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Perspectives

Towards Primary Health Care Systems That Produce Impact

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How To Cite: Michel, J.; Green, G.; Tanner, M. Towards Primary Health Care Systems that Produce Impact. *Global South & Sustainable Development* **2026**, *1*(1), 2.

Received: 24 November 2025
Revised: 4 January 2026
Accepted: 6 January 2026
Published: 14 January 2026

Abstract: Community and primary health care facilities are the first level of contact with the conventional health systems, thereby bringing health care close to where people live. Primary health care (PHC) is defined as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain, at every stage of their development in the spirit of self-reliance and self-determination. PHC is therefore the bedrock of a country's health system and the overall social and economic development of the community. To strengthen and build health systems that produce positive patient and community outcomes, we recognize the need to design and implement interventions differently. Existing data is often poorly utilized and many service and intervention designs are based on historical practice. To avoid a repeat of historical outcomes and to design and implement interventions that are relevant and suited to contexts, we propose to start with a bottom-up participatory approaches from project inception, co-design, co-implementation and co-evaluation as the directionality of research determines the themes of focus. Research that starts by engaging national Ministry of health actors going down to province, district, sub-district to facility level is shaped by the themes that matter to the top health system actors, themes that emerge in the data analysis and in turn shape the interview guide as data collection cascades down. We would like to argue that bottom-up research that starts by engaging with the community, is shaped by the themes of focus, the themes that matter to the community, captured during analysis and in turn shape the interview guide as data collection proceeds to higher health system levels. To that end, we propose a bottom-up approach to data collection in research and programs to facilitate responsive primary health care systems.

Keywords: directionality of data collection; community driven research; bottom-up research; bottom-up data collection; responsive PHC; impact

1. Background

Community and primary health care facilities are the first level of contact with the conventional health systems, thereby bringing health care close to where people live [1]. Primary health care (PHC) is defined as essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community, through their full participation and at a cost that the community and country can afford to maintain, at every stage of their development in the spirit of self-

reliance and self-determination. PHC is the bedrock of a country's health system and the overall social and economic development of the community [1]. Though clearly emphasized in the PHC definition, community participation has not been fully institutionalized in *low- and middle-income countries* (LMICS) and as a result, community trust in healthcare systems is a major stumbling block to resilience and responsiveness. According to literature, the status of community participation in programs, the community and health system's perception of participation, health system management approaches, cultural and institutional obstacles have a bearing on PHC success [2,3].

Many communities in sub-Saharan Africa utilize plural health systems. For example, 80 percent of the patients in South Africa visit a traditional healer before seeking care in the conventional health system [3]. The involvement and collaboration with these key players in the health system has a bearing on the health system outcomes and responsiveness [4,5].

Noteworthy is that PHC in many LMICs and sub-Saharan Africa is nurse—led with the health care workers playing a critical role in supporting nurses at community level. To strengthen and build health systems that produce positive patient and community outcomes, we recognize the need to design and implement interventions differently. Existing data is often poorly utilized and many service and intervention designs are based on historical practice. To avoid a repeat of historical outcomes and to design and implement interventions that are relevant and suited to contexts and in line with evidence—based decision making, the involvement of all key-stakeholders is key, as this influences the uptake of the evidence. In light of all of the above all key stakeholder engagement that brings the policy makers (National Department of Health), policy implementers (the health care service providers, doctors, nurses and allied professions) and the beneficiaries (the community) together is paramount [6]. The direction of engagement, is paramount too. The role of leadership in achieving UHC in sub-Saharan Africa cannot be overemphasized [4].

The aim of this view point is not only to initiate discussions around the directionality of key stakeholder engagement is the health care system but to also offer an approach that facilitates the use of the limited health care funds towards projects that enable primary health care systems in LMICs to deliver quality, community and gender responsive care in the context of the current and future stressors, such as pandemics, climate change, democratic deficit and weak governance.

1.1. Health System Resilience and Health System Responsiveness

We would like to start by stating that the concept health system resilience is contested. Most scholars define health system resilience as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks [5], where shock is defined as a sudden and extreme change which impacts a health system, different from the predictable and enduring health system stressors, such as population ageing. A broader resilience definition extends to looking at the minimization of exposure (risk and susceptibility), vulnerability (shocks) as well as the management of predictable and enduring system strains or stressors, such as population ageing or increasing incidence of multi-morbidity. The latter is known as everyday resilience, i.e., resilience to stresses that are commonplace and chronic [7,8]. In health systems performance, resilience is not only defined as how a system absorbs a shock and adapts to it, but also **how it transforms** and **evolves**, ideally into something better [5], bearing in mind that a shock cycle has four stages: 1: Preparedness; 2: Shock onset and alert; 3: Shock impact and management; 4: Recovery and learning [5].

Drawing from our knowledge and experience, health systems in LMICs need both preparedness for shocks and as well as every day resilience as both the demand and supply sides are chronically in distress. Shocks can affect both the demand and supply sides of the health system e.g., an epidemic increases health care needs while as an economic crisis causes a reduction in available resources. We also believe that resilience is not a plan but a dynamic state, therefore signs of resilience in every day health system activities today are a good proxy for resilience in case of a shock in future [5,9]. We opt for the above broader definition of resilience and would call that health system responsiveness in this paper for consistency.

A policy is defined as what the government chooses to do or not to do. A policy cycle is described as policy development, policy communication, policy implementations and policy evaluation [10]. Building resilient or responsive health systems can therefore be both a policy, what the government chooses to do and practice, what health systems implement. According to literature many good policies are developed but unfortunately do not see the light of the day due to the implementation gap [11]. In our earlier work in a South African UHC context, we identified five groups of factors that bring about these policy-practice gaps [10]. This is of utmost importance since the COVID-19 pandemic revealed that plans for becoming a resilient health system do not always translate into resilience when a shock hits, as all health systems were found wanting [12]. Drawing from our experience tracking UHC policy implementation in South Africa, policy makers, implementers, and beneficiaries rarely sit together

nor are the official channels of communication effective, hence they have different perspectives on what needs to be done where and for whom [10,11,13].

1.2. Bottom-Up and Participatory Approaches to Facilitate PHC System Responsiveness

To strengthen and build responsive health systems, we recognize the need to design and implement interventions differently. Existing data is often poorly utilized and many service and intervention designs are based on historical practice. To avoid a repeat of historical outcomes and to design and implement interventions that are relevant and suited to contexts, we propose to start with a bottom-up participatory approaches from project inception, co-design, co-implementation and co-evaluation.

- **Local Ministries of Health as Key Partners:** It is imperative to partner and work with local Ministries of Health so as to align with local health system gaps and priority needs. An additional reason to do this is to ensure local capacity building, skills transfer and ownership all of which are critical for resilience and sustainability. This approach will ensure an integrated and sustainable approach, grounded in the social, economic and environmental determinants of health, to improve the quality and accessibility of health services for the most marginalized [4].
- **Stakeholder Mapping:** This should be done to identify key stakeholders in the community including traditional healers, leaders, other sectors, private partners, nurses, doctors and other cadres in the PHC system, cognizant of the different contexts and levels. This process is key as this ensures community and all stakeholder participation and involvement through-out.
- **Stakeholder Engagement and Co-design workshops:** We propose participatory bottom-up approaches where engagement starts at community level, followed by facility level and subsequent health system level as this facilitates evidence informed policy making and intervention design. According to literature, there is a need to confront the messy engagement of multiple players with diverse sources of knowledge. The involvement of policy implementers (health care workers) and policy makers (district, provincial and national department of health officials) and their presence during engagements from community to national level ensures coherence since these key stakeholders rarely sit together. We propose to bring together policy implementers, policy makers and beneficiaries to design interventions suited to needs, context and resources. The stakeholder group consists of community members, PHC, subdistrict, district, provincial, national and all other multisectoral key stakeholders, known as the Health System Resilience Team.
- **Directionality of data collection and engagement:** Traditionally by default engagement in health research starts with national actors, provincial, district down to community level. This process influences the interview guide evolvement. Based on the top health system actors' responses and what they deem as important, the subsequent questions and narratives are shaped.

We propose the opposite, to start the engagement from the bottom, starting with the community, HCW, facility, subdistrict, district, provincial to national actors. This way the interview guide development, issues deemed as important to the community will shape the interview guide and consequently the narratives. See Figure 1.

- **Data collection and analysis**: Utilizing participatory methods, reflective inquiry and appreciative inquiry, we propose to engage with the all key-stakeholders to explore and understand issues of concern to them using an adapted interview guide see appendix. Guided by strategies identified for ensuring responsive health systems [5] we propose to use the interview guide at each level of the health system not as a checklist with tick boxes [14] but discussion points, while at the same time eliciting both quantitative and qualitative evidence to support statements given. See Table 1
- **Consensus is key to successful collaboration and implementation**: Methods to build consensus e.g., Delphi techniques and other locally accepted methods ought to be utilized during the workshops to ensure that stakeholders agree on the needs identified and the rank of their importance and the solution.

HSRT in the depiction below stands for Health Systems Resilience Team or Health System Responsiveness Team.

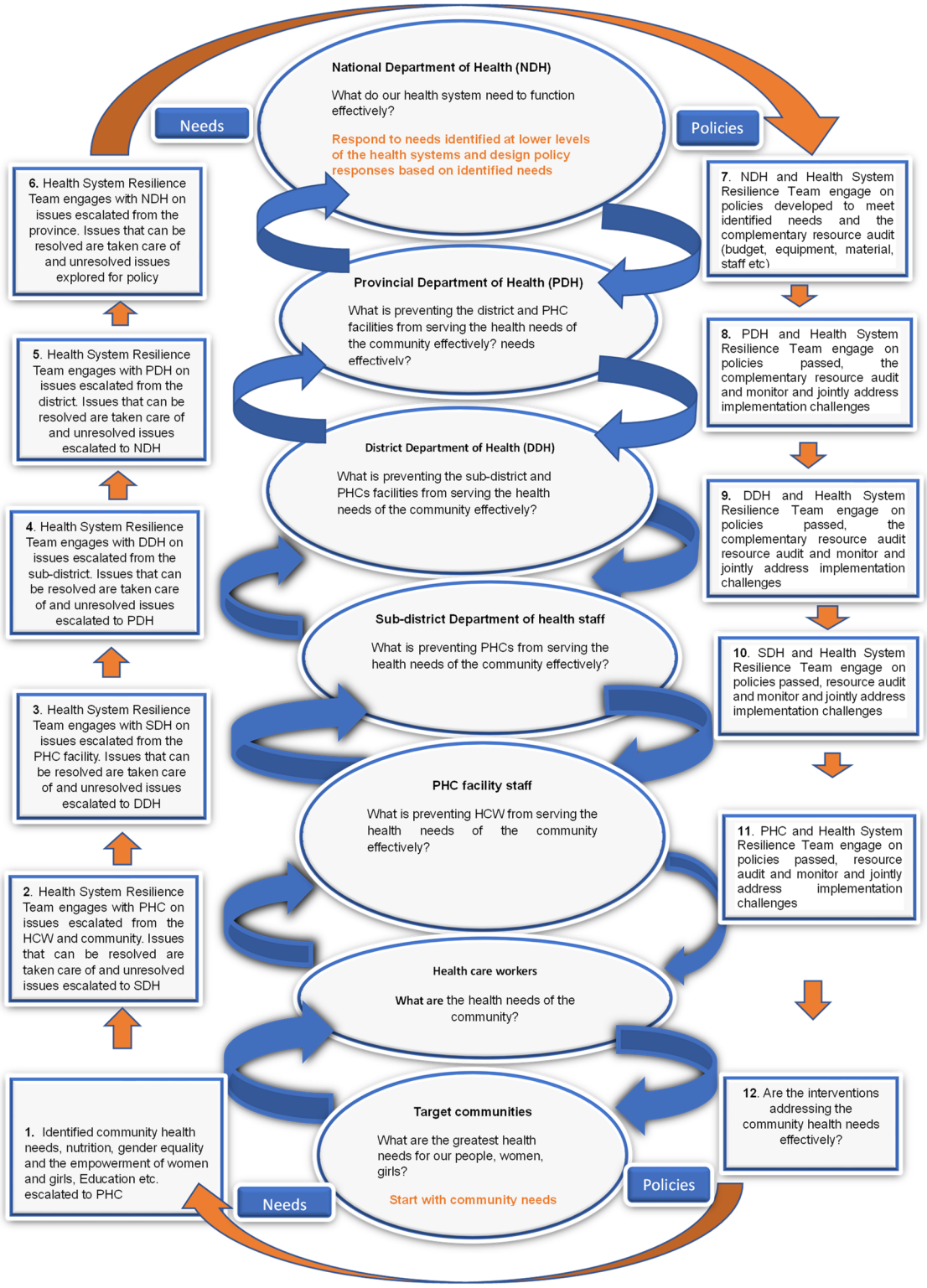

Figure 1. Directionality of engagement starting with the community bottom -up.

2. Moving towards Needs Based Policies

Universal health coverage (UHC) policies are often designed by people removed from the field leading to policies that are developed and implemented untouched by evidence or needs on the ground [10,15]. Inadequate collaborative policy-making leads to policy failure-policies developed in administrative siloes. To be successful, policy making needs to connect actors vertically and horizontally in a process of collaboration and joint deliberation [4,16]. Human centered designs, PHC and community led solutions stress the need to engage and involve beneficiaries, target communities and implementers throughout from co-design, co-implementation (campaigns) and co-evaluation. In most LMICs, policies are developed at provincial and or national level.

We propose that meetings are held at each level of the health system with representation from all key stakeholders the health system resilience team (HSRT). See Figure 1. Issues, needs and challenges identified at community level that could not be resolved, would be discussed at PHC facility level and issues that can be resolved are taken care of and feedback given to the community-Step 1and 2. Issues that cannot be resolved would be escalated to the sub-district and district levels respectively, and the HSRT with representation from community, PHC staff and all other key stakeholders ought to be present when the issues are discussed-Step 3 and 4. What can be resolved should be resolved and feedback should be sent to the facility and community while issues that could not be resolved are escalated to the province-Step 5. Here again, HSRT with representation from community, PHC staff and all other key stakeholders ought to be present when the issues are discussed. Issues that can be resolved should be attended to and those that cannot be, escalated to the national level-Step 6. Here again, HSRT with representation from community, PHC staff and all other key stakeholders ought to be present when the issues are discussed.

Issues that can be resolved should be attended to and communicated to all stakeholder representing all health system levels province, district, facility to community. Issues that need new policies should be deliberated and the HSRT should be involved. New polices would then be jointly developed and communicated to the province, district, facility and community through those communication channels with the support of the HSRT.

3. Resource Audit before Any Policy Roll-Out

The announcement and roll-out of new policies should always be accompanied by a complementary resource audit: are the needed resources available to ensure successful policy implementation? This should be done jointly by the department of health and the HSRT-Step 7–12. See Figure 1.

The HSRT will sit at each health system level and review the new policy against existing resources. Policies without corresponding resources are taken back by the HSRT to National Department of Health-policy maker for discussion and review. Only policies supported by corresponding resources are taken for implementation. This step is critical in our view because policies have been made without corresponding resource audits, leading to blame games, implementation failures with no-one being held accountable. Co-design and co-creation of evidence is not only key in enhancing implementation but also in facilitating evidence decision making and accountability, key features in building responsive health systems. Our approach is in line with the EU framework for resilience principles; (i) ensuring long-term stability of resources (ii) responding efficiently utilizing available resources and (iii) strengthening governance i.e., ensuring accountability, transparency, stakeholder involvement and use of evidence for monitoring and performance evaluation.

4. Framework for Data Collection and Analysis

A theory or framework provides a road map for systematically identifying factors perceived by all stakeholders as affecting health system resilience or responsiveness to address local health system gaps and strengthen one or more of the inter-related six (6) building blocks of health systems as per the World Health Organization: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance.

4.1. Limitations of the WHO Building Blocks Framework

We acknowledge the importance and usefulness of the health systems building blocks in identifying health system challenges, its simplicity and ability to provide a common language for all stakeholders. We however, would like to pinpoint some limits particularly its unsuitability when analysing dynamic, complex and inter-linked system impacts. The mechanical segmentation of the WHO building blocks, without recognition of their interactions can be an obstacle to the understanding of impacts on systems as a whole. For example it is not clear where in which block infrastructure falls. Furthermore, the focus on the blocks has often led to the neglect of the dynamic process and outcome aspects of health systems.

4.2. Five-Factor Framework

We propose to utilize our five-factor framework. The framework components cover all the six health systems building blocks and more, acknowledges the importance of health system actors, their motivation, the importance of context and systems thinking. The five-factor framework was developed in a UHC context in South Africa, uMgugundlovu district, one of the 10 poorest districts in terms of socio-economic status, health service, financial and resource management performance, selected by the Department of health as a pilot site [17]. This is a context found in many LMIC contexts. The framework itself is inspired by Bressers 2004, contextual interaction theory, a

third-generation implementation theory [11]. It is a simple framework with high explanatory power that moves from identifying factors that affect policy implementation to explaining how and why the absence or presence of these five-group of factors affect policy implementation. The five-factor framework has been tested and proven useful in identifying policy gaps in a Swiss COVID-19 digital tool project [18], proving adaptability to different contexts. The five-factor framework can be used as a both policy implementation and evaluation tool to understand why policy failed or succeeded [10,18].

Central to the five-factor framework is that involving end users, community, policy makers, and policy implementer, the health care providers facilitate successful policy implementation. This is in line with the Communiqué: Outcome Statement by Africa CDC's Primary Health Care (PHC) Digitalization Expert Committee [19]. See Figure 1.

4.3. Five Factor Groups

1. Primary factors stem from a direct lack of a critical component for policy implementation, whether tangible or intangible—resources, the policy itself, information, motivation, power, and context;
2. Secondary factors stem from a lack of efficient processes or systems, e.g., budget processes, financial delegations, communication channels, top-down directives, supply chains, supervision, and performance management processes;
3. Tertiary factors stem from human factors—perception, cognition, and calculated human responses to a lack of primary, secondary, and or extraneous factors as coping mechanisms (ideal reporting and audit-driven compliance);
4. Extraneous factors stem from beyond the health system—economy, weather, climate, and drought;
5. An overall lack of systems thinking also brings about this type of gap [10].

Table 1. Example of domains and questions for the interview guide.

Domain	Components	Interview Guide Question
Governance/leadership **Dedicated and committed political will is required over the long term for UHC to be achieved**	1. Effective and participatory leadership with strong vision and communication 2. coordination of activities across government and key stakeholders 3. an organizational learning culture that is responsive to crises	Describe how are decisions affecting your facility, are made and communicated Who does that? Describe how the activities you carry out here are coordinated with other governmental institutions and stakeholders How are mistakes handled?
Financing **Lack of power, financial delegations at district and facility level, coupled with lack of accountability, affect policy implementation**	1. Ensuring sufficient monetary resources in the system and flexibility to reallocate and inject extra funds 2. Ensuring stability of health system funding through countercyclical health financing mechanisms and reserves 3. Purchasing flexibility and reallocation of funding to meet changing needs comprehensive health coverage	Who handles the budget? Do you have flexibility to reallocate or seek extra funding, when and how? How often do you get your budget, amount and predictability? When a need arises how is funding mobilized-explain
Resources	1. Appropriate level and distribution of human and physical resources 2. Ability to increase capacity to cope with a sudden surge in demand 3. Motivated and well-supported workforce	Do you have sufficient staff and describe their motivation and performance Do you have the power to hire more staff based on needs?
Service delivery	1. Universal health coverage 2. Alternative and flexible approaches to deliver care	Who has access to health care services type of services, quality and challenges? Describe your relationship to traditional and other alternative health care providers
Systems and processes	1. Surveillance enabling timely detection of shocks and their impact 2. effective information systems and flows; and surveillance enabling timely detection of shocks and their impact	Describe your data needs and HIS-what works and what does not.? What type of data do you collect and how do you use the data

5. Strategies Identified for Ensuring Responsive PHC Systems

We propose to use this at each level of the health system not as a checklist with tick boxes [14] but discussion points at the same time eliciting both quantitative and qualitative evidence to support statements given.

Community, PHC, subdistrict, district, provincial, national and all other key stakeholders form the Health System Resilience Team or Health System Responsiveness Team (HSRT).

6. Conclusions

The current top-down approaches to policy development in PHC is partly to blame for the lack of progress seen, limited health outcomes and poor community trust and ownership. The above bottom-up approach to engagement with health system actors has the potential to create community relevant and led policies with the potential to improve uptake, implementation, ownership and patient and community outcomes and impact [4].

Author Contributions

J.M. had the initial concept, wrote the first draft, created images and tables, edited and wrote the final draft. K.G. reviewed the first draft and provided comments. M.T. was involved in the discussing of concept, writing of the original draft, editing and supervision. All authors have read and agreed to the published version of the manuscript.

Funding

No funding was received for this work.

Institutional Review Board Statement

Not Applicable

Informed Consent Statement

Not Applicable

Data Availability Statement

Not Applicable

Conflicts of Interest

The authors declare no conflict of interest.

Use of AI and AI-Assisted Technologies

No AI tools were utilized for this paper

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