WHO-EM/PHC/175/E

Report on the

Regional consultative meeting on primary health care for universal health coverage

Cairo, Egypt
30 July–1 August 2019

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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1. INTRODUCTION

A regional consultative meeting on primary health care (PHC) for universal health coverage (UHC) took place on 30 July–1 August 2019 in Cairo, Egypt. The meeting saw the formal launch of the Primary Health Care Measurement and Improvement (PHCMI) initiative, which had been announced by Dr Ahmed Al-Mandhari, WHO Regional Director for the Eastern Mediterranean, at an event celebrating World Health Day on 5 April 2019. The initiative aims to support countries to fulfil the commitments made in the Astana Declaration on PHC.

The three-day meeting was attended by ministry of health focal persons for PHC and health information from 20 countries, as well as PHCMI initiative partners, representatives from the Bill & Melinda Gates Foundation and the World Organization of Family Doctors (WONCA), and WHO country office health system focal points and the WHO Secretariat (for the meeting's programme see Annex 1 and for the list of participants see Annex 2). This was the first in a series of meetings focused on improving PHC. A second meeting is scheduled for December 2019.

The objectives of the meeting were to:

- share the current status of PHC implementation in the Eastern Mediterranean Region from the UHC perspective and as related to the recommendations of the Astana Declaration and the PHCMI initiative;
- disseminate the findings of the PHC assessment conducted in three pilot countries (Egypt, Jordan and Pakistan) as part of the Measurement Phase of the PHCMI initiative, and share related PHCMI tools, including PHC country profiles and vital signs profiles;
- establish a mechanism for integrating PHC services in the Region in a manner that enhances efficiency and ensures people-centredness, with the goal of attaining health for all; and
- explore the health system requirements – in terms of governance, workforce, financing, technologies, infrastructure and information – needed to ensure successful implementation of the PHCMI initiative to enhance UHC in the Region.

The PHCMI initiative builds on the Primary Health Care Performance Initiative (PHCPI), PHC Operational Framework, pre-existing regional efforts on the family practice approach, PHC quality indicators, and the WHO Regional Office's health system profiles. The initiative seeks to build national capacity for evidence-based PHC improvement, including the established family practice approach.

Results from the initiative will be driven by three primary goals: (1) building regional and national capacity and awareness for an enhanced evidence-based approach to PHC improvement; (2) institutionalizing PHC measurement in existing health system performance assessments; and (3) improving PHC performance/scaling-up of family practice to help countries accelerate progress towards the achievement of UHC.

To improve the PHC assessment tool and conduct a baseline assessment of the PHC sector, three pilot countries (Egypt, Jordan and Pakistan) have started the Measurement Phase of the PHCMI initiative. The remaining 19 countries of the Region will learn from the experiences of the pilot countries.

2. OVERVIEW OF PROCEEDINGS

2.1 Opening and setting the scene

Opening remarks were made by: Dr Ahmed Al-Mandhari, WHO, Regional Director for the Eastern Mediterranean; Dr Anirban Chatterjee, Regional Advisor, Health and Nutrition, UNICEF; Ms Katie Porter, Senior Programme Officer, Bill & Melinda Gates Foundation; and Dr Jinan Usta, President, Eastern Mediterranean Region, WONCA. The speakers outlined the importance of PHC and family-based care in the Region, the history of the Declaration of Alma-Ata and the strong need in the Region for improvements in PHC in order to advance towards UHC. An introduction to the main objectives and background of the PHCMI initiative was given and the importance of health information systems in providing integrated and accessible patient-centred primary care was outlined.

In addition to the official objectives of the meeting, participants shared other expectations for the meeting, such as determining solutions to the challenge of financing the PHCMI initiative and identifying how partners such as WONCA can contribute to these strategies and plans.

Concerns were raised regarding the difficulty of collecting data for the Measurement Phase, as well as the current fragmentation of health information systems in several countries, which may be exacerbated if the technical support given is not integrated into the country context. Technical support provided by WHO will strive to aid in collecting data for those indicators where sources of data may not be readily apparent. In regard to the health information system, a major theme of the meeting covered integration and its importance for the PHCMI initiative. Regional models or frameworks for strengthening health information systems and improving health service delivery were requested; however, country specificity is crucial, particularly for data collection and the analysis of existing programmes.

2.2 PHC Measurement Phase

The three pilot countries (Egypt, Jordan and Pakistan) presented their main findings from the PHCMI Measurement Phase and outlined the implementation process, challenges experienced, and what parts of the implementation methodology had worked and what had not; a summary is presented in Annex 3. Each country also presented, based on the findings of the Measurement Phase, their priorities for action and action plans, which will be completed during the Improvement Phase. Challenges identified included the number and fit of the indicators and the difficulty of obtaining reliable and accurate data. The action plans contained the common elements of improving data collection, integration of information systems, and improving the education and training of PHC health workforce. PHC

expenditures of the pilot countries were also presented, with an analysis of the source of the data, how much was spent on PHC, and a cross-country comparison. The definition of PHC, for the purposes of the evaluation, was defined as all "first point of contact" services.

There was discussion over whether the pilot country PHC services strategies were applicable to other countries, as potential elements of the Improvement Phase of the initiative. For example, the training of Pakistan's Lady Health Workers to provide PHC, their scaling up and the widening of their scope of practice. The current family medicine fellowship programme in Egypt was also discussed; it aims to increase the number of family physicians in rural areas through compulsory service and by creating a clear career path for family practitioners.

It was noted that the level of the health system chosen for initial implementation needs to be decided (national, provincial, district or local). Countries can start the initiative at the subnational level depending on country context, and in consultation with WHO. In the case of Pakistan, the Islamabad Capital Territory was the initial focus, with the rest of the country planned to participate in January 2020.

The sheer number of indicators was a concern, and there was a request to minimize the number and potentially integrate them with Sustainable Development Goals (SDG)-related indicators. Pakistan found the timescale of the tool a challenge, and faced difficulty in obtaining data from the private sector. Other countries wanted suggestions on the way forward with regard to the private sector. Pakistan had mapped those clinics unwilling to collaborate, passing legislation binding them to provide data and obtaining a letter from the District Commissioner. However, the sector is currently unregulated and this presents a major challenge.

The definition of PHC as the "first point of contact" was discussed. It was felt that hospitals should be excluded from the definition as they should not be the first point of contact. However, until another definition is agreed upon by the Region, the most feasible method of defining PHC remains this one. A definition based on the service provider rather than function was attempted, but was found to be too complex as hospitals are often visited as the first point of contact. Further assistance is required for defining PHC within the Region as definitions impact data collection and therefore policy formation.

For Egypt, the lessons learned from implementation included allowing flexibility in the methodology, which was finalized with WHO. However, the results matched the previously conducted SWOT analysis, demonstrating the tool's strength.

The potential decrease in health expenditure due to investment in PHC was discussed. The indicators alone do not currently allow evaluation of this; however, PHC investment cases per country could allow comparison of intervention costs and the cost-benefits of PHC.

2.3 Implementing the PHCMI initiative

Introductions to the PHC Operational Framework and PHCMI initiative were given. The recommended actions for improving the three components of PHC contained in the Operational Framework were described, while an overview of the PHCMI initiative outlined the steps, requirements and timeline of implementation. Experiences from the pilot countries of indicator tailoring, data collection and validation were shared.

The PHCPI's PHC Progression Model was introduced and its link with the outputs of the PHCMI initiative described. The PHC Progression Model focuses on qualitatively measuring the health system and capturing aspects not otherwise obtained through routine data collection methods. PHCPI is a partnership of country policy-makers, health systems managers, advocates and others dedicated to transforming the global state of primary health care. It supports countries to strengthen monitoring, tracking and sharing of key performance indicators for primary health care. PHCPI's Vital Signs Profiles are another key measurement tool for service delivery in relation to PHC in countries. One way the PHCMI initiative differs from PHCPI is that it includes multisectoral policy and action and empowered people and communities.

Plans will be developed for incorporating the routine measurement of PHC indicators on a regular basis based on the outcomes of implementing the PHCMI initiative. The indicators used in each country will be determined through consultation with ministries of health and WHO. Indicators may vary slightly from one country to another to allow for differing situations. The sole focus of the governance indicators on regulation was raised as a concern, as was the lack of embedded implementation research for areas not directly related to public health.

PHC in the private sector will be a separate initiative, starting in September and requiring further coordination with partners to ensure that it runs in parallel with the current PHCMI initiative.

2.4 Health system contribution to PHC: challenges and strategic directions

A series of presentations were given to participants regarding the health systems contribution to PHC. This included presentations on:

- financing frameworks and tools for effective implementation of PHC for UHC;
- the importance of investment in the health workforce for PHC;
- effective and quality essential medicines and technologies;
- viewing hospital roles and operations through an integrated and people-centred lens;
- the challenges in quality and safety in health systems, with recommendations for improvement;
- improving health service delivery by implementing robust health information systems; and
- building resilient health systems as a prerequisite to achieving UHC.

Strengthening the health system contribution to PHC is being accomplished using new ways of thinking, focusing on a patient-centred approach and on community needs. The discussion also sought to consolidate the new paradigm and explore how the PHCMI initiative can be used to strengthen existing regional agendas.

A paradigm shift was proposed whereby UHC is perceived through the lens of health systems strengthening. A key element of this shift is discussing health service delivery outputs first and financing second, rather than the other way around. The efficiency of financing is also important and was discussed in the 2010 World Health Report; the inclusion of financing-efficiency indicators in the PHCMI initiative are to be considered.

Challenges to the health workforce are many, including maldistribution and increased mobility. Benefits packages, in the context of a country, need to take into account the scope of practice of the health workforce. The move to family-based practice PHC is another challenge for the Region. Training family physicians will take years and will require additional transitional measures. Participants agreed that bridging programmes to encourage general practitioners to become family physicians are needed, rather than relying on specialist family medicine programmes and financial incentives. However, this will not be sufficient; the environment of the health system needs to be transformed to be conducive for family physicians. Strengthening the health workforce to strengthen PHC will also require reliable and accurate data. While the presentations discussed the various challenges regarding health systems, the aim of the session was not to indicate that the PHCMI initiative would solve these challenges, but rather to encourage discussion on them in relation to the initiative.

It was acknowledged that most of the tools presented were designed for stable health systems. For emergency contexts, there is a need to have resilient health information systems that can continue to collect valuable data during and after an emergency. However, there is a lack of knowledge on how to adapt these methods to emergency situations and it was felt that health system strengthening after conflict needs further attention. Although implementation priorities for post-conflict contexts are country-specific, they should generally start with a benefits package.

2.5 Integration of PHC service delivery

Presentations were made outlining challenges and recommendations for the integration of PHC service delivery, emphasizing the importance of integration. This included presentations on:

- the adoption of a system-wide integrated PHC-based approach that reduces harmful impacts and redundancies and improves intervention delivery and finance;
- including noncommunicable disease (NCD)-related interventions in the PHC benefits package;
- a guidance package for integration of mental health into PHC;
- the integration of communicable disease interventions into people-centred health systems;
- opportunities to integrate health protection and promotion interventions in PHC;

- advancing PHC to promote the health of populations in fragile, conflict-affected and vulnerable settings; and
- the UHC priority benefits package.

While strengthening health systems is important when focusing on integration of PHC service delivery, the importance of integration at the level of individual programmes should not be minimized. There is evidence that investment in PHC has benefits for the outcomes of both individual programmes and PHC. Each programme has a responsibility to integrate with PHC service delivery. Further guidance on how to integrate PHC with disease and mental health programmes is needed to enable this.

It was felt that the definition of integration in the Region needs more clarity. Overall, it was agreed that PHC is not only health care, and that integration is not just the collation of disease programmes at PHC-level. It was agreed that an integrated PHC approach should look at an individual's life-course and focus on well-being, and that the key is to address the individual within their family context, not only through a disease focus. As an example, it was suggested that PHC can be visualized as a mother coming to get her child immunized and at the same time being asked about breastfeeding, postnatal care, anaemia, family planning, and postnatal depression.

The example of Somalia was discussed, noting that a national health policy written over five years ago, stating the need for integration and defining a minimum services package, had not been implemented due to the political situation. As a result, HIV and tuberculosis facilities stand alone and there is no integration. The way forward will require articulation and collaboration in the Improvement Phase of the initiative.

2.6 Challenges for integration of health services in PHC

A panel discussion with seven country representatives was held on the challenges for integration of health services in PHC. It aimed to raise awareness on the current challenges facing integration of service delivery in PHC, present successful experiences from the Region, and draw attention to the value of integrating service delivery within PHC.

Islamic Republic of Iran/Dr Alireza Moghisi, Deputy Director-General for NCD, Ministry of Health and Medical Education

Given only four countries in the Region have comprehensive treatment for NCDs, Islamic Republic of Iran has one of the most successful models in the Region for integration of NCD treatment at the PHC level. The country's successful model for integration of NCD prevention into PHC is called IraPEN. It is closely aligned with the WHO Package of Essential Noncommunicable Disease Interventions (WHO PEN) and is dedicated to the early detection of NCDs and related risk factors. It is planned to be scaled up and rolled out nationwide by the end of 2020. Challenges experienced in the reorienting of PHC for integration with NCD prevention were described. It was felt that the WHO PEN protocol, although feasible, is costly and requires a high level of political and stakeholder engagement.

The example of cancer prevention programmes was given, outlining the integrated, evidence-based and patient-centred methods used.

The role of the family physician in providing integrated health services in a PHC setting in Bahrain/Dr Manal Amin Al-Alawi, Assistant Undersecretary for PHC, Ministry of Health

Given the severe shortage of family physicians in the Region, Bahrain presents a unique situation. Almost 93% of PHC facilities are run by certified family physicians as opposed to general practitioners. Bahrain strongly believes that family medicine is the core of PHC, and as such invests heavily in it, with 30% of government health expenditure being spent on PHC. Efforts have been made to make the profession of family medicine attractive, including the provision of a clear career path and additional financial incentives such as a good salary, almost equal to that of hospital doctors. In addition, as the training programmes of family physicians are public ones, retention in the public system is maintained through the use of dedicated hours that have a salary equivalent to private sector consultancy work. Services integrated in PHC include curative, preventative, radiology, physiotherapy, pharmacy and laboratory services. Electronic health records ensure integration with secondary care and help to lower the cost of health care.

Islamic Republic of Iran's experience in human resource development for integration of service delivery in PHC/Dr Mohammadreza Rahbar, Manager, Human Resources Development Department, Ministry of Health and Medical Education

The Islamic Republic of Iran is unique in being the only country in the Region with a combined Ministry of Health and Medical Education. Human resources are key for service delivery, and the country has valuable experience in the development of PHC through the provision of community health workers in rural areas. Multiple human resource strategies have been applied to develop PHC and move towards UHC. The integration of medical education in the service provision sector increased access to courses and enabled the revision of the curriculum based on community needs. One example is the distance-learning Masters in Family Medicine. Task-oriented training has provided community health workers on a large scale in rural areas to deliver PHC services that are community-specific. Retention of family physicians in rural areas is ensured through compulsory service, with each of the 66 universities responsible for providing health staff in the regions.

Jordan, a model for the integration of mental health in PHC/Dr Mohammed Rasoul Tarawneh, Secretary-General of the High Health Council

There are a limited number of countries in the Region that have integrated mental health services at the PHC-level. Jordan provides a good example of doing this. To scale up mental health services, the Ministry of Health adopted the policy of integrating mental health services into PHC. The initial challenges included the stigma attached to mental health among policy-makers, professionals and the community, insufficient recruitment and retention of staff, gaps in financial resources, and a lack of health centre staff trained in mental health. Despite this, a shift from the provision of acute psychiatric care in specialized

centres to general support in PHC centres was accomplished, as was training for family doctors based on a psychosocial model. In 2018, an online mental health diploma for family physicians and GPs was launched.

Development of an integrated package of essential health services in Afghanistan/Dr Najibullah Safi, Programme Manager, Health System Development, WHO Afghanistan country office

While all countries in the Region have essential health services packages, in practice only 40–50% of package contents are available. Afghanistan has developed and implemented an essential health services package, and despite conflict and poverty, this has so far been a major success. Various changes have occurred in the causes of illness and death in Afghanistan since the development of the basic package of health services and the essential package of health services in early 2000, when their focus was on mother and child health. However, today Afghanistan suffers from a triple burden of diseases. In 2019, in order to address these existing and emerging needs, Afghanistan developed an integrated package of essential health services to ensure access to primary and secondary health care according to local epidemiological and demographic needs. Given the current fragmentation in the health system, efforts to measure coverage, cost and accountability have included a Ministry of Public Health contract management unit and third-party monitoring, previously done by Johns Hopkins. These efforts could be adopted in countries such as Libya aiming to develop an integrated package of health services; however, nongovernmental organization saturation creates difficulties. In addition, there has been increased investment in nursing education.

The extended model of PHC in Oman/Dr Said Al Lamki, Senior Consultant in Family Medicine and Director-General of PHC, Ministry of Health

Oman has a fully implemented essential services package, and an assessment has found that service delivery in PHC facilities covers 90% of morbidity in the country. PHC services have designed to match changes in epidemiology through a focus on expanding primary care services to include outpatient specialized care. This transformation in care delivery is in response to changing disease trends, changing population needs, and the increased cost of health care. It was achieved by providing specialized care at the PHC level and making PHC the first point of contact in an emergency. Furthermore, health care costs were lowered. Although contested, moving a secondary care doctor to the PHC level is more cost-effective than not doing so, as is increasing the training of the nursing workforce who see more than 40% of patients at PHC centres.

Introducing the family-based health approach/Dr Akihiro Seita, Director of Health and WHO Special Representative to UNRWA, Jordan

The Region is suffering from a severe shortage of family physicians. The maximum number of family physician graduates is 3500 per year. In Jordan, the family health approach was introduced due to the massive influx of refugees and the increased burden of disease. However, the speed of production of family physicians is insufficient, so bridging and transition programmes are needed as well as advocacy efforts to increase the number of people

using primary care centres. Initially general practitioners were used in PHC centres, but recognizing the importance of family physicians, the Ministry of Health decided to create online professional development training in family medicine for general practitioners. The resulting one year online diploma course costs US$ 5000 per person. The course started with 115 doctors participating per year and has expanded to cover Gaza and the West Bank, Lebanon and Syrian Arab Republic, as well as Jordan. Discussion also addressed task shifting. It was noted that most primary care services can be provided by non-physicians, with associated cost reductions. However, in some countries there is an excess of physicians and a shortage of nurses and restrictions on the nursing scope of practice. A request was made for a regional framework/guidelines, which could then be adapted to the country context.

2.7 PHCMI implementation plan to December 2019

Participants were divided into working groups to produce tangible and fast-track action plans for the initiative. The members of each group are detailed in Annex 4. Following the group work, presentations were made by each group addressing:

- What has already been put in place?
- What will happen next and by when?
- What are the challenges anticipated?
- Commitment to participate in December workshop.

The group presentations are summarized in Annex 4. However, there were common themes across all groups. All countries had completed existing health surveys and had identified potential sources of data for the indicators. Challenges that were anticipated, or identified by the pilot countries, included the difficulty in obtaining data from multiple institutions/sectors, as well as time and resource constraints. The indicators were perceived as being too numerous and repetitive of national indicators already being collected.

The countries requested technical support from WHO in using the tool, collecting data, developing an action plan, refining the indicators and providing guidance to focal points. In addition, they identified next steps including adapting the indicators to the country context, committing to the December workshop and, if not done already, appointing a focal point.

A call for action was presented, outlining the significance of the PHCMI initiative in producing sustainable improvement in PHC/family practice in the Region. This needs to be done by focusing on a people-centred approach and supporting countries to transform the commitments of the Astana Declaration and the PHC Operational Framework into action. The aim is to ensure the Eastern Mediterranean Region serves as a model for the rest of the world. It was felt that the call to action should also include the promotion of financing efficiency and, as the cornerstone of the curative aspect of PHC, it was recommended that there is a focus on the deficiencies of family medicine in the coming years.

Financing has been the deciding factor when planning health services in past PHC improvement efforts. Currently this is shifting; first, the desired health outputs of service delivery are determined, and then the structure of the finance system is created based on these

priorities. To increase advocacy for PHC, an evaluation of the gap between the funds needed and the funds spent on programmes, including the minimum essential package, is needed and should be distributed to governments in the Region.

It was noted that when discussing integration, rather than discussing the integration of disease programmes, discussion should centre on the integrated minimum benefits package. It was felt that while integration of the components of PHC had been discussed, guidance notes need to be written for other sectors to ensure that any interventions created are integrated into PHC.

Concerns were raised regarding overlap and the lack of integration of the PHCMI indicators with others, such as those for UHC and WHO's Thirteenth General Programme of Work (GPW 13). However, it was pointed out that the PHC monitoring and evaluation indicators are built from the UHC index. This ensures that PHC measurement is at the heart of UHC. Although the 126 indicators seems a large number, not all are expected to be completed and the Improvement Phase will aim to facilitate data collection, thereby increasing the number of indicators with data. Gaps in data for indicators are expected and meetings with focal points and relevant staff from WHO Regional Office and WHO headquarters will be scheduled. Staff should not be overloaded as there is limited additional data collection.

It was noted that difficulties arose for pilot countries when validating data and trying to use unpublished data. However, it is important to use the most recent and accurate data and technical support may be provided to enable data to be published. The availability of data from the private sector remains a concern. For instance, in Lebanon only 220 of the 1100 existing PHC posts are in the public sector. However, for now, the initiative will only focus on the public sector.

Feedback on the Implementation Manual is expected within the following two weeks; 13 of the 19 countries entering the Measurement Phase already have focal persons nominated. There is a need for greater collaboration with ministries of finance, who need to be involved in the discussion so that PHC becomes a priority for them. Focusing only ministries of health will limit progress towards UHC, which cannot be achieved purely through improving health service delivery. Therefore, attendees of the next meeting will not only come from ministries of health in order to increase diversity and broaden political commitment.

3. MEETING OUTCOMES AND NEXT STEPS

3.1 Meeting outcomes

By the end of the meeting, participants had heard presentations and engaged in discussions on the state of PHC in the Region, the PHCMI initiative, definitions and mechanisms of integration, as well as the health system requirements for achieving UHC. After the dissemination of findings to the pilot countries, practical workshops were held aimed to encourage the 19 countries in the Measurement Phase to take action. (See Annex 5 for a survey of the meeting participants).

3.2 Next steps

For Member States

- Commit to attend the PHCMI workshop in December 2019.
- Provide feedback on the Implementation Manual.
- Appoint a focal point for the remaining six countries without a focal point.
- For the pilot countries, begin the Improvement Phase and commence the action plans developed in the meeting. Egypt and Pakistan have been recommended for partner collaboration for PHC implementation, which will increase technical (and potentially increase financial) support for PHC strengthening in the two countries.
- For the remaining countries, begin the Measurement Phase in close collaboration with WHO.
- Continue close coordination with WHO and partner organizations towards a second regional workshop in December 2019.

For WHO

- Finalize indicators and disseminate to Member States.
- Continue close coordination between the different levels of WHO and with countries and partner organizations towards a second regional workshop in December 2019.
- Hold a two-day workshop for the 19 PHCMI focal persons on 25–26 September with the following objectives:
  - to understand the routine data collection and reporting system;
  - to share and discuss the PHCMI indicators and identify potential data sources;
  - to develop an action plan together with country focal points for the completion of a PHC country profile and Vital Signs Profile;
  - to discuss the feedback on the PHCMI implementation manual; and
  - to create a PHCMI focal person network.
- In future workshops, learn from and build upon the feedback given during the first workshop (see Annex 4).

3.3 Expected challenges and mitigation

Expected challenges/Issues to overcome	Mitigation plan
Short period to collect data and to present PHC profile and Vital Signs Profile by December 2019	• Agree on a work plan with the countries at the meeting on 25 September meeting • Weekly follow-up by WebEx • WHO headquarters and Regional Office staff field visits
The three pilot countries present PHC profiles as a draft	WHO will request ministries of health for clearance
The three pilot countries do not present their Vital Signs Profiles	WHO will request ministries of health for clearance
The three pilot countries will need financial resources for the priorities of the Improvement Phase	WHO Partner Collaboration for PHC Implementation will allocate funds for Egypt and Pakistan initially, followed by the remaining countries
The PHCMI manual receives several comments	Revision and updating of PHCMI manual
Not all countries have an assigned PHCMI focal person	Will assign all PHCMI focal persons before 25–26 September meeting

Annex 1

PROGRAMME

Tuesday, 30 July 2019

Time	Session	Speaker
8:00–8:30	Registration	
	Opening and setting the scene	
8:30–10:00	Short video: WHO World Health Day 2019, Regional Office for the Eastern Mediterranean (4m)	
	Opening remarks: • Dr Ahmed Al-Mandhari, WHO Regional Director for the Eastern Mediterranean • Dr Anirban Chatterjee, UNICEF Representative, Regional Advisor, Health and Nutrition • Ms Katie Porter, Bill and Melinda Gates Foundation Representative, Senior Programme Officer • Dr Jinan Usta, World Organization of Family Doctors (WONCA) Representative, President for the Eastern Mediterranean Region	
	Objectives and agenda Introduction of participants:	*Dr Aya Thabet, Programme Assistant, Primary Health Care, WHO Regional Office for the Eastern Mediterranean*
	"From Alma-Ata to Astana": Introduction to PHCMI initiative	*Dr Hassan Salah, Regional Advisor for Primary Health Care, WHO Regional Office for the Eastern Mediterranean*
	Health information, a main element of a functioning PHC system	*Dr Arash Rashidian, Director, Information, Evidence and Research, WHO Regional Office for the Eastern Mediterranean*
	Discussion and feedback	
	PHC Measurement Phase **Chaired by: Ms Hagar Azab, Dr Karen Kinder and Dr Bassant Mohamed**	
10:30–12:30	Short video: 2. Primary health care throughout our life (1.5m)	
	Measurement Phase: Main findings from the three pilot countries	
	• Egypt	*Dr Soad Abdel Megid, Head of Primary Health Sector, Ministry of Health, Egypt*
	• Jordan	*Dr Adnan Ishaq, Assistant to Minister of Health for Primary Health Care, Jordan*
	• Pakistan	*Dr Sabeen Azfal, Director General, Regulations/Health System, Ministry of National Health Services, Regulations and Coordination, Pakistan*
	Resources tracking: How much countries spend on PHC	*Dr Ilker Dastan, Technical Officer, Health Economist, WHO Regional Office for the Eastern Mediterranean*
	Discussion and feedback	

Implementing the PHCMI initiative
Chaired by: Dr Anirban Chatterjee and Dr Jeff Markuns

13:30–15:00	Short video: 3. Why PHCMI initiative (3m)	
	PHC: Post-Astana	*Dr Karen Kinder, PHCMI WHO headquarters*
	PHCMI initiative: background, objectives and outcomes	*Ms Hagar Azab, PHCMI Regional Health Systems Development Focal Person*
	Data collection and validation processes	*Dr Bassant Mohamed, PHCMI, Regional Information, Evidence and Research Focal Person*
	Introduction to progression model	*Dr Dan Schwarz, Director of PHC, Ariadne Labs*
	Discussion and feedback	

Health system contribution to PHC: challenges and strategic directions
Chaired by: Dr Edward Kelley

15:30–17:30	Short video: 4. Universal health coverage, the best investment for healthier world (2m)	
	Health governance and financing	*Dr Awad Mataria, Regional Advisor, Health Economics*
	Health workforce development	*Dr Gulin Gedik, Coordinator Health Workforce Development*
	Essential medicines and technologies	*Dr Houda Langar, Regional Advisor, Vaccines Regulation and Production, Essential Medicines and Health Technologies,*
	Hospital care management, quality and patient safety	*Dr Hamid Ravaghi, Regional Advisor, Hospital Care Management*
	Health information system	*Dr Henry Doctor, Technical Officer, Technical Officer, Health Information Systems, Information, Evidence and Research*
	Health systems in emergency	*Dr Ali Ardalan, Regional Advisor, Health Systems in Emergencies*
	Discussion and feedback	

Wednesday, 31 July 2019

Integration of PHC service delivery
Chaired by: Dr Rana Hajjeh

08:30–10:30	Short video: 5. Family Practice in Eastern Mediterranean Region towards UHC (5m)	
	Introduction to programme integration into PHC from a health system perspective	*Dr Awad Mataria, Regional Advisor, Health Economics*
	Noncommunicable diseases: progress, challenges, opportunities and the way forward	*Dr Asmus Hammerich, Director, UHC/NCDs*
	Guidance package for the integration of mental health into PHC	*Dr Khalid Saeed, Regional Advisor, Mental Health and Neurological Disorders*
	Integration of communicable diseases interventions in PHC: challenges and opportunities	*Dr Supriya Warusavithana, Regional Advisor, Neglected Tropical Diseases*
	Discussion and feedback	
	Health protection and promotion: challenges and opportunities	*Dr Maha Al-Adawy, Director, Department of Healthier Populations, Regional Office*
	Advancing PHC in fragile, conflict-affected and vulnerable settings	*Dr Richard Brennan, Director, Health Emergencies, Regional Office*
	UHC priority benefits package	*Dr Reza Majdzadeh, Consultant, UHC–Priority Benefits Package, Regional Office*
	Discussion and Feedback	

Panel discussion: Challenges for integration of health services in PHC, seven regional successful models
Moderator: Dr Hassan Salah

11:00–13:00

- Dr Alireza Moghisi, Deputy General Director for NCD, Ministry of Health and Medical Education, Islamic Republic of Iran
- Dr Manal Amin Al-Alawi, Assistant Undersecretary for PHC, Ministry of Health, Bahrain
- Dr Mohammadreza Rahbar, Manager of Human Resources Development Department, Ministry of Health and Medical Education, Islamic Republic of Iran
- Dr Mohammed Rasoul Tarawneh, Secretary General High Health Council, Jordan
- Dr Najibullah Safi, Programme Manager Health System Development, WHO Office, Afghanistan
- Dr Said Al Lamki, Senior Consultant Family Medicine and Director General of PHC, Ministry of Health, Oman
- Dr Akihiro Seita, Director of Health and WHO Special Representative to UNRWA, Jordan

Questions and answers

PHCMI Implementation plan to December 2019
Chaired by: Ms Hagar Azab, Dr Karen Kinder, Dr Henry Doctor and Dr Bassant Mohamed

14:00–15:30	Working groups: Workplan/action points for data collection to November 2019 • Objectives, topics of discussion and expected outcomes • Assign participants to four working groups	
16:00–17:30	Working groups: Workplan/action points for data collection to November 2019	

Thursday, 1 August 2019

PHCMI Implementation plan to December 2019
Chaired by: Dr Hilda Harb and Dr Michael Kidd

08:30–10:00	Short video: 6. Spirit of Astana Declaration – Primary health care (2m)	
	Call for action	*Dr Edward Kelley, Director, Service Delivery and Safety, WHO headquarters*
	Introducing PHCMI implementation manual	*Dr Karen Kinder, PHCMI WHO headquarters* *Ms Hagar Azab, PHCMI Regional Health Systems Development Focal Person* *Dr Bassant Mohamed, PHCMI Regional Information, Evidence and Research Focal Person*
	Discussion and feedback	
10:00–12:30	Working groups presentations Discussion and feedback	
12:30–13:00	Next step and closing remarks	*Chaired by: Dr Ahmed Al-Mandhari, WHO Regional Director*
14:00–16:30	Closed door meeting with Advisory Group, PHCMI initiative partners, WHO headquarters and Regional Office, and PHCMI focal points, undersecretaries, WHO country office representatives for the three pilot countries	*Chaired by: Dr Ahmed Al-Mandhari, WHO Regional Director*

Annex 2

LIST OF PARTICIPANTS

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Dr Mohamed Abbass, GIS and information system, WHO Sudan
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Annex 3

MAIN FINDINGS OF THE MEASUREMENT PHASE FROM THE THREE PILOT COUNTRIES: EGYPT, JORDAN AND PAKISTAN

Pilot country	What worked in the Measurement Phase?	What did not work in the Measurement Phase?	What are the decided priorities of action?
Egypt	Review of indicators provided evidence of what data is missing	The indicators needed to be tailored to Egypt: for example, the malaria-related factors were not useful due to the low burden in Egypt The role of governing bodies and nongovernmental organizations was not clear There was a lack of coordination between different sectors delivering services through PHC: for example the preventive and curative sectors	• Establishment of integrated information systems • Put human resources retention strategy into action • Strengthen the referral system • Train PHC physicians on 2019 clinical guidelines • Integrating civil society organizations into health systems of Egypt through measures including health initiatives and raising awareness
Jordan	The tool helped collect all sources of reliable data available Methodology was broad enough to capture the picture of PHC Data collection team had a person responsible for data collection, the other for data validation	Reliability and validity of the data Generating indicator values from other data was difficult Qualitative indicators distracted from collection of quantitative indicators Duration of data collection needs revision PHCMI is an extra duty for national team members Added unexpected expenses to the project budget	• Managing and centralizing PHC data • Increase capacities to collect, organize, analyse, use and act on data for policy making • Review, restructure and strengthen financial administration for PHC • PHC heath workforce need special attention in terms of enhancing capabilities and competencies in providing the services
Pakistan	N/A	The tool was found to be inflexible in assessing all levels of health care, lengthy, complex, lacked alignment with SDGs and overlapped with other indices Lack of private sector data Concerns about creating another vertical information system Working on PHC profile at country level in a devolved setup is challenging	• Implementation of Islamabad Health Strategy • Expansion of UHC (Sehat Sahulat, social protection) programme • Scaling up of implementation of family practice approach • Strengthen referral linkages/specialized clinics of hospitals • Recruitment and deployment of necessary health workforce • Update DHIS to incorporate PHC elements • Defining catchment population for health facilities and issue of smart card • Development of DCP-3 packages • Planned relocation/upgrade of family welfare centres

Annex 4

GROUP WORK DETERMINING THE WORKPLAN/ACTION POINTS FOR DATA COLLECTION TO NOVEMBER 2019 AND ANTICIPATED SUPPORT NEEDED FROM WHO

Group allocations

Group A: moderated by Dr Karen Kinder
1. Bahrain
2. Kuwait
3. Oman
4. United Arab Emirates
5. Jordan

Group B: moderated by Ms Hagar Azab
1. Egypt
2. Iraq
3. Lebanon
4. Palestine
5. Syrian Arab Republic

Group C: moderated by Dr Bassant Mohamed
1. Iran (Islamic Republic of)
2. Libya
3. Morocco
4. Tunisia
5. Yemen

Group D: moderated by Dr Henry Doctor
1. Afghanistan
2. Djibouti
3. Pakistan
4. Somalia
5. Sudan

Discussion questions

1. *Status:*
   a. Where does your country stand with regard to PHCMI (have you started vs. have not considered it)?
   b. When do you anticipate beginning the process?
   c. Do you have a PHCMI focal point already named?
      - If so, who is it?
      - If not, who will decide and when?

2. *Challenges/enablers:*
   a. What assessments are already being done in your country?
   b. How can this PHCMI Initiative best be integrated into your current health system plans and/or national health strategies?
   c. What are some of the challenges you anticipate and how do you plan to mitigate them?
   d. What support do you anticipate needing from WHO country office/Regional Office?

3. *Process:*
   a. Addressing the pilot country in the group – what is your advice to the others?
   b. General Q&A

4. *Development of Work Plans and presentations*
   a. What are the take home messages you will be bringing back to your country?
   b. Will it be possible to have a PHC country profile by the December workshop?

GROUP PRESENTATIONS SUMMARY

Group	What has already been put in place?	Challenges encountered/anticipated	What support is needed from WHO Office for the Eastern Mediterranean?	Steps forward/Take home messages
A	• All countries except Kuwait have a focal point. • All countries except. Jordan are beginning the Measurement Phase. • The data available is country specific; however, all have health surveys and Ministry of Health indicators.	• Collecting data from multiple institutions and sectors was difficult and time consuming. • Communication difficulties working with different Ministry of Health units • The need for Ministry of Health data approval before use • National indicators do not match PHCMI indicators, which are general and not focused. • Lack of monitoring and technical staff	• Need training, guidance and technical support throughout the initiative • Setting a timeline and completing discussion on a country-specific indicator list • Involve ministers to simplify data collection. • Maintain communication with all Member States to distribute learnings.	• Determine indicators and plan next steps. • Commit to participating in the December workshop • Assign focal points. • Meet stakeholders and create a team. • Receive regular updates from other Member States • Report the monthly status using a checklist.
B	• All countries except Syrian Arab Republic have a focal point. • All countries except Egypt are beginning the Measurement Phase. • Country specific situations include Lebanon having all PHC centres run by nongovernmental organizations and majority of centres being privately owned.	• Fragmentation • Unknown or low quality of data • Need for capacity building	• Assistance in clarifying indicators for each country	• Countries who have identified a focal point will review indicator list when provided to determine data sources and key informants. • Countries who have not yet identified focal points will continue working on this. • For Egypt, the action plan presented by Dr Soad will begin to be followed.
C	• All countries are beginning the Measurement Phase; some have started looking at the indicators. • Each country excluding Yemen has a national health plan/policy that has a focus on PHC improvement and can align with the initiative. Yemen is currently creating a national health plan and will strive to include PHC. • Assessment of PHC and health systems have been carried out in each country in collaboration with	• National indicators do not match PHCMI indicators • Unknown additional cost • Fragmentation of services • Inadequate coordination among partners • Overlap among different tools for information collection • Political fragmentation causing low political will • Difficulty of stakeholder engagement • Short timeline	• Forming a methodical approach • Clearly defining roles of Ministry of Health and focal points • Financial support for PHCMI until the next workshop • Assistance in high level advocacy • Technical support in using the tool • Translation of the tool into French	• Bringing back the take home messages: the necessity of improving PHC, importance of health information system for achieving UHC, and the need for integration

	WHO headquarters and Regional Office for the Eastern Mediterranean.	• Low resource and data availability due to crisis		
D	• All countries except Pakistan are beginning the Measurement Phase. • All countries except Djibouti run routine DHIS2 data and had completed vertical programme surveys. • Health surveys were done in Somalia and Afghanistan in addition to other assessments carried out by all countries.	• Tight timeline • Data not readily available • Long and complex tool • Scoring for the progression model is difficult • Stakeholder involvement is, and will be, difficult	• Continued support from focal points at WHO representative offices and Regional Office for the Eastern Mediterranean • Comprehensive tool guidance from WHO headquarters and Regional Office for the Eastern Mediterranean on a weekly basis and a monthly basis from WHO headquarters and Regional Office for the Eastern Mediterranean • Progress report/update feedback	• Form PHCMI teams. • Appoint focal points. • Determine an action plan for data collection, organizing based on indicators. • Develop country operational plan for implementation of PHCMI. • Begin lobbying of government and other stakeholders to get necessary buy-ins.

Annex 5

SURVEY RESULTS FROM MEETING PARTICIPANTS

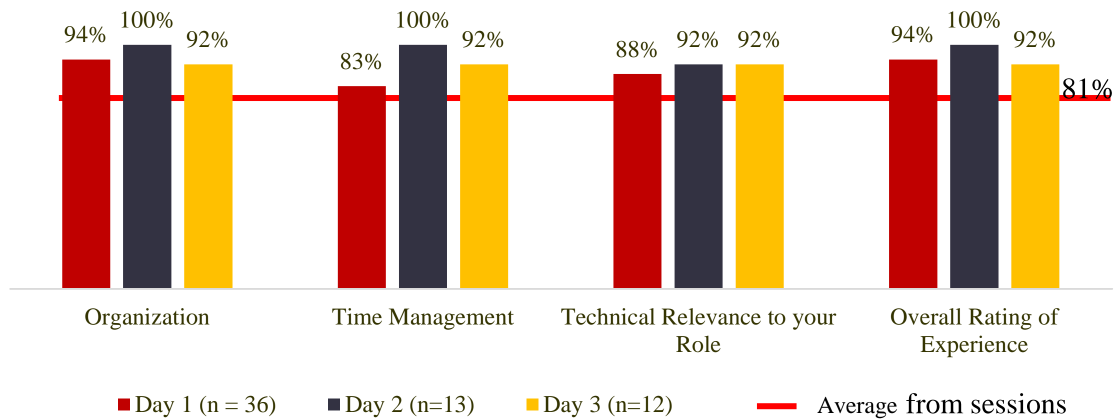

Fig.1 Quantitative analysis: Results from a 5-point scale

Percentage of participants who scored a 4 or 5 on a 5-point scale when grading each day of the meeting (see meeting programme in Annex 1). The categories were: organization, time management, technical relevance to your role and overall rating of experience. All categories received higher than the average session scores (81%) for all three days. Day 2 had the highest overall score for all categories; however, sample size had decreased.

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