

SEA-HSD-298
Distribution: General

Strengthening Health Systems Based on Primary Health-Care Approach

*Report of a Regional Consultation
Pyongyang, 18–20 April 2007*



**World Health
Organization**

**Regional Office for South-East Asia
New Delhi, August 2007**

Department of Health Systems Development
Health Service Delivery and Policy (HSP)
World Health Organization
World Health House
Indraprastha Estate
Mahatma Gandhi Marg
New Delhi 110002
India

Telephone: +91-11-23370804, Fax: +91-11-23370197

© World Health Organization, 2007

This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced or translated, in part or in whole, but not for sale or for use in conjunction with commercial purposes.

The views expressed in documents by named authors are solely the responsibility of those authors.

Contents

	<i>Page</i>
1. Introduction	1
2. Background.....	1
3. Opening session.....	3
4. Preparing the ground for health systems strengthening in South-East Asia.....	5
5. Country presentations.....	6
5.1 Bangladesh.....	6
5.2 DPR Korea.....	6
5.3 India.....	7
5.4 Indonesia.....	8
5.5 Maldives.....	8
5.6 Myanmar.....	9
5.7 Nepal.....	9
5.8 Sri Lanka.....	10
5.9 Thailand.....	10
5.10 Timor-Leste.....	11
6. Field visits.....	12
7. Health systems strengthening based on the PHC approach in the South-East Asia Region	13
8. Group discussions.....	14
9. Recommendations.....	17
10. Closing session	18

Annexes

1. List of participants.....	20
2. Programme.....	23

1. Introduction

A Regional Consultation on Strengthening Health Systems based on the Primary Health Care (PHC) Approach was held in Pyongyang, the Democratic People Republic of Korea (DPR Korea), from 18 to 20 April 2007. The participants constituted PHC Focal Points, planning officers, and managers for district health facilities from Bangladesh, DPR Korea, India, Indonesia, Maldives, Nepal and Sri Lanka. Delegates from Bhutan, Thailand, Myanmar and Timor-Leste were represented by their WHO Focal Points. In addition, staff of the World Health Organization's South-East Asia (SEA) Regional Office, and Country Offices in the Region were present. Two participants from United Nations (UN) and international agencies also attended the consultation.

The programme for this three-day meeting and the list of participants are given at Annexes 1 and 2.

2. Background

Strengthening health systems in all Member countries of the South-East Asia Region is fundamental to the goal of achieving the Millennium Development Goals (MDGs) as well as other international and national health targets. Without more efficient and equitable health systems, countries will not be able to scale up the disease prevention and control programmes required to meet the specific health goals of reducing child and maternal mortality and rolling back HIV/AIDS, TB and malaria.

A functional national health system will ensure the availability of an effective continuum of public health services and medical care that is: 1) affordable – all members of the population can afford to use; 2) acceptable – consumers can find services that are welcoming, confidential and in keeping with their culture; 3) accessible – within easy reach and available at convenient times, and 4) professional – care received is based on known evidence of what is effective and of good quality.

Due to several constraints and impediments, many countries in the Region do not have fully functional systems in place. Such setbacks have been partly attributed to socio-economic factors, the presence of marginalized population living in inaccessible areas and a paucity resource. However, in line with WHO global review, strengthening health systems through a renewed and reinvigorated primary health care approach can not only meet today's health challenges but also address medium-term development goals.

The subject of strengthening health systems, particularly its components such as human resources for health, quality control and patient safety, were discussed at the Fifty-ninth Session of the Regional Committee (RC) held in Dhaka in August 2006. The Regional Consultation on Strengthening Health Systems through the PHC approach in Pyongyang was convened as a follow-up to this keeping in view the discussions at the Fifty-fourth World Health Assembly that led to drafting document A54/12 on "Strengthening Health Systems in Developing Countries", Resolution SEAR/RC55/R3 on Management of Decentralization of Health Care was adopted at the Fifty-fifth Session of the Regional Committee in Jakarta in 2002. The Resolution urged Member States to ensure equity in access and efficiency of quality health care while strengthening their district health systems, and to attach greater importance to stronger, effective and more efficient health systems keeping in mind the PHC approach in particular also served as a resource paper for the Pyongyang Consultation. The Regional Consultation had the following objectives:

The general objective being to improve efficiency and equity of national health systems, the specific objectives were:

- (1) To review and exchange experiences about health system strengthening activities in the Member countries based on PHC approach
- (2) To discuss in depth the basic elements of effectively functioning health system activities in Member countries focusing on healthy public policy, decentralization, community involvement and private participation.
- (3) To develop a regional framework and strategic actions to strengthen national health systems based on PHC approach.
- (4) To recommend the framework of country actions to strengthen national health systems.

The expected output of this consultation is a corpus of pragmatic recommendations on framework for strategy and future course of action on the subject of health systems strengthening through PHC approach, following careful deliberations and extensive discussions.

3. Opening session

Dr Tej Walia, WHO Representative (WR) to DPR Korea, welcomed the participants. This was the second such Regional Meeting held in Pyongyang, he said, the first being the Regional Consultation on Traditional Medicine in June 2005. He thanked the Minister and Regional Director for agreeing to hold the meeting in Pyongyang.

The Regional Director for the WHO's South-East Asia Region, Dr Samlee Plianbangchang, said in his inaugural address that strong health systems are a prerequisite for the achievement of national health goals, including the Millennium Development Goals (MDGs). One of the main challenges facing the health system is lack of access to care for large section of the population, particularly the poor, the underprivileged, the marginalized and the vulnerable. The primary purpose of primary health care is to ensure health for all; and close the gap between the "haves" and the "have nots". Primary health care aims to promote and support the active involvement of people in their health and its development. This is the "Health For All and All For Health" approach. Such involvement of people must be at various levels: individual, family, community and national. The goal of health for all can be achieved if all people are involved in the process through the primary health-care approach. The Regional Director also underlined the need to revisit the primary health-care approach in order to ensure its relevance in keeping with current developments.

His Excellency Prof. Choe Chang Sik, Minister of Public Health, DPR Korea, in his inaugural address recalled that in 1992 a Regional Consultation on Strengthening Health Systems based on the PHC approach was held in Pyongyang, the capital of DPR Korea. Under direction from Presidents Kim Il Sung and Kim Jong Il the Government of DPR Korea put into practice mechanisms to ensure complete and universal free medical care, the household doctor system, the upgradation of infrastructure and raise the quality of PHC.



Dr Jong Chol U of DPR Korea was nominated the Chairman, Dr Tarun Seem from India the co-chairman, and Dr Suwandi Makmur of Indonesia was nominated the Rapporteur for the meeting.

4. Preparing the ground for health systems strengthening in South-East Asia

Dr Sultana Khanum, Director, Health Systems Development, WHO/SEARO, presented the working paper on 'Preparing the ground for health systems development'. She provided an overview on Health for All and primary health care in the South East Asia Region, and elaborated on health systems and their importance. She began by outlining the current global health targets in support of Health For All, including: health equity; survival; reversal of global trends of major pandemics; eradication and elimination of certain diseases; improved access to water, sanitation and food; improved access to comprehensive essential and quality health care; implementation of global and national health information and surveillance systems, and support for research for health. From the time of the Alma-Ata declaration in 1978 till today, the PHC approach has provided the impetus for progress toward Health-For-All. Primary health care remains a valid entry point to a comprehensive health-care system. While the PHC approach has made ensured progress, particularly in ensuring access to eight key elements, intersectoral action for health has not been fully achieved while community participation has been inadequate and reorientation of health services and personnel to PHC principles remains elusive.

Essential health system functions complement and support PHC by providing sustainable financing, investment in human and institutional capacity for health, optimization of the private and public sector through appropriate regulation, strengthening of research to support and advance PHC, and implementation of global, national and local surveillance and monitoring systems. Well-functioning health systems make quality health care available across life spans, prevent and control diseases, provide information and conduct surveillance, promote research, build and maintain quality human resources for health, secure adequate and sustainable financing, provide essential drugs, and promote regulation and legislation in support of sustainable health systems development, Dr Khanum explained. She ended the presentation by inviting the audience to consider how to link health systems strengthening with primary health care to achieve current international, national and local health goals.

5. Country presentations

5.1 Bangladesh

The participant from Bangladesh presented an overview of the health services delivery system in that country. The public sector health system is structured as a hierarchical pyramid with five layers: three at the primary (*ward, union, upazila*) and one at the secondary (district), and tertiary care levels. At the base or ward level a Health Assistant caters to a population of about 7000, undertaking home visits and operating from a community clinic (where operational) tasked with maternal and child health concerns. Functions of such clinics include immunization, communicable disease control, symptomatic curative care of common complaints and upward referral. The next level is the Union Health and Family Welfare Centre (UH and FWC) staffed with a medical officer and two paramedics, i.e medical assistants and pharmacists providing maternal and child health services and some curative care. The next level is Upazila Health Complex (UHC) which is the first referral centre for the population of the upazila. The fifth layer of the public health system comprises the medical college and specialized hospitals providing referral care at the tertiary level. He also elaborated on several national programmes on primary health care.

5.2 DPR Korea

The DPR Korea delegation stressed that financial guarantee is fundamental to the development of PHC and medical care, including sanatorium and return travel, is free. In keeping with this, the core of the public health policy of the country is equitable access to unbiased PHC that focuses on disease prevention and health management of the community. The policy also focuses on improving the quality of PHC and maintaining self-reliant status of units delivering it. The sanitary and anti-epidemic institutions specializing in control of infectious diseases are extensively located at the central, provincial, city, district and county levels. The household doctor system is responsible for the integrated and comprehensive health-care throughout the country. There are hospitals at the central and provincial levels and a number of specialized ones including maternity centres and pediatric clinics at both – as well as in some cities. Access to the first-level health-care services for the population is provided by polyclinics or clinics in urban areas, Ri people's hospital or Ri clinic in rural areas and the

industrial hospital or clinic in industrial zones. The hospital at the next upper level (city, district and county) is the general hospital with specialized departments, which meets the requirements of first referral of PHC.

Health care for the staff and their families living around the industrial hospitals is provided by the industrial hospital. Ri hospitals and polyclinics are responsible for preventive health-care, sanitary propagation, sick-call treatment, visiting treatment, consultation for women and infants, birth assistance, specialized diagnosis and treatment. Ri hospitals and polyclinics, the direct performers of PHC set up to provide primarily specialized care, are distributed evenly to ensure that at least one is reached by an hours travel by road from any part of the country. The presenter concluded that (a) it is proven facts that primary health care is the right route to Health For All, (b) PHC can only be developed on the edifice of sound healthy public policy and strong community backup, (c) the principle of collective self-reliance should be maintained for the development of PHC; and (d) PHC development can be ensured when recruitment and training of health workers are well provided for and their qualifications and expertise are enhanced.

5.3 India

The participant from India outlined that PHC has significantly contributed to some major health outcomes in the country. He cited success stories such as the eradication of smallpox in 1977, guinea worm disease in 2000, substantive reduction in cases of leprosy, the elimination of neonatal tetanus from several states and the elimination of yaws, along with a marked improvement in select health parameters, improved disaster management/public health response, and a TB cure rate higher than the global target of 85%. However, in order to scale up coverage and quality of primary health services, particularly for the rural population and disadvantaged groups, the Government has launched a National Rural Health Mission. The main aims are to rejuvenate the health delivery system and to develop an accessible and affordable quality of Universal Health Care. The strategy includes: reconfiguration of the public system through increased funding, rights-based service delivery, strengthening infrastructure, augmenting manpower, ensuring systemic corrections, capacity building, providing for locally resident community health workers, bolstering local self governments, establishment of patient welfare societies, and concurrent evaluation with infrastructure upgradation.

5.4 Indonesia

The participant from Indonesia dwelled on three major issues related to decentralization in health. These were: (a) Availability and equitable distribution of qualified human resources: following the onset of decentralization in 2001, the management of the health work force management was also decentralized. In order to guarantee more equitable distribution of the workforce, the Central government employs contract doctors and provides more incentives to HRH deployed in remote areas and far-flung islands. (b) Adequacy of health financing: Decentralization included the fiscal decentralization. The Central government has set up a Minimum Service Standards at the district level to guarantee adequate health funding in the lower tiers of administration. The Central government also provides a Block Grant and Special Allocation Budget to support the local government in financing priority health interventions. (c) Clarity in obligatory functions and institutional arrangement: The government is revising Rule No. 25/2000 with regard to obligatory functions of authorities at the central, provincial and district /municipal level.

5.5 Maldives

The Government of Maldives reported that focus on prevention and public health aspects of health service together with unrestricted access to primary health care at the individual island level is the main contributing factor for achievements in implementing PHC. Major communicable diseases have been eliminated, leprosy and filaria have reached the regional elimination targets and the prevalence of both TB and HIV is low. However, diarrhoea and ARI is still causing significant morbidity to children and adults along with high prevalence of malnutrition. The growing number of accidents and injuries leading to death and disabilities compound the chronic burden of noncommunicable diseases (NCDs) and add to the emerging problem of communicable diseases. Currently the focus is on improving access to rapid diagnostic and test results, improving public knowledge on healthy practices, developing a mechanism to make available pharmaceutical drugs in remote and sparsely populated islands, bolstering the transport mechanism for seeking health, implementing a social health insurance scheme, intensifying the procurement and supply of drugs and equipment, improving the supervision and monitoring mechanism, strengthening the existing health information system and the referral mechanism (telemedicine).

5.6 Myanmar

Myanmar has successfully implemented several primary healthcare principles such as: (a) Equitable distribution aided by national policies focusing on equality and needs-based service; (b) Community participation that draws upon tenets of society, culture and the tradition of voluntarism in Theravada Buddhism which advocates doing good to others with real 'cetana' dedicating the heart and soul; (c) Intersectoral coordination involving, in addition to the health sector, related sectors and aspects of national and community development, such as the Ministry of Education, police, NGOs etc.; (d) Appropriate technology (for example construction of sanitary latrines with local material). Constraints and areas that needed strengthening were ascertained. These include sustaining motivation, seen to be a challenge in the long run; lack of objective indicators for community participation that makes evaluation difficult; improving the accessibility and availability of health services; and the need to expand infrastructure, particularly to ensure increased primary healthcare coverage to remote areas. Special attention to border areas and increased access and regular supply of essential medicines were also identified as priorities.

5.7 Nepal

After providing basic information on the status of health and delivery systems in Nepal, the delegate from that country outlined the National Health Policy 1991. The policy emphasized the importance of a decentralized approach to health systems management in order to realize universal coverage of PHC to its people. The Second Long-Term Health Plan 1997-2017 envisaged a PHC strategy to improve inter- and intrasectoral coordination and to provide the necessary support for effective decentralization of health-care services with community participation. The local Self Governance Act (LSGA) 1999 takes the process of decentralization forward by charting a process of cross-sectoral devolution with municipalities on planning and roles for the health-care delivery system. The Tenth Five Year Plan (2002-2007) and other key health sector strategies focused on (a) Making essential health-care services available to all people; (b) Establishing decentralized health systems to encourage people's participation; (c) Establishing public-private-NGO partnerships in the delivery of health-care services, and (d) Improving the quality of health care through total quality management of human, financial and physical resources.

The major issues and challenges relating to decentralization in Nepal are: (a) A policy document that is clear about vision, contents, development processes, responsibilities and the designated authority at various levels; (b) The need for detailed information about institutional arrangements at various levels (central, regional, district and local) and their roles; (c) The need to clarify potential benefits and/or problem, and the need for more preparatory steps to effectively implement decentralization in health services. It was also observed that decentralization is being sought to be implemented in a political environment where no elected local bodies exist.

5.8 Sri Lanka

The Sri Lankan presentation focused on their experiences in intersectoral collaboration. To improve the health of the population, Sri Lanka has implemented a set of intersectoral strategies aiming at better living conditions, an enhanced quality of life and greater economic and social development. Several committees, such as the Nutrition Coordination Committee, Dengue Control Committee, etc. have been established. At the divisional level, the committee consists of the political authority of the local governments, officials from the relevant sectors and representatives of NGOs and the community. Priority sectors involved were education, public works, water supply and sanitation, housing, communication, animal husbandry, and agriculture. Primary health care is strengthened by the Mahinda Chanthanaya Policy which envisages bringing health services to the underserved and needy, improving their quality and strengthening existing ones, and according equal priority to the curative and preventive sectors. While encouraging the free health services, the Policy also advocates upgrading 17 hospitals located in less privileged areas, the provision of drugs at reduced prices for children, pregnant women and the elderly, raising the nutritional levels of pregnant women and children.

5.9 Thailand

Thailand has implemented several new initiatives in strengthening PHC. These include: (a) An overhaul of the primary care centre through renovation coupled with ensuring an adequate supply of medical and non-medical equipment; (b) Establishment of public primary care centres operated by full-time -time physicians (community medical centres-CMC);

(c) involvement of private clinics through the financing mechanism of the 30 Baht Scheme; (d) Increasing the competency levels of health personnel at primary care centre through changing general practitioner (GP) residency training programme to family physician (FP) training programme, developing context-based learning/learning at the workplace, and establishing 12 regional training centres; (e) Increasing incentives of health personnel at the primary care centre through bonus payments for those units that meet the performance criteria set up by the national committee along with more social recognition of health personnel engaged at the primary care level; (f) Establishment of the Referral Coordinating Centre (RCC) that manages referral systems effectively in Bangkok and other big provinces and earmarking financial incentives for hospitals which reserve beds for admission; and (g) Integration of community based preventive and health promotion services and Thai traditional medicine in primary care centres.

In Thailand, the primary care system is the main contracting unit for registration of the population and acts as the gatekeeper for the "30 Baht Scheme". In 2006, part of the capital replacement budget (about 1 billion Baht) was allocated to strengthen primary care to support the establishment of CMC and upgrading existing health centres (including financial incentives for health personnel), and development of knowledge management mechanisms, assist in the training of health personnel involved in primary care, expedite reform of tertiary hospitals to support primary care, and promote public advocacy.

5.10 Timor-Leste

Timor-Leste is one of the least developed countries in Asia with a per capita GNP of approximately US\$ 478. More than 40% of population lives on an average income of less than 75 US cents per day. Malaria is highly endemic with more than 130 000 suspected cases every year. Tuberculosis is a major health problem and leprosy too is highly endemic. Timor-Leste is also highly endemic for dengue, Japanese encephalitis (JE) and chikungunya, yaws, scabies and other skin infections. The PHC Policy was established to (a) ensure the availability, accessibility and affordability of health services to all people of the country; (b) to regulate the health sector; and (c) to promote community and stakeholders' participation. Some early achievements include rebuilding the infrastructure for PHC after the destruction caused

by political crisis in 1999, establishing a Basic Services Package strategy for PHC and hospitals, training and gainfully deploying health staff, implementing facility-based Basic Services, and a higher coverage of certain services, such as antenatal care. The gradual increase in immunization coverage, approval of the inter-sectoral action framework and the launch of the Family Health Promotion programme also count among the recent measures.

6. Field visits

Field visits were arranged on the morning of the second day of the meeting to three places: Puksae Polyclinic (the most peripheral-level health facility), Institute of Public Health Administration-IPHA (WHO Collaborating Centre for primary health care) and Pyongyang Maternity Hospital (the Central-level maternity hospital).

Puksae Polyclinic

Located in Moranbong district, Pyongyang, it caters to a population of 14,500 with 55 staff, including 35 household doctors. The "household doctor system" is unique to DPR Korea. One household doctor takes care of 130 families on an average. They are responsible for: (1) *health education of the community*; (2) *Vaccination as per the EPI plan*; (3) *Monitoring the health status of the families, living in their "catchment areas" or places under their purview, and* (4) *Counselling children, women and the elderly on a regular basis*. The clinic also has specialized sections, such as, surgical, ENT, etc,

Institute of Public Health Administration (IPHA) (WHO CC for primary health care)

Situated in Daedonggang district of Pyongyang, it was established in October 1962 and designated a WHO CC for primary health care in October 1988. This institution is the technical counselling body of the Ministry of Public Health (MOPH). It offers technical assistance to the MoPH to further improve and develop public health policy and strategy and public health management/administration. It combines the roles of a scientific research institution for management/organization of medical care

services, a WHO CC for primary health care, and a computer centre of the MoPH. The institute consists of seven research sections, namely, research section for organization of medical care services, research section for health planning and health economy; research section on health statistics; section on international health; research centre for computerization of public health and hospital management; research section for pharmaceutical organization, and a theoretical research section on public health. It is commonly perceived that WHO should invest in enhanced capacity building of the institution as a centre for educating public health professionals in DPR Korea in keeping with the key role it plays in improving the health of the community.

Pyongyang Maternity Hospital (Central-level maternity hospital)

This is centrally located in Pyongyang city. It serves as a central-level hospital for providing obstetric and gynecological medical care to residents of Pyongyang, particularly women with complicated pregnancies and with breast and other gynecological cancers and medical care to newborns. It is well equipped with advanced therapeutic and diagnostic facilities and is generously supported by the government. The hospital runs 1,500 beds and has a staff complement of 1,500.

The field visits revealed the high degree of the commitment of the DPR Korea government for a healthy society.

7. Health systems strengthening based on the PHC approach in the South-East Asia Region

Dr Sultana Khanum, Director, Health Systems Development, WHO/SEARO elaborated core concepts of Primary Health Care (PHC): universal coverage, balanced mix of services, effectiveness of services, cultural acceptability and affordability, maximum community involvement and viable intersectoral collaboration. She illustratively explained how every Member country adopted and adapted the PHC approach in accordance with its own health situations and socio-economic conditions and has achieved certain HFA goals through the PHC approach. Countries which have succeeded in implementing PHC were those which had robust and

functioning health systems, she pointed out. She listed some underlying factors that hindered the optimal performance of the PHC, such as: complexity, broadness and vagueness of the definition; inadequate operationalization of standard guidelines; difficulties in translating the concept into action; insufficient guidance and assistance to integrate PHCs into the national health systems, and inadequate involvement of other sectors in the conceptual stage. Dr Khanum put forward certain issues for discussions. These were:

- What are the priority health problems, and is the system in place to address these?
- What factors need strengthening in the health system?
- How to maximize community involvement in health systems strengthening (HSS) in order to ensure intersectoral action in HSS?
- How to establish adequate financing mechanisms?
- How to improve health systems management and establish a responsive health system?

She concluded by saying that PHC values and principles are still valid and need to be linked to health systems strengthening.

8. Group discussions

On the second day of the meeting, following the field visit, participants were divided into three groups and each group assigned a topic for discussion. These topics were from the gamut of issues raised by Dr Khanum in her presentation, where she said discussions on the same would pave the way for substantive recommendations on health systems strengthening based on the PHC approach.

Some priority health problems identified were: maternal and child health (MCH), under- five and neonatal care, communicable diseases, resurgence of new disease and non-communicable diseases. The specific groups to be addressed were: mothers and children, the poor and rural population, disadvantaged groups, migrant and displaced populations, tribal/indigenous populations, and those residing in remote inaccessible

areas. The priority health problems till 2015 were identified to be continuation of disorders, non-communicable diseases, death due to disasters and road traffic accidents, HIV and mental health.

The most conspicuous problems confronting health systems were found to be many. These included lack of competence, maldistribution and poor planning in human resources for health; inadequate financing, low fiscal capacity and misallocation of pecuniary resources; inequitable distribution of and inadequate maintenance of health facilities and medical supplies; insufficient transportation, management and leadership capacities; inefficient monitoring and evaluation procedures coupled with weak evidence-based information systems; a palpable paucity in levels of intersectoral participation and dearth of community involvement; and, inherent flaws in decentralization and policy guidance.

Issues with the PHC approach for health systems strengthening are: referral system, decentralization, resources (financial and human), strengthening of the secondary level of primary healthcare, comprehensive services, flexibility of in-service provisions, defining and providing essential health services, curative services including basic diagnostic services, bolstering referral services, reporting of diseases, adequate funding for PHC, involving the private sector in PHC and granting healthcare the status of a basic human right.

Several recommendations were made to address the question of community involvement. These included: establishing district health committees, maximizing the involvement of formal and informal leaders, granting the local community more financial control and a wider ambit over powers regarding recruitment, supervision and termination of service of volunteers, and greater say over the provision of health services. It was also recommended that the ownership of health facilities should be vested with the local community which should not only monitor health service but also be involved in the development of the health information services system.

Another recommendation was to develop and institutionalize intersectoral collaboration through the establishment of an independent body to advocate and influence health policy planning, implement non-health programmes and conduct health impact assessment. Establish a National Advisory Board/National Committee, Joint Health Council, district health committees and village health committees with representation from

professional bodies, trade unions, NGOs and autonomous groups was recommended as a vital step to institutionalize intersectoral collaboration.

Recommendations were also made for additional funds through reallocation of the budget, advocacy, public-private partnerships, and through health insurance and other financing mechanisms.

Areas needing improvement in health systems management include political stewardship, the appointment of suitable managers with stable tenures, evidence-based decision making, programme designing, monitoring and evaluation for mid-course corrections, programme accounting and Health Management Information System, optimal utilization of manpower, quality assurance of services provided, functional decentralization, skilled management of human resources, and supportive supervision.

On to raising the levels of public-private partnership (PPP) and non-governmental organization (NGO) involvement, the participants identified prerequisites (public health standards for both public and private facilities, standard treatment protocols, costing and guidelines, adaptive standard treatment costing, and a health ombudsman), different strategies (engagement with for-profit public private partnerships, engagement with not-for-profit public private partnerships, who generate resources and engagement with not-for profit public-private partnerships), and areas of PPP and NGO involvement (services delivery, training, diagnostics, ancillary services and accounting, and referral transport).

The strategies to develop a mechanism to encompass PPP and NGO are: (a) Define profile of service delivery (on the basis of place, capacity of provider and funds available), (b) Strengthen public health delivery system to negotiate with private providers from a position of strength (rationalize recruitment and employment rules, rationalize medical education, demystify medical practice, prepare long-term policies involving private providers, and enumerate legislation such as the National Health Security Act of Thailand). Maximizing PPP collaboration through balanced allocation of public resources, developing a mechanism to ensure accountability to clients, negotiating service range, standards and costing, creating room for private players and NGO providers and positioning public system to optimally facilitate and fill gaps were also part of the corpus of recommendations.

Strategy to develop responsive and close-client: decentralize, community ownership, rational Manpower policies, appropriate Infrastructure, exit reviews, sensitizing service provider, rights based approach/respect based approach, and establish charter of client and service provider rights and guidance as to how to exercise them. Strategies to maximize community participation included: (a) Awareness, advocacy, political commitment; (b) Empowerment and accountability, ownership; (c) Linkages with cross cutting issues and state/countrywide policies; (d) Service providers as facilitators; (e) Facility-based recruitment with residency criteria, and (f) Community monitoring and local loop feedback and local resource mobilization.

9. Recommendations

The key recommendations that originated from the country and group discussions are given below:

- (1) All countries in the South-East Asia Region have varied experience in implementing PHC and have benefited from it, particularly in term of attaining better health status.
- (2) Political commitment, intersectoral collaboration and community involvement are among the key success factors in strengthening health systems and improving the health status of the population.
- (3) The major common issues are:
 - (a) Limited coverage of quality health services.
 - (b) Inadequate health financing.
 - (c) Shortage and inequitable distribution of health workforce.
 - (d) Weak health management, particularly at the district level.
- (4) PHC values and principles (e.g. Health for All and All for Health) are still relevant.
- (5) The approach and basic elements should be revisited to ensure that actions are relevant in the current context and to meet current challenges.

- (6) Priority activities to be strengthened in the PHC services include:
 - (a) Comprehensive preventive – promotive packages.
 - (b) Essential curative package depending on available funds, epidemiology and community requirements.
 - (c) Overall advocacy, information education and communication, orientation to screen and detect early the non-communicable diseases.
- (7) The strategy to address the problem of accessibility and coverage includes:
 - (a) Improving intersectoral convergence with roads and better connectivity.
 - (b) Developing workable outreach initiatives.
 - (c) Improving organization of the health systems.
 - (d) Social security for the poor.

10. Closing session

During the closing session, the Chairman reported briefly on the overall progress and Rapporteur presented the conclusions and recommendations of the Regional Consultation.

The Regional Director for WHO South-East Asia Region, Dr Samlee Plianbangchang, in his address thanked all participants for their efforts towards achieving the objectives of the conclave. He also expressed his gratitude to the Ministry of Public Health of DPR Korea and the WHO country office for their invaluable support. Dr Samlee also commended the Secretariat for its effective and efficient assistance in conducting the consultation. He expressed satisfaction with the conclusions drawn and recommendations made during the course of the consultation and assured WHO's support in the implementation of the recommendations with commitment from Member Countries.

His Excellency Prof. Choe Chang Sik, Minister of Public Health, DPR Korea, expressed his gratitude to the Regional Director, the WHO Country Representative to DPR Korea, and the Chairman of their diligent efforts. He also thanked the participants who shared valuable experiences and

opinions. The consultation, which seemed “productive”, provided a key platform for the accentuation of regional health programmes, he said. Participants had reviewed and shared their experiences in activities to strengthen health systems based on PHC, with emphasis on healthy public policy, decentralization, community involvement and participation of the private sector. The Regional Framework of Strengthening National Health Systems based on the PHC approach would provide guidelines for effective performance of health systems in Member States, he concluded.

Annex 1

List of participants

Bangladesh

Dr Md Shukuruddin Mridha
Director (PHC)
Directorate-General of Health Services
Mohakhali
Dhaka

Dr Mohammad Abdul Matin Patwary
Civil Surgeon
Comilla Hospital
Comilla

DPR Korea

Dr Jang Jun Sang
Deputy Director
Department of Therapeutic and Prevention
Ministry of Public Health
Pyongyang

Dr Jong Chol U
Senior Official
Department of Therapeutic and Prevention
Ministry of Public Health
Pyongyang

Dr Ri Yong Hwa
Director
Institute of Public Health Administration
Ministry of Public Health
Pyongyang

Dr Jon Sang Chol
Official interpreter
Ministry of Public Health
Pyongyang

India

Dr Tarun Seem
Director
National Rural Health Mission
Ministry of Health and Family Welfare
210, D-Wing
Nirman Bhavan
New Delhi 110011
Mobile - +919868844114
Office - 011 23061360
Email - tarunseem@hotmail.com

Indonesia

Dr Siswanto
Head
Division of Programme and Collaboration
Centre for Health Policy and
Systems Research and Development
Jl. Indrapura 17
Surabaya

Dr Suwandi Makmur
Chief
Centre for Research and Development on
Health System and Policy
National Institute of Health Research and
Development (NIHRD)
Ministry of Health
Jakarta

Dr Andi Saguni
Head
Sub-Division of Specific Programme Planning
Bureau of Planning and Budgeting
Ministry of Health
Jakarta

Dr Poppy Jadis
Staff
Directorate of Community Health
Directorate-General of Community Health
Ministry of Health
Jakarta

Maldives

Ms Thasleema Usman
Deputy Director of Nursing
Department of Medical Services
Male

Nepal

Mr Arjun Bahadur Singh
Chief, Policy Planning and International
Cooperation Division
Ministry of Health and Population
Government of Nepal
Ramshahpath
Kathmandu

Dr Mingma G. Sherpa
Focal Point for Curative Division
Ministry of Health and Population
Government of Nepal
Ramshahpath
Kathmandu

Sri Lanka

Dr RMSK Ratnayake
Deputy Provincial Director of
Health Services
Puttalam

UN/Bilaterals/Nongovernmental Organizations

Mr Jean-Pierre de Margerie
Representative Designate
World Food Programme
Pyongyang
DPR Korea

Dr Gopalana Balagopal
Representative Designate
United Nations Children's Fund
(UNICEF)
Pyongyang
DPR Korea

Mr Yu Yu
Head of Office
United Nations Population Fund
(UNFPA)
Pyongyang
DPR Korea

Mr Jaap Timmer
Head of Delegation
International Federation of Red Cross
(IFRC)
Pyongyang
DPR Korea

Mr Thierry Germond
Delegate
International Committee of the Red Cross
(ICRC)
Pyongyang
DPR Korea

Dr Massimo Urbani
Consular Correspondent
Italian Development Cooperation Office
Pyongyang
DPR Korea

WHO Secretariat

Dr Myint Htwe
Director-Programme Management
WHO South-East Asia Regional Office
IP Estate, Ring Road
New Delhi 110002, India

Dr Sultana Khanum
Director, Health Systems Development (HSD)
WHO South-East Asia Regional Office
IP Estate, Ring Road
New Delhi 110002, India
Email: khanums@searo.who.int

Dr Gunawan Setiadi
Regional Adviser, Health Systems
WHO South-East Asia Regional Office
IP Estate, Ring Road
New Delhi 110002, India
Tel : 0091-11-23370804
Fax: 0091-11-2337 9507
Email: setiadig@searo.who.int

Dr Tej Walia
WHO Representative to DPR Korea
Pyongyang

Dr Nagi M. Shafik
Project Manager
Office of the WHO Representative
to DPR Korea
Pyongyang

Ms Choe Suk Hyon
Secretary to WHO Representative
Office of the WHO Representative
to DPR Korea
Pyongyang

Mr U.S. Baweja
Senior Administrative Secretary
WHO South-East Asia Regional Office
IP Estate, Ring Road
New Delhi 110002, India
Tel : 0091-11-23370804
Fax: 0091-11-2337 9507
Email: bawejau@searo.who.int

WHO Country Office Staff

Dr Alex Andjaparidze
WHO Representative to Timor-Leste
Dili
Timor-Leste

Mr Sunil Nandraj
Office of the WHO Representative to India
New Delhi
India

Dr Mohammad Shahjahan
Technical Officer-District Health System
Office of the WHO Representative to Indonesia
Jakarta
Indonesia

Dr Margrata Skold
Office of the WHO Representative to Myanmar
Yangon
Myanmar

Dr Shailesh Kumar Upadhyay
National Professional Officer
Office of the WHO Representative to Nepal
Kathmandu
Nepal
upadhyays@searo.who.int

Dr Somchai Peerapakorn
Office of the WHO Representative to Thailand
Bangkok
Thailand
GPN #24801, Tel +662 590 1524
Fax +662 591 8199
somchai@searo.who.int

Annex 2

Programme

Wednesday, 18 April 2007

- 08:30-09:00 Registration
- 09:00-10:00 Opening session
- Welcome Remarks – *Dr Tej Walia*, WHO Representative to DPR Korea
 - Opening Address – *Dr Samlee Plianbangchang*, Regional Director, WHO South-East Asia Region
 - Inaugural Address – *HE Prof. Dr Choe Chang Sik*, Minister for Public Health, DPR Korea
- 10:30-11:00 Business session
- Introductory remarks – *Dr Sultana Khanum*, Director-Health Systems Development, WHO South-East Asia Regional Office
 - Objectives of the workshop and introduction of participants – *Dr Gunawan Setiadi*, Regional Adviser, Health Systems, WHO South-East Asia Regional Office
 - Nomination of Chair, Co-Chair and Rapporteur
- 11.00-11.30 Plenary 1: Preparing the ground for health system strengthening in South-East Asia
- Preparing the ground for health systems strengthening in South-East Asia – *Dr Sultana Khanum*, Director, Health Systems Development, WHO South-East Asia Regional Office
 - Questions and answers
- 11:30-12:30 Plenary 2: Country presentations by India, Sri Lanka and Timor-Leste
- Theme: Healthy public policy (Intersectoral cooperation)*
- 13:30-14:30 Plenary 3: Country presentations by Bangladesh, Myanmar, DPR Korea
- Theme: Community involvement*
- 14:30-15:10 Country presentations by Indonesia and Nepal
- Theme: Decentralization*

15:40-16:20 Country presentations by Thailand and Maldives

Theme: Working with the non-public sector

16:20- 17:00 Preview of the next day

Thursday, 19 April 2007

09:00-13:00 Field visit

14:00-14:30 Plenary 3: Health System Strengthening based on PHC Approach

- Health Systems Strengthening based on PHC Approach in South-East Asia Region – Dr Sultana Khanum, HSD-WHO/SEARO
- Questions and answers

14:30-15:30 Group work on Strategic Framework on Health Systems Strengthening based on PHC Approach

15:30-17:00 Group work (continued)

Friday, 20 April 2007

9:00-10:30 Plenary 4: Reporting on group work

- Presentations of group work
- Discussions

11:00-13:00 Plenary 4 (continued)

- Presentations of group work
- Discussions

14:00-15:30 Plenary 5: Conclusion, recommendations and closing remarks