# Advancing Family Medicine in the Middle East: A Comprehensive Analysis of Development, Challenges, and International Partnerships

**Faisal A Alnaser [1]; Nagwa N Hegazy [2]; Taghreed M Farahat [3]; Abdulaziz Al-Mahrezi [4]; Samar Almoazen [5]; Shaymaa M Ahmed [6]: Oraib H Alsmadi [7]; Mohammad alazemi [8]; Razan Abyad [9], Abdulrazak Abyad [10]**

1. MBBS, FPC, MICGP, FRCGP, FFPH, FAM (USA), PhD, Honorary Faculty; Department of Primary Care & Public Health Imperial College, London; President-Elect WONCA Emr (World Congress for Family Physicians); President, Bahrain Family Physician Association, Chairman; Home Health Care Centre, Chairman; American Foot & Ankle Centre, Vice President, International Society for the History of Islamic Medicine (ISHIM), WHO EMRO Temp Advisor, WONCA EMR Regional Adviser, Bahrain Representative in Anti-Smoking International Alliances
2. MD, Professor of Family Medicine Departments of Family Medicine; Faculty of Medicine, Menoufia University
3. MD, Professor of Community & Family Medicine, Departments of Family Medicine, Faculty of Medicine, Menoufia University
4. MD, Abdulaziz Al-Mahrezi, Director General of Sultan Qaboos University Hospital, University Medical City, Sultanate of Oman
5. MSc, MD , Professor of Family Medicine, Faculty of Medicine, ALSHAM Private University, Syria. Chairperson of Syrian Association of Family Medicine SAFM, Head of Examination Committee of Syrian Board Council of Family Medicine
6. FABHS, FM, D.F.M, Member of Iraqi Family Medicine Society
7. MD, Family Medicine Consultant, President of Jordan Society of Family Medicine
8. MBBS, MD, MRCGP , Director of Public Relations and Health Media, Director of South Sulaibiya PHC, President of Kuwait Association of Family Medicine, President of Gulf Association of Family Medicine, MSc leadership and organizational development-RCSI
9. Razan Abyad, Bsc, MSc International Health, General Manager, Abyad Medical Center, Lebanon
10. MD, MPH, MBA, DBA, AGSF, Consultant Internal and Geriatric Medicine, Dar Al Shifa Hospital, Kuwait Chairman, Middle-East Academy for Medicine of Aging. President, Middle East & North Africa Association on Aging & Alzheimer's, Editor, Middle-East Journal of Family Medicine www.mejfm.com, Editor, Middle-East Journal of Age & Aging www.me-jaa.com, Editor, Middle-East Journal of Nursing www.me-jn.com

**Correspondence:**
Dr Abdulrazak Abyad,
Consultant Internal and Geriatric Medicine, Dar Al Shifa Hospital, Kuwait
Chairman, Middle-East Academy for Medicine of Aging.
President, Middle East & North Africa Association on Aging & Alzheimer's
Editor, Middle-East Journal of Family Medicine www.mejfm.com
Editor, Middle-East Journal of Age & Aging www.me-jaa.com
Editor, Middle-East Journal of Nursing www.me-jn.com
**Email:** aabyad@cyberia.net.lb

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# Abstract

Family medicine has become essential to the healthcare systems across the Middle East, providing comprehensive, continuous care and addressing a broad range of health issues. This paper explores the historical evolution, challenges, advocacy efforts, and impact of family medicine in several Middle Eastern countries, namely Lebanon, Bahrain, Egypt, Oman, Jordan, Syria, Kuwait, and Iraq. By examining these diverse national experiences, we assess how family medicine has influenced population health, navigated barriers, and fostered international collaborations. By analyzing the experiences of these countries, we identify successful efforts, ongoing challenges, and international collaborations that can strengthen the field of family medicine across the region.


Keywords: Family medicine, healthcare systems, comprehensive anslysis, development, challenges, international partnerships, Middle East

## Introduction

Family medicine is a vital healthcare specialty focused on delivering continuous and comprehensive care to individuals and families. It covers a broad spectrum of health concerns across all ages, organ systems, and diseases, with a strong focus on preventive care. This paper explores the historical evolution, educational advancements, public health impact, encountered challenges, and creative solutions achieved through international collaborations. It provides an analysis of the progress, barriers, and innovative practices in family medicine across eight Middle Eastern countries (1). Family medicine is a vital healthcare specialty focused on delivering continuous and comprehensive care to individuals and families. It covers a broad spectrum of health concerns across all ages, organ systems, and diseases, with a strong focus on preventive care. This paper explores the historical evolution, educational advancements, public health impact, encountered challenges, and creative solutions achieved through international collaborations. It provides an analysis of the progress, barriers, and innovative practices in family medicine across eight Middle Eastern countries (1).

## Historical Background and Challenges Faced

In 1978, the Alma Ata Conference in Kazakhstan highlighted the critical role of Primary Health Care (PHC) in addressing the root causes of poor health. At this conference, 134 countries adopted a resolution for “health for all by the year 2000,” prioritizing efforts to address social, economic, and political determinants of health (2).

The first family medicine academic program was established in Canada in 1967, followed by the United States in 1969. When the model reached the Middle East, Lebanon and Bahrain were early adopters in the 1980s. In the region FM has faced several challenges, including economic instability, fragmented healthcare systems, resistance from established healthcare sectors, and a shortage of trained family physicians. Each country has encountered distinct obstacles, shaping the development of family medicine practice within unique contexts (1,3).

**Successful efforts**

Countries such as Lebanon, Bahrain, and Oman have developed comprehensive family medicine (FM) training programs, with notable contributions from universities and international partners.

The “Arab Board of Health Specialisations (ABHS)” was established in 1978 by the Council of Arab Health Ministers to enhance medical standards across the Arab world. In 1985, the Family Medicine Council within ABHS was created to aid Arab countries in developing FM services, accrediting programs, and producing competent FM specialists through standardized exams.

## Country by Country analysis

**Lebanon:**
Family medicine was introduced in 1979 and key universities, have lead FM training. Established in 1991, the Lebanese Society of Family Medicine advocates for FM as a primary care foundation, collaborating with the Ministry of Public Health. As of 2021, Lebanon had five FM training programs and approximately 96 FM physicians actively practicing. However, challenges persist, including economic instability, physician emigration, and a culture where patients often bypass family doctors to consult specialists directly (1,4).

**Bahrain:**
Primary healthcare (PHC) services have been available in Bahrain for over 40 years, with family medicine formally introduced in 1981 through the Family Practice Residency Program (FPRP). Bahrain's FM program at Arabian Gulf University integrates problem-based learning and community-focused care. Bahrain played a leading role in establishing the Arab Board of Health Specializations, which has helped extend FM training across the region. The program's emphasis on research-oriented training and academic rigor has become a model for other countries (5). Bahrain still faces a shortage of family physicians, limited funding, and lack of public awareness of family physicians' role (5,6).

**Egypt:**
Egypt's focus on FM started in the 1990s when the Supreme Council of Universities recommended that each medical school establish a training program for general practice. By 2004, Egypt's FM initiative had expanded, with medical faculties urged to establish dedicated FM departments and curricula (13,14). Currently challenges include fragmented healthcare structures, a shortage of trained professionals, and low public awareness of family medicine's role in primary care (7).

**Oman:**
Oman's FM training, started in 1987 at Sultan Qaboos University. The first locally trained family physicians graduated in 1998. The program received RACP recognition in 2001, making it the first regional provider of the MRCGP (INT) exam (17). By 2016, Oman had increased its PHC centers to 206 and improved its general practitioner ratio significantly. Oman still faces resource shortages and a rising burden of non-communicable diseases, with ongoing efforts focusing on technology integration and disease management (8).

**Jordan:**
Family medicine residency programs started in Jordan in the early 1980s, and the specialty has since become central to primary healthcare. Currently, four residency programs exist at Jordan University. The Jordan Medical Council accredits structured FM residency programs, which include both hospital and primary care settings. Jordan's FM residency curriculum spans four years, with residents completing three years in hospitals and one year in primary healthcare settings. The residency culminates in board exams, with initial assessment at the end of the second year and a final evaluation after the fourth year. To bridge the gap of 1 FM doctor per 12,138 patients, the WHO and Jordan's Ministry of Health offer a two-year Professional Diploma in Family Medicine. However, limited training resources, financial constraints, and a preference for higher-paying specialties among graduates present ongoing challenges.

**Syria:**
With support from the Ministry of Health and WHO, Syria's family medicine program began in 1992. Family physicians undergo four years of training in Ministry hospitals and PHC centers. By 2008, the program produced 400 family physicians. Despite ongoing conflict, Syria has maintained a family medicine residency program with support from the Syrian Association of Family Medicine, which promotes training and development in the field. The University of Damascus introduced a Masters degree in FM in 1998, later expanded to a four-year program. In 2004, the Scientific Council of Family Medicine began conferring Masters and Doctoral degrees, with a PhD program added in 2017.

**Kuwait:**
The Kuwait Board of Family Medicine was founded in 1983, and achieved MRCGP (INT) accreditation in 2005. Kuwait has made significant advances in FM by establishing specialized training centers and expanding residency programs, with support from international bodies. Kuwait has 50 specialized FM training centers, and 84 trainers, enhancing mentorship and instructional quality. Since the programs began, approximately 554 graduates have joined the FM workforce. The Kuwait Association of Family Medicine has been instrumental in advocating for FM's integration into medical education and the development of residency programs (1,18). Barriers remain, including insufficient training facilities, a shortage of family doctors, low financial incentives, and challenges of integration (1,4,10).

**Iraq:**
Introduced in 1995, family medicine gained the Arab Board Specialization in 2008. However, the specialty faces obstacles, including limited resources, political instability, and a system that still favours specialized care. Efforts are underway to integrate family medicine across all healthcare levels, but structural challenges remain heightened by economic instability (11). Despite these challenges, Iraq has seen a growing interest in FM, supported by the Arab Board of Health Specializations and the Iraqi Family Medicine Society (Table 1).

**Table 1: Historical Development of Family Medicine in the Middle East**

| Country | Year Family Medicine Introduced | Key Milestones | Challenges |
|---|---|---|---|
| **Lebanon** | 1979 | Structured program with support from the American University of Beirut. | Economic instability, physician emigration, patients bypassing family doctors. |
| **Bahrain** | 1981 | Family Practice Residency Program (FPRP) established. | Shortage of family physicians, limited funding, low public awareness. |
| **Egypt** | 1980s | Programs at Suez Canal University expanded to other institutions. | Fragmented healthcare, shortage of trained professionals, low public awareness. |
| **Oman** | 1980s | PHC network strengthened, 206 PHC centres by 2016. | Resource shortages, rising burden of non-communicable diseases. |
| **Jordan** | Early 1980s | Residency programs established. WHO support for training. | Limited training resources, financial constraints, preference for higher-paying specialties. |
| **Syria** | 1992 | Ministry of Health and WHO support, 400 family physicians by 2008. | Political instability, resource shortages. |
| **Kuwait** | 1983 | Kuwait Board of Family Medicine founded MRCGP accreditation in 2005. | Insufficient training facilities, shortage of family doctors, low financial incentives. |
| **Iraq** | 1995 | Arab Board Specialization in 2008. | Limited resources, political instability, preference for specialized care. |

**Comparative Analysis and recommendations**

- Challenges: Funding, public perception, and professional.
- Strategies: Effective international partnerships, policy support, and educational reforms.
- Recommendations: Enhance collaborations, increase public awareness, and strengthen government support (Table 2).

**Table 2: Family Medicine Training Programs in the Middle East**

| Country | Key Institutions | Training Duration | Accreditation | Graduates (Approx.) |
|---|---|---|---|---|
| **Lebanon** | American University of Beirut, Saint Joseph University | 3-4 years | Lebanese Society of Family Medicine | 96 |
| **Bahrain** | Arabian Gulf University | 3-4 years | Arab Board of Health Specializations | N/A |
| **Egypt** | Suez Canal University, Menoufia University | 3-4 years | Egyptian Fellowship Board | N/A |
| **Oman** | Sultan Qaboos University | 4 years | Royal College of General Practitioners (MRCGP) | 300+ |
| **Jordan** | Jordan University, Royal Medical Services | 4 years | Jordan Medical Council | N/A |
| **Syria** | University of Damascus | 4 years | Scientific Council of Family Medicine | 100+ |
| **Kuwait** | Kuwait Institute for Medical Specialisations | 4 years | Royal College of General Practitioners | 554 |
| **Iraq** | University of Baghdad | 4 years | Arab Board of Health Specializations | 200+ |

**Impact Assessment of Family Medicine on Populations**

The introduction of Family Medicine has led to significant health improvements across the Arab region, particularly in managing chronic diseases and enhancing preventive care. FM's emphasis on continuous, community-based care has proven especially valuable in rural areas previously lacking healthcare access (Table 3).

**Table 3: Impact of Family Medicine on Population Health**

| Country | Key Health Improvements | Challenges |
|---|---|---|
| **Lebanon** | - Improved chronic disease management.<br>- Enhanced preventive healthcare. | Accessibility gaps in rural areas. |
| **Bahrain** | - High-quality PHC services.<br>- Improved population health standards. | Limited public awareness of family medicine. |
| **Egypt** | - Increased healthcare access in underserved areas.<br>- Reduced healthcare costs. | Fragmented healthcare system. |
| **Oman** | - Lower mortality rates.<br>- Improved disease management in rural areas. | High burden of non-communicable diseases. |
| **Jordan** | - Improved access to primary care.<br>- Reduced disparities in underserved regions. | Strain from refugee influx, economic hardships. |
| **Syria** | - Maintained primary care services despite conflict.<br>- Mobile clinics reaching conflict zones. | Devastated healthcare infrastructure, brain drain. |
| **Kuwait** | - Enhanced continuity of care.<br>- High patient satisfaction in chronic disease management. | Overreliance on expatriate workforce, integration issues. |
| **Iraq** | - Strengthened primary healthcare.<br>- Critical support during COVID-19. | Political instability, resource shortages. |

**Lebanon & Bahrain:**
FM has improved health outcomes in Lebanon and Bahrain, focusing on managing chronic conditions and promoting preventive healthcare. In Bahrain PHC services supervised by qualified FPs have continuously been able to offer a variety of high-quality easily accessible healthcare services. FPs across the country have started gaining a good reputation for providing efficient and high-quality health services that have helped in promoting the standard of health of the population. However, accessibility gaps remain in rural areas (1,5).

**Egypt:**
FM has increased healthcare access in Egypt, especially in underserved areas by providing comprehensive, continuous, and community-centered care, thereby addressing both immediate and long-term health needs. Emphasizing preventive care and early intervention, FM has reduced healthcare costs and improved public health outcomes. The Healthcare Authority reported that over 35.5 million family medicine services were delivered through healthcare units and centers in governorates implementing the Universal Health Insurance System (21).

**Oman:**
FM has significantly boosted Oman's healthcare, lowering mortality rates and improving disease management. Community-oriented care has shown marked benefits in rural areas. Oman's healthcare system was ranked seventh globally by the WHO in its 2000 report, recognizing its achievements (22). The integration of noncommunicable diseases (NCDs) into primary care in Oman has proven to be a valuable approach for data collection and surveillance of selected NCDs.

**Jordan, Syria & Iraq:**
Although FM is still developing in Jordan, Syria, and Iraq, it has improved access to primary care and reduced disparities in underserved regions. During COVID-19, FM practitioners in Iraq provided critical support through home visits and telemedicine (20,24).

**Kuwait:**
FM in Kuwait has enhanced continuity of care and patient satisfaction, particularly in specialized clinics managing chronic conditions. As per a 2018 World Health Organization Review in the Eastern Mediterranean, 90 percent of PHC centres in Kuwait provided dental and diabetes care, with 38 percent providing gynaecological and obstetric care (24,25). PHC centres use an electronic health file which can be accessed across all centres and is planned to be linked to hospitals. A majority (90 percent) of PHC centres are open until midnight, with all centres offering walk-in services (26).

## Barriers to Family Medicine Training and Implementation

Despite advancements in Family Medicine, several barriers persist, including limited resources, policy issues, financial disincentives, and lack of public awareness. Solutions include infrastructure investment, policy reforms to prioritize family physicians as first contacts, and public campaigns to raise FM's profile.

**Primary challenges affecting FM across the region:**

- **Limited Resources:** A lack of infrastructure, training facilities, and technological tools like telemedicine hinders FM development. Increased investment is essential.
- **Shortage of Trainers:** Many countries, including Egypt, face a shortage of trained FM educators and adequate training programs due to underrepresentation in medical education (13).
- **Limited Undergraduate Exposure:** Students receive minimal exposure in medical schools, often limited to brief rotations, impacting its visibility as a career path.
- **Healthcare System Modernization:** A centralized FM system could better serve as the first point of patient contact.
- **Insufficient Specialists:** Expanding postgraduate FM programs and offering incentives can help increase the number of family medicine specialists.
- **Independent Departments:** In several countries, FM departments are not autonomous within universities, limiting their influence.
- **Policy Challenges:** In Lebanon, Egypt, and Syria, policies do not mandate FM as the initial patient contact, reducing FM's role.
- **Financial Disincentives:** Low salaries and limited career growth discourage physicians from FM.
- **Economic Crises:** Financial strain in countries like Lebanon, Syria, and Egypt has impacted healthcare, raising costs and limiting access to FM services.
- **Physician Emigration:** Economic and political instability in Lebanon, Syria, and Egypt has led many doctors to emigrate.
- **General Practitioner vs. Family Medicine:** In the region, general practitioners (GPs) often lack the advanced training of FM physicians, leading to a role distinction that can affect public understanding.
- **Public Perception:** Low awareness among policymakers and the public limits FM's perceived value. Public health campaigns could improve understanding of FM's role.

## Creative Partnership Approaches and International Collaborations

International partnerships have played a vital role in advancing family medicine (FM) education and raising practice standards in the Middle East. Collaborations with established institutions like the Royal College of General Practitioners (RCGP) have enabled knowledge sharing, curriculum development, and international exposure, aligning training with global standards (Table 4).

**Table 4: International Collaborations and Partnerships**

| Country | Key Collaborations | Impact | Challenges |
|---|---|---|---|
| **Lebanon** | WHO, Médecins Sans Frontières (MSF). | Strengthened PHC system, mental health, and chronic disease management. | Economic instability, refugee crisis. |
| **Bahrain** | Gulf Health Council, WHO. | 98% immunization coverage, 90% PHC access within 5 km. | Limited funding, low public awareness. |
| **Oman** | Royal College of General Practitioners, University of Sydney. | Over 300 family physicians trained, reduced infant mortality. | Geographic challenges, retaining physicians in rural areas. |
| **Kuwait** | Royal College of General Practitioners, University of London. | 95% immunization coverage, 85% PHC access. | Overreliance on expatriate workforce, patient preference for specialists. |
| **Jordan** | WHO, UNHCR, MSF. | Enhanced PHC in refugee-hosting areas. | Strain from refugee influx, economic hardships. |
| **Syria** | WHO, MSF, UNICEF. | Over 500,000 patients served annually, mobile clinics in conflict zones. | Devastated infrastructure, economic sanctions. |
| **Egypt** | WHO, international universities. | Improved training quality, resource sharing. | Fragmented healthcare system, low public awareness. |
| **Iraq** | WHO, Arab Board, MSF. | Over 1,200 PHC centres established, 200+ family physicians trained. | Political instability, resource shortages. |

**Lebanon, Bahrain, Oman, and Kuwait** have benefited from partnerships with organizations such as RCGP and WONCA. These collaborations have enabled standardized curricula, knowledge exchange, and best practices sharing, enhancing FM training quality and providing physicians with international exposure.

In Lebanon, partnerships and collaborations, particularly with the WHO, have been crucial in strengthening its primary healthcare system amid challenges like the Syrian refugee crisis and the aftermath of the Beirut explosion in 2020. NGOs like Médecins Sans Frontières and International Medical Corps also play a significant role, with MSF operating 12 centres serving 200,000 patients each year (28).

Bahrain collaborates with Gulf Cooperation Council (GCC) countries through the Gulf Health Council to share best practices in family medicine, achieving a notable 98% immunization coverage. The World Bank and WHO have supported the strengthening of primary healthcare infrastructure, ensuring over 90% of Bahrain's population has primary healthcare access within 5 km (29).

Oman has significantly advanced its primary healthcare system with WHO support, reducing infant mortality from 118 per 1,000 live births in 1970 to 9.7 in 2020. The Oman Medical Specialty Board collaborates with the RCGP , training over 300 family physicians. Sultan Qaboos University's collaboration with the University of Sydney has produced over 50 primary care research papers. Despite these advances, Oman struggles with geographic challenges in remote areas, a high chronic disease burden, and retaining trained family physicians in rural settings (30,31).

In Kuwait, the collaboration with GCC countries through the Gulf Health Council has led to a 95% immunization coverage rate. WHO support has helped strengthen its primary healthcare system, with over 85% of the population having access to primary care. Kuwait University's partnership with the University of London has developed a robust family medicine program, graduating about 30 physicians annually. Kuwait faces challenges such as an overreliance on an expatriate healthcare workforce, patients preferring specialist care, and the integration of healthcare services (32).

Lebanon, Bahrain, Oman, and Kuwait have made significant progress in family medicine through **creative partnerships and international collaborations**. These efforts have improved access to care, chronic disease management, and health outcomes. However, challenges such as workforce shortages, chronic disease burdens, and integration issues persist.

## Regional Collaboration

In the Gulf, countries like Kuwait, Oman, Saudi Arabia, and Qatar have fostered partnerships to share resources, training methods, and expertise, strengthening FM education regionally. Bahrain and Lebanon maintain a long-term collaboration, reinforcing their FM programs.

**Jordan and Syria:**
Exchange programs allow FM residents in Jordan and Syria to gain experience in countries with established FM systems. The Royal Medical Services in Jordan has previously sent family physicians abroad for advanced training in specialties like geriatrics, facilitated by WONCA conferences and other international forums.

Jordan has become a regional leader in healthcare due to its response to the Syrian refugee crisis, with family medicine at the forefront of its strategy. WHO, NGOs like Médecins Sans Frontières, and international organizations such as the UNHCR have been pivotal, enhancing primary healthcare, especially in refugee-hosting areas. However, the influx of refugees strains the healthcare system, compounded by economic hardships and a shortage of trained family physicians in rural and refugee-hosting areas (33, 34).

Despite ongoing conflict, Syria continues to maintain primary care services through international aid and collaborations. WHO and NGOs like Médecins Sans Frontières and UNICEF have been instrumental, with MSF operating eight primary healthcare centers serving over 500,000 patients yearly. Academic partnerships, continue to produce healthcare professionals, with over 100 family physicians graduating in the past decade. Mobile clinics and outreach programs have reached over a million people in conflict zones. Yet, the war has devastated healthcare infrastructure, economic sanctions restrict medical supplies, and a significant brain drain due to unsafe conditions and poor work environments persists (35-37)

**Egypt:**
Egypt's FM training has benefited from partnerships with institutions abroad, providing exposure to advanced educational practices. Joint research initiatives and conferences help foster an international dialogue on best practices in FM education, improving training quality and resource sharing (38). The WHO has collaborated with Egypt to bolster public health and family medicine services, to provide equitable access to quality healthcare for all Egyptians (39).

**Iraq:**
With support from the Arab Board and WHO, Iraq has developed its FM training program, though additional international partnerships are needed to address the country's healthcare professional shortages. Iraq has made significant progress in strengthening family

medicine and primary healthcare despite enduring decades of conflict, economic instability, and infrastructure damage. Key partnerships with the WHO have led to the establishment of over 1,200 primary healthcare centers, significantly impacting millions annually. NGOs like Médecins Sans Frontières and International Medical Corps, alongside academic institutions like the University of Baghdad, have crucially supported family medicine services and training, with over 200 family physicians graduating from Baghdad in the last decade. Collaborations with regional bodies and global entities like the World Bank have further supported these initiatives (40-42).

Despite significant progress through international collaborations and improvements in access to care and chronic disease management, challenges like workforce shortages, chronic disease burdens, and integration issues remain.

**Limitations**

While the paper provides valuable insights, we confronted several limitations, including unreliable data, especially from conflict-affected areas like Syria, Iraq, and Lebanon. This region's diversity in healthcare systems and economic conditions also challenges the generalizability of findings. There is lack of longitudinal data, and insufficient consideration of cultural factors and patient perspectives.

Finally, ethical concerns in conflict zones and the challenge of implementing policy recommendations due to resource constraints are significant hurdles. Addressing these limitations would necessitate a comprehensive, nuanced approach involving mixed methods and local stakeholder engagement.

## Conclusions

Family Medicine (FM) in the EMRO region has demonstrated remarkable resilience and growth despite significant challenges. This progress is largely due to the commitment of policymakers who prioritize health accessibility for all. Many countries within the EMRO region have integrated family practice as a foundational element of their primary healthcare delivery systems. In conflict zones, family physicians often expand their roles to adapt their services to the specific health needs created by war-related injuries, underscoring their versatility and critical importance.

Overcoming these barriers will require detailed and strategic efforts across several fronts:

**1. Policy Support:** Specific actions such as the implementation of favorable regulatory frameworks can empower family physicians. Additionally, policies that recognize and financially support the broad scope of services provided by family physicians will ensure their roles are both sustainable and impactful.

**2. Strategic Resource Allocation:** Effective resource allocation is crucial for the enhancement of Family Medicine. This might include investing in medical infrastructure that supports telemedicine technologies, which are particularly beneficial in remote or conflict-impacted regions. Allocating funds for research into local health challenges and the efficacy of family medicine practices in these contexts can also provide data to further optimize healthcare delivery.

**3. Education and Training:** Investing in education involves both the initial training of family physicians and their ongoing education. Enhancements in training programs to include specialized modules on managing chronic diseases, mental health, and trauma related to conflicts can prepare physicians for the wide range of challenges they face in the region. Further, creating partnerships with international medical schools and institutions can enrich local training programs with global best practices and innovations in family medicine.

Addressing these areas through comprehensive policy support, strategic resource allocation, and targeted educational investments will sustain and significantly enhance the effectiveness of Family Medicine. Such efforts are crucial for improving the overall health of populations across the region and ensuring the long-term viability and influence of Family Medicine.

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