PMAC Side Meeting on People-Centered Care

Framework Testing and Evidence Generation for the Lancet Global Health Commission on People Centered Care for Universal Health Coverage

1. Background and Context

The Lancet Global Health Commission on People-Centered Care (PCC) for Universal Health Coverage (UHC) is currently in a formative ‘Discovery Phase’ of its work, in part focused on refining a shared definition of people-centered care and developing an operational framework to guide implementation, measurement, and policy translation across diverse contexts.

The official side meeting at Prince Mahidol Awards Conference (PMAC), which took place on Tuesday 27th January 2026, was intentionally designed to serve a dual purpose. First, it aimed to socialize and expose a broad, global audience to the Commission’s aims, draft definition, and framework. Second, it sought to invite active, substantive engagement from participants willing to contribute lived experience, implementation insight, and policy perspective to directly shape the Commission’s work.

While hosted at PMAC and shaped by the Asia-Pacific context, the session attracted a high-level, multi-sectoral global audience and generated insights intended to inform the Commission’s work across regions, income settings, and health system configurations.

This session was envisaged as the first in a series of Discussion Labs, aligned with the Commission’s commitment to co-production, participatory inquiry, and grounding global guidance in lived experience and implementation realities.

2. Objectives of the Side Meeting

The objectives of the PMAC side meeting were to:

1. Test whether the Commission’s draft definition and operational framework for PCC resonate with lived experience, implementation practice, and policy realities
2. Capture regionally grounded and practice-based insights to inform refinement of the framework and ongoing Discovery Phase research
3. Promote participant agency, explicitly framing attendees as contributors shaping the Commission’s work

4. Establish an accountability loop, committing to integrate insights into Commission workstreams and share back with participants
5. Set precedent for future Commission engagements and Discussion Labs as a mechanism for active evidence generation, rather than passive consultation

3. Methods

3.1 Rationale for Session Design

The session design reflected the Commission's commitment to "walk the walk" of PCC. The format intentionally valued lived experience, frontline practice, implementation leadership, and policy decision-making as equally legitimate forms of knowledge as academic enquiry.

The design combined broad exposure (presentation and panel) with deep engagement (Commissioner-facilitated discussion labs). This allowed participants first to understand the Commission's work, and then to opt into sustained, participatory engagement.

3.2 Participants and Representation

A total of **59 participants** attended the plenary and panel session. **30 participants**, plus facilitators and organizers, participated in the discussion labs.

Participants represented a diverse mix of sectors and roles:

Sector	Organizations / Participants Represented
Community and civil society	Asia Pacific Network of People Living with HIV (APN+); Civil Society Platform for Health Equity and Inclusiveness; Young person from the Chula Clinic youth advisory group
Health workforce and trainees	Clinicians and public health practitioners; Nursing students; Medical students from local institutions
Academic and research institutions	Chulalongkorn University; National University of Singapore; La Trobe University; Health and Global Policy Institute (Japan)
Implementation-focused organizations	FHI 360; Clinton Health Access Initiative (CHAI); Vital Strategies
Policy, government, and multilateral actors	Ministry of Health of Chile; World Bank; IGAD; Swedish Embassy; Thai Red Cross
Private sector and philanthropic organizations	Roche; Gates Foundation

This mix reflected genuinely multi-sectoral participation, spanning academic, public, private, and social sectors, and including both senior leaders and early-career participants. While Asia-Pacific perspectives were prominent due to location, the audience and discussions were explicitly global in scope.

3.3 Session Format

The session comprised four components:

1. **Plenary framing**, introducing the Commission, its objectives, and the draft PCC definition and framework
2. **Panel presentations**, featuring four short lightning talks illustrating PCC in practice across sectors
3. **Discussion labs**, with three facilitated stations focused on lived experience and empowerment, implementation, and policy translation
4. **Synthesis and closing reflections**, reinforcing the accountability loop and next steps

Distinct “hats” were encouraged across discussion labs, ensuring lived experience, implementation, and policy perspectives were surfaced explicitly rather than conflated.

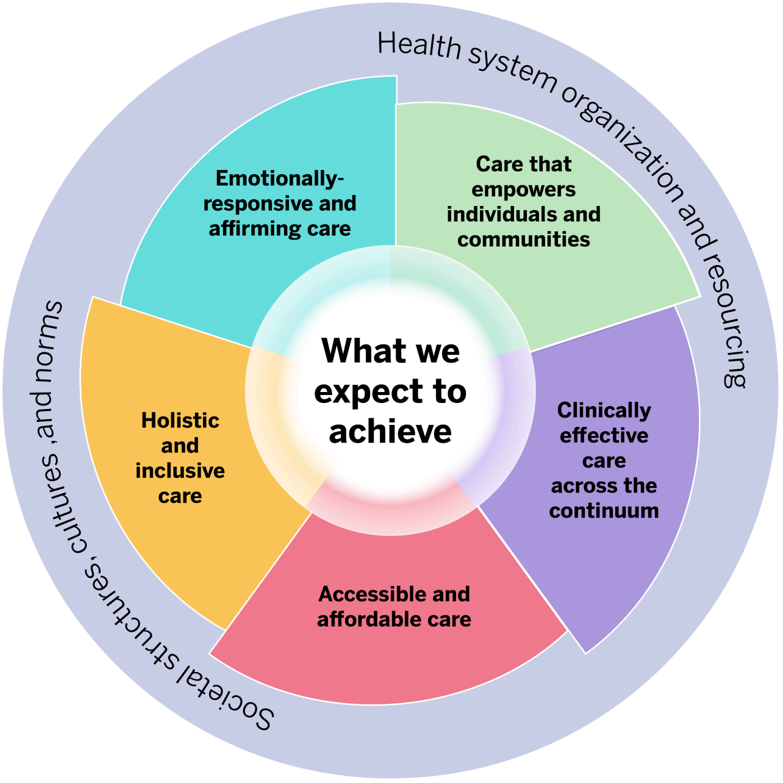
3.4 Documentation and analysis

Short-hand notes were taken in real-time by Commissioners in attendance (BH, MW) for the Plenary, Panel and Closing Remarks. Facilitating Commissioners (BW, MW, DD) took handwritten notes on flipcharts during the Discussion Labs, supported by detailed digital notes taken by IFMSA representatives. All notes were reviewed and common themes synthesised under report headings within 48 hours of the event (MW and BH) and turned into this full report within another 24 hours to maximize accuracy.

4. Results

4.1 Framework Presentation and Plenary Q&A

The presentation of the draft PCC definition and framework generated active engagement and critical questioning. Overall, there was **strong affirmation and excitement** expressed about the definition framework. It was presented as a ‘North Star’ for health systems to strive for, and particularly emphasizing characteristics of emotionally responsive and empowering care, as distinct from existing definitions and frameworks that privilege the health system and clinical perspectives



Antecedents

Conditions needed for people-centred healthcare to be enacted

Health system	Societal factors
Integrated health systems that are adequately resourced, managed and organized around people's' needs, cultures and contexts, and are underpinned by a commitment to staff training, education, and positive safe working conditions.	Social governance and community structures, cultures and norms that promote equity, social participation, accountability and culturally-safe practices, to address structural and social determinants of health and well-being

Characteristics

The defining features of people-centred care that distinguishes it from other modes of healthcare delivery

Clinically effective care that ensures technical, evidence-based quality of prevention, promotion, diagnosis, treatment, rehabilitation and palliation across the continuum of care

Care that empowers individuals and communities to meaningfully participate in health promoting behaviours, individual care and service/system design

Emotionally-responsive and affirming care mediated through respectful, trustworthy, compassionate, collaborative relationships with providers, families and the care team

Holistic and inclusive care that promotes wellness, is safe, responds to diverse personal and community preferences, cultures and contexts, including the SDoH and is rooted in lived experiences

Care that is easy to access, affordable and which maximises continuity of experience, as well as health system efficiency, utilisation and effectiveness

Consequences

What we expect to achieve when people centered care is enacted

Personal Agency & Self-Efficacy: Growth in individuals perceived control and capability to influence their health and care

Engagement in Care: Active participation in care processes and decisions, leading to more consistent health behaviours

Access & Continuity of Care: Improved ability to obtain services and maintain ongoing, coordinated care over time

Wellbeing: Improved physical, psychological and social outcomes through affirming and trusting relationships

Cultural Safety & Equity: Care environments and practices that are respectful, responsive, and safe for service users and service providers

Collective Empowerment: Communities exercising decision-making authority and influence over health priorities and services through inclusive governance.

Figure 1, Framework presented in Plenary Session

During the question and answer section, participants from the academic sector emphasized the importance of **acknowledging broader contextual antecedents** to PCC, including environmental degradation, climate vulnerability, and conflict. These were seen as shaping people's experience of care and health system capacity. This discussion extends beyond traditionally understood social determinants of health as currently reflected in the framework (and the literature on which it was based) to include commercial and environmental determinants of health.

A participant from the World Bank questioned whether PCC is achievable only within "integrated health systems", noting that they had seen people-centered approaches enacted even in constrained contexts, such as humanitarian crises and conflict zones. The discussion clarified that the framework's antecedents describe conditions that make PCC more likely to be universal and sustained, rather than strict prerequisites.

Finally, **equity considerations** were raised, with one civil society representative emphasizing that the framework applies meaningfully to migrants, refugees, undocumented populations, and minorities, and avoids implicit assumptions of stability, citizenship, or formal system access.

4.2 Panel Presentations: People-Centered Care in Practice Across Sectors

The panel featured four selected speakers from community advocacy, clinical care, the private sector, and health system reform. Together, their contributions illustrated how **people-centered care is experienced, enacted, and institutionalized** across different contexts, populations, and system levels. Rather than presenting abstract models, speakers shared concrete stories that highlighted the relational dimensions of care and the conditions under which people-centered approaches emerge.

Lived Experience, Empowerment, and Emotionally Responsive Care: Harry Prabowo (Asia Pacific Network of People Living with HIV – APN+)

Harry Prabowo began by situating his engagement with health systems through personal and family experience. He described how his introduction to HIV came through his brother's diagnosis, which was managed poorly and marked by stigma. These early experiences shaped his own relationship with care; despite working for many years in HIV advocacy, he avoided testing himself because he was afraid of receiving a positive result.

When he later entered care, Harry described a profound sense of vulnerability and powerlessness, noting that he "*felt how small I am within the health system*." He characterized these encounters as occurring within a disease-centered model, in which "decisions were made about me rather than with me."

In contrast, he described a later experience of care that felt fundamentally different. In this interaction, he was meaningfully involved in decisions about how his condition would be managed. Providers took time to explain options, allowing him to choose an approach that aligned with his priorities and circumstances. He described this interaction as one of trust and affirmation, remarking that it was the first time he "*actually wanted to see them again*" — returning for follow-up at six months rather than delaying care for a year.

Harry’s contribution illustrated the framework characteristics of care that empowers individuals, and emotionally responsive and affirming care. The consequences he described included increased engagement in care, improved well-being, and strengthened continuity of care, demonstrating how relational quality directly shapes health system use and outcomes.

Holistic, Lifecycle-Oriented Care and Co-Design: Dr Wipaporn Natalie Songtaweesin (Chula Clinic, Chulalongkorn University)

Dr Wipaporn Natalie Songtaweesin reflected on her dual perspective as both a provider and a recipient of care. In response to the Commission’s framework presentation, she described feeling excited as a patient — *“that is the kind of care I want”* — but simultaneously overwhelmed as a clinician, questioning how providers could realistically deliver all aspects of people-centered care. She noted that framing PCC as a “North Star”, rather than a checklist, helped reconcile this tension.

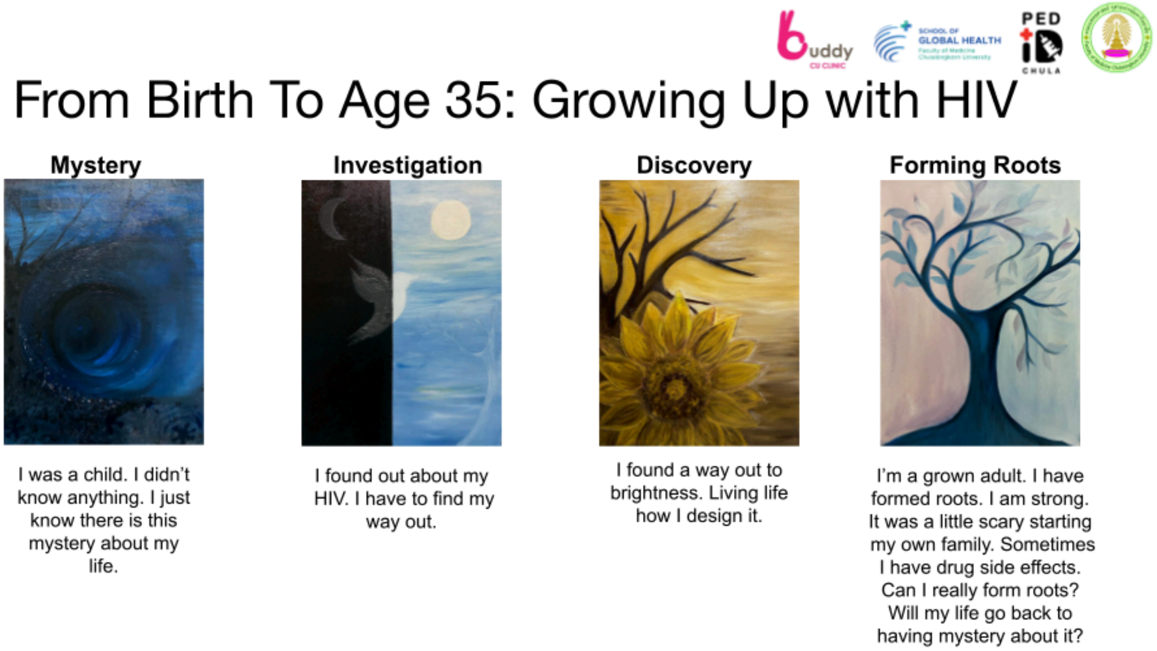
She then described the natural and responsive evolution of care at the Chulalongkorn CU Buddy Clinic. Originally designed to care for young people diagnosed with HIV perinatally, the clinic’s patient population grew into adolescents and young adults, forming families and facing new health and social needs. In response, the clinic expanded beyond HIV care to include STI, mental health, family planning, gender affirmation, substance addiction, and broader adolescent and young adult services.

A defining feature of the clinic’s approach is its holistic orientation. Dr Songtaweesin explained that consultations often begin not with HIV status or sexual health behaviours, but with questions such as “How is school?” or “How are your friends?” Clinicians ask young people what matters most to them and what their goals are — recognizing that HIV, or even physical health needs in general, is often not the primary concern shaping their lives.

She shared examples of artwork created by patients, depicting initial feelings of brokenness and fragmentation, and how — through the way care was delivered and relationships were built — these images evolved to reflect a sense of wholeness, potential, and hope (see Figure 2).

She also described the development of a youth advisory board, on which a young person named Boom (also in attendance at the side meeting) sits, that provides ongoing input into which services are offered and how care is delivered, helping the clinic remain accountable to the voices of young people.

Nat’s contribution illustrated the framework characteristics of holistic and inclusive care, clinically effective care across the continuum (across life stages and health needs), and elements of empowerment through co-design, with consequences related to well-being, trust, and long-term engagement in care.



From Birth To Age 35: Growing Up with HIV

Mystery

I was a child. I didn't know anything. I just know there is this mystery about my life.

Investigation

I found out about my HIV. I have to find my way out.

Discovery

I found a way out to brightness. Living life how I design it.

Forming Roots

I'm a grown adult. I have formed roots. I am strong. It was a little scary starting my own family. Sometimes I have drug side effects. Can I really form roots? Will my life go back to having mystery about it?

Figure 2, Example of Artwork from patients of the Chula Clinic shared in Panel

Access, Affordability and Continuity of Care through Service Delivery Innovation: Logan Caragata (Roche)

Logan Caragata reflected on his transition from his role in Canada to his APAC regional role, noting that one of his first instincts in any new role is to ask colleagues what motivates them to do the work. He shared a story from a colleague in Malaysia who had been deeply affected by meeting a woman at a market who had forgone breast cancer care — not because treatment was unavailable, but because she could not afford the indirect costs associated with accessing it, including lost wages, travel, and time away from family responsibilities.

In response to these realities, Roche partnered with the state government in Sabah to pilot the decentralization of breast cancer treatment, including intravenous and subcutaneous chemotherapy, by training nurses in district facilities closer to where people live. Logan emphasized that the initiative was designed from the outset with scale and sustainability in mind, including train-the-trainer models and alignment with existing systems of service delivery and financing.

He noted that the government has since expanded the model across Malaysia for breast cancer and is extending it to colorectal cancer, illustrating how people-centered service delivery innovations can be embedded within mainstream systems when they align with policy priorities and system constraints.

Logan's example illustrated the framework characteristics of care that is easy to access and affordable, and care that maximizes continuity of experience, with consequences including improved access to care and strengthened continuity across the care journey.

System Reform, Community Engagement, and Health System Conditions: Diah Satyani Saminarsih (CISDI)

Diah Satyani Saminarsih situated people-centered care within the broader challenges of implementing primary health care reform in Indonesia. She described persistent issues related to the maldistribution of the health workforce, uneven infrastructure, and variability in system capacity across regions.

She emphasized that people-centered care cannot be achieved through service delivery changes alone, but requires attention to health system factors, including governance, workforce planning, and community engagement. Diah highlighted the importance of involving communities in determining health priorities, shaping policy decisions, and informing system design — not only as beneficiaries, but as partners.

Her contribution underscored that institutionalizing PCC requires deliberate system-level action, including mechanisms for participation, accountability, and alignment between policy intent and implementation reality.

Diah's reflections connected directly to the framework's health system antecedents, illustrating how conditions such as workforce distribution, infrastructure, and governance shape the feasibility and sustainability of people-centered care.

4.3 Discussion Lab Findings

Lab 1: Empowerment, Dignity, and Lived Experience of Care

This Lab asked the question:
"Think of a moment in care when you felt truly seen, respected, and supported — or clearly not. What happened, and what made it feel that way?"

Participants were prompted to use their personal lived experience of receiving care, rather than their "professional" hat.

Stigma, discrimination, and institutional bias
Participants shared many stories of experiencing stigma related to a variety of health conditions and social circumstances, and reiterated the importance of this being reflected in the framework.

One participant reflected:

> *"If I stubbed my toe, when I couldn't get pregnant, it was always because I was overweight — that's how it was explained to me."*

The discussion also highlighted examples of discrimination embedded in policies, legal frameworks, and clinical norms, including criminalization of certain behaviours, and documentation requirements that acted as barriers to care. In another example, participants described pregnancy care contexts where the absence of a marriage certificate resulted in providers calling the police rather than offering support. The importance of acknowledging these factors, as well as issues such sexism, racism, and poverty, was raised.

Being seen and treated as a person in context
Participants described PCC as being acknowledged as a person — spoken to directly, not talked about while present, communicated with in one's own language, and treated with respect for their values and priorities. Emotional reassurance and non-verbal communication were repeatedly cited as central.

One participant noted:

> *"I just want to know what is happening to me — I felt like a lab rat as they did all the procedures."*

Information, agency, and confidence
Participants emphasized the importance of clear, respectful information-sharing. Strengths- and assets-based approaches were valued, such as explicitly incorporating supportive family and social networks into management planning.

Participants expressed a preference for transparency about system limitations. For example, if a medication was recommended but was not available, that they were told that explicitly and advised on where else, or when it would be available. They also raised the importance of mistakes being acknowledged.

Several highlighted how knowledge of how to navigate the health system, or support from someone familiar with it, is essential for access, and from this perspective is not seen as inclusive. The need to explicitly define what "inclusive" means, and for who, was stated. Participants also emphasized the importance of confidence and agency to be able to advocate for the care you need.

Time, continuity, and navigation
Time emerged as a central theme from the patient perspective — the time needed and valued for providers listening and trust to develop, and the negative experiences created by waiting times and referral delays. Providers acknowledged trade-offs:

> *"To do all these things well, I would need to see 50 patients a week, not 50 patients a day."*

Continuity of relationships and confidence in coordinated care teams were seen as essential. It was reported to be comforting to trust that the team of providers was working together "for me" rather than to address a specific disease.

Lab 2: Implementation – Enabling People-Centered Care in Practice

This Lab asked the question:

“In your experience, where have you seen an aspect or aspects of people-centered care actually happen in a service, team, or pathway? What made that possible?”

Team-based care, task sharing, and accompaniment

Again participants consistently emphasized that people-centered care is enabled when care is delivered by teams, rather than isolated providers. Several participants noted that from the patient perspective, PCC is experienced when providers appear coordinated and aligned, even when multiple professionals are involved. This sense of accompaniment was described as particularly important for people with complex needs or chronic conditions.

Participants also emphasized that responsibility for PCC should not fall solely on individual clinicians. Instead, team-based models distribute responsibility for communication, follow-up, and emotional support across providers. This was seen as essential both for quality of care and for provider wellbeing.

Providers noted that they must feel supported — and permitted — to acknowledge uncertainty, mistakes, or system limitations. Creating organizational cultures where this is acceptable was seen as a prerequisite for people-centered practice.

Role of community-based workers and organizations

The role of community-based workers, community health workers (CHWs), and civil society organizations emerged as a central theme. Participants emphasized that these actors are often critical for reaching marginalized populations, supporting navigation, and building trust — particularly for people who face stigma, discrimination, or legal barriers.

Community-based workers were described as playing multiple roles, including:

- Accompaniment and navigation through complex systems
- Translation — linguistic, cultural, and institutional
- Continuity across settings and over time
- Trust-building between communities and formal services

However, participants also identified significant implementation barriers, including:

- Regulatory restrictions on task-sharing
- Lack of reimbursement or formal recognition of community roles
- Fragmented funding and short-term project cycles

Several participants noted that as global health financing shifts, the scope and control of service delivery are changing, creating both risks and opportunities. Community pharmacies, informal providers, and non-traditional actors were cited as potential entry points for more people-centered models, if appropriately regulated and supported.

Physical space, infrastructure, and environment

Participants highlighted that physical space and infrastructure are often overlooked determinants of PCC. Confidentiality, privacy, and safety were repeatedly cited as essential conditions for people to feel respected and willing to engage in care.

Examples included:

- Layouts that prevent private conversations
- Overcrowded waiting areas
- Shared consultation spaces that undermine dignity

These issues were discussed not as abstract design problems, but as daily realities that shape whether people feel safe, respected, and willing to disclose sensitive information.

Technology as an enabler — and a risk

Technology was discussed as a potential enabler of PCC when used intentionally. Participants highlighted several positive use cases:

- Supporting informational continuity across providers and settings
- Enabling task-sharing and role differentiation
- Increasing efficiency to free up time for patient interaction
- Supporting communication and follow-up with communities

At the same time, participants were clear that technology should not be used for its own sake, or in ways that replace human interaction. Several warned against digital tools being deployed in ways that strips care of its relational and emotional dimensions.

One participant noted that technology should be judged not by novelty, but by whether it creates *more time, trust, and connection* between people and providers.

Practical tools to support emotionally responsive care

Participants shared examples of practical tools that support people-centered interactions in everyday practice, including:

- Motivational interviewing and counseling techniques
- Physical models and visual aids to support understanding
- Communication prompts and structured conversation guides
- Health literacy tools adapted to the local context

These were seen as concrete ways to operationalize emotionally responsive and affirming care, particularly in high-volume or resource-constrained settings.

Lab 3: Policy Translation and Systems Change

This Lab asked the question:

"From a policy or system perspective, what one decision or reform could most improve people's everyday experience of care in your context?"

Participants were asked to start from their real context, rather than build a system from scratch.

No one-size-fits-all: adapting PCC to context

Participants emphasized that people-centered care does not imply a single model of service delivery. Instead, PCC requires context-specific translation, shaped by population needs, culture, geography, and health system structure.

Examples discussed included:

- Adolescent-friendly clinics designed around young people's schedules, privacy needs, and communication preferences
- Indigenous- or ethnic-minority-owned clinics grounded in community leadership and cultural safety
- Rural and remote service models adapted to geography and workforce constraints

Participants stressed that in many contexts, PCC may mean decentralizing services to primary care and bringing care closer to communities through alternative entry points, such as pharmacies. In others, it may mean transforming facility-based care to be more relational, inclusive, and responsive.

Health workforce as a central policy lever

Health workforce policy emerged as one of the most important levers for enabling PCC at scale. Participants discussed multiple dimensions, including:

Recruitment and distribution

- Recruiting health workers from the communities they serve, especially for groups such as ethnic minorities and Indigenous populations in order to support trust and continuity
- Addressing geographic maldistribution, in particular between urban and rural areas, and speciality and primary care

Training and competencies

- In addition to clinical competence, a great emphasis was placed on ensuring providers have interpersonal skills, communication, and emotional responsiveness
- Great importance was attributed to cultural safety and "knowing the community," regardless of demographic or social similarities between providers and their patients
- Integrating PCC principles into medical and health professional education, including community-based learning, was identified as a critical enabler

Support and incentives

- Participants highlighted the importance of adequate compensation, correct incentives, and performance management aligned with the provision team-based and longitudinal care
- Professional development and career pathways that enable advancement and value relational work not just clinical delivery

Participants emphasized that professional associations and regulatory bodies must be engaged as allies in these reforms.

Service organization and delivery

As a key principle, participants discussed the need to organize services around people's needs and outcomes, rather than around diseases, departments, or funding silos. This included:

- Supporting continuity across the care journey
- Integrating preventive, curative, and social services
- Enabling task-sharing and demedicalization where appropriate

Several participants noted that PCC often requires reorganizing care pathways, not just adding new programs.

Governance, measurement, and accountability

Governance mechanisms such as community-led monitoring and engagement were highlighted as essential for accountability and learning. Participants emphasized that these mechanisms require:

- Investment in leadership development and capability building for community members
- Sustainable resourcing
- Formal roles and clear pathways for feedback to influence decision-making

Measurement was discussed as critical for evidence-informed policymaking, but participants stressed the importance of:

- Capturing relational and experiential dimensions of care
- Minimizing reporting burden on providers
- Recognizing that PCC is dynamic and evolves over time

Participants cautioned against relying solely on narrow quantitative indicators and emphasized the value of mixed-methods evidence.

Financing and payment systems

Financing and payment mechanisms were identified as powerful drivers of behavior. Participants discussed the need for payment systems that:

- Cover the "right" services, including community-based and preventive care
- Support team-based and longitudinal models

- Distribute resources equitably

Participants acknowledged the difficulty of aligning performance-based financing with PCC, given challenges in measurement, but emphasized that financing must not undermine relational care.

Making PCC legible to policymakers

Across discussions, participants emphasized that PCC must be framed in ways that resonate with policymakers. Ministries and system leaders need to understand:

- What problem PCC is solving
- What trade-offs are involved
- What outcomes matter to system performance

Participants noted that demonstrating value — for example through trust, adherence, continuity, and system efficiency — is essential for sustaining political commitment.

5. Discussion

5.1 Implications for the People-Centered Care Definition and Framework

Across the plenary discussion and Discussion Labs, there was strong affirmation of, and enthusiasm for, the Commission's draft definition and operational framework for people-centered care. Participants responded particularly positively to elements emphasizing **emotional responsiveness, dignity, empowerment/agency, and trust,** noting that these dimensions resonated strongly with lived experience and practice across contexts.

At the same time, participants reinforced the importance of accessible language and called for **further clarity** around several key terms. In particular, participants noted the need to sharpen definitions of *inclusivity*, *social determinants of health*, and *integrated health and care systems*, to ensure the framework can be clearly understood and operationalized by diverse audiences, including policymakers, implementers, and communities.

Participants recommended that the framework's antecedents more e**xplicitly capture broader contextual conditions** that shape the feasibility and sustainability of people-centered care. These included environmental factors, climate vulnerability, and conflict or peace contexts, which participants argued directly influence people's experience of care, trust in systems, and ability to engage meaningfully.

A strong theme across discussions was the importance of **centering the margins** as a core component of inclusivity and equity. Participants emphasized that people-centered care must be tested and defined through the experiences of those who are most likely to be excluded, marginalized, or harmed by health systems, rather than assuming a "typical" user. This included explicit attention to migrants, refugees, undocumented populations, ethnic minorities, adolescents, and other groups whose needs are often overlooked.

Finally, participants acknowledged that many elements of people-centered care have been discussed for decades — particularly within areas such as the HIV response. There was broad agreement that the Commission's contribution must **clearly articulate what is distinct** about this framework, and how it can **provide the spark needed to shift** from long-standing rhetoric to sustained implementation and system change.

5.2 Considerations for Applications of the Framework to Implementation and Policy Translation

The Discussion Labs highlighted several priority areas where the Commission's framework could be further applied, tested, and refined through research on implementation and policy translation.

The **health workforce** emerged as a central domain. Participants emphasized the need for research and guidance on:

- Individual competencies and support required for people-centered practice, including interpersonal skills, emotional responsiveness, and cultural safety
- Organizational and education and training models that facilitate team-based care, task sharing, and shared responsibility
- Policy alignment in workforce planning and payment systems to support longitudinal, preventive, demedicalized, and integrated care

Community engagement and partnership were identified as another critical area. Participants highlighted the importance of:

- Community-led monitoring and accountability mechanisms as tools for improving care experience and system responsiveness
- Social contracting and formal partnerships between health systems and community-based organizations
- Regulatory frameworks that enable, rather than constrain, meaningful community participation and shared delivery models

Measurement was discussed as essential for both implementation and policy legitimacy. Participants emphasized the need to:

- Develop and use measures that capture relational and experiential dimensions of care, alongside objective indicators
- Using existing surveys, systems and metrics, where possible, to minimize reporting burden on providers and communities and enable comparison
- Draw on multiple sources of evidence — including qualitative, community-generated, and routine data — to inform policymaking

Delivery models and platforms were also a focus. Participants emphasized:

- The importance of decentralized and integrated delivery models that bring care closer to people
- The need for clarity on appropriate use cases for digital interventions, particularly for management and administrative functions, informational continuity, task sharing, and access
- Policy-level standards of care that embed people-centered principles across delivery platforms

Across these areas, participants stressed that implementation and policy research should prioritize practical translation, explicitly addressing trade-offs, incentives, and system constraints faced by decision-makers.

5.3 Reflections on Process and Engagement

In addition to generating substantive input for the Lancet Global Health Commission on People-Centered Care, the PMAC side meeting provided an opportunity to reflect on the strengths and limitations of this **participatory engagement approach**. These reflections are intended to inform both the interpretation of the findings and the design of future regional discussion labs and Commission consultations.

There was high interest in the session, with strong attendance at the opening plenary and panel, and a smaller but highly engaged group remaining for the discussion labs. The participatory nature of the discussion labs was particularly well received. Participants expressed appreciation for being treated as contributors shaping the Commission's work, rather than as an audience or consultation group, and emphasized the importance of maintaining this level of engagement in future activities.

The **multi-sectoral and multi-generational** composition of the group was a particular strength of the convening. This did require a concerted effort to explicitly identify and invite individuals from civil society, and early career health professionals, who generally do not have the opportunity to attend PMAC. Whilst logistically challenging, this did strengthen the quality of discussion and move away from the usual 'elite' focus of such conferences.

The location of the conference in the Asia Pacific enabled a diverse representation of the region, including high and low and middle income contexts. However there was naturally absence of some geographic regions, including Africa, EMRO, and Latin America. This was seen as an important consideration for future regional engagement efforts.

Although the organizing team attempted to conduct a formal evaluation, time constraints prevented its completion. Nevertheless, informal feedback suggested that several aspects of the process worked particularly well, including:

- Very targeted discussion questions grounded in both personal and professional experience
- Priming discussions through real-world panel examples rather than abstract presentations
- A short, focused format that prioritized discussion over slides
- Broader exposure through pre-event communication and the opening session, followed by deeper engagement among those who chose to stay

In her closing remarks, Hally Mahler – Vice President of Family Health and FHI360 – reflected on the unusual nature of a Lancet Commission engaging in open consultation and framework testing. She noted that PCC has been discussed for decades — particularly within the HIV response — yet embedding and sustaining it remains challenging. A central question she posed was how to make PCC a "win" for all stakeholders and identify the spark that moves it from framework to action. FHI 360 affirmed readiness to engage with and implement the Commission's outputs as they continue to evolve.

6. Next Steps

Building on the insights generated through the PMAC side meeting, several immediate and medium-term next steps were identified to ensure that participant contributions meaningfully inform the ongoing work of the Lancet Global Health Commission on People-Centered Care.

6.1 Integration into Definition and Framework Development

Insights from the plenary discussion, panel presentations, and discussion labs will be systematically reviewed and integrated into the Commission's **ongoing refinement of the people-centered care definition and operational framework.** In particular, findings related to emotional responsiveness, dignity, agency, trust, and the importance of centering marginalized populations will be used to:

- Clarify and strengthen language within the definition
- Refine key terms to improve accessibility and usability across audiences
- Expand or adjust the framework's antecedents to better reflect environmental, conflict, and broader contextual conditions

6.2 Informing Research Priorities on Implementation and Policy Translation

Findings from the discussion labs will be synthesized and shared with Commissioners to help **prioritize areas for further inquiry** related to implementation and policy translation. Priority domains identified through the session include:

- Health workforce competencies, organization, and financing aligned with people-centered models of care

- Community engagement mechanisms, including community-led monitoring and social contracting
- Measurement approaches that capture relational dimensions of care while supporting evidence-informed policymaking
- Delivery models and digital platforms that enable continuity, access, and task sharing without undermining relational care

These insights will inform the development of future case studies, analytical sections of the Commission manuscript, and potential companion outputs focused on implementation.

6.3 Feedback and Accountability to Participants and Co-Organizers

Consistent with the Commission's commitment to co-production, there will be an explicit effort to close the feedback loop with participants in the PMAC side meeting. Planned actions include:

- Sharing this report with participants
- Inviting participants to continue to engage as Commission's work evolves through social media channels and future in-person events
- Exploring options to more formally engage organizers who were involved in the event, such as FHI360 in early feedback and testing of recommended implementation approaches and IFMSA in exploring healthcare worker training and competency in PCC

This approach aims to sustain engagement and reinforce participant agency beyond a single event.

6.4 Continued Regional and Thematic Engagement

The PMAC side meeting will inform the design of **future regional discussion labs**, using a similar participatory format that balances exposure with deep engagement. Future sessions may target under-represented regions identified through this process and focus on specific themes such as workforce reform, measurement, or policy translation.

Lessons learned from the PMAC session — including optimal group size, targeted questioning, and panel priming — will be applied to strengthen future engagements.

Acknowledgements

This side meeting was co-organized by the **Lancet Global Health Commission on People-Centered Care**, **Harvard Medical School's Program in Global Primary Health Care (PGPHC)**, and **FHI 360**, with support from Commissioners, advisors, and partners.

The Commission gratefully acknowledges its **sponsors** for enabling this work, and thanks all participants for contributing their time, experience, and insight.