World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

PHC Measurement &Improvement

TOWARDS UNIVERSAL HEALTH COVERAGE:

Lessons learned from the implementation of the Primary Health Care Measurement and Improvement (PHCMI)

in the Eastern Mediterranean Region

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Foreword

The primary health care (PHC) journey in the Eastern Mediterranean Region (EMR) dates back to the 1978 Alma-Ata Declaration. Since then, the Region has remained committed to the PHC philosophy, values and the approach enshrined in the declaration. Through the Doha Declaration in 2008[1], Salalah Declaration in 2018[2], Astana Declaration on PHC in 2018[3], United Nations General Assembly political declaration on universal health coverage (UHC) in 2019[4] and the Seventy-second World Health Assembly resolution WHA72.2 on PHC in 2019, Member States in the Region reaffirmed their commitment to PHC as a cornerstone of sustainable health systems for the achievement of UHC and the health-related sustainable development goals (SDGs).

Dr Ahmed Al-Mandhari, WHO Regional Director for the Eastern Mediterranean, told the recent World Organization of Family Doctors (WONCA) conference held in Muscat, Oman, that "strengthening primary health care through family practice-based models of care is essential for achieving universal health coverage, a key health-related sustainable development goal".

The PHC approach is defined by three components: integrated health services to include primary care services and essential public health functions; addressing the broader determinants of health through multisectoral policy and actions and empowering individuals, families and communities to take charge of their own health. Overall, primary care in the Region has been disease-centred rather than people-centred. It is important to shift the focus from disease to people and bring others on board with the idea that PHC is not limited to health systems. There is also a need to collaboratively shift from elements of the Alma Ata Declaration to the three components of PHC established in the Astana Declaration which are at the forefront of new challenges, including health emergencies.

1 Primary health care in the Eastern Mediterranean Region: from Alma-Ata to Doha: http://www.emro.who.int/emhj-volume-16-2010/volume-16-issue-12/article-14.html

2 Salalah Declaration on Universal Health Coverage 2018: http://www.emro.who.int/images/stories/health-topics/uhc/salalah_uhc_declaration_-_final.pdf

3 Declaration of Astana: https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf

4 Political Declaration of the High-level Meeting on Universal Health Coverage "Universal health coverage: moving together to build a healthier world": https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf

The COVID-19 crisis exposed structural, institutional, financial and resource availability shortcomings at the primary care level across the Region, and a lack of clarity about the role of PHC in COVID-19 responses. The lack of systematic community engagement and empowerment and sustainable multisectoral actions and policies made it challenging for governments to mount an effective COVID-19 response, especially at the start of the pandemic.

The pandemic also underlined the centrality of the PHC approach, and that primary care clinicians should be the first point of contact for individuals and communities, constituting a critical interface for health security. This resulted in a movement to "make PHC everybody's business" by promoting cross-departmental collaborative projects within the WHO Regional Office and promote a shared understanding of the role of PHC in advancing UHC and health security across the region.

As Dr Al-Mandhari has pointed out, the WHO Regional Office for the Eastern Mediterranean is supporting many initiatives aimed at strengthening PHC. They include a diploma programme that aims to increase the supply of family physicians, and by doing so enhance the role of PHC in responding to, and preparing for, health emergencies, furthering the development of PHC oriented models of care. All these efforts come within the framework of WHO's regional vision of "Health for All, by All".

Acronyms

CHE	current health expenditures
CHW	community health worker
CMW	community midwives
COVID-19	coronavirus disease
DHIS2	2nd District Health Information System
DTP3	diphtheria, tetanus toxoid and pertussis vaccination
EHR	electronic health record
GCC	Gulf Cooperation Council
GDP	gross domestic product
GPW13	13th General Programme of Work
HiAP	health-in-all policies
HIS	health information system
HIV	human immunodeficiency virus
IHR	International Health Regulations
IPC	infection, prevention, and control
LHW	lady health workers
MIL	Master Indicator List
MOH	Ministry of Health
MOHSP	Ministry of Health and Social Protection
MOPH	Ministry of Public Health
NCD	non-communicable disease
NGO	non-governmental organization
NHA	national health accounts
PHC	primary health care
PHCC	primary health care cooperation
PHCCP	Primary Health Care Country Profile
PHCMI	Primary Health Care Measurement and Improvement Initiative
PHCPI	Primary Health Care Performance Initiative
RPD-FM	Regional Professional Diploma in Family Medicine
RMNCH	reproductive, maternal, newborn and child health
SARA	service availability and readiness assessment
SDG	sustainable development goal
STI	sexually transmitted infections
TB	tuberculosis
UHC	universal health coverage
UNICEF	United Nations International Children›s Emergency Fund
UNRWA	United Nations Relief and Works Agency
VSP	Vital Signs Profile
WASH	water, sanitation, and hygiene
WHO	World Health Organisation
WONCA	World Organisation of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

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This report was written based on data collected by the PHCMI focal points under the guidance of WCO health systems focal points. [name all here]

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Introduction

Primary health care in the Eastern Mediterranean Region

The Eastern Mediterranean Region includes 22 countries and accounts for almost 9% of the world's population. In 2017, the regional average for the Universal Health Coverage (UHC) Index stood at just 57, compared to the global average of 64[1]. In paving the way towards UHC, a strong PHC approach is recognized as a foundation of effective and efficient health systems. PHC in the Region is largely characterized by disparity in health service delivery, where 70% of outpatient services are provided by the private health sector, 93% of primary care facilities are managed by generalists, 57 % of prescriptions out of primary care facilities include antibiotics, and 1 out of 10 patients admitted to public hospitals experience adverse events.

PHC is a recognized cornerstone of UHC. UHC is what we are aiming for and PHC is the approach towards its realization. In the Astana Declaration, Member States recognized that elements of PHC needed to be updated to respond to ongoing and new health and health system challenges, as well as to take advantage of new resources and opportunities for success in the 21st century. This recognition has inspired global commitment towards the reorientation of health systems and pushed a series of regional resolutions. In recent years, the WHO Regional Office has launched several initiatives driven by this commitment, including the Primary Health Care Measurement and Improvement Initiative (PHCMI), the Regional Diploma for Family Medicine, COVID-19 response training for physicians, enhanced engagement with the private sector and the development of PHC-oriented models of care.

Using PHC as a roadmap for UHC requires collaboration across technical departments and programme areas and engagement with other sectors, communities and organizations. A change in mindset is needed to tackle disease-related problems in a way that adopts a holistic health systems approach.

1 Primary Health Care on the Road to Universal Health Coverage (file:///C:/Users/azabh/Downloads/WHO-HIS-HGF-19.1-eng.pdf)

2. The primary health care approach

In October 2018, the global health community came together in Astana, Kazakhstan to celebrate the 40th anniversary of the 1978 International Conference on Primary Health Care and the resulting Alma-Ata Declaration. The Declaration describes the key principles of the primary health care (PHC) approach: health as a human right; communities driving decisions that influence their health; health care close to where people live, and coordinated efforts across society to create health. All the principles of the Alma Ata Declaration have retained their relevance.

The 2018 Global Conference on Primary Health Care renewed commitment to PHC, adopting a modern perspective that resulted in a series of technical documents that took the Astana Declaration as their foundation. "A Vision for primary health care in the 21st century" made the investment case for PHC while the "WHO PHC Operational Framework"[1] provided guidance to take a country from vision to action.

To ensure consistency and mitigate confusion in the use of the terms "primary health care", "primary care", "public health", and "population health", the definitions established in 2018 by the WHO and UNICEF in preparation for the Global Conference on Primary Health Care, presented below, will be used.

2.1. Primary health care

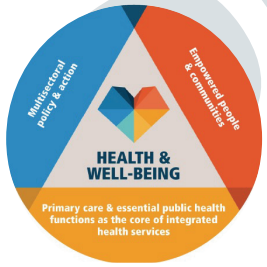

Figure 1. Primary health care definition, WHO 2018

WHO describes primary health care as "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 communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment".

PHC has three inter-related and synergistic components: (a) multisectoral policy and action; (b) empowered people and communities and, as its foundation, (c) primary care and essential public health functions as the core of integrated health services.

2.2. Primary care

Provision of primary care services is a critical component of PHC. WHO defines primary care as "a key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care".

This is in part derived from the definition of primary care put forward by primary care advocate Prof. Dr. Barbara Starfield who defined primary care as "the provision of first contact, person-focused, ongoing care over time that meets the health-related needs of people, referring only those too uncommon to maintain competence, and coordinates care when people receive services at other levels of care".

Dr. Starfield listed five cardinal functional attributes which together delineate primary care: first contact (accessible), comprehensive, continuous, coordinated, and person-centered. A sixth attribute, community engagement, was added later to acknowledge the critical role the community plays in the delivery of primary care. The following definitions are taken from the PHCPI Improvement Strategy, High-Quality PHC.

First-contact

"First contact accessibility refers to the capacity of a primary care system to serve as the first point of contact, or a patient's entry point to the health system and main coordinator of care, for the majority of a person's health needs."

Continuous

"Continuity refers to a long-term healing relationship between a person and his or her primary care provider or care team. There are at least three types of continuity considered to be important for primary care:
Relational continuity: an ongoing therapeutic relationship between a patient and one or more providers

1 Primary health care: transforming vision into action. Operational Framework outlines a series of levers that can be actioned to align health systems according to a PHC approach. The Operational Framework was published on 14 December 2020. The PHC measurement framework and indicators were published 28 February 2022 (https://www.who.int/publications/i/item/9789240044210), accessed 18 September 2022).

Informational continuity: the use of information on past events and personal circumstances to make current care appropriate for each individual
Management continuity: the extent to which services delivered by different providers are timely and complementary such that care is experienced as connected and coherent. It can also be thought of as a consistent and coherent approach to the management of a health condition that is responsive to a patient›s changing needs."

Coordinated

"Care coordination involves managing and integrating care across levels of the system and across time in order to ensure patient information is communicated at the right time and to the right people to facilitate the delivery of safe, appropriate and effective care."

Comprehensive

"Comprehensiveness refers to the provision of holistic and appropriate care across a broad spectrum of health problems, age ranges, and treatment modalities. Comprehensive care should address a wide range of preventive, promotive, chronic, behavioural, and rehabilitative services and include an assessment of a patient's risks, needs, and preferences at the primary care level."

Person-centered

"Person-centered care involves engaging with people as equal partners in promoting and maintaining their health and assessing their experiences throughout the health system, including communication, trust, respect, and preferences."

Community engagement

"Community engagement is the inclusion of local health system users and community resources in all aspects of design, planning, governance and delivery of health care services. Community engagement is a central component of effective population health management and helps ensure that services are appropriately tailored to population needs and values."

WHO has defined community engagement as "a process of developing relationships that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes."

2.3. Public health functions

Essential public health functions include "the spectrum of competencies and actions that are required to reach the central objective of public health – improving the health of populations… Core or vertical functions [include]: protection, promotion, prevention, surveillance and response, and emergency preparedness".

Health protection

Health protection "includes risk assessment, and… supervision of enforcement and control of activities for minimizing exposure to health hazards in order to protect the population by ensuring environmental, toxicological, road and food safety. It overlaps with health care delivery through patient safety, and with self-care through consumer safety. Health protection shapes the physical and social environment to allow people to live healthy lives".
WHO & UNICEF: Vision

Health promotion

"While health protection guards against potential threats to good health, health promotion enables people to have more control over their own health through better health literacy and improved ability to provide self-care and care for others. In addition, health promotion aims to create health enhancing physical and social environments through a wide range of social and environmental interventions."

Disease prevention

Disease prevention "is delivered at both the individual and the population level and in many settings is linked to health promotion and health care delivery. Disease prevention has been shown to be an essential steppingstone to achieve health and well-being, responding to clearly established and universal health needs; as such it is an integral part of UHC and should be planned, coordinated and resourced as such".

Surveillance and response

Surveillance and response "combine monitoring and prevention, and highlight the importance of readily usable health information at the population and community level, including through engagement of primary care workers".

Emergency preparedness

Emergency preparedness "aims to address unforeseen and catastrophic

circumstances that create a surge of demand for health services and strain resources and infrastructure. A strong and well trained PHC workforce is needed during emergencies to ensure that the health system is responsive and adaptable, and to help with planning, thus helping to avoid the rapid and uncontrolled depletion of health resources."

"In PHC-oriented systems, public health functions may be delivered as separate national or subnational programmes (e.g. disease prevention may include a school-based immunization programme) or through primary care services such as cancer screening, according to what is most appropriate in the particular setting. In both cases, public health functions should be coordinated and integrated with each other and with primary care, in a coherent PHC approach with integrated policies, adequate resources, aligned leadership, and effective communication. Better integration of public health and primary care has been associated with improvements in health behaviour, a range of health outcomes including reduced rates of chronic disease and maternal and child health, improved access to health services and health literacy."

2.4. Population health

WHO defines population health as "an approach to health care that seeks to improve the health outcomes of a group of individuals, including the distribution of such outcomes within the group".

According to the Primary Health Care Performance Initiative (PHCPI), population health is "the foundation of primary health care service delivery and, when done effectively, can contribute to an array of downstream effects."

PHCPI elaborates: "Population health management is an approach to primary health care (PHC) provision that integrates active outreach and engagement with the community in care delivery. This approach shifts primary care service delivery from reactive to proactive management of a segment of the population. Effective population health management typically occurs both in established clinics and in the community. It requires a strong organizational structure, efficient information systems, and an appropriate mix and sufficient quantity of providers. Inherent in population health management is the provision of a broad range of health activities including curative and preventive care, health promotion activities delivered through broad public health initiatives, and engagement with social determinants of health".

Population health management stands at the intersection of primary care (clinical aspects) and public health (well-being).

3. PHCMI: background and methodology

To support Member States in implementing resolution EM/RC63/R.2 and fulfil commitments made in the 2018 Astana Declaration the WHO Regional Office for the Eastern Mediterranean established the Primary Health Care Measurement and Improvement Initiative (PHCMI) in 2019, in collaboration with UNICEF, the World Organization of Family Doctors (WONCA) and the Primary Health Care Performance Initiative (PHCPI), with support from the Bill & Melinda Gates Foundation, to evaluate the current state of PHC performance in the region and to determine focus areas to improve the delivery of essential health services.

PHCMI provides a regional foundation for PHC assessment and has opened a discourse for an improvement-based approach in all settings. The resulting assessments have helped identify the strengths, weaknesses, gaps and challenges faced by countries in the Region and explored a whole-of-government approach to advancing PHC.

The objectives of PHCMI are to:

- develop a common language/framework through which to explain the process of PHC strengthening;
- identify and aggregate data that assess key aspects of PHC;
- create tools, such as PHC Country Profiles (PHCCP) and Vital Signs Profiles (VSP), that policymakers, development partners and advocates can use to better assess and improve PHC;
- highlight progress, and identify key challenges to improving PHC performance; and
- develop PHC improvement plans and strategies as part of routine policy, planning, management, supervision and service delivery processes.

PHCMI is built on the global Primary Health Care Performance Initiative (PHCPI),[1] the PHC Operational Framework,[1] existing regional efforts to strengthen PHC, established WHO PHC quality indicators and the WHO regional health system profile.

PHCMI aims to build national capacity to enable countries to undertake assessment-based improvements to PHC services and promote greater adoption of the people-based family practice approach to facilitate more equitable and efficient access to essential health services for individuals, especially the most vulnerable, residing in the catchment area of a primary care facility.

PHCMI also aims to provide a holistic overview of PHC performance in countries of the Region, with a special focus on data availability and use. The first phase of the initiative assessed the performance of PHC to help policymakers plan for improvement. Out of 22 countries in the region, 20 participated in the initiative and 14 are included in this report. Most countries had data gaps and missing information for indicators, and none of the countries provided data for all the indicators in the Master Indicator List (MIL).

PHCMI consists of three phases: planning; measurement and improvement.

During the planning phase, the responsible team:

- conducts a thorough stakeholder analysis as the first step in implementing PHCMI, following approval from the relevant Ministry of Health to commence the initiative. The stakeholder analysis systematically gathers and analyses qualitative information to determine whose interests should be considered when implementing a policy or programme;
- defines the desired outcomes and objectives of the assessment, its scope, and parameters;
- establishes effective communication and collaboration between all stakeholders; and
- develops a workplan that will facilitate the regular monitoring of progress.

1 The Primary Health Care Performance Initiative is a partnership of policy-makers, health systems managers, advocates and others who are dedicated to improving the global state of primary health care in low- and middle-income countries. PHCPI is a partnership between the Bill & Melinda Gates Foundation, UNICEF, World Bank Group, and World Health Organization, with technical partners Ariadne Labs and Results for Development (https://improvingphc.org/, accessed 18 September 2022).

1 Primary health care: transforming vision into action. Operational Framework outlines a series of levers that can be actioned to align health systems according to a PHC approach. The Operational Framework was published on 14 December 2020. The PHC measurement framework and indicators were published 28 February 2022 (https://www.who.int/publications/i/item/9789240044210), accessed 18 September 2022).

The measurement phase

- Following selection by the Regional Office of the indicators to be used in the assessment, countries have an opportunity to review the MIL and propose alternative indicators based on their specific context given it may not always be possible for a country to collect data for the selected indicators. In collaboration with WHO, country teams review and finalize a list of alternative indicators.
- After finalizing the MIL, if necessary, the PHCMI country focal point liaises with other team members/stakeholders to identify what data are available or missing. Together, the team will determine if data exist or need to be collected in Phase II. After identifying which information is available, the PHCMI country focal point will contact key informants to collect data. As a general rule, for phase I the team should rely only on existing data and identify missing data.
- Qualitative data collection may be conducted in a number of ways. Some qualitative data may already be available while collection of other data may require interviews with key informants to determine if data are available. A part of the PHC assessment is informed by the progression model qualitative assessment tool, covered in more detail later in this report.
- Once data have been collected, validated and approved by the Ministry of Health, a formal clearance process is initiated.
- If any discrepancies are identified by WHO at the country, regional or global level, they must be addressed before data are made public.
- Finalized data is used to inform the PHC country profile (PHCCP) and the vital signs profile (VSP) for publication.

The improvement phase

Using the lessons learned from the measurement phase, countries are encouraged to identify priority areas of improvement and collaboration to address gaps, challenges and weaknesses. For some countries, this could involve incorporating PHCMI findings in existing reforms, using PHCCs as evidence for driving policy dialogue and/or engaging country leadership and partners in collaborations that strengthen PHC.

4. Progression model

The primary health care progression model is a mixed method assessment tool used to populate the capacity pillar of the Vital Signs Profile. The assessment aims to measure core primary health care capacities, including governance and leadership, adjustment to population health needs, service delivery inputs and the management of health facilities.

- Governance and Leadership capacities refer to the existence of evidence-based policies designed around primary health care that are part of the National Health Plan, and the presence of a national coordinating authority accountable for coordinating, monitoring, integrating and implementing national PHC strategies and policies in the country.
- Adjustment to Population Needs requires the presence of a strong surveillance system that enables the systematic collection, analysis, and interpretation of health-related data which can be used to set service delivery priorities at a national and sub-national level.
- Service Delivery Input capacities reflect the availability, equitable distribution and quality of drugs, supplies, workforce, facility infrastructure, information systems and funding at the facility level.
- Population Health Management capacities include activities such as community engagement and proactive population outreach.
- Facility Organization and Management capacities include team-based care organization, regular and structured measurement of facility performance and the presence of supportive supervision.

The progression model enables standardized, systematic assessment of basic areas of PHC performance and allows comprehensive understanding of PHC strengths and weaknesses. Assessment relies on locally available data, knowledge and evidence, including information obtained through document review, quantitative data mining, and qualitative interviews with key informants with local PHC expertise. The tool consists of a set of quantitative and qualitative measures, each of which refers to a specific system capacity (see below).

Through the collection of data, country teams provide the answers to each component. According to the answers, a score is assigned that can range between Level 1 (low performance) and Level 4 (high performance). The results of the PHC progression model – along with a country's Vital Signs Profile – can be used by health system leaders, decision-makers and development partners to identify opportunities for improvement. The PHC Progression Model also provides a basis for countries to track their progress in improving capacities for stronger performance .

Measure 1: Primary health care policies (1/2)

Primary health care policies are decisions and plans that are undertaken by governments with input from other stakeholders to achieve specific primary health care goals. PHC policies promote, support, and establish system orientation, financing, inputs, and service delivery mechanisms to ensure quality and improve and develop PHC functions and outcomes.

COMPONENTS	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Number of elements below that can be answered positively:	2 or fewer	3-4	5-6	All 7
☐ Is there an active National Health Plan or National Strategic Plan in the country?				
☐ Is the National Health Plan and/or National Strategic Plan designed around PHC? This could occur either through the existence of an explicit PHC plan, strategy, or policy and/or through embedding of core PHC principles into the Plan?				
☐ Are policies around PHC evidence based?				
☐ Are policies around PHC formulated through a participatory process?				
☐ Are policies around PHC embedded in a legal framework?				
☐ Do policies around PHC include the fundamentals? a. Service package defined b. Financing mechanism c. M&E framework				
☐ Is there a joint review of the progress towards the objectives set out in PHC-related policies?				

DEFINITIONS

Evidence-based policy
Incorporates research-identified effective solutions or approaches, knowledge and experience, and values and goals.

Joint review
A shared approach that includes a diverse range of stakeholders to assess the progress, outcomes, strengths, and weaknesses of a policy.

The progression model is implemented through a joint internal/external assessment, consisting of an internal self-assessment conducted by an in-country team and an external validation completed by the Regional Office Progression Model Focal Point. The goal of external validation is to ensure results are evidence-based and calibrated across countries.

General trends and analyses observed from progression model assessments

Differences that emerged during the assessments and in the final results reflect the diversity of the Region. In the Eastern Mediterranean Region eight countries – Afghanistan, Bahrain, Jordan, Islamic Republic of Iran, Iraq, Morocco, Oman, and Pakistan – finalized the progression model. There were differences in the implementation process as countries employed multiple approaches and strategies to finalize the project.

While most of the countries formed a core team responsible for implementing the assessment, in others a single focal point in the country office was responsible for the collection of data and coordination with the PHCMI secretariat at the Regional Office. Some countries organized workshops that gathered stakeholders with primary health care expertise, to collect interviews and surveys or to have comprehensive discussions about each topic. Participants could share their experiences, competencies and knowledge which would then inform the scoring. According to the approach employed, the time needed for the progression model varied, ranging between three to over 11 months.

Major divergences were mostly dependent on the geopolitical and economic situations of countries which could create both challenges and opportunities that had a significant impact on the collection of data and the results. Countries with limited resources would often face challenges in finding available and reliable data at national and sub-national levels.

Afghanistan relied mostly on interviews with key informants. Given that PHC is implemented by non-governmental organizations (NGOs) in most provinces, the majority of informants worked under the auspices of the implementing NGOs or alliances of national and international health NGOs operating in the country.

Lack of data from rural and remote areas of Iraq, where over 2000 facilities operate, was overcome by adopting a tailored approach that allowed for the collection of information otherwise impossible to obtain. The focal point organized a workshop for subnational representatives of the most relevant health directorates in the country who in turn submitted comprehensive surveys to the facilities within their areas of responsibility.

Information about service delivery inputs and facility management was collected from 240 facilities in seven health directorates. The directorates included not only the better performing region of the capital but the semi-independent region of Kurdistan and the conflict-afflicted region of Mosul, the region with the least resources. The sample data collected provided a representative picture that allowed for a more exact assessment of the whole country.

In Gulf countries, the cultural and political context influenced the assessment of PHC capacities and also required a more tailored approach. These countries are high performing. The main challenge related to determining workforce density and distribution. The relevant measure required the ratio between the total number of actively practicing doctors, nurses and midwives in the country to be calculated, raising the problem of total population being defined differently in different countries.

Oman, for example, has different systems in place for citizens and for migrant and foreign workers. The ratio changes if only citizens are considered or if the foreign population is included. A major challenge related to the extent to which the assessment should be adapted to take account of a system that provides different services to different categories of its population while remaining in line with WHO definitions which assess the effective coverage of health services on the basis of skilled health professionals being equitably distributed and accessible by all segments of the population. The problem is not faced solely by Oman.

Challenges also arose in relation to the levels of expertise of key informants. In some cases, involved stakeholders did not have basic knowledge about public health and it was difficult for them to understand the topics presented in the assessment or to speak about the performance of the system. In other cases, responsible informants and stakeholders were reluctant to share information and evidence of low-performing systems.

5. Regional reflections

The need to strengthen PHC in the region cannot be overstated. The initiative benefited from the political support provided by stakeholders in participating countries and Ministries of Health commitment to improve primary care services in line with achieving UHC. There was a high level of cooperation from colleagues assigned to the initiative in each country. In addition, the use of international standards adopted for key indicators helped ensure standardization and comparability.

Weaknesses in most countries included missing data on infrastructure and processes as well as outdated clinical guidelines which, even when available, were not always implemented. Some countries disclosed a lack of proper implementation and/or the utilization of accredited points for continuous medical education for health care workers, an important factor in ensuring the sustainability of primary care service provision. It also emerged that perceptions of primary care and the experiences of service users were not always clearly evaluated.

The experiences of countries with the PHCMI initiative highlighted the importance of leveraging existing efforts to collect data to improve reform efforts and identify data gaps.

Although implementation of the assessment has been a challenge for most countries, a clear direction towards strengthening PHC is being observed by many countries in the Region. They noted issues to do with the primary care health workforce, primary care financing, systemic fragmentation, inadequate infrastructure and the lack of community involvement as overall weaknesses.

A majority of countries reported that primary care services were acceptable, accessible and affordable. Immunization, water sanitation and infection control in facilities were reported as being widely implemented in most countries. Other areas of strength included the existence of national health policies and strategies that reflect the three components of PHC and the engagement of stakeholders, including the community, in policy and strategy development.

As for the overall challenges facing the PHC approach, 29% of countries noted

poor engagement with the private health sector, 17% noted health work force issues, programme fragmentation and problems facing quality measurement of services and 5% noted a need for more consistent essential health services. Having a comprehensive package of services is meaningless unless it is acted upon and delivered which requires onsite verification at the facility level.

Committed leadership and strong political support stood out as major strengths in relation to PHC improvement. There was acknowledgement of PHC in national health strategies, quality standards and reform in all 14 responding countries. Social, economic, environmental and commercial determinants of health were included in the national health policies of nine of the 10 countries which submitted replies. All but one of the 10 responding countries indicated they had adopted a Health-in-All-Policies approach and had a mechanism for multisectoral governmental coordination.

In the Region, total annual spending per capita on PHC ranges from $28 (Afghanistan) to $310 (Qatar), with a median of $183. The median percentage of PHC expenditure from general government health spending is 27%, with actual figures varying from 1% in Afghanistan to 49% in Egypt.

While some countries reported that primary health care workers were qualified and that essential drugs were available, others suffered from a shortage of qualified primary care staff, limited availability of essential medicines and ineffective family medicine services. The percentage of the health workforce providing primary care services differs by country and occupation, with a high of 68% of doctors in Jordan to just 1.8% of midwives in Libya. The density of primary care providers is also important to assess access. The metric also displayed a wide range, with a low of one doctor per 10 000 population in Morocco to a high of 38.7 nurses per 10 000 in Libya. Another measure of access is the percentage of the population that has to travel more than 5 kilometers/1 hour to arrive at a primary care facility. It ranged from 56.6% in Afghanistan to none in Bahrain, though it should be noted only five countries were able to supply a value for this measure.

A lack, or limited use of, any centralized health information system (HIS) across levels of care at both the national and subnational level was also reported, especially in low-income countries. Gulf Cooperation Council (GCC) countries, however, reported strong connected digital systems. Some countries reported the presence of multiple parallel HISs. On major gaps in collecting PHC information, 27% of participating countries noted data availability, 24% mentioned unclear data routes and 20% highlighted overall data reliability and fragmentation. All nine countries that reported on the use of unique identifiers for patients actually did so, and five countries reported using patient health records to follow patients through their encounter.

The model of primary care service provision reflects the degree to which a country embraces the PHC approach. Among the five countries which reported the percentage of patients registered with a primary care facility, the range varied from 27% (Lebanon) to 95% (Iran). Of eight countries reporting a formal process for referrals, seven cited general practitioners as playing gatekeeper roles. Lack of patients' records and a formalized referral system mechanism is a challenge in many countries. In most countries, the provision of mental health services was found to be limited and the quality of the services inadequately assessed.

Community engagement is a core component of the PHC approach. All nine countries reporting indicated there was community and/or patient participation in facility management meetings. To assess patient-centered aspects, countries were asked what percentage of primary care facilities monitored patient experiences. Six countries responded, and the range varied from 15% (Morocco) to 100% (Qatar). The average was 64.5%.

Maternal mortality ratios varied from a low of nine (Oman) to a high of 638 (Afghanistan). It was found that coverage of reproductive, maternal, newborn, and child health (RMNCH) services ranged from 38% in Afghanistan – for mothers with no formal education – to 100% in Bahrain for all maternal educational levels. The average availability of the five tracer RMNCH services differed from 60 (Libya) to 100 (Bahrain, Lebanon and Oman). The range in under-five mortality rates per 1000 live births between rural and urban settings remains an area of concern. Rural setting rates varied from 0 (Bahrain) to 83 (Pakistan), while urban settings ranged between 0 (Bahrain) to 56 (Pakistan) in the eight countries reporting.

In the end, of course, it is the health of the population that matters. As with the variance in inputs, there are differences in outcome measures. Life expectancy at birth ranges from 65.3 (Afghanistan) to 80.7 (Qatar), suggesting a correlation between PHC spend per capita and years of life. Premature NCD mortality varied from 11.3% (Bahrain) to 30.6% (Yemen).

Afghanistan

NOTE: PHCMI efforts were conducted in 2019, 2020 and the first half of 2021. Political changes in the country in late 2021 mean they are unlikely to reflect the current state of affairs.

Primary Health Care is a focus of Afghanistan's National Health Plan. Policies around PHC are evidence-based and the country uses the Basic Package of Health Services.

National coordinating authorities responsible for monitoring, coordinating and implementing PHC policies have only a moderate reach at the subnational level. The surveillance system in each province is responsible for detecting, reporting and responding to disease outbreaks. Information flow and feedback mechanisms are available from the health facility to the national level and include all stakeholders.

Limited financial resources, especially government contributions – 1% of domestic general government health expenditure is directed toward PHC – contribute to low overall spending on PHC ($28 per capita annually). Currently, 95% of PHC spending is derived from donors and out-of-pocket expenditures, and 33% of the population perceive barriers due to treatment cost or distance from services.

The MOPH has set performance related targets for each province which reward facilities with a fixed amount of funds when targets are achieved. This system relies on effective monitoring of performance indicators.

Despite data challenges and gaps, Afghanistan was keen to provide the needed information and suggested alternative indicators when the indicator originally requested was unavailable. Afghanistan finalized reporting on the indicator values in a short period of time despite sometimes finding the process of data collection and validation complex. The country's commitment and cooperation contributed to facilitating the validation of data and finalization of profiles. Participating in the initiative was found to be an important learning experience.

Afghanistan reported challenges in implementation, including limited contributions from the MOPH and the existence of multiple sources with different figures for the same indicator. There was also the challenge that indicators did not always match with available assessment indices of PHC, private sector data was not available, and the reliability and validity of data was sometimes questionable. To address the latter challenge, Afghanistan relied heavily on key informant interviews to provide information which could not be captured by quantitative data. The involvement of relevant stakeholders in the process was found to contribute to the success of the initiative.

Findings of the initiative revealed a number of strengths, including the presence of an integrated Basic Package of Primary Care Services since 2003, a national health policy and a strategy that reflects the importance of all three components of PHC, an annual assessment of PHC (balanced scorecard "BSC") through KIT Royal Tropical Institute, active stakeholder engagement in policy and strategy development and the biennial Afghanistan Health Survey (AHS), all of which contributed to the results presented in the PHC Country Profile and Vital Signs Profile.

Weaknesses identified included gaps in the health workforce, especially female doctors, the absence of a family medicine approach, a poor referral system and the absence of non-communicable disease services in the current Basic Package of Primary Care Services.

The proportion of facilities that have essential medicines, consumable commodities, basic equipment, diagnostic supplies, amenities and safety standards, ranged from 60% to over 90% depending on location.

The findings and data gaps will help Afghanistan identify priority areas for improvement, and gaps to fill. This can be achieved by prioritizing data use and clarifying definitions for some of the indicators.

Identified priority areas include working with the government to recognize the critical role PHC plays within the health system and enable primary care clinicians to fulfil their role as the first point of contact, acting as gatekeepers for the rest of the health care system. Additional areas being focused on include increasing financial resources dedicated to primary care, improving community engagement and multisectoral collaboration, initiating family medicine practice and improving the referral system. Supporting the MOPH to introduce an electronic health

information system at the primary care facility level and improving the quality of primary care services are also priorities. The Basic Package of Health Services should be based on the burden of disease. Since non-communicable diseases are the number one cause of death, it is critical that such services be included in the primary care service package.

Following the first initiative to assess PHC comprehensively, Afghanistan found that a whole-of-government approach is key to creating resilience in the health care system by reinforcing the value of multisectoral coordination and collaboration alongside community empowerment, all key components of PHC.

While it is hoped that assessments can be conducted annually, the current political climate presents obstacles to the sustainability and institutionalization of PHCMI.

Bahrain

Bahrain's assessment provided insights into how PHC can be improved when there is already a high-performing infrastructure that supports the health system to deliver safe, effective and efficient care. Bahrain has implemented a series of interventions at the PHC level which aim to reduce harm to patients, improve clinical effectiveness, create an enabling system environment and engage patients and communities.

The National Health Regulatory Authority (NHRA) regulates the provision of health care in both the public and private sectors. Governance indicators revealed a specific plan for PHC and evidence-based policies embedded in a legal framework. A Central Committee for Primary Health has been established to coordinate PHC at a national level. Efficient management of the infrastructure and multisectoral action on PHC contributes to the delivery of high-quality care.

The government of Bahrain spends 2% of GDP on health, an amount that covers 22% of PHC expenditures. A total of $295 per capita is expended on PHC, accounting for 30% of overall health spending.

Primary care facilities are required to be accredited by independent entities that follow internationally established standards. Primary care in Bahrain has obtained international accreditation certificates from international institutions such as Accreditation Canadian. Currently, accreditation is overseen by the NHRA. Regular workshops and lectures on quality, patient safety and risk management contribute to increased awareness among the health workforce.

Bahrain has a strong health information system (HIS) and an E-government system which has connected citizens and residents to government services electronically since August 2007. *Telemedicine and teleconsultations are also in place. Doctors are tasked with informing patients about abnormal laboratory and radiology results and/or to refer them to secondary care. An E-service facilitates the process of ordering medicines for home delivery to chronic patients.*

PHCMI findings highlighted that, despite the existence of a strong HIS in all primary care facilities, HIS cannot replace household surveys, audits and qualitative surveys. There is a need to consider adding questions to current

surveys, particularly questions that relate to health workers' performance and patient satisfaction.

The PHCMI also reflected rapid population growth and changes in the country's demographic structure. There is an increased burden of non-communicable disease. Chronic diseases cause 81% of deaths and the estimated cost of diabetes is roughly a third of treatment expenditure in the country. There are also challenges facing the National Health Insurance programme caused by the exit of a large number of health workers.

The policies in place ensure that essential medicines, equipment and diagnostics are always available and of high quality, that health care providers are trained and deliver quality primary care, and that facilities are evenly distributed and easily accessible by all communities, including the most vulnerable segments of the population.

Bahrain has a system in place to ensure, through regulations and policies, that the workforce is qualified to deliver high-level primary care services. Regulations mandate that health care professionals be licensed before being employed and the licenses are regularly reviewed. Health care facility surveys and consultation visits are conducted regularly, and there are annual follow up visits. There are systems in place to ensure the workforce receives ongoing training, and there are additional and comprehensive requirements for members of the workforce with foreign credentials.

Of the 72% of physicians and 21% of nurses specialized in family practice, all receive continuous professional training. One aspect that could be improved is the lack of a system that assigns the entire population to facilities, care teams and providers. The efficient system in place for local priority settings, community engagement and population outreach, however, enables the efficient management of population health.

To guarantee that quality standards are met in practice, a system is in place to collect and act on complaints. Complaints related to primary care services, whether they are entered directly into the national complaints and suggestions system, published on social media or arrive via letters, are forwarded by the office of the Assistant Undersecretary for Primary Health to the competent authorities. They are followed up until a response clarifying the circumstances is received and, where appropriate, corrective actions decided.

The delivery of mental health services requires further support. Currently, only 16% of facilities offer such services.
All facilities have adequate WASH, provide rooms with auditory and visual privacy and communication equipment, have standard diagnostics equipment, and provide access to a computer and the internet.

Bahrain provides promotive and preventive services to communities, including those that are marginalized and underserved. Proactive population outreach contributes to the successful management of population health. Health care services, including medical and psychological care, are provided to older people and physically challenged individuals through mobile units that cover every area. Social services are provided by social workers who make field visits to assess individual and community needs.

Facilities have developed health promotion activities and programmes tailored to the local context which aim to increase awareness of disease and prevention. These programmes are often conducted in collaboration with other entities and institutions and range from programmes about the harm of tobacco for school students to supporting associations that work with women who have been victims of abuse.

Patients, families and communities are engaged through annual satisfaction surveys and online communication channels that enable them to submit suggestions and complaints. The consistent monitoring of performance indicators for both facilities and workforce, together with the employment of trained managers, guarantees the effective management of facilities.

Reduction of harm to patients is facilitated through well-established IPC programmes, an incident report framework, improved allergy documentation in patients› electronic medical records (EMR), and improved staff vaccination rates.

The decline in oil prices, and government efforts to tackle rising debt and maintain growth rates, are a major challenge to the health system. For the improvement phase, an empanelment mechanism will be a priority. Surveys will also be updated.

There is a need to reorganize the MOH and strengthen its role in the provision of health promotion, social care and environmental health services in coordination with the Supreme Council of Health and the Environment Regulatory Authority.

Bahrain has prioritized primary care and made great strides towards achieving an exemplary PHC approach to delivering affordable and acceptable health care to its entire population.

Egypt

NOTE: The results highlighted below are based on the finalized PHCCP and VSP. Neither profile have been endorsed by the Ministry of Health.

Egypt's health system benefits from a large network of primary care facilities, a National Health Policy and strategies emphasizing PHC, a well-defined basic benefits package, a strong civil and vital registration system, implementation of the universal health insurance (UHI) law, updated quality standards and clinical guidelines, as well as political support.

The challenges faced in reporting for the PHCMI initiative were mainly related to PHC governance under the umbrella of the new UHI law, the definitions of various indicators and their relevance to the Egyptian context, a lack of coordination and fragmentation at the service provision level, reporting, remuneration and the existence of parallel health information systems. The tight schedule of the initiative also proved burdensome.

Although 46% of overall health spending goes towards PHC, the PHCMI assessment highlights low government health spending as a percentage of GDP (2%), and the fact that only 33% of PHC spending comes from the government.

Though there are shortages within the health workforce access seems not to be severely impacted. Less than 5% of the population were reported as having to travel more than 5km/1 hour to a primary care facility.

Although there is no formal gatekeeper role for primary care providers, a system for referrals does exist.

Other findings included multiple uncoordinated health information systems, limited community involvement and supply chain management issues.

While 100% of primary care facilities report on performance, the lack of numerous indicators reveals areas for improvement in data collection.

Based on these findings, priority areas for improvement are to support governance and leadership at the central level and to integrate health delivery through a family

medicine model and district health management. Training and capacity building of physicians and nurses is needed to advance family health management, services need to be integrated to counter fragmentation, and the referral system and retention policies require strengthening.

There is also a need to support PHC monitoring and evaluation through a robust HIS, to support research and improve patient registration, not least by using unique identifiers, and to further integrate family health into existing reforms and the new UHI law.

The PHCMI experience demonstrated the importance of a robust digitalized HIS, IPC surveillance, the need to revisit the delivery of essential health services, invest in health workforce training and capacity building, address retention policies to overcome work force shortages and improve supply chain management.

Islamic Republic of Iran

The Islamic Republic of Iran's health system has many points of strength: strong governance and the presence of existing legislation and a strategic plan for PHC improvement; use of a multi-purpose primary care workforce; a strong health information system; a high standard of infrastructure for primary care facilities and a renewed and prioritized model of care that integrates primary care services.

Underscoring the multisectoral nature of the health system is the existence of cross-governmental groups with clearly defined roles and transparent proceedings. A High Council for Health and Food Security has been established to create and implement policies related to food security and every level of health care. The Council, which includes representatives from relevant ministries and stakeholders, meets regularly.

In the Islamic Republic of Iran the project was overseen by both a steering and technical committee. Challenges that Iran reported during implementation included the lack of up-to-date evidence for some measures, the absence of data for some indicators, and the fact that data collection at times needed to be conducted through fieldwork and sometimes required tools to be adapted and customized. As a result, some new indicators were incorporated into the routine data collection system.

The government spends 4.4% of GDP on health, of which 26% is devoted to PHC. Still, only 30% of PHC spending is covered by the government. Apparently, the system mitigates against catastrophic health costs. Only 4% of the population reported cost as a barrier to treatment.

The health care system ensures consistent availability of essential medicines, basic equipment, diagnostic supplies and safety equipment across the country, with minimal to no variability.

Another strength is the capacity of the system to ensure the primary care workforce receives training and possesses qualifications based on the country's health priorities and burden of disease. A high percentage of primary care providers – 83% of doctors, 84% of midwives and 100% of behvarz (rural community health workers) – specialize in family practice. Passing an exam is required for

primary care clinicians to begin practicing. Afterwards, periodic monitoring and evaluation, together with the annual provision of in-service training courses, ensures workforce qualifications are maintained, including workforce members with foreign credentials. Measures are in place to deal with workforce members who do not meet the established standards.

Proactive outreach is impressive. A system that includes community health workers, community engagement and population outreach is in place to reach the most vulnerable segments of the population and narrow the rural-urban gap. Health Houses in rural areas, combined with the work of community health workers who provide care in the Health Houses, at home and in schools, are complemented by mobile units to serve nomadic populations. Less than 1% of the population perceives access as an issue due to distance, i.e., having to travel more than 5km/1 hour to arrive at a primary care facility.

The PHCMI and PHCPI assessments revealed weakness in the areas of social accountability, surveillance, priority setting, innovation and learning, community engagement, facility management, capability and leadership and performance measurement and management. Significant declines in maternal and child mortality rates and increased life expectancy, especially among females, were among the positive findings.

The initiative demonstrated the importance of improving the measurement of standard and key indicators and implementing assessments at the sub-national level. There is also a need to focus on ways to increase efficiency in the provision of primary care services and reduce the number of referrals to secondary care. Iran is scaling up the PHCMI initiative in 31 provinces of the country in selected University of Medical Sciences and health facilities and it is anticipated that the initiative will eventually be implemented in primary care facilities throughout the country. The assessment has already resulted in the development of an upstream policy document for strengthening the PHC network. It was also suggested that WHO update the country profile on an annual basis. The first and so far only update was conducted in 2018.

Iraq

PHCMI in Iraq benefited from the existence of a health and vital statistics department within the Ministry of Health (MOH) that defines roles for collecting, managing and disseminating health data. The availability of standard definitions for diseases and syndromes under surveillance, and the adoption of international standards for key indicators, facilitated the endeavor. Collected data provided a representative picture that allowed for a more accurate assessment of the whole country.

A strong legislative structure supports PHC. There is a comprehensive National Health Policy (2014–2023) encompassing quality improvement processes and UHC legislation that includes a PHC focus, and a four-year National Health Strategic Plan (2018–2022) that determines which regulatory bodies oversee the health workforce, health care facilities and essential medicines. The essential package of services for primary care was published in 2010 and reviewed and updated in 2016.

While the government contributes 2% of GDP to health care, little is known about the percentage directed towards PHC, what this represents in terms of total PHC expenditure, or the extent of out-of-pocket costs.

Challenges faced during implementation of the initiative included rapid turnover of MOH officials at the national level, political instability which delayed data collection, the impact of the global pandemic, limited multi-stakeholder coordination, mulitiple sources for some indicators, an absence of data for some measures and outdated data. Many national surveys have been delayed and the most recent national census was conducted in 1997. Contradicting figures for some indicators also raised concerns over data quality.

The differences in capacities in administrative divisions across regions were also a concern. A lack of data concerning rural and remote areas of Iraq, where over 2000 facilities operate, was addressed via a tailored approach which allowed the collection of information otherwise impossible to obtain. A workshop was organized for subnational representatives from the most relevant directorates of health. The representatives then undertook comprehensive surveys of the facilities in the areas for which they are responsible. Accurate information on service

delivery inputs and facility management was subsequently collected from 240 facilities in seven directorates of health, including not only the better performing region of the capital but also the semi-independent region of Kurdistan and the conflict-afflicted regions of Mosul and Al-Muthanna.

Iraq found that of the 124 MIL indicators, data for 43 quantitative indicators were not available, and 22 indicators otherwise available on a subnational level were absent in the Kurdistan region. It was recommended that some missing indicators be added to routine national surveys.

While the MOH has highlighted PHC as a priority, primary care facilities remain unequally distributed, with large differences between and within governorates. Operational rules, regulations and performance standards are either absent, or outdated and poorly enforced. While modernization of the public sector remains a top priority, limited focus on good governance is affecting the implementation of laws, the provision of services and effective management of the country's resources.

In terms of monitoring the sustainable development agenda, a seamless and well-integrated HIS is the ultimate goal. The limited use of HIS capabilities, especially at the local and sub-regional levels – only 46% of primary care facilities use a HIS – constitutes a problem. Data fragmentation for some primary care services, particularly for NCDs, prevented the calculation of some indicators. Poor data sharing between the central ministry and the Kurdistan region further complicates comprehensive reporting.

Priority actions should include the development of an HIS strategy for Iraq to act as a resource mobilization document. The HIS strategy should be costed based on the type of intervention, estimated persons/days and any additional materials and equipment needed. Further action on HIS includes: improving and expanding clients' registration with specific primary care centres at the local level; digitalizing data collection at primary care centres, and utilizing reportable data that are collected but not shared.

Other areas requiring attention include: inadequate primary care funding to cover the objectives of UHC; inconsistent availability of essential medicines and basic equipment in every facility; infrastructure data not being evaluated and updated routinely; community engagement that lacks a standardized approach and has ill-defined roles and objectives, and the lack of private sector inclusion. The need to organize quality management at the ministerial level to ensure the integration of functions and sharing of analyses was also acknowledged.

On a positive note, there is a strong system in place for proactive population outreach, with three out of four primary care facilities monitoring patient experience. The system was established in the wake of conflicts that resulted in a large number of internally displaced people.

Key strengths include the availability of mechanisms for multisectoral action and a competent surveillance system that tracks health and disease through the submission of timely reports. Existing policy also recognizes the family health model as a basis for achieving UHC. Unfortunately, a shortage of primary care health workers, especially family medicine specialists, has resulted in a 57.8% vacancy rate in primary care. Improving primary care health workers' training and enhancing their evaluation, especially in the aftermath of COVID-19, would help ensure sustainability.

Additional positive aspects include the presence of a comprehensive package of primary care services, a vibrant system of civil registration and vital statistics that includes births (98.8%) and deaths (94.8%), and the provision of preventive services such as childhood vaccinations. An active referral system that strengthens primary care providers' gatekeeper role is also in place. As a general rule, the Iraqi health system does not allow self-referrals: within the public sector patients require a referral from a primary care centre, emergency hospital or private clinic to seek secondary care services.

There is a well-established system for primary care centres to provide health care to prisons and detention camps. These services are coordinated by a dedicated department within the Directorate of Public Health inside the MOH. Although not inclusive of all vulnerable segments of the population, the system is strong.

Activities anticipated in the short-term to address identified gaps include:

- monitoring and evaluating progress towards achieving the targets of the national health policy;
- conducting a national census;

- improving National Health Account (NHA) mechanisms for better measurement of the primary care financial profile;
- improving measurement of NCDs and data reporting through upgrading HIS mechanisms and conducting routine national surveys;
- recognizing the role of community health workers through the development of job descriptions and conducting necessary training; and
- establishing measurement mechanisms for infrastructure and WASH data.

The health system biennium development plan in Iraq is based on the framework for action on advancing UHC and, as a result of the PHCMI, will prioritize and channel WHO technical and financial support to strengthen the health system and develop and implement evidence-based health policies that effectively contribute to UHC, GPW13 and the SDGs.

The current action plan is to set national policy targets based on the evidence that emerged during the PHCMI exercise and establish mechanisms for improvement based on available capacities while working simultaneously on capacity building.

Increasing the number of family physicians is currently a focus and needs to be accelerated to support delivery of primary care services.

The MOH in Iraq is also committed to updating the comprehensive basic benefit package, the reform of health financing and the introduction of a health insurance system. It is anticipated that these measures will include a Health-in-All-Policies approach.

By identifying strengths and bottlenecks in PHC performance, the PHCMI Initiative will contribute to widescale improvements to health in Iraq as long as the recommended actions are implemented. Despite the challenges, Iraq has recognized the importance of the PHC approach and the steps it has taken to implement such an approach are commendable.

Jordan

Jordan reported both strengths which could facilitate the successful execution of a PHC approach as well as barriers which hinder implementation.

Weak governance of the primary care sector affects service delivery. A highly centralized system, limited cooperation/coordination between the various components of the health sector, and inadequate leadership and strategic planning and training constitute challenges. Additionally, as stated in the Primary Health Care in Jordan Synthesis Report, December 2021, there is no clear national direction on quality or strategy, and meagre application of social accountability principles.

Other challenges identified in the Report are:

- limited multisectoral action toward achieving a PHC approach;
- insufficient overall use of information for priority setting;
- an absence of clearly defined roles and responsibilities;
- a lack of awareness among key informants of national health strategies; and
- no active system that routinely collects and publishes data on quality primary care, especially in the private sector.

Strengthening PHC is explicitly mentioned in the National Health Sector Strategy 2016–2020 and in other national policies, including Jordan Vision 2025. The policies, however, are not evidence-based or the result of a participatory process. Nor do they include fundamentals such as a basic service package, monitoring and evaluation framework or financial mechanisms. While there is a national coordinating authority responsible for implementing PHC strategies it has limited capacity and reach at the subnational level. On a more positive note, the engagement of relevant stakeholders on PHC-related issues is systematic and includes occasional public disclosures of the status of implementation and results.

The financing of primary care involves multiple actors, including the government (responsible for the civil insurance programme), multinational agencies (e.g. UNRWA, UNHCR), NGOs and private insurance companies. During the last assessment (2018), it was found that almost 72% of the population was covered by some form of insurance scheme. The funding of primary care services is

split 44%/56% between the government and other sources. The government's contribution of $142 per capita spent on PHC represents 37% of its expenditure on PHC. It is unclear what the out-of-pocket financial burden is on families, and to what extent this represents a barrier to accessing care. The 2018 District Health Survey indicated that 22% perceived cost to be a barrier.

Findings confirmed that a qualified health workforce provides accessible and affordable care, with 39.2% of the public health workforce allocated to the delivery of primary care services. Only 4.1%, however, is specialized in family medicine. While 4.59 skilled personnel (doctors, nurses and midwives) per 1000 population slightly exceeds the 4.45 level recommended by WHO, gaps nonetheless exist in the primary care workforce's capacity and training. The Synthesis Report identified variations between health care centres in terms of the categories and numbers of physicians, nurses, midwives, pharmacists and clerks as well as shortages in some areas.

On a positive note, the majority of primary care facilities in Jordan (93%) are managed by GPs and public primary care service providers are eligible for ongoing training and professional development. Given that training activities are usually donor dependent, rather than being comprehensive courses tend to follow the vertical nature of the public primary health programmes of the donor.

Strengths include the availability of immunization, particularly childhood vaccinations, lab services and essential drugs. A high percentage of facilities have sanitation and safe water, basic equipment and diagnostic supplies, with minimal variability across provinces. Use of family planning services was relatively high.

While there are ongoing efforts to integrate mental health into primary care services, currently there is under-provision of such services, particularly in poorer areas. However, because of the reporting and database structure of primary care facilities, it is difficult to determine consistent availability of the full range of service delivery inputs in primary care facilities.

A national health information system, Hakeem, is computerizing the public health sector and facilitating health care communication through an electronic health record (EHR) system covering hospitals and some primary care centres and there are plans to expand coverage. Jordan's nationwide surveillance systems include a notifiable disease surveillance system, cancer registries, and a civil registration and vital statistics system. It is anticipated that integration and communication between Hakeem and ministries will facilitate a multisectoral approach and help combat HIS fragmentation.

Jordan has a young population, making investment in building a primary care system that incorporates non- NCD services critical. NCDs account for 78% of deaths.

A majority of the population perceives no geographical barriers to access, with over 90% living within 5km of a primary care health centre. Discussions are nonetheless underway to increase access.

Unfortunately, community engagement continues to be fragmented and based on donor specified vertical programmes. A review of community engagement would serve all actors: political, donor, community and the wider population.

There are challenges related to quality and patient safety in primary care. The PHCMI highlighted that the quality of services is not clearly assessed in most primary care facilities, service users' perceptions of primary care are not sufficiently captured and the referral system is not fully functioning. Education regarding prevailing health problems and how to prevent and control them is managed at the central level. Guidelines and protocols are available but not implemented.

In the area of population health management, one strength is the provision of proactive outreach to underserved communities. Mostly involving refugees, the activities provided range from family planning to surveillance, health education and promotion.

- Planned next steps are to identify priorities and assign each priority to a task force to implement the improvement plan and evaluate progress in achieving goals. Areas of improvement will focus on:
- a PHC component in all policies;
- more funds and investment in PHC;
- increased equity in the distribution of health centres and staff;
- creation of a database for primary care; and
- enhanced training of staff.

With a UHC service coverage index of 76 in 2020, one of the highest in the world, Jordan possesses the ingredients necessary to ensure the entire population is provided with accessible, affordable and quality primary care services. There remain many aspects in need of improvement but, with the requisite political will, these will be addressed.

Lebanon

NOTE: Results are based on the finalized PHCCP and VSP. Neither profile has been endorsed by the Ministry of Health.

Lebanon faces numerous economic, political and security challenges. Much has happened since the PHCMI began and the findings no longer fully represent the current situation.

Qualitative data was not widely collected due to a general worsening of the socio-economic situation in Lebanon. Steps to institutionalize the process have not been taken: by the time the assessment was completed Lebanon had entered an economic recession which fed into an increasingly volatile and fragile setting. The number of primary care centres able to provide information varied, depending on the type of indicator, from 70 primary care centres to 800 dispensing centres. This led to inconsistencies in the definitions of the indicators, particularly between the public and private sectors, the latter representing 90% of all centres. Moving forward, it is important to capture data across all primary care services in the country, not just primary care centres in the MOPH network.

Figures calculated on a per capita basis exclude refugees. Unification of the denominator across the indicators should decrease the confusion, which also impacts financial indicators given inflows of donations from UN agencies and NGOs to cover the cost of delivering care to refugees is not reflected in National Health Account data. Data continues to be collected on a periodic basis and the manner of gathering and presentation has helped standardize and visualize the data in a concise dashboard.

A comprehensive national plan, the Strategic Plan of the Ministry of Public Health 2016–2020, exists but needs updating. Although there is a vision of an integrated public system and the MOPH is committed to the UHC agenda, it is unclear what role the private practice sector will play.

The government spends 4% of GDP on health (note the exclusion of expenditure on refugees above). A third – 33% – of current health expenditures (CHE) goes to PHC. This represents 35% of all PHC spending. Limited information is available on the extent of out-of-pocket payments or perceived barriers to access due to

treatment costs and distance from a facility.

At 14.47 skilled professionals (doctors, nurses, midwives and dentists) per 10 000, primary care workforce density is well below the WHO recommended 44.5 professionals per 10 000. It is acknowledged that, despite a large cadre of doctors, there is a shortage in licensed nurses. The health workforce working in primary care varies by profession: 13% of physicians, 5.2% of dentists, 3.1% of nurses and 6.4% of midwives provide primary care services. Only 1.4% of physicians specialize in family practice.

Lebanon has instituted unique patient identifiers to support patient health records and 27% of patients are registered at a primary care facility. A total of 88% of facilities have access to a computer linked to the internet, and 83% of facilities report using an electronic health information system.

Facilities seem to be well equipped: 100% reported having standard precautions for infection prevention and provisions for privacy. The percentage of facilities with standard priority diagnostic supplies and equipment is unknown.

Primary care physicians see an average of 27.8 patients per day. The average number of visits annually per capita to a primary facility is unknown. While no information was given regarding the presence of a basic benefits package, it was reported that 30% of primary care facilities provide mental health services. There is no gatekeeper role for family physicians and no formal referral process.

All facilities provide performance reports, and 48% of primary care facilities have quality improvement systems in place. No data was available to assess the degree of professional management at the primary care facility level.

While adverse events were reported, data on indicators such as the percentage of prescriptions that include antibiotics, and the percentage of facilities that assess patient experience, were unavailable. Neither was data provided on community participation in facility management meetings or the percentage of the population who believe decision-making is inclusive.

There was very limited information on many important outcome indicators, particularly NCDs (diabetes, chronic respiratory disease and cardiovascular disease) and the three tracer communicable diseases (STI, TB and HIV). It is known that 70% of deaths are attributable to NCDs and 87% of TB cases are detected and successfully treated.

Lebanon is making strides in its care of children, with 93% receiving DTP3 immunizations and a second dose of measles vaccines, and 85% of all children under 5 monitored for growth.

Many of the identified next steps revolve around the health information system, including:

- upgrading the health information system in all primary care centres, including the 70 centres in the Emergency Primary Healthcare Restoration Project;
- endorsing unique identifiers for patients; and
- converting the health information system of centres that are still sending data manually.

Lebanon has learned from the PHCMI experience and is eager to conduct the assessment on an annual basis to improve data collection, enable observation of trends and assess progress. Numerous indicators have changed, and figures need to be updated to reflect the current situation.

Libya

Libya faces ongoing conflict and numerous challenges. The lack of security across the country has hampered the population's access to health care services and led to severe shortages of medicines, medical supplies and vaccines.

Problems implementing PHCMI included difficulties collecting data due to siloed health information systems, political fragmentation and limitations on available data which, when presented, is often outdated. Discrepancies between national and global health estimates were also uncovered.

Spending on PHC is $243 per capita, 48% of overall health spending. Limited PHC expenditure from sources other than the government remains a concern.

Key points of strength include the existence of regulatory authorities and a national health policy, a widespread network of primary care facilities, an adequate health workforce and the presence of an RMNCH strategy and NCD guidelines.

That the majority of the 1355 facilities are concentrated near the coast reflects the distribution of the population. A high number of public health care facilities – 22% –, especially at the primary care level, are closed or in need of repair and rehabilitation. The main reasons for closures are that the structures are damaged, occupied, under maintenance (both short- and long-term repairs) or are being upgraded to hospital level facilities. There is also a lack of staff and/or of patients. All five types of essential services are offered in just 121 of the 897 open PHC facilities. Apart from immunization programmes, there are currently no services available in 230 open PHC facilities.

Additional findings showed limited availability of essential medicines, ineffective family medicine services, very limited mental health services, an absence of patient records which capture the patients' experience with the health system, the absence of a referral system mechanism and weaknesses in the qualifications and distribution of the health workforce.

Based on the assessment, priorities in the improvement phase include the need to enhance data collection, improve investment in the health workforce, introduce and expand a family medicine/practice approach in all primary care facilities, ensure continuity of supplies of essential lifesaving medication and activate provision of essential medicines based on the national essential drug list, improve mental health services and introduce the WHO mental health gap package, establish a health information network using the District Health Information System Platform (DHIS2), and create a patient record registry.

In order to achieve these priorities it is critically important that the security situation improves.

Morocco

A social protection law passed in 2021 which encompasses the provision of UHC, a national health map which provides guidance for the regulation and structure of the health system and a Health-in-All-Policies approach governs the health system in Morocco.

The primary care benefits package is comprehensive and includes services for communicable diseases, NCDs, maternal and child health, older patients and other priority health programmes. Institutions responsible for generating data include the MOHSP, the High Commission of Planning, the National Human Rights Council, the National Observatory of Human Development and the National Human Development Initiative. Together, they have created a valuable repository.

Health innovation pillars currently being focused on are: digital health care; advancing regionalization and administrative decentralization; engaging with the private sector and multisectorial cooperation. Additional areas receiving attention include increasing population coverage and the comprehensiveness of vaccines offered by the National Immunization Programme and aligning essential medicine lists with the current WHO list.

There is good coverage of primary care facilities in both rural and urban areas and the UHC index currently stands at 68%. Recommendations of the international PHC Forum held in Rabat and hosted by the MOHSP, in partnership with WHO and UNICEF, between 18 and 19 December 2019, formed the basis of a roadmap to improve PHC performance. Directions that emerged from the forum were in line with the Astana Declaration and formed the foundation for the development of Morocco's PHC strategy.

The government of Morocco contributes 2.2% of GDP to the provision of health services. While the methodology adopted in the latest National Health Accounts (2018) does not allow the percentage that goes to PHC financing to be calculated, it is important to note that the costs of all primary care services and medicines are covered in public facilities, eliminating any financial barriers to access. More information on the financing of primary care services would improve evidence-informed policy and decision-making. The extension of health insurance to the whole population by the end of 2022 should further reduce financial barriers to health care access by decreasing out-of-pocket spending which currently stands at 45.6%.

Implementing the first phase of the initiative faced many obstacles, including the non-availability of data for several key indicators, particularly those related to primary care financing and quality. Difficulty in calculating composite indicators was also experienced. Additional challenges included the increased workload placed on members of the steering committee and difficulty in contacting stakeholders and partners for feedback during COVID-19 lockdowns. Subjectivity in scoring certain measures made consensus difficult to attain. Nor are the results comprehensive given the lack of inclusion of the private sector.

Findings from the initiative did reveal several positive trends in PHC performance.

The use of unique patient identifiers is the start of building a HIS that will eventually include an electronic health record for each individual. The status of the current information system is insufficient to capture data for many indicators.

Findings revealed only 12% of the population need to travel more than 5 kilometers (or more than an hour) to reach a primary care facility. Additional effort is needed to ensure this particular population receives health care closer to home.

On another positive note, 90% of the population has access to RMNCH services. According to the National Population and Family Health Survey 2018, 86.1% of deliveries occurred under skilled supervision, the maternal mortality ratio decreased from 332 per 100 000 in 1991 to 72.6 in 2016, and infant mortality decreased from 76 per 1000 children under the age of five in 1991 to 22.16 in 2018.

Unfortunately, many successful PHC-related experiences in Morocco have yet to move beyond the pilot stage. Challenges include reduced accessibility to primary care services due to physical barriers in some rural and remote areas; shortages in human resources; unavailability of data for qualitative indicators and low governmental health expenditure, particularly that devoted to primary care. Although facilities are equitably distributed, and there is a good system in place for assuring the quality of the primary care workforce, workforce density is low. There is a shortage of 4800 medical staff and 12 000 nursing staff according to

the Human Resource Report 2020. At 3.6 per 1000, the density of primary care health workers is below the WHO recommended level of 4.45.

Another area which deserves increased attention is the prevention, detection, treatment and management of NCDs which account for 80% of all deaths. The prevalence of hypertension (29.3%), obesity (20%), diabetes mellitus (10.6%) and tobacco use (13.4%) is concerning. And while all 2888 primary care facilities provide mental health services delivered by trained general practitioners, only 83 facilities have a psychiatrist on staff.

Community representation is included in health sector strategic planning, development of the MOHSP Action Plan, and the allocation of financial resources to the health sector. Local committees also discuss development priorities, and many health programmes are implemented through committees that involve multiple ministries in addition to the MOHSP, ensuring that comprehensive and organized multisectoral action is taken.

Monitoring of patient experience could be increased from the current 15% of facilities measuring this outcome.

Some of the best performing proactive population outreach initiatives target vulnerable and remote populations. They include youth health screenings in schools, the revitalization of mobile health teams, Operation Riaya, which targets vulnerable populations in areas prone to cold snaps, youth health spaces in which to discuss high-risk activities and diseases and screening of the university population.

The assessment found that governance capacities are strong. There is a focus on PHC in the National Strategic Plan and policies are evidence-based, embedded in a legal framework, systematically formulated through a participatory process, and include fundamentals such as a basic benefits package, a monitoring and evaluation process and a financing mechanism to support the delivery of services.

National coordinating authorities are responsible for implementing PHC policies. However, at the subnational and subregional levels operational capacity varies according to directorates and levels of the system. At the regional level, health authorities coordinate with national authorities to implement PHC policies and interventions. These structures have decision making powers, including over budgets and staffing (e.g., managers, medical specialists in public health and programme coordinators). In the meantime, some regions suffer from a shortage of health professionals, a problem worsened by retirement and difficulties in recruiting staff in certain areas.

Quality interventions at the facility level are complemented by a system that collects and shares learning and experiences at the subnational level, which are then discussed at the national level.

While most facilities are provided with essential medicines, basic equipment and diagnostic supplies from the MOHSP, there is no nationally representative data source that accurately monitors the availability and functioning of equipment, highlighting a gap in information rather than performance. The routine information system in place focuses on PHC performance in terms of results, without taking into consideration the functionality and availability of specific inputs and processes.

One of the strongest characteristics of facility management is the provision of supportive supervision to primary care facilities. Supervisory visits include open dialogue on components including: human resources; operations; information systems; infrastructures; drug availability; quality of care and management of the facilities. The dialogue concludes with a formal account of the discussions.

Numerous steps were identified as priority areas for the improvement phase.

Priority actions based on identified weaknesses include:

- motivating and incentivizing the health workforce, especially in rural areas, through reforming the status of civil servants and introducing a new mechanism of performance-based payment;
- prioritizing PHC in terms of funding;
- adjusting the health information system by developing integrated, computerized systems;
- scaling up successful strategic primary care programmes currently in the pilot stage, particularly the pilot project on the practice of family medicine in Casablanca Settat Region, to ensure integrated, coordinated and people-centred health services; and

- assessing the quality of services and programmes by implementing quality competitions and accreditation programmes in all primary care facilities.

Priorities based on existing reforms will:

- focus on health care reform based on primary care and create territorial health networks grouping hospitals and primary care facilities;
- adopt a HiAP approach by institutionalizing health impact assessments and implementing policies that promote health and well-being;
- link PHC reforms to health programmes proactively and be responsive to the health needs and preferences of the population, particularly those left behind;
- extend training in family medicine by accelerating the deployment of the bridge programme and the Regional Professional Diploma in Family Medicine as a way to progress towards UHC; and
- engage the community by institutionalizing and financing sustainable community health interventions and strategies.

Measurement gaps in the health information system will be addressed by:

- filling gaps in the existing PHCMI MIL by conducting clinical studies;
- improving the accuracy of SARA and National Health Accounts surveys with regards to measures specific to PHC;
- advocating for the integration of data obtained through ongoing surveys to provide information on important aspects of the functioning of the primary care system and PHC quality indicators; and
- advocating for PHCMI to be used as a leverto improve PHC and monitor on-going progress at the regional level.

As Morocco strives to achieve UHC it will focus on extensive reforms to overhaul the national health system and create a national health insurance scheme that allows access to both public and private sector providers. This will facilitate the expansion of the health information system to include the private sector. As an evidence-based assessment, conducting the PHCMI regularly will support sustainable progress and improve the delivery of primary care services.

Oman

Oman's health system has many points of strength. Primary care providers act as gatekeepers and are responsible for referring cases to secondary and tertiary health institutes with a clear pathway between primary, secondary and tertiary levels of care. There is strong commitment to achieving UHC through available, accessible, cost-free primary care services, and the health information system is robust. As a result, 90% of outpatient care is provided in primary care facilities.

Primary health care features prominently in Oman's National Health Policy, policies are evidence-based and are embedded in the Oman Medical Regulatory Law which helps translate major policy objectives into action, using sanctions and incentives to exert leverage over the health system. Policies have been developed through the participation of several ministries and departments within the Ministry of Health. An efficient quality infrastructure, multisectoral action around PHC and a comprehensive and efficient surveillance system contribute to the strength of governance capacities.

The Directorate of Quality Centre within the Ministry of Health is responsible for the identification and implementation of packages of quality interventions to create an enabling systems environment, to reduce harm to patients and improve the clinical effectiveness of health services. This quality infrastructure is complemented with a strong culture of learning that translates into an active system to collect and share data on quality.

Oman dedicates 4% of GDP to health care, with 27% directed toward primary care, amounting to $242 annually on a per capita basis.

Numerous clinical guidelines and standard operating procedures regulate the delivery of primary care. There is continuous monitoring and evaluation of ongoing programmes like the accredited Oman Medical Specialty Board (OMSB) training for family and community doctors and the accredited higher nursing diploma for senior and community nurses. Primary care services are consistent across geographical areas.

Oman has parallel systems in place for citizens and migrant and foreign workers. The measures change if only citizens are considered, in which case the system is

ideal, or if the foreign workforce is included, when the system performs less well. Given this context, one challenge facing the assessment concerned discussions as to the extent indicators should be based on the national system that provides services to citizens, or whether the foreign population should be included.

Multisectoral action takes the form of PHC goals being included in the discussions of cross-governmental groups that address topics that range from the environment and tourism to agriculture and livestock.

While criticism was raised that the PHCMI tool fails to measure the performance of some services and programmes directed toward primary care, the initiative nonetheless helped identify challenges such as the limited number of family doctors, staff shortages including nurses and midwives, the absence of a specific budget for primary versus secondary and tertiary care, a limited approved drug list, outdated clinical guidelines, lack of an organized appointment system, limited space in primary care facilities and the absence of proper implementation or utilization of accredited points for continuous medical education for health care workers. It also threw light on the increased workload needed to manage NCDs, including diabetes, hypertension, coronary heart disease, asthma and hypercholesteremia.

A majority of facilities are provided with essential medicines, basic equipment, diagnostic supplies and safety equipment, with little if any geographical variability. The workforce includes community health workers who are trained and integrated into health facility service delivery systems. The system in place ensures that the workforce is highly qualified and meets consistent standards.

The electronic surveillance system, which connects all facilities, efficiently tracks health and burden of disease metrics, detects notifiable diseases and collects and collates data.

The strongest capacities to emerge were in the area of facility management. Policies that regulate a team-based care organization are complemented with an efficient system to measure and manage performance. Performance indicators are regularly monitored and used to inform objectives and goals as part of the quality improvement process and all facilities receive supportive supervision annually, a process that includes observing clinical interactions, teaching/coaching, goal setting, progress review and collaborative problem-solving.

Though Oman realizes that a strong focus on monitoring health indicators is critical, there is limited focus on what impacts indicators and how elements of the system result in specific outcomes. The plan is therefore to focus more on the system to create strategies for improvement.

Planned steps for improvement focus on supporting PHC to be the driver, via structural intersectoral collaboration, pushing forward with NCD prevention and working on associated risk factors, using new diagnostic and intervention technologies, increasing the number of cancer screening centres and expanding telemedicine. Identified priority areas include:

- increasing the number of qualified health care professionals;
- improving primary care facilities;
- expanding the primary care essential drug list;
- organizing service provisions through appointments and reducing the number of walk-ins;
- strengthening public health functions within primary care operations;
- altering the current concept of primary care to include prevention and the implementation of health promotion via structural intersectoral collaboration;
- using new technologies such as telemedicine and artificial intelligence;
- allocating a quantifiable budget for primary care;
- strengthening the quality management system;
- basing decisions on evidence; and
- aligning specific key performance indicators for primary care with global indicators.

Primary health care in Oman is accessible through the wide distribution of facilities across the country, acceptable and trusted by the community, affordable in terms of cost, offers high standards and is comprehensive, covering essential health care services, communicable and non-communicable diseases, emergencies, dental services, maternal and child health and community services such as school health.

Looking towards improvement, increasing the number of qualified health care professionals, strengthening the quality management system and introducing electronic health care will boost PHC in Oman.

Pakistan

NOTE: The Progression Model results below are based on findings for the Islamabad Central Territory and not the country as a whole.

Pakistan is the fifth most populous country in the world with a population of 236 million people in 2022. It also hosts more than 1.4 million Afghan refugees.

Though Pakistan has made positive strides in economic and social development and in the health of its people, not all citizens have benefitted from the progress. The low level of health workforce development, coupled with insecurity, fragility, economic challenges and recurrent humanitarian crises, has resulted in parallel and fragmented health systems, structures and health workforce shortages.

Health, as defined by the constitution, is a provincial issue with limited health functions at the federal level. The health system consists of a complex mix of public, parastatal, private, civil society and philanthropic players. Both vertical and horizontal health care delivery systems exist in Pakistan. One of the strengths of the health care delivery system is its primary health care (PHC) approach consisting of community level and primary care facilities. Community and outreach health services are delivered by community-based Lady Health Workers, vaccinators, environmental workers and community midwives, with backup support from a network of dispensaries, basic heath units, rural health centres in the public sector and general practitioners in the private sector.

The country is undergoing epidemiological and demographic transitions. The National Health Vision (NHV) 2016–2025 aims to provide a responsive, unified direction to overcome health challenges while ensuring adherence to UHC as the ultimate goal. Pakistan also benefits from the Islamabad Capital Territory Health Strategy 2019–23 and a family practice model. There is commitment from leadership, support and supervision from the MOH and effective stakeholder engagement at the ministry level. There is also a national coordinating authority with responsibility for implementing PHC strategies.

Implementation of the initiative faced many challenges in the areas of coordination, data availability and devolution of authority.

Identified challenges include a limited health workforce, weak infrastructure, limited outreach services, a paper-based health information system and low spending (1% of GDP) on health. Annual PHC expenditures per capita amount to $142, with the government providing 24% of total PHC costs. While no information was available regarding out-of-pocket expenditure, it was reported that barriers to access due to costs are perceived by 30% of the population, while 42% perceived distance to be a barrier.

All facilities submit annual performance reports. While community engagement does exist through community leader participation in facility management meetings, it was not clear what percentage of the population believe that decision-making is inclusive. Unfortunately, no information was captured on the health workforce, model of care characteristics, quality processes or infrastructure attributes such as WASH.

A fragmented health information system with multiple sources meant data was not aligned, or not available. It is challenging to assess the availability and consistency of essential services, essential medicines and contraceptives, basic equipment, diagnostic supplies and other service delivery inputs and results. Due to the lack of evidence, it was not possible to get an accurate picture of the strengths and weaknesses of the system and use such information for evidence-based policy decisions.

The challenges related to governance and coordination which were identified are being addressed by establishing national and provincial health sector coordination mechanisms while ensuring the engagement of all stakeholders, including public, private, community, civil society, academia and development partners. Provincial variations in terms of capacity to coordinate, analyse, strategize and use data for action need to be addressed.

While a health care commission has been established to ensure quality of health services in both the public and private sector, the commission needs to be made more functional to play an effective role in ensuring quality health care services, especially in primary care facilities.

Some PHC- and UHC-related reforms have already been initiated, including the development of an Essential Package of Health Services (EPHS) /UHC

Benefit Package based on localized evidence and Disease Control Priorities-3 recommended global practices. To fill programmatic gaps in the implementation of the EPHS, especially at the community and primary care level, a National Health Sector Programme has started with the support of development partners, and a number of vertical programmes are being horizontally integrated.

Health emergencies and disease outbreaks pose a threat to an already weak primary care system, as demonstrated during the COVID-19 pandemic. Renewed efforts will therefore be given to strengthening IHR core capacities, with a focus on effective coordination, integration of the disease surveillance and response system, establishing a public health lab network, increasing the skilled health workforce and updating anti-microbial resistance and all hazards contingency plans.

Pakistan has prioritized several actions based on identified areas of weakness demonstrated by the PHCMI findings, including:

- recruiting and deploying additional primary care health workforce resources;
- updating the paper-based health management information system to DHIS2;
- investing a greater proportion of GDP in PHC; and
- enhancing efforts towards UHC.

Priorities based on identified measurement gaps include strengthening referral linkages, investing more in the quality of health data and advocating for the engagement of stakeholders.

Pakistan has commenced the process of developing a national PHC vision and practical delivery plan to advance PHC for UHC agenda. Government and development partners are finalizing an action plan to implement and fund PHC related reforms which will include regular monitoring routines to track progress, problem solve and make necessary course corrections/adjustments.

Palestine

NOTE: General indicators were taken from the Palestinian Central Bureau of Statistics and STEPWISE survey on NCD indicators which include the UNRWA refugee population. National indicators taken from the annual health report are not inclusive of the refugee population except when it comes to maternal and child health (MCH), immunization and maternal and infant mortality. The results below are based on the finalized PHCCP and VSP. Neither profile has been endorsed by the Ministry of Health.

The situation in Palestine places unique burdens on the health system. The current blockade constitutes a major obstacle to medical teams delivering services. The conflict has also resulted in considerable damage to the health care infrastructure. Almost 43% of the population are refugees who receive primary care services in the 62 primary care centres run by the United Nations Relief and Works Agency (UNRWA) that account for almost 9% of all facilities. Of the remaining facilities, 64% are run by the MOH, 25% by NGOs and 2% are military medical centres.

The PHCMI initiative proved to be an excellent starting point in the adoption of a PHC approach. For partners, including WHO and the MOH, the participatory process enhanced appreciation of the impact such efforts might have in facilitating better understanding of the PHC context in Palestine, and how this might contribute to improving access to, and the quality of, health service provision.

Steps to institutionalize the process are underway. The collection of missing data required to calculate indicators is taking place, not least by the STEPWISE survey. The digitalization of NCD reports is contributing to filling data gaps, making NCD indicators available. Discussions with the newly appointed director of the Palestine Health Information Centre (PHIC) are planned, to brief the director on the assessment and discuss the way ahead on institutionalization. To ensure progress, the committee composed from MOH units and co-chaired by WHO and MOH, will remain responsible for following up with WHO and PHIC.

Several challenges in the collection of data were identified. Many indicators were not reported at the country level. These were left blank rather than being substituted by alternative indicators. Restrictions imposed by COVID-19 also created a situation in which follow-up was difficult.

Moving forward, the committee will need to use global estimates or pursue clinical audits to determine control indicators, and use the electronic patient file to extract indicators such as the percentage of patients registered with a primary care facility. As noted above, the STEPWISE survey will help fill gaps related to risk factors and NCD related indicators.

The available indicators did provide insight into the current situation in Palestine.

While the Palestine National Health Strategy 2017-2022 provides a strategic plan to build a sustainable health care system, a specific focus on a PHC approach is missing. It is important that the plan be updated to cover the remainder of the decade.

A HiAP approach to ensure multisectoral coordination as well as indicators on social, economic, environmental and commercial determinants of health, has been adopted. While UHC legislation is lacking, regulatory authorities oversee the workforce, facilities and essential medicines and other products.

Over half (55.7%) of current health expenditures is directed to PHC. At $183, per capita spending on PHC is low. Of total government health spending, 33% is directed to PHC, comprising 20.5% of all PHC spending. There is no information on the extent of out-of-pocket payments or perceived barriers to access due to treatment costs or distance.

According to the Health Annual Report 2018, almost 24% of physicians and dentists, and 20% of nurses and midwives, work in primary care, though less than 2% of physicians are specialized in family medicine.

A unique patient identifier has been implemented, but there is no requirement for patients to register with a specific primary care facility and only 35.7% of patients have individual patient health records. Information regarding the percentage of facilities possessing a computer with internet access was not available. And while an electronic DHIS2 is functioning at the facility level in some districts (Salfit, Tubas, Jericho), there has been no reporting on clinic/facility level functionality or the percentage of clinics with a health information system.

None of the indicators on facilities and equipment, including the percentage of facilities with standard diagnostic equipment, precautions for infection prevention and adequate WASH provisions, were available.

Regarding primary care service utilization, it was found that the population utilizes outpatient services on average 2.1 times annually. Primary care physicians conducted 39.5 consultations per day on average, and nurses made 37.7 visits per day. Although there is a basic benefit package of services, it is neither costed nor comprehensive and requires updating. Only 3.8% of primary care facilities provide mental health services.

In terms of models of care, facilities operate on the basis of multi-disciplinary teams. There is no gatekeeper role for family physicians, however, and no formal referral process, areas of weakness which Palestine will need to overcome to fully implement a PHC approach.

All facilities provide performance reports, though no data was available to assess quality improvement efforts or the degree of professional management at the primary care facility level.

Data was unavailable on indicators such as reported adverse events and the percentage of prescriptions that include antibiotics. There was also no assessment of the percentage of facilities that monitor patient experience, and neither the degree of community participation in primary care facility management, nor the percentage of the population who believe decision-making is inclusive, was reported.

Information on many important outcome indicators is limited. Indicators showing positive trends include 80% of TB cases detected and treated with success, and 96% of patients with HIV receiving anti-retroviral treatment. However, 82.5% of deaths are attributable to NCDs, and there is 35.8% prevalence of hypertension, figures that highlight the need to focus on NCD prevention, detection, treatment and management in moving forward.

All children are reported as having received the full complement of DTP3 immunizations and a second dose of measles vaccines, and 88.5% of all children under 5 were monitored for growth.

Palestine is piloting implementation of the PHC-oriented model of care and assessing PHC with a two-year European Investment Bank grant. PHCMI is a key initiative that will be used in the planning and development of Palestine's PHC strategy, and the PHC Country Profile will provide a basis for policy dialogue during the WHO mission to discuss the PHC model of care and future implementation scheduled for November 2022.

While Palestine has reason to be proud of the primary care system it has established given the circumstances, insufficient monitoring prevents adequate performance assessment.

Qatar

NOTE: The results below are based on the finalized PHCCP and VSP. Neither profile has been endorsed by the Ministry of Health.

The PHCMI effort was boosted by strong support from the MOPH and the numerous indicators that could be gathered from existing country reports under the auspices of the Primary Health Care Corporation (PHCC), Qatar's centralized entity which organizes the delivery of primary care services. The PHCC, the single corporate public health care provider covering over 80% of primary care services in the country, demonstrates a robust governance infrastructure.

The government covers 96% of PHC expenditures. Government health spending stands at 2.11% of GDP which equates to a per capita spend of $319, or 14.1% of the total government expenditure on health.

Challenges reported in the course of the PHCMI included the identification of data sources for non-health sector indicators, and the shift from output to outcome measures as a concept for assessing PHC performance. There were data gaps, and it was reported that many indicators were not applicable within the Qatari context, suggesting that indicators need to be tailored.

The PHCMI assessment revealed several strengths. There is a centralized health information system that supports the continuum of care through longitudinal medical records across all levels of care and in all primary care facilities. A health needs assessment tool for planning is employed and all PHCC facilities are accredited by Accreditation Canada International (ACI).

Qatar's primary care workforce density of 14.78 per 1000 exceeds WHO's recommended 4.45 providers per 1000, and 70% of primary care doctors specialize in family practice.

The population perceives no barriers to care access due to cost or distance.

All primary care facilities deliver a comprehensive range of services, including mental health, and essential medicines, diagnostics and equipment are readily available.

The main weaknesses identified were gaps in data collection and the inability to connect with private primary care providers.

Based on the findings of the assessment, improvement phase priority areas are focused on:

- integrating private primary care providers to ensure comprehensive monitoring of primary care services;
- standardizing the data collection process at the national level in coordination with MOPH and non-health sectors;
- improving the centralized health data repository at PHCC level;
- introducing the balanced score card tool to measure strategic performance; and
- building on existing reforms and mapping PHCMI measures with national health strategy KPIs.

The PHCMI initiative has encouraged Qatar to transform PHC performance measurement and improve accountability among leaders on key measures to facilitate efficient and effective reporting and adopt a standard model – input, processes, output, outcome and impact – to align with PHCC's strategic reporting.

Orienting PHCC to a PHC approach is not a major task. The system already incorporates the essentials – gatekeeping, empanelment, a formal referral process, and a health information system, including unique patient identifiers, which captures all levels of care – of a well-functioning primary care system. With a slight nudge to incorporate a community voice, the system is almost there.

Yemen

For Yemen, the PHCMI underlined the importance of having a primary care system that provides services based on actual needs and evidence. It also showed the necessity of documenting all health policies and conducting periodic research studies and surveys to update health and demographic indicators. The importance of having a good health information system to obtain the indicators required for the planning and decision-making process was also recognized.

These conclusions were reached against a backdrop of ongoing conflict in the country which imposed significant challenges on the collection of data. Many leaders felt they did not have enough, or the right, information to confidently pinpoint where their health system was strong or weak, especially at the primary care level, underscoring the need to work closely with the MOH, health development partners and other sectors to promote an all-of-government approach and improve health data resources.

The National Primary Health Care Strategy (2020–2030), which includes primary care, quality improvement and assurance processes, and the earlier National Health Strategy (2010–2025), have guided the country for over a decade. UHC legislation which includes PHC also exists, as do regulatory authorities for both the public and private sectors.

While it is estimated that the government spends 5.6% of GDP on health, neither the percentage of health expenditures directed toward PHC, nor the percentage of PHC expenditures covered by the government, are known. Though little is documented regarding the extent of out-of-pocket payments, it is reported that 56% of the population perceive barriers to access due to treatment costs, and 59% report barriers due to distance from a facility.

As efforts were made to complete the MIL, it was found that available data to address the requested indicators needed updating through studies and surveys. The measures that were available reflected the deteriorating health situation in Yemen. Some local indicators, especially those derived from surveys, differed from international indicators. Variance in values collected from different sources, different sectors within the Ministry, as well as across development partners, also emerged. Having multiple data sources without a single administrative unit

responsible for documentation and archiving is a far from ideal situation. In the future, to address these issues, financial and technical support should be provided to the responsible health authorities to conduct surveys.

To inform policy-makers on the results of the assessment an in-country workshop to be conducted with MOH leaders, practitioners and advocates working to improve the health system, has been suggested. Such outreach could mitigate misgivings over providing information and concerns about confidentiality and intent.

The available data paints a mixed picture regarding outcomes. It is encouraging to note that 88% of children receive DTP3 immunizations and 75% of children receive the second dose of measles vaccines. In addition, 73% of tuberculosis cases are detected and treated with success. Yet half of all deaths are attributable to NCDs, 51% of adults have abnormal blood pressure, and only 8% of patients with cardiovascular disease receive a diagnosis and treatment.

Determining areas of strengths and weaknesses from the findings problematic given that a majority of indicators were not captured. The percentage of facilities with access to computers or with internet access, for example, is not known. One conclusion that can be reached is that there is an urgent need to improve the ability to collect data and improve the health information system.

None of the indicators regarding facilities and equipment, including percentage of facilities with standard precautions for infection prevention and adequate WASH provisions, were available, and there was no data on the composition of the health workforce or its density.

According to the Matrix of the Second Interim Plan for the Health Axis 2020-2021, 40% of patients are registered at a primary care facility. However, the average number of visits per capita to a primary care facility, and the average number of visits per day, are unknown.

There is no information on the percentage of facilities reporting quality improvement or performance, and no data was available to assess the degree of professional management at the primary care facility level. No data was presented to measure quality of care, reported adverse events or the percentage of prescriptions that include antibiotics.

It was also impossible to assess the degree of community engagement and the percentage of the population that believes decision making is inclusive.

Moving forward, improving the health information system is a starting point to enable collection of data. This requires raising awareness among leaders and health workers of the importance of collecting information and using it in the decision-making process. The MOH needs support to establish a platform for the coordination, standardization, sharing, verification and endorsement of collected data. Establishing an administrative unit within the Ministry responsible for health data would greatly assist such efforts. There is also a need to train health care staff in the recording and reporting of data which will facilitate research studies to better understand the impact of reforms within the health system.

As a result of the PHCMI, community participation will be promoted and the expertise of national and sub-national leaders who are trailblazers in the field of PHC improvement will be better utilized.

Despite considerable obstacles, the Yemen team was able to provide insights into the situation on the ground. Although it is not an optimal picture, there is now an opportunity to identify gaps in a countrywide PHC approach and identify areas for improvement.

6. Conclusion

The experience of countries during the PHCMI initiative highlighted the importance of supporting existing efforts to prioritize capacity building in primary care. Using lessons learned from the measurement phase, countries were encouraged to identify priority areas for improvement and collaboration to address gaps, challenges and weaknesses.

Opportunities identified in the governance domain include incorporating PHCMI findings into existing reforms and using the profiles as evidence to drive policy dialogue and engage country leaders and partners in collaboration aimed at PHC strengthening. The creation of a stronger system for priority setting at the national level which allows communities to have a say in resource allocation, is also recommended.

To improve health information systems, priority actions include: enhancing national HIS functionality and implementing regular national surveys; supporting the standardization of data collection processes nationally in coordination with Ministries of Health and non-health sectors; digitalizing data collection at the primary care level in order to improve data registration and utilizing data to inform decision-making. Centralized health data repositories also need to be upgraded. Increasing the capacity to collect data through PHC monitoring and evaluation via a robust HIS and a review of reimbursements for virtual consultations are also being considered by a number of countries in an effort to improve primary care service delivery.

Other priority areas uncovered include improving measurement and collection of data on NCDs as well as incorporating NCD services into essential benefit packages. This is especially relevant given that NCDs are a leading cause of death in much of the Eastern Mediterranean Region.

The main recommendations on inputs address the density and qualifications of the workforce and include training and capacity building of physicians, particularly family doctors, and nurses.

Enhancing accreditation programmes in order to strengthen quality management systems and promote a protocol and guidelines-based practice towards UHC were also mentioned as focus areas.

It was recognized that multisectoral coordination and collaboration is key to better responding to people's needs, especially those in low-income countries, that there is a need for a better definition and employment of community engagement, and that community health workers should be fully integrated into the health care system.

7. Impact of the pandemic

"The pandemic shone a light on the importance of the role of community engagement during public health emergencies"
Iraq presentation

In the first year of the pandemic, it was emphasized that most COVID-19 cases could be managed at home, with some intervention at the primary care level, while maintaining essential health services. Most countries, however, experienced a decrease in the provision of essential health services, as exemplified by Qatar's plummet in breast cancer screening. Given the heavy restrictions in place in many countries, the pandemic exerted strain even on countries with strong heath systems.

The delivery of primary care services was directly affected by the pandemic which led to an increase in the working hours of primary care facilities resulting in an exhausted workforce. In many countries, primary care facility networks were central to the COVID-19 response, case notification and distribution of COVID-19 vaccines. Some countries developed online platforms to overcome the partial failure of their health information systems. The pandemic revealed critical data gaps and the need for a strong and robust digitalized HIS and an enhanced IPC surveillance system. Restructuring of the health care delivery system, with the health workforce shifting from outpatient clinics to primary care facilities (Egypt), or COVID-19 treatment wards (Iraq), was also reported.

Country experiences with the pandemic in 2020 and beyond underlined the value of collecting reliable data. We cannot improve what we cannot measure. During PHCMI workshops conducted in 2020–21, it was pointed out that starting the PHC measurement process had contributed to countries' successes in tackling the pandemic and reinforced their abilities to respond to crises.

Many countries were still completing their assessments and moving toward the improvement phase when the emergence of the pandemic in early 2020 interrupted the process, reducing the availability of stakeholders as Ministries of Health focused on combating the pandemic. This resulted in delays in endorsing profiles, and a reduction in in-person communication and access to information.

Despite its impact on the ability to meet the health needs of populations, the pandemic served to reinforce the value of multisectoral action and community empowerment, both of which are in line with the PHC approach.

It was strongly recommended to include a specific component and programme for prevention and control of COVID-19 in the assessment as well as improvement phase.

8. Assessment of PHCMI

Countries faced several challenges during the implementation of the initiative. As mentioned above, the COVID-19 pandemic, which started shortly after the initiative began, slowed the responses of countries.

The quality of data reported across the 124 indicators of the MIL also presented challenges. The MIL did not always align with the PHC assessment indices current within countries. Adapting the tools took considerable effort and time.

Understanding of the WHO PHC approach and of the methodology of global health estimates compared to the methodologies used at a national level to provide similar estimates, was sometimes limited, contributing to the low uptake of global estimates, and there were discrepancies between the values derived from national and global estimates.

It could also be challenging for country focal point to identify data sources. Rapid turnover of MOH officials was reported as contributing to delays in data collection. Other challenges included data fragmentation, poor data sharing mechanisms, outdated data and lack of up-to-date evidence for some measures. In many countries, data from the private sector was not reported, and confidentiality concerns made some countries unwilling to share all the necessary data.

Several recommendations were made to simplify the process, including reducing the extensive list of indicators. Some indicators were seen as irrelevant given the country's situation, and a flexible approach to the use of alternative indicators emerged as a major factor in the successful implementation of the initiative. Metadata for some of the indicators was not always clear and affected the understanding of the indicators. A request was also received to establish complete, concise definitions of indicators. There were a handful of indicators – deemed unclear or too complicated to calculate – on which no country reported. Examples include the antenatal quality score and the family planning quality score.

Efforts to revise the MIL commenced at the global level and the PHC Measurement Framework and Indicators[1] has been developed with a reduced set of core indicators, with additional indicators from which countries can choose.

While Palestine was keen to take part in the PHCMI out of an interest in country comparisons, comparisons proved difficult given that indicators were not measured consistently across all countries, leading to suggestions that a core of indicators of common interest be identified.

The need to focus on the ways services can be provided to reduce the burden of referrals elicited discussions of the empowering of individuals to self-manage their care, enhanced use of telemedicine and self-assessment software applications, and the enabling of virtual medical consultations with telephone follow-ups.

To direct focus to the local level, particularly in larger, more decentralized countries, interest was expressed in applying the assessment on a provincial/district level. While initial findings have already been utilized in national policy documents, Iran has scaled up assessment at the subnational level.

Yemen suggested that the results of the initiative to measure and improve primary health care be translated into Arabic for publication and presented in a workshop for all stakeholders striving to improve primary health care, the better to inform decision-making, planning and research.

There was a proposal to improve linkages between the measurement and improvement phases, and concern was expressed over the need for on-going financial and technical support through all stages of the assessment.

A clear desire exists for the assessment to be repeated on an on-going basis, thereby enabling a trend analysis. This is being considered, and the recently released WHO PHC Measurement Framework and Indicators will form the basis of any future assessments.

9. Moving towards improvement

"It was first ever initiative in the country to comprehensively assess primary

1 Primary health care: transforming vision into action. Operational Framework outlines a series of levers that can be actioned to align health systems according to a PHC approach. The Operational Framework was published on 14 December 2020. The PHC measurement framework and indicators were published 28 February 2022 (https://www.who.int/publications/i/item/9789240044210), accessed 18 September 2022).

health care, and from 360 degrees, and included assessing the system/structure, inputs, process, outcome, multisectoral approach, community empowerment and impact by using a single initiative (Master Indicator List) to set a baseline for the implementation of the Astana Declaration."
Afghanistan questionnaire response

Following the implementation of the assessment, which resulted in a comprehensive picture of the capacities that must be present for a health system to work for all people, many countries used the findings to develop improvement strategies.

While Morocco's data revealed strong national PHC leadership and accountability, data collected from sub-national directorates revealed a different picture. Staffing and budget shortages negatively impacted the sub-national ability to effectively manage the delivery of primary care services. The assessment led the government to take action to improve PHC leadership at all levels, with a focus on involving sub-national directorates in priority setting exercises and strategic planning.

Oman realized that while it has a strong focus on monitoring health indicators, there is limited focus on factors that impact the indicators, making it difficult to identify what in the system results in specific outcomes. The plan now is to place more focus on the system rather than the indicators in order to create improvement strategies.

In response to the assessments, Qatar is establishing new services, including delivering medications to chronically ill and other high-risk patients via the postal service.

During Iraq's assessment process, improvement measures were undertaken to support more comprehensive and effective data collection. During the assessment of the service delivery inputs a list of essential consumable commodities recommended for primary care centres was compiled, allowing for the identification of gaps in essential supplies. A general recommendation to redirect more funds towards PHC related goals was also followed by several specific recommendations based on identified areas for improvement.

10. The way forward

"In order to improve the country›s service delivery system, it is necessary to measure the different dimensions of PHC based on standard and key indicators and plan for its improvement based on this assessment."
Iran's questionnaire response

The implementation process and the results of the assessment reflect the heterogeneity of the Eastern Mediterranean Region. Some similarities and trends did, however, emerge in relation to the impact of the project. Most countries reported that bringing together different data sources created an opportunity to holistically understand capacities in a way that challenged expectations, even for stakeholders embedded in the system. In some cases, gaps came to light for the first time. The process of conducting interviews with informants with diverse expertise resulted in a more accurate and wider picture of the situation in the country. There is hope such connections will continue.

The focus on assessment of the health system's ability to deliver quality primary care services rather than on the outcomes of primary care led to a broader appreciation of PHC and furnished the basis of a roadmap on how to make improvements.

To support such efforts, the Regional Office has launched several initiatives to support countries strengthening their health systems through the PHC approach. A regional initiative has been developed with the goal of supporting Member States in developing PHC-oriented models of care. In line with the PHCMI Framework, PHC-oriented models of care rely on the PHC approach as outlined in the WHO/UNICEF PHC Operational Framework and defined as the "conceptualization and operationalization of how services are delivered, including the processes of care, organization of providers and management of services, supported by the identification of roles and responsibilities of different platforms and providers along the pathways of care".[1] Following the same vision, and considering the need for conceptualizing and operationalizing the PHC approach comprehensively through its three components, WHO, UNICEF, UNFPA, UNAIDS and UNHCR have

1 Operational Framework for Primary Health Care: Transforming Vision Into Action https://www.who.int/publications/i/item/9789240017832

prioritized implementation of primary health care-oriented models of care.

There is a need to continue showcasing the lessons learned from countries› responses to the pandemic, highlight the importance of PHC and generate more political advocacy for strengthening PHC as a cornerstone of responsive and resilient health systems. There is also a need to advocate for service delivery to be more tailored to the PHC approach and to encourage a more holistic view of the PHC approach as central to UHC and health security. In short, there is a need to make PHC everybody's business and call on global, regional and national leaderships to voice their commitment.

To achieve UHC, countries must consolidate gains on three fronts: the services they provide, who they provide them to, and at what cost to the consumer. In addition to the monitoring and evaluation of PHC, the integration of the PHC approach can be seen in other regional initiatives, including those directed at private sector engagement, strengthening the capacity of family medicine within regional institutions, recognizing the role of health workers in maintaining essential health services and advocating for sustainable resources to ensure continued improvement and support.

Although much work is being done in relation to PHC at the national and regional levels, it is important to acknowledge where efforts have not been focused and where a new approach may need to be considered. In the areas of physical infrastructure, digital technologies for health and monitoring and evaluation, there is little or no work currently taking place at the regional level. It is in these areas where we can begin to approach PHC in a systemic way and make it a component of all health system strengthening efforts.

Key enablers of PHC strengthening include equity-informed financing models, health system and governance frameworks that differentiate multisectoral PHC from more discrete service-focused primary care, and governance mechanisms that strengthen linkages between policymakers, civil society, NGOs, community-based organizations and private sector entities. Coordination and collaboration in these areas, however, remains dependent on a functioning health information system.


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