I. Background

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

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

WHAT ARE PRIMARY CARE NETWORKS?

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

WHY PCNS?

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

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

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

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

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

II. Peer Learning Approach – *Implementation Learning*

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

IMPLEMENTATION LEARNING METHODOLOGY

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

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

DEFINING AN IMPLEMENTATION CASE

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

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

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

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

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

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

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

III. Country Implementation Cases

The Implementation Case Process

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

Colombia

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

> ***PROBLEM STATEMENT:***
>
> Answers the question "What is the key system challenge being addressed?"

Ghana

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

Kenya

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

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

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

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

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

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

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

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

Developing and Deploying a Causal Chain

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

> ***CAUSAL CHAIN:***
>
> *a visual representation of an interlinked series of events or steps, leading to a result or outcome.*

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

Aligning with National, Subnational, Community, and Facility Priorities

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

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

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

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

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

Responsiveness and Adaptability

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

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

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

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

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

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

IV. Primary Care Networks: Learning Themes

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

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

Financing Primary Care Networks

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

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

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

Piloting, Operationalization, and Scaling-up PCNs

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

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

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

Governance and Accountability of PCNs

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

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

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

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

Measuring Effectiveness of PCNs

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

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

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

V. Key Lessons on Designing and Implementing PCNs

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

What We Learned About PCNs

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

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

[5] Ghana Health Service and Health Systems Strengthening Accelerator, "Leaving No One Behind: The Role of Primary Care Provider Networks in Advancing Equitable Universal Health Coverage in the South Dayi and South Tongu Districts in Ghana, 2021.
[6] ResilientPHC@PHCPI.groups.io
[7] Primary Health Care Systems (PRIMASYS) "Comprehensive case study from United Republic of Tanzania", WHO 2017; "Health system performance assessment: A primer for policy-makers, European Observatory on Health Systems and Policies, Nov 2022; Analysis of Primary Health Care System Capacity in the Huetar Atlantica Region of Costa Rica, Ariadne Labs, 2022.

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

- Participating countries identified several ingredients for success (highlighted in text box) and essential tools for successfully implementing a PCN, including (1) Developing and using causal chains to map action steps and outcomes and regularly assess progress; (2) Consulting and aligning with key stakeholders throughout the health system – from local to national levels; and (3) Using systematic learning and continuous feedback processes to ensure responsiveness and adapt and improve the implementation process. **Implementation learning can be an effective approach to support implementers in advancing their goals in a relatively short period and to continuously improve their implementation efforts.**

- PCNs require accountability frameworks to clarify roles and lines of accountability to ensure responsiveness to the community. Community participation in PCNs needs to be strong to ensure that the network can meet the priority needs of patients and families. **It is essential to delve more into promising practices and evidence about how to ensure accountability of PCNs and effectively engage communities as participants in and supporters of PCNs.**

- Measuring PCN effectiveness is a complex and evolving topic, made more challenging by the context-specific nature of defining "effectiveness." **The monitoring and evaluation of PCN effectiveness emerged as an important cross-cutting topic and was identified as a top priority topic for future joint learning.**

ESSENTIAL ELEMENTS FOR PCN SUCCESS

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

Country Demand for Future Learning

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

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

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