SZABIST International Journal of Management Sciences

Journal Homepage: https://sijms.szabist-isb.edu.pk

Inclusive Primary Health Care: Comparative Analysis and Measurement Tool Development

Mareya K. Ali

Organisation: Conceivian, UK
Email: mareya@conceivian.com

Abstract

Significant progress has been achieved in health outcomes globally; however, the needs of marginalized groups remain inadequately addressed. Inclusive health care aims to minimize barriers to access, fostering equity for vulnerable populations. This study explores the primary healthcare systems of South Asian countries, identifies marginalized groups, and introduces a Key Performance Indicator (KPI)-based inclusion measurement tool. By leveraging existing frameworks and literature, the research underscores the importance of inclusivity in enhancing health systems and draws comparative insights across South Asia.

Key Words: *primary healthcare systems, inclusivity*

Introduction

Primary health care (PHC), as defined by the Alma Ata Declaration (1978), encompasses essential health services that are accessible, affordable, and equitable. Effective PHC improves disease prevention, treatment, and health promotion. The Alma Ata Declaration emphasized that health is a fundamental human right and a critical driver for socio-economic development. Despite significant advancements, disparities persist globally, particularly in South Asia, where systemic barriers often exclude vulnerable groups from accessing quality health care.

Inclusive primary health care acknowledges these challenges, striving to integrate marginalized populations into mainstream health systems to achieve better health outcomes and fulfill Sustainable Development Goals (SDGs). For example, SDG 3 (Good Health and Well-being) directly aligns with PHC's objectives to ensure healthy lives and promote well-being for all ages. Strengthening PHC systems is a transformative pathway to achieving broader developmental goals. Recent efforts by the World Health Organization (WHO) and regional collaborations such as the South Asian Association for Regional Cooperation

(SAARC) aim to address these disparities by prioritizing inclusivity in health care systems (WHO).

Inclusivity in Health Care

Inclusivity in health care involves deliberate efforts to remove barriers that restrict access for marginalized populations, fostering an environment where everyone can access quality health services without discrimination. Social, cultural, economic, and geographical factors play pivotal roles in perpetuating exclusion, necessitating tailored interventions that address these barriers holistically. An inclusive primary healthcare system is a socially integrated system where need is the driving force. It can be achieved by addressing their needs, obstacles and challenges. Health is important in itself, because it enables a person to have a good life, and a full life expectancy. However, poor health or lack of access to needed healthcare also makes it more difficult for other rights to be realized. If an individual does not have access to needed medical care or rehabilitation services, they may be unable to attend school, access livelihood opportunities, or participate in society. Inclusive environment in any Healthcare setting can benefit all patients and lead to improved health outcomes and a better overall life experience for everyone.

Key dimensions of inclusivity include:

- Equity: Ensuring services are distributed based on need rather than socio-economic status.
- Accessibility: Addressing physical, financial, and informational barriers to health care.
- Dignity and Respect: Cultivating culturally competent care that respects diverse identities.

The concept of inclusivity has gained prominence as nations strive to bridge disparities and provide equitable health systems. For instance, the "Health for All" agenda of the 1978 Alma Ata Declaration continues to inspire global health policy (WHO Alma Ata).

Literature Gaps

Existing literature underscores several gaps in the understanding and implementation of inclusive primary health care, particularly in the South Asian context. This thesis addresses these gaps by:

- Comparing Primary Health Care Systems: Comprehensive comparisons of PHC systems in South Asia are limited. This study evaluates systems in Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka.
- Identifying Marginalized Groups: Systematic identification of excluded populations (e.g., women, transgender individuals, ethnic minorities) and the barriers they face remains underexplored.
- Developing Measurement Tools: There is a paucity of frameworks to assess inclusivity in PHC facilities. This research introduces a KPI-based tool to fill this gap.

Furthermore, while regional studies focus on specific health outcomes, they often overlook systemic issues of inclusion. For example, gaps in addressing cultural competence and financial equity persist, as evidenced by limited research into grassroots-level implementation (PubMed).

Primary Health Care in South Asia

Inclusion may be defined as a virtuous circle of improved fundamental human rights of access to social, economic benefits, new opportunities with adjustment and support when needed (Sayce, 2001). In our given context, inclusion is providing more equity-oriented health care (EOHC) in primary health care which ultimately predicts improved health outcomes across time for people living in marginalizing conditions. This concept is associated with the all-encompassing and undivided tolerance to all. A more inclusive society is more sensitive to defend the most vulnerable. At the same time, it reduces social asymmetries and economic inequalities. Inclusivity is about addressing not just gender and racial groups but also to people from different skill set, different abilities, and different challenges (mental and physical). It ranges from simpler things as a disabled person able to visit a hospital via public transportation or more complex things – Healthcare inclusivity and equity oriented healthcare.

As WHO (World Health Organization) declared ‘a health crisis’ in South Asia at the start of (2011), marginalized groups were facing the greatest challenges in access to primary health care. Michel Rutkowski, the South Asian Director of Human Development by World Bank stated, South Asian countries are at crossroads with increasing health disparities, poverty, illiteracy, rising population and health systems that are failing to adjust to specific needs of people at large. For instance, there are three countries in the world only which are still struggling with polio vaccinations, two of which are in South Asia i.e. Pakistan & Afghanistan (WHO, 2018).

A South Asian regional conference World Organization of Family Doctors (WONCA) in Colombo took the initiative to compare the health systems of five significant South Asian member states. The five member states subjected to the analysis were Bangladesh, India, Nepal, Pakistan and Sri Lanka. It was documented that the development status of health systems ranged from absent to fully developed, also because countries analyzed varied in their history and development of health systems (van Weel,C et al., 2016). India and Bangladesh combined account for about 90% of the region’s population and about half of the world’s malnourished population. As the low nutritious value of processed foods in widely known, the population masses consuming low-cost processed foods is resulting in a decreasing health status. Being underweight is common for women of reproductive age in India, Afghanistan, Bangladesh and Nepal, with lower levels of Vitamin A and Vitamin D, residing in rural areas, belonging to low-education households and lower quintiles of wealth. Pakistan stands at acute level of inadequate access of water, sanitation and hygiene (WASH) services and facilities (Nadeem et al., 2024).

South Asia presents a diverse landscape of health challenges, shaped by socio-economic disparities, cultural norms, and policy inefficiencies. Despite signing the Alma Ata Declaration, the region struggles with fragmented PHC systems that fail to meet the needs of marginalized groups.

Recent Developments

Several initiatives signal progress:

- Bangladesh: Pilot health financing schemes and awareness campaigns have improved maternal health and immunization rates (World Bank Bangladesh).

- India: Corporate policies offering LGBTQ+ medical insurance and government-issued transgender health cards have set benchmarks for inclusivity (India Health Ministry).
- Sri Lanka: Decentralized health services and high immunization coverage exemplify robust PHC frameworks. In 2024, the World Bank allocated $150 million to improve access to quality primary health care (World Bank Sri Lanka).

Comparative Analysis

Using the Alma Ata Declaration's eight elements, this study compares PHC systems across South Asia:

- Nutrition: Persistent malnutrition reflects systemic inequities, with undernutrition and obesity coexisting in many regions.
- Sanitation: Despite advancements, millions lack access to clean water and hygienic sanitation facilities.
- Maternal and Child Health: While countries like Sri Lanka have made strides, high maternal mortality persists in Afghanistan and Pakistan.
- Immunization: Gaps in vaccine access have left Pakistan and Afghanistan as global outliers for polio prevalence (UNICEF Immunization)

Table 1.

Comparative Indicators (2023-2024) (Source: UNICEF, World Bank Data)

Indicator	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka
Malnutrition (%)	45.2	15.8	30.5	18.7	39.2	12.4	32.6	26.1
Sanitation Access (%)	41	57	68	72	90	55	61	91
Maternal Mortality Rate	High	Medium	Low	Medium	Low	High	High	Low

Immunization Coverage (%)	55	90	92	88	95	85	72	96

Identification of Marginalized Groups

Marginalized groups in South Asia face systemic barriers to accessing PHC. This study highlights:

- Women: Gender biases, limited reproductive health services, and socio-cultural restrictions perpetuate exclusion. Programs like Pakistan's Lady Health Workers initiative demonstrate potential to bridge these gaps (WHO Gender Equity).
- Transgender Individuals: Societal stigma, discrimination, and limited legal protections hinder access. India's transgender health card program marks progress (India MOHFW).
- Rural Populations: Geographic isolation, inadequate infrastructure, and low health literacy exacerbate disparities. Community health initiatives, such as mobile clinics, can mitigate these challenges (World Bank Rural Health).
- Ethnic Minorities: Linguistic and cultural barriers restrict access to culturally competent care. Targeted outreach programs are essential to fostering inclusion (PubMed).

Measurement of Inclusivity

Inclusivity in PHC is evaluated using a comprehensive KPI-based tool developed in this study. The tool encompasses five dimensions:

***Physical Accessibility*:** Assessing facility infrastructure to ensure it accommodates people with disabilities, including ramps, elevators, and accessible restrooms. Measurement involves site audits, compliance reviews, and patient feedback.

***Service Availability*:** Evaluating the range and quality of essential services provided. Indicators include maternal and child health, immunizations, mental health support, and chronic disease management. Surveys and data reviews identify service gaps.

Cultural Competence: Assessing staff training and practices to provide respectful and culturally sensitive care. Indicators include language services, diversity training, and patient satisfaction surveys.

Affordability**:** Analyzing financial mechanisms, such as subsidized care and insurance schemes, to reduce out-of-pocket expenses. Cost-benefit analyses and patient expenditure tracking underpin this dimension.

Community Engagement: Evaluating outreach programs, participatory governance, and health education initiatives. Community feedback and program participation rates measure effectiveness.

Development of an Inclusion Measurement Tool

The levels of inclusion from the measuring inclusion tool developed by Zenev and Associates Diversity & Inclusion Consultants in partnership with the Alberta Urban Municipalities Association (2017) and published in a scientific report funded by Alberta (Canada) government were adopted.

The five levels of inclusion are used as (1) Invisible, (2) Awareness, (3) Intentional Inclusion, (4) Strategic Inclusion, and (5) Culture of Inclusion.

In the second part of developing the inclusivity standard, indicators from two journals were combined publications as listed below:

1. 'Development of Health Equity Indicators in Primary Health Care Organizations Using a Modified Delphi' (Wong, et al., 2014).

2. Rapid assessment of infrastructure of primary health care facilities – a relevant instrument for health care systems management (Scholz et al., 2015).

The two sources were selected because they develop indicators to measure the inclusivity of a healthcare facility appropriately. The first research conducted by Wong et al., developed seventeen indicators using a Modified Delphi process. Over two rounds, indicators were circulated to the healthcare staff at the selected health centers. The indicators were scored by the staff in ranking of their importance. Only the indicators that received a >8.0/9 score were recorded and short listed (17).

Using indicators from both resources, five groups of indicators were formed, on basis of the barriers they address.

Table 1:

Selected Indicators organized in groups of barriers addressed

BARRIER ADDRESSED	INDICATORS	THEMES
1. Infrastructural Access	1.1 Assess the infrastructure of health care facility (physical & services infrastructure)	Inequity-responsive care Contextually-tailored care
2. Training	2.1 Provide ongoing training for all staff to support achieving the clinic's mandate to promote equity 2.2 Ensure the staff works to the full scope of practice to optimize the clinics capacity to provide equity oriented care and services 2.3 Provide strategies to support staff to deal with the emotional impact of working with patients who experience trauma including interpersonal and structural forms of violence	cultural competence inequity-responsive care trauma-informed care cultural competence inequity-responsive care Trauma/violence-informed care

3. Attitudes & Perceptions	3.1 Provide culturally safe care and practices as evidenced by, for example, staff questioning their assumptions about 'culture', taking sociopolitical and historical contexts into consideration, acknowledging and addressing contexts such as language, religion, sexual orientation, age, geography, spirituality, etc.	· culturally safe care
	3.2 Include an explicit statement regarding commitment to foster health equity in Vision and Mission Statements 3.3 Regularly examine how the verbal and non-verbal interactions impact the patients	Inequity-responsive care, Trauma/violence-informed care Culturally-safe care Inequity-responsive care,
4.Inclusive Health Programs/Awareness Programs	4.1 Assess patients level of trust in staff 4.2 Assess levels of improvements in patients' quality of life (as a result of receiving care at the clinic)	· culturally safe care · Inequity-responsive care

5. Availability of Services	5.1 Create processes to identify and follow-up with patients who are at risk of "falling through the cracks" (e.g., patients who repeatedly miss appointments or do not follow through referrals, etc.)	· Follow-up services
	5.2 Tailor services and programs to meet the health and healthcare needs of local populations served. (e.g., outreach services; in-patient visits; assistance with child care; assistance with transportation; gender-specific services, trauma-specific services; assistance with accessing housing, income and food)	· Inequity-responsive care
	5.3 Engage and coordinate with community services, and government and non-governmental organizations, in planning and providing care for patients, including for example: Housing services; Social welfare services; Child welfare services and support services for parents; Counseling services for trauma or other mental health issues	· Contextually-tailored care · Culturally-safe care · Inequity-responsive care, Contextually-tailored care

7. MEASUREMENT OF KPIS

For each of the five groups only one Key Performance Indicator (KPI) is developed that will combine together all the indicators in one group as one indicator defined in a health care context rather than the context of organizational inclusivity.

KPI: **Inclusive Infrastructure**

Group: (Barrier Addressed)	Infrastructural Access
Type of Indicator:	Qualitative
What to observe	Availability Lifts/ Wheelchair ramps to access every lab Runners to help support those physically challenged Gender Unisex Public Toilets in addition to male & female restrooms Gender Inclusive Patient Form Women breastfeeding areas Culturally appropriate seating areas Subsidized pharmacies for economically disadvantaged (illegal immigrants, refugees or poor who can't afford to buy a health insurance) Transportation services
Possible Sources of data	Observation of infrastructural services
Relative Progress	To be analyzed every time with reference to previous progress made

KPI:	**Inclusive Training of Clinical Staff**
Group: (Barrier Addressed)	Training
Type of Indicator:	Qualitative
What to observe	Sustainable emotional support for staff dealing with patients of violence & abuse Awareness session on cultural diversities Training to equip staff with strategies to make their dealings inclusive Training to deal with trans gender patients Training on how to deal with patients from ethnic minorities
Possible Sources of data	Number of trainings, content of trainings, staff interviews
Relative Progress	To be analyzed every time with reference to previous progress made

KPI:	**Inclusive Attitudes**
Group: (Barrier Addressed)	Attitudes & Perceptions
Type of Indicator:	Qualitative

What to observe	Translators be arranged for patients belonging to different/ far flung areas Training to use culturally appropriate words to address the patient and to show a welcoming attitude towards the patients Staff equipped to deal with mentally challenged patients Harassment cell available for patients (as patients have been denied services because of their gender, religion, ethnicity and legal status) Evaluate the Vision & Mission Statement
Possible Sources of data	Content of trainings, patient surveys
Relative Progress	To be analyzed every time with reference to previous progress made

KPI:	**Inclusive Programs**
Group: (Barrier Addressed)	Lack of availability of services
Type of Indicator:	Qualitative
What to observe	Outreach programs for marginalized groups Awareness Sessions Collaborations with other INGOS or other governmental organizations to devise ways to reach the marginalized populations

	Free dental and medical camps for trans genders Complaint cell (patients can report discrimination)
Possible Sources of data	Number of free camps, number of outreach programs, patient surveys, complaints received, number of collaborations on inclusive projects
Relative Progress	To be analyzed every time with reference to previous progress made

KPI:	**Inclusive Services**
Group: (Barrier Addressed)	Inclusive primary care programs to counter lack of awareness
Type of Indicator:	Qualitative

What to observe	Transportation services & Waiting times (emergency care) On-line e-care Personalized Awareness care Follow-up procedure Patient satisfaction surveys Housing services (domestic violence patients or those not accepted by families i.e. mostly trans gender patients) Counseling services Mental health awareness programs Specialized care for patients with mental health challenges
Possible Sources of data	Subsidized services, free housings provided, number of awareness services taken up by patients, privacy bonds signed by staff, number of gender specific services, patient surveys, follow-up of patients belonging to marginalized groups
Relative Progress	To be analyzed every time with reference to previous progress made

Discussing these five indicators it can be concluded whether the organization can be termed as being invisible, aware, intending to be inclusive, strategically inclusive or having a culture of inclusion in each of these five domains.

Table 2:

Key Performance Indicators

KPI	**Description**	**Measurement Method**	**Examples of Initiatives**
Physical Accessibility	Facilities for disabled individuals	Site audits and patient surveys	Installation of ramps, Braille signage, auditory assistance
Service Availability	Range of essential services offered	Facility data and health records	Availability of immunizations, chronic disease clinics
Cultural Competence	Staff diversity training	Training logs and feedback surveys	Training on transgender health needs, multilingual staff
Affordability	Financial assistance programs	Analysis of patient costs and support	Government health cards, insurance for low-income groups
Community Engagement	Outreach programs	Surveys and participation rates	Mobile clinics, health fairs, participatory planning boards

8. CONCLUSION

Inclusive healthcare is not just a moral imperative but a cornerstone of sustainable development, enabling marginalized populations to access their fundamental rights and realize their full potential. The findings of this research underscore the urgent need to prioritize equity-oriented primary healthcare systems across South Asia. By addressing systemic barriers, empowering marginalized groups, and fostering inclusivity at every level, healthcare can be transformed into a vehicle for social justice and equity.

This study highlights critical disparities in healthcare access and outcomes, particularly for women, children, disabled individuals, and economically disadvantaged communities. The comparative analysis of South Asian healthcare systems reveals the alarming extent to which societal inequities impede health outcomes, perpetuating cycles of poverty and exclusion.

Meanwhile, the development and application of the inclusion measurement tool offer a tangible framework for healthcare facilities to assess and enhance their inclusivity.

Achieving inclusive healthcare is not an isolated challenge but a shared responsibility that transcends borders and disciplines. It is only by recognizing the intrinsic value of every individual and addressing the root causes of exclusion that a future can be envisioned where healthcare is truly accessible to all. The transformative potential of inclusive healthcare lies in its ability to uplift communities, reduce inequalities, and catalyze sustainable development. The time to act is now, and the path forward demands collective commitment, innovation, and resilience

REFERENCES

van Weel, C., Kassai, R., Tsoi, G. W., Hwang, S. J., Cho, K., Wong, S. Y., ... & Goodyear-Smith, F. (2016). Evolving health policy for primary care in the Asia Pacific region. *British Journal of General Practice*, *66*(647), e451-e453.

Fikree, F. F., & Pasha, O. (2004). Role of gender in health disparity: the South Asian context. *Bmj*, *328*(7443), 823-826.

Nadeem, M., Anwar, M., Adil, S., Syed, W., Al-Rawi, M. B. A., & Iqbal, A. (2024). The Association between water, sanitation, hygiene, and child underweight in Punjab, Pakistan: An application of population attributable fraction. *Journal of Multidisciplinary Healthcare*, 2475-2487.

Sayce, L. (2001). Social inclusion and mental health. *Psychiatric Bulletin*, *25*(4), 121-123.

Scholz, S., Ngoli, B., & Flessa, S. (2015). Rapid assessment of infrastructure of primary health care facilities–a relevant instrument for health care systems management. *BMC health services research*, *15*, 1-10.

Mathieson, J., Popay, J., Enoch, E., Escorel, S., Hernandez, M., Johnston, H., & Rispel, L. (2008). Social Exclusion Meaning, measurement and experience and links to health inequalities. *A review of literature. WHO social exclusion knowledge network background paper*, *1*, 91.

Wong, S. T., Browne, A. J., Varcoe, C., Lavoie, J., Fridkin, A., Smye, V. & Tu, D. (2014). Development of health equity indicators in primary health care organizations using a modified Delphi. PLoS One, 9(12), e114563.

WHO. (1978). *Alma Ata Declaration*. Link

UNICEF. (2023). *Immunization Coverage Trends*. Link