



# **The 7th Annual Besroul Forum**

## **Building on Astana 2018: Global Family Medicine for Healthy Communities**

**November 13–17, 2018**  
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**Final Report**



# Table of Contents

Executive Summary.....	3
Alma-Ata 40th Anniversary Dinner and Dialogue.....	4
Socially Accountable Family Medicine Worldwide: The critical role of deans and academic leaders .....	9
Family Medicine Innovations: Snapshots from around the globe .....	15
Successful Home Visits Experience in a Family Medicine Residency Program in Saint Marc, Haiti .....	15
Family Medicine Residents’ Annual Health Fair in Saint Marc, Haiti .....	16
A Comprehensive Collaboration Fostering Primary Health Care in Brazil.....	17
Primary Care and Family Medicine in Brazil .....	17
Family Medicine in Ethiopia .....	19
Drug-Resistant Tuberculosis in Aceh Province, Indonesia: Threats and challenges .....	20
Modified World Café: Besroure Centre current and future state/reflections of the global family medicine community.....	21
Update on the Research Working Group .....	21
Report from the Faculty Development Working Group.....	22
Modified World Café and Reports from Table Discussions.....	22
Wrap-up/Closing Session .....	28
References .....	31



## Executive Summary

The Besroul Centre is a hub of international collaboration dedicated to advancing family medicine as a pathway to health equity around the world. The 7th Annual Besroul Forum was held in Toronto, Ontario, from November 13–17, 2018, bringing together over 135 delegates from 14 countries. The theme of the 2018 Forum was how to build on the Astana Declaration on Primary Health Care and on the role of global family medicine in improving the health of people and communities around the world.

The Forum launched with a panel of global stakeholders including representatives from the World Health Organization (WHO), the World Bank, and national leaders reflecting on the significance and momentum generated by the adoption of Astana Declaration on Primary Health Care and the Global Conference on Primary Care held in Astana, Kazakhstan, in October 2018. A common theme in the presentations was that health systems that are integrated, built on a foundation of primary care—with family medicine as an essential component—are going to make the difference in improving the health for all people and communities around the globe.

The second day of the Forum saw a panel of seven deans and vice deans of faculties of medicine reflecting on the role of faculties of medicine and academic leaders in promoting, contributing to, and leading social accountability. An emphasis emerged about organizing all faculty activities around the needs of the population in the geographical territory that the university has a mandate to serve. The discussion also centred on social accountability as being expressed and achieved through multisectoral action, empowering people and communities, ensuring the medical school population is reflective of the general population, and orienting faculties toward a primary care vision.

From a broad discussion of academic institutions fostering social accountability, the Forum's focus shifted to examining specific on-the-ground innovations in family medicine training and practice. Presenters from Brazil, Haiti, Indonesia, and Ethiopia highlighted the achievements and challenges of family medicine and primary care initiatives in their local environments. Family medicine as a bridge to the community and thriving best in partnerships were key themes of the presentations. As a tangible example of the Besroul Centre's commitment to partnership, the Forum saw the signing of a Letter of Intent between the Canadian College of Family Physicians (CFPC) and the West African College of Physicians.

The Forum culminated with a modified world café discussion of the essential roles of education, research, community engagement, and leadership in strengthening family medicine and primary health care globally. Besroul Forum participants identified key next steps in each of those areas including the creation of a platform for disseminating and sharing knowledge, creation of tools and templates to be adapted to the needs of local context, increased emphasis on implementation research, and continued social commitment to improving the lives of patients and communities everywhere. Disseminating learning beyond the Besroul network, while maintaining its richness and diversity, was stressed.



## **Alma-Ata 40th Anniversary Dinner and Dialogue**

### **Dr. Shannon Barkley, WHO, Switzerland**

Dr. Barkley opened the panel presentations and discussion by addressing the Global Conference on Primary Health Care in Astana, Kazakhstan, and the Declaration of Astana. Over 2,000 people from 149 countries—health professionals, family doctors, nurses, community health workers, civil society organizations, and 71 ministers of health and deputy ministers—gathered in Astana to see how they might collaborate for improving the health of all around the globe.

At the Global Conference on Primary Health Care, WHO member states unanimously adopted the Declaration of Astana. This declaration was participatory, written by governments with input of over 1,000 people collected through various means including meetings and online consultations. The Declaration envisions:

- Governments and societies that prioritize, promote and protect people’s health and well-being, at both population and individual levels, through strong health systems
- Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed
- Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being
- Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans<sup>1</sup>

Dr. Barkley believes that it is an exciting time for family medicine, primary care, and primary health care. The world is asking how primary health care can support universal health coverage and the attainment of the sustainable development goals (SDGs), how we can work together to increase people’s health and well-being, how health and well-being in turn impact people’s socio-economic level, and how health and well-being are critical drivers of economic development. Health systems that are integrated, built on a foundation of primary care—with family medicine as an essential component—are going to enable the system for health to work effectively. We need to think big about what we are not doing today and how we can do it tomorrow. We have to take advantage of this moment in time, we may not get another for another 40 years.

### **Dr. Jeremy Veillard, Primary Health Care Performance Initiative, World Bank Group, United States of America/Canada**

The second panelist, Dr. Veillard, spoke about the work of the World Bank in human capital and strengthening the investment in people in government. He stressed how the economic competitiveness of national economies lies in the ability of governments to transform investments in human capital into



to greater abilities for people to contribute to the economy. The World Bank is exploring this through various initiatives:

- The Global Forum for Human Capital, which developed the Human Capital Index that ranks every low- and middle-income country (LMIC) on its human capital score. The Index takes into account child survival, education (how much is completed and how much is learned), and health, which are key contributors of productivity of future workers and, in turn, competitive economies. High performing primary health care systems are key to building up and preserving human capital over the life cycle and nurturing inclusive economic growth. Achieving high performing primary health care means putting primary health care workers at the front lines and making sure they are competent and well trained to deliver the type of health care that the population needs.
- The Primary Health Care Performance Initiative is a collaboration between the World Bank, WHO, and Gates Foundation. It is an attempt to measure impact in primary health care systems in LMICs and exploring best practices and strategies for strengthening primary health care. Most recently, in Astana, the World Bank released a resource for countries called the Primary Health Care Vital Signs Profile, which provides snapshots of the strength of primary health care in LMICs. The Profile captures data such as the amount the country spends on primary health care, the policies that prioritize primary health care, the accountability and engagement of leaders, and the quality of the care the population receives.

In addition, the World Bank has been involved in a number of other collaborations, including one with the Government of China aimed at strengthening primary health care in the country and another with Harvard University to develop a schematic of mechanisms and system-level functions required to deliver high performing primary health care.

Dr. Veillard concluded his remarks by stressing how health system change is complicated and hard, but possible. The measurement agenda is key because it will maintain pressure on governments and the private sector to deliver outcomes. High-performing primary health care is critical to human capital growth and preservation. Dr. Veillard looks forward to collaborating with the Besroul network in building stronger health care capacity in LMICs.

## **Dr. Nebiha Borsali Falfoul, Ministère de la Santé, Tunisia**

Dr. Falfoul presented the journey of family medicine in Tunisia, underscoring three key factors impacting the emergence and development of the discipline in the country: national health care reforms, a demographic and socio-economic transition, and the ever-evolving socio-political context. Since the 1960s Tunisia has made significant health reforms that have led to the improvement of certain health indicators in the country. These national reforms include establishing primary care centres, specialized hospitals and university medicine, national maternal health, child protection and family planning initiatives, and a national office of health and a national health insurance fund. The country's demographic and socio-economic transition has meant a decreasing birth rate and aging population



alongside the emergence in high rates of non-communicable diseases and growing urbanization. Finally, the socio-political context is critical in the contemporary health care reform in Tunisia. The revolution of January 2011 led to major political change and a greater sense of freedom, agency, and dignity among the population, who demanded change in the area of human rights, social and regional equity. As such, the New Constitution (January 2014) recognizes citizens' right to health and social security.

Through its commitment to achieving the SDGs and universal health coverage, the Tunisian government is making efforts to enhance primary health care through family medicine. The state has the goal of improving service delivery through a family medicine approach, with a target of having three family doctors per 10,000 inhabitants by 2030.

A Decree in November 2011 established a general framework for family medicine. The formalization of academic family medicine in Tunisia over the course of 10 years, including partnerships with the University of Montreal, led to the graduation of their first family medicine resident class in January 2017. The next steps for Tunisia is to recognize family medicine as a specialty, creating the academic departments and a college of family medicine, as well as having an accreditation process for family medicine.

## **Dr. Luis Alberto Giménez, Ministry of Health, Argentina**

Dr. Giménez presented the national health care system in Argentina and the current administration's health care strategy, particularly the role of the family medicine program in their efforts to attain universal health coverage. Argentina, a country of 44 million people, has mixed private and public system that is divided into three sub-sectors: social security insurance (covering 26 million people), private sector (2 million people) and the public system (16 million people). The public system guarantees all Argentinians the right to any public hospital, primary care centre, or public provider without paying for this service. The 16 million people who only have public coverage are the country's most socio-economically vulnerable.

Dr. Giménez highlighted how universal health coverage means more than episodic care, it means effective care with comprehensiveness, health promotion, and protection. Although well-intentioned, the three subsystems still largely operate from a disease and physician-centred model rather than one based on families and communities. Therefore, the current administration has a strong focus on universal health coverage, and the implementation plan has three axes: a family and community health approach, effective care with quality, and information technology. The administration believes that a family and community health approach, with family medicine as a key component, is necessary to achieve comprehensiveness, promotion, and protection.

Argentina has gone through an epidemiological transition where now 60 to 80 per cent of the causes of illness and death are due to chronic and preventable factors—alcohol, smoking, sedentary lifestyles, and obesity. Family doctors have strong role to play; however, there are challenges. Less than five per cent of physicians in the country are family physicians, they are not well remunerated, and they often leave



the discipline to pursue other specialties. Dr. Giménez believes that the CFPC and the Besroul Centre have a rich experience from which Argentina can learn, particularly in quality improvement in family medicine residency, incentive programs, and recruitment and retention of family doctors.

## **Dr. Vincent Cubaka, University of Rwanda, Rwanda**

Dr. Cubaka, the final panelist, presented the study that he and his colleagues from the Besroul Narrative Working Group conducted on Global Family Medicine Stories. The study was presented as a poster at the 2017 Besroul Forum, winning the best poster competition, and has been accepted for publication in *BMC Family Practice*. The focus of the study was to explore the traits that family doctors share despite differences across various social and cultural settings. A total of 135 family doctors, from 55 countries, participated in the study.

The key attributes identified were provision of holistic care, prevention and health promotion, comprehensive care, universal care, patient-centred and people-oriented, bridging family and community, proximity to community, rural health, continuity of care, and recognition. The shared traits identified were being specialists of common issues, an advisor and a leader, and being adaptable and versatile. The core family medicine values identified by the study were enthusiasm, human encounters, patient-provider relationship, enquiry, accountability, caring for the vulnerable, happiness and fun, and motivation.

The story booth was set up at WONCA 2016 in Rio de Janeiro, where participants were asked about key attributes of family physicians. The short two- to three-minute responses were video recorded. The stories that were collected may inspire and serve as clear and positive tracks for young programs. The expressed commonalities may foster the spirit of unity of global family medicine and boost common endeavours in improving global health through family medicine.

## **Discussion: Participant comments**

- In my experience I have seen such an emphasis on demand-side interventions, and so little on the supply side. Should we be perhaps investing more on the supply side, and going slowly with the demand side? (Dr. Anil Shrestha, Nick Simons Institute, Nepal)
- The Astana Declaration makes clear that we not only need increased numbers of primary care professionals, but that we need them to have the right competency. Coming from an LMIC, this is one of the questions that I grapple with, especially given the challenge of a brain drain. Therefore, how do we increase that critical mass of people in the country that can diagnose and provide quality care? Secondly, how can I hold my own country accountable to this declaration and values? Are there examples? (Dr. Kenneth Yakubu, University of Jos, Nigeria)
- We know there are many primary care interventions that work, how do we scale up these interventions? There is a need for more implementation science research. Is there any initiative



aimed at building capacity of researchers in LMIC to scale up interventions to improve primary care systems? (Dr. Aboi Madaki, West African College of Physicians, Nigeria)

- From my experience, in LMICs we can start many programs and they take off, but many times there is a lack of a sustainability strategy. Is there a clear methodology for sustaining programs, and maintaining partnerships with stakeholders such as policy makers and funders? (Dr. Innocent Besigye, Makerere University, Uganda)
- What do each of the panelists, in their level of professional engagement, do to promote sustainability? As we know often governments last three to four years and then they change. Family doctors, in many parts of the world, work with patients over a long period of time, but sometimes this doesn't happen, like in some LMICs. What can be done to promote sustainability? (Dr. Adelson Guaraci Jantsch, Sociedade Brasileira de Medicina de Família e Comunidade, Brazil)
- How have you been able to attain a good universal health coverage? How have you been able to train and distribute primary care professionals? We know that in some LMICs, like Tanzania, many of the human resources are located in urban areas, so I am interested to learn about how human resources can be better distributed (Dr. Donatus Mutasuinga, Markham-Stouffville Hospital, Canada)

## Socially Accountable Family Medicine Worldwide: The critical role of deans and academic leaders

Chaired by Dr. Ahmed Maherzi, Université de Montréal, Canada

Dr. Maherzi chaired a panel of seven deans and vice deans who offered their perspectives on the critical role of faculties of medicine and academic leaders in promoting socially accountable family medicine.

In his opening remarks, Dr. Maherzi revisited the key messages of the First Global Conference on Primary Health Care and the Declaration of Alma-Ata (1978), and the recent Declaration of Astana (2018) where health is seen as a pre-requisite, result, and indicator of all aspects of sustainable development. Citing the work of Dr. Barbara Starfield, he reiterated family medicine's key role in achieving health equity and ensuring the health of people and communities. Therefore, family medicine has a key role in the social accountability of medical schools.

In 1995 the WHO defined the social accountability of medical schools as “the obligation to direct their education, research, and service activities toward addressing the priority health concerns of the community, the region, or nation they have a mandate to serve, with particular attention to the most vulnerable populations.”<sup>2</sup> Further, if we look at the partnership pentagon (see Figure 1), academic institutions occupy a key place.<sup>3</sup>

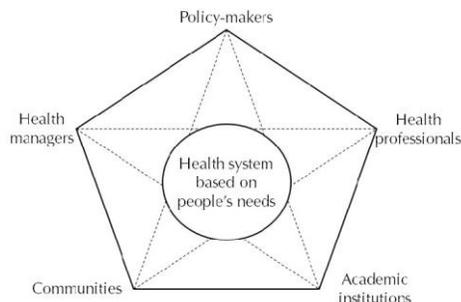


Figure 1. Partnership pentagon

It is through training socially accountable physicians who are committed to society and advocating for their patients that medical schools will contribute to realizing the goal and challenge of achieving quality health for all and improving equity.

Dr. Maherzi posed the broader question—how do we train socially accountable physicians—and invited the deans and vice deans to comment on the following:

Three Questions for the Deans



1. How can deans/faculties of medicine train and motivate their undergraduate students to improve primary care?
2. How can deans/faculties of medicine train and motivate their postgraduate students to be socially accountable?
3. How can deans/faculties of medicine integrate family medicine as a specialty?

### **Dr. Roger Strasser, Northern Ontario School of Medicine, Canada**

Dr. Strasser indicated that before anyone is an undergraduate student there is an issue of who is selected into medical school. The key is to have an admission/selection process that reflects the population that the medical school has a mandate to serve. This is a large part of social accountability. The concept that the whole school and its activities—training, research, and service—address the priority health concerns of the community. It is important that students admitted to that school reflect that population and its various sectors, and this varies from country to country.

Medical students should have exposure to family practice and family medicine role models as undergraduate students so that they are exposed to family medicine as a cornerstone of health systems, and also see it as an exciting profession they may wish to pursue in the future.

### **Dr. Jean-Luc Dumas, Conférence Internationale des Doyens des Facultés de Médecine d'Expression Française (CIDMEF)**

Dr. Dumas sees the work of a dean as significant for improving the academic position of family medicine. The faculty should be oriented toward primary health care. The faculty ought to be organized around the global vision of serving the territory. This primary health care orientation must include a vision of social accountability, and faculties should organize all student activities around this spirit so that they understand why they are in the faculty. Deans should work with administrators, assistants, and support staff so they understand the global vision and so they develop pride in the work of their faculty as they represent the population. Partnerships with the community are an important part of social accountability and serving the people in the territory.

In their management, deans and academic leaders must be disruptive. Waiting for the budget or consensus may mean waiting for forever. Academic leaders need to take some risks and position themselves strongly. The CIDMEF is large organization, with many country members with medical faculties. A CIDMEF role, among others, is to help faculties choose if and how family medicine will become a specialty and help support the process. The academic foundations of family medicine are not isolated, and they are intimately linked to social accountability.

### **Dr. Hélène Boisjoly, Université de Montréal, Canada**

Dr. Boisjoly highlighted the importance of students being exposed as early as possible to primary care role models. It is important for deans to approach community care with concrete examples, not just a



theoretical perspective. Current and future family doctors are those most needed by the populations in an era of technology and artificial intelligence. The population will need professionals who can integrate huge amounts of knowledge, explain it, and ensure that everyone receives the best possible treatment. The world will need more family doctors in the future. Finally, schools and government need to find ways to better support the development of clinician scientist programs and nurture research in their programs.

### **Dr. Maimun Syukri, Syiah Kuala University, Indonesia**

Dr. Syukri commented that it is clear that across different countries there are different systems. In his faculty at Syiah Kuala University, they have a family medicine department and all undergraduate students undergo four weeks of training in public health centres in Banda Aceh. It is also mandatory for all postgraduate learners to do a one-year placement in a public health centre. Currently, however, they do not have a family medicine specialty.

Dr. Syukri and his colleagues have been collaborating with the Besroul Centre and McMaster University in assessing the family medicine faculty development needs at his university and have published this work.

### **Dr. Hery Nirina Rakoto Ratsimba, Faculté de Médecine, Université d'Antananarivo, Madagascar**

Madagascar is beginning to establish family medicine. The dean and his team at Université d'Antananarivo are motivated to reflect on the importance of primary care and social accountability, and frequently work with personnel from the Ministry of Public Health. However, in the current system medical training generally happens in the large hospitals in major cities, despite the fact that a significant portion of the population lives in rural and isolated areas, without electricity, and in conditions of poverty.

The Université d'Antananarivo will be participating in a meeting with the Ministry of Public Health, deans of faculties of medicine in Madagascar, the Ministry of Higher Education, and experts from the University of Laval. The goal of the meeting is transforming medical education in Madagascar so that it is in line with what is happening on the ground in the country.

Dr. Rakoto Ratsimba believes it is critical to work with other sectors, and other ministries to develop strong primary care oriented toward the needs of the population. Regarding the development of family medicine, he believes it will happen with time and perseverance. And, his faculty has a dean who is committed to social accountability.



## **Dr. Mohamed Jouini, Université de Tunis El Manar, Tunisia**

In Tunisia primary care was well developed in the 1970s but there was an evolution of different specialties that resulted in specialties and general medicine. The first promotion of family physicians graduated this year.

The dean must recognize the importance of the social accountability of medical schools and have experience in collaboration between universities, authorities, and politicians. The teaching in faculties must be aligned with needs in the country, especially when it comes to health care. The selection of students must be based on needs of the community. For example, the University of Tunis is engaging in creating primary care internships for students in rural areas and away from the large cities. It is essential that faculties have courses adapted to what a family doctor should be.

## **Dr. Lynn Wilson, Faculty of Medicine, University of Toronto, Canada**

Dr. Wilson asked the group to reflect on the reframed question: how can we get a large number of students to choose a career in family medicine at a research-intensive, subspecialty-focused medical school? The first step should be for university presidents to appoint deans of medicine who walk the talk regarding the social accountability of medicine. The next step is for the deans to inform themselves about the growing body of evidence about the positive impact of primary health care systems on improving health and reducing costs. The faculty of medicine's strategic plan should include a plan for advancing the social accountability of medicine. The medical school has to be careful in who it admits to its school.

In the early 2000s the University of Toronto (U of T) put together a generalism task force, which was charged with dispelling common negative biases toward the discipline of family medicine within the medical community. The task force identified a significant need for student exposure to family medicine during medical school. Since then some of the developments have been establishing a student-led family medicine student interest group, increasing the number of family physicians in pre-clerkship teaching, creating the family medicine longitudinal experience, and creating the family medicine clerkship. Family medicine teachers participated in reviews of all problem-based teaching cases to make sure the perspective of family medicine was considered.

Today, one third of the undergraduate medical teachers are family physicians, including the director of the Foundations Curriculum, the first two years of the MD program. A family physician led the restructuring of a mandatory research course, family physicians serve as leads in areas such as Black health, LGBTQ health, and leadership. The director of the U of T's Wilson Centre for Research on Medical Education is a family physician. Academic leaders have engaged the community—examples include Inner City Health, the Temmy Latner Centre for Palliative Care, addiction medicine/mental health, and care of the elderly, among many others.



## Discussion: Participant comments

- A question for Dr. Lynn Wilson: do you have a mandatory research component at both the undergraduate and graduate levels? And do students have to finance their research training? (Dr. Ichsan Ichsan, Syiah Kuala University, Indonesia)
  - At the undergraduate level the U of T has all students participate in a health services research course, some participate in a special MD/PhD stream, some do a summer program, and others an 18-month program. In the family medicine postgraduate program there is a clinician-scholar program where, instead of a two-year residency, students will do three to four years of residency and obtain a master's degree. Two thirds of tuition is covered for family medicine residents doing master's and half of the tuition for those pursuing PhDs. (Dr. Lynn Wilson)
- If health care transformation is no more than moving resources in the system, how do we convince specialist colleagues to give up resources to nurture family medicine?
  - We have to give more value to social accountability in our schools. In Quebec the four medical schools decided to make social accountability a priority. Social accountability is a good way to develop family practice. According to the WHO and the SDGs we have to work together (family physicians, other medicine specialists, allied health professionals, civil society) to respond to the needs of the population. And if we stay focused on this, the money will go where it needs to. (Dr. H  l  ne Boisjoly)
  - We need to start with the health needs of the population, to be outcomes focused. If we think back to the partnership pentagram, at the centre is addressing the health needs of the population. Often it is the policy-makers making the decisions—sometimes they may ask the health services managers for input, they might ask providers, may even ask academics, but communities too often are left out. If we want to level the playing field, the key to the reallocation of resources is social accountability and active community participation. (Dr. Roger Strasser)
- How do we ensure that our faculty has an understanding of issues such as social accountability, cultural safety, anti-oppression, and our history of colonization? Do you have examples of faculty development on social accountability? (Dr. Ritika Goel, University of Toronto, Canada)
  - At the U of T, Dean Dr. Trevor Young appointed a Chief Diversity Officer. The faculty started collecting data looking at the background of medical school classes and found that there were some populations that were significantly under-represented including Black, Indigenous, and Philippine communities. The faculty created specific pathways for these populations. The medicine leadership is also advocating at a higher level, beyond faculty so that the university pays more attention to issues of diversity. (Dr. Lynn Wilson)
- How do we train our faculty and senior administrators to be more socially accountable? We all do bits and pieces of social accountability, but in academia we are typically held accountable for other



deliverables such as grants, or being principle investigator, not the process of health services delivery or social accountability. What do we do when the deputy minister calls us to report? (Dr. David Morris, University of Alberta, Canada)

- The Northern Ontario School of Medicine (NOSM) was created with a social accountability mandate in everything it does. Maybe NOSM is the exception to the rule, but in the past 16 years all of our schools have been making a commitment to social accountability. With regard to reporting, we have been documenting our outcomes so that we can show value for money spent. (Dr. Roger Strasser)
- NOSM is a great example and was able to establish itself in an era where social accountability is being called for. For older schools such as Université de Montréal, which is 175 years old, the faculty was not traditionally formed with this approach. Therefore, it had to look to the needs of the population, and in Montreal they were end-of-life care, refugees, and Indigenous health. The faculty has been trying to bring the different medical specialties together with family medicine to respond to the needs of the community and making space for family medicine leadership. (Dr. Hélène Boisjoly)
- It is important to establish a culturally-based definition of social accountability. For schools that are new to the concept of social accountability, a needs assessment survey of the different stakeholders—students, learners, and administrators—is necessary to clarify and define what social accountability means in that context. (Dr. Baraa Alghalyini, Al Faisal University, Saudi Arabia)
  - The link between the ministry of health and the faculty of medicine is a critical one. While the university produces the physicians, there is an aspect of territorial organization that corresponds to regional and national governments and the connections between them is important for responding to the needs of the population. (Dr. Nebiha Borsali Falfoul)



## **Family Medicine Innovations: Snapshots from around the globe**

Moderated by Dr. Kenneth Yakubu, University of Jos, Nigeria

Dr. Yakubu introduced and moderated the session highlighting family medicine innovations around the world. In his opening remarks he highlighted how Canada has a great success story in family medicine, as do other countries. Although success may look different, it is important to share successes from countries where family medicine is new and emerging. The presentations from Besrou colleagues from LMICs may be an opportunity for reverse innovation, and for Canada to reflect on how to improve an already strong system. Furthermore, it's an opportunity to celebrate the important achievements of colleagues from around the world and offer our support.

### **Successful Home Visits Experience in a Family Medicine Residency Program in Saint Marc, Haiti**

#### **Dr. Rodney Destine, Zanmi Lasante/Partners in Health, Haiti**

Dr. Destine presented the Home Visits initiative at the Family Medicine Residency Program in Saint Marc, Haiti. He highlighted how around 40 per cent of patients hospitalized at Saint Marc Hospital have palliative and complex needs. To respond to community needs, he and his colleagues at Saint Marc Hospital developed a Home Visits initiative that takes a holistic approach and provides a unique opportunity to better understand the local environment, the psychosocial aspects of patient's health, and how the social determinants of health affect the lives of the patients and families they serve, thus addressing the health advocate role.

The objectives of the Home Visits program include being able to assess community needs, the patient's social and living conditions, and health practices, and to provide appropriate health education, basic health services, palliative care, and psychosocial support to patients and families. A key objective is to establish a close relationship to patients as part of a health promotion strategy. There is a strong teaching component to this program. During the home visits faculty provide bedside teaching; following the visits they debrief the experience with learners, reflecting on how the visit contributes to and supports patient care.

Achievements to date include an increase in the frequency of visits from two days per month to weekly, more 50 visits per year. Three to five patients are seen per visit. The team has found the home visits to be a rewarding activity in training residents. Patients and their families are often grateful and express their comfort as they feel respected, fully supported, honoured, and, more importantly, that their dignity is restored.



## Discussion: Participant comments

- An inspirational presentation. In our country we have a great divide between the care of people in their homes and in institutions. Haiti's model of home visits provides a potential solution for bridging this gap. (Dr. Robert Woollard, University of British Columbia, Canada)
- It seems like the visits are very intensive. Aside from the home visits, how is care coordinated? (Dr. Stephen Cashman, Locum Physician, Canada)
- Is geography a barrier? (Dr. David Ponka, University of Ottawa, Canada)
  - The visits are intense, and you need the human resources to be able to do this—faculty members, residents, PGY3s and PGY2s, sometimes PGY1s, nurses, and psychologists. There are weekly visits, sometimes twice per week. Patients don't pay, since it is part of our family medicine mandate. But of course, money is needed for fuel, to buy medicines for patients, and yes, distance is a barrier. (Dr. Rodney Destine)

## Family Medicine Residents' Annual Health Fair in Saint Marc, Haiti

### Dr. Emmanuel Fabrice Julcéus, Zanmi Lasante/Partners in Health, Haiti

Dr. Fabrice Julcéus presented the Annual Health Fair Initiative of the Family Medicine Residency Program in Saint Marc, Haiti. The Annual Health Fair is part of the three-year family medicine curriculum, which has strong community, social, and preventive medicine components. The Annual Health Fair is a mandatory project for the third-year residents. The objectives of the initiative are that third-year residents demonstrate leadership and management capacity in mobilizing colleagues and communities around a health activity, contribute to health promotion in the community, and create awareness of family physicians and their important role in health.

The Annual Health Fair, a one-day event, is held in a public venue, and different booths and stations are set up. For example, there are booths for health education, screening, product distributions, simulations, and family medicine information.

Accomplishments to date include five fairs, from 2014 to 2018, successfully led by residents, with more than 50 faculty, staff, and resident volunteers involved each year. Each year there have been over 1,000 participants and awareness has been raised around women's and children's health, chronic and infectious diseases. There have been screenings for HIV, cervical cancer, diabetes, and hypertension, and product distributions such as contraceptives, hygiene kits, and mosquito nets/repellent. Importantly, through the fairs, awareness has been created around the importance of family medicine: what it is, where to access it, when, and why.



## Discussion: Participant comments

- When you do the screenings at the fairs do you know how many people are retained as patients at the primary care centre?
  - A follow-up appointment is arranged for people who do screenings at the fair. A big proportion come back to the centre. (Dr. Emmanuel Fabrice Julcéus)

## A Comprehensive Collaboration Fostering Primary Health Care in Brazil

### Dr. Samuel Soares, Santa Marcelina Primary Health Care, Brazil

Dr. Soares highlighted the international collaborations to strengthen primary care in which Santa Marcelina Primary Health Care in Sao Paolo, Brazil, are engaged. Brazil is one of the largest economies in the world yet has among the highest levels of social inequality. Sao Paolo's population is over 20 million. The Santa Marcelina Group is located in the eastern part of Sao Paolo, one of the poorest areas of the city, and cares for approximately 2 million underserved people. Santa Marcelina has three hospitals and 68 clinics with 200 teams to take care of this population; the teams are located in the *favelas*.

Santa Marcelina is recognized as having one of the best family medicine undergraduate programs in Brazil, and a significant number of national and international publications for fostering primary health care. Furthermore they have developed an innovative team model, with professionalism, social accountability, and a horizontal organization to address non-communicable diseases, maternal and child health, patient safety, mental health, and emergencies in primary health care.

Engaging in partnerships is an important part of Santa Marcelina's work. Santa Marcelina has partnerships with McGill University, the U of T, and the Besroul Centre. The partnership with McGill University focuses on faculty development and research capacity strengthening. With the U of T, the partnership is that each year one or two PGY3 fellows in Global Health and Care of Vulnerable Populations from Toronto spend up to three months at Santa Marcelina. There is planning for future exchange of undergraduate students. Finally, with Dr. Clayton Dyck and the Besroul Centre, the partnership centres on curriculum design for undergraduate education and evidence-based learning.

## Primary Care and Family Medicine in Brazil

### Dr. Adelson Guaraci Jantsch, Sociedade Brasileira de Medicina de Família e Comunidade, Brazil

Dr. Jantsch addressed family medicine and primary care in Rio de Janeiro, Brazil. Brazil is a place of polar extremes where the poor live alongside the rich. Brazil is also living a polarized epidemiological transition, with a high prevalence of chronic health conditions, violent deaths, and infectious diseases.



Brazil's health system is two-tiered. There is a public system that covers approximately 75 per cent of the population, and a private system (in the form of private insurance and out-of-pocket payments) covering the other 25 per cent of the population. However, public health care costs represent 3.59 per cent of the gross domestic product whereas the private system represents 4.41 per cent.

In 1994 the National Family Health Program was introduced as a federal policy for the country. The 10 policy commitments were:

- Health protection and promotion
- Geographically delimited areas
- Interdisciplinary teams
- Teams living in the community where they work
- Community engagement in health promotion
- Comprehensive and continuous care
- Coordination with the local health system
- Continuous professional education
- Higher salaries
- Encouragement of community participation

The policy allowed for funding to the municipalities and laid down a strategy for primary care reform.

Community health agents play a central role in the Brazil's primary health care system, as core members of the Brazilian primary health care strategy. They must live in the family clinic's catchment area, are the connecting point between primary health care professionals and the community, know their community's main health problems, and their focus is not merely disease conditions, but prevention.

The achievements of the Rio Family Medicine Residency Program include growing from 60 places in 2012 to 150 in 2018 and 100 preceptors, two thirds of whom were students in the program. All preceptors must be members of one of our different committees including a committee on multimorbidity, research, quality improvement, health systems, and others. Challenges include financing residencies and the current cancellation of a program for foreign doctors, namely doctors from Cuba. In the current political climate and its uncertainty, the Government of Cuba decided to take their doctors out of Brazil, which will represent a significant loss for the primary care sector.

## **Discussion: Participant comments**

- What are the chances of Rio's graduates filling the rural spots left by Cuban doctors?
  - Brazilians are able to apply for rural spots, but typically half of these spots were occupied by Cubans. Cuban doctors are really good doctors, they did a great job in Brazil and we have to be grateful to them. I am very sorry to hear this news. (Dr. Samuel Soares)



- What have you done in Brazil that you have three institutions from Canada collaborating with you? (Dr. Aboi Madaki)
  - Perhaps our attractiveness to partners is related to the National Health System in Brazil and our strong primary health care, especially after 1994. Santa Marcelina is located in the eastern part of Brazil, an area where there is a lot of poverty, but this group has been working closely with the communities since the 1960s. Perhaps it also has to do with the group's leader Sr. Monique, a family doctor from Canada. (Dr. Samuel Soares)
  - If you knock on doors and ask for help, you can find a lot of willing collaborators. With regard to the Cuban doctors, it is a shame that we are losing them. (Dr. Adelson Guaraci Jantsch)

## **Family Medicine in Ethiopia**

### **Dr. Sawra Getnet, Department of Family Medicine, Addis Ababa University, Ethiopia**

Dr. Getnet presented the development and achievements of the Addis Ababa University (AAU) Family Medicine Program. Ethiopia is a country with a population of approximately 100 million people and it is a young population. The initial discussions concerning family medicine in Ethiopia date back to 2008 and culminated in a note from Dr. Atalay and Dr. Miliard to Dr. Tedros, Minister of Health, in August 2011. This communication described family doctors who could lead district hospitals, supervise general practitioners and other health professionals, and deliver life-saving clinical services. Dr. Atalay and Dr. Miliard identified family physicians as “specialists trained at the postgraduate level to serve as frontline clinicians and to prevent and manage common problems for patients of all ages-for everyone in the family including pregnant women, children, and adults.” In October 2011 the Federal Ministry of Health officially approved the concept and requested that AAU proceed with plans to develop a new residency program in family medicine.

The Family Medicine Program was developed in partnership with the U of T and the University of Wisconsin, and started in February, 2013. Since then there have been 18 graduates of the three-year program. In their first year, residents are required to complete a quality improvement project and in third year a mandatory research project. During the third year, there is a heavy skills-based curriculum with a focus on obstetrics and surgery given the needs of the population. Residents also do a one-month rotation in palliative care.

The strengths of the program include having a family medicine department; being the only family medicine program in Ethiopia; focusing on palliative care, research, mentorship; and having formed a



Family Medicine Society. The challenges are a lack of a family medicine-specific teaching site and that teaching is not a requirement of the program.

Opportunities for the program include a new Federal Ministry of Health (FMoH) residency matching system, faculty recruited from the graduate pool, a palliative care mandate given by the FMoH, the creation of a Society for Family Medicine, and partnerships with the U of T and other volunteers.

## **Drug-Resistant Tuberculosis in Aceh Province, Indonesia: Threats and challenges**

### **Dr. Ichsan Ichsan, Syiah Kuala University, Indonesia**

Dr. Ichsan Ichsan presented about drug-resistant tuberculosis (TB) in Aceh, which remains a significant problem in Indonesia as in other LMICs. There is a significant gap between treated and non-treated drug-resistant TB. The government of Indonesia has set up a National Surveillance System to report TB cases from the sub-district to the district and federal levels, but it is not a perfect system. The data show there is a significant number of people who do not seek treatment. A major problem is the loss of patients for follow-up and retention in the treatment program and many hospitals don't have reliable data. The reporting is improving and many hospitals are now using GeneXpert to detect drug-resistant TB, but not all hospitals have the technology. Therefore, there are significant gaps in the data and there is a high proportion of missing patients that are not being detected. Many patients who suspect they may have drug-resistant TB do not go to the hospital and they may seek other types of treatment such as traditional treatment.

The major causes of drug-resistant TB in Aceh are poverty and lack of education, incomplete therapy by patients, lack of diagnostic equipment, and lack of skilled providers to diagnose and treat the condition.

Indonesia's plan to manage drug-resistant TB includes a political will to eradicate the condition, case detection by sputum smear and microscopy, a standardized treatment regiment, an improved drug supply, and a good recording and reporting system.

### **Discussion: Participant comments**

- Looking at Ethiopia with a population of 100 million people and 18 family medicine graduates to date, are there plans to scale up? (Dr. Vincent Cubaka)
  - There is currently a plan to start two new residencies in family medicine (Dr. Sawra Getnet)
- In Rwanda, there is also a problem of drug-resistant TB and given the seriousness of the problem when it concerns drug-resistant TB, there can sometimes be aggressive approaches to demand people take treatment (Dr. Vincent Cubaka)



# **Modified World Café: Besroul Centre current and future state/reflections of the global family medicine community**

## **Update on the Research Working Group**

### **Dr. David Ponka, University of Ottawa, Canada**

Dr. Ponka provided an update on the research activities of the Besroul Research Working Group over the past year. He began his presentation by encouraging partners to create research committees in their own environments and stressed the importance of implementation science research.

Dr. Ponka acknowledged the Research Committee and the Scientific Committee for excellent work to increase the poster submissions to the Besroul Forum. There was an increase from 15 posters in 2017 to 22 in 2018. The Research Working Group has published papers in *Canadian Family Physician*. There were five papers, and one is forthcoming, in the first Besroul Paper Series focusing on methodology in family medicine research. The second series of papers, a between-country comparison of family medicine and primary care in Canada and Brazil, was launched in November 2018 with two articles in *Canadian Family Physician*.

The committee still largely relies on volunteers. The next challenge is to keep thinking about funding models, perhaps fellows and research assistants. Alignment is also important, and the committee has aligned itself with many organizations including: Sociedade Brasileira de Medicina de Família e Comunidade (Brazil), Réseau international francophone pour la responsabilité sociale en santé (RIFRESS), the WHO, WONCA, and Ariadne Labs, among others. With Ariadne Labs the group has an important seat on a major research project that is looking at unmet needs in family medicine around the world.

At last year's Besroul Forum the research priorities identified by the group were mental health in primary care, supporting new family medicine graduates, and how to best set up team-based care, themes that continue to be salient and kept coming up at the most recent North American Primary Care Research Group Conference.

Dr. Barkley asked the group to do a scoping review of leadership in family medicine and of how to support new graduates to develop leadership skills. On the subject of mental health, there have been discussions with Dr. Patrick Chege to work on a project about mental health screening by community agents in Kenya.

Dr. Ponka concluded his update by reiterating that there is enough evidence in family medicine to affect policy. There are tools such as GAPMaps, where you can see what studies and of what quality have been



done in different areas. Efforts should be directed at filling gaps such as mental health research as well as working with a transdisciplinary approach.

Dr. Ponka posed the following questions to the group:

- How do you think we should be moving from knowledge synthesis and generation to knowledge implementation?
- In what areas should the research focus?
- Should the Besroul Centre be defining a focus or staying general?
- What are the funding opportunities to make this happen and the needed human resources?

## **Report from the Faculty Development Working Group**

### **Dr. Lynda Redwood-Campbell, McMaster University, Canada**

Dr. Redwood-Campbell provided a brief report on the work of the Besroul Faculty Development Working Group and expressed her excitement about the direction of the group's work.

Several years ago the Working Group conducted a focus group among Besroul members, who were asked about the faculty development needs in their own setting; 10 different countries and 12 different universities were represented. The results of this work was recently published in *Education for Primary Care*. One of the themes that came out of this research was the need for templates to be developed over time by the group, using competency-based approaches to family medicine training. Dr. Redwood-Campbell asked the audience to consider the following questions in their world café discussions:

- What would a template look like in terms of a workshop that could be developed in your own area?
- What pieces would you like to see in it?
- Are there gaps that need to be filled in your area?

Dr. Redwood-Campbell concluded by stating that the Medical Education Working Group and the Continuing Professional Development Group have merged. The challenges, opportunities, and activities of both groups are similar, so it makes sense to combine the groups and have them feed off of each other. The new group is the Medical Education and Training Working Group.

## **Modified World Café and Reports from Table Discussions**

### **Moderated by Dr. Katherine Rouleau, University of Toronto, Canada**

During the World Café session, the audience was asked to break out into different groups, or stations, according to five themes: leadership, research, community engagement, education, and team-based care.



The participants were free to choose the station in which they wanted to participate and were given 20 minutes to discuss, as a group, directions for the Besroul Centre in the respective theme. After 20 minutes participants were given the choice of staying at their original station or switching to a new station for the second 20 minutes.

The group naturally divided into four stations—leadership, research community engagement, and education—of approximately equivalent size (8-10 people per group). There was no uptake for the team-based care theme. After 20 minutes, despite having the option to move, everyone except one individual stayed at their stations.

## Report from the Education Table

The education table identified the following future directions, recognizing that everyone is at a different stage of family medicine development:

- Develop a template for training to be used in different contexts of family medicine teaching to address health system needs
- Share documents that already exist, such as WONCA standards. These documents could be helpful for colleagues who are in environments where family medicine is just beginning to be developed.
- Develop a platform for sharing different experiences, what has or has not worked
- Share curriculum development experiences and content for undergraduate and postgraduate teaching
- Exchange of knowledge between sites such as the Chinese and Canadian family medicine programs that have received WONCA accreditation and other sites that might be thinking about seeking that accreditation

How do we get there?

- Develop a strategic plan for the Besroul Education Working Group
- Volunteer experts are needed in some areas (e.g., curriculum development, health systems strengthening) to go to other countries to support colleagues in the areas where support is needed. Identifying experts in different areas is an important step.
- Strengthen collaborations to keep momentum going on projects in between Forums

What are the next steps?

- Having a good platform is important, and the Besroul Centre has been providing that
- Developing a needs assessment template, to identify needs within a particular training context
- Beginning by looking at what needs assessments already exist and building on them

Who else should be involved?

- It will be different in different contexts



## Report from the Community Engagement Table

The community engagement table identified the following future directions:

- Define community and community engagement. Patient and community engagement means different things to different people, and engagement can take place at different tiers.
  - Community engagement is one of the pillars of the partnership pentagram, it gives balance to the pentagram, it is not an ideology, but a mechanism for translating ideas into reality
- Build true partnerships: community engagement has to be a true partnership. It is often tokenism, where clinicians/advocates/administrators/politicians say they have spoken to a community. However, the objective should be to empower, so that the community has the ability to influence the direction of what their needs are.
- Move from focusing on needs to focusing on strengths. It is important to take an appreciative inquiry lens and ask what success stories are happening around community engagement, especially in the Besroul Group. This may help elucidate what creates success.

How do we get there?

- Collect success stories in the Besroul community and conduct a thematic analysis to identify key elements of community engagement that others could learn from. Besroul could be a hub for collecting these stories. It would be ideal if there was an interactive space where these stories could live and be exchanged.
- Make community engagement an all-encompassing theme or create a community of practice to expand the learning, since community engagement intersects with the other parts of the partnership pentagram and also involves research, education, leadership, and team-based care.

What are the next steps?

- Find a place where this project could live
- Find success stories from the Besroul community and build on them, creating a community of practice to amplify learning

## Response from Dr. Shannon Barkley

It's wonderful to see these topics that are discussed at a high theoretical level at the WHO being brought to application. It is striking to see how the Besroul Centre is at a crossroads: on the one hand continuing the work as a group and community, and on the other hand amplifying the learning to the broader global community and to make that learning accessible.

## Report from the Leadership Table

The leadership table identified the following future directions:



- Leadership needs to be developed as a quality in students, residents, and colleagues
  - Leadership is seen as showing the way to engagement/commitment, and in turn engagement and commitment leading to leadership.
- Actions of social commitment and engagement have to be fostered within the training environment. Student and resident initiatives should be supported, and they will do wonderful things. They are good communicators and very talented at social media. Giving trainees space to initiate activities and mentorship will go a long way to develop them as leaders.
- Students need to be guided toward primary health care so they can be leaders for family medicine, and their leadership should be encouraged early

How do we get there?

- Residents should do training in the community as soon as possible, outside of tertiary hospitals, in community health facilities
- Training should be ambulatory, distributed across the territory not kept within the capital city, and it should be supervised (with tutors and preceptors), rather than just abandoning the trainee in an environment they don't know

## Report from the Research Table

The research table identified the following future directions:

- Develop more collaborative research, especially in common shared issues
- Improve the quality of research and move from volunteer work to professional research endeavours

How do we get there?

- Develop resources and training, as not everyone is at the same level of skills in terms of research methodologies in primary care
- Create a research platform or repository of research to facilitate communication
- Develop/run training about methodology to do implementation research and knowledge translation
  - The WHO has some resources in implementation research
- Increase participatory research and trans-disciplinary research.
- A twinning model with north-south students matched to develop a proposal to respond to issues in the south.

What are the next steps?

- Further reflection on ideas discussed and on how to fund research, since quality research requires funding

Who do we involve?



- Research teams in our settings, stakeholders, community leaders, and policy makers

## Response from Dr. Shannon Barkley

- The leadership group raised some good questions, what is the purpose of leadership, and what is the purpose of family medicine? An important question to ask is how can family medicine lead health systems?
- The research group also raised important points, from building capacity to improving the quality of research generation. I agree that implementation research is the way of the future.

## Discussion

Following the presentations by each of the tables, a group discussion highlighted the following points:

- There is a need to create a database containing information on each member of the Besroul Centre. (Dr. Ihsan Ihsan)
- The themes discussed (leadership, research, education, community engagement) are all interconnected. Instead of seeing the four areas as destinations, we should see each as roots and motors. (Dr. Ahmed Maherzi)
- Family medicine is not the end point, it is a means to an end. So, we should advocate for family medicine, and grow the discipline as a means to keeping people and communities healthy. (Dr. Shannon Barkley)
- There has been a lot of discussion around having an online platform for the Besroul network, a discussion that has been going on for a few years. How do we make it happen? (Dr. Rodney Destine)
  - There is a platform created by the WHO that is free of cost and can host communities of practice. There is a significant time investment in moderating these platforms, but this space exists and the Besroul Centre is invited to apply to host a community of practice on the platform. (Dr. Shannon Barkley)
  - All participants in attendance were in favour of the Besroul Centre looking into using the WHO platform
- The CFPC has agreed to support the Besroul Centre through providing \$500,000 per year over the next five years. A portion of this funding will go toward funding two positions: an education lead and a research lead. The Besroul Centre is also in the process of hiring a research assistant who could help with the Centre's various research activities. (Dr. Katherine Rouleau)
  - The research assistant could liaise with the different research teams of the international Besroul partners (Dr. Ihsan Ihsan)
- As the Besroul Centre expands and is linked to large pots of funding, it should be cautious about keeping its diversity and not try to homogenize. The Centre should be cautious not to fall into linear



forms of thinking, but maintain its diversity and complexity, and celebrate and use its differences.  
(Dr. Robert Woollard)

## Wrap-up/Closing Session

Dr. Rouleau provided a summary of the different sessions making up the Besroul 2018 Forum. She thanked those who joined the conference for the first time.

The session had two main objectives. The first was to wrap up the meeting, and the second was to tell those who are new about the Centre and its activities.

The Besroul 2018 Forum started the week on the momentum of Astana Declaration and the commitment to a renewal of primary health care. Presentations from five international leaders—respectively representing the WHO, the World Bank, the Ministry of Health of Argentina, the Ministry of Health of Tunisia, and the University of Rwanda—spurred reflection on the Astana Declaration and the role of primary health care in achieving health for all.

The three pillars of primary health care as defined by the Declaration of Astana are multisectoral policy and action for health, empowered people and communities, and primary care and essential public health functions as the core of integrated health services (see Figure 2).



Figure 2: The components of primary health care<sup>4</sup>

The technical background document to the declaration, *A Vision for Primary Health Care in the 21st Century*,<sup>4</sup> defines what kind of primary care is expected in order to achieve equity, and that includes robust, high quality primary care that contributes to continuity, comprehensiveness, continuity, coordination, first contact, and person centredness.

The second day saw a panel of deans speaking to the theme of social accountability, organized by Dr. Ahmed Maherzi, a dean with deep experience in what it means to be a dean with a vision to usher in family medicine in a country. The panel discussed the important role of faculties of medicine in advancing social accountability in different contexts.



There were country presentations on family medicine and primary care innovation in many settings, including Brazil, Haiti, Indonesia, and Ethiopia that provided concrete examples of projects responding to concrete needs on the ground.

The conference ended with a rich discussion about the essential role of education, research, and community engagement, and leadership in strengthening family medicine and primary health care globally. There were other presentations, including one by the Faculty Development Working Group about creating a template for family medicine faculty development around the world. There was also the signing of a Letter of Intent between the CFPC and the West African College of Physicians.

Dr. Rouleau invited all participants to offer their perspectives and experiences at the 7th Annual Besroul Forum.

## **Discussion: Participant comments**

- I learned about social accountability, and how it is being understood in different cultures. I am reflecting on how to bring social accountability back home to Saudi Arabia. (Dr. Baraa Alghalyini)
- There is much for us to learn from low- and middle-income countries that can inform our practice. It is always going to be in a reciprocal relationship, and the Besroul Centre is one way that this reciprocity can be magnified. (Dr. Warren Bell, Canadian Association of Physicians for the Environment, Canada)
- This was a special week for me. We initiated an approach to start a collaboration three years ago. This week was a culmination with the signing of an expression of interest letter with the CFPC. (Dr. Aboi Madaki)
- The Besroul Forum has once again been an expression of the generalist approach to life: keeping the whole intact, as you attend to the different parts. (Dr. Robert Woollard)
- When we look across the world, we have the same solution for strengthening primary health care, family medicine, and general medicine. (Dr. Jean-Luc Dumas)
- It is important for us to assume leadership, hold ourselves and others accountable to our societies. All the pentagram components were here: policy-makers, the WHO, the World Bank academics. They have the same objective—health for all by 2030, and the Besroul network can play a crucial role. (Dr. Ahmed Maherzi)
- Through taking part in the Besroul community, I started to feel more confident, that I could contribute, and I joined groups. I return home encouraged and energized. (Dr. Vincent Cubaka)
- I am proud that we have gone from 15 academic posters in 2017, to 22 in 2018. Please submit a poster next year! (Dr. Innocent Besigye)
- I was struck by the empathy, humanity, and universal brotherhood/sisterhood comprising the Besroul Network. (Dr. Hery Nirina Rakoto Ratsimba)



- I had a great experience with Canadian and international colleagues. The exchanges between Canadian universities and Tunisia are bearing great fruits as many of those that came on exchanges to Canada are now teachers of family medicine in Tunisia. (Dr. Mohamed Jouini)
- There will be Besrou presence at a meeting on social accountability in Morocco in March 2019, as well as at the WONCA Africa Region Conference in Kampala, Uganda, in June 2019. (Dr. Katherine Rouleau)



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