certification. Discussing accreditation, Dr Chege said his country suddenly has six new medical schools and needs support with standardization.

Talking about certification, Dr Ischan (Indonesia) described his country's emerging family medicine system, developed in collaboration with McMaster University. Dr Ousmane Faye (Mali) and Dr Seydou Doumbia (Mali) suggested that the newly-implemented certification for family medicine in Mali was better than the existing certification protocols for specialists, and could be expanded to these other specializations.

In contrast, Ethiopia is just now graduating its first cohort of family doctors and has yet to develop a final exam or certification process.

The unique system in Rio de Janeiro has universities and the municipality evaluating in different ways. There was discussion about whether imposing an exam in family medicine might discourage enrolment, versus the benefit of increased patient confidence by the addition of certification.

Thinking provocatively from a Canadian perspective, Dr Woollard questioned the wisdom of summative exams, for which students tend to cram, and suggested that a formative assessment might

be a more meaningful focus. Dr Madaki countered that from the perspective of his emerging system, family medicine struggles to be recognized as a legitimate specialty, and it is therefore strategic to hold it to similar standards as other specialists.

Dr Maherzi tied the discussion to the larger goals by saying that good quality general practitioners are the backbone of the system, and that whatever names and mechanisms are used—which are ultimately political considerations—the goal needs to remain training doctors to have the capacity to handle any medical problem at any stage of development.

Next steps

In CME, conference discussions highlighted the importance of developing locally-adaptable and practical tools. Dr Meuser identified the potential for adapting an existing Besrour document, created as a continuing professional development manual for health professionals in Tunisia, for broader use. A goal was set to develop this tool for presentation in a workshop at next year's Besrour conference.

In Faculty Development, as identified by participants in both the 2015 focus group and 2016 workshop, the Besrour Centre will develop a faculty development support network, including mentor resources, a tool kit, and workshops to support the local faculty development needs of Besrour partners.

Developing a strategy for addressing the local needs of Besrour international partners relative to accreditation and certification will require further focused discussion.

Conclusion

A look at the Besrour Centre

At the end of the first day of the conference Dr Rouleau led a group discussion about the Besrour Centre as an organization. She began by emphasizing that the world needs family physicians, and the Besrour collective is being sought out by new partners, such as the West Indies, the Kingdom of Saudi Arabia, and China. To accommodate the growth of the Besrour network and ensure that its strategic priorities are being met, the Besrour Centre plans to establish a Besrour Centre advisory council.

Dr Rouleau noted that the Besrour Centre is growing, but it also needs to 'keep its ear to the ground'—she considers this conference group to be Besrour's ground. Together, participants have developed an ambitious strategy involving education, research, and advocacy. A survey suggested that the conference should be more engaging and practical, with a focus on education and research. Looking ahead, she asked the group what work they wished to prioritize.

Dr Madaki suggested that Besrour move forward with the research network project. He also asked if there was a possibility that the Centre could advocate for the Canadian government to provide support for family medicine in other countries. Dr Rouleau said she could not make promises but pledged to pursue this idea.

Dr Tepper suggested that by next year an outcomes measure could be the development of a research agenda for people in each partner country.

Dr Dyck suggested the Besrour Centre should hire an IT person to develop an easy-to-use, robust sharing network.

Dr Doumbia suggested that by next year the Besrour Centre should offer small grants for research.

Dr Rouleau explained that the yearly conference is a significant cost and a challenge to organize and wanted to know if people felt it was absolutely necessary. Overwhelmingly, people felt that it was. The possibility of introducing a modest registration fee ($100–$500) was mentioned. She asked whether people may be able to find funding for their own travel and many indicated that they likely could.

The road travelled, the road ahead

This process of reflection continued during the closing session of the conference on the final day.

That day saw an MOU signed by the CFPC, the Brazilian Society of Family and Community Medicine, and the University of Toronto Department of Family and Community Medicine. Dr Michael Kidd (Australia), WONCA's outgoing president, attended briefly to offer encouragement and to commend the important contributions of the Besrour Centre, shaking hands with each person in the room. Similarly, Dr Montenegro briefly addressed the group to offer his support and thanks.

Roughly 60 delegates took part in the closing discussion, a mix of delegates from the earlier days in Copacabana as well as new participants from the wider WONCA delegation.

The five Besrour working groups offered brief reports and shared plans for the future.

Dr Maherzi spoke about the importance of the work that the Besrour Centre is doing and remarked on the fact that it is growing and improving every year, but what is most difficult is to maintain quality. The various university deans need to be convinced of the importance of this work, kept informed and included in the next conference. Dr Rouleau replied that Besrour is inviting Dr Montenegro (WHO) to Montreal in 2017 and could use that to attract the deans.

Dr Madaki, as a first-time delegate, said he was very impressed and would be taking many ideas back to the 15-member West African College of Family Physicians. He sees potential to encourage regional forces to pool resources at the level of academia and colleges.

Dr Chi (China) offered heartfelt thanks and said her belief that primary care was essential to a better future was redoubled. Dr Rouleau reiterated the great potential she sees for the family medicine model in China.

Dr Innocent Besigye (Uganda) said it was his fourth Besrour conference, that the sum is clearly more than the parts, and that he looks forward to presenting in 2017 about the year's successes.

Dr Ischan said that at the conference he feels he is among family. He now knows when facing a problem at home he can find someone within the network who has faced the problem before and can offer a solution. The 23 hours he spent on a plane to get to Rio de Janeiro was well worth it.

Dr Rodney Destine (Haiti) said it was his first Besrour Conference, that he is now joining the Faculty Development and Research working groups. He said he believes the next conference needs a specific practical session on QI and a session on IT.

Dr Yakubu said this was his first conference and that it really was a different kind of conference, full of ideas, concepts, frameworks, but also rolling up of sleeves, boots on the ground, and solving problems. Besrour should be excited about growing, but also be circumspect, conserving and protecting what has been created here.

Dr Rouleau summarized the feedback and vision for the 2017 conference, involving smaller workshops, broader attendance, the idea of self-funding, and possible charging a small fee. She hoped to maintain the intense and intimate feel of the proceedings, but also did not want the group to turn inwards and suffocate.

What emerged powerfully between sessions and over lunches, and occasionally inserted into discussions ostensibly directed elsewhere, were the stories of so many international delegates who are grappling with systemic change in their own national contexts. Efforts to capture and document these experiences, such as the Storybooth Project and the country comparison study, only begin to scratch the surface. Each emerging family medicine system is a dynamic work in progress. As the capacity

builds within the Besrour network, these foot soldiers promise to bring a wealth of new insight to next year's Besrour Conference.

Acknowledgements

At the end of the conference in Copacabana and again at the closing, Dr Rouleau offered thanks to the many people whose hard work and dedication had made the conference possible. The long list included Rio de Janeiro colleagues from the Family and Community Residency Program of the Municipal Health Secretary of Rio de Janeiro (PRMFC-SMS-Rio), WONCA conference organizers and logistical support, the College of Family Physicians of Canada leadership and staff, the Besrour Centre staff, Meril Rasmussen and the rest of the report writing crew, and the on-site venue support staff.

Appendix A: Conference schedule highlights

Day 1

- Opening & Welcome – Katherine Rouleau and Sadok Besrour
- Keynote Address: The Intersection of Social Accountability, Family Medicine & SDG3 – Ahmed Maherzi
- Towards SDG3: Generating Knowledge for Family Medicine
- Developing Research-Ready Practices and Practice-Based Research Net works (PBRNs) – Aashka Bhatt
- Developing Research Skills in Family Medicine – David Ponka and Adelson Guaraci Jantsch
- The Role of Quality Improvement in Generating Knowledge in Family Medicine – Joshua Tepper
- Towards SDG3: Through Family Medicine Education - Moderator – Clayton Dyck
- Continuing Professional Development for Generalists – Jamie Meuser, Patrick Chege, Aileen Standard-Goldson
- Accreditation & Certification – Ric Almond
- The Besrour Centre Update & Forecast – Katherine Rouleau
- Faculty Development Focus Group Results – Lynda Redwood-Campbell
- Besrour Centre Working Group Updates
- Besrour Centre Forecast

Day 2

- Family Medicine for Primary Health Care (PHC): How do We Measure What We Do
- Using Primary Care Models – Adelson Guaraci Jantsch
- The Cumulative Patient Profile Survey – David Ponka
- PHCPI Panel – Chelsea Taylor, Katherine Rouleau

Day 3

- Besrour Concurrent Workshops:
- Ethics Workshop - Towards a Socially Responsible Partnership – Janie Giard and Beatrice Godard
- Faculty Development Workshop - Global Partnerships and Local Contexts: Moving Forward Together in Faculty Development for Family Medicine – Lynda Redwood-Campbell and Clayton Dyck
- A partnership between the College of Family Physicians of Canada, the University of Toronto Department of Family and Community Medicine - and the Brazilian Society of Family and Community Medicine

- Pentagram Partner Workshop – Bob Woollard
- Reflections from the Pentagram Partner Workshop
- The Besrour Centre: The Road Travelled, The Road Ahead – Katherine Rouleau