Primary Care 2030 Dialogue
Actualizing the Declaration of Astana:
Leveraging partnerships to create an ecosystem to achieve UHC with PHC
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Actualizing the Declaration of Astana: Leveraging partnerships to create and ecosystem to achieve UHC with PHC

PROCEEDINGS

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Abbreviations

CBO  community-based organization
EMRO  Regional Office for the Eastern Mediterranean
GDP  gross domestic product
HIV  human immunodeficiency virus
LIC  low-income country
LMIC  low- and middle-income countries
MOU  memorandum of understanding
NCD  noncommunicable disease
NGO  nongovernmental organization
PHC  primary healthcare
PHCPI  Primary Healthcare Performance Initiative
PHCMI  primary healthcare measurement and improvement initiative
SDG  sustainable development goal
UHC  universal healthcare
UNGA  United Nations General Assembly
USAID  United States Agency for International Development
WHO  World Health Organization
Executive summary

On October 16th and 17th, 2019, the workshop Actualizing the Declaration of Astana: leveraging partnerships to create healthcare ecosystems to achieve UHC with PHC, as apart of the second annual Primary Care 2030 Meeting, was convened in Dubai (UAE) by the Harvard Medical School Program in Global Primary Care and Social Change, the World Bank and the World Economic Forum, with support from the Harvard Medical School Center for Global Health Delivery—Dubai. Stakeholders from multiple disciplines and sectors shared best practices, discussed methods for measurement and evaluation, and explored strategies for greater engagement with patients, families, and frontline workers. Through collaborative dialogue, they also established high-level action items for all stakeholders in pursuit of UHC with PHC. Workshop participants included experts from WHO, USAID, The World Bank Group, the World Economic Forum, delegates from Kenya’s and Vietnam’s National Ministries of Health, and non-governmental organizations.

EFFORTS OF INTERNATIONAL ORGANIZATIONS TO PROMOTE UHC WITH PHC

Karen Kinder (WHO) contextualized global efforts to improve UHC and PHC in alignment with the Declaration of Astana and the SDGs. WHO’s forthcoming operational framework is designed to help implementers deliver on their commitments to realize UHC with PHC. Kelly Saldana (USAID) presented USAID’s framework for PHC and UHC, which is designed to support the critical role of partnerships within healthcare ecosystems. Dessislava Dimitrova (World Economic Forum) described the launch of the UHC 2030 Partnership’s private-sector contribution statement, which highlights the need to build trust and a shared language among public and private sectors as well as the need for collective action to bring about UHC and PHC. Irina Nikolic (World Bank) situated PHC and UHC in an economic context and highlighted the need for leapfrog innovations, because current strategies for achieving UHC with PHC and meeting 2030 SDG targets will be insufficient even if successfully implemented.

INITIATIVES TO SUPPORT MEASUREMENT AND EVALUATION

Measurement and evaluation are the foundation of robust UHC and PHC ecosystems. Several initiatives are supporting countries in improving those capacities. The Primary Healthcare Performance Initiative (PHCPI) has prioritized a set of measurements to capture data on inputs, service delivery, outputs, and outcomes; the PHCPI’s Vital Signs Assessment tool supports country partners in measuring key health system indicators of financing, capacity, performance, and equity. PHCPI also collaborates with national-level implementers to develop innovative measurement approaches and fill gaps in available data. WHO-EMRO’s Primary Healthcare Measurement and Improvement Initiative (PHCMI) aims to empower its member nations to actualize the Declaration of Astana and strengthen their existing health systems by establishing clear indicators and building their capacities for measurement. To help optimize productivity, health, and individual learning toward fully realizing human potential, the Human Capital Project measures and ranks countries in terms of their utilization of human capital as well as providing tools for countries to conduct their own internal analyses of resource utilization. Participants explored strategies to improve in-country monitoring and evaluation and brainstormed about innovations to address gaps in data.
NATIONAL-LEVEL EFFORTS TO ACHIEVE UHC THROUGH PHC

The Kenyan delegation discussed the state of PHC in Kenya, strengths and areas for improvement, and opportunities for partnerships. As a trailblazing member of the PHCPI, Kenya was among the first countries to develop their PHCPI Vital Signs Profile. This novel assessment tool has enabled Kenya to utilize its available data more effectively and to identify its data needs. The Vietnamese delegation described their country’s context and outlined plans to strengthen PHC at the grassroots level using specific levers for improvement. To collect sufficient data to complete their PHCPI Vital Signs Profile, Vietnam plans to build community-level electronic health record systems and expand the capacity to measure and collect PHC indicators. Both delegations leveraged the workshop’s collective expertise to develop country-specific action items for achieving strengthening their UHC and PHC ecosystems.

CULTIVATING STAKEHOLDER ENGAGEMENT AND PERSON-CENTERED CARE

UHC and PHC should be delivered within a health system that has person-centered care at its core and fosters active engagement with a broader range of stakeholders, including patients and their families. Participants considered principles of person-centered care that could be applied to drive this paradigm shift. A panel of frontline workers explored their critical role in achieving UHC with PHC; they discussed strategies for leveraging technological innovations and integrating their voices more prominently within the PHC ecosystem. Catalyzing the health system improvements needed to develop ecosystems for UHC with PHC will depend upon cultivating strong partnerships and proactively engaging with all stakeholder in the spirit of helpfulness, trust, and cooperation.
1 Introduction

The workshop Primary Care 2030 Dialogue, Actualizing the Declaration of Astana: Leveraging Partnerships to Create an Ecosystem to Achieve UHC with PHC was convened by the Harvard Medical School Center for Primary Care, alongside the World Bank and the World Economic Forum, and was hosted by the Harvard Medical School Center for Global Health Delivery-Dubai on October 16th and 17th, 2019 in Dubai, United Arab Emirates. The facilitators for this meeting were David Duong, Director of the HMS Program in Global Primary Care and Social Change and Lindsay Hunt, Director of Systems Transformation, HMS Center for Primary Care. More information about the Harvard Medical School Center for Global Health Delivery-Dubai is provided in Box 1-1. The workshop convened delegations from Kenya and Vietnam that consisted of representatives from each country’s ministry of health, as well as representatives from the United Nations (UN), non-governmental organizations (NGOs), the private sector, and academia who are active in those countries. In addition to these delegations, a diverse group of expert stakeholders was invited to represent various international organizations, private-sector organizations, and advocacy groups (i.e., patient representation groups, community-based organizations, etc.).

Box 1-1. Harvard Medical School Center for Global Health Delivery-Dubai

Harvard Medical School’s mission is to nurture a diverse, inclusive community dedicated to alleviating suffering and improving health and wellbeing for all through excellence in teaching and learning, discovery and scholarship, and service and leadership. The Center for Global Health Delivery-Dubai contributes to this mission through its focus on the last phase of health care delivery. Research, medical education, and training activities at the Center are aimed at addressing some of the most pressing health challenges in the region and at improving health care delivery systems and patient outcomes for diseases prevalent in the United Arab Emirates, Middle East, North Africa, and neighboring regions in Africa, Asia, and Europe. The Center’s areas of focus are diabetes and obesity, surgical care, infectious disease, and mental illness, with special consideration granted to projects that focus on the health of women and children. Cooperative and faculty research awards offered at the Center link Harvard researchers with local practitioners and scientists working to ask important questions and generate new knowledge around the myriad delivery gaps being faced. The Center has hosted workshops, symposia, and major courses for more than 2,500 attendees from more than 100 countries, with accompanying proceedings and policy briefs. The practical goal of the Center’s work is to affect meaningful changes through a two-pronged approach of accompaniment and praxis—that is, the process by which a theory, lesson, or skill is enacted, embodied, or realized.

1.1 WORKSHOP OBJECTIVES

David Duong, Director of the HMS Program in Global Primary Care and Social Change and the HMS Center for Primary Care, shared the context and vision for the meeting. Since the last primary healthcare (PHC) meeting that was hosted by the Harvard Medical School Center for Global Health Delivery-Dubai in June 2019, the Declaration of Astana was ratified, the World Health Assembly passed a series of PHC resolutions, and there was a United Nations General Assembly (UNGA)
high-level meeting on universal healthcare (UHC). These events have created a new context for the discussion of PHC, with much attention and political resources currently being directed toward PHC-related efforts. Most UN member states have ratified the Declaration of Astana. Rather than focusing on evidence and justifications for PHC, the meeting focused on implementation and stakeholder engagement for PHC. The workshop had six primary objectives:

• To review and share existing tools, guidelines, operational frameworks and implementation efforts post-Declaration of Astana, including the WHO Primary Health Care Operational Framework, and discuss opportunities and challenges toward actualization;

• To review research on primary care delivery models and systems and analyze case examples of high-functioning primary care delivery from various national and sub-national contexts, including common themes (e.g., team-based care) to actualize the Declaration of Astana;

• To discuss with patient group representatives the importance of partnering with patients and families, and its integration into the development and delivery of new models of care;

• To discuss standards and mechanisms for measuring and evaluating PHC systems and innovations, including innovations in measurement and evaluation tools from a variety of stakeholders;

• To outline, articulate and align guidelines to establish enabling ecosystems that create meaningful multi-stakeholder partnerships to catalyze innovation and adoption at scale of innovative PHC service delivery models, products, and technologies; and

• To identify opportunities for multi-stakeholder partnerships toward the goal of improving primary care delivery models, aligning with quality and accountability, to actualize the Declaration of Astana.

In addition to these objectives, the workshop organizers identified outcomes and deliverables that should come subsequent to the workshop:

• The publication of these proceedings;

• The identification of key principles that can build a consensus statement around multi-stakeholder collaboration, engagement, and investment in PHC to actualize the Declaration of Astana;

• The obtaining of commitments toward investments for PHC innovations in select countries; and

• The development of a Primary Care 2030 community of practice that includes ongoing networking, sharing, and collaborative problem solving.

1.2 ORGANIZATION OF THE WORKSHOP

The workshop took place over two days. Day 1 began with presentations that set the context and vision for PHC and the workshop, followed by case example presentations from Kenya, Vietnam, and the World Health Organization (WHO) Regional Office for the Eastern Mediterranean (EMRO). The next session focused on measuring the success of PHC and included presentations on frameworks for measurement along with an example of Kenya’s work to improve their PHC measurements. The remainder of the workshop consisted of numerous interactive activities, discussions, and report-backs. Day 1 concluded with an interactive group exercise and closing remarks. Day 2 began with opening remarks, a presentation about patient-centered care and person-centered perspectives in healthcare systems, and a panel on integrating frontline health workers into the PHC ecosystem. This was followed by a World Café group activity that was intended to stimulate new ideas and conversation.

1 The workshop agenda is provided in Appendix 8-1.
The workshop concluded with a series of discussions and report-backs that culminated in the development of action items for all participants and stakeholders.

1.3 ORGANIZATION OF THE PROCEEDINGS

These proceedings are organized into six chapters:

• Chapter 1. Introduction
• Chapter 2. Context setting and vision
• Chapter 3. Country case examples
• Chapter 4. Measuring success in strengthening primary care
• Chapter 5. Integrating patients, families, and frontline health workers as members of a healthcare ecosystem
• Chapter 6. Action plans for change
2 Context setting and vision

The workshop opened with brief statements on the meaning of primary care. Salim Hussein, Government of Kenya – MOH, Chomba Sinyangwe, Community Health Academy/Last Mile Health, Ruben Vellenga, UN SDG Partnership Platform, and Sheree Williams, Pfizer, were asked to share what primary health care means to them. Karen Kinder, World Health Organization – HQ, provided a global context, connecting the efforts to improve PHC to UHC and the sustainable development goals (SDG). Kelly Saldana, USAID, shared USAID’s frameworks for PHC and UHC. Dessislava Dimitrova, World Economic Forum, explained the events leading up to the development of the private-sector contribution statement on UHC through World Economic Forum partnerships. Irina Nikolic, World Bank, discussed the economic context of PHC and UHC and the need for innovation. The session concluded with an open discussion.

2.1 VISIONS OF PRIMARY CARE

Sinyangwe opened by reflecting on his work as a young clinician in a rural area providing obstetric care for women. He often encountered obstetric fistula among young, newly married women who were experiencing poverty. His frustration that he could not offer more care to these women upstream in primary health facilities has informed his view of PHC. He described his vision as a model of PHC that can address the issues that contributed to the experiences of his patients in rural areas. In the case of these young women, the issues contributing to their experiences could be addressed through policies to prevent early marriage, community interventions on early marriage, health education for parents, antenatal health care for young mothers, and addressing the causes of poverty. He suggested that the key aspects of PHC include health protection, health promotion, preventive, curative, and rehabilitative services, and reintegration of patients into society.

Vellenga described that in Kenya, the government, with the support of the UN and other key stakeholders, established in 2017 a novel SDG Partnership Platform (SDGPP)\(^2\). The SDGPP convenes and connects leadership from government, development partners, private sector, philanthropy, civil society, and academia to create SDG accelerator windows to catalyze SDG Partnerships, Financing and Innovations in alignment with government development priorities. The SDGPP has become a flagship initiative under Kenya’s United Nations Development Assistance Framework (UNDAF) 2018-2022\(^3\) and received global recognition from the United Nations Development Coordination Office (UNDCO) and the Dag Hammarskjold Foundation as a best practice to accelerate SDG financing in line with the 2030 agenda and ongoing UN reform\(^4\). Primary Healthcare (PHC) has been the first window established, with a goal to be a key driver towards the attainment of Universal Health Coverage (UHC), which is in line with Kenya’s framework for the third Sustainable Development Goal and Big Four Agenda.

The intergovernmental system advocates for PHC because it is comprehensive, in that it offers a package of prevention, promotion, treatment, rehabilitation, and palliative care. PHC brings care to those who need it through an integrated approach that addresses the social determinants of health. PHC promotes the efficient use of health funding to achieve intergovernmental targets for UHC. He suggested that, through the combination

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\(^3\) https://www.undp.org/content/dam/kenya/docs/unct/UNITED%20NATIONS%20DEVELOPMENT%20ASSISTANCE%20FRAMEWORK%20(UNDAF)%20Big%20B5%20web.pdf
of effective partnerships and national commitments, PHC represents one of the best approaches to realizing UHC.

Williams explained that Pfizer Upjohn’s mission is focused on relieving the burden of noncommunicable diseases (NCD) and she shared how the vision of PHC informs aspects of how they execute their mission. They see PHC as the primary access point for patients, many of whom require long-term care to manage NCDs. Hospitals and medical specialists are not best equipped to provide this kind of long-term care. Thus, PHC represents a key partner and stakeholder in relieving the burden of NCDs. Hussein remarked that PHC means providing appropriate and timely health services to individuals and communities at a cost that is affordable for both the providers and recipients of care.

What single word describes primary health care?

Responses to the real-time poll of workshop participants:

2.2 PRIMARY HEALTH CARE: TOWARD UNIVERSAL HEALTH COVERAGE AND THE SUSTAINABLE DEVELOPMENT GOALS

Karen Kinder discussed the definition of PHC, how PHC contributes to achieving UHC and related SDGs, the Declaration of Astana, and events following its ratification. She also discussed the transition from the Declaration of Astana to the implementation of PHC and the operational framework developed to facilitate this process.

PHC has repeatedly been reinterpreted and redefined since Alma-Ata in 1978, Kinder remarked. As defined by WHO, PHC is a whole-of-society approach to health that aims equitably to maximize the level and distribution of health and well-being by focusing on people’s needs and preferences (both as individuals and as communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, all while being as close as possible to people’s everyday environment. Primary care and essential public health functions are the core of integrated health services. As such, PHC has three interrelated and synergistic components: (1) multi-sectoral action; (2) empowering people, families, and
communities; and (3) integrated service delivery.

Multisectoral action should systematically address social, economic, environmental and commercial determinants of health through evidence-based public policies and actions across all sectors. People, families, and communities should be empowered to take control of their health and act as caregivers, as co-developers of health and social services through social and community participation, and as advocates for multisectoral policies that promote and protect health. Integrated service delivery should ensure that people’s main health problems are addressed through comprehensive care throughout the life course, strategically prioritizing essential public health functions and primary care services as the central elements of integrated service delivery across all levels of care.

Kinder remarked that PHC is often primarily associated with public health functions and integrated service delivery; however, there are numerous global challenges that quickly come to light when PHC is considered. These challenges include: limited access to comprehensive services; inequalities; under-emphasis of health promotion and disease prevention; the growing burden of NCDs; fragmented, inefficient, or poor-quality health services; and war, violence, epidemics, climate change, environmental disasters, poverty, and poor living conditions. PHC and UHC mutually reinforce each other, Kinder explained. The discussion of UHC often stops after addressing the question of what packages of care and services should be provided to what people. PHC addresses the question of how to deliver effective, equitable services in a cost-effective and efficient manner. PHC and UHC are necessary to achieve the health-related SDGs.

2.2.1 The Declaration of Astana

Kinder noted that the Declaration of Astana awakened an enormous interest in PHC. The declaration was the result of a process that began in February 2018. The declaration includes four commitments:

- to make bold political choices for health across all sectors;
- to build sustainable PHC;
- to empower individuals and communities; and
- to align stakeholder support to national policies, strategies, and plans.

The commitment to make bold political choices for health includes promoting and protecting the right of everyone to the enjoyment of the highest attainable standard of health, the promotion of multisectoral action and UHC, the engagement of stakeholders, and the empowerment of local communities to strengthen PHC. This commitment calls for actors to address economic, social, and environmental determinants of health and to aim to reduce risk factors by mainstreaming a “health in all policies” approach. She described this approach as including the provision and allocation of resources, along with the aim to leave no one behind, to use coherent, inclusive approaches to expand PHC as a pillar of UHC, and the provision of essential health services in line with humanitarian principles.

The commitment to build sustainable PHC includes enhancing capacity and infrastructure for primary care while avoiding fragmentation and ensuring a functional referral system between primary and other levels of care. It also includes the development of a range of comprehensive, accessible, equitable, safe, efficient, acceptable and high-quality services. The commitment to empower individuals requires that actors support the involvement of individuals, families, communities, and civil society through their participation in the development and implementation of policies and plans that have an impact on health. It also includes the commitment to promote health literacy, solidarity, ethics, and human rights and to increase community ownership and contribute to the accountability of the public and
private sectors. The commitment calls on all stakeholders to align with national policies, strategies, and plans across all sectors in a participatory manner. It also calls for all stakeholders to work together in a spirit of partnership and effective cooperation.

Kinder described how the call for PHC has been affirmed with intergovernmental commitments since the ratification of the Declaration of Astana. In May 2019, the World Health Assembly passed an agenda item on PHC. At G7 in 2019, it was affirmed that “PHC is a cornerstone of a sustainable health system for UHC.” Then later in 2019, the UNGA high-level meeting on UHC resulted in the recognition that “PHC is the cornerstone of a sustainable health system for UHC and health-related SDGs, as was declared in the Declaration of Alma-Ata and reaffirmed by the Declaration of Astana.”

2.2.2 Operational framework: transforming vision into action

Kinder pointed out that the Declaration of Astana closes with the commitment to “act on this Declaration in solidarity and coordination between governments, WHO, the United Nations Children’s Fund and all other stakeholders.” The operational framework was developed to help make the Declaration of Astana actionable. A draft of the operational framework is under review and is expected to be adopted in 2020. The consultation process which led to the current draft of the operation framework included public consultation, civil society consultation, and informant interviews.

The operational framework comprises 14 strategic and operational levers, with actions and interventions proposed for each lever. These levers are intended to be integrated into routine national health strategies, both in ministries of health and other ministries. The framework is intended to be adaptable, responsive, and flexible to a country’s needs. The levers are interdependent, requiring that countries work on each of the levers simultaneously. These levers include:

- political commitment and leadership
- governance and policy frameworks
- funding and allocation of resources
- engagement of the community and other stakeholders
- PHC workforce
- physical infrastructure
- medicines and other products
- models of care
- engagement with private-sector providers
- purchasing and payment systems
- digital technologies
- systems for quality improvement
- PHC-oriented research
- monitoring and evaluation

2.2.3 Engagement with the private sector

Kinder highlighted the level of engagement with private-sector providers. The private sector delivers more than 50% of primary care services in many LMICs. The private sector can play a role in numerous aspects of PHC, such as innovation, technology, and supply chains. Engagement can include training and quality improvement, social marketing, social franchising, and purchasing. Engagement can also involve legal arrangements, including public ownership with private management, joint ventures with shared ownership, transferring ownership over time, using public financing to support private activities, or using private financing to support public activities.

Private-sector providers can also be a key part of the provision of primary care services. Engagement with private-sector providers is necessary to deliver on the commitments outlined in the Declaration of Astana.

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5 World Health Organization 2018b
Engagement with private-sector providers raises other important issues such as equity, regulation, and alignment with each country’s health goals. WHO has developed a model and decision-making tool to inform evidence-based decision making. The information used to create the decision-making model includes: (1) understanding a country’s health markets; (2) identifying potential areas of risk and opportunity posed by the private sector to a country’s health goals; (3) identifying different models of engaging the private sector; and (4) assessing governance and regulatory capacity, matching this capacity to its envisioned role for the private sector, and helping with the design of reforms to address capacity gaps.

In summary, Kinder remarked that PHC is a health systems approach and that orientation needs to be integrated into policies and actions across sectors. Engagement with all stakeholders is key to delivering on the bold vision of PHC, and alignment of donors and technical partners around national health priorities will be a key aspect of achieving the goals of PHC.

### 2.3 USAID Frameworks for PHC and UHC

Saldana discussed USAID’s work and position regarding PHC and UHC. USAID’s work on these topics began as USAID participated in the work leading up to the Declaration of Astana. Their work has since transitioned based on the UNGA high-level meeting on UHC.

#### 2.3.1 Statement on implementation of PHC

Saldana explained that, around the time of the Astana conference, USAID worked with other international organizations, donors, and implementing partners to articulate a set of principles of PHC. These principles reflect the ways in which USAID intends to engage with stakeholders to support the implementation of the Declaration of Astana. Support for PHC should start with a basic set of services that are available to all, then expand from there in a progressive way. The work of PHC must include partnerships among private and public sectors, along with civil society and faith-based organizations. Promoting such partnerships reduces fragmentation and leverages the strengths of individual stakeholders. The role of communities is critically important in delivering PHC services. In addition to recognizing the role of communities, it is necessary to recognize the linkages between communities and health services, such as community health workers. It is crucial to support the development of PHC systems, but also to redirect existing resources—both human and financial—into the development of such systems. USAID wants its efforts to improve the quality and availability of care, training, supervision, drugs, and supplies. They aim to identify existing solutions that are working in countries and replicate and support those solutions in other countries. There is much ongoing work in the PHC space that can be learned from, she noted, as well as an emerging role for data and technology to support achieving the goals backing PHC. USAID values the role of technology within the context of supporting PHC systems.

#### 2.3.2 High-performing health care

Saldana noted that, in addition to establishing their principles of PHC, USAID set out to internally define UHC. USAID wanted to define UHC in a way that clearly indicates that USAID embraces the SDG definitions of UHC, including financial protection, access to quality essential services and using limited jargon. To attain this, USAID developed the terminology “high-performing health care,” defined as “a constellation of high-performing public and private health institutions that work together to ensure that people get the care they need in ways they trust. When they need care, it is available at an affordable cost, and within a reasonable distance.” High-performing health care was further defined as healthcare that is accountable, affordable, accessible, and reliable.
Healthcare is accountable when systems work with society as a whole to provide healthcare that meets people’s needs. This means that communities, civil society, faith-based organizations and the private sector are engaged with the government as partners in the management and oversight of healthcare systems. This includes instituting mechanisms to ensure service quality and patient satisfaction, as well as recourse options for patients or communities dissatisfied with healthcare services. Accountable healthcare systems require information regarding the financing, delivery, and outcomes of care to be publicly available to ensure sustainability. Finally, accountable healthcare licensing agencies exist to set standards and credential providers and accredit facilities.

Healthcare is affordable when healthcare systems ensure that the money spent on healthcare provides the best value possible. This means people are not impoverished from routine or unexpected healthcare costs including the cost of medicines, and that they continue to seek needed care after considering the total cost of that care. Additionally, people freely choose to participate in pre-payment or insurance plans to improve their ability to access healthcare and protect themselves from financial hardship due to illness. At the national level, governments allocate financial and human resources to meet the priority needs of their populations and work with a broad range of stakeholders to increase the resources available for healthcare and ensure adequate distribution of resources.

Healthcare is accessible when healthcare systems provide care when and where people need it. People understand when, why, and where to get the care they need and are motivated to seek it. When people do seek care, providers deliver healthcare in a manner that ensures equitable health outcomes and promotes dignity and respect for all patients and providers and complies with established standards. Accessibility is also achieved when health facilities and medicines are located within a reasonable distance, are consistently open on a regular schedule known to the community and have the staff and equipment to fulfill their designated functions, including during emergencies. Transportation to facilities is available in case of emergencies as well. Finally, alternative care options exist to extend the reach of traditional health facilities, including both paid and volunteer community health workers, as well as digital or e-health applications, drug shops/pharmacies, mobile outreach, etc.

Healthcare is reliable when healthcare systems provide quality health services in a timely and confidential manner that ensures dignity and respect for all patients. To be reliable, health facilities and health workers must have the right supplies and commodities to deliver needed services. Moreover, there must be systems to manage pharmaceuticals and logistics so that medicines, devices, and commodities are safe and of expected quality, and with controls that minimize the risk of theft or falsification. Health workers must have the right knowledge, motivation, skills and cultural understanding to provide the care they are entrusted with; they should be able to participate in continuing education and be regulated through professional and licensing associations; they should have adequate incentives to stay in their jobs and be safe and protected from harm. Patients must trust that the system will provide them with the care they need in a way that meets their needs respectfully, without stigma, shame, fear, or abuse and help them understand proper use of medicines; and the overall system must ensure continuity of services during times of disruption, shock or crisis.

2.3.3 How USAID works with partners to create high-performing healthcare systems

Taking these principles and definitions into account, USAID has developed key principles that guide USAID’s work, Saldana explained. These principles include focusing on PHC, supporting patient ecosystems, letting countries lead, helping build resilience, emphasizing sustainability, engaging and
aligning efforts with a wide variety of partners and stakeholders, designing new approaches for scale, scaling proven approaches, and considering market dynamics for new products—especially those targeted to the poor.

2.3.4 USAID inclusive health access prize

USAID is focused on identifying, replicating, and scaling exemplary solutions, Saldana reiterated. The USAID inclusive health access prize was developed to promote that aim. The program launched in May 2019 and accepted nearly 400 applicants from 68 countries. The prize recognizes proven, locally led innovations from private-sector organizations collaborating with the public health sector to expand access to care. Five winners were selected from Cameroon, India, Nigeria, and Senegal who received cash prizes (see Box 2-1). Each solution has potential for adaptation and replication, or to be scaled in other countries or local contexts to meet priority healthcare needs. Implementers are encouraged to reach out to USAID to discuss any of these solutions, as they are available for replication and scale up in other settings.

Box 2-1. Private-sector innovations to expand access to care

- In Cameroon, GIC Med uses a portable microscope connected to a smartphone and telemedicine app to improve women’s access to services they might not otherwise seek or receive in rural public and private health centers.

- Infiuss, an online blood bank and digital emergency supply monitor in Cameroon, provides hospitals and patients reliable and affordable access to blood. Using a database, users can identify a blood supply and arrange its transportation.

- JokkoSanté is a digital payments app that improves accountability in the health system in Senegal by tracking medicines and enabling payments for health services. Users buy points in health facilities or with mobile money as a micro savings account and spend them in times of need. The app also manages drug traceability and prescriptions.

- In Nigeria, mDoc advances the accessibility and reliability of health care for people with a range of health conditions through a high-tech, high-touch mobile and web-based solution that provides personalized preventive and integrated care support.

- Piramal Swasthya Management and Research Institute provides community outreach programs and telemedicine services that complement the public health care system and make health care more affordable and accessible to underserved and marginalized populations in India.

2.4 THE UHC 2030 PARTNERSHIP PRIVATE-SECTOR STATEMENT

Dessislava Dimitrova, World Economic Forum, described the context and events leading up to the launch of the UHC 2030 partnership’s private-sector contribution statement. She also discussed the statement itself and shared

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6 For more information about the USAID inclusive health access prize, see https://competitions4dev.org/healthaccessprize/winners (Accessed Dec 1, 2019)
some insights from and reactions to the statement.

2.4.1 The healthcare transformation team at the World Economic Forum

Dimitrova explained that the healthcare transformation team at the World Economic Forum works to connect healthcare companies and other companies with governments and other international organizations to think through new and innovative ways to address the challenges related to healthcare. The team works along the continuum of care, and their theory of change holds that greater investment made in PHC—e.g., prevention and treatment—will help deliver healthcare to the projected 9.7 billion humans that will be living on earth in by 2050. The healthcare transformation team works on prevention by focusing on health security. Ongoing experiments in the field include a tool that enables companies to assess their readiness for epidemics. The team aims to be a hub for public-private partnerships and has also done much work on NCDs, treatment, and leapfrogging data for precision medicine, and value-based healthcare.

2.4.2 Developing the private-sector constituency and statement within the UHC 2030 partnership

Once the private-sector statement was developed, it was shared with the broad constituency of the UHC 2030 partnership and launched at the UNGA, Dimitrova explained. The statement comprises seven main points, which represent seven areas of contribution. The private-sector partners also identified the need for an enabling environment created by the public sector. The seven areas of contribution include:

- Offering quality products and services that consider the needs of all people, including poor and marginalized populations, and making these products affordable, accessible, and sustainable;
- Incorporating UHC principles, including the principle of leaving no one behind, into core business models and objectives;
- Developing, testing and scaling up innovative business models that align with UHC goals;
- Creating, adapting, applying, and scaling up innovations;
- Incorporating UHC principles, including the principle of leaving no one behind, into core business models and objectives;
- Developing, testing and scaling up innovative business models that align with UHC goals;
- Creating, adapting, applying, and scaling up innovations;
• Helping to strengthen the health workforce, responding to local context, priorities, and needs;
• Contributing to efforts to raise the financing available for UHC; and
• Engaging in championing and building capacities for relevant policy dialogue and partnerships with government and other stakeholders.

Both the public and private sectors reacted well to the private-sector statement (see Figure 2-1). Some ministers of health noted that this statement could serve as a basis for establishing partnerships in their countries. The private-sector constituency intends to use this statement to (1) hold themselves accountable to the principles described in the statement and (2) as a platform on which individual company initiatives can be advanced and exposed to other constituencies. For example, Philips was motivated by the principle to create, adapt, apply, and scale up innovations and has approached the UHC 2030 partnership constituency to engage and create the digitally enabled care coalition. This coalition will work to advance the digital agenda in a synchronized way. Novartis, similarly, may test a new model for leaving no one behind in PHC in Vietnam. The private-sector statement serves in this way as a platform through which the private sector can engage in PHC. If more private-sector constituents use this framework as a platform for engagement, then private-sector actors can identify areas of contribution that still need more activity or join existing efforts rather than start from scratch. This framework also enables private-sector actors to take ownership of certain areas of contribution in a transparent and accountable manner that can also be used for monitoring and evaluation in the future. Organizers are planning to create a representation of this framework and private-sector contributions online so that actors can market their efforts and see other ongoing efforts on the platform.
2.5 HUMAN CAPITAL: INVESTMENT FOR FUTURE PROSPERITY AND QUALITY OF LIFE

Irina Nikolic, World Bank, discussed the role of the human capital index as an indicator for decision makers, global spending on health, and the need for innovation and leapfrog technological solutions. She also discussed challenges and opportunities to strengthen leadership and improve outcomes.

2.5.1 Human capital

Human capital represents two-thirds of global wealth, Nikolic explained. The human capital index ranks countries by level of human capital measured by health and education outcomes, creating demand among ministries...
of finance to invest in people. These simple indicators serve as a powerful tool for dialogue and they capture the imaginations of global leaders. The human capital project supports countries in their efforts to increase the level and improve the yields of investment in their people.

2.5.2 Global spending on health and UHC

Health is one of the leading public expenditure items and one of the fastest growing sectors of the global economy. In the past, the health sector was not often thought of as a ‘productive’ sector. As human capital investment increases, this mindset should begin to shift. Figure 2-2 shows that countries with lower income spend a smaller proportion on health. Still, global spending on health has consistently risen since 2000 to USD$7.7 trillion in 2016, 11% of the global gross domestic product (GDP). While global spending on health increases, UHC remains an unfulfilled promise; 3.6 billion people do not receive the essential health services they need. Additionally, 100 million people are pushed into extreme poverty each year by out-of-pocket payments for health services. Quality, access, and affordability in healthcare are certainly not universal. The pace of progress toward UHC has been slow, with great insufficiencies, inefficiencies and inequities that remain to be addressed. Low-income countries (LIC) and low- and middle-income countries (LMIC) are facing a funding gap of USD$176.3 billion to achieve UHC by 2030. An estimated 20%-40% of spending on health is wasted (USD$1.5 trillion - USD$3 trillion). Each year, individuals pay a total of USD$0.5 trillion in out-of-pocket expenditures. Enhanced leadership, governance, and organizational capacity are needed to address these issues. Solutions that work to address these issues must be scaled, innovations must be accelerated, and all sectors must be engaged.

![Figure 2-2: Health as a share of government spending](image)

Source: Nikolic presentation

Notes: LIC = low-income country; LMIC = lower-middle-income countries; UMIC = upper-middle-income countries; HIC = high-income countries
2.5.3 The need for innovation

Nikolic explained that, as The World Bank Group prepared for the publication of Business Unusual: Accelerating Progress Toward Universal Health Coverage, researchers evaluated all known successful innovations in health coverage. They looked at countries who were outliers in terms of their progress toward UHC and discovered that even if all proven strategies were implemented immediately, it would not be sufficient to reach the SDG goals by 2030. It was determined that disruptive, leapfrog solutions would be required to achieve the SDG goals. Several initiatives have been developed to promote such innovations—for example, TechEmegre matches digital health solutions with country systems. The adoption of this program in India and Brazil has been successful but only in the private provider systems.

2.5.4 Emerging challenges

The need for innovation was identified in a context of emerging and intensifying challenges that drive up healthcare costs and constrain fiscal capacity. Nikolic remarked. Among these challenges are numerous cost pressures, such as rising expectations, technical progress, aging populations, and a growing burden of NCDs, the cost of which represents 4% of the global GDP. Factors that constrain fiscal capacity include limited capacity to raise tax revenue, persistent informality, automation, and high dependency ratios. Health system and economic shocks include disease outbreaks, antimicrobial resistance, and forced displacement. For example, the costs of the Ebola epidemic in three African countries totaled USD$2.2 billion in 2015.

2.5.5 Strengthening leadership, governance, and organizational capacity

Nikolic pointed out the need to find new ways of working together. Solutions that work must be scaled up and strategies that do not work should be abandoned. Widespread adaptation and adoption of proven healthcare delivery and financing strategies should be promoted. The financing of primary and community healthcare services should be prioritized to ensure quality affordable healthcare. Resilience and sustainability need to be developed through contingency financing and health taxes. Innovations can be accelerated through digital financial inclusion, automated billing and payment, prediction data mining, and engaging private and social sectors. Governance and organizational capacity can be strengthened through investing in health, public financial management, and a whole-of-government approach.

It is necessary to accelerate innovations and engage all sectors, Nikolic explained. This includes the need to expand evidence on and adopt what works, to evaluate and adapt strategies to improve resilience and sustainability, and to generate new solutions to challenges. She presented examples including Big Data mining on claims, monitoring performance and driving deep learning, decision-making with predictive models, cashless health contributions, and smarter financing of global health security. Overall, there must be a shift from volume-driven healthcare to value-driven healthcare in order to promote access, quality, and affordability of care.

2.5.6 Improving health outcomes: priorities for action

In closing, Nikolic shared the four priorities for action for improving health outcomes that were identified at the recent UNGA meeting:

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7 The World Bank 2018
9 The World Bank 2018
• Ramp up investment in affordable quality primary healthcare, scale what works to ensure affordability and quality of healthcare, and to improve health security.

• Support a UHC financing and delivery innovation portfolio, including engaging with the private sector to unlock new models for health solutions, financing and delivery.

• Go beyond health to improve health outcomes, supporting communities by improving education, broadening social services and creating jobs.

• Ensure high performance health financing: better outcomes for the money spent, better alignment to catalyze domestic resources and sustainability.

2.6 DISCUSSION

2.6.1 WHO’s operational framework and engagement with the private sector

Sejal Mistry, Access Health International, remarked that the WHO operational framework acknowledges the role of the private sector but calls for a focus on private-sector providers rather than broad private-sector engagement; the World Economic Forum was more keen on engaging with the private sector broadly. She asked whether any of the presenters could comment on this tension or difference in approach, e.g., how multi-stakeholder partnerships can engage broadly with the private sector when the operational framework calls for a narrower engagement with the public sector. Karen Kinder, World Health Organization – HQ, acknowledged Mistry’s point and conceded that the WHO operational framework focuses on the role of the private sector in the provision of primary care. She pointed out that in many settings, the majority of primary health services are provided by private providers. Thus, the provision of primary care was identified as a starting point for engagement with the private sector in terms of regulation, quality assurance, and alignment with public sector providers. Kinder explained that, although the operational framework does emphasize the focus on engagement with private-sector primary care providers, she does not see engagement with private-sector providers and engagement with the broader private sector as mutually exclusive; rather, these forms of engagement can be conducted in parallel.

2.6.2 Matching innovations with the needs of healthcare systems

Pascal Fröhlicher, Accessible Quality Health Services (U-CARE), asked how scalable innovations can be found, identified, and subsequently presented to those who will implement them on a broad scale? Irina Nikolic, World Bank, agreed that this question is the crux of the issue. This is the issue that The World Bank is trying to solve. A top-down approach cannot be relied upon, as this approach will shut out many promising opportunities. The World Bank is investigating approaches that encourage both bottom-up innovations that are matched to country needs and guided innovations based on known gaps. They are seeking opportunities to invest in numerous approaches and in companies working on innovative solutions. They are also interested in opportunities that may allow them to partner with broader private-sector actors and partners who are already working in-country to develop innovations. The TechEmerge matchmaking program is a good example of a program that strikes a balance, connecting the need for innovations with existing technologies and innovators in the private sector. Forthcoming efforts are aiming to strike a similar balance, but there is still no straightforward answer to the deeper question of how to connect implementers with the right innovations. Deliberate streamlining and guiding of the matchmaking process can quickly lead to the stifling of innovation, an outcome that should be avoided. Nikolic reiterated the value of forging alliances and partnerships at the global and country level, encouraging investment, and connecting hubs of innovation with areas of need.
Nikolic remarked that enabling policy makers to see innovative technologies first-hand has great value. In 2017, The World Bank Group partnered with numerous organizations to bring together 40 innovations from 25 companies for a meeting on UHC. The conversations and energy of the meeting shifted when these innovations were presented. The policymakers’ imaginations were captured by the innovations, which ranged from basic neonatal solutions that could be applied in the field to sophisticated data mining AI-based technology. There are still gaps in need of innovations, including regulatory gaps, but there is limited space for missteps or ineffective moves. This underlines the question of how to ensure a regulatory framework and contracting ability for governments to support the adoption of the right innovations—for example, how implementers can prove an evidence-based approach without taking years to establish evidence.

2.6.3 USAID’s vertical funding for PHC

Salim Hussein, Government of Kenya – MOH, pointed out that much of USAID funding is very vertical, yet PHC is intended to be more horizontal and comprehensive. He noted that this poses a challenge when trying to spend UHC dollars on PHC programming. He asked whether USAID or others are developing any framework or mechanism designed to revert the highly vertical nature of funding and programing in countries like Kenya. Kelly Saldana, USAID, conceded that USAID’s funding is verticalized and surmised that it will continue to be verticalized going forward. In 2015, USAID issued a vision for health system strengthening, which is a strategic document intended to promote more horizontal programming; an updated version of the document is forthcoming. Although this updated document will further promote a horizontal approach, USAID funding will likely continue to be verticalized.

Bram Wispelwey, Health for Palestine, asked whether USAID has an updated strategy for providing UHC and PHC to vulnerable populations, especially stateless and refugee populations. Saldana explained that USAID begins their strategic process by identifying the desired health system outcome. In this case, USAID is aiming to achieve equity in health coverage, quality of care and services, and resource optimizations. These three guiding principles are the driving force behind USAID’s current approach to UHC and PHC. The guiding principle of equity would suggest that vulnerable populations should have access to health systems, but the field has become stagnant amidst numerous efforts to more effectively measure inequities in healthcare. USAID is trying to move beyond measurement by thinking creatively and innovatively about ways to solve these inequities by asking the right questions in program design to ensure that healthcare is delivered to these vulnerable populations.
3 Country case examples

3.1 PRIMARY HEALTHCARE IN KENYA

Agatha Olago, Government of Kenya–MOH, discussed the current state of health in Kenya, Kenya’s indicators relating to PHC, the roles of governance, policy, and partnerships in Kenya’s endeavor to achieve UHC and PHC, areas of strength, and areas of needed improvement.

3.1.1 Need for improved PHC

Olago raised questions that are often posed in communities discussing UHC and PHC: “What happens when I go to the [community-level] health facility? How do I know that I will get drugs when I go to the health center?” Patients who have gone to community facilities have become accustomed to not receiving needed care or drugs, so they go instead to hospitals or other higher-level facilities where they anticipate care will be provided. This pattern was revealed in Kenya’s UHC pilot counties. Many patients went directly to higher-level facilities to obtain basic prescriptions, knowing that those basic drugs would not be available at the primary care facilities. This highlights the issue of access as well as the lack of trust in the primary health facilities within the community—the prevailing belief is that the care provided at the primary care facility is inferior to the care available at higher-level facilities.

3.1.2 Kenya’s PHC vision and current status

Olago explained that Kenya’s vision is to be a healthy, productive, and globally competitive nation; this vision includes PHC. She shared data from Kenya’s PHC vital signs profile (see Figure 3-1).10 Kenya’s GDP per capita is $3,286, with 2% of GDP going toward health spending, and 37% of people living in Kenya live in poverty. The life expectancy in Kenya is 67 years, with neonatal mortality at 23 per 1,000 live births and a premature NCD mortality rate of 13%. The maternal mortality rate in Kenya has been disputed and so has not been included in the PHC vital signs data. However, Olaga shared that Kenya’s demographic health survey reported a maternal mortality rate of around 362 per 100,000 live births. Communicable diseases and other conditions are the leading causes of death in Kenya, accounting for 63% of deaths; however, 27% of deaths are caused by NCDs. Kenya’s HIV prevalence is 4.8% among those aged 15-49 years, which is also relatively high. Kenya’s health equity needs improvement. For example, the coverage of reproductive, maternal, newborn, and child health services is low. She pointed out that most of the health spending in Kenya is spent on curative services, not on preventive or promotive services. Kenya is lacking data on their PHC capacity—such as governance, inputs, and population health and facility management—but they are working to collect these data. She presented a map of Kenya color-coded to indicate the health coverage in each county (see Appendix 82). Only nine counties have coverage above 90%, while 22 counties have coverage between 50% and 89%, and 16 counties have coverage below 50%. The mapping of coverage in Kenya shows where improvement is needed and Kenya’s UHC plan aims to increase coverage.

Kenya’s health system is divided into six levels of care:

- Level 1 care: community health centers
- Levels 2 and 3 care: dispensaries and health centers
- Level 4 care: primary referral centers

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• Levels 5 and 6 care: county- and national-level referral centers

Of the roughly 9,944 level 2 or 3 primary care facilities in Kenya, 50% of these are public facilities, 37% are private for-profit facilities, and 13% are private not-for-profit facilities. The mean availability of essential medicine in Kenya is 44% and dispensaries have 37% (on average) of the essential drugs on hand. The mean availability of basic equipment is 77%, but only 24% of health facilities have all basic equipment items. Kenya is also managing large staffing gaps, with 24 doctors per 100,000 population, 41 clinical officers per 100,000 population, and 172 nurses per 100,000 population.

Figure 3.1. Kenya Primary Health Care vital signs profile

Source: Olago presentation

3.1.3 What makes Kenya unique?

Olago explored some of the ways that Kenya is unique. Kenya has 47 county governments and a decentralized system of government; each county independently manages its healthcare system and administrative structure. This can be beneficial, but it also raises certain challenges. While it is an advantage that healthcare decisions are
managed locally, the various administrative structures and financing strategies are not easy to orchestrate at the national level. President Uhuru Kenyatta announced his ‘Big Four’ plan for Kenya in 2017, with affordable healthcare as one of the four key items on his agenda. UHC is currently being piloted in four counties with the intention to scale up UHC nationwide. Numerous assessments were carried out before the implementation of UHC in these counties to investigate the need for human resources, essential medicines, and required equipment. For example, there were funds available to meet the needs for human resources, but only one of the four pilot counties was able to use this funding to fill their staffing gap; the other three counties have been unable to fill their staffing gap. Public communication about UHC and PHC also needs to be strengthened, she noted.

3.1.4 Governance and policy
Kenya has high-level political commitment and has developed a primary healthcare strategic framework that is awaiting final approval, Olago explained, but coordination structures also need to be developed at the county level. The discussion of UHC has brought about increased commitment of resources to PHC and the upcoming national health financing strategy will include financing for UHC in Kenya. The current funding at the national and county levels remains inadequate, however. The decentralized county-level implementations employ different funding mechanisms, adding further complexity. She added that the classification of Kenya as a lower-middle-income country has resulted in decreased funding for existing programs in the country. For example, the HIV program in Kenya had been reliant on donor funds that have dissipated and the blood donation program in Kenya has received fewer donor dollars since this classification.

3.1.5 PHC partnerships
Olago described a government committee in Kenya that is working to bring together stakeholders from the community and primary care facilities. The committee is working to improve broad systems that impact the delivery of healthcare, such as transportation. They are targeting integrated services and comprehensive care, attempting to pool funds for PHC services and to strengthen and coordinate health systems. There has been private-sector involvement in these efforts, especially from manufacturers and providers of healthcare equipment. Kenya has also received support from pharmaceutical companies, particularly for the management of NCDs and maternal health.

3.1.6 Areas of strength
Olago noted that Kenya benefits from strong political leadership and commitment to healthcare, as well as high levels of stakeholder engagement in identifying issues, solving problems, and prioritizing actions. Governance, policy frameworks, and physical infrastructure for the implementation of PHC are additional areas of strength. Kenya has also benefited from integrating PHC indicators into their monitoring and evaluation efforts.

3.1.7 Areas for improvement
Olago identified several areas in which Kenya could improve, including the provision of adequate funding and equitable allocation of resources for PHC. Kenya’s health information systems and digitalization need improvement. Improving health information and digitalization would also benefit community health workers by simplifying their workflow and ensuring that the data they collect is securely transmitted to the national level upon being entered into the data management system. Kenya also faces challenges in implementing models that prioritize PHC in both public and private healthcare settings. Specifically, Kenya is looking for ways to incorporate the private sector into its PHC models. Kenya’s monitoring and evaluation systems also need improvement.

3.1.8 Discussion
Cristin Lind, Patient Advocate, asked whether Kenya has considered engaging with patient
advocacy organizations. Olago explained that the stakeholder engagement process is still in the development stage, but patient advocacy groups have been engaged.

3.2 PRIMARY HEALTHCARE IN VIETNAM

Hang Nguyen, Government of Vietnam—MOH, described the current state of PHC in Vietnam. She discussed the political commitment and existing partnerships underway to strengthen PHC, along with Vietnam's strengths, weaknesses, and challenges faced in their efforts to improve PHC. Nguyen opened with a story of a man who spent a whole day traveling to and waiting in a central hospital for a simple hypertension examination. This underscores a key issue related to PHC in Vietnam: patients should be able to receive a certain level of care at the community level. Vietnam is working to solve this problem; their vision for UHC is to provide all people with access to health insurance and quality healthcare in an equitable way. Developing PHC in Vietnam is a part of achieving this vision. Resolution 20- NQ / TW has set the goal of implementing universal health care coverage; all people are medically treated and provided with quality health care services; equality in rights and obligations in access to health insurance and health care services is ensured.

Vietnam comprises 63 cities and provinces that are home to more than 95 million individuals, 35% of whom live in urban areas. Life expectancy in Vietnam is 76.5 years. Around one-quarter of children under five experience moderate or severe stunting, the infant mortality rate is 17.3 per 1,000, and the under-five mortality rate is 21.6 per 1,000. The HIV prevalence among adults aged 15-49 years is 0.4%. Vietnam's GDP per capita is around USD$2,300 and health expenditure in Vietnam is 5.7% of GDP.

3.2.1 Primary health care context in Vietnam

Nguyen explained that when Alma-Ata was ratified in 1979, Vietnam added two components to the core Alma-Ata agenda for their national healthcare plan: strengthening Vietnam’s healthcare network at the grassroots level and health management. The health system in Vietnam has four levels. The commune and district levels are considered to make up the ‘grassroots’ level of the healthcare system. Vietnam has 11,793 community health centers and 35,000 private practices, with 8 doctors and 2.1 pharmacists per 10,000 people. Around 87% of community health centers are served by a doctor and 98% of community health centers have a midwife or pediatric/obstetric assistant doctor. Almost all rural villages (97.5%) are served by a village health worker. More than half of community health centers are able to maintain the mandated supply of essential drugs and there are 4.5 retail drug outlets per 10,000 people in Vietnam. Community health centers perform 70% of the number of services in the regulated list and 6% of community health centers meet the national health benchmarks.

Nguyen discussed some of the advantages and disadvantages that make Vietnam unique. Vietnam’s total health expenditure accounts for nearly 6% of its GDP, which is high compared with other lower-middle-income countries. Similarly, Vietnam’s per capita health spending is about USD$150 per year, which is higher than the minimum for implementing UHC (USD$100 per capita per year). Vietnam’s health insurance coverage has rapidly increased over the past three decades and is currently at 87.7% coverage. Vietnam’s grassroots healthcare system is widespread with a strong trend toward decentralization, giving local governments strategic control of their healthcare systems. Vietnam has achieved high ratings on health indicators compared with countries with similar income, and the country achieved the Millennium Development Goals. Public spending on health is low in Vietnam (2.9% of GDP), and out-of-pocket spending is high (44%). Fiscal space for health in Vietnam is limited and the current spending on health is inefficient. Payment methods, dependence on central and provincial facilities, excessive
spending on drugs, and weak monitoring and accountability all contribute to the inefficiency of health spending. Furthermore, the health sector in Vietnam has limited capacity to determine national or local priorities, and there is currently little mobilization of stakeholder involvement. Additionally, there are significant disparities in health status among income groups, ethnic minorities, and those in various geographic regions.

3.2.2 Levers to improve primary health care in Vietnam

Nguyen explored a range of potential levers to improve PHC in Vietnam. With respect to political commitment and leadership, the country benefits from high-level buy-in for the achievement of the SDGs, including UHC by 2030. This commitment includes mandates that 30% of health spending be budgeted for preventive medicine and that the burden of delivery of PHC services be shifted from higher-level facilities to lower-level PHC facilities. Accessibility of health care services could be improved by determining and appropriately reallocating resources. Vietnam has yet to develop comprehensive national health sector policies and plans, and they should include goals and targets aimed at improving all components of PHC.

Levers also exist within governance and policy frameworks. The PHC policy and legislation system has been reformed and improved, with PHC linked to all relevant policy initiatives (e.g., the Health Development Program at the Grassroots Level, Healthy Vietnam Program, the national TB program, and health financing reform). Enhanced partnerships, especially with private-sector actors, will also play a significant role in this policy shift. They are planning to pilot a standardized PHC model at 26 community health centers. Improved monitoring and evaluation, including health data and information management systems, and strengthened PHC management protocols will be needed to ensure the success of this endeavor. Vietnam has established three programs that will contribute to the strengthening of Vietnam’s PHC system: the Healthy Vietnam Program, the Health Development Program at Grassroots Level, and the Targeted Health and Population Program. Combined with reform in health financing and improved provisions of medicines and vaccines, strengthening primary care will help Vietnam achieve its goals for UHC and health-related SDGs.

Nguyen explained that Vietnam’s policies and reform priorities can be divided into three categories: policies for healthy people, priorities for sick people, and priorities for resource allocation (see Figure 3-2. Health reform policies in Vietnam). The Healthy Vietnam Program (Decision 1092) and the grassroots health development program (Decision 2348) are for healthy people. The priorities for sick people are to improve the quality of care, provide high-tech services, increase patient satisfaction, and offer green, clean, well-organized facilities. Resource allocation will be improved through reform in human resources training, reform in health financing, infrastructure development, ICT development, improved medicine and vaccine supply, and international integration.

Another lever to support PHC is to garner adequate funding and allocate resources equitably. Investment should be shifted from curative care to PHC and health financing should be reformed to include budget allocations and spending for PHC. In addition to improving fund mobilization, allocation, and utilization, Vietnam also needs to strengthen its public financial management system to monitor PHC-related expenses effectively. Vietnam’s PHC is under-used and under-resourced, Nguyen added. In 2017, 49% of health insurance expenditures were spent on services in provincial hospitals and 27% and 21% of expenditures were spend at district and national hospitals, respectively. Only 3% of health insurance expenditures were spent at community-level care facilities. The majority of resources are utilized for provincial and central level care, and only 30% of patients are seeking care.
3.2.3 Partnerships to support primary health care

Nguyen described the existing and needed partnerships for shaping PHC in Vietnam. The Health Partnership group was formed in 2004 with participation from development partners, Vietnam’s ministry of health, provincial governments, and nongovernment organizations (NGO). The technical working group on strengthening PHC is working under the health partnership group. The working group is led by the ministry of health and other actors from the public, private, and non-profit sectors. There is a need for strengthened inter-sectoral collaboration in disease prevention and treatment. Greater stakeholder engagement is needed among civil society, professional associations, beneficiaries, and communities.

3.2.4 Strengths and opportunities for improvement

Nguyen pointed out some of Vietnam’s strengths and successes. Vietnam has engaged stakeholders to define problems, identify solutions, and prioritize needed actions. They also benefit from sustained health committees at the community level and they have developed family medicine training programs for community healthcare staff. However, Vietnam lacks inter-sectoral collaboration in disease prevention and control and needs greater cooperation between systems for preventive and curative medicine. Vietnam also needs to improve in terms of results-based management, monitoring, and evaluation. They must also develop professional standards to manage the quality of healthcare services.

3.2.5 Discussion

Members of the Kenyan and Vietnamese delegations were invited to comment on each country’s presentation, followed by reflections from representatives from community-based and civil society organizations. Speaking on behalf of the Kenyan delegation, Salim Hussein, Government of Kenya–MOH, Helen Kairie, Government of Kenya–MOH, and Agatha Olago, Government of Kenya–MOH, shared their reflections. Hang Phan Le, Government of Vietnam–MOH, and Chau Nguyen, Government of Vietnam–MOH, shared their reflections on behalf of the
Vietnamese delegation. Other reflections were shared by Ruth Ngechu, Living Goods Kenya, and Mai Huong Kieu, Center for Supporting Community Development Initiatives, Vietnam.

Hussein remarked that Kenya can benefit from adopting a community health program similar to the one used in Vietnam. Kenya struggles with the provision of family medicine; they have recently developed a family medicine association to improve the delivery of community health services. Kairie noted that Vietnam and Kenya face similar issues in the delivery of PHC. These countries have both been neglecting primary care, which is the most important level of care for population health. In Vietnam, there is great investment in higher-level care facilities; this leads to high costs for services that might otherwise be provided in the community care setting. This reveals the opportunity for cost savings by strengthening lower-level care. In Kenya, there is an underutilization of existing lower-level facilities. In the PHC pilot counties, it was observed that patients sought care at the higher-level facilities instead of dispensaries and health centers. These patients expect that if they do go to the lower-level facilities, they will just be referred to the higher-level facility. This presents a challenge that must be addressed in order to strengthen the delivery of PHC services at the community level.

Olago pointed out that insurance coverage in Vietnam is rather high at 88%, compared with the rather low coverage in Kenya, at ~19%. Similarly, Vietnam has managed to allocate significant resources to preventive health services; whereas, Kenya has not been able to affirmatively calculate spending specifically on preventive, versus curative, services. There is still much room for improvement in Kenya: next steps are to develop strategies for implementing and measuring preventive care interventions.

Phan explained that Vietnam must make policy changes to address NCDs, aging, and climate change. The private health sector plays a significant role in the delivery of PHC. Kenya has a well-developed private sector, accounting for ~20% of health facilities. She asked how the Kenyan government manages the private sector to ensure quality and equity in the delivery of PHC, because Kenya’s model for public-private partnership may be informative for Vietnam. She also asked about the typical out-of-pocket expenditure for health services in Kenya and what policies Kenya has established to address the issue of out-of-pocket expenditure. She remarked that Kenya has relatively few doctors per capita and asked how Kenya might approach this issue. Nguyen replied that Kenya discussed their development of a national framework and offered to share the legal framework used to develop the PHC plan in Vietnam. Vietnam’s framework is well developed and includes policies and guiding principles. In spite of their development of a strong framework, Vietnam has struggled with implementation and translation. They are committed to an approach that involves community engagement and implementation with partners and stakeholders, including patient associations.

Ngechu explained that the civil societies in Kenya feel involved in the development of PHC, which is a new and beneficial development. Although the country has strong high-level political commitment to UHC and PHC, Kenya remains grossly underfunded, especially the health sector—health spending accounts for only 2% of the GDP. She pointed out that the political commitment to health is not being translated into action and it is part of civil society organizations’ roles to hold the government accountable to their commitments. However, it can be difficult to balance the aim of supporting the government with the responsibility of holding the government accountable, and it can be complicated to pursue multiple strategy developments simultaneously because certain strategies or agendas may conflict in their implementation. Countries should prioritize how their simultaneous development efforts will be coordinated and prioritized when they conflict, which is especially relevant for Kenya’s decentralized implementation system. It is important that new initiatives
and strategies do not cause confusion or send mixed messages when implemented in local settings. She implored all parties to prioritize the alignment of parallel programs to address the need for harmonization. Numerous pilot programs in Kenya are tracking various indicators, but the vertical nature of these programs complicates the delivery of PHC services. Currently, there are several international agendas at play in Kenya, including the Declaration of Astana, UNGA, and other WHO commitments. To align efforts to fulfill these distinct commitments, there has been high-level buy-in for numerous programs, but a unified, comprehensive strategy is needed. Like Vietnam, Kenya has strong documentation and political buy-in for PHC, but is lacking in terms of implementation. The roadmap for PHC should include not only development but also dissemination and implementation.

Kieu explained that the Vietnamese government has been receptive to input from civil society organizations. They have been actively engaged with civil society in the policy development process, inviting representatives from civil society to policy making meetings. She noted that this communication is necessary not only in the policy making process but also in the implementation process; there is a need for a channel of communication between civil society organizations and policy makers during the implementation process. She also remarked that mental health is not highly prioritized in Vietnam—around 20%-25% of drug users, for example, have some mental health issues—so PHC efforts should be expanded to include mental health. In Vietnam, the healthcare system operates separately from the wellbeing and social welfare system. These two systems work together on policy development, but they implement these polices independently; it would be more effective for them to work together. In Vietnam, many diseases are not treated at the community level, but they could be if PHC policies are implemented effectively. For example, a pilot project was conducted to treat hepatitis C at district-level primary healthcare centers, showing that these facilities are capable of providing this care; yet the policies in Vietnam still call for this treatment to be provided at higher-level facilities. Traveling for care can be burdensome for families who often travel together and must pay for food and other expenses associated with traveling to receive care at the higher-level facilities.

3.3 PRIMARY HEALTHCARE MEASUREMENT AND IMPROVEMENT INITIATIVE: EMRO REPORT

Karen Kinder, World Health Organization–HQ, discussed the primary healthcare measurement and improvement initiative created by the WHO Regional Office for the Eastern Mediterranean (EMRO). She shared the motivation and process that led to the development of this tool, along with the experiences and lessons associated with its preliminary implementation.

3.3.1 The creation of the primary healthcare measurement and improvement initiative

Kinder explained that the primary healthcare measurement and improvement initiative (PHCMI) began shortly after the Astana conference to make the results of the conference actionable. This activity was prompted by requests from EMRO for support in developing PHC programs. Once work began to develop supportive systems and indicators for PHC, it became clear that there was an absence of common language for policy frameworks and a need for tools that could be utilized by policy makers, as well as a lack of aggregated data. PHCMI was developed to address these needs. WHO adapted the Declaration of Astana into a vision statement that provides more technical detail that, together with the operational framework, can help inform policy makers on how to pursue PHC. The operational framework identifies numerous levers along the dimensions of the PHC approach and are correlated with results and impacts. The final
desired outcome of this framework is the achievement of PHC and the relevant SDGs.

In coordination with EMRO, WHO has been investigating how to make this model more actionable. They have focused on developing indicators along the chain of action that will allow for measurement of the progress toward PHC. Some of these indicators are familiar and are already being collected, while others are adapted specifically to measure the delivery of PHC. For example, rather than the typical measurement of all health facilities per 10,000 population, they have called for the measurement of the primary care facilities per 10,000 population. They have also called for the measurement of the percentage of the healthcare workforce that is dedicated to the delivery of primary healthcare services. They are also developing and refining a PHC profile, which will facilitate countries in assessing their current status in terms of PHC. PHCM is aiming to balance the desire to use these profiles for inter-country comparison with the need for countries to use these profiles for internal assessment. The profiles will vary across countries, and the priority is for these profiles to be internally useful for countries striving to improve the delivery of PHC services in their countries. They will be incorporated into routine monitoring and evaluation processes within countries. She stressed that WHO does not intend to create additional work for implementers; rather, they are seeking to direct and repackage existing efforts so that they have a greater focus and usefulness for PHC.

To address consistent calls for integration from numerous stakeholders—including the need to integrate vertical systems and develop partnerships among disease-specific programs and agencies—the global action plan represents a commitment made among the 12 UN agencies to improve inter-agency coordination. The efforts to coordinate and integrate were a direct outcome of the Astana conference, and progress has already been made in these areas. The primary healthcare accelerator and the primary healthcare measurement and improvement plan are forthcoming results of these efforts.

### 3.3.2 Description of the primary healthcare measurement and improvement initiative

PHCM is a regional, cross-collaborative, multisectoral program that is assessment-based and improvement oriented. The program has two phases—measurement and improvement—that will be carried out in an iterative manner. The measurement phase includes stakeholder buy-in, planning, establishing a team, setting milestones, gathering data, identifying gaps in data, data verification, finalization of the plan, and dissemination of the data and plan. The improvement phase should begin with stakeholders already having been aligned with the plan. The improvement phase consists of setting priorities, identifying short term goals, implementing interventions and policies, evaluations of interventions, and iterative adjustments to the plan.

The initial discussion with PHCM pilot countries began early in 2019, and the initiative was officially launched on World Health Day, 2019. The first regional workshop was held in July 2019, at which the initial pilot countries (Egypt, Jordan, and Pakistan) shared their preliminary measurement phase results. In October 2019, the first focal point training was held for the remaining 19 participant countries, where a workplan was developed for the entire region. A second regional workshop was to be held in December 2019, at which all participant countries would present their results and discuss next steps. Future meetings are planned for July 2020 and December 2020, where the participant countries will further share their results and refine their plans.

### 3.3.3 Lessons learned

Kinder shared the lessons learned through the PHCM initiative. Data capture and validation has taken longer than was initially anticipated. Each country needs a singular
point of contact for carrying out the PHCMI initiative; this person should be familiar with the local political and data landscape. Former employees of the ministries of health, academics, or WHO country offices are good candidates for this role. This individual must also be surrounded by a capable, supportive team. Because EMRO is a data-poor region, WHO recognized the need to identify alternative indicators using data that are already being captured and reflects similar concepts as the indicators detailed in the PHCMI protocol. Each country will be gathering unique sets of indicators and, through the network of country point persons, WHO will be able cross-fertilize alternative indicators. The focus of this collaborative process is for implementers to learn through the journey toward PHC.

PHCMI is helping countries take a significant step toward long-term PHC and family care practice in the EMRO region. The initiative supports EMRO member states in their effort to transform the commitments in the Declaration of Astana and the operational framework into action. Additionally, the initiative puts a focus on PHC delivery in the public sector. Around 70% of the PHC services in the region are provided by the private sector and there is a separate private health sector PHC initiative which is underway. The early success of PHCMI is entirely dependent on WHO and stakeholder commitments to improvement, she noted. Certain countries in the EMRO region are facing persistent emergency situations, so WHO is also working to adapt the PHC approach for countries with large refugee populations or persistent, prolonged emergency situations, such as Lebanon, Jordan, and Palestine. The issue of health security often fails to consider the physical security of healthcare workers and facilities.

3.4 DISCUSSION

Kinder asked the Vietnamese delegation about the implications of their decentralized government. She remarked that this devolved system creates a tension between the need to tailor interventions for local contexts and the need to deliver consistent quality services and reduce variation between districts. She asked how the Kenyan government addresses this tension. Chau Nguyen, Government of Vietnam–MOH, acknowledged that this is a significant challenge for Vietnam. They are striving to meet the health needs of each local setting while also balancing the agendas of the national and subnational governments. She described Vietnam’s health partnership group as an example. This group provides a forum for health policy dialogue among various stakeholders. They try to discuss both a top-down and bottom-up approach to reflect the needs and barriers of all stakeholders. She also discussed Vietnam’s UHC program as another example of this tension. Vietnam has a singular, centralized social health insurance program, yet to accommodate the decentralized system, certain policies and decisions are left to the subnational governments. They have also established ‘cross-subsidies’ from wealthier provinces to poorer provinces to balance the funding of the social health insurance system and ensure adequate care provision in poorer provinces. Salim Hussein, Government of Kenya–MOH, remarked that Vietnam reported 88% coverage under their social health insurance program, yet had out-of-pocket expenditures at 44%. In Kenya, insurance coverage is at 20% while out-of-pocket expenditure is at 37%. He asserted that both countries’ insurance coverage and out-of-pocket expenditures are out of balance.

Todd Pollack, The Partnership for Health Advancement in Vietnam, inquired about Kinder’s presentation of the PHCMI initiative and specifically her point about the importance of measurement and using data to drive improvement, along with the timely process required to validate collected data. He reflected that these kinds of programs often result in great efforts being put forward to collect, analyze, and validate data, but this process often leaves little time for programs to put these data and analyses to use. Furthermore, he pointed out that often
these data must be collected by grassroots actors and sent up the chain of command for analysis. Frequently the analysis never makes it back to the grassroots actors, and they get little immediate benefit from their efforts to collect data. He asked Kinder whether PHCMI involves a mechanism to deliver data back to the local or facility level so that data can drive improvement at the level of healthcare delivery. He pointed out that in Vietnam, the innovations and changes in care delivery will be carried out at the provincial level; this means that local decision makers in Vietnam need access to data to make well-informed decisions. Kinder agreed with this sentiment and explained that many countries’ plans will include the improvement of data collection as an action step. She expressed confidence that subsequent to the improvement of data collection, countries will be seeking ways to ensure that data get delivered back to the local level. It is not possible to write and implement an action plan for local-level stakeholders without presenting them data that explain the decisions in the action plan. Since PHCMI is still in its first year of development, the details and mechanisms of data transfer have yet to be fully developed.

A delegate from Kenya noted that most of the PHCMI framework indicators are based on population-level surveys that are periodic and collect static measures. She asked how WHO recommends countries incorporate the use of routinely collected, local-level data into the new PHC indicators. Kinder remarked that often the process of setting up a formal data collection system to support the new indicators naturally promotes the collection of all data. She reiterated that when data collected at the local level are never returned to those who collect it, the local-level partners tend not to see great value in collecting those data. The implementation of a new, iterative, feedback loop for data collection and sharing data at the local level can solve multiple system issues around data collection. Beth Triter, Primary Healthcare Performance Initiative (PHCPI), explained that the introduction of WHO tools at the national level is a powerful way to begin the conversation around PHC improvement, but the path toward actual improvement involves taking those tools to the lower levels of care delivery and implementation. She called out the exemplary work that has been done by Helen Kairie and Salim Hussein, Government of Kenya—MOH, to adapt the PHC vital signs profiles for use at the county level. This is an example of how countries can take the national-level tools provided by WHO and adapt them for use at lower levels of implementation. This has value both in that data collectors see the data come back in a useful manner and in that more routinely collected data can be incorporated into PHC indicator data. Ghana has also taken their national-level tool to multiple regional dissemination workshops with their regional health managers. In these workshops, the managers called for their own regional versions of the tools; Ghana is now also adapting their national tools to the regional level. The PHCPI will be working to develop a template to help countries more easily follow the path of Kenya and Ghana.

Thu Thien Do, Novartis, asked how monitoring and evaluation could be used to incentivize public-private partnerships. She pointed out that both Kenya and Vietnam acknowledged the need for multisectoral engagement, yet many implementers are uneasy working with private industry. She suggested that monitoring and evaluation with clearly identified expected outcomes could help encourage implementers to work with private companies. She also asked how private companies can add value to PHC efforts through the provision of data. Helen Kairie, Government of Kenya–MOH, explained that in Kenya, there are existing opportunities for private organizations to utilize existing mechanisms of collaboration and to report data to the national data collection system.

11 For more information about PHCPI, see section 4.2 of these proceedings
Most of Kenya’s private facilities do not report to the national reporting system. About half of the care provided in Kenya is provided by private providers, so the lack of reporting from private providers makes it difficult to ensure adequate data collection. Policy efforts are underway in Kenya to compel private care providers to report data to the national data collection system. Although mechanisms for private-public partnerships are well established in Kenya, they are not necessarily well utilized.

Chau Nguyen, Government of Vietnam—MOH, acknowledged the high out-of-pocket expenditure in Vietnam. She pointed out that the high nominal rate of insurance coverage does not necessarily indicate its effectiveness. Many people in Vietnam underutilize, misuse, or bypass the insurance system and thus may not receive the benefits of social health insurance. She said that education and dissemination of insurance and healthcare information are needed to promote effective use of existing healthcare resources. She addressed Do’s question about public-private partnerships, explaining that Vietnam has worked with international organizations and development partners to create a database that tracks the involvement of private organizations. The Vietnamese delegation is interested in assistance in using collected data to inform policy decisions. The data system in Vietnam is poor both in term of data collection and data reliability, which they are working to address with support from multi-national organizations.

Lucky Emmanuel, World Health Organization—Young Leaders Network, pointed out that Kenya is surrounded by countries in conflict and has displaced populations living in the country. He asked the Kenyan delegation how they budget and manage care for these displaced populations within the context of a devolved healthcare system. He also pointed out that both Vietnam and Kenya reported having developed sound frameworks for PHC improvement but limited success in implementation. He asked how young people will be engaged and encouraged to solve these implementation barriers. The wealth of intellectual capacity among young people, especially in regard to technological innovations, should be engaged to solve the problems of implementation. Hussein explained that the Kenyan UHC and PHC programs are actively recruiting unemployed young people with bachelor’s degrees who will be deployed in internship positions in the public health sector in positions that suits their skillsets. Kenya has a national youth service that specializes in vocational training for young people. The government is working to provide a health training curriculum through this national service that will train young people to be deployed in the newly established community health units. Another organization has volunteered to assist Kenya in the provision of emergency and accident-related health services; Kenya is working with this organization’s instructors to create a program that will train young people through the delivery of these free health services.

Nguyen explained that Vietnam has numerous local-level advocacy associations that represent the interests of women and young people. The Vietnam youth union has a strong network, both nationally and at the local level. The youth union drives a lot of activity at the community level, particularly in the provision of healthcare services.
4 Measuring success in strengthening primary care

This session of the workshop began with a group activity (see Box 4-1), followed by a presentation from Beth Tritter, PHCPI, about the tools offered by PHCPI, including the vital signs profile. Helen Kairie, Government of Kenya–MOH, shared Kenya’s experiences in participating in the PHCPI vital signs profile program. Irina Nikolic, World Bank, discussed the human capital project. Delegates from Kenya and Vietnam shared their experiences and reflected on how these programs aimed at measurement have impacted their efforts to improve PHC. Cristin Lind, Patient Advocate, shared her perspective as a clinical quality improvement advocate.

Box 4-1. Group activity: useful PHC data points

“What is one data point related to PHC that you wish you had but do not. How would having that data point help you do your work?”

During this session, the workshop participants engaged in an exercise called “think, pair, share.” Participants were asked to consider the prompt above and then break into small groups to discuss the prompt and their thoughts on the topic. Cristin Lind, Patient Advocate, reported that her group discussed missing data points in numerous levels of measurement, ranging from funding data to practical clinical measurement. She explained that in her work as a patient advocate it would be helpful to have self-reported data. Such data would let her track her patients’ wellbeing without reliance on the absence of diagnosed illness as the sole measure of wellbeing. Another participant mentioned the need for maternal mortality data in settings where it is often under-reported. In rural communities, the true rates of maternal mortality are not well understood by the public. He also pointed out that the gaps in data have an impact on financing decisions; as data becomes more available and more reliable, implementers can rely more on data to make financial decisions about healthcare.

4.1 PRIMARY HEALTHCARE PERFORMANCE INITIATIVE

Tritter explained the context in which the Primary Healthcare Performance Initiative (PHCPI) was developed and how countries participate in this initiative; she also shared examples of the country vital signs profiles that they develop. The PHCPI initiative was founded to facilitate global investment in PHC and is a partnership between the Bill & Melinda Gates Foundation, The World Bank, WHO, Ariadne Labs, and Results for Development. PHCPI has three key aims: (1) to create a partnership dedicated to transforming the global state of PHC; (2) to focus on catalyzing this improvement through better measurement of PHC; and (3) to work with governments, development partners, and international experts to achieve these goals. The initiative is motivated by the tenets that high-performing primary care systems drive progress toward SDG 3, that PHC is the foundation of UHC, and that PHC is key to health equity and nurturing inclusive economic growth. PHC is also foundational to other major global health goals, including vertical goals related to HIV/
AIDS, tuberculosis, malaria, and global health security.

Tritter provided an overview of the core principles and approach of PHCPI. The primary aim is to meet the needs of countries. In order to fulfill this aim, PHCPI also aims to complement and collaborate with existing global health initiatives and to catalyze performance improvement through measurement and knowledge. Development partners often have a preconceived idea of what they want to fund that do not necessarily reflect the needs of the countries in which they work. In this respect, PHCPI can act as a bridge to connect development groups and countries using a common framework. This is achieved through working with countries and development initiatives and through embedding PHCPI tools into the workflow of development partners. PHCPI aims to encourage development initiatives, such as GAVI, WHO, the Human Capital Project, and the Global Fund, to use shared conceptions of development principles so that investments can be directed in the most beneficial manner. Additionally, Tritter suggested that this shared conception of development may lead to greater flexibility on the part of donors in terms of how funds are spent in-country.

PHCPI assists countries with measurement, performance improvement and cross-country learning, Tritter explained. Their measurement tools help countries identify gaps and inform country priorities based on existing PHC-specific data. They help countries improve performance by curating and highlighting global evidence about successful strategies for improving PHC systems and services. Cross-country learning is facilitated through meetings among the countries using PHCPI tools that allow implementers to share data, knowledge, and experiences with implementers from other countries and global stakeholders.

4.1.1 PHCPI conceptual framework

PHCPI adds value beyond existing measurement frameworks through its focus on whether systems are designed for success and its emphasis on the service delivery “black box,” said Tritter. PHCPI began with by developing a conceptual framework as an iteration of the traditional measurement frameworks that have been used in the past (see Figure 4-1). PHCPI evaluated the traditional and commonly used conceptual frameworks and identified service delivery as a key component of PHC; they expanded the considerations of service delivery in their conceptual framework based on this insight. They also highlighted the role of systems design and identified an over-emphasis on outputs and outcomes in previous models, which they addressed by disaggregating outputs from outcomes and reducing the overall emphasis placed on these two aspects of the conceptual framework (see Figure 4-2).
4.1.1.1 PHCPI core indicators

PHCPI’s 38 core indicators provide a snapshot of primary health care performance based on existing, globally comparable data (see Table 4-1). The tools enable users to quickly assess a country’s performance and create custom comparisons. The identification of these indicators was conducted through extended, collaborative efforts made by a panel of experts, academics, and practitioners. Only 11 of the subdomains had specific indicators associated with them, leaving eight subdomains without indicators. This is due, in part, to the current state of data sources and availability; PHCPI and its collaborators were unable to identify internationally comparable indicators for these 8 subdomains. The lack of indicators for these 8 subdomains does not reflect intractability in these domains; rather, it reflects the lack of widely used indicators with broad coverage that are comparable across countries in these domains. She acknowledged that certain countries may have indicators that address more than 11 of the 19 subdomains, but most do not.

To address the gaps in indicators, PHCPI mapped those unaddressed subdomains to other parts of their system. They developed a progression model that can assess certain aspects of healthcare systems, particularly in the realm of capacity. This model addresses some of the gaps in indicators by examining qualitative and quantitative information in the unaddressed subdomains. PHCPI works to address other subdomains that are not addressed by indicators through identifying proxy indicators that may be available in any given setting. This is done during the vital signs profile assessment. These country-specific ways of addressing subdomains that lack indicators help countries to work with the data they have in their efforts to improve PHC. PHCPI also engages with countries that wish to suggest and develop new internationally comparable core indicators in the unaddressed subdomains. PHCPI works with international partners, such as the Health Data Collaborative, to innovate and develop new PHC indicators. PHCPI has also worked to develop a greater understanding of the dependencies between data sources; for example, in recent years they have worked...
with a family planning, water, and sanitation survey program, called PMA 2020, to understand the correlation between facilities management and health outcomes. They are looking for ways to incorporate these data sources and approaches to assessment into surveys in a broader context.
Table 4.1. PHCPI core indicators

<table>
<thead>
<tr>
<th>Domain</th>
<th>PHCPI Indicators</th>
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<tbody>
<tr>
<td><strong>System</strong></td>
<td>□ PHC spending per capita ($USD)</td>
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<tr>
<td></td>
<td>□ % of government health spending allocated to PHC</td>
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<tr>
<td></td>
<td>□ Government PHC spending as % of current PHC spending</td>
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<tr>
<td></td>
<td>□ Out-of-pocket PHC spending as % of current PHC spending</td>
</tr>
<tr>
<td><strong>Inputs</strong></td>
<td>□ Basic equipment availability</td>
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<td></td>
<td>□ Essential drug availability</td>
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<tr>
<td></td>
<td>□ Vaccine availability</td>
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<tr>
<td></td>
<td>□ Facilities with clean water, electricity, sanitation</td>
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<tr>
<td></td>
<td>□ Health center density</td>
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<tr>
<td></td>
<td>□ Health post density</td>
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<tr>
<td></td>
<td>□ Community and traditional health worker density (per 1,000 population)</td>
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<td></td>
<td>□ Nurse and midwife density (per 1,000 population)</td>
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<tr>
<td></td>
<td>□ Physician density (per 1,000 population)</td>
</tr>
<tr>
<td><strong>Service delivery</strong></td>
<td>□ Perceived access barriers due to treatment costs</td>
</tr>
<tr>
<td></td>
<td>□ Perceived access barriers due to distance</td>
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<tr>
<td></td>
<td>□ Provider absence rate</td>
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<td></td>
<td>□ Diagnostic accuracy</td>
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<td>□ Adherence to clinical guidelines</td>
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<td>□ Caseload per provider (daily)</td>
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<td></td>
<td>□ DPT3 dropout rate</td>
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<tr>
<td></td>
<td>□ Treatment success rate for new TB cases</td>
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<tr>
<td></td>
<td>□ Care-seeking for suspected child pneumonia</td>
</tr>
</tbody>
</table>
### Outputs

- Demanding for family planning satisfied with modern methods
- Antenatal care coverage (4+ visits)
- Births attended by skilled health personnel
- DTP3 immunization coverage
- Children under 5 with diarrhea receiving ORS
- TB cases detected and treated
- People living with HIV receiving ART
- Use of insecticide-treated nets for malaria prevention
- Cervical cancer screening rate
- Hypertension control
- Diabetes mellitus control

### Outcomes

- Under-five mortality by wealth quintile
- Maternal mortality ratio
- Premature NCD mortality
- Under-5 mortality rate
- Neonatal mortality rate

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**Notes:** ART = antiretroviral therapy; NCD = noncommunicable disease; ORS = oral rehydration solution; PHC = primary health care

Source: T ritter presentation

### 4.1.2 PHCPI’s vital signs profile assessment tool

PHCPI has developed a set of characteristics of high-performing PHC systems that span four domains, said Titter. In the financing domain, PHC is prioritized in the budget and out-of-pocket expenditures are low. In the capacity domain, staff, facilities, supplies, and drugs are adequate and the system is well-governed, with good facility management and effective, proactive management of population health. The domain of performance has three subdomains: access (minimal financial barriers and travel distance); quality (accurate and appropriate diagnosis, treatment, and coordinated follow-up) and effective coverage of essential PHC services. The equity domain includes better population outcomes and good quality, access, and outcomes for the most vulnerable.

PHCPI created an assessment tool called the vital signs profile that uses a simplified approach to provide countries with a snapshot of PHC status. The vital signs profile provides several key indicators for each domain along with a selection of contextual country-specific
data. It consists of a consolidated front page (shown in Figure 4-3), along with two additional pages that provide more detailed data in the capacity and performance domains. PHCPI has identified data sources for each domain of the vital signs profile, although they work with countries to best complete their profiles with whatever data are available. In the financing pillar, data sources include publicly available country health accounts information and WHO SHA2011 standards calculated by the WHO Finance Team. If SHA2011 data are not available, locally available data sources are identified and reviewed for suitability. Data sources for the performance pillar include standard indicators using survey datasets from SDI (World Bank), SPA and DHS (USAID), SARA (WHO), Harmonized Health Facility Survey, and MICS (UNICEF). Data sources in the equity pillar include standard indicators using survey datasets from DHS and MICS. Where these surveys have not been implemented or are dated, alternative data sources and indicators are identified and reviewed with country lead/PHCPI Team for suitability. In the capacity pillar, WHO recently developed novel methods for calculating PHC expenditure that is used in these country profiles. A mixed methods approach, or progression model, is used to capture capacity across governance, inputs, and populations. This method uses 33 separate measures that are scored between 1 and 4 and provide a mixture of qualitative and quantitative information. Triter explained that this mixed methods approach is valuable for countries as a method for organizing a ministry around PHC improvement.

PHCPI approaches ministers of health directly to initiate a vital signs program in any country. PHCPI asks to partner with ministries and request that they appoint a technical liaison within the ministry who will serve as the focal person for the PHCPI vital signs profile program. PHCPI requires ministerial buy-in and the appointment of a focal person because they believe that these are required to make the vital signs profile useful. The PHCPI vital signs profile is not useful unless countries are committed to take action based on their profiles. PHC is not often prioritized over other vertical programs and PHCPI’s approach helps to promote the prioritization of PHC. PHCPI began the vital signs profile program with five pilot countries and quickly found that the process of developing the vital signs profile brought to the table data from owners within the healthcare system who had never been engaged previously. In addition to encouraging data owners to come together, discuss, and share information, the process also drives implementers to focus on areas of PHC that are not often well measured.
4.1.3 PHCPI trailblazers
PHCPI works in partnership with low-income, middle-income and some high-income countries that are committed to measuring and tracking progress of their PHC system performance for transparency and accountability. Triter identified 12 trailblazer countries that have begun developing their vital signs profiles: Argentina, Senegal, Cote d’Ivoire, Ghana, Burkina Faso, Rwanda, South Africa, Tanzania, Kenya, Nepal, Sri Lanka, and Malaysia. The Ministers of Health and their delegates from these countries participated at a high-level side event at the Global Conference on Primary Health Care in Astana, Kazakhstan in October 2018 to showcase their leadership on strengthening measurement systems and using data for PHC improvement. All of those countries unveiled their profiles at the conference in Astana and five of them have completed their profiles in full, including the progression model in the capacity domain. Many countries have since begun the process of developing their own country profiles. Among these countries are Egypt, Jordan, and Pakistan, which are a part of the EMRO region; the EMRO PHCMI program builds on the PHCPI platform and toolset.

4.1.4 Using the vital signs profiles
Triter acknowledged that many assessment tools are developed but never used. However, PHCPI has seen countries take the vital signs profile forward in their PHC efforts. PHCPI is
hopeful that each country that completes a country profile will be able to use it effectively. Several countries have approached PHCPI with proposals for using their vital signs profiles to address needs and challenges in their PHC systems. PHCPI has created a PHCPI trailblazer opportunity fund that will offer grants to countries who wish to use their vital signs profiles to implement PHC improvement plans. For example, Ghana is developing a national- and district-level PHC implementation plan. They received a grant to disseminate their vital signs profile from the national level to the district level. The district-level health managers decided that they wanted to develop district-level vital signs profiles as well. Similar grants have been provided to fund vital signs profile initiatives in other participating countries. Rwanda used their grant to establish a baseline PHC understanding across ministries and develop PHC financing indicators. Senegal used their grant to disseminate their vital signs profile at the regional level and determine how to incorporate the vital signs profile indicators into their routine data collection. Malaysia used their grant to conduct a nationwide cross-sectional study of clinics on provider competence and person-centeredness of care, as these were the data gaps identified by their vital signs profile creation process. PHCPI provides additional guidance to countries on moving from measurement to improvement. They offer strategies for countries to determine the best course of action based on their vital signs profile data, the experiences of other countries, and the latest evidence. They also offer a platform for cross-country learning, offering a community of practice for countries using the vital signs profile and other PHCPI tools.12

Tritter closed by reiterating that the PHCPI vital signs and other tools do not accomplish anything if they are not put to use. She praised the participant countries for their commitment to PHC improvement, and expressed her gratitude that countries are adopting the vital signs profile in these efforts. She described a vision of the future in which global funders use the vital signs profile as a framework for discussing funding with recipient countries.

4.2 STRENGTHENING PHC IN KENYA THROUGH BETTER MEASUREMENT: KENYA’S PHCPI PROJECT

Helen Kairie, Government of Kenya—MOH, described Kenya’s participation in the PHCPI program and shared how the findings from the vital signs profile have been used to inform their PHC decision makers. She also discussed the challenges Kenya encountered in their work to develop their vital signs profile and the impact of their participation in the program. She explained that PHCPI’s vital signs program pilot was presented to the country just as they were beginning to implement their UHC program; they saw the vital signs profile program as a valuable opportunity. PHC is an essential part of promoting health and wellbeing; in Kenya, PHC has been a weak link in the health system. They recognized the need for better data and measurement in order to improve their PHC system. Because the vital signs profile provides a snapshot of the strength of PHC and provides insight into data and measurement gaps, it was a useful tool for achieving their goals.

Kenya launched their vital signs profile program in 2018, and the program has been key in fostering continuous improvement in PHC since its launch. The PHCPI vital signs profile program has buy-in from the highest levels of the Kenyan government, she added. In summarizing Kenya’s vital signs profile (see Figure 3-1), Kairie pointed out that Kenya spends 57% of health spending on PHC, while only 2% of GDP is spent on health. Life expectancy has increased in recent years, but still needs improvement. Maternal mortality has been difficult for Kenya to measure. Because there was a significant variation between national survey data and WHO

12 For more information about PHCPI and the Vital Signs Profile, see improvingphc.org (accessed January 20, 2020).
estimates for Kenya’s maternal mortality, they decided to omit maternal mortality from their vital signs profile until they can better determine it. They have not yet completed the capacity progression model, so there is no data for the capacity domain in the Kenyan vital signs profile.

4.2.1 Learnings from Kenya’s vital signs profile

Kairie shared Kenya’s preliminary findings from their participation in the vital signs profile program. Currently, 37% of the Kenyan population is living in poverty, and communicable disease accounts for the greatest number of deaths in the country (67%). Noncommunicable diseases contribute to 27% of all deaths and 13% of early deaths, or deaths among those aged 30-70 years. As mentioned previously, Kenya has not invested in PHC adequately—PHC spending accounts for only 57% of health spending, while PHC-related health needs account for 70%-80% of the population’s health needs. General access and quality of care in Kenya are acceptable, but the availability of a variety of essential health services was just 58%.

Kenya was able to utilize their vital signs profile to identify areas for PHC improvement and gaps in data, such as data related to financing and capacity. They have implemented facility-level surveys to help generate performance data. To fully utilize the vital signs profile, they disseminated their profile at the national-level Kenya health forum. This dissemination reached national- and regional-level politicians; the vital signs profile has been shared with nearly all stakeholders. Kenya is working to determine the appropriate proportion of health spending on PHC; the vital signs profile will help guide this determination. They are also developing county-level vital signs profiles so that inter-county variability can be assessed and used to support decisions at the county level. Vital signs profile indicators are also being integrated into PHC performance reviews. Kairie noted that while developing the county-level vital signs profiles, implementers realized that many of the indicators currently being used are survey-based and static in nature. It has historically taken a long time for updated data to reach the county level and county health managers often have not felt that they could rely on these outdated data. The vital signs profile data—for both national- and county-level profiles—should be updated with the release of each iteration of routine data collection. This should provide county health managers with much more recent and useful data, she suggested.

Kairie remarked that the vital signs profile offers countries several opportunities for strengthening their PHC. The profile helps countries use their own data in a meaningful way—for instance, it has helped Kenya understand the strengths of their existing PHC system. The profile helps implementers leverage new measurements that would not have been utilized previously, such as community involvement in management of facilities, governance, and policy prioritization of PHC. The profile empowers implementers to seek out data and learn from the data that they have available to them.

4.2.2 Development of county-level vital signs profiles

Kairie reiterated that Kenya has had a devolved health system since 2013. The country vital signs profile is being developed in order to foster the use of county-level data as well as to help counties to prioritize PHC and implement mechanisms to address areas of poor performance. Certain indicators have been customized to suit county-level PHC systems with performance monitoring. The county vital signs profile mostly uses routinely collected indicators, which should help Kenya monitor counties with regularly updated data. This approach also facilitates the integration of the county vital signs profiles into existing quarterly and annual performance review mechanisms. Data mining is being done for all indicators, and the county vital signs data are now being analyzed and prepared for visualization. Data and findings from the
county vital signs profiles should be available in the near future, she added.

4.3  HUMAN CAPITAL PROJECT

Irina Nikolic, World Bank, explained that the human capital project offers a variety of data for numerous countries. The project was developed to optimize the productivity, health, and learning of individuals so that they can fully realize their potential human capital. The project uses data in three different ways. The human capital index ranks countries using national data that reflects their standing in terms of the utilization of human capital. They offer a data and measurement component which is useful for countries who wish to conduct internal analysis. Finally, the project involves country engagement. In April 2020, a human capital plan will be launched for Africa. This plan will direct $15 billion in investment funds into African nations between 2021 and 2023. Both Kenya and Vietnam are ahead of their regional peers in this project, she added.

4.4  REFLECTIONS ON MEASUREMENT PROGRAMS FROM COUNTRY DELEGATES

4.4.1  Kenya

Kairie remarked that Kenya was heavily involved in the development and implementation of the vital signs profile program, so it is difficult to compare their experience with that program to the human capital index or other programs. Kenya’s sense of ownership regarding the development of the vital signs profile program helped bolster commitment and ensure the success of that program locally. She has come to appreciate the need for numerous reports and mechanisms of measurement. In Kenya, for example, they use individual dashboards for UHC, the national strategic health plan, the PHC vital signs profile, and the nutritional scorecard. In a sense, each of these items is a separate report, but they do each provide for a specific need. While there are cross-cutting indicators and concerns within each report, they have value as stand-alone implements for policy makers and health managers. As long as the reports or measurement tools are well designed, they do not necessarily add any significant burden to the people who use them. Kenya is currently developing a national health observatory that will consolidate all of the multiple health reports and scorecards so that they can be easily accessed in one place.

4.4.2  Vietnam

Chau Nguyen, Government of Vietnam–MOH, reported that Vietnam does not have access to many of the indicators that Kenya was able to measure for Kenya’s vital signs report. At the PHC level, there are many reports being filled out by clinicians and healthcare workers for numerous vertical and national programs. Similarly, at the district hospitals in Vietnam, there are hospital-specific data collection tools being used. This gives rise to serious concerns as to whether these numerous, uncoordinated reports are compatible with one another or can be consolidated for assessment of PHC indicators. The Vietnam delegation is open to the vital signs profile program. Vietnam is currently working to develop community-level electronic health records. If they are successful in this effort, it would facilitate Vietnam’s efforts to measure PHC indicators.

4.5  CLINICAL QUALITY IMPROVEMENT

Christin Lind, Patient Advocate, remarked that this discussion has been informative and that her perspective is not based on experience of being a patient in Vietnam or Kenya. Many of the activities in PHC are reasonable from the healthcare perspective, but these activities do not always map on to the concerns and desires of patients. She referred to a pilot project where diabetes patients in PHC centers were allowed to

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set their own measurements for successful treatment. In a situation where clinicians may define success through A1C measurements over time, patients developed measurements of success that had more to do with their own lives. One patient chose to measure how often they were able to attend church services; for that patient, more frequent church attendance was associated with better diabetes management. Weight is often the very first clinical measurement taken when a patient seeks healthcare, but this procedural measurement is a reason that many people avoid seeking care. Lind suggested that all of these measurements are aiming to measure wellness or wellbeing, yet it is important to consider how each measurement will affect peoples’ engagement with the healthcare system. She encouraged implementers to think about how PHC measurement initiatives will impact the experiences of patients and to perhaps consider engaging with patients in the development of future measurements. Sejal Mistry, Access Health International, agreed with Lind’s remarks, pointing out that digital technology has enabled individuals to take control of their own measurements of health. Fitness and nutritional trackers have created social and behavioral incentives that can revolutionize the way people think of their own health. She noted that there is interest in engaging patients and clinicians in health measurement systems, and she asked whether PHC measurement systems are being designed in a way that accounts for how individuals live and measure their own health. A participant added that developing customized indicators at the facility level is a valuable innovation.

4.6 DISCUSSION ON INNOVATIONS IN MONITORING AND EVALUATION

During the subsequent discussion, participants were asked to discuss two questions:

• What innovation would you like to see that would address the data gap in your setting?

• In your specific sector, what can you do to support countries like Kenya and Vietnam to improve their monitoring and evaluation?

Pascal Fröhlicher, Accessible Quality Health Services (U-CARE), reported that that his group discussed the potential usefulness of GIS mapping of morbidity prevalence. This kind of innovation would let PHC centers develop processes and prepare based on local prevalence. They also discussed how public and private sectors can work together. For example, in Kenya there are more private than public healthcare providers. The group discussed how these private and public providers might be integrated and work together to support specific populations. He noted that GIS mapping is restricted by the availability of morbidity prevalence data, but there has been GIS mapping based on population density, income level, and transportation. Improved data collection within healthcare facilities would facilitate GIS morbidity mapping. Thu Thein Do, Novartis, reported that their group discussed an innovation being developed through a partnership with Medtronic Labs, which is being piloted in three counties in Kenya. They are developing an app that delivers an intervention by supporting the day-to-day duties of primary care providers through offering clinical diagnostic support, particularly for NCDs. Because the app takes diagnostic measurements and other data as inputs, it also has great utility as a data collection system. The app can capture real-time data to be synced over the cloud. The app can provide useful data to implementers along with care providers; it can also use the data collected to provide patients with information and prompts to support their treatment and care. The hope is that the app will inform county governments and other stakeholders who want to understand prevalence and outcomes associated with the provision of primary healthcare. This greater understanding of outcomes and prevalence may lead to specific finance allocation decisions for the public sector and a greater
understanding of the market for the private sector.

One participant reported that their group discussed the gap in data related to referrals from community-level to facility-level care. In Kenya, data about referral and referral adherence are not collected. Data on referrals may give some indication about public confidence in health services that are provided in the community and facility levels. Some projects use mobile apps to measure issues related to referrals, collecting data for both facilities and the referring health workers. They also discussed the social and cultural issues around referral adherence: often transportation and financial constraints impact compliance.

**4.7 REPORT BACK FROM WORKING GROUP SESSIONS**

Day 1 concluded with a working group session exploring the challenges and opportunities of measurement and data collection from the perspectives of multilateral stakeholders, private-sector, community-based organizations and implementers, and government. The Kenyan and Vietnamese delegates reported on the discussions within their own groups, along with reflections on the ideas and commitments presented by the nongovernmental working groups.

### 4.7.1 Multilateral stakeholder working group

A participant from the multilateral stakeholders working group shared the PHCPI offer to adapt the vital signs to meet Vietnam’s needs. Vietnam may offer provincial support to adapt the vital signs profile tools for provincial use. The UN offered continued support to Kenya with new financing models, along with technical assistance. The World Economic Forum offered to feature PHC in upcoming regional summits in Africa and Asia; they also offered their input to other working groups. The World Bank offered matchmaking to support healthcare innovation.

### 4.7.2 Private sector working group

A participant from the private sector working group shared the group’s findings. The group included pharmaceutical companies, medical supply companies, private healthcare providers, and a digital vendor. They identified opportunities for private-sector engagement based on the reports from Vietnam and Kenya. They felt that working to improve data quality and collection was a win-win opportunity that would help both Kenya and Vietnam make better funding and allocation decisions. They agreed that they should support the use of a shared, unified coding system to facilitate data sharing across the multiple parallel data and technology systems being used throughout Vietnam’s healthcare system. The pharmaceutical companies in the group discussed the importance of supply price transparency. This is important so that institutional pharmaceutical customers can make informed purchasing decisions whether purchasing directly from suppliers or purchasing from resellers or brokers. The group discussed the value of working to build capacity in both Vietnam and Kenya. The group’s members offer a wealth of expertise and experience and suggested that they could work with each country’s providers to improve clinical care and support innovations. Many of the group’s members work for companies that have a presence in both Africa and Asia. This presence could help distill and share learning with and between Kenya and Vietnam to inform and support in-country innovations.

### 4.7.3 Community-based organizations and implementers working group

A participant from the community-based organization and implementers working group remarked that the group focused on the issues facing both Kenya and Vietnam. Observing the need for greater accountability to the served population, they saw opportunities for governmental partnerships that increase accountability. They discussed the ability and capacity within CBOs to implement and
manage digital health data systems. They saw an opportunity to present this capacity to Kenyan and Vietnamese governments, along with the opportunity to generate and present policy makers with evidence that can inform future decision-making. The group’s members intend to commence multi-stakeholder meetings in Kenya and Vietnam to discuss health data. They intend to invite members of the ministry of finance, particularly for the meetings in Kenya, to promote financial support for each decision made at these meetings. They also intend to support the dissemination of data. If a government has approved or confirmed the use of a specific indicator, the group will engage the government and aid in the public dissemination of those data. The group intends to advocate for policy change and a review of data management policies. Within the group, there is capacity to provide pilot findings from data visualizations; these findings could be shared with governments to inform government policies regarding data. The group agreed that they should collaborate with governments to determine policies that best ensure data security on the cloud.

4.7.4 Reflections from the government working

A member of the governmental working group shared insights from the discussion between the Vietnamese and Kenyan delegations. The Kenyan delegation can help Vietnam by sharing their approach to monitoring the private healthcare sector. They can also share their model for public-private partnerships, where the private sector is involved in the delivery of healthcare services. They specifically discussed their model of accrediting private-sector hospitals for the delivery of care within the national insurance system. Kenya noted that their approach to managing the private sector has contributed to high out-of-pocket expenditures. Vietnam has noted that calculating the percentage of Vietnam’s health spending spent on PHC services is challenging, especially because of the numerous levels of healthcare delivery.

Vietnam also faces challenges associated with their paper-based health data system. Kenya was able to determine the percentage of health spending on PHC services when developing their vital signs profile; they calculated this based on existing data and WHO and PHCPI recommended methods. They had very limited county-level data, so they used alternative information to develop country-level data (e.g., national economic surveys). Kenya benefited from an open-source digital data system.

The Vietnam delegation can help the Kenyan delegation by sharing interventions designed for healthy people. Most public health interventions only address those who are sick, but a life-course approach that includes health promotion should include interventions for those who are healthy. One example might be an intervention to encourage healthy people to exercise. They can also assist Kenya in targeting certain diseases through vertical programs. Their model aims to use PHC, a horizontal program, for healthy people and health promotion, while using vertical programs to target specific diseases. They can assist Kenya with implementation, such as through the development of educational materials, grassroots engagement programs, and national and multisectoral engagement. The group discussed how Vietnam achieved its high insurance coverage rate—nearly 88% of people in the country are insured. The delegates from Vietnam explained that a large proportion of those insured received subsidized coverage, including children aged ≤6 years, adults aged ≥80 years, government workers, and poor and vulnerable populations. Around 30% of insurance subsidies in Vietnam are covered by funding from development programs.

A delegate from Vietnam shared three areas of common interest for Kenya and Vietnam: monitoring and evaluation, service delivery, and technology and innovation. Regarding monitoring and evaluation, countries face challenges of insufficient data. These countries are seeking diversification in their data sources and improvement in the
reliability of their data. They are hopeful that their partners will be able to deliver on their commitments to work to improve the quality of data. Regarding service delivery, both countries face the challenge of patients bypassing the formal health system. To fix this issue, both countries need to provide better quality of care at the primary level, develop public trust in the primary healthcare system, and fix the broken referral systems. Kenya and Vietnam need technical support in order to make these improvements to their countries’ service delivery systems. Both countries have shared interests in technological innovations. They are particularly interested in innovations in impact assessment and health technology assessments that can be used to develop evidence that will persuade stakeholders and partners to invest in PHC.

David Duong, HMS Center for Primary Care, closed the session by pointing out the overlap between the areas of interest identified by Kenya and Vietnam and the ideas and offerings presented by the other stakeholder groups. The issues of data, measurement, and monitoring and evaluation may be addressed through a framework for sharing data among the public and private sectors. Improvement of service quality may be facilitated through partnership with multi-stakeholder platforms, particularly through collaboration, training, and capacity building efforts of private-sector stakeholders. He connected Kenya and Vietnam’s interest in technology and innovations to produce evidence for investing in PHC with the suggestion from the private sector to develop a unified code for data.
5 Integrating patients, families, and frontline health workers as members of a healthcare ecosystem

The second day of the workshop began with a presentation from Cristin Lind, Patient Advocate, on models of patient-centered care and the importance of person-centered approaches in healthcare. David Duong, HMS Center for Primary Care, led a discussion with Lucky Emmanuel, World Health Organization—Young Leaders Network, Bram Wispelwey, Health for Palestine, and Chomba Sinyangwe, Community Health Academy/Last Mile Health, about their experiences as frontline health workers. This was followed by a series of activities and discussion that culminated in the development of action items for Vietnam, Kenya, and other participating stakeholders.

5.1 HEALTH FOR PATIENTS, WITH PATIENTS, AND BY PATIENTS

Lind discussed the importance of language in shaping perspectives of person-centered care. She explained the principles of person-centeredness and explored several models of healthcare that relate to people in different ways. She provided examples of person-centered approaches and processes in healthcare settings.

Lind pointed out that it is challenging to bring patients and families to the table in meetings and workshops that convene stakeholders. One aspect of this challenge is determining who to invite to such a meeting. Patient advocacy groups are usually organized around specific diseases or diagnoses. PHC is largely focused on keeping healthy those who are healthy; these features of PHC make it difficult to identify stakeholders to represent the beneficiaries of PHC. In Lind’s work, this is a common area of discussion. Patients, families, and caregivers are often considered as stakeholder candidates. She is a part of a global movement in which patients and families are beginning to understand that healthcare must change in order to keep people healthy and safe in a way that is fair for everyone. Patients and families want to help bring about the needed changes in healthcare. She suggested that Kenya and Vietnam draw upon similar resources within their own communities by engaging individuals who want to help improve healthcare.

Lind shared a personal story about her son, who was born with a rare genetic condition. By the time he was 2 years old, he had been the recipient of numerous operations and treatments to address his condition. He has participated in speech therapy and occupational therapy along with other cognitive programs. Lind explained that in her experience raising her son, there were some weeks where she rarely left the house except to visit a healthcare center. She reflected that her situation was the inverse of the situation for many people in Kenya and Vietnam; she had access to too much healthcare. She asserted that more care is not necessarily better. In trying to get the best treatment for her son, Lind accepted every referral and medical suggestion she was offered. This led to an overwhelming situation for Lind; she had become a full-time healthcare coordinator for her son. She described a moment where another parent challenged her to focus on how to improve the healthcare situation; this moment set Lind on the path to becoming a patient advocate. Later, she was invited to participate in a quality improvement program at the hospital where her son received care; her participation in this project motivated her current work, which is focused on helping healthcare providers engage with patients.
Subsequently, Lind and her family moved to Sweden, which offers universal healthcare. When she first moved there, she thought that the challenges of her son’s care would be eliminated, but she discovered there are challenges even in the Swedish healthcare system. For example, the free system in Sweden is challenging to navigate. She invoked two Swedish sayings: “you need to be well to be sick” and “a saved life must be lived.” The first refers to the difficulty in navigating Sweden’s healthcare system. The second refers to the fact that many people have lifelong conditions: these people need to find a way to live their lives with their condition.

5.1.1 Health, persons, and the use of language

Lind noted that there are many words and terms used to describe how patients relate to the healthcare system, particularly as healthcare systems change through increased engagement with patients. Many of these terms have subtly different meanings but have not been rigorously defined. Terms such as ‘patient-centered’, ‘person-centered’, ‘family-centered’, ‘people-centered’, and ‘user-centered’ may not all be describing the same ideas. Other terms like ‘patient engagement’, ‘empowerment’, ‘involvement’, ‘participation’, ‘partnership’, ‘co-creation’, ‘co-design’, and ‘activation’ are used to describe ways of engaging patients with healthcare delivery. She asked the participants to reflect on the language they use to engage with and talk about patients relating to healthcare. Sheree Williams, Pfizer Upjohn, shared that Upjohn has a focus on pro-patient policies. She shared that Upjohn has a focus on pro-patient policies. She shared the importance of every colleague having a mutual definition of what pro-patient policies are and an understanding of how to drive these policies forward externally. Lind expressed her sense that organizations often scramble to create new terms that make strong statements. These linguistic efforts reflect the large, sweeping changes that are happening in healthcare.

Lind shared a personal example of the impact of language. In Dubai, she saw a sign that said, “accessible taxis for people of determination”; in America, this sign would have said “accessible taxis for people with disabilities.” This sign made her think about how the lives of people with disabilities might be different if they had been described as “people of determination” instead of “people with disabilities.” She expressed a preference for language that refers to people rather than patients, encouraging the participants to think about the words they use, but not to let their concern about language lead to inaction. She encouraged implementers to use the discussion of terminology as a tool for discussing person-centeredness with their staff. She played a short video from WHO about people-centered care, suggesting that this video could also serve as a tool to initiate conversations about person-centered care.14

5.1.2 Principles of person-centered care

Lind pointed out that in many cases there is limited room for people to make affirmative decisions about their care. For instance, if a person breaks a leg and has access to care, that person will get a cast and be given routine treatment for a broken leg. However, in many cases and for many noncommunicable diagnoses, there are numerous options for people engaging with the healthcare system. She suggested that there are certain core principles that should drive notions of person-centeredness, regardless of the language used to refer to them. These principles indicate that care should:

- Acknowledge and account for patient’s preferences;
- Include emotional support;
- Accommodate for people’s physical comfort;

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14 To watch the video, visit https://www.youtube.com/watch?v=pj-AvTOdk2Q&feature=youtu.be (accessed January 20, 2020).
• Inform and educate those who engage with the health system;
• Be continuous and coordinated;
• Acknowledge the roles of people’s families and friends in their wellbeing, as caregivers or otherwise; and
• Be accessible.

5.1.3 Why person-centered care matters

Lind explained that person-centered care has emerged based on the moral commitments of democratic cultures. She emphasized the concept of “nothing about us without us,” which refers to the importance of decision makers involving those who will be impacted by their decisions in the decision-making process. This notion has a more immediate implication in healthcare; it demands that people whose bodily health and wellbeing are affected by decisions have a role in making those decisions. Recent evidence suggests that there are health outcome benefits associate with this approach. Person-centered care has been associated with improved patient outcomes, increased patient satisfaction, shorter hospital stays, reduced readmission, improved functional status, reduced mortality, improved equity and cost effectiveness, enhanced decision-making, reduced medical errors and adverse events, improved adherence, optimized self-management, increased staff retention, and more relevant research questions. She added that the European Patients Forum is a patient organization that developed a patient charter, called the Patients’ Charter on Patient Empowerment. The charter is focused on empowerment, which is distinct from engagement and person-centered care. The charter sets forth ten statements that represent what patients want (see Box 5-1).
Box 5-1. Patients’ Charter on Patient Empowerment

I am more than my health condition.

I am empowered to the extent I wish to be.

I am an equal partner in all decisions related to my health.

I have the information I need in an easily understandable format, including my own health records.

My health professionals and our health system actively promote health literacy for all.

I have the ongoing support I need to manage my own care.

My experience is a vital measure of healthcare quality.

I can participate in evaluating and co-designing healthcare services, so they work better for everyone.

Through patient organizations, my voice becomes part of a bigger, united voice.

Equity and empowerment go hand-in-hand—I want a fair deal for all patients.

5.1.4 Healthcare to people, for people, with people, or by people

Lind discussed the divergent ways in which healthcare models can stand in relation to people: health care to, for, with, or by people. She identified models of healthcare that are related to people by bringing healthcare to them, providing healthcare for them, delivering healthcare with them, or creating healthcare by them. The first model is the model of the traditional awareness of healthcare. It is hierarchical and authoritatively driven by institutions. The second model is a model of ego-system awareness. It uses markets and competition, making it outcome centered. It is driven by a notion of managed care. The third model is the model of stakeholder awareness. This model relies on networks and negotiation to be patient-centered. This model is needs-driven with an emphasis on pathogenesis. The last model is the model of ecosystem awareness. The model uses awareness-based collective action to be citizen-centered; it is driven by wellbeing with an emphasis on “salutogenesis.”17 She remarked that the aim of person-centered care is to achieve healthcare by people, the model of ecosystem awareness. This is not a new model; rather, it is a return to the principles of healthcare before healthcare became medicalized. She acknowledged that there is much nuance around this issue and that there is a need for networks, negotiation and stakeholder awareness. The key point is that healthcare systems must shift from a focus on illness to focus on wellness.

17 These models of healthcare have been adapted from the work of Otto Scharmer on Theory U. For more information, see https://www.ottoscharmer.com/theoryu (accessed January 20, 2020).
5.1.5 Example of person-centered care

Lind shared some examples of person-centered care in practice. The first example came from her primary care system in Stockholm, which asked residents to provide feedback to help develop the primary care system. The campaign accepted feedback online through a survey and through two resident dialogue events. She was hopeful that some action would come from the feedback collected through these efforts. Another example comes from the organization Changedirection.org, which recently ran an innovative mental health campaign. The event was a global, online, virtual conversation that was open to anyone for 48 hours and was intended to provide ideas and develop initiatives around mental health. This open format is very different from traditional approaches to engagement where people must come into an office or healthcare facility to formally provide feedback. More open, democratic, and digital engagement in the future will help promote an ecosystem awareness within healthcare, she suggested.18 She presented another example from the Southcentral Foundation in Alaska. This health center is run for and with Alaska’s native peoples. Legislative action in the US gave these peoples the power and budget to run their own healthcare system. The foundation used its own culture to make their healthcare system more people-centered. She played a video from the foundation in which representatives talked about their sense of pride associated with healthcare.19

5.1.6 Participatory processes for PHC

Lind closed with a discussion of how the ideas of person-centered care can be included within efforts to strengthen PHC. She pointed out that the operational framework developed by WHO includes guidance on participatory processes. It also identifies patient and family engagement as an operational lever. The framework calls for participatory processes, originating in communities, that empower people to define their own priorities and their own solutions. It also calls for incorporating community voices at all levels, building the capacities of health service providers to partner with patients, building relationships, and mobilizing through innovative and traditional community methods. The notion of participatory healthcare is not a foreign concept for health systems, but it can be challenging and is not the typical approach. While the operational framework does call for participatory processes and uses much language that suggests participation, it does not offer many specific examples of participatory processes. Lind offered several participatory processes as examples for consideration. There are multiple levels of patient empowerment and many possible activities that promote patient engagement. Patients can be empowered in their own care; these processes encourage patients and families to become their own advocates. At this level, people are encouraged to recognize their health needs and seek care and to ask questions and express their concerns. They are included in decisions about their own care, and they are asked what matters to them. Patients and families can be empowered at the level of clinical improvement. At this level, patients could be encouraged to identify and prioritize ideas for improvement and to develop tools and educational materials. They could be included in steering groups and engaged through the creation of patient and family advisory groups. Patients could also be invited to select and train staff. Patients can be empowered at the leadership level. At this level, patients can be engaged by creating health committees and community advisory panels or training programs for staff and clinical leaders. They can be engaged by making healthcare records accessible and

18 For more information, see www.changedirection.org (accessed January 20, 2020).
19 For more information, see https://www.youtube.com/watch?time_continue=1&v=pbByBqlTdA (accessed January 20, 2020).
sharing data on clinical quality. They can also be engaged by developing participatory research programs.\textsuperscript{20}

Lind closed with several specific, simple suggestions for actions that healthcare leaders can take immediately. Healthcare leaders can lead by example and be a visible presence. If leaders are not committed to person-centeredness, it makes it very difficult for health systems to change. This may include simply asking staff how they know what patients want or asking communities or social media followers what they want directly. Healthcare leaders can include goals related to patient and family engagement in their plans. They can add patients to boards and committees, inviting them to participate in board discussions and commissions.

5.1.7 Discussion

5.1.7.1 Patient inputs and representation

Pascal Fröhlicher, Accessible Quality Health Services (U-CARE), asked how representative patient inputs should be included before taking action, how patient inputs should be regarded when making decisions, and how clinicians can resolve conflicting inputs when sharing decision making with patients. He asked if there was a good method for balancing conflicting inputs to make the best decisions. Lind remarked that representation is an important consideration when engaging with patients and families. People must feel comfortable acting on suggestions. In her work, she uses anthropological methods. When interviewers interview patients, they look for ‘saturation’; this means that the interviewers have higher confidence that the next interview will not give them new information. There is a variety of methods to ensure representative patient input. Each process of patient engagement will create very specific insights and the more that health systems use patient engagement processes, the more likely they are to get representative input. Health systems can also work with patient advocacy groups; although these groups are not always representative of vulnerable groups and should be used to supplement other forms of patient engagement.

5.1.7.2 Stakeholder reflections on the principles of person-centeredness

Helen Kairie, Government of Kenya–MOH, remarked that Kenya has many opportunities to improve their engagement with patients and families. The PHCPI progression model for measuring health systems evaluates community involvement in decision making. She agreed that it is important to integrate person-centeredness into health systems, and she expressed interest in applying these ideas to improving PHC in Kenya. Lind commented on the description of the work done by Living Goods Kenya, which is exemplary in terms of person-centeredness. Person-centered care is not an evolution in healthcare, it is a return to practices that had great value before technology and science dominated the health sector. She cautioned against excessive focus on health technologies, digitalization, and evidence-based interventions at the expense of person-centeredness.

Beth Triter, PHCPI, commented that it is important to represent the person-centered perspective when convening public health stakeholders. PHCPI has been working to develop a plan of action for promoting person-centeredness. They have developed a plan to evaluate areas that are difficult to measure. Instead of finding proxy indicators for these measures, they will begin working to find ways of addressing those areas in a way that reaches a variety of people and patients. They are looking for ways to collect data that facilitate the use of those data for serving people.

Irina Nikolic, World Bank, suggested that patient advocates may be brought into health facilities to tour and evaluate the

\textsuperscript{20} \textit{World Health Organization 2018a}
challenges to person-centered care in those facilities. She suggested that facilities often fail to create a sense of safety and security, and often do not treat patients with dignity: for example, patients and families may be using dirty, inaccessible bathrooms in health facilities while staff use their own bathrooms. Facilities may also offer separate waiting rooms for those who are sick or actively contagious and those who are chronically ill, not contagious, or are healthy and are seeking active care. These kinds of opportunities for small changes may be best highlighted by patients advocates and would require minimal investment to implement. Other opportunities for person-centeredness would require some investment, such as developing patient rooms and facility design generally in a way that improves outcomes. She explained that she and her colleagues have been evaluating principles of behavior that may help health systems interact with stakeholders. They developed a document outlining ethical principles in healthcare. The document could be used to implement policies that promote basic person-centered principles in healthcare facilities.21 She suggested that there may be a hierarchy of principles of person-centered care: certain basic needs that must be met in all facilities, followed by progressive levels of patient engagement and person-centeredness that are built on the foundation of meeting patients’ basic needs. Lind agreed that meeting basic needs and ensuring quality and safety are fundamental to person-centered care. Clinicians cannot simply do what patients request and feel as though that absolves them from their responsibility to provide effective care. Although healthcare contexts vary widely, the principles of person-centeredness are universal.

5.2 INTEGRATING FRONTLINE HEALTH WORKERS AS MEMBERS OF ECOSYSTEM

Duong opened the panel discussion with the observation that frontline health workers are often left out of meetings involving health systems stakeholders. He invited each of these frontline health workers to introduce themselves and explain what they do. Emmanuel explained that he is a general practitioner practicing in the northeastern region of Nigeria. He is a member of the WHO Young Leaders Network. He works in a region that has been impacted by conflict, and he deals with vulnerable people in his practice. Wispelwey is an internal medicine doctor at Brigham and Women’s Hospital and he directs a community health program for the refugee camps in the West Bank, Palestine. Like Emmanuel, he works with vulnerable refugees who live in constant crisis. Sinyangwe is the director for clinical education at the community health academy at Last Mile Health. Last Mile Health works to provide care to the most remote areas of developing nations. Much of their work takes place on the African continent and they are rapidly expanding their operations. They also have a focus on developing health systems leaders, people who will organize and coordinate community health systems.

5.2.1 The role of frontline workers in achieving the aims of the Declaration of Astana

Duong remarked that in discussing the events following the Declaration of Astana, the definitions of PHC and UHC have expanded to include preventive care, promotive care, rehabilitative care, palliative care, and other kinds of services. He asked the panel of frontline workers what they believe is the appropriate role of frontline workers in delivering on the promises of UHC, PHC, and the Declaration of Astana.

Emmanuel shared an analogy that he has shared with his team in which a person is waiting in an airplane for a flight to depart. In this analogy, the plane has been cleared for takeoff and all the passengers are in the plane awaiting takeoff; however, the pilot has not reported for duty. Everything is set and prepared for takeoff, but without a pilot the plane will never fly. He suggested that frontline workers are analogous to the missing pilot in this analogy. The current global context of health policy is filled with frameworks, declarations, agreements, and commitments, but without frontline workers and implementers there will be no result. As a frontline worker, Emmanuel hopes to provide people with the best preventive, promotive, rehabilitative, and curative care possible, but the population of frontline workers have not changed with the development of new frameworks, declarations, and commitments. The responsibilities and tasks have been expanded, but there has been no matching change in the number of frontline workers. It must be recognized that the number of frontline health workers is too low. In many settings, a single community health worker is responsible for providing care to thousands of people. It is not possible for these health workers to provide quality care, and it is certainly not possible for these health workers to manage the expanded responsibilities and protocols that come with each new framework, declaration, and commitment. These health workers struggle to find motivation to stay in their practice.

Wispelwey agreed that there are difficulties facing frontline workers who provide care, suggesting there is a gradient of difficulty and preferability for frontline workers and providers. For example, in the Boston area there is an abundance of doctors and healthcare workers, while in other parts of the US there are shortages in healthcare staff. To deliver on the promise of the Declaration of Astana, policy makers must think about where the most vulnerable communities are located or where healthcare workers do not experience safe working conditions; they must find ways to bring healthcare providers to those places and populations. As more populations become displaced or isolated, the scale of this challenge will continue to grow. Sinyangwe added that community health workers tend to work in the most remote places with the least support. Many of these workers started their work with minimal diagnostic training mandates, focusing on malaria, diarrhea, and pneumonia. As more responsibilities have been added to their work, there have not been new systems put in place to ensure that they are supported in this expanded scope of work. Many of these workers are expected to continue as volunteers. He questioned the rationality of the global health community of stakeholders which places the burden of achieving the numerous goals of UHC and PHC on the backs of volunteers. The approaches to training, supervision, and workload for community health workers need to be standardized to help alleviate some of this burden.

Duong asked what support is currently being provided to frontline health workers and what support is needed that is not currently provided. Emmanuel pointed out that the working conditions and the quality of service by frontline health workers vary by region and country. In some regions, the remuneration is excellent, and the working conditions are acceptable, but in most low- and middle-income settings, community health workers are poorly paid and poorly managed. The workforce has also been hampered by the exodus of health workers leaving Nigeria to work in the UK, Europe, and other regions. In Emmanuel’s setting, he is the only physician serving a population of 100,000 people; he works with support from just a few nurses and community health workers. In many communities, the condition of service, the remuneration of workers, the availability of equipment, the supply of drugs, and the access to basic diagnostic materials are all lacking. Operations may be better in city centers, but these issues are exacerbated at the community level, where facilities and service quality receive less attention. The aim
of UHC is to provide high-quality services to populations, but the provision and quality of service varies across settings. Significant challenges arise when providing primary care in settings that are insecure and have large populations of displaced people. For instance, few health workers will agree to work in an area where there are millions of displaced people and active terrorist groups and, as a result, the provision of healthcare is not adequate in these settings. Infant mortality due to severe malnutrition is also high in these types of settings. Aside from the risks and inconveniences of traveling to deliver healthcare services, the grim realities disincentivize healthcare workers from agreeing to work in these settings. These issues must be addressed in order to provide universal, high-quality care. Sinyangwe agreed that frontline health workers are needed in order to achieve the goals of UHC. This especially includes the need for community health workers, who are most often the only healthcare workers providing care to remote, hard-to-reach, and vulnerable groups. The compensation provided to these workers is often inadequate. For instance, the provision of bicycles and bags for community health workers’ supplies should not be thought of as compensation, but as the provision of tools that are required for their work. He maintained that community health workers need to be formally compensated comparably to other health workers. Community health workers provide a valuable service, and they should not be overlooked.

Wispelwey shared his experience from a refugee camp in Bethlehem that is constantly experiencing attacks. Many health professionals in the area will not enter the refugee camp to provide care due to the risks and insecure environment, but refugees are often unable to leave the camp to seek care at the UN clinic across town. This situation was the impetus for creating a community health worker project that helps bring people out of the refugee camp in order to access medical care. These community health workers have taken on the burden of linking the community to primary care services. Regarding necessary support for frontline workers, Wispelwey explained that he and his colleagues are working to develop approaches for supporting community health workers. They meet with social workers once per week to talk about vicarious trauma and the many difficulties they face in conducting their work. They are working to develop and acquire resources to fund a trauma and mental healthcare component for their community health worker program, which would include support from mental health professionals.

5.2.2 How to retain and recruit healthcare workers

Duong highlighted the recurring theme of needing to retain the healthcare workforce. He asked the panel what approaches should be considered to retain existing healthcare workers and to recruit new healthcare workers. Emmanuel shared that Nigeria spends around 4% of its national budget on healthcare. Nigeria’s budget for the national parliament, which comprises 400 individuals, is greater than the combined budget for Nigerian health and education. The health of the Nigerian population is largely being neglected and, in this context, the welfare of healthcare workers is not a priority. The number of healthcare workers in Nigeria is decreasing. He argued that the remuneration for healthcare workers must be reconsidered and the status and value of community health workers must be confirmed, beginning in the recruitment process. The introduction of some form of insurance for healthcare workers working in high-risk areas may help counteract the disincentive to serving in such settings. It is every nation’s responsibility to supply basic diagnostic tools; neither patients nor healthcare workers should bear the burden of paying for them. Beyond these material issues, healthcare workers need greater motivation. Tasks based on a clear motivation and performance-based tasks are associated with better quality of services provided, he explained. A performance-based approach to healthcare remuneration could involve
monetary performance-based incentives in addition to base payment. This model aims to compensate workers as individuals for the value they add to the healthcare system.

Wispelwey explained that the camps in the West Bank benefit from the high unemployment rate in that setting by engaging the large number of talented, ambitious, educated individuals who want to work. In addition to working as health workers in their refugee camps, most of these people want to continue their education and imagine a path forward. Providing them with opportunities for growth and leadership can help them to envision healthcare work as a future career. The camps have partnered with local universities to help facilitate these processes and retain healthcare workers.

Sinyangwe considered why a member of a community should be interested in becoming a community health worker. He suggested that a community member would be interested in healthcare work if his or her training were going to be recognized by the government and community; as such, training and qualifications should offer value in terms of recognition. People also need opportunities to progress. For example, Ethiopia has several levels of community health worker training. At the lowest level, community health workers work on health promotion activities; this builds up through levels of training involving more curative services. They now offer bachelor’s degrees in community health work, which provide an even higher level of training which may be achieved. People must see a clear career path associated with community health work in order to improve recruitment and retention, he maintained. He also reiterated the importance of compensation; the pay to community health workers should reflect the burden and workload that they manage.

5.2.3 Integrating the voices of frontline workers into the PHC ecosystem

Duong asked how the voices of frontline healthcare workers can be formally integrated into the PHC ecosystem so that they are involved in financial and policy decisions. Wispelwey pointed out that frontline workers work more closely with patients than any other healthcare workers; this connects to the issues of person-centeredness and community-centeredness in healthcare. Many frontline health workers are a part of the community they work in and their valuable insights should be included when evaluating the healthcare system. Emmanuel suggested that frontline workers can be integrated into the design of practical community projects. Community health workers are often not consulted in making policy decisions for the areas where they work; in many cases, decisions and programs are simply passed down to community health workers without any engagement. The workers’ views and experiences should be a part of the decision-making process. For example, a program may call for a community health worker to be trained for a program dealing with severe acute malnutrition, despite the fact that the community health worker has not seen a case of severe acute malnutrition in the past 6 months and in fact cases of river blindness are the most common. This kind of disconnect between the agenda of decision makers and the experience of frontline workers is problematic for community healthcare workers. He suggested that when policy makers are developing protocols, they should at least send their ideas to a representative group of healthcare workers for review. Healthcare workers should be given some opportunity to review the frameworks, protocols, and policies that are being developed before they are passed down as policy. Community health workers should also be empowered to prioritize the services provided based on the needs in their specific community to avoid a mismatch between the priorities of the national agenda and the needs in that community. Sinyangwe explained that Zambia does annual planning for their health programs that starts from the bottom levels of healthcare. They sit with representatives at the local health facilities and discuss what should be included in that year’s budget. These meetings are held at the district and province
level, and people from all levels convene at the provincial level to represent their ideas and shape the inputs that lead to the final budget. However, there is often a disconnect between these planning discussions and the final budget. The right processes exist, but they do not have the appropriate effect on the result. It appears that decisionmakers are merely going through the motions of holding these meetings, rather than truly taking the ideas of health workers as guiding inputs for creating the healthcare budget.

5.2.4 Technology and the work of frontline health workers

Pascal Fröhlicher, Accessible Quality Health Services (U-CARE), asked how technological innovations, particularly those aimed at improving quality and access to data, have improved the day-to-day work of frontline workers. Wispelwey explained that these innovative solutions have greatly impacted the work done by Health for Palestine. Community health workers use mobile devices to collect data that can be utilized in their work. For example, measurements of a patient with diabetes can be recorded and referenced using a mobile device. The system provides weekly monitoring and evaluation feedback, along with guidance for care. Emmanuel described his work designing an algorithm for managing childhood illnesses. It was recognized that community health workers were having difficulties calculating doses for pediatric cases. The doses for children are based on the weight of the child, and the risk of overdose is high. To address this challenge, they developed a clinical diagnostic support system using an algorithm implemented through software on a mobile device. This tool allows community healthcare workers to enter patient data and diagnostic indicators into the algorithm; the tool then generates a diagnosis. If the diagnosis is in line with the healthcare workers’ diagnostic assessment, then the healthcare worker can rely on the prescription given by the app, which is accurately calculated. This tool improved the safety of care delivered by community healthcare workers, especially in the use of antibiotics. The tool also identified that they had been overusing antibiotics for certain cases, such as simple cases of malaria.

Sinyangwe explained that technology is a major part of the work done at Last Mile Health and in the Community Health Academy. They use technology in their training to improve the effectiveness and efficiency of training community health workers. The traditional approach is not well suited for training community health workers; additionally, the approach to training health workers has evolved toward more interactive methods. Last Mile Health seeks opportunities to incorporate interactive training methods through technology. Even simple technologies, such as incorporating multimedia elements such as audio and animation into training tools, can be very effective. Through this technology, organizations can also collect data about which training materials captured the interest of trainees. These technologies need to be interoperable, as new technological platforms are shared with developing countries. Efforts should also be made to ensure that coexisting technological platforms are compatible with each other. The platforms should be open source to limit restrictions on implementers and health systems.

5.2.5 The roles of community health workers

Agatha Olago, Government of Kenya–MOH, commented that she has seen the burden on community health workers in Kenya increase. Trainings have been provided to some community healthcare workers, but some health workers working in the primary care facilities have been neglected. There is some fear among health workers that the government will continue to shift its focus toward community health workers and away from health workers in community health facilities. In order to address these concerns, frontline health workers must be engaged in decision making processes.
Salim Hussein, Government of Kenya–MOH, commented that implementers should avoid adding more duties to community health worker roles. To help improve retention, implementers should aim to reduce the workload of community health workers. For example, a community health worker’s role could be reduced to three tasks: community ownership, early community diagnosis, and referral. The additional tasks that have been added to the work of community health workers could be distributed among a team. For example, nutritional services and social work services could be done by a community nutritionist and a community social worker. These services should be provided at the community level but should not be expected to be performed by community health workers. Service needs to be coordinated across the lower and higher levels of service provision.

Ruth Ngechu, Living Goods Kenya, questioned the notion of designing an ‘optimal package’ of services that community health workers should provide. She suggested that the optimal package has not been defined; rather, implementers have continuously dumped one set of training and programs after another onto community health workers as development partners have brought new vertical systems to the community healthcare level. She agreed with previous comments that technological innovations must be implemented with consideration of existing technologies in the field, pointing out that there are numerous technological innovations being used in healthcare systems in Kenya that do not interoperate. Many of these innovations deal with very specific issues, such as nutrition. This has led to situations where community health workers use two phones with two different health technology applications. In one case, a community worker was using two phones for two apps that were both collecting the same information and performing the same analysis. This complicated the work of the community health worker and raised questions of whether this health worker’s cases were being doubly reported to the government. This highlights the importance of interoperability and open-source technology; if there is a technology in use, it should be able to be utilized to whatever extent possible for additional healthcare applications. She acknowledged the concerns about remuneration of community health workers, but she pointed out that the economies of countries that depend on community health workers cannot sustain the true cost of paying community health workers even a minimum wage. She advocated for pay-for-performance systems so that workers get paid for specific services they provide. These systems help motivate workers and pay them for the services they deliver. Regarding the acceptance of community health workers by other frontline workers, she explained community health workers have often been trained through partnerships and special programs that lead to tension between community health workers and other frontline healthcare workers. For example, some community health workers are trained to administer specific injectable drug treatments. In many settings, health facility personnel have no awareness of this training and are rightfully concerned about community health workers administering these treatments. In this sense, the training practices and the segregated approach to managing community health workers and other frontline workers directly contribute the tensions between frontline workers. The links between communities and health systems need to be strengthened overall, she suggested. Frontline workers in health facilities should have a greater awareness of the work being done by community healthcare workers and both groups should participate in the same trainings. Community health workers and other frontline health workers should not be estranged—they should be engaged as part of the community as a whole.
6 Action plans for change

The final session consisted of multiple group discussions leading up to the development of action items. The session began with a World Café activity that facilitated the discussion of what specific strategies could be used in Vietnam or Kenya to make improvements in the areas of measurement, technology and innovation, patient and family engagement, and service delivery. The participants were divided into four groups to explore these areas for improvement. After the discussion, the groups gave brief reports of their preliminary ideas.

A participant from a group discussing service delivery reported that their group identified three determinants of service delivery: policy, implementation, and measurement and evaluation. Ensuring service delivery means ensuring that the right people are in the right places providing the right care at the right time. They agreed that wide sweeping reforms are necessary, focusing on capacity building, facility improvement, access to needed diagnostic tools, and development of appropriate staff to deliver healthcare services. They also discussed the importance of monitoring and evaluation so that it can be ensured that the changes and reforms put in place lead to the desired outcomes and performance.

A participant from the patient and family engagement group said they felt strongly that health systems should listen to community voices. They discussed the development of solutions communities did not want, such as weighing stations for pregnant women and commune-level health centers in Vietnam. The group agreed that these situations could have been prevented if communities were involved in the decision-making processes. Channels of communication need to be strengthened to address this issue. Frontline health workers are hearing the voices of patients and families routinely, but there is no protocol for transmitting those messages up to decision makers. This is a major challenge for patient advocacy that should be addressed by health systems implementers.

A participant from the measurement group remarked that the group discussed the need for patient-focused measures, such as measures for patient satisfaction. The measurement of utilization of services is not a good proxy for user satisfaction. More and better population data should be collected and integrated into traditional health data sets; existing data can be better utilized through visualizations and the creation of dashboards. In these ways, data can more effectively drive decision making. Data-related products should be designed with the roles of the recipient of those products in mind. Furthermore, data security is essential to protect individuals’ privacy and dignity. Privacy must not be neglected as the use of data expands to inform health decisions.

A participant from the technology group said that the group agreed technology is not an end unto itself. Implementers should consider their healthcare goals and then assess how technology will help make that vision possible. The term technology is often used only to refer to digital devices, hardware, and software innovations, but technology and innovation touches other aspects of health systems as well, such as the use and development of processes and procedures and the incorporation of feedback and reporting into systems. Innovation should be thought of in a broad sense as realizing new ways of conducting business. The group discussed the crucial role of the government as the steward of all health endeavors. The government should not be expected to be an innovator itself, but it should align and convene dialogues around the implementation of all innovations.
6.1 DEVELOPMENT OF ACTION ITEMS IN EACH AREA OF IMPROVEMENT

For each area of improvement, the participants within each of the four groups identified specific action items along with the necessary contributions from stakeholders. This activity was intended to shape a clear understanding among the groups about the roles and responsibilities of each stakeholder and the synergistic opportunities to strengthen PHC. After these discussions, each group presented their action items and responded to questions and comments.

6.1.1 Technology and innovation

The technology and innovation group identified the stakeholders that have roles and responsibilities in the development, implementation, and adoption of technologies and innovation;

- National governments should set clear priorities that can be implemented at the local level in a context-appropriate way. Governments should create space for innovation and distinguish between technology and innovation relating to data and IT and innovations and technology relating to health processes.

- Ministries of health and finance, regulating and legislating bodies, and developers all have roles and responsibilities in developing, adopting, and implementing technology.

- Researchers play a role in the development of innovations and technology through piloting tools that have been developed. Researchers should use randomized controlled trials to determine the real benefits, flaws, shortcomings, and areas to improve their innovations. This will prevent the implementation of innovations that have unforeseen negative impacts on the community.

- Technological developers should work with institutions, frontline workers, and other experts in healthcare so that they develop innovations that are informed by the needs of the healthcare system.

- Project managers or implementation offices will play a role in the physical implementation process. Project management offices should be involved in the innovation process from the beginning and should be staffed in a way that facilitates innovation and supplements the gaps in governmental innovation.

- Frontline workers should be continuously trained and educated as new innovations and technologies are implemented. They should also be involved in feasibility testing, having opportunities to voice their input throughout the development process rather than after the development process.

- End users, patients, and families should have a role in developing and implementing the technologies that have been adopted.

- Nontraditional stakeholders and international organizations that set frameworks also have potential roles.

As a potential action item, the group discussed the creation of a platform that allows patients to access information about their own care and see the line of care that has been outlined for them. The information presented to patients in such a platform should be simplified so that it is easy to understand, but it should not withhold information about their treatment and health status.

David Duong, HMS Center for Primary Care, pointed out that the group identified a wide range of stakeholders, but they did not specify a way to convene them in the development, adoption, and implementation of innovations and technology. He asked how the group felt that such convening might be done. A participant from the group explained that the group felt that state, regional, and local governments are the stewards of innovations and technologies. They should act as conveners and work to integrate all
stakeholders into the innovation process. The roles and timing of participation of stakeholders will vary; not all stakeholders need to be engaged for the entire duration of the innovation process. At the point when the innovation process moves toward implementation, all stakeholders should be engaged by the government.

Duong asked the participants whether they agreed with the notion that the responsibility for convening falls to the government. The Kenyan and Vietnamese delegation agreed with this sentiment. Duong followed by asking whether the delegates felt they had the time and capacity to take on this responsibility. Salim Hussein, Government of Kenya—MOH, explained that Kenya relies on its partners. For example, they have a partner that organizes and represents the NGOs that are active in Kenya collectively to the Kenyan government. The Kenyan government could take on the convening responsibility through these kinds of partnerships. A delegate from Vietnam suggested that a working group might be able to support the Vietnamese government in executing on the convening responsibility. Such a working group could help with coordinating and mobilizing the efforts to convene stakeholders to implement innovations and technologies.

6.1.2 Measurement

The measurement group began by identifying the action items:

- Measure patient satisfaction
- Collect and integrate more and better data
- Improve the use of data, particularly for visualization
- Strengthen data privacy

The group looked at the model being used in Kenya to inform their recommendations. The Kenya Health and Research Observatory is being developed by a core team that is working on plans, budgets, and the inclusion of particular data, with support and funding from partners. Once implemented, the observatory will be a ‘one stop shop’ for all health data and indicators. The observatory was designed with the intent of better organizing and using existing data. The group discussed the appropriate balance of data visualization and clarity with analytics. Data visualization makes it easy for people to comprehend data points, but there is also a need for more complex and powerful analysis of data.

The Kenyan Health and Research Observatory was developed by two core teams; one team was focused on the technical work related to data and the other group was focused on the information technology and backend. These core teams report to a steering committee that provides oversight and deals with issues of sustainability. Wider stakeholder engagement is carried out through meetings and workshops organized around specific themes, health sector structure, or stakeholder groups. The group suggested that governments should engage stakeholders in civil society, academia, faith-based groups, funders and other sectors. There is a clear role for the private sector and the data that private-sector actors can contribute to measurement efforts. Any stakeholder with a role in creating, sharing, or using data could be engaged in projects to improve measurement.

Duong asked how Kenya identified the need for and then developed their core teams. He also asked how these core teams were given their mandate and how they receive their funding. A group member explained that the Kenyan Health and Research Observatory core teams were funded and staffed by the ministry of health along with academic partners. These teams are fulfilling a very technical role; they are focused on operationalizing the plans for the Kenyan Health and Research Observatory. The steering committee is more involved in determining the mandate, timing, and priorities for the project. The project is being supported by WHO and The World Bank, along with local organizations. The hope is that the initial data system prototype will generate interest and support for the second phase of the observatory project.
6.1.3 Patient and family engagement

The patient and family engagement group discussed how to engage patients and families in the development, implementation, and monitoring of health activities. Input and feedback from patients and families should be incorporated at all levels of the healthcare system, so the group identified the need to bring patients and families on board (e.g., through focus groups). The group agreed that patients and families should be engaged from the beginning of the policy making process through implementation. To support this effort, stakeholder organizations and representatives need to be identified. This can be done by mapping the civil society registry, which lists registered NGOs, CBOs, and other societies. It would be helpful if some overarching body exists or can be created to represent the voices of all of these stakeholders. Channels of communication need to be established, both between the recipients of services and policy makers and between frontline workers and policy makers. Kenya is in the process of finalizing the PHC strategic framework. The group agreed that this process should be used as a pilot to explore ways of engaging patients and families. The Kenyan delegation agreed to explore these ways in the finalization of the bill. They also discussed the role of families in developing policies. In Vietnam, the government has reached out to CBOs and NGOs in the past for assistance. Members of the group from the private sector offered models, funding, and expertise on partnering with patients, and members of the group representing NGOs offered support in disseminating those policies once they are developed.

6.1.4 Service delivery

The service delivery group focused on the need to develop trust in service delivery at the PHC level. They identified two action items that could support this need: (1) to improve health staff capabilities and (2) to improve the accessibility and availability of services at the PHC level. The group considered action items that would help improve health staff capabilities, specifically focusing on action items related to implementing new training protocols. These action items include identifying the model of care at the PHC level, conducting a needs assessment of current staff, developing a curriculum and job aids to support healthcare workers, planning and implementing new training protocols, and monitoring and evaluation. These steps offer an iterative approach to improving the health staff capacity at the PHC level. The group developed a framework of potential stakeholders in this effort, ranging from government stakeholders at every level to health staff, patients, NGOs, CBOs, private healthcare providers, other private actors, funders including health insurance companies, and international organizations.

In Vietnam, a technical working group is engaged with multiple stakeholders. The group agreed that this working group is well suited to manage the development of a new training program for PHC staff in Vietnam. In Kenya, technical working groups at the national and local level are engaging with various stakeholders as well. These two groups may be able to facilitate stakeholder engagement to develop a new training program.

The group identified numerous roles and responsibilities associated with developing a training program. At the ministry level, government is responsible for leadership and endorsement of training programs and providing technical guidance to ensure that new training programs are aligned with the ministry’s vision. Healthcare staff may be responsible for providing input on training needs and offering mentorship. Patients can provide feedback on service quality and gaps in service. CBOs and NGOs can provide technical assistance and implementation support, and resources to support these programs would come from funders involved in developing the programs.

To address service accessibility, the group discussed mapping the modalities of care that
may be needed in different areas based on setting and geography. Accessibility may be improved through community-based care or mobile care delivery. The group felt that the stakeholders and methods of engagement for addressing accessibility and availability were similar to those used for improving health staff capabilities. They noted the important role of the government in setting a legal framework, offering technical guidance, and setting forth a vision for improving service delivery. The group identified the opportunity for private-sector actors to contribute technical assistance, products, training on the use of products, advocacy, and monitoring and evaluation.

The group also identified action items to address issues around service accessibility and availability. A core package should be developed, followed by a needs assessment conducted by implementors, which will determine the equipment, diagnostics, and drug requirements to fulfill that core package.

### 6.2 ACTION ITEMS FOR KENYA, VIETNAM, AND OTHER STAKEHOLDERS

For the final discussion period, participants assembled into three groups. The first two groups comprised the Kenyan and Vietnamese delegations, along with any stakeholders who wished to convene with either country’s delegates. These groups were tasked with identifying action items for their countries’ PHC strategies. The third group comprised those participants who did not join a specific country’s delegations. This group focused on the common themes from the workshop in order to develop broad action items for stakeholders to facilitate global efforts to strengthen PHC. They focused on the action items, stakeholders, roles, and responsibilities identified by the four groups in the previous discussion groups and synthesized these ideas into the key elements that are needed to create an enabling ecosystem.

#### 6.2.1 Kenya’s action items

The Kenyan delegation focused on the importance of patient and family engagement. They expressed interest in developing a formal public consultation framework within their PHC strategic framework.

National and local governments were identified as the key stakeholders responsible for engaging patients and families, along with patient organization, NGOs, CBOs, faith-based organizations, and development partners. They identified the adverse selection of patient groups as a challenge to engaging patients and families. It is possible that patients easiest to engage with will be those that are strongly motivated by a single issue, claim of negligence, or other potentially complicated issues. The most vocal patients may bring a very critical perspective. The delegation feels that it is important to engage with these patients and face their criticisms. There will be costs associated with engaging with patients at each level of the healthcare system. These costs highlight the consequences of Kenya’s devolved healthcare system. Each county will have to collect feedback independently, and that feedback will need to be collected, coordinated, and organized at the provincial and national level. Kenya will require funding and technical assistance in carrying out their plans to engage with patients and families. They may rely on outside facilitation to help ensure an objective representation of patient and family inputs. Kenya will also need to rely on outside expertise on how to consult with patients and families. They will measure patient and family engagement by holding inclusive meetings and addressing inclusivity in their reports. The increase in inclusivity should lead to the development of a better framework.

In the domain of technology and innovation, the group discussed the standardization of e-health technologies and the development of a health technology assessment. They felt that all stakeholders should be engaged in these activities, including county governments and private partners. They discussed the potential
challenges posed by regulatory constraints, procurement of funds, and the lack of evidence around the use of technologies.

In the domain of service delivery, the group focused on the availability of services, including human resources, drugs, and equipment. They identified the ministry of health and county leadership as the responsible stakeholders, along with implementing partners. They anticipated the challenge of funding and identified the need for funding and human resources in order to improve and manage service delivery in Kenya. Service delivery should be measured through both a needs assessment and utilization of services assessment.

Finally, the group discussed the SDG Partnership Platform which was launched as a high-level collaboration with the UN system in Kenya and other stakeholders in pursuit of accelerating the attainment of the SDGs through multi-stakeholder and cross-sectoral partnerships. The Platform aims to scale up transformative primary health care interventions to improve health and well-being of Kenyans and support the attainment of Kenya’s Universal Healthcare agenda. The goal is to utilize the SDG Partnership Platform as a vehicle for galvanizing more support from the private sector, including philanthropic efforts. The Platform model could be enhanced to drive government-led multi-stakeholder action on the ground. See Box 6-1 below for a list of Kenya’s PHC action items.

**Box 6-1. Kenya’s PHC Action Items**

1. Engage patients and families, patient organizations, NGOs, CBOs, faith-based organizations, and development partners through national and local government.
2. Obtain funding and technical assistance in order to effectively engage and respond to the needs of patients at the local level.
3. Develop ways to measure patient and family engagement, such as holding inclusive meetings with patients and families as stakeholders and addressing inclusivity in their reports.
4. Standardize e-health technology and develop a health technologies assessment.
5. Improve service delivery through increasing the availability of services, drugs, and equipment, while expanding human resources to manage service delivery throughout the country.
6. Utilize the SDG Partnership Platform to not only galvanize stakeholder buy-in from the private and philanthropic sectors, but also achieve Kenya’s Universal Healthcare agenda by driving tangible action in the field.

**6.2.2 Vietnam’s action items**

The delegation from Vietnam identified action items that included taking stock of current PHC resources. They noted that they benefit from their existing strategic legal framework as well as their existing PHC system and its connection with the hospital system, key financing streams, and the availability of technical assistance.


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The Vietnam delegation agreed that they need support in their efforts to:

- Develop a PHC service delivery model
- Improve technology and innovation
- Improve monitoring and evaluation
- Expand human resources development
- Promote quality assurance for PHC
- Secure PHC financing
- Foster relational management and behavioral changes

In order to create an enabling ecosystem for PHC, the Vietnamese delegation identified several key activities. The first is to define key stakeholders in the PHC ecosystem. These may include central and local governments, public health systems, multilateral and bilateral development partners, private-sector actors, NGOs, training and research institutions, civil society, patients, families, and communities. They agreed that Vietnam should establish rules for effective and fair cooperation among stakeholders that promote transparency, accountability, and win-win situations. Along these lines, they identified the need for strong leadership during challenging times, the alignment of individual stakeholder priorities with strategic priorities, and an effective monitoring and evaluation system. The delegates agreed that they should advocate for stakeholder engagement and agree on action plans in collaboration with stakeholders to help create a healthy ecosystem for PHC. All of these activities should be incorporated into the broader monitoring and evaluation framework. The group asserted that a healthy ecosystem for PHC will be more beneficial than the actions of any single stakeholder.

The group also discussed the creation of a technical working group for Vietnam made up of stakeholders that are piloting integrative PHC models. The group includes representatives from the ministry of health, the ministry of planning and finance, The World Bank, Harvard, and other actors. The working group has been investigating new models for PHC improvement, and the Vietnam delegation is open to exploring these new models that may be useful and applicable for the integration of the PHC system into the community with a focus on patient-centered care in Vietnam. See Box 6-2 for a list of Vietnam’s PHC action items.

### Box 6-2. Vietnam’s PHC Action Items

1. Take stock of the country’s existing PHC resources; Vietnam benefits from its existing PHC system and its connections to hospitals, funding, and technical assistance.

2. Define the key stakeholders in the PHC ecosystem. This includes a variety of groups and organizations listed above.

3. Establish rules for fair cooperation among stakeholders that promote transparency, accountability, and win-win situations.

4. Develop strong leadership within the PHC ecosystem that can align the priorities of individual stakeholders with the overall strategic priorities.

5. Develop effective monitoring and evaluation systems so that action plans created through collaboration with all stakeholders achieve their initial aims.

6. Create a technical working group composed of stakeholders that are piloting integrative PHC models in Vietnam.
Primary Care 2030 Dialogue

6.2.3 Synthesis of action items to create an ecosystem for PHC

The third group developed a list of key themes and mapped those ideas into a broad framework for developing an ecosystem that is supportive of PHC. The group identified governance as a key theme. This theme is emergent in its relation to several other areas. Government was key in the discussion of procurement and supply chains; this area connects with anti-corruption concerns as well. Government must be involved in engaging with and regulating technology providers. The group agreed that government should be the primary steward of engagement with stakeholders in PHC. Governments’ role in engagement is linked to their role in shaping and guiding the vision for PHC. The group also discussed the need to improve patient engagement and experience. This issue touches on the importance of facility and service quality. They drew a connection between technology and patient experience, suggesting that the patients’ digital experiences should be considered in addition to their physical experiences. Next, the group considered the issues around sustainability. They asked what would happen to stakeholders once programs end. For example, once vertical funding for an HIV or tuberculosis program ends, there must be some plan to maintain the services provided by that program. Data was a recurring theme; they considered how data quality can be improved, how governments can ensure data consistency, how data can be interoperable, and how it can be ensured that data are delivered back to the local level where they can be used at the level of care delivery. The group discussed the adaptation of technology to changing environments and the role of technology in ensuring the promise of UHC. Finally, they highlighted the need for leapfrog technology to ensure UHC.

6.3 KEY TAKEAWAYS FROM THE WORKSHOP

Duong closed the discussion by asking the participants to share their key takeaways. Cristin Lind, Patient Advocate, explained that the workshop expanded her appreciation for the complexity of healthcare and wellness. Improving healthcare is not a task that can be carried out unilaterally by any stakeholder group. The workshop renewed her commitment to listening to and collaborating with other stakeholders. Lucky Emmanuel, World Health Organization—Young Leaders Network, shared that the workshop broadened his appreciation for stakeholder engagement. Certain key stakeholders must be involved in planning activities going forward. He recognized the need for growing and retaining the frontline workforce and building healthcare capacity. The workshop gave him valuable insights for dealing with the critical issue of the diminishing healthcare workforce in his setting. Sejal Mistry, Access Health International, shared that her key takeaway was the insight that innovation refers to new ways of doing things and is not limited to technology. The open approach to innovation, engaging all stakeholders and evaluating processes, is a valuable insight. Beth T ritter, PHCPI, remarked that if all stakeholders approach their engagements with other stakeholders with an attitude of helpfulness and engagement, much of the mistrust and suspicion that can be associated with stakeholder meetings could be dissolved. A participant pointed out that the great complexity of PHC requires stakeholders to share information and cooperate in order to improve it. The lesson of person-centeredness was a key insight of the workshop. PHC is about putting people first, getting them out of the healthcare system and back to their normal lives.
7 References


8 Appendices

Appendix 8-1. Workshop Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>8:30-9:15</td>
<td>Welcome and Introductions</td>
<td>David Duong and Lindsay Hunt (Harvard)</td>
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<tr>
<td>9:15-10:15</td>
<td>Context Setting and Vision</td>
<td>Sunny Khan (WHO HQ), Kelly Saldana (USAID), Dessi Dimitrova (WEF) &amp; Irina Nikolic (World Bank)</td>
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<tr>
<td>10:15-10:30</td>
<td>Break</td>
<td>Kenya and Vietnam Ministry of Health Representatives, Karen Kilner (WHO)</td>
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<tr>
<td>10:30-12:30</td>
<td>Country Case Examples</td>
<td>Rapporteur: Ruth Ngechu (Living Goods Kenya), Huong Mai Thi Kieu (CSCDI-Vietnam)</td>
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<tr>
<td>12:30-13:30</td>
<td>Lunch</td>
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<tr>
<td>13:30-15:15</td>
<td>How Do We Measure Success for PHC: From Partnerships to PHC</td>
<td>Beth Titter (PHCPI), Irina Nikolic (World Bank), Kenya Ministry of Health Representative</td>
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<tr>
<td>3:15-3:30</td>
<td>Break</td>
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<tr>
<td>3:30-4:45</td>
<td>Connect and Synthesize</td>
<td>All participants</td>
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<td>4:45-5:15</td>
<td>Pulling it All Together: Observations from Day 1, Plan for Day 2 &amp; End of Day</td>
<td>David Duong (Harvard)</td>
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<td>6:30</td>
<td>Group Dinner</td>
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### 17 October Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>9:00-9:30</td>
<td>Welcome Back &amp; Day 1 Insights</td>
<td>David Duong (Harvard)</td>
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<tr>
<td>9:30-10:15</td>
<td>Integrating Patients, Families as Members of Ecosystem</td>
<td>Cristin Lind (Patient Advocate)</td>
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<td>10:15-11:00</td>
<td>Integrating Front Line Health Workers as Members of Ecosystem</td>
<td>Bram Wispelwey (Health for Palestine), Lucky Emmanuel (WHO-Young Leaders Network), Sunny Khan (WHO-Young Leaders Network), Chomba Sinyangwe (Last Mile Health/Community Health Academy)</td>
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<tr>
<td>11:00-11:15</td>
<td>Break</td>
<td>All participants</td>
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<tr>
<td>11:15-12:15</td>
<td>Ecosystem ‘Elements’ World Café</td>
<td>All participants</td>
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<td></td>
<td>• Funding/Funders</td>
<td>All participants</td>
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<td>• Patient/Family Engagement</td>
<td>All participants</td>
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<td>• Tech/Technology and Innovation</td>
<td>All participants</td>
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<td>• Government/Reg. Frameworks for Private</td>
<td>All participants</td>
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<td></td>
<td>• Measurement</td>
<td>All participants</td>
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<tr>
<td>12:15-13:15</td>
<td>Lunch</td>
<td>All participants</td>
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<td>13:15-14:30</td>
<td>Fertilizing the Ground for Change</td>
<td>All participants</td>
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<td></td>
<td>• What are the components of an eco-system to enable UHC via PHC?</td>
<td>All participants</td>
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<td></td>
<td>• How to create symbiotic relationships?</td>
<td>All participants</td>
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<td>• What does it take to create a multi-stakeholder platform?</td>
<td>All participants</td>
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<tr>
<td>14:30-14:45</td>
<td>Break</td>
<td>All participants</td>
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<tr>
<td>14:45-15:45</td>
<td>Action Plans for Change: Kenya and Vietnam</td>
<td>All participants</td>
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<td>• Next steps and Consensus Building around Core Component of an eco-system that enables UHC via PHC</td>
<td>All participants</td>
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<tr>
<td>15:45-16:15</td>
<td>Wrap up and Final Thoughts</td>
<td>David Duong (Harvard) and All Participants</td>
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### Outcomes/Deliverables

1. Conference proceedings, including key findings and documentation of tools presented
2. Identify key principles that can build a consensus statement around multi-stakeholder collaboration, engagement and investment in PHC to actualize the Declaration of Astana
3. Obtain initial commitments toward investments for PHC innovations in select countries
4. Primary Care 2030 community of practice, with ongoing networking, sharing and collaborative problem solving
Appendix 8-2. Community health coverage in Kenya 2019

Note: CHS = community health service
Source: Olago presentation; Kenya CHS program data, 2019