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PHC Measurement &Improvement

Brief guide to implementation of the Primary Health Care Measurement and Improvement Initiative (PHCMI)

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1. Introduction

In 2018, a Global Conference on Primary Health Care took place in Astana, Kazakhstan, co-hosted by the Government of Kazakhstan, WHO and UNICEF. It brought together 2050 delegates from 147 countries. Its aim was to commemorate the 40th anniversary of the Alma-Ata Declaration and renew political commitment to strengthening primary health care (PHC) as the foundation of universal health coverage (UHC) and essential to progress towards the Sustainable Development Goals. It explored the whole-of-government approach to advancing primary health care.

The Declaration of Astana was unanimously endorsed by Member States and made pledges in four key areas:

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

To transform these commitments into action, the WHO Regional Office for the Eastern Mediterranean launched the Primary Health Care Measurement and Improvement Initiative (PHCMI), supported by the Bill & Melinda Gates Foundation, UNICEF and the World Organization of Family Doctors (WONCA),[1] in April 2019.

The objectives of PHCMI are to:

- develop a common language/framework through which to explain the process of PHC strengthening;
- identify and aggregate data that assess key aspects of PHC;
- create tools, such as PHC Country Profiles and Vital Signs profiles,[2] that policy-makers, development partners and advocates can use to better assess and improve PHC services;
- highlight progress, and identify key challenges to improving PHC performance;
- develop PHC improvement plans and strategies as part of routine policy, planning, management, supervision and service delivery processes.

[1] WONCA is an acronym comprising the first five initials of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. WONCA's short name is World Organization of Family Doctors.

[2] To learn more about preparing a Vital Signs Profile visit: https://improvingphc.org/preparing-Vital-Signs-profile-step-step-process-guide, accessed 12 August 2020.

PHCMI is built on the global Primary Health Care Performance Initiative (PHCPI),[3] the PHC operational framework,[4] existing regional efforts to strengthen PHC services, PHC quality indicators and the WHO regional health system profile[5].

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

1.1 About this guide

PHCMI comprises three phases:

1. Planning
2. Measurement
3. Improvement

This guide has been developed to provide guidance to stakeholders and key players involved in the planning and measurement phases of PHCMI in low- and middle-income countries of WHO's Eastern Mediterranean Region. It focuses primarily on the planning and measurement phases and describes the necessary steps and processes through which to ensure effective planning, objectively assess current PHC services and collect accurate data. It also highlights the importance of compiling detailed documentation that outlines key findings and policy recommendations for improving PHC services in a country.

This document is based on the experience of the three pilot countries – Egypt, Jordan and Pakistan – and is informed by their experiences. Pilot countries were chosen based on the diversity of their PHC systems and their willingness to participate in the pilot. Each country worked closely with WHO Regional Office and headquarters throughout each phase tracking and using data to inform development of strategies to improve PHC services in their respective countries.

[3] The Primary Health Care Performance Initiative is a partnership of policy-makers, health systems managers, advocates and others who are dedicated to improving the global state of primary health care in low- and middle-income countries. PHCPI is a partnership between the Bill & Melinda Gates Foundation, UNICEF, World Bank Group, and World Health Organization, with technical partners Ariadne Labs and Results for Development (https://improvingphc.org/, accessed 12 August 2020).

[4] Primary health care: transforming vision into action. Operational framework outlines a series of levers that can be actioned to align health systems according to a PHC approach. The Operational Framework is currently undergoing review by Member States and a final version is anticipated to be presented for endorsement in 2020 (https://www.who.int/docs/default-source/primary-health-care-conference/operational-framework.pdf?sfvrsn=6e73ae2a_2, accessed 12 August 2020).

2. Planning for PHCMI implementation

2.1 Conducting a stakeholder analysis

Countries need to conduct a thorough stakeholder analysis as the first step in implementation of PHCMI, following approval from the minister of health to commence the initiative. A stakeholder analysis systematically gathers and analyses qualitative information to determine whose interests should be taken into account when implementing a policy or programme.

In the context of the PHCMI Initiative, a stakeholder is an individual, such as a policy-maker, or group, such as a patient advocacy group, with an interest in improving PHC services. Stakeholder analysis yields useful information about these key individuals and groups that can be used to provide input for other analyses, develop action plans to increase support for reform policy and guide a participatory, consensus-building process. For PHCMI, stakeholders may include representatives of ministries of health, health system/PHC focal points at WHO country offices, officials from national information centres and data repositories, academicians, practitioner organizations, United Nations agencies, civil society organizations, nongovernmental organizations and private sector organizations.

The stakeholder analysis will assess the anticipated impact of the PHCMI project on existing PHC services and evaluate the potential contribution of key stakeholders to the success of the initiative. This evaluation is critical to ensuring the collection of accurate data and highlighting potential data gaps. Accurate data are a critical component of the measurement phase of PHCMI.

Following identification of relevant stakeholders, it is important to thoroughly brief them on the goals and the aims of PHCMI to ensure that they have a clear understanding of the processes needed to implement the initiative.

The level of involvement of stakeholders will vary throughout the project depending on the tasks and deliverables of each phase, and accordingly, subsequent situational analyses should be conducted at various stages to identify and realign the roles of each stakeholder.

2.2 Defining scope of the assessment

During the planning phase, the desired outcomes and objectives of the assessment, its scope and any parameters must be clearly defined.

The outcomes and objectives of an assessment include:

- completion of a situational analysis of PHC services in the country based on data collection using PHCMI indicators;
- verification of PHC data;
- completion of PHC Country Profiles and Vital Signs Profiles;
- use of key findings to inform the improvement phase.

Countries need to consider which financial and human resources are needed to fulfil the objectives of the PHCMI initiative, in addition to any time constraints.

Financial costs will include recruitment of a PHCMI focal point who may be an individual from within or outside the ministry of health to carry out quantitative and qualitative data collection. Human resources may also include other individuals whose involvement is necessary in this process, including, but not limited to additional staff from the ministry of health or WHO country office or another United Nations agency. Depending on the country context, it may also include staff from national information or data centres.

These individuals will form a technical assessment team and will be responsible for conducting the situation analysis of PHC services within the country, with technical and financial support from WHO. The team will define the scope and any parameters of the assessment, verify the PHC data and complete the PHC Country Profiles and Vital Signs Profiles. The key findings arising from the assessment will inform the improvement phase and the assessment team will provide regular updates to a steering committee.

Additional financial resources will be required to cover the transportation costs involved in the data collection process. A comprehensive budget needs to be developed to determine anticipated financial costs prior to project commencement.

Additional parameters to be considered when developing the team's workplan include the timing of any planned meetings, as well as external events such as holidays and planned leave of team members.

In determining the scope of the assessment other factors also need to be considered, such as what is the definition of a PHC facility in the country context and will data on migrant and refugee populations, for example, be included.

In addition to planning for quantitative data collection, special consideration should be given to qualitative data collection. The PHC Progression Model is a mixed-methods assessment tool used to populate the Capacity pillar of the Vital Signs Profile.[6] The aim of the assessment is to measure core PHC capacities, such as governance, inputs and management of population health. The Progression Model assessments rely on document review, quantitative data extraction and key informant interviews to yield an objective, comparable assessment of PHC capacity. The whole process should last between three and four months, which may be done in parallel with, or following, the quantitative assessment. As part of the overall workplan, time should be devoted to receiving training on the tool and conducting the qualitative assessment with all relevant members of the team.

[6] The "capacity" of a Primary Health Care (PHC) system refers to the foundational properties of the system that enable it to deliver high quality PHC. The Capacity pillar of the Vital Signs Profile provides information that can answer questions like, "does your system have the policies, infrastructure and other physical and human resources to deliver primary health care?" and "Are the fundamentals of PHC service delivery – such as strong population health management and effective facility management – in place?", taken from: https://improvingphc.org/primary-health-care-progression-model, accessed 12 August 2020.

2.3 Establishing an assessment team

Effective communication and collaboration between all stakeholders is critical to the success of PHCMI implementation and to ensure its success a team of highly committed members from the different entities should be established at the onset of the project.

Team members include:

- WHO health services delivery focal point
- PHCMI country focal point
- ministry of health focal point
- other stakeholders/partners (United Nations agencies, academicians, civil society organizations, nongovernmental organizations)
- staff of the WHO Regional Office for the Eastern Mediterranean.

The first step is the identification of a health service delivery focal point in the WHO country office. This focal point will, in turn, identify a PHCMI focal point in the country office, or alternatively, the ministry of health will select a focal point from within the ministry of health, in consultation with the WHO Representative. The PHCMI focal point will be responsible for everything from data collection to liaising with stakeholders and the WHO Regional Office. The PHCMI focal point may be an outsourced consultant or existing staff member in the WHO country office.

The PHCMI focal point will also work with other relevant entities, such as national health information centres, nongovernmental organizations and United Nations agencies, which also collect and report data on PHC.

Contact information for all members should be distributed among the team. An initial introductory meeting has been found to be beneficial to ensure that everyone shares a common vision and that various team members are introduced to each other.

Pre-determined schedules for communication between all team members throughout all steps of implementation will facilitate effective and valid data collection and keep team members engaged. Regular meetings and updates have been shown by the pilot countries to be a key factor in offsetting any potential delays, these should include:

- weekly (minimum) meetings between the health service delivery focal point in the WHO country office and the PHCMI focal point;
- weekly meetings between the country focal point and WHO Regional Office;
- monthly meetings between the ministry of health, WHO country office, country focal point and WHO Regional Office;
- regular updates to all stakeholders.

Additional regular meetings may be warranted, particularly between the country focal point, WHO country office and ministry of health.

The roles and responsibilities of each team member should be clearly delineated at an early stage in the process and key informants in the qualitative assessment identified.

2.4 Developing a workplan

A workplan will facilitate the monitoring of progress on a regular basis. It will also help to identify potential barriers in order that these can be addressed during the early stages of implementation. All team members should be involved in the development of the workplan and adjustments made to the plan when the need arises.

The workplan should include:

- names and roles of team members
- breakdown of activities by category
- timeline for agreed upon activities
- expected milestones, deliverables and outcomes.

3. Collecting data

3.1 Reviewing the master indicator list

Following selection by the WHO Regional Office of the relevant indicators to be used in the assessment, countries have an opportunity to review the master indicator list and propose alternative indicators based on country context, as it may not always be possible for a country to collect data for the selected indicators. In collaboration with WHO, country teams will review and finalize the list of alternative indicators based on country context. The selected indicators will be reviewed and assessed by the WHO and country team together.

It is important to consider that indicators selected for the master indicator list were selected to provide a comprehensive situational analysis of PHC in the Region. While some indicators may not seem directly relevant to a country's context, data gaps for these indicators will be addressed in the improvement phase of PHCMI. One of the goals of PHCMI is to create a common language/framework for discussing PHC in WHO's Eastern Mediterranean Region, and to achieve this, as well as to facilitate improvements to PHC, as much data for as many of the indicators as possible should be collected.

3.2 Mapping data

After finalizing the master indicator list, if necessary, the PHCMI focal point should liaise with other team members/stakeholders to identify what data are available or missing. Together, the team will determine if data exist or need to be collected in Phase II. After identifying which information is available, the PHCMI focal point will contact key informants to collect data. As a general rule for Phase I, the team should rely only on existing data and identify missing data as such.

Data mapping will likely be conducted for each indicator. Using the provided data source templates, data sources will be identified by informant information and various other sources. It is important to keep track of all relevant information, including the contact information of the informant, their position and title and source of the data for tracing and validation purposes. This will be most helpful when providing the Regional Office with accurate data for an efficient data validation process.

The process of identifying data sources will vary from country to country. Pilot countries conducted this process differently: Jordan's PHCMI focal point sought the assistance of the ministry of health and academia to collect the data, Pakistan's PHCMI focal point reviewed indicators one by one with the ministry of health to identify data sources, and Egypt held a meeting with all relevant team members to finalize the master indicator list. Countries may use one or a combination of these methods or, in coordination with the Regional Office, develop a different method.

During data mapping, it is important that reliable and accurate sources are identified and used – this is crucial for the validation phase. Doing this efficiently from the beginning will save time in the validation phase as it will minimize the need to address discrepancies. It is also important to consider whether the data and data sources represent national or subnational values and whether these data are in the public domain.

3.3 Mining quantitative data

As part of preparation for data collection, quantitative data mining and document review need to be conducted. This entails the identification of data sources and overall availability of quantitative data. Such activities include desk review of data repositories and available reports. As this will vary based on country context, it is important for the PHCMI country focal point to identify key people within the relevant data entities. In addition to ministry of health data, data may also be available in a national repository. All data must be supported by documentation.

Some examples of data that may not be approved:

- Data that are collected at facility level but not reported.
- Data that are verbally reported but do not have supporting documentation.
- Data that are not approved by the ministry of health.
- Data with major discrepancies.

If any of the collected data falls into one or more of the above categories, the PHMI focal point can work with the ministry of health, WHO country office or Regional Office to either produce valid documentation or mark data for the indicator as absent. In some cases, the indicator may have alternate terminology at country level. In collaboration with the WHO country office or Regional Office, countries can propose an alternate indicator provided it captures the concept of the original indicator. Alternative indicators will be reviewed by the WHO Regional Office for validity and approval.

Gaps in data can be addressed during the improvement phase of this initiative. Note that if data are collected but not reported this can be stated in a footnote in the report.

3.4 Collecting qualitative data

Qualitative data collection may be conducted in a number of ways. Some qualitative data may already be available while collection of other data may require conducting interviews with key informants to determine if data are available. In some cases, the PHCMI focal point might be able to locate data through public resources, for instance, through the availability of certain PHC policies, but all data must still be confirmed and cleared by the ministry of health.

A part of the PHC assessment is informed by the previously mentioned qualitative assessment tool the 'Progression Model', which captures 33 rubrics to be collected and scored based on a set of interviews. Separate training will be provided on how to complete this model.

3.5 Reviewing data

Once data have been collected, validated and cleared by the minister of health, a formal clearance process should be initiated. Data, with all supporting documentation, should be submitted in a timely manner to the WHO Regional Office for external validation. Before sending the data, all indicators should be reviewed and checked for anomalies. Stakeholders and policy-makers should be involved in this process in order to ensure that their approval of the data is obtained. At this stage, also solicit their suggestions for the way forward and how to overcome potential obstacles during the improvement phase of the initiative.

A data focal point at the Regional Office will validate each indicator value and data source individually and will work closely with the PHCMI focal point to address any gaps and propose alternative indicators. Following validation, the data will be sent to WHO headquarters for a final review.

3.6 Resolving discrepancies

If any discrepancies are identified by WHO at country, regional or global level, they must be addressed before data are made public. Examples of discrepancies may include but are not limited to:

- dispute in values
- large gaps in values available at country and regional levels
- inappropriate numerators or denominators
- missing or inappropriate data sources.

The process of resolving these discrepancies should involve the PHCMI focal point, the ministry of health, WHO country, Regional Office and headquarter focal points.

4. Preparing final documentation

4.1 Finalizing PHC Country Profiles and Vital Signs Profiles

As development of the PHC Country Profile is entirely informed by the data collected according to the master indicator list, the completion of data collection and verification is essential for populating the profile. The content of Country Profiles is standardized with data provided for a select set of indicators. Identification of missing data is labelled as:

- collected but not reported at national level
- collected but not reported at all
- missing/not collected.

Although the Vital Signs Profile indicators are included in the master indicator list and presented in the PHC Country Profile, once the content of the master indicator list has been collected, the Vital Signs Profile indicators will be extracted to populate three out of its four domains. After all data have been compiled, they are reviewed by the WHO Regional Office and headquarters and inserted into each profile. After completion, both the Country Profiles and Vital Signs Profiles will be sent to the ministry of health for final sign-off.

4.2 Submitting a final report

A report outlining the methodology should be developed to detail how the initiative has been customized according to country context, which indicators were selected for measuring improvements to PHC services and how data were collected and verified. The report should be based on the key findings presented in the country's PHC profile, including a situational analysis of PHC services and outline of strategies to improve services.

As data collection is central to the success of the initiative, an evaluation of the collection and validation process must be included. Data gaps that identify areas requiring action from other sectors to improve health information necessary for measuring progress towards UHC need to be highlighted. The report should provide key policy recommendations to improve data and information management and facilitate health system strengthening based on the results of findings. Countries should tailor their process reporting, key indicators and next steps according to local context.

At the end of each phase, the WHO Regional Office will convene a meeting for countries to present their profiles, experiences, including main findings, successful experiences, challenges and recommendations for the way forward and an overview and evaluation of their assessment and data collection process.

5. Next steps

Throughout the project, stakeholders will have identified areas for collaboration to address the gaps identified in Phase I and II. Potential interventions will be prioritized and translated into next steps toward improvement in Phase III.

Each implementing country will be encouraged to host multi-stakeholder dialogue to identify areas of collaboration. This should involve partners outside of the health system, including but not limited to, ministries of health, finance, human resources, planning, information and statistics, in addition to non-ministry actors from the WHO country office, Regional Office, UNICEF, civil society, private sector, nongovernmental organizations, and international donors and partners. This multisectoral approach allows discussion, feedback and engagement from all sectors through each phase of the initiative which further encourages active participation and eventual implementation of a national action plan.

A series of regional workshops will be held, including all stakeholders, and an action plan based on the findings of Phase II will be developed by each country for presentation to the minister of health for endorsement. These action plans will inform the development of a regional action plan.


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