World Health Organization
Regional Office for South-East Asia

# Regional Consultation on Innovations in Primary Health Care

Chiang Mai, Thailand, 17-19 August 2010

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*Chiang Mai, Thailand, 17-19 August 2010*

World Health Organization
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## *Annexes*

# Executive summary

There is wide consensus that the values and approaches of Primary Health Care (PHC) should underpin ongoing initiatives for health systems development. The overarching principles of PHC: social equity, universal coverage, inter-sectoral collaboration and people's participation remain valid in the context of health development in the 21st century. Currently, when health systems are confronted with an urgent need to explore ways and means to become more efficient and more responsive to changing contexts and community needs, countries in the South-East Asia Region need to revisit and revitalize the PHC agenda. While doing so it would be important to contextualize the revitalizing process to current country and epidemiological realities.

The Commission on the Social Determinants of Health highlighted the importance of factoring socio-cultural imperatives in health programme planning. This is critical for the achievement of the Millennium Development Goals. In addition, the Commission on Macro-economics and Health recommended that each country guarantee universal coverage through public financing, provide people-centered health care services, and secure community involvement in health care delivery. PHC offers an approach that can facilitate incorporation of socio-cultural dimensions in health planning and health care delivery and facilitate interventions towards universal coverage.

The South-East Asia Region has a rich heritage of PHC initiatives both within the public and NGO sectors. Examples include the Community Health Clinics (CHC) initiative in Bangladesh; Community Development for Health in Bhutan, Household Doctors in DPR Korea; ASHA initiative in India; Alert Village (Desa Siaga) in Indonesia; Female Community Health Volunteers in Nepal; Strategic Route Map (SRM) in Thailand; and Servisu Integradu da Saúde Communitária or Integrated Community Health Services (SISCa) in Timor-Leste.

In the recent past SEAR Member States and WHO at all levels have reaffirmed their resolve to revitalize PHC. One of the seminal events where Member States of WHO's South-East Asia Region reiterated the commitment to PHC was the Regional Conference on Revitalizing Primary Health Care held in Jakarta, Indonesia, in August 2008.

The WHO Regional Office for South-East Asia organized the Regional Consultation on Innovations in Primary Health Care, Chiang Mai, Thailand during 17-19 August 2010 with the broad objective of advocating innovative approaches for revitalization of Primary Health Care in South-East Asia. The specific objectives were:

(1) To review and share experiences in PHC innovations in South-East Asia,

(2) To identify issues and challenges faced in revitalizing PHC; and

(3) To develop recommendations for strategic approaches to accelerate revitalization of PHC.

A total of 62 participants from Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste attended the consultation.

During the inaugural session the Governor of Chaing Mai welcomed the participants. Dr Samlee Plianbangchang, the WHO Regional Director for South-East Asia in his opening address reminded the participants that this consultation was a part of the ongoing process that Member States and WHO-SEARO were engaged in revitalizing PHC. He highlighted the continuing need for health systems strengthening (HSS) based on PHC to address current and emerging epidemiological and demographic health needs and high out-of-pocket health care costs. He mentioned that countries in South-East Asia had developed initiatives to revitalize primary health care and this consultation would provide a platform for exchange of experiences from some of these countries and exploring how best we could optimize the learning from these experiences. He also elaborated on SEARO's forthcoming work on PHC related matters. These included the meeting on PHC and Emergencies and the consultation on Health of the Urban Poor. On behalf of the Ministry of Public Health, Thailand, the opening address was delivered by the Director-General, Department of Health Service Support.

The business session started by a presentation on "*Primary Health Care Challenges in the 21st Century:* A Framework for Action". The presentation included clarification about some concepts related to PHC; evidence supporting the view that PHC is effective, rationale for revitalising PHC and proposing an agenda for PHC revitalization under the broad headings: a) refocussing on communities b) addressing emerging challenges, and c) planning and advocacy for advancing PHC. This was followed by presentations on PHC innovations in each of the Member States. The topics were selected to showcase real life experiences and challenges in achieving universal coverage, community participation and intersectoral collaboration.

A presentation on national health policies and strategies to support the strengthening of health systems based on primary health care was made. The presentation included feedback from a recent meeting on health planning held in Bali and information about the forthcoming Global Learning Programme. The participants were introduced to the Primary Health Care Innovations Network – an initiative undertaken by SEARO to provide a regional platform for exchange of information and experiences among Member States. Thailand has pioneered a strategy that undertakes a holistic "developmental approach" to health rather than focusing exclusively on service delivery and it is popularly known as 'Strategic Route Map' (SRM). A detailed presentation was made on the experience with implementation of the SRM.

A field visit to rural areas in Chiang Mai was organized to enable the participants to experience the implementation of SRM in the community. Participants witnessed innovative financing for income generation; protection of the environment by converting organic waste into fertilizer and generating energy; organic farming; a food safety project; community-based screening for noncommunicable diseases; health promotion through anti-tobacco and anti-alcohol campaigns, promotion of exercise etc. This was immediately followed by group discussions to analyse the lessons learned from respective experiences.

The final day was devoted principally to develop recommendations for the way forward. The participants worked in groups and discussed the following topics

(1) Making health services responsive to people's needs.

(2) Mechanisms to strengthen inter-sectoral collaboration for healthy public policies.

(3) Strengthen continuity of care – focus on referral services.

(4) National health policy for health systems strengthening based on PHC.

The output of the group work was presented and discussed in a plenary session. Based on these, an overall synthesis of the conclusions and recommendations were presented. The recommendations that emerged are:

**For Member States**

- Assess national policies/strategies to further strengthen PHC. Equity monitoring and targeting exercises may be necessary to inform national health policy development.
- Establish mechanisms, including health impact assessments, to develop and strengthen healthy public policies for inter-sectoral collaboration.
- Revisit the role of CBHWs/CHVs to reflect the emerging epidemiological, behavioural, and demographic change. For this, a revision of job responsibility, training (in-service and pre-service) reorientation/adaptation is necessary.
- Develop strategies to further enhance community participation by implementing community education and empowerment initiatives based on experiences shared in the consultation.
- Strengthen family medicine to improve access to and quality of primary health care.
- Examine feasibility and sustainability of innovative financing mechanisms to reduce OOPs (out-of-pocket expenditure on heatlh). This may include tax-based, social- and community-based health insurance schemes.
- Continue and further strengthen integration of herbal medicine in national health programmes.

**For WHO-SEARO**

- Assist Member States to develop capacity for development/strengthening of national health policy/strategy and healthy public policy and plans based on PHC.
- Disseminate innovations and evidence and information for effective PHC-based health systems strengthening to Member States.
- Assist Member States in operational research to improve effectiveness of PHC-based interventions.
- Improve capacity of WHO Country Offices to assist Member States for PHC-based health systems strengthening.

# 1 Introduction

There is wide consensus that the values and approaches of primary health care (PHC) should underpin ongoing initiatives for health systems development. The overarching principles of PHC: social equity, universal coverage, intersectoral collaboration and people's participation remain valid in the context of health development in the 21st century. In the present day context when health systems are confronted with an urgent need to explore ways and means to become more efficient and more responsive to community needs, countries in the Region need to revisit and revitalize the PHC agenda. While doing so it would be important to contextualize the revitalizing process to current social and epidemiological realities. Member States of WHO's South-East Asia Region reaffirmed their commitment to PHC in the landmark Regional Conference on Revitalizing Primary Health Care held in Jakarta in 2008.

The Commission on the Social Determinants of Health highlighted the importance of factoring socio-cultural imperatives in health programme planning. It is accepted that health programming with due considerations for socio-cultural determinants is critical for the achievement of the Millennium Development Goals. PHC offers an approach that can facilitate incorporation of socio-cultural dimensions in health planning and health care delivery.

The Commission on Macroeconomics and Health recommended that each country should define an overall programme of "essential interventions" and should guarantee universal coverage through public financing. Further, the Commission advocated a "Close to Client" delivery system and community involvement in health care delivery. The role of partnerships was emphasized. These recommendations are in line with the PHC principles.

The South-East Asia Region has a rich heritage of PHC initiatives both within the public and NGO sectors. Examples of PHC innovations in SEA include the Community Health Clinics (CHC) initiative in Bangladesh; Community Development for Health in Bhutan, Household Doctors in DPR Korea; the ASHA initiative in India; the Alert Village (Desa Siaga) in Indonesia; Female Community Health Volunteers in Nepal; Strategic Route Map (SRM) in Thailand; and SISCa in Timor-Leste. Learning from these experiences provides a platform for deliberation on factors that contribute to success, the remaining challenges and how these could be overcome and reasons for failure, if any.

# 2 Objectives

The Regional Consultation on Innovations in Primary Health Care was organized to serve the following objectives.

## 2.1 General objective

To advocate innovative approaches for revitalization of Primary Health Care in South-East Asia.

## 2.2 Specific objectives

(1) To review and share experiences in PHC innovations in South-East Asia;

(2) To identify issues and challenges faced in revitalizing PHC; and

(3) To develop recommendations for strategic approaches to accelerate revitalization of PHC.

3

# Inaugural session

The welcome address was delivered by Mr Amorapun Nimanandh, Governor of Chiang Mai Province. He expressed his gratitude to the World Health Organization for selecting Chiang Mai as a venue for this important meeting. He stressed the important role of primary health care in community health development in this province. He mentioned that his province was implementing the "Strategic Route Map" – a holistic approach to development that focuses on community participation for health development.


In his inaugural address, Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia reminded the participants about the regional commitment to revitalize primary health care. He stated that this consultation was a part of the ongoing process that Member States and WHO-SEARO were engaged in to revitalize PHC. He highlighted the continuing need for health systems strengthening (HSS) based on PHC to address current and emerging epidemiological and demographic health needs and addressing the high out-of-pocket health care costs. He acknowledged that countries in South-East Asia had developed initiatives to revitalize primary health care to serve their respective health needs and stated that the consultation would provide a platform for exchange of experiences among the countries and provide an opportunity to explore how best the lessons learned could be adapted. He emphasized the need to strengthen PHC based health system strengthening. He also informed the participants about SEARO's forthcoming work on PHC-related matters. These included the meeting on PHC and Emergencies and the Consultation on Health of the Urban Poor.

Dr. Nara Nakawattananukool, Director-General, Department of Health Service Support delivered the opening address on behalf of the Ministry of Public Health, Thailand. He referred to primary health care as a strong foundation of the health system in Thailand which had been gradually developed for more than 30 years. It was a key success factor of the universal coverage policy in this country. He also addressed the need to strengthen the role of the community to manage their own health care needs and stated that the Strategic Route Map has been widely applied to achieve this goal.

4

# Technical sessions

The nominations of Dr Narongsakdi Aungkasuvapala, Director of the Institute for Primary Health Care Innovation as chairperson; Mr Alok Mukhopadhyay, Chief Executive, Voluntary Health Association of India as co-chairperson; and Dr Chencho Dorji, Director of the Royal Institute of Health Sciences, Bhutan, as rapporteur, were endorsed by acclamation by participants.

## 4.1 Primary health care challenges in the 21st century: a framework for action.

In his presentation, *Dr Sudhansh Malhotra, Regional Adviser, Primary and Community Health Care, WHO-SEARO* recapped the principles of primary health care which include, but are not limited to health care services that address social determinants of health; community mobilization and participation; continuity of care; use of appropriate technology; inter-sectoral collaboration; and a multi-disciplinary approach. The definitions of primary care and primary health care were revisited.

He stressed the need for revitalization of primary health care in the South-East Asia Region. The PHC approach is needed to address the following topical concerns:

(a) The persisting health inequities and barriers to access to health services, both within and among Member States.

(b) Changing demographic and epidemiological profiles: Countries are facing a double burden of infectious and non-infectious diseases. People live longer and most countries are moving towards and increase in the aging population. Health care systems including primary health care must accommodate these changes and challenges.

(c) Rapid urbanization especially due to migration from rural areas and incompatible public services has plagued the countries with social, physical and mental ailments. Innovative approaches are needed to address these problems, particularly among the urban poor.

(d) An increasing focus on specialized curative care and donor-driven vertical programmes have resulted in a disproportionately low budget allocation to promotive and preventive care.

(e) High out-of-pocket expenditures for health care due to overwhelmingly commercialized expansion of the private sector in health.

(f) Existing health system is focusing on taking care of sick persons, but not enough attention has been paid to health promotion and disease prevention. It is therefore important to shift from the current focus on "service delivery" to "health development".

Practical steps for revitalizing PHC in South-East Asia were suggested. These include:

- *Refocusing on communities:* which includes revisiting roles and competencies of community-based health workforce and community health volunteers to meet the changing health needs and challenges the countries are now facing; community education and empowerment to motivate and support people's self reliance and active involvement in community health care services; exploring the feasibility and mechanism of involving family physicians in providing primary care services; health financing reform to protect the poor and marginalized population; and strengthening of referral systems at all levels to support the continuity of care and optimize the effectiveness of resource utilization.
- *Addressing new challenges for primary health care:* This includes healthy public policy and intersectoral collaboration to increase the quality of life of the people; improving health of the urban poor so that they could live a socially and economically satisfied life; and increasing health care coverage by making more efficient use of the human resource already available through appropriate task shifting.
- *Planning for advancing primary health care:* This includes reviewing the health policy and plan to ensure that these adhere to the principles of primary health care; the use of operational research to identify health problems and related factors and effective measures; and the use of networking to share and expand the primary health care revitalization innovations.

## 4.2 Country presentations (Theme 1: Towards universal coverage)

### 4.2.1 Universal coverage and experience of people-centered care in Thailand

*Dr Yongyuth Pongsupap, National Health Security Office*, Thailand, presented the country-wide implementation experience of the universal coverage scheme. The scheme emerged as the Thai Government implemented the national response to the Alma Ata declaration on PHC. While in the beginning, the thrust to achieve universal coverage was on the development of Village Health Communicators and Village Health Volunteers, later a new health financing measure, the health card scheme was introduced. The health care scheme is based on three principles: equity, efficiency, choice and good health for all. Presently, 76% of the Thai population is enrolled in the system.

Key features of the scheme are: (i) universal coverage, (ii) capitation-based financing of area based providers, (iii) continuum of care, and (iv) health education. Universal coverage is a tax-financed benefit package. It includes primary care, specialized care at the hospital, health promotion and disease prevention, most high-cost health services, dental care, medicines, and surgical care. The referral system from

**The declining incidence of catastrophic health payments in Thailand, 2000 to 2007**

| Quintiles | 2000 | 2002 | 2004 | 2006 | 2007 |
|---|---|---|---|---|---|
| Q1 (Poorest) | 4.0% | 1.7% | 1.6% | 0.9% | 1.9% |
| Q5 (Richest) | 5.6% | 5.0% | 4.3% | 3.3% | 2.8% |
| **All quintiles** | **5.4%** | **3.3%** | **2.8%** | **2.0%** | **2.2%** |

**Note:** Catastrophic health expenditure refers to household out-of-pocket payments for health exceeding 10% of household consumption expenditure
**Source:** Viroj Tangcharoensathien, et al.

primary to tertiary care has been reinforced. A demonstration-diffusion strategy, political advocacy, and networking have been used to move from hospital-centred and diseases oriented care to people-centred care.

Many challenges remain but benefits are accruing. Health care coverage has increased and 18.5 million previously uninsured Thais have now been included under this scheme. Out-of-pocket expenditure on health, especially of the poor has decreased and impoverishment due to catastrophic illnesses has decreased. Overall strong and continuous political commitment, support from civic society and sound and evidence-based technical planning are seen as keys to success. Thailand is now focussing on quality and management aspects.

### 4.2.2 Using community volunteers to improve MCH coverage in Nepal

*Dr. Bhim Singh Tinkari, Director of Primary Health Care Revitalization Division, Department of Health Service, Ministry of Health and Population, Nepal*, presented the country's experience with using community volunteers to improve maternal and child health (MCH) coverage. The 1991 national health policy provided an emphasis on PHC to the rural population with a focus on MCH. In 1988, the ministry started training female community health volunteers (FCHV), which now covers 97% of all rural wards.

FCHVs are the backbone of the country's strategy to achieve MDG5 and the FCHV programme has many innovative features. A FCHV is selected by local mothers' groups from local residents. They receive basic training (18 days), 5-yearly refresher training (5 days), and ad-hoc training on specific topics as and when required. Although they do not receive salaries, they receive incentives in the form of gifts, per diem for trimester meetings, donations from communities and payments from NGOs for specific activities.

Achievements to date have been impressive. All 75 districts are covered by the FCHVs and as an example of performance, country-wide Vitamin A supplementation of children 6-59 months is 95%. 90% of Vitamin A is provided by FCHVs. Referral cases for

a number of illnesses have increased, safe pregnancy messages are disseminated and about one third of all contraceptives are distributed by FCHVs. Crucial to the success is the fact that FCHVs effectively provide the link between communities, village health workers and health centres. Especially the latter linkage, the referral to health centres, remains a challenge in the mostly mountainous regions of Nepal. Other challenges include securing full community ownership and lack of community networking.

### 4.2.3 Role of family doctors in primary health care in DPR Korea

At the request of the WHO country office in DPR Korea, *Dr Boosaba Sanguanprasit, Temporary International Professional, Primary Health Care, WHO-SEARO,* presented DPR Korea's innovative approach to health by using household (HH) doctors. Important features of the HH doctor system are clear responsibilities, availability and easily accessible health infrastructures for all areas, integration of traditional and modern medicine services within the same premises, and partnership with other sectors.

Each HH doctor, trained after 1998, is responsible for universal and comprehensive health care of up to 130 households. Services are provided both at health care institutes and at home. Health care facilities in rural areas and polyclinics are within 30 minutes of walking distance, while city (district) and county hospitals providing primary and specialized services are located within a couple of hours travelling. An innovative feature of the HH doctor scheme is that it integrates traditional and modern medicine. It also promotes intersectoral collaboration with institutions that promote healthy lifestyles.

The scheme proved to be very effective – PHC is accessible to all citizens. As an example, the maternal mortality ratio (MMR) decreased from 105 to 85 per 100,000 births between 1996 and 2008. Also, the infant mortality rate (IMR) and under-five mortality were significantly reduced during that period. Challenges remain especially in the area of skills development for the promotion of healthy lifestyle and also in technical areas such as cold chain management for the immunization programme.

### 4.2.4 Demand-side financing for improving maternal health coverage in Bangladesh

*Dr Naruzzaman, Deputy Director of Primary Health, DGHS, Bangladesh,* presented the country's innovative Maternal Health Voucher scheme. In 2004 the Ministry of Health and Family Welfare (MOHFW), in response to lack of progress on MDG5 indicators, decided to design a demand-side financing approach where a voucher holder would be entitled to free maternal health care at the point of delivery.

Inaugurated in 2007, currently 174,000 poor pregnant women in 35 Upazila annually receive MCH services against submission of vouchers free of charge at point of service. Voucher benefits include three antenatal check-ups, safe delivery, post-natal care, treatment of pregnancy complications (including caesarean section), transportation and medicine costs and a conditional cash transfer after safe delivery.

Service providers (public, private, NGO) are designated for service delivery if they meet pre-determined criteria. Management, monitoring and financial reimbursement of the voucher is decentralized to upazila level while a central management and monitoring and evaluation unit is attached to the MOHFW. Public providers receive 50% of the value of the voucher as incentive, private and NGO providers are reimbursed at 100%. An economic evaluation of the scheme in 2009 highlighted that an average pregnancy coverage through voucher costs USD 25. In the intervention areas all MDG5 indicators had been achieved, stillbirths and neonatal mortality rates have decreased significantly, out-of-pocket expenditures were significantly reduced and both provider and client satisfaction with the scheme was excellent. Challenges for the future are related to the areas of service

| Maternal Health Voucher Scheme (Comparison of selected maternal and child health indicators between intervention and control areas after approximately two years of implementation beginning mid-2007) | | |
|---|---|---|
| **Selected Indicators** | **Intervention Upazila** | **Control Upazila** |
| Birth attended by skilled staff | 70% | 27% |
| Institutional deliveries | 44% | 19% |
| Caesarian section rate | 8% | 9% |
| Had at least 3 ANC | 58% | 34% |
| Had PNC within one month | 41% | 21% |
| Out-of-pocket expenditures | Reduced by 35% | NA |
| Time to prepare referral | 33 minutes | 53 minutes |
| Percentage of stillbirths | 1.54% | 2.45% |

quality assurance, financial sustainability, institutional home / anchoring of the scheme and applicability of the scheme in urban areas where primary care is mostly implemented through private medical workforce.

## 4.3 Country Presentations (Theme 2: Community participation and appropriate technology)

### 4.3.1 Reaching the Unreached (KHOJ Project), India

*Mr Alok Mukhopadhyay, Chief Executive, Voluntary Health Association of India (VHAI),* presented recent experiences in primary health care innovations in India. The presentation covered a brief introduction of the National Rural Health Mission (NRHM) followed by details on the KHOJ project run by VHAI.

One of the key innovations under NRHM is Accredited Social and Health Activist (ASHA) – a community-based, multipurpose volunteer who helps in ensuring quality treatment at affordable cost; and integration of traditional medicines with western medicine.

The KHOJ project is a rights-based comprehensive development project implemented in different parts of India (see Table below). Communities play a key role in the development and implementation of the project. "Learn from the community, talk to the community and work with the community" is the key strategy.

Health interventions are implemented through KHOJ health centres. A re-energized Indian health system is used as a core principle of KHOJ health interventions. Women are the mainstream of service. KHOJ health interventions are linked to political, economic and social development including the income generation programme. It works within close collaboration with public sector programmes of the Government of India.

Potentials for sustainability include income generating programme; human resource development; and involvement of the local village council.

| Health Impact of the KHOJ Project | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Project | Health Indicators | | | | | | | | | |
| | IMR | | Number of Maternal Deaths | | Percentage of women receiving complete ante-natal care | | Percentage of deliveries conducted by TBA | | Immunization Coverage | |
| | 2000 | 2006 | 2000 | 2006 | 2000 | 2006 | 2000 | 2006 | 2000 | 2006 |
| Sacred Heart Health Centre, Bihar | 62 | 25 | 10 | 4 | 64 | 86 | 63 | 95 | 74 | 92 |
| People's Action for National Integration, Faizabad, Uttar Pradesh | 44 | 34 | 5 | 1 | 78.8 | 83.1 | 72.8 | 96 | 78.7 | 94.1 |
| MSK Chandauli | 50 | 53 | 1 | 1 | 68 | 100 | 76 | 98 | 50 | 75 |
| ECAT Karauli | 36.8 | 50.6 | 1 | NIL | 85 | 95 | 83 | 81 | 74 | 80 |
| Shramjivi Unnayan | 52 | 30 | 5.2% | 2.3% | 53 | 94 | 61 | 98 | 53 | 98 |
| CREFTDA, Orissa | 72 | 68.9 | NIL | NIL | 56 | 71 | 96.6 | 97 | 67.7 | 83 |
| SURE, Barmer | 85.5 | 25.7 | - | 1 | 83.4 | 92 | 92.7 | 98 | 53.8 | 82.2 |
| Nagaland VHA | 46 | 32 | 2 | 1 | 56 | 85 | 20 | 50 | 52 | 80 |
| Arunachal Pradesh VHA | 52 | 20 | 7 | 2 | 38 | 53 | 45 | 41 | 27 | 56 |

### 4.3.2 Role of traditional medicine in PHC in Bhutan

*Dr Chencho Dorji, Director of the Royal Institute of Health Sciences, Bhutan,* presented the integration of traditional and modern medicine in primary health care services in Bhutan. Traditional medicine is an integral part of the national health care services and national health policy. The integration is not only at the primary health care service delivery level but also at medical education and knowledge sharing levels. The National Institute of Traditional Medicine (NITM) is responsible for training on traditional medicine and the graduates from NITM are exposed to the Royal Institute of Health Sciences (NIHS) and vice versa. At district level, traditional medicine units are directly under the control of the district health administration.

The key feature of this innovation is that modern medicine and traditional medicine are integrated and complement each other. Traditional medicines are also included in essential medicine/drug policy and list. Traditional and modern health care services are under the same roof with provision for cross-referrals.

**Key success factors in integrating traditional and modern medicine in Bhutan**

- Political commitment
- Taking/bringing care closer to the people where they work and live
- Committed health workers
- Monitoring and Supervision
- Appropriate HMIS
- Both traditional and modern health care services under one roof – cross-referral
- Increased communication facilities
- Community as partners

### 4.3.3. Community participation for health- the SISCa experience in Timor-Leste

*Mrs Isabela Exposto, Unit Officer, Health Promotion, SISCa, Timor-Leste,* presented experience in community involvement in health care services. SISCa stands for "Integrated Community Health Services". It provides health assistance down to the community level with two main priorities. These are improving the quality of and access to health services. Health workers are closely working with the community, where community leaders involve community groups in creating a demand for participation in and utilization of health services and health workers from the community health centre and health posts are responsible for providing quality services.

The services are provided through an innovative "six tables system", namely, the village health database; nutrition assistance; health assistance for mothers and children; personal hygiene and sanitation; health assistance based on patients' complaints and; health promotion and education.

Recent data indicated positive impacts on infant and child mortality, immunization coverage, and total fertility rates.

### 4.3.4 Using Community Resources for PHC "Healthy Mother Project" – Myanmar

*Dr Aung Tun, Deputy Director (School Health), Ministry of Health, Myanmar,* presented Myanmar's experience in using community resources for primary health care or the "Healthy Mother Project". The healthy mother project is a community-oriented approach to improve the health of mothers. The project is implemented by the Ministry of Health with financial support from JICA. The project adopted a lifecycle approach, which addresses the childhood and pre-pregnancy period with adequate knowledge on health and childbearing issues which would, in turn, ensure better pregnancy outcome.

Key features of the project are community-based capacity building and skill-building of basic health staff and female health promoters/ volunteers; strengthening community knowledge and awareness of reproductive health; and establish a model approach to ensure participation of various stakeholders. The

**Some Results of the SISCa Experience in Timor-Leste**

- **SISCa implementation**: SISCa now covers all villages of Timor-Leste (472) and many more people are now able to receive integrated health care closer to their homes. SISCa has also boosted the volunteers' programme, which trained 2,277 volunteers in 2008.
- **Recent results due to better access to health care**:
  - Impressive reduction in newborn, infant and child mortality
  - Immunization coverage has improved greatly (SISCa takes advantage of children being weighed and medically treated to also give immunizations, vitamin A and deworming tablets)
  - The number of children with pneumonia, malaria and diarrhoea being treated has increased significantly
  - Pregnant women are getting more ANC and becoming committed to delivering their children with a skilled birth attendant
  - Exclusive breastfeeding of children has doubled since 2003
  - The total fertility rate has declined rapidly from 7.8 to 5.7 in five years

project used single-purpose volunteers contrary to multipurpose health volunteers which proved to be effective.

The major constraint needed to be overcome is to build leadership, commitment and skill among the female MCH volunteers.

## 4.4 Country presentations (Theme 3: Intersectoral collaboration)

### 4.4.1 Multisectoral approaches to health development in Sri Lanka

*Professor Saroj Jayasinghe, Faculty of Medicine, Sri Lanka,* discussed three innovative models of PHC-based health care delivery in Sri Lanka: (i) NGO-based: Sarvodaya; (ii) State and private sector: Gemidiriya; and (iii) State: Health Unit System.

**Sarvodaya**, an NGO, adopts a bottom-up approach focused on basic needs of the people with health as one of the sectors .The projects were based on volunteers and community empowerment.

**Gemidiriya** is a community-driven development model which aims at removing root causes of poverty by providing information, decision-making power and resource assistance to support self-development. It is also a "bottom-up" approach that utilizes volunteers and promotes community empowerment. It focuses on poverty alleviation with state assistance to support self-development.

**The government system** is State-based, with the top-bottom approach and focuses mainly on health.

The models were compared in terms of responsiveness, intersectoral action and continuity of care.

### 4.4.2 The Alert Villages (Desa Siaga) - Indonesia

*Dr Adang Bachtiar, President, Indonesian Public Health Experts Association, Indonesia,* presented the Indonesian experiences in implementing Alert Villages or Desa Siaga. The health system performance was analysed on the basis of progress in reducing infant mortality and under-five mortality, geographic and economic disparity, financial protection and demographic and epidemiologic transition.

Since the economic crisis in the 1980s and decentralization of health care services, Posyandu and other community health efforts received less emphasis. A small portion of

**Comparison of salient features of the Sarvodaya, Gemidiriya and Government models of health care delivery in Sri Lanka**

| Item | Sarvodaya | Gemidiriya | Government |
|---|---|---|---|
| Unit | Village | Village | Admin. Unit |
| Funds | NGO | World Bank and State fund | State |
| Process | Bottom-up | Bottom-up | Top-bottom |
| Empowerment | Community | Commmunity | State |
| Organization | Society | Company | State |
| Focus | Development | Poverty reduction | Health |
| Multisectoral | Basic needs | Business | Schools, water and sanitation |
| Social determinants of heatlh (SDH) | By its very approach | By its very approach | |
| Sustainability | Self-help | 70% external | MOH |

266,827 Posyandu (integrated health posts), and 32.887 Polindes (birth delivery post) are fully active. To reach the health-vision of "Healthy Indonesia", the Ministry of Health established the Alert Village (Desa Siaga) in 2006.

In the Alert Village model, the community carefully plans its own resources and capacities to prevent and manage health problems, even during disasters. The objectives of the Alert Villages are to:

(1) Improve health knowledge and competencies among the villagers to practice clean and healthy lifestyle.

(2) Improve capacity of individuals and their willingness to help themselves to lead a healthy lifestyle.

(3) Establish vigilance and preparedness of the village to combat health risks and emergencies.

(4) Improve environmental health of villages.

To achieve these objectives, a community surveillance system has been developed.

### 4.4.3 The healthy Villingili island - Maldives

*Ms Nazeera Najeeb, Public Health Programme Coordinator, Centre for Community Health and Disease Control, Maldives,* presented details about the healthy Villingili island programme. The programme was initiated as a 'healthy setting' in Maldives. The key elements of a healthy setting programme were: raising people's awareness and building their capacity to be ready for change; a written plan of action; managerial set up for implementation and the opportunities presented in the operational mechanism for community participation and ownership creation. The implementation process included community volunteer teams-each team focused on a specific area, home visits, issue-specific pamphlets, etc. The teams encouraged the community on investment, created awareness etc.

Key successful factors identified were the healthy island work-plan, the managerial process, community participation/ownership, support from the centre for the national initiative, potential for sustainability and resource mobilization.

Problems and challenges included implementation difficulties faced by the community when the community could not take a decision owing to legal or technical constraints.

**Healthy Villngili Island: Key Strategies and Methods**

- Key elements of a healthy setting programme
  - Written plan of action
  - Managerial set up for implementation
  - Opportunities presented in the operational mechanism for community participation
- Implementation process
  - Community volunteer teams-each team focused on a specific area
  - Home visits
  - Pamphlets specific to the issue
  - Teams encouraged the community on investment, created awareness etc.

5

# National health policy and strategies to support the strengthening of health systems based on PHC

*Dr Athula Kahandaliyanage, Acting Director, Health Systems Development, WHO-SEARO,* presented a paper on National Health Policy and Strategies to support the Strengthening of Health Systems Based on PHC.

He mentioned that after 32 years of PHC implementation in SEAR, inequity in health status and access to services still exist, both at the regional and country levels. This is partly due to the fact that health service systems do not effectively balance the budget allocation, address determinants of health, protect consumers from commercialization of health care services, and prepare for emerging health care demands.

To achieve Health For All, health systems must be strengthened to ensure health equity which includes availability, accessibility and quality of care; social justice and the end of exclusion; responding to the challenges of a changing world and growing expectations for better performance; and putting people at the centre of health care.

Actions needed for PHC-based Health Systems Strengthening are:

- Reaffirm political commitment towards PHC
- Foster effective multisectoral collaboration for the establishment of healthy public policy
- Strengthen health workforce with due recognition given to the importance of Community Based Health Workers and Community Health Volunteers.
- Implement equitable healthcare financing with the aim of achieving universal coverage
- Promote better transparency and accountability of health systems through improved leadership and governance
- Ensure continuity of care by strengthening referral systems and improving primary care.

These actions will be effectively implemented if they are supported by concrete and coherent strategies and policies in national health plans, which are in line with the overall development plan of the country. However, many Member States are weak in these aspects. Country case studies were carried out to assess the strengths and weaknesses in the NHPs of Member States, the results of which led to a regional consultation on Strengthening of National Health Planning, held in Bali in August 2010. The recommendation of this consultation was to strengthen capacity of countries in national health planning with multi-sectoral involvement and community participation based on evidence gathered through improved health information systems. The need for research and monitoring and evaluation of NHPs was also stressed.

He informed that at the global level WHO decided to launch a Global Learning Programme in September 2010 to improve national health planning capacity of WHO staff, especially those based in WCOs, so that they could support countries to strengthen their capacity to develop better and effective national health plans.

### *Discussion points*

(1) Government commitment is crucial for effective national health policy and plan development and implementation.

(2) WHO should take a lead role in assisting Member States in developing health policies, especially for small countries that have to submit to donor-driven activities.

(3) Primary care should be improved through strengthening family medicine.

(4) Health planning must address the regulation of the private sector at all levels.

(5) Active community participation is needed in the development of a national health policy and plan.

(6) Budget allocation and distribution must be balanced in terms of proportions allocated among curative, promotive and preventive services; and the overall proportion allocated to the health sector.

(7) People must be empowered to enhance their health literacy to be effectively involved and respond to their own health care services.

(8) Health planning should give priority to strengthening referral systems at all levels

(9) Information technology should be used to reach out to marginal populations, especially rural migrants.

(10) Health care financing must effectively reduce out-of-pocket expenses, particularly among the poor.

(11) Health planning should take into account health workforce task shifting and multi-purpose skills to efficiently respond to new challenges.

(12) National health planning should be based on evidence, as such information systems should be functioning and health policy research should be carried out.

(13) Sustainability of free health care services must be addressed in long-term plans.

6

# Strategic route map (SRM) – a developmental approach for health care

*Dr Amorn Nondasuta, President, Foundation for Quality of Life (S. Sithigarn), Thailand,* made a presentation on SRM which is an outcome of one of the recommendations of the Regional Conference on Revitalizing PHC held in Jakarta in August 2008, to shift the focus from service delivery to a development model.

Dr Amorn made a detailed presentation on the various phases of PHC development in Thailand. He also presented the various eras of PHC, which started in 1978. The focus of this concept was on increased coverage and service orientation. This was a phase that emphasized integrating quality of life based on the three pillars of community self-reliance, namely, organization, finance and manpower which began in 1986. This led to the stage of strategic management which began in 2010. He clearly mentioned that currently, the focus is on the role of people and changing behaviour. No change was possible without these key elements. He further mentioned the need to apply social measures leading to social interventions that involve the people in innovations, research and designing their own programmes.

The SRM model first assists the people to analyze the situation, identify issues, provide support, organize training and then monitor and evaluate the progress. He suggested that the process has to start with a vision that needs to be shared with everybody and needs to be tangible. People are willing to take care of their community's health and environment, the answer lies in behavioural change.

There were four elements of SRM. First, destination which needs to be clear, everybody should know about it, have a goalpost and time frame; second, the Strategic Linkage Model; third, clear objectives which need to be defined in terms of tasks; and fourth, the plan of action that would be from bottom-up, simple with a strategic route map that would lead to the destination in the shortest possible time. Further expanding on the Strategic Linkage Model, it was mentioned that it had seven critical elements, namely, human resources, IEC system, local government's role, social intervention measures, target group behavioural changes, surveillance/screening system and people's project. When the Strategic Linkage Model is in place, each of these elements needs to be defined further in strategic objectives.

Dr Amorn further presented the essential elements of innovation which would include social intervention measures, surveillance, technical intervention by the staff and target changing health behaviours. Emphasis was laid on establishing a PHC innovation learning centre which could facilitate possible areas of exchange. The areas could be alcohol, drugs, NCD, collateral development programmes, waste management, food safety, AIDS and TB among other areas as these were all are interconnected.

He also proposed a regional PHC collaborative programme. He suggested that this programme could begin with a regional consultation that could analyse the situation and assign areas and establish a regional task force. The need to prepare trainers, run courses and explore possibilities of inter-country and country collaborative projects that could be undertaken was emphasized. Over a period of time these could be monitored and evaluated.

# 7 Field visit

A half-day field visit was organized on 18 August 2010 with the objective of demonstrating the implementation of SRM for sustainable community and health development.

Participants had an opportunity to experience a PHC Innovation project "Strategic Route Map" in three different locations: San Sai of Saraphi district, Sanpatong district, and Hang Dong district. The participants were divided into three groups. Each group consisted of about 25-30 members.

### *Site 1 – Sansai Sub-district*

This site is located in Saraphi district and the highlight of this sub-district was the "Food Safety Activities". Most of the people in this community are farmers; they grow rice, vegetables, longan etc. The farmers in this community were an energetic group. SRM was implemented in this community for the "Chiang Mai Food Safety Project". After implementing SRM various stakeholders in the community (villagers, community leaders, village health volunteers, health workers, NGO, GO) worked closely for "Food Safety Activities".

### *Site 2 – Makunwan Sub-district*

Makunwan community has been implementing SRM for the community health fund. The fund provides financial support to people for health emergencies. As many villagers in this community suffer from diabetes mellitus, SRM was implemented to support the idea of "more vegetable and fruit consumption; more exercise and decrease sweet and salty food". The highlights of this community are energetic villager groups and active local public health staff.

### *Site 3 – Ban Rai Gong King Village*

This site is located in Hang Dong District and the highlight of this community is a proficient village headman who applies the philosophy of "Sufficiency Economy" to the development of the village. The powerful group of "Saving Fund" is an important strategy to develop the village. SRM and is under implementation for the last six months.

For each site, there was a presentation by host team, followed by question-and-answer sessions, and field observation. After visiting the field site, each team convened to analyse the experience and draws up their conclusions and insights gained on the visit. The information was shared among groups and later used as an input for their group discussions.

## 7.1 Observations from field visits

### 7.1.1 Sansai Mahawong Municipality, Saraphi District.

- Projects observed: Organic farming; mixed vegetable and fruit juice for health; pesticide-residue-free vegetable; food safety surveillance of housewife club; community health innovation school (Disease control); Thai traditional massage and sauna.

- Objectives of the projects:
  (a) Improve food safety to mitigate health and environmental problems.
  (b) Counter the negative impact of external crop and external price dictate on household income.
  (c) Promote healthy lifestyle as a counter measure to a perceived increase in non-communicable disease incidence
- Principles used:
  (a) Adult learning approach
  (b) Multisectoral approach
  (c) Focus on health and nutrition problems perceived by communities / individual
  (d) Focus on projects that improve household income
  (e) Economic self-sufficiency.
- SRM implementation process and key players:
  (a) "Home grown" projects, many started before SRM arrived
  (b) SRM proved a good catalyst to speed up and make implementation process easier
  (c) Good technical support from central and local government institutions (public health, agriculture, municipality), universities, NGOs and foundations
  (d) Medium- / long-term vision present.
- Social and technical measures used:
  (a) Focus on local community
  (b) Centrality of regular and solid technical training
  (c) Extension of benefits to community at free or below market price
  (d) Measures include externalities, that is benefits accrue not only to implementers
  (e) Ongoing development of support measures such as structured market access development
- Impact on health outcomes and behaviours:
  (a) Behavioural changes such as drinking and smoking behaviours
  (b) Decrease in NCD risk behaviour
    i. Increased physical activities
    ii. Reduced smoking
    iii. Reduced drinking
  (c) Strong perceived personal benefits from the project:
    i. Health
    ii. Wealth
    iii. Happiness
    iv. Self reliance
  (d) Stronger sense of community
- Sustainability of activity:
  (a) Strong leadership encourages sustainability
  (b) Focus on self reliance (fertilizer, seeds) is crucial for sustainability
  (c) Income now spreads over 12 months, benefits accrue also over 12 months
  (d) Better health and environment gives people satisfaction.

Traditional hot massage

### 7.1.2 Sanpa Tong district, Ma Khoon Wan sub-district

- Projects observed: organic garden and biogas plant, primary care innovation school, Chinese Jee Kong exercise club and bicycle club.
- Innovations:
  - (a) Community-driven
  - (b) Intersectoral actions
  - (c) Promotes continuity of care
  - (d) Various activities to maintain good physical and mental health along with assurance of social contacts among members

Food safety demonstration by housewives

- Success factors for the initiative:
  - (a) Continuity of commitment of the local administration
  - (b) Commitment of the community
  - (c) Commitment of the local health staff supported by the provincial health authorities
  - (d) Shared problems
  - (e) Learn from each other
  - (f) Use of SRM
  - (g) Availability of information played a key role to look at the problems/issues.
- Project financing:
  - (a) National Health Security Office
  - (b) Local government
  - (c) Voluntary contribution by the community members.
- Impact on health outcomes and behaviours:
  - (a) Regular cycling in the morning and/or in the evening.
- Sustainability of activity
  - (a) The project has been supported by both national and local organizations and is running for many years.

### 7.1.3 Hang Dong district, Ban Rai Gong King village: Theme: Sufficiency Economy

- Projects observed: saving fund club, wholesale group buyers; traditional Thai herb, modern exercise and traditional Thai massage; free-time farmer (Household Garden), Bio-gas group

Sufficiency economy – locally made handicrafts to boost village economy

– Lessons learnt:

(a) A creative use of the saving fund club can have direct and indirect health benefits:

i. Direct: defraying incidental costs for health care; and

ii. Indirect: support for health promoting activities like promotion of herbs, organic farming, biological waste disposal, etc.

(b) Traditional and herbal medicine can be supported.

(c) Environmental protection (insecticide-free farming and effective disposal of biological waste).

(d) Technical support is provided by line ministries like agriculture, land development, education, etc. for community development, and NGOs like FQL – an example of intersectoral collaboration.

(e) Social mobilization has had an effect on reducing alcoholism and tobacco use.

(f) Experiences have been replicated in other villages.

# 8 Group discussions

The participants were divided into four working groups of 13-15 participants each to develop a regional strategic framework for primary health care innovations and to discuss the following pre-assigned topics:

## 8.1 Making health care services responsive to people's needs:

- Meaning of people-centred care.
- Providing service to meet people's needs.
- Competencies and roles of community-based health workforce.

## 8.2 Mechanisms to strengthen intersectoral collaboration for healthy public policies

- Sectors other than health whose policies and programmes influence health.
- Factors impeding effective inter-sectoral collaboration.
- Innovative strategies and steps to establish and sustain effective inter-sectoral collaboration.
- Focal points for inter-sectoral collaboration.
- Practical and actionable recommendations for enhancing community participation in health programmes.

## 8.3 Strengthen continuity of care: focus on referral services

- Definition of a referral service.
- Reasons of weak referral services.
- Reasons for poor quality primary care.
- Innovations.

## 8.4 National health planning for PHC-based health systems strengthening

- Issues addressed in policy but not implemented properly.
- Issues to be addressed in the national health plan.
- Steps to strengthen health planning process.

# 9 Conclusions and recommendations

*Dr Chencho Dorji, Director, Royal Institute of Health Sciences, Bhutan,* presented the conclusions and recommendations of the consultation.

## 9.1 Conclusions

(1) The participants of the regional consultation reaffirm that countries need to continue to revitalize PHC in order to achieve the national and international health goals including the MDGs.

(2) National health policies/strategies and plans need to be strengthened to reflect the current epidemiologic and demographic changes. PHC-based approaches are necessary to address emerging health needs.

(3) Budgetary allocations for health need re-examination. A balance between allocations for primary care and secondary/tertiary care needs to be ensured.

(4) In several countries CBHWs and CHVs are playing a significant role in health care to the community. There is a need to re-examine their roles and competency vis-à-vis current and emerging health needs.

(5) Many innovations in involving CHVs are currently under implementation in countries. There is concern about the sustainability of such initiatives as some of these are supported by external donors.

(6) Access to better quality primary care is an area of concern. In addition to care provided by CBHWs, family physicians play an important role in improving access to better quality primary care.

(7) There is a need to promote family medicine in the Region and involve family physicians in PHC. They need to be more involved in preventive and promotive health activities.

(8) The private sector is growing at a rapid pace in many Member States. There is a need to involve this sector more in primary care. The government must play a proactive regulatory and facilitating role to involve the private sector in PHC.

(9) NGOs and civil society organizations play an important role in several countries. Countries need to re-examine how best to promote public-private partnerships in PHC.

(10) The Region has a rich heritage in traditional and herbal medicine. This needs to be further strengthened in national health programmes.

(11) Increasing out-of-pocket expenditure on health is an area of concern. The Region has rich experience in implementing social protection through innovative health financing/ insurance. Countries need to rapidly scale up such initiatives

to break the circle of ill health and poverty.

(12) Countries need to establish mechanisms and structures to develop and strengthen healthy public policies.

(13) The social determinants of health have an important bearing on equity of health outcomes. Health ministries need to take a lead to ensure that national planning includes interventions for addressing social determinants by multiple sectors.

(14) The rich experiences with PHC innovations in Member States need to be disseminated widely among the Member States.

(15) The rapid urbanization in the Region is a challenge to the health system. PHC based health policies and strategies are needed to address this issue.

(16) Community education and empowerment is an essential requirement for success. Countries have good experience in this area e.g. Innovations like the strategic route map, innovative financing schemes and effective utilization of community resources like CHVs. Experiences presented in the consultation can be considered for country adaptations to further improve community education and empowerment.

## 9.2 Recommendations

### For Member States

(1) Assess national policies/strategies and further strengthen national health planning for PHC-based health systems strengthening. Equity monitoring and targeting exercises may be necessary to inform national health policy development.

(2) Establish mechanisms, including health impact assessments, to develop and strengthen healthy public policies for inter-sectoral collaboration.

(3) Revisit the role of CBHWs/CHVs to reflect the emerging epidemiological and demographic change. For this revision of job-responsibility, training (in-service and pre-service) is necessary.

(4) Develop strategies to further enhance community participation by implementing community education and empowerment initiatives based on experiences shared in the consultation.

(5) Strengthen family medicine to improve access to and quality of primary health care.

(6) Examine feasibility and sustainability of innovative financing mechanisms to reduce OOPs. This may include tax-based, social and community-based health insurance schemes.

(7) Continue and further strengthen integration of herbal medicine in national health programmes.

### For WHO-SEARO

(1) Assist Member States to develop capacity for development/ strengthening of national health policy/strategy and healthy public policy and plans based on PHC.

(2) Disseminate innovations and evidence and information for effective PHC-based health systems strengthening to Member States.

(3) Assist Member States in operational research to improve effectiveness of PHC-based interventions.

(4) Further improve capacity of WHO COs to assist member-states for PHC based health systems strengthening.

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# Closing session

In his closing remarks, *Dr Narongsakdi Aungkasuvapala, Director of the Institute for Primary Health Care Innovation and Chairperson of the consultation* congratulated all participants for the successful and fruitful consultation and expressed his confidence that the recommendations made by the participants would be energetically pursued by the Member States to further revitalize primary health care in respective countries. He hoped that WHO-SEARO will continue to provide support and opportunities for Member States to make health equitable to all people through strengthening health care systems based on primary health care. He also thanked his co-chairperson, Mr Alok Mukhopadhyaya and rapporteur, Dr Dorji Chencho for their excellent support.

Dr Amorn Nondasuta, President of the Foundation for Quality of Life, who is considered the father of PHC in Thailand, in his concluding remarks, addressed the need for active cooperation and collaboration among Member States to enhance the primary health care programme to improve health and quality of life of the people.

Dr Athula Kahandaliyanage, Acting Director, Department of Health Systems and Development, WHO-SEARO, ensured the audience that WHO would continue to support country activities for the improvement of health of the people in the Region.

# Annex-1: Speech by Dr Samlee Plianbangchang,

## Regional Director, WHO South-East Asia Region

Excellency, Mr Amorapan Nimaman, the Governor, Chiang Mai, Thailand,

Dr Nara, Director-General, Department of Health Services Support, Ministry of Public Health, Thailand,
Distinguished participants,
Honourable Guests,
Ladies and gentlemen,

I warmly welcome you all to the Regional Consultation on Innovations in Primary Health Care. I thank all participants for sparing their valuable time to deliberate upon this important subject.

Distinguished participants,

Almost two years ago, we met in Jakarta, to lay down a roadmap for revitalizing PHC in SEAR. And at that meeting we resolved to redouble our efforts to strengthen health systems based on the primary health care approach. We are here now to examine how far we have gone towards revitalization of PHC. Certainly, a lot more remains to be done to ensure a strong PHC approach in supporting the functioning of health systems.

We will be able to reach health-related MDGs only when we have health systems that are functioning efficiently and effectively. We have only five years to go before the target date for the world to achieve MDGs. Therefore, we need to exert all our efforts to further explore innovative avenues to accelerate progress towards health systems based on PHC.

There is evidence that countries have gained vast experience in their efforts to reduce health inequities and in their endeavours towards universal health care coverage. On the basis of PHC principles, different intervention modes have been developed to address the prevailing health problems. Consequently, substantial improvements in people's health have been achieved. Life expectancy has further increased. Infant and child mortality has been significantly reduced. Countries in SEAR have recorded substantial success in improving access to safe water and sanitation. The coverage of immunization and antenatal care services has increased. Significant progress has been made in controlling and eliminating communicable diseases. The incidence of vaccine preventable diseases has significantly declined. Neonatal tetanus has been eliminated from a large part of the Region. These are significant contributions of the PHC approach.

Ladies and gentlemen,

The South-East Asia Region is undergoing demographical and epidemiological transition. We are facing challenges of a double burden of communicable and non-communicable diseases.

We are facing threats from:

- Epidemics of new and emerging pathogens.
- The ageing population.
- Lifestyle changes.
- Rapid urbanization
- Impact of climate change, etc.

Of the strategic options in health development efforts we have to believe that revitalization of PHC with innovative actions to address these issues is a vehicle through which health systems can be effectively strengthened to meet the old, the new and the emerging health challenges in an equitable, efficient and effective manner.

There is widespread consensus on the validity of the overarching principles of PHC, which particularly include equity, universal coverage and social justice. The PHC principles need to be applied through multi-disciplinary/ multi-sectoral actions. The application of PHC principle must be done with full participation and involvement of people in the community. What is needed is a fresh look as to how health problems and issues can be practically addressed through the PHC approach and in the process we need to keep in mind that health outcomes are influenced by a very complex interplay among socio-cultural, economic, political and environmental factors.

Health for All is predicated by actions of multiple players and multi-stakeholders. We all know very well that to address the current health issues effectively, we need to go far beyond the confines of the health sector. Coordinated multi-sectoral and multi-disciplinary actions are imperative. With these requisites as the background revitalization of PHC should, therefore, adopt a development approach. PHC may not only focus its activities on the delivery of health services. It has to be research-oriented and research-based.

Distinguished participants,

The international community is committed to achieving MDGs by 2015. We, in South-East Asia, have to think of strategies that can help us reach the goals within the remaining five years. I believe that our Region has sufficient resources to pursue these goals; especially goals 4, 5 and 6. What is needed is a strategy to deploy and harness the available resources in a cost-effective manner. There are several examples from within the Region and elsewhere to demonstrate that adoption of innovative PHC approaches can help accelerate the pace of progress towards MDGs. This consultation will provide a platform for exchange of experiences from some countries and also provide an opportunity for exploring how best we can optimize the use of our available resources for this purpose.

Ladies and gentlemen,

Some contemporary issues are affecting the functioning of health systems. Among others, health services today have become overwhelmingly commercialized with the increased use of market mechanisms. Out-of-pocket expenditure for health care in the Region has been sky-rocketing. Catastrophic expenditure on health is recognized as a major cause for people to become poor. This phenomenon can be effectively dealt with through the development of health systems based on PHC approach whereby equitable access to health care services is promoted within the spirit of equity and social justice. The emphasis should be on care that places primary focus on promoting healthy growth and development; on maintaining healthy status and or preventing ill health and keeping diseases away from people.

During the past two years, we have energetically collaborated with countries in their initiatives to revitalize PHC.

These are:

- Strategic Road Map (SRM) in Thailand;
- Development of Community Health Clinics in Bangladesh;
- ASHA (Assistant Social Health Activists) scheme in India;
- Integrated Development of Community Health Services (SISCA) in Timor-Leste; etc.

A number of regional consultations and meetings were organized to provide a platform for Member States to deliberate upon aspects of PHC approaches, such as:

- Self-care in the context of PHC;

- Use of herbal medicines in PHC;
- Application of socio-cultural approaches within the context of PHC, to accelerate the achievement of MDGs 4 and 5.
- Health care reform for the 21st century with emphasis on strengthening health systems based on PHC.
- Decentralization of health care services delivery to ensure health equity and universal coverage; and
- Most recently – development of national health policies and strategies in support of strengthening health systems based on PHC.

Several important recommendations emerged from these meetings. WHO will continue to work closely with Member States to ensure implementation of these recommendations. Later this year, WHO plans to organize at least two more important regional meetings on related topics. These are:

Regional Meeting on PHC Approach in Emergencies; and

Regional Consultation on Health of the Urban Poor; with particular attention to the application of PHC principles in urban settings.

WHO will continue promoting exchange of experiences that contribute towards the PHC revitalization process. The South-East Asia PHC Innovations Network has been established, with the initiative of the Foundation for Quality of Life. The first meeting of the Network will be held immediately after this consultation.

Ladies and gentlemen,

We need to focus our attention especially on the "thrust areas" that will effectively contribute to revitalize PHC in our countries. It is an imperative that people in the community must be educated and empowered to enable them to take informed health decisions. Towards this end, and among others, equipping the community for "self-care" assumes great importance. In this connection, we need to re-double our efforts to strengthen community-based health workforce. We need to equip the Community-based Health Workers adequately to ensure that they are able to face today's community health challenges in the most efficient and effective manner and we need to ensure that these workers are capable as change agents in the community in educating and empowering people.

Furthermore, innovative approaches to "health care financing" need to be explored to ensure that people will not fall into the poverty trap due to the high cost of health care. We need to advocate for correction of the "imbalance" in health resource allocation at national level to ensure a fair share of national health resources for promotive and preventive care.

We have not only to ensure that the national health policy adequately reflects PHC principles but also that health matters are taken care of in other sectoral development policies. There is a reason why PHC has not succeeded to the extent of its potential. It is due to the relatively weak "referral support" from the "higher levels of care". Innovative approaches to strengthening referral systems need special attention. In this connection, the role of a vibrant private sector, which is growing rapidly in our Region, needs urgent attention.

I am sure our deliberations over the next three days will provide further guidance on various issues involved. The recommendations from the consultation will provide a blueprint for accelerating actions towards strengthening of health systems based on PHC. WHO will make every effort to collaborate with all Member States in the development of innovations in PHC.

Ladies and gentlemen,

Let me also take this opportunity to thank our host institute, the Institute for PHC Innovations (IPI) for their warm hospitality and the excellent arrangements made for the consultation. Finally, I wish you all successful deliberations and a fruitful outcome from the consultation.

Thank you.

# Annex-2: Working paper: Primary Health Care Challenges in the 21st Century: A Framework for Action

## 1. Introduction

The Declaration of Alma-Ata on Primary Health Care (PHC)[1] made in 1978 indicates that Primary Health Care is essential health care, based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the sprit of self-reliance and self determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals and the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

There is no a single definition for Primary Health Care, however, according to WHO[2], Primary Health Care is a set of PRINCIPLES that should:

- "Reflect and evolve from the economic conditions and socio-cultural and political characteristics of the country and its communities, and be based on the application of the relevant results of social, biomedical and health services research and public health experience".
- "Address the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly".
- "Involve, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all these sectors".
- "Promote maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develop through appropriate education the ability of communities to participate".
- "Be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need".
- "Rely, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community."

The 1978 Declaration enjoined countries to include *at least eight* elements under PHC depicted in Box 1. It must be emphasized that this was a minimum list; and by implication the list could be modified and expanded depending upon evolving country needs and changing public health imperatives.

## 2. Primary care and primary health care

The terms "Primary Care" and "Primary Health Care" are often confused with each other. It is important to draw a distinction between the two.

Primary Care is commonly considered to a client's first point of entry into the health system when medical assistance is sought[3]. In contrast Primary Health Care is a multidisciplinary approach that encompasses a continuum of care: health promotion, disease prevention, treatment, and rehabilitation by addressing a range of social, cultural, economic and environmental factors that cause ill health as well as those that sustain and maintain health. It is axiomatic that PHC be customized to suit and meet the needs of different population groups[2].

The bottom line is that PHC seeks health solutions that go beyond the bio-medical domain. It seeks to create conditions to dismantle barriers to health creation and preservation. On the other hand Primary Care has a narrower connotation of service delivery to the client at the first point of contact with the health service. *Primary Care nevertheless is an important component of PHC*.

## 3. Evolving paradigm of PHC

After the declaration of Alma Ata, a debate on the possibilities for implementation was opened. Two major schools of thought dominated the debate: those supporting "selective" primary health care (SPHC) and those advocating "comprehensive" primary health care (PHC).

The advocates of selective primary health care stated that the large and laudable scope of the Alma Ata Declaration was unattainable due to its prohibitive cost and the numbers of trained personnel required to implementing the approach. A more selective approach would attack the most severe public health problems facing a locality in order to have the greatest chance to improve health and medical care in less developed countries[4]. The advocates of comprehensive primary health care emphasized that the improvement of health care delivery systems is only one aspect of health care reforms. This school of thought incorporates a philosophy of health and health care as basic human right that requires community participation in the decision-making and the implementation of primary health care activities. It also recognizes that improvements in health have been due to

**Box 1: The 8 elements of PHC included in the Alma-Ata Declaration**

- Education about prevailing health problems and methods of preventing and controlling them.
- Promotion of food supply and proper nutrition.
- Adequate supply of safe water and basic sanitation.
- MCH including family planning.
- Immunization.
- Prevention and control of endemic diseases.
- Appropriate treatment of common diseases and injuries.
- Provision of essential drugs.

changes in the economy and social and political structures rather than changes in the health sector alone[5].

Further, there is still a need to dispel some common misperceptions about PHC. Often, PHC is perceived as a set of interventions primarily focused on delivering "cheap" services or services of inferior quality to the deprived sections of the population. The World Health Report 2008 (Primary Health Care- now more than ever) has examined the different dimensions of PHC as these have evolved over time[6]. Table 1 summarizes the shifting focus of PHC over the decades.

Epidemiological transition, whereby countries now face the dual burden of communicable and non-communicable diseases; frequent occurrence of pandemics; an ageing population; lifestyle changes; rapid urbanization; an increasing burden of injuries; the effects of globalization and climate change; and, the economic crisis mandate a fresh examination of options that countries need to consider in their on-going health development initiatives. Revitalization of PHC

**Table 1: The shifting focus of PHC over the decades**

| Early attempts at implementing PHC | Current concerns of PHC reforms |
|---|---|
| Extended access to a basic package of health interventions and essential drugs for the rural poor | Transformation and regulation of existing health systems, aiming for universal access and social health protection |
| Concentration on mother and child health | Dealing with the health of everyone in the community |
| Focus on a small number of selected diseases, primarily infectious and acute | A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses |
| Improvement of hygiene, water, sanitation and health education at village level | Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards |
| Simple technology for volunteer, non-professional community health workers | Teams of health workers facilitating access to and appropriate use of technology and medicines |
| Participation as the mobilization of local resources and health-centre management through local health committees | Institutionalized participation of civil society in policy dialogue and accountability mechanisms |
| Government-funded and delivered services with a centralized top-down management | Pluralistic health systems operating in a globalized context |
| Management of growing scarcity and downsizing | Guiding the growth of resources for health towards universal coverage |
| Bilateral aid and technical assistance | Global solidarity and joint learning |
| Primary care as the antithesis of the hospital | Primary care as coordinator of a comprehensive response at all levels |
| PHC is cheap and requires only a modest investment | PHC is not cheap: it requires considerable investment, but it provides better value for money |

with innovative action to address these issues is a vehicle through which health systems can be strengthened to meet the existing and emerging health challenges in an equitable, efficient and effective manner[7].

## 4. Key elements For revitalizing PHC

WHO has identified five key elements to achieving the PHC goal[8]:

- ***Reducing exclusion and social disparities in health*** (universal coverage reforms): This includes all measures that contribute to health equity and social justice primarily by ensuring universal access and social protection.
- ***Organizing health services around people's needs and expectations*** (service delivery reforms): This implies people centered care that gives due cognizance to socio-cultural factors, is relevant and responsive to local needs.
- ***Integrating health into all sectors*** (public policy reforms): Inclusion of health related concerns in public policies across sectors to ensure that public health actions enshrining PHC will ensure wider application of PHC principles.
- ***Pursuing collaborative models of policy dialogue*** (leadership reforms): This points towards participatory, inclusive, negations based leadership, which will go a long way in ensuring civil society participation and ownership of health actions.
- ***Increasing stakeholder participation***: Stakeholder participation, whether they be the community, service providers mid-level managers or partners in health policy making, programme development and implementation is a necessity to ensure that community needs are adequately reflected in initiatives to promote and preserve health.

## 5. Primary health care in South-East Asia

Countries in the South East Asia region have adopted PHC as the foundation on which health systems have been built. Countries have gained vast experience in reducing inequities and achieving universal coverage. These include involvement of community based health workers and volunteers, for delivery of preventive, promotive and curative health care including a health component in community development and income generation schemes, working towards social protection though innovative cost-sharing mechanisms, involving civil society in health programming and implementation, public-private partnerships for delivery of services, launching health promotion campaigns and so on.

Annexure 1 provides an overview of some of the PHC innovations that the Member States of the WHO South-East Asia Region are currently implementing.

### 5.1 The achievements of PHC in the past three decades

After the Alma-Ata Declaration, WHO/SEAR Member Sstates have applied the principles of PHC and developed different models to address their health. Strategies and approaches according to local problems and needs were adopted. These include initiatives for improving availability of safe drinking water and sanitation, maternal and child health care, health care financing and universal coverage. Health component was included in several holistic community development projects and programmes. Consequently, substantial improvements have been made in the South-East Asia Region in increasing life expectancy and reduction of infant and child mortality; in improving access to safe water and sanitation; in coverage of the immunization and antenatal care services. The average annual rates of decline in mortality in children under five years old in SEAR was 2.5% and 3.8% during 1990-1999 and 2000-2008, respectively. Life expectancy in Asia region increased from 41 years during 1950-1955 to 66 years during 1995-2000[9,10,11,12]. In spite of

massive challenges, the Member States have made significant progress in controlling and eradiating communicable diseases such as guinea worm disease, leprosy, and tuberculosis. The incidence of vaccine preventable diseases like diphtheria, pertussis, and measles has declined significantly. Neonatal tetanus has been eliminated from large parts of the region and it is close to eradication of poliomyelitis[13]. Figure 1 depicts the steady increase in measles vaccination coverage and the consequent decline of measles cases in the Region.

Figures 2 and 3 indicate the steady improvements in access to improved sanitation and safe water. While much more needs to be done to improve sanitation the significant improvement of safe water supply has contributed to the reduction of childhood mortality due to diarrheal diseases.

# 6. Why is PHC revitalization necessary?

## 6.1 Persisting health inequities and barriers to access to health services

Despite the significant contribution of PHC to the decline in communicable and vaccine preventable diseases, under-five mal-nutrition, and maternal, infant and child mortality rates, many countries are falling short of achieving the Millennium Development Goals. People live longer, but not healthier. Inequity in health outcomes and accessibility to quality health care services within and between countries are substantial[14]

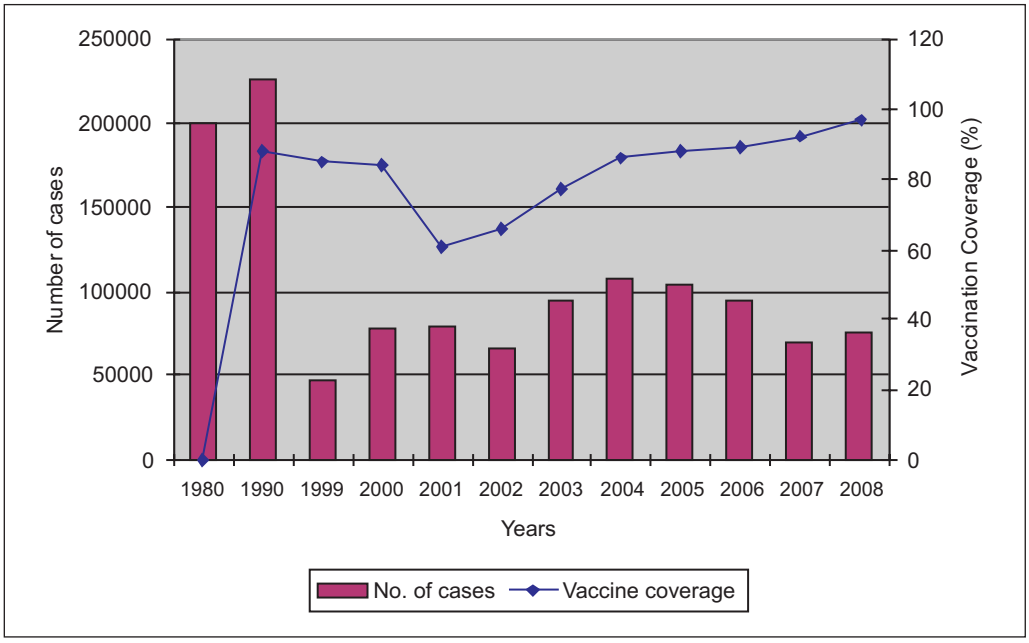
As an illustration of inequity in infant survival Figure 4 depicts differential infant mortality rates by maternal education. Children born to mothers who had no education have higher mortality rates than those born to mothers with secondary education. Access to health services is influenced by several factors including financial status. Figure 5 depicts differential skilled birth attendance rates between rich and poor mothers.

Revitalization of Primary Health Care provides an opportunity to reduce inequities and promote principles of social justice. Further, innovative PHC approaches can address socio-cultural and financial barriers to access health services.

## 6.2 The changing demographic and epidemiological profiles

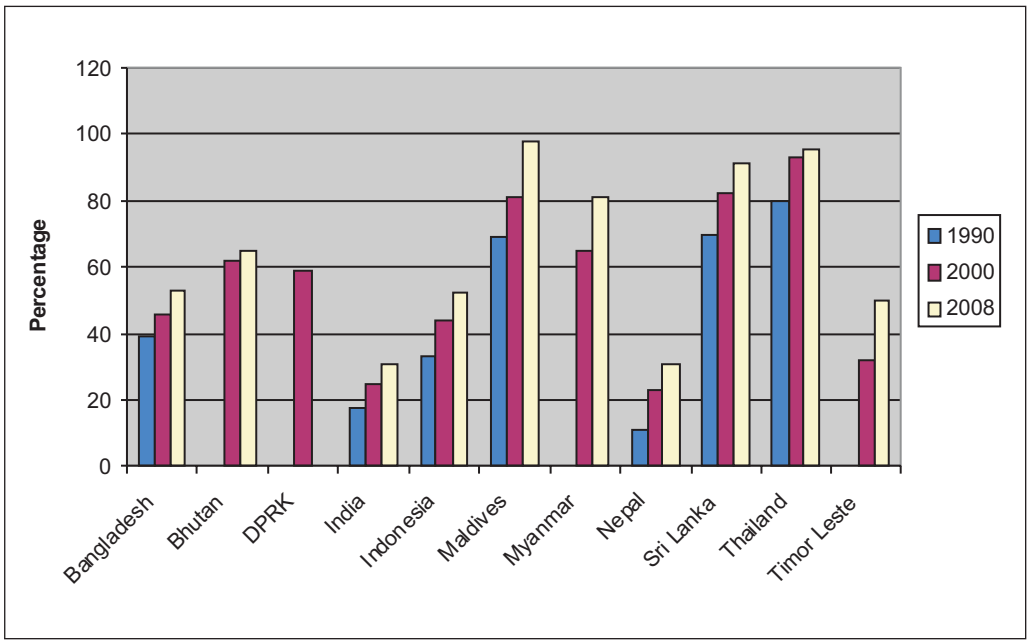
The overriding public health focus in the late seventies and eighties was on communicable

**Figure 1:** Annual Report of Measles cases and Vaccination Coverage, South East Asia Region, 1980 - 2008



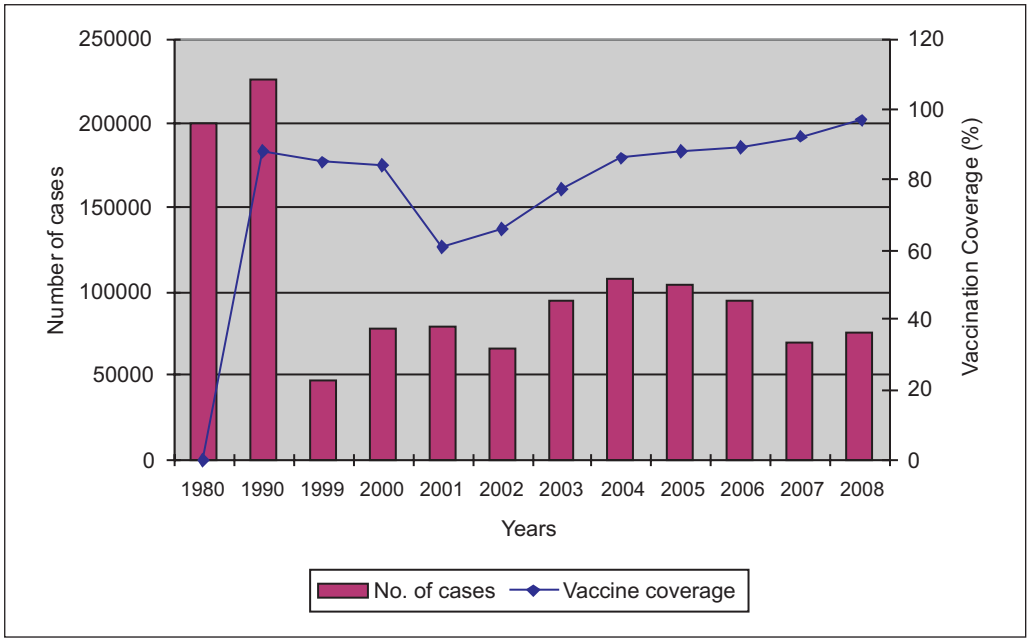

**Source:** WHO Vaccine preventable diseases: monitoring system. 2009 summary

## Figure 2: Percentage of Access to Improved Sanitation Facilities in SEAR Countries from 1990 - 2008



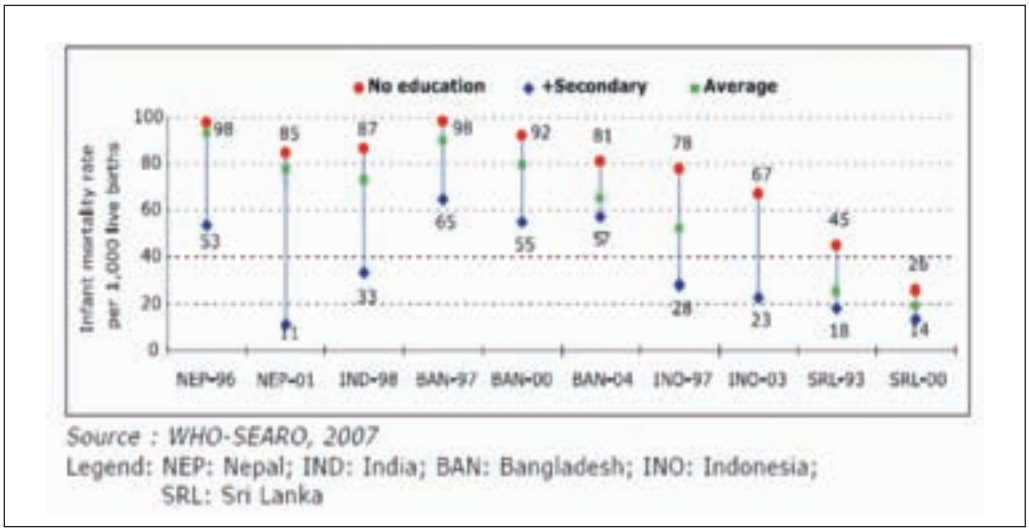

**Source: Progress on Sanitation and Drinking-water: 2010 update, WHO and UNICEF**

## Figure 3: Percentage of Access to Safe Drinking Water in SEAR Countries from 1990 - 2008



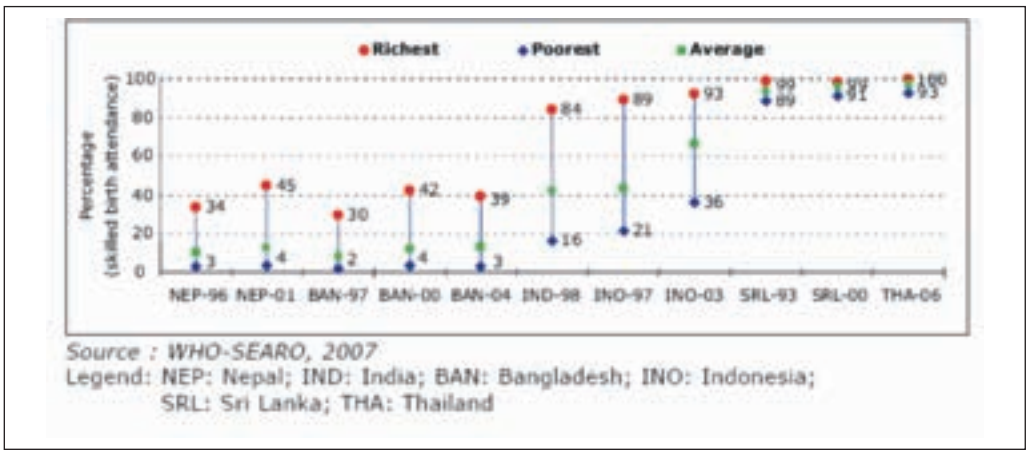

**Source: Progress on Sanitation and Drinking-water: 2010 update, WHO and UNICEF**

## Figure 4: Inequity in infant mortality rates by mother's education by country




**Source: Progress on Sanitation and Drinking-water: 2010 update, WHO and UNICEF**

## Figure 5: Inequity in skilled birth attendance between the poorest and richest wealth quintiles by country




**Source: Progress on Sanitation and Drinking-water: 2010 update, WHO and UNICEF**

disease control and maternal and child health. Due to advanced medical and public health technology, people live longer and the population of most countries in the region is aging. The percentage of people aged 65 and above will continue to increase in all WHO/SEAR member states. In 2005, out of 1.64 billion population in SEAR, 5.25% were 65 years and above. By 2015, the proportion of population aged 65 years and older will range from 3.0% in Timor-Leste to 10.4% in DPR Korea[15]. At the same time the percentage of young people in the overall population will gradually decline.

It is thus evident that health systems need to gear up to provide health care for the ageing population. Primary Health Care approaches that take into consideration the socio-cultural factors in South-East Asia (including community-based care) can go a long way in providing health care to the ageing population.

The health forecast shows that the world will experience dramatic shifts in the distribution of deaths from younger to older ages and from communicable diseases to non-communicable diseases during the next 25 years. The proportion of all deaths due to communicable, maternal, perinatal and nutritional causes is expected to decrease from 30% in 2005 to 22% in 2030, while the share of non-communicable diseases is likely to increase from 61% to 68%. Injuries are estimated to account for 9% of all deaths during this period[16]. However, since most developing countries are yet to control infectious and communicable diseases. Thus Member States will be faced with a dual burden of communicable and non-communicable disease. This necessitates a fresh look at options and approaches for managing the current burden of disease that countries are facing. PHC is a sustainable and cost-effective option for managing the emerging epidemiology scenario.

## 6.3 Rapid urbanization

In South-East Asia, 600 million people live in urban areas. Of this number, 25% are estimated to be poor. This population is growing rapidly from natural growth and migration_causing tremendous pressure on all public services including health care services, transport systems, water supply, sanitation and electricity. Urban life styles lead to neglect of appropriate nutrition and lack of physical exercise. Crowded living conditions exacerbate communicable diseases among the urban poor, as well as social tensions and stress. Heavy and unregulated road traffic puts the population at risk of accident and injuries. Consequently, the countries have been plagued with social, psychological and physical ailments. Most countries in the region do not have efficient health systems that are strong enough to cope with such emerging problems[17].

It is a common observation that in spite of satisfactory availability of health services in urban areas, wide sections of populations do not or cannot access health services. Urgent action based on PHC principles is needed to provide health care to this burgeoning section of society.

## 6.4 Increasing focus on specialized curative care and vertical programmes *– the relative neglect of public health*

Health sector reforms of the 1980s and 1990s which were driven by cost-containment and reducing the role of the state contributed to undermining the modest progress towards universal coverage. Professional interests of the medical profession combined with the profit-motives of the health technology and pharmaceutical industry make the health systems focused on specialized curative care rather than comprehensive. More and more vertical programmes have emerged as "cost-effective" solutions to control specific diseases, supported by international donors interested in seeing visible returns to their investments. It is observed that in most countries, the health budgets are heavily skewed towards provision for secondary and tertiary care. Preventive and promotive care initiatives receive a disproportionately low allocation. The PHC revitalization debate provides an appropriate forum to see how best the imbalance can be corrected.

## 6.5 High out-of-pocket expenditures for health care – *a significant contributor to impoverishment*

Health care systems have become overwhelmingly commercialized with the expansion of the private sector in health on the one hand and the increasing use of market mechanism in the public sector in health, on the other. Out-of-pocket expenditures for health care in the region have been sky-rocketing.

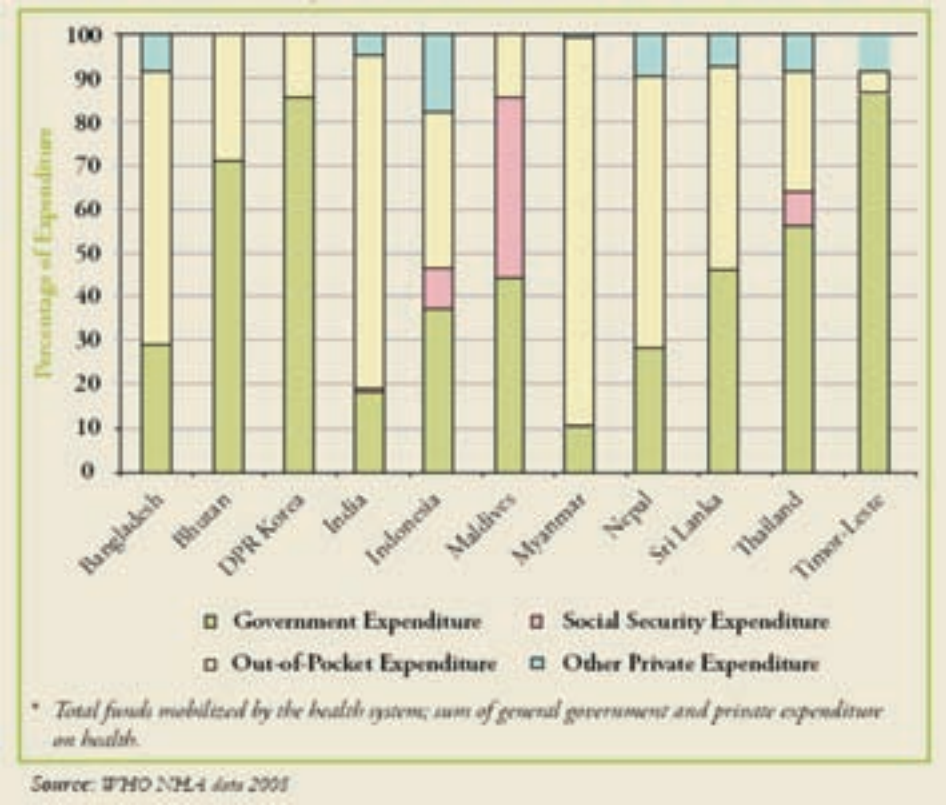
Figure 6 shows the contribution of out-of-pocket expenditure tooverall health expenditure in SEAR Member States. Data suggest that out-of-pocket expenditure as proportion of total expenditure on health was 65% in 2000 in Bangladesh, 82% in 2002 in India, 58% in 2001 in Indonesia, 75% in 1994-95 in Nepal, 50% in 1996-97 in Sri Lanka and 33% in 2000 in Thailand[18]. Significant out-of-pocket expenditures on health are recognized as one of the most significant cause of indebtedness. According to one study in India approximately 32.5 million persons fell below the poverty line in 1999–2000 through OOP payments[19,20].

Few member countries have developed complementary community health insurance to relieve financial burden of community people. Examples are Integrated Social Security Scheme in India, developed by Self Employed Women's Association (SEWA) and 30 baht scheme in Thailand. There is a need to develop processes to support communities to develop social health promotion schemes according to their own objectives, but coherent with nationally set objectives for universal coverage.

## 6.6 Need to refocus from "service delivery" to "health development"

Health is determined by a complex interplay between biological, socio-cultural, economic, political, behavioral and environmental factors. Figure 6 depicts the spectrum of health problems in any community. It must be

**Figure 6: Out-of-pocket health expenditure to overall health expenditure in South-East Asia Countries, 2006**



admitted that conventional approaches have paid overwhelming emphasis to addressing the "visible" declared morbidity and mortality. Attention to social-cultural and other factors that impact risks and vulnerabilities have largely been ignored by health programmes. Focused attention to prevention of non-communicable diseases and health promotion will preclude large expenditures on treating these conditions. Concerted efforts at the primary level to effect life-style changes vis-à-vis food habits, exercise, tobacco and alcohol use, and stress management has the potential to improve the health status of the population. This is would be possible only if the mandate of the health sector were to be broadened to a more "development oriented approach" rather than a restricted "service delivery" focus. It is clear that to achieve this multiple sectors including the people themselves and civil society will have to be co-opted for this purpose.

In view of the foregoing, the Regional Conference on Revitalizing Primary health Care[7] deliberated on this issue at length and recommended:

"Strengthen human resources and service delivery systems to support PHC, especially:

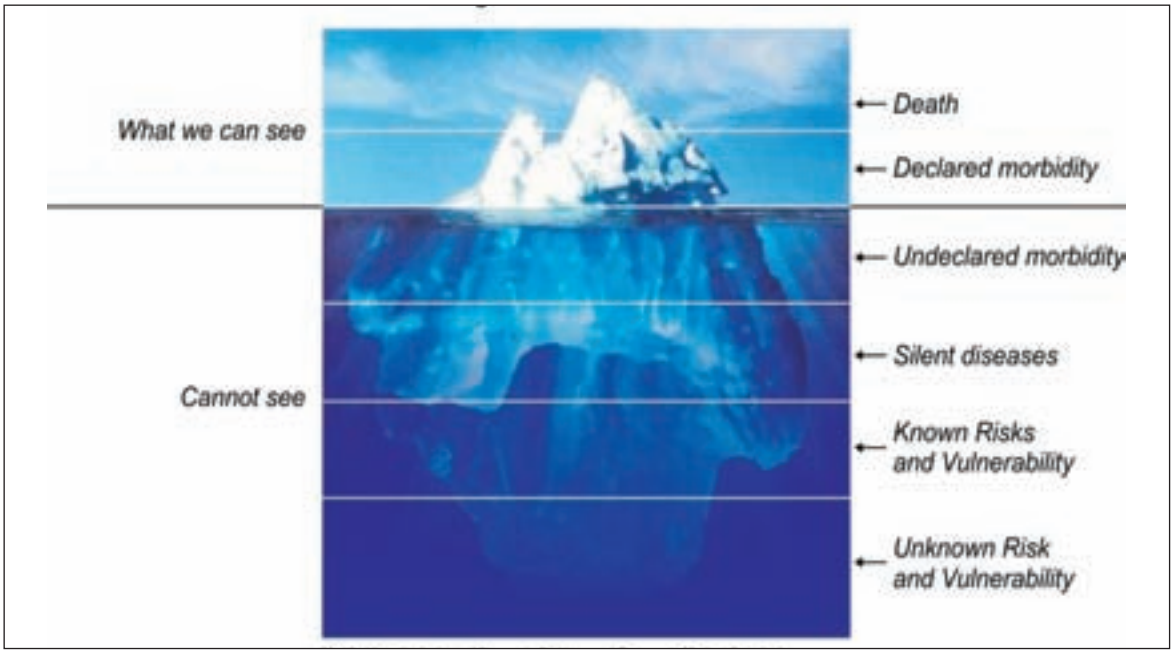
- capacity building of CBHWs and CHVs;
- appropriate training of health workers consistent with the needs of PHC, including review of the skills mix and curriculum;
- review of incentives for recruitment, deployment and retention of all health workers, particularly in poor and underserved rural as well as urban areas;
- in improving the effectiveness of the referral system; and
- the availability of infrastructure and supplies, including appropriate procurement and equitable distribution of medicines."

# 7. Suggested practical steps for revitalizing PHC in South-East Asia

## 7.1 Refocusing on communities

**Revisit roles of CBHWs/CHVs.** The South East Asia region has a rich tradition of community based action in which a community based health workforce comprising community based health workers (CBHWs) and community health volunteers (CHVs) and others have

**Figure 7: Iceberg of Health Problems**



participated in various health initiatives. The community based health workforce has become an integral component of the human resources for health. They are not only an effective medium for community participation but go a long way in efficient delivery of health care and in reducing health inequities. The changing epidemiology and socio-political realities necessitate a reexamination and revitalization of the role of this category of workers to meet the current ground realities. New approaches that effectively address new challenges need to be explored. This includes capacity-building of the community-based health workforce through strengthening pre-service and in-service training programs. This may need attention to additional knowledge, attitudes and skills such as communication for behavior modification, leadership, advocacy and community organization. One must keep in mind that one of the important success factors in moving primary health care into the new direction is the political commitment. Therefore, how to advocate and convince policy makers is also important. This was a prime recommendation made by the participants of the Regional Meeting on "Revisiting Community-based Health workers and Community Health Volunteers[21].

**Community education and empowerment for self-care.** Improvement in the health status of people is not possible unless the community is empowered to take health related decisions and action. Community must be empowered so that they will be genuinely self-reliant and be able to appropriately take care of themselves and their environment. To this end, both people and community based health workers must be re-oriented in terms of attitudes and practices to ensure the continuity of care, from community to health care facilities. People must be empowered to realize that health and environment are their own responsibility. In addition to providing health care services, community health workers and volunteers should play a role of change agents to facilitate the development of appropriate health behaviors among local people.

Self care support has crucial enabling value in developing countries with an already overburdened health care system. Community education and empowerment for self-care will contribute to prevent avoidable morbidity and help improve the efficiency of the health system. Empowerment of the community for health is a step towards ensuring equity. The Regional Consultation on 'Self-care in the context of Primary Health Care', inter alia, called upon countries to "give serious consideration to including strengthening of self-care as a programme in their efforts to revitalize PHC"[22].

**Promote Family Physicians.** The importance of family physicians as providers of quality primary health care is often underestimated. Family physicians, often also called general practitioners, are the chief conduit in many communities, through which the population accesses primary care. They are the first point of contact between the public and the health system.

As countries undertake to revitalize primary health care and health systems strengthening, it is important to examine the role of the family physician in the emerging epidemiological, social, political and economic context. The Member States of the South-East Asia Region may like to re-examine how this important resource can be effectively utilized to provide evidence-based quality health care (preventive, promotive and curative) to the population. Indeed, it would be desirable if countries could consider formally articulating the role of family physicians and plan for their career advancement. WHO/SEARO will provide technical support to countries in their efforts to strengthen Family Medicine.

**Health Financing and Social Protection.** Health financing provide one of the most powerful options to advance the principles of Primary Health Care and, has in fact, been used to lead PHC-orientated health sector reform by many countries. The way health is financed critically determines the three dimensions universal coverage - in summary: *what to cover* (the benefit package or the health dimension – ideally 'people centred' care); *whom to cover* (the population dimension – reducing social exclusion); and, *how much to cover* (the

subsidy dimension – increasing financial and social protection).

Financing mechanisms may be selected in a way that resources are collected and pooled equitable - to provide adequate financial and social protection for the poor and other vulnerable groups. Modes of collection and pooling also determine the volume of funds available for health; however, equally important is the way these finances are used – i.e. both 'more money for health *and* more health for the money' is a very relevant motto for health financing. Financing arrangements with respect to purchase of services and provider payment methods influence the incentive structure of a health system with the potential to improve performance and efficiency - both in the public provision as well as through the effective engagement of the private sector.

Finally, financing tools – particularly budgeting and resource tracking (National Health Accounts) - are effective platforms to integrate health related activities of other sectors within a consolidated national health effort. Financing and purchasing strategies need to be systematically reviewed based on evidence to (a) strengthen public investment in public health; (b) shift from out of pocket spending to pre-payment schemes that provide financial and social protection, especially to the poor – increased government spending targeted at the health needs of the poor and/or social insurance with subsidies for the poor; and, (c) move out of fee-for-service provider payments to other methods that improve systems performance while effectively engaging the private sector.

**Strengthen referral system.** A large proportion of health problems can be managed at the community level. However, there will be instances that require referral care. Most health systems in the Region have developed first-referral health facilities. However, it is a common observation that these facilities remain under utilized. On the other hand secondary and tertiary level institutions are overcrowded. There is a need to examine and the reasons for this as it leads to wastage of scarce resources on the one end and over crowding of more central facilities on the other. Well functioning first referral units close to the communities they serve that provide affordable good quality care are not only necessary to provide a continuum of care but also an important input to realize the principles of PHC. The Regional Seminar on Decentralization of Health Services (Bandung, Indonesia, July 2010) provided a platform to discuss this important issue and provide guidance on how to move forward.

## 7.2 Addressing new challenges for PHC

**Healthy Public Policy and Inter-sectoral collaboration.** Healthy public policy is characterized by an explicit concern for health and equity in all areas of policy and by accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. It makes social and physical environments health-enhancing. In the pursuit of healthy public policy, government sectors concerned with agriculture, trade, education, industry, and communications need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health consequences of their policy decisions. They should pay as much attention to health as to economic considerations[23]. Member-states may like to set up structures and processes to ensure that health related issues are included and addressed in policies of all related sectors. Further, in a region where private provision dominants from the supply side, this contribution could make a significant impact on the PHC effort and it this therefore important to include effective engagement of the private sector in a multi-sectoral agenda for health.

**Focus on urban health.** Member States are witnessing a surge in urbanization which is often unplanned. This has seen the rapid emergence of megalopolises where as much as half the population lives in slums. The problem is slated to become more acute in coming decades. Projections suggest that by 2030 about 60% of the world's population (4.9 billion people) will be living in urban areas[24]. It is a common observation that the health

status of the urban poor is poorer in urban poor populations as compared to the rural populations. This is evidenced by the adverse health indices like the infant mortality rate, proportion of children immunized, prevalence of anemia etc. in these population groups. It is also observed in several countries that primary health care system does not exist in urban areas; only secondary and tertiary facilities which are not easily accessible to the urban poor. This often leads to a mismatch between the need and supply of health services. Member States may re-examine urban health services and strengthen primary health care in urban areas.

**Task-Shifting as a strategy for health equity and improving efficiency.** Task shifting is the delegation of tasks, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting presents a viable solution for improving health care coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programmes are expanded[25]. A well-articulated policy developed through a consultative approach involving professional groups, programme managers and others that addresses technical issues, training and supervision needs and provides a legal framework will go a long way in institutionalizing task-shifting as a strategy for maximizing health system efficiency and improving access to critical health interventions.

## 7.3 Planning for advancing PHC

**Health Policy/Plan review.** The foundations of health programme action are contained in national health policies. Member states may undertake a review of the National Health Policies and Plans to ascertain whether these adhere to the principles of Primary Health Care. This could be done in reference to three areas: in explicit linkages to PHC in the Policy/Plan document; in the processes of developing and monitoring policy/plans along the lines of the PHC principles, particularly with respect to policy dialogue and stakeholder participation; and, normative support for both these aspects. It would be critical to ensure inclusion, participation and ownership of communities through their strengthening and empowerment. WHO/SEARO is in the process of developing protocols and tools that countries will be able to customize to conduct reviews of national health policies and plans.

**Operational Research.** Even though there are common issues that affect health systems that transcend national boundaries, countries need to find solutions specific to the political, socio-cultural, economic and epidemiologic conditions. It is evident what works in one particular country may not necessarily work in another. While a lot of bio-medical research is conducted in member-states Health Systems Research is a relatively neglected area. Countries may like to strengthen national health capacity for Health Systems Research to find local specific answers to issues related to equity, accessibility, financing, effect of socio-cultural determinants on health care etc. Effectiveness studies to ascertain alternative mechanisms of health care delivery meeting the needs of the local population should be encouraged.

**Networking.** Annexure 1 depicts some of the impressive PHC innovations carried out by Member States in South-East Asia. Technical forum should be made available for member countries to share and discuss their experiences so that the innovations can be further expanded. Therefore, primary health care network is important to the unification and strengthening primary health care in the Region. WHO/SEARO has established the South-East Asia PHC Innovations Network for this purpose. This Network will provide a forum not only to share and disseminate experiences and challenges in PHC innovations but also serve as an advocacy forum for accelerating PHC revitalization in South-East Asia.

# 8. Conclusion

During the past three decades, primary health care has contributed significantly to the improvement of health among people of WHO/SEAR Member States. However, much more remains to be done. Only five years remain for the achievement of the Millennium Development Goals. It is clear that a multi-sectoral effort based on PHC principles is

needed for accelerated action for achievement of health-related MDGs.

In addition to the existing health problems, new challenges have emerged. These include socio-demographic and epidemiologic transitions. In addition to the existing burden of communicable disease, Member States now also face the huge burden of non-communicable and mental illnesses. The aging population poses new challenges of chronic care. Industrialization and rapid urbanization have given rise congested communities, polluted environment and unhealthy lifestyles. Moreover, health care has been increasingly commercialized resulting in high out-of-pocket expenditure for health care. Climate change and new and emerging infections pose additional challenges.

It has been widely accepted that the principles of PHC remain key to the attainment of the social goal of Health for All and the health related Millennium Development Goals. The challenge before countries of the South-East Asia Region is to take bold innovative steps to revitalize PHC to effectively serve the community's contemporary health and development needs.

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## Primary health care innovations in SEAR

| Country | Innovation | Areas of focus | Target group | Key principles | Key players | Stakeholders | Strategy/method |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| Bangladesh | Micro-credit scheme | Essential drugs services | Poor, mostly women | Community participation | Community health volunteers | BRAC | Empowerment for poverty alleviation to improve health |
| | | | | | | Village organizations | Revolving funds for basic drugs |
| | | | | | | | |
| | Maternal Health Voucher scheme | MCH services | Poor pregnant women | Universal access to MNHC services | Public and private health care providers | WHO, MOHFW, Local government | Financing initiative for accessibility to MNHC |
| | | | | | | World Bank, United Kingdom (UK), European Community, Germany, Sweden, Canada, Netherlands, and the United Nations Population Fund (UNFPA). | Incentives both providers and customers |
| | | | | | | | |
| | Community Clinic | Essential Services package | Rural community (Women, children and the poor) | Community participation | Village health volunteers | Health and Population Sector Program (HPSP), NGOs | Trained VHVs, Clinics managed by community, |
| | | | | Inter-sectoral cooperation | | | VHVs link between community and clinics |
| Bhutan | Integrated health services for the control of HIV, TB and Malaria | HIV, TB and Malaria | General population | Inter-sectoral cooperation | Village Health Workers (VHWs), health personnel at BHU and at community health unit of the District Hospital | Representatives from related ministries, businessman, local leaders and general public | Establishement of Multi-sectoral Task Force |
| | | | | Community participation | | | Sensitize people's awareness |
| | | | | | | | Advocacy |
| | | | | | | | Health Trust Funds |

| Country | Innovation | Areas of focus | Target group | Key principles | Key players | Stakeholders | Strategy/method |
|---|---|---|---|---|---|---|---|
| India | VIMO SEWA | Health & income insurance | Poor women workers | Community participation | Poor women workers | Self-Employed Women's Association | Cashless payment for health care |
| | | | | | | | Micro-finance |
| | | | | Universal access to health care services | | | Integrated insurance scheme (Work, income, health) |
| | ASHA (Accredited Social Health Activist) | Promoting household toilet, immunization, MCH | Community people | Community participation | Accredited Social Health Activist, an honorary volunteer who is accountable to the community | NRHM, Panchayat Health Samiti | Performance-based payment |
| | | | | | | | Well recognized volunteers |
| | | | | | | | |
| Indonesia | Jamkesmas: Health insurance for the poor | Accessibility to health care services | Poor, un-insured people | Universal access to services | Health care providers | MOH, Local government, Central Bureau of Statistics | Health care financing |
| | | | | | | | Down payment paid to public and private contracted hospitals |
| | | | | | | | Reimbursement done by using package payment system and INA-DRG |
| | | | | | | | Reduce out-of-pocket payments |
| | Posyandu (integrated service post /ISP) | Integrated health services | Mothers and children | Community participation | Community health volunteers | Family Empowerment for Welfare (FEW) and MOH | Posyandu is classified and awarded according to performance (Performance-based) |
| | | | | Inter-sectoral cooperation | | | Operates once a month |
| | | | | | | | |

| Country | Innovation | Areas of focus | Target group | Key principles | Key players | Stakeholders | Strategy/method |
|---|---|---|---|---|---|---|---|
| | Polindes (Village Maternity Home-VMH) | MCH services | Mothers and children | Inter-sectoral cooperation | Midwives were trained, posted, supplied by government; providing professional services | Community make available VMH building and concensus in managing services | Polindes is classified and awarded according to performance (Performance-based) |
| | | | | | TBA working with midwife, providing traditional services | | |
| Country | Innovation | Areas of focus | Target group | Key principles | Key players | Stakeholders | Strategy/method |
| DPR Korea | Universal free medical care system | Integrated health care services | General population | Universal coverage of services | Household doctors (HH) | Ministry of Health | Providing promotive, preventive, and curative services by medically trained doctors |
| Maldives | Healthy Villingili Island | Integrated 8 elements including HIV/AIDS, TB | Community people | Multi-sectoral collaboration | Community health volunteers (semi-skilled birth attendant, traditional medicine practitioners) and community health workers (Health assistant, community health workers, family health workers, semi-skilled birth attendant) | WHO, MOH, Atolls Administration, Urban Development, Ministry of Planning. | Empowerment, Community organization, leadership building, community sensitization,needs-based operation |
| | | | | Community participation | Community people | | |
| Myanmar | Healthy Mother Project | MCH | Mothers & children | Community participation, | Trained MCH promoters-female (1 day) | Myanmar maternal and Child Welfare Association (MMCWA) | Community mobilization, |
| | | | | | | JOICFP | Referral system |
| | | | | | | Community leaders | |

| Country | Innovation | Areas of focus | Target group | Key principles | Key players | Stakeholders | Strategy/method |
|---|---|---|---|---|---|---|---|
| Myanmar | Ten Household Health Worker (THHW) | Integrated 8 elements | Township people | Community participation | Basic health staff (midwives, lady health visitors, health assistant) and trained community health workers, auxiliary midwives, trained birth attendants and household workers) | Ministry of Health | Essential health care services provided to the people through the cooperation between Government health personnel and volunteers. |
| | | | | | | | |
| | Community-Owned Resource Persons (CORPS) | Malaria diagnosis and treatment | 50 Villages in Eastern Shan State | Community participation | Trained (5 days) CORPS selected from the communities | ADB | Capacity building |
| | | | | | | MOH | Referal system |
| Nepal | Female Community Health Volunteer (FCHV) | MCH, FP, Immunization | Women and children in rural communities | Universal access to MNHC services | Female Community Health Volunteer (FCHV) | Ministry of Health and Population | Maternal Incentive Scheme to increase demand for maternity services |
| | | | | | | | Door-to-door services |
| Country | Innovation | Areas of focus | Target group | Key principles | Key players | Stakeholders | Strategy/method |
| Sri Lanka | National Health Development Network | Emerging health issues | Health related organizations | Inter-sectoral cooperation | National Health Council (chaired by PM); Health minister, other ministers from health related ministries. | National Health Council, Prime Minister, Health minister, other ministers from health related ministries. | Inter-sectoral committee, regular meeting, Prime Minister as champion |
| | | | | | | | Policy advocacy |
| | Hospital committee | Quality of health care services | Health care providers and community people. | Community participation | Community representatives | Local hospital administrators | People are empowered to the degree that power structure is shifted to favor community people. |

| Country | Innovation | Areas of focus | Target group | Key principles | Key players | Stakeholders | Strategy/method |
|---|---|---|---|---|---|---|---|
| | | | | | Hospital's administrators | Community people | Real community participation in managing health care services. |
| | | | | | | Clients | |
| | | | | | | | |
| Thailand | Strategic Route Map | Sustainable community and health development | Community people | Community participation | Community people (leaders, lay people, VHV) | Local administration (TAO) | Community Organization |
| | | | | Inter-sectoral cooperation | | Community health workforce | Community Resources (funds from TAO) |
| | | | | Appropriate technology | | | |
| | | | | | | Related government officers | Community empowerment for attitude and behavioral changes |
| Country | Innovation | Areas of focus | Target group | Key principles | Key players | Stakeholders | Strategy/method |
| Thailand | | | | | | Ministry of Public Health | Evidence-based practice (Situation analysis, activities, monitoring and evaluation) |
| | | | | | | | Policy advocacy |
| | 30 Baht Scheme | Health care services | Un-insured people | Universal access to services | Health care providers in public & private institutions | National Health Security Office | Health care financing reform |
| | | | | | | MOPH | Pre-registration with a health care facility |
| | | | | | | Public and private hospitals | Per capita budget allocation to health care facilities |
| | | | | | | | 30 baht for each medical visit |
| | | | | | | | Referral systems (Service reform) |

| Country | Innovation | Areas of focus | Target group | Key principles | Key players | Stakeholders | Strategy/method |
|---|---|---|---|---|---|---|---|
| Timor-Leste | SISCA (Integrated Community Health Services) | Registration, growth monitoring, personal hygiene, health promotion, immunization | Mothers and children | Universal access to basic health care services | Government health staff | Ministry of Health | Package Services provided by health staff |
| | | | | Community participation | | | Community empowerment |
| | | | | | | | Community "mobilized" health center to provide integrated services to mothers and children in the community once a month. |
| Note: 1. Most of the countries "community participation" refers to the participation of community volunteers or the participation of community leaders. Only few countries have real community participation and have power structure shifted to favor community people. | | | | | | | |

# Annex-3: Programme

| Day/date/time | Topic | Responsible person(s) |
|---|---|---|
| **DAY 1: Tuesday, 17 August 2010: Opening Session** | | |
| 08.00 - 08.50 | **Registration** | |
| 09.00 - 10.00 | **Inaugural Session** | |
| | • Welcome address by the Governor, Chiang Mai, Thailand | Mr Amorapun Nimanandh |
| | • Inaugural Address by the Regional Director, WHO/SEARO | Dr Samlee Plianbangchang |
| | • Opening Address by the Director-General, Department of Health Service Support, Ministry of Public Health, Thailand | Dr Nara Nakawattananukool |
| | • Introduction of participants | Dr Athula Kahandaliyanage |
| | **Business Session** | |
| 10.30 - 10.40 | • Appointment of Chairperson, Co-Chairperson and Rapporteur | Dr Samlee Plianbangchang |
| 10.40 - 10.45 | • Objectives of the Regional Consultation<br>• Announcements | Dr Sudhansh Malhotra |
| 10.45 -11.15 | **Primary Health Care Challenges in the 21st Century: A Framework for Action**<br>– Discussion | Dr Sudhansh Malhotra |

| Day/date/time | Topic | Responsible person(s) |
|---|---|---|
| 11.15 -12.45 | **Country innovations in revitalization of PHC**<br>**Theme 1: Towards Universal Coverage** | |
| | • Universal coverage and experience of people-centred care in Thailand | Dr Yongyuth Pongsupap |
| | • Using community volunteers to improve MCH coverage in Nepal | Dr B.S. Tinkari |
| | • Role of Family Doctors in primary health care in DPR Korea | Dr Boosaba Sanguanprasit |
| | • Demand side financing for improving coverage in Bangladesh | Dr Nuruzzaman |
| | – Discussion | |
| 14.00 - 15.30 | **Country innovations in revitalization of PHC (contd...)**<br>**Theme 2: Community participation and appropriate technology** | |
| | • Reaching the Unreached, India | Mr Alok Mukhopadhyay |
| | • Role of Traditional Medicine in PHC, Bhutan | Dr Dorji Wangchuk |
| | • Community participation for health – the SISCa experience, Timor-Leste | Mrs Isabel Exposto |
| | • Using community resources for PHC in Myanmar | Dr Aung Tun |
| | – Discussion | |
| 16.00 - 17.30 | **Country innovations in revitalization of PHC (contd...)**<br>**Theme 3: Intersectoral collaboration** | |
| | • Multi-sectoral approach to health development in Sri Lanka | Prof Saroj Jayasinghe |
| | • The Alert Village (Desa Siaga) concept – Indonesia | Dr Adang Bachtiar |
| | • The healthy Villingli island – Maldives | Ms Nazeera Najeeb |
| | – Discussion | |

| Day/date/time | Topic | Responsible person(s) |
|---|---|---|
| **DAY 2: Wednesday, 18 August 2010** | | |
| 08.30 - 09.00 | **Recap of Day 1** | Dr Kumara Rai |
| 09.00 - 10.30 | **National Health Policies and Strategies to support the Strengthening of Health Systems based on Primary Health Care**<br>– Discussion | Dr Athula Kahandaliyanage |
| 10.30 - 11.00 | **Presentation on PHC Innovations Network** | Dr Sudhansh Malhotra / Dr Boosaba Sanguanprasit |
| 11.30 - 1200 | The Strategic Route Map (SRM), the development approaches for PHC | Dr Amorn Nondasuta |
| 12.00 - 12.30 | Briefing for field visit | Dr Somchai Peerapakorn / Dr Surasing Visarutaratana |
| **DAY 3: Thursday, 19 August 2010** | | |
| 08.30 - 09.30 | **Reflections from the Field Visit** | |
| 09.30 - 11.00 | **The Way Forward: Group Work on Strategic Approaches**<br>• Guidance for Group Work<br>**Group Work**<br>Group 1: Making health services responsive to people's needs<br>Group 2: Mechanisms to strengthen intersectoral collaboration for healthy public policies<br>Group 3: Strengthen continuity of care – focus on referral services<br>Group 4: National health policy for health systems strengthening based on PHC | Dr Boosaba Sanguanprasit |
| 11.15 - 12.15<br>11.15 -11.45<br>11.45 -12.15 | **Group Work Presentations**<br>**Group 1**<br>**Group 2** | Moderator<br>Dr Tirtha Rana |
| 14.00 - 15.00<br>14.00 - 14.30<br>14.30 - 15.00 | **Group Work Presentations (contd…)**<br>**Group 3**<br>**Group 4** | Moderator<br>Prof Saroj Jayasinghe |
| 15.30 - 16.00 | **Concluding Session**<br>• Conclusions and Recommendations<br>– Recommendations for Member countries<br>– Recommendations WHO<br>• Closing | |

# Annex-4: List of participants

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The South-East Asia Region has a rich heritage of Primary Health Care (PHC) initiatives within both the public and NGO sectors. In the recent past, SEAR Member States and WHO at all levels have reaffirmed their resolve to revitalize PHC. One of the seminal events where Member States of the Region reiterated the commitment to PHC was the Regional Conference on Revitalizing Primary Health Care held in Indonesia in August 2008. As a follow up the WHO Regional Office for South-East Asia organized a Regional Consultation on Innovations in Primary Health Care in Thailand in August 2010 with the objective of advocating for innovative approaches to revitalization of PHC in South-East Asia. Participants from Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste reviewed and shared experiences; identified issues and challenges faced in revitalizing PHC; and developed recommendations for strategic approaches to accelerate revitalization of PHC in the Region.

There is wide consensus that the values and approaches of PHC should underpin health systems development. First enunciated three decades ago, the overarching principles of PHC – social equity, universal coverage, intersectoral coordination and people's participation – remain valid in the context of health development today. At a time, when health systems are confronted with an urgent need to explore ways and means to become more efficient and more responsive to changing contexts and community needs, countries in the South-East Asia Region need to review and revitalize the PHC agenda. It is important to contextualize the revitalizing process in terms of current country and epidemiological realities.

This publication contains an account of the deliberations of the Regional Consultation on Innovations in Primary Health Care and the recommendations made by the participants to further revitalize PHC in the Region.

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