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Discussions and debates around primary health care, reaching the unreached, and financial protection during the 6th Global Symposia on Health Systems Research 2020

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Abbreviations

AI	Artificial intelligence
BMGF	Bill and Melinda Gates Foundation
CCAH	climate change adaptive health
COVID-19	Coronavirus disease 2019
CT	Computerized tomography
DOH	Department of Health
eMIS	electronic management information system
GBV	Gender based violence
HSG	Health Systems Global
HSR2020	The Sixth Global Symposium on Health Systems Research 2020
ICT	Information and communication technology
MOH	Ministry of Health
NGO	Non-governmental organization
PHC	Primary health care
RMNCH	Reproductive, maternal, neonatal and child Health
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health
UHC	Universal health coverage
UNICEF	The United Nations Children's Fund
WHO	The World Health Organization

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Executive Summary

Introduction

The 2018 Astana Declaration on primary health care (PHC) positions PHC as the cornerstone of sustainable health systems, underpinning achievement of universal health coverage and the health-related Sustainable Development Goals (SDGs). The three main components of PHC are: (1) primary care and essential public health functions as the core of integrated health services; (2) multi-sectoral policy and action; and (3) empowered people and communities. The primary intent of this report is to synthesize discussions at the Sixth Global Symposium on Health Systems Research (HSR2020) relating to PHC, and to identify and explore themes, commonalities, and tensions that arose.

Methods

HSR2020 is not explicitly a primary health care conference and as such some sessions and posters in HSR2020 were about topics peripheral to PHC. We thus applied an inclusion and exclusion criteria to all session and poster abstracts in order to determine their relevance to PHC. Subsequently, we developed and applied a data extraction framework, presented in Annexure 1, mapping **the questions on PHC and equity presented in Health Systems Global's request for proposals against the three broad components of PHC, namely: i) healthcare service provision, ii) multisectoral determinants, and iii) empowerment / participation.** This approach combined Health Systems Global's interest in compiling information that broadly covered the measurement and improvement of service provision and equity with an explicit thematic focus on the three PHC components specified in the Astana Declaration, in order to avoid a narrow service delivery-only view of PHC.

Data characteristics

After excluding content of lower relevance to PHC, we included 217 presentations, spread across three plenaries, 78 oral sessions, and 18 satellite sessions, and 326 posters. Over half of the presentations focused on the first PHC pillar of healthcare services and financial protection, 12% focused on broader determinants of health, and only 6% focused on empowerment and participation. The remaining sessions focused on more than one pillar. It is noteworthy that among the sessions that focused on the first pillar, about half covered healthcare services and financial protection while the remainder related to health system governance. Sessions presented evidence from a range of countries, with "global" being the most frequent geographic descriptor, followed by India, Uganda, Bangladesh and Kenya.

Findings

A. Healthcare service provision

Presentations selected for review under the first major PHC component **– healthcare service provision** - integrated information about healthcare service provision and the governance of the health systems that deliver these services. We grouped findings under three major thematic areas: improving the provision of healthcare services, routine data and measurement, and financial protection.

Improving healthcare service provision

HSR2020 participants strongly communicated that while we

> Without transparency and social accountability … innovative service delivery programs will be undermined by political and other interests.

often know what is needed to improve healthcare services, we lack the **required political will** to provide the resources to follow through. A range of actions were identified as generating political will including legal frameworks that mandate specific health policy actions, advocacy from civil society, media engagement, and cross sectoral political and financial engagement. Presenters emphasised the **need for strategic and longitudinal thinking** in Ministries of Health, rather than reactive approaches to scandals and emergencies.

Alongside political will and strategic thinking, **accountability and monitoring** were demonstrated to be key to improving service provision, in particular for vulnerable populations. Presenters noted that strong oversight through governance improvements or universalizing services was critical to ensure all citizens (poor/non-poor and marginalised/non-marginalised) had a stake in their quality. Without transparency and social accountability, and capacity to keep political interests in check, innovative service delivery programs will be undermined by political and other interests at odds with the goal of enhancing health service. Poor quality care at the frontlines, which included corrupt practices and failure to adhere to standards of care, were described and measured in a number of sessions and posters. **Strategies** for addressing these failures that were **sensitive to the context-specific root causes of corruption** included: salary increases, stronger supervision, discipline by district authorities, opportunity for private practice, notice boards and hotline, and better access to promotion and training opportunities.

Presenters evinced widespread agreement that there are **no magic bullets to strengthening technical quality of healthcare** noting services will better meet the needs of the population when they are adequately funded, when healthcare workers are engaged and well supported, and when community level stakeholders have a voice. **New services must be developed as integrated parts of the community health system**, rather than as standalone 'interventions', and should use the principles of human centred design. A '**culture of quality' is also required**, which involves technical inputs to improve knowledge and capacity, social and governance inputs to remove commercial interests that create perverse incentives, and systems level improvements including adequate pay and respect, particularly for community health workers and nurses. The importance of **robust data to support evidence informed decision making and improve healthcare services** was also part of a culture of quality.

mHealth, or the use of wireless technology to advance health sector goals, was identified as having enormous potential to facilitate coordinated, comprehensive, and continuous PHC. Presentations identified some specific frontier areas of mHealth and digitization, including in expanding the capacity of health workers to provide a wider range of services. Such innovations are particularly important in conflict affected settings, such as areas of Mali, where digital tools support health workers and improve the distribution of resources by sustaining contact with the broader health system. However several presenters noted that **no digital tool can overcome fundamental gaps in the health system**, such as in health worker training or data systems. A system's "readiness for digitization" should be considered before digital tools are proposed, which accounts for internet availability and bandwidth, electricity, hardware, and other infrastructure, health system actor capacity, staff attrition, and staff interest.

Improving data and measurement in the health system

Robust data to support evidence-informed decision making and improve healthcare services is critical, but is only valuable when it is accessed and analysed (i.e. when there is a 'culture of quality'). To allow data-driven decision-making **data must be i) accurate and complete; ii) accessible** (such as data that's integrated into a user-friendly dashboard) and **ii) stakeholders must have the skills, incentives, confidence, and decision space to engage with this data**. The interlinkage between service improvement measurement and governance emerged across many presentations with many examples of the reciprocal relationship between poor quality data and weak governance and vice versa, often with implications for equity. A lack of data or lack of disaggregated data for marginalized populations (including migrants), or overlooked disease burdens (including mental health), for instance, hinders efforts to design interventions, measure progress, and evaluate interventions.

Recommendations for improving the quality of routine health-related data included ensuring that frontline workers and service users **consider the data to be relevant**; **reducing the burden of data collection and entry on frontline workers** through user-friendly and **integrated (harmonized) routine measurement systems**; and improved supervisory approaches **that shift focus from punitive target-driven approaches to supportive approaches emphasising data accuracy** and verification. Notwithstanding these observations, a number of presentations noted that routine measurement systems are not good at capturing information about service quality beyond clinical performance, including broader organization-level factors. Artificial Intelligence was discussed as having potential to support health service administrative functions by working in conjunction with routinely collected data to better track and predict health and healthcare service trends.

While **data sharing among countries within a region is essential for joint planning**, international data sharing arrangements are **hindered by political interests and poor standardization of indicators**. Evidence from the HSR2020 presentations suggests some of these challenges can be overcome through **data sharing arrangements facilitated by independent third-party organizations** who can provide a central data processing unit, act as a cultural broker for linguistic and other barriers, provide an institutional platform for the development of shared norms and regulations, and provide an independent management system that could divide tasks in a more equitable way.

Financial protection and cost effectiveness

HSR2020 addressed a range of issues related to improving financial protection and cost effectiveness in healthcare, from the politics of national level reform efforts to frontline efforts to decrease informal payments, that can broadly be divided into technical and political considerations. Common technical challenges related to financial protection reforms included increases in staff workload; insufficient reimbursement ceilings

to cover actual costs; high rejection rates of insurance claims; slow reimbursements; unaffordable premiums; and unavailability or conversely over-provision of certain services. Presentations identified several ways that digital technology could improve technical aspects of financial protection and cost-effectiveness. **AI-informed diagnostic tools for example could increase efficiency** by predicting service needs and health trends at the population level (instead of the individual level). Digital financial services could be used to expand the coverage of financial protection programs and payment for delivery of services. **Strategic purchasing reforms move from an integrated public system to a public contracting system** wherein health insurance programs purchase healthcare from facilities (usually a mix of public and private facilities). Governments can use strategic purchasing to expand financial risk protection coverage and improve quality of services. Strategic purchasing can incentivize private facilities to provide healthcare to insured users, without users having to pay out of pocket. Contracting private facilities to provide specific primary health services was discussed in several sessions as a way to harness the private sector's human resource capacity and competitive engagement.

> Many of the challenges to achieving financial protection are political and institutional in nature.

While these technical decisions matter, presenters at HSR2020 repeatedly pointed out that **many of the challenges to achieving financial protection are political and institutional in nature**. For example, there is no financial protection without adequate financing. Presenters noted that healthcare services in many countries, in conflict affected or fragile settings, and for marginalized people, such as refugees and economic migrants, are often significantly underfunded and thus unable to provide high quality services to all who need them. While seemingly obvious, therefore, expanding fiscal space for healthcare must not be overlooked as a critical prerequisite to financial protection. Insufficiently financed government insurance programs may set reimbursement rates too low in an attempt to reduce costs and improve 'efficiency'. But such cost saving measures lead to health facilities turning away people with government insurance coverage or charging informal out-of-pocket fees to patients to make up for the shortfall.

The **dual importance of** implementing **technically sound health financing reforms** and **also ensuring political and institutional support for equitable PHC** was a theme emerging from multiple presentations and sessions. Without adequate governance and mechanisms of accountability, power asymmetries and perverse incentives in health systems can frustrate even technically sound financial reform. These power asymmetries are particularly pronounced in healthcare markets and the private sector wherein medical professionals hold informational power as well as social and economic power over patients, who must make decisions for themselves or family members, often under time pressure. Several sessions focused on migrants in particular, emphasizing that financial protection and service access should be portable both within and between countries and must account for family members who move with the migrant worker and who remain home.

A key theme emerging from financing-focused presentations was that **governance arrangements should be at the center of the health financing policy agenda**. Health **insurance providers must become "learning organizations**" that can take and respond to feedback, and a **robust regulatory infrastructure must be in place** in particular with regards to government and donor engagement with the private sector. Researchers and implementers noted that **governance and accountability mechanisms are highly context dependent,** and it is likely that each setting will require a different set of mechanisms to effectively engage multiple stakeholders. This was particularly the case given that **social and cultural norms and hierarchies**, whether at healthcare facilities or in society more broadly, emerged as **a determinant of social accountability**. Social norms in health facilities may strongly support the persistence of informal payments among healthcare providers, and may lead to healthcare providers resisting governance reform to remove these payments. Widespread cultural acceptance of informal healthcare payments among patients and providers may stem from and be reinforced by power and class differentials.

B. The broader determinants of health

Incorporating a focus on the **determinants of health**, including nutrition, gender relations, housing, food insecurity, climate change, and employment, reflects global understanding that a broad range of factors beyond healthcare services shape health and well-being. HSR2020 provided promising directions for the **integration of health and social services, including in the context of COVID-19**. Examples included collaborations between health programs and local social welfare departments to ensure targeted referrals and support, and income compensation activities to support breastfeeding for women working in informal sectors. In the context of highly vulnerable communities, such as those living in informal settlements or refugee and migrant populations, presenters noted an urgent need for an integrated, holistic approach that positions health, nutrition, housing, security, employment, water, sanitation, and other needs as complementary and interdependent. **Accountability initiatives, such as the use of mobile phones to document and expose failures in health and social service delivery, can also facilitate improvements for remote or underserved areas.** Improvements to health

Broader social context will shape citizen willingness to demand accountability for PHC.

services had the potential to directly improve trust and collaboration between political factions in fragile settings, and to therefore improve broader determinants of health such as peace and security.

Linking broader determinants of health to PHC requires multisectoral action, which several presenters noted was hindered by **weak governance mechanisms to coordinate within and across sectors**. There were, however, promising examples of institutional arrangements and governance to facilitate coordination and multisectoral action across government and civil society, such as **coordination units, committees, and national consultative meetings**. The **politics of non-state actors** whose interests might stand in opposition to key public health measures, such as industry groups, was also discussed at several sessions.

HSR2020 included several promising examples of measurement approaches to assess and track progress on the broader determinants of health, including from climate sciences and migration studies. This type of research provides a clearer picture of the drivers of inequitable access to PHC and also underscores the need for a **multisectoral approach to PHC improvements**. Presenters emphasized the urgent need to expand research on the multi-sectoral challenges faced by **vulnerable or marginalized** communities, for example understanding marginalized communities' exposure to climate change and pollutants, or expanding research on informal settlements.

C. Empowerment and participation

Improving empowerment and participation demands an understanding of the drivers of the disempowerment faced by many communities, particularly the most vulnerable. **Broader social context will shape citizen willingness to demand accountability for PHC.** Power differentials between providers and patients, social norms around informal payments and other facets of corruption, fraud and abuse, and intersecting vulnerabilities for the most marginalized, strongly impact initiatives to expand participation and empowerment for PHC and health and social services more broadly.

HSR2020 highlighted some key initiatives to strengthen empowerment in the context of PHC. Approaches that address either 'bottom-up' (grassroots, community-driven) or 'top-down' (structural and financial reform at facilities, organizations and government) were considered by many presenters to be insufficient; research presented at HSR2020 indicates that multi-pronged strategies are needed to fully address the underlying drivers of disempowerment. The engagement of community members in the **co-production of research, monitoring, and evaluation**, through 'bottom up' mechanisms such as scorecards, community advisory boards, and needs assessments, facilitated improvements in health and social service delivery within enabling 'top down' environments. Initiatives such as **multi-level citizen engagement efforts** and **expanding underrepresented groups in health workforces** directly resulted in improvements in the availability of services, supplies and staffing, and, ultimately, health outcomes.

Efforts to strengthen participation and accountability must specifically engage the most vulnerable. Presenters at HSR2020 provided key insights on how this can be accomplished. **Institutionalizing citizen participation in agenda setting and planning through laws and policies** has shown to be effective in several South American countries. In addition to legal requirements, participatory processes must ensure inclusivity and effective participation through **targeted promotion among citizens and citizen groups, practical support, and development of multiple avenues for input and debate**. These supports can include orientation and training processes for citizen participants, and the use of practical frameworks to guide step-by-step progress.

HSR2020 contained very little content on the routine assessment and tracking of empowerment and participation within the health system. Presentations and posters focused more on research methods involving the community as a means to capture community voice (particularly scorecards but also methods such as PhotoVoice). Nonetheless, some overarching principles were articulated that can be used to generate the indicators, data collection methods, reporting systems, and frameworks necessary to measure empowerment and participation in health systems at scale. **First, the co-production of knowledge and co-design of services in health systems must become the norm.** HSR2020 included presentations on useful approaches in this space, such as the institutionalization of community-led governance tools (e.g., scorecards), multi-level monitoring, accountability frameworks, and human centered design approaches. **Second, routine tracking of components to foster empowerment and participation in health systems is necessary and possible.** For example, health committee contributions to accountability in Brazil were assessed across three aspects of accountability: level of performance, level of community engagement and participation, and degree of influence on issues pertaining to the community.

Conclusion

HSR2020 showcased that achieving PHC for all requires both **technically sound policies** and programs **as well as political support in the form of adequate financing and governance structures**. The three pillars of PHC - healthcare services, multisectoral determinants, and empowerment and participation - must intersect and engage closely to ensure lasting improvements, particularly for marginalized and vulnerable communities.

Discussions and debates around primary health care, reaching the unreached, and financial protection during the 6th Global Symposia on Health Systems Research 2020

Introduction

Health Systems Global, with support from the Bill and Melinda Gates Foundation (BMGF), commissioned this report to capture discussions and debates around primary health care (PHC), including reaching the unreached and ensuring financial protection, during the 6th Global Symposium on Health Systems Research. This symposium was scheduled to take place November 8 to 12, 2020 in Dubai. Due to the coronavirus disease 2019 (COVID-19) pandemic, HSR2020 was converted into a virtual symposium that took place as a series of livestream and on-demand sessions over 13 days from 8 November 2020 to 31 March 2021.

HSG and BMGF commissioned this work to bolster the impact of HSR2020 in furthering PHC for all by enabling a wide audience to comprehend and engage with the symposium's sessions and by shaping future research, funding, and policy priorities for health systems strengthening and universal health coverage. HSR2020 is a space where cutting edge research, current policy debates, and community voices intersect to shape PHC research agendas, activist demands, and, ultimately, health policies and programs.

The 2018 Astana Declaration on PHC positions primary health care as the cornerstone of sustainable health systems, underpinning achievement of universal health coverage and the health-related Sustainable Development Goals (SDGs). The three main components of PHC are: (1) primary care and essential public health functions as the core of integrated health services; (2) multi-sectoral policy and action; and (3) empowered people and communities (Figure 1) (WHO & UNICEF 2018). The primary intent of this report is to synthesize HSR2020 discussions relating to PHC, and to identify and explore themes, commonalities, and tensions that arose.

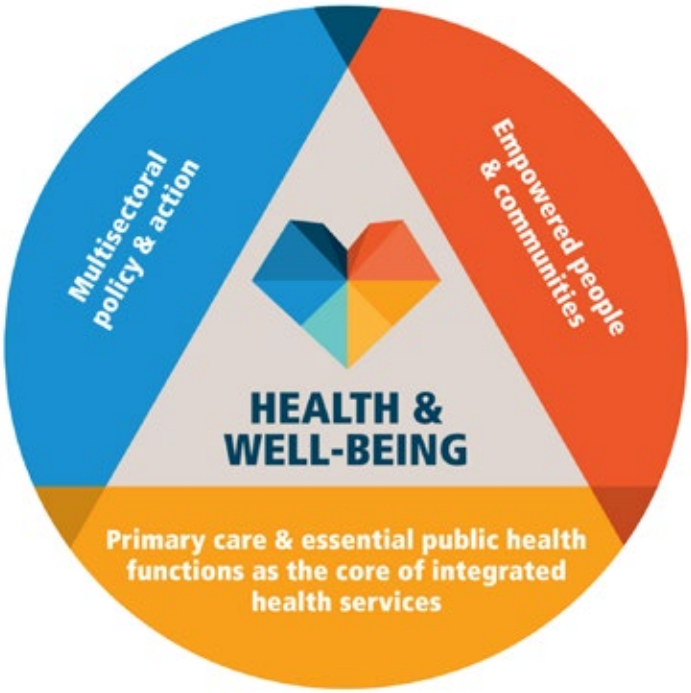

Figure 1. The components of primary health care, reprinted from the WHO & UNICEF (2018) under the CC BY-NC-SA 3.0

Methodology

Team

Our team consisted of six researchers (Scott, Sriram, Kabue, Schaaf, Topp, & Mohan), who joined this project as independent consultants; several held affiliations with public health institutions: the Johns Hopkins Bloomberg School of Public Health (Scott, Mohan), the University of British Columbia School of Population and Public Health (Sriram), Jhpiego (Kabue), and the James Cook University College of Public Health, Medical and Veterinary Sciences (Topp). We brought to this assignment diverse global perspectives, professional backgrounds, and methodological expertise, united by deep commitment to strengthening PHC and health equity.

Inclusion and exclusion

While all oral sessions and posters in HSR2020 could have some relevant content on PHC, financial protection and reaching the unreached, HSR2020 is not explicitly a PHC conference. As a health systems research symposium, some sessions and posters in HSR2020 were about topics that were peripheral to PHC, financial protection, and equity; in particular, many sessions were focused on approaches, methods, and uptake of research, which were of lower relevance to this report's focus on PHC itself. Given the need for efficiency, we applied an inclusion and exclusion criteria to all session and poster abstracts in order to determine their relevance to PHC (Table 1).

Framework and data extraction

We developed a data extraction framework, presented in Annexure 1, that encompassed: (1) the specific questions proposed in Health Systems Global's Request for Proposals on Capturing PHC discussions from 26 June 2020: (2) the HSR2020 theme ("Re-imaging health systems for better health and social justice") and sub-themes (engaging political forces; engaging social, economic and environmental forces; and engaging technological, data and social innovations); (3) the WHO primary health care framework (2018) in "A Vision for Primary Health Care in the 21st Century" and (4) the framework developed by the Primary Health Care Performance Initiative (Veillard 2017). **We mapped the questions on PHC and equity presented in HSG's RFP against the three broad components of PHC specified in the WHO & UNICEF (2018) framework: Healthcare service provision, multisectoral determinants, and community empowerment/participation**. We decided to combine HSG's interest in compiling information that broadly covered the measurement and improvement of service provision and equity with an explicit thematic focus on the three WHO-specified PHC components. This would ensure that we avoided a narrow view of PHC (focused on health services) in favor of a more

Table 1. Classification criteria for sessions and posters in HSR2020 by relevance to primary health care, financial protection, and equity

Inclusion	Classification system	Definition
Include	Higher relevance	Focused on the actual provision of health services or other multi-sectoral or community engagement actions, including studies exploring the link between health outcomes and various healthcare programs, services, policies. Evaluations of healthcare insurance schemes and other financing systems and studies describing the current access-to-care or care-seeking situation or attempts to improve these.
	Medium relevance	Focused on one level removed from service provision, such as improving routine data management, supply chains, financing mechanisms. Also includes research on factors that shape the nature of health services, programs and policies (norms, priorities, governance). Sessions on who has a voice in policy making and sessions on improving how to track or measure health indicators and challenges such as out of pocket expenditures were also considered to be medium relevance.
Exclude	Lower relevance	Focused on two levels removed from service provision such as research on the impact of or methods used in health systems research, or research describing the nature of a problem (like climate change or how much households spend on illness) but not the health system program or policy approach to addressing the problem.

comprehensive one (focused on health services, intersectoral action on broad determinants of health, and empowerment). The framework systematized our data extraction process into a Google Sheet.

Sessions and posters were divided among the research team. The researcher responsible for a session listened to it while viewing the visual material (e.g., PowerPoint slides, presenter videos) and reviewing the chat box dialogue. Whenever the data extractor identified content on PHC/equity/financial protection, they summarized what was said into the appropriate cell(s) of our data extraction framework.

Analysis and writing

Analysis involved identifying and summarizing themes that emerged across presentations and discussions relating to PHC and financial coverage and equity, according to the three pillars of primary health care (healthcare services, multisectoral determinants, and community empowerment/participation). Early themes were identified through writing a longform analytic synthesis document that drew out findings and linkages. These themes were then synthesized into a shorter thematic report and consolidated into this report. The initial themes were augmented and adjusted in light of the discussions captured in later sessions.

We avoided a narrow view of PHC.

Findings

Overview of sessions and posters

After excluding content of lower relevance to PHC, we included 217 presentations, spread across three plenaries, 78 oral sessions, and 18 satellite sessions, and 326 posters. Over half of the presentations focused on the first PHC pillar of healthcare services and financial protection, 12% focused on broader determinants of health, and only 6% focused on participation. The remaining sessions focused on more than one pillar. It is noteworthy that among the sessions that focused on the first pillar, about half covered healthcare services and financial protection while the remainder related to health system governance.

Sessions presented evidence from a range of countries, with "global" being the most frequent geographic descriptor, followed by India, Uganda, Bangladesh and Kenya. Figure 1 presents a word cloud of the geographic descriptors, wherein larger text size indicates greater frequency of appearance.

We now present thematic findings on primary healthcare, reaching the unreached, and financial protection, grouped according to the three pillars of primary healthcare: (A) healthcare services, (B) broader intersectoral determinants of health, and (C) governance and participation. Within each pillar, we focus on funding, policy, and practice relevant lessons, with particular attention to equity and the role of measurement in tracking and facilitating progress.

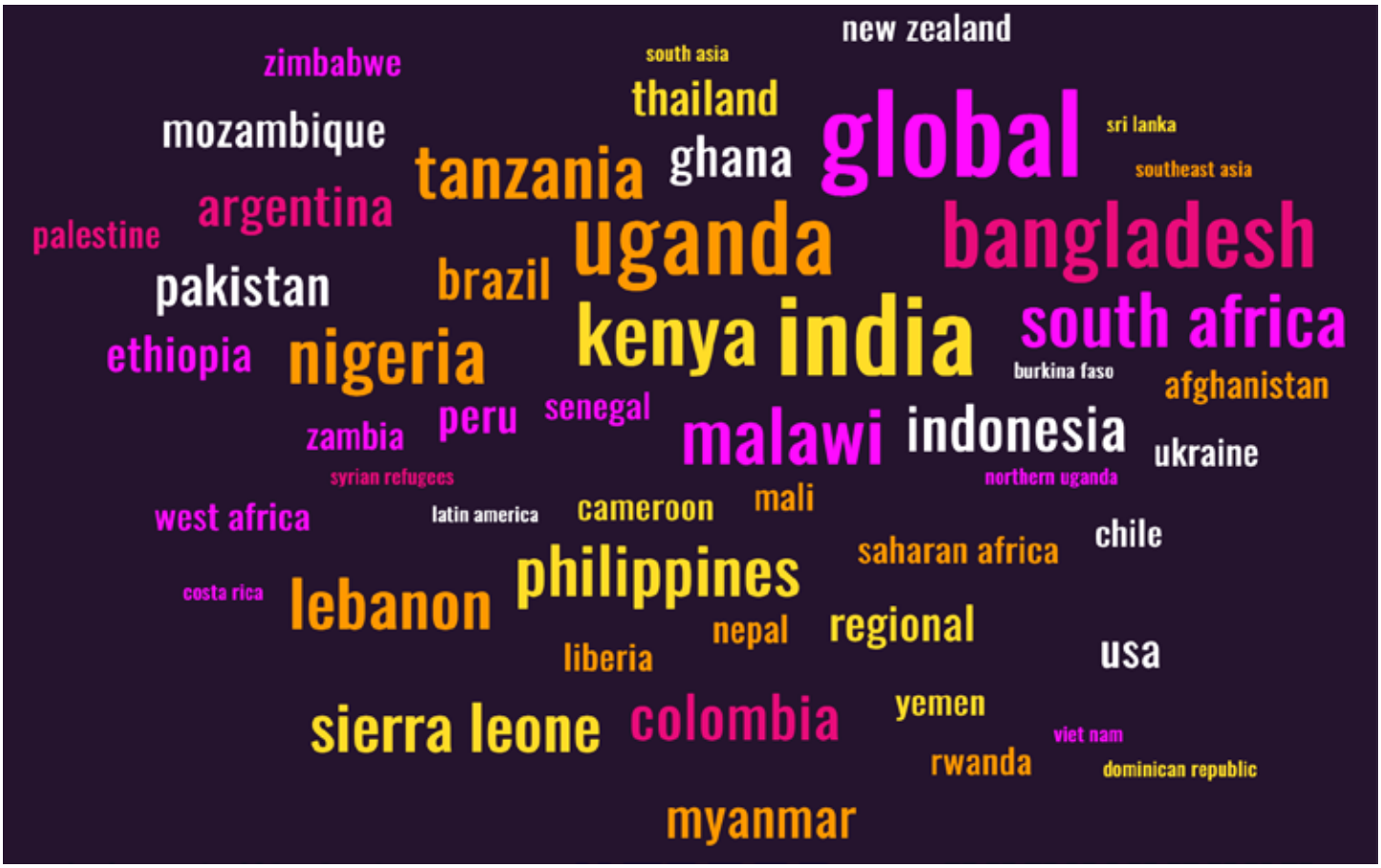

Figure 2. Word cloud of geographies represented in the HSR2020 sessions and posters that we included in this analysis of discussions on PHC

A. Healthcare services

The first pillar of PHC is integrated healthcare service provision, which includes health education and outreach; promotive and preventive care such as screening, immunization, health monitoring, and health behavior change support; maternal healthcare; and the treatment of illnesses and disease. These services rely on the health workforce, health information systems, medicines and commodities, health systems financing, and leadership and governance. Presentations and posters in HSR2020 discussed these building blocks in an integrated manner. We present themes that emerged from HSR2020 on healthcare services, first in terms of improving the provision of healthcare services (A1), then in terms of routine data and measurement (A2), and finally in terms of financial protection (A3).

Political commitment is vital.

A1. Improving healthcare service provision - what works?

Political will is needed to improve service provision

HSR2020 participants strongly communicated that while we often know what is needed to improve healthcare services, we lack the required political will to provide the resources to follow through. Political commitment to extending healthcare access to all is vital and includes broad commitments to adequate financing as well as specific political facilitators such as giving residence permits to refugees. Political commitment is required to ensure that guidelines to promote equity in health are coupled with rapid evaluations to track implementation. The Sustainable Development Goals (SDG) focus on "leaving no one behind" may be able to generate or harness political will specifically for marginalised populations - such as migrant access to healthcare - through building synchronized data systems to ensure continuity of care, and implementation research to adjust health interventions in rapidly changing contexts.

But how does a society generate political will on healthcare service provision issues? Box 1 synthesizes the range of actions that may be required.

BOX 1

What factors emerged from HSR2020 on generating political will to improve healthcare service provision?

- Advocacy from civil society (particularly when seeking to generate political will on sensitive topics, such as abortion and comprehensive sexual and reproductive health services, or for populations with limited political voice, such as minorities, migrants, adolescents, and survivors of gender-based violence)
- Research evidence to illuminate the scope of the problem and to mobilise commitment to policy development
- Media engagement
- Cross sectoral political and financial engagement
- Legal frameworks that mandate specific health policy actions, such as on urban health
- Collaboration among key stakeholders
- A collaborative framework that specifies roles and responsibilities

BOX 2

Example from an urban healthcare program in Bangladesh, which was undermined by poor governance

The government in Bangladesh contracted non-governmental organizations to provide urban primary health care services. However, the program was stymied by governance issues, linked to:

- Party politics, wherein project staff affiliated with the opposition party had trouble working with staff appointed from the leading party;
- Inter-ministerial friction between the local government and the Ministry of Health and Family Welfare, resulting in, for example, delays in supplying essential supplies such as contraceptives;
- Corruption in the selection of NGOs, including NGOs being selected through bribery;
- Resource hoarding, wherein more affluent community leaders channeled resources towards their allies and communities, excluding the most marginalized;
- Political meddling, wherein government actors pressured NGOs to hire preferred personnel, even when they lacked qualifications.

(Contracting-out urban primary health care for the urban poor in Bangladesh: Influence of politics and power on provider performance)

Two examples from HSR2020 exemplify these principles. Advocacy coupled with rigorous and compelling research data forced government actors in Colombia to acknowledge the crisis of Venezuelan migrants being excluded from healthcare, and ensured the continuity of Nigeria's maternal and child health policy after a change of government in 2015.

Reactive policies and fragmented health system components undermine PHC

There is a need for strategic and longitudinal thinking in Ministries of Health, rather than reactive approaches to scandals and emergencies. Fragmented systems (information systems that are siloed from each other or from quality improvement processes, disease-focused systems, patchwork insurance systems) must be unified, using a PHC lens, to enable them to absorb shocks while maintaining essential services, including for vulnerable groups such as migrants. Guinea and Thailand were discussed as two countries that learned from health crises (Ebola in Guinea and H1N1 and a tsunami in Thailand) and are now coping with COVID-19 with longer term vision, strengthened epidemiological surveillance, and new governance, ethics and community engagement structures that better cope with system shocks.

Accountability and monitoring are required to improve service provision

The refrain that services for the poor are often poor services was reiterated at HSR2020. Participants pointed out that this tendency towards poor quality can be assumed and can be prevented through two key approaches: either coupling these services with strong oversight through governance improvements or universalizing services so that the non-poor have a genuine stake in their quality. Without transparency and social accountability, and capacity to keep political interests in check, innovative service delivery programs will be undermined by political and other interests at odds with the goal of enhancing health service (see Box 2 for an example from Bangladesh). Poor quality care at the frontlines, which included corrupt practices and failure to adhere to standards of care, were described and measured in a number of sessions and posters. A range of frontline strategies for reducing corruption among health workers exist, but it is not always obvious which ones will work, as health systems are complex adaptive systems. Strategies to consider include: increasing healthcare provider salaries, stronger supervision, discipline by district authorities, opportunity for private practice; use of receipts, notice boards and hotlines; and better access to promotion and training opportunities. Measuring the extent of corruption

was discussed as challenging, and most presenters focused on strategies to reduce rather than assess corruption. One session *(Addressing corruption, fraud and abuse in human resources for health: a policy lens)* noted that health worker shortages can indicate the underlying presence of corrupt practices, while another *(Achieving progress on anti-corruption and accountability: towards policy options that recognise power and politics)* flagged that data on health worker staffing may mask corruption in the form of persistent absenteeism. Reducing corruption in the non-profit sector was discussed in *What do we know about corruption in nonprofit health sector organizations? A systematic review of evidence from South Asia,* and suggested interventions included that more data be recorded electronically, including data on supplies and payments; that these data are shared/transparent; and that data be open access, including for vacancies. Several presenters emphasized that common practices - such as demands for informal payments - can have different rationales and meanings in different settings, and thus, that policy responses should be responsive to the local context.

Corruption in frontline service delivery emerged as a key manifestation of lack of accountability and effective monitoring. Presenters explained that corruption emerges from a complex interplay of factors, including: informal relationships and conflicts of interest that impede regulation; the challenge of transforming the whole sector, and related failure to recognize the way corruption and informality can involve a problem-solving element in response to resource and commodity shortages in frontline services.

HSR2020 brought us several examples of success, where accountability and governance reforms to reduce corruption or malpractice succeeded in improving healthcare service provision and health outcomes. Scorecards in Kenya and Malawi showed potential to improve quality in health facilities, in part by initiating competition between facilities. An evaluation of social accountability interventions for RMNCH in multiple countries found that the interventions improved intermediary outcomes such as increased funding for services, improved rates and timeliness of healthcare seeking, improved staffing, improved capabilities of rights holders, and improved provider practices (*Evaluating and implementing a social accountability intervention for family planning and contraceptive service provision*). Ukraine's 2014 health system reform provides a compelling positive case (see Box 3). In Uruguay, tobacco consumption has declined due to evidence-based tobacco cessation interventions coupled with successful legal action against "big tobacco." This legal action used acts passed by a tobacco control committee that included the representatives from the Ministry of Health, civil society, academia, cancer and cardiovascular health commissions, and the national medical association.

Scorecards in Kenya and Malawi showed potential to improve quality in health facilities, in part by initiating competition between facilities.

BOX 3

Case study: Ukraine's health system reform

There were very high levels of corruption in the Ukraine health financing system, especially at the level of primary care. Informal payments for health services were widely accepted and expected. The government initiated a health system reform process in 2014, which improved leadership and governance at national, regional, and provider levels; increased financing; expanded the health workforce; and improved access to essential medicines. Key ingredients of success included the media's important role in highlighting progress and challenges, evidence-based policy changes, and the use of technological innovations that introduced greater transparency. This reform process has reduced corruption and increased healthcare access and equity.

(Health System Strengthening Using Systematic Health Reforms and Accelerators: Ukraine Experience and Imagining the Future of Health Systems).

What strategies, interventions, and policies improve primary healthcare services?

The importance of accountability for the rights of specific populations were emphasised; general reform or improvement efforts do not necessarily address the needs of all groups or all services. For example, despite international human rights commitments, health services and providers may directly violate peoples' sexual and reproductive rights through the use of coercive policies and practices. The session *Reclaiming the Cairo Agenda: Demanding accountability for sexual and reproductive rights through bottom-up, people centred accountability practice* identified vital features of ensuring rights-based contraceptive and maternal healthcare services including: raising women's awareness of their rights and entitlements; building women-

centred and community driven evidence collection; building alliances among lawyers, journalists, universities, and civil society organizations; and seeking accountability through ombudsman, legal interventions, and global forums. We distilled several key themes and lessons from the discussion regarding PHC service improvement. We present these below.

PRESENTERS EVINCED WIDESPREAD AGREEMENT THAT THERE ARE NO MAGIC BULLETS: Healthcare services will better meet the needs of the population when they are adequately funded, when healthcare workers are engaged and well supported, and when community level stakeholders have a voice. New services must be developed as integrated parts of the community health system, rather than as standalone 'interventions', and should use the principles of human centred design. Health system leadership and governance requires strengthening planning and management processes (tangible) and aligning human behaviour, norms and relationships (intangible) towards common health goals. Programs designed to improve care systems must be constantly monitored and adapted; for example, a program in South Africa – the Ideal Clinic Initiative – sought to strengthen out-patient primary care and found that numerous improvements were needed to streamline patient flow, reduce waiting times and ensure patient and health worker safety. (Poster: Interacting Policy Imperatives: Is the Clinic a Safe Space for its Workers and Users?). In another example, a study assessing primary care services in high and low performing health facilities in seven LMICs found that good management, support and skills building for clinical staff contributed to better performance. (Poster: Best performers in resource-constrained health systems: Determinants of facility primary care quality)

IMPROVEMENTS TO HEALTHCARE SERVICES BEYOND THE 'KEY POPULATIONS' BOX: There is an enormous need for an infusion of resources and capacity for reproductive, maternal and child healthcare services, particularly in fragile settings. Presentations at HSR2020 noted that these efforts must be coupled with integrated care for mental health, disability, palliative care, and non-communicable disease care.

HEALTH FACILITIES PLUS OUTREACH: Researchers called for accessible primary healthcare services as well as outreach targeting particular groups. Primary care facilities are vital and must be geographically, financially, and socially accessible and friendly to youth. Peer and health worker outreach and community/school based activities, such as for youth migrants regarding sexual and reproductive health, were found to be more effective than concentrating care in facilities and expecting youth to come in. Similarly, in the context of mental health, there is an urgent need to build more community-based systems that support the psychological needs of patients that cannot be addressed in short appointments with doctors.

A 'CULTURE OF QUALITY' AND WELL-RESOURCED SYSTEMS TO SUPPORT AND GUIDE SKILLED PROVIDERS: Improving the quality of healthcare workers' skill and adherence to best practice guidelines requires: (a) technical inputs to improve knowledge and capacity, (b) social and governance inputs to develop a "culture of quality" and remove commercial interests that create perverse incentives, and (c) systems level improvements (including adequate pay and respect, particularly for community health workers and nurses). These three requirements apply not only to improving biomedical capacity but also to ensuring the provision of respectful and accountable healthcare. A number of negative coping behaviors and unethical practices were identified among frontline health workers, including rationing care through making services less attractive, routinizing substandard care by doing a less thorough job, prioritizing some patients over others, subverting policy goals through a focus on only a narrow set of rewarded tasks, emotionally withdrawing from their work, and promoting medically unnecessary or inappropriate practices (e.g., excessive cesarean sections or unnecessary referrals or lab tests) in order to profit. The underlying drivers of these behaviors were identified as health system commercialization, minimal regulation and oversight, working within resource constrained and punitive health systems, and having little community engagement. Negative experiences at facilities and high-out of pocket costs that arise from such practices disproportionately impact vulnerable groups such as migrants; these and other individuals may avoid healthcare services because of bad experiences. Box 4 presents learnings on improving healthcare provider performance drawn from three case studies.

BOX 4

What can we learn from case studies to improve healthcare provider performance?

Three case studies: the Ethiopian Health Care Quality initiative, Dakshata in India, and The Safe Care Saving Lives initiative in India.

- All programs experienced some successes, which were linked to monitoring, building relationships, mentorship, leadership and rewards.
- Programs also experienced some failures, which were linked to weak mechanisms to build ownership, few local champions, incomplete intervention packages, and the selection of an implementing NGO that was not well known in the hospital settings.
- Take away learnings:
  - Quality improvement, assurance and planning needs to incorporate attention to scale and sustainability from the start
  - In the absence of reform of the foundational meso/macro levels systems that support long term change, facility-based micro-level quality projects may form 'pockets of success' but are unlikely to be transformative or sustained long term
  - Both health system 'hardware' (financing, human resources, regulatory infrastructure and information systems) and 'software' (leadership for work culture that promotes and incentivises quality) must be addressed at multiple levels for sustainable change

EVIDENCE INFORMED DECISION-MAKING AT ALL LEVELS: Improving the provision of healthcare services requires high quality data and stakeholder engagement. Presenters highlighted cases where incomplete data resulted in inappropriate healthcare service policy. For example, low rates of COVID-19 testing in Argentina, Brazil, Costa Rica, Chile, and Ecuador resulted in a lack of data regarding disease incidence and prevalence, undermining effective high-level public health response. Presenters also showcased examples wherein careful research helped to generate the data necessary to formulate effective change. For example, in Kenya, research on the high hospital admission rate among newborns was fed into a human centred design process that involved the labour ward team, resulting in an intervention to reduce the rate of admissions of newborns.

Digital health services have the potential to improve healthcare services

mHealth, or the use of wireless technology to advance health sector goals, has great potential to facilitate coordinated, comprehensive, and continuous PHC. It can support task shifting and boost health worker competency, streamline data collection and analysis, and improve the reach of health information and services. Presentations identified some specific frontier areas of mHealth and digitization. In China, a cluster randomized controlled trial found that the use of smartphone-based virtual patients as a training tool showed promising results in improving providers' skill, as well as improved quality of services to patients (from the presentation: *Smartphone-based Virtual Patients to Improve Competency of Primary Healthcare Workers in Rural China - A cluster randomized controlled trial study*). In conflict affected settings such as Mali, digital tools supported health workers and improved the distribution of resources by sustaining contact with the broader health system. A number of mHealth interventions are being developed and tested to improve referrals through better prediction or detection of health issues (sepsis, cardiac events, Schistosomiasis). Artificial Intelligence (AI) may improve the reach and accuracy of clinical services and free up clinician time. We extracted several principles to ensure that digital innovation effectively contributes to improved healthcare services.

SITUATING DIGITAL SOLUTIONS WITHIN BROADER HEALTH SYSTEM STRENGTHENING: No digital tool can overcome fundamental gaps in the health system, such as in health worker training or data systems. Health policymakers, researchers and donors need to move away from considering stand-alone digital tools and mHealth pilot projects. Instead, mHealth tools must be well designed to meet a need (clinical support, improved transparency, etc.) *and* must be introduced to a health system through an intervention that includes broader system strengthening and stakeholder engagement. For example, a community-based mental health service for marginalized people in India involved not just disseminating a digital component (tele-consultation) but also community engagement, devolution of care, and support for CHWs and social workers in mental health counselling. Furthermore, a system's "readiness for digitization" must be considered before digital tools are proposed. A presentation from Uganda noted that more than half of digitization projects in the country failed due to lack of an enabling environment, such as inadequate electricity, hardware, and other infrastructure; as well as due to inadequate health system actor information and communication technology (ICT) capacity, staff attrition and staff interest).

DEVELOPING DIGITAL REGULATION AND SYNCHRONIZING REGULATION ACROSS COUNTRIES: Multi-national and collectively developed legal and regulatory frameworks for data sharing, equity, and governance will prevent abuse (such as privacy violations) and improve efficiency. When countries share common regulations, digital solutions can more easily spread from country to country. With consistent regulations, such as patient confidentiality and privacy laws, digital tools do not need to be redesigned to meet varying standards across contexts.

A2. Improving data and measurement in the health system

Match efforts to improve data quality with improving data accessibility and stakeholder engagement

Data is only valuable when it is accessed and analyzed. Presenters emphasized that accurate and complete data are necessary but not sufficient for improving decision-making in health service provision. There are three requirements to improve data-driven decision making:

1. Good quality data (accurate, complete, timely);
2. Accessible data (such as data that's integrated into a user-friendly dashboard) and;
3. Stakeholders with the skills, incentives, confidence, and decision space to engage with this data.

In Bangladesh, researchers reported that urban health governance was strengthened through addressing all three of the above data-related processes. The quality and accessibility of data was improved through collecting routine health information and regularly updating the Urban Health Atlas, a novel geo-referenced, web-based visualization tool. In addition, the Urban Health Atlas was integrated into government decision-making processes. In another example from Bangladesh, a collaborative electronic management information system (eMIS) was initiated in 32 districts (22 million population) that connected community health workers and facilities with clients, enabled management oversight, and facilitated data sharing with other national data collection systems (Poster: *eMIS Initiative: Facilitating SDG3 monitoring through an electronic health information system in Bangladesh*). Indonesia also provided a positive example wherein the health system invested in building stakeholder engagement and capacity to use data. This capacity building paid off during the COVID-19 pandemic.

Stakeholders will make use of evidence that they own and trust. Involving stakeholders in the processes of measurement thus

increases the likelihood that findings are used, moving evidence into informal and formal policy. This ownership and trust can be generated through early and ongoing stakeholder engagement, including in co-production of evidence, and through collective processes to evaluate system capacity. For example, policymakers and health system actors (medical officers) in Uttar Pradesh (India) conducted a "functional analysis" of the state level health system, which led to consensus about major issues and the development of institutional reforms.

Measurement and governance go hand in hand

The interlinkage between measurement and governance emerged across many presentations. This relationship was reciprocal, wherein poor quality data undermined governance and poor governance undermined data quality, and manifested across a range of domains. Insufficient health worker oversight and accountability, coupled with perverse incentives, will result in poor quality data. For example, in contexts where absenteeism is commonplace, data on staffing levels is almost irrelevant. Efforts to address these issues focused on improving data accuracy and improving broader data governance at the frontlines. Box 5 synthesizes ways to improve data quality; the approaches identified focus primarily on the frontlines. Political interference in data collection and reporting also emerged as a major threat to data quality, but no clear strategies to overcome it were discussed.

Routine measurement systems are not good at capturing information on service quality

The focus of routine measurement remains on access to care and delivery of certain services rather than quality of care. Moreover, when measured, "quality of care" tends to be reduced to clinical performance of healthcare workers, with far less attention paid to broader, organization-level factors and to the delivery of respectful, patient-centered care. And yet it is these broader, organization-level factors that indirectly affect service quality. Well managed facilities provide care that better aligns with clinical best practice guidelines. Even facility waiting rooms and wait times ought to be assessed as micro-systems with clinical significance (for example, crowded waiting rooms increase the spread of communicable respiratory illnesses) that showcase facility functionality. Research examining the failure of appointment booking systems in South Africa identified insufficient technical expertise for policy translation; hierarchical organizational structure; poor differentiation; and poor team synergies between cadres, staff, patients, managers, and workers – all of which stifled innovation and manifested in crowded waiting rooms.

How can this measurement gap be overcome? To facilitate this assessment, a new tool was presented that measures management practices across six domains (data monitoring, target setting, human resource management, financial management, drug management, and operations). A presentation on quality improvement also noted the importance of first assessing system "readiness" for change efforts, such as the state of communication patterns, workflow, decision making capacity among the providers and workers concerned, motivation, and provider empowerment. A session on Health System Performance Assessments (called *Health System (Performance) Assessment – how to stop performance from drifting away?)* identified seven health system assessment tools: USAID's Health System Assessment Approach; FHI 360's Health System Rapid Diagnostic Tool; the European Observatory on Health Systems and Policies' Health Systems in Transition; WHO EURO's Pathways to Health System Performance Assessments; the World Bank's Health Systems Analysis for Better Health System Strengthening; the WHO's Situation Analysis of the Health Sector; and the WHO's Monitoring the Building Blocks of Health Systems. The presenters noted that this plethora of different health system assessment tools must be harmonized, the results of these assessments must actually be utilized, and the assessments must re-center on evaluating the fundamentals of whether health systems are actually performing (e.g., are they improving health?) rather than just describing static elements of health systems. AI was also discussed as having potential to support health service administrative functions by working in conjunction with routinely collected data to better track and

BOX 5

How can we improve the quality of health-related data from frontline services?

- Increase the relevance of data to the data collectors (frontline workers) and service users
  - Capture indicators that truly matter to health service users and health workers
  - Assess provider performance in relation to what providers can control, rather than upstream factors
  - Train health workers on the importance of quality data
  - Enable providers and health service users to use data for decision-making. For example, user-friendly home based records can bolster patient knowledge about their own healthcare and increase patient investment in caring for these records.
- Reduce the data collection and data entry burden on frontline workers
  - Implement user friendly routine measurement systems
  - Integrate data across records to avoid duplication
- Improve the supervisory environment
  - Shift the focus of oversight from targets to accuracy
  - Foster a supportive rather than punitive supervisory environment
  - Reduce lower level discretion
  - Strengthen verification mechanisms

predict health and healthcare service trends.

HSR2020 drew attention to new healthcare service measurement tools, indicators, data collection methods, tools, reporting systems, and frameworks

Numerous new frameworks and indicators were discussed at HSR2020 to overcome measurement gaps or shortcomings (Box 6).

Political interests and technical strategies influence the comparability of measures across countries

While data sharing among countries within a region is essential for joint planning, international data sharing arrangements are hindered by political interests and poor standardization of indicators. In the Mekong delta, a data sharing arrangement was undermined by different definitions, varying quality of data, and varying ability/desire to participate in cross-border discussions.

BOX 6

Innovation healthcare service measurement

Examples of systematizing thinking and measurement on challenging issues

- The fragility framework conceptualizes and appraises health system fragility across five domains: environmental, economic, societal, political, and security.
- New "resilience indicators" were presented, which include awareness of population needs; adaptability to changing needs; diversity of services; and integration with stakeholders and communities.
- The gender based violence quality assurance tool offers a checklist to map and standardize healthcare procedures for victims of GBV.
- The coverage cascade facilitates nuanced understanding of effective coverage (Target population → Service contact → Likelihood of service → Crude coverage → Quality adjusted coverage → User adherence coverage → Outcome adjusted coverage).

Examples of improving the assessment of health service equity and pro-poor targeting

- The ICEBERG tool systematizes thinking about how to address health inequity.
- The Equity Tool makes it faster and easier to assess wealth status, which in turn will facilitate assessing who accesses and benefits from health services.
- The Benefit Incidence Analysis method and price-gap approach are both valuable mechanisms to assess the equity of a treatment approach.
- A new framework on drivers of the gender gap in mobile phone use encourages greater precision and nuance in assessing women's use of digital technology in comparison to men's.
- ArcGIS mapping was used for geospatial mapping to improve geographic access to health care facilities:
  - ArcGIS mapping accounted for the actual distances between communities and health services using roads (versus a direct line) and showed that all urban people are not the same in terms of access to facilities. While metropolitan residents have good geographic access, township residents may have the same or worse access compared to many rural people.
  - The enhanced two-step floating catchment area (E2SFCA) method under ArcGIS 10.5 was used to map accessibility to primary care services, and then to map where primary services should be located within various catchment areas in order to minimize distance between residents and health centers.

Examples of improving measurement in challenging contexts

- A new method to improve measurement in humanitarian settings by identifying constructs of interest, breaking them into sub-constructs, developing measurement indicators, identifying tracers, and measuring outcomes.
- Early evidence suggests that mobile phone surveys can effectively measure several important health system constructs, including OOP expenditure. Further validation is needed.
- A district level planning tool involved qualitative assessment of the essential health package succeeded in coordinating the delivery of PHC services in "donor heavy" contexts in Malawi.
- The Pivot tool was used in rural Madagascar to develop very precise, context-specific estimates of the geographic accessibility of health care. These estimates were then used to develop an e-health tool enabling health workers to access remote populations that live 4-5 hours one way from a health center.

Similarly, the "One Health" health security program in Cameroon, Chad, Côte d'Ivoire, Mali, Niger and Uganda was hampered by a lack of institutional alignment in policymaking, lack of harmonized donor support, short time frames of donor support, poorly regulated governance, limited political incentives to invest in these systems, limited accountability, lack of social pressure on governments to ensure health security, and conflict and insecurity within and among the countries under study. Evidence from the HSR2020 presentations suggests some of these challenges can be overcome through data sharing arrangements facilitated by independent third-party organizations. They can provide a central data processing unit, act as a cultural broker for linguistic and other barriers, provide an institutional platform for the development of shared norms and regulations, and provide an independent management system that could divide tasks in a more equitable way.

Equity in data: Who is served by existing data systems? Who and what gets counted?

OVERLOOKED POPULATIONS: It is simply not possible to measure and address equity with aggregated data. There is a lack of data or lack of disaggregated data about many marginalized populations, which hinders efforts to design interventions, measure progress, and evaluate interventions. These overlooked populations include people with disabilities, marginalized racial, caste and ethnic groups, slum residents, people in humanitarian settings, migrants, women overall (ongoing need for sex disaggregated data), those in informal employment, and people vulnerable to climate shocks. A lack of data inhibits good governance and facility-level planning in complex contexts by masking the intersecting needs of certain populations.

OVERLOOKED DISEASE BURDENS: Mental health was highlighted in many presentations as an overlooked disease, with maternal mental health being a particularly neglected sub-area. Routine maternal health records used in low- and middle-income countries, including home based records, fail to include data fields on maternal mental health.

OVERLOOKED HEALTH WORKERS AND HEALTHCARE SECTORS: Many countries lack data on the geographic location of human resources for health, frustrating efforts to improve distribution and achieve geographic equity. There is also a lack of data on overlooked healthcare worker cadres, such as community health workers, which makes it difficult to measure the size and scope of the cadre. Beyond any specific cadre, there are also massive data gaps related to what the private sector is doing. Universal Health Coverage requires publicly accessible data from the private health sector (including "big pharma"). Improving the private sector's data reporting and synchronization with the public sector and passing data ownership legislation that favours public sector planning will be vital to tracking progress on UHC.

A3. Financial protection and cost effectiveness

Financial protection refers to policies and programs to ensure that health system users are not adversely affected economically by their healthcare needs. Cost-effectiveness refers to the extent to which the services offered provide the highest "value for the money" possible. Presenters addressed a range of macro and micro issues related to these two domains, ranging from the politics of national level reform efforts to frontline efforts to decrease informal payments.

BOX 7

Common governance challenges facing government insurance programs?

- Persistent catastrophic out-of-pocket costs to patients
  - E.g., in India, once admitted, patients had little bargaining power despite having Ayushman Bharat insurance coverage that should have guaranteed them access to free-at-point-of-service care; patients seeking to negotiate lower fees were harassed, intimidated and prevented from switching hospitals
  - E.g., Doctors in the Philippines would make patients buy prescription medicines from outside the facility
- Fraud, inconsistencies in healthcare records
  - E.g., In Peru one person with 100 cataract surgeries; multiple burial payments for one death
  - E.g., providers claiming they provided a service when they did not
- Unjustified deviation of resources to private sector
- Financial mismanagement, stock outs, service unavailability
- Excessive increase in payments to private sector for "emergencies"
- Problems with targeting:
  - In Peru more than 1 million non-poor people received SIS despite the program being designed to target the poor
  - Governments may manipulate health insurance pools to benefit the relatively better-off civil servants

While technical aspects of health financing reform matter, it is equally important to overcome political and institutional challenges

Researchers, funders, and policymakers spend a lot of time on technical aspects of health financing reforms, such as the nature of insurance program enrollment or health facility reimbursement. These technical decisions matter. However, presenters at HSR2020 repeatedly pointed out that many of the challenges to achieving financial protection are political and institutional, and these challenges receive far less attention. Some of these challenges are presented in box 7. Presenters at

HSR2020 drove home the dual importance of implementing technically sound healthcare service financing reforms and also ensuring political and institutional support for equitable primary health care. We thus first identify political and institutional considerations, and then discuss the technical. For example, the presentation *A brief institutional analysis of public health insurance in Peru: the case of Seguro Integral de Salud* highlighted that political support for health system reform and motivation to reduce inefficiency and corruption were central to improving the functioning of Peru's Seguro Integral de Salud.

Political and institutional considerations to improving financial protection

There is no financial protection without adequate financing. Presenters noted that healthcare services in low- and middle-income countries, conflict affected or fragile settings, and for marginalized people, such as refugees and economic migrants, are often significantly underfunded and thus unable to provide high quality services to all who need them. Expanding fiscal space for healthcare must not be overlooked as a critical prerequisite to financial protection. Zimbabwe, for example, has endured the withdrawal of funding support for district hospitals by international NGOs, compromising their service provision. Using the guise of "cost effectiveness" to cut corners due to inadequate funding will ultimately undermine broader financial protection. For example, insufficiently financed government insurance programs may set reimbursement rates too low in an attempt to reduce costs. But this cost saving measure leads to health facilities turning away people with government insurance coverage or charging informal out-of-pocket fees to patients to make up for the shortfall.

Strong accountability and governance must be embedded in health insurance programs or PBF strategies to improve both equity and cost effectiveness

Without adequate governance and mechanisms of accountability, power asymmetries and perverse incentives in health systems can frustrate even technically sound financial reform. Good governance improves patient care (especially for the most marginalized) and cost effectiveness. In Tanzania, better managed facilities were found to provide higher quality care while charging similar prices (*Does management matter for quality of care? Evidence from Tanzania's private healthcare sector*). The Presentation "*Failure of publicly-funded health insurance schemes to provide financial protection: Role of power, social institutions and political economy of healthcare*" showcased how, in the absence of accountability measures in India's Ayushman Bharat insurance program, healthcare facilities were known to harass and intimidate patients who fought back against high out of pocket expenses. Hospitals would withhold patient health information, such as x-rays and laboratory reports, preventing them from seeking lower cost care at another facility. Another study from India showed how even technically sound funding arrangements did not overcome corrupt practices: in Rajasthan, some private hospitals continued charging patients out-of-pocket fees for care that should be free even when insurance reimbursements increased to fully cover the cost of care. Multiple HSR2020 presenters highlighted that reducing corruption reduces wasted resources, thereby increasing efficiency and cost effectiveness. When providers accept informal fees from patients this reduces financial protection. "Ghost workers" and high absenteeism depletes resources that could be used to deliver services. Absent health workers are a major driver of financial inefficiency.

In the session *Failure of publicly-funded health insurance schemes to provide financial protection: Role of power, social institutions and political economy of healthcare* (available **here**) presenters emphasised the links between health and broader social institutions and the need for policy makers to account for power asymmetries. These power asymmetries are particularly pronounced in healthcare markets and the private sector wherein medical professionals hold informational power as well as social and economic power over patients, who must make decisions for themselves or family members, often under time pressure. Rapidly scaling up India's Ayushman Bharat health insurance program in a weak regulatory environment resulted in reinforcing inequities rather than ensuring more equitable healthcare. The scheme worked from a market logic, rather than a rights and entitlements logic in a context where private providers had normative and cultural power over poor patients and where informal healthcare payments (bribes) were widely accepted.

> Good governance improves patient care and cost effectiveness.

So what works? Political and governance-oriented mechanisms for improving financial protection

Governance arrangements should be at the center of the health financing policy agenda. Health insurance providers must become "learning organizations" that can take and respond to feedback. Good governance also requires a robust regulatory infrastructure. Any government and donor engagement with the private sector must be coupled with regulation. The private sector provides a huge portion of global healthcare, yet regulation has not kept up and there is limited guidance on how governments should engage, align with, and harness the private sector. The World Health Organization's new framework on how to effectively engage the private sector, focuses on 1) Building intelligence; 2) Fostering relationships; 3) Enabling stakeholders; 4) Aligning structures; 5) Nurturing trust; and 6) Delivering strategy.

Potential accountability mechanisms that were presented at HSR2020 are listed in box 8.

Researchers and implementers explained that when applied in different settings, some of these mechanisms have worked well and others have not, with contextual factors playing a large role. It is likely necessary to try different governance mechanisms that engage multiple stakeholders to improve the reach and efficiency of financial protection and health financing reforms. In some contexts, government efforts to facilitate health insurance coverage failed to reach large sections of the population and NGO campaigns successfully "picked up the slack." Presentations noted that few countries had formalized participatory governance mechanisms that enable people to influence the policy and design of financial protection programs and that where they existed, many were poorly designed or incompletely implemented. For example, in Colombia, despite the presence of user associations, and a nominal role in oversight of health insurance schemes, these organisations had no funding, did not seek representativeness, and had no formalized role in the scheme design process, committees, or oversight bodies. These shortcomings were attributed to poor design and the lack of a champion within the government.

BOX 8

Political and governance-oriented mechanisms for improving financial protection

- Information provision so that citizens understand their financial entitlements
- Exit interviews and phone surveys with patients to assess facility compliance with quality of care and free care regulations
- Brokers and navigators
- Customer care centres and telephone lines
- Reporting and grievance mechanisms
- User associations
- Community participation in stakeholder meetings and oversight
- Engagement and advocacy by NGOs, including through mandated boards of trustees that oversee the health insurance program and are largely composed of civil society organizations
- Explicit bans on problematic practices, such as banning doctors from sending patients elsewhere to fill prescriptions
- Create financial incentives and use quality of care scores to recruit, retain and motivate staff
- Overcome resource shortages by adequately funding facilities (including through multiple government streams and community contributions)

India's SEWA community centres were cited as best practice for improving the responsiveness of the Government of India's health insurance program (PM-JAY), a state-level catastrophic expenses coverage scheme. Key ingredients for success mentioned by presenters were:

- The community centers were staffed by SEWA community health workers
- The community centres were sometimes co-located with government offices
- The centers helped people access and submit basic documents and access information about the health insurance program, with a focus on consumer empowerment

Nonetheless, ongoing challenges included low awareness among community members about the schemes, challenges faced by community members in obtaining Below Poverty Line ID cards in order to access coverage, and the fact that many preferred hospitals are not covered by the scheme.

In Nigeria, government run customer care telephone centers and desk officers tried to increase uptake (serving as health insurance navigators), and a board of trustees composed of civil society organizations oversaw the insurance program. However, people were largely unaware of the insurance navigators, the customer care center was not toll free, desk officers lacked training in grievance redressal, and civil society organizations lacked the capacity to fulfill their oversight role.

Good governance also requires a robust regulatory infrastructure.

Technical considerations to improving financial protection and cost effectiveness

Common technical challenges facing government health insurance programs discussed during presentations are synthesised in box 9.

Improving the cost effectiveness in government healthcare services was discussed in the context of national efforts to achieve self-reliance through domestic financing. Tanzania introduced direct health facility financing, which funded government health centres and dispensaries depending on their need, performance, and remoteness, to improve resource efficiency. This program was found to reduce fragmentation and improve facility autonomy and accountability. Facilities bought only the supplies they needed at the times they needed them, thereby reducing waste. Managers considered this form of funding to be efficient, simple, accurate, involving less paperwork, and to be more transparent. Facility governing committee members were more active at facilities receiving direct funding.

Digital technology may facilitate insurance coverage and increase cost effectiveness

Presentations identified several ways that digital technology could improve financial protection and cost-effectiveness. AI-informed diagnostic tools could increase efficiency by predicting service needs and health trends at the population level (instead of the individual level). Digital financial services can be used to expand the coverage of financial protection programs and payment for delivery of services. (Session *Expanding digital financial services for health to scale-up UHC 2.0: Towards a pro-poor health reform agenda*) Health workers can be trained using virtual patients on smartphones, which is less expensive than traditional in-person training (Presentation *Smartphone-based Virtual Patients to Improve Competency of Primary Healthcare Workers in Rural China - A cluster randomized controlled trial study*). However, HSR2020 participants noted that digital technologies to support financial protection programs are tools that require implementation support and an enabling environment as with any other new intervention. In Tanzania, staff filed very few claims for payment because of lack of engagement with the data system, high workload, lack of training, and frustration due to slow or insufficient payments.

Strategic purchasing may improve financial efficiency but has many potential pitfalls that can only be managed through active regulation

Strategic purchasing reforms move from an integrated public system to a public contracting system wherein health insurance programs purchase healthcare from healthcare facilities (usually a mix of public and private facilities). Governments can use strategic purchasing to expand financial risk protection coverage and improve quality of services. Strategic purchasing can incentivize private facilities to provide healthcare to insured users, without users having to pay out of pocket. Governments can also use reimbursements to public facilities to incentivize aspects of performance, such as improving the quality or coverage of their care. However, if reimbursement rates are lower than market rates, if the administrative burden associated with filing for reimbursement is too high, or if the transfer of reimbursement payments from government to facilities is too slow, facilities will respond in ways that reduce the quality and accessibility of care. Common challenges include: the over-provision of services (e.g. Caesarean sections), turning away patients on government insurance or for services not sufficiently reimbursed, providing poorer quality of care for patients on government insurance, and continuing to demand informal out of pocket payments. Some countries also face challenges in securing sustainable funding,

BOX 9

Common technical challenges facing government insurance programs

- Increase in staff workload
- Insufficient budget
  - The reimbursement ceiling was not high enough to cover actual costs and patients were either made to pay the difference or were denied care (e.g. healthcare providers are told not to send patients for laboratory tests because the consultation alone used up the amount of money the hospital can claim for them on that visit)
- High rejection rate of insurance claims
- Context agnostic reimbursement rates
  - In India, neither Bihar nor Rajasthan changed the package pricing that was set at the federal level suggesting poor adaptation to local context
- Slow reimbursement
  - Delayed reimbursements led private hospitals to refuse patients who seek care under Kenya's national health insurance program
- Unaffordable premiums
  - In Kenya, premiums were unaffordable to many poor and unemployed people, so they abandoned the insurance program
- Unavailability of services
  - In Kenya, researchers found that even though benefits exist on paper, many public facilities lack the capacity to provide these services. E.g., CT scans and ultrasounds are covered by the insurance scheme but many facilities could not offer these services.

whether due to governmental fiscal policy or donor priorities. An example from Indonesia is in box 10.

Countries must actively identify perverse incentives and revise their strategic purchasing arrangements to counter them. The Strategic Purchasing Africa Resource Center (SPARC) has identified the following aspects of active strategic purchasing: Better alignment or coordination of purchasing systems; leadership by the MOH/DOH; appropriate policy changes - a gradual process; increased accountability of all players; and avoiding fragmentation / verticalization of services.

Public Private Partnerships, like strategic purchasing, offer a mechanism to engage private sector resources, but are vulnerable to regulatory challenges

Contracting private facilities to provide specific primary health services was discussed in several sessions as a way to harness the private sector's human resource capacity and competitive engagement. In Bangladesh, skilled birth attendants were paid for their midwifery care either by patients or by civil society organizations (for the very poorest patients). The program lifted the skilled birth attendants out of poverty and improved a range of maternal and child health indicators. These skilled birth attendants were trained by the Ministry of Health and Family Welfare and supported by local civil society organizations and the local government. Local civil society organizations raised funds to cover the costs for poor patients and also generated demand for the entrepreneurs' services.

In one area of Kenya the government undertook a public-private partnership called the Corporate Engagement Twinings Tea Partnership that harnessed financial inputs from the private sector (a large tea company, Twinings) and in-kind contributions from small scale farmers organized into women's groups. The corporate financial inputs and community contributions of land and labour improved health facility performance, including increasing staffing, introducing electronic medical records, enabling 24/7 services, and providing a wider range of contraceptive services. In South Africa, the government relaxed regulations to allow private pathology laboratories to process COVID tests. This well-regulated private sector engagement drove down the cost of pathology tests because regulation enabled better engagement between funders and laboratories.

Public private partnerships were said to benefit from strong contractual relationships designed with and for the government, and to function best when referral, training, and support systems are in place to facilitate collaboration between private and public providers, and when targeting regions where the government struggles to retain health workers.

Measurement and data in financial protection

Improving evidence and data on financial protection and health insurance coverage was widely called for. However in "*Serious about UHC? Let's get serious about migration as a determinant of health"* a presenter noted that efforts to track access to health services can actually deter marginalized people; healthcare services trying to assess equity in access may ask users to provide identification that marginalized people may lack or be afraid to share, thereby driving them away. Presenters who discussed data in the context of financial protection tended to highlight the importance of improving the accuracy and completeness of routine health information system data. For instance, in order to calculate health insurance coverage, a country needs complete population level data to know the denominator. Health management information systems may need to be modified to capture financial protection. Presenters also noted that there was a lot of economic evaluation data on sexual and reproductive interventions.

BOX 10

Strategic purchasing introduced perverse incentives for TB treatment in Indonesia

Primary care facilities, especially private ones, received low reimbursement for treating simple TB cases. Secondary care facilities received much more lucrative payments for TB treatment. Thus, primary care facilities referred even simple TB cases for in-patient treatment at secondary facilities. Secondary facilities kept simple TB cases for long periods of time and overused expensive tests and diagnostic tools (such as overuse of chest x-rays).

To counter these issues, a revised payment method has been proposed. This method will use fee-for-service for diagnosis and an episode-based payment for treatment, with clear links to notification. Despite reducing unnecessary referral to higher level facilities, this new scenario is expected to increase costs to motivate primary facilities to provide rational community-based care. (Presentation: *Health Financing and Strategic Health Purchasing Innovation to support TB Elimination in Indonesia: Evidence to Policy*)

Equity and financial protection for the most vulnerable

Many vulnerable groups are susceptible to financial exclusion. Several sessions at HSR2020 focused on migrants in particular. Cost is a huge barrier to seeking healthcare for migrants, including for sexual and reproductive healthcare among migrant women, undercutting UHC goals. Refugees may hide or give incomplete information because of fear of violence and threats of deportation. They may also avoid seeking care out of fear of mistreatment, denial of service or deportation.

To address these challenges, financial protection and service access should be portable both within and between countries and must account for family members who move with the migrant worker and who remain home. This would require

sending and receiving states establishing their respective contributions. The Philippines offers a case study in developing an integrated healthcare strategy covering citizens both inside and outside the country, which highlights the importance of multi-stakeholder and multi-sectoral mapping and engagement ("whole of government" approach), a clear understanding of migrant health needs, and the establishment of an office that focuses on migrant health.

B. Broader determinants of health

The second pillar of PHC is systematically addressing the broader determinants of health through evidence-informed policies and actions across all sectors. These broader determinants include social, economic and environmental factors, such as poverty, racism, climate change, and armed conflict. We present themes that emerged from HSR2020 on broader determinants of health, first in terms of improving these determinants (B1), then in terms of routine data and measurement (B2).

B1. Improving broader determinants of health

What are the innovations in integrating PHC and social needs?

Presenters discussed promising interventions connecting health service users with resources from other sectors, including in the context of COVID-19. The session on social assistance provided a range of examples from programs run by Partners in Health, a global non-profit health organization focused on social justice through the provision of high quality healthcare to vulnerable populations. These programs collaborated with government programs, including at local social welfare departments, to integrate health and broader social support (see Box 11 for an example). Presenters from other sessions highlighted that digital innovations could enable citizens to document and expose failures in health and social services, such as long queues for services or broken equipment. Other social interventions targeted individuals working in the informal sector or in sectors with limited organizational support for health, such as income compensation for working mothers to encourage breastfeeding.

Efforts to improve local cooperation in health services also appeared to have wider impacts on broader determinants of health. A program in the Eastern border region of Myanmar focused on improving coordination in areas where services are provided by both Ethnic Armed Organizations and government authorities. Presenters noted promising evidence regarding improvements in service delivery and access, as well as around social cohesion and trust building between Ethnic Armed Organizations and the government. The project therefore provided an interesting example of the political impacts of health projects, and ways in which stakeholders can improve health and political contexts simultaneously.

Complex governance mechanisms limit the ability to address intersecting needs in informal settlements

The interconnections between health and other social needs are critical in all contexts, but especially so in marginalized settings, such as informal settlements. Residents of informal settlements face numerous health and social risks that are closely interconnected, such as hazardous shelter, violence and insecurity, the impacts of climate change, and poor access to safe drinking water, sanitation, transport, energy, food, healthcare, and social services. These issues are sometimes exacerbated by the issue of migrant populations not being included in census or voting lists (e.g., discussed in the poster Health Behaviour of Migrant Labourers in Special Economic Zone Gujarat (India)). In the session '*Conceptualizing urban health systems and their governance*', a presenter drew on experience from Sierra Leone to note that insufficient resource allocation in informal settlements results in competition between health and other issues intrinsic to good health, such as water, security, and income support. This lack of resources was driven by discriminatory budgeting that favours citizens in formal housing over those in informal settlements. In another session, '*Digging into urban health: uncovering concepts and action for health and social justice in informal settlements*', presenters noted that another challenge in addressing these intersecting needs is the complexity of governance arrangements for these sectors. For example, in Freetown, Sierra Leone, the governance of water services is fragmented due to poor governance and oversight, resulting in a provision gap for informal settlements. The delivery of health and social services for these communities needs to be undergirded by a rights approach, with non-discrimination as a foundational principle and mechanisms of accountability to ensure them.

BOX 11

Case study: Integrating social assistance with contact tracing during COVID-19: experience from Massachusetts, USA

During the COVID-19 pandemic, Partners in Health collaborated with government-led contact tracing programs in Massachusetts, USA, to link people to key health and social supports. This program incorporated care response coordinators who helped people get tested and stay home safely by ensuring their social and health needs were met. They identified 20,000 people (approximately 17% of the individuals screened) who needed support to stay home and referred them to existing government and on-governmental programs for food, funds for utility bills, primary health care for chronic medical conditions and prescriptions, childcare help, masks, diapers, and legal assistance to avoid eviction.

Policy and programs for refugees and migrants must be multisectoral and holistic

Research on refugee and migrant communities highlighted the challenges of access to a range of services for refugee and migrant communities, and underscored the importance of adopting an integrated approach to health, economic and social support. In Bangladesh, one study looking at healthcare utilization and empowerment of women in terms of their exposure to spousal migration and the influence of gender norms found lower use of health services by wives of migrant spouses compared to the non-migrant spouses. The potential benefits of migration for women's healthcare utilization (i.e., greater access to economic support) may be diluted by family structures that perpetuate unequal gender norms. Other presenters noted the harsh realities of accessing health and social services as a refugee or migrant.

Gender is insufficiently integrated into policy and programs across a wide range of health and social issues

There is a need for gender transformative policy and programming in social sectors tackling the broader determinants of health. The use of a gender lens facilitates an understanding of the perpetual marginalization of particular groups, as well as an awareness of the need for interconnected policy and programs to overcome patriarchal structures in education, livelihood, and health. For example, a study in Mozambique found that higher levels of maternal education resulted in increased levels of birth preparedness and health care seeking, adjusting for confounders such as age, distance from facility and spouse's education and occupation (poster: The Impact of Maternal Education on Birth Preparedness and Care-Seeking Tendencies in Mozambique). Understanding the intersection of gendered social and cultural norms and workforce governance of health cadres such as community health workers - who often deliver services and programming around nutrition, gender and other topics in addition to health - is key. Presenters shared some promising examples of efforts in this space. A mentorship program in Liberia supported women in leadership positions in the health sector, using training programs, mentorship, and a WhatsApp group.

> A gender lens facilitates an understanding of the perpetual marginalization of particular groups.

BOX 12

Case study: Lessons on multisectoral action from Senegal's COVID-19 response

The Senegalese response to COVID-19 was informed by experience during the Ebola outbreak. The overarching principle was to ensure that multi-sectoral planning was initiated before the onset of the emergency. Senegal instituted a multisectoral approach, managed by the Head of State and the cabinet. Decision makers had regular meetings with very clear objectives that needed to be completed before subsequent meetings. These approaches were successful in minimizing the impact of the pandemic on Senegal, and has key lessons for health policy planning beyond COVID-19. (From *Health Financing and Self – Reliance: country experiences on engaging all forces for a sustainable approach*)

Develop institutional and governance arrangements to facilitate multisectoral action

Presenters shared examples of institutional arrangements and governance to facilitate coordination and multisectoral action. The key lesson was to create coordination structures that enable action and alignment across departments, alongside commitment from leadership. Examples of specific units created to coordinate between departments of health and other sectors of government included those created to address migrant health in the Philippines, the COVID-19 response in Senegal (see Box 12), and efforts to improve primary health care in the Eastern Mediterranean region. In addition to creating coordination structures, presenters noted the importance of careful planning and design of funding streams, due to the fact that multisectoral mechanisms were often not institutionalized. Strengthening constructive partnerships and collaboration with external groups (for example, civil society), was found to be important. A presenter from Thailand noted the importance of the National Health Assembly, a consultative body that involves government representatives, researchers, members of civil society, and more as an institutional approach to building and growing these connections.

The need for improved multi sector coordination was also noted in the context of strengthening health services in fragile settings. Three sets of stakeholders - organizations from humanitarian, development and peace sectors, also termed the 'triple nexus' - were critical to health systems strengthening. One presenter shared results from a study on the issue of coordination amongst the 'triple nexus', and found that while efforts to strengthen coordination to improve health outcomes in fragile settings were recognized as very necessary, there were critical gaps. Operationalizing coordination policies and

tools remains a challenge. Practical guidance and local level lessons need to be captured and disseminated. Similarly, a study exploring district level implementation of a multi-sectoral strategy in South Africa found several challenges. The study found that after one to two years, the intersectoral element of the strategy was eroded, with activities among Ministry of Health staff defaulting to a more traditional, siloed approach. Reasons included a lack of understanding of how to engage non-health stakeholders, workplace pressures, and a lack of bureaucratic commitment.

Policy studies identified political and structural factors needed to improve broader determinants of health

Addressing broader determinants of health at a policy level requires an examination of political and structural forces that drive these inequities. Presenters shared insights from several studies that explored these forces and their impact on health and social policy. One scoping review explored fiscal measures to address non-communicable diseases in low- and middle-income countries (e.g. "sin taxes" imposed on the purchase of tobacco and alcohol). Much of the research in this area was published in the last ten years, and focused on tobacco. The authors of the review found that research tended to focus on the influence of industry, but there was less discussion of macroeconomic structures, such as anti-regulatory pressures, on the appetite to design and implement reforms. They also noted that more attention needs to be paid to contextual and procedural aspects of policy development. Box 13 showcases how tobacco control in India evolved from a commercial issue to a health concern through an examination of dialogue during parliamentary question periods.

Presenters also shared insights on what can be done to harness political and structural factors for policy change at multiple levels. Advocates should align where possible with global goals around particular issues. Multi-stakeholder coalition building (i.e., different government agencies, provider associations, civil society groups, etc.) are needed to address commercial determinants of health, as well as countering efforts of industry to promote products. Framing is also an important consideration for any policy issues, but is particularly important for multi-sectoral policy questions, where the selection of one frame or another can result in 'policy thinning' or the simplification of complex policy objectives into a narrow set of policies. Finally, presenters noted the need to engage with government agencies that might take opposing views on a policy due to its relative benefits. A study from Vietnam highlighted Ministry of Finance concerns around tobacco taxation due to the revenues brought in by tobacco sales, but noted that the Ministry ultimately came around to the policy due to evidence on the financial and health harms caused by tobacco.

BOX 13

Understanding tobacco policy in India through an examination of question period transcripts in the Parliament of India

A study examined how the Parliament of India dealt with tobacco policy, and in particular, explored how tobacco was understood and discussed by elected leaders. The study found that over time, the framing of questions shifted. During 1999-2004, most questions regarding tobacco were directed to the Ministry of Commerce and Industry. By the later 2000s questions were increasingly directed to the Ministry of Health and Family Welfare, signaling a shift in the perception of tobacco as a health issue. Geographic and commercial interests also played a role, with the major tobacco growing states asking the most questions. Using an innovative research approach, this study highlighted the need to adopt a multi-sectoral, multi-institutional approach to policy development.

(From *Situating tobacco in health policy: Using parliament as an instrument of accountability*)

What are the gaps in improving the broader determinants of health?

Presenters shared a range of gaps in current efforts to improve broader determinants of health, many of which have relevance for PHC. The conceptualization of UHC needs to be viewed beyond health systems strengthening to engage other sectors, such as education and the environment. This is particularly important in the context of marginalized communities, where efforts around nutrition, poverty, security, and education are critical. Programs to address these needs must be better coordinated using approaches such as Health in All Policies, wherein policymakers are held accountable for the health impacts at all levels of policy-making. Governments also need to take better stock of external 'shocks', that are becoming more endemic, and to better understand and address the specific risks of climate change to vulnerable populations. Finally, there has to be more practical guidance on operationalizing coordination mechanisms and understanding lessons from local levels, and how those can serve as learning opportunities for other contexts.

B2. Measuring broader determinants of health

While presenters from a variety of perspectives and backgrounds emphasized the importance of measuring broader determinants of health in the context of PHC, several gaps were identified that have relevance for PHC. These included siloed research approaches to health and other sectors, and an enduring lack of data on the intersectoral needs and experiences of specific populations, including internally displaced persons and refugees, economic migrants (especially on their occupational health and social needs), and gender disaggregated research on the health workforce. Despite these gaps, sessions at HSR2020 provided key insights into the measurement of broader determinants of health from a PHC perspective.

Need for better integration of non-health sectors in PHC research

The importance of integrating drivers and domains of impact outside of traditional health areas into PHC research was frequently invoked. In particular, many sessions highlighted the importance of assessing the drivers of health status, rather than health services; many sessions focused on climate change as a significant, increasingly important, and under-studied determinant of health status and health inequities. Presenters discussed varied examples, from the use of indicators from climate science to big data analytics to understand migration patterns, which have relevance for understanding access to PHC. Examples from the Philippines (see Box 14) highlight the archipelago's climate change-related vulnerability and innovativeness in studying and mitigating these risks.

An approach to proactively link health with non-health sectors is the use of health impact assessment of various development or business interventions. One study, again from the Philippines. examined the potential impact of a coal fired power plant project on environmental issues like air and water quality. Ideally, such assessments need to occur before projects begin, but in reality, such assessments happen after the fact, but can still be a tool for accountability where the project is damaging the environment.

Given the inequitable impacts of broader social determinants of health for vulnerable or marginalized communities, there was a stated need to expand data collection in this area. for example, research is needed to understand marginalized communities' exposure to climate change and pollutants, or the intersecting health and social needs of people living in informal settlements. Additionally, underlying information systems need to be strengthened in order to precisely measure the impact of broader social determinants of health on outcomes. This gap came through clearly in a study assessing mortality attributable to climate change and environmental challenges in Latin America and the Caribbean. The authors drew upon data relating to climate change variables (temperatures, rainfall, and CO2 emissions), human development indices, disaster incidence, and mortality rates attributable to air pollution, water, sanitation and hygiene, but could not complete the study as mortality data was not available except for 2016, thereby limiting their ability to assess trends.

Measurement tools to examine inequity across sectors

Tools focused on measuring equity, such as the EquityTool, developed by Metrics for Management (see **here** for more), are used across sectors, such as health, nutrition, and disaster relief. In the session titled, 'Improving Equity in Health Services by Improving Measurement of Wealth in Programs and Policies – a learning session', presenters noted that the tool has been used in a wide range of health and social programs including integrated child nutrition (Nepal), water interventions (Myanmar) eye health (Sightsavers, multiple countries) and results-based financing (Benin). In Nepal, a Community Mapping project for an integrated child nutrition program combined data collection - drawing on the Equity Tool - with service delivery. The Government of Nepal was very interested

BOX 14

Two examples from the Philippines exploring the linkages between climate change and health

In a study titled 'Assessing and Projecting Climate-Related Infectious Diseases in an Urban City in the Philippines', the research team used machine learning and advanced modelling techniques to find associations between climate factors and two diseases - dengue and leptospirosis - focusing on barangays with a high prevalence of dengue and leptospirosis. This study serves as a proof of concept on the use of machine learning methods for disease forecasting at a micro-scale, as well as an illustration of the importance of data robustness. They found an association between annual dengue and relative humidity and an association between leptospirosis and all exposure variables, with the greatest effect from maximum and mean temperature. Their model enabled prediction of when dengue and leptospirosis would peak (July and August). Such data can allow decision makers to plan programs and services at a PHC level accordingly. (From *Climate Changes Health: Emerging Disease Trends for Reorienting Health Services*)

In another study from the Philippines, researchers shared the example of establishing climate change adaptive health (CCAH) monitoring and evaluation to support evidence based policy and planning at the local level. Such CCAH systems are enabled by widely available global and local climate change data, existing capacity for disease surveillance and high uptake of the use of technology at regional/local levels. The research team noted that this project was enabled by the critical role of development partners and NGOs, community training on CCAH, and a recently enacted law on UHC which facilitated strengthening health promotion initiatives. The barriers included limited awareness, responsiveness and ownership among communities for adaptation and preparedness, the basic level of training, and limited engagement of vulnerable populations. (From *Health System Resilience and Adaptation to Climate Change: Lessons from Developing Countries*)

in using this tool to take community indicators of socioeconomic status down to households in the context of disaster relief, but questions remain regarding how the Government can take data that is anonymized and target specific households. Similarly in Myanmar, the EquityTool was used in the context of a mobile monitoring and evaluation program for water services (mWater) that was scaled up nationally. There are remaining questions on whether such tools that are designed specifically for research can be used for the purposes of programming (for example, targeting specific households for services).

Promising examples of measuring (and addressing) social need in PHC programs

There were few examples of approaches to measure unmet social need in the context of PHC. However, the examples that were presented highlight a promising way forward. Partners in Health used an innovative model in Liberia and Malawi where social needs were determined through short, 10-item, structured assessment forms developed from the EquityTool, the Multidimensional Poverty Assessment, and the Demographics and Health Survey. This data informs client-centered service delivery and social needs packages that take disease conditions into consideration. For example, based on their social needs assessment, an individual's diabetes support could include beans that help control blood sugar, as well as personal items such as shoes.

Malawi and Liberia represent different mechanisms for engaging with patients around social needs. In Malawi, the community-assisted pathway follows the following steps: 1) Client referrals (referred from the hospital or directly from the community by cadre of 1200 CHWs who are attached to every household in the district); 2) Client assessment; 3) Home visit to assess household size, education level, etc. 4) Vulnerability score is summed up after home visit.

In Liberia, the pathway is initiated by clinicians. The clinician works with a social assistance officer, who then links the patient with services ranging from extra nutritional support to social support during hospitalization to home-based needs (i.e., mobility assistance, safe housing). CHWs can also identify needs at the community level and then request the Social Protection Officer to proceed. A new pilot dashboard provides program managers with visual data integrating clinical and social support, as well as enrollment data by quarter.

Examples of frameworks used to explore broader determinants of health

While presenters noted the need for cohesive frameworks linking multisectoral action to PHC, two frameworks were discussed as suitable for the exploration of broader determinants of health. First, the socio-ecological model was valuable in positioning the health impacts of climate change at multiple levels; this framework could be utilized to understand the connections between health and other broader determinants of health in a holistic approach. Second, the Human Capital Index integrates health and education measures (child survival, school enrolment, quality of learning, health growth, and adult survival) to summarize the extent to which children are able to attain their productive potential by age 18.

Poor availability of systems to routinely capture data on broader determinants of health

Overall, there was a dearth of examples pertaining to routine capture of social needs. There was one example of a national system - Costa Rica, which has a national digital health record system that collects data on health, housing and family. Other examples were largely from Partners in Health, which has been operating a social protection component of their health programs, in partnership with governments. Part of the challenge in routinizing data on broader determinants of health is the concern that even pared down tools such as the EquityTool might be too labour intensive for regular monitoring. In one example from Myanmar, government officials felt that the EquityTool could not be used for regular monitoring, but that it could be used in a complimentary way to understand how to target subsidies or shape behavioral interventions.

C. Empowerment and participation

The third pillar of PHC is empowered individuals, families, and communities who can work collectively to optimize their health, to advocate for policies that promote and protect health and well-being, to co-develop health and social services, and

The socio-ecological model was valuable in positioning the health impacts of climate change at multiple levels.

to provide care to themselves, household members and others in the community. In this section of the report we first discuss content from HSR2020 that addresses ways of fostering or increasing citizen empowerment and participation in health systems (C1) and then cover measurement and data related to assessing this empowerment (C2).

C1. Fostering empowerment and improving participation in health

Strategies for improving empowerment must arise from an understanding of the drivers of disempowerment

Before identifying strategies for empowering health service users, the barriers to participation and the drivers of community or individual disempowerment in relation to health systems must be understood. Participants at HSR2020 spoke extensively about reasons for limited participation and drivers of ongoing disempowerment in the health system. Identifying these barriers to participation and empowerment can suggest the strategies and changes needed to overcome the barriers.

ACCOUNTABILITY AND PARTICIPATION ARE SOCIALLY AND CULTURALLY GROUNDED: The role of broader social and cultural norms and hierarchies, whether at healthcare facilities or in society more broadly, emerged as a determinant of social accountability. Social norms in health facilities may strongly support the persistence of informal payments among healthcare providers, and may lead to healthcare providers resisting governance reform to remove these payments. Widespread cultural acceptance of informal healthcare payments among patients and providers may stem from and be reinforced by power and class differentials. In many contexts, health service users perceive free services as lower-quality and thus accept out-of-pocket payments (whether formal or informal) as necessary to access quality care. The social normalization of informal payments was identified as a factor reducing the effectiveness of India's Ayushman Bharat in achieving financial coverage.

HOLDING POWER TO ACCOUNT IS DANGEROUS: There are many organizations and individuals who benefit from the status quo of the $8 billion dollar global health system. Whistleblowers within the system or citizens who call out corruption or poor quality care can face genuine safety risks. Frontline healthcare providers who, for instance, speak out against problematic practices in their facility, can lose their jobs, lose promotions, or experience harassment and other punishment. Patients who refuse to pay informal fees or who participate in accountability processes may be assaulted, denied healthcare, or receive poorer quality care.

> Social norms in health facilities may strongly support the persistence of informal payments.

INFORMATION ASYMMETRY DISEMPOWERS HEALTH SERVICE USERS: Different actors have access to different amounts of information, making it difficult for less informed players to participate in informed decision making, or play an oversight and governance function. Patients, for example, often do not know whether the laboratory tests or medical procedures recommended by their physician are genuinely necessary or are an attempt at increasing the clinician's income. Citizen groups often lack access to data on clinic expenditure or quality of care indicators, hindering oversight.

POWER ASYMMETRIES WITHIN PARTNERSHIPS RESULTS IN LIMITED VOICE FOR LOCAL PROGRAM MANAGERS: Frontline staff, including local program managers, are central to the effective development and implementation of policies and programs; yet presenters noted that unequal power dynamics within partnerships often stymies their voice. For example, a study on the withdrawal of international NGOs from a district in Zimbabwe noted that local managers were not consulted in withdrawal plans, jeopardizing progress that had been made in the program and diminishing trust between the international NGO and their frontline partners.

INTERSECTING FORMS OF DISADVANTAGE SIMULTANEOUSLY DRIVE VULNERABILITY AND SAP RESOURCES FOR RESISTANCE: The most disadvantaged people (poorer, lower caste, racially marginalized, less educated, female or transgender, and those with stigmatized health needs such as HIV or requiring an abortion) are the most likely to receive poor quality care and encounter corrupt practices in the health system. And yet these populations, by nature of their disadvantaged status in society, have the fewest resources and least clout to demand change. Many citizens thus accept corruption, poor quality care, and informal payments because they lack the capacity to participate in improvement initiatives.

One presentation (*Social Justice, Eradication Programs, and Community Relations: Understanding vaccine refusals and resistance in polio's last strongholds*) highlighted how some disadvantaged groups formulated resistance in a creative but risky manner. Polio vaccine refusal among marginalized communities in Nigeria and Afghanistan arose from their deep frustration at being offered just one intervention (polio vaccines) in a context of broader governmental neglect or persecution. Refusing polio vaccination became a means of raising awareness among government and international agencies of the larger issues affecting them.

CORRUPT PRACTICES WITHIN HEALTHCARE SETTINGS ARE DRIVEN BY SYSTEMIC FACTORS THAT CANNOT ONLY BE ADDRESSED AT THE CITIZEN-PROVIDER INTERFACE: Healthcare workers may engage in coping behaviors that result in poorer quality patient care and

inappropriate financial costs to patients because of systemic issues. Presentations and posters at HRS2020 illuminated that many healthcare providers report feeling physically and emotionally unsafe at work, experience high workload (partially due to colleagues being frequently absent), lack support from communities and government officials, were expected to receive and then share informal payments within the health facility, or navigated between political actors and local authorities, wherein the politicians over-powered attempts by authorities to censor problematic behavior at health facilities.

So what works to foster empowerment and participation in health systems?

MULTI-PRONGED STRATEGIES ARE ESSENTIAL: HSR2020 presentations and posters highlighted that multifaceted efforts are required to improve citizen empowerment. The overriding message was that bottom-up (community-level or at the patient-provider interface) and top-down (structural and financial reform in the health facility, management, and governmental levels) interventions must be engaged in tandem. Intervening at only one level in isolation will be unable to overcome the complex drivers of disempowerment discussed above. Presenters explained that tackling the most visible or peripheral manifestations of systemic corruption (informal fees, unnecessary laboratory tests, etc.) without tackling the larger structural issues will likely shift the manifestations of corruption to different forms. Corruption can be understood as an adaptive outcome to a dysfunctional system, a response to an unjust system, and/or a coping mechanism. Box 15 presents the intervention areas discussed, which, when engaged strategically and collectively, create space for individuals, families, and communities to genuinely optimize their health by advocating for responsive policies and co-developing health and social services.

HSR2020 included many examples of these participation and empowerment interventions having a direct and indirect positive impact on health and social outcomes. While most examples included engagement across many of the components in Box 15, some focused only on one technical tool, such as scorecards, or one strategic interface, such as data transparency. In one example from Kenya, a collaboration involving the Kenyan Slum Dwellers Federation and its partner NGO as part of the research team resulted in a comprehensive assessment of health and social needs in Kisumu's 28 informal settlements. This research led to the commitment of local governments to upgrade health and social services in the area. These presentations may have focused on one part of a broader intervention due to time constraints. Full sessions focused on topics related to participation and empowerment emphasized the need for multi-pronged strategies.

BOX 15

Box 15. Multifaceted components to foster empowerment and participation in health systems

- Transparent, accessible and comprehensible data on health financing, quality indicators, staffing, supply chain, etc.
- Co-design of policy or interventions with local actors
- Co-producing data generation and analysis with communities
- Legally mandated spaces for community participation (such as health councils)
- Time and consistency
- Representation of marginalized populations in healthcare positions (including through community health worker programmes, and among medical staff)
- Partnerships across government, civil society, and the media
- Using the courts system
- Media coverage to generate indignation among citizens, counter messages from corporate actors, politicize and collectivize personal experiences, and galvanize pressure for change
- Oversight bodies that monitor human rights abuses
- Issuing public calls to point out violations of rights
- Health sector reform including sufficient investment in social services

Corruption can be understood as an adaptive outcome to a dysfunctional system, a response to an unjust system, and/or a coping mechanism.

IMPROVED HEALTH AND HEALTH SERVICE OUTCOMES: Several presenters highlighted the linkages between participation and empowerment and key health and health service outcomes. One project in Bangladesh involving community dialogue and media outreach resulted in an increase in the number of staff posted to a remote health facility, increased the bed occupancy rate, and increased the institutional birth rate. In Australia, increasing the representation of Aboriginal communities and Torres Strait Islanders (marginalized Indigenous groups) among health workers cadres was considered one important component in improving health outcomes for this population. Thailand's multi-level citizen engagement structure resulted in an expanded healthcare benefits package and fostered strong public ownership of the universal healthcare coverage scheme. A social accountability intervention in Ghana improved facility staffing, reduced commodity shortages, improved provider attitudes and resulted in community-led infrastructure development. In Malawi, community action groups and youth groups in one district engaged periodically with district health managers, improving responsiveness of frontline health staff and decision-makers.

Scorecards were also highlighted as a key intervention in improving health and health service outcomes. For example, the State Led Accountability Mechanism (SLAM) in one region of Nigeria involved the implementation of scorecards by a multisectoral partnership to assess maternal, newborn and child health services. In 2015, when the coalition initiated its work, only 45% of facilities assessed in Lagos had stock. By late 2019, this increased to 98% due to this form of tracking. The budget for maternal, newborn and child health services went from 0 in June 2020 (caused by delays) to 81% by August 2020 due to these accountability processes. While the session did not discuss scaling up SLAM, external resources[1,2] suggest that attempts are being made to do so.

IMPROVED TRUST AND RESPONSIVENESS: HSR2020 included several examples where bringing actors together to develop or assess health services facilitated positive relationships, and particularly increased stakeholder trust in the program and improved responsiveness to local needs and context. For example, polio immunization programs in Nigeria and Afghanistan in underserved, hard-to-reach areas of these countries have worked through local influencers, such as traditional leaders, to enhance trust in the programs. These efforts have worked - to a degree - but have still not addressed the larger social justice issues at the heart of concerns around the polio program. In another example, a presenter noted that when given adequate resources (payment and supervision), community health workers have the capacity to serve as accountability agents for local government to the community, and to build trust between health services and communities.

EXPANDED ENGAGEMENT FROM HEALTH TO OTHER SECTORS: A community scorecard program in Malawi found that two years after the intervention, youth groups were still using the scorecards even though the project had ended and were applying them to new issues, such as child marriage and natural resource protection.

MULTIFACETED APPROACHES TO ACCOUNTABILITY AND PARTICIPATION: The Maternal Perinatal Death Surveillance and Response involves multiple forms of accountability, including "soft" recourse mechanisms, which incentivizes improvements within health facilities through benchmarking and competition, and "medium" recourse mechanism, involving supportive supervision, the review of maternal and perinatal deaths in order to collectively identify problems and discuss solutions. Exclusively relying on legal or regulatory actions might disengage providers due to their potentially punitive nature.

In Tunisia, the Societal Dialogue for Health System Reform which launched following the Arab Spring revolution, provides an interesting example of the range of participatory mechanisms that can be initiated in health reform processes. The goal of this dialogue was to engage the public in decision-making about new health system reforms. The program involved multiple platforms - thematic groups, focus groups, open mics, regional meetings, citizen juries and a National Health Conference. The process was not without challenges, such as the fluctuation of interest from decision-makers as well as the need to shore up and maintain civil society participation. Yet, the process yielded good results, and there is now an effort to institutionalize the National Health Conference within the country's health laws.

ONGOING CHALLENGES: Governance challenges were found to diminish the potential of citizen engagement through health councils and committees. Brazil's health councils, although making an overall positive impact on the quality of health services, were at times very slow and bureaucratic due to legal requirements. In Uganda, patient participation in accountability processes was impeded by low levels of literacy, information asymmetry and underlying power differences between policy makers, health workers, and patients. The relative importance of bottom-up versus top-down empowerment action remains contested. In Tanzania, the many improvements arising from a social accountability program were largely linked to health worker training and socialisation, improved service design (outreach and service timing/location), and better infrastructure rather than community participation.

Equity: How can participation and empowerment include the most vulnerable?

LEGAL MANDATES: Presenters noted that mandating participation (through laws and policies) can not only improve health system governance but can also promote equity in terms of who engages in these new participatory spaces. Several South American countries have legal requirements mandating civil society participation in agenda setting and planning. Formal laws or policies to require participation by community, patient, and under-represented groups will promote equity in health

1 Asishana, J. (2019). CSO sets up state-led accountability mechanism for maternal health. The Nation. https://thenationonlineng.net/cso-sets-up-state-led-accountability-mechanism-for-maternal-health/

2 Nigeria Health Watch. 2019. Partnering for Accountability: Nothing About Us Without Us. https://nigeriahealthwatch.medium.com/partnering-for-accountability-nothing-about-us-without-us-cb3bcf332f6c [Accessed 9 June 2021]

Routine tracking of empowerment and participation in health systems is necessary and possible.

systems. Formal legal requirements and practical support are both needed to ensure that Community Health Impact Assessments generate community-owned knowledge that is considered in policy-making on par with "expert" knowledge.

PRACTICAL SUPPORTS: Participatory processes must ensure inclusivity not only through legal mandate but also through providing practical support. Uganda's citizen panels engaged citizens in high level policy making and included an orientation and training process specifically designed to make these panels accessible to people across a range of socio-economic strata. The session '*Accountability in Practice: practical application and learnings from implementing accountability programmes. What works and how?*' highlighted that vulnerable and neglected communities can unfold their own barriers to equity and inclusion with the help of a practical step-by-step framework called Identify, Define, Assess, Record, Expand (IDARE).

C2. What is being said about the measurement of empowerment and participation?

HSR2020 contained very little content on the routine assessment and tracking of empowerment and participation within the health system. Presentations and posters focused more on research methods involving the community as a means to capture community voice (particularly scorecards but also methods such as PhotoVoice). Nonetheless, two overarching principles were articulated that can be used to generate the indicators, data collection methods, reporting systems, and frameworks necessary to measure empowerment and participation in health systems at scale.

First, the co-production of knowledge and co-design of services in health systems must become the norm. Community-led governance tools (such as scorecards) can, when embedded in the health system, become a routine data source to assess health system functionality and some aspects of participation. Some measurement frameworks (such as the PowerCube and multi-level monitoring and accountability frameworks) can be used by marginalized groups to co-produce knowledge. Human centred design approaches can empower communities in shaping their health services to ensure that new interventions are locally appropriate and acceptable. Research moves from one-off data extraction to empowering co-production and co-design in primary health care when it is led by communities, embedded in health systems over long periods of time, and engaged with stakeholders to ensure outputs are actually used to shape health services.

Second, routine tracking of empowerment and participation in health systems is necessary and possible. Health committee contributions to accountability in Brazil was assessed across three aspects of accountability: level of performance, level of community engagement/ participation, and degree of influence on issues pertaining to the community. Frameworks that showcased how participation would improve community empowerment and health system governance were discussed as valuable not only from an academic perspective, but for the rigour they can promote in thinking through the multi-level actions required to plan quality improvement in a whole-of-system manner.

Conclusions

HSR2020 showcased that achieving PHC for all requires both technically sound policies and programs as well as political support in the form of adequate financing and governance structures. The presentations and discussions at HSR2020 added context, nuance, and richness to our current pathways for assessing and improving these technical and political drivers PHC. The three pillars of PHC used for this report - healthcare services, multisectoral determinants, and community empowerment and participation - must intersect and engage closely to ensure lasting improvements, particularly for marginalized and vulnerable communities. HSR2020 presented a plethora of insights for stakeholders to consider in the development and implementation of PHC programs, including in relation to ensuring financial protection. PHC must be developed as part of community health systems with political and financial commitments to ensure their growth and sustainability. PHC cannot be viewed independently of broader determinants of health, such as safe housing, food insecurity, employment, protection from violence, and safe water and sanitation, particularly for those marginalized communities where health is intrinsically linked with these determinants. Community participation and empowerment is also showing promising results in improving services and health outcomes.

References

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Annexure.
Data extraction framework

Please note that we have transposed the columns to improve readability in this report. The actual data extraction framework was a Google Sheet wherein each row in the below table (session number, session title, paper number…) served as columns. The rows in the Google Sheet were the sessions, presentations and posters.

1. General session information	Session number
	Session title
	Paper number
	Paper title
	Speaker / presenter first name
	Speaker / presenter last name
	Abstract
	Phase
	Inclusion
	Date
	Researcher responsible for data extraction
2. Overview: General classification and overall assessments	Symposium sub-theme
	Country / region of focus
	Health system level of focus: individual/household, community, health facility, local health system (block / province / state), national, regional, global; multiple; not applicable
	Explain your response for "Health system level of focus"
	Which of the three pillars of PHC does this presentation focus on? 1a) health care services & financial protection; 1b) health system governance; 2) broader determinants of health; 3) empowerment and participation, or 4) multiple pillars/other
	Explain your response to "Which of the three pillars of PHC does this presentation focus on"
	Is this presentation about (1) a pilot intervention / small scale program, (2) a scaled up program, (3) policy; (4) methodology; (5) other
3. Context/problem	What is the impetus for this work? What are the key problems, resources, opportunities, challenges that this presentation grapples with? Is there an "unreached" population? If yes, what is the scope/ size of the issue?

4. Health care services: meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population, with essential public health functions as the central elements of integrated health services.	Measurement (general/routine): What is being said about measurement in health care service provision? What indicators, data collection methods, reporting systems, frameworks are being used? Is anything said about the comparability of measures across countries or within countries? Is anything said about the capacity for routine measurement systems to capture information on service quality? Was anything said about measurement of health care provision for non-routine purposes (e.g., specific research studies)? Specify if measurement is linked to: - health information systems - monitoring and continuous improvement
	If you filled out the previous section on measurement, did this presentation discuss the measurement of equity, reaching the unreached? If yes, how? E.g., what are the challenges in measuring equity in health care services? How are interventions to improve equity assessed for effectiveness?
	Improvement (quality): What is being said about improving health system governance or improving the quality of health care service provision through policies / strategies / interventions (at global, regional, national, local system level and/or facility level)? What works (pilot programs or scaled up)? What's the evidence? What are the innovations and best practices? What are the barriers to improving health care services provision? Specify if the improvement is linked to: - human resources for health effectiveness (competence, motivation, remuneration, worker rights) - facility organization and management (leadership, management capacity, team based care, supportive supervision, trust and relationships within the health services) - coordinated, comprehensive and continuous care - other aspects of service provision
	If this presentation covered improvement in health service quality, did it say anything specific about improving the equity of health services? If yes, elaborate. What are the innovations and best practices? What countries or sub-national regions have really done well? What partnerships have excelled? What are the main challenges in reaching the unreached? Specify the ways in which equity considerations link to - geographical accessibility - financial accessibility - cultural accessibility
	Improvement (financial protection and cost effectiveness): What is being said about improving financial protection or the cost effectiveness of health care service provision, particularly around reaching the unreached? What works (pilot programs or scaled up)? What's the evidence? What are the innovations and best practices? What are the barriers to financial protection and cost effective health care service provision?
	Other / misc.: Was anything else said about improving health services that is relevant? What key tension or debate emerged?

5. Broader determinants / multisectoral action: systematically addressing the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors;	Measurement: What is being said about the measurement of broader determinants and multisectoral action? What indicators, data collection methods, reporting systems, frameworks are being used? Is anything said about the comparability of measures across countries or within countries? Is anything said about the capacity for routine measurement systems to capture information on quality or equity in access?
	Improvement: What is being said about improving broader determinants of health or achieving multisectoral action through policies / strategies / interventions (at global, regional, national, local system level and/or facility level)? What works? What's the evidence? What are the innovations and best practices?
	Other / misc.: Was anything else said about improving broader determinants of health and achieving multisectoral action? What key tensions or debate emerged?
6. Empowerment and participation: empowering individuals, families and communities to optimize their health, as advocates of policies that promote and protect health and well-being, as co- developers of health and social services, and as self-carers and caregivers.	Measurement: What is being said about the measurement of empowerment and participation? What indicators, data collection methods, reporting systems, frameworks are being used? Is anything said about the comparability of measures across countries or within countries?
	Improvement (overall): What is being said about improving community empowerment and participation (including through civic, legal and political processes) in health? What works? What's the evidence? What are the innovations and best practices? What are the major barriers to participation and empowerment?
	If this presentation covered improving empowerment and participation, did it have any specific content on equity considerations? What works? What are the major barriers to equitable participation and empowerment?
	Other / misc.: Was anything else said about improving community participation and empowerment? What key tensions or debate emerged?

Discussions and debates around primary health care, reaching the unreached, and financial protection during the 6th Global Symposia on Health Systems Research 2020