INTERNATIONAL
PRE-CONFERENCE ON
PRIMARY HEALTH CARE

ICPHC

Primary Health Care in the face of a changing world: the past, present, future, as well as challenges and opportunities for financing PHC

500
Participants

81
Countries

2
Planery Sessions

7
Concurrent Sessions

INTERNATIONAL PRE-CONFERENCE ON PRIMARY HEALTH CARE

IPCPHC

In September 2022, over 500 attendees were welcomed on September 7-8, 2022 to the virtual pre-conference event hosted by the Ethiopian Ministry of Health in collaboration with the International Institute for Primary Health Care – Ethiopia (IPHC-E) and supported by the Johns Hopkins Bloomberg School of Public Health for our first gathering of Primary Health Care (PHC) leaders, decision makers, and thinkers. It was a unique opportunity to exchange best practices and innovative ideas with one another in order to push the needle forward in PHC. This event was a prelude to the main International Conference on Primary Health Care (ICPHC) that will occur in 2023, focused on investments needed in PHC for global health strengthening.

The theme for the pre-conference was Primary Health Care in the face of a changing world: the past, present, future, as well as challenges and opportunities for financing PHC. This gathering was an integral part of the bigger conference as it offered a glimpse of the main conference's offerings, jump started discussions, and launched a longer-term networking platform for collaborative action and learning. Implementers, academics, government leaders, donors, private sector individuals, and other community health advocates convened in this content-rich meeting that features knowledge sharing sessions, recent evidence on cross-sectoral technical areas, dialogues on community health, and professional networking.

Opening Remarks

"The Ethiopian government has set a vision of achieving Universal Health Coverage through Primary Health Care"

H.E. Dr. Lia Tadesse

Minister of Health,
Federal Democratic Republic of Ethiopia

Plenary Day 1:
Core Principles of PHC

The first plenary session, Core Principles of Primary Health Care (PHC), aimed to review the historical arc of PHC and identify future directions. Participants were warmly greeted by IPHC-E Team Lead Luidina Hailu, and welcomed by Dean Ellen MacKenzie of Bloomberg School of Public Health and Dr. Lia Tadesse, Ethiopian Minister of Health. Dean Mackenzie called back to the Declaration of Alma Ata and the origins of PHC, emphasizing the importance of partnership, communication, and inclusion of stakeholders in PHC work. Dr. Lia introduced IPHC-E as a national and global resource center for PHC and advocacy initiatives and emphasized the importance of sharing experiences and learning from each other in PHC.

Following the introduction, a documentary, produced by IPHC-E, was featured on the Yejube health center, which served 55,000 people in Amhara, Ethiopia, and included interviews from health administrators and community members speaking on its impact. The documentary served to share effective PHC best practices, such as efficient inventory of supplies and universal health insurance, with conference participants.

"We must also support community health services that are closer to the people and look for innovation that supports Primary Health Care..".

Dr. Githinji Gitahi

Group Chief Executive Officer,
Amref Health Africa

Concurrent Session Day 1:
Community Engagement

This session aimed to highlight how communities can be engaged to strengthen PHC programming, drawing on lessons from previous assessments of community engagement processes and attempts to improve them. Rachel Deussom from Chemonics International commenced the session by discussing person centered systems thinking approaches taken to engage communities and shared key considerations for integrating community contributions to health systems in order to strengthen the quality, equity, and effectiveness of PHC. The focus of her presentation centered around the notion that community members represent and lead local health systems and how we can leverage that to increase sustainability of PHC.

The next speaker, Asiya Odugleh-Kolev, Technical Officer of Community and Social Interventions at the World Health Organization, shared her story as it strongly relates to concepts of community engagement. She emphasizes three main points.

- The first being that family is our first community which shapes our resilience as well as health and wellbeing.
- The second message is that community is experienced as a dynamic and continuous process of learning and relationship building, with connection and belonging at its core.
- The third is that there is an urgent and compelling need to embrace a broader, more holistic mindset using the best of science and indigenious wisdom to explain how and why community engagement works. A definition of community has to bring together a life course perspective with a localized, contextual, and bounded-settings approach.

Asiya Odugleh-Kolev

Technical Officer, Community & Social Interventions, World Health Organization

"Family is our first community and mold's our identity. Our lived experiences and our relationship with others determine our resilience, and our ability to navigate human life, and profoundly impact our life and wellbeing."

Lastly, Professor John Parrish-Sprowl from Indiana University School of Liberal Arts builds on Asiya's remarks by exploring some possibilities of relational community engagement and how we can use this concept to improve people's health. He emphasizes that if we want to achieve PHC goals, we need to enable communities to engage in health promoting ways using relational processes. Some ways to do this is ensuring positive interactions and relationships with communities during regular health care delivery and collecting large level data such as relational mapping and case studies as well as individual data.

Participants raised questions about engaging religious and political organizations in health systems and what strategies exist to sustain community engagement for the future. Rachel highlighted that to determine how much to engage religious and political organizations, it depends on the extent of their integration into the community and build on existing community structures. In terms of sustainability, she comments that formal structures and proper representation also helps contribute to the sustainability of community engagement. Asiya added on to Rachel's response by pointing out that we need more intentionality and documentation around how engagement is occurring through social relational processes. Professor John also emphasized the importance of empowering community leaders and fostering invitational discussions centered around the indigenious perspective.

Concurrent Session Day 1:
Integrated Service Delivery

This session aimed to understand how to best leverage different actors within health care delivery and within communities to improve PHC systems. Nazo Kureshy, Senior Community Health System Advisor at the United States Agency for International Development (USAID), started and supported the discussion around integrated service delivery by focusing integration of community health workers and communities in PHC systems, giving examples of such from USAID efforts with the Community Health Roadmap platform. Dr. Shunsuke Mabuchi, Head of Resilient and Sustainable Systems for Health at the Global Health Fund, furthered the discussion by exploring an example of the post Ebola PHC work in Liberia. The country achieved three things. First, they maintained and built on the government public health and emergency response mechanism they developed for Ebola by creating the National Public Health Institute of Liberia responsible for integrating services. Second, they turned the fragmented community health worker programs into a standardized, nationwide program, with a strong community health unit which had a number of sources of support. Third, the Liberian government applied leadership and coordination functions they established to manage Ebola response to strengthen integrated implementation of PHC reforms. Both speakers shared their experience working for organizations that are key players in the global health context and recommended convening and elevating country voices on what they need as well as building evidence of positive health outcomes as a result of community health systems in order to continue the momentum for a stronger focus on PHC.

In summary, fragmented health system strengthening, financing, and other unintegrated vertical program deliveries in PHC have been a problem globally. Integrated service delivery in PHC is a critical pillar for delivering best global health services. Integration with country governments, community health workers, partners, donors, and leaders to deliver functional health care services is very important. Aligning internally and externally with key collaborators in national policy design including financing, community engagement management, data system, and monitoring and evaluation frameworks for national PHC delivery are included in the integrated service delivery model. Pandemic managements, such as for COVID-19, Ebola, HIV, and malaria management, are examples for integrated service delivery and the effectiveness if implemented correctly. The speakers emphasized the need to have ongoing data and strong support from national governments to support service delivery.

Concurrent Session Day 1:
Multisectoral Collaboration

This session highlighted how diverse community actors, sectors, and stakeholders can be sustainably engaged to strengthen implementation and delivery of PHC. Dr. Sentayehu Tsegaye, Chief of Party and Deputy Country Director at Amref Health Africa, commenced the session by covering data on health inequities (especially concerning the COVID 19 pandemic), how these inequities depend on social determinants of health (using the World Health Organization's conceptual framework), and the PHC components that address those determinants (primary care, empowering communities, and evidence driven multi sectoral policy & action). Providing the example of Ethiopia's path to achieving some Sustainable Development Goals (SDGs) through PHC, he suggests the following: anchor development around households, package/synergize interventions, promote public sector collaboration, and have a holistic performance monitoring framework that addresses multidimensional poverty. Warren Blessing Tukwasibwe, Senior Manager Partnerships and Stakeholder Engagements at Living Goods, added onto the discussion by sharing the contributions of community health workers (CHWs) to achieving PHC goals due to their versatile and critical roles. He urges us to ensure that the work of CHWs should be adequately equipped with essentials, digitized to ensure consistency, supervised to optimize support, and compensated to increase motivation.

Lastly, Dr. Lisa Hilmi, Executive Director of CORE Group, delivered her remarks recognizing multi-stakeholder partnerships as a key to improve PHC service delivery and prevention, urging the need to act on these partnerships, and providing examples for PHC sustainability. She emphasized that we should integrate PHC in both development settings and humanitarian-fragile settings, focus on reaching missed populations like people with disabilities and mental illness, and integrate multi sectoral approaches such as WASH, reproductive health, and immunizations.

Participants inquired about the responsibility of the health sector in terms of multi sectoral collaboration and the disconnect between nationwide leadership and community health. Speakers responded with the following: all partners must be accountable to move PHC forward, governments need to address structural barriers to health by following policy frameworks, and health includes more than the absence of disease so it should be addressed as such.

Plenary Session Day 2:
Deeper Dive in PHC Financing

The aim of the second plenary session was to review historical strategies, new approaches, and remaining challenges in PHC financing. Professor Kara Hansson from the London School of Hygiene and Tropical Medicine highlighted some key facts about financing PHC, such as low government spending on PHC, high out-of-pocket payments, and the positive correlation between the amount governments spend and improvements in service coverage. Dr. Hansson also explained the importance of pooled funds for PHC financing (like tax revenue and domestic resource mobilization), the Ministry of Health's role in advocating for these funds, and the importance of people-centered financing arrangements for PHC. Her call to action was that we need to switch to a more strategic provider payment system, specifically a blended system that's built on capitation. The second speaker, Dr. Angela Gichaga, CEO of Financing Alliance for Health spoke of the importance of investing more in preventative than in curative care. Her call to action was that we need to build resiliency by applying a systems lens and focusing on strengthening platforms of delivery, integrating service delivery, extending the point of care to the point of need, and empowering communities. Next, Gina Lago Marsino from Research for Development re-emphasized the importance of designing financing systems that support the delivery system. She cited a case study from Ghana about a failed capitation-based health pilot due to unequipped service delivery for that model of financing and highlighted that the lesson learned was that health financing reforms require strong political leadership. Another lesson that Gina shared was the key role that health organizations, non governmental organizations (NGO's), and external stakeholders can play in supporting the priorities of national and local leaders. Finally, youth speaker Somto Chloe Keluo-Udeke gave a spotlight to youth inclusion as we think about PHC.

The main takeaways from the second plenary include first that we need to coordinate with political leadership for reforming PHC financing systems and NGOs, external stakeholders, and nongovernmental actors need to seek supportive, facilitating roles while allowing local and national leaders to lead. Second, financing systems need to synchronize with delivery systems, complement each other, and advance together.Thirdly, the community needs to be involved in development of financing systems to maintain accountability, make recommendations, and inform what a responsive system can look like. The speakers also emphasized that data must be used to inform reforms in PHC financing systems. There is already abundant data, such as the WHO health financing progress matrix, yet new data can still be generated on how countries are implementing financing systems. Lastly, youth need to be involved in the design of and decision-making for PHC reforms.

Concurrent Session Day 2:
Political Economy of PHC Financing

This session highlighted how to effectively analyze and navigate both local and global political economies to better promote financing for PHC. Professor Fina Balabanova, Professor of Health Systems and Policy at the London School of Hygiene and Tropical Medicine, started the session by discussing the findings of the Lancet Global Health Commission report on Financing PHC and its relation to the political economy of PHC financing. She reframes political economy as an advantage rather than a barrier to strengthen PHC, presents a political economy analysis framework, and provides examples of how politics has shaped PHC financing in the past through forming alliances and using a whole government approach. Professor Balabanova recommends asking the right questions to design politically informed strategies for people centered PHC financing, building capacity for political economy analysis intertwined with managing financing, and using the analysis to inform proactive or responsive strategies to support reform. Dr. Alison Mhazo, Supply Chain Technical Advisor and STAR Fellow at the Public Health Institute, discussed the political economy of PHC financing from the context of Zimbabwe which includes its historical milestones, policy context, and state of PHC. He supports the idea that capitalizing on windows of opportunity (such as crisis or new evidence) using political economy analysis approaches as a part of PHC advocacy. Lastly, Dr. Lamidhi Salami, President of the National Council for PHC at the Ministry of Health of Benin, presented on the impact of policy and using PHC as a strategy to respond to demands of communities in Benin. He discussed his vision for the role of political actors of the government in proactively and clearly designing a PHC system in action that delivers financing at the community level with monitoring systems in place to ensure that as well as engaging with the community in an inclusive way towards decision making.

The speakers addressed questions around the difference between political commitments to financing PHC and the reality. Dr. Alison suggests that a potential reason is that political will can be manipulated and there is no space for citizens to hold their governments accountable. For the context of Benin, Dr. Lamidhi adds that the allocation for PHC could be used on many different sectors that contribute to health such as water or sanitation so it's challenging to see its direct translation of health outcomes. Professor Balabanova also responds to a question on major gaps in PHC financing research given the political economy by emphasizing we need more evidence on tactics and examples that have led to strong financing for PHC. The main calls to action is to invite the right people (formal and informal) to the table, examine power constructively, and galvanize effort to mobilize stakeholders.

Concurrent Session Day 2:
Role of Donors in PHC Financing

This session discussed the impact, role, sustainability, motives, and benefits of donors and investors in PHC financing. Dr. Pierre Yameogo, Technical Secretary of the Burkina Faso Ministry of Health, presented on the importance for donors to coordinate and align to a national government plan as well as PHC advocates to map resources that are aligned with the government. The next speaker, Dr. Helina Worku, Team Lead for Health Systems Strengthening at USAID, discussed the importance and impact of donor funding, with examples from Ethiopia. She also discussed some challenges to donor financing such as verticality of external funds (and therefore introducing parallel systems), potential misalignment with national government resources, unpredictability of donor funds, increased levels of inefficiency due to start up/close down costs, and the declining trend in donor funding. Some options for donors to address these challenges include focusing funding on broader interventions for health systems strengthening, donating over a multiyear period and providing full information on aid flows, aligning funding to government planning, increasing resources for low-income countries, and investing in PHC financing research. Lastly, Pauline Irungu, Global Policy and Advocacy Advisor at PATH International, emphasizes that donors should work with countries and build their capacity to ensure strong PHC policies are implemented, allow flexibility for innovation and support country learning/decision making from peer healthy systems, and combine catalytic financing with approaches to grow country investment progressively. She also emphasized multisectoral approaches that connect with communities (or civil societies) and collaboration with other donors to ensure the sustainability of PHC financing. Participants inquired about how to shift donor funding from emergency response to strengthening PHC systems that eventually respond to crisis and Dr. Helina noted we are seeing a shift of donors investing in the long term with the hopes that this will continue to grow.

Concurrent Session Day 2:

Integration of Fragmented PHC Financing

This session highlighted the costs and value of integrating fragmented health care financing and how it can support PHC financing, with the intention to understand how fragmented PHC financing can impact continuity of patient care. Dr. Cheryl Cashin, Managing Director at Results for Development, started the discussion by sharing sources of fragmentation in PHC financing and recommendations to move forward in reducing it. Recommendations from the Lancet Commission Report on PHC Financing include centering PHC funding around public resources, using pooled funds to cover PHC so it is free at point of service, allocate resources equitably to reach frontline providers, and use a blended mechanism with capitation at the core to pay providers. She also shares three main lessons: resist new fragmentation moving forward, integrate funding streams from the PHC provider level up, and harmonize one function at a time. Dr. Gerald Manthalu, Deputy Director of Planning of the Republic of Malawi's Ministry of Health, furthered the discussion by providing examples from Malawi of how fragmented financing has driven significant inefficiencies in implementation leading to community fatigue. In terms of solutions, the Malawi Ministry of Health has adopted an integrated service delivery strategy by implementing a one plan, one budget, one report approach as well as strengthening government aid at the district level.

Both speakers emphasized leveraging the country platform as a mechanism to integrate financing from domestic and international efforts. They also clarified the private sector's role in PHC financing and fragmentation is related to out of pocket payments issues and we need to engage them in public financing arrangements with the right incentives in order to deliver equitable essential services.

Concurrent Session Day 2:

Future of PHC Financing

This session unpacked the variety of possibilities for the future of PHC financing given historical and present approaches, incorporating a forward looking perspective, and reimagined what PHC financing can look like both in local and global contexts. The first speaker, Temesgen Tesfu, PHC Program Lead and Health Financing Advisor at Clinton Health Access Initiative (CHAI), presented challenges of PHC financing (revenue collection, donor fatigue, pooling and risk protection, etc) as well as hopes for the future, with examples from Ethiopia. To overcome these challenges, we should increase domestic financing through increased government allocation, introduce different innovative financing, ensure technical and allocative efficiencies in health spending, engage the private sector to fill any gaps, and ensure universal access to health insurance. Dr. Muyiwa, Deputy Director of PHC at PATH International, contributed to the discussion by sharing financing strengths such as advocacy and public policy reforms, decentralization, and evidence generation and unpacking challenges and opportunities such as policy, operating systems, leveraging human capacity for delivery, inclusive and integrated service delivery, and community confidence in the health system. Using a mix of upstream, mid-stream, and downstream financing, Dr. Muyiwa believes we can improve the future of sustainable PHC financing. Finally, Dr. Regis Hitimana from the Rwanda Social Security Board shares Rwanda's PHC journey and success factors such as high political commitment and action, zero tolerance to corruption, community ownership, and complementarity with other financing mechanisms, with the need to evaluate some challenges with a fragmented financial transfers and the fee-for-service model. The speakers give final reflections around building up the sustainability of community based health insurance given the lack of readily available income. , ensuring quality delivery of services, and including government in order to expand resources.

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