Strengthening primary care through family medicine around the world

Collaborating towards promising practices

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BASIC PROJECT INFORMATION

Abstract: *Strengthening primary care through family medicine around the world: collaborating towards promising practices* is a project that brought together physicians and academic leaders from low and middle income countries (LMICs) and Canada to develop a collaborative and evidence-informed resource to guide the development of context-responsive family medicine worldwide. In the first phase of the project, co-PI's were supported to conduct research toward the drafting of a country case study on the development of family medicine in their respective contexts, outlining key enablers and challenges. The second phase of the project consisted of an international two-day workshop where participants achieved the following: presentation of case studies and sharing of experiences, development of a framework of common successes and strategies for advancing family medicine and primary care outlining a number of promising practices, and recommending future directions for research, policy and training globally. The overarching goal of this project was to advance family medicine training and practice in LMICs, as a component of a broader primary care strategy, to improve health outcomes and health equity globally.

Keywords: family medicine, global health, promising practices, case studies

THE RESEARCH PROBLEM

Despite an increasing number of parallel efforts to increase access to quality family medicine around the world (CCFP 2013), there is a paucity of rigorous and accessible literature describing and critically comparing the contemporary experiences, successes, challenges and lessons learned among LMICs engaged in establishing and strengthening family medicine. The existing literature focuses on three areas: family medicine and primary care's link to improved health outcomes and equity mostly, but not exclusively in high income countries (Starfield et al., 2005; Shi, 2012; Shi et al., 2003; WHO, 2008), factors that hamper physicians from selecting family medicine as a specialty (van der Voort et al., 2012), and family medicine curricula in specific countries (Kanashiro, 2007), with a handful of articles addressing the state of the discipline in individual locales (Osman et al., 2011; Al-Shafaee, 2009). This relative lack of comparative evidence regarding the establishment of family medicine as a discipline prompted the development of the collaborative research project, *Strengthening primary care through family medicine around the world*, funded by the International Development Research Centre (IDRC) of Canada. Composed of family medicine practitioners and academics from Canada, Brazil, Ethiopia, Haiti, Indonesia, Kenya, and Mali, our team came together in 2014 with the aim of producing a compilation and comparative analysis of structured case studies, including key steps, challenges, enabling strategies, and shared lessons about the development of family medicine in local contexts around the world.

In addition to an existing working relationship, the LMIC partners represented three regions of the world, namely Latin America, Sub-Saharan Africa and Asia. Such heterogeneous contexts allowed for rich comparison among cases. The discipline of family medicine in the countries represented in this project is also at different stages of development, thus offering a generous pool for comparative analysis.

OBJECTIVES

This project convened LMIC and Canadian family physicians, physician champions from other disciplines, and academic leaders to create a context-specific, evidence-informed resource to guide the establishment and strengthening of family medicine training and practice in LMICs. A central goal of this project was to inform global health policy through outlining recommendations for future research, policy and practice for strengthening family medicine in local contexts around the world. Our project achieved the following objectives:

a) Produce a compilation and comparative analysis of structured case studies, including key steps, challenges, enabling strategies, and shared lessons, in the development of family medicine in local contexts around the world.

b) Develop, based on the compilation and analysis, an evidence-informed framework of promising practices for the integration of family medicine in broader primary care services globally.

c) Gather an international group of family medicine and primary care stakeholders, community-representatives and scholars for a workshop to discuss experiences in family medicine development.

d) Outline recommendations for future research, policy, and practice for strengthening family medicine in various contexts around the world.

METHODOLOGY

This project was informed by complex adaptive systems thinking and the appreciative inquiry and promising practices frameworks (Cooperrider and Whitney 2005; Leseure et al., 2004). According to complexity theory, change is to be understood in terms of co-evolution with all other related systems rather than as adaptation to a separate and distinct environment. Complex adaptive systems are dynamic systems able to adapt in and evolve with a changing environment. Given the heterogeneous contexts in which the seven family medicine initiatives were implemented, a theoretical lens premised on tenets of non-linearity and dynamic systems (Glouberman and Zimmerman, 2002) was particularly relevant for this project. Appreciative inquiry is a framework for examining organizational and system practices from the standpoint of what works, by examining past and present strengths and potentials and attempts to build upon and enhance strengths (Cooperrider and Whitney 2005). Applying this model allowed us to explore the context-specific factors that facilitate the fortification of family medicine and primary care in the participating LMICs.

Promising practices are practices or interventions that have the potential to be effective in addressing concerns in a given setting, as they have typically been effective in other domains, organizations, and systems (Leseure et al., 2004). This framework is proposed as an alternative to the concept of "best practices" which has been critiqued for often universalizing the adequacy of practices to all contexts (Leseure et al., 2004). A case study methodology was used since this method is ideal for capturing a thorough understanding of a process or phenomenon. Case study methodology helps illuminate something that cannot be understood without looking at it in its context and helps understand *how* something works and *why* it works in a particular way (Yin, 2003). The project also drew upon case study research methodology (Yin, 2003) for gathering data on the emergence, development, and enhancement of family medicine and primary care in defined settings worldwide.

In the FIRST phase of this project, Canadian and international researchers collaborated to provide guidance to the co-PIs to ensure that key structured information on family medicine and primary care in the selected countries is gathered while also allowing for the provision of new and unanticipated information. Our case study guide included the following elements: a) services and challenges in moving toward universal coverage within the defined local context; b) the implementation of the principles of family medicine and primary care (comprehensiveness, coordination and continuity of care, responsibility for a well-defined population, person-centered and community-based) and challenges; c) policy dimensions of implementing effective family medicine and primary care; and d) leadership development for strengthening of family medicine and primary care.

In the SECOND phase, participants from LMICs conducted research to develop a country case study on the development of family medicine. LMIC participants and cases were selected with a number of objectives in mind. First and foremost, co-PI collaborators had established relationships with Canadian partners. The literature on global health partnerships underscores the importance of trust in forming equitable research partnerships (Costello and Zulma, 2000). The Canadian and LMIC partners had collaborated in the past, had mutual trust, and were keen to participate in potential future collaboration around the outcomes of this project. Furthermore, the LMIC co-PI's and their Canadian partners had participated in the Besrour Conference of the Canadian College of Family Physicians of Canada in 2012 and 2013, which had served as strategic consultations to discuss avenues for future collaboration (CFPC, 2013) and thus had begun collective discussions about key stepping stones for local family medicine.

The THIRD phase of this project consisted of a two-day international workshop held in Quebec City in the fall of 2014.

The final and FOURTH phase of the project focused on knowledge translation and management. Upon completion of the case studies, a Research Assistant at the DFCM at the University of Toronto conducted a series of interviews with each co-PI to extract key insights, lessons and recommendations emerging from the different country cases. A standardized template for the interviews was developed in collaboration with team members. (Please see Appendix A).

PROJECT ACTIVITIES

Case Studies

In adopting a case study methodology, each co-PI was responsible for identifying a suitable approach to develop their case study. A varying number of interviews with key informants were used by most co-PIs. Key documents were also reviewed by several individuals.

Quebec City Workshop

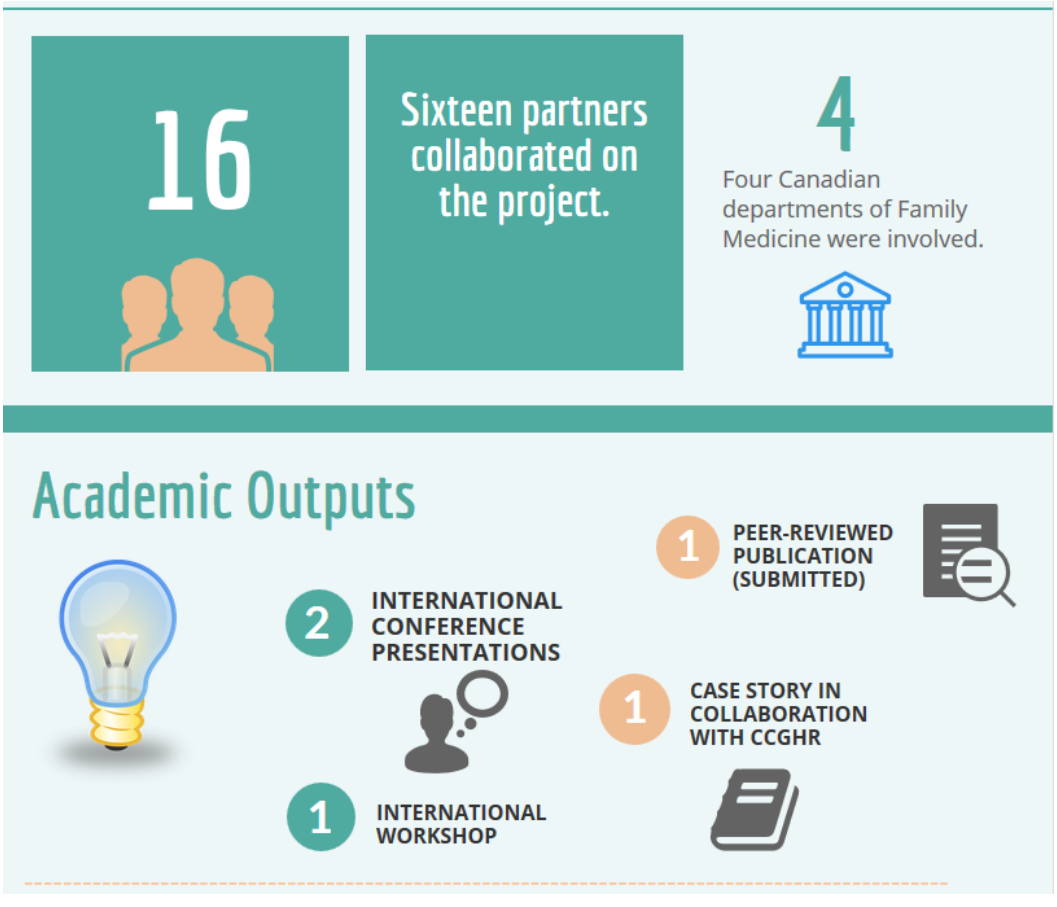
On November 10th -11th, 2014, Canadian and international delegates gathered for a two day workshop as part of the project. Delegates from Canada, Brazil, Ethiopia, Haiti, Indonesia, Kenya, and Mali came together in Quebec City. On the first day of the workshop, case studies were presented highlighting key enablers and challenges in the development and strengthening of family medicine in each context. Case studies were discussed by participants and invited Canadian and international leaders in family medicine and primary care, deepening the groups understanding of the evolution of family medicine in each setting. On Day 2, after a brief review of the key issues previously highlighted, participants organized the information extracted to develop insights. A skilled facilitator led the case study discussion, highlighting key and common issues and strategies. The workshop on Day 2 generated important "meta" lessons and the development of a framework of common successes and strategies. Participants further distilled the framework into a number of promising practices and began to outline a knowledge translation plan to disseminate the outcomes of the workshop.

In addition to the rich exchanges of experiences, participants engaged in discussions of the collective lessons learned across the case studies, common challenges and opportunities, and future directions for the project. Consensus was reached regarding the need to disseminate the results of the case studies. Participants proposed a number of ideas for future directions: a) the case studies should be prepared for publication in article and/or book formats and; b) a second phase of the project should involve the development of a toolkit in the development of family medicine.

Case Study Completion and Interviews

Following the workshop, each of the authors was invited to finalize their case study. Subsequently, a DFCM Research Assistant conducted interviews with each co-PI, which served to inform the development of an academic paper summarizing the process and outcomes of the project and to crystalize the emerging framework for understanding family medicine implementation in LMICs. A standardized interview guide was developed to examine the strategies adopted in the various settings to implement family medicine. (See Appendix A). Specifically, a matrix of predisposing, facilitating and reinforcing factors was developed using the content from the structured in-depth interviews with the co-PIs.

PROJECT EVALUATION



PROCESS EVALUATION

All project activities were implemented as intended and resulted in the outputs and outcomes outlined below.

PROJECT OUTPUTS

The resulting resources of this project include the following: evidence-informed case studies describing family medicine initiatives in select LMICs; an academic paper providing a comparative analysis of the case studies and the extraction of meta-lessons; a framework outlining "promising practices" for family medicine development; recommended directions for research, policy and training; a case story examining key principles of equity, effectiveness and engagement in Canadian global health research; and a framework of predisposing, facilitating and reinforcing factors.

Case Studies

The project resulted in seven case studies from each of the following countries: Brazil, Ethiopia, Haiti, Indonesia, Kenya, Mali, and Ontario. Table 1.0 provides a brief summary of each case study.

Academic Paper & Poster Presentation

An academic paper was developed that offers a comparative compilation and analysis of family medicine programs in seven countries, namely: Brazil, Canada, Ethiopia, Haiti, Indonesia, Kenya and Mali. The paper describes the process of developing family medicine programs, including enabling strategies and barriers, and shared lessons. The paper identifies committed partnerships, the contribution of champions, and general health policy were identified as key enablers in all seven case studies. The barriers that emerged across the seven case studies include the following: resistance from other medical specialties, lack of resources and capabilities, lack of political will and challenges in brokering effective partnerships. The application of an appreciative inquiry framework allowed us to identify enablers and barriers in family medicine implementation, as presented in tables 2.0 and 3.0. The paper is currently being finalized and will be submitted for publication.

An academic poster presentation of the project results will be presented at the 21st WONCA World Conference of Family Doctors, November 2-6, 2016 in Rio de Janeiro, Brazil.

Case Story

In collaboration with the Canadian Coalition for Global Health Research (CCGHR), a case story was developed that examined key principles of *equity*, *effectiveness and engagement* in Canadian global health research (GHR). In particular, it examined how the many institutions involved in this research project navigated the partnership and issues of *ethics, equity, and engagement within a north-south partnership*. The case study will be published online, along with a number of other case stories, in a casebook that will be made available as an open-access electronic book on the CCGHR website, as part of the 'Resources' section.

Framework

Anchored in a framework of complex adaptive systems thinking and appreciative inquiry, we created a typology of predisposing, facilitating and reinforcing factors that have shaped the implementation of family medicine in the seven different country contexts. Predisposing factors are those elements that the initiative *inherited* prior to the establishment of family medicine and were helpful in achieving success (e.g., an expressed need for primary care or policy direction on the part of the government, the school or others). Facilitating factors are elements that LMIC communities and partners *created* to advance family medicine as a practice (e.g., a venue to build new relationships, collaborative partners, resources, etc.). Reinforcing factors are elements that *support the new state of affairs* once the initiative was established (e.g., relationships, policies and/or resources that made the innovation sustainable). (See Appendix B for results).

PROJECT OUTCOMES

This collaborative research project achieved the following outcomes: relationship building among pre-existing partners as well as among the various co-PI's of this project, behavior change, and capacity building in research and methodology to advance family medicine. The project forged critical internal and external relationships with key stakeholders in the north and the south, generated changes in behavior that contributed to observable shifts in more positive

attitudes towards family medicine amongst key stakeholders (e.g., deans of medicine, departments of medicine) in LMICs. The project adopted a collaborative process to distribute funds and make decisions regards tasks and work plans.

Relationship Building

This research project fostered strong relationships between Canadian Departments of Family Medicine and individual champions in Canada and the six countries: Brazil, Haiti, Ethiopia, Indonesia, Kenya and Mali; such relationships have been instrumental in advancing family medicine initiatives on the ground. Across all countries, institutional partners and individual champions acted as family medicine "facilitators." At a global level, facilitators such as the Universities of McMaster, Sherbrooke, British Columbia and Toronto played a pivotal role in developing and disseminating the critical knowhow that enabled diffusion and implementation of the family medicine model.

With regards to champions, while the role of Canadian collaborators was highlighted as being important, typically in the context of institutional "committed partnerships", the key champions, commonly identified as key enablers, were physicians, often not family physicians themselves and were from LMIC communities. This key role for someone deeply connected to the local community is highly congruent with the nature of family medicine as a discipline rooted and defined by the local community and population.

Partnership Feedback

A short anonymous survey, developed based on sub-section II of the Partnership Assessment Tool (2009), was administered to all project partners to gather feedback on fairness, effectiveness and satisfaction with the research partnership itself (See Appendix C for survey). All twelve partners were emailed the survey and six responses were recorded.

Satisfaction: On average, more than 85% of survey respondents indicated that they were "extremely satisfied" in regards to fairness in resource sharing, allocation of roles and responsibilities, performance of roles and responsibilities, capacity building opportunities, and authorship opportunities. Four out of six respondents (67%) felt that there was a high degree of effective communication and 85% felt there was effective conflict management. Finally, 85% of respondents reported being "extremely satisfied" with the functioning of the partnership structure, mentorship opportunities, skills development, respect and ethical conduct.

Strengths of the partnership: The opportunity to collaborate with international partners and a diverse group of participants was cited by 5/6 respondents. Administrative support, mentorship, team work, and commitment of the partners were also cited as strengths of the partnership.

Challenges: Finding the time to participate in team meetings and having minimal research experience were identified as challenges. A lack of clear goals and tasks were identified by 2/6 participants as a challenge to effective management of the project.

Behavior Change

In this project, champions, while not always family physicians themselves, essentially acted as family medicine *facilitators.* Champions brokered key relationships between individuals who had decision-making authority that could positively impact the implementation of the family medicine programs. Champions were crucial for example in brokering ties between deans of medicine and other academic leaders in the north and the south. An insight emerging from this project is that strenuous advocacy efforts, often over the long term, were typically required to obtain buy-in from key stakeholders in national medical schools and ministries of health.

The success of the Mali family medicine program, for example, is partly attributed to the fact that the program had "champions" in Bamako and Sherbrooke that drew attention to the program and created a sense of urgency to the need for implementing family medicine in a resource-constrained setting. The success of the Banconi initiative stems in part from the early involvement of key champions that were crucial in moving the initiative forward. The visit of Dean Hébert, from the Faculty of Medicine and Health Sciences at Sherbrooke, to Mali was instrumental in convincing Dean Anatole Tounkara, from Bamako, of the importance of creating a Faculty of Medicine and Dentistry (Faculté de médecine et odonto-stomatologie) to support medical training that was better adapted to Mali's needs. Their combined involvement was decisive in obtaining funding from the Canadian government.

Champions from the University of Toronto, namely Dr. Jane Philpott played a catalytic role in facilitating implementation of family medicine programs. Dr. Dawit Wondimagegn at Addis Ababa University in Ethiopia provided leadership, stimulated appropriate actions from other stakeholders and enhanced coordination between all facilitators in Canada and Ethiopia. Champions in all seven contexts provided the global direction and leadership that positively shaped the way family medicine was perceived and implemented. Ultimately, champions were critical in the *facilitative* process underpinning implementation in all seven countries and in persuading other actors — deans of medicine in the south, and government stakeholders to take action to advance family medicine implementation. In all the countries, multiple facilitators worked alongside each other to support implementation.

Capacity Building

The case study development strengthened the scholarly competencies of partners in the north and the south. In the beginning of the project, the project coordinator, Dr. Paula Ruiz, at DFCM had sessions with each of the southern partners to provide a workshop on developing case studies and to introduce the appreciative inquiry framework as a conceptual tool to inform the case study design. As an anthropologist skilled in qualitative research methods, Dr. Ruiz' mentorship was important in building capacity and confidence among the research partners, some of whom had limited experience in qualitative research.

Select partnerships offered capacity-building support in implementing family medicine. Committed partnerships and alliances with partners such as Partners in Health (PIH), PRIMAFAMED and the various Canadian Departments of Family enabled programs to build family medicine *capabilities* (e.g., Haiti and Kenya). In Banconi, a poor and overpopulated neighborhood of Bamako, Mali, the University of Sherbrooke in collaboration with the Faculty

of Medicine and Dentistry and the Fédération Nationale des Associations de Santé Communautaire have collaborated to strengthen primary care in a number of health centres, eventually leading to the emergence of a program in family medicine.

In Haiti, the ability of Zanmi Lasante and Partners in Health to aid in sourcing local and international experts through partnerships with academic institutions strengthened the implementation of the family medicine programs and in particular bolstered curriculum development and training programs. The Ministry of Health and Zanmi Lasante partnership transformed l'Hopital Saint Nicolas of Saint Marc' (HSN) in Haiti into a public hospital that offers accessible and affordable health care services. Partners provided resources to enable programs to adequately compensate and remunerate family physicians, which was critical in the ability of programs to attract medical graduates to pursue family medicine as a specialty area (e.g., Haiti, Mali).

Alliances with *influential* organizations such as Partners in Health and the Canadian departments of family medicine were effective in enhancing the visibility of family medicine programs (e.g., Haiti and Mali). Committed partners offered family medicine programs a number of intangible benefits, including visibility for programs that were confronting considerable resistance from other medical specialties.

The ability of the project to produce the above outcomes was in part driven by committed leaders and project staff.

PROJECT IMPACT

Family Medicine as a Focus of Global Health

This project also served to legitimize the discipline of family medicine not only as a key and worthwhile discipline in efforts to achieve health for individuals and communities globally, but also as an academic discipline and a deserving focus of scholarship. Too often removed from the academic forum, family medicine in this project emerged as a rich research interest, thereby lending support to the efforts of our international partners and validating their identity as academic experts.

CHALLENGES

Understanding Challenges

As per the application of the appreciative inquiry framework, the project sought to understand the main challenges that the programs experienced in the establishment and strengthening of family medicine and how these were addressed. Table 4.0 below outlines the key challenges that emerged through the various case studies.

OVERALL RISKS AND KEY INSIGHTS

In addition to the lessons learned regarding the establishment of family medicine in each of the seven settings studied, this project provided a number of key overarching lessons.

Implications of working with partners using a partnership model

Our decision to engage co-PI's associated with existing partnerships provided a rich and effective foundation on which to build our collective enquiry. The expertise, dedication and knowledge of the southern partners were key in making this project a rich discovery process. Nonetheless, working through a partnership-based team of co-PI's required significant resources and time from partners in the north and the south and shared decision-making. Building consensus on the outputs of project was a time-intensive process, and at times a difficult process, as it meant refining and negotiating amongst a diverse group of individuals working on projects embedded in heterogeneous contexts.

A model of working in partnership with teams in the north and south also necessitated flexibility. The initial plan was premised on the assumption that co-PI'S from LMIC's would identify local research assistants to develop the case studies. In all cases, however, and for a variety of reasons, the co-investigators ended up leading and developing the case studies themselves. As co-investigators tended to be individuals with key roles and responsibilities, their direct involvement, while rich, also resulted in delays in the development of some of the case studies as investigators juggled their busy schedules and workloads.

The project was useful in fostering relationships between individuals and institutions in the north and the south and in engaging a large group of family medicine champions across seven countries. The project allowed for mutual exchange and reflection. The project further legitimized family medicine as a critical element of global health and as an area warranting rigorous and in-depth research and collaboration. The seven case studies comprising this project served to validate the efforts of international family medicine champions who often work in small groups, frequently against a tide of general indifference and incomprehension or, in some case, outright hostility from other specialist colleagues. This study confirmed the importance of creating not only national, but also international communities of practice around family medicine and family medicine development.

The role of family medicine in global health and development

The project's major contribution to development is in providing insight, legitimization and understanding of family medicine in health systems strengthening and in the potential role of family medicine as a lever of universal health coverage and health equity. In the context of the *Sustainable Development Goals* (SDGs), the impact of family medicine in primary care and its deeply relational aspect is a natural bridge to other SDGs focused beyond health care (e.g., education, livelihoods, etc.). The push for universal health coverage and the recent launch of the *Sustainable Development Goals* raise questions as to whether more deliberate, robust and sustained efforts are need to establish and strengthen family medicine globally. Family medicine as a constitutive component of primary health care comprises a core aspect of UHC. The findings

from these case studies suggest that perhaps the creation of new funding mechanisms and partnerships to scale up family medicine globally are needed. While current global health frameworks such as the Global Fund and a focus of some of the MDG's have favored the implementation of vertical interventions, we believe the principles of health equity and access are, at this time, most readily achieved through global health architecture that can bolster access to comprehensive primary and secondary care including through family medicine anchored in primary care. Family medicine, if well implanted could potentially provide the integrative pathway required to address the increasingly complex conditions presented by individuals around the world. The underlying attributes of family medicine — comprehensiveness, adaptability, and attention to both local and patient needs — are key to achieving and advancing global health priorities. Family medicine, as a source of robust, comprehensive, first-contact, person-centered, and community-based generalist medical care also aligns with the call of a number of key global health documents published over the past decade including the World Health Organization (WHO) report 2008: *Primary Health Care: Now More than Ever* and the Lancet Commission.

Funds dispersal and accountability mechanisms

A key lesson learned from this project is the importance of fostering a spirit of mutual accountability. We learned that being specific about project expectations and consequences produced positive outcomes and led to swift project implementation.

Internal policies related to the administration and disbursement of research funds at the Department of Family and Community Medicine at the University of Toronto sometimes resulted in challenges in transferring of funds to our southern partners and consequently resulted in delays in project implementation. In order to transfer payments for this project, southern partners were asked to draft contracts with specified Terms of Agreement for the case studies. The payment deadlines stipulated 50% payment upfront and 50% upon completion of the case study. While the spirit and aim of the project was one of collaborative partnership, such administrative requirements introduced a hierarchical dynamic between the northern partner (i.e., University of Toronto) and our southern partners. Since the project has been implemented, our Department of Finance has become more flexible and also benefited from working on a project with partners based in the south. The institutional learning related to the administration of a project that involved disbursement of funds to a number of partners from the global south points to the importance of patience, persistence and flexibility in working across borders.

Knowledge management

In regards to lessons learned in project implementation, the project would have benefited from a Research Assistant on board from the outset to coordinate the knowledge management and translations aspects of the project. The interviews conducted in the fourth stage of the project served three key purposes. First, the interviews conducted by the RA were highly useful in understanding the experiences of implementation from the perspective of each co-PI in the south. Second, the interviews removed the potential burden off of co-PIs in having to respond to potentially lengthy emails. The interview approach was respectful of the workloads of co-PIs who were extremely busy *implementing* family medicine, in addition to compiling the case

studies. Third, the interview format alleviated the burden on co-PIs of writing responses in English for those who were not fluent in English.

CONCLUSION AND RECOMMENDATIONS

We are deeply grateful to have been part of this process of knowledge generation to advance family medicine as a model in global health. We believe Canada, as a country, is a convener of reflection around developing robust family medicine. While the field of global health tends to be dominated by a focus on infectious disease, public health and vertical disease interventions, the findings from this project suggest a need to consider how *family medicine* can improve the health of populations globally at a time when the complexity of concurrent and lifelong conditions is compelling us all to identify appropriate models of care.

Our recommendation to IDRC is to make explicit its stance and interest in family medicine, as a constitutive component of primary care. We hope that the project's findings can be disseminated to a broader IDRC landscape. We are satisfied and appreciative of the support we have received from IDRC throughout the project's duration.

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