

# PRIMARY HEALTH CARE SYSTEMS (PRIMASYS)

*Case study from Lebanon*

Abridged Version



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# Primary Health Care Systems (PRIMASYS)

## *Case study from Lebanon*

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### 1. Overview of primary health care system

Lebanon is an upper middle-income country in the Eastern Mediterranean Region with an estimated native population of 4.3 million individuals (1). Almost half of the population is active, with an age dependency ratio of 47%. Lebanon's demographic transition translates into an epidemiological transition, with noncommunicable diseases (NCDs) accounting for 85% of the burden of disease. The country records a relatively low fertility rate of 1.7 and a life expectancy at birth of 74.9 years (see Table 1).

Since the 1970s, Lebanon has endured civil wars, economic downturns and political instability, which has taken a toll on the health care sector. The long history of conflict contributed to the weakening of the public sector and the rapid growth of private institutions and nongovernmental organizations (NGOs) in an unregulated manner (2). Currently, the health care system in Lebanon is pluralistic due to the public-private mix involved in the financing and provision of health services. The per capita total expenditure on health (current US\$) is \$568.7 (or \$987 based on purchasing power parity), with out-of-pocket payments accounting for 36.4% of total health spending (3).

In the past six years, Lebanon has witnessed a massive influx of Syrian refugees as a result of the Syrian crisis. According to the government's latest estimates, the country hosts 1.5 million Syrian refugees (both registered and unregistered), along with 31 502 Palestinian refugees from Syria and a pre-existing population of more than 277 985 Palestine refugees (4). Lebanon records the highest refugee density of any country worldwide since 1980 (5). The refugee crisis has had a substantial impact on Lebanon's health care services and finances, which have been stretched very thin.

Despite the tremendous strain on the health system, both in case load and financially, the Ministry of Public Health was able to maintain the gains of the health-related Millennium Development Goals (MDGs 4, 5 and 6) (6, 7). However, a question that remains unanswered is the longer-term sustainability of the current response (7, 8). Table 1 provides an overview of key primary health care (PHC) indicators.

**Table 1. Key PHC indicators**

| Indicator   | Result   | Source of information   |
|---|--|---|
| Total population of country   | 6.3 million<br>(including Syrian and Palestinian refugees)   | Latest figure provided by Ministry of Public Health (not published yet) |
| Distribution of population (rural/ urban)                                 | No definition for rural and urban in Lebanon   | –   |
| Income or wealth inequality (Gini coefficient)                            | 86.1%  | Credit Suisse (9)   |
| Life expectancy at birth  | 74.9 years   | WHO (10)  |
| Infant mortality rate   | Total: 7.1 deaths/1000 live births<br>Male: 7.3 deaths/1000 live births<br>Female: 6.8 deaths/1000 live births   | World Bank (11–13)  |
| Under-5 mortality rate  | 8.3 per 1000 live births   | UN Inter-agency Group for Child Mortality Estimation (14)               |
| Maternal mortality ratio  | 15 deaths/100 000 live births  | World Bank (15)   |
| Immunization coverage under 1 year (including pneumococcal and rotavirus) | OPV3 (90%)<br>PENTA3 (91%)<br>MCV1 (91%)<br><br>Information on pneumococcal vaccines (PCV13, PPSV23) and rotavirus (RV5, RV1) are not available because Ministry of Public Health does not provide such vaccines | Ministry of Public Health, Lebanon (1)                                  |
| Total health expenditure as proportion of GDP                             | 6.4% of GDP  | WHO (16)  |
| PHC expenditure as % of total health expenditure                          | Work in progress in generating this information  | –   |
| % total public sector expenditure on PHC                                  | Less than 10%  | Council for Development and Reconstruction (17)                         |
| Per capita public sector expenditure on PHC                               | Work in progress in generating this information  | –   |
| Out-of-pocket payments as proportion of total expenditure on health       | 36.4%  | WHO Global Health Observatory (18)<br>World Bank (19)                   |

## 2. Timeline

The timeline for the evolution of key PHC policies and programmes is provided in Figure 1. The first call to build the PHC system in Lebanon dates back to 1977 (20). Almost 20 years later, Lebanon held its first national conference on PHC. This was subsequently followed by the development of the first National Strategy for PHC in 1994. Two years later, a comprehensive assessment of health centres and dispensaries in Lebanon was conducted to identify those able to provide PHC services. Among more than 800 facilities, only 29 centres were chosen to form

the epicentre of the Ministry of Public Health National PHC Network (21). Since then, the PHC Network has been expanding through contractual agreements with NGOs for the provision of publicly funded PHC to reach a total of 207 PHC centres (21). This has been paralleled by an increased trust in and utilization of PHC services.

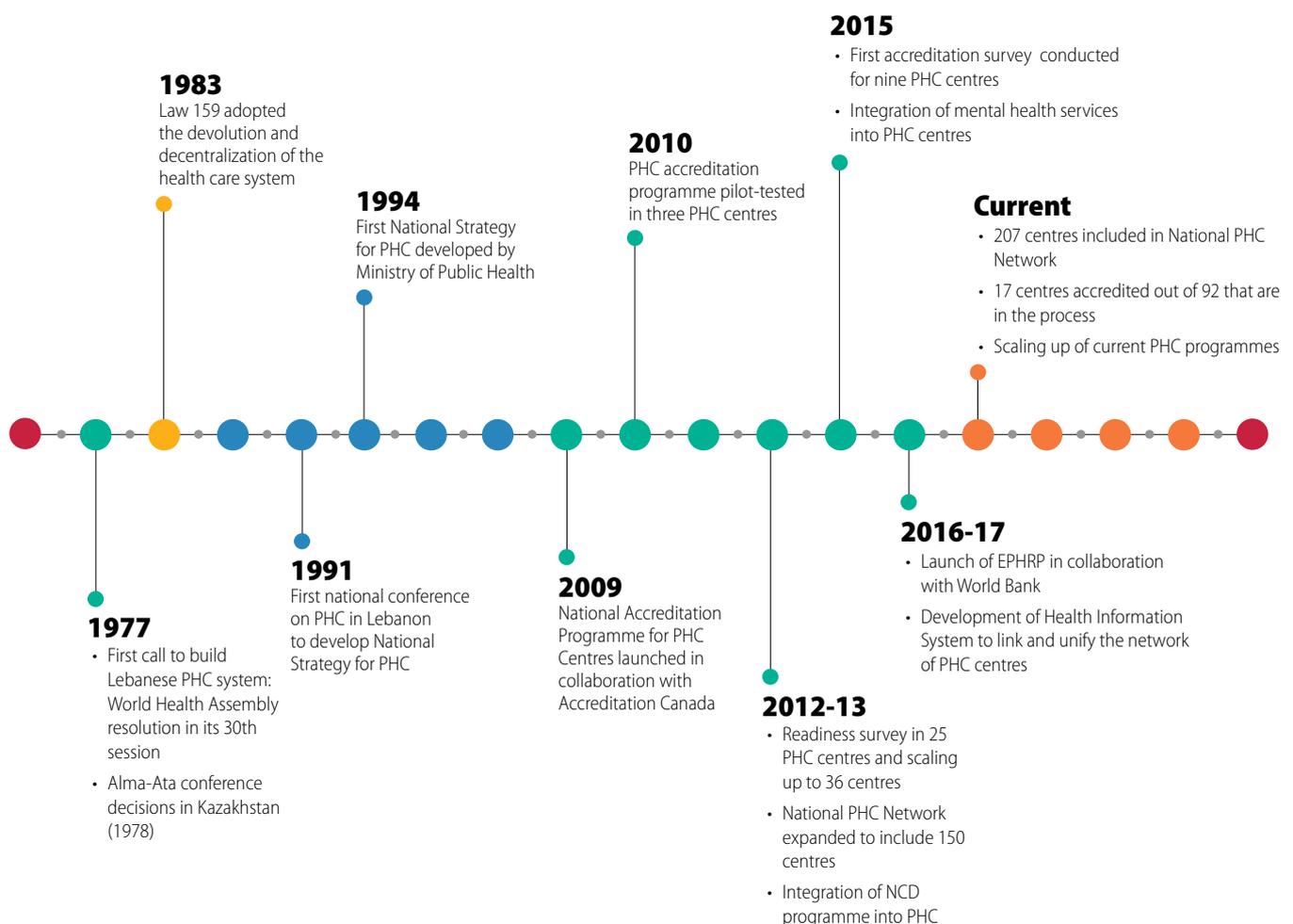
In 2009, as part of its efforts to promote the quality of PHC, the Ministry of Public Health collaborated with Accreditation Canada International to develop a National Accreditation Programme for PHC Centres in Lebanon

(22, 23). In 2010, the accreditation standards were developed and piloted in selected PHC centres. In 2015, the first official accreditation survey was conducted. Currently, 17 PHC centres are accredited out of the 92 PHC centres that are in process.

In 2016, the Ministry of Public Health in collaboration with the World Bank launched the Lebanon Emergency Primary Healthcare Restoration Project towards Universal Health Coverage (EPHRP) with the aim of providing 150 000 underprivileged citizens that are registered with the Ministry of Social Affairs with free PHC services. The services provided are based on a pre-identified set of

packages of preventive health services. Seventy-five PHC centres have been identified to provide this package of services and were provided with the list of beneficiaries in their catchment area (24). This project is considered a stepping stone to accelerate progress towards universal health coverage in Lebanon. Moreover, as part of the EPHRP, the Ministry of Public Health has recently established a Health Information System to register beneficiaries and to monitor specific health indicators related to the project (21). This system will help reinforce public sector institutions and promote transparency by providing information for the citizens and allowing them to track their administrative formalities.

**Figure 1. Evolution of PHC policies and key programmes, Lebanon**



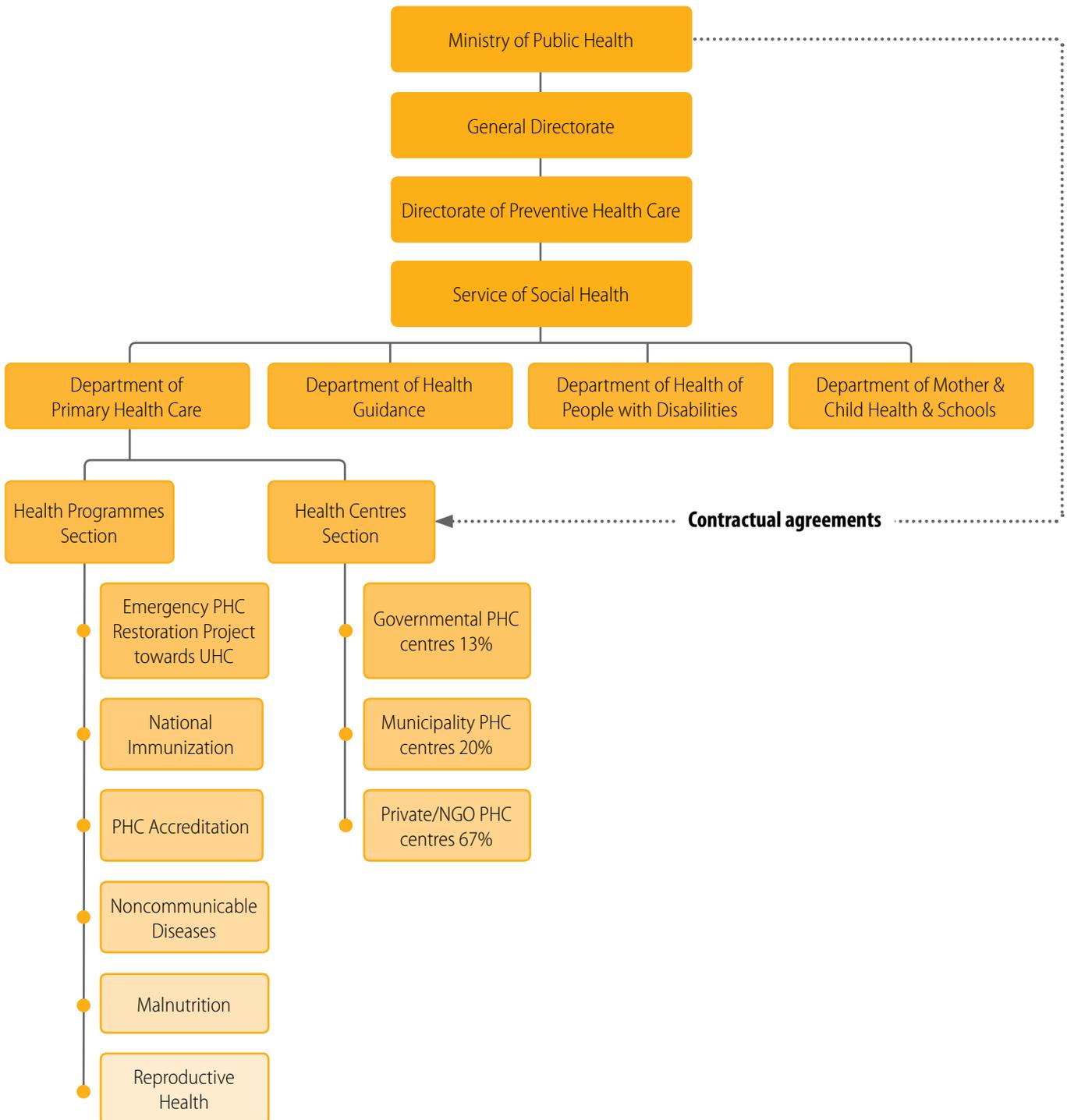
### 3. Governance

Figure 2 depicts the governance structure of the National PHC Network.

PHC centres in Lebanon are operated by several entities, including the Ministry of Public Health, the Ministry of

Social Affairs, NGOs, and municipalities (Figure 2). The majority of centres are owned and managed by NGOs (23). In an attempt to increase the accessibility of PHC services, the Ministry of Public Health developed a special type of

**Figure 2. Governance structure of National PHC Network**



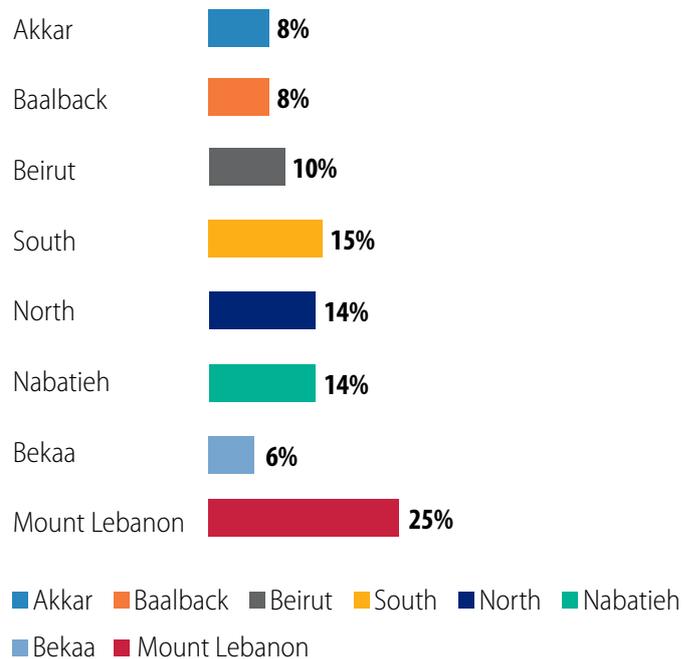
Source: Ministry of Public Health, 2015.

contractual agreement with public and private centres (including NGOs) that fit a delineated set of criteria (25). This has led to the creation and expansion of Lebanon's National PHC Network from an initial 25 contracted PHC centres in 2012 to 207 PHC centres distributed across Lebanon's eight provinces in 2017 (Figure 3) (21). PHC centres are distributed according to catchment areas, where each area has an average of 15 000–20 000 inhabitants (26, 27).

The contractual agreement between the Ministry of Public Health and PHC centres does not involve financial transactions. Rather, it focuses on encouraging PHC centres to improve the health status of the communities they serve. In return, these centres benefit from Ministry of Public Health support in terms of provision of essential drugs, vaccines, and medical and education supplies, as well as staff training and capacity-building (22). The provision of essential drugs and other services, as well as immunization activities, are reported on a regular basis to the Ministry of Public Health for evaluation and feedback (28). This public–private “organizational management approach” has enabled the Ministry of Public Health to ensure a primary medical safety net, in addition to providing an alternative to secondary care to the uninsured (27). Moreover, with the intention to regulate quality of care, the Ministry of Public Health initiated the National Accreditation Programme for PHC Centres in Lebanon in 2009 in collaboration with Accreditation Canada. Since then, patient safety and quality of care have been gaining momentum and this has reflected positively on both the clinical and administrative areas of PHC.

At the start of the Syrian crisis, there was no clear government policy regarding the Syrian population. A multitude of international and local NGOs, humanitarian agencies and governmental bodies were involved in the delivery and financing of health services, which led to fragmentation of health system governance and poor coordination of response to the refugee crisis (7). To promote an evidence-informed response to the crisis, the Ministry of Public Health collaborated with the Center for Systematic Reviews of Health Policy and Systems Research (SPARK) and the Knowledge to Policy (K2P) Center to produce policy-relevant systematic reviews and knowledge translation products and promote their uptake in decision-making (29, 30). Based on these collaborations as well as deliberations with key stakeholders, the Ministry of Public Health established a National Steering

**Figure 3. PHC distribution among governorates**



Committee, including major international and local partners, to develop response plans that detailed all funding sources, activities performed, and coordination efforts (7). This prompted a more integrated approach to planning, financing and service delivery by embedding refugee health care within the national health system.

As of 2013, the National PHC Network had witnessed significant expansion, with a steady increase in the number of PHC centres and beneficiaries. The network's beneficiaries exceeded 1.2 million in 2014, compared to 700 000 in 2009 (27). Syrian refugees accounted for almost 35% of the total number of PHC beneficiaries. PHC centres treat Lebanese and non-Lebanese patients equally in terms of service provision and nominal fees. The Ministry of Public Health has capped medical visit fees in centres within the National PHC Network to a maximum of US\$ 12, while providing essential medications for acute illnesses free of charge and chronic medications for a dispensing fee of less than US\$ 1 (31). Refugees registered with the United Nations High Commissioner for Refugees (UNHCR) have access to subsidized primary care in PHC centres for a fee of US\$ 2–US\$ 3. These subsidies are available at approximately 100 PHCs countrywide (31, 32).

Despite the limited increase in system inputs, service provision at the PHC level has been maintained throughout the Syrian crisis (7). Health programmes,

including immunization, epidemiological surveillance, medication for chronic illnesses, and reproductive health, remained fully functional (33). Also, programmes such as the integration of NCD management within PHC progressed as planned in spite of the crisis (33). The resilience of the health system has been attributed to four major factors: (a) networking of partners in the health

sector and mobilization and support of global partners; (b) diversification of the health system and health human resources; (c) comprehensive communicable disease response; and (d) integration of refugees into the health system (7). An overview of the entities contributing to the success of PHC service delivery is provided in Figure 4.

**Figure 4. Overview of entities contributing to the success of PHC service delivery**



MOSA: Ministry of Social Affairs; CDW: Central Distribution Warehouse; CDU: Communicable Disease Unit; MOE: Ministry of Education; UNHCR: United Nations High Commissioner for Refugees; WHO: World Health Organization; UNICEF: United Nations Children's Fund; UNRWA: United Nations Relief and Works Agency; UNFPA: United Nations Population Fund; UNDP: United Nations Development Programme; FHS: Faculty of Health Sciences; VMP: Vascular Medicine Program; HIS: Health Information System; NCD: Noncommunicable disease; NCPNN: National Collaboration Perinatal and Neonatal Network; EPHRP: Emergency Primary Healthcare Restoration Project; IFS: Information for Stability; PHC: Primary Health Care; YMCA: Young Men's Christian Association; AUB: American University of Beirut; AUBMC: American University of Beirut Medical Center

Source: Ministry of Public Health (21).

## 4. Financing

Total expenditure on health accounts for 6.4% of the gross domestic product (GDP) (16). The private sector is the main source of financing for health care (71%). Approximately half of the population is not covered by any formal insurance, and thus is eligible for coverage by the Ministry of Public Health, which serves as an “insurer of last resort” for hospital care and expensive treatments (27). While private out-of-pocket expenditure has decreased considerably over the years, it remains significant, as it still accounts for 36.4% of total health expenditure (3, 19). However, this decline in out-of-pocket expenditure may be indicative of citizens’ increased trust in and utilization of PHC services.

In a curative-oriented health system, it is not surprising that preventive and primary care account for less than

10% of public health sector expenditure on PHC services (18). Difficulties in deriving exact expenditures on PHC have been attributed to the various activities and partners contributing to PHC in Lebanon. Nonetheless, work is currently in progress at the Ministry of Public Health to generate this information. The Ministry of Public Health also relies on international donors for funding certain programmes related to PHC (34). Amidst the Syrian crisis, the country received external (humanitarian) aid, which remained insufficient in light of the magnitude of the crisis. It is worth noting that the Ministry of Public Health is not a direct recipient of donation funds, but rather coordinates with the international agencies to make sure these funds are channelled to the appropriate priority areas and populations through different international and local NGOs (7).

## 5. Human resources

Table 2 presents the most recent data on human resources for health within the National PHC Network.

There is a surplus of specialists and a shortage of competent primary care physicians (that is, family physicians) in Lebanon. This can be attributed to the scarcity of family medicine residency programmes (35); however, there are prospects of change as more universities are now including family medicine training programmes in their curricula. Additionally, low reimbursement rates fail to attract family physicians and result in their replacement with GPs. Under Lebanese law, medical graduates are licensed to practise

as GPs once they pass the colloquium exam without the need for any vocational training (36). Moreover, the scarcity of nurses and midwives may have negative impact on the availability and quality of care. In fact, shortage of nurses is one of the major challenges facing the Lebanese health care system, and it is primarily attributed to limitations in incentives and work environment, and migration of Lebanese nurses to the Gulf, Europe and North America (37). Also, due to financial constraints, PHC centres may not have the capacity to recruit and retain sufficient numbers of competent and skilled health care workers, including physicians, specialists and social workers.

In light of the above challenges, the Ministry of Public Health has engaged in various interventions to address shortages in health workforce supply, particularly nurses (38). These interventions have played a significant role in promoting the nursing profession through funding university educational programmes, training, supporting the nurses’ order, and improving nurses’ working and financial conditions (38). In addition, as part of the PHC rehabilitation project towards the achievement of universal health coverage, the Ministry of Public Health took part in capacity-building by training 592 primary health care workers (21). Nonetheless, Lebanon still lacks a coherent human resources strategy that provides strategic direction for recruitment, retention, performance improvement and capacity-building of the health care workforce.

**Table 2. Human resources for health in the National PHC Network**

| Health care worker categories  | Number      |
|--|-------------|
| <b>Total physicians</b>  | <b>942</b>  |
| • Specialist physicians  | 767         |
| • GP + family medicine   | 175         |
| <b>Nurses</b>  | <b>435</b>  |
| <b>Midwives</b>  | <b>80</b>   |
| Support personnel (including pharmacists, laboratory and radiology technicians, dieticians and social workers) | NA          |
| <b>Total</b>   | <b>1457</b> |

### 6. Planning and implementation

In 2016, the Ministry of Public Health developed and published a national strategic and operational plan for the health sector, spanning the period 2016–2020. This plan constitutes an important step for enhancing the Ministry of Public Health stewardship function and strengthening PHC (27).

While there is no official or formal referral system in Lebanon, referral between primary and secondary care is required as part of the National Accreditation Programme for PHC Centres (23). However, data and information flow from primary to secondary care is a noted shortcoming in the current system. Furthermore, given the current health system arrangement, there are significant obstacles to PHC centres acting as effective gatekeepers that regulate access to secondary and tertiary care levels. This means that a number of patients can bypass PHC and seek secondary care directly, which in turn can contribute to escalating health care bills. In fact, the most complex aspect of referral care is patients' acceptance of and compliance with referral (39). Thus, it is important to understand the structural changes that need to be made within the current health system and the incentives that need to be put in place to enable a functional gatekeeping system in a context such as Lebanon.

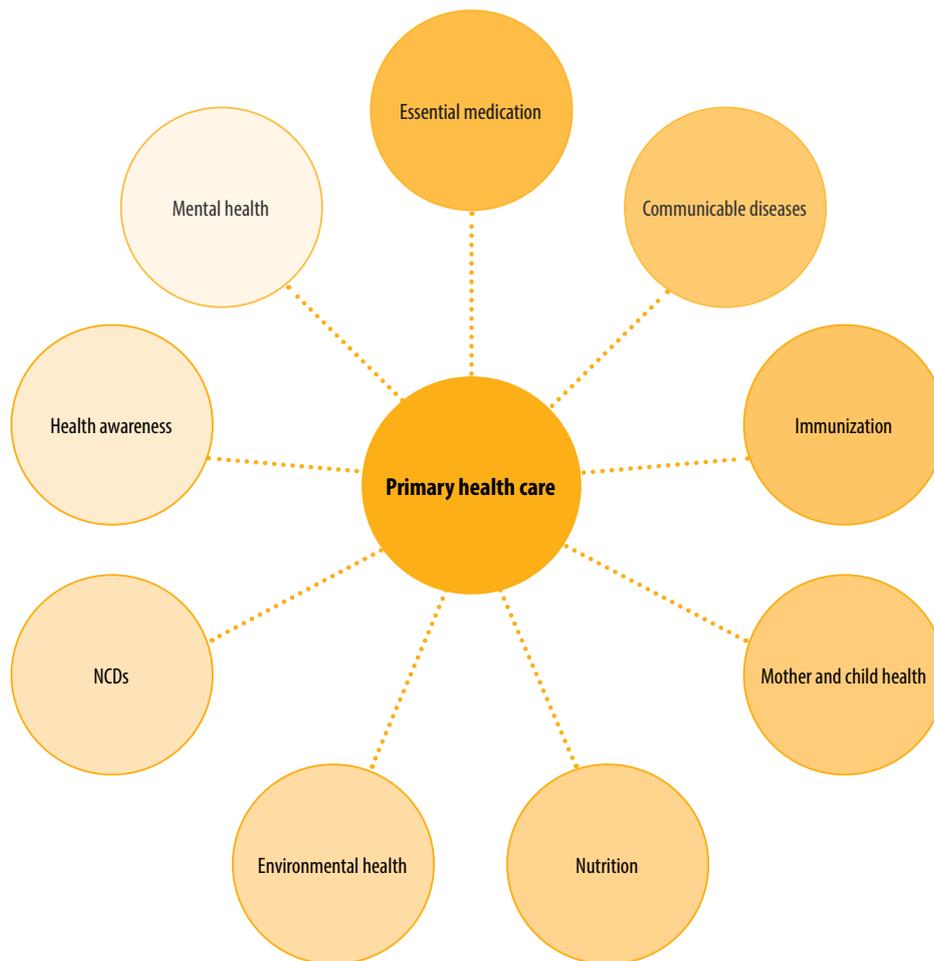
While no community needs assessment has been conducted at the national level, some PHC centres that are undergoing accreditation have attempted to elicit community needs using a number of approaches. However, standardized tools to conduct community needs assessment are still non-existent. As part of accreditation standards, accredited PHC centres have recently been required to establish a local community committee in order to promote community engagement. The voices of communities and citizens are further reflected in health service organization and planning through the municipalities and NGOs contracted by the Ministry of Public Health to deliver PHC. Moreover, PHC centres involved in the EPHRP are required to engage in proactive outreach activities to engage communities and link them to the PHC system. Efforts to integrate community and citizen engagement as a central component of a PHC approach are critical to strengthening accountability, transparency and responsiveness of the PHC system.

The PHC centres within the National PHC Network are committed to provide a comprehensive package of services, including immunization, essential drugs,

paediatric care, dental and oral health, reproductive health, chronic disease prevention and treatment programmes, and recently mental health services (27) (Figure 5).

The lack of geriatric care in PHC raises concern, taking into consideration that 26% of the Lebanese population is forecasted to fall in the 65 years or older age group by 2050 (40). This can be attributed to the lack of deployment of human resources in geriatrics, whereby only one medical school in Lebanon has a fellowship programme for geriatrics (41). Nonetheless, the integration of elderly health services at PHC level has been highlighted as a priority in the health strategic plan (27). Moreover, attempts to implement social and youth-friendly services have been limited. For instance, services related to gender-based violence have been pilot-tested with few selected PHC centres. Similarly, the Ministry of Public Health, in collaboration with the United Nations Children's Fund (UNICEF) and Himaya (a local NGO), is working on a child protection policy in order to integrate child protection practices in health care institutions. However, it is critical to ensure proper follow-up on the implementation of these initiatives.

Since the development of the National PHC Network, strengthening the PHC system has been a major strategic direction for the Ministry of Public Health (42). However, the Syrian crisis has placed an unprecedented burden on the health care system, particularly the primary care system. According to the World Bank, this has led to an overcrowding of PHC centres, consequently leading to a decrease in utilization of PHC services by the Lebanese population (43). In an attempt to address the emerging health crisis, particularly in underserved host communities, the Ministry of Public Health launched the Emergency Primary Healthcare Restoration Project towards Universal Health Coverage (EPHRP) in 2016 (44). Currently, the project has contracted 59 PHC centres, selected based on the number of beneficiaries within their catchment area. Of these, 48 started enrolling beneficiaries (42). Provider participation is voluntary and governed by the legal agreement between Ministry of Public Health and PHC centres, while payment is based on capitation. To ensure proper incentives are in place, the per capita payment has been split into three parts: (a) a contract advance, (b) use of services by beneficiaries, and (c) user satisfaction (45). Once the pilot phase is completed, the Ministry of Public Health plans to gradually scale up the project to the entire National PHC Network.

**Figure 5. Services provided by PHC centres**

## 7. Regulatory processes

The establishment of a National Accreditation Programme for PHC Centres in collaboration with Accreditation Canada International is considered a milestone in regulating the quality of care in the National PHC Network (22, 23). Currently, 92 PHC centres are undergoing accreditation, of which 17 have been fully accredited. While accreditation is a quality management strategy to ensure that institutions have the foundation to be able to provide quality care, it is also important to promote a culture of measurement, transparency and continuous quality improvement within PHC centres. Efforts and strategies are currently under way by the Ministry of Public Health to ensure the sustainability of quality improvement and patient safety initiatives in PHC.

At present, there are no standardized national indicators that need to be reported by all PHC centres. However, plans are under way to establish a standardized set of indicators,

though the reporting of these indicators will be confined to those centres involved in the EPHRP. The indicators will reflect measures related to overall beneficiary description (age, sex, and region); wellness package (0–18 years); wellness package (19+ years); reproductive services; treatment of diabetes; treatment of hypertension; and grievances. Considerations could be given to include explicit patient safety and outcome indicators. Moreover, the Ministry of Public Health could benefit from leveraging incentive systems that link contractual agreement, regulations, accreditation, and performance indicators (46). Insights could be drawn from the IMPROVE project, which describes the implementation of the first national set of standardized hospital indicators for performance benchmarking and reporting in Lebanon (47).

Outside the National PHC Network, regulation of quality is less rigorous and varies across health centres and

dispensaries. At a minimum, dispensaries and primary care providers are subject to general licensing (27). On a positive note, the Ministry of Public Health is planning to link dispensaries to PHC centres through satellite units and establish standards of operation. These dispensaries could be leveraged for immunization outreach.

Regarding medical products, the Ministry of Public Health uses three different procurement mechanisms, depending on the type of product. Vaccines and essential medicines for use at the PHC level are procured through UNICEF (which uses an international bidding system), while

chronic medications are procured and distributed through a large NGO (YMCA) in Lebanon (48). Medications for severe diseases such as cancer, HIV and some psychiatric illnesses are procured through a local tender procedure by the Ministry of Public Health. All medical products have to meet regulatory requirements set by the Ministry of Public Health (UNICEF has its own quality control system for drugs) (48). As for medical equipment, these are provided through donations to the Ministry of Public Health and subsequently distributed to PHC centres depending on their needs. Nonetheless, maintenance of equipment has been reported as challenging.

## 8. Monitoring and information systems

PHC centres within the network are required to submit monthly reports to the Ministry of Public Health. These reports include aggregate data on number of services delivered at the level of PHC. While the majority of centres have adopted the Ministry of Public Health's Health Information System, few have developed their own unique data systems, though they still report on the same required information. Follow-up on reporting and data related to PHC programmes is done by PHC coordinators who are assigned to each governorate. The coordinator visits the PHC centres on a monthly basis to follow up and report on programme implementation.

Recently, as part of the EPHRP, the Ministry of Public Health has upgraded the Health Information System to register project beneficiaries and to monitor health and financial indicators related to the project (21). This online system connects 75 PHC centres to the Primary Health Care Unit in the Ministry of Public Health, which ensures the transfer of information in a rapid, safe and accurate manner (21). The Ministry of Public Health is planning to have this system fully operational in all PHC centres within the network

so that all PHC centres become linked to the ministry's central database. This system will permit precise collection and centralization of information by linking it to a unified database, thus allowing the extraction, documentation and monitoring of various indicators. It is important to ensure that social and clinical data are also documented and reported, and not only demographic data.

Regarding patient satisfaction surveys, these are required as part of PHC accreditation standards. Although the Ministry of Public Health has designed a template for this purpose, many PHC centres have opted to develop their own surveys. Efforts should be made to ensure better use of survey results by PHC centres and the Ministry of Public Health to enhance service provision. The situation is different for PHC centres involved in the EPHRP, where patient satisfaction is solicited through standardized surveys and results are entered into the Health Information System. To verify these results, an external auditor readministers half of the surveys through phone calls to the beneficiaries and compares the answers.

## 9. Ways forward and policy considerations

Priorities that need to be addressed at the governance, financing and delivery arrangement levels of the health system in order to strengthen PHC in Lebanon are presented below.

### Governance arrangement level

- Create the right mix of incentives for both providers and patients to enable a functional gatekeeping system in a context such as Lebanon. Also, ensure transportation,

information, communication and other logistics for referrals are put in place for effective two-way referrals.

- Leverage incentive systems that link contractual agreements, regulations, accreditation, and performance indicators to strengthen PHC performance.
- Develop a set of standardized performance indicators for PHC in order to improve reporting on structure, process and outcomes and in order to encourage benchmarking among PHC centres. This should be

coupled with systems to counter data manipulations and unintended consequences.

- Strengthen PHC accreditation process and standards and ensure mechanisms are in place to sustain quality beyond accreditation.
- Establish a coherent human resource strategy that provides strategic direction for recruitment, retention, performance improvement and capacity building of the primary health care workforce.
- Develop decision support standards and revise clinical practice guidelines for PHC.
- Conduct standardized community needs assessment at the national level.
- Ensure continuous efforts to integrate community and citizen engagement as a central component of a PHC approach to enhance accountability, transparency and responsiveness of the PHC system.
- Ensure better integration of programmes and projects initiated by development partners within the overarching vision for PHC.
- Promote intersectoral collaboration in order to address the social and environmental determinants of health.
- Institutionalize processes and competencies needed to support inter-ministerial collaborations for health.
- Ensure mechanisms are in place to translate policies into operational plans and practical interventions with proper follow up to ensure sustainability of interventions.
- Institutionalize monitoring and evaluation as part of the national health information system.

### **Financing arrangement level**

- Help secure sufficient financial resources to support expansion and scaling up of PHC.
- Consider how best to integrate community-based health insurance within the broader health financing system to achieve universal health coverage.
- Encourage the international humanitarian community to meet the funding requirements to sustainably respond to the Syrian refugee crisis in Lebanon.
- Promote systems that can generate accurate and reliable information on PHC expenditures to facilitate evidence-informed decision-making and enhance transparency and accountability of government.
- Leverage Health Technology Assessment (HTA) programs to guide priority setting and ensure cost-effectiveness of interventions implemented in PHC.

### **Delivery arrangement level**

- Expand the number and scope of services provided by the National PHC Network and ensure they reflect the needs of the population.
- Adopt a hub-and-spoke service delivery model in PHC, whereby each primary health care centre (or hub) is linked to satellite units (nearby dispensaries or spokes) to ensure effective and efficient coordination of care at the primary level.
- Ensure availability of a sufficient, well-trained, gender-sensitive and motivated health workforce.
- Scale up the accreditation of PHC centres and monitor the quality of services on a regular basis.
- Scale up the EPHRP to the entire National PHC Network.
- Shift from vertical programmes to family practice, and reassemble PHC teams such that they become led by general practitioners or family medicine physicians.
- Integrate medical and social care provision, with a particular focus on youth-friendly services and programmes such as those related to child abuse, domestic violence, HIV/AIDS and drug addiction.
- Build a robust health information system to improve documentation, monitoring and collection of performance indicators.
- Develop a unique patient identifier and a unified medical record across all levels of care.
- Focus on vaccination and family planning as top priorities brought to the forefront by the Syrian crisis.
- Scale up mental health services by addressing challenges such as the lack of trained human resources.
- Conduct network mapping between different and same levels of care in order to make services more accessible and comprehensive and to improve patient and information flow.
- Promote longitudinal continuity with primary care team across separate illness episodes.
- Market the services of PHC centres and increase their media visibility, and engage the Ministry of Information in promoting primary health care.

Future considerations should be given to positioning PHC to become a central component for achieving the health-related Sustainable Development Goals (SDGs). This would entail reorienting PHC plans, programmes and activities to ensure they align with SDG targets; raising awareness and educating PHC workers, managers and leaders about the SDGs; and mobilizing collaboration across social, economic, and political domains to align and prioritize efforts to achieve the health-related SDGs.

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