World Health Organization
REGIONAL OFFICE FOR South-East Asia

South-East Asia Regional Strategy for Primary Health Care: 2022-2030

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Foreword

Primary Health Care (PHC) is the critical enabler for achieving Health for All. The identification of PHC as the most suitable approach to meet the health needs of the poor and hard-to-reach was articulated as early as 1937, in Bandoneng, Indonesia at the League of Nations Health Organization Conference on Rural Hygiene.

The COVID-19 pandemic has highlighted the urgent need for countries of the South-East Asia Region to strengthen PHC, building on previous investments. Member States with strong PHC-oriented systems, including established systems for community and multi-sectoral engagement, have been better able to respond to the pandemic, rapidly mount public health actions, and maintain essential services with minimal disruption.

This South-East Asia Regional Strategy for Primary Health Care: 2022-2030 aims to accelerate progress in all countries of the Region towards universal health coverage (UHC), health security and the health-related Sustainable Development Goals (SDGs). It is intended to provide Member States with guidance on facilitating PHC-orientation through the identification of seven values and 12 strategic actions that collectively embody the philosophy and practice of PHC, enunciated in the 1978 Declaration of Alma-Ata and reaffirmed in the 2018 Declaration of Astana.

The Strategy is aligned with and advances the commitments made by Ministers of Health at the Seventy-fourth session of the Regional Committee through the Declaration on COVID-19 and measures to build back better essential health services to achieve UHC and the health-related SDGs. It recognizes that while COVID-19 has highlighted critical health system gaps, it has also catalysed or expanded innovations in community engagement, digital technology and reorganizing primary care services. It is intended to be a living document that will be reviewed throughout the implementation period.

I urge Member States to make full use of this Strategy and look forward to supporting them in their efforts to update plans, policies and operational strategies to strengthen PHC orientation, with the aim of achieving Health for All, leaving no one behind.

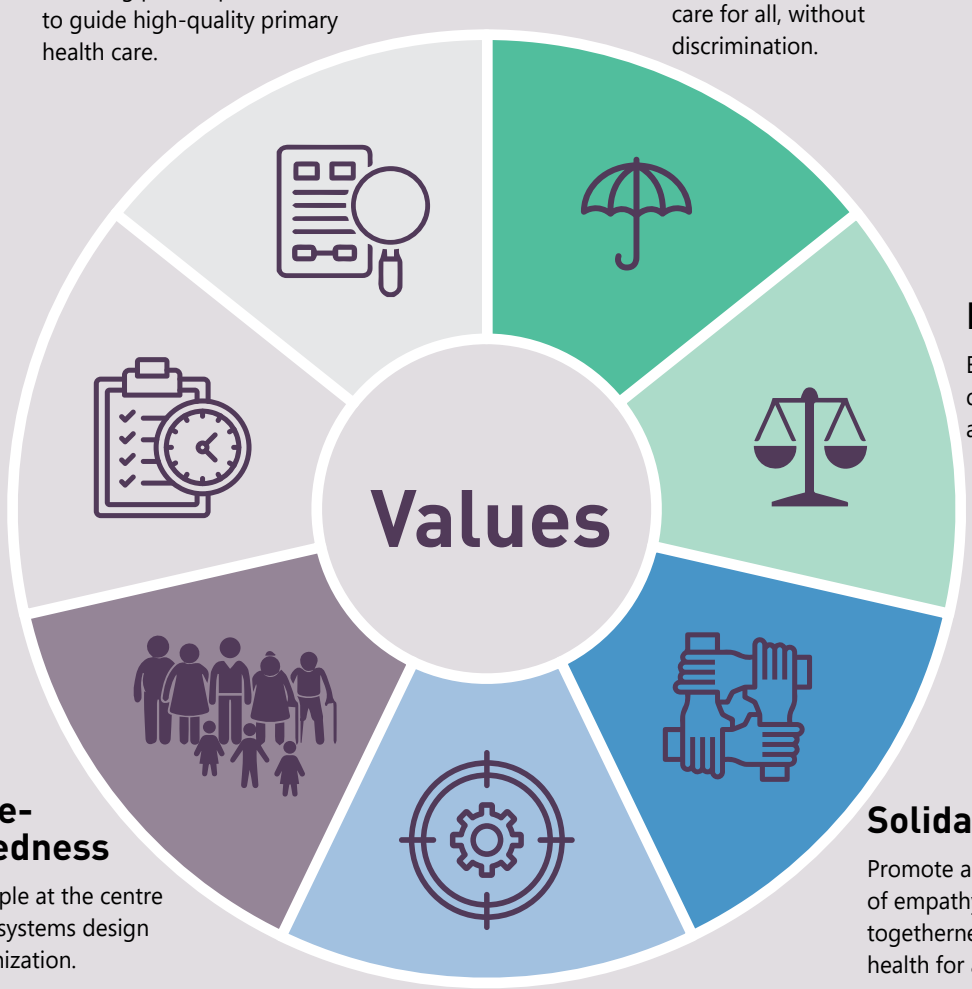
Dr Poonam Khetrapal Singh
Regional Director
WHO South-East Asia Region

Universality

Ensure available, accessible, acceptable, and high-quality primary health care for all, without discrimination.

Evidence-driven action

Integrate best evidence, including patient preferences, to guide high-quality primary health care.



Resilience and adaptiveness

Prepare for, respond to, adapt to, and continuously learn from adverse and changing circumstances.

Equity

Eliminate systematic disparities in health and its determinants.

People-centredness

Place people at the centre of health systems design and organization.

Solidarity

Promote a spirit of empathy and togetherness towards health for all.

Accountability

Answerability for action on defined responsibilities.

Overview of the regional PHC Strategy

VALUES: The regional PHC Strategy seeks to realize the values of universality; equity; solidarity; accountability; people-centeredness; resilience & adaptiveness; and evidence-driven action.

GOAL: Achieve universal health coverage, health security, and the health-related SDG targets by 2030, through a PHC oriented health system.

OBJECTIVES:

1. Support Member States in enabling PHC-orientation of their health systems
2. Serve as a resource for stakeholders to engage in PHC transformation
3. Strengthen monitoring of PHC performance
4. Stimulate cross country learning and advocacy

12 STRATEGIC ACTIONS

This set of 12 strategic actions are interdependent, overlapping, and not exhaustive. Progress on one action is often dependent upon and can catalyse and complement improvement in others.

Strategic action 1: Review and update health-related national policies and plans to reflect PHC orientation

- Develop a context-appropriate national PHC strategic action plan through robust stakeholder participation
- Improve emergency preparedness and response
- Incrementally introduce a comprehensive set of services
- Develop a PHC strategic action plan, including strengthening of district and subdistrict health systems
- Harmonize externally financed interventions and support with national PHC policies and plans

Strategic action 2: Increase and improve financing of PHC

- Mobilize and pool additional resources
- Prioritize resource allocation to PHC within the health sector budget
- Assess health financing systems and policies
- Strengthen strategic purchasing
- Strengthen capacities for planning, budgeting and public financial management at all levels to improve PHC

Strategic action 3: Implement governance reforms and enable multi-sectoral convergence, especially for action on Social Determinants of Health

- Engage in partnerships to advance PHC
- Decentralize reforms
- Institutionalize a Health in All Policies approach and enable multisectoral collaboration

Strategic action 4: Reimagine and reorganize primary health care service delivery

- Develop policies, strategies and service standards that support a continuum of care across programmes and services and ensure people-centred care
- Integrate essential public health functions into PHC
- Strengthen urban primary health care
- Integrate traditional and complementary systems of medicine into PHC

Strategic action 5: Build a culture of wellness to promote well-being

- Strengthen community-based PHC to promote wellness
- Enable attention to mental health and well-being
- Undertake capacity-building for implementation of wellness interventions

Strategic action 6: Ensure community engagement and empowerment

- Enable community participation in local health service governance structures

- Promote community-based PHC systems through enhancing the role of community health workers
- Facilitate creation of patient support groups
- Develop models of community engagement in urban areas
- Create mechanisms for effective communication between the health system and the community
- Engage the community for enhanced accountability

Strategic action 7: Strengthen the availability, competence and performance of a multidisciplinary PHC workforce team

- Include the full array of available health workers in PHC-related policies and plans
- Improve the distribution and strengthen the capacities of PHC workforce teams
- Address human resources for health challenges across district and subdistrict health systems
- Strengthen the planning, management, quality, and performance of PHC workforce teams

Strategic action 8: Promote availability and affordability of quality essential medical products for PHC

- Ensure access to affordable, quality-assured essential medical products
- Ensure rational selection and use of medical products
- Improve storage and maintenance of medical products
- Strengthen regulatory systems for medical products and promote local manufacturing capacity

Strategic action 9: Strengthen the quality of PHC care

- Establish, monitor and ensure quality standards and systems
- Ensure quality infrastructure
- Enable grievance redressal mechanisms

Strategic action 10: Leverage the potential of digital technology to improve access to and quality of equitable PHC

- Review existing interventions and reform architecture
- Consider data as a public good
- Explore opportunities for digital technologies to advance PHC

Strategic action 11: Strengthen health information systems to enhance PHC

- Strengthen the quality of health management information systems
- Institute or expand surveys to capture PHC parameters
- Strengthen civil registration and vital statistics systems
- Utilize routine data systems to enable dynamic PHC-oriented health systems

Strategic action 12: Institutionalize learning systems for sustainable PHC

- Ensure the creation of learning health systems
- Build institutional partnerships to strengthen learning health systems
- Design monitoring mechanisms to enable learning

Monitoring of the 12 strategic actions can serve to assess, track, and drive progress towards PHC-oriented health systems in the South-East Asia Region. Member States are encouraged to include PHC-related monitoring indicators as they review and update health-related national policies and plans.

WHO is fully committed to supporting Member States in the South-East Asia Region to realize the once-in-a-century opportunity to enable the necessary transformation towards PHC-oriented health systems.

Key milestones: Primary Health Care

August 1937

Bangdoeng Conference on Rural Hygiene, League of Nations Health Organization, Indonesia

September 1978

Alma Atta International Conference on Primary Health Care, Kazakhstan

August 1978

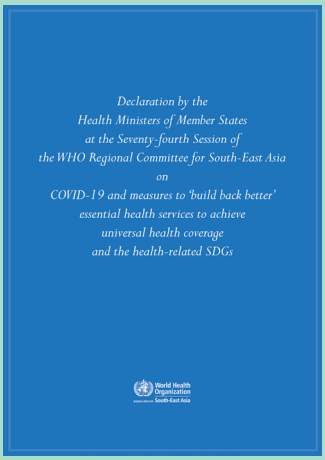
Approval of the WHO SEARO Charter for Health Development, India

August 2008

Regional Conference on Revitalizing Primary Health C Indonesia

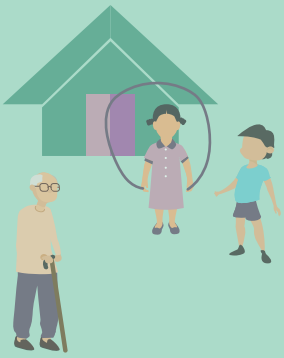
September 2021

74th Session of the WHO Regional Committee for South-East Asia and Minister of Health Declaration on "COVID-19 and Measures to Build Back Better", Nepal (Virtual)



August 2010

Regional Conference on Innovations in Primary Health Care, Thailand



October 2018

Global Conference on Primary Health Care, Kazakhstan

1 Introduction

Robust primary health care-oriented health systems form the cornerstone for achieving universal health coverage and other health-related Sustainable Development Goal (SDG) targets. There is significant evidence that primary health care (PHC) leads to improved population health outcomes, health system efficiency and health equity *(1)*. Studies have also demonstrated that there are multiple pathways through which PHC can lead to inclusive economic growth *(2)*. Through the Declaration of Alma Ata, 1978 *(3)*, and the Declaration of Astana, 2018 *(4)*, all World Health Organization (WHO) Member States reaffirmed their commitment to PHC-oriented health systems. Member states of the South-East Asia Region have responded to and played a key role in shaping the global agenda for PHC.

Successive waves of the COVID-19 pandemic have further highlighted the urgent need for a transformation to PHC-oriented health systems across the South-East Asia Region. Indeed, the COVID-19 pandemic has impacted the economies and societies of the countries of the Region, and the health and well-being of their people, to an extent previously unimagined. The scale and severity of the pandemic exposed long-standing gaps in national and subnational health systems, disrupted essential health services, and exacerbated inequities across the Region. The pandemic also stalled multiple decades of economic growth and progress towards poverty alleviation. The World Bank estimated an economic contraction of 5.4% in 2020 across the South-East Asia Region, with impacts on government budgets forecast to last for years to come *(5)*.

While the COVID-19 pandemic demonstrated the vulnerability of health systems, it also provided important learning on the factors associated with the resilience of health systems to such shocks. It is increasingly recognized that most of the defining features of high-performing PHC systems are the same as those required to address health emergencies, as well as achieve universal health coverage and the health-related SDGs *(6)*.

Within the Region, there is further evidence that countries with strong PHC-oriented systems were better able to respond to the pandemic, rapidly mount public health actions, and maintain essential services with minimal disruption *(7)*. The COVID-19 pandemic has also made evident that accountability for respecting, protecting and fulfilling the human right to health rests firmly with government. The pandemic has highlighted that a robust public sector health service independent of market forces has the resilience to survive and continue to provide services, especially related to PHC.

Within and across Member States of the South-East Asia Region, there has been significant deliberation on the imperative, opportunity and approach to "build back better". Notably, at the 74th session of the WHO Regional Committee for South-East Asia, ministers of health committed to reorient the health systems of Member States towards PHC through increased public investment as the preferred approach to simultaneously ensure health system resilience, the achievement of universal health coverage, and attainment of the health-related SDGs. They further emphasized the "once-in-a-century opportunity to advance transformation towards resilient primary health care-oriented health systems as the means to achieve population health, well-being and prosperity" in the South-East Asia Region. The ministers of health accordingly committed to update their national PHC strategies based on "lessons learned from the COVID-19 pandemic, the Operational Framework for PHC and the forthcoming PHC South-East Asia Regional Strategy" *(8)*.

This South-East Asia Regional Strategy for Primary Health Care 2022–2030 seeks to enable the transformation envisioned by the ministers of health of the Region through prioritization of, monitoring of, and support for 12 strategic actions. The strategy is adapted from the WHO and UNICEF Operational Framework for Primary Health Care *(9)* and is based upon the specific context and conditions of the 11 Member States of the Region and the substantial learning from the COVID-19 pandemic.

2 South-East Asia Regional Context

2.1 Political, economic and social context of primary health care in South-East Asia Region

The 11 countries[a] that make up the WHO South-East Asia Region are diverse in culture, demography, geography, history and level of socioeconomic development. The Region is also home to more than 2 billion people – over a quarter of the world's population, including a large share of the world's poor – with the majority residing in rural areas, but with rapid urbanization taking place across countries.

The South-East Asia Region includes countries with varying political systems, including established and emerging democracies, democratic republics and constitutional monarchies. Countries in the Region span political and administrative contexts ranging from federal and highly decentralized systems to more centralized forms of administration. Indonesia *(10)* and Nepal *(11)* are countries that recently decentralized their administrative systems. Country health systems in this Region are also at different stages of health sector-related institutional development, which has consequences for the management, financing, capacity and delivery of PHC services. The role of the public sector in the provision of social services, including health and education, varies considerably across the Region.

a Bangladesh, Bhutan, Democratic People's Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor-Leste.

Notably, in the decade prior to the COVID-19 pandemic, the Region experienced the most rapid growth in gross domestic product (GDP) worldwide. The economic downturn due to the COVID-19 pandemic has particularly affected the Region, with the World Bank estimating that 60% of the 119 million to 124 million pushed into extreme poverty in 2020 reside in South Asia (including in six countries of the South-East Asia Region) *(5)*. The number of people estimated to have been pushed into extreme poverty in 2020 due to COVID-19, conflict and climate change has also increased in several countries of the Region.

The impact of demographic change is also increasingly felt by countries in the Region, with steady growth in overall population. A key challenge is rapid urbanization, and it is expected that the urbanization rate in the Asia and the Pacific region will reach 50 per cent in 2026 *(12)*. As a result, countries in the WHO South-East Asia Region are trying to keep pace with social change through development of health infrastructure and services in growing cities and towns, while at the same time struggling to maintain or expand services in rural and remote areas. The Region is also increasingly facing common threats related to climate change and the escalating scale of health emergencies.

The variation in development conditions is also reflected in wide inequities in health status and health service utilization both within and between countries. The Region has some of the highest rates of extreme poverty *(13)*, with persistent inequities within countries. These inequities span gender and socioeconomic classes, and are evident in variations in healthy life expectancy, health security *(14)*, financial protection, literacy, health service coverage, digital access *(15)* and COVID-19 vaccine access *(16)*.

In addition to persistent health challenges of reproductive health, food security and communicable diseases, the health systems of the Region are increasingly challenged to prevent and manage a more complex set of health conditions across the life course, including noncommunicable diseases and mental health disorders, as well as ensuring that the required public health capacities are in place to respond to acute periods of health emergency. The determinants of many of the challenging health conditions are often external to the health sector, with road traffic accidents, high rates of malnutrition including obesity, crowded substandard housing, climate change, and the quality of air in cities being major drivers of either chronic conditions or emerging public health threats *(17)*.

2.2 Health system context in the South-East Asia Region

Prevalent across the Member States of the WHO South-East Asia Region is evidence of financial barriers to health care access, low levels of public investment in the health sector in several countries *(18)*, persistent health inequities related to the social determinants of health *(16)*, the emergence of mixed health care systems *(19)*, a rapidly urbanizing population *(20)*, the significant role of traditional medicine and informal providers in health care, particularly for the poorest *(21)*, and the vulnerability of the population to health emergencies and climate change *(22)*.

2.2.1 Health system organization

Countries in the South-East Asia Region vary in their health system

organization. In the three largest countries of the Region (Bangladesh, India and Indonesia), the private sector is utilized by 60–80% of the population for outpatient visits, and by 40–60% of the population for inpatient care *(19)*. In other countries, such as Bhutan, the Democratic People's Republic of Korea, Maldives and Thailand, the public sector is the main provider of health services. Countries of the Region are also at very different stages of progress towards universal health coverage. Moreover, some nations have comprehensive PHC systems in place, whereas others still have selective packages of primary health care. The complexity of management and delivery of health care services is also reflected in regional trends towards decentralized health care management through subnational government entities *(10, 11)*, which presents significant challenges in terms of developing local government capacity for health service management and financing. Civil society organizations have demonstrated their capacity during the COVID-19 pandemic to bridge gaps between communities and local governments *(23)*.

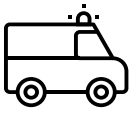
2.2.2 Health financing

Public financing of health care is a persisting challenge in the Region. The South-East Asia Region has the highest share of out-of-pocket health spending, standing at 40% of current health expenditure in 2018, compared to other WHO regions. Even before the COVID-19 pandemic, it was estimated that each year 65 million people in the Region experienced poverty due to out-of-pocket spending on health care *(24)*. Nonetheless, where public sector investments have led to increased quality and range of services provided, evidence from India shows a shift in utilization to the public sector *(25)*.

In some countries, the share of out-of-pocket expenditure is very high, and in others it has even been increasing, while yet others have succeeded in keeping out-of-pocket expenditure at or below 20%. Public financing is the predominant source of financing in some countries, as seen in Bhutan, Maldives and Thailand. Social health insurance is only a small source of health financing in most countries except for Indonesia, where social health insurance is growing in significance *(13)*.

There are also signs of a health financing transition, with a decline in donor financing as a proportion of current health expenditure in most countries. Public expenditure on health is increasing but remains low as a percentage of general government expenditure. Seven out of 10 countries for which data are available increased domestic government expenditure on health by a factor of 2 or more between 2008 and 2018. Despite this trend, private spending per capita was higher than public spending per capita on health in six out of these 10 countries in 2018. Additionally, domestic government expenditure on health as a percentage of general government expenditure was lower than 10% for eight out of 10 countries in 2018. Only six countries provide information on expenditure on PHC as a percentage of GDP in their national health accounts, and that expenditure constituted a very small fraction of GDP *(18)*. This highlights the urgent need for additional financial allocations for PHC, and improved monitoring of PHC investment in order to ensure sufficient financing for high-quality primary care systems among countries in the Region *(15)*.

2.2.3 Health service coverage



Across the Region, countries have committed to universal health

coverage objectives and strategies, including essential health service benefit packages, underpinned by a variety of financial protection mechanisms that are country specific. The universal health coverage monitoring report of 2020 for the South-East Asia Region identifies a positive association between levels of financial protection and the level of service coverage *(15)*. The high service coverage index in Thailand (82%), Sri Lanka (66%) and Bhutan (62%) are linked to high levels of financial protection. This is primarily due to high levels of tax-based financing of the health system in these countries, indicative of political commitment to tax-based financing and financial protection as major reform agendas for the coming decade.

The persistence of inequities in health care access and outcomes, and the expanding role of health ministries as stewards and regulators of decentralized and mixed health care systems, highlights the central role of the public sector in attaining universal health coverage objectives through expanded public financing of PHC, increased regulatory stewardship of the private sector, and establishing incentive systems that are aligned with the goal of universal health coverage. The COVID-19 pandemic across countries in the Region has also shown that essential public health functions and the delivery of essential PHC services are fundamentally the responsibility of the State. The public sector is therefore positioned to provide direct resources to meet the health needs of the most vulnerable and socially disadvantaged communities. Experience from the South-East Asia Region has shown that PHC reform initiatives are most successful when political commitment, resource allocation, governance reforms and community engagement are aligned. Examples from across the Region highlight the potential or success of these reform initiatives in strengthening the health sector and improving health outcomes *(26)*.

The rise of noncommunicable diseases requires more complex health care arrangements for prevention, promotion, treatment, rehabilitation and palliative care. Much of this complexity arises from the fact that, unlike communicable diseases, which are largely episodic in nature, the diverse set of noncommunicable diseases – including diabetes, heart diseases, cancer, sickle cell disease, epilepsy, mental health problems, chronic arthritis, and other chronic conditions (including HIV management) – tend to require longer-term interaction and trust building between communities and the health care system, as well as coordinated action across different levels of health care delivery and across different sectors of government and society. The potential of PHC to address chronic diseases is therefore high.

2.2.4 Health workforce

The availability of a skilled and well distributed health workforce also persists as a challenge. While the Region experienced a 21% increase in the average density of doctors, nurses and midwives between 2014 and 2019, the average density across the Region stands at 26.0 per 10 000 population. Only two countries are above the WHO threshold of 44.5 health workers per 10 000 population. Inequalities in distribution, as well as challenges related to the quality of education and practice, skills mix, policy dilemmas in handling traditional and informal practitioners, productivity, and performance, are also prominent within countries *(27)*. The challenges of misdiagnosis and irrational

treatment appear to be prevalent among formal and unqualified providers *(28)*.

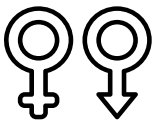
2.2.5 Health management information systems and availability of data for decision-making

Timely and reliable data to support evidence-based decision-making are critical to strengthen performance of PHC-oriented health systems. Member States of the WHO South-East Asia Region have been standardizing their efforts to enhance various components of health information systems by using the SCORE for Health Data Technical Package.[b] However, gaps and challenges still exist, and are common to all countries of the Region. They include limited availability of disaggregated data and monitoring inequalities, lack of availability of information from the private sector, challenges in maintaining and monitoring data quality metrics, and gaps in data use. During the COVID-19 pandemic, the lack of timely, reliable and disaggregated data was a challenge to enabling targeted policies and resource allocation. In some countries robust routine health management information systems proved invaluable in making data available on a real-time basis, even during the pandemic *(29)*.

2.2.6 Essential medical products

Availability and affordability of essential medicines, vaccines, diagnostics and devices is also a challenge, with expenditure by households on these components being the main driver of financial hardship related to health in the South-East Asia Region *(30)*. Several countries in the Region are major manufacturers of generic medicines and vaccines and supply those items to the Region and to the global market. However, there are variations in capacity for procurement, distribution, regulation, quality assurance and rational use that affect access to medicines, particularly for the poor.

2.2.7 Gender and equity



Pervasive inequity and gender-based discrimination are seen across the Region. While equity-stratified data in the Region are limited, available data highlight persistent inequities spanning economic status, education, sex and place of residence. For example, data from Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) in the South-East Asia Region undertaken during 2010–2019 show that for eight countries, children aged under 5 years from the poorest households are 2–4 times more likely to die than those from the richest households. The same data sources also show disparities across eight indicators of service coverage related to antenatal, delivery (including access to caesarean section), and postnatal care by income, place of residence and mother's education. Institutional deliveries for the urban poor are similar to or worse than those living in all but one of the seven countries for which data are available (DHS 2016–2018, and fifth National Family Health Survey of India) *(16, 31, 32)*. In 2018, one in three women of reproductive age experienced intimate partner violence, which is rooted in gender inequality *(33)*. Models of PHC designed to provide comprehensive, accessible, and responsive care to suit gender-specific needs are critical.

b SCORE = survey, count, optimize, review, enable.

Box 2.1 provides examples of PHC initiatives and reforms in the South-East Asia Region.

Box 2.1 PHC initiatives in countries of the South-East Asia Region

Bangladesh. The Ministry of Health and Family Welfare, in alignment with its goal of universal health coverage, committed to ensuring access to essential health services through its Essential Health Service Package (2016). Community clinics designed to improve access in hard-to-reach rural areas were initiated in Bangladesh in the 1990s and now number over 13 000. They provide services for maternal and child health and communicable diseases, with noncommunicable disease screening now a part of their mandate (though in the early stage of implementation). Bangladesh has introduced quality improvement committees at all levels of care, with a facility performance scoring system.

Bhutan. The health care delivery system is based on the principles of PHC and is committed to achieving universal health coverage by 2030. The people-centred health care services under the 'Service with Care and Compassion' initiative address patient needs, by integrating care for chronic conditions, and ensuring early detection and treatment by taking services to where people live. This model of service delivery integrates PHC across different levels of the health system and identifies clear roles for community and traditional health workers. Bhutan has promoted community engagement at the core of all its development process.

Democratic People's Republic of Korea. Primary care is provided through a "section doctor" system. A primary care doctor works with a community team that provides acute and continuous care to individuals registered in their village. Section doctors provide integrated first line preventive and curative services. The country has benefitted from having an extensive PHC system that prioritized the control of communicable disease, based on an expansive network of facilities throughout the country.

India. The National Health Mission focuses on decentralizing planning and management, strengthening public health service delivery at primary and secondary levels, and promoting social participation and community empowerment, backed by increased funding to the government health system. Health and wellness centres, launched in 2018, are designed to deliver comprehensive PHC. The health and wellness centres involve a paradigm shift – entailing expansion of a selective package of PHC services, enabling a team of health workers led by a non-physician health worker, and including financing and information technology (IT) reforms.

Indonesia. Four sets of reforms to strengthen PHC have been implemented, spanning universal health coverage, service delivery, public policy, and leadership reforms. These include initiation of the universal health coverage programme under the National Health Security Act, development of an accreditation system for first level healthcare facilities, development of national health programmes to promote a paradigm shift from curative to preventive measures to achieve healthier

communities, and underscoring the role of general practitioners as gatekeepers in the more structured healthcare delivery system.

Maldives. The Ministry of Health is planning a revitalization of PHC services with a focus on strengthening organizational capacity, integrating services, and improving the skills of health workers.

Myanmar. Primary health services are provided through a mixed system of public, private for-profit, and not-for-profit, and ethnic health organizations. PHC provision in the public sector is through four main channels: rural health centres, sub-rural health centres, maternal and child health centres and urban health centres. Myanmar's primary health care system is reliant on an out-reach model, whereby front-line health workers provide a majority of primary care services including preventive care, at the community level.

Nepal. Nepal has made impressive headway in health service provision since signing the Alma Ata Declaration in 1978. In 1991, PHC became a pillar of the country's national health policy and has supported efforts to achieve universal health coverage through national health strategies. Similarly, the new 2019 National Health Policy aims to decentralize PHC services by establishing primary hospitals in each of the 753 local government areas and health posts in all 6,684 municipal wards.

Sri Lanka. New PHC service organization structures have been adopted, based on the shared care cluster model, with services grouped around a hospital providing specialist care at the apex, and surrounding primary care curative institutions at divisional and primary levels. The reforms are designed to introduce a system of accountability related to care provision, with defined areas of responsibility for a specific population catchment.

Thailand. Thailand has consistently invested in a PHC approach over four decades. PHC networks of health centres and hospitals provide essential care services, with substantial emphasis on preventive and promotive health including through village health volunteers. The policy on universal health coverage has made significant progress since its inception in 2002, and every Thai citizen is now entitled to essential health services at all life stages.

Timor-Leste. The health system was designed on the basis of PHC. SISCa (an integrated community health services effort) is at the heart of a new 20-year National Strategic Development Plan. The SISCa framework enables the prioritisation of a number of cost-effective interventions related to PHC, with the objective of increasing access to health services for village communities.

Sources: 11, 17, 26, 34–40.

2.3 Impact of COVID-19 on PHC in the South-East Asia Region

Successive waves of the pandemic exposed long-standing gaps in national and subnational health systems, disrupted essential health services and exacerbated existing inequities. The challenges were most acute for Member States in the Region for whom significant gaps existed even prior to the pandemic in coverage of essential services and financial protection. Pulse surveys of maintenance of essential health services have highlighted the chronic challenges of limited availability of human resources and essential medicines and equipment, including at primary care levels. The surveys have also revealed gaps in primary care coverage due to the pandemic, including reduced access to community-based care and mobile clinics, and scaling back of public health functions and activities *(42)*. The pandemic demonstrated the limited preparedness of the emergency care system, especially regarding availability of oxygen, beds, ventilators, and medicines, as well as emergency care human resources.

While the pandemic has highlighted the vulnerability of health systems, it has also provided important learnings on the factors associated with the resilience of health systems to such shocks. Countries with strong PHC-oriented systems were better able to respond to the pandemic, rapidly mount public health actions, and maintain essential services with minimal disruption *(24)*. Developments in telemedicine, workforce management, community communication and novel dispensing approaches demonstrate that countries have the capability to innovate and respond after successive pandemic waves *(42)*. Examination of best practices in maintaining essential services during COVID-19 found that service disruption was minimized or mitigated in countries where services were more decentralized, where networks for community health workers were engaged, where there was a supported and committed workforce, where services were integrated, and, finally, where a whole-of-government approach was adopted for the pandemic response *(43)*. The impact of COVID-19 has also reinforced the need for development of PHC-oriented health service models that are characterized by robust community-based services and reinforced essential public health functions *(24, 44)*.

An opportunity for building back better has therefore emerged from the experience of COVID-19. Integrated health services and systems, community engagement, equity-based and gender-responsive strategies, and cross-sectoral partnerships have emerged as the main directions for the future of PHC and health security in the Region.

3 South-East Asia Regional Strategy for PHC: goal, objectives and strategic actions

3.1 Strategy development process

The South-East Asia Regional Strategy for Primary Health Care 2022–2030 has been informed by the Declaration by the health ministers of Member States at the 74th session of the WHO Regional Committee for South-East Asia on Covid-19 and measures to "build back better" *(8)*; a technical working paper, and detailed discussions with Member States. It has also been informed by the WHO and UNICEF Operational Framework for Primary Health Care *(9);* the World Bank report *Walking the talk: reimagining primary health care after COVID-19 (6);* two rounds of pulse surveys on continuity of essential health services during the COVID-19 pandemic *(42)*; annual reports monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region *(15, 30, 33)*; regional country profiles on health financing in times of uncertainty *(13)*; a special issue of the South-East Asia Journal of Public Health on primary health care *(7)*; 10 country case studies on primary health care and COVID-19 *(41)*; and a background paper to the Global Conference on Primary Health Care, Astana, 2018, reflecting on 40 years of primary health care *(17)*.

An expert group was convened by the WHO Regional Office for South-East Asia during the period October to December 2021 to review content of and provide input into the strategy development process and advise the Regional Office towards finalization of the strategy. The

expert group comprised over 20 members, including senior PHC experts from Member States of the Region and WHO headquarters, representatives of development partners and international organizations, and global experts. The expert group was tasked with ensuring that the recommended strategic actions were sufficiently generalizable to cover different country and regional contexts, while also ensuring that the strategy addressed key PHC policy and programmatic priorities for countries of the Region.

The South-East Asia Regional Strategy for PHC identifies a set of 12 common and interlinked strategic actions to guide the transformation towards PHC-oriented health systems in the Region during the period 2022–2030.

These strategic actions are guided by the Declaration by the health ministers of Member States at the 74th session of the WHO Regional Committee for South-East Asia *(8)*. They also reflect the strategic and operational levers of the WHO and UNICEF Operational Framework for Primary Health Care and are based on the South-East Asia Region context and regional flagship priorities.

These actions are cross-cutting enablers covering the key areas of PHC reform that allow health systems not only to adapt more readily to sudden shocks, but also to grow and sustain health systems to meet universal health coverage and SDG targets, as well as progress towards the WHO triple billion targets. Member States would need to adapt these strategic actions and translate them into operational sectoral plans and implementation arrangements that are aligned with and driven by respective national health, social, economic, and political contexts and priorities.

The primary intended users of the South-East Asia Regional Strategy for PHC are national and sub national governments, particularly ministries of health and health systems managers. The strategy is additionally targeted at academia, civil society, elected representatives, development partners, international financing institutions, and the private sector, with the objective of assisting advocacy and alignment of efforts towards the implementation of PHC-oriented health systems in the South-East Asia Region.

The strategic actions described in the document advance the three components of PHC (Figure 3.1) that are articulated in the WHO and UNICEF Operational Framework for Primary Health Care, namely:

- integrated health services with an emphasis on PHC and essential public health functions.
- multisectoral policy and action;
- empowered people and communities.

Figure 3.1 Components of PHC

3.2 Goal and objectives of the regional PHC strategy

Goal

Achieve universal health coverage, health security, and the health-related SDG targets by 2030, through a PHC oriented health system.

Objectives

1. Support Member States in enabling PHC-orientation of their health systems.
2. Serve as a resource for stakeholders to engage in PHC transformation.
3. Strengthen monitoring of PHC performance.
4. Stimulate cross country learning and advocacy.

To ensure that the strategic actions for reorienting country health systems to PHC are realized, political commitment and technical leadership will be critical. Political commitment enables policy and investment functions, including expanding public investments, ensuring efficient and equitable allocations, oversight, building coalitions, ensuring a whole-of-government approach, and developing regulatory capacity and accountability mechanisms *(9)*. Technical leadership of the ministry of health spans stewardship of pluralistic and decentralized health systems, including the design and strengthening of a learning PHC health system. Technical leadership also entails building leadership skills for district and sub district managers and service providers, setting of standards of care applicable to private and public sectors, creating effective monitoring and measurement systems, designing improvements in service delivery based on evidence, documenting best practices, nurturing innovation, and enabling scaling up.

What is a PHC-oriented health system?

A PHC-oriented health system is composed of a core set of structural and functional elements that support achieving universal health coverage and access to services that are acceptable to the population and equity enhancing.

3.3 Strategic actions

This set of 12 strategic actions are interdependent, overlapping, and not exhaustive. Progress on one action is often dependent upon and can catalyse and complement improvement in others.

Strategic action 1: Review and update health-related national policies and plans to reflect PHC orientation

National health policies should reflect a PHC orientation by promoting universal health and well-being through integrated health services emphasizing primary care and essential public health functions, empowering people and communities, and enabling multisectoral action.

1.1 Develop a context-appropriate national PHC strategic action plan through robust stakeholder participation

- The 12 strategic actions outlined in this document should serve as a foundation for a review of current policies in developing or updating a national PHC strategic action plan, suitably modified to reflect the country context (national priorities, disease burden, resources and capacities), with a clear understanding that PHC encompasses district- and subdistrict-level health systems.
- This process would be facilitated by creating a national task force comprising key stakeholders to share experiences and perspectives and serve as useful allies and advocates in the envisioned transformation. Stakeholders should be drawn from relevant government departments and sectors, practitioner bodies, civil society organizations, patient organizations, academic and research institutions, development partners, and the private sector.
- The updated plan should include institutional mechanisms and pathways to reach the most socially disadvantaged or hard-to-reach populations as part of efforts to progress towards universal health coverage.

1.2 Improve emergency preparedness and response

- Updating national plans and policies should include plans for preparing for and responding to public health emergencies. This should be aligned with appropriate national disaster plans and enable climate resilient health systems.This would include improving the capacity to manage supply chains, meet surge capacity requirements, leverage and repurpose existing PHC systems and facilities to meet emergency needs, and maintain essential health services.

1.3 Incrementally introduce a comprehensive set of services

- Member States should seek to incrementally introduce a comprehensive set of assured services in national and subnational health systems by expanding the universal benefits package and including essential public health functions.
- Countries should institutionalize health technology assessments to help design benefits packages.
- Health technology assessment, the UHC Compendium, and the Disease Control Priorities 3 (DCP3) UHC Country Translation Project could serve as useful tools for prioritization of cost-effective interventions to achieve universal health coverage.
- Gender, equity and rights considerations should be taken into account in the process of prioritization.
- Such prioritization would require adequate financial and human resource allocation and appropriately redesigned health systems for effective implementation of the priority interventions.

1.4 Develop a PHC strategic action plan, including strengthening of district and subdistrict health systems

- The capacity of district and subdistrict health systems for oversight, mentoring, and supervision should be increased to ease PHC implementation.
- District and subdistrict teams should be empowered with adequate resources and decision space to be responsive to local needs and priorities, should have the authority to procure locally, undertake public health action, and empanel private

sector facilities (for-profit and not-for-profit), and should be capacitated for community engagement.

- The plan would also include augmenting the role of the district hospital (ensuring effective care coordination across levels for a seamless continuum of care for patients), enabling it to serve as a reliable referral centre and to provide secondary care services.

1.5 Harmonize externally financed interventions and support with national PHC policies and plans

- Member States are encouraged to utilize existing donor and development partner coordination platforms, such as the Global Action Plan for Healthy Lives and Well-being for All (SDG 3 Global Action Plan), in order to ensure alignment of external resources with national PHC plans and policies.

Strategic action 2: Increase and improve financing of PHC

Most Member States of the South-East Asia Region have high out-of-pocket spending on primary care. PHC should be universal, and primary care should be free at the point of care.

2.1 Mobilize and pool additional resources

- Member States should seek to mobilize additional financial resources for strengthening PHC, primarily through domestic government sources. Countries are encouraged to allocate or reallocate atleast 1% of GDP to PHC. Member States could:
  - consider introducing pro-health taxes as a public health tool *(48)*, and preferably dedicating these resources for PHC;
  - undertake advocacy with heads of government and ministries of finance and planning on the benefits of PHC investment for health and inclusive economic growth;
  - choose pre-payment and pooling mechanisms to reduce out-of-pocket spending while mobilizing additional resources for PHC, with government paying for the poor.
  - consider social health insurance mechanisms to mobilize additional resources for PHC.

2.2 Prioritize resource allocation to PHC within the health sector budget

- Member States should ensure that all ministries with a health budget allocate a higher proportion of budgetary resources to PHC. At a minimum, a higher proportion of additional resources that become available for health should be allocated to PHC.

2.3 Assess health financing systems and policies

- Member States should consider the application of the WHO Health Financing Progress Matrix to assess country health financing systems against a set of evidence-based benchmarks, and provide regular action-oriented feedback to policy makers.

2.4 Strengthen strategic purchasing

- Member States should use strategic purchasing (such as contracting and provider payment mechanisms, as appropriate), with well designed institutional arrangements and information systems, to provide incentives for effective PHC services and to enhance access, equity, affordability and quality. For instance,

capitation models could be considered as a possible payment mechanism to advance equitable and efficient PHC.

- In countries with a substantial private sector, measures should be undertaken to ensure that strategic purchasing decisions take into account the strength of regulatory frameworks and incentive systems, and to build capacity to manage the risks of private sector engagement and to ensure the reduction of out-of-pocket expenditure.

2.5 *Strengthen capacities for planning, budgeting and public financial management at all levels to improve PHC*

- Capacity should be built for efficient and equitable planning and budgeting.
- Public financial management systems should be strengthened, including through use of information technology.
- Institutionalization of national health accounts will help ensure improved data collection, analysis, and reporting on a regular basis, including analysis of PHC expenditure.
- Decentralized and flexible budgetary financing mechanisms should be enabled within a strong accountability system

Strategic action 3: Implement governance reforms and enable multisectoral convergence, especially for action on social determinants of health

Member States are encouraged to develop and update policy frameworks and regulations for partnerships, decentralization, and multisectoral collaboration. Member States should strengthen the health ministry's stewardship role and technical capacities to facilitate multisectoral arrangements with other ministries and institutions and to enable engagement of or partnerships with the private sector and other actors (such as professional associations and trade unions), when and where useful and appropriate.

3.1 *Engage in partnerships to advance PHC*

- Governance reforms require crafting strategic partnerships to harness comparative advantages and strengths of the community and civil society (covered in strategic action 6) and the private sector (for-profit and not-for-profit).
- Private sector engagement in PHC should be considered to meet those health system gaps acknowledged by the government and public and based on local contexts.
- Private sector engagement strategies for service delivery should also seek to ensure that costs are supported through public financing systems or social health insurance rather than through increased out-of-pocket expenditure. Several countries have a range of concessions in place for the private sector. Care needs to be taken to ensure that the concessions yield commensurate benefits for people.
- The private sector is a dominant player in primary care in several countries of the Region. While the private sector in such countries may be a useful resource for advancing universal health coverage, the risks of private sector management should be strictly regulated.
- In addition to filling gaps in service delivery and public health functions,

Member States could also use the private sector (for-profit, not-for-profit, and philanthropic) to undertake health facility-related ancillary services (diet, laundry, cleanliness and environmental hygiene of facilities, maintenance and upkeep), ambulance services, low-volume and high-end diagnostics, managing helplines and counselling centres).

- The responsibility of the private sector with reference to public health emergencies and public health functions, including reporting and surveillance, should be defined and monitored.

3.2 Decentralize reforms

- Funds, functions and functionaries should be decentralized to strengthen local oversight of PHC services and implement interventions related to multisectoral action. Such efforts would go hand in hand with PHC-oriented capacity-building of local authorities.
- Another key governance reform is enhancing the role of communities in local health governance (discussed under strategic action 6).

3.3 Institutionalize a Health in All Policies approach and enable multisectoral collaboration

- Multisectoral governance is a complex task, requiring considerable paradigm shifts, including with regard to sectoral financing, power sharing, collaborative governance, and accountability systems. Multisectoral convergence requires a multilevel approach, not limited to PHC and the local community level.
- Member States will need to specify a mechanism for institutionalizing a Health in All Policies approach that will effectively address the social, environmental and commercial determinants of health through coordinated government and civil society action. Each country will have its own model of Health in All Policies based on national institutional contexts.
- Member States should adopt a Health in All Policies approach, preferably backed by a legislative mandate and dedicated resources to support and sustain multisectoral work.
- Multisectoral action plans with accountability frameworks should be developed jointly by all concerned ministries to encourage shared ownership and accountability. Such plans should also be available in the public domain to enable community engagement and social accountability.
- Member States should consider creating an overarching coordination and governance mechanism to enable multisectoral planning and monitoring.

Strategic action 4: Reimagine and reorganize primary health care service delivery

A people-centred PHC system requires significant reorganization of health services to ensure a continuum of care across the life course and levels of care, and the integration of essential public health functions. The rapidly urbanizing population in the Region demands specific attention in PHC system design and operation. Moreover, traditional and complementary medicine systems serve as an important resource for communities in the Region and should be factored into the organization of PHC services.

4.1 Develop policies, strategies and service standards that support a continuum of care across programmes and services and ensure people-centred care

- This action would improve the care continuum for integrated services across service delivery levels (community, primary, secondary and tertiary care), including stronger system linkages between communities and hospitals, with defined care pathways and referral protocols to guide bidirectional referrals and flows and enhance the "gatekeeping" functions of PHC based on the country context. Such a provision would not be exclusionary but would reduce access and financial barriers.
- Individuals and families should be empanelled and registered to easily accessible facilities, to ensure universal coverage.
- Member States should clearly define primary care services to be delivered through health facilities, mobile health clinics (especially for remote areas), community outreach, and home-based care, as appropriate to their contexts, with equitable access as a key consideration.
- The PHC service delivery platform would also enable integration of vertical programmatic interventions such as disease control and immunization programmes. The technical and resource support of such programmes could be leveraged to enhance delivery of a wider package of services and enable greater access of the population to essential health services.
- Member States should consider assigning populations within a defined catchment area to a PHC facility, with the facility team being responsible for ensuring access to comprehensive PHC services. Such empanelment would give the PHC team responsibility for enabling care for all population subgroups across service delivery levels as well as across the life course, spanning preventive, promotive, curative, rehabilitative and palliative care.
- Member States should consider a cluster approach for optimal use of resources (including infrastructure, human resources for health, finance, and laboratory capacity). Resources could be pooled for a cluster or network of health facilities of different levels (primary, secondary, tertiary levels) within a defined catchment area. This would enable better organization of PHC services in different levels of health facilities within the cluster. Higher-level facilities in the cluster would support PHC facilities to provide selected services such as mental health, cervical cancer screening, or conditions with higher levels of care complexity, through outreach or within these facilities. Transport of laboratory samples from PHC facilities to higher levels could improve access to care for the community in the catchment area. Communities would need to be made aware of the availability of such services.
- Given the emerging burden of noncommunicable diseases, including the challenges of treatment adherence and costs of care, Member States could embark on a process of service delivery reorganization, so that those diagnosed with noncommunicable diseases have easy and ready access to medicines and periodic follow-up related to treatment adherence and control at the primary health centre. This would enable increased service coverage and financial protection.
- Member States could also consider reorienting services so that those requiring

emergency care or surgical interventions or those that have the potential risk of life-threatening complications, such as complications in pregnancy or delivery, would be progressively moved to higher-level facilities, while care for chronic conditions (including screening, early detection, prevention, and supporting lifestyle change, notably for conditions associated with metabolic syndrome) would be managed at lower-level health facilities and through community outreach.

- Primary care facilities should be equipped (infrastructure, equipment, medical products, and skilled human resources) to enable provision of emergency care in order to stabilize and refer patients appropriately.
- The existence of treatment gaps and a high burden of disease in relation to mental health will require investments in models of care and workforce capacity to respond to this urgent public health need.
- There have been sustained improvements in reproductive, maternal, newborn, child and adolescent health coverage across the Region over the past two decades; to accelerate reductions in maternal and child mortality, these areas should remain a high priority for Member States.

4.2 Integrate essential public health functions into PHC

- This is important to ensure coordinated responses during outbreaks and emergencies and ensure minimal disruption to essential public health functions, including services covering health protection, health promotion, disease prevention, surveillance, response, and emergency preparedness.
- The integration of essential public health functions will require organizational modifications and reforms, as well as increased investment across the health system.

4.3 Strengthen urban primary health care

- The context and organization of PHC in urban areas is significantly different from that in rural areas; the PHC approach should therefore be tailored to the distinct urban contexts.
- Reorganizing PHC services in urban areas should take into account the specific needs of marginalized populations living in slums and slum-like conditions.
- Designing strategies to improve urban PHC would need to take the presence of the private sector into consideration (as discussed under strategic action 3).
- The proximity of facilities offering various levels of care requires that referral pathways from primary care facilities are well defined.

4.4 Integrate traditional and complementary systems of medicine into PHC

- A PHC-oriented system would also enable the integration of traditional and complementary medicine into the national health system and into the essential health care package, with provision for cross-referral between conventional and traditional systems of medicine, while ensuring an appropriate workforce to undertake the provision of such services.
- Well trained and skilled traditional and complementary medicine practitioners could be utilized at appropriate levels of care, with appropriate regulatory provision.

- With nationally standardized and accredited training and registration, traditional and complementary medicine practitioners could support public health programmes and reorient services towards a people-centred model of care.

Strategic action 5: Build a culture of wellness to promote well-being

A reoriented PHC system would enable an environment in the community and in the facility to promote overall well-being and provide both sickness- and wellness-related services. Wellness interventions to enable behavioural change for a wide variety of risk factors are needed at critical points in the life course, such as gestation, early childhood, adolescence, adulthood and ageing.

Wellness interventions require multisectoral convergence and action on social, environmental and commercial determinants of health to facilitate healthy behaviours, for example through the provision of pedestrian walkways and parks and restricting the sale of tobacco, sugar-sweetened beverages and unhealthy foods.

5.1 Strengthen community-based PHC to promote wellness

- Community-based PHC provides an opportunity to reorient care towards a culture of wellness, such as the promotion of:
  - healthy dietary behaviours that address nutrition across the life course, which is key to reducing child mortality, improving child development, and reducing premature morbidity and mortality from noncommunicable diseases.
  - physical activity, sports and yoga while recognizing and addressing constraints on mobility placed on girls and women in some contexts, for example by creating safe exercise spaces in communities.
  - healthy homes and environments, including hygiene and sanitation, smoke free homes and public places, reduction of air and environmental pollution and environmental management for vector control and waste management.
  - regular screening programmes for cardiovascular disease, cancer and other chronic diseases, including oral health (specific wellness initiatives that raise people's awareness about risk factors).
- Wellness interventions would use the platforms of multisectoral convergent action in educational institutions and workplaces to ensure school health and health-promoting schools, expand exercise spaces in the community, promote interventions for tobacco, alcohol and substance abuse avoidance, develop workplace wellness interventions, and leverage community structures, including peer groups, to encourage the spread of healthy behaviours.

5.2 Enable attention to mental health and well-being

- Mental health is a key element of health and well-being.
- Improving contacts with primary care providers can promote mental health and well-being, reduce risk behaviours, and prevent mental health disorders.

5.3 *Undertake capacity-building for implementation of wellness interventions*

- The reorientation of PHC towards a culture of wellness and well-being will require significant investment in capacity-building of PHC professionals and community health workers.

Strategic action 6: Ensure community engagement and empowerment

The vision of more people-centred services is a necessary condition for development of PHC-oriented health systems. Community engagement in PHC improves equity, enhances trust in the health system, strengthens communication between the people and the system, creates a culture of accountability and strengthens overall PHC performance. Community-based organizations have an important role in supporting community engagement.

6.1 *Enable community participation in local health service governance structures*

- In addition to strengthening community-based PHC, robust representation and participation by the community in local health service governance structures or processes, service facilitation provided by community- or facility-level health committees, participation in needs assessment, quality improvement, and priority setting, and ensuring accountability are all potential actions for deepening community engagement and ensuring accountable PHC services.
- Membership of such structures and processes should ensure that socially excluded and underserved groups and communities, including women, are represented.

6.2 *Promote community-based PHC systems through enhancing the role of community health workers*

- Community health workers embedded in the community, with strong linkages to the health system, are best suited to enable community-based PHC. Community health workers and other front-line workers are the community's first point of contact with the health system and need to be equipped to build and sustain community confidence in the PHC system.
- It is important to provide these cadres with good working conditions and ensure that they are well-trained and equipped to address first-contact care and enable health prevention and promotion interventions. This would enhance the community's trust in the health system and also promote solidarity between the community and the front-line workforce.

6.3 *Facilitate creation of patient support groups*

- Community engagement could also be leveraged for creating collectives, such as patient support groups, who could support facility and outreach services and participate in home care where appropriate.
- One specific intervention, especially relevant for managing noncommunicable diseases as well as other chronic ailments, that has been shown to be effective in increasing well-being, knowledge and treatment adherence is the existence of patient and peer support groups. Such groups can be strong advocates of their care requirements within health systems and can serve as effective voices for community needs.

6.4 *Develop models of community engagement in urban areas*

- Health systems and local authorities need to proactively develop models of community engagement in urban areas.
- Urban community engagement requires markedly different approaches, and innovative methods are needed to engage urban populations, including use of community- and workplace-based social and digital platforms.

6.5 *Create mechanisms for effective communication between the health system and the community*

- Establishing communication with the community is integral to ensuring trust in the PHC system.
- Community empowerment would be enabled by the health system to strengthen agency and capacity for action for personal care (including self-care) and to increase health literacy, including through the use of interpersonal communication and leveraging digital infrastructure for improved access to various forms of media, including the carefully considered use of social media.
- Strategies for communication with the community would need to be adapted to context (rural–urban, gender, literacy, and access to digital health technology).
- Community communication strategies are particularly useful in the context of pandemics and emergencies, to support risk awareness, provide timely and accurate updates on the situation, counter myths and combat misinformation.
- In addition to strengthening the communication capacity of the health system, engaging community representatives to become effective communicators would also serve to increase trust, provide momentum for the spread of positive health behaviours, and address the needs and preferences of excluded groups.

6.6 *Engage the community for enhanced accountability*

- Establishing systems that ensure accountability to the community include creating effective grievance redressal mechanisms in case of denial of or poor-quality service, including the use of call-in numbers.
- Another accountability measure is to establish systems for data sharing with the community, including civil society and community-based organizations. Sharing disaggregated data in a form that is comprehensible to citizens would enable the community to hold the system accountable in the case of inadequate or poor quality service provision and would increase community members' understanding of their roles and responsibilities in improving health outcomes.
- Another mechanism for community empowerment is strengthening accountability through establishing monitoring systems for communities to undertake audits of service availability and quality.

Strategic action 7: Strengthen the availability, competence and performance of a multidisciplinary PHC workforce team

Planning and management of the PHC workforce should be informed by consideration of other

strategic actions, particularly with regard to service reorganization, community engagement, financing and governance.

7.1 Include the full array of available health workers in PHC-related policies and plans

- The full array of health workers who are active in advancing health and well-being, as appropriate to the national context, should be included in, and organized as, multidisciplinary PHC teams, through appropriately resourced health workforce, primary health care, and national and subnational health policies and plans. That workforce would include not only the major health professions, but also, allied and auxiliary health workers, community health workers, and registered traditional and complementary medicine practitioners.
- Consideration should be given to regulatory and operational flexibility to enable greater access to health workers while maintaining priorities related to safety and quality.
- Additional health emergency-related surge capacity should be taken into account in the PHC workforce-related planning processes.

7.2 Improve the distribution and strengthen the capacities of PHC workforce teams

- Approaches to improve health workforce distribution (including development, attraction, recruitment and retention policies) and alignment of health workforce education with local population health needs (for example through transformative education) remain critical in the Region to enable PHC-oriented transformation.
- PHC teams should have the competencies and capacity to provide personal health care (preventive, promotive, curative, rehabilitative and palliative) and public and population health functions, with a focus on local health needs and settings. Wider competencies related to providing person-centred care that is respectful and compassionate, communication, and personal conduct are equally important for ensuring acceptability of the services provided and building community trust in the health system.
- Adaptation of pre- and in-service education, and development of PHC-focused training pathways with prioritization of local health needs, are increasingly being utilized in the Region and hold promise. Digital technology should be used to train mentor, and provide clinical guidance and decision support to the PHC workforce to improve the quality of service delivery.
- International recruitment of health workers should be conducted in an ethical manner that supports rather than compromises PHC orientation efforts.

7.3 Address human resources for health challenges across district and subdistrict health systems

- Strengthening PHC requires reinforcement not only of the health workforce at the first point of care but also of the entire district health system, including through staffing of hospitals with the necessary and competent human resources for health (specialist cadres included) to support the PHC workforce through effective management of referrals, maintenance of continuous communication, and necessary supervision. Moreover, dedicated programme managers at district level

are needed to support PHC-oriented transformation.

- Institutionalizing systems for team and individual mentoring of the PHC workforce is critical.
- Based upon their availability, specialists in family medicine could be considered to lead and support PHC workforce teams at secondary and primary levels.

7.4 Strengthen the planning, management, quality, and performance of PHC workforce teams

- Of fundamental importance is improved planning and responsive management of PHC teams, including systems for recruitment, posting, transfer, supportive supervision, career progression and remuneration, based on regular and reliable information.
- Regular monitoring of the quality and performance of PHC teams, linked to facility and community assessments, should be conducted. Incentives to strengthen the quality and performance of PHC teams could be considered.
- Ensuring a positive, supportive, safe and quality work environment that meets national labour standards remains fundamental to improving health worker practice.
- Countries that allow dual practice should ensure appropriate frameworks to minimize risks of patient hardship and poor quality care.
- Strengthening human resources for health information systems and establishing links to health management information systems are needed to enable the above functions.

Strategic action 8: Promote availability and affordability of quality essential medical products for PHC

While this action is relevant for the entire health system, weaknesses in medical product regulation, lack of adherence to quality standards, limitations in selection, procurement, storage and distribution systems, irrational use, poor maintenance, and lack of IT-enabled real-time supply chain and monitoring systems have significant implications for access to affordable, quality-assured essential medical products for PHC.

8.1 Ensure access to affordable, quality-assured essential medical products

- Action is required to enable universal access, primarily via adequate public financing, and to ensure availability of quality medical products, including generic medicines, at affordable prices via effective price control mechanisms.
- IT-enabled supply chain mechanisms should be established to avert stock-outs and wastage.
- Consider teleradiology and hub-and-spoke models for laboratory investigation to improve access to quality diagnostics.
- Expand the range and use of point-of-care diagnostics (especially for screening for a range of conditions).

8.2 Ensure rational selection and use of medical products

- A list should be established of essential medicines, vaccines, blood products, diagnostics, medical devices and assistive technology specifically for PHC using

evidence-based selection methods, including health intervention and technology assessments aligned with the essential health service packages based on disease prevalence, evidence on efficacy and safety, and comparative cost–effectiveness.

- Capacity should be built for the appropriate prescribing, dispensing and use of medical products, and carrying out prescription audits.
- Standard treatment guidelines should be developed and updated for PHC-specific clinical conditions, including simplified treatment protocols for chronic diseases and provision of adequate information and training for health care professionals.
- It is important to implement antimicrobial stewardship programmes, improve compliance with standard treatment guidelines, and put in place a national essential medicines list in line with the Access, Watch, Reserve (AWaRe) classification of antibiotics in the WHO Essential Medicines List, while taking account of resistance patterns and national action plans for antimicrobial resistance.

8.3 Improve storage and maintenance of medical products

- Appropriate infrastructure should be in place for storage of medical products, with due regard for space, hygiene, temperature and humidity control.
- Management and maintenance of medical devices is an important consideration, especially maintenance protocols and training on usage and basic maintenance of medical equipment.
- It is also crucial to rationalize the range of spare parts, accessories and consumables required in order to simplify sourcing, purchasing and storage of medicines and other products.

8.4 Strengthen regulatory systems for medical products and promote local manufacturing capacity

- The national medicines regulatory authority should be adequately empowered to ensure the safety, efficacy, performance and quality of medical products, using the WHO Global Benchmarking Tool for evaluation of national regulatory systems as a guide when formulating institutional development plans.
- Regulatory oversight of pharmacies in urban and rural areas should be strengthened.
- The development of domestic manufacturing capacity for essential medical products is an important measure to address supply-side resilience and affordability.
- A post-market surveillance system for medical products can help monitor quality and safety and enable efficient product recall when necessary.
- Research and development of medical products that serve the health needs of the poor should be prioritized, including innovative approaches such as patent pools and prize funds.

Strategic action 9: Strengthen the quality of PHC care

Quality health care means that services are effective (providing evidence-based health care services), safe and people centred. To realize the full benefits of health care, services should be timely, equitable, integrated and efficient.

Quality of health care also encompasses a holistic understanding of the individual care seeker.

Quality cuts across all the strategic actions of PHC, with the quality of health services in particular dependent on the quality of health infrastructure, health workforce (strategic action 7), and medical products (strategic action 8). The role of regulating the facility, the provider and medical products is fundamental to ensuring quality across the public and private sectors.

9.1 Establish, monitor and ensure quality standards and systems

- A national quality strategy for PHC should be established, with associated quality monitoring indicators.
- Minimum standards should be put in place for PHC-oriented services for inpatient and ambulatory care, national standards established for infection prevention and control, protocols developed to ensure equity and gender-sensitive facilities that are free of violence, discrimination and harassment, processes such as clinical governance and prescription audits implemented for improved patient safety, quality monitoring systems developed for primary care services in facilities and in outreach platforms, and feedback systems created that identify and correct gaps in real time.
- Joint monitoring mechanisms by key stakeholders can address quality in its multiple dimensions – quality of infrastructure, adherence to standards and protocols, health worker qualifications and practice, and quality of medical products, with an integrated feedback loop for improvement.
- Local quality improvement strategies should be enacted, based on local team-based approaches of problem analysis and solution development, enabled by systems of subdistrict and district support.
- Patients and communities should be continuously engaged through appropriate feedback mechanisms to build trust and improve people's health.

9.2 Ensure quality infrastructure

- An important aspect of quality is to undertake the development and strengthening of public health system infrastructure to reduce access barriers and to ensure provision of universal physical access to health facilities for people of all ages and abilities, reliable and accessible water, sanitation and hygiene systems, telecommunications connectivity, and a reliable power supply.
- Attention should also be paid to creating climate-resilient and green infrastructure.

9.3 Enable grievance redressal mechanisms

- Establishing robust grievance redressal systems, including through the use of call centre-based mechanisms, should be considered.

Strategic action 10: Leverage the potential of digital technology to improve access to and quality of equitable PHC

Digital technologies have the potential to transform healthcare, including PHC, as demonstrated by Covid-19. Digital health interventions need to ensure that people benefit in a way that is ethical, safe, secure, reliable,

equitable and sustainable, and should be based on the principles of transparency, accessibility, scalability, replicability, interoperability, privacy, security and confidentiality.

10.1 Review existing interventions and reform architecture

- A review of existing digital health interventions should guide reform of the digital health architecture, ensuring that introduction of technology is appropriate to the social, institutional and health system context.
- Digital health interventions should be selected so that they complement one another and maximize the effectiveness of the PHC system.
- The use of digital health systems would include essential public health functions and would span the range of health states from wellness to disease management, in order to enhance the quality and reach of PHC.
- Interoperable PHC electronic medical record systems should be put in place as part of a national digital health framework. The framework should consider issues such as data access, sharing, consent, cybersecurity, privacy, interoperability, connectivity, inclusivity, and unique personal health identifiers, consistent with international human rights obligations.

10.2 Consider data as a public good

- Priorities include development of systems to establish and manage core digital health data and digital infrastructure to enable interoperability and seamless exchange, adoption of open standards by all actors to facilitate the development of multiple digital health systems, ensuring data safety and security standards, establishing data ownership pathways, and enabling data use in research and analytics.
- Health-related information and data should be shared with patients to empower them to use their data for better care management, including self-care.

10.3 Explore opportunities for digital technologies to advance PHC

- Possible applications include the creation of electronic health records that are easily accessible to citizens and service providers to ensure continuity of care and empower patients for self-care, expanding population registers to strengthen public health functions such as screening, surveillance, detection of disease outbreaks, and responding to disease trends, use as a capacity-building and mentoring platform for service providers including PHC workforce teams, and enabling data collection, reporting, and feedback in real time, to minimize the burden on front-line workers and allow them to use data for prompt action and improved performance.
- Digital technology could also include applications for district-level health managers to improve supply chain and logistics systems, tracking availability of medical products in peripheral health facilities, tracking emergency transport vehicles, and human resource management.
- Use of telemedicine in PHC should be explored, based on the country context and legislative framework, to improve the care continuum and referral system, bring specialist care closer to people, and reduce patient hardship. Attention should also be given to extending the use and reach of diagnostic technology, such as telediagnostics.

Strategic action 11: Strengthen health information systems to enhance PHC

The availability and quality of relevant health information, from multiple sources, is necessary to support PHC strengthening, including monitoring implementation and performance, ensuring equity and accountability, and enabling continuous improvement. A robust health information system needs to be tailored to the needs of policy makers and practitioners for informed decision making.

11.1 Strengthen the quality of health management information systems

- The quality of health management information systems at national and subnational levels should be strengthened to ensure integration of data from multiple programmes, inclusion of disease surveillance into monitoring systems, and assessment of service coverage by equity stratifiers such as sex, income and age, and to enable analysis of PHC implementation and quality. The WHO SCORE health data technical package could be used to assist Member States in enhancing country data systems to support PHC strengthening.
- National and subnational health information systems should be strengthened to capture and analyse data from the private sector.

11.2 Institute or expand surveys to capture PHC parameters

- In addition to routine monitoring systems, countries would need to enhance the scope of existing large-scale surveys or design new surveys to reflect PHC-specific parameters, including as related to people's perceptions of service quality and satisfaction, out-of-pocket expenditures, service coverage, and overall progress in population health outcomes.
- Innovative methods of information collection, such as crowd sourcing and telephone surveys, could be also considered, as appropriate.

11.3 Strengthen civil registration and vital statistics systems

- While civil registration and vital statistics are not strictly a function of PHC, strengthening those systems enables monitoring of PHC performance. It would require building the capacity of subdistrict personnel, often at peripheral health facilities, in providing standardized death registration information, especially for non-facility-related deaths.

11.4 Utilize routine data systems to enable dynamic PHC-oriented health systems

- Data availability should be customized to needs at different levels of the health system to enable informed and timely decision-making and action, prioritizing the PHC needs of providers and managers.
- Data should be also shared with communities and civil society for improved transparency, accountability, advocacy and actionable information for improved health and well-being.
- In addition to ensuring that monitoring is used to measure the strength of implementation processes, robust monitoring and evaluation systems should ensure accountability of service providers for improved PHC performance.
- In order to monitor disaggregated data on equity (for example, gender, urban–rural, age, vulnerable populations, provinces,

districts), health information system innovations with data dashboards at district level, implementation of district health information systems, use of geographic information systems, analyses of relevance for policy, case studies, sample surveys, implementation research, and assessments of coverage should be implemented to support transition to a dynamic PHC-oriented health system.

Strategic action 12: Institutionalize learning systems for sustainable PHC

Learning health systems are a means by which data from various forms of research (including health systems and policy research) and practice are combined with other sources of information, including from beneficiaries, the community at large and the health workforce, to inform decision-making and make iterative changes in the health system to improve PHC services and population health outcomes.

12.1 Ensure the creation of learning health systems

- A routine monitoring system identifies implementation gaps in planned strategies and activities. A learning health system on the other hand would identify design failures, understand the day-to-day challenges of implementers, assess the effectiveness of context-specific solutions to address specific problems, and identify and evaluate local innovations for potential scaling up.
- Member States would create or strengthen learning health systems that would not only inform the PHC system specific to their country but also serve as a collective repository of knowledge for the Region and beyond. This strategic action is linked to strategic action 11 on strengthening health information systems to enhance PHC, since one source of learning is data collected through routine health management information systems, surveys and commissioned studies.

12.2 Build institutional partnerships to strengthen learning health systems

- Member States would need to build knowledge partnerships with research and academic institutions, including enhancing capacity and skills, to apply a learning lens to the process of reorienting health systems towards PHC so that there is a continual focus on performance and improvement and application of lessons learned from local innovations, based on multidimensional learning. This would institutionalize the process of concurrent learning to inform policy and modify implementation in support of a robust innovative, dynamic, adaptive PHC-oriented health system.
- In order to institutionalize internal learning processes, Member States may also consider the establishment of or provide support to organizations that are mandated and competent to support implementation, undertake assessments and research, and inform policy modification and development.[c] Such organizations could also be linked to academic and research bodies and enable integration of new research into implementation and policy.

c Specific examples of such boundary organizations include India's National Health Systems Resource Centre and Thailand's Internal Health Policy Programme.

12.3 Design monitoring mechanisms to enable learning

- Monitoring systems should also include obtaining community feedback, gathering tacit knowledge of implementers and practitioners, and identifying innovations through implementation research to assess PHC functionality.
- Monitoring and evaluation systems should use triangulation and other tools to complement health management information system data. This would enable policy or programmatic modification and improvement, based on ground reality and the day-to-day implementation challenges encountered by communities and the PHC workforce.

4 Monitoring of the South-East Asia Regional Strategy for PHC

Monitoring of the 12 strategic actions can serve to assess, track, and drive progress towards PHC-oriented health systems in the South-East Asia Region. Member States are encouraged to include PHC-related monitoring indicators as they review and update health-related national policies and plans (strategic action 1).

A set of core indicators that explicitly link to the 12 strategic actions described in the regional PHC strategy are listed in Annex 1. These core indicators were selected with the following considerations:

- build on information already collected at national and regional levels (for example, universal health coverage monitoring reports, health financing reports, human resources for health reports, medicine data reports) in order to reduce the reporting burden;
- assist performance measurement of PHC systems across Member States;
- align with the WHO and UNICEF Primary Health Care Monitoring Framework and Indicators *(45)* to ensure coherence and efficiency;
- enable the biennial reporting to the WHO Regional Committee for South-East Asia, as mandated by its resolution SEA/RC74/R1;
- support monitoring of progress towards attainment of the SDGs and universal health coverage targets and goals.

5 Support from WHO

WHO is fully committed to supporting Member States in the South-East Asia Region to realize the once-in-a-century opportunity to enable the necessary transformation towards PHC-oriented health systems.

WHO, as the lead United Nations agency for health, will maximize the technical and political capacities across its three levels in order to support the vision, objectives and strategic actions elaborated in the South-East Asia Regional Strategy for Primary Health Care 2022–2030. Support will be provided through concerted advocacy, technical and implementation support, and strengthening of partnerships within and across countries.

At the national level, the role of WHO country offices will be critical in providing direct technical support to Member States based upon their specific needs and priorities. WHO, through its country offices, will also support ministries of health in bringing together other line ministries, the private sector (for-profit and not-for-profit), communities, civil society, development and United Nations partners, and other relevant stakeholders to define, drive action towards, and monitor progress in achieving a common vision. The review, update and monitoring of national PHC strategic action plans, and alignment of partner support, will be fundamental to this effort.

At the regional level, the WHO Regional Office for South-East Asia will serve as a platform to bring together regional and global best practices and innovations to support progress across the 12 strategic actions, while

ensuring linkages across the Regional Office's eight flagship priorities. Moreover, the Regional Office will utilize its collaborating centres and existing regional networks, including the Asia Pacific Observatory on Health Systems and Policies, the Asia-Pacific Action Alliance on Human Resources for Health, and the South-East Asia Regulatory Network, to advocate and support cross-country evidence-based learning to inform PHC-related policy action in the Member States of the South-East Asia Region. The WHO Regional Office for South-East Asia will also establish an expert group of eminent practitioners to guide and support Member States in implementing the regional Strategy for PHC.

The Regional Office will utilize its existing collaborations with development partners, global health initiatives, international financing institutions, and United Nations agencies to leverage required resources and capacities that are aligned to nationally defined PHC priorities. Finally, the Regional Office will support Member States in monitoring PHC orientation and performance, with associated biennial progress reports presented to the Regional Committee, as called for by resolution SEA/RC74/R1.

At the global level, the WHO Special Programme on Primary Health Care will support progress in advancing the South-East Asia Regional Strategy for PHC through producing PHC-oriented and implementation-focused evidence and tools (such as the WHO Academy PHC course and implementation solutions for PHC) as well as through promoting PHC renewal through advocacy and partnerships. The Joint Working Team for primary health care and universal health coverage serves as an additional means to provide the necessary support to Member States of the South-East Asia Region.

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Annex 1
Selected indicators to monitor PHC orientation and performance

Table A.1 outlines a selection of PHC indicators that have been mapped against the 12 strategic actions of the South-East Asia Regional Strategy for PHC. The indicators and definitions have been sourced from the draft WHO and UNICEF document – "*Primary health care monitoring framework and indicators*", October 2021.

Table A.1 Selected indicators for strategic actions of the South-East Asia Regional Strategy for PHC

No.	Indicator	Description
Strategic action 1: Review and update health-related national policies and plans to reflect PHC orientation		
1	Existence of national health policy oriented to PHC and universal health coverage	The country has a national health sector policy, strategy oriented to PHC and universal health coverage based on minimum standards
2	Existence of health emergency and disaster risk management strategy	There is a health emergency and disaster risk management strategy that is measured against key criteria
Strategic action 2: Increase and improve financing of PHC		
3	Government PHC spending as percentage of government health expenditure	Domestic general government expenditure on PHC as a share of domestic general government health expenditure
4	Sources of expenditure on health (and PHC specific)	Distribution of expenditure on health by source (private, domestic government, external), with a focus on out-of-pocket expenditure (PHC specific)
5	Services included in health benefits package (including primary care)	Health benefits package defines services to be financed from public sources that have been assessed for inclusion in the benefit package as part of a systematic transparent process, including criteria on economic evidence and budget impact/cost-effectiveness
Strategic action 3: Implement governance reforms and enable multisectoral convergence, especially for action on social determinants of health		
6	Existence of supportive supervision system	Percentage of facilities that implement or receive supportive supervision, including key attributes

No.	Indicator	Description
Strategic action 4: Reimagine and reorganize primary health care service delivery		
7	Health facility density/ distribution (including primary care)	Total number of health facilities (and primary care facilities) per 10 000 population, disaggregated by managing authority
8	Service package meeting criteria	Service package of essential health services (including primary care services) and public health functions is developed and meets set criteria
9	Roles and functions of service delivery platforms and settings defined	The roles and functions of service platforms, including scope of services, are defined within integrated health service delivery networks
10	Protocols for patient referral, counter-referral, and emergency transfer	Explicit protocols and structured communication mechanisms are in place to promote reporting and feedback between primary care practitioners and other levels of care (referral and counter-referral) to promote coordination and information, continuity that incudes key data elements
11	Outpatient visits	Number of outpatient visits (for example, to facilities or doctors) per person per year
Strategic action 5: Build a culture of wellness to promote well-being		
12	Patient-reported experiences	Percentage of key attributes for patient experience, satisfaction, and health system responsiveness being met
Strategic action 6: Ensure community engagement and empowerment		
13	Coordination mechanisms with multistakeholder participation and community engagement	National, subnational coordination mechanisms for PHC towards universal health coverage exist and meet key criteria
14	Proactive population outreach	Percentage of facilities that actively provide services to communities according to local health needs and priorities
Strategic action 7: Strengthen the availability, competence and performance of a multidisciplinary PHC workforce team		
15	Health worker density and distribution (SDG indicator 3.c.1)	Number of health workers per 10 000 population, by occupation, by subnational area (disaggregated by level of care)
16	Functional national human resource information system and national health workforce accounts	National human resource information system is in place and functional and can generate key required human resource information
Strategic action 8: Promote availability and affordability of quality essential medical products for PHC		
17	Availability of essential medicines (SDG indicator 3.b.3)	Percentage of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis

No.	Indicator	Description
18	Availability of essential in vitro diagnostics	Percentage of health facilities that have an appropriate set of diagnostics for their health care facility level, based on the WHO Model List of Essential In Vitro Diagnostics
Strategic action 9: Strengthen the quality of PHC care		
19	Existence of policy, strategy or plan for improvement of quality and safety	There is a validated national strategic direction on quality and safety, measured against key criteria
20	Availability of basic water, sanitation and hygiene (WASH) amenities	Percentage of facilities that have basic WASH amenities
21	Percentage of facilities offering services according to national defined service package	Percentage of primary care facilities/units offering services according to national defined service package
22	Percentage of facilities compliant with infection prevention and control (IPC) measures	Facility meets standards based on the eight core components of the Infection Prevention and Control Assessment Framework
Strategic action 10: Leverage the potential of digital technology to improve access to and quality of equitable PHC		
23	National e-health strategy	There is a national digital/e-health strategy that includes key criteria
Strategic action 11: Strengthen health information systems to enhance PHC		
24	Completeness of birth registration	(i)Percentage of births that are registered, (ii) Proportion of children aged under 5 years whose births have been registered with a civil authority
25	Completeness of death registration	Percentage of deaths that are registered (with age and sex) and include valid cause of death
26	Existence of effective surveillance system	Country has an effective surveillance system based on the average of two SPAR indicators on early warning function and mechanisms for event management
27	Regular system of population-based health surveys	Country can generate regular, comprehensive, high-quality, nationally representative statistics with equity dimensions on population health status, health-related behaviours and risk factors, access to health interventions and out-of-pocket spending on health
Strategic action 12: Institutionalize learning systems for sustainable PHC		
28	Priority setting is informed by data and evidence	Priority setting in the national health strategic plan/ policy is based on data and evidence, and is measured against key criteria
29	Perceived barriers to access (geographical, financial, sociocultural)	Percentage of target population reporting problems in accessing care when they have a health care need, by problem

Annex 2
Expert group

WHO SEARO constituted an expert group of regional and global leaders in PHC, who contributed substantially to the development of the regional PHC Strategy.

Members of the expert group are listed below:

1. Dr. Aishat Aroona Abdulla, Senior Medical Officer, Vice Chair, Tobacco Control Board, Ministry of Health, Maldives
2. Dr. Liaquat Ali, Honorary Chief Scientist & Advisor, Pothikrit Institute of Health Studies, Bangladesh
3. Dr. Sara Bennett, Director Health Systems and Vice Chair International Health, Johns Hopkins Bloomberg School of Public Health, USA
4. Dr. Dana Burduja, Senior Health Economist, European Investment Bank, Luxembourg
5. Prof. Stephen Hodgins, Associate Professor, University of Alberta, Canada
6. Dr. Yogesh Jain, Public Health Physician, India
7. Prof. Sharad Raj Onta, Country Coordinator, People's Health Movement, Nepal
8. Prof. Lalaini Rajapaksa, Emeritus Professor of Community Medicine, University of Colombo, Sri Lanka
9. Prof. K. Srinath Reddy, President, Public Health Foundation of India, India
10. Prof. Helen Schneider, University of the Western Cape, South Africa
11. Dr. Prastuti Soewondo, Special Staff to the Minister of Health, Public Health Services, Indonesia
12. Prof. T. Sundararaman, Former Executive Director National Human Systems Resource Centre, India
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