Multi-stakeholder design and assessment of primary health care (PHC) policies: insights from the Primary Health Care Performance Initiative (PHCPI) and the Collective Impact approach

Luis Gabriel Bernal Pulido

Principal Lecturer, School of Public Health and

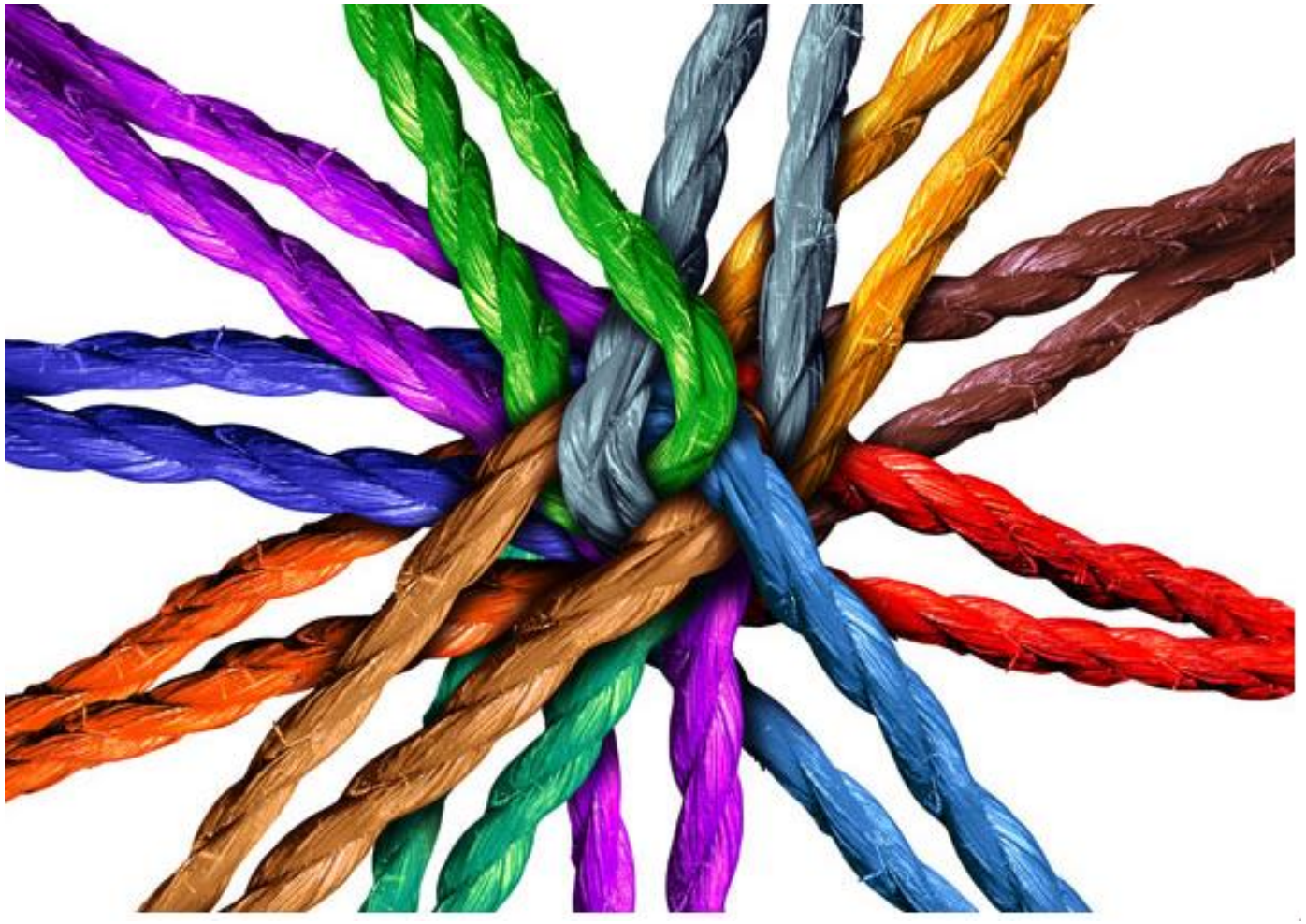
Department of Family Medicine and Primary Care

香 港 大 學
THE UNIVERSITY OF HONG KONG

HKU Med
LKS Faculty of Medicine
School of Public Health
香港大學公共衞生學院

HKU Med
School of Clinical Medicine
Department of Family Medicine
& Primary Care
香港大學家庭醫學及基層醫療學系

Collective Impact Approach



From Ramalingam, Ben Aid on the Edge of Chaos Oxford Press 2013

What is Collective Impact?

- Convene the main stakeholders of a situation or problem
- Collect and review data, identify needs, and effective strategies to address the problem
- Open political windows and attain political will
- Create an enabling environment
- Achieve alignment, coherence and coordination
- Mobilize resources
- Obtain impactful results

Collective Impact Approach

Common Agenda	• Common understanding of the problem • Shared vision for change
Shared measurement	• Collect data, measure results • Shared accountability
Mutually Reinforcing Activities	• Differentiated approaches • Coordinated through joint plans of action
Continuous Communication	• Consistent and open communication • Build trust
Backbone Support	• Staff with resources and skills to convene

Kania and Kramer 2011. Stanford Social Innovation Review

Examplar Cases of Multistakeholder engagement in Primary Health Care Policy

Early Childhood Development Program in Chile: “Chile Crece Contigo – (ChCC)”

*CHCC is a national social protection, comprehensive, and multisectoral program, promoting optimal development of children from conception to the school age through “universal and targeted benefits”.

Social Determinants of Health Approach



Challenges Addressed

- High rates of children with developmental delays, particularly in the poorest quintile.
- Inequities in access to quality health, education, and social services.
- Socioeconomic barriers impacting child development.

Innovations of the Program

- Integration of services across sectors: health, education, and social protection, leveraging existing programs and services.
- Ministry of Social Development as coordinating body
- Shared electronic database for tracking developmental assessments and actions.
- Direct transfers of financial resources to municipalities based on fulfillment of quality standards and KPIs.

Community and stakeholder’s Involvement

- Broad consensus and political support, and strong government leadership.
- Extensive involvement of national and regional stakeholders, civil society, and academia.
- Local implementation through municipal networks, allowing community-driven programming and local accountability.

Budget allocations guaranteed by Law



Milman, H. M., Castillo, C. A., Sansotta, A. T., Delpiano, P. V., & Murray, J. (2018). Scaling up an early childhood development programme through a national multisectoral approach to social protection: lessons from Chile Crece Contigo. *bmj*, *363*.

Early Childhood Development Program in Chile: “Chile Crece Contigo – (ChCC)”

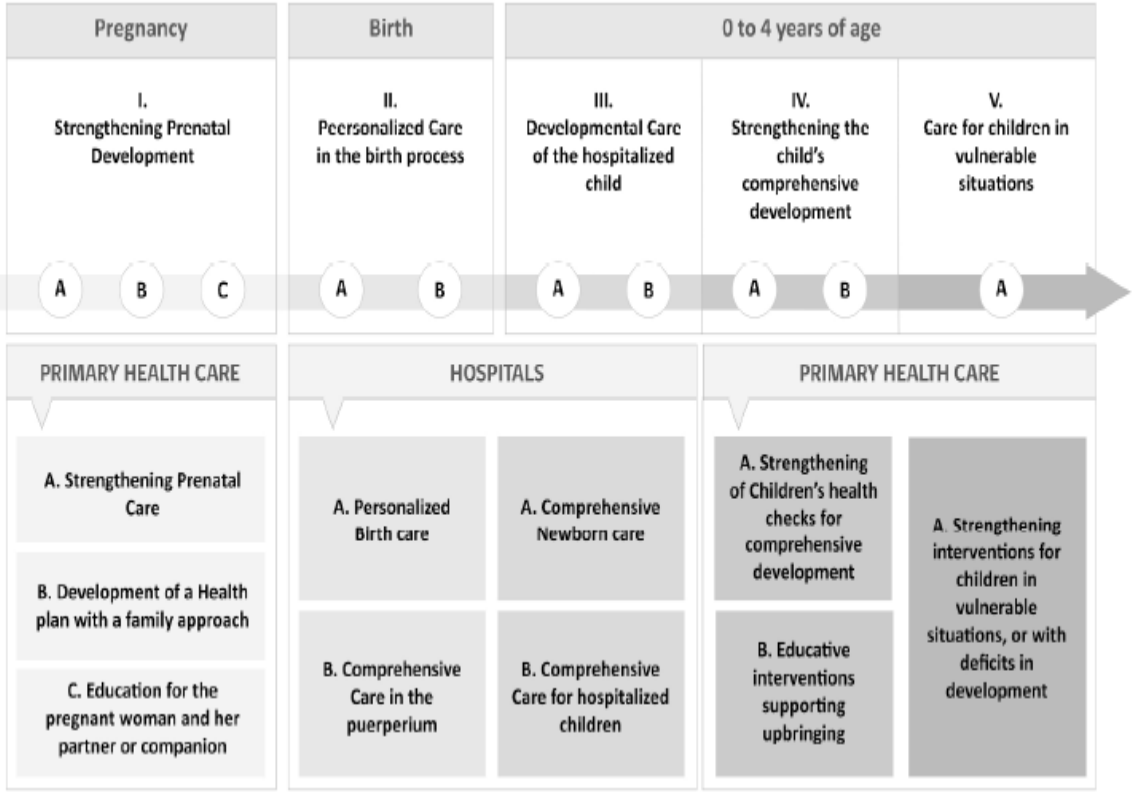


Table 2: Key ChCC country indicators, 2007-2018[1]

	Indicator	2006-2010	2011-2014	2015-2018
Public financing	Total expenditure - ChCC (US$ millions, 2017)	7.809 (2007)	72.715 (2012)	80.989 (2017)
Prenatal care	Home visits: pregnant women with psychosocial risk (total number)	13 310 (2007)	88 103 (2012)	72 547 (2017)
	Prenatal care with spouse, family member, or significant other (% of prenatal visits)	18 (2008)	30 (2014)	34 (2017)
Delivery and early postpartum care	Birth companion (% deliveries)	-	59 (2012)	67 (2017)
	Skin-to-skin contact for at least 30 minutes (% deliveries)	-	52 (2010)	76 (2017)
	Exclusive breastfeeding for 6 months (% infants < 6 months)	49 (2008)	43 (2012)	57 (2017)
Early child home care and education	Home visits: children with psychomotor delay (total number)	2 754 (2007)	41 001 (2012)	46 033 (2017)
	Parents attend motor and language development workshops (% of parents of children < 1 year)	0 (2006)	-	63 (2017)
	Routine health visits for children 0-4 attended by the father (% of health visits)	14 (2010)	16 (2014)	19 (2017)
	Pre-school education 0-3 years (% of children attending)	12 (2006)	26 (2011)	29 (2015)
	Pre-school education 4-5 years (% of children attending)	63 (2006)	83 (2011)	90 (2015)

[1] Source: Ministry of Health, Ministry of Education, Ministry of Social Development and Budget Directorate, Ministry of Finance, Chile

Confidential: For Review

Proportion of kids with developmental delay: 14% (2006) → 10% (2017)

Milman, H. M., Castillo, C. A., Sansotta, A. T., Delpiano, P. V., & Murray, J. (2018). Scaling up an early childhood development programme through a national multisectoral approach to social protection: lessons from Chile Crece Contigo. *bmj*, *363*.

Local Health Administration Committees (CLAS) in Peru

CLAS manage PHC services under agreements with the government, using public funds under private sector laws



Clinic Health Care Community Health Center Doctors Office Clip Art, PNG, 981x651px, Clinic, Building, Community Health Center, Doctors Office, Facade Download Free

Results:

Improved equity, equality, quality, comprehensiveness, effectiveness, and coverage of health services

Higher efficiency and better health outcomes.

Increased access and utilization of health services, especially among disadvantaged populations.

Challenges addressed by CLAS:

Inefficiencies and underfunding of public health services

Social, cultural, and economic barriers preventing access to health services

Innovations brought by CLAS:

Decentralized financial management and formalized social participation

Community empowerment, capacity building and direct control of health workforce

Flexibility in spending and faster response to community health needs

Community Involvement:

Legal authority given to communities

Community members elect CLAS representatives

Community participation in planning and decision-making processes

Support of Community Health Agents

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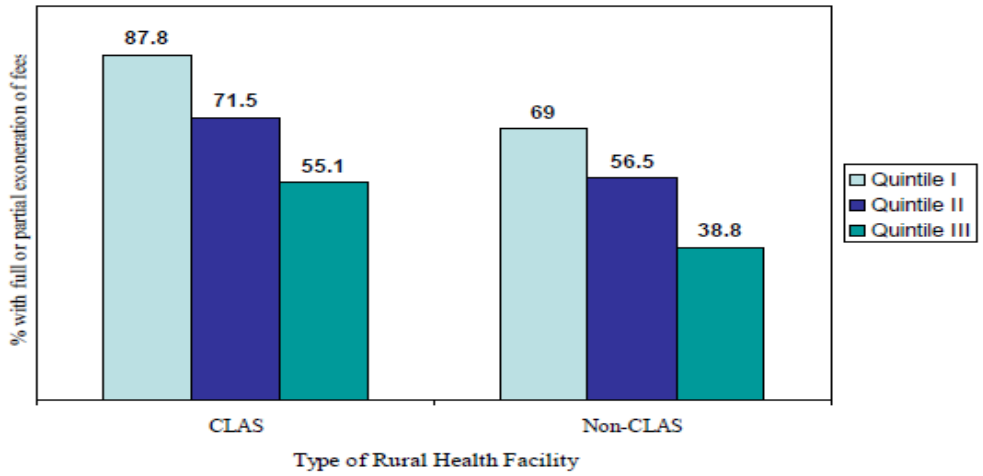




Altobelli, L. C. (2008). Case study of CLAS in Peru: opportunity and empowerment for health equity. *Future Generations-Peru. Lima*.

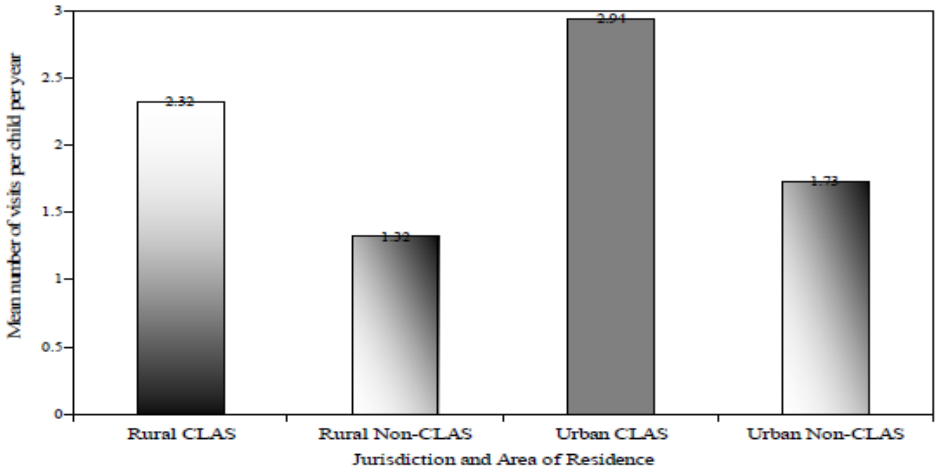
Local Health Administration Communities (CLAS) in Peru

Graph 2: Percent of patients in three lowest income quintiles with full or partial exoneration of fees, by type of rural facility



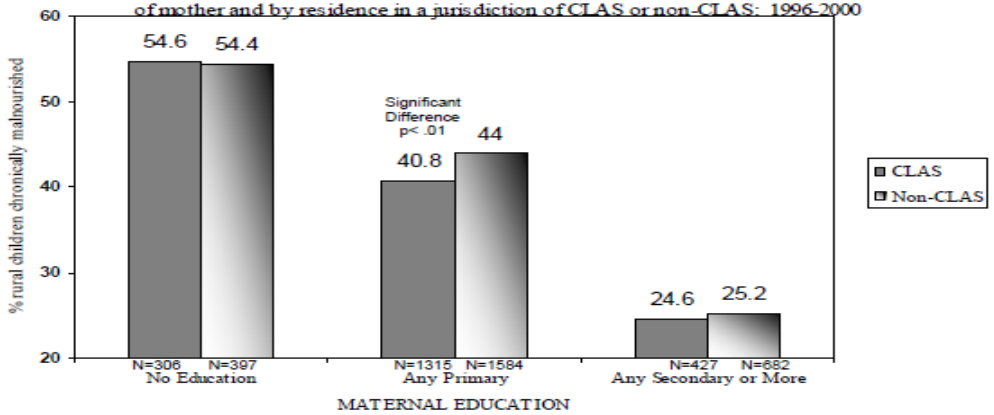
Source: L. Altobelli (1998) Health reform, community participation, and social inclusion: the Shared Administration Program. Lima, Pe
UNICEF. (Data used from the 1997 National Living Standards Survey in Peru)

Graph 4: Average number of annual clinic visits per child by residence in a jurisdiction of CLAS or non-CLAS, rural or urban: Cusco, Huánuco, La Libertad Regions 2002



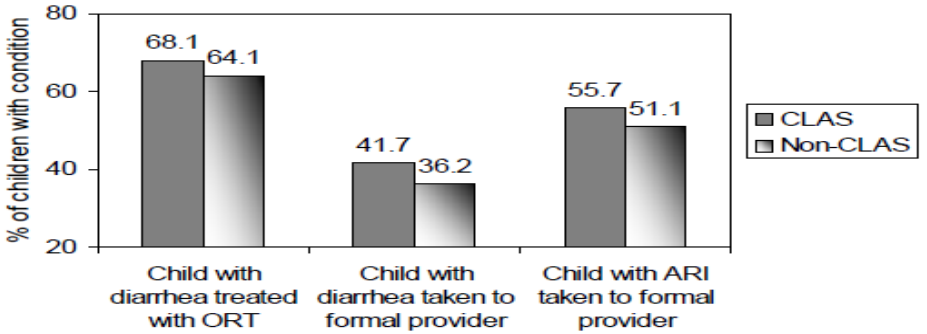
Source: Altobelli, L and A. Sovero (2004) Cost-Efficiency of CLAS Associations. Lima: Future Generations with support from DFID.
www.future.org (Data based on Integrated Health Insurance (SIS) reimbursements for Plan A - Children 0-4 Years of Age 2002)

Graph 6: Percent of rural children under age five with chronic malnutrition by education of mother and by residence in a jurisdiction of CLAS or non-CLAS: 1996-2000



Source: Altobelli, L (2006) Comparative Analysis of Health Impact and Health Services Utilization in CLAS and Non-CLAS Primary Health Care Services in Peru. Lima: Future Generations www.future.org (Data source: Peru Demographic and Health Survey IV, 2000)

Graph 5: Percent of rural mothers seeking health care for a sick child under age five, by residence in a jurisdiction of CLAS or non-CLAS: 1996-2000



Source: Altobelli, L (2006) Comparative Analysis of Health Impact and Health Services Utilization in CLAS and Non-CLAS Primary Health Care Services in Peru. Lima: Future Generations www.future.org (Data source: Peru Demographic and Health Survey IV, 2000)

Altobelli, L. C. (2008). Case study of CLAS in Peru: opportunity and empowerment for health equity. *Future Generations-Peru. Lima*.

Model to increase access to PHC for patients with Chagas Disease in Boyacá (Colombia)



Source: Prepared by the authors from data collected for the study.

Number of people tested before and after the implementation of the Project (period 2017-2020).

Municipality	Baseline, before implementation*	Post-RIA Implementation	Increased (+) or decreased (-) fold
Mean number of people tested per year			
Támara, Casanare	10	245	+24.5
Nunchia, Casanare	25	338	+13.52
Soatá, Boyacá	250	796	+3.18
Mogotes, Santander	119	225	+1.89
Tame, Arauca	22	823	+37.4
Total	426	2,427	+5.69
Average days between medical order and final result			
Támara, Casanare	306	30	-10.2
Nunchia, Casanare	516	24	-21.5
Soatá, Boyacá	120	43	-2.79
Mogotes, Santander	90	20	-4.5
Tame, Arauca	No data	6	No data
All	258	19	-13.58
Mean number of people confirmed positive per year			
Támara, Casanare	2	42	+21
Nunchia, Casanare	10	63	+6.3
Boyacá	5	63	+12.6
Santander	2	61	+30.5
Arauca	18	33	+1.83
Total	37	262	+7.08

* Baseline estimates reflect averages of the three years prior to the pilot in Arauca (2016-2018) and Boyacá (2013-2015). In Casanare and Santander, data from the year immediately preceding the pilot (2016) were used.

Access to antiparasitic treatment compared to baseline, project to increase access to diagnosis and treatment of Chagas disease, Colombia*.

Municipality	Baseline Data*	Post-RIA Implementation	Fold Change
Mean number of patients initiating antiparasitic treatment per year.			
Támara, Casanare	4	15	+3.75
Nunchia, Casanare	4	30	+7.5
Soatá, Boyacá	6	11	+1.83
Mogotes, Santander	10	47	+4.7
Tame, Arauca	4	6	+1.5
All	28	109	+3.89
Mean days between confirmed diagnosis and initiation of treatment			
Támara, Casanare	472	192	-2.45
Nunchia, Casanare	443	115	-3.85
Soatá, Boyacá	350	131	-2.67
Mogotes, Santander	150	171	+1.14
Tame, Arauca	ND	64	
Total	354	135	-2.62

* Baseline estimates reflect averages of the three years prior to the pilot in Arauca (2016–2018) and Boyacá (2013–2015). In Casanare and Santander, data from the year immediately preceding the pilot (2016) were used.



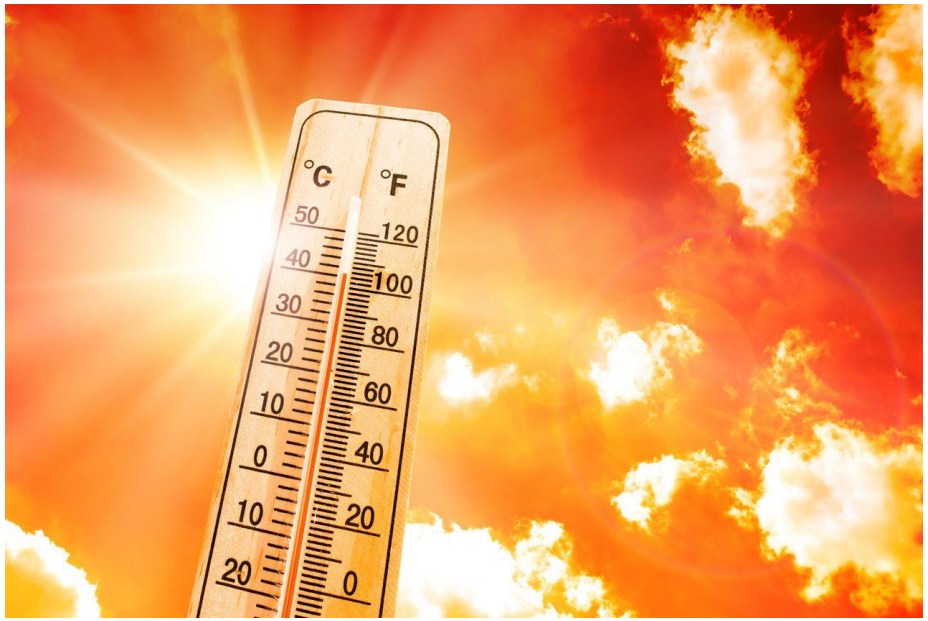




Marchiol, A., Forsyth, C., Bernal, O., Hernández, C. V., Cucunubá, Z., Abril, E. P., ... & Batista, C. (2017). Increasing access to comprehensive care for Chagas disease: development of a patient-centered model in Colombia. *Revista Panamericana de Salud Pública*, *41*, e153.

Herazo, R., Torres-Torres, F., Mantilla, C. A. G., Carillo, L. P., Cuervo, A., Camargo, M. A. M., ... & Marchiol, A. (2022). On-site experience of a project to increase access to diagnosis and treatment of Chagas disease in high-risk endemic areas of Colombia. Acta tropica, 226, 106219.

Heat Health Action Planning for Hong Kong: bridging gaps between academy and society

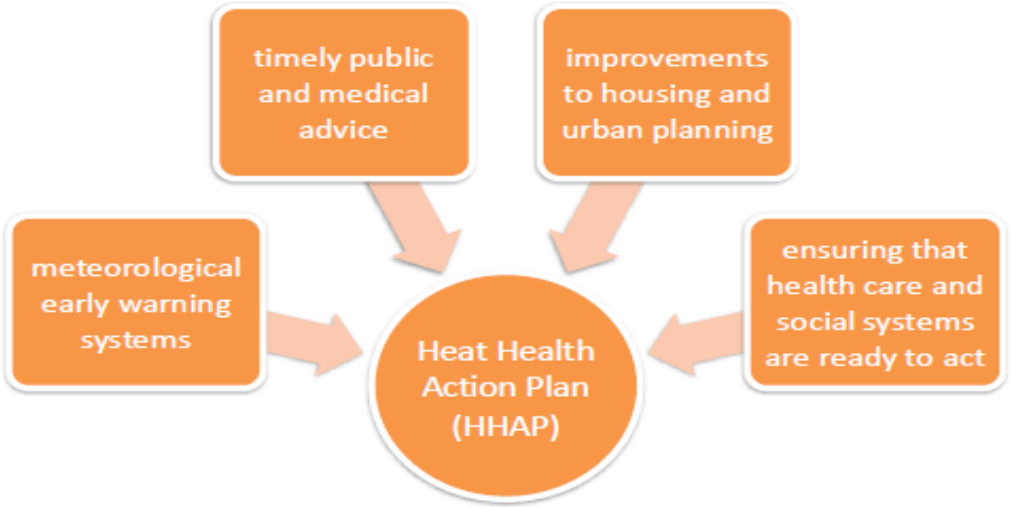


www.theweather.com

Heat Health Action Planning

Preventable !

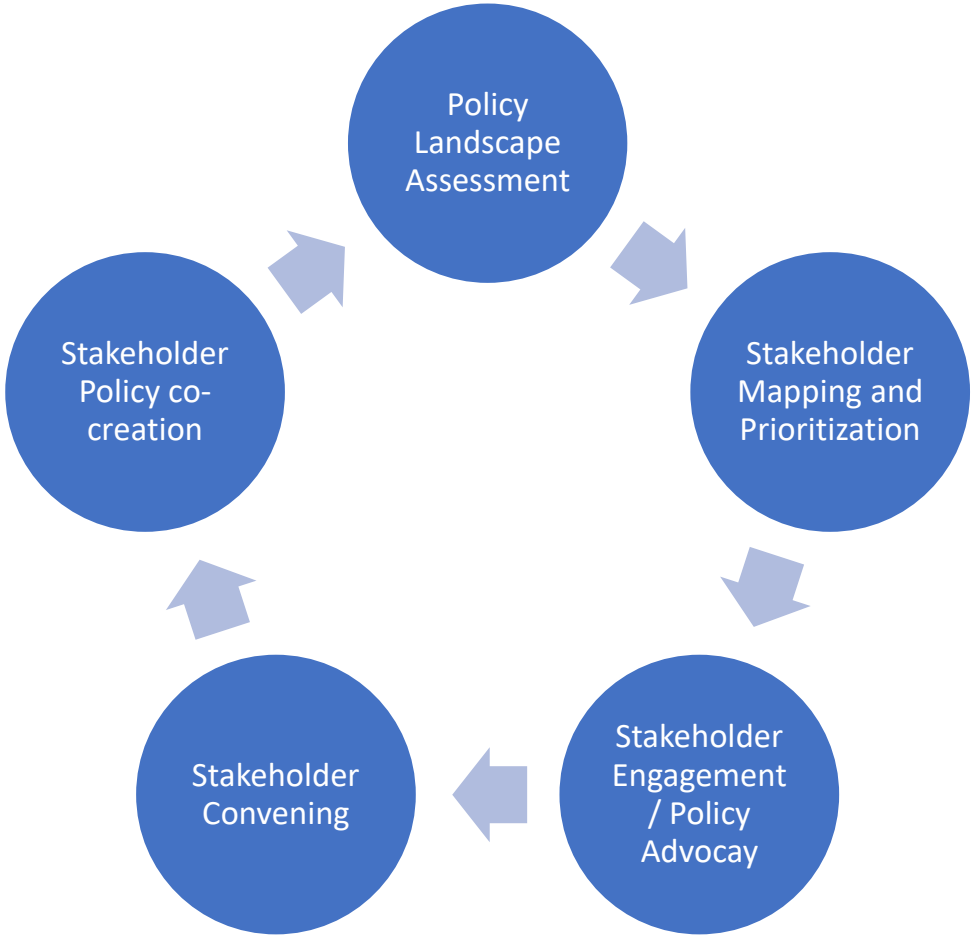
From the perspective of public health, the focus of HHAP lies on the **capacity building in the health and social care system preparedness** against to the extreme heat, especially for the elderly and other population at high risks.



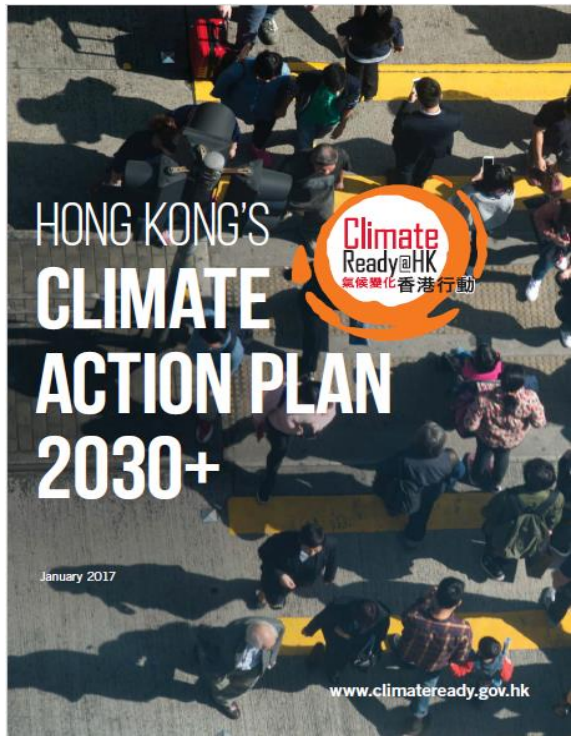


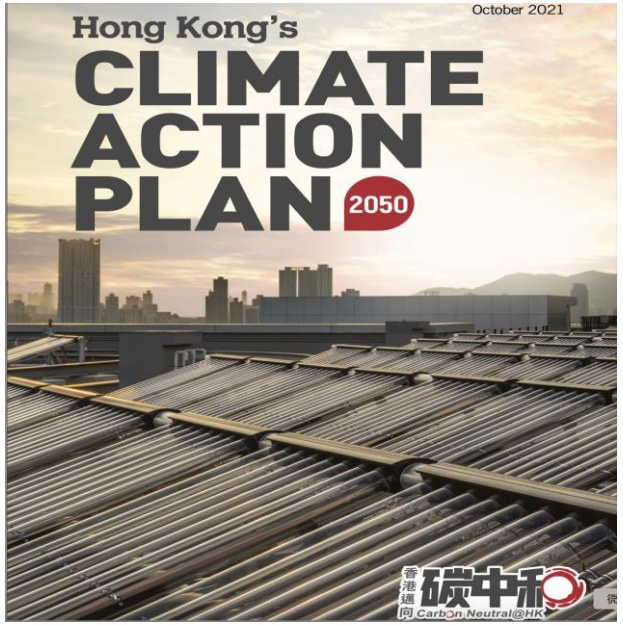
Source: Matthies, F., Bickler, G., Marín, N.C. and Hales, S. eds., 2008. Heat-health action plans: guidance. World Health Organization.

Heat Health Action Planning for Hong Kong



Policy Landscape







Guidance Notes on Prevention of Heat Stroke at Work

(published by the Labour Department)



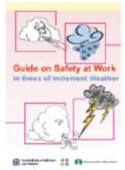
Cold and Very Hot Weather Warnings

(published by Hong Kong Observatory)



Code of Practice in Times of Adverse Weather and "Extreme Conditions"

(published by the Labour Department)



Guide on Safety at Work in times of Inclement Weather



Prevention of Heat Stroke at Work in a Hot Environment



Safety and Health at Work in Hot Environments

(Chinese version only)

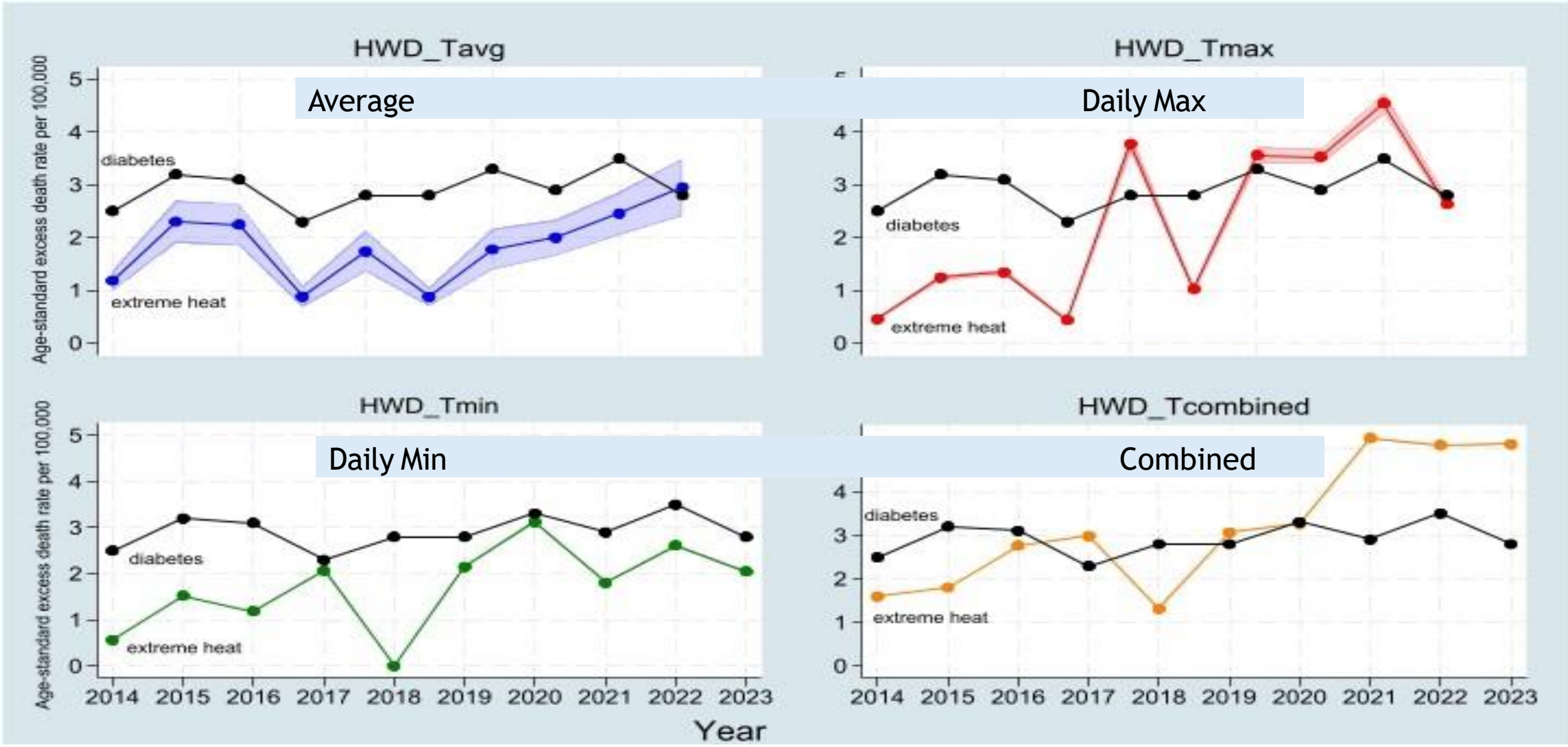


Courtesy of HKU Knowledge Exchange Fund

Stakeholders Mapping and Prioritization

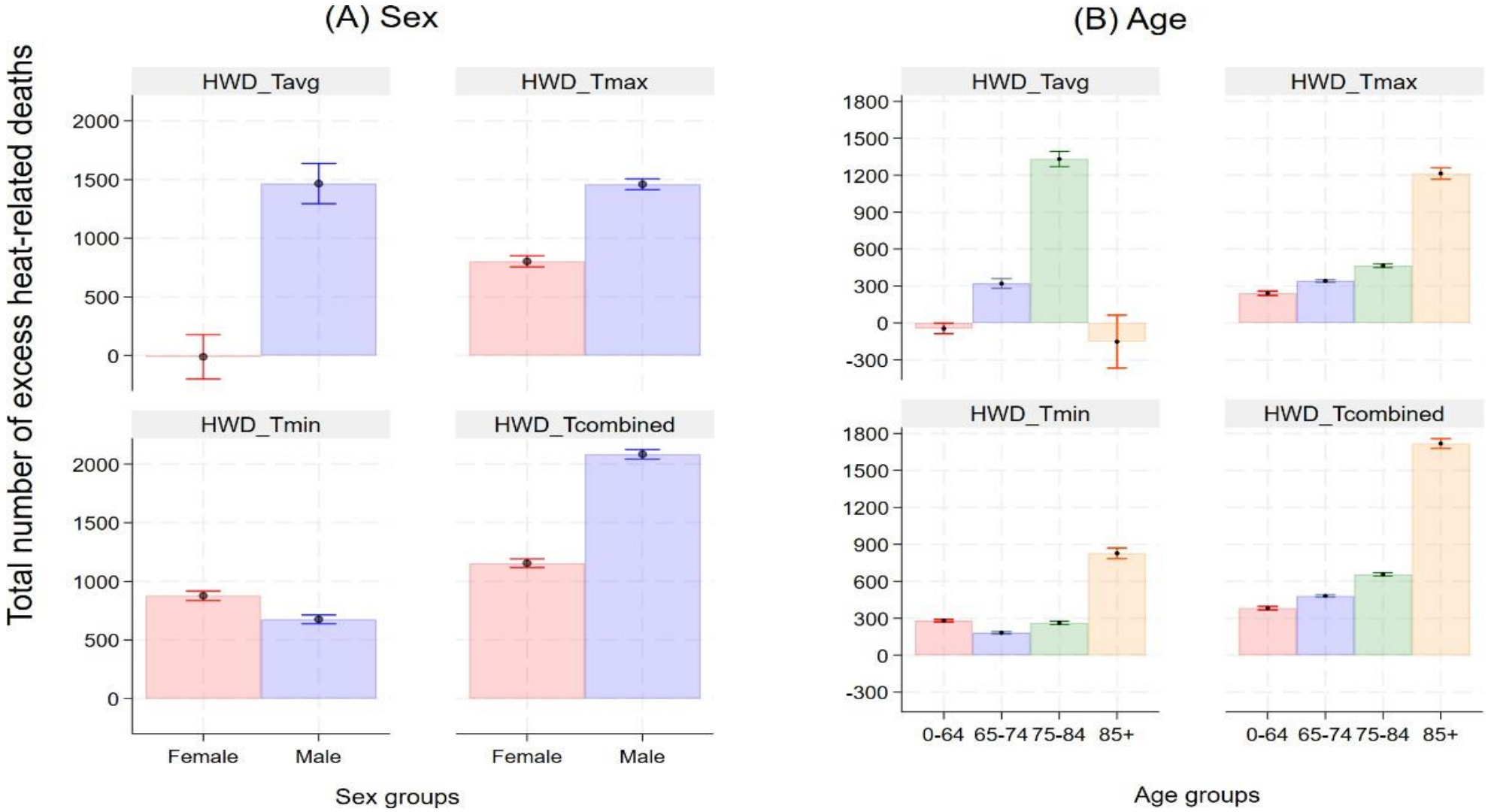
Stakeholder	Sector	Role
HK Observatory	Science	Weather alert
Environmental Protection Dept	Science	Air quality
Centre for Health Protection	Health	Central Convener
Home Affairs Dept	Politics	Cooling Centers
Leisure and Cultural Department	Leisure	Communications
Labour Department	Commerce	Outdoor workers
Planning Department	Planning	Coordination
HK Red Cross	NGO	Emergency Response
St John's	NGO	Emergency Response
District Councils	Government	Local Advisor
District Health Centers	Health	Service delivery at local level

Stakeholder Engagement and Policy Advocacy



Courtesy of HKU Knowledge Exchange Fund

Demographic heterogeneity in total number of excess heat-related deaths: who are more vulnerable when facing the threat of heat wave



Courtesy of HKU Knowledge Exchange Fund

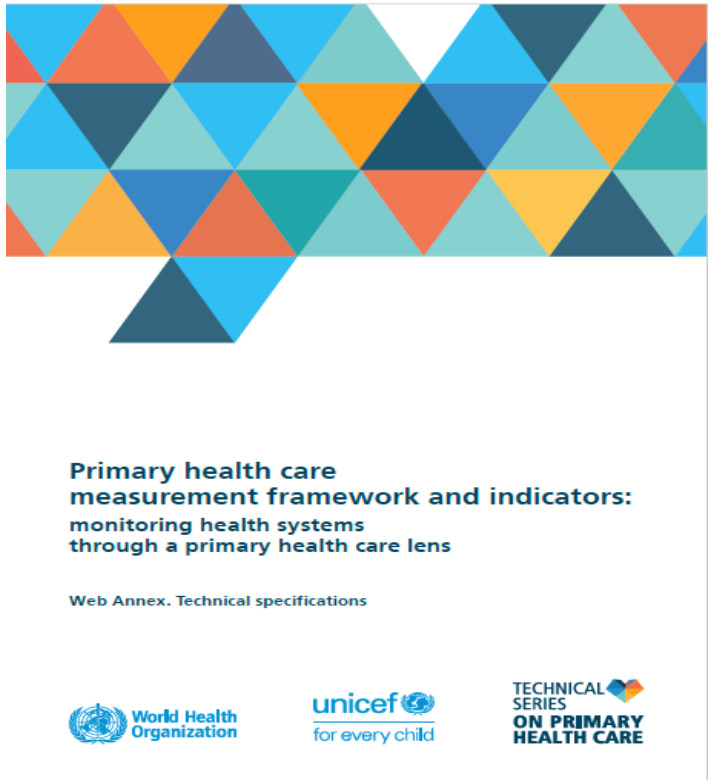
Stakeholder Convening and Policy Co-creation



Performance Assessment of Primary Health Care

phcpi

PRIMARY HEALTH CARE
PERFORMANCE INITIATIVE



What was PHCPI?



Partnership dedicated to **transforming the global state of primary health care**



Focused on **catalyzing improvement through better measurement of PHC**



Working with governments, development partners and international experts in PHC to achieve these goals

Led by:

Bill & Melinda Gates foundation

The World Bank
IBRD • IDA | World Bank Group

World Health Organization

unicef

The Global Fund
To Fight AIDS, Tuberculosis and Malaria

In partnership with:

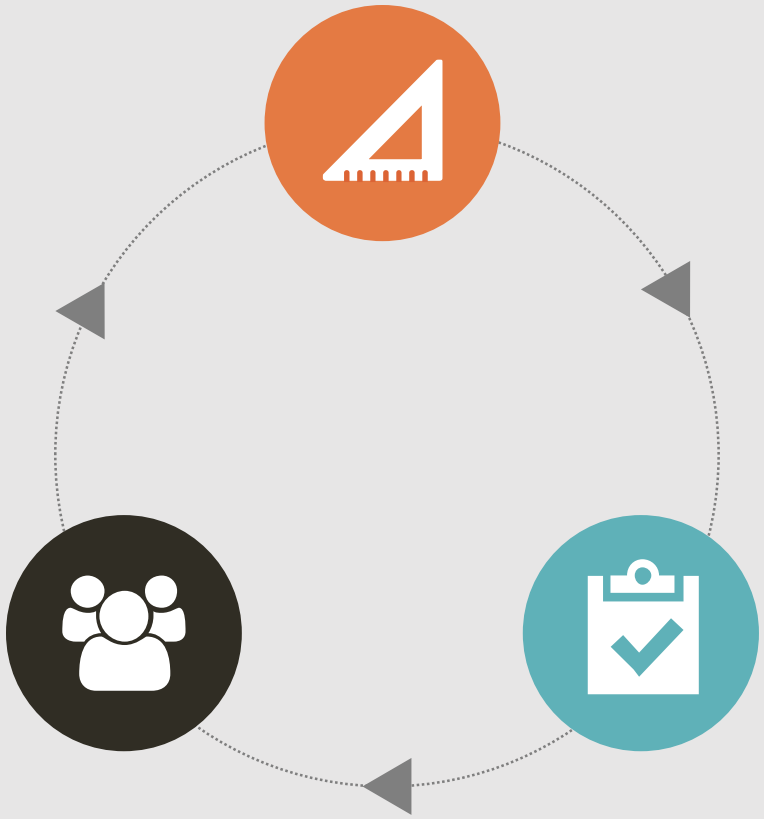
Ariadne Labs

Results for Development

The World Bank
IBRD • IDA | World Bank Group

How PHCPI worked

PHCPI worked with countries on:



Measurement for Decision-making

Identify gaps and inform country priorities based on existing PHC-specific data; more and better data for PHC

Performance Improvement

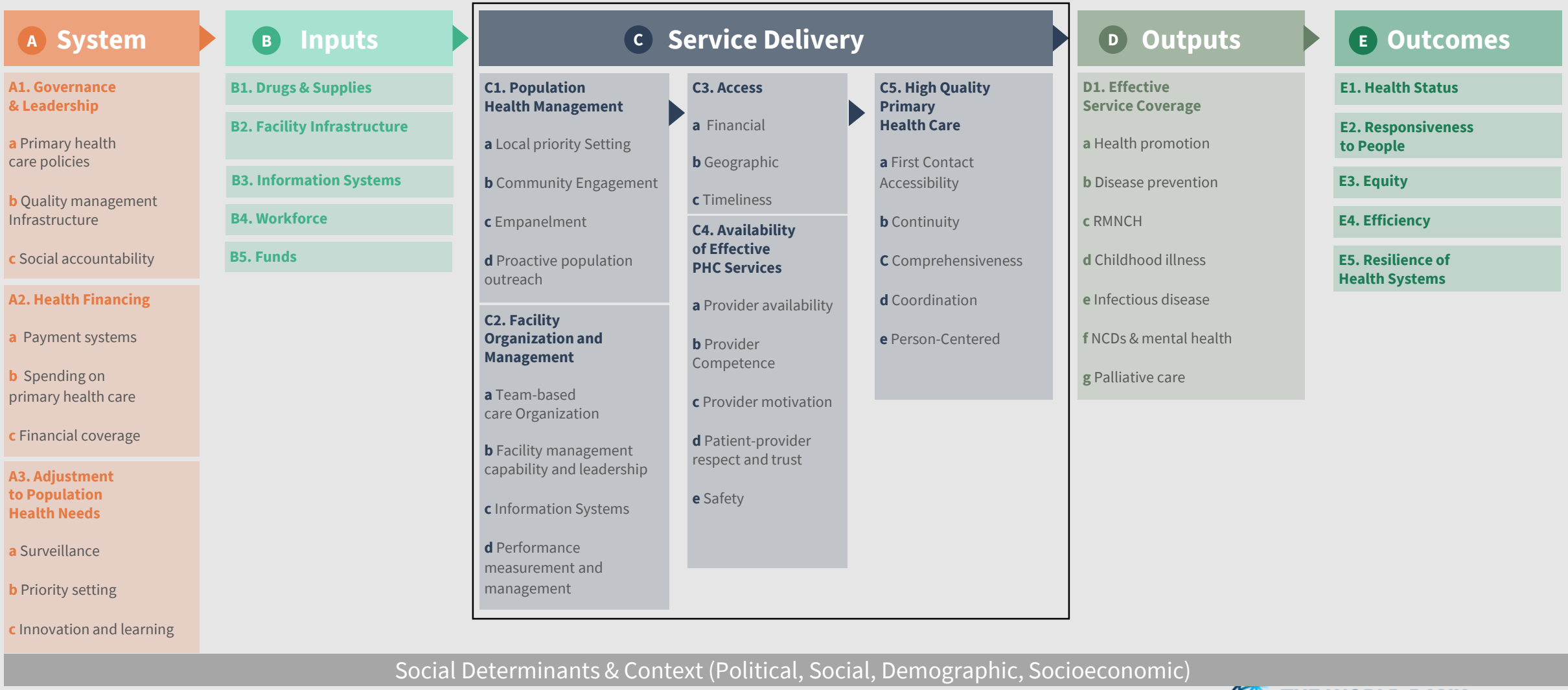
Curate and highlight global evidence about successful strategies for improving PHC systems and services.

Cross-Country Learning

Share data, knowledge, and experience with implementation among countries and global stakeholders.

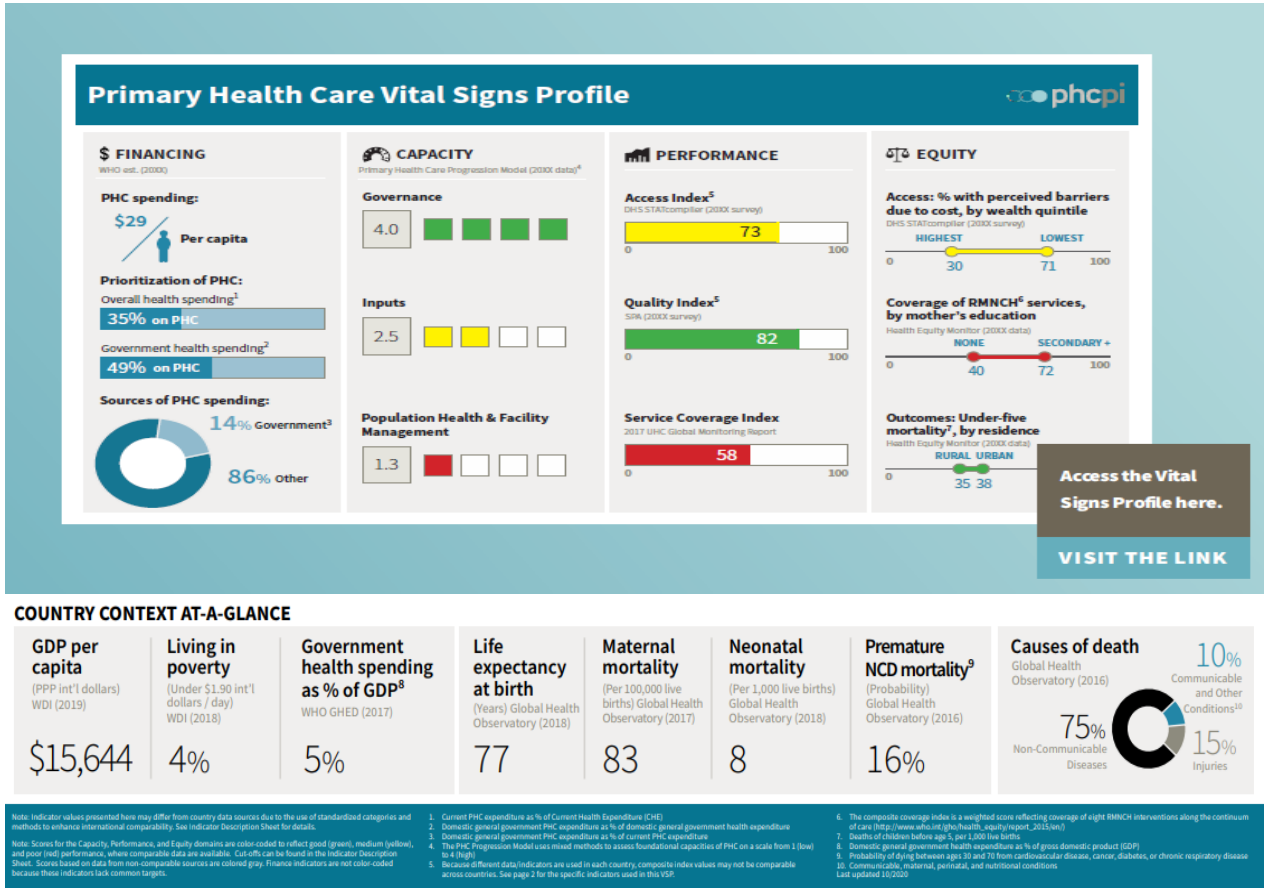
THE WORLD BANK
IBRD • IDA | WORLD BANK GROUP

The PHCPI framework for understanding PHC and guiding measurement approaches



THE WORLD BANK
IBRD • IDA | WORLD BANK GROUP

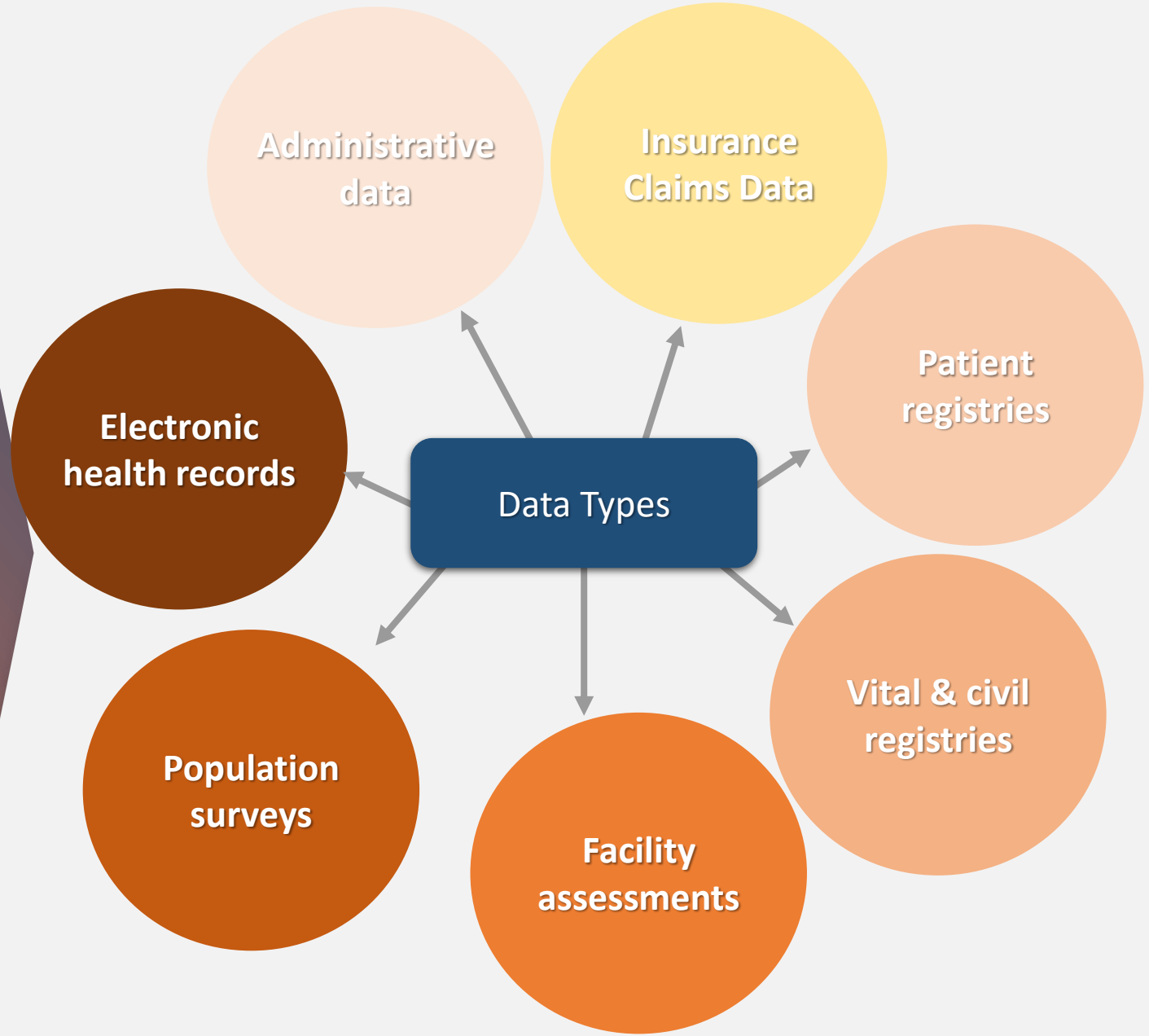
PHCPI - PHC Vital Signs Profile



Ariadne Labs - PHCPI. Measuring and Improving Primary Health Care: Tools from the Primary Health Care Performance Initiative A Reference Guide. Available in: measuring_and_improving_phc_tools_from_phcpi_a_reference_guide.pdf

What kind of data can be used?

What are the stakeholders to approach?



Assessment of Performance Pillars

ACCESS

Access includes measurements of financial barriers and geographic hardship due to distance, as well as the timeliness of care provided.

COUNTRY	SCORE	PERCENTAGE	SOURCE	YEAR
ACCESS	86			
Financial				
Perceived access barriers due to treatment costs*		92%	DHS STATcompiler	2016
Geographic				
Perceived access barriers due to distance*		80%	DHS STATcompiler	2016

These variables are transformed by subtracting the value from 100 when calculating summary scores.

QUALITY

Quality of care delivered is determined through measures organized around core principles proven to impact the quality of PHC service delivery at the point of care.

COUNTRY	SCORE	PERCENTAGE	SOURCE	YEAR
QUALITY	62			
Comprehensiveness				
Avg. availability of 5 tracer RMNCH services		65%	SPA	2015
Avg. availability of services for 3 tracer communicable diseas		56%	SPA	2015
Avg. availability of diagnosis & management for 3 tracer NCD		74%	SPA	2015
Continuity				
DTP3 dropout rate*		7%	WHO/ UNICEF	2016
Treatment success rate for new TB cases		91%	WHO TB Programme	2014
Person-Centeredness				
% of caregivers who were told sick child's diagnosis		63%	SPA	2015
Provider availability				
% of family planning, ANC, and sick child visits over 10 minut		63%	SPA	2015
Provider absence rate*		25%	SDI	2013
Provider Competence				
Antenatal care quality score		77%	SPA	2015
Family planning quality score		55%	SPA	2015
Sick child quality score		43%	SPA	2015
Adherence to clinical guidelines		69%	SDI	2013
Diagnostic accuracy		51%	SDI	2013
Safety				
Adequate waste disposal		89%	SPA	2015
Adequate infection control		95%	SPA	2014

These variables are transformed by subtracting the value from 100 when calculating summary scores.

SERVICE COVERAGE

Coverage looks at the effective application of a broad range of PHC-focused clinical services based on the UHC essential health services for the population in need of such services from the joint WHO/World Bank Group report in December 2017.

COUNTRY	SCORE	PERCENTAGE	SOURCE	YEAR
SERVICE COVERAGE	52			
Reproductive, Maternal, Newborn and Child Health				
Demand for family planning satisfied with modern methods		58%	UHC Global Monitoring Report	2017
Antenatal care coverage (4+ visits)		43%	UHC Global Monitoring Report	2017
Coverage of DTP3 immunization		89%	UHC Global Monitoring Report	2017
Care-seeking for suspected child pneumonia		34%	UHC Global Monitoring Report	2017
Infectious diseases				
Tuberculosis cases detected and treated with success		39%	UHC Global Monitoring Report	2017
People living with HIV receiving anti-retroviral treatment		45%	UHC Global Monitoring Report	2017
Use of insecticide-treated nets (ITN) for malaria prevention		52%	UHC Global Monitoring Report	2017
Children under 5 with diarrhea receiving ORS		32%	DHS STATcompiler	2016
Non-Communicable Diseases (NCDs)				
% of population with normal blood pressure***		58%	UHC Global Monitoring Report	2017

****Age-standardized (see detailed indicator descriptions). This is further scaled before use in the summary score.*

Equity

There are three representative indicators of equity in PHC on the VSP.
These cover the domains of access, coverage, and outcome measures.
The three indicators are:

Domain	Indicator	Disaggregation	Source
Access	Perceived barriers to care due to cost	Wealth Quintile (Q5-Q1)	DHS
Coverage	RMNCH Coverage Index	Mother's Education (At least secondary – none)	WHO Health Equity Monitor using DHS/MICS
Outcome	Under-five mortality	Place of Residence (Rural-Urban)	WHO Health Equity Monitor using DHS/MICS

The Reproductive, Maternal, Newborn and Child Health (RMNCH) Index, used in Countdown to 2030's routine reporting, covers reproductive, maternal and newborn health, as well as both preventive and curative interventions. It is described at www.countdown2015mnch.org and is a weighted average of eight RMNCH intervention indicators.

PHCPI – Key questions for key stakeholders (Progression Model)

Governance and leadership

- Do countries have evidence-based PHC policies and strategies in place?
- Are there effective governance structures to implement and enforce these PHC policies?
- Is there a robust quality management infrastructure for PHC, including quality policies and strategies, legislation and regulation, quality standards, and use of continuous quality improvement programmes and methods?
- Does the country have a system that formalises and ensures strong social accountability mechanisms, including the systematic engagement of private sector, civil society, non-governmental organisations, and non-health actors in the integrated planning and governance of PHC and public disclosure of performance?

Adjustment to population health needs

- Do countries have comprehensive and reliable surveillance systems in place to detect and respond to changing disease burden and emerging outbreaks?
- Are national health priorities set based on disease burden, health outcomes, and user needs?
- Does the PHC sector have a learning system that prioritises continual reflection and improvement?

Inputs

- Are key inputs—including drugs and supplies, facility infrastructure, information systems, health workforce, and funds at the facility level—available?
- Are they equitably distributed?
- Are they of sufficiently high quality to meet population health needs?

Ratcliffe, H. L., Schwarz, D., Hirschhorn, L. R., Cejas, C., Diallo, A., Garcia-Elorrio, E., ... & Bitton, A. (2019).

PHC Progression Model: a novel mixed-methods tool for measuring primary health care system capacity. BMJ global health, 4(5), e001822.

PHCPI – Key questions for key stakeholders (Progression Model)

Population health management

- Are local priorities evidence based and determined in collaboration with local communities and stakeholders?
- Do communities have input to and impact on the way that PHC is financed, governed, and implemented?
- Is a system of empanelment, or rostering, in place to ensure that the entire population is known to the health system and that specific service providers have responsibility for specific panels of patients?
- Does proactive population outreach occur to deliver essential health services to those in need?

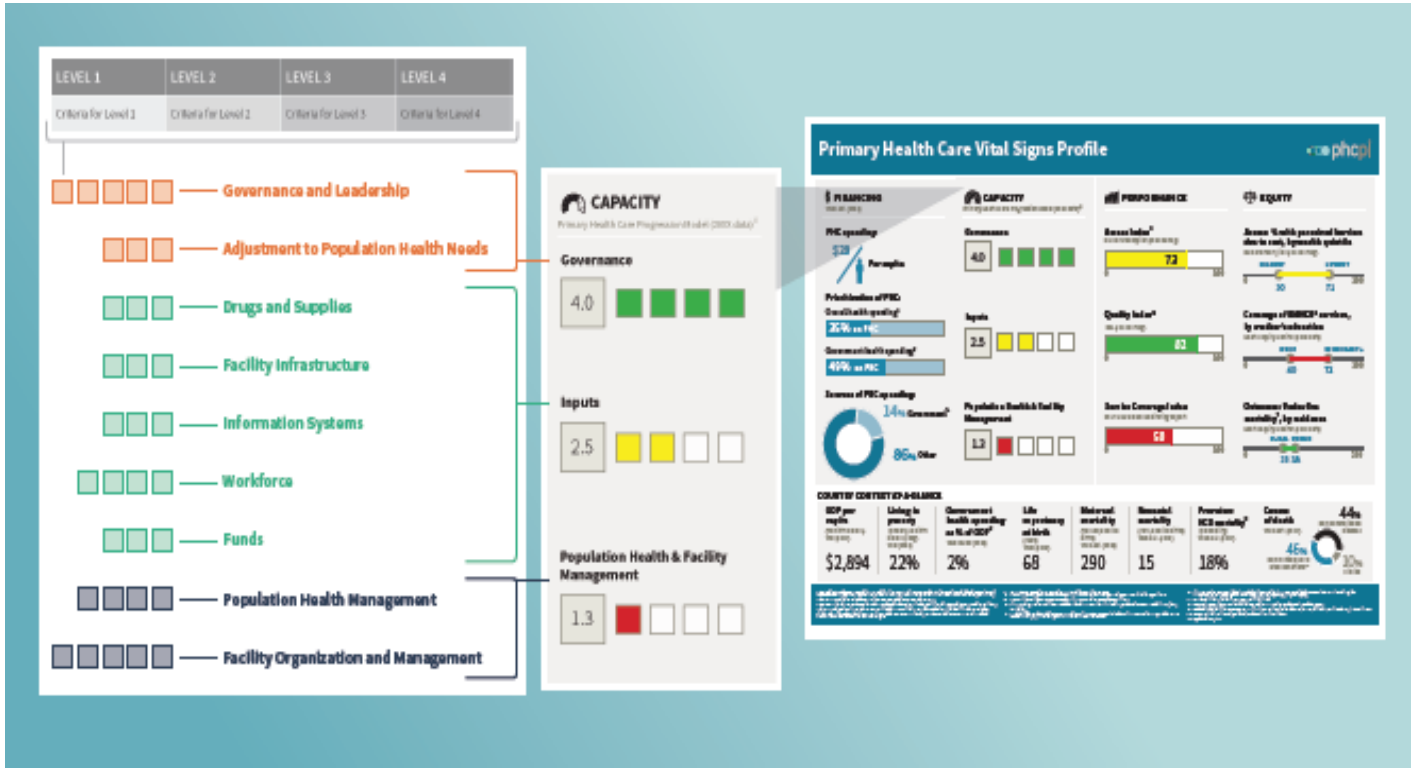
Facility organisation and management

- Are primary care services organised and delivered by effective provider teams, capable of ensuring comprehensive and coordinated care?
- Are facilities effectively led by managers with the ability to organise operations, motivate staff, and deploy resources?
- Do facilities set performance targets, have staff capacity to capture and use data at the point of care to monitor and improve performance, and implement quality improvement activities?
- Is supportive supervision routinely conducted?

Ratcliffe, H. L., Schwarz, D., Hirschhorn, L. R., Cejas, C., Diallo, A., Garcia-Elorrio, E., ... & Bitton, A. (2019).

PHC Progression Model: a novel mixed-methods tool for measuring primary health care system capacity. BMJ global health, 4(5), e001822.

PHCPI – Progression Model



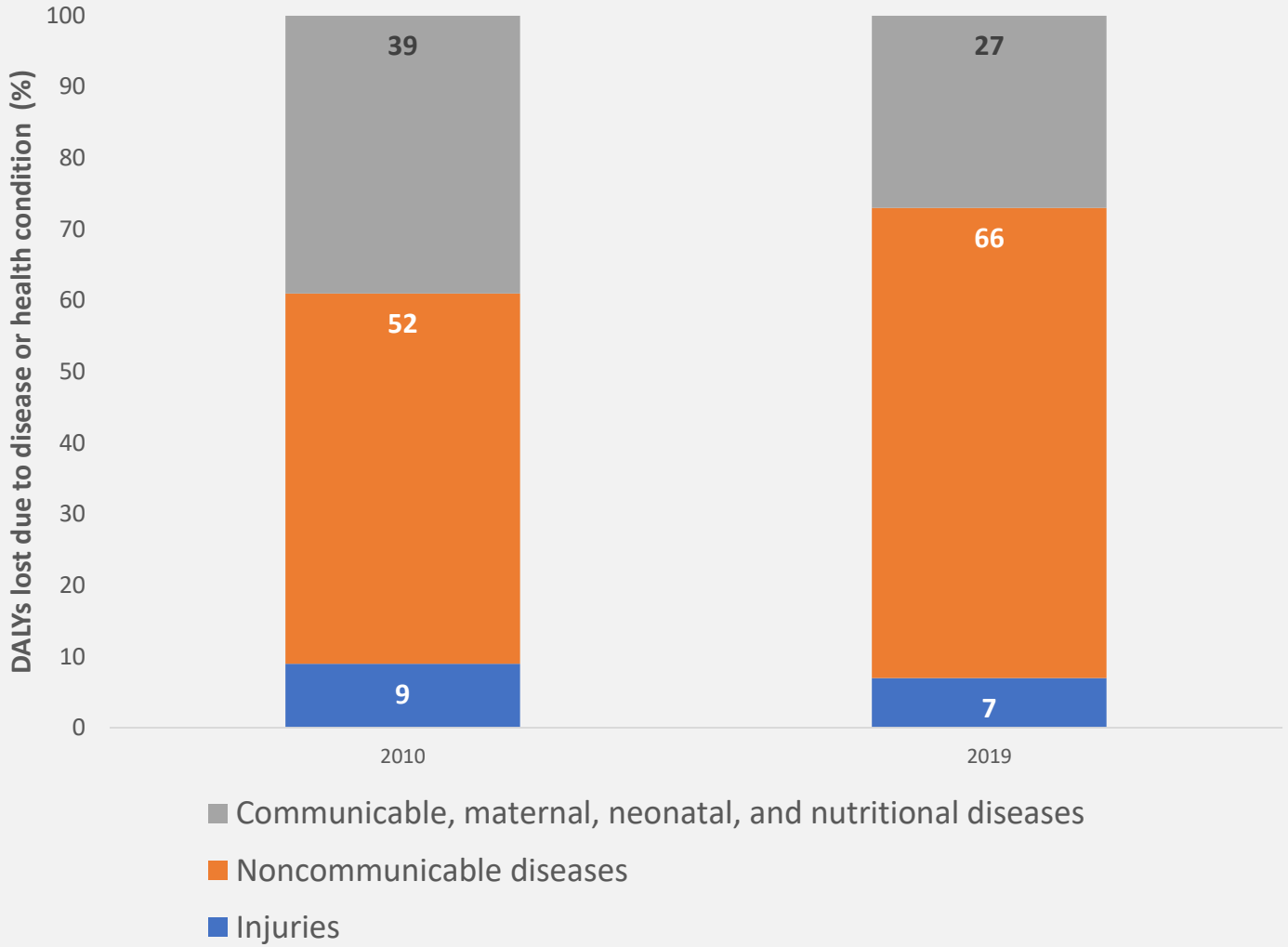
Ariadne Labs - PHCPI. Measuring and Improving Primary Health Care: Tools from the Primary Health Care Performance Initiative A Reference Guide. Available in: measuring_and_improving_phc_tools_from_phcpi_a_reference_guide.pdf

Examples of PHCPI metrics and sources of data

What is the burden of disease in my country?

In the last decade, Bangladesh has seen an important increase in the burden of Non-Communicable Diseases (NCDs)

Disability Adjusted Life Years Lost Due to Injuries, Noncommunicable Disease, and Communicable, Maternal, Neonatal, and Nutritional Diseases, 2010 and 2019 in Bangladesh



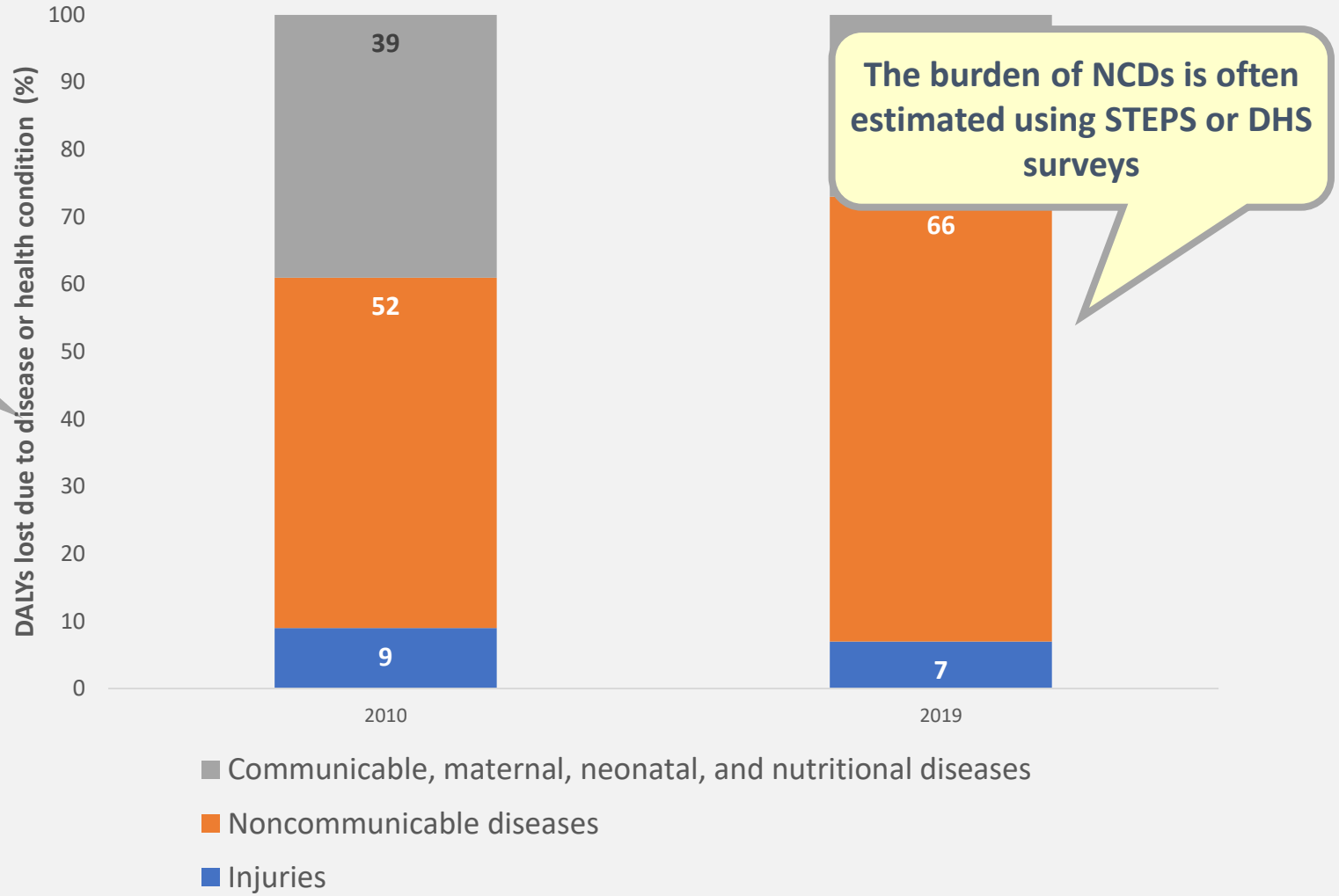
Source: IHME

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The burden of disease is calculated using routine or survey-based epidemiological data on illnesses, age and gender.

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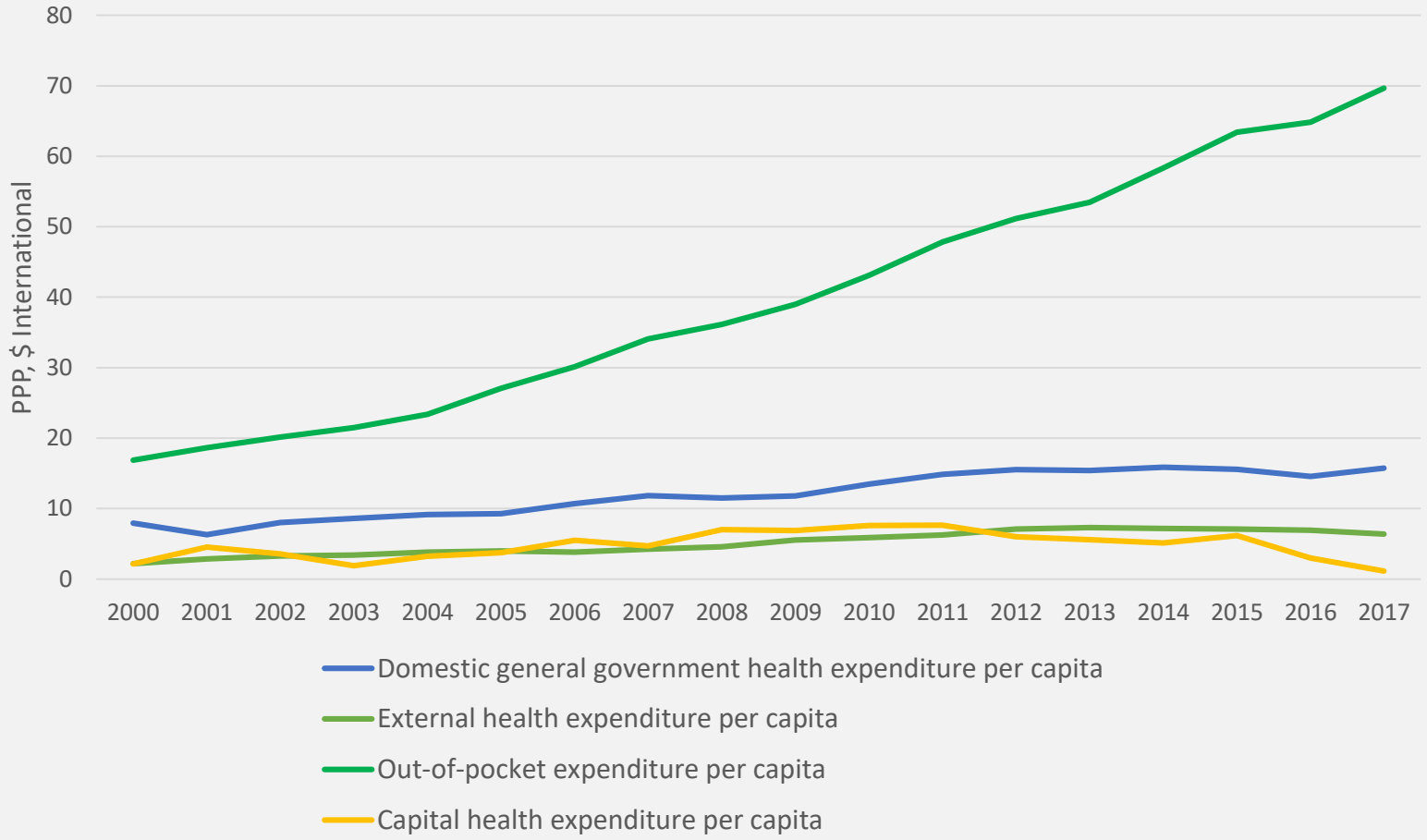
The burden of NCDs is often estimated using STEPS or DHS surveys

Source: IHME

How well is my system protecting people from out-of-pocket expenditures?

In Bangladesh, out-of-pocket expenditures have increased rapidly in the last decades compared to government and external expenditures on health.

Evolution of Health Expenditures by Revenue Source in Bangladesh (2000-2017)

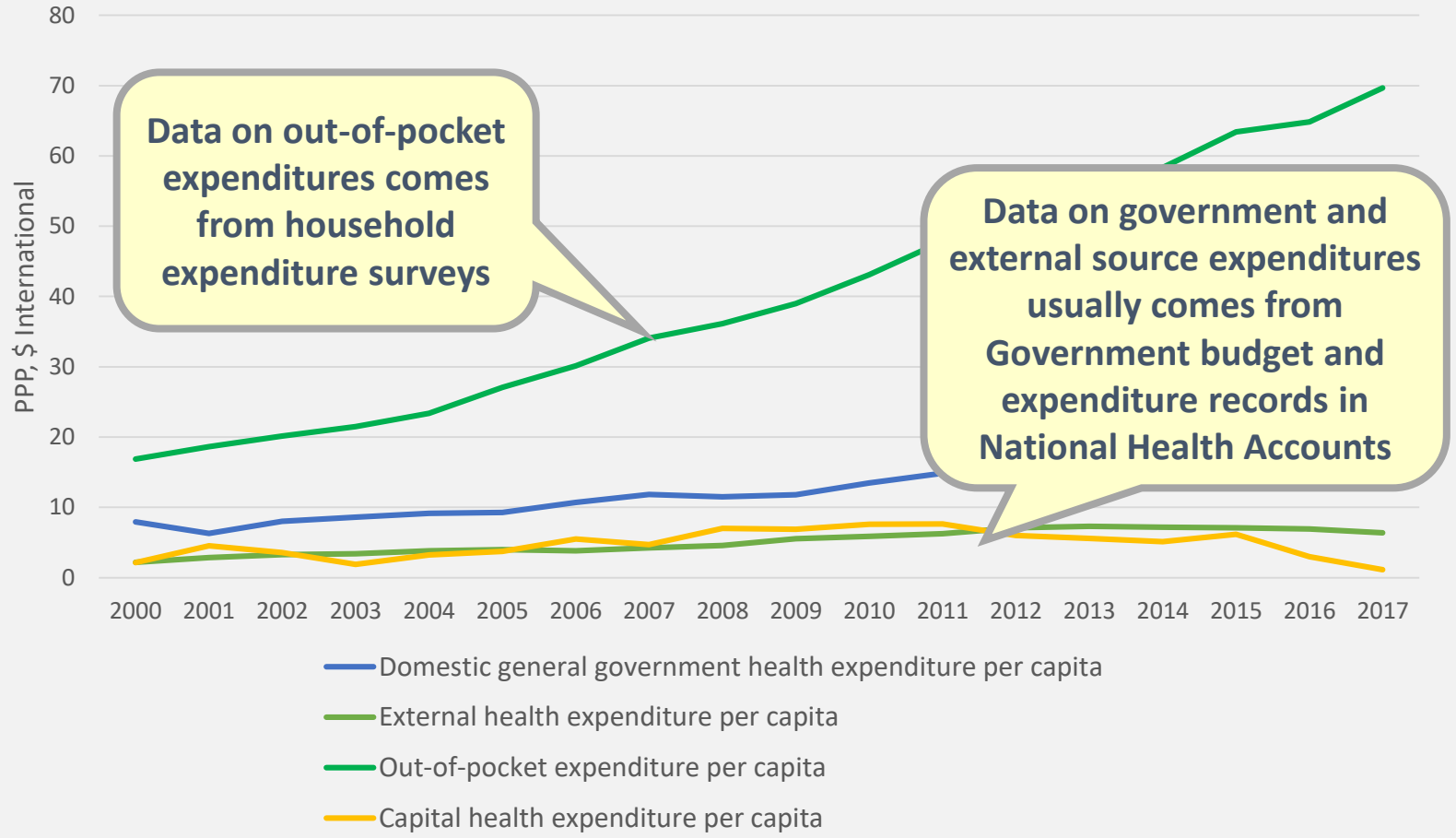


Source: World Development Indicators

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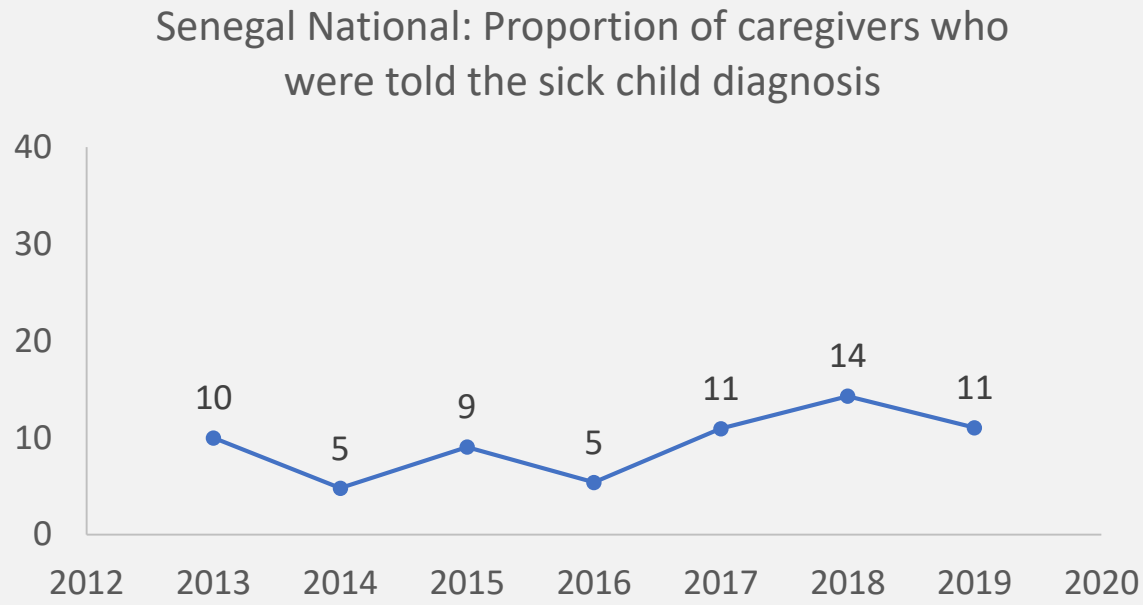
Changes in Health Expenditures by Revenue Source, 2000 to 2017 in Bangladesh

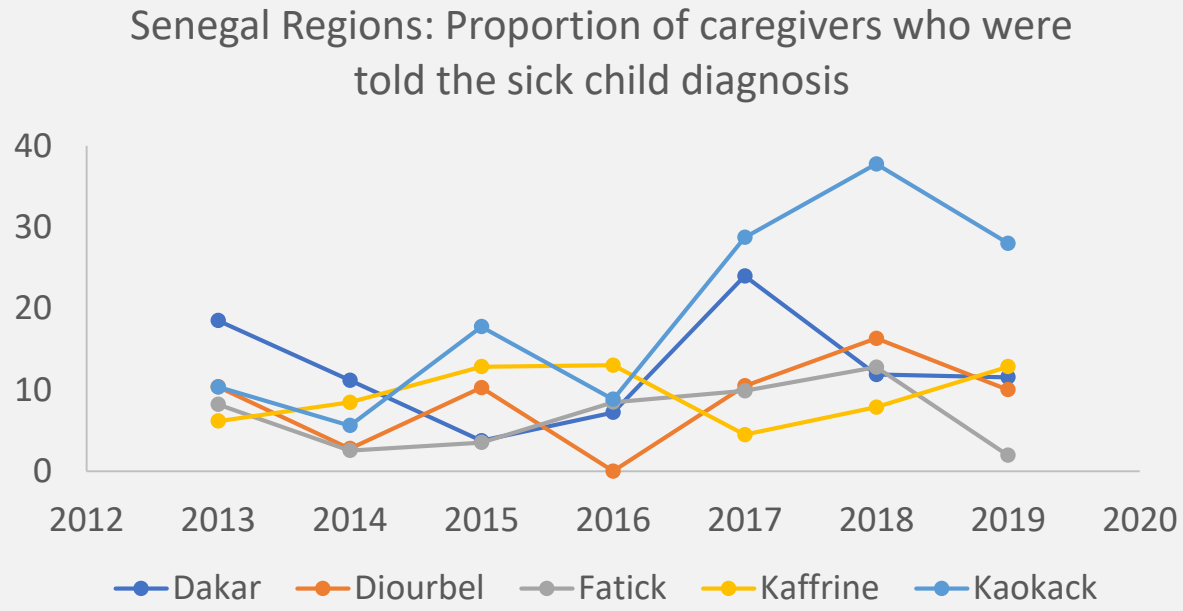


Source: World Development Indicators

Are health care workers in my country providing patient-centered care?

Between 2013 and 2019, Senegal saw only a **slight change** in the percentage of caregivers who were told the sick child diagnosis. There are important **differences across regions**.





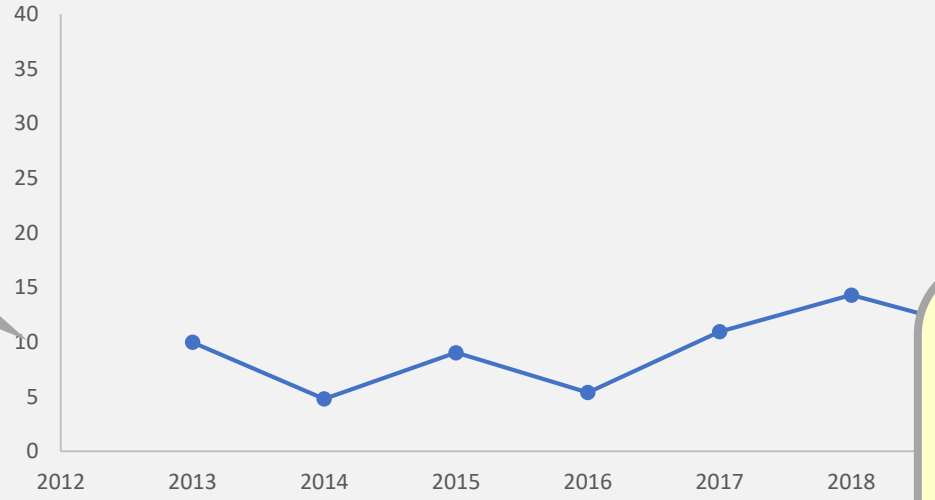
Source: SPA 2013-2019

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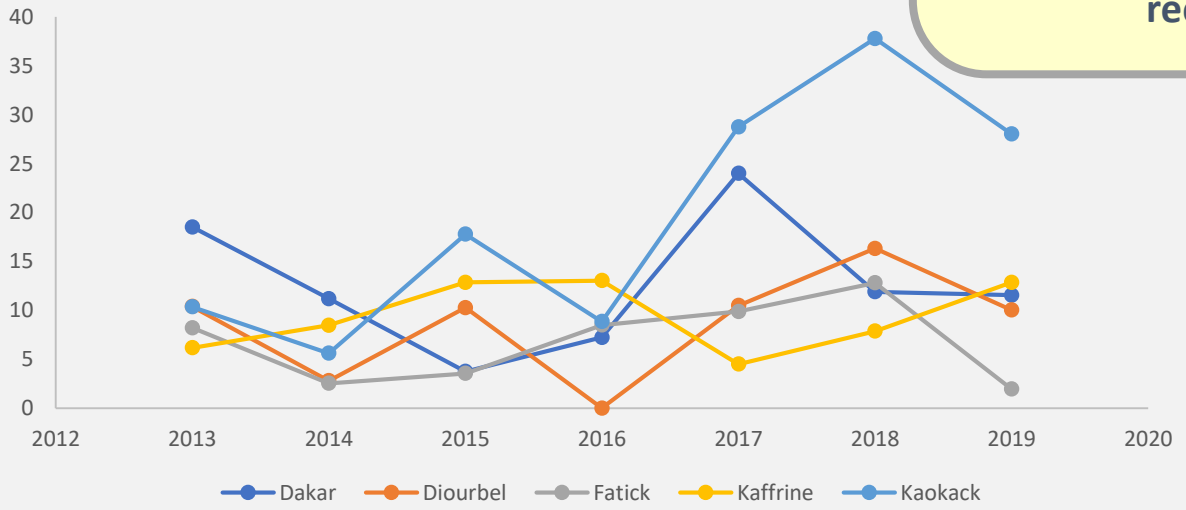
Between 2013 and 2019, Senegal saw only a **slight change** in the percentage of caregivers who were told the sick child diagnosis. There are important **differences across regions**.

Proportion of caregivers who were told the sick child diagnosis is used as a proxy for person-centered care

Senegal National: Proportion of caregivers who were told the sick child diagnosis



Senegal Regions: Proportion of caregivers who wer sick child diagnosis

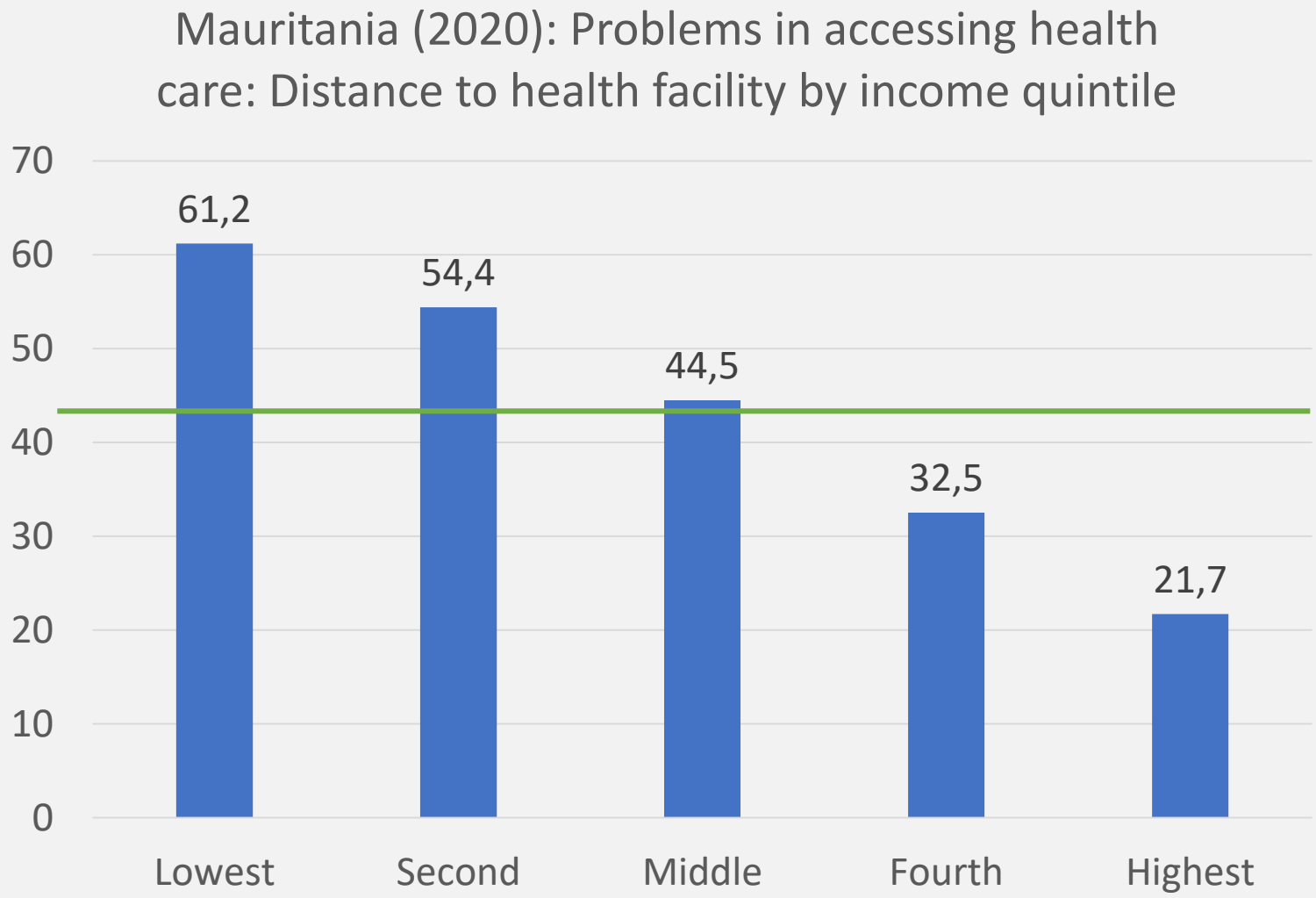


Proportion of caregivers who were told the sick child diagnosis is estimated using facility surveys that observe consultations or that ask patients about the care they received

Source: SPA 2013-2019

Does the population have access to health services when they need?

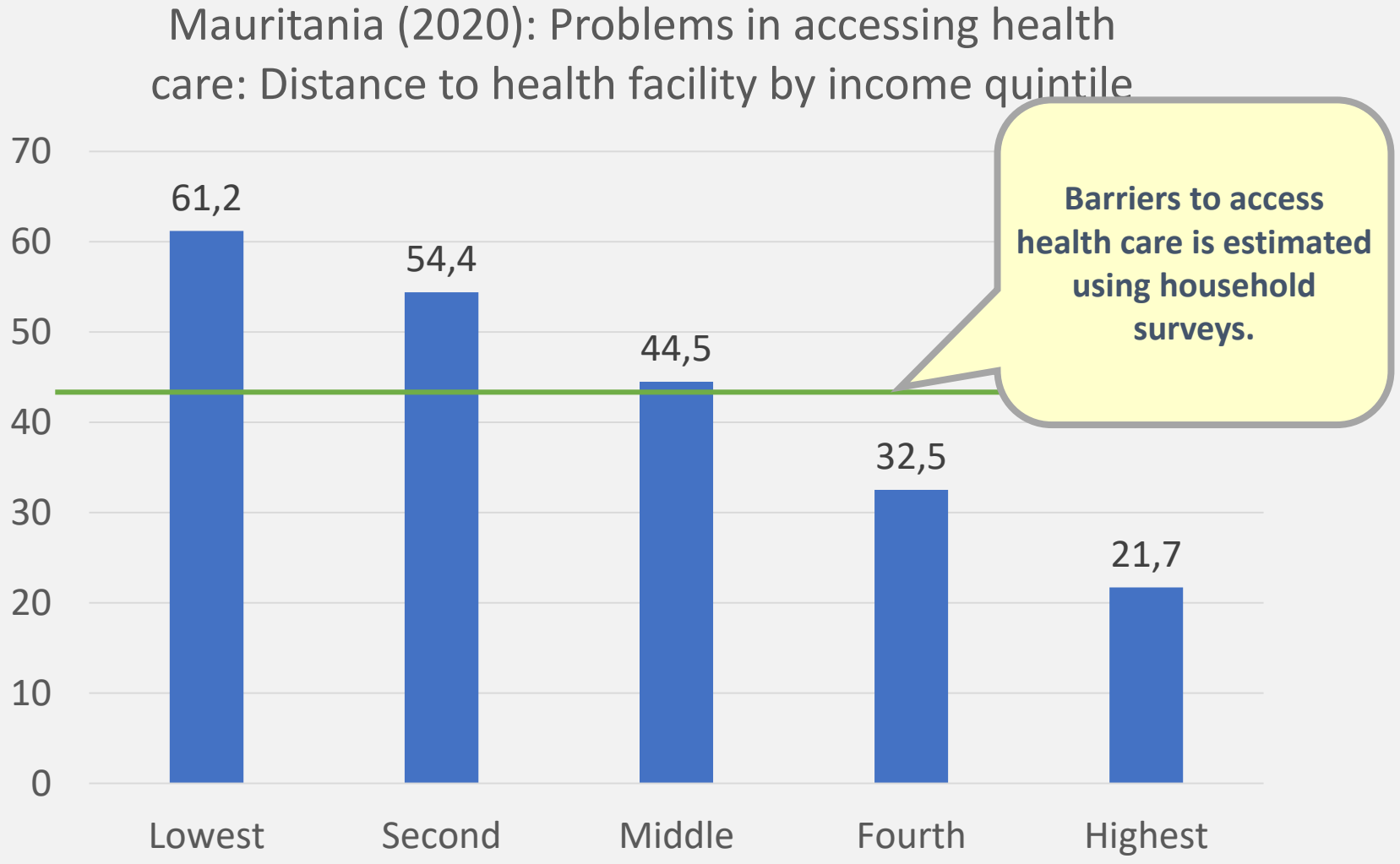
In Mauritania, 41% of women report problems in accessing health care when in need, because of distance. Those in the lowest income quintile face 3X the barriers to access that the wealthiest face.



Source: Demographic and Health Survey 2020

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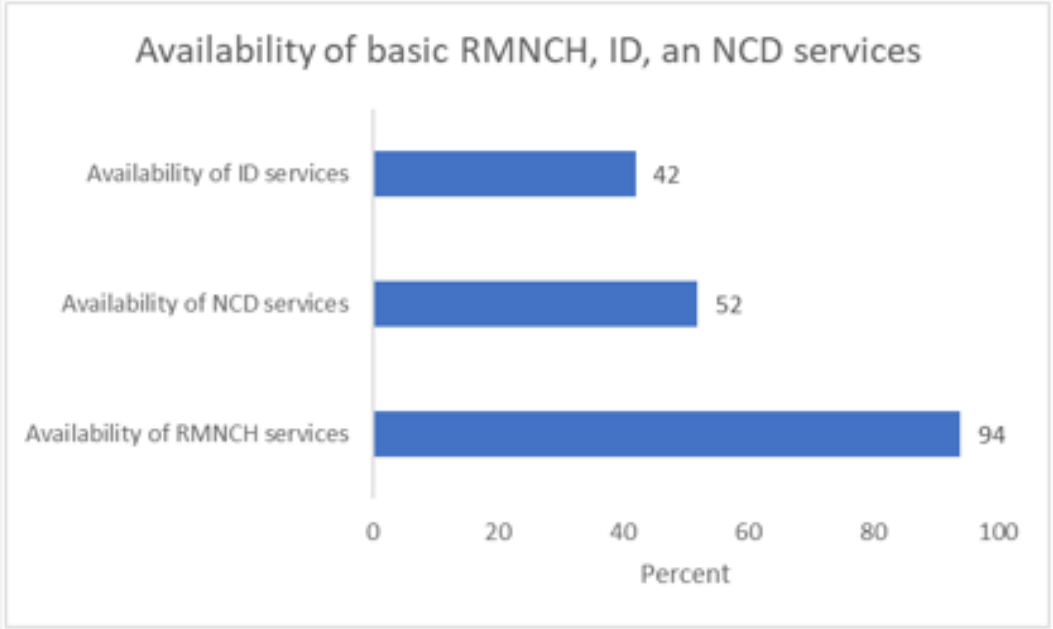


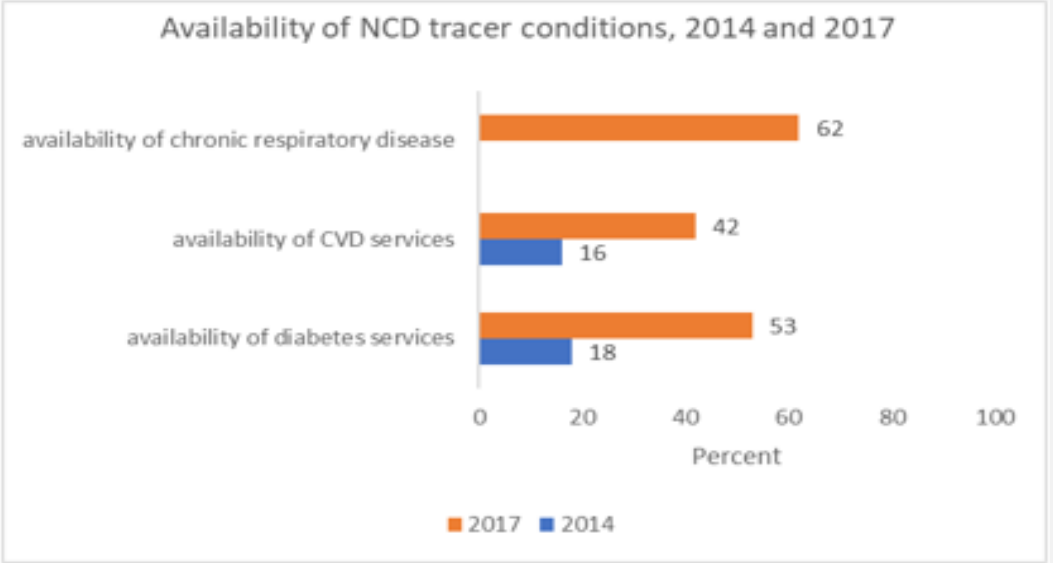
Source: Demographic and Health Survey 2020

Are facilities delivering the services that my population needs?

In Bangladesh, only half of all facilities have NCD services available; this has improved since 2014 but more efforts will be necessary

Availability of services in health facilities across Bangladesh



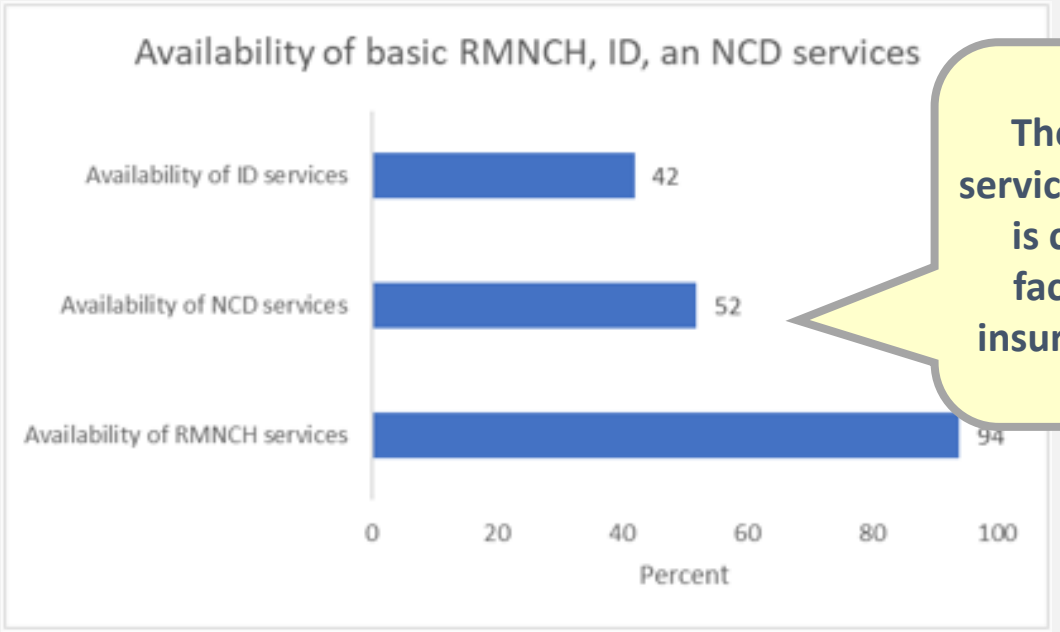


Source: Service Provision Assessment Survey

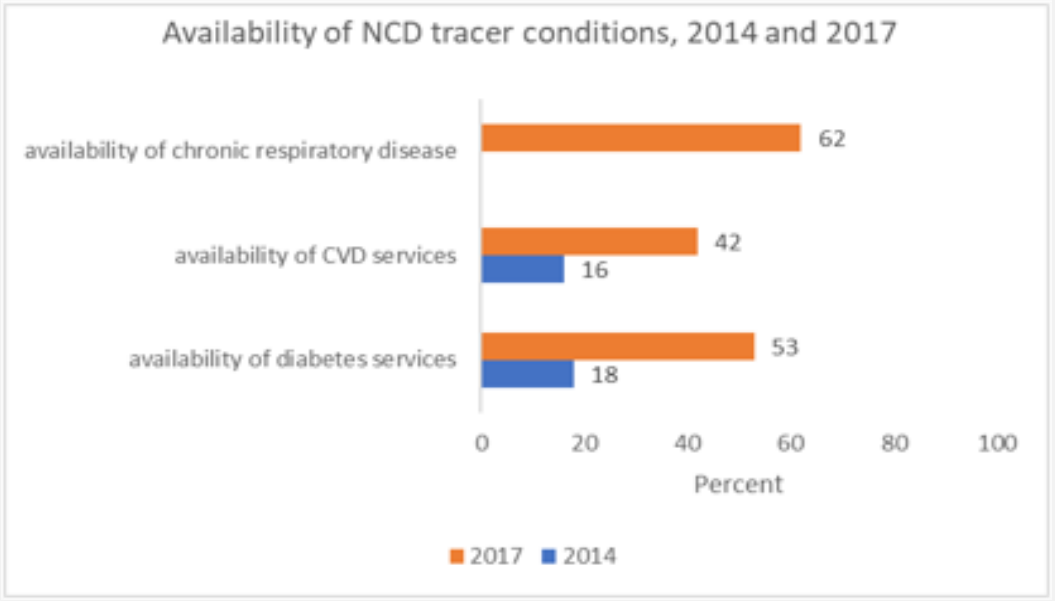
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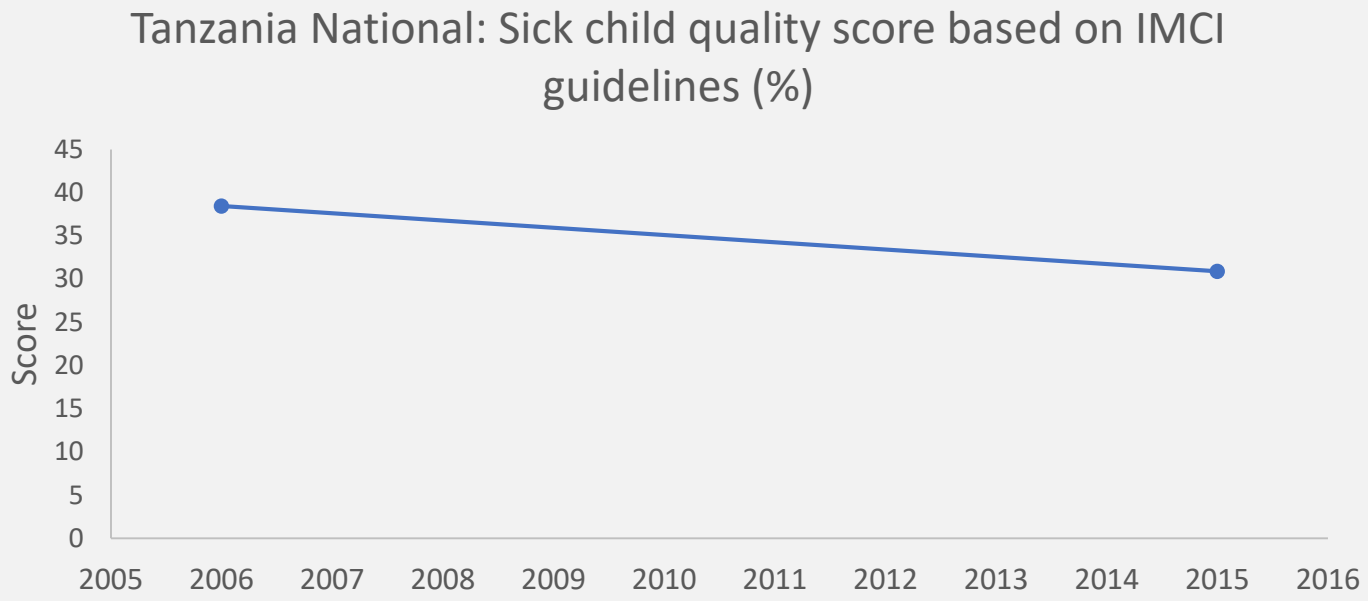
The availability of services across facilities is calculated from facility surveys or insurance claims data

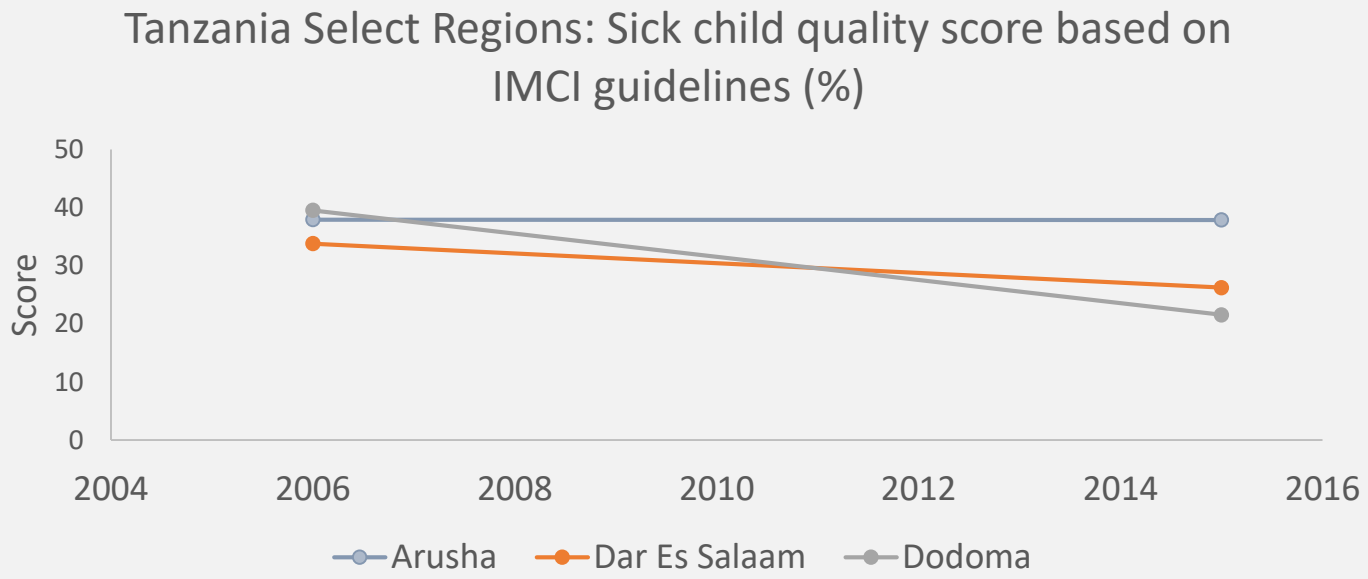


Source: Service Provision Assessment Survey

When patients receive care, is it of high quality?

In Tanzania, between 2006 and 2016, health worker's adherence to IMCI guidelines for sick children declined to a score of 30%. The difference is due to lower competence providers in some regions but not all.



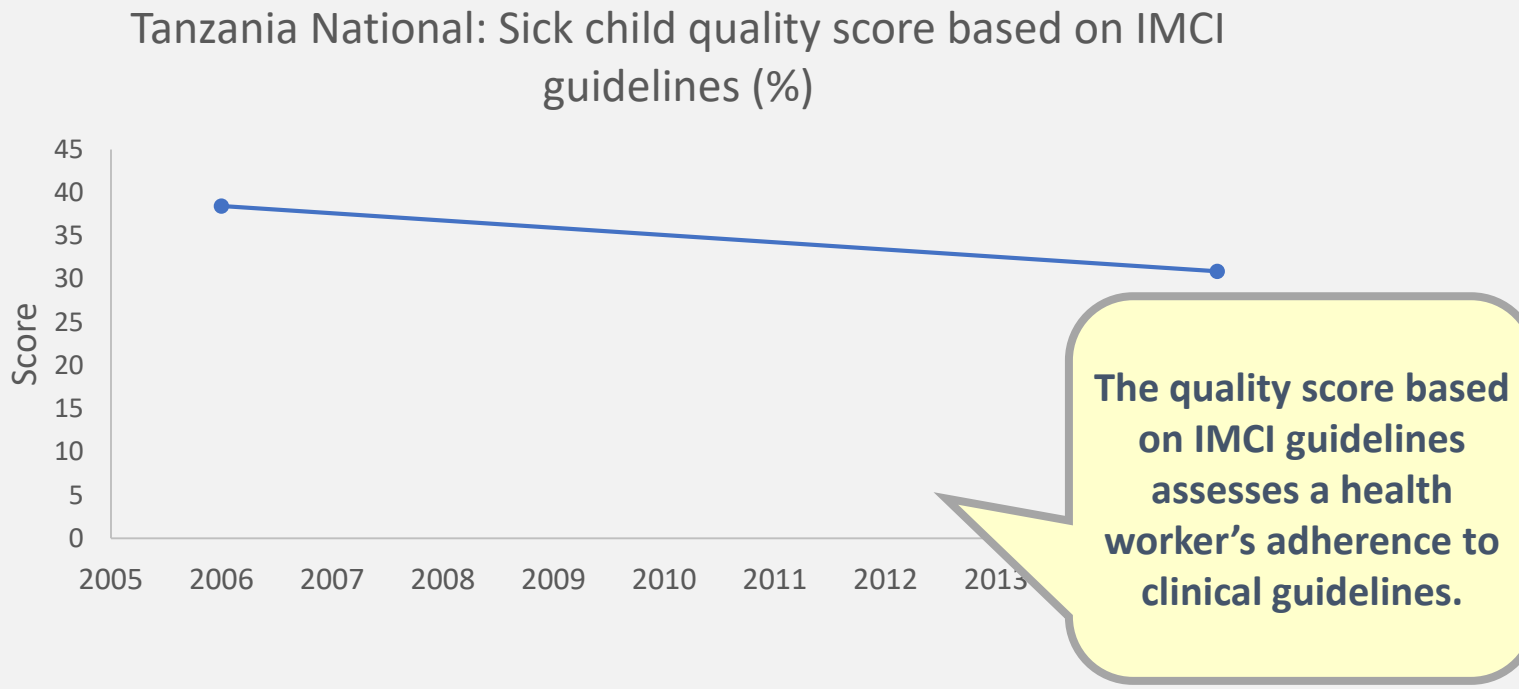


Source: Service Provision Assessment Survey (2006 & 2015)

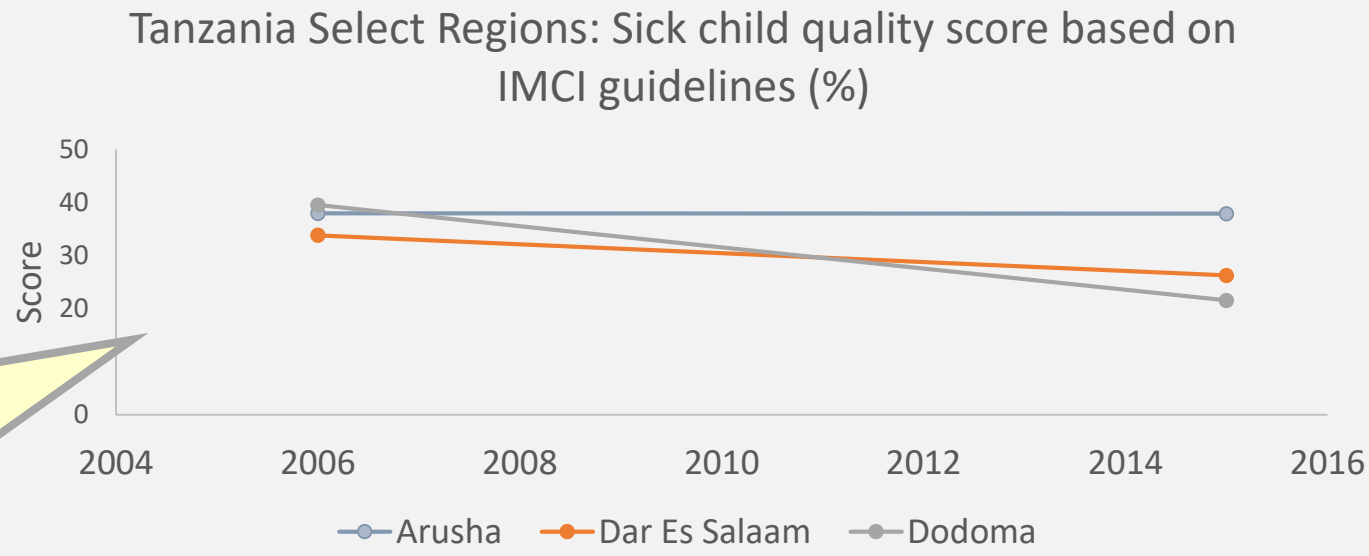
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The quality score based on IMCI guidelines assesses a health worker's adherence to clinical guidelines.



Adherence to clinical guidelines is estimated using health facility surveys where enumerators observe a patient's consultation.

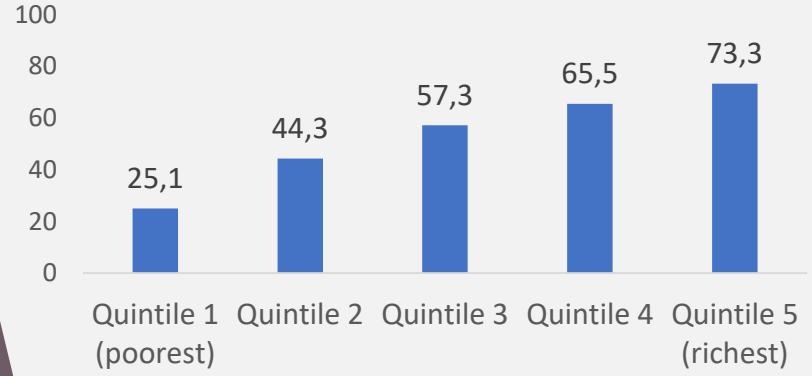
Source: Service Provision Assessment Survey (2006 & 2015)

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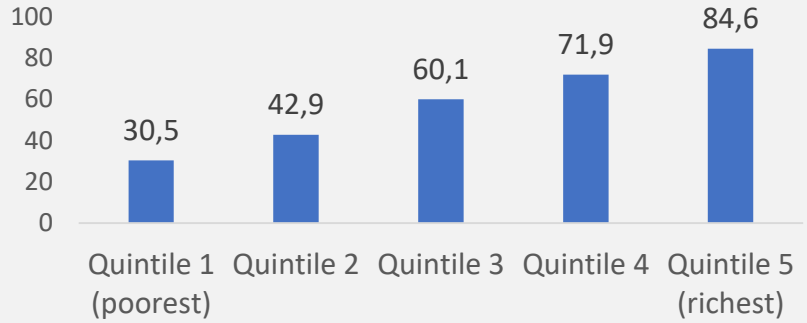
How equitably are services provided in my country?

In both India and Nigeria, persons of lower income or lower level of education are less likely to receive the care they need than compared to wealthier or more educated persons.

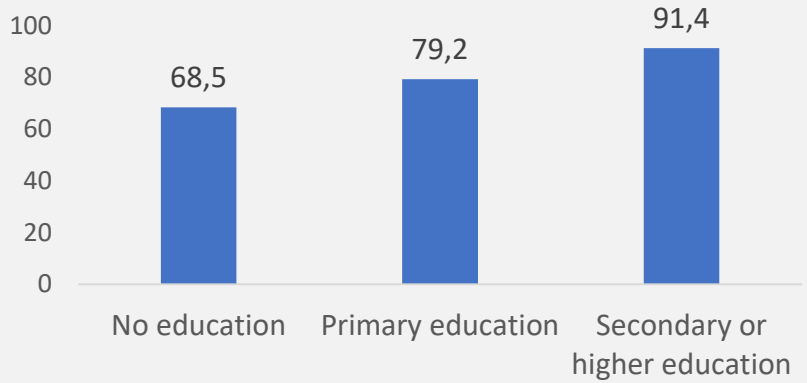
India 2015: Antenatal care coverage - at least four visits (%) (in the two or three years preceding the survey)



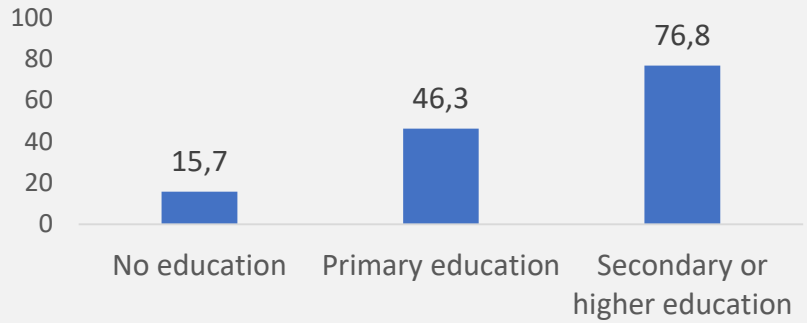
Nigeria 2018: Antenatal care coverage - at least four visits (%) (in the two or three years preceding the survey)



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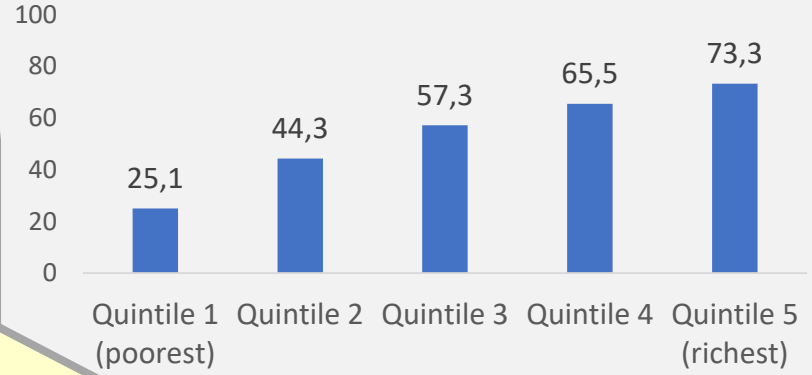
Source: Demographic and Health Survey

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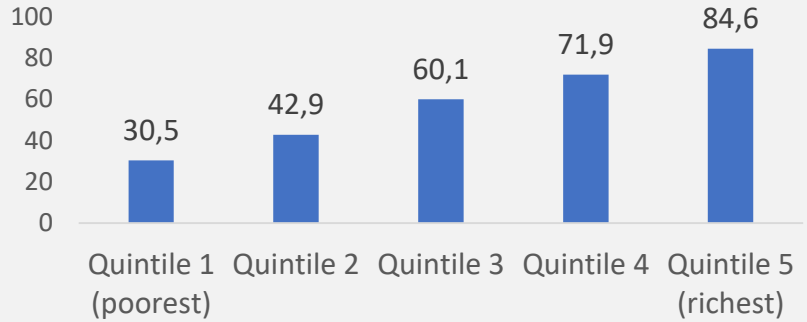
Equity in health service coverage is often estimated using household surveys. Administrative data and claims data can also be used to assess equity.

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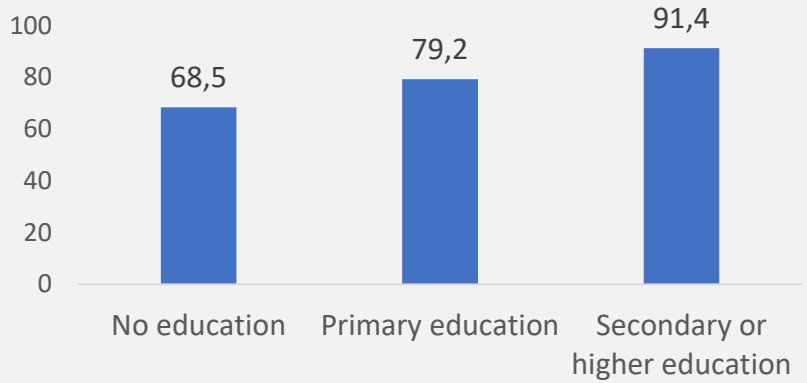
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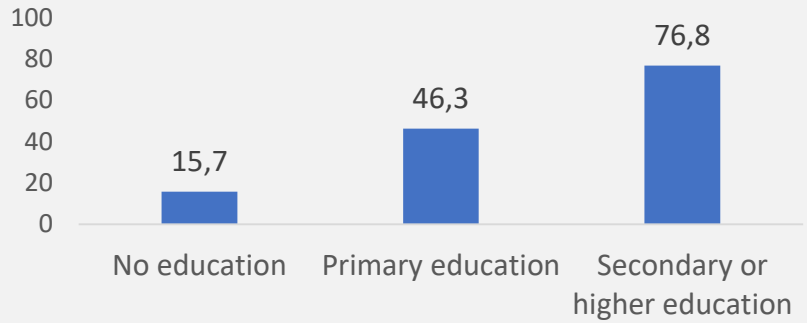
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Source: Demographic and Health Survey

Key takeaway messages

- Multi-stakeholder engagement and community involvement are key for effective, sustainable and equitable PHC policy development, implementation and evaluation.
- Policy implementation comprising community empowerment and intersectoral coordination leads to better health outcomes, transparency, accountability, inclusiveness and sense of belonging.

- The Collective Impact is an effective approach to meaningfully engage multiple stakeholders towards the attainment of common goals, applicable in PHC policy:
  - Strong political will and evidence-informed advocacy are crucial for success.
  - Setting a common agenda and having a lead body are fundamental to ensure collaborative efforts.
  - Information systems and continuous monitoring, evaluation, and adaptation are key to ensure sustainability and continuous improvement.



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