Strengthening frontline services for universal health coverage by 2030

Report of the Regional Consultation, 23–25 July 2019, New Delhi, India
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1. Introduction

This consultation was held at a time of unparalleled international commitment to universal health coverage (UHC), but with rising concerns about the pace of progress since the adoption of the 2030 Agenda for Sustainable Development in 2015. Despite encouraging recent progress, projections suggest that, at the current rate, few countries in the South-East Asia Region (SEAR) will reach 80% essential service coverage by 2030. This is where the renewed attention to primary health care (PHC), especially frontline health services, comes in. Well-functioning frontline (primary care) services are part of the solution to accelerating progress towards UHC. They can safely meet the majority of a person’s health needs, whatever their age or health condition, and are also equitable and efficient.

Today, many countries in SEAR recognize the need to strengthen frontline services, and much is happening. However, there is no blueprint on what to do. Common questions are: How can we introduce the new services needed to respond to changing health problems into our existing primary care? What can we do to increase use of frontline services? How can we best manage the required changes? To what extent do new technologies help accelerate progress? Can we afford these changes? Can we afford not to make them? How will we know if the changes are working?

A key objective of this consultation was to discuss the changes needed – or already happening – to strengthen frontline health services in ways that enable more people, especially the vulnerable, to actually receive the health care they need, without incurring financial hardship. The programme (Annex 1) was designed to share experiences, identify strategic priorities and agree on next steps on:

- the organization, management and staffing of frontline health services to accelerate progress towards UHC
- effective strategies to improve health service quality and safety; and
- monitoring trends in the performance of frontline health services.

There were 89 participants from governments, nongovernmental organizations, academia, WHO and other international development partners (Annex 2). All presentations are available at: http://extranet.searo.who.int/meetings/UHC2019/.
2. Concluding key messages

- The world is seeing renewed attention to PHC, but we cannot just do "more of the same". Given the changing health needs the South-East Asia region is facing, all countries recognize that it is now a time for change. The video shown on the first day of the consultation poses the challenge: are we doing the best we can do?
- Countries are not starting from scratch. A lot is now happening in SEAR. The posters and presentations at the consultation are a testament to the range of policies, actions and interventions under implementation across the Region. These offer promising lessons that need to be documented and shared between Member States in country consultations.
- New models of care and improved quality of care will be key. Countries need to be forward-looking and implement changes such as primary care redesign, minimum standards and facility assessments. Health workers need the skills to deliver competent and respectful care in an era of chronic diseases. These efforts need to be part of a whole-of-system approach, with other health systems strengthening efforts reinforcing frontline services improvement.
- Improving the quality and safety of frontline services is essential to strengthen trust. Trust builds gradually, through deliberate engagement with patients, families and communities. Several actions can be taken in addition or differently to 'ignite the change' for cleaner, safer facilities.
- Policies and actions need to be informed by good evidence. Better monitoring is needed as part of routine health information systems, including of quality of care and patient safety.
- Improving data collection and quality is not enough. Countries need to improve their analysis and use to inform implementation and policy (re-)design.
- Political commitment is crucial and is linked to governance and accountability. Stronger civil society and community engagement can help hold governments to account. At the global level, political advocacy is needed to keep PHC high on the agenda.
3. Summary of key issues and discussions

In the opening session, Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, reminded participants about recent global commitments to UHC and PHC, summarized recent gains and highlighted remaining and emerging challenges, especially: inequities in coverage; care fragmentation; inadequate quality and safety of frontline services; the rise of non-communicable diseases, population ageing and urbanization; the need to harness the private sector; and rising public expectations along with weak trust. She urged participants to consider how to better organize, manage and pay for frontline health services and workers to provide life-long care for people with chronic conditions; how to address frontline and hospital services together; how to devise fresh approaches to community engagement; and how best to measure results and increase accountability, keeping a clear focus on reducing health inequities and leaving no-one behind.

In his keynote speech, Dr Vinod Paul noted that countries with strong primary care systems have better health outcomes, lower health care costs and—consequently—improved overall development outcomes. Drawing on examples from the United Kingdom, Sweden, Brazil, Thailand, and India, he emphasized that PHC is the responsibility of the government and requires multisectoral approaches and services delivered close to people and their communities. Operations research can help fill knowledge gaps to support implementation.

Dr David Evans highlighted constraints to timely care-seeking, such as lack of service availability and persistent financial barriers. He noted that out-of-pocket expenditures by households at the time of care-seeking have not significantly reduced in most low- and middle-income countries. Health systems are also still quite under-funded. Recalling Alma Ata, Dr Evans urged countries to build on the past but look forward.

“Last night, how many mothers in how many villages around the world were worried about their sick child, and whether their local health worker would be there and able to treat their child?” — David Evans

3.1 changing models of care for today’s health needs

Key issues

The magnitude and inequities of existing health service coverage gaps threaten the achievement of UHC by 2030. Better primary care services hold part of the solution to accelerating progress towards UHC. Commitment to PHC in the Region has been sustained, but progress has not been smooth. The rise in chronic health conditions and population ageing have led to a growing need for greater continuity of care over time and across levels of care. There are increasing calls for people to receive more ‘integrated’ and person-centred care. From the users’ perspective, integrated care provides services that are not disjointed and can be easily navigated. Person-centred care includes getting people to play a more active role in their own well-being.
In plenary and parallel sessions, participants discussed what needs to be done differently to make greater progress in delivering good quality primary care services to all those that need them, regardless of their age or health condition.

In plenary discussions, examples of experiences from India, Indonesia and Sri Lanka highlighted ongoing PHC reforms and shifts from the MDG agenda, largely maternal and child health (MCH), to the SDG agenda. Countries shared their current range of approaches to organizing, staffing, managing and paying for frontline services, and how they are re-examining and adjusting existing models (i.e., publicly-financed frontline services with a focus on MCH) in the context of ongoing rapid epidemiological and demographic changes. Critical challenges include: empaneling the catchment population; ensuring a continuum of care; implementing effective referral/gatekeeping; developing an adequately skilled and competent health workforce; leveraging information systems, medicines and diagnostics; increasing community and multisectoral participation; and linking to broader health system reform efforts.

A first set of parallel sessions (Box 1) discussed health systems issues such as: using essential health service packages to introduce new models of care; adapting the frontline health workforce to new models of care; improving access to quality care through purchasing and provider payment systems for primary care; and including traditional medicine in frontline services.

**Box 1. Changing models of care for today’s health needs—health system dimensions: country experiences**

*Using essential health service packages to introduce new models of care*

- **Thailand** costed health benefit packages were introduced as part of the universal health coverage reform in 2002 to pay providers through capitation and DRGs.
- **Sri Lanka’s** essential service package, developed as part of PHC reorganization, is to be implemented through a new functional unit, the shared care cluster.
- **India** has defined a comprehensive service package and standards within its primary health care reform to upgrade primary health centres into health and wellness centres.
- **Nepal** has developed a basic health care package as a constitutional mandate, to be implemented within the context of a “federalism” process. In **Timor-Leste**, the essential service package is limited to the PHC level. In these countries, as well as **Bangladesh**, implementation of these packages is yet to begin.

*Adapting frontline health workforce to new models of care*

- **India** is reforming its PHC workforce planning to appropriately staff health and wellness centres.
- In **Myanmar**, public health supervisors support midwives to deliver health promotion and NCD prevention services.
- **Sri Lanka** plans to conduct a health workforce needs assessment based on the disease burden to inform frontline health workforce planning in response to NCDs.
To respond to NCDs, **Thailand** has strengthened public trust in the last two decades through improved service availability, improved capacities and skill mix of frontline health workers, and strengthened community and civil society participation.

**Bangladesh** has assessed staffing needs using WHO’s workload indicators of staffing needs tool to respond to shortages, uses a biometric attendance system to address absenteeism, and is assessing gaps in the medical curriculum with regard to NDCs and ageing.

Given its dispersed population, **Bhutan** engages communities in frontline health infrastructure building and health workforce planning through a bottom-up process.

**Increasing access to quality care through purchasing and provider payment systems for primary care**

Performance-based financial incentives are used as part of PHC reforms to incentivize care providers as well as facilities in **India**; as part of the total capitation amount in **Indonesia**, and as an add-on to the total payment in **India** and **Thailand**.

To assess performance, **India** uses output, outcome and process indicators, while **Indonesia** has adopted a fewer number (three) of more simple and targeted indicators for ease of monitoring.

**Including traditional medicine in frontline services**

Traditional medicine is officially recognized and incorporated into health care provision in the **Republic of Korea** based on independent traditional medicine policy, education, delivery and licensing systems. National health insurance coverage makes traditional medicine services more accessible and affordable to all. Evidence suggests that integrating traditional and Western medicine significantly decreases mortality among stroke patients compared to Western medicine-only patients.

In **India**, health services will be provided through traditional medicine systems in 12,500 health and wellness centres.

**Thailand** uses a digital application for real-time monitoring of traditional medicine services in out-patient and in-patient settings, including diagnosis and treatment, herbal medicine prescriptions, manual therapies, health promotion activities, and share of traditional medicine in all services.

Examples from **Thailand, Republic of Korea** and **India** reveal common challenges, including: aligning human resources between traditional and allopathic medicine, understanding patient demand and use of services and medicines, as well as broader integration and alignment issues, including cross-referral, within the existing health system.

A second set of parallel sessions (Box 2) discussed health programme dimensions such as: adapting frontline services for people needing continuing/life-long care—experience from NCDs; new developments in community-based care: lessons from communicable diseases; and priorities in preparing frontline services to better cope with emergencies.

In plenary sessions, participants discussed how to harness the power of new technologies at scale (Box 2), strengthen the role of hospitals in primary care, and manage the process and politics of change. In a Helpdesk session at the end of the second day, country participants sought one-on-one advice from resource persons on solutions to specific policy implementation bottlenecks (see Annex for a summary of topics discussed).
Adapting frontline services for people needing continuing/life-long care: experience from NCDs

- Although the health service delivery system in the Maldives currently has weak capacity for NCD care, the country has developed an NCD action plan and training of community health workers in the WHO package of essential NCD interventions for primary health care (PEN). It plans to consolidate the 4-tiered system under one platform with central level monitoring control.

- Bhutan began piloting PEN implementation in two districts in 2019. Hospitals collaborate with primary health care centres for clinical mentoring and supervision through a mobile application. Its people-centred care also includes team-based approaches, as well as strengthened information management, patient recall and follow-up and referrals.

New developments in community-based care

- Nepal is using the services of female community health volunteers to bridge health workforce shortages. The volunteers receive 18 days’ training on national health programmes before working in communities.

- Timor-Leste provides comprehensive primary care services at community and municipality levels through mobile outreach medical teams under the Saude na Familia programme. Over 97% of families have received at least one visit for ante-natal care, health education and referral.

- To address the high work burden in community health clinics, Bangladesh has trained about 9000 multipurpose health volunteers, selected from the local communities, to conduct health education in community group meetings as well as door-to-door visits on MCH, immunization and communicable diseases in selected pilot districts.

Harnessing the power of new technologies at scale

- Bhutan and the Democratic People’s Republic of Korea are using telemedicine to connect providers across health facilities.

- India uses about 30 mobile applications to report, monitor and evaluate frontline services. It has recently developed a National Digital Health Blueprint.

- Myanmar is using mobile tablets to build health workforce capacity and provide decision support, with initial focus on communicable diseases.

- WHO’s MedMon application has been piloted in Sri Lanka and Cox’s Bazar, Bangladesh, to monitor medicines’ prices and availability in a sustainable, cost-effective and timely manner.

- The Vihaan eMpower solution has significantly improved HIV testing, tuberculosis screening and treatment adherence among people living with HIV/AIDS in India. Under the BeHealthy BeMobile initiative, 19% of a sample of users of the mTobaccoCessation in India reported having quit smoking and users of the mDiabetes improved their diet and increased their physical activity and screening for diabetes.
The changing role of hospitals in primary care

- Hospitals cannot work in isolation. A paradigm shift is needed from hospitals being technocratic and relatively isolated institutions to becoming people- and community-centered—as part of a social and medical system that provides complete health care.

- Bhutan has expanded its hospital services to include prevention, promotion and rehabilitation, through health education, attending referrals, specialist support and outreach. Hospital doctors provide clinical mentoring and supervision. Specialist teams from referral hospitals conduct district outreach.

- In Sri Lanka, a middle-level cadre in secondary facilities with appropriate skill mix identifies and treats people with mental illness. Community psychiatric teams in primary health care centres provide follow up treatment. Guidelines clarify the responsibilities by level to ensure the continuum of care. Outreach ambulance services provide emergency care in the community.

“Don’t make use of excellent technology, make excellent use of technology.” — Sonalini Khetrapal

Conclusions and next steps

- The concepts of person-centered and integrated care are relevant in SEAR today. There is no single design or blueprint for strengthened frontline services, but many useful tools are available, and much wisdom exists in Member States across the Region. Countries need to continue to share their experiences on ongoing reforms.

- An essential service package can be a tool to facilitate change but cannot stand alone. Similarly, new provider payment mechanisms alone will not deliver more integrated care, but bundled and blended approaches can be used to nudge the system. It is important to link changes in service delivery models to policies and actions on frontline human resources for health, medicines, and financing. Digital solutions can be usefully deployed across a range of functions, including prevention, treatment, training, management and monitoring, but they must be appropriate for the objective. Technology changes rapidly and can be intimidating; guidance is needed to support its introduction.

- To strengthen frontline services to respond to current and emerging population health needs, health workers need to learn new public health and clinical competencies and perform new roles, e.g., how to be people-centered, work in teams, and encourage people to become more proactive in their own health care. The role of primary care providers needs to be reframed in positive terms, as care coordinators rather than gatekeepers. Retaining health providers in rural areas is also critical. Recruiting health workers from underserved populations may be a worthwhile strategy. Nurses, midwives and community health workers are untapped and relatively neglected cadres of the health workforce.
Hospitals and primary care services cannot work in isolation from each other. Countries need to strengthen the relationship between them to achieve UHC. Ways to get these service levels to work together include: reorganizing (vertical integration) and carrot and stick approaches (aligning incentives and introducing regulations). Strengthening the hospital-frontline services relationship also entails changing mindsets and missions. Staff are among the greatest resources and can be harnessed to this end.

Traditional medicine has been a part of PHC since Alma Ata and this Region has particularly strong experience in this area. There is a need to better understand how to integrate traditional medicine with western medicine and monitor what is working in light of patients’ needs to inform decision-making.

Being points of first contact, frontline health services are readily mobilizable in the acute phase of emergencies. Frontline health workers are key members of rapid response teams in remote and hard-to-reach areas. Strong advocacy, stewardship and investment are needed to in emergency preparedness based on risk, hazards and vulnerability mapping of health facilities (frontline health services to tertiary care levels) as well as risk-informed and context-specific capacity building of frontline health workers.

Various transitions are needed in frontline services to respond to today’s health needs. Managing these transitions often entails changing mindsets more than technocratic solutions. Policy-makers need to tackle the politics of implementing change, managing the many vested interests that may be involved. Leadership is key and enables other stakeholders to play their part. Working from and building on current reality, keeping the objectives in mind, can ensure effective translation of the vision into reality.

3.2 Improving quality and safety

Key issues

Improving access to poor quality health services is wasteful as well as unethical. Nevertheless, poor quality care remains common, especially in low- and middle-income countries. Disadvantaged groups are particularly affected.

Quality health services cannot be delivered without some basics being available, such as clean water, adequate sanitation, essential equipment, health workers and medicines. Although data are limited, information from a few SEAR countries shows significant variations and gaps in the availability of basic amenities in frontline health facilities. The overall availability of health workers (doctors, nurses, midwives) has improved in almost all SEAR countries in recent years, although little is known about some important cadres of frontline health workers. Most SEAR countries still face challenges in recruiting and retaining health workers in rural areas, where frontline services tend to be more accessible than hospitals. Continuity of care (one dimension of quality), as roughly represented by coverage for conditions needing repeated contact with the health system, varies widely across countries, with rates
of four antenatal care visits ranging from 94% in Democratic People’s Republic of Korea to 31% in Bangladesh and estimated screening rates for hypertension ranging from 55.3% in Thailand to 6.5% in Timor-Leste. Limited data from case studies of antibiotic use in SEAR show an inappropriately high percentage of upper respiratory tract infections being treated with an antibiotic.

Most SEAR Member States have long had strategies to improve quality and safety, but challenges remain. Many interventions are implemented by specific programmes. To date, frontline services quality appears to have received less attention than hospital quality. Experts at an informal consultation held in early 2019 suggested that there remains a need to get back to some real basics on quality and safety in the Region, especially for frontline facilities, with water, sanitation and hygiene as well as basic infection prevention and control (IPC) interventions being key entry points. The experts recommended identifying more synergies between programme-specific activities, to scale up and sustain their benefits. They also suggested raising awareness and creating a sense of urgency for improved health care quality and safety, especially at the frontline.

In a plenary session featuring country examples and expert panelists, participants discussed regional issues and challenges in improving health care quality and safety and shared effective approaches in the context of SEAR countries (Box 3).

**Box 3. Cleaner, safer frontline health facilities: how to accelerate progress—country experiences**

- Alongside policy initiatives including setting up a total quality management unit (2009), accreditation of women-friendly hospitals (2011) and establishment of a quality improvement system (2016), Bangladesh introduced the principles of Kaizen total quality management in 3 district hospitals on 2011, focusing on infection prevention and control, waste management and cleanliness through a peer learning approach and online reporting through DHIS2. The proportion of moderately good facilities rose from 53 to 68% and those assesses as good from 4 to 15%. The country now aims to strengthen service quality standards and improve patient responsiveness and health worker motivation and competence.

- In the last 5 years, Sri Lanka has introduced several system improvements including work improvement teams, suggestions schemes, total productive maintenance, mistake-proofing, improving efficiency and reducing waste. Quality and safety units have been set up in all district hospitals and quality management units in all secondary and tertiary hospitals. Several low-cost interventions have been introduced including visual control, identification tags, checklists and work instructions. These actions have resulted in reduced infection rates and medical errors and fewer preventable deaths. Future plans include creating a positive patient safety culture and strengthening adverse event reporting.

- Under Thailand’s 2016 2-P (patients and personnel) Safety Goal Policy, implementation strategy (2017), and goals (2018), almost 52% of hospitals have achieved the status of 5-stars health promoting hospitals, nearly 48% of health ministry hospitals have achieved “very good” status as green and clean hospitals. A key future priority is to strengthen adverse event reporting.
In a world café format, participants then generated ideas about what can be done differently to ensure that more facilities have the basics in place and on health workforce and management and policy for accelerated progress, as well as suggestions on a draft SEAR progress dashboard for cleaner, safer health facilities (Box 4).

**Box 4. Cleaner, safer frontline health facilities: getting the basics right, igniting change—key ideas**

What can we do differently to ensure that more facilities have the basics in place for cleaner, safer care?

- Ensure the essentials: Ensure adequate sanitation and water and power supply through multisectoral collaboration. Promote community engagement in demanding the essentials. Advocate with parliamentarians. Supply protective equipment to cleaners.
- Define clear standards for basics in frontline facilities, using tools such as Service Availability and Readiness Assessments as a reference, and disseminate these to all stakeholders. Use legislative support to enforce standards.
- Strengthen management, monitoring and supervision: Train frontline facility managers. Introduce accreditation systems based on standards for basics. Systematically report adverse events.
- Improve health facility resilience: Sterilize medical equipment to prevent infections. Ensure essential water and power supply to respond to emergencies. Implement health infrastructure standards to protect facilities from earthquakes, fires or floods.

What can we do differently on health workforce and management and policy to accelerate progress towards cleaner, safer health facilities?

- Policy and management essentials
  - Develop national policy in line with international standards. Ensure applicability of standards to private sector facilities. Use accreditation systems to strengthen quality.
  - Monitor and evaluate facilities against defined key quality- and safety-related performance indicators, benchmarks or targets, preferably through regular reporting systems such as DHIS2.
  - Award (including financially) facilities and health workers for optimal performance and implement disincentives for non-performance.
  - Set up patient committees and hospital quality management committees.
  - Engage communities in planning to strengthen demand and ownership and in feedback to strengthen accountability.
  - Document and widely share good practices.
- Health workforce essentials
  - Build health workers’ capacity, including of cleaners, through pre- and in-service training. Strengthen social competencies, including effective communication.
  - Develop job descriptions with clear roles and responsibilities for all staff.
  - Foster a safety culture through team-based approaches, peer learning and supportive supervision.
What are some features and uses of a SEAR progress dashboard for cleaner, safer health facilities?

- A dashboard is potentially useful to raise awareness among policy-makers and as a standardized way for countries to track progress. Use it in reporting to and discussions at the Regional Committee.
- The dashboard structure is appropriate. The third component may be re-titled "effective services". Having a core list of indicators is useful despite the variable frequency and availability of information.
- A section containing indicator explanations/definitions is needed.

“Do not call it a health care facility if there is no WASH.” — David Sutherland

Conclusions and next steps

- There is a real need for change, since improved coverage has not reduced mortality as fast as expected. Improving the quality and safety of frontline services still gets less attention than improving hospital quality and safety. Many frontline services still lack the basics.
- Countries have undertaken many initiatives, which often use similar principles. There is considerable potential for synergies between initiatives.
- Data on frontline service quality and safety are quite scarce in the Region. Simple indicators are needed that are derived from surveys and linked to impact.
- Improving the quality and safety of frontline services is essential to strengthen trust. Trust builds gradually, through deliberate engagement with patients, families and communities.
- Several actions can be taken in addition or differently to ‘ignite the change’ for cleaner, safer facilities. These include:
  - Finding champions and generating a demand from the public: creating a culture rather than a programme.
  - Developing effective advocacy tools, such as the dashboard presented at the consultation, which is worth developing further.
  - Supporting health workers, especially nurses and cleaners. To strengthen their capacity, there is a need to change curricula; include skill development on quality and safety in their continuing professional development; and create a learning culture, complemented by a supportive environment.
  - Promoting accountability, including by setting up mechanisms such as a responsible national focal point or unit in the Ministry of Health
  - Advocating the issue of improved health service quality and safety in major regional events with health ministers.
3.3 Monitoring performance; accelerating progress

Key issues

Without good information, decision-makers cannot know whether their policies and strategies are making a difference. Recent years have seen real momentum in SEAR on monitoring UHC – both service coverage and financial protection. Monitoring service quality, equity and accountability for progress are beginning to get more attention, including through the SDGs. Fewer and better metrics are needed that can capture effective coverage, competent care processes, confidence in health systems and quality impacts. The private sector, where many seek care, needs to be included – a challenge for all monitoring exercises.

Under this thematic focus, participants considered questions such as: Are we doing better in detecting trends in who is getting access to care, and in identifying whether the poor and other vulnerable groups are being reached? What additional steps can be taken to improve measurement of performance and accountability for progress on frontline services for UHC? What is the experience in SEAR with using data to raise awareness and stimulate policy debate about reaching those being left behind? How can better data be used in countries to drive improvements? Country experiences from Bangladesh, Maldives and Nepal and some measurement frameworks were discussed (Box 5).

Box 5. Monitoring and communicating progress and performance: country experiences

- In Bangladesh, data from public health facilities are reported through DHIS2, HRIS and biometric attendance and analyzed to guide resource allocation and health workforce deployment. A dashboard that includes indicators on access and quality monitors facility performance; results are communicated to sub-districts through videoconference. Future plans include data quality review, alignment of DHIS2 with SDGs, digital health strategy development and coordination between public and private sectors.

- The Maldives monitors all private and public health facilities according to the national health care quality standards. Key indicators include staff competence, patient satisfaction, diagnostic process, record and data management, and referrals. In future, the government intends to strengthen quality and safety monitoring, including patient experience and adverse events, to inform corrective actions.

- Nepal's monitoring systems include the health management information system, supervision, clinical audits, minimum service standard scoring and maternal and perinatal death reviews. Monthly multi-stakeholder progress and performance reviews are conducted across levels. In future, Nepal will expand online monitoring and strengthen data analysis.

- Equity-focused monitoring and closing equity gaps involves community engagement, appropriate tools locally adapted from global standards, adequate capacity for uptake, and attention to political economy. For example, a WHO-supported report on the state of health inequality in Indonesia included a public health development index that made data locally meaningful. A health SDG monitoring framework developed in Kerala, India built on and added value to existing processes. Patient experience research on health-seeking in homeless communities in Delhi, India, learned from community members as experts.
Tools such as the Primary Health Care Performance Initiative, developed by WHO and partners, offer ideas on measuring focused on outcomes to inform decisions to improve performance. Sri Lanka and Nepal are PHCPI trailblazer countries. Domains of PHC-IMPACT, developed by WHO’s Regional Office for Europe measure primary care capacity, performance and outcomes, incorporating today’s health issues, such as NCDs, and health system outcomes such as quality, equity and efficiency.

“We should see what indicators are showing... and hiding!” — Devaki Nambiar

Conclusions and next steps

- Policies and actions need to be informed by good evidence. To know whether strategies are working, countries need to track whether performance is improving or not, focusing on results, not just inputs or processes.
- Improving data collection and quality is not enough. Countries need to improve their analysis and use to inform implementation and policy (re-)design.
- An equity focus is critical when monitoring progress and taking steps to accelerate progress towards UHC. All Member States have committed to leaving no-one behind, as part of the SDG process.
- Indicators and data remain a challenge at primary care level. Any new actions in countries must recognize and build on existing monitoring processes.
- Countries in the Region can consider various new ideas, tools and frameworks for possible adaptation and use.
- Comparisons through dashboards, within and between countries, are useful.
- Political commitment is crucial and is linked to governance and accountability. Stronger civil society and community engagement can help hold governments to account. At the global level, political advocacy is needed to keep PHC high on the agenda.
4. Concluding remarks on discussions and next steps

In a plenary session on making transitions and accelerating progress, the WHO draft operational framework on PHC was presented. The framework consists of four governance, policy and finance levers and 10 operational levers for action. A global Member States consultation process is ongoing and will inform finalization and submission of the framework to the 2020 World Health Assembly.

Thereafter, a panel of Member State representatives, resource persons and partners identified emerging priorities and reflected of future actions to implement the changes to frontline services needed to achieve UHC by 2030. Panellists agreed that a primary health care system for today and tomorrow must offer service integration and care continuity, especially for chronic conditions. This entails a redesign of service delivery models, improving trust in primary care services through improved quality and safety, changes in the role of hospitals within a more integrated system, and mindset and culture changes.

In a final session to bring together ideas from the consultation and agree on strategic priorities and next steps, participants worked in small groups to generate ideas on the most important changes needed and actions to implement on returning to their countries.

Participants agreed that discussions at the consultation were practical and focused on implementation. As next steps, participants agreed to:

- On return to countries, **function as change agents** to strengthen frontline services, building on the current situation. Feed the recommendations from the consultation into other discussions.

- **Accelerate improvements in regional evidence on strengthening frontline services**: scale-up real-time documentation of the design, implementation and results of new frontline service delivery models being implemented in the Region and the lessons they hold for others, including on reducing inequities. Share good practices, including of cross-country experience with new reforms to date and integrating traditional medicine into frontline services. For continued peer learning, participants set up a problem-solving network (e.g., a WhatsApp group) to discuss issues and share solutions.

- Create a social movement and **ignite demand for cleaner, safer health facilities** among parliamentarians and the general public, as well as health workers and managers. Set a mid-decade target/s for the Region. Communicate status and progress on cleaner, safer health facilities with a dashboard, revised in line with suggestions made at the consultation, and share at Regional Committees as part of WHO’s annual report on progress on UHC and the SDGs.

- **Strengthen** the skills and **competencies of all health workers**, through greater attention to quality and safety in pre-service training and continuing professional development, including for nurses and cleaners, who play an especially key role in ensuring cleaner and safer health facilities.
- Put in place **accountability mechanisms**, locally as well as at national and provincial levels.

- **Support** facility and district/provincial **management capacity development** (in areas such as human resources for health, financial and support system management), including through regional courses, networks, cross-country learning and more cross-programme and inter-agency collaboration.

- **Implement fresh approaches to community engagement.** Foster a culture of engagement with patients and their families and communities as partners for action, not just as passive recipients of services. Get youth as well as more experienced stakeholders on board, as it is their future at stake.

- **Overcome silos (when it matters),** especially with regard to the relationship between PHC and hospitals. The need to link these levels of care is well recognized but less successfully addressed. New approaches are needed to foster better links between PHC and hospitals.

- Convene a small initial expert brainstorming meeting to work on how to **improve monitoring the performance of frontline services** and present their recommendations subsequently to all Member States in a larger meeting.
# Annex 1: Programme

## Tuesday 23 July 2019

### Theme 1: Changing models of care for today’s health needs

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<td>0900–1030</td>
<td><strong>Opening session. Where are we now?</strong></td>
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<tr>
<td></td>
<td>Chair: Mr Mohamed Zuhair, Minister of State for Health, Maldives</td>
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<td>Facilitator: Ms Kaveri Mukherji</td>
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<td>Welcome: Dr Manisha Shridhar, a/Director Health Systems Development, WHO/SEARO</td>
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<td>Developments in thinking about UHC and PHC since 2010: Dr David Evans, former Director, Health Systems Financing, WHO/Geneva</td>
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<td>Keynote: Learning from primary care country models to inform frontline service reform: the case of India: Dr Vinod Paul, Member, NITI Aayog, India</td>
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<td>Opening address: Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia</td>
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<td>Status of frontline services in SEAR, consultation objectives and agenda: Ms Anjana Bhushan, Regional Advisor, Service Delivery Systems, WHO/SEARO</td>
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<td>My expectations from this meeting: Mr Mohamed Zuhair, Minister of State for Health, Maldives and session Chair</td>
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<td></td>
<td>Introductions: Dr Tomas Zapata, Regional Advisor, Human Resources for Health, WHO/SEARO</td>
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<td>Group photo</td>
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<tr>
<td>1100–1300</td>
<td><strong>Session 1.1. Changing models of care for today’s health needs: towards more integrated and person-centred care</strong></td>
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<td>Chair: Mr Mohamed Zuhair, Minister of State for Health, Maldives</td>
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<td></td>
<td>Health system gaps in addressing NCDs: Video</td>
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<td></td>
<td>Person-centred and integrated care: Moderated discussion of issues arising from video—Dr Phyllida Travis, former Director, Health Systems Development, WHO/SEARO</td>
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<td>Country perspectives:</td>
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<td>Discussants:</td>
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<td>— Dr Xavier Modol, Independent expert</td>
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<td>— Dr Somsak Chunharas, Secretary-General, National Health Foundation, Thailand</td>
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<td>— Dr Ajay Tandon, Lead Economist, World Bank</td>
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<td>Discussions</td>
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<td></td>
<td>Summary: Dr Viroj Tangcharoensathien, Senior Adviser, International Health Policy Programme, Ministry of Public Health, Thailand</td>
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<tr>
<td>1400–1500</td>
<td><strong>Session 1.2. Changing models of care for today’s health needs – health systems dimensions: parallel sessions I</strong></td>
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<tr>
<td></td>
<td>1.2.1 Can essential health service packages help introduce new models of care? (Royal Ballroom)</td>
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<td>1.2.2 Adapting the frontline health workforce to new models of care (Breakout space A)</td>
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<td>1.2.3 Purchasing and provider payment systems for primary care: can they increase access to quality care (Breakout space B)</td>
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<td>1.2.4 Including traditional medicine in frontline services: opportunities and challenges (Heritage Suite)</td>
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<tr>
<td>1500–1600</td>
<td><strong>Session 1.3. Changing models of care for today’s health needs – programme dimensions: parallel sessions II</strong></td>
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<tr>
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<td>1.3.1 Adapting frontline services for people needing continuing/life-long care: experience from NCDs (Royal Ballroom)</td>
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<td>1.3.2 New developments in community-based care: lessons from communicable diseases (Breakout space A)</td>
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<td>1.3.3 Preparing frontline services to better cope with emergencies: what are the priorities? (Breakout space B)</td>
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<tr>
<td>Time</td>
<td>Session 1.4. Changing models of care: managing change</td>
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<td>1630–1730</td>
<td>Chair: Dr Henk Bekedam, WHO Representative, India</td>
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<td>- Experience of an ongoing reform: PHC reorganization in Sri Lanka: Dr Palitha Abeykoon, Chair, National Authority on Tobacco and Alcohol, Sri Lanka</td>
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<td>- The role of civil society in pushing changes—how Thailand stimulated it: Dr Somsak Chunharas, Secretary-General, National Health Foundation, Thailand</td>
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<td>- Change management in India’s primary health care reform: Dr Rajani Ved, Executive Director, National Health Systems Resource Centre, India</td>
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<td>- Discussions and summary</td>
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**Wednesday 24 July 2019**  
**Theme 2: Improving quality and safety**

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<tr>
<th>Time</th>
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<tr>
<td>0900–1030</td>
<td><strong>Session 1.5. Harnessing the power of new technologies at scale</strong></td>
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<td>Chair: Ms Shamima Nasrin, Deputy Secretary, Health Services Division, Ministry of Health and Family Welfare, Bangladesh</td>
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<td>Moderator: Dr Oommen John, The George Institute, India</td>
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<td></td>
<td>- Country perspectives on past experiences, future plans:</td>
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<td>- Bhutan</td>
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<td>- Democratic People’s Republic of Korea</td>
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<td>- Myanmar</td>
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<td>- Promising solutions:</td>
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<td>- BeHealthy BeMobile—mHealth for NCD prevention: Dr Jagdish Kaur, Regional Advisor, Tobacco-Free Initiative, WHO/SEARO</td>
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<td>- MedMon—WHO essential medicines and health products price and availability monitoring mobile application: Dr Klara Tisocki, Regional Advisor, Essential Medicines and Drugs, WHO/SEARO</td>
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<td>- Digital health tools for community monitoring of HIV and adherence to treatment for TB: Dr Vineet Bhatia, Medical Officer, MDR-TB, WHO/SEARO</td>
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<td>- Technology-enabled frontline health workers: Dr Ramanan Laxminarayan, Senior Research Scholar, Princeton University</td>
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<td>- How ADB supports digital health: Discussant: Dr Sonalini Khetrapal, Social Sector Specialist, South Asia Region Department, Asian Development Bank</td>
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<td>- Discussions: Taking solutions to scale—priorities and actions; summary</td>
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<tr>
<th>Time</th>
<th>Session 2.1. Cleaner, safer frontline health facilities: how to accelerate progress?</th>
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<tr>
<td>1100–1300</td>
<td>Chair: Dr Palitha Abeykoon, Chair, National Authority on Tobacco and Alcohol, Sri Lanka</td>
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<td>- Thinking differently about quality and safety—time for a revolution: Dr Phyllida Travis, former Director, Health Systems Development, WHO/SEARO</td>
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<td>- Country perspectives:</td>
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<td>- Discussants:</td>
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<td>- Dr Elizabeth Mason, former Director, Maternal, Newborn, Child and Adolescent Health, WHO Geneva</td>
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<td>- Dr David Sutherland, Consultant, Health Emergency Programme, WHO/SEARO</td>
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<td>- Professor Dr Akmal Taher, Special Adviser to the Minister on Healthcare Strengthening, Indonesia</td>
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<td>- Dr Viroj Tangcharoensathien, Senior Adviser, International Health Policy Programme, Ministry of Public Health, Thailand</td>
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<tr>
<td></td>
<td>- Moderated discussions and summary: Dr Phyllida Travis, former Director, Health Systems Development, WHO/SEARO</td>
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### Session 2.2. Cleaner, safer frontline health facilities: getting the basics right, igniting change

Chair: Dr Palitha Abeykoon, Chair, National Authority on Tobacco and Alcohol, Sri Lanka

- **World Café:**
  1. What can we do differently to ensure that more facilities have the basics in place for cleaner, safer care?
    - Dr David Sutherland, Consultant, Health Emergency Programme, WHO/SEARO
    - Dr Rajesh Mehta, Regional Advisor, Newborn, Child and Adolescent Health, WHO/SEARO
  2. What can we do differently on health workforce and management and policy to accelerate progress towards cleaner, safer health facilities?
    - Dr Tomas Zapata, Regional Advisor, Human Resources for Health, WHO/SEARO
    - Dr Viroj Tangcharoensathien, Senior Adviser, International Health Policy Programme, Ministry of Public Health, Thailand
  3. What are some features and uses of a SEAR progress dashboard for cleaner, safer health facilities?
    - Dr Phyllida Travis, former Director, Health Systems Development, WHO/SEARO
    - Dr Elizabeth Mason, former Director, Maternal, Newborn, Child and Adolescent Health, WHO Geneva

- **How to build:**
  - Stronger synergies across programmes/initiatives?
  - A social movement for cleaner, safer health facilities and ignite change?

- **Moderated plenary discussion—Dr Elizabeth Mason, former Director, Maternal, Newborn, Child and Adolescent Health, WHO Geneva**

### 1600–1730 Helpdesk (discussions between countries and experts)

Country participants seek one-on-one advice from up to 2 experts/resource persons each on solutions to specific implementation bottlenecks

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### Thursday 25 July 2019

**Theme 3: Monitoring performance; Accelerating progress**

<table>
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<tr>
<th>Time</th>
<th>Session 3.1. The changing role of hospitals in primary care</th>
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<tr>
<td>0845–0900</td>
<td>Recap of Day 2</td>
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<tr>
<td>0900–1015</td>
<td><strong>Session 3.1. The changing role of hospitals in primary care</strong></td>
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Chair: Mr Horacio Fernandes Ribeiro, Head, Department of Human Resources Provision, Ministry of Health, Timor-Leste

- **Synergies and complementarities between hospitals and frontline services: moderated “fishbowl” activity**
  - Why do hospitals matter to PHC? Why does PHC matter for hospitals?
  - What are the risks of competition between “levels” of care?
- **Country perspectives:**
  - Bhutan
  - Sri Lanka
- **Discussants:**
  - Professor Gabriel Leung, Dean, Li Ka Shing Faculty of Medicine, University of Hong Kong
  - Dr Rajani Ved, Executive Director, National Health Systems Resource Centre, India
- **How to break down the silos?: Moderated discussions—Dr Ann-Lise Guisset, Technical Officer, Services Organization and Clinical Interventions, WHO/Geneva**
- **Framework on role of hospitals in PHC: Dr Ann-Lise Guisset**
1045–1245

Session 3.2. Monitoring and communicating progress and performance
Chair: Professor Dr Akmal Taher, Special Adviser to the Minister on Healthcare Strengthening, Indonesia

Keynote: Who is still being left behind and why?: Professor Gita Sen, Director & Distinguished Professor, Ramalingaswami Centre on Equity & Social Determinants of Health, Public Health Foundation of India

Country perspectives:
- Bangladesh
- Maldives
- Nepal

How do we know we’re making progress, closing equity gaps?: Dr Devaki Nambiar, Programme Head, Health Systems and Equity, The George Institute of Global Health, India

Learning from experience using the European PHC IMPAC-Tool: Dr Ioana Kruse, Consultant, Health Service Delivery, WHO European Centre for Primary Health Care

What is the PHCPI framework and its indicators and how can it be used? Dr Ann-Lise Guisset, Technical Officer, Services Organization and Clinical Interventions, WHO/Geneva

Discussant: Mr Stefan Nachuk, Country Lead, Health Systems Design, Bill and Melinda Gates Foundation, India

Discussions and summary

1330–1500

Session 4. Making transitions, accelerating progress: emerging priorities
Co-Chairs:
Dr Viroj Tangcharoensathien, Senior Adviser, International Health Policy Programme, Ministry of Public Health, Thailand
Dr Phyllida Travis, former Director, Health Systems Development, WHO/SEARO

WHO’s operational framework for PHC: Dr Ann-Lise Guisset, Technical Officer, Services Organization and Clinical Interventions, WHO/Geneva

Reflections on key messages emerging from the consultation: panel discussion:
- Professor Dr Akmal Taher, Special Adviser to the Minister on Healthcare Strengthening, Indonesia
- Dr Palitha Abeykoon, Chair, National Authority on Tobacco and Alcohol, Sri Lanka
- Dr Elizabeth Mason, former Director, Maternal, Newborn, Child and Adolescent Health, WHO Geneva
- Dr Paul Rutter, Regional Health Advisor, Unicef Regional Office for South Asia

Group work: Member States work in three groups to identify ideas and actions on:
- What are the 2-3 most important national level changes needed on:
  - changing the models of care to respond to today’s health needs?
  - improving quality and safety?
  - monitoring performance and accelerating progress?
- What are the 2 most important things for you to do first on returning home to your country?
- What should WHO and other development partners do, do differently?

1530–1630

Session 5. Bringing it together: strategic priorities and next steps
Co-Chairs:
Dr Viroj Tangcharoensathien, Senior Adviser, International Health Policy Programme, Ministry of Public Health, Thailand
Dr Phyllida Travis, former Director, Health Systems Development, WHO/SEARO

Selecting priorities, managing change: facilitated discussion, on:
- What are the most important changes needed?
- What are the most important things to do on returning home?

Conclusions and recommendations: Ms Anjana Bhushan

Closing: Dr Manisha Shridhar
Annex 2: List of participants

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Annex 3: Country posters

### Bangladesh

<table>
<thead>
<tr>
<th>Population (000s)</th>
<th>Urban population</th>
<th>Poverty ≤ $1.90 a day</th>
<th>GCP per capita</th>
<th>Current US$</th>
<th>Current Health Expenditure as share of GDP</th>
<th>OPH per person per year</th>
<th>OPH distribution</th>
<th>Health workers doctor, nurse, midwife</th>
<th>Children in public sector</th>
<th>Hypertension undiagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>166,368</td>
<td>35.9%</td>
<td>18.5%</td>
<td>1516.5</td>
<td>3.0%</td>
<td>0.90</td>
<td>2.45</td>
<td>8.3 / 10000</td>
<td>20%</td>
<td>54%</td>
<td></td>
</tr>
</tbody>
</table>

### Services today (1.0)

- More than 75% of frontline health facilities have five of the six specified amenities in 2017.
- One community clinic (3000 pop) within 30 minutes walking distance.
- Health workforce shortages: 0.8 doctors, nurses and midwives per 10,000 population in 2018.
- Skill mix imbalance: 0.6 nurses/nurse-midwife and 0.4 paramedical staff against 1.0 medical doctor in 2018.
- Inadequate resource allocation due to lack of need consideration (pop/disease burden/vulnerability).
- 90% of PHC providers are female.
- 64.5% of OOP on medicines in 2015.
- 7% of population pushed into poverty due to OOP on health in 2015.
- UHC services coverage index of essential health services is 50% in 2018.

### Services tomorrow (2.0)

- Effective patient referral mechanism established and Essential Service Package coverage expanded.
- Essential Health Facilities strengthened.
- Equitable and efficient financial risk protection and strategic purchasing mechanism in place.
- Increased Health Work Force (HWF) production and deployment.
- Rust retention through appropriate policies.
- Resilient health education system responsive to changing needs.
- Adequate availability of quality essential medicines at all health facilities.
- Preventive & promotive health services strengthened at frontline health facilities.

### Quality and safety

- Frontline health facilities equipped with essential medicines, diagnostic capacity, competent and motivated health workforce.
- Regulation of service quality standards across all frontline health facilities-public and private.
- Strengthens policies and implementation of infection prevention and antibiotic resistance control measures.

### Progress monitoring

- Facility performance scoring system using real time online data.
- Weekly video conference with the district (upazila) health facilities.
- Review of health facilities with functioning computer internet access.
- Biometric attendance system institutionalized to monitor health workforce attendance across the country.
- UHC and SDS monitoring system institutionalized.

### How to get there

1. Essential service package for frontline health facilities updated effectively.
2. Community Health Workers program strengthened to improve access to essential PHC services.
3. Integrated referral mechanism developed.
4. Need based resource allocation formula developed.
5. Staffing norms updated as per facility standard to improve skill mix.
6. Digital health strategy drafted and data quality review conducted.

### Data Sources:

3. 2010 Health SDSs Profile Bangladesh.

### Strengthening frontline services for universal health coverage by 2030

Regional consultation, 23-27 July 2019, New Delhi, India
Bhutan

Population (000s) | % of Urban population | Poverty (as per national poverty line) | GDP per capita (Current US$) | Current Health Expenditure as share of GDP | OPD per person per year | OPD waiting time | Health workers (doctor, nurse, midwife) | Children treated in public sector | Hypertensons untreated
--- | --- | --- | --- | --- | --- | --- | --- | --- | ---
735¹ | 37.8%¹ | 8.2%⁶ | 3438¹ | 3.7%² | 3.5³ | NRH-47 mins⁴ | CRHH-17 mins | ERRH-15 mins | District Hospitals-10 mins | 19.3/1000⁵ | ~100%⁶ | 32.9%⁷

Frontline services today (1.0) | Frontline services tomorrow (2.0)
--- | ---
Service delivery model
'vision' for how frontline health services will/should be organized, managed and financed in five years’ time: 3 key differences from today?
*Frontline health services should be more responsive to the NCD needs
*Address the social determinants of health to promote well-being and happiness
*Community focused, community-driven and community-led implementation and interventions

Quality and safety
Please give a snapshot of the quality and safety of frontline services today
Quality aspects of health services are regulated in terms of human resource, medicines and equipment
• % of essential medicines available in all health facilities at any point of time is above 95%
• % of medical equipment functional at all health facilities at any point of time is above 95%
• Staffing as per the service standards
• 93% of Bhutanese people were satisfied with the services received from the health care providers (GNH Survey)

Monitoring progress
Please briefly describe how you monitor progress in frontline health services today
*HMIS collects aggregate data on disease morbidity and mortality from all health facilities
*DHIS2 has been rolled out to all health facilities
*At the national level, aggregate data are used to track indicators for various public health programmes

Sources
1 Population and Housing Census, 2017, National Statistical Bureau
2 National Health Accounts Study 2015-16
3 Bhutan HIT Report 2016
4 HAMT Report (OPD waiting time)
5 Annual Health Bulletin 2019, Ministry of Health
6 There are no private clinics so all children are treated at public facilities
7 Bhutan STEPs survey 2014

Strengthening frontline services for universal health coverage by 2030
Regional consultation, 23-25 July 2019, New Delhi, India
### DPR of Korea

#### Service delivery today (1.0)

<table>
<thead>
<tr>
<th>Population (n/a)</th>
<th>Urban population</th>
<th>Poverty &lt; $1.9 a day</th>
<th>GDP per capita Current USD</th>
<th>Current Health Expenditure as share of GDP</th>
<th>OPD per person per year</th>
<th>OPD consultation time</th>
<th>Health workers (doctors, nurses, midwife)</th>
<th>% children u 5 with diarrhea sought care from public sector</th>
<th>Hypertensions undiagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 159</td>
<td>≈61%</td>
<td>NA</td>
<td>1 053</td>
<td>6.6%</td>
<td>6.9</td>
<td>18.3 min</td>
<td>85 /10 000</td>
<td>NA</td>
<td>40.4%</td>
</tr>
</tbody>
</table>

#### Service delivery tomorrow (2.0)

**Service model and management**
- Complete and Universal Free Medical Care System
- Maternal & Child Health Care System

**Quality and safety**
- Development of Essential Service Package at PHC level
- Development and Update of Health care Guideline for HHDs
- Updating in-service training Module for HHDs

**Progress monitoring**
- Reporting system for population health care through routine health information system
- Reporting system of communicable diseases
- Regular review of the work of HHDs based on assessment tools

**How to get there**
- To develop and introduce e-health care to utilize at peripheral health facilities
- To print and disseminate ESP at PHC level and in-service training module for HDDs
- To increase the proportion of Koryo medicine and self production and supply of EDs

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**Strengthening frontline services for universal health coverage by 2030**

*Regional consultation, 23-25 July 2019, New Delhi, India*
India

Service delivery model

• Sub Health Centres at (3000-5000); Primary Health Centres and Urban Primary Health Centres at (20,000-50,0000) population
• Management by State Government; selected range of services focused on RMNCH+A and selected communicable diseases
• ASHAs at community level, Multi-purpose workers at SHCs; PHCs have MBBS Doctor, one to three Nurses, Paramedical, Public Health Staff
• Performance linked payments limited only to ASHAs, fixed salaries for facility-based staff and hard area allowances for high priority districts

Quality and safety

• Frontline health facilities often underutilized
• Adherence to standard clinical guidelines not uniform across facilities
• 51% of households bypass their nearby public facility for availing routine care; of these, 80% cited at least one quality concern as a reason (India’s District Level Household and Facility Survey)

Monitoring progress

• Systems of grading of PHCs in place
• Include indicators for Infrastructure and amenities, lab services, drugs and logistics and service utilization limited to RMNCH+A
• HMIS, NIKSHAY, RCH Portal measure service utilization related to OP/IP/RMNCH+A/TB programme
• Multiple levels of review-Programme Managers at state/district level, MoHFW, NITI Ayoga

How to get there

• Year wise targets for operationalizing HWCs
• State/District wise action plans for operationalization
• Financial allocations to all states to supplement need for HR Training, Medicines, Diagnostics, infrastructure, repairs, IT support etc.
• Incremental addition of services based on state context
• Under National Health Policy, 2017, it is envisaged to increase government health expenditure on health care to 2.5 of GDP and allocate two-thirds to primary health care

Strengthening frontline services for universal health coverage by 2030
Regional consultation, 23-25 July 2019, New Delhi, India
• Gatekeeper for primary care with medical doctors in charge on:
  - 9,678 Puskesmas (Community Healthcare Center)
  - 6,091 Private Primary Clinic
  - 6,196 Private Solo Practice,
    in cooperation with BPJS (National Health Insurance Board)

• According to the MOH regulation for health workers in Puskesmas, it should comprises at least 9 types of health workers (doctors, dentists, nurses, mid-wives, nutritionists, sanitarians, pharmacists, public health workers and laboratory technicians). Currently 15% Puskesmas have no doctor

• Puskesmas provides integrated personal and public health services

• Private Primary Clinic and Solo Practice provides only personal health services

• Puskesmas uses family approach to emphasize preventive and promotive healthcare and early detection

• Community Health Center in remote area with shortage of health worker are supported by multidiciplinary team. Until now 3,380 Puskesmas in this program

• Piloting of family doctor as gate keeper

• Special incentive for family doctor

• Integrated personal and public health service delivery.

• Private sector involvement in implementing national program i.e. immunization, family planning, tuberculosis, control blood pressure, blood sugar and cholesterol level

• Family doctor ensure comprehensive, coordinated and continuous and longitudinal service delivery

• 100% population covered by health insurance

• Improved health facilities infrastructure

• Using digital decision support system

• Internet-based health services and management

• Commitment-based capitation aims to measure the commitment of primary health provider in delivering comprehensive treatment including on NCD case management

• Optimum collaboration in referral system

• Gatekeeper for primary care with medical doctors in charge on:
  - 9,678 Puskesmas (Community Healthcare Center)
  - 6,091 Private Primary Clinic
  - 6,196 Private Solo Practice,
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• Piloting of family doctor as gate keeper

• Special incentive for family doctor

• Integrated monitoring and recording-reporting system, supported with digital system

• Establish One Health Data through integrated health information system

• Family health status data are widely use for health management and decision-making

• General Service readiness: 70% Puskesmas meet minimum infrastructure and medical equipment standard

• ≥17% referral from Primary healthcare to higher level of care

• Three component of Puskesmas Accreditation assessment are management, public and personal health services.

• 75% Puskesmas have been accredited with leveling status

• Preliminary phase implementation of Patient Safety and Prevention and Infecton Control Regulation

• There is no nationwide quality indicators in primary care

• HRH quality improvement has been carried out through continuing education

• Availability of essential medicine, vaccine and medical devices

• General Service Readiness: 70% Puskesmas meet minimum infrastructure and medical equipment standard

Less than 10% referral from Primary healthcare to higher level of care

100% Puskesmas accredited without leveling and accreditation of primary clinic and solo practice

Increase quality by assigning family doctor in leading inter-professional collaboration team with comprehensive and health-system thinking approach

National Quality Indicators for primary health services

Periodical credentialing of health workers

Optimization of quality management on essential medicine, vaccine and medical devices
Maldives

<table>
<thead>
<tr>
<th>Population</th>
<th>Poverty</th>
<th>GDP per capita</th>
<th>Current Health Expenditure as share of GDP</th>
<th>OPD per person per year</th>
<th>OPD consultation time</th>
<th>Health workers (doctor, nurses, PHU, attendants)</th>
<th>Children treated in public sector</th>
<th>Hypertensions undiagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>444</td>
<td>39.4%</td>
<td>-</td>
<td>11151</td>
<td>10.61</td>
<td>NA</td>
<td>NA</td>
<td>118.3/10,000</td>
<td>81%</td>
</tr>
</tbody>
</table>

**Frontline services today (1.0)**

**Service delivery model**

Please give a snapshot of the organization, management and financing of frontline services today, (e.g. facility types, range of services available, staff mix, payment methods)

- Health centers at island level, Atoll hospital and regional hospitals with coordination at the central level (MOH)
- All health facilities equipped with basic medical services and staff (doctor, nurses, PHU, attendants) with a public private pharmacy
- Sub-specialized medical interventions available at tertiary levels and specialized medical interventions available at atoll level.
- Overall medical supply and logistics chain is coordinated at the central level with the assigned atoll focal points at the atoll/island level.
- Healthcare expenditures are covered by the government with support from few Donors (i.e. UN Agencies)
- Major portion of the government budget assigned to healthcare goes to Aasandha (i.e. affordability as part of universal health coverage) and immunization programme. Most of the expenditure is incurred on curative medicine. Preventive side of public health is run in additions to government funds support from donors

**Quality and safety**

Please give a snapshot of the quality and safety of frontline services today

- Spot checks on the quality and safety of frontline services at health facilities and hospitals.
- Training on safety and quality monitoring of the island level health facilities by the atoll hospitals and monitoring the implementation practices.
- Implementation of measures such as incident reporting.
- All private and public health facilities are monitored according to Maldives Healthcare Quality Standards and relevant regulations

**Monitoring progress**

Please briefly describe how you monitor progress in frontline health services today – which key indicators, data sources (e.g. HMIS reporting, facility surveys), who reviews this?

- All health facilities are inspected and monitored by quality assurance division (Ministry of Health) according to Maldives Healthcare Quality Standards and relevant regulations
- Government health facilities are daily coordinated and monitored by the Regional Atoll Health Service division of MOH.
- Each department is inspected by its expertise.
- Key indicators addressed include staff competence, patient satisfaction, diagnostic process, record and data management etc.

**Frontline services tomorrow (2.0)**

**Service delivery model**

What is your ‘vision’ for how frontline health services will/should be organized, managed and financed in five years’ time: what are the 3 key differences from today?

- Reform primary healthcare services with well defined organizational structures and roles
- Delegating healthcare preventive services via expansion of advocacy and outreach programs to mitigate the lack of human resources and enhance the efficiency.
- Motivation of healthcare frontline workforce through improved and adequate remuneration for the work.
- Patient-focused diagnostic and curative care
- Better decisions using the Health Information System
- Consolidating the existing healthcare systems into one service delivery platform with central level monitoring controls.
- Emphasis on preventive side of medicine via awareness and advocacy to leverage healthcare costs.

**Quality and safety**

What is your ‘vision’ for improved quality and safety of frontline services in five year’s time. What are the 3-4 key differences from today?

- Develop / train health workers in an effective and sustainable manner at island level in order to maintain and improve their knowledge and skills to work with a wide range of competencies.
- Reliable access to safe and affordable medicine
- Diffusion of responsibility among frontline healthcare workers
- Implementing data-centered information on quality and safety.
- Examination of the interactions between the different frontline service roles held to improve understanding on how these differences reflect in their time spent and actions undertaken in remote communities such as the Maldives.

**Monitoring progress**

Please indicate the top 3-4 changes you wish to achieve in improved frontline services monitoring, in 5 years time?

- Use predominant data from incident reporting tools to change policy/practice and training/education and communication between care providers.
- Taking corrective action based on adverse incidents or trends emphasized from patient satisfaction surveys and reports and providing feedback.

**Strengthening frontline services for universal health coverage by 2030**

Regional consultation, 23-25 July 2019, New Delhi, India
**Population**

<table>
<thead>
<tr>
<th>Country</th>
<th>Urban population</th>
<th>Poverty ≤ $1.9 a day</th>
<th>GDP per capita</th>
<th>Current Health Expenditure as share of GDP</th>
<th>OPD per consultation time</th>
<th>OPD per year</th>
<th>Health workers doctor/nurse/midwife</th>
<th>Children treated in public sector</th>
<th>Hypertension uncontrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td>53856</td>
<td>30.3%</td>
<td>6.4%</td>
<td>1257</td>
<td>-</td>
<td>-</td>
<td>179/10000</td>
<td>57%</td>
<td>52%</td>
</tr>
</tbody>
</table>

### Frontline services today (1.0)

**Service delivery model**

- Please give a snapshot of the organization, management and financing of frontline services today. (e.g. facility types, range of services available, staff mix, payment methods)
- *PHC level-Township Hospital, Station Hospital, RHC, Sub RHC for public, GPs for private, Traditional Medicine clinics, Ethnic Health Organizations*
- *Achieving promotion of population health, comprehensive health care service ie. promotive, preventive, curative and rehabilitative care at TH, SH, RHC and SRHC*
- *TH & SH provide general medical, surgical, obstetric and paediatric care at OP & IP*
- *RHC & SRHC more focused on promotive and preventive services*
- *GPs providing general medical care and EHOs providing ambulatory care*
- Doctors, nurses at the hospitals and Basic Health Professionals including Health Assistant, Lady Health Visitor, Public Health Supervisor 1 & 2: CBHWs, Traditional medical practitioners, GP doctors, Ethnic Health Workers in the communities
- Payment- Salary, incentives for the CBHW and EHWs
- Prevention, promotive and curative care for CDs and NCDs are provided at RHC level and NCD Clinic

**Quality and safety**

- Please give a snapshot of the quality and safety of frontline services today
  - *education: accreditation of medical/nursing and midwifery education initiated in 2017 and now in progress*
  - *Initiation of off campus B.NSc training for nurses with Nursing Diploma in service (around 200)*
  - *Service Delivery: List of essential medicines according to type of facilities identified and already supplied up to SRHC including NCD drugs*
  - *MOHs- distributed a total of 11,186 mobile tablets to 402 TMOs & SMOs and 10,784 Basic Health staff who are working at the RHC & SRHcs from seven States and Regions for easy access to standard health messages book, national standards and guidelines disseminated by the MoHS, signs and symptoms for common diseases including CD and NCD in the form of more than 120 documents and references which can be accessed both offline and online*
  - *PPP in the area of telemedicine and tele-radiography*
  - *Use of mobile apps in different programmes*
  - *NMCP- malaria surveillance system covers all malaria endemic townships (291) out of which 289 townships are managed by township malaria staff*
  - *Malaria cases from all townships (aggregate data) are reported to DHIS2, and 801 malaria volunteers are using MCBIR app (mobile application) for case-base reporting*

**Monitoring progress**

- Please briefly describe how you monitor progress in frontline health services today – which key indicators, data sources (e.g. HMIS reporting, facility surveys), who reviews this?
- NHF M & E indicators, HRH indicators, specific project indicators
- *Routine HMIS reporting already changed to DHIS 2 over the whole country in 2018 for public sector and 43 private hospitals*
- *SARA, DHS, Health facility survey in NHF, Geospatial survey*
- *Reviewed by HMIS division, specific programs*
- How to get there? Operationalizing the following:
  - Annual Operational Plan Year 1&2 NHP (2017-2021)
  - Annual Operational Plan, year 1 of HRH Strategic Plan (2018-2021)
  - Strengthening the Rural Health Workforce for UHC in Myanmar- developing Rural Retention Strategies
  - Develop, Adopt & adapt the Health Financing Strategy
  - Advocate, sensitize and publicize UHC/SDG to "ALL"
  - National Strategic Plans of different programmes operating at frontline

### Frontline services tomorrow (2.0)

**Service delivery model**

- What is your 'vision' for how frontline health services will/should be organized, managed and financed in five years' time: what are the 3-4 key differences from today?
- *Basic Essential Package of HS at the PHC level, including (76) categories of interventions for clinical OP+IP at Township hospital and (78) categories of interventions at RHC/SRHC level will be available to serve the communities*
- *Supply side readiness- Standardized infrastructure for public sector will be improved but not to cent percent*
- *SOP for minimum services of care, ready for use*
- *Provider payment mechanism developed*

**3 Key Differences from today**

1. Inclusiveness of EHO, CSO, GP and Traditional medicine in front line service provision, ensuring inclusion in national monitoring and evaluation systems
2. Communities become more participative in health movements through engagements, knowledge sharing, networking, and listening to their voices
3. Financial incentives to providers such as provider payment system

**Quality and safety**

- What is your 'vision' for improved quality and safety of frontline services in five year's time: what are the 3-4 key differences from today?
- *Accreditations of dental and other professionals' education, GPs and EHWs*
- *Rural Retention of health workforce for frontline health services will be accomplished thru' bundled approach*
- *Leveraging and recognition of EHO and Public sector with more coordination efforts*
- *Further Facility survey and other health information will be put in the tablets so that information flow will be much improved*
- *Expansion of usage of e-health in collaboration with different stakeholders*
- *National Health Workforce Account*
- *3 Key Differences from today*
- *Use of mobile phone for more efficient referral system, feedback information and continuity of care*
- *Use of more digital technologies in frontline service delivery such as portable ultrasound training and access by Health Assistants and midwives*
- *Availability of essential medicine (quality generic drugs) and affordable on a sustainable basis at all levels including CBHWs*

## Monitoring progress

- Please indicate the top 3-4 changes you wish to achieve in improved frontline services monitoring, in 5 years time?
- *Electronic reporting starting from Sub RHC using tablets*
- *Expanding DHIS 2 to the remaining private hospitals*
- *GIS mapping for assessing facilities, HRH, services and monitoring real time data*
- *Monitor and tracking of the achievement of existing health status plus be able to track achievements of health-related SDGs, SDH and many related issues*
Nepal

Population (000s) | Urban population | Poverty < $1.9 a day | GDP per capita | Current Health Expenditure as share of GDP | OPD per person per year | OPD consultation time | Health workers doctor, nurse, midwife | Children treated in public sector | Hypertensions undiagnosed
---|---|---|---|---|---|---|---|---|---
29624 | 19.3% | 15% | 849 | 6.29% | 0.8 | 33.5/10,000 | 24% | 80%

Frontline services today (1.0) | Frontline services tomorrow (2.0)

**Service delivery model**

*Frontline service delivery in Nepal*

*Community Health Units (404) through PPP/Public Private Partnership are providing partial Basic health services, lead by HA & Nurse;*
*Urban Health promotion centers (20) through PPP are providing partial Basic health services, by MO, HA & Nurse;*
*Basic health Centers (1200) through PPP, by HA & Nurse;*
*Health post (3815), Public services, are covering partial Basic health services, lead by HA, AHW & ANM;*
*Every month, PHC Out Reach Clinics & Immunization ORC are extending Basic health services to the community level;*
*Primary hospitals (100), Public services, providing complete Basic health services, lead by MDGP, MO, AHW & ANM;*
*Free care for Basic health services & essential health services;*

**Service delivery model**

*Increase Access to Essential Health Services*

*Community Health Unit & Urban Health Center will be merged into Basic health Centre (2500 units) and will cover partial Basic health services;*
*Health post (3815 units) will provide partial Basic health services and Primary hospital (753 units) will cover complete Basic health services;*
*Number of health institutions and human resources will be increased and more ownership will be shifted to the local government and community;*

**Quality and safety**

*To improve Quality and Safety, policies and tools have been developed.*
*Public health Act (2018) to govern the public health services;*
*Quality Assurance Committee and QA modules;*
*Minimum Service Standards for all levels of health facilities;*
*Standard Treatment protocol;*
*Patient Safety Action plan (drafted);*
*Multiparto Anti Microbial Resistance Action Plan (drafted);*
*Continued Professional education for quality and safety;*

**Quality and safety**

*Improving Quality of Health Services,*
*Public health Regulation will be enacted;*
*QA committee will be established at all levels and QA modules will be expanded;*
*Minimum service standard is implementing at all levels of health facilities and institutions;*
*Compliance to Standard treatment protocol is increasing;*

**Monitoring progress**

*HMIS/DHIS2 and LMIS in progress;*
*Quarterly and Annually program review including progress review of frontline health services;*
*Staff meeting;*
*Annual report;*
*Nepal Demographic and Health Survey (NDHS);*
*Health facility survey;*
*eHealth and Digitalization;*

**Monitoring progress**

*eMIS and eLMIS;*
*Develop Dashboard system and improving data use in evidence-based planning, monitoring & evaluation and decision-making at all levels of health institution;*
*Improving digitalization in healthcare services;*

**How to get there**

**Action Plan for Moving forward:**

*Expansion of frontline health facilities and Basic health services package implementation across the country;*
*Increase the number of health human resources and budget allocation for frontline health services;*
*Expansion of Health insurance implementation;*
*Improving evidenced-based planning and decision-making at both national and local levels;*
*Strengthening Public Private Partnership models;*

Strengthening frontline services for universal health coverage by 2030
Regional consultation, 23-25 July 2019, New Delhi, India
Frontline Services Today

Service Delivery Model

Regional Director of Health Services (RDHS)

District Level

HR management, Planning and resource allocation, Administrative and technical supervision, Financing through the provincial + central budgets

Preventive Sector

MOH area with a defined pop: served through a network of field clinics. (n=360)

HR - skill mix – Doctors, PHM,PHI and other supportive staff

Range of services (MCH, women’s health, disease prevention and control, environmental and occupational health, food safety and health promotion)

- State health services are tax financed and free at point of delivery, private sector accounts for % of ambulatory care and % of in-patient care.
- Overall there is 53% OOPE in SL, majority for OPD consultation (NHA 2016).

Curative Sector

Divisional Hospitals and Primary Medical Care Units (n~980)

Staff mix - Doctors, nurses and other supportive staff.

Range of services - Emergency care, treatment of common illnesses, minor surgeries, screening and management of NCDs,

Quality and Safety

- Quality of service delivery of preventive sector assured through adhering to the guidelines, protocol standards at each level, enforced through supportive supervision and M & E.
- Quality management units at district level are responsible to monitor quality of service delivery at curative sector.

Monitoring Progress

- Annual Health Bulletin based on HMIS.
- Annual reviews at national and district level, by the public health programs.

Frontline Services Tomorrow

Service Delivery Model

- “Shared Care Cluster Model” based service delivery to improve coverage of essential services.
- Empanelment of the population to primary level institution.
- Family doctor approach for delivery of primary care.

Key Differences -
- People centered, integrated and comprehensive care
- Accountability for health outcomes in the empaneled population.
- Improved overall user satisfaction on health experience.

Quality and Safety

- Adhere to the national policy & guidelines on ‘Quality and Safety’.
- Assessment of performance of clusters based on set of agreed indicators.
- Regular supervision of primary care institutions, using standard tools.

Monitoring Progress

- Functioning, interoperable HMIS with patient tracking system for outcome monitoring.
- Improved capability for data analysis by clusters for decision making.
- Communities are empowered to review the performance of their clusters.
Thailand

Population (000s)  
Urban population  
Poverty - $1.9 a day  
GDP per capita  
Current health expenditure as share of GDP  
OPD per person per year  
OPD consultation time  
Health workers - doctor, nurse, midwife  
Children treated in public sector  
Hypertensions undiagnosed

<table>
<thead>
<tr>
<th>Population</th>
<th>Urban population</th>
<th>Poverty - $1.9 a day</th>
<th>GDP per capita</th>
<th>Current health expenditure as share of GDP</th>
<th>OPD per person per year</th>
<th>OPD consultation time</th>
<th>Health workers - doctor, nurse, midwife</th>
<th>Children treated in public sector</th>
<th>Hypertensions undiagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>69183</td>
<td>49.2%</td>
<td>0</td>
<td>6595</td>
<td>3.71%</td>
<td>3.6</td>
<td>2 - 5 min*</td>
<td>non official</td>
<td>38.2/10,000</td>
<td>59%</td>
</tr>
</tbody>
</table>

Frontline services today (1.0)  
Service delivery model

* 94% of health care providers are in the public sectors.  
* Public sectors provide comprehensive care. Private sectors focus on providing treatment.  
* Primary care in rural area is mainly provided by nurses and community health workers.  
* Focusing on diseases and catchment area based approach rather than the holistic care approach  
* Different group of health care scheme has got different health care services and payment mechanism.  
* Health information system is un-linkage and complicated.  
* Community participation is under the regulation of the Office of the Prime Minister on Quality of Life of people in district level.

Frontline services tomorrow (2.0)  
Service delivery model

**PRIMARY HEALTH SYSTEM ACT, B.E. 2562 (2019)**

1. The registration system of the family doctor and the people in the responsible area (Section 18)  
2. The registration of primary care unit from private and public sector (Section 17)  
3. One family doctor and other multidisciplinary team: 10,000 populations (Section 22)  
4. Primary care is an essential health package for all health care scheme. (Section 15,16)  
5. Payment mechanism is based on unit cost and capitation system. (Section 16)  
6. Develop a health information exchanged system using "National Digital ID" (Section 21)  
7. Strengthen the community participation following the regulation of the Office of the Prime Minister on Quality of Life of people in district level (Section 30)  

Quality and safety

1. Health services accreditation: Primary care unit / Sub district health promotion hospital  
2. Un-unified standard services at all types of primary care unit  
3. More quantity indicators than quality indicators  

Monitoring progress

1. Monitoring system : Public sectors under the Ministry of Public Health (MOPH) such as Annual year report, Progression report  
2. Lack of data report of the service providers outside the MOPH

Quality and safety

1. Setting the center of primary health care unit accreditation (Section 14, 24)  
2. More quality indicators than quantity indicators : well-being, continuous care, ACSC (NCD, UTI, Asthma, Admission), cost effectiveness  

Monitoring progress

1. Develop a platform for data collecting, monitoring, analyzing, and reporting for both public and private sectors (Section 21)  
2. Develop a ten year primary health system strategic plan (Section 10, 14)  
3. People-participated monitoring approach (Section 24)

How to get there

* To enforce PRIMARY HEALTH SYSTEM ACT, B.E. 2562 (2019) at all stakeholders  
* Producing and retaining a family doctor in the primary care system  
* Encouraging the health care workers to apply the family medicine concept at all levels of primary care  
* Promoting health literacy and self management
Timor-Leste

<table>
<thead>
<tr>
<th>Population (m)</th>
<th>Urban population</th>
<th>Poverty &lt; $1.9 a day</th>
<th>GDP per capita</th>
<th>Current Health Expenditure as share of GDP</th>
<th>OPD per person per year</th>
<th>OPD consultation time</th>
<th>Health workers (doctor, nurse, midwife)</th>
<th>Children treated in public sector</th>
<th>Hypertensions undiagnosed</th>
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</thead>
<tbody>
<tr>
<td>1324</td>
<td>30.2%</td>
<td>30.3%</td>
<td>2279</td>
<td>4.02</td>
<td>2.4</td>
<td>25/10,000</td>
<td>88%</td>
<td>94%</td>
<td></td>
</tr>
</tbody>
</table>

**Frontline services today (1.0)**

**Service delivery model**

Please give a snapshot of the organization, management and financing of frontline services today. (e.g. facility types, range of services available, staff mix, payment methods)

- * Network of PHC focused health facilities supported by regional and national hospitals, operated in a decentralized framework
- * Community based care provided through domiciliary visits by health professionals (SnF) and outreach (SISCa)
- * Financing and delivery primarily through the public sector with significant inputs of dev. Partners

**Quality and safety**

Please give a snapshot of the quality and safety of frontline services today

- * Inconsistent knowledge and use of clinical guidelines and standards
- * No independent registration, licensing or external evaluation bodies

**Monitoring progress**

Please briefly describe how you monitor progress in frontline health services today – which key indicators, data sources (e.g. HMIS reporting, facility surveys), who reviews this?

- * DHIS 2 (TL-HIS) for routine health information
- * Census (latest 2015), Demographic and Health Survey (latest 2016), Living Standard Surveys (latest 2014)

**Frontline services tomorrow (2.0)**

**Service delivery model**

What is your ‘vision’ for how frontline health services will/should be organized, managed and financed in five years’ time: what are the 3 key differences from today?

- * Universal access to explicitly defined benefit package
- * HRH as per standards and staffing norms for all levels of health facilities
- * Sustainable health financing and financial protection

**Quality and safety**

What is your ‘vision’ for improved quality and safety of frontline services in five year’s time. What are the 3-4 key differences from today?

- * Strong legislative frameworks for quality (human resources and medicine)
- * Quality and safety standards implemented
- * All health facilities engaged in QI initiatives

**Monitoring progress**

Please indicate the top 3-4 changes you wish to achieve in improved frontline services monitoring, in 5 years time?

- * Strengthening DHIS2 (policy, architecture and use)
- * Data quality improvements

**How to get there**

* Revision/update and implementation of PHC essential services package
* Health financing strategy to ensure sustainable financing
* HRH strategy with an updated staffing norms and standards
* Revision and update of Standard Treatment Guidelines and Essential Medicine List
* Strengthening HMIS, PIS and interoperability
## Annex 4: Helpdesk topics

<table>
<thead>
<tr>
<th></th>
<th>Leadership and governance</th>
<th>Service delivery</th>
<th>Health financing</th>
<th>Health workforce</th>
<th>Medical products, vaccines, and technologies</th>
<th>Health information systems, eHealth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td>Rural and specialty workforce distribution</td>
<td></td>
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<tr>
<td></td>
<td>'Women’s health services, adolescent girls’ empowerment</td>
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<tr>
<td></td>
<td>Health waste disposal</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Caesarean section rate reduction</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Bhutan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Indicators to measure service delivery</td>
</tr>
<tr>
<td>Democratic People’s Republic of Korea</td>
<td>Strategic planning for UHC</td>
<td>Monitoring and evaluation</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>India</td>
<td>Long-term planning on locating facilities to increase use</td>
<td></td>
<td>Referral / gatekeeping systems</td>
<td>PHC for NCD treatment adherence</td>
<td></td>
<td>- Telemedicine for referral</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Increasing use of PHC</td>
<td></td>
<td>Health provider engagement in financing</td>
<td>Adequate PHC workforce</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevention and basic health services</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Maldives</td>
<td>PHC for NCDs</td>
<td></td>
<td>Attracting and retaining workforce</td>
<td>Better nurse training</td>
<td></td>
<td>- Telemedicine for rural communities</td>
</tr>
<tr>
<td></td>
<td>Leadership and governance</td>
<td>Service delivery</td>
<td>Health financing</td>
<td>Health workforce</td>
<td>Medical products, vaccines, and technologies</td>
<td>Health information systems, eHealth</td>
</tr>
<tr>
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<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>---------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Myanmar</td>
<td>- Monitoring and coordination with international NGOs</td>
<td>- Community-level health system support to improve IPC, service delivery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
<pre><code>                                                                                                                                       | - Coordination with ethnic health organizations on frontline services             |                                                                                   |                                           |                                           |                                             |
</code></pre>
<p>| Nepal            |                                                                                         | - Essential service package implementation and urban PHC                         |                                                                                   | - Access to essential medicines         |                                             |                                             |
| - Increasing primary care use                                                     |                                                                                   | - Stock-outs, expired drugs               |                                             |                                             |
|                                                                                   |                                                                                   | - Procurement price and quality           |                                             |                                             |
| Sri Lanka        |                                                                                         | - Benefits assessment for financial sustainability                              |                                                                                   |                                          |                                             |                                             |
| - Out-of-pocket spending, equity                                                 |                                                                                   |                                           |                                          |                                             |
| - Domestic resource mobilization, to prepare for upper-middle income country transition |                                                                                   |                                           |                                          |                                             |
| Thailand         |                                                                                         | - Traditional medicine integration into UHC package through pre-determined criteria |                                                                                   |                                          |                                             |                                             |
|                                                                                   |                                                                                   |                                          |                                          |                                             |
| Timor-Leste      |                                                                                         | - Economic diversification, macroeconomic sustainability                         |                                                                                   | - Training on STG                       |                                             |                                             |
| - Resource mobilization                                                           |                                                                                   | - Training to improve workforce           |                                             |                                             |
| - Water supply and infrastructure                                                |                                                                                   | - Recruiting better nurses               |                                             |                                             |
|                                                                                   |                                                                                   |                                           |                                             |                                             |</p>
Annex 5: Feedback summary

Feedback from participants was collected through self-administered feedback forms. Figure 1 summarises the feedback received. Overall, participants felt that the meeting objectives were met, the session topics and content were relevant and useful, the materials distributed were helpful and the time allotted was sufficient.

**Figure 1: Overall feedback**

<table>
<thead>
<tr>
<th>Feedback Item</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting objectives were met (average 4.3/5)</td>
<td>1%</td>
<td>2%</td>
<td>4%</td>
<td>8%</td>
<td>46%</td>
</tr>
<tr>
<td>Topics covered were relevant to me (4.4)</td>
<td>4%</td>
<td>2%</td>
<td>4%</td>
<td>2%</td>
<td>50%</td>
</tr>
<tr>
<td>Content was organized and easy to follow (4.2)</td>
<td>2%</td>
<td>4%</td>
<td>4%</td>
<td>8%</td>
<td>50%</td>
</tr>
<tr>
<td>Materials distributed were helpful (4.0)</td>
<td>4%</td>
<td>2%</td>
<td>4%</td>
<td>8%</td>
<td>40%</td>
</tr>
<tr>
<td>Meeting experience will be useful for my work (4.6)</td>
<td>29%</td>
<td>67%</td>
<td>15%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time allotted for the meeting was sufficient (3.8)</td>
<td>54%</td>
<td>35%</td>
<td>11%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

n=52, average score out of 5 is presented in parentheses

**Figure 2: Session-wise feedback**

<table>
<thead>
<tr>
<th>Session</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
<th>n=51, average score out of 5 is presented in parentheses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opening session. Where are we now? (4.1/5)</td>
<td>2%</td>
<td>1%</td>
<td>5%</td>
<td>46%</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Session 1.1. Changing models of care (4.0)</td>
<td>2%</td>
<td>24%</td>
<td>51%</td>
<td>8%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Session 1.2. Essential health service packages (3.9)</td>
<td>2%</td>
<td>22%</td>
<td>48%</td>
<td>25%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Session 1.2.2. Adapting the frontline health workforce (4.2)</td>
<td>2%</td>
<td>27%</td>
<td>54%</td>
<td>12%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Session 1.2.3. Purchasing and provider payment systems (3.9)</td>
<td>7%</td>
<td>26%</td>
<td>50%</td>
<td>17%</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Session 1.2.4. Traditional medicine in frontline services (3.8)</td>
<td>2%</td>
<td>15%</td>
<td>59%</td>
<td>32%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Session 1.3.1. Continuing/life-long care (4.1)</td>
<td>2%</td>
<td>30%</td>
<td>60%</td>
<td>10%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Session 1.3.2. Community-based care (3.8)</td>
<td>2%</td>
<td>16%</td>
<td>54%</td>
<td>24%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Session 1.3.3. Frontline services to cope with emergencies (3.8)</td>
<td>4%</td>
<td>26%</td>
<td>57%</td>
<td>13%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Session 1.4. Managing change (3.9)</td>
<td>16%</td>
<td>18%</td>
<td>51%</td>
<td>20%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Session 1.5. New technologies at scale (3.8)</td>
<td>18%</td>
<td>49%</td>
<td>21%</td>
<td>33%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Session 2.1. Clearer, safer frontline health facilities (4.1)</td>
<td>18%</td>
<td>22%</td>
<td>30%</td>
<td>20%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Session 2.2. Getting the basics right, igniting change (4.2)</td>
<td>14%</td>
<td>50%</td>
<td>20%</td>
<td>30%</td>
<td>20%</td>
<td></td>
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<tr>
<td>Helpdesk (4.3)</td>
<td>16%</td>
<td>56%</td>
<td>20%</td>
<td>40%</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>
Common points of positive feedback included the following:

- The interactive, informal and participatory nature of the consultation sessions enabled constructive reflections and learning.
- The country experience-sharing and in-depth technical discussions were the most useful aspects of the consultation.
- The innovative session formats, especially the Helpdesk and World Café, were very helpful in achieving the session objectives.

Suggestions for future improvement included the following:

- Improve the logistical management of the group work and parallel sessions.
- Have more focus on country specific issues.
- Engage higher level of policy-makers.
Strengthening frontline services for universal health coverage by 2030

Report of the Regional Consultation, 23–25 July 2019, New Delhi, India