

TRANSFORMING PHC DELIVERY AND FINANCING THROUGH PRIMARY CARE NETWORKS

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Acronyms List

CHPS	Community-Based Health Planning and Services
COP	Community of practice
GHS	Ghana Health Service
HSPA	Health Systems Performance Assessment
IC	Implementation case
JLN	Joint Learning Network for Universal Health Coverage
KII	Key informant interview
LMIC	Low- and middle-income country
M&E	Monitoring and evaluation
MEL	Monitoring, Evaluation and Learning
MSC	Most Significant Change
NGO	Non-government organization
NHIS	National Health Insurance Scheme
NOP	Network of practice
PCN	Primary care network
PHC	Primary health care
PHCPI	Primary Health Care Performance Initiative
R4D	Results for Development
UHC	Universal health coverage

Executive Summary

As countries work to improve access to and utilization of essential health services for their populations, many are undertaking health system transformations to prioritize and strengthen primary health care (PHC). Between 2020 and 2021, in partnership with the Joint Learning Network for Universal Health Coverage (JLN), the Primary Health Care Performance Initiative (PHCPI) and Results for Development (R4D) launched a Community of Practice (COP) that facilitated two peer Learning Exchange communities, dedicated to fostering action-oriented shared learning focused on best practices in measuring and strengthening PHC systems across countries. The Learning Exchange agendas focused on two themes: *Transforming the Health System to Prioritize PHC* and *Understanding and Utilizing Data in COVID-19 Response and Recovery*. The COP launched a third Learning Exchange (March – November 2022) to focus on *Implementing and measuring the performance of primary care networks*. A growing number of countries are designing and implementing primary care networks (PCN) to strengthen PHC financing and delivery and ultimately improve access to and utilization of care, a process that can be supported through shared knowledge and peer to peer learning.

The learning community—comprised of peer learners and country implementation case (IC) teams from Colombia, Ghana, and Kenya—created a shared learning agenda and came together for bi-monthly Learning Exchange sessions to share country progress and exchange on topics such as *Financing PCNs, Governance and accountability of PCNs, Piloting and scaling up PCNs, and Measuring the effectiveness of PCNs*. Over the course of the learning exchange, IC teams worked to refine their problem statements, outline long-term vision statements, and develop causal chains and short-term outcomes, which served as a framework for reflecting on progress and drawing on peer and facilitator support during monthly IC team check-ins, called Learning Checks.¹

This PCN Learning Exchange revealed PHC stakeholders' deep curiosity to better understand PCNs, as well as a strong appreciation among participants for the value of the peer learning approach. Participant feedback and results suggest that the COP provided an important and valued forum for cross-country experience-sharing and learning. The experience also highlighted the need for deeper and sustained systematic learning initiatives for countries to continue to improve PHC to better meet the needs of their populations.

This paper highlights the process for developing this learning community and some of the key learnings on how to successfully implement PCNs. Furthermore, it provides key recommendations for country policymakers, practitioners, and development partners based on lessons from the PHCPI COP.

¹ Due to the COVID-19 pandemic and international travel restrictions, the COP utilized a fully virtual implementation model; all meetings were hosted on Zoom, where live interpretation was provided to ensure accessibility for all participants.

I. Background

As countries work to improve access to and utilization of essential health services for their populations, many are undertaking health system transformations to prioritize and strengthen primary health care (PHC). The COVID-19 pandemic further highlighted the critical need for strong PHC systems that are patient-centered and provide well-coordinated care across providers. Between 2020 and 2021, in partnership with the Joint Learning Network for Universal Health Coverage (JLN), the Primary Health Care Performance Initiative (PHCPI) and Results for Development (R4D) launched a Community of Practice (COP) that facilitated two peer Learning Exchange communities, dedicated to fostering action-oriented shared learning focused on best practices in measuring and strengthening PHC systems across countries. The Learning Exchange agendas focused on two themes: *Transforming the Health System to Prioritize PHC* and *Understanding and Utilizing Data in COVID-19 Response and Recovery*. The first Learning Exchange focused on collaborative problem solving (October 2020 – May 2021) while the second facilitated an implementation learning approach (June 2021 – January 2022). The implementation learning approach enabled the broader community of learners to follow and learn from three implementation country case teams—Ghana, Kenya, and Uganda—and share knowledge and experiences with their peers.

At the conclusion of these two exchanges, there was demand from the learning community for continued implementation learning support with a focus on innovative solutions to strengthen PHC. This was prioritized after triangulating country demand from the implementation case (IC) teams, peer learners, and the PHCPI intensive engagement countries. Thus, the COP launched a third Learning Exchange (March – November 2022) to focus on *Implementing and measuring the performance of primary care networks*. A growing number of countries—including Colombia, Costa Rica, Ghana, Kenya, and the Philippines—are designing and

WHAT ARE PRIMARY CARE NETWORKS?

PCNs are networks of collaborating primary care providers working together to provide quality primary care to patients in a coordinated approach.^{2,3} While PCNs are still emerging as a well-understood model for organizing PHC, adopting PCNs as the learning focus for the COP in 2022 presented a unique opportunity for knowledge generation and cross-country learning about good practices for designing, implementing, and scaling up PCNs.

WHY PCNS?

Evidence shows that having a well-coordinated network of primary care practices enables countries to work at scale to provide a broad range of services and connect easily to higher levels of care, including integration with community services. In addition to enhancing the quality of health service delivery and providing comprehensive services, a strong PCN may provide a platform to demand and attract better remuneration for providers, which in turn allows providers to better manage resources. PCNs may also utilize common technology to share information and facilitate better care for patients. One unique advantage of PCNs is that both public and private primary care facilities can collaborate and provide more services that are equitable, sustainable, and of high quality.

² WHO Service Delivery and Safety Department Universal Health Coverage and Health Systems, World Health Organization. Reforming Health Service Delivery for UHC Integrated people-centred health services policy brief. Geneva (Switzerland): WHO; 2017. Report No: WHO/HIS/SDS/2017.9.

³ Primary Care Networks have also been defined as “a group of public and/or private sector service delivery sites deliberately interconnected through an administrative and clinical management model...” Carmone, Andy E., et al. (2020). Developing a Common Understanding of Networks of Care through a Scoping Study, *Health Systems & Reform*, 6:2, DOI: [10.1080/23288604.2020.1810921](https://doi.org/10.1080/23288604.2020.1810921)

implementing primary care networks (PCN) to strengthen PHC and improve coordination, access, quality, and efficiency within the health care system. In many countries, health facilities operate as individual entities, causing inefficiencies through duplicated efforts and fragmentation.

The Learning Exchange also provided an opportunity to enhance PHCPI direct country engagements, linking cross-country learning with direct technical assistance support provided by the World Bank and UNICEF. While the themes for each of the PHCPI Learning Exchanges differed, the goal of each exchange has remained consistent: bring together groups of learners to share, brainstorm, and crowd-source solutions and tap into the wealth of knowledge that exists among policymakers, practitioners, and other PHC stakeholders working to measure and improve PHC.

II. Peer Learning Approach – *Implementation Learning*

The implementation learning methodology from the second Learning Exchange was adapted in the third phase to facilitate peer learning tailored to specific implementation challenges countries are facing. The approach supports a small set of country implementation teams (two to four teams) to receive more intensive, focused peer learning and problem-solving support as they advance and share updates on their implementation efforts. A wider community of individual peer learners from multiple countries participate in the Learning Exchange, are paired with an IC team and participate in community-wide Learning Exchange events and online discussions. Peer learners benefit by learning from other countries and are able contribute their experience and expertise to support the implementation teams.

The *Implementing and Measuring the Performance of Primary Care Networks* Learning Exchange identified 95 peer learners representing 28 countries through an open expression of interest process. An additional 30 individuals acted as IC team members, creating three teams from Colombia, Ghana, and Kenya. These teams were identified with support from PHCPI partners and in consultation with JLN country core groups. The Colombia IC team—formed with the support of the World Bank and the PHCPI Intensive Country Engagement Working Group—included members of the El Tambo Hospital team as well as representatives of the Secretariat of Health and Ministry of Health responsible for supporting the Cauca Province, where El Tambo resides. The Ghana IC team was formed with the support of the World Bank through the PHCPI Intensive Country Engagement Working Group and R4D’s engagement in Ghana through the Health Systems Strengthening Accelerator. The Kenya IC team was comprised of participants, primarily from the Ministry of Health, who participated in the previous Learning Exchange and chose to continue their engagement and were joined by subnational actors and UNICEF.

IMPLEMENTATION LEARNING METHODOLOGY

- Focused & action-oriented
- Connects peer learners from different countries with other doing similar work
- Showcases Implementation Cases that were selected by the group as a focus for collaborative problem-solving

DEFINING AN IMPLEMENTATION CASE

- I. Articulate a problem statement
- II. Create a Vision Statement
- III. Identify near-term, achievable objectives
- IV. Develop causal chains

The learning community—comprised of the IC teams and all peer learners—was supported by four expert technical facilitators who facilitated the ongoing knowledge sharing and linked IC teams with needed evidence, experience, and problem-solving support. The three selected IC teams worked first to refine their problem statements, outline long-term vision statements, and develop short term outcomes. They also developed a causal chain—a series of steps to take to achieve the short-term outcomes. Participants were invited to participate in bi-monthly Learning Exchange sessions that brought together the whole learning community to learn new PCN elements and share country progress as well as monthly IC team Learning Checks, where the IC teams presented and discussed their progress towards their target outcomes while peer learners and the facilitation team provided technical advice and proposed solutions to the presented challenges based on their expertise, evidence, and previous or current similar experiences.⁴



Figure 1. Dr. Agatha Olago speaking at the hybrid Kenya Learning Check in July '22. She served as the IC team lead until August '22.

During the first virtual meeting, each IC team presented their causal chain, objectives, and anticipated outcomes to the learning community. Afterward, peer learners were asked to choose which IC most closely aligned with their interests. Based on their indicated preference, peer learners were then assigned to closely follow and engage more deeply with one of the IC team and their work during the monthly Learning Checks. In previous phases, peer learners only attended the bi-monthly Learning Checks; this adapted model allowed for increased opportunities for learners and IC teams to share ideas, ask questions, and brainstorm.

As in previous exchanges, the bi-monthly Learning Exchanges proved to be a valuable virtual gathering space, where participants were able to hear from guest technical experts, technical facilitators, the IC teams, and their peers while engaging in open dialogue on a variety of topics and voicing questions and challenges. These convenings focused on challenges such as financing PCNs and provider payment mechanisms, governance and fund management, accountability, and operationalization and scale-up. The Learning Exchange culminated in a final Experience Showcase at the end of the engagement where all three teams presented their most significant milestones, key lessons learned, and major challenges.



Figure 2. The GHS Policy, Planning, Monitoring and Evaluation (PPME) Division, headed by director Dr. Alberta Biritwum-Nyarko (center right, blue jacket), visited the Ve Golokwati NOP in Afadzato South District and were joined by District Health Directorate staff.

⁴ Due to the COVID-19 pandemic and international travel restrictions, the COP utilized a fully virtual implementation model; all meetings were hosted on Zoom, where live interpretation was provided to ensure accessibility for all participants.

III. Country Implementation Cases

The Implementation Case Process

The first task for each IC team was to develop mutually agreed-upon problem statements and causal chains to guide and focus discussions on the challenges they were trying to solve.

Colombia

Colombia IC team focused on reducing maternal and perinatal morbidity and mortality in the Municipality of El Tambo through the strengthening of an existing public PCN. The team focused on identifying the key system challenges affecting PCN development in their rural district and developing a maternity data monitoring systems needed to measure progress.

PROBLEM STATEMENT:

Answers the question “What is the key system challenge being addressed?”

Ghana

Ghana’s IC team focused on developing policy guidelines to lead the PCN (called “Networks of Practice” [NOP]) operations in Ghana’s health system, mobilizing community leadership to support the networks, strengthening capacity of district and sub-district leadership to coordinate facilities within the NOP, and supporting resource allocation for the NOP within sub-districts to enhance shared needs and equitable distribution of resources.

Kenya

The Kenya IC team worked to optimize the financial arrangements for PCNs in Kenya by defining a clear and sustainable financial plan that allows for direct flow of funds to health facilities. The IC attempted to identify which payment models were or were not working in PCNs, explore ways of integrating the private sector into the PCNs, and devise a payment arrangement for shared resources. In addition, the IC sought ways of adapting the Kenya health information systems to adequately measure and track progress of PCN financing.

Each IC team identified a team lead and were assigned a technical facilitator, the pair of whom supported the team by creating structured discussion opportunities and fostering safe spaces for open collaboration and problem-solving. IC teams developed their own cadence for hosting Learning Checks based on their availability, country contexts, and needs. For instance, Colombia and Ghana hosted monthly virtual meetings whereas, due to availability and Kenya’s implementation process, Kenya met every other month using a hybrid format to enable stronger relationships with the county and national governments and linkages into their planning.

During their Learning Checks, each IC team presented updates to their IC teammates and the peer learners assigned to follow along. These meetings were used to reflect on progress, discuss specific challenges they were experiencing, and brainstorm solutions with the peer learning community. In addition to the Learning Checks, IC teams shared perspectives from their implementation progress during the community-wide bi-monthly Learning Exchanges and engaged the larger community in discussions on



Figure 3. Dr. Mohamud Mohamed moderating a session during the Kenya IC hybrid Learning Check. Dr. Mohamed took over as the IC team leader in September 2022.

specific challenges. Often members of the peer learning community were invited to present on how they were applying their learnings to their specific country context and receive feedback from the group.

This meeting cadence enabled the community to come together in some form at least monthly. Between meetings, online forum discussions were hosted to specifically support the community in crowdsourcing ideas, sharing information, and answering questions. The goal was to build connections and relationships between different countries to enable future sharing and learning, beyond the end of the PHCPI COP.

At the onset, each IC team was in a different phase of implementing their PCN. The variation between each team's PCN design and implementation efforts enabled rich experience-sharing, collaborative problem-solving, and the opportunity for countries early in PCN planning and implementation to anticipate future opportunities and challenges. For example, in Colombia, the team focused on developing a multidisciplinary approach to PHC teams and facilities in rural territories within a PCN; the Ghana team focused on improving the existing PCNs; and the Kenya team worked towards appropriate financing mechanisms for PCNs during scale-up. Many essential learnings were identified including the need for teamwork, triangulating data, effective tools to measure progress, strategic communication platforms, understanding one's political environment, and identifying appropriate funding sources.

However, the following **three key learnings were flagged by all countries as the essential tools for successfully implementing a PCN.**

Developing and Deploying a Causal Chain

Each country developed a causal chain to support the team in outlining the necessary steps and anticipated outcomes for their actions (Appendix 2). Each country noted that this had significant impact on their ability to achieve their goals in a relatively short period. In Colombia, the El Tambo PCN team noted it is essential to correctly delineate objectives and action steps to enable efficient and effective work. By taking this first action step, the team was able to set their expectations for results and appropriately align their available resources and capacities to achieve their goals.

CAUSAL CHAIN:

a visual representation of an interlinked series of events or steps, leading to a result or outcome.

The Kenya team also felt that by using the causal chain, it enabled them to use both quantitative and qualitative evidence to breakdown the challenges into actionable components. Given the complexity of Kenya's implantation context, the causal chain enabled participating counties to break down their steps and measure where they were in their process to hold each other accountable.

Aligning with National, Subnational, Community, and Facility Priorities

PCNs do not work in a vacuum, and neither should their planning. The learning community agreed that consulting and aligning with the key stakeholders throughout the health system, from local to national levels is a crucial step to ensure appropriate funding, participation, and both government and community support. Each IC team specifically noted that this was a crucial step in the PCN development and strengthening process. For instance, if the PCN does not align to national or subnational priorities it will not receive the financial resources necessary to succeed. Furthermore, without community's or facility's involvement in the design and support of the PCN, they will not be able to adequately advocate for or support the PCN. In Colombia specifically, the team aligned their proposed actions with the El Tambo

hospital's strategic platform because it enabled the plans to be contextualized to the characteristics of the municipality and its community.

In Ghana, the IC team realized that stakeholder consultation was critical in developing the operational guidelines. The consultative process they undertook was interactive, with the goal of getting inputs from every key stakeholder. The process reinforced the importance of community participation, not only for generating demand for health services, but also for holding the NOP accountable.



Figure 4. Representatives from the Colombia IC Team present at a hybrid event in Bogotá (Oct'22). From left: PHCPI Facilitators Dr. Luis Bernal Pulido and Leizel Lagrada-Rombaua, Colombia IC Team members María Fernanda Mejía-Martínez, Diana Marcela Figueroa Hurtado, Dr. Nelly Ante, and R4D staff Emma Satzger, Dr. Laurel Hatt, Amanda Folsom.

Kenya also found a multi-stakeholder approach essential to their success. During their first hybrid session, the Kenya IC team participants identified parliamentarians as key actors with whom to form alliances due to their role in resource allocation and oversight of the executive arm of government. Including them, as well as other previously targeted actors such as NGOs, academia, private sector, and think tanks, could result in more sustainable and effective advocacy for better financing mechanisms for PCNs. Additionally, the involvement of county governments in the Kenya IC team was crucial, as they are at the frontline in implementing PCNs. Given their mandate regarding health care service delivery, county governments are the ones capable of implementing desired changes in the architecture and financing of their PCNs. Their insights and experience in the journey thus far continue to inspire other counties and provide important reference information for those at the start of the process. By supporting the county governments, it also means establishing the resources, human, financial and otherwise, necessary for advocacy with them and development partners to catalyze wider adoption of PCNs in Kenya.

Responsiveness and Adaptability

Finally, IC teams highlighted the importance of being responsive and adaptable, both in the implementation and learning processes. Colombia noted the need to develop a responsive and adaptable PCN strategy that defines intersectoral actions aimed at improving a population's living and health conditions. The strategy must be focused on the social determinants of health, key actors, and interests and expectations, as well as implementation advocacy activities supported by evidence and indicators. The strategy must also use effective data



Figure 5. Participants during a session of the Kenya IC team's hybrid learning check.

visualization strategies and mechanisms to enhance data uptake and community participation.

The Ghana IC team found that a responsive and adaptive approach in establishing NOPs was useful because it allowed implementors to tailor services according to local context and its challenges. An adaptive approach offered the ability to improve sensitization/orientation among participating facilities, build skills and competencies, improve infrastructure and equipment, work to identify an adequate mix of skilled staff, improve leadership, and address other governance issues. Communicating and managing these changes is essential when setting up NOPs.

In Kenya, adaptability continued to be an area for continued learning and insights. Given the disruptions the IC team faced to the underlying processes for implementation of the PCNs—particularly in the progress towards design and implementation of financing arrangements—it was necessary for the team to adjust. The pressure on IC team members' time made it difficult to consistently hold virtual meetings, which resulted in moving the meetings to a hybrid format and taking advantage of already-planned events to co-host the Learning Checks.



Figure 6. Ghana IC Team. From L-R: Ms. Winifred Addo-Cobbiah (PPME Policy Unit), Dr. Andrews Ayim (Director for Policy, Lead of NOP team), Ms. Elizabeth Hammah (R4D Accelerator Project), Dr. Alberta Biritwum-Nyarko, Dr. Senanu Kwesi Dzakoto (RDHS Director of Volta Region), Mr. Michael Sottieb (PPME Planning Unit).

IV. Primary Care Networks: Learning Themes

Participant demand for learning about PCNs was first identified through previous Learning Exchanges under the COP umbrella. The PCN learning agenda was then narrowed and prioritized through the EOI process, online polling and priority-setting during the Learning Exchange launch, evidence review, and facilitator consultations with IC teams. The learning agenda was organized around four main topics:

- Financing PCNs
- Governance and accountability of PCNs
- Piloting and scaling up PCNs
- Measuring the effectiveness of PCNs
- Understanding that PCNs are still emerging as an approach to organizing PHC, the learning community was interested in practical, implementation-focused topics that would be relevant to the design, piloting, operationalization, financing, and measurement of PCNs.

Financing Primary Care Networks

While participants did spend some time discussing various mechanisms of financing PCNs (e.g., moving toward the optimal mix of provider payment mechanisms, or strategies for managing funds within networks), most of the Exchange focused on country experiences using PCNs to improve PHC financing. For example, the Ghana IC team highlighted their efforts to negotiate a mechanism of financing preventive and promotive care at the PHC level and the importance of designing and costing essential care packages to ensure proper payment. They also discussed their efforts to ensure proper credentialing of PCNs as a group rather than individual facilities to ensure reimbursement from the National Health Insurance Authority. The Kenya IC team described their effort to develop costing reports of the networks in various regions to ensure that the PCNs were properly financed. The Colombia IC team shared their experience wherein health insurers pay PHC providers and PCNs for preventive care and local health authorities support population-based health promotion activities, partly through the PCNs and partly through other types of organizations. In Lebanon, PCNs are regulated and co-financed by the MoH, providing them with in-kind donations (e.g., essential medicines, vaccines, administrative IT equipment and main medical ones) in addition to the financing of non-government organizations (NGO) and international NGOs.

The discourse demonstrated that financing PCNs is highly context specific and that countries need to test, adopt, and adapt approaches that will be practical within their context. For example, in Ghana there is a mixed ownership structure for the networks of care (including public, private, NGOs, hospitals). It has been challenging to get provider buy-in for a unified financial account. Some providers were more comfortable with sharing resources like commodities (gauze, drugs, etc.). The group was able to discuss the benefit of pooled procurement as an incentive to drive networking.

The community agreed that more focus on accountability in funds management was needed. Enabling PCNs to increase efficiency and control administrative costs allows them to focus on channeling funds to the front line of service delivery. This discussion also highlighted the critical need for PCNs to clarify decision-making roles and lines of accountability, including who decides what is purchased and how resources are allocated.

Piloting, Operationalization, and Scaling-up PCNs

By showcasing two examples from Costa Rica and Ghana, the community learned about the process of how PCNs are designed, established, and operationalized. The Ghana IC team highlighted the ‘hub and spoke’ approach used in their PCN implementation and shared more insight into the country’s PCN journey piloting PCNs in a few districts and scaling up nationwide to include private providers. Ghana’s approach was compared to Costa Rica’s long-term approach, which dates to the 1940s, and how it has evolved and expanded over time to address changing needs and political environments. Costa Rica emphasized the need to be adaptive and to ensure that plans are aligned with national and subnational priorities as well as the community context. For example, Costa Rica has a large migrant population with their own cultural practices for maternal and child health. The PCNs serving that population worked with their communities to understand and respect the cultural practices to ensure that all mothers were willing to receive the care at PCN facilities, reinforcing the principle that PCNs must be designed to respond to the communities needs and cultural context.

By comparing these two different PCN models and journeys, the learning community was able to better understand how expansive PCNs can be. The Ghana example greatly emphasized the need to explore

models for financing private facilities for PCNs. The Kenya IC team agreed and recommended slow transition strategies to carefully scale-up and operationalize the PCN to ensure that funding effectively shifts from facilities to networks. Finally, the group identified major administrative challenges that occur across contexts, including how to track and manage patients within the PCN, connecting data to national systems, among others. PCNs are complex, but to become sustainable they must connect to larger systems that can leverage each other for efficiency.

Governance and Accountability of PCNs

The question of governance and accountability arose from prior conversations on PCN financing. The Colombia IC team sought to identify resource management strategies that would increase efficiency in spending for services provided by PCNs, while the Ghana IC team sought to understand how resources could be allocated for PCNs to form and involve government, faith-based, and private health facilities. The resulting discussion presented examples from Iran, Lesotho, and the UK, on how PCNs' resource allocation, fund management, and governance functions can be structured.

A common thread throughout these discussions was how to build accountability into PCNs. Many participants highlighted the importance of having an accountability framework during the conceptualization phase of PCNs and integrating it as a foundation at the national and subnational levels. The community also identified several key factors required for accountability in PCNs to succeed, including strong political will, coalition building by different actors within and outside of the health sector, and advocacy for a solid accountability structure. Creating and fostering an enabling environment where accountability – and accountability actors – can thrive was a shared value.

Participants grappled with the interconnectivity of PCN governance, accountability, and resourcing. The PCN governing body is mostly responsible for how resources are allocated and managed. In some instances, governance is shared, and fund management/ resource allocation are coordinated by a committee made up of government actors, community members, and some external entities. Shared PCN governance opens an accountability space between the government and the people, which can promote transparency in decision-making and resource allocation.

For PCNs to achieve what they are established to deliver, accountability mechanisms should align with the aims of the networks. Accountability mechanisms can be geared toward promoting social accountability driven by citizens or financial accountability of payors/insurers and providers. PCNs must ensure they have political will and alignment with both national and subnational priorities as well as transparency and open communication with their civil society to ensure they are able to provide access to the appropriate services based on community needs

Measuring Effectiveness of PCNs

The monitoring and evaluation of PCN effectiveness emerged as an important cross-cutting topic during the Learning Exchange. The El Tambo team in Colombia highlighted the need to tie PCN performance to improvements in maternal health outcomes and described their work to link various data sources (vital statistics, health insurance administrative data, etc.) into one database. The Ghana IC team discussed how they measured Networks of Care during the piloting process, and recently completed implementation

research on the equity outcomes of PCNs.⁵ The Kenya IC team drew upon the learning community’s inputs as they worked to develop a monitoring, evaluation, and learning (MEL) framework and advance subnational PHC measurement efforts in partnership with PHCPI.

In November 2022, the COP hosted an online dialogue facilitated by Ariadne Labs on measuring PCN effectiveness.⁶ “Effectiveness” can be defined differently in different contexts; however, integration, care coordination, responsiveness, and quality were also emphasized as essential domains for measurement. Participants shared tools and resources for measuring PCN effectiveness from both demand and supply perspectives, including community scorecards for measuring key domains of patient satisfaction and community participation, supply-side assessments including a case study of Tanzania’s PHC Systems and the Health Systems Performance Assessment (HSPA) Framework for Universal Health Coverage (UHC) and subnational PHC capacity analysis in Costa Rica.⁷ Ultimately, participants noted the importance of processes for using data for decision-making but cautioned that these data and measurement processes should not overwhelm the system and those in it.

V. Key Lessons on Designing and Implementing PCNs

The PCN Learning Exchange revealed PHC stakeholders’ deep curiosity to better understand PCNs, as well as a strong appreciation among participants for the value of the peer learning approach. They valued the responsive and demand-driven learning approach and expressed interest in engaging in more cross-country learning on transforming PHC through PCNs. What follows are several key lessons about PCN design and implementation and participants’ feedback about the implementation learning methodology, captured through systematic MEL efforts.

What We Learned About PCNs

Throughout the course of the PCN Learning Exchange, several key lessons surfaced about how countries are designing and implementing PCNs to transform the financing and delivery of PHC.

- Several countries are piloting and scaling up their PCNs in the absence of sufficient evidence on how this model of care could be effective. **The Learning Exchange highlighted the need for more cross-country and subnational joint learning initiatives, implementation research, and evidence to evaluate the effectiveness of PCNs.**
- PCNs are continuously evolving to address countries’ unique and changing contexts. PCNs in LMICs are designed around existing systems which face persistent resource constraints and challenges. PCN governance and fund management arrangements, for example, are highly variable and context specific. **More evidence and rapid-cycle, implementation-oriented learning**

⁵ Ghana Health Service and Health Systems Strengthening Accelerator, “Leaving No One Behind: The Role of Primary Care Provider Networks in Advancing Equitable Universal Health Coverage in the South Dayi and South Tongu Districts in Ghana, 2021.

⁶ ResilientPHC@PHCPI.groups.io

⁷ Primary Health Care Systems (PRIMASYS) “Comprehensive case study from United Republic of Tanzania”, WHO 2017; [“Health system performance assessment: A primer for policy-makers, European Observatory on Health Systems and Policies, Nov 2022; Analysis of Primary Health Care System Capacity in the Huetar Atlantica Region of Costa Rica, Ariadne Labs, 2022.](#)

is needed to understand optimal PCN governance and financing mechanisms, and to adapt promising practices to countries' varied contexts.

- Participating countries identified several ingredients for success (highlighted in text box) and essential tools for successfully implementing a PCN, including (1) Developing and using causal chains to map action steps and outcomes and regularly assess progress; (2) Consulting and aligning with key stakeholders throughout the health system – from local to national levels; and (3) Using systematic learning and continuous feedback processes to ensure responsiveness and adapt and improve the implementation process. **Implementation learning can be an effective approach to support implementers in advancing their goals in a relatively short period and to continuously improve their implementation efforts.**
- PCNs require accountability frameworks to clarify roles and lines of accountability to ensure responsiveness to the community. Community participation in PCNs needs to be strong to ensure that the network can meet the priority needs of patients and families. **It is essential to delve more into promising practices and evidence about how to ensure accountability of PCNs and effectively engage communities as participants in and supporters of PCNs.**
- Measuring PCN effectiveness is a complex and evolving topic, made more challenging by the context-specific nature of defining “effectiveness.” **The monitoring and evaluation of PCN effectiveness emerged as an important cross-cutting topic and was identified as a top priority topic for future joint learning.**

ESSENTIAL ELEMENTS FOR PCN SUCCESS

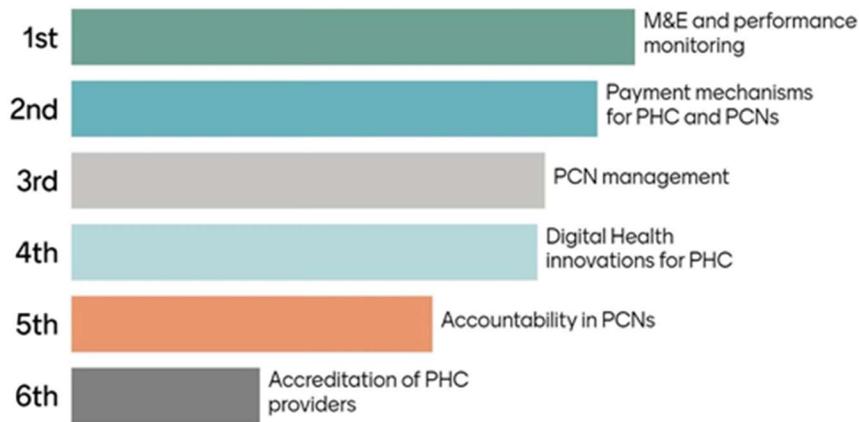
- Careful implementation planning with clear outcomes and action steps (i.e., causal chains)
- National-level PCN policies
- Multi-stakeholder approach, from national to local levels
- Provider and patient behavior change
- Clear accountability framework
- Rapid feedback and M&E tools for continuous learning and adaptation
- Engaged community actors and stakeholders, and alignment among those key groups
- Strategic communications to key actors
- Ability and willingness to adapt approaches based on context

Country Demand for Future Learning

Participants in the Learning Exchange identified several PCN sub-themes for which they would value deeper joint learning. These included deeper-dives on financing and payment mechanisms for PCNs, accountability, and measuring the effectiveness of PCNs. Several other priority topics emerged, including using digital health and telemedicine for care coordination, data management and information technology practices, provider accreditation, and good practices in PCN management.

During the final Showcase event in November 2022, participants ranked priority topics for future learning. Monitoring and evaluation (M&E) of PCNs and payment mechanisms for PCNs were highlighted as the highest-priority PCN sub-themes for future learning.

Figure 7. PCN Learning Exchange Showcase Participant Ranking of Future Learning Topics (Nov 2022)



VI. Monitoring, Evaluation, and Learning Results

This Learning Exchange presented an opportunity to evaluate the effectiveness of the COP’s Implementation Learning approach. The goal was to assess networking and new relationships formed from participating in the COP, knowledge gain of key and relevant themes, and the application of the knowledge and relationships into practice. The M&E approach included primary data collection from a baseline and endline comparison and light-touch outcome harvesting, supplemented by key informant interviews (KII) with PHCPI partners, implementation case team members, and peer learners.⁸

Findings

Overall, the findings from the assessment show strong evidence that participants made significant relationship, knowledge, and practice gains at the end of the COP.

Relationships

One important goal of the COP was to expand networking to create a strong responsive and enduring community of practice for knowledge sharing and problem-solving support. At endline, participants registered more than a 54% increase in networking opportunities, access to a trusted network, and

*“Through COP, I **have extended my professional networks** that I am certain I can count on to have further engagement or even collaboration in PHC advancement. Participation in COP fit with my mission to engage with regional and global PHC advancement efforts.”*

- Peer Learner, Indonesia

number of professional relationships able to discuss practical, job-related lessons. This leveraging of relationships was particularly prominent among the Colombia IC, where members of the Colombia government as peer learners and provided strategic support and networking for the Colombia IC team. The El Tambo team also presented their IC progress as part of a PHCPI presentation during the Global Symposium on Health Systems Research held in Bogotá, Colombia, exposing their

work widely to national level stakeholders. Peer learners’ involvement across the various virtual Learning Exchanges and Learning Checks also built a network of experience and knowledge that directly contributed to strategic problem-solving support. For instance, members received materials and lessons

⁸ A comprehensive overview of the results framework, MEL Plan, findings, and implications can be found in Appendix 3.

learned from Colombia and the Ghana cases to help advance their efforts, and a Ghana team member noted that feedback from peer learners directly helped to improve aspects of their implementation.

Several participants noted, however, that the virtual nature of the Exchange made it difficult to take full advantage of networking opportunities and limited participants ability to form professional relationships. One participant noted, “I don't think there were opportunities apart from the emails back and forth to have the networking. But I believe it's an area where more can be applied.”

Knowledge

Knowledge of relevant topics related to PCNs improved greatly at endline. 40% of participants mentioned having familiarity with financing and payment models of PCNs at baseline. This figure rose to 96% at endline. Indeed, from interviews, several peer learners highlighted newfound knowledge on PCNs. One peer learner in Indonesia started out “with preliminary knowledge on PCNs” but experienced a vast growth in knowledge—enough to discuss with co-workers and directors in the hopes of introducing the initiative in Indonesia. Another peer learner from the Philippines mentioned that the in-depth discussions gave them the tools and knowledge to pursue PCNs as a strategy to support UHC. Overall, the COP was able to effectively create environments where the community was able to learn about and directly engage with technical information on PCNs (e.g., financing and payment models, M&E, governance, PCN design), as well as PHC tools and resources.

Practice

Respondents expressed a strong desire to apply the learnings in their own settings. At endline, they registered a marked increase in their confidence to implement reforms related to a PCN, their ability to problem-solve on topics related to PCNs, and their ability to convey knowledge on PCNs. Peer learners attributed this increase in confidence and ability to their COP participation. A peer learner from the Philippines mentioned being more confident and optimistic in PHC efforts. Another peer learner felt a renewed interest in PHC effort and is planning to apply to a PhD program to strengthen knowledge in PHC efforts.

Outcomes

The conclusion of the Learning Exchange also offered an opportunity to identify any IC outcomes to which participation in the COP may have contributed and long-term outcomes related to changes in the quality, efficiency, and equity of PHC services in PHCPI countries.

Through the KIIs with the IC case team members at the end, the COP was able to assess the completeness of the identified outcomes in the causal chains and to what degree the COP contributed to that outcome.⁹

Colombia

The Colombia IC team achieved three of the four outcomes in their causal chain, and partially achieved the fourth. The IC team confirmed that the COP had a major, direct, and real-time contribution to all four outcomes. They noted that the COP directly aided in the characterization of the maternal-perinatal beneficiary population in real time, the selection of the topics to include in PCN staff trainings, and the design, improvement, and development of the SIMAPE tool.

⁹ KIIs or data collection could not be completed for the Ghana IC due to scheduling challenges and competing priorities.

Kenya

The Kenya IC team partially achieved three of their four causal chain outcomes and noted that the fourth is still in the development phase. The team found that the COP had some direct real-time contribution to one of their outcomes (that which related to the review of the PCN financial arrangements), that the COP had indirect contribution to two outcomes (completing the costing of the PCN and trying out the PCN arrangements), and that the COP had no impact on their last outcome (the development of the MEL plan). The team also noted that the COP had a major direct contribution to an *additional* outcome: the creation of county-level knowledge sharing learning forums, which were modeled after the COP's modality. The team said that the COP acted like a nudge to get things done, saying: "The COP and of course the regular check-ins and learning from what Ghana was doing, what Colombia was doing, just reemphasize on the need for us to figure out what to do working in our context."

Long-term Outcomes

Though it is difficult to examine the COP's contributions to the improvement in the quality, efficiency, and equity of PHC services, elements of this type of longer-term impact were mentioned by IC teams. For instance, the Colombia team predicts efficiency improvement in the efficiency of broad PHC services at the El Tambo PCN and the local and national levels due to the development of tools like the SIMAPE database, though the long-term impacts of this time-saving tool are not yet known. The Colombia IC also facilitated community involvement in the PCN improvement and decision-making process, thus empowering the community and potentially leading to improved equity of PHC services—another impact that cannot yet be measured or examined. Additionally, there has been new interest in the El Tambo case as the program is continues to yield good outcomes. As a PHCPI institutional partner mentioned when interviewed, there is a desperate search for good examples to support the country's PHC reforms. The work in El Tambo could have longer term effects for how PHC reforms are implemented in-country.

While Kenya did not explicitly mention improvements in equity, efficiency, and quality of care, the team is making advancement through the PCNs to measure and improve the efficiency of care. The long-term outcomes in Ghana remain to be documented.

Additional Outcome: Satisfaction

At endline, 92% of participants expressed being satisfied with the COP with 71% being extremely likely to continue learning in a similar format and 21% expressed that they are very likely like to continue.

In terms of the usefulness of the approach, participants highly rated all methods of the COP with technical resources and summaries of the virtual Learning Exchanges rated the highest. Through the interviews, participants also discussed the COP modality and its usefulness, and a many emphasized how helpful the creation of a problem statement and causal chain, as well as the continued engagement, feedback and guidance on these elements and their progress, was to overall implementation.

Takeaways

At the individual level, participants made significant relationship, knowledge, and practice gains from participating in the COP. There is a lot of desire to replicate the PCN model in different country contexts. Regarding the COP's modality, being adaptable and flexible to the community's needs was a strong component in the success of the COP.

Overall, participants expressed the desire to continue engaging in a similar community, though the virtual nature of the latest exchange made networking challenging. Some even noted a desire to be more embedded in the IC teams; one participant recommended having more peer learners join the IC teams, and another suggested that peer learners should have opportunities to develop thought pieces from their participation in the COP. These suggestions show that participants valued the COP despite the challenges, and that the COP is a technical assistance strategy that should continue to be adapted and used.

VII. Recommendations for the Future

Over three years during the COVID-19 pandemic, the PHCPI-JLN COP worked to support countries to transform their PHC systems to be more responsive and resilient. Participant feedback and results suggest that the COP provided an important and valued forum for cross-country experience-sharing and learning. The experience also highlighted the need for deeper and sustained systematic learning initiatives for countries to continue to improve PHC to better meet the needs of their populations. Joint learning that is demand-driven, responsive, and tailored to implementers' needs can help countries accelerate their progress. Below are five recommendations for country policymakers, practitioners and development partners based on lessons from the PHCPI COP:

1. Provide opportunities for continued joint learning on PHC measurement and improvement, with a focus on developing the networks, knowledge, skills, and capacity needed by current and future PHC leaders to transform PHC financing and delivery.
2. Invest in joint learning, implementation research, and evidence generation on PCNs as an emerging, but not yet well understood, approach to transforming PHC delivery. Participants highlighted the need for more learning and evidence generation on measuring the effectiveness of PCNs and financing PHC through PCNs.
3. The PHCPI COP's approach to implementation learning can be adapted and applied to provide real-time, tailored collaborative learning and problem-solving support to implementers working on a range of health system and other development challenges. In addition to providing focused support to a set of implementer countries, the approach provides a forum for a larger learning community to accompany and learn from other countries' implementation efforts.
4. Facilitate flexible modalities for countries to learn from one another in more customized and deeper-dive formats (e.g., country pairings and study visits). For example, the PCN Learning Exchange highlighted an opportunity for more structured pairings between Colombia/Costa Rica and Ghana/Kenya to enable deeper implementation learning and problem-solving support.
5. Support subnational joint learning mechanisms, such as the PHC COP in Colombia, to provide a forum for regular experience-sharing among PHC stakeholders across the country. Subnational joint learning communities can be linked to cross-country learning platforms to support the cascading of learning.

Appendix 1. Country Implementation Cases

COLOMBIA: Strengthening of multidisciplinary PHC teams and facilities in rural territories within the primary care network of El Tambo Hospital in Colombia

Country Context

Colombia has a decentralized health system that currently provides 99% of its residents with comprehensive health insurance.¹⁰ Employers and employees make monthly financial health insurance contributions which allows them access to primary and complementary health care services included in a comprehensive health care benefit package through a network of private and public health providers. The Government subsidizes low-resource populations to ensure access to an equivalent health care benefit plan that is managed by health insurers, which offers health services mainly through public health providers.

The El Tambo municipality covers 3,280 km² and has a total population of 54,198 people, of which 94.9% live in rural areas and 4,242 are indigenous. The population density as of 2021 is 16.52 per km². El Tambo is in the Cauca province in the southwest region of Colombia. There are 19 districts and 215 rural zones, and the urban area has 19 neighborhoods. Most causes of death are related to external events (violence and accidents) and cardiocirculatory diseases. With respect to mortality associated with perinatal causes, there was an increase in this indicator in the previous years that is attributed to the high dispersion of the rural territory and lack of primary health care facilities.^{11,12}

The El Tambo Hospital Primary Care Network opened in 2000. The hub of the network is located in the El Tambo urban area; there are six health posts evenly distributed across the rural areas that serve the remote communities. The main center has ambulance, pediatric, obstetric, and adult admission wards, in addition to an emergency department, clinical laboratory, x-ray, and an outpatient clinic that is comprised of a general practitioner, nurse, dentist, nutritionist, basic medical specialists (i.e., internal medicine, obstetrics and gynecology, pediatrics and psychiatry) as well as physical, respiratory, and speech therapists. Other medical specialties are accessible via telemedicine through agreements held with tertiary care hospitals located in the country's bigger cities. This PCN works in coordination with higher levels of public hospitals located in Popayán, the capital city of the Cauca province that is 40 minutes away by ground transportation, referring more complex patients that need specialized care.

El Tambo hospital mostly receives funding from health insurers under capitation agreements that are linked to the empanelment of a known group of users. Additionally, the health secretariat of the El Tambo municipality allocates resources for the hospital to implement health promotion activities at the community level and also covers costs for health care of a small group of uninsured population. The earnings before interest, taxes, depreciation, and amortization (EBITDA) of the PCN was 14% in 2021.

Based on the current national guidelines for health promotion, health maintenance, and control of the principal causes of disease in Colombia, the El Tambo Hospital health posts offer health promotion and basic preventative services and conduct community outreach for primary care services deployed from the

¹⁰ <https://minsalud.gov.co/proteccionsocial/Regimensubsubido/Paginas/coberturas-del-regimen-subsubido.aspx>

¹¹ Análisis de situación de salud del municipio – El Tambo Cauca. ASIS 2021.

¹² Learn more: <https://www.youtube.com/watch?v=4lyRoloYNU8>

main health care center. Each health post has basic biomedical equipment and a nurse assistant that plays the role of community health worker, who acts in coordination and under the supervision of nurses and general practitioners of the center's hub.

El Tambo hospital also runs an antenatal care program in the territory. However, the PCN faces the challenge of improving the care for the mother-child binomial, particularly in remote rural areas of El Tambo where the access to health services is more difficult. The population has a strong ethnic background with marked cultural differences, and there are harsh topographic conditions, restricted mobility, and safety issues due to the presence of illegal army groups that control the drug traffic in that zone of the country. Other challenges include limited information on the pregnant women within the territory which hinders appropriate follow-up, poor means of communication, scarce resources to invest in technology equipment and qualification of the health personnel, as well as high fragmentation in the sectoral and intersectoral response to address known social determinants of health affecting the health of expectant women. The baseline uptake of the antenatal program was 65.5%, attendance to at least 4 antenatal appointments was 84.5%, and the perinatal mortality rate was 19 per 1,000 live births in 2021. Figures that showed an increase trend in the perinatal mortality rate as compared to previous years, reflecting accessibility barriers to the program, the disruption of the health care services experienced during the COVID-19 pandemic, and quality issues in the health care.

The Implementation Case

The IC team was formed to help strengthen the multidisciplinary health care teams and primary health care rural facilities at El Tambo Hospital PCN, aiming to optimize the performance of the antenatal care program and improve maternal-perinatal health outcomes. The Engineer—María Fernanda Mejía Martínez, Head of the Planning Department—led the team with the support of Diana Marcela Figueroa Hurtado, Coordinator of Specific Protection and Early Detection and registered nurse, as well as Flor Nelly Ante, PCN General Manager. All three are part of El Tambo Hospital Steering Committee.

The IC team defined the following problem and vision statements, and end goals with the support of the facilitation team and peer learners of the Colombian Learning Group and the whole PHCPI COP.

Problem Statement

A high maternal-perinatal morbidity and mortality rate has been recorded in rural areas of El Tambo, particularly during the last year, due to limitations in access and continuity of antenatal care offered by El Tambo Hospital PCN. Social determinants of health such as low educational level of the population, little culture of self-care, working conditions that expose pregnant workers to risks, low economic income of families, food insecurity, pregnancy in adolescence, and poor housing health conditions contribute to this problem. The situation is aggravated by difficulties in the coordination among health services and health posts of the PCN, mainly due to geographical dispersion of the territory, inadequate staffing, limited technical capabilities of the existing health personnel, lack of equipment and biomedical supplies, poor connectivity, lack of an efficient information system, limited intersectoral action, and limited community involvement in the planning and monitoring of the health care services offered.

Vision Statement

Ensure a robust and high-quality primary health care system that contributes to reducing maternal and perinatal morbidity and mortality in rural areas of El Tambo over the next five years, by

addressing the most relevant social determinants of health, strengthening the network of primary health care posts and services of the hospital's PCN, improving intersectoral action and community participation, and ensuring financial sustainability over time.

End Goals

- Goal #1: Characterize the beneficiary population of the maternal-perinatal PHC services of El Tambo Hospital and their sociodemographic and health needs.
- Goal #2: Train and provide appropriate medical equipment and supplies for the multidisciplinary health teams at the health posts of the PHC network located in rural areas.
- Goal #3: Develop tools for capturing, processing, and systematizing the information of the antenatal care program, for the follow-up of pregnant women and technical support of the health care teams in rural territories of El Tambo.
- Goal #4: Define a strategy to strengthen the territorial health management, increase intersectoral action and community participation, and improve the antenatal services and the timely intervention of social determinants of health associated with maternal-perinatal morbidity and mortality in rural areas.

After discussion within the learning community, and considering the knowledge gaps that the IC team recognized as relevant to close to strengthening the implementation efforts of the project, the following learning agenda was jointly defined:

Box 1: Colombia IC Learning Questions

Characterization and risk prioritization of pregnant women:

- Which variables are pertinent to consider for the categorization and risk prioritization of pregnant women in rural areas, in consideration of their social and health situation?
- What methodologies can be applied to achieve the interoperability of the various sources of information for an adequate characterization of the beneficiaries of maternal-perinatal services?

Optimization of the prenatal care information system:

- What clinical and operational variables and indicators are relevant to monitor within an information system aimed at strengthening antenatal care in a PCN in rural areas?

Intersectoral action and community involvement:

- What models of territorial healthcare management, intersectoral action, and community participation have proven to be effective in improving antenatal care and maternal-perinatal outcomes in PCNs, and particularly in rural areas? How to identify the most appropriate community leaders to involve?

Implementation Process

Goal #1. After cross-referencing the "Safe Maternity" database of Cauca, which contains basic clinical data of pregnant women that reside in the province, with the SISBEN (Social Programs Potential Beneficiaries Identification System) database, the team **characterized the clinical condition and socio-demographics health determinants of 265 expectant mothers residing in El Tambo and 30 expectant mothers residing in the urban area of the town.** This characterization allows for a comprehensive assessment of social conditions and health needs of the pregnant population in the territory as well as geolocation of expectant mothers in case of absenteeism to antenatal appointments and a faster response and mobilization in case warning symptoms occur. However, the unsafe conditions of certain rural areas of El Tambo and lack of

connectivity did not allow for socio-demographic characterization nor the geolocation of women in several zones.

Goal #2. After an initial diagnosis of training needs, and with the support of local education institutions, several **continuing education courses were delivered to qualify and certify the PHC staff** of the Hospital (prioritizing 32 assistant nurses/community health workers) in topics such as birth care, health care of victims of intrafamily violence, and basic life support. In addition, the hospital purchased biomedical equipment required to streamline the provision of antenatal care services at the rural health posts, and **lobbied health authorities of Cauca province and external funders to obtain financial resources to acquire computers** to support the systematic follow-up of pregnant women in the municipality's scattered rural areas. At the end of the implementation period, no funding had been received by the hospital for this purpose.

Goal #3. The team **developed an interactive software called "SIMAPE"**, which captures daily individual data of each pregnant woman residing in El Tambo, from existing databases (including the Cauca Safe Maternity and SISBEN databases). This allowed for real-time clinical and socio-demographic information collection by community health workers as they directly evaluated patients at health posts or in their homes during scheduled visits. The SIMAPE tool also facilitates the monitoring of pregnancy progression and the appearance of warning symptoms and biopsychosocial risk factors that demand intervention, therefore supporting the coordination among lower and higher cadres of health staff between the main health care center of the PCN and the health posts in rural areas, and promoting appropriate and timely decision-making. At the end of the implementation period, the SIMAPE software pilot was pending roll-out at the health posts of the PCN due to lack of technological devices.

Goal #4. The IC team **mapped and approached key sectoral actors and stakeholders pertaining to other social sectors of El Tambo** and presented the current situation and associated risks of expectant mothers of the territory in relation with the presence of critical social determinants of health. The team **obtained the buy-in of the Major of El Tambo and some community leaders and started to outline an inter-sectoral roadmap** that determines which interventions should be led by the different actors to comprehensively address significant health determinants. The roadmap defined the *what, how, and when* for each intervention interventions and included efforts to ensure coordination among actors.

Key Lessons and Insights

Main Achievements

1. This work strengthened the characterization system of pregnant women in El Tambo, and particularly of those living in rural areas, through the cross-referencing of existing sectoral and non-sectoral databases of the territory that contain relevant clinical and socio-demographic information.
2. The SIMAPE tool was successfully created for the systematization of pregnant women's most relevant clinical variables and social determinants, in modules that are accessible to health staff of the Hospital's PCN, thus optimizing patient monitoring (including early warning signs) and supporting timely decision-making processes.
3. The problem-solving capacity for those PCN health personnel who work in rural areas of the municipality improved via continuous education actions, the provision of required biomedical

equipment and supplies, and real-time access to pregnant women's clinical and socio-demographic information.

4. A group of nursing assistants/community health workers in rural communities of El Tambo received dedicated skills strengthening as an essential pillar of the Hospital's PHC model.

Key Lessons

The following pillars were identified as essential elements of the IC team's success:

- Teamwork. It is important to define a teamwork strategy that enables synergy of actions, delegation of responsibilities, and monitoring of execution to achieve intended goals.
- Clear objectives and causal chains. The correct delineation of objectives and steps to take to achieve them is essential to conducting efficient and effective work that is rooted in an assessment of needs and priorities. Expectations for results must always align with available resources and availability of team members to execute action.
- Strategic alignment. Aligning proposed actions with the Hospital's strategic platform is crucial, contextualized to the characteristics of the municipality and its community.
- Triangulation of available information sources. The identification and triangulation of information from existing databases within the health sector and other sectors allow for a comprehensive characterization of target populations.
- Tool contextualization and validation. Tools to support monitoring and decision-making for adequate healthcare of a population must respond to that population's characteristics and must be developed in line with the available scientific evidence, current regulations, official guidelines. Tools should also be validated by both technical experts and the PCN teams to ensure the tools will be readily adopted.
- Strategic communication for intersectoral mobilization. A strategy should be developed that defines intersectoral actions aimed at improving a population's living and health conditions. The strategy must be focused on the health social determinants, key actors and their interests and expectations, as well as the implementation of advocacy activities that are supported by evidence, the collection of meaningful indicators, and the prioritization of messages to be communicated. The strategy must use effective data visualization methods and mechanisms to enhance community participation and accountability.

Insights from Peer Learning Process

The PCN COP and the peer learners assigned to follow the Colombia IC, contributed to the design and progress of the IC. Peer learners and technical facilitators were always very engaged during discussions and Learning Exchange events. They shared insightful experiences and technical resources that supported the implementation and addressed challenges identified by the IC team. The facilitators regularly accompanied and offered technical coaching to the team, guiding them across the implementation phases and helping them to solve specific issues. The peer learners following the IC case were particularly useful in the validation of the team strategy to map and link existing databases of pregnant women in El Tambo to improve comprehensive characterization, as well as in the selection of relevant variables to include in the SIMAPE software and the identification of best strategies to approach sectoral and intersectoral

stakeholders in order to build the intersectoral roadmap to tackle social determinants of health responsible of poor maternal-perinatal outcomes.

Next Steps

The IC team will continue strengthening the antenatal care program and other health maintenance programs. Moving forward, the team will focus on the following activities:

1. Complete the clinical and socio-demographic characterization and geolocation for 100% of the pregnant women in the municipality of El Tambo, through domiciliary visits performed by the community health workers and the use of GPS of their mobile phones, as connectivity and the local safety situation allow.
2. Continue strengthening the competencies and capabilities of the PCN health care teams through additional trainings delivered by local education partner institution. Develop additional tools that facilitate updates and evidence-based decision-making processes for other health programs to promote health; prevent and control cardiovascular diseases, neoplasms, and mental health conditions; and monitor growth and development for children under 10 and adolescents.
3. Pilot and encourage the adoption of the SIMAPE tool to facilitate monitoring of pregnant women in remote rural areas of El Tambo (when connectivity issues are overcome). Expand the applicability of the tool for the follow up of other cohorts of patients and users of the hospital's health promotion and maintenance programs.
4. Continue to lobby before territory key actors, with the support of the Major of El Tambo, and share with them strategic information, evidence, indicators, and analysis regarding the condition of pregnant women in the municipality, as well as the maternal-perinatal outcomes and their relationship with social determinants of health, to secure their active involvement in the intersectoral strategy and roadmap to improve the living and health conditions of pregnant women.
5. Promote the involvement of the pregnant women and community leaders to advocate before sectoral and non-sectoral relevant actors that are responsible of improving living conditions, wellbeing, and maternal-perinatal health conditions in El Tambo in an effort to obtain these actors' endorsement, their commitment, and their active participation in the intersectoral strategy and roadmap proposed by the hospital.

GHANA: Striving toward universal health care by transforming care systems with Networks of Practice

Country Context

Through the years, Ghana has undertaken major steps to improve health outcomes, particularly by strengthening PHC. These include committing to PHC in 1978, adopting the Community-Based Health Planning and Services (CHPS) strategy in 1999, and implementing the Community Scorecard in 2018. More recently, Ghana has committed to achieving universal health care (UHC), with PHC at its core and funded by the National Health Insurance Scheme (NHIS) to minimize the impact of catastrophic health spending, especially among the poor.

The past two decades have seen Ghana strengthening PHC by investing in district hospitals and operating CHPS. Less investment was provided to health centers, which inadvertently broke down the critical referral link between the community and district health services. As a result, health centers became the weakest link in health service delivery. As of 2018, only 43% of health centers were fully equipped to provide PHC and by 2020, only 4% of health centers provided Basic Emergency Obstetric and Neonatal Care (BEmONC).¹³ Moreover, the three layers of PHC facilities (i.e., district, health centers, and CHPS) were working in silos, only providing services to communities within their jurisdiction.

Cognizant of the breakdown in Ghana's gatekeeping system, the Ghana Health Services (GHS) proposed to upgrade health centers into Model Health Centers and set these facilities as the hub of networks of sub-district facilities. This idea of organizing PHC service delivery through Primary Care Provider Networks was piloted in ten networks in two districts from 2017 to 2019 with the goal of efficiently using resources to improve quality and coverage of PHC services. The pilot phase generated lessons that PCNs can:

- Be an effective mechanism to deliver quality PHC services to its communities
- Promote collaboration instead of competition, thereby resulting in cohesive services across facilities
- Create an environment for effective task-shifting
- Facilitate effective technical support and promote mentoring
- Increase and result in more effective NHIS reimbursements
- Re-establish and improve referral arrangements and feedback rate, which promote greater client satisfaction

Building on these lessons, GHS was tasked to scale up PCNs by organizing 52 networks in ten districts between 2020 and 2021. Now called Networks of Practice (NOPs), GHS has identified that community participation in the network is critical in generating demand while also strengthening the capacity and leadership of health centers as effective hubs of the network. GHS created core resource teams and developed tools to support the networks. The agency also commissioned implementation research on the equity value of PCNs.

Currently, GHS is leading the nationwide implementation of NOPs, described as groups of facilities (both public and private) organized as hubs-and-spokes, connected to each other functionally to maximize efficiencies, and designated to serve specific geographic areas. This design is founded on Ghana's three-

¹³ Ghana Health Service and Ministry of Health. Concept Notes on Networks of Practice. March 2022.

tier district health system, with particular focus on subdistrict health facilities (health centers and CHPS) while keeping the District Health Management Teams and district hospitals as key support in technical matters and referral system.

Despite current efforts in scaling up PCNs, health centers continue to work in silos without any support from surrounding facilities. Each facility is focused only on its specific catchment population, which is the basis for its performance target. There is no policy that compels them to work together. On the contrary, they compete with one another in getting more clients, since they are paid through capitation as individual facilities and not as a network. District-level leaders also deal with sub-district level facilities directly since these facilities have weak leadership. This further supports the individualistic behavior sub-district health facilities. Health center managers are supposed to oversee CHPS, pharmacies, infirmaries, health work force in marketplaces, sick beds in schools, etc. Finally, community members themselves reinforce the idea that health centers operate in silos by being possessive with their own health facility.

The Implementation Case

The Ghana NOP IC team joined the PHCPI COP in March 2022 with a vision of health facilities at the sub-district level working together as one entity to meet the health needs of the people by providing a package of quality essential health services within five years. To achieve this end, the IC team wanted to learn how to (1) transform the sub-district structure to promote leadership in a network arrangement; (2) shift the culture among health workers to promote co-responsibility in attaining the health outcomes; (3) change the appraisal mechanism from a facility- focused system to network-focused system; and (4) organize the facilities into a network and improve how facilities and health providers are paid in such an arrangement.

The IC team also set out the following short-term goals in this Learning Exchange:

- Develop policy guidelines to guide the operations of NOP within Ghana’s health system.
- Mobilize community leadership to provide support for the NOP.
- Improve the capacity of district and sub-district leadership to provide better coordination for all facilities within NOP and at the district level.
- Improve resource allocation for NOP rather than facilities within sub-districts to enhance shared needs and distribution.

The IC team discussed the causal chain for each of these outcomes to establish a collective understanding between the IC team members and the peer learners on critical activities to achieve them. For instance, developing the operation guidelines for the NOP implementation would require creating a team who would review related policies, draft the policy, and disseminate it for stakeholder comments before finalization. Mobilizing community leaders meant identifying them, orienting them on the objectives of the NOP (particularly in terms of resource sharing), and signing a Memorandum of Understanding with them. Improving the capacity of district and sub-district leadership to lead and manage the NOP would require designing the training program and training the identified district and sub-district leaders. Resource allocation for NOP would require a needs assessment for the entire network and the prioritization of component facilities’ needs. Each of these outcomes became the theme of the monthly Learning Checks with the IC team and assigned peer learners.

During the monthly Learning Checks, the Ghana IC team highlighted their progress towards achieving their identified goals for this Learning Exchange. Achievements included:

- Director of PPMED and team visiting two implementation sites to assess practical inputs into draft guidelines.
- Drafting, then socializing NOP operational guidelines among Regional Directors for input and to draw from lessons in piloting NOP in their area.
- Mobilizing community leaders to support the implementation of the networks.
- Improving leadership capacity within the NOP.
- Drafting guidance for resource allocation across health facilities in the network.

Key Lessons and Insights

The IC team identified several milestones in scaling up the NOP during the Learning Exchange, including:

- An increased sense of ownership/commitment by policymakers and implementers in the NOP/PCN strategy. Stakeholders who support the implementation of NOPs include Regional Directors of Health Services, District Directors of Health Services, Medical Directors, Health Center leads, Private Facilities, communities, civil society organizations, and agencies of the Ministry of Health. Commitment and buy-in are particularly important since the NOPs are purely functional arrangements and not administrative.
- Improved collaboration and sharing of resources (e.g., human resources, supplies) among public, private, and faith-based facilities thereby promoting teamwork.
- Reduced NHIS-denied claims as each network jointly vetted their claims resulting to increased revenue for the facilities.
- Improvement in referral system through use of common communication platforms (e.g., WhatsApp, teleconsultation, and written and oral feedback).
- Large scale consultation with over 400 participants from professional and governance clusters in three regions to finalize the operational guidelines.

Key Lessons

The IC team realized that **consultation with various stakeholders was crucial** to the development of the operational guidelines. The consultative process was interactive, with the goal of getting everyone's inputs. The consultation process also illuminated issues that were originally not included in the subdistrict package, including telemedicine, task shifting, and outreach services.

The IC team also found that **an adaptive approach in establishing NOPs was useful** as it allows the implementors to tailor services according to local context. This approach was particularly effective as the implementors faced challenges in setting up NOPs in areas like sensitization/orientation of participating facilities, building skills and competencies, provision of infrastructure or equipment, appropriate mix of skilled staff, as well as leadership and governance issues. Communicating changes being made in an adaptive approach is particularly important when setting up NOPs.

Engaging the community in the design and implementation of NOPs was also identified as a crucial element of success. Community participation is not only important in generating demand for health services but also important in holding the NOP accountable through the Community Score Card.

While funding for the NOP remains a challenge, the team has been collaborating with many partners including World Bank, USAID, and Ministry of Finance to explore financing options.

Insights from Peer Learning Process

The IC team appreciated the inputs received during the bi-monthly Learning Exchanges and monthly Learning Checks. They referenced these presentations during consultations with stakeholders as they worked to fine-tune the NOP operational guidelines. They applied some of the questions in the learning sessions to evaluate their implementation sites. The IC team also appreciated learning from other countries' experience, which validated what the team was doing and gave them the patience to proceed progressively. They are confident that they will continue to use the discussions and experiences that were shared in shaping the implementation of their NOP policies.

The IC team expressed appreciation of the safe peer learning environment, where they felt encouraged to share their challenges without fear or embarrassment.

Next Steps

Moving forward, the IC team will continue to:

- Finalize the NOP operational guidelines,
- Work with Regional Directors of Health Services, development partners, other government agencies, civil society organizations, service providers, faith-based organizations, National Health Insurance Authority, and other state agencies to scale up the implementation process,
- Collaborate with various stakeholders to enhance the service capacity of health centers and other facilities, build capacity of NOP leaders, and strengthen community participation,
- Advocate for policy change with other government agencies (e.g., group credentialing and accreditation of NOPS with the National Health Insurance Authority and the Health Facilities Regulatory Agency),
- Develop policies in funding NOPS as a unit along with capacity building for fundholding and financial management,
- Strengthen research and documentation to guide the nationwide roll-out and to improve for global learning.

Future Learning Agenda

The IC team has identified three future learning topics to support the implementation of the NOP:

1. **Exploring financing for PCNs and identifying suitable provider payment mechanisms.** This will support their continuing engagement with NHIA to align the benefit package with NOP design, particularly in terms of task sharing, revenue sharing, and financing of preventive services.
2. **Understanding PCN governance and fund management,** particularly in defining the roles of component facilities of the network, establishing the decision-making process in the network, and identifying accountability in financial management and service delivery. This is particularly important since NOPS are functional arrangements and not administrative. Member facilities of the network find the arrangement difficult to separate, making implementation murky.
3. **Methods for operationalizing and scaling up PCNs.** This is topic is of interest as GHS leads the nationwide roll-out of NOPS in the country.

KENYA: Primary care networks in Kenya - It's all about the Money

Country Context

UHC is a national priority for Kenya. Since 2018, it has been one of the country's four priorities for socio-economic transformation. With a population of over 55 million people, Kenya has prioritized PHC as a critical pathway for achieving UHC and allocates as much as 57% of its health budget to PHC.¹⁴ To support Kenya's advancement towards PHC, the country launched a new PHC strategic framework in 2019 based on the existing Health Policy (2014-2030) and the country's UHC roadmap to guide PHC implementation. The framework seeks to ensure that quality PHC services are equitably available to the population and intends to achieve this by organizing PHC service delivery around a network of community and PHC facilities modeled as PCNs. Since the launch of the strategic framework, Kenya has made slow steps in implementation to bring the PCN vision to life. COVID-19 further widened existing inequities in service coverage and quality and demonstrated the imperative need to ensure quality health service was within reach to the entire populace. As a result, Kenya set out to pilot PCNs, as stipulated in the PHC framework and accompanying PCN operational guidelines. This was intended to demonstrate the effectiveness of the approach and utilize the learnings from the process to inform the scale up of PCNs in the country.

As PCN implementation launched in a few counties, the challenge of finding appropriate, sustainable, and adequate financing and resourcing solutions became more pronounced.

The Implementation Case

The initial 2021 pilot project team that operationalized the PCN reconvened as the IC team for the Learning Exchange, with expanded membership that included representatives of county governments and partners. The newly expanded team met as a virtual collaborative and created a safe space for collaborative problem-solving and lesson-sharing. The team consisted of in-country PHC actors in the public sector, civil society organizations, and NGOs.

Problem Statement

The team began by developing a problem statement to guide the learning process. The agreed statement was:

*"Several counties in Kenya are setting up PCNs, with the support of partners. Currently, the financing arrangements for the PCN are unclear and suboptimal. The National Health Insurance Fund contracts and reimburses PHC facilities directly for services given. The benefit package does not cover health promotion and preventive services adequately; the main service provided/catered for is maternity service under the **Linda Mama** program. The PCN governance, coordination, monitoring structures, and mechanisms may therefore not fully support appropriate policies and financing arrangements. How do we ensure PCNs get supported under the current financial landscape?"*

End Goals

Next, the IC team received support to conduct a causal chain analysis which defined the following expected outcomes:

1. Complete costing of PCNs at the national and subnational level.
2. Review of the PCN Financing arrangement.

¹⁴ Click [here](#) for additional data on Kenya's PHC system

3. Model the financial arrangement within the PCN.
4. Monitor, evaluate, and learn from the financing arrangements of PCNs and then document experiences.

The overall goal was *“a well-resourced PHC system supported by a clear and sustainable financial plan that allows for direct flow of funds to health facilities and responds to community needs.”*

Implementation Process

The bi-monthly Learning Exchanges facilitated by the technical facilitators and R4D provided an opportunity for candid discussions on what was unfolding as the IC team worked through the various stages of the causal chain and any challenges they were facing. Since the aim was to learn together as Kenya implemented the case, the IC team also participated in monthly Learning Checks with the facilitation team and peer learners. During these meetings, the IC team would share any questions or challenges they had and provided progress updates.

Midyear in 2022 however, it became clear that monthly virtual Learning Checks for were no longer feasible due to the team’s intense schedules related to the implementation of PCNs and other day-to-day activities. The check-ins moved from monthly to once every two months and from virtual to a hybrid format, incorporating peer learners and remote participation. The desire to incorporate face-to-face meetings, which first emerged as a desire during the previous phase, could now be fulfilled, although the frequency of the meetings could not be as frequent as the original design envisioned.

The first hybrid meeting was held on July 8 and included IC team members as well as representatives from the subnational governments implementing PCNs, PHC researchers, and development partners supporting both the national government and the subnational governments. Some of the members’ presentations included an update on the status of their county-level PCN and the established financing mechanisms. A presentation on making a financial case for PCNs proved to be the highlight of the meeting and a key issue for those trying to convince leadership to increase budgetary allocations. How to measure the performance of the PCNs as well as the financing mechanisms for the PCNs also emerged as key issue areas during the meeting, which coincided with outcome areas in the causal chain.

Other than the competing demands on the IC team’s time due to the government’s financial year, the Kenyan general elections further complicated the team’s efforts to convene due to the voting and the subsequent Supreme Court case challenging the results. Only one subsequent hybrid meeting was possible in October 2022 after the initial meeting in July. It was held as part of a national sensitization meeting of family physicians, since it is envisioned that family physicians should lead the multidisciplinary health teams for the PCNs at the subnational level.

By the end of the 2022, 13 counties were implementing PCNs, which is a significant increase from the initial 5 when the IC team first begun during the pilot phase in 2021, with growing interest from additional county governments.

Key Lessons and Insights

This learning exchange process provided valuable insights for PCN financing, with outputs such as a costing study report completed during Q4 2022 that is likely to contribute to the overall goal of *“A well-resourced PHC system supported by a clear and sustainable financial plan that allows for direct flow of funds to health facilities and responds to community needs.”*

The approach of using causal chains that make use of both quantitative and qualitative evidence to breakdown challenges into actionable components proved to be very useful to the IC team.

Four key lessons emerged from this work:

Design with the public sector calendar in mind. The IC team meetings kicked off as the public sector was in the final weeks of the financial year. This means that the team’s ability to participate in monthly meetings was challenged by the need for them to execute tasks related to budgets, planning, and resource allocation in preparation for the next financial year. Soon after the start of the financial year in July 2022, the country was amid a highly contested general election that also created an atmosphere that made it difficult to convene IC team meetings. Future activity plans of the COP should factor in these types of considerations, both for their potential for advocacy and the possible challenges they may pose.

Be Adaptable. Adaptability continued to be an area for continued learning and insights. With the disruptions to the underlying processes for implementation of the PCNs, particularly the progress towards design and implementation of financing arrangements, it was necessary for the IC team to adjust. The pressure on IC team members time and difficulty of consistently having virtual meetings resulted in the move to a hybrid format and taking advantage of already-planned events to collocate the Learning Checks. This adjustment made it possible to start establishing a cadence for the COP Learning Checks and avoid the barrier of costs might have otherwise kept the hybrid meetings from happening.

Build alliances proactively. Building on previous learnings, IC team participants during the first hybrid session identified parliamentarians as key actors with whom to form alliances due to the role they play in resource allocation and oversight of the executive arm of government. Including them, in addition to other previously targeted actors such as NGOs, academia, private sector, and think tanks, could result in more sustainable and effective advocacy for better financing mechanisms for PCNs.

Proactively support subnational implementers. The involvement of county governments in the IC team was vital, as they are at the frontline in implementing PCNs. Given the county governments’ mandate regarding health care service delivery, they are the ones capable of implementing desired changes in the architecture and financing of their PCNs. Their insights and experience in the journey so far continue to inspire other counties and provides important reference information for those at the start of the process. Supporting county governments also means establishing the resources—human, financial, and otherwise—necessary for advocacy activities aimed at them and development partners to catalyze wider adoption of PCNs in Kenya.

Next Steps

Implementation of PCNs in Kenya continues, with the number of implementing counties expected to grow significantly into the first half of 2023. As more implementers begin the journey of actualizing PCNs, the need for information and insights gleaned by others further along the implementation continuum is becoming more pronounced. The Kenya IC team is exploring how to extend its life beyond 2022 and to proactively include the focal points for PCNs in each county who are likely to be the family physicians.

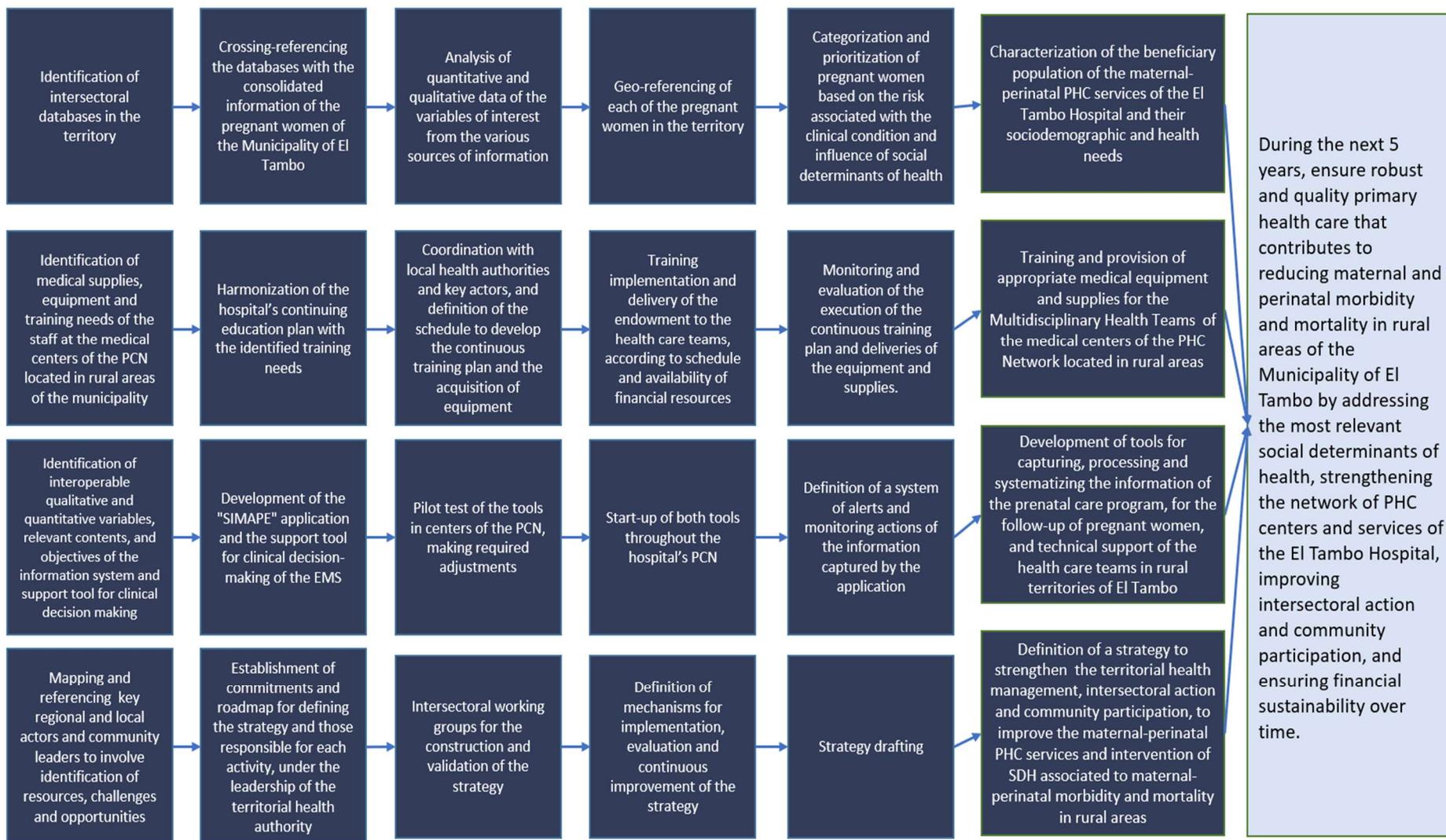
Outreach to and sensitization of both the national Parliament’s relevant committees and the county legislative assemblies was identified during the Learning Checks as a missed opportunity. Outreach to and sensitization of the leadership in the National Treasury and the county government Finance and Planning ministries was also a missed opportunity area for the IC team to focus on in the future. As the

implementors generate evidence on the economic benefits of the PCNs, possible financing arrangements and data on the functionality of existing financing mechanisms, products, and events that target these two main categories of public sector actors could be produced to support progress in implementation of appropriate financing arrangements.

The Council of Governors is a non-partisan body made up of the 47 county Governors and is established under the Intergovernmental Relations Act 2012. Establishing engagement with the Council of Governors, whose mandate includes to support peer learning between county governments through sharing of best practices, will be key for them to host and disseminate the lessons and other products of the PCN implementation to the subnational governments on a consistent basis.

Appendix 2. Causal Chains

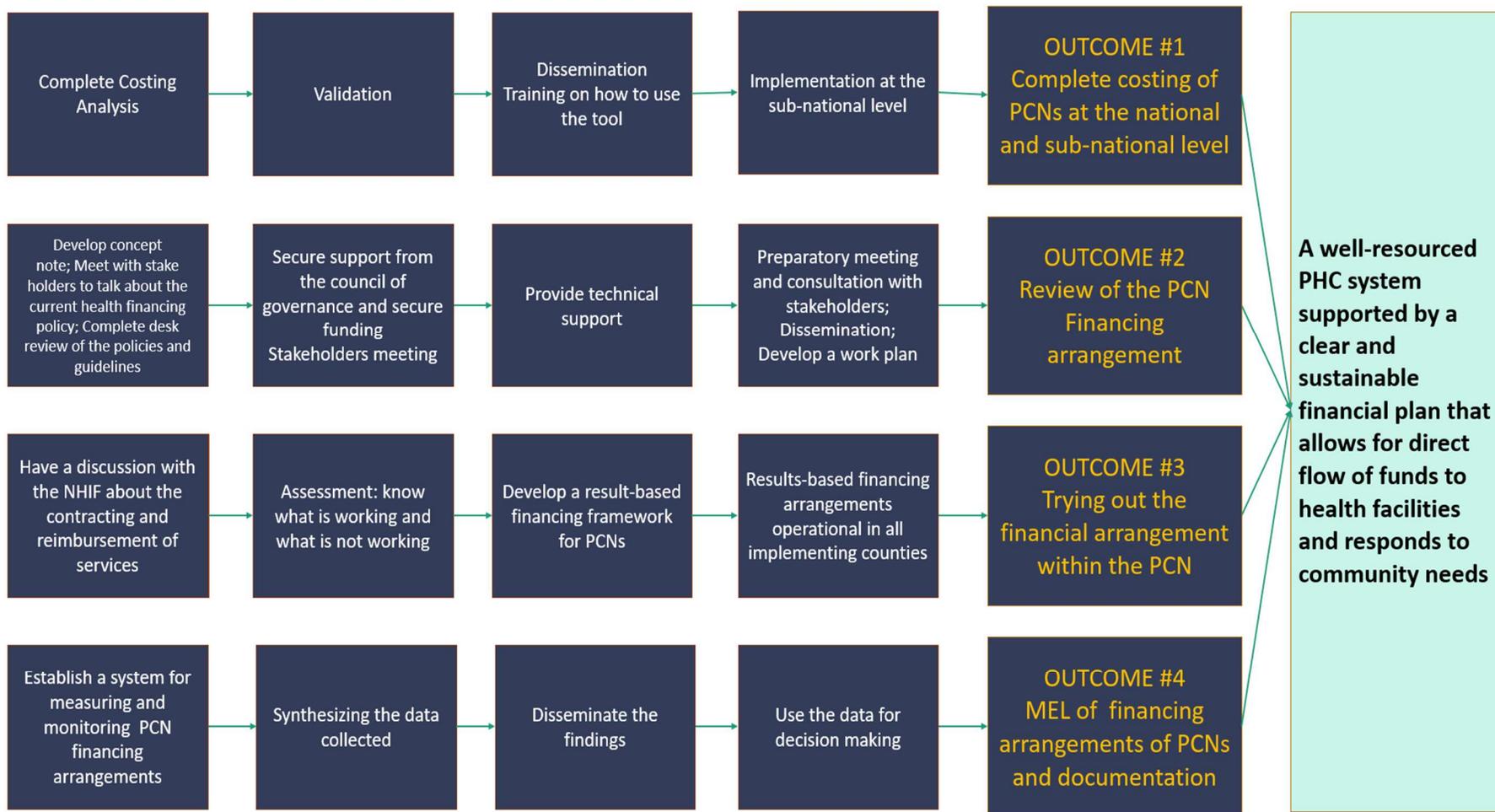
Colombia



Ghana



Kenya



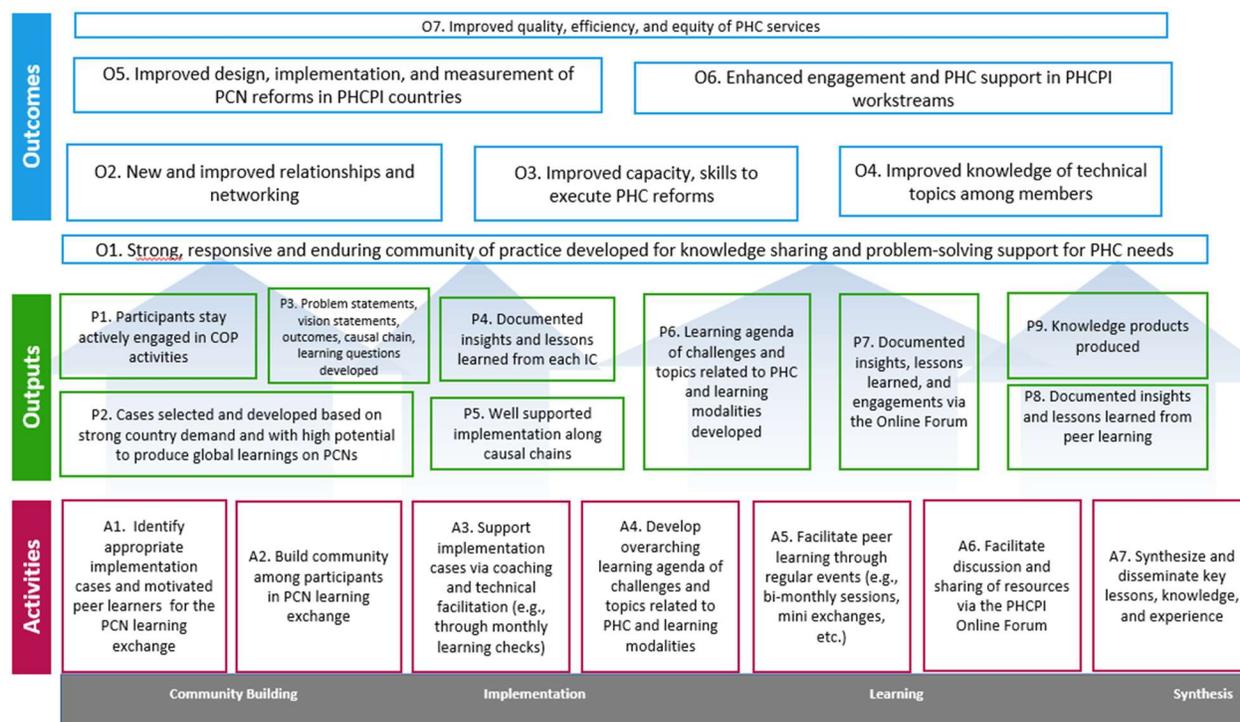
Appendix 3. Monitoring, Evaluation, and Learning Report

Purpose

As PHCPI and JLN embarked on the “Implementing and Measuring the Performance of Primary Care Networks” Learning Exchange, there was an opportunity to monitor, evaluate the effectiveness of, and learn from the COP’s innovative implementation learning approach across the COP individual participants. It was also valuable to assess whether and how the COP may have contributed to outcomes in IC countries related to the design, implementation, and measurement of PCN reforms, and how, if at all, participation in the COP supported PHCPI’s objective of improving the quality, efficiency, and equity of PHC services.

To do this, the COP developed a results framework (Figure 1) and the following Monitoring, Evaluation, and Learning (MEL) plan, which focused on key research questions around the COP approach and outcomes in line with the COP’s results framework. The MEL plan aims to assess the activities and outcomes of the COP and to share with PHCPI and partners evidence on whether and how the COP’s modality can support individual participants, and how that in turn translated into contributions to IC and PHC outcomes.

Figure 1. COP Results Framework



The results framework and associated research questions (Figure 1) adopted the JLN’s outcomes (knowledge, relationships, and practice), as well as additional outcomes related to PCN design and improvement and the quality, efficiency, and equity of PHC services.

Figure 2. Evaluation questions

<p><i>Short-Term Outcomes</i></p> <ul style="list-style-type: none"> • Knowledge: Did knowledge of relevant topics improve among COP members (implementation case teams and peer learners)? • Relationships: Were relationships created or strengthened among members (implementation case teams and peer learners) over the course of the COP? • Practice: How, if at all, did participants (implementation case teams and peer learners) put new knowledge and relationships gained through the COP into practice? • Satisfaction: What is the satisfaction level of COP participants with the COP’s approach? <ul style="list-style-type: none"> ○ What are participants’ perspectives regarding the value of the COP and its objectives of knowledge sharing and problem-solving support for PHC needs? <p><i>Intermediate Outcomes</i></p> <ul style="list-style-type: none"> • Did participation in the COP support the improved design, implementation, and measurement of PCN reforms in PHCPI countries? (high priority outcome) • In what ways did engagement with the COP enhance the performance or outcomes of other PHCPI workstreams? (low priority outcome) <p><i>Long-Term Outcome</i></p> <ul style="list-style-type: none"> • Did participation in the COP support improved quality, efficiency, and equity of PHC services in PHCPI countries? (low priority outcome)
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The MEL Plan was quite comprehensive and, to respond to partners’ demand, ranked outcomes according to their priorities to gauge areas that would need systematic and additional M&E.

Methods and Data Sources

The evaluation questions were answered using a mixed methods approach with primary data collection from a baseline and endline survey including IC team members and peer learners, which was supplemented by KIIs with PHCPI partners, IC team members, and peer learners. Recognizing that outcomes beyond those identified in the results framework may occur and that intermediate and long-term outcomes may be difficult to capture within the scope and timeline of the work, elements of an outcome harvesting approach were embedded in the KII questionnaires for IC team members. Questionnaires for peer learners included a set of *Most Significant Change* questions to assess what outcomes occurred for peer learners.

Table 1. Supplemental Key Informant Interviews

Endline Interviews	No. of Interviewees
IC Team members	7
Peer Learners	7
PHCPI Partner	1

The findings also include analysis from ongoing monitoring of the COP’s activities and their intended outputs via a set of key performance indicators such as participation data and feedback from COP events. Throughout the course of the COP, the MEL plan supported ongoing learning and adaptation of the COP’s implementation learning approach through the facilitation of Learning Checks with the facilitation team to generate timely feedback and evidence to respond to demand from the community of learners.

Limitations

Though the methods provided useful information, there were several limitations. First, the team employed a light-touch outcome harvesting approach where verification was conducted with IC team

members. The team was not able to further substantiate outcomes with independent stakeholders and do a systematic validation due to time constraints but was able to triangulate with documentation captured throughout the implementation learning process by the facilitators. Second, the team was only able to conduct a limited number of KIIs at endline than originally anticipated. Third, the endline survey encompassed a smaller number of respondents (N=24) than the baseline survey (N=50). However, the team was able to conduct direct comparisons between the responses of 18 individuals that completed both surveys. Furthermore, due to translation constraints, Dr. Luis Bernal—the technical facilitator for Colombia—conducted the interviews with the peer learners and IC team members from Colombia, which might have introduced some response bias during the process. However, responses were triangulated and validated as much as possible with IC team responses from the online endline survey. Finally, it was not possible to conduct any KIIs with the Ghana IC team due to availability constraints.

Findings

The MEL approach evaluated anticipated short-term outcomes related to individual participant outcomes (i.e., relationship, knowledge, practice, and satisfaction). The overall goal was to assess networking and new relationships formed from participating in the COP, knowledge of key and relevant themes, and the application of the knowledge and relationship gains into day-to-day practice. Findings from the assessment show that there is strong evidence that participants made significant relationship, knowledge, and practice gains by the end of the COP.

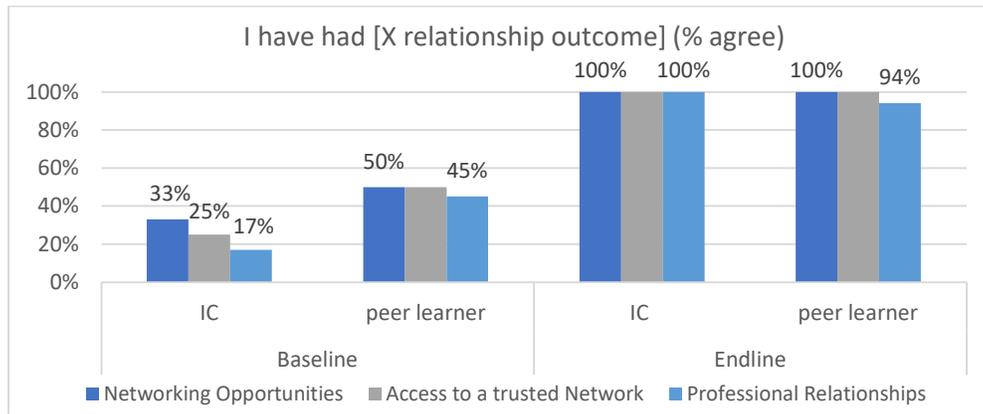
Relationships

A main goal of the COP was to expand networking to create a strong responsive and enduring community of practice for knowledge sharing and problem-solving support (Outcome 1 in the result framework).

At endline, all respondents registered a 54% increase from baseline in networking opportunities, 56% increase in having access to a trusted network, and 58% increase in having professional relationships to openly discuss practical job-related lessons (Figure 3). Peer learners and IC team members both mentioned making new and impactful connections from the COP. When disaggregated by ICs versus peer learners, data showed a stronger increase in networking outcomes for IC team members, as they started out with a lower baseline.

KIIs with IC teams and peer learners provided additional insight into whether and how participant relationships changed throughout the course of the COP. In Colombia, where members of the government served as peer learners, an IC team member from El Tambo remarked that having access to ministerial peer learners exposed their case to policymakers and allowed them to make contacts to strengthen their PHC efforts. When the PHCPI COP hosted a meeting during the Global Symposium on Health Systems Research in Bogotá, the Colombia IC team was able to present and expose their work to national-level stakeholders, further growing their network to support their PHC advocacy efforts.

Figure 3. Average percentage in agreement among relationship outcomes



Peer learners similarly noted increased access to a responsive community of learners and new and impactful connections. One respondent mentioned that they now have a vibrant community to draw upon and work with, and another noted that they now have access to a global network of peers that can point them to the right resources and materials. **The COP also provided an opportunity to form connections with experts in the field.** Three peer learners specifically cited the team of technical facilitators as new connections that could help them in their PHC efforts.

In creating a strong and responsive COP, the team wanted to ensure that participants could conduct outreach to peers outside of the formally scheduled COP events. 38% of respondents at endline mentioned that they reached out to another member within the community for advice or feedback outside of the formal events, and 13% indicated “maybe”. Several noted reaching out to members of IC teams for additional information and fruitful discussions, with one peer learner citing independent conversations with members of the Ghana IC team on Whatsapp.

Both IC team members and peer learners noted that the community of learners allowed them to receive real-time problem-solving support for PCN challenges. Members of the Colombian IC team mentioned that they received support to determine which variables were to be include in the SIMAPE tool the team developed. They also made connections through the Learning Checks with contacts at other universities to support the continuous training of their staff. Members of the Kenya IC team also received materials and information from Colombia and the Ghana ICs to help advance their efforts, and a Ghana team member noted that feedback from peer learners helped to review aspects of their implementation.

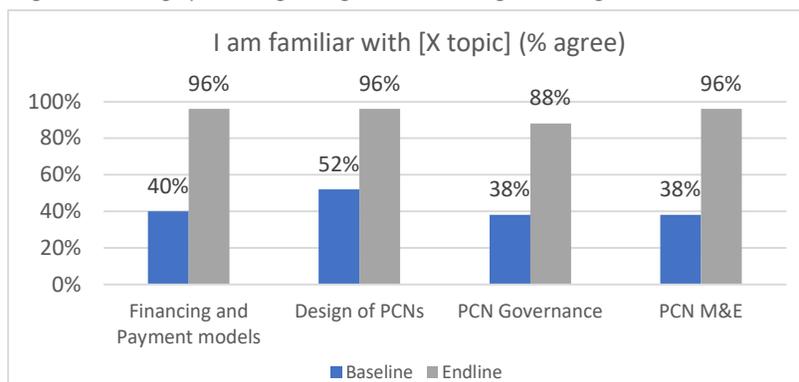
Peer learners also mentioned receiving valuable inputs to support their own work. One peer learner from the Philippines mentioned receiving helping feedback and inputs when discussing difficulties on engaging the private primary care providers in their country.

There were challenges pertaining to the Relationship outcome, however. Several participants noted that they did not fully take advantage of networking and that the virtual platform limited them from forming professional relationships. One participant noted, “I don't think there were opportunities apart from the emails back and forth to have the networking. But I believe that it's an area where more can be applied.” Another noted feeling external as a peer learner that wasn't so engrained within the IC team which made it difficult for them to engage. A peer learner in Indonesia attempted to create a community of learners within their country but found it difficult to engage them.

Knowledge

Knowledge of relevant topics related to PCNs also improved greatly at endline. At baseline, 40% of respondents agreed having familiarity with financing and payment models of PCNs. At endline, this figure rose to 96% – a 56% increase. Similarly, respondents registered a 58% increase on the topic of measuring and evaluating the performance of PCNs, a 50% increase in governance of PCNs, and a 44% increase in the design of PCNs.

Figure 4. Average percentage in agreement among knowledge outcomes



Though knowledge of PCN-related topics was lower at baseline for peer learners compared to IC team members (38% versus 56%), knowledge gains were about the same at endline, signifying a greater improvement in knowledge of topics related to PCNs for peer learners. Peer learners experienced on average a 55% increase in knowledge gained compared to 40% for IC team members (Table 2). Specifically, peer learners registered a 60% increase in knowledge of PCN governance while IC team members only experienced a 16% increase. This could be that peer learners were less knowledgeable of PCN governance at the onset thus further improving their knowledge on the topic. Interestingly, IC team members registered a 67% increase in knowledge of PCN M&E, signifying a large gap in knowledge of measurement at the onset. Peer learners experienced a 55% increase.

Table 2. Average percentage in agreement of knowledge of PCN topics

	Baseline	Endline
IC team members	56%	96%
Peer learners	38%	93%

Indeed, from interviews, several peer learners highlighted newfound knowledge on PCNs. One peer learner in Indonesia started out “with preliminary knowledge on PCNs” but experienced a vast growth in knowledge—enough to discuss with co-workers and directors in the hopes of introducing the initiative in Indonesia. Another peer learner from the Philippines mentioned that the in-depth discussions gave them the tools and knowledge to pursue PCNs as a strategy to support UHC.

The COP also offered an opportunity for peers, even in the implementing countries, to learn more about PHC and PCNs. A peer learner in Kenya mentioned that as someone working with the PHC system, it was important for them to gain this knowledge on the PCN model in relation to their current work. IC team members also learned from the other cases to support proper implementation. A member of the Ghana IC case team cited learning about the inclusion of improvement of clinical experience as a key objective of the PCN in Kenya.

There was also increased access to general PHC tools and resources. A peer learner from Guinea Bissau mentioned the PHC Progression Model and that their COP participation will be useful in their efforts to present and describe recommendations to the government.

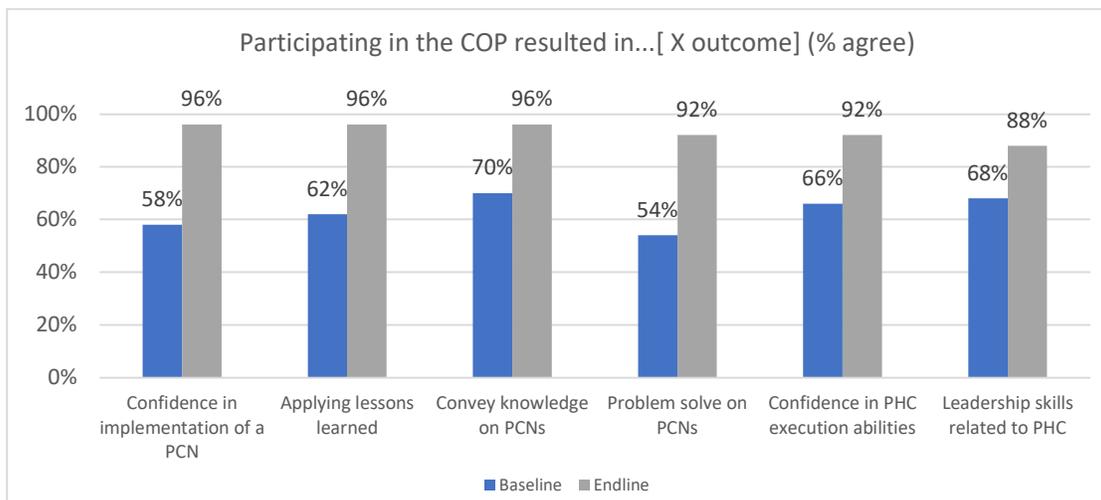
Perhaps an unintended outcome that occurred as a result of the COP is the knowledge in strategies to effectively engage the community in PHC efforts, which was a large focus of the Colombia IC team. A peer learner from the United States noted learning new local community engagement techniques from the Colombian team, and a peer learner from Colombia similarly mentioned the significance of learning about the process that the El Tambo team took to integrate the community in their work. This was similarly cited as a key learning for a peer learner in Costa Rica.

Participants also widely experienced increased knowledge on financing, which was the topic of the first Learning Exchange meeting, and greater knowledge in measurement topics. This could be due to the last facilitated online forum discussion being reoriented to focus more on measurement in response to a survey halfway through the Learning Exchange that examined gaps in learnings.

Practice

One recurring theme from respondents was the desire to translate and share the knowledge gained. Overall, though respondents started with a higher baseline along the practice outcomes (i.e., respondents expressed having confidence and leadership skills at baseline), there were also significant improvements in applying knowledge and relationship gains in practice.

Figure 5. Average percentage in agreement among practice outcomes

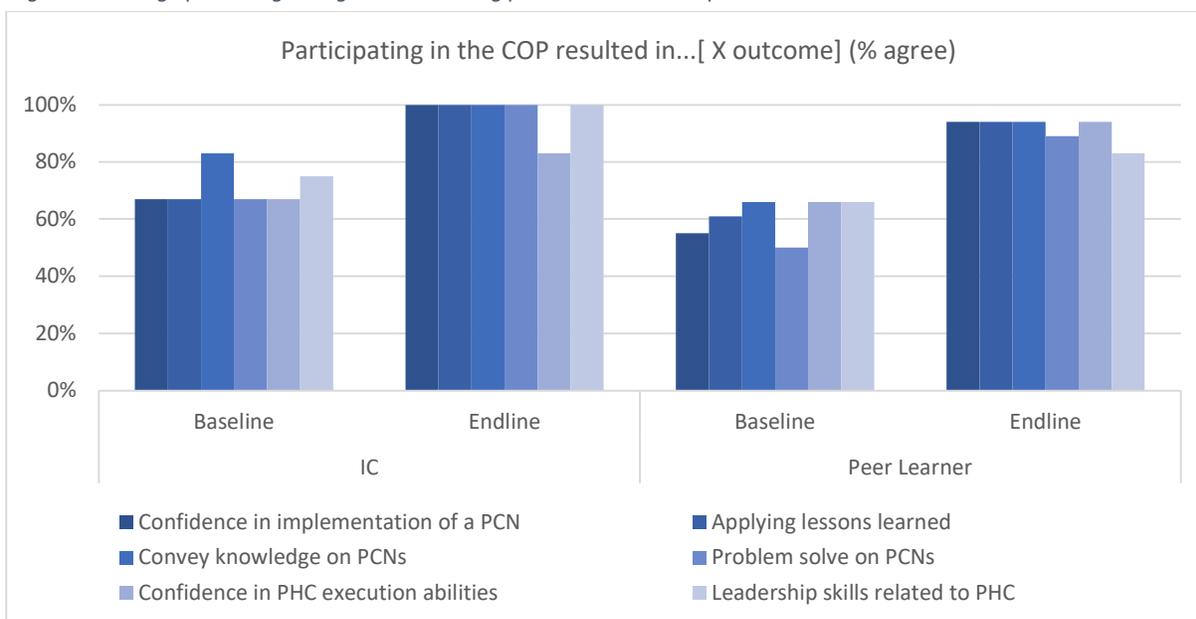


In terms of outcomes related to the knowledge gained on PCNs, all respondents did note a 38% increase in their confidence to implement reforms related to a PCN, a 38% increase in their ability to problem solve on topics related to PCNs, and a 26% increase in their ability to convey knowledge on PCNs.

Disaggregating data shows that peer learners began with a lower baseline than IC team members. Among the practice outcomes, peer learners registered a 31% increase compared to 26% for IC team members. Peer learners registered smaller gains (17%) in their leadership skills related to PHC and larger gains (39%) in their ability to problem solve on PCNs and their confidence in the implementation of PCNs. IC team members experienced the lowest gains in their confidence in their abilities to execute PHC

reforms (16%) and the larger gains (33%) in their confidence in the implementation of a PCN, their ability to apply lessons learned, and ability to problem solve on PCNs.

Figure 6. Average percentage in agreement among practice outcomes – peer learners versus IC team members



Perhaps the most widely cited practical change from respondents was the ability to share learnings in and outside work settings. 75% of respondents mentioned using the content from the COP and the Learning Exchange in their daily work. A peer learner from Lebanon was able to share the knowledge to their PHC teams through trainings, and another mentioned promoting the PCN strategy in their work setting and engaging in multisectoral discussions. One peer learner published an introduction to PCN article and was able to promote it through various platforms.¹⁵ One peer learner also used the information gained to prepare for panel discussions and to advise their respective Ministry of Health during policy development. Another peer learner has shared the learnings during local health board meetings.

Peer Learners also widely cited an increase in confidence as a result of participating in the COP. A peer learner from the Philippines mentioned being more confident and optimistic in PHC efforts. "I became more vocal during discussions with my division, especially when the sharing sessions started," noted the peer learner. The peer learner from Kenya that mentioned the knowledge gained on PCNs similarly expressed a strong desire to replicate the PCN within their county. Some learners highlighted that the COP allowed them to feel motivated, more optimistic because of the knowledge, and driven to further engage in PHC work. One peer learner referred to moving "from frustration to inspiration" as a result of their engagement in the COP. An IC team member from Kenya remarked, "I have adopted a solution-oriented attitude, knowing that there are people I can learn from to help with problem solving." Another peer learner felt a renewed interest in PHC and is planning to apply to a PhD program to strengthen their knowledge in PHC efforts. A consultant in the field that cited not necessarily having a passion for PHC before felt that the COP gave them "the knowledge and awareness to include PHC efforts" in their consultations and "the tools, connections, and resources" to make it happen.

¹⁵ <https://jurnal.ugm.ac.id/jkki/article/view/76236>

Respondents also highlighted a variety of skills (e.g., research, program implementation, measurement, presentation and moderation, and problem-solving) gained from the Learning Exchange. A peer learner mentioned that the learned skills are based “in the involvement and management of communities, which enhances social and community participation in networks.”

One PHCPI partner interviewed mentioned how the COP was a great opportunity for Costa Rica, a country that has also been implementing PCNs, to discuss actively their strategy and provide advice, as they haven’t had a platform to do this yet.

Overall, the findings show that respondents were able to achieve their short-term goals, capture knowledge, and form new relationships. When compared directly at the individual level—among participants that completed both baseline and endline surveys (N=18)—these trends still held, on average. Among those 18 respondents (14 peer learners and 4 IC team members), they showed an average increase of 55% in relationship outcomes, 43% on knowledge of relevant topics, and 29% in knowledge application.

Intermediate Outcomes

The MEL plan additionally sought to identify intermediate outcomes at the country level to which participation in the COP may have contributed—related to the systematic implementation of PCN reforms in-country as well as outcomes related to PHCPI workstream engagement—and the potential for long-term outcomes related to changes in the quality, efficiency, and equity of PHC services in PHCPI countries.

At the beginning of the Learning Exchange, the three IC teams identified a series of short-term outcomes that they would seek to achieve by November 2022. Through the KIIs with the IC case teams at the end of the engagement, the COP was able to assess to what degree the teams achieved those identified outcomes, how the COP may have contributed to those outcomes, and if any other unanticipated outcomes occurred.

Colombia

The Colombia IC team had identified four outcomes in their causal chains (Appendices 1 and 2). By November 2022, they achieved three of the four outcomes, and partially achieved the final outcome. For each outcome achieved, members of the IC teams also identified to what degree the COP contributed to that outcome. The team confirmed that the COP had a major, direct, and real-time contribution to all four outcomes. For Outcome 1 (characterization of the beneficiary population of the maternal-perinatal PHC services), IC team members confirmed that the COP helped in carrying the characterization in real time, and cited support from peer learners from *Javesalud*, a private PCN that offers a large number of PHC services in several cities in Colombia. They also mentioned that a member of the government and peer learners from Costa Rica who supported the identification of topics to include in the trainings (Outcome 2), and, specifically related to the development of the SIMAPE tool (Outcome 3), a team member cited that “the COP helped us on what to incorporate in the database and how we can do things better.” Another member remarked, the COP “gave us a light to follow. If alone, we would have been acting blind.”

Kenya

The Kenya case similarly documented four outcomes (Appendices 1 and 2) in their causal chains with three outcomes partially achieved, and the fourth in development phase. In the previous phase of the Learning Exchange, the Kenya IC had an objective of creating county learning fora for knowledge exchange and implementation learning sharing across the different counties in Kenya. The team was able to create these

fora and replicate the COP's model at the county level, identifying this as an additional outcome and noting that the COP had a major, direct contribution to this outcome. As for the other achievements for the Kenya case, the team found that the COP had some direct real-time contribution to their outcomes related to the review of the PCN financial arrangements. The COP had indirect contribution to two of other outcomes—completing the costing of the PCN and trying out the PCN arrangements. The COP had no impact on the last outcome—the development of the MEL—which is still in development. The IC team said that the implementation acted like a nudge for them to get things done. A team member mentioned that “the COP and of course the regular check-ins and learning from what Ghana was doing, what Colombia was doing, just reemphasize on the need for us to figure out what to do working in our context.”

Intermediate outcomes were not able to be gathered from the Ghana IC team due to scheduling challenges and competing priorities.

Long-term Outcomes

While it was difficult to directly connect outcomes related to improvements in the quality, efficiency, and equity of PHC services to the COP, there were a few relevant mentions of this by both peer learners and IC team members. The COP contributed to the SIMAPE tool in Colombia through peer support during variable selection, and the Colombia IC team predicts an improvement in efficiency of the broad PHC services at the El Tambo PCN and the local and national level due to the SIMAPE tool's facilitation of data collection. The SIMAPE tool was designed to serve as an easy-to-use early warning system to identify symptoms and signs of pregnancy complications in a timely manner and increasing the likelihood of heart treatment or referral to higher levels of care. This type of tool could also be applied to other health programs (beyond just maternal care) such as care for those with non-communicable, chronic diseases or early childhood care. Having a dynamic information tool with centrally accessible data allows providers to closely track PHC activities and the health status of patients, thus allowing them to react more quickly when required. The tool's easy-to-use design also allows providers to have more time with patients when seeking care, which could in turn improve quality of care. The tool is expected to be piloted in some of the PCN's rural health outposts. A member of the IC team mentioned seeing improvement in outcomes as the tool facilitated data collection and as staff were appropriately trained in knowledge and expertise to better carry out their work.

Additionally, the Colombia IC brought the local community into the improvement processes for the delivery of PHC services by the PCN. When community members are integrated into the process they can provide feedback on the quality of care, which can work to improve the quality of services. Allowing communities to be part of the decision-making process gives them a sense voice, which can also work to strengthen the equity of PHC services. Finally, an IC team member mentioned that the COP improved the operation of PHC activities in El Tambo. “The correct delineation of objectives, and the steps to take to achieve them, is essential to carrying out efficient and effective work,” they remarked.

There is new interest in the El Tambo case as the program yields good outcomes, which has allowed the IC team to advocate for an increase in their resources to strengthen the PHC strategy. As a PHCPI institutional partner mentioned, there is a desperate search for good examples to support new PHC reforms coming through, so all the work done in El Tambo could have longer-term effects for how PHC reforms are implemented in-country. While the Kenya IC team did not explicitly mention improvements in equity, efficiency, and quality of care, the team has made advancements through the PCNs to improve the efficiency of care. Additionally, strengthening the knowledge sharing at the county level has allowed

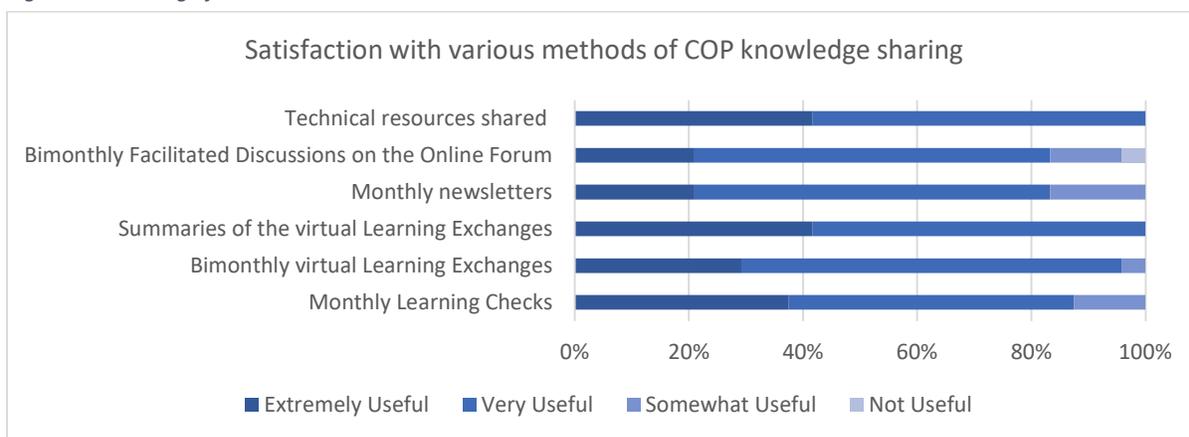
the county teams to learn from one another to implement the PCNs more efficiently in their own context. While information related to improvement in the quality, efficiency and equity of services were not collected from peer learners, through the analysis, a peer learner working on the implementation of a PCN in Costa Rica did participate in a subnational evaluation process with PHCPI and lessons learned on evaluation and measurement is influencing the PCN work to continue improvements in the performance and quality of PHC services.

Additional Outcomes

Satisfaction

Overall, participants were very satisfied with the COP approach. 92% were very satisfied and 8% of respondents were neutral (neither satisfied nor dissatisfied). When asked if they would be willing to continue to learn in a similar format, 71% of respondents were extremely likely and 21% responded very likely. One participant even noted that the COP needs to be a long-term technical assistance strategy. A peer learner from Costa Rica considered it “an excellent learning and growth experience” that can hopefully continue in the future. At endline, participants also rated their satisfaction with the different modalities of the COP (Figure 7).

Figure 7.4 Ranking of COP modalities



Participants rated the technical resources shared and the summaries of the Learning Exchanges as highly useful, and the monthly newsletters and facilitated online discussions very useful. A member of the Kenya IC team mentioned the resources shared, especially the lessons learned from Ghana and Kenya, as very useful. Participants also discussed the COP modality and its usefulness during KILs, where one Kenya IC team member mentioned that the exchange, guidance, problem statement, and causal chain helped them in their implementation.

Challenges

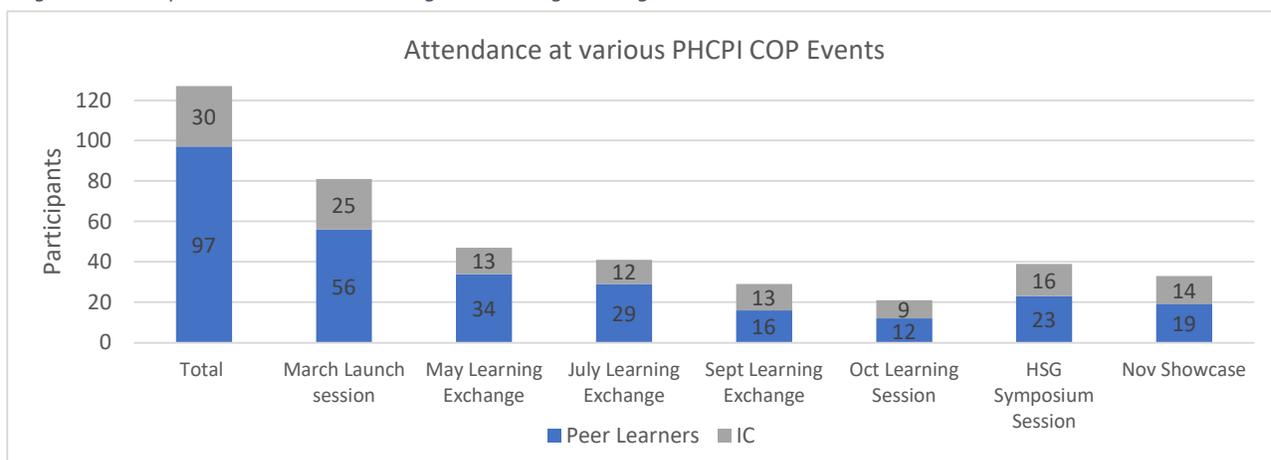
The COP modality was not without its challenges. First, the COP experienced a decline in participation. While 81 members participated in the launch session in March, only 29 participated in the Learning Exchange in September and 33 members were present in the final Experience Showcase in November.

At midpoint, the COP conducted an informal questionnaire with several peer learners, where participants identified other competing commitments as the main barrier to participation. At endline, the most commonly cited challenge related to participation was due to their own time management, followed by

connectivity issues. A participant from Asia noted that the sessions were too late, while others mentioned that it was difficult to carve out two hours to dedicate to the sessions. Despite these challenges, nine participants—including four from Costa Rica—consistently attended all the Learning Exchanges.

Participants mentioned that the virtual nature of the COP made it difficult to stay consistently engaged. One peer learner cited an example where they wanted to provide some input but lost connection. By the time they were reconnected, the facilitators had moved on to another section of the agenda. When probed on why the peer learner did not follow up on their question, they did not feel that it was important to do so. Outside of the sessions, the COP provided the Online Forum and the facilitated discussions as opportunities to continue engagement, but participation was low for these modalities. Some participants mentioned that they were not able to read the different emails from the facilitated discussions, and others just did not have the time.

Figure 8. Participation and retention during the Learning Exchange



Despite the aim to make the sessions inclusive with translation, at times there were translation challenges. Participants from Colombia noted that they had difficulties benefiting from other resources because the newsletters and summaries weren't translated into Spanish. They also did not participate in the facilitated discussions due to translation.

Finally, the COP experienced difficulties integrating the COP within the wider PHCPI Country Engagement workstream despite that being one of the forefront goals of the Learning Exchange. The partner interviewed found it difficult to increase coordination among the COP and other PHCPI workstreams, though the two programs were operating simultaneously in the implementing countries. At the country level, the COP missed the opportunity to further bring in partners.

Recommendations

Respondents were given the opportunity to make recommendations to further support their goals to strengthen PHC. Participants were interested and willing to continue engaging with the COP. Several requested in-person interactions for the future. The team also recommended different modes of communication for the COP (e.g., a Whatsapp or Telegram chat). Other participants noted the desire to have regular access to facilitators despite the ending of the COP.