Regional Conference on
Revitalizing
Primary Health Care

Jakarta, Indonesia, 6-8 August 2008
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Contents

Acronyms and abbreviations .............................................................. iv
Foreword ........................................................................................ v
Executive summary ......................................................................... vii
1. Introduction ............................................................................... 3
2. Inaugural session ....................................................................... 7
3. Keynote addresses ................................................................... 13
4. Working paper ......................................................................... 19
5. Technical discussions ................................................................ 25
6. Recommendations .................................................................... 53
7. Closing session ........................................................................ 59

Annexes

1. Agenda .............................................................................. 63
2. List of participants .............................................................. 64
3. Address by Dr Samlee Plianbangchang Regional Director,
   WHO South-East Asia Region ................................................. 82
4. Speech by H.E. Mr Aburizal Bakrie, Coordinating Minister
   for People’s Welfare, Republic of Indonesia ......................... 88
5. Remarks by H.E. Dr Siti Fadilah Supari, Minister of Health,
   Republic of Indonesia .......................................................... 91
6. Keynote Address by Dr Halfdan T. Mahler,
   WHO Director-General (Emeritus) ....................................... 95
7. Keynote speech by Dr. Amorn Nondasuta,
   former Permanent Secretary of Health, Ministry of Health,
   Royal Thai Government .......................................................... 108
8. Working paper on Revitalizing Primary Health Care .............. 114
9. Revised MDG monitoring framework including new targets
   and indicators, as noted by the 62nd General Assembly, and
   new numbering, as recommended by the Inter-agency and
   Expert Group on MDG Indicators at its 12th meeting,
   14 November 2007 ............................................................ 163
10. Panel discussions: Health System Strengthening using
    Primary Health Care approach .............................................. 166
## Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>antenatal care</td>
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<tr>
<td>ASHA</td>
<td>accredited social health activist</td>
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<tr>
<td>BRAC</td>
<td>Bangladesh Rural Advancement Committee</td>
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<tr>
<td>CBHW</td>
<td>community-based health worker</td>
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<tr>
<td>CHV</td>
<td>community health volunteer</td>
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<tr>
<td>CSMBS</td>
<td>Civil Servants’ Medical Benefit Scheme</td>
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<tr>
<td>DOTS</td>
<td>directly observed therapy, short-course</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunization</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GNH</td>
<td>Gross National Happiness</td>
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<tr>
<td>IHP</td>
<td>International Health Partnership</td>
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<tr>
<td>IMR</td>
<td>infant mortality rate</td>
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<tr>
<td>IPHS</td>
<td>Indian Public Health Standards</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MMR</td>
<td>mumps, measles and rubella (vaccine)</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>NRHM</td>
<td>National Rural Health Mission (India)</td>
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<tr>
<td>PHC</td>
<td>primary health care</td>
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<tr>
<td>RHC</td>
<td>rural health centre</td>
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<tr>
<td>SEWA</td>
<td>Self-Employed Women’s Association</td>
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<tr>
<td>SOP</td>
<td>standard operating procedure</td>
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<tr>
<td>SSS</td>
<td>Social Security Scheme</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>UC</td>
<td>Universal Healthcare Coverage (Scheme)</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>VO</td>
<td>village organization</td>
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<tr>
<td>WHO SEARO</td>
<td>WHO Regional Office for South-East Asia</td>
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<td>WHO</td>
<td>World Health Organization</td>
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The Regional Conference on “Revitalizing Primary Health Care” held in Jakarta, Indonesia, from 6 to 8 August 2008 was an important milestone in our quest for achieving the health-related Millennium Development Goals and ultimately health for all. It not only commemorated the 30th anniversary of the historic Declaration of Alma-Ata on Primary Health Care (PHC), but also signified renewed determination by Member countries in the South-East Asia Region to strengthen equitable health development.

A lot of progress has been made but good health for all people needs to be pursued with more vigour. The social goal of health for all continues to be an inspirational target, which all countries are striving to achieve. And PHC is still considered to be vital to the attainment of this social goal. It is realized that during the past three decades, there have been many changes in all spheres: social, economic, political and technological. At the same time, significant environmental, ecological, demographic and epidemiological transitions have taken place. These changes and transitions have had a profound effect on the way we plan and manage our health policy and programmes today.

It is a fact that, through the application of the principle of the goal of health for all, health has gone far beyond the confines of the health sector. The roles of other sectors are considered indispensable for the attainment of the goal. The results will be healthy public policy and better social determinants of health. Increasingly, health issues are becoming the concern of the general public, as well as subjects for public debate. The reflection of health issues in the political agenda for social and economic development is very clear today. Health is becoming more prominent on the international
development agenda. With rapid global changes and the prevailing formidable health challenges, it is time to revisit PHC. We must ensure that PHC will continue to be firmly embedded as an indispensable element of public health interventions at all levels.

The Regional Conference also served as Technical Discussions prior to the Sixty-first session of the WHO Regional Committee for South-East Asia, convened in September 2008.

The participatory process in both panel and group discussions yielded important recommendations covering areas of leadership and governance; human resources; multisectoral collaboration; managing financial resources; and knowledge generation.

The important messages from this conference are: Member countries in South-East Asia Region reaffirm their political commitment to revitalizing PHC as an effective approach to strengthen health systems. This approach is anchored at the community level and responsive to its health needs; emphasizes overall health system strengthening to improve equity and efficiency; and shifts from a focus on service delivery to a development orientation in the country’s social, political and economic contexts.

I hope that this report of the Regional Conference will be found useful in applying primary health care as a tool for policy formulation and programme implementation, as well as for monitoring and evaluation purposes.

Dr Samlee Plianbangchang
Regional Director
The Regional Conference on Revitalizing Primary Health Care was held on 6–8 August 2008 in Jakarta, Indonesia. The overall objective of the Regional Conference was to revitalize primary health care (PHC) in the changing context of health development and its risk factors and social determinants to achieve the Millennium Development Goals (MDGs) and Health for All. The specific objectives were to take forward the PHC agenda in the South-East Asia Region, and provide recommendations on revitalizing PHC.

Over 200 participants attended the Conference. These included representatives from all 11 Member countries of the South-East Asia Region as well as health-related stakeholders – from grassroots-level community workers to national officials to international development partners.

The Conference was inaugurated by H.E. Mr Aburizal Bakrie, Coordinating Minister for People’s Welfare, Republic of Indonesia. The inaugural session was also addressed by H.E. Dr Siti Fadilah Supari, Minister of Health, Republic of Indonesia and Dr Samlee Plianbangchang, WHO Regional Director for South-East Asia.
Dr Halfdan T. Mahler, WHO Director-General (Emeritus); Ms Erna Witoelar, former UN Special Ambassador for MDGs in Asia and the Pacific; and Dr Amorn Nondasuta, former Permanent Secretary, Ministry of Public Health, Royal Thai Government delivered keynote addresses.

The technical sessions focused on health systems strengthening using the PHC approach and were organized under four themes:

1. Equity in health
2. Multisectoral collaboration and its impact on health and quality of life
3. Health financing and poverty alleviation
4. Societal partnerships and local development to improve health.

Panel discussions were held on these topics, with experts highlighting the key issues within each topic through presentations. Group discussions were facilitated on the same themes for participants to develop actionable recommendations to revitalize PHC for consideration by the Sixty-first Session of the World Health Organization (WHO) Regional Committee for South-East Asia.

**Conclusions**

After the group discussions, the participants concluded that to revitalize PHC, the following factors are crucial:

1. Leadership and governance
2. Human resources
3. Multisectoral collaboration
4. Managing financial resources
5. Knowledge generation
Recommendations

It was recommended that Member States:

(1) Reaffirm their political commitment to PHC as an effective approach to address national health needs. Such an approach should be anchored at the community level and be responsive to its health needs; emphasize overall health systems strengthening to improve equity and efficiency; and shift from a focus on service delivery to development orientation in the country’s social, political and economic contexts.

(2) Review health financing and expenditure with respect to equity and efficiency of tax-based funding vis-à-vis national health priorities; financing options for funding gaps, especially contributory schemes such as social and community insurance that can support PHC principles; flexibility of the financing structure and strategic use of the non-state sector to advance the PHC effort.

(3) Strengthen human resources and the service delivery system to support PHC, especially capacity building of community-based health workers (CBHWs) and community health volunteers (CHVs); appropriate training of health workers consistent with the needs of PHC; review incentives for recruitment, deployment and retention of all health workers; improve the effectiveness of the referral system; and ensure availability of infrastructure and supplies.

(4) Develop a strategy for improving health information systems that can better support setting of priorities and targets, identifying indicators as well as monitoring progress towards national goals and health-related MDGs; monitoring of equity as well as correcting the inequity gap; and multisectoral collaboration in planning, implementation and monitoring progress of PHC.

(5) Establish mechanisms as well as strengthen capacity for health systems research and ensure its linkage with health policy and programme implementation.
(6) Empower communities, especially women, to take an active role in ensuring responsiveness and accountability in PHC.

(7) Strengthen the capacity of ministries of health in governance and stewardship to coordinate all health and health-related sectors and stakeholders. 
This needs to be done in the light of overall public sector reorientation towards PHC.

(8) Advance PHC by ensuring governance and stewardship which is critical for PHC to reorient the public sector towards PHC; coordinate other health and related sectors and stakeholders to strengthen PHC particularly by regulating the non-state sector, comprehensive monitoring and evaluation and conducting advocacy.

It was recommended that WHO:

(1) Assist in direct capacity building at country level for strengthening PHC-oriented health systems;
(2) Provide normative support for country capacity;
(3) Advocate with national governments on the need for multisectoral action for PHC;
(4) Provide global leadership in orienting other development partners towards PHC.

These recommendations were discussed by the subsequent Sixty-first Session of the WHO Regional Committee meeting.
one

Introduction
Introduction

The Health for All movement was part of the Alma-Ata Declaration on primary health care (PHC) in 1978 and was to be achieved by the year 2000. This target has not yet been achieved. Thirty years after PHC was adopted as an approach to operationalize health systems, there are different perceptions of PHC which sometimes yield unfavourable health outcomes. Thirty years later, it is now time to revitalize PHC in the light of the changing burden of disease, globalization, trade agreements, social determinants of health, climate change, and other factors that influence health.

To this end, a Regional Conference on Revitalizing Primary Health Care (PHC) was organized on 6–8 August 2008 in Jakarta, Indonesia. Over 200 participants attended the Conference, representing all 11 Member countries of the South-East Asia Region as well as all health-related stakeholders – from grassroots-level community workers to national government officials to international development partners.

Objectives

General objective
To revitalize primary health care (PHC) in the changing context of health development and its risk factors and social determinants to achieve the Millennium Development Goals (MDGs) and Health for All.

Specific objectives

(1) To take PHC forward in the South-East Asia Region in the current context; and

(2) To provide recommendations on revitalizing PHC for consideration by the Sixty-first session of the WHO Regional Committee for the South-East Asia.
two Inaugural session
In his address, **Dr Samlee Plianbangchang**, Regional Director, WHO South-East Asia Region underlined the enduring relevance of PHC principles even 30 years after the Alma-Ata Declaration. He emphasized that PHC remains a powerful approach to addressing public health needs at country level and is key to achieving Health for All and national health targets, including those related to the MDGs. He also noted that PHC is an approach for social and economic advancement and, as such, must be planned for and implemented in the context of overall development.

Dr Samlee stressed that PHC means quality care for everyone, rich and poor, urban and rural, with an emphasis on protecting people from falling sick and encouraging them to lead a socially and economically productive life. PHC is an integrated element of total health care for the individual, family and community.

The Regional Director urged participants to reaffirm the commitment to attaining the social goal of Health for All through the PHC approach, and to continue to advocate for more political commitment to the development of national health systems based on PHC.
Revitalizing Primary Health Care

H.E. Mr Aburizal Bakrie, Coordinating Minister for People’s Welfare, Republic of Indonesia further detailed the Indonesian experience with PHC, highlighting the improvements in maternal and child health and life expectancy. He used the case of Social Health Insurance, which provides financial protection for 76.4 million people in Indonesia, to illustrate the importance of financial protection in national policies to improve equity in health. He mentioned the problem of those who are not yet covered by government insurance and said that a way will have to be found to implement compulsory health insurance for all.

Congratulating participants for their commitment to PHC, Mr Aburizal Bakrie hoped the conference would provide an effective forum for an exchange of ideas and experiences to move the agenda forward.

Reiterating the comprehensiveness of PHC, H.E. Dr Siti Fadilah Supari, Minister of Health, Republic of Indonesia presented the examples of Posyandu (Integrated Health Post) and Desa Siaga (Alert Village) in Indonesia, which have successfully captured community participation and
multisectoral collaboration within the PHC framework to make significant advances towards universal coverage. Moreover, as the Minister pointed out, this PHC foundation is also proving to be an effective platform to meet the challenges of food shortages, energy crisis and climate change – other issues that impact the poor disproportionately.

Dr Halfdan T. Mahler, Dr Samlee Plianbangchang and Dr Budihardja Singgih (Indonesia) at the press conference.
Revitalizing Primary Health Care
three

Keynote addresses
The social litmus test

*Dr Halfdan Mahler, WHO Director-General (Emeritus)*

Dr Mahler called for a recommitment to PHC principles and said that health is the fundamental right of every human being as mentioned in WHO’s Constitution, and reminded participants that PHC was at the heart of WHO’s objectives and its definition of health. In underprivileged populations, a persistent combination of several problems including ill health constrained the will and initiative to make changes for the better.

The significance of PHC for health policy and planning, he pointed out, is greater than ever today because it is anchored at the community level and captures contextual relevance and is responsive to health needs, particularly issues of equity and use of appropriate technology. Further, PHC encapsulates both sectoral and intersectoral aspects of all health and health-related interventions, including prevention and promotion. He urged the participants to radically change their attitude of narrowly relating health to the achievements of the health services, acquire a broader perspective, and think of health as resulting from overall
socioeconomic development of which the health services are a part. He also stressed the need for health systems research to achieve real progress in the organization and management of health care.

As the way forward, Dr Mahler singled out problem-setting, interventions assessment and information systems and the need to align these to the PHC framework. He warned that the fight for social and economic justice can often be frustrating, since development knows no limits, and “the more you move along its road, the more you want to move. You cannot blame people if they strive to join up with those who are further along the road than they are. That is only human nature.” Injustice, however, has to be seen through the eyes of those who are furthest behind on that road, and should not take over the world.

He urged participants to use the vision generated by the Health for All and PHC Strategy of Alma-Ata to guide us along the bumpy health development road.

**Revitalizing primary health care to catalyse MDGs’ achievement**

*Ms Erna Witoelar, former UN Special Ambassador for MDGs in Asia and the Pacific*

Ms Witoelar emphasized that PHC was crucial to meet all the MDGs. The world today has the resources, knowledge and technology to meet the challenges to development, but no sector can do this alone. She suggested that a multisectoral approach such as the PHC approach forms the nucleus of a comprehensive development strategy. Such a holistic approach that takes into account the social, economic and political contexts
builds synergies among sectoral policies and strategies, and develops multistakeholder partnerships at all levels.

**Primary health care, what is it all about?**

*Dr Amorn Nondasuta, former Permanent Secretary, Ministry of Public Health, Royal Thai Government*

Dr Nondasuta underlined the importance of a managed strategy in revitalizing PHC. This needs to be based on widely acceptable defining indicators, e.g. basic minimum needs. Building on this, the strategy itself would need four components: (i) inputs into its development – organization, human resources and information; (ii) appropriate processes, particularly efficient management; (iii) inclusion of all stakeholders, especially communities; and, importantly, (iv) an empowered public. While emphasizing the role of community health workers and volunteers, he cautioned that developing such cadres must be seen as a means and not an end – they are not the only path to realization of PHC and, in fact, need to be given a broader development orientation rather than being restricted to service delivery.

**Revitalizing PHC strategy: A move from service delivery to a development approach**

Dr Nondasuta compared realization of the PHC concept to horticultural practice. To reap the benefits, at least three favourable components are needed; good seed (the concept of quality of life/PHC), good soil with light and water (the community), and good gardening practices (right or appropriate technology).
Presenting the perspective of the United Nations Children’s Fund (UNICEF), Mr Gianfranco Ratigliano, UNICEF Country Representative highlighted the importance of PHC in country efforts towards achieving MDGs 4 and 5. Mr Joachim von Amsberg, World Bank Country Director, Jakarta placed health at the centre of development and poverty alleviation, and underlined the role of PHC in addressing these issues from the community upwards. Both representatives noted the importance of opportunities such as the conference for countries and development partners to come together and agree on practical steps to support national development agendas.
Revitalizing primary health care

Dr Somsak Chunharas, Chairman of WHO Expert Group on Revitalizing Primary Health Care

Dr Chunharas presented the working paper on revitalizing PHC. He identified the three perspectives of PHC: (1) a package or set of activities that contains a minimum of eight elements that combine selective and comprehensive PHC; (2) provision of care at various levels – primary, secondary and tertiary; and (3) approach: universal coverage, intersectoral collaboration, community participation and use of appropriate technology.

Dr Chunharas touched upon the misperceptions of PHC, i.e. PHC is only for poor, developing countries; it is cheap and low-quality care; it is only for rural populations and is synonymous with primary care or the first point of contact. There is a need for better partnership with the private sector, though this aspect was not specifically addressed at Alma-Ata.

There is a need for health systems strengthening using the PHC approach to better accommodate the needs of various vertical programmes and as an effective framework to address key challenges.
in the implementation of PHC. These challenges include inequities, particularly in financial access; service delivery, including integration of programmes and inclusion of the private sector; integration beyond the health sector for all health-related issues, including social determinants of health and macroeconomics and trade; and political commitment and governance. He proposed a new definition of “Health for All” without a time definition for the process of revitalizing PHC:

A stage of health development whereby everyone has access to quality health care or practices self-care protected by financial security so that no individual or family experiences catastrophic expenditure that may bring about impoverishment.

Dr Chunharas mentioned that the MDGs provided a universal framework for development and a means for developing countries and their development partners to work together, and that routine monitoring of MDGs is necessary. He further proposed to use the MDGs as proxy indicators for health for all. Health systems using the PHC approach comprise all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence the determinants of health as well as more direct
health-improving activities. Health systems are highly context-specific; there is no single set of best practices that can be put forward as a model for improved performance. He also explained the aims and requirements of each factor in the “six building blocks” of the WHO Health Systems Framework based on the *World Health Report 2000* which have been advocated since 2007. He urged the participants to review health systems based on PHC and elaborated on inequities in health outcomes within and across countries.

Dr Chunharas listed the challenges in implementing PHC; misinterpretations of the concept of PHC; burden of diseases; inequity in health; escalating health care cost; trade agreements; interdependence of the world; inadequate performance or low efficiency of the health system; the need for more research; financing the health system; the need for integrated services; public–private partnership; and climate change.

The graph below highlights the gap in coverage of skilled birth attendance between the rich and the poor, which has remained the same or increased between the 1990s and post-2000. However, in India, the richest 20% of women are five times more likely to receive skilled attendance at birth and, in Indonesia, they are four times more likely to do so than the poorest 20%.

*Inequities in skilled birth attendance between the poorest and richest wealth quintiles by country and survey year*

![Graph showing inequities in skilled birth attendance between the poorest and richest wealth quintiles by country and survey year.](image)


Legend: NEP: Nepal; BAN: Bangladesh; IND: India; INO: Indonesia; SRL: Sri Lanka; THA: Thailand.
Dr Chunharas proposed the following steps to revitalize PHC:

- reaffirm high political commitment toward PHC, improve health equity through specific actions in the health sector as well as in the social determinants of health; and foster more effective multisectoral collaboration for establishing and implementing a healthy public policy;
- strengthen the health workforce including CBHWs and CHVs;
- implement equitable health-care financing;
- strengthen partnerships with civil society;
- promote better transparency and accountability of the health systems through improved leadership and governance; and
- utilize to its fullest various global health initiatives such as the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and International Health Partnership (IHP).
five Technical discussions
The discussions focused on “Health systems strengthening using the primary health care approach” and were organized under four themes:

1. Equity in health
2. Multisectoral collaboration and its impact on health and quality of life
3. Health financing and poverty alleviation
4. Societal partnerships and local development to improve health

5a. Panel sessions

Panel A: Equity in health – Moderator: Dr Gado Tshering

1. Role of social determinants in health equity – Dr Ravindra Rannan-Eliya

The reality of health inequalities: The infant mortality rate (IMR) in countries reflects inequities in urban–rural, male–female, and
education-income quintiles. The Social Determinants Framework provides reasons for these health inequalities.

- **Causes of social inequalities in health:** Social position affects exposure to environmental risk factors, access to medical interventions, and is associated with differences in health-seeking behaviour. The social determinants approach shows that medical care does matter for PHC. Health care is a key social determinant, and can reduce the impact of differentials in risk exposure for many health conditions. Access to medical care is a key intervention that can reduce social inequalities in health outcomes. Countries that provide universal access to medical care have smaller inequalities in most health outcomes (Maldives, Sri Lanka and Thailand). Universal access is achievable at low incomes and without heavy expenditures on health.

The impact of medical technology is changing as shown by the global decrease in IMR. Demand-side factors such as the knowledge and awareness of patients and their carers may require a change in existing beliefs.

**Social determinants are the root cause of health inequity**
- **Intersectoral actions are needed to address it.**

2. **Role of the health sector in promoting health equity – Professor Vinod Paul**

The health sector can and must promote health equity by increasing its efficiency and coverage to reach the poor and disadvantaged. There are several evidence-based ways in which health systems can alleviate the current inequities in service provision and utilization.

Principles of equity must be reflected in the entire landscape of health action, including programme goals, financing, infrastructure, allocation of human resources, grassroots activities as well as monitoring. Objectives/targets of the programme, and monitoring
indicators should be equity-sensitive – i.e. stated in terms of coverage levels and outcomes among the poor.

Health infrastructure and worker density among disadvantaged populations and regions should receive priority attention and resources. Programme interventions need to be channeled through the workers and facilities that the poor reach out to.

Poor communities are often better served by services delivered at their doorstep, and by those that mobilize local resources such as CBHWs/CHVs. In specific situations, targeting interventions to the most needy is the best approach. Targeting may be direct or indirect, or based on a specific characteristic such as pregnancy or HIV status.

Public–private partnerships may be more successful than the government in reaching the poor and vulnerable. User fees are a deterrent to service utilization by the poor. Innovative demand-generation strategies, in particular, conditional cash transfers, have been shown to benefit the poor.

The PHC approach aims at making basic health services affordable and widely available, especially to poor and rural populations. Pro-equity underpinnings are germane to the PHC approach, and it is therefore logical to mainstream them into strategies to strengthen, reposition and reform health systems to make them pro-poor, especially in the context of the MDGs.

A pro-poor policy can improve health equity.

3. Healthy urbanization and social determinants of health – Dr Jacob Kumaresan

Global estimates show that three billion people, or half of humanity, live in urban areas. The impact of urbanization on health is significant in the South-East Asia Region, due to the sheer size of its urban population and, more importantly, because it houses nearly half of the world’s poor. The urban setting is a determinant of health, a lens that modulates the other social determinants of health. Healthy
urbanization is the assessment and promotion of a reduction in health inequity in urban settings, recognizing that cities have distinct qualities, resources and problems.

The Declaration on Health Development in the South-East Asia Region in the twenty-first century reaffirmed the unstinted commitment of local stakeholders to address the rising challenges of health gaps and inequities.

In 2006, the WHO Centre for Health Development, Kobe, Japan, in collaboration with WHO Regional Office for South-East Asia (SEARO), the WHO India Country Office and the Bangalore Municipal Corporation, India, supported an integrated and multisectoral process in Bangalore to address strategic local health issues in the community. This approach led to several action research projects where a blend of community health, public health and public policy interventions were made through the participation of decision-makers and stakeholders in health, education, welfare, law, transport, gender issues and faith. This resulted in 34 recommendations, of which 25 have been translated into concrete action. The overwhelming success of this initiative has led to ongoing efforts by the Bangalore Municipal Corporation to institutionalize this process by setting up an intersectoral board to promote the health of city dwellers. This is an excellent example of how city officials and leaders can reduce health inequities among local residents.

**Health of the urban population is not always better than those residing in rural areas. An intersectoral approach addressing the social determinants of health plays an important role in healthy urbanization.**

Rapid and unplanned urbanization results in new challenges for global health and PHC systems. To ensure that urbanization is beneficial for health and a driver of positive health outcomes, good governance is needed, which includes empowering individuals and communities to achieve collective social action. PHC can contribute to this goal due to its community-based dimension,
comprehensiveness and coordination with other sectors. Achieving healthy urbanization and health equity in all countries is a global and shared responsibility.

**Discussion**

During the presentations, the following points were noted:

- The public health system is a major determinant of health. The importance of health equity through a functioning, effective public sector health system was recognized, in conjunction with an appropriate role/contribution of the private sector. Primary first-level care can be given higher priority and linked up with referral care.

- The promotion of health equity needs to be an integral part of all sectors, not health alone. A healthy public policy can be a way to obtain other sectors’ sustained commitment. Health-seeking behaviour contributes to inequality and demand creation is important to increase equity. Equity in health has to be supported by political commitment, and promotion and planning for equity must involve local action and responsibility.

- Targeted approaches for addressing equity in health have the potential to reach the poor. The poor have problems in accessing health services and the quality of service delivery can reflect inequity, e.g. the quality of providers is often worse in poorer areas. There are financial barriers that create inequalities; adequate funding and incentives are needed for health promotion activities/staff, and to address the role and management of CHWs.

- Research must be conducted on health systems to study inequities in service provision and use, and patterns of public and private use.

- Empowerment must be improved and made sustainable through improving education and income level, and take into account gender mainstreaming in health.
Revitalizing Primary Health Care

- Decentralization of the health system to the district level is needed to increase equitable progress across all geographical regions/socioeconomic classes. Civil society must be involved from the planning stage until implementation and monitoring of health programmes. The health information system must also be strengthened to support an evidence-based decision-making process.
- Strategies and policies are needed to address the social and health concerns among urban populations of the South-East Asia Region, particularly in slum areas.
- Political action is critical to ensure equity in health.

Panel B: Multisectoral collaboration and its impact on health and quality of life – Moderator: Dr George Fernando

1. Multisectoral collaboration in primary health care – Dr Sheena Moosa

Health system in the PHC era: The Alma-Ata Declaration and adoption of SEARO Regional Charter for Health Development held in 1980 in
the Maldives led to a paradigm shift in the health system. The first country health plan developed with intersectoral support was in 1981 – “On the way towards Health for All”. The Allied Health Training School was also established during this era, when visiting WHO consultants as lecturers.

**Maldives’ experience in the PHC era:** In the epidemiological context, progress has been made in eliminating malaria and decreasing the prevalence of tuberculosis (TB) and leprosy. With regard to multisectoral collaboration, malaria elimination in the Maldives started through a health plan supported by the Finance Ministry for free services, policy advocacy and facilitation of legislative support by the Ministry of Health (MoH) and continued political commitment. Control of TB and immunization gained community support by involving island chiefs as coordinators.

**Immunization coverage:** Maldives has achieved more than 95% coverage for immunization. In 1993, hepatitis B vaccine was introduced; the coverage in 2006 was 95%. The mumps, measles and rubella (MMR) vaccine, which was introduced in 2007 after an initial mop-up, has 85% coverage. The last indigenous reported case of poliomyelitis was in 1981. Surveillance for acute flaccid paralysis is being maintained.

**Critical success factors for multisectoral collaboration:**

- **Stewardship** – leadership and advocacy for PHC from WHO, public health officials;
- **Governance** – commitment of executives, ministers;
- **Financing** – resource allocation, mobilization for health sector investment and support services;
- **Skilled human resources** – dedicated and motivated health-care workers;
- **Technically effective interventions** – timely and continuing technical support and guidance from WHO and public health officials;
- **Empowerment of other sectors** – capacity building of focal points from other sectors;
• **Community action** – community support and volunteerism; and
• **Education** – a literate population.

Maldives’ experiences: Healthy public policy translated into multisectoral action, has been able to improve the health status of Maldivians.

2. **Healthy public policy** – *Dr Arum Atmawikarta*

The health system in Indonesia has improved over the past three decades. This improvement is reflected in the longer life expectancy and decreased rates of infant and child mortality.

However, Indonesia still faces significant health challenges. Maternal mortality and malnourishment among children are high. The health status of Indonesians also varies considerably depending on their socioeconomic circumstances. Moreover, the existing disparities in health status between urban, rural and remote areas are influenced by poverty-related health inequalities. Demographic and epidemiological transition has increased the demand on the health services. Economic growth, political stability, the democratization process and a decentralized policy would provide opportunities for health development in future.

Currently, health development in Indonesia has a strong legal basis. It is integrated into the long-term, medium-term and annual development plans. The health development plan has been integrated as a part of human resource development, economic development and poverty reduction.

There is ongoing political support from legislative and executive bodies. This is indicated by a significant increase in budgetary allocation since 2004. Besides, health has been included as a priority for national development along with the education sector and infrastructure development.
Intersectoral collaboration for health development has been strengthened. Health is now becoming a central issue in local government election campaigns in some areas. Many local governments have issued regulations to show commitment to the health sector. Health development programmes such as nutrition, water supply, sanitation, maternal health, and control of communicable and noncommunicable diseases are no longer health issues alone, but are considered as intersectoral issues of concern for central and local governments.

However, significant efforts must be made to link economic, social and health policies for integrated action. Regulatory structures pose the greatest challenges to this. Continual efforts are also needed to improve advocacy to stakeholders in order to ensure sufficient support, especially from the local government.

3. **Use of positive indicators to measure quality of life** – *Ms Tshoki Zangmo*

Gross National Happiness (GNH) is the official development philosophy of Bhutan, stemming from His Majesty Jigmi Singye Wangchuck’s belief. Happiness is the main objective of Bhutanese society and government policies and programmes aim to promote GNH. At present, GNH indicators are being developed to measure Bhutanese development.

Gross National Happiness is one of the positive health indicators that is being developed in Bhutan. This indicator is used along with conventional health indicators using the burden of disease approach.
Discussion

Following the presentations, the following key factors for successful multisectoral collaboration were noted:

**Political commitment and leadership:** Health should be included in long-term multisectoral national development plans and translated into the strategic plans of all relevant sectors. In addition, there should be a platform to facilitate multisectoral collaboration (this could be an existing forum for interaction). Such a collaboration should involve all stakeholders in the development, adoption and implementation of healthy public policies as an entry point for revitalizing PHC. All stakeholders should be taken on board, and civil society involved from the planning stage down to the implementation and monitoring stages.

**Health financing:** Adequate financial support should be ensured from different sources including the government sector, private agencies and donors. Other sectors should be involved in providing health insurance in different settings, e.g. the workplace.

**Involvement of the people in disease prevention and control:** NGOs and community-based organizations should be involved and empowered. Reliable and timely information should be available regarding the activities of the private sector and development of the National Health Account. Good stewardship by the government is also needed.

**Knowledge management:** Research should be conducted to harness evidence-based information for multisectoral programme planning and development. Bhutan’s “Gross National Happiness” was cited as a unique multisectoral approach to well-being.
Panelists: Dr Pongpisut Jongudomsuk, Dr J.P. Gupta, Professor Dr Ali Gufron Mukti and Ms Mittal Shah.

1. Equitable health financing – Dr Pongpisut Jongudomsuk

Thailand achieved universal coverage of health care in 2002 and the entire population is covered by three main public health financing schemes. The Social Security Scheme (SSS) covers employees in the formal sector while the Civil Servants’ Medical Benefit Scheme (CSMBS) covers government employees and their dependents. The rest of the population is covered by the Universal Healthcare Coverage (UC) Scheme, which is being implemented since 2002.

Universal coverage (financial security) can be achieved through third-party payment, i.e. tax-based health insurance schemes or social health insurance.

The UC Scheme has been in operation for six years with its management structure becoming more and more institutionalized. However, the main characteristics of the scheme have not changed
since the beginning. The scheme could improve access to health care of beneficiaries both for ambulatory services and hospital admissions.

Financing of the UC Scheme is progressive although it is a tax-based system. The key policy features that ensure benefit to the poor include a universal access for health care, health service provision based on primary care and the district health system, and a tax-based financing system. The administrative system for implementation of these policy features is not complex and improves management efficiency. Health service provision based on primary care improves access to health care for the poor as well as system efficiency. The poor benefit more from this improved access to health care than the rich, especially at public health facilities, and this prevents impoverishment. The quality of health care provided needs to be improved continually to increase the confidence of the beneficiaries in the scheme.

2. Health insurance for the poor – Professor Dr Ali Ghufron Mukti

As in other developing countries, Indonesia is facing problems of access, equity, efficiency and quality of health services. Approximately 70% of health-care expenditure is currently paid “out-of-pocket”. These problems have been exacerbated by the 1997/98 economic crisis and the implementation of decentralization since 2001. The most vulnerable and affected group is the poor. To protect the poor and reduce out-of-pocket payments, the central government started with the development of a health social security programme (JPS-BK) in 1998. The name of this programme has changed several times. In 2005, it became known as Poor Community Health Security (JPKMM), later as Health Insurance for Poor (Askeskin) and since 2008 it has been known as Community Health Security (Jamkesmas).

Health-care programmes in Indonesia are run under a three-tiered health insurance system. Under the first tier, social health insurance is provided through PT Askes and PT Jamsostek. Askes is a compulsory health insurance scheme for active and retired civil servants, retired military and police officers, veterans and national
patriots, and their families. Jamsostek is the social security scheme for private sector workers and includes a health component. It provides health insurance for some formal sector workers. Under the second tier, private health insurance is provided through private insurance companies, self-insured schemes and other initiatives.

Under the third tier, the Ministry of Health and local authorities run public health-care systems for the uninsured through Jamkesmas and Jamkesda (local government initiatives). Jamkesmas covers about 76,400,000 people with an almost unlimited benefit package. The premium for the poor is paid by the Government, and is currently IDR 5000 (US$ 0.50) per person per month. Jamkesmas allocates a down payment to both public and private contracted hospitals. Hospitals are reimbursed by Jamkesmas using a package payment system and INA-DRG (diagnostics-related groups in Indonesia. Reimbursement for primary care services is allocated directly.

This scheme has improved financial protection and access for the poor. The utilization of health-care services, both primary care and hospitals, has increased dramatically. However, the scheme has some challenges; for example, transport costs for those who live far from health facilities are high. Some hospitals face difficulties in covering the cost of drugs prescribed outside the standard formulary. Some patients admitted to hospitals fraudulently claim to be a Jamkesmas card holder, etc.

The number of the poor is estimated by the Central Bureau of Statistics, whereas local governments identify potential beneficiaries for Jamkesmas. The signed list of these beneficiaries is sent to PT Askes, which issues membership cards. Those who are non-poor may be covered by their local government. Due to overstretching of
services in 2007, funds were not sufficient to compensate PT Askes. Various measures were taken, such as tight monitoring of medical investigations in some hospitals, reduced benefit packages, etc.

To ensure financial feasibility and sustainability of scaling up the number of beneficiaries, sharing responsibilities and finances with other parties, for example, local governments and communities, is being considered. Currently, strategies to integrate the schemes into a consolidated national pool are being developed. One alternative is “integrated decentralized management of the system”. Another is to request local governments to contribute to the central management of Jamkesmas.

Lessons learnt from the Jamkesmas scheme can be summarized as follows. The scheme has made a significant impact on reducing financial barriers for the poor. This has increased the utilization of services, both in PHC and hospitals. However, some homework needs to be done, especially on management and administrative issues, the role of various stakeholders, management information systems, financial sustainability and benefit packages.

3. Health, income generation and poverty alleviation – Ms Mittal Shah

The Self-Employed Women’s Association (SEWA) is a trade union of over 1.1 million women workers in the informal sector. SEWA aims to achieve full employment and self-reliance for poor women workers. Through organizing women workers, SEWA attempts to ensure income security, work security, food security and social security.

SEWA members work long, hard hours in difficult conditions. They get sick frequently and, as a result, often fall into debt from illness expenditure – and deeper into the cycle of poverty. Thus, SEWA found that health security is a critical component of income security. To protect women from debt, a needs-based integrated insurance product has been developed that provides illness, life and asset coverage. SEWA’s insurance programme, Vimo SEWA, is integrated with microfinance, economic and health activities.
Vimo SEWA’s scheme and design innovations encompass a cashless payment mechanism to promote quality health-care services and equity for members. Vimo SEWA is fully implemented by the grassroots women themselves, thereby ensuring that services remain needs- and community-based.

SEWA’s preventive and promotive health activities are fully integrated within the insurance programme – a unique approach to promoting primary health while improving programme efficiency.

**Vimo SEWA: Cashless payment promoting health care.**
Community-based health insurance has been successfully achieved through women’s empowerment linked to income generation.

Vimo SEWA’s experience in scaling up health insurance for the poor, including through a new government insurance scheme, was also discussed.

**Discussion**

The presentations highlighted the following key points:

- The cost of accessing health care is a major cause of impoverishment.
- Social protection schemes for the poor are being implemented in different ways:
  - Thailand has incorporated protection for the poor through broad-based social security and universal coverage.
  - Indonesia has a targeted scheme for the poor through a social aid programme financed by the national budget (tax revenues).
  - The Self-Employed Women’s Association in India is a community-based financing scheme that focuses on income generation and empowerment of women.
- Challenges to social protection include securing financial protection for high-cost private care; increasing demand/utilization of services among the poor; improving efficient
resource use; and ensuring overall sustainability of social protection schemes.

Other key management issues in efficient integration of the referral system include: establishment of standard operating procedures (SOPs) for a referral system that is linked with cost at the first level of entry. The primary level of care should act as a gatekeeper to prevent unnecessary referral to the secondary or tertiary level of care. For life-saving procedures, the primary level of care should ensure fast and timely referral. Third-party payment or health insurance schemes that ensure efficient use of funds (capitation or diagnostic-related) are other ways of improving referral efficiency.

The non-state sector can be effectively tapped in safeguarding the needs of the poor by establishing public–private partnerships with strong government stewardship, and with the government focusing more on public goods.

The key changes needed in the government’s role and responsibilities in addressing the challenge of health financing and poverty are: enacting pro-poor laws and regulations to promote health and gender equity, law enforcement, incentives for the health workforce to boost efficiency and establishment of healthy public policies.

Panel D: Societal partnerships and local developments to improve health – Moderator: Dr B.D. Chataut

Panelists: Dr Kim Sung Chol, Dr B.D. Chataut, Dr San Shway Wynn and Mr Faruque Ahmed.
1. Community empowerment through micro-credit scheme to improve community health – Mr Faruque Ahmed

The Bangladesh Rural Advancement Committee (BRAC), one of the largest nongovernmental organizations (NGOs) in Bangladesh, takes a holistic view of development and effectively uses a micro-credit scheme for poverty alleviation and empowerment of the poor. Through village organization (VO), BRAC has organized 7.3 million poor, mostly women, into 260,785 VOs, which serve as forums where they can collectively address the principal impediments to their development paths.

BRAC’s outstanding achievements for decades in development, including in health, were achieved by empowering the community through micro-credit schemes.

VOs are the nucleus of BRAC’s development interventions. They carry out health interventions through CHVs culled from the VOs. The CHVs are linked with a livelihood strategy through both micro-credit and a revolving fund for basic drugs. BRAC’s 70,000 CHVs reach 92 million people throughout Bangladesh. BRAC’s micro-credit scheme for VOs has provided a critical foundation for the sustainable scaling-up of BRAC’s health programmes.

In 2007, BRAC’s TB case detection rate was 79% and the BRAC-VO member child immunization rate was 96% compared with national rates of 71.5% and 82%, respectively.

2. Community-based health workers and community health volunteers in local health development – Dr San Shway Wynn

Myanmar has adopted the PHC approach. Since 1978, four-yearly plans have been drawn up and implemented. National health plans have been developed and implemented since 1991.

CBHWs led by township medical officers play the main role in health-care coverage of the community, both in urban and rural areas.
Health care delivery in urban areas is undertaken by urban health centres, school health teams, and maternal and child health centres.

For rural health care, each township has four to seven rural health centres (RHCs), and each RHC has four subcentres. For a population of 55.4 million, the country had 1452 RHCs in 2005; 28,872 CHWs in 2003; and 6 beds/10,000 in 2005. In 2004, there were 9.9 CHWs/10,000 population.

**Community-based health workers and community volunteers in local health development are essential components of PHC in achieving universal coverage in Myanmar.**

The proportion of CBHWs to the rural population is as follows: health assistants 1/23,100; lady health visitors 1/3970; and midwives 1/4580. CBHWs are voluntary health workers and auxiliary midwives, in a proportion of 1/900 and 1/1258, respectively. CHVs are trained for four weeks to six months by the township training team.

**Progress towards the MDGs:** Targets for improved water supply and sanitation have been achieved. The child mortality rate has been halved during 1990 to 2003, and the country is on track for achieving this MDG target. Maternal health and nutrition may require scaling up. The major health problems are low birth weight (10% in 2004), stunting (32% in 2004) and underweight children (32% in 2004).

**Main achievements:** There has been a steep increase in TB case detection (38% in 1990, 55% in 2000 and 95% in 2005) and an increase in coverage with directly observed therapy, short-course (DOTS).

**Coverage of health services:** Coverage with antenatal care (ANC) for pregnant women was 66% in 2004 (four visits), deliveries by a qualified attendant 68% in 2003, and immunization of children was 76% for BCG and 72% for measles in 2005.
**Issues and challenges in scaling up services:** These include improving community participation and managerial performance, teamwork between the CBHW and CHV, as well as productivity, efficiency and staff motivation. Attention is needed to ensure universal coverage of health services and to adjust to the rapid changes in the political, economic and social environment, and technology.

3. **Community-based health workers and community health volunteers in local health development** – Dr Kim Sung Chol

DPR Korea introduced PHC through the section doctor system that targeted family members in urban and rural communities, and workers in industrial areas. Services were provided to family members by household doctors and by workshop doctors to factory workers. The section doctors provide health care, disease prevention and outpatient services.

There are 16.6 household doctors/10,000 population or about one household doctor for 134 families. Service coverage of family health care is 97.3%, ANC 99.4%, delivery by health personnel 98%, immunization more than 82%, and distribution of iron–folic acid tablets to pregnant women 74%.

The challenges/issues include sustaining technical capacity of household doctors, uninterrupted provision of medicines and supplies, and monitoring and supervision of household doctors. The future plan includes developing training modules, reference materials and a reporting system.

There is a health committee at the community level in every administrative block in DPR Korea. It is headed by the chairman of the county committee, and members include heads of health institutions, representatives from the civil society city management
and food service sectors. Their main responsibility is to plan and implement public health programmes through health promotion and disease prevention. The challenges are financial constraints and coordinating with the household doctors.

4. Role of civil society in supporting the district health system – Mr Amarjeet Sinha

The thrust of India’s National Rural Health Mission (NRHM) is on securing quality health services that are accessible, affordable and accountable in remote rural areas. The assumption is that only by having people’s health in people’s hands can the wider determinants of health care be addressed in India. The effort has been to craft a credible public system of health care by establishing decentralized institutions for local communities from the village to the district level. Such committees are under the umbrella of the local governments and allow for involvement of all those with the motivation to improve the lives of people.

The following are the salient features of NRHM:

- Support states to improve infrastructure and human resources for health by using flexible financing procedures and decentralization measures.
- Support community monitoring to allow for the setting up of monitoring committees at primary health centres, block, subdivision and district levels.
- The accredited social health activist (ASHA) or CHW is envisaged as a social health activist who connects households with the health facilities.
- A broad framework has been recommended to states for promoting communitization of all their institutions and activities.

Action to enhance human resources comprises nine key activities which provide for improved coverage, motivation and competence of health workers in the health system. Many of the reforms advocated by the NRHM have also been taken up by the state governments to manage their own cadres and monitor their career.
progression against standards. These include identifying the key shortages against the Indian Public Health Standards (IPHS); improving nursing institutions; and mobilizing district hospitals to set up medical colleges. Flexibility in human resource management is key to improving and increasing health service delivery at all levels.

Monitoring against the IPHS: (1) The NRHM has developed standards for health institutions to make them reach a certain basic level of services. (2) An intensive accountability framework is planned through a three-pronged process of community-based monitoring, external surveys and stringent internal monitoring. (3) To increase accountability, wide dissemination of the surveys results in a comprehensible format is planned. All health institutions are required to display information regarding grants received, medicines and vaccines in stock, user charges, and other aspects as envisaged in the Right to Information Act, 2005.

Expected outcomes of the NRHM: These include setting up health infrastructure at various levels, establishing village health and sanitation committees, improving health infrastructure through utilization of untied funds, ensuring availability of drugs, training CHWs, improving public health-related services at Anganwadi centres (village level), contracting various categories of health workers at different levels, distributing funds to health institutions to improve services and cater to the increased demand for services.

Significant increase in outputs: The coverage of sterilization has increased; there has been a 20% increase in births attended by health workers. Most states have reported an increase in the numbers of outpatients, inpatients and institutional deliveries, and coverage with family planning services and immunization.
Discussion
The following key points were noted after the presentations:

- Adequate and competent CBHWs and CHVs play a vital role in health development of the community. Efforts related to empowerment should be linked to income generation. Factors that may impede community participation is a top-down approach that does not sufficiently involve civil society, and insufficient monetary and non-monetary incentives.

- NGOs and the private sector working in partnership with the government can lead health-care initiatives and enhance community movement. Involving them from the planning stage and developing a body or committee in the decentralized administration system that can voice community concerns can strengthen this partnership.

- A strong civil society can push the agenda for local development of community health care. Health promotion, self-care and risk prevention should be intensified.

- Decentralization of the roles and functions of health specialists to CBHWs and CHVs as well as community trusts contribute to positive community health outcomes. Good supervision and ensured referral, provision of monetary and non-monetary incentives are some factors that contribute to their sustainability.

5b. Group discussions
The purpose of the group discussions was to reflect on the key issues for revitalizing PHC and propose strategic actions to the Sixty-first Session of the WHO Regional Committee for South-East Asia. The participants were divided into four groups and asked to discuss issues relating to the following themes.
Group discussion 1: Equity in health.

Group discussion 2: Multisectoral collaboration and its impact on health and quality of life.

Group discussion 3: Health financing and poverty alleviation.
5c. Conclusions

Conclusions from the group discussions have been categorized into five areas:

1. Leadership and governance
   - Strengthening PHC should be viewed as an integral part of overall development and central to equity and poverty alleviation.
   - A high degree of political commitment is necessary to ensure equitable health care. This could be reflected by adequate and appropriate budgetary allocations for health.
• The health system building blocks may be seen as effective entry points for non-state (private and non-profit) participation in the PHC effort; the regulatory and facilitatory role of the government is important for this.
• Decentralization of health management (financial and administrative), in a country-specific context, with effective capacity building, should be considered as a part of revitalizing PHC.

2. Human resources
• Capacity building of all stakeholders in PHC at all levels needs re-emphasis, with a focus on first-level and community-level providers.
• Adequate and well-trained human resources are necessary. The role of CHWs and CHVs in the changed context needs to be revisited and redesigned.
• Innovative ways are needed to reward and motivate CBHWs/CHVs.
• PHC principles must be integrated in the curricula of educational institutions – medical, nursing, midwifery and public health.

3. Multisectoral collaboration
• The health sector should play an important, proactive and sensitizing role in effecting intersectoral collaboration. The roles of the other sectors in health should be recognized, monitored and promoted using a common agreed framework and indicators.
• Avenues for an interface between the public and private (profit and non-profit) sectors need emphasis. Operational research can help define the most efficient means for effective public–private collaboration.
• Participation of civil society networks should be promoted so that they play an important role in revitalizing PHC.
• Innovative ways for community empowerment, especially of women, need to be explored and implemented. One way to do this is to give the community a role in monitoring and supervision.

• Governments should explore setting up an institutional mechanism to foster multisectoral collaboration at all levels; this will also facilitate effective community-based action.

4. Managing financial resources

• Financial barriers are an important constraint for marginalized populations in accessing care.

• Government financing through general taxation is the most equitable mechanism to finance health.

• Social and community health insurance supplement tax-based financing. These are equitable mechanisms to finance health systems in line with the PHC approach.

• Corporate social responsibility as a means to finance community empowerment should be explored.

• It is essential to effectively allocate, manage and utilize resources across different types of care (preventive, promotive, curative and rehabilitative), and all levels of care as well as sectors (health and health-related).

5. Knowledge generation

• Health systems research needs to be strengthened to promote effective and efficient functioning of health systems based on PHC.

• Social determinants are important for equitable health. More research is needed to understand how the health sector can address the social determinants of health.

• Health impact assessments, as part of a healthy public policy, need to be done at regular intervals.

• Research findings on health systems must be disseminated, and their link to policies and programmes strengthened.
Six Recommendations
Recommendations

Recommendations for Member States

It was recommended that Member States:

1. Reaffirm their political commitment to PHC as an effective approach to address national health needs. This approach:
   - is anchored at the community level and is responsive to its health needs;
   - emphasizes overall health systems strengthening to improve equity and efficiency; and
   - shifts from a focus on service delivery to a development oriented one in the country’s social, political and economic contexts.

2. Review health financing and expenditure with respect to:
   - equity and efficiency of tax-based funding vis-à-vis national health priorities;
   - financing options for funding gaps, especially contributory schemes such as social and community insurance that can support PHC principles;
   - flexibility of the financing structure to improve responsiveness in resource use at all levels of public health administration/management; and
   - strategic use of the non-state sector to advance the PHC effort.

3. Strengthen human resources and service delivery systems to support PHC, especially:
   - capacity building of CBHWs and CHVs;
• appropriate training of health workers consistent with the needs of PHC, including review of the skills mix and curriculum;
• review of incentives for recruitment, deployment and retention of all health workers, particularly in poor and underserved rural as well as urban areas;
• in improving the effectiveness of the referral system; and
• the availability of infrastructure and supplies, including appropriate procurement and equitable distribution of medicines.

(4) Develop a strategy for improving health information systems that can better support:
• setting of priorities and targets, identifying indicators as well as monitoring progress towards national goals and health-related MDGs;
• monitoring of equity as well as correcting the inequity gap; and
• multisectoral collaboration in planning, implementing and monitoring the progress of PHC.

(5) Establish mechanisms as well as strengthen capacity for health systems research and ensure its linkage with health policy and programme implementation.

(6) Empower communities, especially women, to take an active role in ensuring responsiveness and accountability in PHC as well as to advance the approach more generally.

(7) Strengthen the capacity of ministries of health vis-à-vis their governance and stewardship responsibilities to coordinate all health and health-related sectors and stakeholders, particularly:
• to profile and advocate for health in the development agenda;
• to regulate the non-state sector; and
to comprehensively monitor and evaluate the multisectoral PHC effort.

This needs to be done in the light of overall public sector reorientation towards PHC.

**Recommendations for WHO**

It was recommended that WHO:

(1) Assist in direct capacity development at country level for strengthening PHC-oriented health systems;

(2) Provide normative support for country capacity, particularly in
   - consolidating and disseminating the lessons learnt from international experiences with PHC; and
   - facilitating exchange and horizontal support between countries.

(3) Advocate with national governments on the need for multisectoral action for PHC.

(4) Provide global leadership in orienting other development partners towards PHC.
seven  Closing session
Dr Budihardja acknowledged the challenges that need to be faced in moving forward but underlined that the public health community today had the capacity to meet these challenges successfully.

Dr Mahler posed a slightly different challenge to the public health community as well as politicians – commitment to PHC. Recalling his words at Alma-Ata, he repeated the same critical question at Jakarta, 30 years later: do we have the commitment to meet the challenges in implementing PHC? Representing the participants, Dr Gado Tshering agreed with the conclusions and recommendations. He expressed appreciation for the opportunity created by WHO SEARO for Member States to discuss and agree upon the way forward in revitalizing PHC.

Dr Tshering particularly called upon WHO to be a key partner for countries in advancing this agenda.
In his closing remarks, Dr Samlee reiterated WHO’s commitment to PHC and to assisting countries to progress towards better health for all. Emphasizing this last point, he added that the segregation of recommendations may be considered artificial, that recommendations for Member States were, in fact, recommendations for WHO as well. He then declared the conference closed.

Glimpses from the dinner and cultural show jointly hosted by the Minister of Health, Republic of Indonesia, and the Regional Director, WHO South-East Asia Region.
Annexes
Annex 1

Agenda

I. Inaugural Session

II. Business Session

(1) Keynote addresses

(2) Presentation of working paper on “Revitalizing Primary Health Care”

(3) Health system strengthening using Primary Health Care approach

(a) Panel discussion:
   - Equity in health
   - Multisectoral collaboration and its impact on health and quality of life
   - Health financing and poverty alleviation
   - Societal partnerships and local development to improve health

(b) Group discussion: (similar topics of panel discussion)
   - Equity in health
   - Multisectoral collaboration and its impact on health and quality of life
   - Health financing and poverty alleviation
   - Societal partnerships and local development to improve health

(4) Recommendations of the conference

(5) Closing remarks
Annex 2
List of participants

Bangladesh
1. Dr Saleh Muhammad Rafique
   Director (PHC)
   Directorate General of Health Services
   Dhaka
2. Professor Dr Khondhaker Md Shefyet Ullah
   Director (Medical Education)
   Directorate General of Health Services
   Dhaka
3. Dr Md Akhter Hossain
   Director (Training)
   National Institute of Population and Research Taining
   Dhaka
4. Ms Rashada Akhter
   Senior Assistant Secretary
   Ministry of Health and Family Welfare
   Dhaka
5. Professor Syed Md. Akram Hussain
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6. Mr Faruque Ahmed
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   Chairman
   Board of Intermediate and Secondary Education
   Rajashahi
8. Mr Md Lokman Hakim Talukder
   Joint Secretary
   Local Government Division
   Ministry of Local Government Rural Development and Cooperatives
   Dhaka
Bhutan
9. Mr Lhaba Tshering
   Planning Officer
   Gross National Happiness Commission
   Thimphu
10. Ms Rinzin Wangmo
    Deputy Chief Programme Officer
    Department of Youth, Culture and Sports
    Ministry of Education
    Thimphu
11. Mr Chencho Tshering  
Governor Thimphu District  
Ministry of Home Affairs  
Thimphu

12. Mr Norbu Gyaltshen  
Senior Programme Officer  
National Commission for Women and Children  
Thimphu

13. Ms Tshoki Zangmo  
Communication Officer  
Centre for Bhutan Studies  
Thimphu

14. Mr Rinchen Namgayel  
District Health Officer  
Chukha

15. Mr Ugyen Thinley  
Basic Health Worker  
Samtse

16. Mr Passang Thinley  
General Nurse Midwife  
Lhuntse

17. Mr Rinchen Dorji  
Chief Programme Officer  
Department of Public Health  
Thimphu

18. Ms Taumo  
Volunteer Village Health Worker  
Zhemgang

19. Mr Dorji Wangchuk  
Director  
Institute of Traditional Medicine Services  
Thimphu

20. Dr Ugen Dophu  
Director  
Department of Public Health  
Thimphu

21. Dr Kang Ha Guk  
Director of City Hospital No.1  
Ministry of Public Health  
Pyongyang

22. Dr Ri Yong Chon  
Director of City Hospital No.2  
Ministry of Public Health  
Pyongyang

23. Dr Ryu Rim  
Director of City Hospital No.3  
Ministry of Public Health  
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24. Dr Han Sok Yong  
Section Chief of National Institute of Public Health Administration  
Ministry of Public Health  
Pyongyang

25. Mr Amarjeet Sinha  
Joint Secretary  
Ministry of Health & Family Welfare  
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26. Mr Shushil Kumar Lohani  
Mission Director (NRHM)  
Unit-6  
Government of Orissa  
Behind Capital Hospital Bhubaneswar Orissa

27. Mr Rajeev Kapoor  
Mission Director (NRHM)  
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28. Dr M. Balasoudarssanane  
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219. Dr Ardi Kaptiningsih  
Regional Adviser for Reproductive Health and Research

220. Dr Sudhansh Malhotra  
Regional Adviser for Child Health and Development

221. Dr Prakin Suchaxaya  
Regional Adviser for Nursing and Midwifery

222. Ms Laksami Suebsaeng  
Acting Regional Adviser for HIV/AIDS

223. Dr Myo Thet Htoon  
Medical Officer, Global Leprosy Programme

224. Dr Davison Munodawafa  
Regional Adviser for Health Promotion and Education

225. Dr Alaka Singh  
Technical Officer for Health Care Financing

226. Ms Renu Sharma  
Administrative Assistant
227. Mr Sunil Jain
Secretary, Health Systems Unit

228. Mr Paramjeet Singh
Secretary, DPM Office

**WHO - Country Office (Indonesia)**

229. Dr S.R. Salunke
WHO Representative to Indonesia

230. Dr S.P. Jost
Senior Health Planner

231. Dr Firdosi Mehta
Medical Officer (Tuberculosis)

232. Dr Mohd. Shahjahan
Technical Officer (DHS)

233. Dr B. J. Rana
Medical Officer (EPI)

234. Ms Yingli Liu
Administrative Officer

235. Ms Kamilani Usodo
Assistant

236. Ms Ambar Widiastuti
Secretary

**WHO - Country Office (Bangladesh)**

237. Dr Frank Herbert Paulin
Medical Officer (PHA)

**WHO - Country Office (DPR Korea)**

238. Dr Kim Sung Chol
National Programme Officer
WHO Office in Pyongyang

**WHO - Country Office (Sri Lanka)**

245. Dr Agostino Borra
WHO Representative to Sri Lanka

**WHO - Country Office (Thailand)**

246. Dr Somchai Peerapakorn
National Professional Officer (Programme)

**WHO - HQ**

247. Dr John Martin
Adviser (Primary Health Care)
Director-General's Office

248. Dr Andrew Cassels
Director a.i./ HDS

**WHO - Country Office (Indonesia) - Observers**

239. Professor Subhash K. Hira
Team Leader, HIV/AIDS

240. Dr Y.C. Chong
Technical Officer-Monitoring

241. Mr Mohammad Luthfi
AI-Risk Communication Officer

242. Mr Omaj Masum
Sutisnaputra
AI-Risk Communication Officer

243. Dra Nani Sukasediati
EDM National Consultant

244. Ms Asmaniar
EPI-National Immunization Officer
Your Excellency, Mr Aburizal Bakrie, Coordinating Minister for Peoples’ Welfare, the Republic of Indonesia; Your Excellency Dr Siti Fadilah Supari, Minister of Health, the Republic of Indonesia; Dr Halfdan T. Mahler, WHO Director-General Emeritus; Dr Uton Muchtar Rafei, WHO Regional Director Emeritus; Ms Erna Witoelar, former UN Special Ambassador for MDG in Asia and the Pacific; Dr Amorn Nondasuta, former Permanent Secretary of Public Health, the Royal Thai Government; Distinguished participants; Honourable guests; Ladies and gentlemen:

With great pleasure, on behalf of WHO, I warmly welcome you all to South-East Asia Regional Conference on Revitalizing Primary Health Care.

First of all, I overwhelmingly thank the Government of the Republic of Indonesia for agreeing to host this conference. I gratefully thank His Excellency, Mr Aburizal Bakrie, Coordinating Minister for Peoples’ Welfare, the Government of the Republic of Indonesia, for his gracious presence to inaugurate the opening of the Conference. I thank all participants and guests for their valuable time to participate in this august gathering.
I specially welcome two of our eminent invitees. I warmly welcome Dr Halfdan T. Mahler, who served WHO in the capacity of Director-General for 15 years during the 1970s and 1980s. Dr Mahler had been “the father” of the Global "HFA/PHC Movement” during that period. Dr Mahler, it is indeed our privilege to have you with us at this important conference. We look forward to listening to your inspiring and thought-provoking keynote address.

I welcome Dr Amorn Nondasuta, former Permanent Secretary for Public Health of Thailand. Dr Amorn was the prime mover who extraordinarily spear-headed PHC development in his country. His work on PHC was well-known and applied not only in South-East Asia but also other regions of WHO. Dr Amorn, we look forward to learning from your rich experience.

I particularly thank both of them for sparing their time to be here with us.

Ladies and gentlemen;

All of us are aware that this year is the Thirtieth anniversary of the Alma-Ata Declaration on Primary Health Care (PHC). PHC, as we know, is the key to the attainment of the social goal of Health for All (HFA). The widening gap between “haves” and “have-nots” in health has been a serious concern all over the world. It is the impediment preventing us from reaching this social goal, the goal of HFA. During the past 30 years, all countries around the world attempted to close this gap – the gap between “haves” and “have-nots” – by developing and implementing their national HFA/PHC strategies. Countries in the SEA Region were among the pioneers in the successful development and implementation of the PHC approach. Experiences of these countries will be shared during the course of this meeting. 

Ladies and gentlemen;

Since we are here in Indonesia which successfully implemented the PHC approach, let me briefly mention their PHC work. Indonesia has made untiring efforts in strengthening health systems based on the PHC concept, even before the Alma-Alta Declaration was adopted
in 1978. Through community empowerment, applying the PHC concept, the country launched the Village Community Health Development scheme during 1960s. Following Alma-Ata Declaration, a system of Integrated Health Posts (POSYANDU) was launched. This system provided community with integrated services of immunization, diarrhoeal disease control, weighing of under-fives, health education and several others. Today, every village in Indonesia has, on an average, five Integrated Health Posts.

Recently, other innovations in community-based health care programme have been added, such as Village Maternity Huts and Alert Village. We must congratulate the Government of the Republic of Indonesia for its success in the development of community-based health services schemes through the PHC approach. I hope we have an opportunity during the course of this conference to learn more from Indonesia’s experience on PHC implementation.

Distinguished participants;

The Alma-Ata Declaration has broadened the medical model of health to include social and economic dimensions. The declaration acknowledged that activities of multiple sectors shaped the prospects for better health. PHC, as defined at the Alma-Ata Declaration, forms an integral part of the country’s health systems, of which it is the nucleus. PHC cannot be developed and implemented in isolation, without the support of national health systems. PHC is designed to be an important part of the overall social and economic development of community. The application of the PHC concept has been carried out in ways that suit the local sociocultural, economic and political context of the countries concerned. The concept of PHC has been adapted, applied and extended progressively in the process of its implementation to satisfy the dynamic health needs in individual countries in both short- and long-term.

In reality, many different forms of PHC exist throughout the world. What forms PHC will take, depends on the ground reality in countries, and on the interpretation of the concept by concerned parties and authorities. Nevertheless, experiences from the
implementation of PHC in countries for the past 30 years can be very useful lessons to learn today, especially by the development authorities and professionals. If properly developed and implemented, PHC will be a powerful tool for public health interventions. The interventions can help ensure reaching the unreached and help ensure equity and social justice in health. The unreached can be everywhere; rural or urban, and of any social class. The HFA goal will not be attained if the unreached are still not reached.

It is universally accepted that during the past 30 years, PHC has significantly contributed to positive changes in the ways that health systems in countries have been developed and managed. And certainly, PHC contributed significantly to the positive impact on the health of people around the world. Health-wise in general, we can agree that peoples of the world today are better off than they were 30 years ago. The application of the PHC concept has far-reaching consequences, which not only pervade the health sector but also impact on other aspects of social and economic development.

Ladies and gentlemen;

Whatever positive changes or positive consequences have taken place, these are not yet enough for HFA. Good health for all people is still to be realized. Today, the social goal of HFA still exists as an aspirational target, towards which all countries should strive in their quest for good health for all their citizens. And PHC is still considered to be the key to the attainment of this social goal. It is realized that during the past three decades, there have been many changes in all spheres: socially, economically, politically and technologically. And there have been significant transitions: environmentally, ecologically, demographically and epidemiologically. These changes and transitions have profoundly affected the ways we plan and manage our health policy and programme today.

It is a fact that, through the application of the principle of HFA, health has gone far beyond the confines of the health sector. Roles of other sectors are considered indispensable indeed for the attainment of HFA. More and more now, health issues become the
concern of the general public, and become subjects for public debate. The reflection of health issues in political agendas for social and economic development becomes very clear today. Health is becoming more prominent on the international development agenda. With the rapid global changes and the prevailing formidable health challenges today, it is now time to revisit PHC. We revisit PHC to ensure the continued relevance and effectiveness of its concept and operational modalities in responding to the current health development needs. We must ensure that PHC will continue to be firmly embedded as an indispensable element of public health interventions at all levels. The interventions can also help ensure timely achievement of health and health-related MDGs. These goals are important milestones in national development agendas, particularly in the area of human resources.

Ladies and gentlemen;

This is the year of revitalization of PHC. In this process of revitalization, we have to take into account the changing scenarios not only of global health, but also global politics and global economy. We have to take advantage, as much as possible, of the proliferation of “global health initiatives” and “international health partnerships” in our health development efforts. These “initiatives” and “partnerships” have important roles to play in shaping global health action in support of national health development in the developing world. In the development process, social and economic determinants of health must be adequately taken into consideration when healthcare services are planned and delivered at various levels of health systems. Consideration of these determinants is indeed required, when health programmes are developed and implemented based on the PHC approach.

All stakeholders have to be taken on board with “strong leadership” and “fair governance” that fully recognize and respect health as a fundamental right of everyone. We have to work much harder to achieve the universal coverage of health services across socioeconomic groups. This is the centre stage of PHC. We have to understand that PHC is “quality care” for everyone: rich and poor,
not only the poor; urban and rural, not only the rural. It is care that places emphasis on protecting people from becoming sick or disabled and promoting people to lead a socially and economically satisfied and productive life. It is an integral element of total health care for the individual, family and community. It is not second-grade care.

Distinguished participants;

At this important conference, let us once again reaffirm our unwavering determination and commitment to the attainment of the social goal of health for all through the PHC approach. Let us continue pursuing our untiring efforts to advocate for more political commitment to the development of national health systems based on PHC. Let us continue our endeavours to ensure quality care and quality services organized and delivered through the PHC approach. WHO will continue to work tirelessly in supporting the efforts of Member States towards these ends.

Finally, ladies and gentlemen, I wish the conference all the best and all success, and I wish all participants an enjoyable stay in this vibrant city of Jakarta.

Thank you.
Speech by H.E. Mr Aburizal Bakrie, Coordinating Minister for People’s Welfare, Republic of Indonesia

Ladies and gentlemen:

I am honored to be with you here in this important conference. The President, H.E. Soesilo Bambang Yudhoyono, sends his best regards to all of you. He is deeply sorry he couldn’t come this morning, but he shares your deep concerns and is waiting for my reports to him about the dialogues and ideas you discuss here.

I truly believe that with this conference, our understanding of the problems, as well as our knowledge about the possible solutions to the problems of universal health care provisions, especially in the developing nations, ASEAN included, will be greatly enhanced.

Here, I also believe that you will exchange ideas and experiences on how to improve the practices we have done so far in our respective countries. Keep on discussing, and keep on sharing. We are neighbours, and we have a lot to learn from each other.

Healthcare provisions actually know no state boundary, because viruses and bacterias have no passport. We just have to fight and control them together, without too much regard to the state and political borders. We have to work together, because that is what’s needed to solve our common problems.
Therefore, conference like we are having today, can contribute a lot to the exchange of ideas and experiences, to achieve better improvement in primary health care for all people.

Ladies and gentlemen:

In Indonesia, as part of our serious effort to improve the Human Development Index (HDI), the continuous development of the healthcare system in the last three decades has been quite successful in enhancing the public health. The mortality rate declined, babies and pregnant mothers are better taken care of, and older people live longer.

But at the same time we also realize that, compared to more successful countries, Indonesia has some homework to do. We have to improve the way we deal with the issue by learning more from them.

The problems we are facing become more complex, because of several factors, including poverty, life-style and public behaviour, and environmental factors (physical, biological and cultural).

But we are not going to let the problems and complexities stop or slow our efforts. The Minister of Health has explained in detail efforts to gently improve the public health.

Other priorities are healthcare provisions to the poor. The government has established Public Health Insurance (Jamkesmas) for 76.4 million people, which is more than twice the number of the poor. With the policy, the poor can go to our public healthcare centres (Puskesmas) and hospitals for all services, including operations, and be taken care of in the hospital for no cost. This is definitely the best achievement by the government. But still there are people, who have better income than these 76.4 million people, which have not been reached by the government-backed insurance. We still have to think of a compulsory health insurance for all.

Here, let me tell you something personal. I feel very proud to be part of this Government for many reasons. But one reason is this: the Government is very serious about this health policy, and the
results so far have been quite encouraging. More and more of our poor are being taken care of, as it must, simply because we need to help them, and they need a lending hand from their government.

Ladies and gentlemen:

Crosssectoral efforts are also needed. Here, the government policy to establish The Village Health Development is designed to meet this need. And with the cooperation with WHO and UNICEF, I am happy to know that this policy has been implemented with great results.

I want to close these short remarks by encouraging all of you to continue your good works and share your experience with one another, especially in doing service to our great and beloved people, and providing for them primary health care services.

You deserve praise and all the support we can give. And from me, I can only say that I am very proud of you, and on behalf of the people, I want to express my gratitude to your dedication, sacrifice and expertise.

Before closing, may I declare the conference open.

Aburizal Bakrie
Remarks by
H.E. Dr Siti Fadilah Supari,
Minister of Health,
Republic of Indonesia

- Honorable Dr Samlee Plianbangchang, Regional Director of WHO’s South-East Asia Region;
- Honorable Dr Halfdan T. Mahler, WHO-Director General Emeritus;
- Distinguished Delegates from the South East Asia Region;
- Distinguished Delegates and Participants from Indonesia;
- Ladies and Gentlemen,

First of all, let us convey our gratefulness to Allah, the Almighty God, for providing us good health and happiness. On behalf of the Government of Indonesia, I would like to express my gratitude and appreciation to WHO SEAR and the team, in conducting this important conference. I would like also to extend my appreciation and warm welcome to all participants for having provided their valuable time to attend this important conference.

This theme of “Revitalizing Primary Health Care” is very relevant in view of its essence and spirit of framework in the ongoing challenge of health development; in particular, to support health and health-related Millennium Development Goals.

Distinguished delegates, ladies and gentlemen,
We may recall that 30 years ago, in Alma-Alta, Member countries agreed to adopt primary health care as an approach for health development, aiming at achieving Health for All in 2000. Our commitment was stipulated in the Alma-Ata Declaration. In compliance to this, Indonesia has established the internationally well-known Integrated Health Post (POSYANDU). POSYANDU embraces four principles of primary health care, namely community participation, multisectoral collaboration, use of appropriate technology and universal coverage. On average, each village has five POSYANDUs, including at remote areas.

On this occasion, allow me to pronounce that upto 1998, the successful approach of POSYANDU contributed significantly to increased access and coverage of health services. The transition process of decentralization in year 2000 has put the Indonesia’s primary health care under challenge, and, therefore, the commencement of POSYANDU revitalization was urgently needed in 2001. Again, we are now experiencing fruitful deliberations of POSYANDU.

Ladies and gentlemen,

In the past decade, the challenges encountered within health development have been complex. While we are focusing on serious issues affecting primary health care, like emerging and re-emerging infectious diseases, public health emergencies and others, we are now faced with new challenges, climate change, an energy crisis and a food crisis. Despite our unfinished agenda in calculating the magnitude of economic costs posed by the above-mentioned factors on our healthcare system, the certainty is that the poor are disproportionately affected, leading to the inhibition of poverty alleviation programmes. This situation requires strong leaders to oversee policy with tangible actions in health sector comprehensively. The MDGs represent a good companion to the Alma-Ata Declaration in achieving Health for All in the years ahead. The establishment of the Commission on Social Determinants on Health (SDH) in the year 2005 has provided another landscape for us in our commitment to the materialization of Health for All.
At the national level, the Ministry of Health of Indonesia launched another form of community participatory approach in 2005, called “Alert Village” or “Desa Siaga”. Desa Siaga is an initiative towards addressing various health problems, including communicable disease outbreaks in the villages and remote areas of the country. Through implementing Desa Siaga, we aim to achieve self-help communities in addressing local health problems. This scheme is also an integral part of the Ministry of Health’s grand strategy, “Community Empowerment of Healthy Life”.

There are four basic principles with respect to Desa Siaga. Firstly, Desa Siaga is the “meeting point” between health services and health-related programmes organized by the government with organized community participation. Secondly, Desa Siaga has a strong notion of “preparedness” and “alertness”, which are basically started by knowing. Therefore, in order to make the community “alert” of any potential health problem, there must be an accurate and rapid information flow in the community. The third principle is “immediate response”. Once there is a recognized potential health problem, the community through the Desa Siaga forum shall take appropriate actions, and whenever these actions are considered insufficient, the formal health service system shall be informed. Fourthly, Desa Siaga is a “vehicle” for the community and health service system to carry out other related health programmes and activities.

To implement these four principles, Desa Siaga needs the following basic elements: (a) establishment of the Village Health Post (Poskesdes); (b) placement of health professionals (midwife and others); (c) community participation in the form of self-assessment; and (d) active roles of Desa Siaga cadres.

This approach is basically to increase access to the community, make closer to community in providing health services on a community basis and continually improve the medical and public health referral system.

Moreover, to improve equity in health, the Government of Indonesia has implemented the “Community Health Care Insurance”
or “Jaminan Kesehatan Masyarakat” scheme, which allows poor communities to get free access to medical services at public health and selected private health facilities.

Overall, these are the Government of Indonesia’s efforts to achieve Health for All, and hence, lead to the increase of Indonesian’s economic capacity, and finally, foster poverty alleviation.

Distinguished delegates and participants,

Before ending my speech, let me go over once again an utmost important notion whenever we put together our collective commitments to revitalize primary health care. Good and sound Health for All will be unreachable without implementing responsible health politics with fair, transparent and equitable mechanisms. My ongoing struggle in the current debate on avian influenza virus sharing and benefits sharing has put significant insights on the proposed international mechanisms, which in one way or another, implicate the materialization of Health for All in the current global challenges. On this valuable occasion, I would like to invite you all, hand-in-hand, to revitalize primary health care to achieve health development objectives in SEAR countries.

Finally, I wish to conclude this speech by saying “Have a Nice Conference” and I do hope that this conference produce fruitful results by Member countries in developing healthy communities for SEA Countries in the years ahead.

Thank you.

Dr. dr. Siti Fadilah Supari, Sp.JP(K)
Annex 6

Keynote Address by Dr Halfdan T. Mahler, WHO Director-General (Emeritus)

“The Social Litmus Test”

“Why Alma-Ata in 1978 and whither the Health for All Vision and Primary Health Care Strategy NOW.”

Distinguished audience, Dear colleagues and friends:

As a precautionary warning let me start with a quote by Mark Twain: “When you part with your illusions you may still exist, but you have ceased to live”. And so, dealing properly with the Alma-Ata HFA and PHC will require a departure from old health paradigms. I also agree with Milan Kundera when he in one of his books said “The struggle against human oppression is the struggle between memory and forgetfulness”. So allow me to remind all of us today of the transcendental beauty of the health definition in WHO’s Constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. This definition is immediately followed by: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition”.

Also, please allow this old man in front of you to insist that unless we all become partisans in renewed local and global battles for social and economic equity in the spirit of distributive justice we
shall betray the future of our children and grandchildren. My memory tells me that the World Health Assembly had this in mind when it in 1977 decided that the main social target for governments and WHO in the coming decades should be the attainment of what is popularly known as “Health for All”. And, the Health Assembly described that as a level of health that will permit all the people of the world to lead socially and economically productive lives. The Health Assembly did not consider health as an end in itself but rather as a means to an end in itself but rather as a means to an end. That is, I believe as it should be. When people are mere pawns in an economic and profit growth game, that game is mostly lost for the underprivileged.

Let me then postulate that if we could imagine a tabula rasa in health, in the sense of being in possession of all today’s scientific knowledge relating to positive and negative states of health but without having to deal with the constraints – tyranny if you wish – of the existing medical consumer industry, we would hardly go about dealing with health as we do now in the beginning of the twenty-first century.

Indeed, I would maintain that a dynamic state of physical, mental, social and spiritual well being let alone a harmonious health-continuum from birth through life to death – as opposed to a discontinuum of disease episodes – are almost nonsensical question marks in today’s medicine-addicted consumer world.

But whatever these existentialist dilemmas may mean to the future health of the populations living in the affluent consumer societies, a few striking characteristics of today’s so-called health care systems seem to me to be beyond reasonable doubt, namely that:

1. Political, social, technical and financial resources are not properly assigned in any country to solve health problems equitably for the total population.

2. Most medical interventions have not been shown in objective terms to be truly effective and specific for health promotion and disease prevention, treatment or
rehabilitation, nor have the risk groups – to which the relatively few truly effective and specific interventions should be applied – been objectively identified.

3. The healthcare systems, as opposed to medical consumer systems are therefore clearly not designed to deliver the most meaningful interventions to the greatest proportion of persons at risk, as early as possible, at the least cost and in an acceptable manner.

Whereas rich countries that have more or less voluntarily accepted to become material waste societies may be able to afford to close their eyes to this situation, this is hardly so far the developing countries, where women and men for many decades to come will remain by far the most important source of energy. The rich countries may be running out of non-human energy but in the poor countries the human energy is sapped by a low level of health, to the point of jeopardizing any aggressive input to social and economic productivity. That more than a billion people living in this so-called third world today have combinations of nutritional deficiencies, acute respiratory and parasitic disease, AIDS, tuberculosis and malaria perhaps is adequate to illustrate this disastrous waste of human energy.

Poor countries can obviously not afford to perpetuate the technological adoption syndrome that so many of us development professionals have been so good at propagating. Because the attainment of health is not only an individual human aspiration but also, and above all, a social goal, a high degree of social relevance must therefore be the keynote to health policy – whereas all too often this policy is dictated by unproved, over sophisticated, overcostly technology without anything like adequate thought being given to its social purpose and its social consequences.

Health, one of the highest aspirations of man, does not exist in isolation. It is related to and influenced by a complex of environmental, social and economic factors ultimately related to each other. In the underprivileged populations I mentioned a moment ago there is, in addition to ill health, a persistent combination of unemployment and under-employment, economic poverty, scarcity
of worldly goods, a low level of education, poor housing, poor sanitation, malnutrition, social apathy and lack of the will and the initiative to make changes for the better. It would be utopian to expect any substantial health improvements in these populations without these constraining conditions first being removed or at least alleviated.

To make real progress we must, therefore, stop seeing the world through our medically tinted glasses. Discoveries on the multifactorial causation of disease have for a long time called attention to the association between health problems of great importance to man and social, economic and other environmental factors. Yet, considering the tremendous political, social, technical and economic implications of such a multidimensional awareness of health problems I still find most of today’s so-called health professionals very, very conventional indeed.

We often use health promotion and health services inputs as if they were interchangeable concepts. It is popularly believed that improvements in health are entirely related to medical interventions and that if additional resources were made available a proportional additional aliquot of health could be purchased. This, of course, is not correct. Health is an objective that a country should seek to attain using all the available means. It is not the monopoly of a particular sector, even if this is the health sector. It is known from past experience that in certain societies undergoing industrialization, major medical discoveries and technological improvements have done little more than simply accentuate a trend that was already in existence. It is also now quite evident that action undertaken outside of the health sector may have health effects much greater than those obtained through health sector action. In addition to the well-known effects of safe water supplies and better waste disposal, improvements of agricultural and animal rearing practice, better marketing of products, better and more widespread general education of the public, etc. are points in case.

As for the situation in the affluent world, we see that in the shadow of today’s vast deployment of resources to cope with
technology-intensive disease and death problems the prevention of disease, let alone the promotion of health, are relegated to a poor second place – man, family and community are left as vegetative onlookers. Indeed we have increasingly forgotten that more than ever before the solutions of today’s health problems, such as cancer, cardiovascular diseases, diabetes, sexually transmitted diseases, traffic accidents, malnutrition including obesity, drug addiction including tobacco and alcoholism, and infant mortality, all depend on what people by themselves do or do not do for themselves. To help them do this is the challenge of a genuine healthcare system as opposed to a dependence-producing medical consumer industry. Indeed, is it not strange that health professionals should be accused of being the most socially alienated profession in contemporary society!

Therefore, I believe we must radically change our attitude of narrowly relating health to the achievements of the health services, acquire a broader perspective, and think of health as resulting from the movement of the whole front of socioeconomic development of which the health services are a part. In this respect, I would consider the health professionals and their intelligence and information mechanisms as the sentinels of society in health matters. They should provide the information essential for defining policies and priorities. They should provide the fundamental information on health and disease and by uncovering meaningful associations with related factors in a time and place perspective, they point the way to intervention; they participate in the process of change by forecasting the effect of alternative healthcare strategies under the different patterns of prevailing conditions; finally, they contribute to assessing the impact of intervention and the identification of possible causes of failure. The health team must therefore accept an increasing social role in promoting health and the sharp distinction between research and training on one side and service on the other is no longer acceptable. We must train a different breed of health professional with an orientation towards healthcare delivery through the application of existing knowledge to the solution of health problems in their holistic setting. We must consider the identification of
epidemiological concepts, approaches and methods not only as relevant to the formation or deformation of professional epidemiologists but also as a part of the training of all health personnel. In my view, such an orientation can contribute to an attitude of mind that can be highly conducive to the fulfillment of the new role that is required of the health professions if we are to arrive at a level of health that will permit all the world’s citizens to lead socially and economically productive lives.

If we look at the lack of progress made in the smoking and dietary habits of men and women, conditions of work, environmental pollution, stability of family environment and last but not least the emergence of an international social and economic solidarity contract as a direct attack on poverty, we as health professionals and as human beings have little reason to congratulate ourselves.

I come now to the most challenging part of our work. I have mentioned the inability of most health services to respond properly to the needs of communities. We often refer to “coverage” by the health services and, with obvious pride, we say that such and such facility has been established to cover such and such an area where so many thousands of people live. We do not seem to realize that coverage, to be valid, must relate to productive contact between the health service and people for specific needs, and that our normative statements easily may become a distortion of reality. The reality is that of the people to whom the facility is said to be available, but in many areas only the minority who live closest to it actually use it. The majority are excluded. Concepts like accessibility and acceptability are seldom properly considered. But I want to add immediately that a simple extension of conventional health services, no matter how far-reaching into the community, is unlikely to produce the necessary improvements. Health is not a commodity that is given. It must be generated from within. Similarly, health action cannot and should not be an effort imposed from outside and foreign to the people; rather it must be a response of the communities to problems that they perceive, carried out in a way that is acceptable to them and properly supported by an adequate infrastructure. This is the essence of the filtering inward process of primary health care. It
requires communities to assume greater responsibilities in defining their needs, identifying solutions, mobilizing local resources and developing the necessary local organizations. It is defined as a series of simple activities, far from all of which are of a medical nature, aimed at meeting the essential health requirements of individuals, families and communities and at improving the quality of life. These activities must be undertaken in a manner consistent with local realities and properly linked to existing health services and other developmental activities undertaken by the communities.

Primary health care is conditioned by its holistic framework and as such may use different entry points and have different expressions. For example, in some countries health management has to be considered along with such things as producing more or better food, improving irrigation, marketing products, etc. It is not that people consider health services as unimportant, but there are other things like getting goods or a piece of land, or a house, or an accessible source of water, which are more of a life and death nature and must, in the wisdom of people, come first to make other things meaningful. We have rarely considered these needs as falling within our expressed policies for health development and therefore we risk being restricted, unilateral and ineffective in our action. This again illustrates the interdependence of health development with other aspects of social and economic development and adds new dimensions to our analyses. Again, I provide scientific credibility to the alleged importance of individual, family and community participation in health promotion.

Some countries have been very active in developing primary health care schemes. From the technical standpoint my prediction is that we are nearing a point where major national and international evaluation efforts will have to be undertaken to decide which of these schemes are most promising and viable, and should therefore be considered for adaptation on a wide scale in other areas of the country concerned or in different countries. This and the initiation and management of primary health care programmes on a large scale will present considerable sociological variables with which we are less familiar, and partly with health workers of a relatively low level of technological sophistication. It is high time that we realize in
concept and in practice that a knowledge of the strategy of initiating social change is as potent a tool in promoting health as a knowledge of medical technology. But this is the direction health development must take, and primary health care is a vital instrument to lead it in this direction.

As we are struggling to reorient the national and global health programmes towards community development and participation, towards primary health care in both its sectoral and intersectoral expressions and towards greater social relevance, I should like to contrast the concept of “high technology” with that of “appropriate technology”. It could be said that ideally we should provide as many people as possible with the “best” existing types of health care. While progress must continue and new and better alternatives be found, this approach could become counter-productive under the most favourable circumstances. If we consider that health technology, in addition to providing the tools for health action, should also take account of matters relating to how people live and behave, the resources available to them, the other problems they have to face and the health delivery mechanisms, then it is clear that there is no ideal standard solution to a problem but only alternatives that are appropriate under the existing level of sophistication, efficiency and professionalism with those of relevance, effectiveness and acceptability.

The development of technology appropriate to specific social and economic conditions is not a simple matter. The discovery of simple tools requires the same level of thinking, originality and use of scientific methods as for any other type of research, and the finding of problem-solving methods which are effective and safe and at the same time cheap and simple to use may require a complex process and a considerable investment. The same applies to the testing of the technology under different conditions of application. I have often stressed that the application of available technology for delivery of health care will require no less research than its generation, and that health systems research is a badly neglected area to which the world community will have to pay much more attention if real progress
in the organization and management of health care is to be made. But there are different ways of doing things. We can no longer accept the results of controlled clinical trials or operational efficiency tests carried out in captive populations or under artificial conditions as the ultimate measures by which the success of an intervention is going to be justified. The questions have changed in the light of the local and global health situation and the criteria must be different – that is, social and economic rather than only professional and technical. The concept of relevance to a given socioeconomic and environmental context should be the dominating one, and this has several interrelated implications: firstly, it implies that the ultimate test of techniques, instruments, methods and approaches is whether they work in the social, economic and physical environment for which they are intended; secondly, because of this, health systems research results mainly apply to the conditions under which they were obtained and their outside replicability is low; thirdly, this kind of research cannot be viewed as a separate effort but only as a part of the action and system to which it is expected to contribute; fourthly, health systems research must continuously permeate the whole process of health systems development, involve policy/decision-makers and health workers along with the research workers, cease to be the preoccupation of the academic few and become the right and responsibility of all concerned with promotion of health.

I therefore conclude that health professionals still have to make major methodological contributions in three key research areas:

1. **Problem setting**

   We are still unable to quantify local health problems within holistic interactive trends and within social preference systems and therefore unable to generate the related local synergies.

2. **Intervention assessment**

   We sorely miss a valid input/output correlation methodology for local interventions into normally functioning – including
community participation – healthcare systems without comparable control systems.

3. **Information systems**

We are still quite unable to generate locally relevant, sensitive and consistent information for decision-making at all political, social and operational levels of existing healthcare systems.

All these concerns to which I have alluded prompted an Organization Study on “Methods of Promoting the Development of Basic Health Services” by WHO’s Executive Board in 1973 in which it is bluntly stated that:

...in many countries the health services are not keeping pace with the changing populations either in quantity or in quality. It is likely that they are getting worse but even if this is looked at optimistically and it is said that the health services are improving, the Board still considers that a major crisis is on the point of developing and that it must be faced at once, as it could result in a reaction that could be both destructive and costly. There appears to be widespread dissatisfaction of populations about their health services for varying reasons. Such dissatisfaction occurs in the developed as well as in the Third World. The causes can be summarized as a failure to meet the expectations of the populations; an inability of the health services to deliver a level of national coverage adequate to meet the stated demands and the changing needs of different societies; a wide gap (which is not closing) in health status between countries, and between different groups within countries; rapidly rising costs without a visible and meaningful improvement in service; and a feeling of helplessness on the part of the consumer who feels (rightly or wrongly) that the health services and the personnel within them are progressing along an uncontrollable path of their own which may be satisfying to the health professions but which is not what is most wanted by the consumer.
This Organizational Study by WHO’s Executive Board led to the decision by WHO, in co-sponsorship with UNICEF to convene “The International Conference on Primary Health Care” in the city of Alma-Ata in 1978.

Let me then repeat with awe and admiration, the consensus concept of primary health care as contained in the Declaration of Alma-Ata 1978:

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

Permit me to insist that this consensus concept of primary health care was and is a very radical contribution to a new social paradigm of health care.

Let me also repeat from the Declaration of Alma-Ata that primary health care includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs. In my opinion, an admirable summation of priorities for any primary health care delivery system.
Alma-Ata was, in my biased opinion, one of the rare occasions where a sublime consensus between the haves and the have-nots in local and global health emerged in the spirit of Lacordaire’s definition of consensus: “I am not trying to convince my adversaries that they are wrong, quite to the contrary I am trying to unite myself with them, but at a higher level of insight”.

The Alma-Ata Primary Health Consensus also reflects a truism: “The Health Universe is only complete for those who see it in a complete light, it remains fragmented for those who see it in a fragmented light”.

And that brings me face to face with the cynics who sneer: “Alma-Ata or no Alma-Ata the difference is the same”. When I ask these same cynics whether they have read the Alma-Ata Declaration and report their reaction usually is” “Who would waste time on such pious rubbish”.

My personal view is that the Alma-Ata Primary Health Care Consensus has had major inspirational and operational impacts in many developed countries because of a critical mass of professional leadership combined with adequate human and financial resources to test its adaptability and applicability within the local realties. Mind you, it is much easier to be rational and innovative when you are rich!

But, please let us not forget the inspirational energies and the evidence base for The Alma-Ata Primary Health Care Strategy came from the developing countries themselves, be they governmental or nongovernmental sources. For a majority of these countries financial support from so-called donors was essential to carry out a broad array of studies in appropriate technology, human resource development, infrastructure development, social participation, financing etc. in order to integrate the Alma-Ata vision into heavily constrained local contexts. Most donors, after an initial outburst of enthusiasm, quickly lost interest or distorted the very essence of the Alma-Ata vision and strategy under the ominous, neocolonial name of “Selective PHC”, which broadly reflected the biases of national
and international donors and not the needs and demands of developing countries. What is worse, this situation coincided with the so-called Structural Adjustment Processes in so many developing countries during the 1980s and 1990s. For billions of the world’s population surviving on less than $2 a day these so-called SAPs did indeed “sap” these people’s miserable livelihoods. But, in spite of these brutal impediments, many developing countries have shown, before and after the Alma-Ata happening, courageous adhesion to its messianic message of equity in local and global health. Civil society movements and nongovernmental organizations have been prime shakers and movers in these admirable efforts. And so, being an inveterate optimist, I do believe that the struggle between memory and forgetfulness can be won, in favour of a successful resuscitation of the Alma-Ata vision. And, when using the word “VISION”, we should remember that “visionaries” were and are the true realists of all human development.

The fight for social and economic justice can often be frustrating since the development knows no limits, and the more you move along its roads the more you want to move. You cannot blame people if they strive to join up those who are farther along the road than they are. That is only human nature. Injustices, however, have to be seen through the eyes of those who are farthest behind on that road. Above all, we must not let these sinful injustices take over our one and only world.

And so, dear friends, let us use the complete light generated by the Alma-Ata Health for All Vision and Primary Health Care Strategy to guide us along the bumpy, local and global health development road.

Thank you.
Now that primary health care is going to be revitalized, thanks to the initiative of the Director-General of WHO, we should see the opportunity to find our way forward.

**Have faith in our own people**

Before we delve deeply into the process, let us stop to think whether we believe in the power of our own people, especially those at grassroots level, to stand up and take development into their own hands. This is all that matters most in all aspects of development, including health.

Our own experience in developing primary health care has led us to believe that the first hurdle that must be dealt with has something to do with the attitude of our own health workers. A paradigm shift is necessary before good things can happen.

Once this is overcome, then comes the second hurdle – the resistance to change. This is particularly true in government organizations in which everyone has to sweat for so long until the organization becomes well-established.
Through the ups and downs during the three decades of primary health care, we may have learned one important lesson: that if we would ever succeed in revitalizing the concept this time around, we have to do things differently from the way we did in the past. It will be self-defeating if we are to think that things could go on in the same way. We need innovation, and innovation can come in various forms.

**Strategic innovation**

Innovation may have to start at the strategic level. We all understand the importance of intersectoral collaboration in achieving primary health care, because we cannot go it alone in developing health programmes and rely on our own health workers, be it government or community, to realize the aspiration. Everyone must have a role to play; some would prefer to use the words “All for Health”. This generally means collaboration of other social development agencies such as agriculture, education, local administration and so forth. But these sectors may agree to collaborate when a health problem becomes a threat to the society, e.g. at times of epidemics. Otherwise, they may be reluctant to encroach upon someone else’s turf. Here, there is a need to find some integrated goal that is understood by all. This is why we should find other key phrases like “quality of life” in order to be more inspirational and strike a chord with our development partners, including the people themselves. Of course, health can be an integral part of quality of life. The scope of development could then be expanded to include other attributes like education, livelihood, life security and the like, all of which have a certain bearing on health. In this way, other sectors will find it easier and be more willing to collaborate.

The next line of innovation will be the development of indicators to go with the term “quality of life”. What do we really mean by that phrase? Everyone must understand clearly what can be expected out of the words “quality of life”, and that must be measurable too. Indicators like “basic minimum need” which is used in Thailand or “basic development need” as used in EMRO that include
health could be developed jointly by participating sectors. This is the prerequisite that should be put in place before active participation of the people and partners can be established. From there on, development will assume a new face. It will be based on the initiative of the people and the community themselves, with proper support by technical and administrative organizations.

In this context, it may be advisable to look into new instruments to help put all the diverse aspects of development into some sort of order, complete with clear destinations to be reached. The strategy map that has been modified for use in social development can be one of the answers.

**Managerial innovation**

In this context, we need to examine one of the components that make up any strategy, i.e. the intervention measures. Here we should give more importance to the social measures because most health problems of today have their roots in improper health behaviour. But the point is we still rely almost solely on technical measures delivered by health personnel to tackle behaviour-based health problems. We give injections, prescribe medicine and so on. We may succeed in controlling or eliminating the health threats at hand, but the result will not last because we have not dealt with the behavioural aspect of the problem.

We do need innovation here in order to integrate both kinds of intervention into one for any health problem, and since development happens in the community, what we need is a process of innovation by which people can join in to solve their own health problems. We have given less thought concerning this aspect of development in the past. We also need to re-examine the roles of various players including the local administrative authority who are part of the development scene and design new managerial processes that involve everyone in support of the people’s endeavour.
The three pillars of self-reliance

If we aim at community self-reliance in health, we need to develop what we call the three pillars of self-reliance, i.e. the “organization” to deal with planning, programming and support; the “manpower” to take care of the operational aspect; and the “financing scheme” to back it up. All these pillars are interdependent. Generally, they are developed and taken care of by different agencies; for example, the “organization” at peripheral level may come under the jurisdiction of the Ministry of Interior or local government, the “manpower” (CHW and the like) under the Ministry of Health, the “financing scheme” under the Ministry of Finance. The speed of development may vary and the whole process requires strong political commitment. We need to examine where we stand now regarding these three pillars and consider our part in developing them.

About community health workers

Community health workers, or whatever name we call them, are not the answer to primary health care. They are just one part, although an important one in the bigger scheme of things. They are not an end in themselves but a means toward some other higher end, and that is people’s empowerment in health development. They are an instrument we could utilize to attain the goal of self-sustainable health. As such, their work should be “development-oriented”, as opposed to “service-oriented” as we have seen in many instances in the past, which time has proven to be a dead-end process.

About the government sector

If we are to realize our vision of the people “standing on their own feet” in terms of health development, we need to work on two principles: first, inputs, including monetary, must be balanced between those that go to develop the community and those that are used within the government sector. It is hypocritical to talk about empowering people but do otherwise. Second, we need as many
partners as we can find to develop primary health care that is embedded in the comprehensive goal of better quality of life. Work can be through other partners as much as what we can do by ourselves.

Conclusion
As a gardener in my spare time, I would like to compare the realization of the primary health care concept to horticultural practice. We all know that if we are to reap benefits, we need at least three favourable components; good seed, good soil with light and water, and good gardening practice.

Good seed: The concept of Quality of Life/Primary Health Care is like a good seed. It needs the right environment in order to sprout. If the environment is not conducive, as we may find in some situations, we would never get a chance.

Good soil with light and water: The community, like good soil, must be organized. The concept of community health worker/village health volunteer and the way it works is a good example. Here we have to choose between a service-oriented or development-oriented approach. Like water, some sort of financing scheme at community level must be put in place in order to be viable, and above all, as light is essential to plants, some sort of policy that empowers the people to make decisions must be there.

Good gardening practice: After sprouting, the seedlings must be carefully tended to. Some fertilizer that would not later damage the soil must be applied; harmful diseases must be prevented and marauding insects must be guarded against. Like people’s projects, it must be supported with the right technology from all relevant sectors and unfavorable incidents must be guarded against.

These three conceptual components could be incorporated into a good programme and applied with a certain degree of success in any country.
Soul-searching

Here we come back to where we first started. We need to do a little soul-searching. “Do we believe in our people? Are we ready to change our concept and attitude?” If the answer is, hopefully, “yes”, then we could embark upon a road that leads to a totally new destination, and primary health care will assume a new look. A whole new horizon will open before us. But If the answer is unfortunately, “no”, then our programme will assume the same old “service-outlook” with no clear-cut destination as to what would happen to the people because they are put at the receiving end. This is what the history of the last thirty years has told us to be a futile approach.

Now that we are going to embark upon a long journey, we should look at primary health care with a new perspective. We should find for ourselves if we have faith in what we are going to do. If we do, then have courage to hold on to what we believe in and keep innovating; anything is possible.

Thanks for your kind attention.
I. Introduction

Attaining good health is one of the basic fundamental rights for every human being\(^1\), as well as a human investment for national development programmes\(^2\). Health is defined as a state of complete physical, mental and social well-being, not merely the absence of disease and infirmity.

To attain good health, several efforts need to be carried out. One of the efforts is provision of health services.\(^3\) Health service is part of a health system. Health system has a broader scope since it includes all the organizations, institutions and resources that are devoted to producing health actions. A health action is defined as any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health.

The Health for All (HFA) movement was part of the Alma Ata Declaration on Primary Health Care (PHC) in 1978. HFA was to be achieved by the year 2000. This target is not yet achieved till date; therefore, we will continue in pursuing it as a vision of health development. Thirty years after PHC was adopted as an approach to operationalize health systems, we observe different perceptions of PHC that sometimes yield unfavourable health outcomes. Now it is very timely to revitalize PHC in light of the changing disease burden, globalization, trade agreements, social determinants of health, climate change, etc.

In 2000 world leaders reached a consensus on a new movement, termed Millennium Development Goals (MDG), to be achieved by 2015. Five out of eight goals are health-related. The World Health Organization sees the MDGs as milestones on the road to HFA since they set clear goals and distinct targets compared with HFA.

This working paper intends to chalk out the road map for Member countries for achieving their health goals as well as health-related
Millennium Development Goals through health systems strengthening using the PHC approach, taking into consideration social determinants of health. The paper will start with revisiting PHC and redefining HFA to have common perceptions in implementing PHC through health systems. Then it continues with MDGs and health systems using the PHC approach. Achievement in health development follows and continues with challenges in implementing PHC. The last part illustrates the need to revitalize PHC. Finally, multitudes of ways forward are proposed to the conference on PHC for its deliberations.

Figure 1: The conceptual framework used in this working paper is shown below:
II. Primary Health Care: then and now

The concept of Primary Health Care emanates from the International Conference on Primary Health Care, jointly organized by WHO and UNICEF in Alma-Ata, the capital city of the Kazakh Soviet Socialist Republic, from 6 to 12 September 1978. Primary Health Care according to the Alma-Ata Declaration is an essential care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

As a concept PHC offers a comprehensive guide on equity, what to prioritize, technology to be applied, sociocultural aspects, target groups, full involvement of the community, cost-effectiveness and efficiency. Perhaps due to its rich and comprehensiveness nature, PHC is oftentimes misperceived. Many misperceive PHC as cheap, second-grade health care, health care at grassroots level, health care for the rural and the poor, health care in developing countries, etc. These misperceptions to some extent are understandable considering that PHC has a multiplicity of meanings depending on which perspective we look into:

(i) a package or a set of activities

(ii) level of care

(iii) an approach, which has been termed interchangeably PHC principle, PHC pillar and PHC strategy.

(i) From a “package” perspective, PHC was defined in Alma-Ata to consist of at least eight activities or elements, namely:
(1) Education concerning prevailing health problems and the methods of preventing and controlling them.
(2) Promotion of food supply and proper nutrition.
(3) An adequate supply of safe water and basic sanitation.
(4) Maternal and child health care, including family planning.
(5) Immunization against the major infectious diseases.
(6) Prevention and control of locally endemic diseases.
(7) Appropriate treatment of common diseases and injuries.
(8) Provision of essential drugs.

Later on this package was labeled as essential health care package, basic health package, essential health services, etc. The content of the package largely depends on the main health problems prevailing in each country. Thus it is not meant to be a rigid package for worldwide implementation. In general, public health problems do not constitute major health problems in most high-income or developed countries. Furthermore, usually there are public institutions that are responsible to carry out public health programmes. For this reason, Primary Health Care in several developed countries focuses more on medical services where family (primary) physicians usually become the main backbone of the health system.

Implementation of the above package, known as comprehensive PHC, requires strong health systems which most low-income countries do not possess. The oil boom in the 1970s brought temporary relief to some countries. Some bilateral and multilateral donors, interested in tackling the unacceptably high child and maternal mortality, were quick in realizing the shortcomings. They are of the opinion that to deal with high mortality conditions, selective PHC, better known as the vertical approach, is preferable; hence, the launch of the Child Survival and Safe Motherhood Project. The smallpox eradication programme was launched by WHO in 1968 and was successful in eradicating it in 1980; this apparently influenced various vertical or semi-vertical programmes in the twentieth century and continues till date.
Implementation of comprehensive care as advocated by the Alma-Ata Declaration is essential in Primary Health Care. However in practice, this strategy, considered to produce the most just outcome, is not easy to achieve. There are two main reasons, namely:

(1) Role of physicians: in many countries, training for medical doctors is focused on medical sciences and technologies. As a result, their competence, attitude and behaviour toward public health are not up to the mark. Not surprising then that their focus in delivering care is biased towards medical care.

(2) Limited resources for health, particularly in human and financial resources.

This constraint has prompted adoption of single disease programmes or selective Primary Health Care. As a result, only a few components of services are provided, which clearly contradicts the original idea of comprehensive Primary Health Care. Some consider implementation of selective Primary Health Care as a threat and regard it as a counter-revolution.

In 2001 the Commission on Macroeconomics and Health, established by WHO, recommended an Essential Health Care Package to be implemented at $34 per capita. GAVI (Global Alliance on Vaccines and Immunization) and the Global Fund for HIV/AIDS, Tuberculosis and Malaria are global health initiatives that pursue selective PHC. The oil crisis, a global recession and the introduction of structural adjustment programmes reduced resources for health. This has resulted, as mentioned earlier, in selective PHC using different packages of interventions gaining favour, over the intended aim of fundamentally strengthening of health systems for delivering comprehensive PHC.

To date more and more global health partnerships/initiatives and multilaterals recognize that sustaining the success of more vertical initiatives is going to depend on the fundamental strengthening of health systems. In 2007 GAVI introduced a health
systems support programme that enables countries to tackle critical bottlenecks to improve immunization coverage.

(ii) From a “level of care” perspective, there are three levels of care with different characteristics for each level of care, in terms of personnel, problems encountered and available facilities, which is depicted below:

(1) Primary care: personnel serving this level are called generalists. Health problems encountered, medical and non-medical facilities available are usually simple.

(2) Secondary care: personnel serving this level are called specialists; health problems encountered, medical and non-medical facilities available are more complex.

(3) Tertiary care: personnel serving this level are called sub-specialists; health problems encountered, medical and non-medical facilities available are the most complex and sophisticated.

Primary Health Care is frequently equated with primary care. Both bring health care as close as possible to where people live and work, thus constituting the first element of a continuing health care process, but the concept of Primary Health Care is different from primary care. Primary Health Care encompasses personal health care (medical care) and public health care. The medical care focus is on treatment and rehabilitation of individuals while public health is on prevention of disease or ill-health and promotion of health of the community. PHC gives higher priority to primary level of care and to public health compared with medical care.

The emphasis put on primary level of care is justified from the point of view of cost-effectiveness and feasibility of implementation. Many ill-health conditions can actually be prevented at this level by implementing primary prevention and promotion measures before they manifest or progress to a higher degree of illness. This is also the focus of public health, where the emphasis of intervention is the community, as opposed to medical care, which deals more with
curative and rehabilitative aspects of health care with the focus on individual and institutional care. Health promotion and disease control, either through immunization or case treatment, are best implemented at the primary level of care. For example, evidence is accumulating for treatment of pneumonia in children with antibiotics: the result achieved in treating them in hospital is almost the same as treatment at home. Currently, more and more countries are examining the possibilities of lowering the level of care to reduce cost without compromising quality and safety of care.

iii) From an “approach” perspective: Primary Health Care is an approach to health development. The Primary Health Care concept refers to implementation of a total health development strategy with emphasis on developing primary care as the first level of care of a continuum of care.

The application of the Primary Health Care concept in total health development requires an integrated and comprehensive approach. It implies the use of the four approaches described below in an integrated manner. While more resources and efforts should be focused on provision of essential or basic health care at the first point of contact with the health system, development of various sophisticated hospitals as referral facilities should also receive appropriate attention in program planning. The four approaches/principles/strategies arise from the concept of Primary Health Care, namely:

(1) Universal accessibility and coverage. Primary Health Care strives to ensure universal accessibility and coverage. This translates into the task of fulfilling needs of the vulnerable and the marginalized such as women and children as well as those living in remote areas and the poor. This principle also implies that equity or social justice be upheld while trying to cover the whole population.

(2) Community and individual involvement and self-reliance. Health should not be the sole responsibility of the government. Each individual and the community should be held responsible as well by involving them from the
planning stage down to the implementation and monitoring and evaluation of health programmes. By so doing the sense of ownership will be promoted that eventually ensures sustainability of the health programme. Evidences are accumulating that community empowerment and advocating self-reliance will further sustain the health programmes.

(3) Intersectoral action for health. The causes of ill-health are twofold, namely health risk and health determinants. Health risks emerge from people’s lifestyles, such as use of tobacco, alcohol consumption, food consumption and physical exercise. The determinants of health cover a broad spectrum of factors that include social, educational, economic, gender, political, security and physical environment, such as water and sanitation. These determinants are certainly beyond the health domain to influence. The implication is that successful implementation of Primary Health Care requires intersectoral action, as well as ability to coordinate with other sectors. Mainstreaming health is the manifestation of intersectoral action for health. One way of mainstreaming health is to advocate the importance of having Healthy Public Policy or policies of other sectors that promote health. One such policy is making all development projects subject to health impact assessments besides enforcement of environmental impact assessment.

(4) Appropriate technology and cost-effectiveness. Right choice of technology (i.e. appropriate and cost effective technology) will ensure better efficiency of the health system. Appropriate technology does not automatically translate into cheap and simple technology like ORS (oral rehydration salts), ITN (insecticide-treated nets) and “kangaroo care” for pre-term infants. We notice that earth satellites for transmitting data for communication in general (telephone, radio and TV) and e-Health in particular (e.g. telemedicine) are not at all simple and cheap technology if
considered in isolation. By comparing it to other technologies that seems to be cheap, such as the use of land or sea cable for telephonic communication, the use of satellites, looks exorbitant. But if we take into account indirect benefits like speed and numbers of people served, it will certainly otherwise. Another example is the use of GPS (Global Positioning System) units in disease surveillance. Cost-effectiveness alone should not be used as determining criterion for developing policy and priorities. It has to be coupled with feasibility for implementation and acceptability by the people at large. The focus on prevention and promotion in Primary Health Care, without neglecting curative and rehabilitative care, is derived from this principle.

By using the Primary Health Care approach as a health development strategy, many developed/high income countries in North America and Western Europe are able to provide effective and efficient health services to the community, through provision of accessible, affordable and quality family health services by family doctors as the first point of contact. At this point, services provided follow the basic principles of family practice, which include (1) continuous, comprehensive and integrated health services; (2) commitment to the person rather than to a particular body of knowledge, group of diseases or special techniques; (3) sees every contact with patients as an opportunity to provide prevention or health education; (4) emphasis on evidence-based medicine; and (5) sees him/herself as part of community-wide network of supportive and health-care agencies.

In developing/low- and middle-income countries in Asia and Africa, the use of the Primary Health Care approach as a health development strategy is manifest as the provision of basic health services to the community through the establishment of community health centres/health posts in every village.
III. Health for all

The basis of the Health for All policy can be found in the WHO constitution. It is mentioned that the objective of WHO is the attainment by all people of the highest possible level of health. The goal of Health for All by the year 2000 embodies this objective and emphasizes the highest possible level of health. At the minimum, all people in the country should have at least such a level of health that they are capable of working productively and participating actively in social life and community activities. This is popularly known as Health for All by the year 2000.  

Health for All as a movement, articulated in the Alma-Ata Declaration, does not mean that in the year 2000 health professionals would provide health care for everybody or that nobody would fall sick or disabled. Health for All is a process leading to progressive improvement in the health of the people. Health for All means:

(1) People use better approaches for preventing disease and alleviating unavoidable disease and disability and have better ways of growing up, growing old and dying gracefully.

(2) There is an even distribution among the population of whatever resources for health are available.

(3) Essential health care is accessible to all individuals and families in an acceptable and affordable manner and with their full involvement.

(4) People realize that they themselves have the power to shape their lives and the lives of their families, free from the avoidable burden of disease and aware that ill-health is not inevitable.

Since Health for All emphasizes the highest possible level of health, each country will have different health targets, which depend on the current status of health, their social and economic condition. Therefore, the Primary Health Care activities that need to be implemented in order to achieve the Health for All goals will vary from country to country. In the current context, HFA can be defined
as: “a stage of health development whereby everyone has access to quality health care or practice self-care protected by financial security so that no individual or family is experiencing catastrophic expenditure that may bring about impoverishment”.

As a vision, HFA does not need a concrete timeline as is the case of MDGs adopted by world leaders in 2000. We can consider health MDGs as the mission or objective of HFA till 2015, and simultaneously as proxy indicators to HFA.

IV. Millennium Development Goals
Since their adoption by all United Nations Member States in 2000, the Millennium Declaration and the Millennium Development Goals have become a universal framework for development and a means for developing countries and their development partners to work together in pursuit of a shared future for all. These goals gave continuity to the values of social justice and fairness articulated at Alma-Ata. They further affirmed the central place of health on the development agenda as a key driver of social and economic productivity and a route to poverty alleviation.

For health systems, commitment to reach the health-related Millennium Development Goals has two main implications. First, delivery systems must do a better job of reaching the poor, who tend to live in remote rural areas and urban shantytowns. Second, schemes for financial protection must be in place to ensure that the costs of health care, especially catastrophic expenses, do not themselves cause poverty.

MDGs constitute a challenge to Member countries in the South-East Asia Region, not only in deploying actions for achieving them but also in monitoring them on annual basis.

The health-related MDGs are still achievable if Member countries act now. This will require sound governance, increased public investment, economic growth, enhanced productive capacity, and strengthening of health systems.
Routine monitoring of MDGs should be undertaken and reported to the concerned officials. For indicators that can be obtained through population-based surveys such as Under-five Mortality and MMR some proxy indicators have been added (Annexure 1).

**V. Health systems using the PHC approach**

A health system consists of all organizations, people and actions whose *primary intent* is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes intersectoral action by health staff, for example: encouraging the Ministry of Education to promote female education, a well-known determinant of better health, and to the Ministry of Transport for the use of safety belt to prevent severe injury to the driver and passengers of motor vehicles.

Health system of some sort have existed as long as people have tried to protect their health and treat disease, but organized health systems are barely 100 years old, even in industrialized countries. They are political and social institutions. Many reforms have taken place, shaped by national and international values and goals. PHC as articulated in the Alma-Ata Declaration of 1978 was a first attempt to unify thinking about health within a single policy framework.

Developed when prospects of growth in many countries were bright, PHC remains an important force in shaping health care worldwide till date. The financial optimism in the 1970s was soon dispelled in many parts of the world by a combination of high oil price, low tax revenue and economic adjustment. Countries seeking to prescribe essential health care as prescribed by the Alma-Ata Declaration were faced with two difficult options: (i) focus public spending on interventions that are both cost-effective and possess
public goods characteristics, and (ii) boost financing through applying user’s fees. While many governments started to levy fees, the poor were deterred from receiving treatment. Limited income yielded from user’s fees has prompted many governments to focus on single disease programmes/selective PHC, which further exclude the poor from getting proper care.

As the crisis in many countries deepened in the 1990s, so many governments looked to the wider environment for new solutions. Infused with ideas from market-based reforms in Europe’s public services and with new experiences emerging from transitional economies, health sector reform focused on improving efficiency. Finally, they arrived at the conclusion that running the health system on $10 per capita or less is not viable. The Commission on Macroeconomics and Health in 2001 came up with a more acceptable proposition i.e. $34 for delivering only essential health care.

Health systems are highly context-specific; there is no single set of best practices that can be put forward as a model for improved performance. The Pan American Health Organization (PAHO)/WHO Regional Office of the Americas defines Health System using PHC approach as follows:\textsuperscript{11}:

(i) A PHC-based health system is composed of a core set of functional and structural elements/building blocks that guarantee universal coverage and access to services that are acceptable to the population and that are equity-enhancing.

(ii) It provides integrated and appropriate care over time; emphasizes health promotion and prevention; and assures first contact care.

(iii) Families and community are its basis for planning and action.

(iv) It requires a sound legal, institutional and organizational foundation as well as adequate and sustainable human, financial and technological resources.
(v) It employs optimal organizational and management practices at all levels to achieve quality, efficiency and effectiveness and develops active mechanisms to maximize individual and collective participation in health.

(vi) It develops intersectoral actions to address determinants of health and equity.

In 2007, based on the functions defined in the *World Health Report 2000*, six building blocks of the health system were identified: (i) service delivery; (ii) health workforce; (iii) information; (iv) medical products, vaccine and technologies; (v) financing; and (vi) leadership and governance (stewardship). Figure 2 depicts the health system framework. It should be noted that the building blocks are closely intertwined; therefore efforts to strengthen health systems should be directed in an integrated manner and not in isolation.

**Figure 2: The WHO Health System Framework**

![Diagram of the WHO Health System Framework]

(i) Service delivery

In any health system, good health services are those which deliver effective, safe, good quality personal and non-personal care to those...
who need it, when needed, with minimum waste. Services delivered, be they prevention, treatment or rehabilitation, may be delivered in the home, the community, in the workplace or in health facilities.

Although there are no universal models for good service delivery there are some well-established requirements:

- Demands for service: raising demand requires understanding the user perspective, raising public knowledge and reducing barriers to care: financial, cultural, social or gender barriers.

- Package of integrated services based on population need, of barriers to equitable access and available resources.

- Organization of provider network. The purpose is to ensure close-to-client care as far as possible, contingent on the need for economies of scale, to promote individual continuity of care where needed, over time and between facilities and to avoid unnecessary duplication and fragmentations of services. This means considering the whole network of providers, private as well as public, the package of services, whether there is over- or under-supply, functional referral system, etc.

- Management: the aim is to maximize service coverage, quality and safety and minimize waste. Whatever the unit of management, any autonomy, which can encourage innovation must be balanced by policy and programme consistency and accountability. Supervision and other performance incentives are also key factors.

- Infrastructure and logistics: this includes buildings, equipment, utilities, waste management and transport and communication.

(ii) Health workforce

Health workers are all people engaged in actions whose primary intent is to protect and improve health. A country’s health workforce consists broadly of health service providers and health management
and support workers. This includes: private as well as public sector health workers; unpaid and paid workers; lay and professional cadres. Countries have enormous variation in the level, skill and gender-mix in their health workforce. Overall, there is a strong positive correlation between health workforce density and service coverage and health outcomes. In any country, a “well-performing” health workforce is one that is available, competent, responsive and productive. To achieve this, actions are needed to manage dynamic labour markets that address entry into and exits from the health workforce, and improve the distribution and performance of existing health workers.

It goes without saying that most countries experience a mismatch in distribution between urban—rural, public health and medical care and between supply and demand. The matter is further aggravated by external as well as internal migration. Since solving these mismatches is very time consuming, we need to fully explore the potential of expanding the role of community-based health workers and community health volunteers in public health activities.

Community-based health workers include all health-care workers who are part of the formal health organization, and have undergone formal training to carry out a series of specified roles and functions, and spend a substantial part of their working time actively reaching out to the community, discharging their services at the individual, family or community level. These may include doctors, nurses, midwives who fulfill above criteria, public health inspectors, health attendants, health supervisors, family health visitors, etc. who spend a substantial part of their working time actively reaching out to the community.

Community health volunteers mean members from communities selected by communities and answerable to them. They have undergone shorter training than professional workers, not salaried, but may receive financial and other incentives. They are predominantly involved in health promotion and prevention of health problems, supported by the community and the health system but are not necessarily a part of its formal organization. In some countries,
community health volunteers are basically village members who work on a voluntary basis and are called village health volunteers. In specific settings, such as post-emergencies, these categories could be rapidly trained and employed to provide very basic health services and to assist the trained health-care workers in service delivery.

To increase the number of public health specialists to cope with increasing demand, public health education has to be enhanced. Health workforce is important since on average it consumes the highest health expenditure with a range of 40% to 50%.

(iii) Information

The generation and strategic use of information, intelligence and research on health and health systems is an integral part of the leadership and governance function. In addition, however, there is a significant body of work to support development of health information and surveillance systems, the development of standardized tools and instruments and the collation and publication of international health statistics. These are the key components of the information building block.

Information in health is increasingly more than just a national concern. As part of efforts to create a more secure world, countries need to be on the alert and ready to respond collectively to the threat of epidemics and other public health emergencies. A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely health information by decision-makers at different levels of the health system, both on a regular basis and in emergencies. It involves three domains of health information: i) on health determinants; ii) on health systems performance; and iii) on health status.

To achieve this, a health information system must:

- Generate population and facility-based data from censuses, household surveys, civil registration data, public health surveillance, medical records, data on health services and health system resources (e.g. human resources, health infrastructure and financing).
• Have the capacity to detect, investigate, communicate and contain events that threaten public health security at the place they occur, and as soon as they occur.

• Have the capacity to synthesize information and promote the availability and application of this knowledge.

Health information plays a pivotal role in making good policy analysis and policy decisions. Besides monitoring inequity, segregation of data by important equity stratifiers such as wealth, education, geography and sex is mandatory. This kind of segregation, unfortunately, is not routinely available. Community-based surveys such as Demographic and Health Surveys, Household Health Surveys and Socioeconomic Surveys are the way out.

Advances in information technology make it possible to link remote health centers with higher levels of expertise. As suggested by some pilot studies, these advances can also revolutionize the collection and use of data within district health systems, thus addressing the perennial problems of inadequate monitoring and evaluation while supporting better priority-setting. Knowledge development and management as part of health systems research undoubtedly can contribute a lot to health systems strengthening.

(iv) Medical product, vaccine and technologies

A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness and their scientifically sound and cost-effective use. To achieve these objectives, the following are needed:

• National policies, standards, guidelines and regulations that support policy.

• Information on prices, international trade agreements and capacity to set and negotiate prices.

• Reliable manufacturing practices and quality assessment of priority products.
• Procurement, supply, storage and distribution systems that minimize leakage and other waste.

• Support for rational use of essential medicines, commodities and equipment, through guidelines, strategies to assure adherence, reduce resistance, maximize patient safety and training.

Medical products, notably medicine, vaccines and technology, are the second-largest health expenditure after that of health workforce. The application of the list of essential medicines coupled with the rational use of medicines has been shown to improve efficiency, quality and safety of health care. The use of generic medicines will reduce the current expenditure. Traditional medicine as an alternative care is not yet gaining momentum although in some countries parallel application of traditional and modern medicine has been practiced. This is partly due to difficulties in measuring its safety and efficacy.

Vaccines are the most cost-effective public health intervention known so far. Yet, in many instances, it is not easy to implement to its fullest, notably in achieving universal coverage. Wrong choices of technologies may lead to technical inefficiency. Research has greatly expanded the range of technical tools suitable for use in households and communities. Some recent examples include drug regimes for the home-based treatment of malaria and childhood pneumonia.

(v) Financing

A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. Health financing systems that achieve universal coverage in this way also encourage the provision and use of an effective and efficient mix of personal and non-personal services.

Three interrelated functions are involved in order to achieve this: (1) the collection of revenues from households, companies or external agencies; (2) the pooling of pre-paid revenues in ways that
allow risks to be shared, including decisions on benefit coverage and entitlement; and (3) purchasing, or the process by which interventions are selected and services are paid for or providers are paid. The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.

Like all aspects of health system strengthening, changes in health financing must be tailored to the history, institutions and traditions of each country. Most systems involve a mix of public and private financing and public and private provision, and there is no one template for action. However, important principles to guide any country’s approach to financing include:

• Raising additional funds where health needs are high, revenues insufficient, and where accountability mechanisms can ensure transparent and effective use of resources.

• Reducing reliance on out-of-pocket payments where they are high, by moving towards prepayment systems involving pooling of financial risks across population groups (taxation and the various forms of health insurance are all forms of pre-payment).

• Taking additional steps, where needed, to improve social protection by ensuring the poor and other vulnerable groups have access to needed services, and that paying for care does not result in financial catastrophe.

• Improving efficiency of resource use by focusing on the appropriate mix of activities and interventions to fund and inputs to purchase, aligning provider payment methods with organizational arrangements for service providers and other incentives for efficient service provision and use including contracting, strengthening financial and other relationships with the private sector and addressing fragmentation of financing arrangements for different types of services;
• Promoting transparency and accountability in health financing systems;
• Improving generation of information on the health financing system and its policy use.

It is ubiquitous for low- and middle-income countries to have a low level of per capita health expenditure. This problem is further exacerbated by misallocation of funds to less cost-effective interventions, resulting in allocative inefficiency. Many Member countries including some countries in the South-East Asia Region have a total per capita health expenditure of less than $34, the level recommended by the Commission on Macroeconomics and Health for implementing an essential health care package. Despite this fact, it is encouraging to note that in some countries or parts of countries, universal coverage with low inequity in health outcome has been achieved.

What matters is high political commitment to allocate sufficient resources to public health and payment schemes that prevent catastrophic expenditure. This kind of third-party payment is preferable to out-of-pocket expenditure which, in many countries, accounts for up to 80% of total health expenditure. Out-of-pocket expenditure is responsible for catastrophic expenditure, which in turn impoverishes the spender.

WHO estimates that, each year, health expenses cause 150 million people to suffer financial catastrophe and push 100 million below the poverty line. Poor households face a double challenge: they experience more illness and thus need more care, yet they are least able to afford the cost of services, especially when paid for out-of-pocket. Government has to increase its role in spending for health and in stewardship. With good stewardship even in highly privatized health systems, good health outcomes can be attained.

(vi) Leadership and governance

The leadership and governance of health systems, also called stewardship, is arguably the most complex but critical building block
of any health system. It is about the role of the government in health and its relation to other actors whose activities impact on health. This involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest. It requires both political and technical action, because it involves reconciling competing demands for limited resources in changing circumstances, for example, with rising expectations, more pluralistic societies, decentralization or a growing private sector.

There is an increased attention to corruption and calls for a more human rights-based approach to health. There is no blueprint for effective health leadership and governance. While ultimately it is the responsibility of government, this does not mean all leadership and governance functions have to be carried out by central ministries of health. Experience suggests that there are some key functions common to all health systems, irrespective of how these are organized:

- Policy guidance. Formulating sector strategies and also specific technical policies; defining goals, directions and spending priorities across services; identifying the roles of public, private and voluntary actors and the role of civil society.

- Intelligence and oversight. Ensuring generation, analysis and use of intelligence on trends and differentials in inputs, service access, coverage, safety; on responsiveness, financial protection and health outcomes, especially for vulnerable groups; on the effects of policies and reforms; on the political environment and opportunities for action; and on policy options.

- Collaboration and coalition-building. Across sectors in government and with actors outside government, including civil society, to influence action on key determinants of health and access to health services; to generate support for public policies, and to keep the different parts connected — so called “joined up government”.
• Regulation. Designing regulations and incentives and ensuring they are fairly enforced.

• System design. Ensuring a fit between strategy and structure and reducing duplication and fragmentation.

• Accountability. Ensuring all health system actors are held publicly accountable. Transparency is required to achieve real accountability.

An increasing range of instruments and institutions exist to carry out the range of functions required for effective leadership and governance. Instruments include: (i) sector policies and medium-term expenditure frameworks; (ii) standardized benefit packages; (iii) resource allocation formulae; (iv) performance-based contracts; (v) explicit government commitments to non-discrimination and public participation; (vi) public fee schedules. Institutions involved may include other ministries, parliaments and their committees, other levels of government, independent statutory bodies such as professional councils, inspectorates and audit commissions, NGO “watch dogs” and a free media.

VI. Achievements in health development

Three decades have elapsed since the inception of Primary Health Care in 1978. All countries in South-East Asia Region have implemented Primary Health Care. Achievements can be measured through three major areas, namely health systems based on PHC, health status improvement and inequities in health outcomes.

1. Health systems based on PHC

All countries in South-East Asia Region, despite different demographic profiles and widely varying economic and social challenges, have developed their health system based on Primary Health Care. Since the beginning of the 1990s all Member States began to reform their health systems by implementing the district health systems with Primary Health Care at their core. 12,13
The physical infrastructures of health services in many SEA Region countries have expanded significantly, particularly at the primary and first referral levels. Most countries have given priority to upgrade the health infrastructure, particularly in rural areas. Practically all Member countries have comprehensive networks of health facilities that extend to the village level. The establishment of primary care infrastructure in rural areas, supported by strong referral system, intersectoral collaboration, and community participation are the characteristics of the health system development based on Primary Health Care in the Region.

Activities or programmes implemented depend on specific health problems encountered and the ability to solve them. All countries in the Region implement both, medical care as well as public health services. In some countries, public health services play more significant roles. Through organized community efforts, these countries implement public health services that reach to the very remote areas in the countries. By encouraging community participation, the health professionals at village level work hand in hand to improve water and sanitation condition. By mobilizing community resources, the community health centre implements the community nutrition improvement programme.

Provision of medical care by family physicians, as practiced in many developed countries, is available only in big cities. The service, however, is still not optimized. The practice of continuous, comprehensive and integrated health services, are not fully implemented, as the payment system is mostly out-of-pocket. In this Region, development of family practice is still in its infancy.

The Prince Mahidol Award Conference in 2008 reviewed the past and defined the future of Primary Health Care, and revealed several obstacles and mistakes in implementing Primary Health Care as follows:

(a) Financial resources become scarcer, due to unexpected and unprepared for world-wide economic crises.
(b) Lack of community participation. Many countries fail to maximize and mobilize the energies and ambitions of locals, civil officers, NGOs and the private sectors.

(c) High expectation from people for better health care and quick results with various choices.

(d) Shortage of human resources, especially trained and motivated health workers who are willing to work at primary care level.

(e) Emergence and re-emergence of infectious and preventable diseases and increased pace of spread of serious and unusual disease events. This has resulted in the implementation of more selective Primary Health Care that will not solve most of the health problems.

(f) Health services have become market- and profit-oriented. Moreover, corruption occurs at many levels of the health sector, making matters worse.

(g) The growing world population has made consumption of food, drugs and fundamental resources increase. People are moving more than ever, seeking greener pastures for survival, wealth or tourism, and giving us greater connectivity. The more interconnected world leads to the rapid spread of epidemic and pandemic diseases. Universalizing of certain food tastes could lead to greater breeding and slaughter of food animals which could lead to greater danger from animal related diseases. Public health events in one location/region may be a threat to others.

(h) Mental health problems, stress and dysfunctional families are all on the increase.

(i) Inequity due to differences in economic growth and geographical challenges. Two-thirds of the vision impaired people in the high-income countries who are not yet blind
have cataract surgery whereas a much greater number of blind people in the developing world have no access to such basic remedies.

Most countries in South-East Asia were turning to community participation as a part of the action needed to reinvigorate the Primary Health Care strategy. In India, community participation was being encouraged for the procurement of medical equipment for hospitals, and cost-sharing schemes have been introduced for the maintenance of health facilities. In Indonesia, dominant community participations were lead by the women’s welfare movement. For improving drug accessibility and affordability, community cost-sharing schemes were implemented in Indonesia, Myanmar, Nepal and Thailand.

**Recent Initiatives in PHC in the Region**

<table>
<thead>
<tr>
<th>No</th>
<th>Country</th>
<th>Initiatives</th>
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<tbody>
<tr>
<td>1</td>
<td>Bangladesh</td>
<td>National health systems development has given high priority to ensure universal accessibility to and equity in healthcare, with particular attention to the rural population.</td>
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<tr>
<td>2</td>
<td>Bhutan</td>
<td>Bhutan has evolved strategies to reach the “unreached” through decentralization of planning and management systems. In recent years the country has also been able to shift the focus from expansion to improvement of quality of services.</td>
</tr>
<tr>
<td>3</td>
<td>DPR Korea</td>
<td>In DPR Korea, all the health establishments are run as public and state responsibilities. Now, with improvement in national economic situation, the country is also witnessing some progress in the health sector with the prospects of better health indicators.</td>
</tr>
<tr>
<td>4</td>
<td>India</td>
<td>The National Rural Health Mission launched in 2005 aims to provide accessible, affordable and accountable quality health services even to the poorest households in the remotest rural regions.</td>
</tr>
<tr>
<td></td>
<td>Country</td>
<td>Description</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>5</td>
<td>Indonesia</td>
<td>Indonesia has significantly scaled up coverage and accessibility of essential health services through establishing a medium of financial protection for its population. In 2006, the Government launched an initiative to develop “Alert Villages” (Desa Siaga) nationwide.</td>
</tr>
<tr>
<td>6</td>
<td>Maldives</td>
<td>The Government of Maldives has expanded curative services to establish a multi-level referral system, which is more decentralized and has greater NGO and private sector involvement in service delivery. Efforts are also being made to establish a social security system, that includes basic healthcare and to encourage individual organizations to establish mechanisms for covering the health expenses of their employees.</td>
</tr>
<tr>
<td>7</td>
<td>Myanmar</td>
<td>Myanmar has given high priority to develop an adequate number of workforces of qualified health personnel. To ensure equity in healthcare and reduce discrepancies between different geographical areas, new universities have been opened in Central and Upper Myanmar.</td>
</tr>
<tr>
<td>8</td>
<td>Nepal</td>
<td>The Government is: (a) working to make essential healthcare services available to all people through primary healthcare centers, (b) trying to decentralize health systems management to encourage greater people participation, (c) trying to promote and facilitate public-private/NGO partnerships in the delivery of health services, and (d) making efforts to improve the quality of healthcare through total quality management of human, financial and physical resources.</td>
</tr>
<tr>
<td>9</td>
<td>Sri Lanka</td>
<td>Sri Lanka has been able to scale-up accessibility and coverage of primary healthcare. To tackle the increasing problem of non-communicable diseases, the Ministry of Health will lead in planning and sponsoring a major national behavior change communication program and set-off activities aimed at healthy lifestyle changes in targeted population groups. It will be carried out through inter-sectoral and multi-sectoral collaboration with relevant departments and agencies.</td>
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</table>
2. Health status improvement

Despite the application of the PHC approach in health system development by all countries in the Region, the health status of the people had not improved significantly. The global community admitted that the Health for All by the year 2000 was not achieved by that target date. As a result, many people in the Region have not achieved the level of health that would make them able to work productively and participate actively in social life and in community activities. The health status of the people in this Region is still unsatisfactory (Table 1) 15.
Achievement in health-related MDGs is as follows:

- The progress on Target 2 of Goal 1 (reduction in numbers of underweight children) needs to be accelerated as only three countries show a good progress rate whereas seven countries are making slow progress and that of one Member country is considerably slower than the rest.

- Goal 4 (reduction of under-five mortality, infant mortality and immunization against measles) shows a better progress in the Region, with eight countries having made palpable progress and insufficient progress in two countries. One Member country has, however, registered no progress in this goal.

- Efforts to achieve Goal 5 (reduction of maternal mortality) needs serious attention of everybody concerned as only three countries have made good progress whereas the rest have been very slow and unlikely to achieve the targets by 2015 with their current rate of success.

- There has been uneven progress with respect to the targets 7, 8 and 9 set under Goal 6 (combat HIV/AIDS, malaria and other diseases) in most countries of the SEA Region.

Table 1: Health status in countries of the South-East Asia Region

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<td>Bangladesh</td>
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<td>Maldives</td>
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<td>Myanmar</td>
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<td>8</td>
<td>Nepal</td>
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<td>9</td>
<td>Sri Lanka</td>
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<td>10</td>
<td>Thailand</td>
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<td>69</td>
</tr>
<tr>
<td>11</td>
<td>Timor-Leste</td>
<td>98</td>
<td>130</td>
<td>800</td>
<td>58</td>
</tr>
</tbody>
</table>

Source: WHO-SEARO, 2007
While the HIV/AIDS epidemic remains at a low-level with the regional prevalence of disease estimated to be 0.3%, five countries (India, Indonesia, Myanmar, Nepal and Thailand) are experiencing high burden of HIV epidemics. Thailand is the only country in the Region that has successfully reversed the HIV epidemic. There are early indications of decrease in HIV prevalence in Myanmar and southern states of India. Unsafe sex and injecting drug use are currently the main drivers of the epidemic in the Region. A scaled-up integrated package of prevention, care and treatment services is necessary to halt and reverse the epidemic and mitigate its impact.

- An estimated 1.2 billion people or 83% of the total population of the SEA Region live in malaria-risk areas. All countries except Maldives have indigenous malaria transmission, predominantly *Plasmodium vivax*. Sri Lanka is targeting eradication of local transmission of malaria by 2012, which will transcend MDG targets.

- Trends in the estimated TB incidence rates with reference to the baseline in 1990 indicate that the SEA Region as a whole has already achieved a reversal in TB incidence. The estimated tuberculosis prevalence and mortality rates similarly reflect a decrease in most Member countries, indicating that the expected reductions in prevalence and mortality will also be achieved by 2015. This is also supported by the current trends in treatment success and case detection rates.

- Goal 7 (ensure environmental sustainability: access to safe drinking water and improvement in sanitation) calls for further accelerated work in the area of sanitation. Available data indicate that the majority of SEA Region countries have made important strides towards increasing water supply coverage during the last decade. However, 14% of the population of the Region (approximately 212 million people) still lacks access to improved water supply while
as many as 900 million people lack access to improved sanitation.

- As far as Goal 8 (develop global partnership for development: access to affordable essential drugs) (Target: in cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries) is concerned, access to essential medicines has been improved, and will continue to be the core element of health care in the Region. Member countries are bolstering their national drug policies, promoting rational use and ensuring quality, safety and efficacy. With the expansion of the private sector in health care, access to essential medicines has become an important issue.

3. Inequities in health outcomes within and across countries

Although equality and equity are used interchangeably, equity should be differentiated from equality. Equality does not take into account whether the existing disparity/gap/difference is fair or just. Simply put, inequity is unfair or unjust inequality.

Data only from seven countries are available namely Bangladesh, India, Indonesia, Maldives, Nepal, Sri Lanka and Thailand, but not for all equity stratifiers, i.e. socioeconomic status, gender/sex, ethnicity and geographical area.

3.1 Infant mortality

In Bangladesh, India and Nepal, infant mortality rates exceed 65 deaths per 1000 live births (Table 2). However, the rate for Sri Lanka was significantly lower at 19 deaths per 1000 live births, while the available data indicate that the infant mortality rate in Maldives is similar to that of Sri Lanka. In both Sri Lanka and Maldives there is greater access to maternal and child health services as evidenced, for example, by their high rates of skilled birth attendance.
The difference in infant mortality rates between children in the poorest quintile and those in the richest quintile are large for Bangladesh and Nepal, but even more substantial for India and Indonesia (Figure 3). The gap in infant mortality between the rich and the poor has narrowed marginally for Bangladesh and Indonesia,

**Table 2:** Selected health outcomes, health systems and health determinants indicators for SEA Region countries

<table>
<thead>
<tr>
<th>Indicator</th>
<th>South-East Asian Region countries</th>
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<tr>
<td></td>
<td>Bangladesh</td>
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<tr>
<td>Health outcomes</td>
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<td>USM</td>
<td>88</td>
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<tr>
<td>Health systems</td>
<td></td>
</tr>
<tr>
<td>% Covered by skilled birth attendant</td>
<td>13</td>
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</tbody>
</table>

Source: WHO-SEARO, 2007

**Figure 3:** Inequities in infant mortality rates between the poorest and richest wealth quintiles by country and survey year

Source: WHO-SEARO, 2007

Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka
and to a larger extent for Sri Lanka. It should be noted, though, that in both Bangladesh and Sri Lanka the richest quintile has experienced a slight increase in infant mortality between the last two survey years. No assessment of inequities in infant mortality rates by income level could be made for the Maldives and Thailand due to unavailability of appropriate data. Differences in infant mortality rates by educational attainment and by urban/rural residence are high in India, Indonesia and Nepal but not as large for Bangladesh (Figure 4 and Figure 5).

**Figure 4:** *Inequities in infant mortality rates by mother’s education by country*

![Diagram showing inequities in infant mortality rates by mother’s education by country.](source)

*Source: WHO-SEARO, 2007*

Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka

**Figure 5:** *Inequities in infant mortality rates by urban/rural residence by country*

![Diagram showing inequities in infant mortality rates by urban/rural residence by country.](source)

*Source: WHO-SEARO, 2007*

Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka
3.2 Under-five mortality

There is a wide range in under-five mortality rates across countries; from less than 20 in Sri Lanka and Thailand to more than 100 in India and Nepal (Table 2). Variations in under-five mortality rates are more likely to reflect differences in access to child health services than in the case for infant mortality. Infant mortality is also influenced by access to adequate maternal care.

In general, under-five mortality rates are two to three times higher in the poorest quintile than in the richest quintile in almost all the countries. Inequities are higher in countries where average under-five mortality rates are also higher (Figure 6). Inequities are greatest in India and Indonesia, where mortality in the poorest groups is more than three times than that in the richest group, while this ratio is less than two in Bangladesh and Sri Lanka.

Similar patterns are observed when viewing differences in under-five mortality rates by education (Figure 7).

In India, Indonesia and Nepal, rural children are much more likely to die before their fifth birthday than their urban counterparts (Figure 8).

Figure 6: Inequities in under-five mortality rates between the poorest and richest wealth quintiles by country and survey year

Source: WHO-SEARO, 2007
Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka; THA: Thailand
3.3 Coverage of skilled birth attendance

Having a skilled birth attendant present during the birth of a child improves the likelihood of a safe delivery. A skilled birth attendant is either a medical doctor, midwife or nurse who has been given appropriate training to care for mothers giving birth. The global experience and scientific evidence is very clear that skilled birth
attendance and access to emergency obstetric care from adequately equipped hospitals are essential and critical to substantially reducing maternal mortality, which is one of the key health MDGs.

Unfortunately, skilled attendance at childbirth is relatively uncommon in most countries of South-East Asia, except Sri Lanka, Maldives and Thailand, where skilled birth attendance is almost universal (Table 2). Almost all babies in Sri Lanka (96%), Maldives (85%) and Thailand (97%) are born with a skilled birth attendant present. In these latter countries, coverage rates are high regardless of socioeconomic, educational and geographical differences.

This seems to be in part because a large percentage of the population in the other countries lives in rural areas, where access to medically trained individuals is in practice limited. This is the case in Bangladesh and Nepal, where only 13 percent of children were delivered with a skilled birth attendant present. Rural areas account for 84% and 74% of the total population in Nepal and Bangladesh, respectively, in 2006.

The gap in coverage of skilled birth attendance is high between the rich and poor, and has remained the same or increased between the 1990s and post-2000 (Figure 9). However, in India the richest 20% of women are five times more likely to receive skilled attendance and, in Indonesia, they are four times more likely to do so than the poorest 20%.

![Figure 9: Inequities in skilled birth attendance between the poorest and richest wealth quintiles by country and survey year](image)

Source: WHO-SEARO, 2007
Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka; THA: Thailand
Similar patterns of coverage are seen with respect to educational attainment of the mother (Figure 10). Mothers with higher levels of education are more likely to have a skilled birth attendant present at their births than those with lower educational levels.

**Figure 10:** *Inequities in skilled birth attendance by mother’s education by country*

![Graph showing inequities in skilled birth attendance by mother’s education by country.](image)

*Source: WHO-SEARO, 2007*

Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka

Mothers who reside in urban areas have higher rates of skilled birth attendant present at their giving birth than those residing in rural areas (Figure 11).

**Figure 11:** *Inequities in skilled birth attendance by urban/rural residence by country*

![Graph showing inequities in skilled birth attendance by urban/rural residence by country.](image)

*Source: WHO-SEARO, 2007*

Legend: NEP: Nepal; IND: India; BAN: Bangladesh; INO: Indonesia; SRL: Sri Lanka
VII. Challenges in implementing Primary Health Care

Despite much progress revealed by many countries in implementing PHC through their health systems, the following are some challenges that need to be addressed if we are to achieve health goals in general and health MDGs in particular.

1. Misinterpretations of the concept of Primary Health Care

Due to the comprehensiveness of the PHC concept mentioned earlier misinterpretations can easily occur. It may include incomplete, erroneous or misleading view of Primary Health Care as follows:

(a) Primary Health Care as community-based care only therefore is not suitable for the entire population.

(b) Primary Health Care as only the first level of contact of individuals and communities with the health system.

(c) Primary Health Care as only care for poor people in developing countries, who cannot afford real doctors.

(d) Primary Health Care as only a core set of health services, often referred to as the eight essential elements of Primary Health Care.

(e) Primary Health Care is concerned only with rural areas, simple, low-tech interventions, and health workers with limited knowledge and training as opposed to doctors, hospitals and modern technology.

(f) Primary Health Care as a cheap and low quality of health services.

2. Burden of diseases

Demographic, epidemiologic and social transition have brought a double disease burden of communicable and noncommunicable diseases. In many developing countries noncommunicable diseases surpass communicable diseases. Added to this is the burden of aging
population, and of maternal and infant death. Shifts in disease burden necessitate mandatory changes in the strategy of health development using the PHC concept. Considering that ill health is the result of various health risks and health determinants that lie beyond the mandate of health sector, strengthening of intersectoral coordination in disease prevention and control and health promotion activities cannot wait.

The burden of noncommunicable diseases is closely related to risk factors. Risk is defined as "probability of an adverse outcome, or a factor that raises this probability". The ten leading risk factors globally are: underweight; unsafe sex; high blood pressure; tobacco consumption; alcohol consumption; unsafe water, sanitation and hygiene; iron deficiency; indoor smoke from solid fuels; high cholesterol; and obesity. Together, these account for more than one-third of all deaths worldwide.18

3. Inequity in health

Health inequities are found in all countries. The magnitude of these inequities, however, varies significantly between countries. South-East Asia is characterized by substantial health inequities both across and within countries. The Region also lags most other regions in its overall health attainments.

A child born in Nepal is twelve times more likely not to live till his or her fifth birthday compared to a child born in Thailand. Within India, children born in the poorest 20% households are more than three times as likely to die before their fifth birthday compared to children in the richest 20% households. Within-country health inequities are dramatic, except in Sri Lanka and Thailand, even though in all countries economic growth has been generally strong and improvements in overall levels of health are visible. Maternal and child health are still major concerns. For example, skilled birth attendance, an important determinant of maternal mortality, is less than 5% among the poorest 40% women in both Bangladesh (2004) and Nepal (2001).
Although the health status of poorer populations has improved, in all countries, the gap between the poor and the rest of the population is getting wider. In Bangladesh, for example, the national average for under-five mortality rate has dropped by 31% from 1997 to 2004, but among the poorest 20% population, it fell by only 14% in the same time period. It has to be remembered that equity is the main value upheld by PHC and constitutes the most important approach in health development.

4. Escalating health-care cost

Despite increased funding, resources for health will always be limited; there is a responsibility to achieve the maximum possible with available resources. The expectations of consumers are rising both in terms of responsiveness and in quality of care. This may lead to unnecessary use of medical technology that ultimately increases cost. The matter is further aggravated by out-of-pocket payment and asymmetry in information. Health systems will not automatically gravitate towards greater efficiency or greater equity in access. Unless deliberate steps are taken, through good stewardship, steady advances in medical care will continue to increase health-care cost and benefit a privileged minority. The poor will continue to be excluded from basic essential care, and the gaps in outcomes will grow wider, both within and between countries. A world that is greatly out of balance in matters of health is neither stable nor secure.

5. Trade agreements

Various trade agreements influence the global availability and prices of commodities, including food and pharmaceutical products, often with little regard for the impact on health for low-income countries.

6. Interdependence of the world

Interdependence means that health increasingly has global consequences as well as global causes, especially when health emergencies require international assistance. Most experts agree
that countries with resilient, community-based systems of care will be best able to respond to the shocks caused by global events, such as food crises, climate change and pandemic diseases.

7. Inadequate performance or low efficiency of the health system

Waste and inefficiency need to be addressed. Better incentive schemes are needed to improve performance. The need for incentives also applies to the health workforce. Pending the training and deployment of more health workers, ways need to be found to motivate service in rural areas and to ensure that different conditions are managed at an appropriate level of skills. A solid body of evidence demonstrates the contribution of a Primary Health Care approach to greater efficiency in the use of resources and better overall performance of health systems. As a way of organizing the health system, Primary Health Care is a gatekeeper that helps keep patients with minor complaints from flooding emergency wards. By ensuring that conditions are managed at an appropriate level of skills, Primary Health Care contributes to the more efficient use of human as well as financial resources.

8. Need for more research

Research has greatly expanded the range of technical tools suitable for use in households and communities. Some recent examples include drug regimes for the home-based treatment of malaria and childhood pneumonia, “kangaroo care” for pre-term infants, ready-to-use-therapeutic foods for the home management of severe malnutrition, simplified test kits for malaria, heat-stable drugs for chronic care and simplified tools for the early detection and management of cervical cancer. Research in general is needed for health systems, practically covering all its six building blocks.

9. Financing the health system

Despite recent increases in external financial assistance for health, more than 75% of all funds for health in an average low-income
country continue to come from domestic sources. Total health expenditure, from all sources including external assistance and loans, averaged less than US$ 30 per capita in 43 low-income countries in 2005. This amount is well below what is considered necessary to purchase an essential set of health interventions. Clearly, many developing countries will need to depend on external financial support for health for some years to come. The need to invest in strengthened health systems has recently been recognized by the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. In addition, the importance of well-functioning health systems is being addressed in new initiatives, such as the International Health Partnership. Experiences in pilot countries should be translated into lessons for use in multiple countries.

10. Need for integrated services

The success of the WHO/UNICEF Integrated Management of Childhood Illness (IMCI) initiative, which has been adopted as the child survival strategy in 100 countries, paves the way for the future of integrated approaches. IMCI delivers quality clinical care, in a public health approach, according to the principles of Primary Health Care, and within the constraints of the existing health system. It includes provisions for training, the selection and quality assurance of essential medicines and the shifting of tasks to the lowest level of safe and acceptable competence. In addition, the related approach, for Integrated Management of Adult Illness, provided the backbone for scaling up coverage with antiretroviral therapy, which is now reaching nearly 3 million people in low- and middle-income countries. Another example is integration of HIV/AIDS and TB control.

11. Public—Private Partnership

Past efforts to implement a PHC approach focused almost exclusively on the public sector. In reality, for many people – poor, as well as rich – private providers are the first point of contact; hence, revitalizing PHC should also involve private as well as public providers. While keeping its focus on the community and first contact care,
Primary Health Care needs to recognize the problems associated with relying on voluntarism alone\textsuperscript{12}.

In most Member countries the private sector is growing at an unprecedented rate. Even the poor are using the private health care provider as their first contact. Yet full information related to the private sector activities in health is mostly unavailable, making it difficult to regulate. Ideally, the government should focus its attention to provision of non-personal health services that are public goods in nature and are mostly in the domain of public health such as health promotion, disease prevention through immunization and control of various communicable diseases. The private sector should be mainly made responsible for personal health care or medical care without preventing them to get involved in public health actions. In big cities the private practitioners are already providing immunization services for children, although still mainly for the middle- and high-income group.

\textbf{12. Climate change}

Global climate change will further burden the already overstretched health system. Till date natural disasters have occurred more frequently: flood, drought and typhoons to mention but a few. The emergency conditions that follow will influence smooth operation of the health system. As a result, many people will not receive adequate health service. The impact is that the mortality rate, especially among the vulnerable group such as children and women, will increase dramatically. Vector-borne diseases such as malaria and dengue will increase due to additional breeding places of the vector. Climate change also influences food production, resulting in severe shortage of various food crops leading to hunger and malnutrition.

\textbf{VIII. Revitalizing Primary Health Care: the way forward}

The global health community agrees that the PHC concept, value and approach are still valid. What is needed is political commitment
and consistency in adhering to those aspects. The relevance of the Alma-Ata Declaration stands even stronger today. Many principles of the Alma-Ata Declaration have been integrated in government policy documents. The strong characteristic of the declaration has been its dynamism, which protects it from becoming obsolete. The realization of the Alma-Ata principles is a cost-effective and appropriate tool for achieving the Poverty Reduction Strategies and Millennium Development Goals. Every government should take health back to basics, and adopt the Primary Health Care approach in the development of the national health system.

The Prince Mahidol Award Conference, aiming to review the past and define the future of Primary Health Care, stated that PHC must be given top priority and we must take advantage of this new high status as a contributor to poverty reduction and economic gain. Health is being seen as a foundation for prosperity and social stability. These assets give health care more political clout.

Primary Health Care remains an important force in shaping health care in both the developed and developing world. The term Primary Health Care signifies an important approach to health-care organization in which the primary or first contact, level – usually in the context of a health district – acts as a driver for the health-care delivery system as a whole.

Various challenges in implementing PHC mentioned earlier will serve as a road map in revitalizing PHC. Revitalizing PHC will be done through strengthening the health system using the PHC approach. The success in revitalizing PHC will be partly measured through annual monitoring of health-related MDG; besides being will be used as a proxy for measuring the status of Health for All.

Some of the focus in revitalizing PHC is outlined below to be used as guideline for the Regional Conference on PHC in its deliberations:

(1) Reaffirm high political commitment toward PHC. The government should strongly support the concept and the
implementation of PHC through health system strengthening as well as in health development. Prioritize allocation of funds to public health.

(2) Improve health equity through specific actions in the health sector as well as other sectors that influence health outcomes i.e. social determinants of health^{19}. Equity or social justice is the most salient feature of PHC. Pro-poor policies in national development in general and in health in particular should be continually promoted.

(3) Foster more effective multisectoral collaboration for establishment and implementation of Healthy Public Policy, i.e. policies of other sectors beyond health that promote health. Health Impact Assessment is one manifestation of Healthy Public Policy that should be implemented along with Environmental Impact Assessment. Implementation of Healthy Public Policy is becoming more important in light of climate change.

(4) Strengthen health workforce including Community-Based Health Workers (CBHW) and Community Health Volunteers (CHV). To ensure the availability of health workforce for Primary Health Care, three strategic pillars have been recommended, namely:

(a) renew political commitment and recognize the importance of Community-based Health Workers and Community Health Volunteers;

(b) strengthen the Community-based Health Worker and Community Health Volunteer system; and

(c) ensure a supportive environment for effective functioning of Community Based Health Workers and Community Health Volunteers.

(5) Implement equitable health-care financing such as tax-based and social health insurance and various community-based health financing. Out-of pocket health expenditure
has been blamed as one factor that leads to widening health inequity and at the same time increases the number of the poor. The aim is to achieve universal coverage of financial security to the population in getting quality and safe health care. This may take years. Germany needs more than 100 years while South Korea and Japan need 50-75 years in attaining universal coverage of their health insurance. In the current globalized world where expertise in health insurance and experience pertaining to it is easily available, targeting universal coverage will take much shorter time.

(6) Strengthen partnership with civil society that includes the community, the private sector and NGOs. The community should be empowered for their active participation in health development. The role of the private sector in health development, which was not given due consideration in the Alma-Ata Declaration, should be better acknowledged and regulated.

(7) Promote better transparency and accountability of the health systems through improved leadership and governance (stewardship). All governments are faced with the challenge of defining their role in health in relation to other actors. For many this is changing, for example, with decentralization. Any approach to leadership and governance must clearly be contingent on national circumstances. Some points for consideration:

(a) Develop health sector policies and frameworks that fit with broader national development policies and resource frameworks, and are underpinned by commitments to human rights, equity and gender equality.

(b) Regulatory framework. Design, implement and monitor health-related laws, regulations and standards, especially in the areas of International Health Regulations; regulation of medical products,
vaccines and technologies; regulation concerning occupational health and workplace safety.

(c) Accountability. Support greater accountability through the Organization’s work on monitoring health system performance as set out in the building block on information.

(d) Generate and interpret intelligence and research on policy options.

(e) Build coalitions across government ministries, with the private sector and with communities, to act on key determinants of health.

(f) Work with external partners to promote greater harmonization and alignment with national health policies.

(8) Utilize to its fullest various global health initiatives (e.g. GAVI and Global Fund for HIV/AIDS, Tuberculosis in Malaria) and partnerships in health (International Partnership in Health) that have shown interest in health systems strengthening.
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All indicators should be disaggregated by sex and urban/rural as far as possible.

<table>
<thead>
<tr>
<th>Millennium Development Goals (MDGs)</th>
<th>Indicators for monitoring progress</th>
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<tbody>
<tr>
<td><strong>Goal 1: Eradicate extreme poverty and hunger</strong></td>
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</table>
| Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day | 1.1 Proportion of population below $1 (PPP) per day*  
1.2 Poverty gap ratio  
1.3 Share of poorest quintile in national consumption |
| Target 1.B: Achieve full and productive employment and decent work for all, including women and young people | 1.4 Growth rate of GDP per person employed  
1.5 Employment-to-population ratio  
1.6 Proportion of employed people living below $1 (PPP) per day  
1.7 Proportion of own-account and contributing family workers in total employment |
| Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger | 1.8 Prevalence of underweight children under-five years of age  
1.9 Proportion of population below minimum level of dietary energy consumption |
| **Goal 2: Achieve universal primary education** | |
| Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling | 2.1 Net enrolment ratio in primary education  
2.2 Proportion of pupils starting grade 1 who reach last grade of primary  
2.3 Literacy rate of 15-24 year-olds, women and men |
| **Goal 3: Promote gender equality and empower women** | |
| Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015 | 3.1 Ratios of girls to boys in primary, secondary and tertiary education  
3.2 Share of women in wage employment in the non-agricultural sector  
3.3 Proportion of seats held by women in national parliament |
| **Goal 4: Reduce child mortality** | |
| Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate | 4.1 Under-five mortality rate  
4.2 Infant mortality rate  
4.3 Proportion of 1 year-old children immunised against measles |
### Goal 5: Improve maternal health

| Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio | 5.1 Maternal mortality ratio  
5.2 Proportion of births attended by skilled health personnel |
| --- | --- |
| Target 5.B: Achieve, by 2015, universal access to reproductive health | 5.3 Contraceptive prevalence rate  
5.4 Adolescent birth rate  
5.5 Antenatal care coverage (at least one visit and at least four visits)  
5.6 Unmet need for family planning |

### Goal 6: Combat HIV/AIDS, malaria and other diseases

| Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS | 6.1 HIV prevalence among population aged 15-24 years  
6.2 Condom use at last high-risk sex  
6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS  
6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years |
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<tbody>
<tr>
<td>Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it</td>
<td>6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs</td>
</tr>
</tbody>
</table>
| Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases | 6.6 Incidence and death rates associated with malaria  
6.7 Proportion of children under 5 sleeping under insecticide-treated bednets and Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs  
6.8 Incidence, prevalence and death rates associated with tuberculosis  
6.9 Proportion of tuberculosis cases detected and cured under directly observed treatment short course |

### Goal 7: Ensure environmental sustainability

| Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources | 7.1 Proportion of land area covered by forest  
7.2 CO2 emissions, total, per capita and per $1 GDP (PPP), and consumption of ozone-depleting substances  
7.3 Proportion of fish stocks within safe biological limits  
7.4 Proportion of total water resources used |
| --- | --- |
| Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss | 7.5 Proportion of terrestrial and marine areas protected  
7.6 Proportion of species threatened with extinction |
| Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation | 7.7 Proportion of population using an improved drinking water source  
7.8 Proportion of population using an improved sanitation facility |
| Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers | 7.9 Proportion of urban population living in slums |

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1For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.
**Goal 8: Develop a global partnership for development**

**Target 8.A:** Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

Includes a commitment to good governance, development and poverty reduction – both nationally and internationally

**Target 8.B:** Address the special needs of the least developed countries

Includes: tariff and quota free access for the least developed countries’ exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction

**Target 8.C:** Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)

**Target 8.D:** Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.

**Official development assistance (ODA)**

8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors’ gross national income

8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)

8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied

8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes

8.5 ODA received in small island developing States as a proportion of their gross national incomes

**Market access**

8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty

8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries

8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product

8.9 Proportion of ODA provided to help build trade capacity

**Debt sustainability**

8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)

8.11 Debt relief committed under HIPC and MDRI Initiatives

8.12 Debt service as a percentage of exports of goods and services

<table>
<thead>
<tr>
<th>Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries</th>
<th>8.13 Proportion of population with access to affordable essential drugs on a sustainable basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications</td>
<td>8.14 Telephone lines per 100 population</td>
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<td></td>
<td>8.15 Cellular subscribers per 100 population</td>
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<tr>
<td></td>
<td>8.16 Internet users per 100 population</td>
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\*The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the four characteristics: (a) lack of access to improved water supply; (b) lack of access to improved sanitation; (c) overcrowding (3 or more persons per room); and (d) dwellings made of non-durable material.
Panel discussions: Health System Strengthening using Primary Health Care approach - Abstract of papers

Panel A: “Equity in Health”

1. Role of Health Sector in Promoting Health Equity

By: Professor Vinod Paul

The health sector can and must, promote health equity by increasing its efficiency and effectiveness with which it reaches the poor and the disadvantaged. There are several evidence-informed ways in which the health systems can alleviate the current inequities in service provision and utilization.

Equity principles must be reflected in the entire landscape of health action, including, program goals, financing, infrastructure, human resources allocation, grassroots activities as well as monitoring. Objectives / targets of the program, and monitoring indicators should be equity-sensitive – i.e., stated in terms of coverage levels and outcomes among the poor.

Health infrastructure and worker density among the disadvantaged populations and regions should receive priority attention and resources. Program interventions need to be channelized through the workers and facilities that the poor reach out to.

Poor communities are often better served by services delivered at their door-step, and by those that mobilize local resources such as community-based health workers/ volunteers. In specific situations, targeting of interventions to the most needy is the best
approach. Targeting may be direct or individual, or based on a specific characteristic such as pregnancy or HIV status.

Public-private partnerships may be more successful in reaching the poor and the vulnerable than the government. User fees are a deterrent against service utilization by the poor. Innovative demand generation strategies, in particular, the conditional cash transfers, have been shown to benefit the poor.

Primary health care approach aims at making basic health services affordable and widely available, especially to the poor and the rural populations. The pro-equity underpinnings are germane to the primary health care approach, and it is therefore logical to mainstream them into our strategies to strengthen, reposition and reform the health systems to make them pro-poor especially in the context of the MDGs.

2. Healthy Urbanization and Social Determinants of Health

By: Dr Jacob Kumaresan

Global estimates show that three billion people, or half of humanity, now live in urban areas. The impact of urbanization on health is significant for the South-East Asia Region, due to the sheer size of its urban population (520 million in 2005) and more importantly because it houses nearly half of the world’s poor. The urban setting is a determinant of health, a lens that modulates other social determinants of health.

The Declaration on Health Development in the South East Asia Region in the 21st century reaffirmed the unstinted commitment of local stakeholders to address the rising challenges of health gaps and inequities.

Healthy urbanization is the assessment and promotion of the reduction of health inequity in urban settings, recognizing that cities have distinct qualities, resources and problems.
In 2006, with collaboration of SEARO, the WHO India Country Office and the Bangalore Municipal Government, the WHO Centre for Health Development supported an integrated and multisectoral process in Bangalore to address strategic local health issues in the community.

This approach led to several action research projects where a blend of community health, public health and public policy interventions were made through the participation of decision makers and stakeholders in health, education, welfare, law, transport, gender issues and faith. This resulted in 34 recommendations, of which 25 were translated into concrete actions so far. This overwhelming success has led to ongoing efforts by the Bangalore Municipal Government to institutionalize this process by setting up an intersectoral board to promote health of the city dwellers. The experience is an excellent example of how city officials and leaders can reduce health inequities among the local residents.

Rapid and unplanned urbanization results in new challenges for global health and primary healthcare systems. Ensuring that urbanization is beneficial for health and a driver of positive health outcomes should be addressed through good governance, which includes empowering individuals and communities to achieve collective social action. Primary healthcare can contribute to this goal due to its community-based dimension, comprehensiveness and coordination with other sectors. Achieving healthy urbanization and health equity in all countries is a global and shared responsibility.
Panel B: “Multisectoral Collaboration and its impact on Health and Quality of Life”

1. Healthy Public Policy

By: Dr Arum Atmawikarta

The health system in Indonesia has been improved in the last three decades. This improvement is indicated by an increased rate of life expectancy and a decreased rate of infant and child mortalities. However, Indonesia is still facing significant health development challenges. The maternal mortality is considerably high and prevalence of malnourished children is also high. The health status of Indonesians also varies considerably depending on their socio-economics circumstances. Moreover, the existing health status disparities between urban, rural and remote areas are influenced by poverty related health inequalities. Demographic and epidemiologic transition will result in the increased demand of the health services. Economic growth, political stability, democratization process and decentralization policy would provide opportunities of the health development in the future.

Currently, health development in Indonesia has a strong legal basis. It is integrated into the Long Term Development plan, Medium Term Development Plan, and Annual Development Plan. Health development plan has been associated as an integrated part of human resource development, economic development and poverty reduction. Political support from legislative and executive bodies has been continuously provided. It is indicated by significant increased of the budget allocation since the year 0r 2004. Beside, health has been put as one of the priorities in the national development which is equal with education sector and infrastructure.

Inter sector collaboration has been strengthened in health development. Health is now becoming a central issue of any campaign for the election of local government at some areas. Many local government have issued the local government regulation to show commitment for the health sector. Health development programs
such as: nutrition, water supply, sanitation, maternal health, CDC, and non communicable disease control, are no longer health issues, but have been considered as inter sector issue of concern for central and local government.

However, significant efforts must be made to link economic, social, and health policies into integrated action. Significant challenges are primarily associated with regulation structures. Continuous efforts to improve advocacy to the stakeholders is necessary in order to assure the sufficient support especially from local government, which take also into consideration the regular turn over of the players in the democratic system.

2. Use of positive indicators to measure quality of life

By: Professor Dasho Karma Ura

Gross National Happiness (GNH) is the official development philosophy of Bhutan, stemming from HM Jigmi Singye Wangchuck who proclaimed it. Happiness is the main objective and value of Bhutanese society and government and policies and programmes aims to promote GNH.

This presentation will focus on policy tools and criterion used to promote GNH, based on research carried out on GNH.

The presentation on GNH will draw on Buddhist perspective as they relate to contemporary development planning, wellbeing and happiness, his presentation will argue, should be used as the new indicators of any good society.
Panel C: “Health Financing and Poverty Alleviation”

1. Equitable Health Financing

By: Dr Pongpisut Jongudomsuk

Thailand has achieved universal coverage of healthcare since 2002 and entire population are covered by three main public health financing schemes. The Social Security Scheme (SSS) covers the formal sector employees while the Civil Servants’ Medical Benefit Scheme (CSMBS) covers government employees and their dependences. The rest of population is covered by the Universal Healthcare Coverage (UC) Scheme which is the most recent scheme being implemented since 2002. This paper is aimed to update development of the UC Scheme and success of the scheme especially in equity improvement both in terms of access to healthcare and financial protection. Key policy features ensuring benefit of the poor would be analyzed to provide some recommendations.

The UC Scheme has been implemented for six years with its management structure becomes more and more institutionalized. However, main characteristics of the scheme remain the same since the beginning. The scheme could improve access to healthcare of beneficiaries both for ambulatory services and hospital admissions. In addition, it was found that the poor benefited from this improved access to healthcare more than the rich especially at public health facilities and this led to prevention of medical impoverishment. Financing of the UC Scheme is progressive although it is tax based system.

Key policy features ensuring benefit of the poor include universal approach, health service provision based on primary care and district health system, and tax based financing system. The administrative system for implementation of these policy features is less complex and improves its management efficiency. Health service provision based on primary care improves access to healthcare for the poor as well as improves system efficiency. Quality of healthcare provided
by primary care needs to be improved continuously to increase confidence of beneficiaries.

**Key words**: universal coverage of healthcare, equity, the poor

### 2. Health insurance for the poor

**By: Professor Dr Ali Ghufron Mukti**

As in other developing countries, Indonesia is facing problems of access, equity, efficiency, quality of health services and approximately 70% of health care expenditure is currently paid “out-of-pocket”. These problems have been exacerbated by the 1997/98 economic crisis and the implementation of decentralization since 2001. The most vulnerable and affected group is the poor. To protect the poor and reducing out-of-pocket payments, the central government started in 1998 with the development of a health social security program (JPS-BK). The name of this program has changed several times. In 2005, it became known as Poor Community Health Security (JPK-MM), then as Health Insurance for Poor (Askeskin) and it has been known as Community Health Security (*Jamkesmas*) since 2008.

Health-care programs in Indonesia have elements of a three-tiered health insurance system. Under the first tier, social health insurance is provided through PT Askes and PT Jamsostek. Askes is a compulsory health insurance scheme for active and retired civil servants, retired military and police officers, veterans and national patriots, and their families. Jamsostek is the social security scheme for private sector workers and includes a health component. It provides health insurance for some formal sector workers. Under the second tier, private health insurances provided through private insurance companies, self-insured schemes and other initiatives. Under the third tier, the Ministry of Health and local authorities run public health-care systems for the uninsured through Jamkesmas and Jamkesda (local government initiatives).

*Jamkesmas* covers about 76,400,000 people with an almost unlimited benefit package. The premium per person for the poor is
paid by the Government, and is currently IDR 5,000 (0.50) per person per month. Jamkesmas allocates a down payment to both public and private contracted hospitals. Hospitals are reimbursed by Jamkesmas using a package payment system and INA-DRG (Diagnosis-related groups Indonesia). Primary care services are allocated directly.

This scheme has improved the financial protection and access to the poor. The utilization of health care services, both in primary care and hospitals, has increased dramatically. However, the scheme has some challenges; for example, transport costs for those who live far from health facilities are high. Some hospitals are facing difficulties to cover the cost of drugs prescribed outside the standard formulary. Some patients admitted to hospitals incorrectly claim to be a Jamkesmas card holder, etc.

The number of the poor is estimated by the Central Bureau of Statistics, whereas local governments identify potential beneficiaries for Jamkesmas. The signed list of these beneficiaries is sent to PT Askes and PT Askes issues membership cards. Those who are non-poor may be covered by their local government. Due to overstretched services in 2007, funds were not sufficient to compensate PT Askes. Various measures were taken, such as tight monitoring, medical investigation in some hospitals, reduced benefit packages etc. Financial feasibility and sustainability of scaling up beneficiaries is being conducted by sharing responsibility and finance with other parties, for example local governments and communities. Currently, strategies to integrate the schemes into a consolidated national pool are still in process of design. One alternative is “integrated decentralized management of the system”. Another is to request local governments to contribute to the central management of Jamkesmas.

Lessons learnt from the Jamkesmas scheme can be summarized as follows. The scheme has made a significant impact on reducing financial barriers of the poor. This increases the utilization of services, both in primary health care and hospitals. However, some homework need to be done especially on management, administrative issues,
role of various stakeholders, management information system, financial sustainability and benefit packages.

3. Health, Income Generation and Poverty Alleviation

By: Ms Mittal Shah

The Self-Employed Women’s Association (SEWA) is a trade union of over 1.1 million women workers in the informal economy. SEWA aims to achieve full employment and self-reliance for poor women workers. Through organizing women workers, we strive to ensure income security, work security, food security and social security.

SEWA members work long, hard hours in difficult conditions. They fall sick frequently, and as a result often fall into debt from illness expenditure – and deeper into the cycle of poverty. Thus at SEWA, we have found that health security is a critical component of income security. To protect women from debt, we have developed a needs-based, integrated insurance product that provides illness, life and asset coverage. SEWA’s insurance programme, VimoSEWA, is integrated with microfinance, economic and health activities.

This paper will outline VimoSEWA’s scheme and design innovations. We have developed a cashless payment mechanism to promote quality of health care services and equity within our membership. VimoSEWA is fully implemented by grassroots women themselves, ensuring that services remain needs- and community-based. SEWA’s preventive and promotive health activities are fully integrated within the insurance program – a unique approach to promote primary health while improving efficiency in the insurance program. Lastly, the paper will share VimoSEWA’s experience in scaling up health insurance for the poor, including through a new government insurance scheme.
Panel D: “Social Partnership and Local Developments to Improve Health”

1. Community Empowerment through Micro-Credit Scheme to Improve Community Health

By: Mr Faruque Ahmed

The Bangladesh Rural Advancement Committee (BRAC), one of the largest NGOs in Bangladesh, takes a holistic view of development and effectively uses a micro-credit scheme for poverty alleviation and empowerment of the poor.

Implementing a ‘credit-plus’ approach through its village organizations (VOs), BRAC provides inputs for development in many areas, including health, education, social development, human rights and legal support. The nucleus of BRAC’s development interventions, VOs carry out health interventions through community health volunteers (CHVs) culled from the VOs.

The CHVs are linked with a livelihood strategy through both micro-credit and a revolving fund for basic drugs. BRAC’s 70,000 CHVs reach 92 million people throughout Bangladesh. In 2007, BRAC’s TB case detection rate was 79% and the BRAC-VO member child immunization rate was 96%, compared to national rates of 71.5% and 82%, respectively.

BRAC’s micro-credit scheme vis-à-vis VOs have provided the critical foundation for the sustainable scaling-up of BRAC’s health programmes.

2. Community-Based Health Worker and Community Health Volunteers in local Health Development

By: Dr San Shway Wynn

Myanmar adopted Primary Health Care (PHC) approach and since 1978 four yearly plans have been drawn up and implemented. Since 1991 national health plans have been developed and implemented.
Community based health workers (basic health staff) led by township medical officer played the main role for health care coverage of the community, both urban and rural. In Urban areas health care delivery is undertaken by urban health centers, school health team and maternal and child health center take care of the health services. For rural health care each township has four to seven Rural Health Centers, and each RHC has four sub centers.

Basic health workers are health assistant, lady health visitor and midwife.

For 55.4 million population the country have 1452 rural health centers in 2005, 28,872 community health workers in 2003 and 6 bed/10,000 in 2005.

Community HW/10,000 population was 9.9 in 2004.

The proportion to rural population are 1/23100, 1/23970 and 1/4580 respectively, while the voluntary health workers are community health worker and auxiliary midwife with proportion of 1/900 and 1/1258 respectively. Community volunteer trained in 4weeks to six months by township training team.

MDG progress: Targets for improved water and sanitation have been achieved, child mortality have been halved in the period of 1990 to 2003, this is on track for achieving MDG targets. Maternal health and nutrition may require scaling up.

The major health problems are Low Birth Weight (10% in 2004), stunted (32% in 2004) and underweight children (32% in 2004). The main achievement: Steep increase in TB case detection (38% in 1990, 55% in 2000 and 95% in 2005) hence the increase in DOTS coverage.

Coverage of health services: Antenatal care/expected pregnant women coverage (four visit) 66% in 2004, deliveries by qualified attendant 68% in 2003, immunized children in 2005 76% for BCG and 72% for measles.
Issues and challenges in scaling up services: Improve community participation, managerial performance, improve CBHW and VHW teamwork, improve productivity efficiency and staff motivation, ensure universal coverage of health services and adjustment to the rapid change in political, economic, social environmental and technology.
Revitalizing Primary Health Care

Regional Conference on

Sitting A

Jakarta, Indonesia 6 - 8 August 2008
At the Sixtieth session of the WHO Regional Committee for South-East Asia held in Thimphu, Bhutan in 2007, “Revitalizing Primary Health Care” was selected as the subject of Technical Discussions to be held prior to the Sixty-first session.

The Regional Conference on Revitalizing Primary Health Care was held from 6 to 8 August 2008 in Jakarta, Indonesia. The objective of the conference was to revitalize PHC in the changing context of health development and, its factors and social determinants to achieve the Millennium Development Goals (MDGs) and health for all. The conference concluded with the following recommendations: For Member States: (1) to reaffirm their political commitment to PHC; (2) to review health financing and expenditure; (3) to strengthen human resources and the service delivery system to support PHC; (4) to develop a strategy for improving health information systems; (5) to establish mechanisms as well as strengthen capacity for health system research; (6) to empower communities, especially women, to take an active role; and (7) to strengthen the capacity of ministries of health; and for WHO: (1) to assist in direct capacity development; (2) to provide normative support for country capacity; (3) to advocate with national governments on the need for multisectoral action for PHC; and (4) and to provide global leadership in orienting other development partners towards PHC.

The conference has come up with a road map that assist Member States to strengthen their health systems using the primary health care approach to achieve the health goals as well as health-related MDGs taking into account the Social Determinants of Health.