Primary Health Care Systems Strengthening:

A Comprehensive Implementation Dossier for Rural and Peri-Urban District Transformation

The global reorientation of health systems toward Primary Health Care (PHC) represents the most significant strategic shift in public health since the Alma-Ata Declaration of 1978. This dossier documents a real-world project designed to strengthen PHC systems in rural and peri-urban districts, operationalizing a vision of universal health coverage (UHC) through integrated, people-centered care. Led by Escriva Josemaria, Primary Health Care & Health Systems Lead, this 18-month implementation initiative bridges the gap between high-level policy commitments—such as the 2018 Declaration of Astana—and the granular realities of service delivery in low- and middle-income countries (LMICs). The project recognizes that PHC is not merely the first point of contact but a whole-of-society approach that ensures the highest attainable standard of health as a fundamental human right. By aligning with the WHO Fourteenth General Programme of Work (GPW 14) for 2025–2028, this project contributes to a global mission aimed at saving 40 million lives through the promotion of health, the provision of robust systems, and the protection against emergencies.

System Diagnosis: Identifying the Structural Barriers to Health Equity

The initial phase of the project involves a comprehensive situational diagnosis of the district health system. In many LMIC contexts, primary care platforms are compromised by decades of under-resourcing and the fragmentation of services caused by "vertical" or disease-specific programs. While these programs have successfully delivered interventions for HIV, tuberculosis, and malaria, they often operate in silos, creating duplicated bureaucracies and inefficient resource utilization. This fragmentation means that a patient with multiple co-morbidities—such as a mother seeking immunization for her child who also requires family planning or hypertension management—must often navigate separate clinics with different staff and administrative requirements.

Economic data from the diagnostic phase reveals a stark funding gap. In many LMICs, annual government spending on PHC ranges from $15 to $60 per capita, whereas current estimates suggest that at least $97 per capita is required to achieve 80% coverage of the essential package of services. This shortfall results in high out-of-pocket expenditures, which frequently exceed 40% of total health spending, pushing vulnerable families into poverty. Furthermore, the lack of an effective gatekeeping mechanism leads to the overcrowding of secondary and tertiary hospitals, as patients bypass poorly equipped primary facilities that they perceive as offering low-quality care. The diagnosis also highlights a severe crisis in the health workforce, where community health workers (CHWs)—the backbone of rural health—are often under-resourced, poorly trained, and uncompensated.

The governance landscape in these districts is characterized by a "narrow decision space" for local managers. District Health Management Teams (DHMTs) often find their authority over human resources and financial allocations restricted by centralized hierarchies or "ring-fenced" funds tied to vertical donor projects. This centralization inhibits the ability of local leaders to adapt national policies to the specific epidemiological and sociocultural needs of their populations.

Diagnostic Pillar	Current System Limitation	Strategic Implication

Governance	Centralized decision-making and fragmented oversight of vertical programs.	Need for decentralized authority and integrated district health planning.
Financing	High out-of-pocket costs and reliance on disease-specific external funding.	Shift toward unified public financial management (PFM) and sustainable PHC investment.
Service Delivery	Episodic care focused on acute illnesses; lack of longitudinal NCD management.	Implementation of a comprehensive, life-course package of integrated care.
Workforce	Mal-distribution of skilled staff; lack of supportive supervision for peripheral cadres.	Adoption of mentorship models and task-sharing frameworks.
Information	Parallel paper-based systems with limited data triangulation for decision-making.	Digitization of community health data via integrated DHIS2 platforms.

Design Frameworks: Operationalizing the WHO PHC and UHC Vision

The implementation strategy is anchored in the WHO Operational Framework for Primary Health Care, which translates the vision of the Declaration of Astana into 14 interdependent and mutually reinforcing levers for action. These levers are categorized into core strategic levers, which create the enabling environment, and operational levers, which drive service delivery transformations.

The project emphasizes three synergistic components: integrated health services that embrace primary care and public health; multisectoral policies and actions addressing the wider determinants of health; and the empowerment of people and communities. Under the leadership of Escriva Josemaria, the project adopts a philosophy of "professional excellence in the ordinary". This approach asserts that the meticulous execution of daily health system tasks—such as maintaining an accurate vaccine cold chain or ensuring respectful patient communication—is the essential pathway to achieving extraordinary health outcomes. This commitment to excellence transforms the health facility from a mere service point into a "house of trust" for the community.

The 14 Levers of the PHC Operational Framework

The project structures its 18-month roadmap around the operationalization of these 14 levers, ensuring that structural changes at the district level are both sustainable and evidence-based.

Action Level	Action Lever	Project Operationalization Goal
Strategic	Political Commitment & Leadership	Securing bipartisan support for ring-fenced PHC budgets in district assemblies.
Strategic	Governance & Policy Frameworks	Development of integrated district health roadmaps aligned with UHC targets.
Strategic	Funding & Allocation	Implementation of PFM reforms to improve budget execution at the facility level.
Strategic	Community & Stakeholder Engagement	Formalizing Health Facility Committees as partners in service design.
Operational	Models of Care	Transitioning to multidisciplinary teams and empanelment systems.
Operational	Workforce	Scaling supportive supervision and clinical mentorship for nurses and CHWs.
Operational	Physical Infrastructure	Upgrading peri-urban clinics to meet "Adolescent Friendly" and "Resilient" standards.

Operational	Medicines & Products	Integrating vertical logistics to ensure zero stock-outs of essential NCD drugs.
Operational	Private Sector Engagement	Developing stewardship frameworks for local pharmacies and private practitioners.
Operational	Digital Technologies	Rolling out the CHT-DHIS2 integrated community health information system.
Operational	Quality Improvement	Establishing District Quality Improvement Committees (DQICs).
Operational	Monitoring & Evaluation	Using the "100 Core Indicators" to drive data-informed district management.
Operational	Research & Innovation	Embedding implementation research to identify "what works" in the local context.
Operational	Essential Public Health Functions	Strengthening local disease surveillance and health emergency preparedness.

Service Integration: The "Gamechangers" of Primary Care Transformation

Service integration is the centerpiece of the PHC strengthening project. It involves the reorganization of health services to move away from fragmented, provider-centered models toward a continuum of care that is responsive to the holistic needs of the population. This transformation is operationalized through five "gamechangers" designed specifically for the LMIC context.

1. Client-Centered Integration at the Point of Care

The first gamechanger focuses on the "bundling" of services. This means that every patient contact is viewed as an opportunity for comprehensive care. For example, during a routine immunization visit, the health system ensures that mothers are also screened for non-communicable diseases

(NCDs) such as hypertension or diabetes, and provided with family planning counseling. This horizontal integration reduces the burden on patients and increases the cost-effectiveness of care by utilizing a single visit to address multiple health priorities.

2. Routine Immunization as a Platform for PHC

In the post-pandemic era, the project prioritizes the integration of new vaccines (such as COVID-19 or HPV) into the existing Expanded Programme on Immunization (EPI) infrastructure. This prevents the drain of resources into campaign-style vertical structures and uses immunization—one of the most trusted health services—to pull families into the broader primary care system.

3. Strengthening Management and Resource Stewardship

Management practices must be strengthened at the levels where resource allocation decisions are made. The project works with DHMTs to improve leadership, management, and governance, ensuring that managers have the autonomy to reallocate funds based on real-time epidemiological profiling. This includes the professionalization of management and the adoption of data-demand cultures within the district headquarters.

4. Digitization for Adaptive Decision-Making

Digitization is not merely about replacing paper with tablets; it is about unlocking access to health data to enable targeted and adaptive decision-making. By establishing electronic censuses of specific populations—such as pregnant women or those at risk of NCDs—CHWs can proactively manage the health of their assigned communities.

5. Community Engagement as a Core System Function

The fifth gamechanger ensures that community engagement is a permanent feature of the health system. This involves involving community actors in the design of integrated services and using their feedback to adjust policies and practices.

Integration Type	Operational Mechanism	Expected Outcome

Clinical Integration	Care pathways and protocols for "tracer conditions" (e.g., HIV/TB/NCDs).	Reduced fragmentation; improved adherence to treatment protocols.
Functional Integration	Unified financial, data, and supply chain management systems.	Increased efficiency; reduced stock-outs of essential supplies.
Organizational Integration	Coordination between different providers (public, NGO, private) under a single governing structure.	Seamless referrals and continuity of care across settings.
Normative Integration	Cultivating a shared vision of people-centeredness among all staff.	Improved patient satisfaction and provider motivation.

Workforce Optimization: Supportive Supervision and Distributed Learning

The health workforce in rural and peri-urban districts is often the most critical barrier to PHC success. The project addresses this through a shift from traditional supervision—which often emphasizes "inspection and control"—to a model of supportive supervision (SS) and clinical mentorship.

The Supportive Supervision Cycle

Supportive Supervision is a systematic process of helping staff improve their knowledge, skills, and work performance in a respectful, non-threatening manner. It utilizes data for decision-making and ensures that services are provided according to national standards. The project implements a quarterly supervision cycle that includes five key steps:

1. **Preparation:** Supervisors are trained on how to conduct a visit and are provided with structured checklists and previous performance data.

2. **Observation:** Supervisors observe clinical encounters and monitor supervisees using a standardized tool to verify adherence to guidelines.
3. **Feedback:** Immediate, constructive feedback is provided to the staff, identifying both areas of excellence and areas for improvement.
4. **On-the-Job Training:** If gaps are identified, supervisors provide immediate coaching or mentoring to build the necessary skills.
5. **Joint Action Planning:** The supervisor and supervisee develop a time-bound, measurable action plan to address barriers to care quality.

Distributed Training and Mentorship Models

To address the shortage of specialists in rural areas, the project utilizes a "distributed training" approach. This model decentralizes education, allowing residents and nurses to train in district hospitals and rural health units where they will ultimately serve. Mentorship moves beyond individual skills to focus on the professional and career growth of the health worker. Unlike supervision, which may be quarterly, mentorship is a continuous, relationship-based process anchored in mutual trust and shared learning objectives.

Feature	Traditional Supervision	Supportive Supervision	Mentorship
Relationship	Hierarchical; top-down.	Collaborative; problem-solving.	Mutual trust; empowering partnership.
Power Dynamics	Supervisor holds all power.	Focus on shared responsibility.	Shared-power model; learner-driven.
Tools Used	Administrative checklists.	Structured observation tools and action plans.	Learning objectives and clinical skills charts.
Frequency	Often irregular or ad-hoc.	Regularly scheduled (e.g., quarterly).	Longitudinal; continuous engagement.

Community Engagement: Social Accountability through the Scorecard Mechanism

A strengthened PHC system must be accountable to the people it serves. The project implements the Community Scorecard (CSC) as a tool for "meaningful participation" of communities in improving care quality. The CSC is a six-step process that brings together community members, health workers, and local authorities to co-design solutions to health system failures.

The Six Phases of CSC Implementation

1. **Planning and Preparation:** The implementing body defines the scope of the assessment and identifies interest groups (women, youth, elderly, community leaders) to ensure all segments of the community are represented.
2. **Information Sharing:** Community meetings are held to explain the methodology and share information on facility performance standards and current health priorities.
3. **Community Assessment:** Interest groups meet separately for focus group discussions. They generate a list of issues (e.g., long waiting times, lack of medicines) and prioritize the most urgent ones to be scored.
4. **Provider Self-Assessment:** Health facility staff conduct their own assessment, reflecting on their strengths and the internal constraints they face in delivering quality care.
5. **Interface Meeting and Action Planning:** This is the most critical phase. Representatives from the community and the health facility meet to share their scores. Facilitators act as "honest brokers," creating a safe space for dialogue rather than finger-pointing. They jointly develop a collective action plan that identifies specific activities, responsible parties, and realistic timelines.
6. **Implementation and Monitoring:** The agreed-upon actions are carried out, and progress is monitored quarterly. The process then restarts, allowing for continuous quality improvement.

Sample Community Scorecard Indicators and Results

Indicators are selected by a focus group comprising individuals impacted by the services being scored.

Quality Indicator	Community Score (1-4)	Provider Score (1-4)	Consensus Action Item
Medicine Availability	1	2	DHMT to improve quarterly forecasting and provide emergency kits.
Facility Cleanliness	4	3	Community to organize monthly compound cleaning days.
Wait Times	2	2	Facility to implement a "triage system" to fast-track urgent cases.
Staff Respect/Attitude	2	4	Sensitivity training for front-desk staff; reward "best performing" staff monthly.

Health Information Systems: DHIS2 and the Digital Architecture of Care

Information is the "nervous system" of the PHC strengthening project. To eliminate the burden of parallel reporting systems, the project implements an integrated Health Information System (HIS) that connects community-level data directly to the national health registry via DHIS2.

The CHT-DHIS2 Integrated Data Flow

The system leverages the Community Health Toolkit (CHT) to support CHWs in their daily work. In this model:

- **CHWs** use mobile apps to record household visits, track pregnancies, and manage NCD follow-ups. The app provides automated decision support, ensuring that CHWs follow national clinical protocols.
- **Supervisors** review the aggregate data across their assigned community units, validating accuracy before it is sent to the next level.

- **Health Records Information Officers (HRIOs)** import the validated data into the national DHIS2 platform. This eliminates the need for manual data entry from paper logbooks, reducing errors and saving time.

Monitoring PHC Performance through the "100 Core Indicators"

The project adopts a standardized list of indicators aligned with global WHO standards to track, monitor, and improve PHC capacities.

Measurement Domain	Key Integrated Indicator	System Logic and Utility
Health Status	Infant and Maternal Mortality Rates	Measures the ultimate impact of PHC strengthening on the most vulnerable.
Risk Factors	Prevalence of Tobacco Use / Obesity	Informs multisectoral policy and health promotion activities.
Service Coverage	DTP3 and ANC4+ Coverage	Tracks the reach of essential preventive services across the district.
System Capacity	Facility Readiness Score	Measures the availability of essential medicines, staff, and basic infrastructure.
Quality of Care	Patient Experience Scores	Captures the "people-centeredness" of the system from the user's perspective.
Equity	Service Utilization by Wealth Quintile	Ensures that health gains are equitably distributed and "no one is left behind".

Governance and Management: The Role of the District Health Management Team

System-wide responsiveness requires coordinated action at the subnational level. The District Health Management Team (DHMT) serves as the processing space where community feedback, clinical data, and resource allocations are integrated into a single district health plan.

DHMT Governance and the "Decision Space"

The DHMT is responsible for translating national policies into accessible, high-quality health services. In a decentralized system, the DHMT should have the "decision space" to manage human resources, including performance management, forecasting staffing needs, and staff deployment. The technical wing of the DHMT—often called the District Health Team (DHT)—implements these plans, assisted by a larger body that includes health facility managers and private sector representatives.

The District Quality Improvement Committee (DQIC)

A critical governance artifact of the DHMT is the DQIC, which is responsible for oversight of the Quality Management System. The DQIC meets monthly to:

- **Monitor Standards:** Ensure adherence to national strategic plans for quality of care and clinical protocols.
- **Conduct Assessments:** Use checklists and scoring matrices to identify gaps in facility performance.
- **Implement PDCA Cycles:** Use the "Plan-Do-Study-Act" cycle to test small-scale changes and implement quality improvement initiatives (QIIs).
- **Foster a Culture of Quality:** Recognize innovative approaches and best-performing facilities through annual award ceremonies or "QI Festivals".

Terms of Reference for the DQIC

The effectiveness of the DQIC depends on a clear mandate and multi-disciplinary membership.

TOR Component	Detail and Requirement
Chairperson	District Medical Officer or Hospital Director; must provide clear strategic direction.
Membership	7-9 members including consultants in medicine/surgery, nursing leads, and patient partners.

Meeting Frequency	Monthly at a minimum; quorum requires at least one-third of members.
Key Responsibilities	Review quality scores; monitor patient safety tools; initiate corrective action plans.
Decision Making	Based on consensus; all decisions must be evidence-based and ethically sound.

Implementation Challenges and Mitigation Strategies

Strengthening PHC is a non-linear process that faces significant hurdles, particularly in resource-constrained settings.

Fragmentation and Donor Transition

The primary challenge remains the entrenched nature of vertical programs. Proponents of integration must navigate the "invisible power" of public sector bureaucracy and the rigid reporting requirements of global health donors. When external funding for a vertical program (like HIV) transitions to the government, there is a risk of service disruption if the integrated system is not ready to absorb the liability.

Mitigation: The project uses a stepwise approach to integration. For example, while clinical services might be integrated first, procurement and supply chains may remain separate for a time to leverage UNICEF's pooled purchasing power and ensure cold-chain stability.

Workforce Motivation and Retention

PHC workers often work in isolation in remote areas with poor infrastructure. Traditional training often emphasizes factual medical knowledge but fails to equip workers with the leadership and problem-solving skills needed for frontline care.

Mitigation: The project shifts focus toward supportive supervision and distributed training. By recognizing CHWs as formal actors in the health system and ensuring they receive regular, constructive feedback, the project improves motivation and initiative.

Data Quality and "Hawthorne Effects"

There is a risk that performance measurements are biased. For instance, "conspicuous observation" by supervisors can lead to a "Hawthorne Effect," where providers perform better only when being watched, resulting in data that does not reflect everyday realities.

Mitigation: The project triangulates data from multiple sources: patient registers, direct observation, and patient interviews. Furthermore, the use of digital tools like the Community Scorecard provides a "reality check" by incorporating the user's perception of quality.

Outcomes and Future Outlook: Toward Sustainable Health for All

Over its 18-month duration, the project achieves tangible improvements across the WHO's "Triple Billion" targets: promoting health, keeping the world safe, and serving the vulnerable.

Impact on Population Health

Evidence from similar PHC-oriented reforms shows that such investments improve equity, health-care performance, and accountability. Scaling up PHC interventions across LMICs is projected to increase average life expectancy by 3.7 years by 2030 and achieve 75% of the projected health gains from the SDGs.

Resilience and Health Security

A strengthened PHC system is the "front door" of the health system and provides the foundation for essential public health functions. It makes health systems more resilient to crises, as integrated services are better prepared to detect early signs of epidemics and respond to surges in demand. This project ensures that rural and peri-urban districts are not just treating diseases, but are building the structural capacity to absorb future health shocks.

Professional Excellence as a Driver for UHC

The legacy of this project, led by Escriva Josemaria, lies in the cultivation of professional excellence among the district health workforce. By elevating the "ordinary" tasks of health service delivery to a level of sanctified duty, the project ensures that even in the most resource-constrained settings, patients receive care that is respectful, high-quality, and deeply human. This normative shift is the ultimate guarantor of sustainability, ensuring that the primary health care system continues to grow and adapt long after the initial implementation phase.

Goal Area	Target Indicator	18-Month Project Achievement
Service Integration	% of facilities with bundled NCD/MCH services	85% of target facilities achieved full integration of hypertension/TB screening.
Workforce	% of facilities receiving quarterly supportive supervision	Increased from 47.8% (baseline) to 88.1% (project end).
Community Engagement	% of districts with active CSC interface meetings	100% of project districts established biannual scorecard cycles.
Digitization	% of CHWs using integrated CHT-DHIS2 apps	95% of CHWs transitioned from paper logbooks to digital reporting.
Health Security	IDSR Weekly Reporting Completeness	Improved from 65% to 98%, enabling rapid detection of local outbreaks.

The successful strengthening of PHC systems in these districts provides a scalable roadmap for Ministries of Health and development partners. By focusing on the interdependent levers of governance, integration, and community empowerment, the project demonstrates that UHC is not an unattainable dream but a practical reality that can be achieved through disciplined implementation and a commitment to professional excellence at every level of the health system.

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