World Health Organization
REGIONAL OFFICE FOR South-East Asia

SEAR PHC FORUM

Positive practices in developing primary health care-oriented health systems

A collection of case stories from the WHO South-East Asia Region

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Content

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Participants in the South-East Asia Regional PHC Forum meetings and thematic working groups, including Member State focal points and representatives, partner representatives, experts, and WHO staff, contributed individually and collectively to gathering over 200 operational examples from which these case studies have been identified (names provided in Annex 1). We are deeply grateful for their substantive and continued engagement, which is enlivening the South-East Asia Regional PHC Forum as a regional knowledge management platform.

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Abbreviations

ASHA	accredited social health activist
AYUSH	ayurveda, yoga and naturopathy, unani, siddha, and homeopathy
BRAC	Bangladesh Rural Advancement Committee
CHO	community health officer
CHW	community health worker
CRM	Common Review Mission
CSO	civil society organization
CUP	contracting unit for primary care
EDCL	Essential Drugs Company Limited
GDP	gross domestic product
GK	Gonoshasthaya Kendra
GPO	Government Pharmaceutical Organization
HPH	health-promoting hospital
HPV	human papillomavirus
HWC	health and wellness centre
ILP	Integrasi Layanan Primer
NGO	nongovernmental organization
NHSO	National Health Security Office
NHSRC	National Health Systems Resource Centre
PCV	pneumococcal conjugate vaccine
PHC	primary health care
PPP	public–Private Partnership
PSF	promotora saude familia (family health promoter)
QOF	Quality and Outcomes Framework
SDG	Sustainable Development Goal
TRIPS	Trade-Related Aspects of Intellectual Property Rights
ULAMA	Usia Lanjut Masih Aktif (Active Elderly)
UNICEF	United Nations Children's Fund
VHSNC	village health, sanitation and nutrition committee
WASH	water, sanitation and hygiene
WHO	World Health Organization

List of case stories

S.No.	Theme	Topic	Country
1	Cross-cutting	Transforming primary health care in Indonesia through scale-up of Integrasi Pelayanan Keshatan Primer (ILP): Case study of implementation at Puskesmas Plantungan, Kendal, Central Java	Indonesia
2	PHC Workforce	Integrated capacity building for primary health care in Faafu Atoll	Maldives
3	PHC Workforce	Re-skilling and organization of the Health Assistant cadre for comprehensive primary health care	Bhutan
4	PHC Workforce	Deploying mid-level healthcare providers at scale for achieving comprehensive primary health care	India
5	PHC Workforce	Capacity building for community health officers: The NHSRC-CMC mentoring programme	India
6	PHC Workforce	PHC team for the provision of Family Health Care approach	Timor-Leste
7	PHC Workforce	Performance incentives linked to quality & outcomes	Thailand
8	PHC Workforce	Common Review Mission: Monitoring for building a learning-adaptive system	India
9	Urban PHC	Public Private Partnerships under the UCS in Bangkok City and Scale Up	Thailand
10	Urban PHC	Bangkok public health and digital health volunteers	Thailand
11	Urban PHC	ULAMA: Engaging elderly in the planning and implementation of healthy city programme of Wajo Regency	Indonesia
12	Urban PHC	The Jaffna Healthy City programme	Sri Lanka
13	Medical products	Government Pharmaceutical Organization for universal access to essential medicines	Thailand
14	Medical products	State role in manufacture and supply of medicines at affordable cost for primary health care	Bangladesh
15	Community engagement	Local government in primary health care and community engagement	Nepal
16	Community engagement	Kerala palliative care programme with involvement of local government (Panchayat)	Kerala/India
17	Community engagement	Inter-sectoral platform for community action on health and determinants: Swasthya Panchayat Yojana	Chhattisgarh/India
18	Community engagement	Grievance redressal with civil society engagement	Thailand
19	Community engagement	Bangladesh Health Watch: Taking voices of the grassroots to policy makers	Bangladesh
20	Community engagement	NGO role in providing Primary Health Care: Gonoshasthaya Kendra	Bangladesh

Foreword

The desire for comprehensive primary health care (PHC) available to all has long been held by countries of the WHO South-East Asia Region, pre-dating the 1978 Alma-Ata declaration. Contemporary climatic, demographic, economic, epidemiological, social, and health emergency-related pressures have provided further motivation to strengthen PHC-orientation of health system across the region and globally.

The 2023 UN General Assembly Political Declaration of the High-level Meeting on Universal Health Coverage identified PHC as the cornerstone for accelerating progress towards Universal Health Coverage and the health-related SDGs, while also contributing to the resilience of health systems. Encouragingly, as evidenced during the 76th Session of the WHO Regional Committee for South-East Asia, there is strong momentum to strengthen PHC-orientation of health system across countries of the SE Asia Region. However, operationalizing the vision of quality PHC across the varied geographies and contexts of the two billion people of the Region remains a major challenge.

This publication, through the selection and presentation of twenty case studies in narrative from, distills the knowledge of how operational challenges are being overcome to realize the vision of PHC. The case stories speak to the possible and give the opportunity to build upon the experience of others. At least as important as the publication itself is how it came to be - by leveraging the collective knowledge present within the Region, as channeled through the South-East Asia Regional PHC Forum.

The WHO South-East Asia Regional Roadmap for Results and Resilience prioritizes WHO's role in supporting future-ready health systems based on a holistic understanding of health, with people - especially the most vulnerable - at the center. It further prioritizes WHO's role in capacity development and knowledge management, including through capturing and contextualizing local and social innovations. This publication, and the process towards its' development, is directly aligned with this vision for WHO and a healthier region.

I urge all stakeholders to use this publication, as well as the broader South-East Asia Regional PHC Forum, to meaningfully advance primary health care across the WHO South-East Asia Region. The practical experiences and attendant learnings contained in these pages can be the building blocks of efforts to enhance primary health care across our Region.

Saima Wazed
Regional Director
WHO South-East Asia

Credit: WHO SEARO

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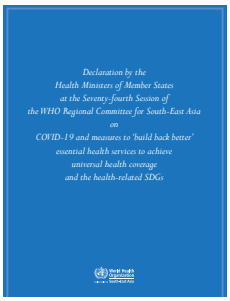
CHAPTER 1

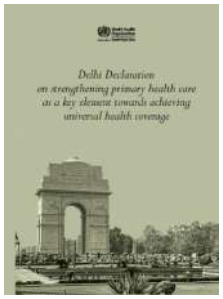
Introduction

Countries of the World Health Organization (WHO) South-East Asia Region, with a quarter of the world's population, have long recognized the importance of advancing primary health care (PHC) as central to health and broader development. The COVID-19 pandemic, subsequent economic challenges, and evolving health needs have added further impetus to strengthening PHC across countries of the South-East Asia Region.



At the 74th session of the WHO Regional Committee, ministers of health in the Region committed to reorienting health systems towards PHC as the means to simultaneously ensure health system resilience and accelerate progress towards universal health coverage and the health-related Sustainable Development Goals (SDGs). Importantly, through the Declaration of Health Ministers (SEA/RC74/R1), ministers of the South-East Asia Region identified a once-in-a-century opportunity to strengthen PHC-oriented health system transformation, and recognized the value of a South-East Asia Regional Primary Health Care Strategy to guide, support and monitor PHC-oriented transformation *(1)*.

The South-East Asia Regional Strategy for Primary Health Care 2022–2030 (South-East Asia Regional PHC Strategy), with participation of ministers of health in the Region, was launched in December 2021. The South-East Asia Regional PHC Strategy elaborates a set of seven values and 12 interdependent strategic actions. During consultations towards development of the strategy, Member States emphasized the need for and opportunity to systematically capture and share implementation-focused PHC learning. Strategic action 12 of the South-East Asia Regional PHC Strategy, "Institutionalize learning systems for sustainable PHC", stands as testament to the importance placed on capturing and actioning learning present within the Region *(2)*.

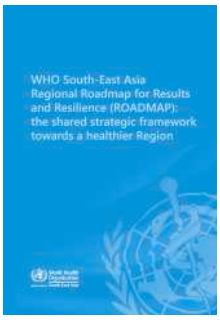


The ministerial commitments expressed in the 2023 Delhi Declaration on Strengthening Primary Health Care as a Key Element towards Achieving Universal Health Coverage, as adopted during the 76th WHO South-East Asia Regional Committee (SEA/RC76/R3), emphasized the importance of subnational, national and cross-country knowledge management with identification, sharing and translation of good practices in PHC *(3)*. The WHO South-East Asia Regional Roadmap

Table 1. PHC as policy priority across South-East Asia Region countries

Country	Policies
Bangladesh	National Health Policy 2011; Sheikh Hasina community clinics incorporated since First Health and Population Sector Programme (1998–2003); Fifth Health, Population, and Nutrition Sector Programme (HPNSP) 2024–2029 developed with strengthened focus on PHC
Bhutan	National Health Policy 2011 (under revision); Service with Care and Compassion Initiative 2018 (integration of noncommunicable diseases into PHC); Thirteenth Five Year Plan 2024–2029 (in development) with focus on PHC
Democratic People's Republic of Korea	Primary Health Care Strategy 2021–2025
India	National Health Policy 2017; Ayushman Bharat – Comprehensive primary health care through health and wellness centres 2018; Ayushman Bharat Digital Health Mission 2021; PM – Ayushman Bharat Health Infrastructure Mission 2021
Indonesia	Health System Transformation 2022 launched at the 58th National Health Day in August 2022: PHC strengthening, Transformasi Layanan Primer, as its first pillar; National PHC Integration and Health Omnibus Law 2023 together driving PHC-oriented reforms
Maldives	Maldives National Health Master Plan 2016–2025; Maldives launched the primary health care demonstration site in Faafu Atoll in December 2022, with anticipated expansion to 10 atolls
Myanmar	National Health Plan 2017 (under revision)
Nepal	Constitution of Nepal 2015 (guaranteeing right to free basic and emergency health services); Public Health Service Act 2018 and National Health Policy 2019 to assure constitutional guarantee
Sri Lanka	Policy on Health Care Delivery for universal health coverage 2018; PHC reforms in progress based on a shared care cluster approach.
Thailand	Thailand PHC Act 2019; Universal Coverage Scheme "Treats All Diseases" to "Treatment Anywhere" reform in process
Timor-Leste	National Health Sector Strategic Plan 2011–2030, 2024 Integrated Health Services Policy with focus on comprehensive primary health care

Source: Table adapted from Dhillon et al. (5).



for Results and Resilience, launched in 2024, similarly prioritizes WHO's role in knowledge management towards the vision of a learning health system *(4)*. Through presentation of a selection of case studies, this report seeks to contribute to the regional vision of collective learning and cooperation.

Across South-East Asia Region countries, there is strong momentum to strengthen PHC orientation of health systems across countries of the Region (Table 1). However, operationalizing the vision of quality comprehensive PHC across the varied geographies and contexts where the 2 billion people of the Region resides remains a continuing challenge *(5)*.

Recognizing challenges in operationalization, Member States of the South-East Asia Region, the 75th Regional Committee meeting specifically requested the WHO Regional Office for South-East Asia Regional Director "to establish and strengthen regional knowledge and experience-sharing mechanisms on PHC through mobilizing expertise from development, implementation and academic partners in the Region" *(6)*. The South-East Asia Regional Forum for Primary Health Care-Oriented

Credit: WHO SEARO

Health Systems (South-East Asia Regional PHC Forum) was formally launched in November 2022 in Bangkok, Thailand *(7)*, with the aim to support implementation-focused knowledge exchange and collaboration *(8)*. One of the main activities undertaken by the South-East Asia Regional PHC Forum *(9)* was the creation of working groups to capture implementation-focused learning across seven thematic areas[1]. Through collective work of the South-East Asia Regional PHC Forum, 200-plus examples of operational learning have been collated, with presentation to the Second Annual Meeting of the South-East Asia Regional PHC Forum, held in Sri Lanka in October 2023. A specific request put forward during the Second Annual South-East Asia Regional PHC Forum meeting in Sri Lanka was to develop detailed case studies on a selection of promising practices, based on a standardized case study template *(10)*.

1 PHC workforce, urban PHC, PHC quality (medical products), community engagement, PHC monitoring, PHC service delivery, and PHC investment case.

It is in this context that a case study template and case studies have been developed to share important learning from across the Region, while also serving as models for how this approach to learning can be enhanced and further built upon. The case study ("story") approach adopted in this report recognizes that specific practices are seldom possible to replicate without adaptation in another country context. As such, a sound understanding of the underlying principles and mechanisms of success and how these played out in a specific context and led to the desired outcomes, along with collateral consequences, is needed for other countries to adapt and translate the learning to their own circumstances.

In the following sections we present the objectives of the report; the methodology for case study selection and development; a set of 20 case studies from across the WHO South-East Asia Region; and a conclusion summarizing the main learnings from this initiative.


Credit: WHO SEARO

CHAPTER 2

Objectives and methods

2.1 Overall objective

To review the collection of South-East Asia Regional PHC Forum operational examples, with the selection and development of detailed case studies for a set of 20 operational examples.

Specific objectives:

- to review the collection of operational examples available through the South-East Asia Regional PHC Forum;
- to develop a methodology to select positive practices from the Thematic Working Group operational examples, as relevant across a diversity of contexts in the WHO South-East Asia Region;
- to prepare detailed case studies on a selection of 20 operational examples, based on established case study research methodology.

2.2 Methods and framework of analysis

In this section we describe (A) the approach to identifying positive practices or innovations for case study selection; (B) the theory underpinning construction of case study questions and methodology; and (C) presentation of a detailed case study template.

Credit: WHO SEARO

A. Considerations for selecting positive practices and innovations

The terms innovation and positive practice need to be used with caution, especially when applied to health programmes and health systems. Any change or any activity undertaken is not necessarily an innovation, though it may have been of benefit. For example, filling up staff vacancies would be an invaluable step, but would not necessarily count as an innovation or positive practice. However, if there were barriers to earlier recruitment that required a new approach to overcome them, or that process led to better quality in outcomes, the same activity could be considered as a positive practice or innovation.

We have applied the definition of innovation from the Sector Innovation Council for the Health Sector (2012–2014), India. Here innovation is defined as a change in activity or strategy that (a) meets a need or solves a problem, (b) is creative and involves a new approach or a new application of an existing approach, and (c) brings significant benefit to one or more groups *(11)*. Where the rest of the definition holds, except the test of novelty (that is, is it new), then the use of the term positive practices could be considered more appropriate.

The pathways by which such innovations develop vary. Three innovations pathways have been proposed in the context of health systems *(12)*. The first of these is the positive practices pathway. In this pathway, many innovations arise as local-level solutions arrived at by local administrators are then noticed and considered for scaling up. Some of these are also pilots driven by specific external donors. Scaling up requires a policy-level decision, and this in turn requires documentation and evidence of the effectiveness of the positive practice. Another pathway, more common in the private sector, is the business model as innovation. Often involving technology upgrading, it addresses a need through market mechanisms and its success relates to its profits and sustainability. The third pathway is where the innovation arises in the form of government formulating and developing a new scheme to respond to policy priorities or implementation challenges.

B. Case study methods and framework of analysis – realist(ic)

The definition of and approach to case studies ("case stories") has been adapted from approaches put forward by Gillham *(13)* and Yin *(14)*. Gillham highlighted the importance of strong research questions in case studies. He viewed case studies as the richest form of descriptive research, leading to theory development *(13)*. Yin defined a case study as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" *(14)*. This method is particularly useful for studying programmes and activities and institutions. The case study is the main method; its sub methods for gathering data include interviews, group discussions, observation (detached and participant), records and document analysis, and even records of seminars. This multimethod approach uses triangulation as the test to verify the convergence of its various evidence items to get a true picture of the phenomenon or process under study.

We additionally use the realistic evaluation framework for analysis *(15)*. The realistic framework sees interventions as complex social and behavioural set of activities that need to be described and understood. The same intervention might be implemented differently in various settings and with different stakeholders. Additionally, different stakeholders might have their own theories about how the intervention works. The realistic framework does not just ask, "Did it work?" Instead, it acknowledges that interventions can work to some extent and sometimes have unexpected effects, which can be either useful or not.

Building on this approach, the following four questions are central to the case stories presented:

- What was the programme theory (or theory of change) of the activity or intervention? This includes the objective and how the mechanisms of the intervention were constituted for the specific contexts.
- When did this intervention start, what are its features and what was the experience in implementation? What were the operational approaches used?
- Did it work? To what extent did the intervention work to achieve the objectives and what were the gaps? In what circumstances did they work best?
- Has there been any formal evaluations or studies? What are the learnings, documented or undocumented, from experience of implementation?

C. Case study template

Based upon the above, we arrived at the following case study template (Table 2).

Table 2: Case study template

Title	A short descriptive title
Background	• Where was the activity undertaken (geography) • When was the activity undertaken (time) • Who undertook the activity (partnership)
Problem Statement / Objectives	• What is the problem being addressed • What is the theory of change
The Activity: Context-Processes- Outcomes	Briefly describe: • Context in which activity was undertaken • Mechanisms / processes that constituted the intervention • Outcomes being measured and/ or achieved • Review or evaluation conducted (if any) • Unintended benefits or consequences
Learnings and continuing challenges	• What worked, to what level, in what circumstances • What did not work and why • Areas of continuing challenge(s) • Lessons for others
Resources and/or References	• Resources and /or references as available.


Credit: WHO SEARO

To arrive at the specific list of case studies, over 200 operational examples of effective practices were captured by members of the South-East Asia Regional PHC Forum. These were listed, categorized and analysed based on the lens identified earlier. Twenty case stories were purposively selected, with the aim of being able to prepare studies that could illustrate an approach to learning and programme improvement across geographies and topical areas. A limitation in our selection process was the lack of sufficient information and evidence to make selections across the variety of operational examples collected. The selection could get skewed by the availability of information, which might not constitute a full assessment of effectiveness. At times, multiple operational examples were combined into a holistic case study. The process of selection and analysis is further detailed in the next section.


Credit: WHO SEARO

CHAPTER 3

Review of the repository of operational examples collected through the South-East Asia Regional PHC Forum

Over 200 operational examples were collected by the participants in the WHO South-East Asia Regional across four themes: PHC workforce (n=56), urban primary health care (n=54), PHC quality with focus on medical products (n=55), and community engagement (n=46) (see Annexes 2 to 5). Three other working groups were active with a focus on PHC monitoring, integrated service delivery, and the PHC investment case, but the methodology of work and output were different. The focus of this report is thus on the four previously identified themes.

3.1 Theme 1: PHC workforce

In countries of the Region and globally, the health workforce is recognized as a fundamental lever for realization of the vision of PHC. The importance of a team-based rather than an occupation-specific approach to the PHC workforce, fully incorporating administrative, clinical and public health capacities, is also increasingly recognized, especially following the COVID-19 pandemic.

Credit: WHO SEARO

The working group decided to focus on "Management approaches to optimize the performance of PHC workforce teams". Within this area, examples are provided on the diversity of composition of PHC teams, approaches for capacity-building and competency assessments, and performance management (see Annex 2).

Regarding the composition of the PHC team, there were 16 case studies drawn from 10 countries. It is of considerable interest to understand both the similarities and differences across these 10 countries. Family care was a recurrent theme and we decided to look at *Timor Leste's family care team*. The introduction of *mid-level health care providers and community health officers (CHOs) for health and wellness centres (HWCs) in India* was also remarkable for the sheer scale and dimension of that intervention. There were also three examples where improved job descriptions were seen as the main intervention to achieve a functional workforce.

On capacity-building, there are 17 examples collected. Of these about five are institutional strengthening, about the same number are examples of on-the-job mentoring, and the rest are examples of digital platforms alone or in hybrid mode to achieve capacity-building. One of these was an *integrated care model for multiskilling of health assistants for providing comprehensive primary health care in Bhutan*, which we considered could make a useful case study. The other two notable examples we selected were *integrated capacity-building for primary health care in Faafu Atoll, Maldives*, as well as the *rapid scaling up of the training of mid-level health care providers in India*. Under competency assessments, six examples were captured, and these overlapped with the earlier subcategory.

There were also a variety of performance improvement measures presented. Some were paying for performance or providing assessments, often largely of individual providers or of facility-level teams. Others were examples of improved assessment of individual providers or of programmes. An important example of overall health system assessment is the *Common Review Mission of India*, which we selected as a more detailed case study. Thailand's *quality of care framework* was another important example to take up for more detailed assessment.

Credit: WHO Maldives

3.2 Theme 2: Urban PHC

The thematic working group focused on capturing examples of "Innovative approaches to strengthen PHC in urban settings". This was framed under three interlinked subthemes: urban PHC policy, governance, and service delivery (see Annex 3).

The three themes were selected due to their interlinkages. First, having a context-specific urban primary health care policy is essential, as it establishes principles and guides action focused on outcomes. Second, urban PHC governance acts as a critical supporting enabler by bridging government policies, optimizing resources, and ensuring effective service delivery. Lastly, urban PHC service delivery mechanisms serve as the driving force for providing quality services to the population.

Among the examples, Thailand's pilot experiment of public–private partnership (PPP) under the Universal Coverage Scheme in Bangkok City holds significant importance due to its scale and policy relevance, as the National Health Security Office (NHSO) is transforming Thailand's Universal Coverage Scheme from "Treats All Diseases" to "Treatment Anywhere". Another noteworthy selection is Bangkok's digital health volunteers, which stands alone as an example with immense potential for learning. Additionally, the healthy city initiatives from Indonesia and Sri Lanka, though substantively different, are important for their focused attention on addressing social determinants of health.


Credit: WHO SEARO

3.3 Theme 3: PHC quality with focus on medical products

Improving the quality of service delivery at the primary care level is critical to advancing PHC orientation of health systems in the WHO South-East Asia Region. Moreover, ensuring access to essential medical products at primary care level, as highlighted in the South-East Asia Regional PHC Strategy, is fundamental to improving quality of, trust in and utilization of PHC. The performance of PHC facilities is directly affected by the supply of essential medicines and, indeed, the lack of availability is a leading factor for patients going directly to secondary level facilities or skipping the public sector entirely.

Recognizing both the importance and complexity of PHC quality, the thematic working group focused on access to essential medicines as the entry door to discussion on PHC quality. Within this area, the thematic working group further narrowed its focus to identify "Select approaches for supply chain management that have strengthened access to essential medicines at primary care level in the South-East Asia Region".

Within this theme, sub thematic areas of institutional mechanisms and innovations for supply chain management; innovations in supply chain operations; and supply chain workforce: capacity development and assessment, with digital technology as a cross-cutting enabler, were identified to ease capture of cross-country learning (see Annex 4). Several of the examples relate to the creation of public institutions to manage the supply chain, while others relate to improved process re-engineering to improve supply chain management. Many of these innovations relate to different forms of digitization. We look at examples of self-sufficiency in pharmaceutical manufacture integrated with supply chain management from two countries: Bangladesh and Thailand.

Credit: WHO SEARO

3.4 Theme 4: Community engagement

While the importance of community engagement is well recognized, success in operationalizing this principle has been a challenge in practice across countries in the Region and Globally. As the same time, significant effort and innovation is evident across countries of the Region.

Given the wide variety and forms of community engagement, the thematic work group decided to capture examples under four distinct but overlapping categories. These include involvement of local self-government structures, involvement of community-based organizations, involvement of community health workers and involvement of civil society organizations (See Annexure 5). Of these we selected three to focus on involvement of local self-government structures: from Kerala and Chhattisgarh in India, as well as from Nepal. Indonesia's National PHC Integration is similarly related to community engagement. We selected an important example from Thailand to focus on

grievance redressal and two from Bangladesh (Bangladesh Health Watch and Gonoshasthya Kendra) to focus on civil society organizations involvement in service delivery.


Credit: WHO SEARO

Selection of examples to develop as case stories

Based on the above review, we shortlisted 20 topics for the development of detailed case studies (see Table 3). One feature we noted was that often the information on a specific intervention was presented across a number of operational examples, under different theme and health system building block areas. In our case study development, since we are looking at problems and solutions more holistically, we have combined many boxes of information across themes and health system building blocks, in order to present case studies more holistically. A narrative form has also been adopted in describing each case study, articulating them as “case stories”.


Credit: WHO SEARO

Table 3. Operational examples selected for case study development

S.No.	Theme	Topic	Country
1	Cross-cutting	Transforming primary health care in Indonesia through scale-up of Integrasi Pelayanan Keshatan Primer (ILP): Case study of implementation at Puskesmas Plantungan, Kendal, Central Java	Indonesia
2	PHC Workforce	Integrated capacity building for primary health care in Faafu Atoll	Maldives
3	PHC Workforce	Re-skilling and organization of the Health Assistant cadre for comprehensive primary health care	Bhutan
4	PHC Workforce	Deploying mid-level healthcare providers at scale for achieving comprehensive primary health care	India
5	PHC Workforce	Capacity building for community health officers: The NHSRC-CMC mentoring programme	India
6	PHC Workforce	PHC team for the provision of Family Health Care approach	Timor-Leste
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10	Urban PHC	Bangkok public health and digital health volunteers	Thailand
11	Urban PHC	ULAMA: Engaging elderly in the planning and implementation of healthy city programme of Wajo Regency	Indonesia
12	Urban PHC	The Jaffna Healthy City programme	Sri Lanka
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14	Medical Products	State role in manufacture and supply of medicines at affordable cost for primary health care	Bangladesh
15	Community engagement	Local government in primary health care and community engagement	Nepal
16	Community engagement	Kerala palliative care programme with involvement of local government (Panchayat)	Kerala, India
17	Community engagement	Inter-sectoral platform for community action on health and determinants: Swasthya Panchayat Yojana	Chhattisgarh, India
18	Community engagement	Grievance redressal with civil society engagement	Thailand
19	Community engagement	Bangladesh Health Watch: Taking voices of the grassroots to policy makers	Bangladesh
20	Community engagement	NGO role in providing Primary Health Care: Gonoshasthaya Kendra	Bangladesh

CHAPTER 4

Case Studies

Case Study 1

Transforming primary health care in Indonesia through scale-up of Integrasi Pelayanan Kesehatan Primer: case study of implementation at Puskesmas Plantungan, Kendal, Central Java, Indonesia

Credit: MoH Indonesia

Organization and scale

Integrasi Pelayanan Kesehatan Primer, also known as Integrasi Layanan Primer (ILP), seeks to revitalize PHC in Indonesia, shifting focus from curative services to core functions of prevention and health promotion with reach to household level. The initiative has been spearheaded by Indonesia's Minister of Health, Mr Budi Gunadi Sadikin, as the foremost pillar of Indonesia's health system transformation. The nationwide programme was launched in August 2023, with current implementation in over 2000 puskesmas across 38 districts in Indonesia.

This case story describes the journey and early success of ILP implementation in Puskesmas Plantungan, a community health centre based in the most rural area of the highlands of Kendal Regency, Central Java Province.

Timeline

Nine design pilots were undertaken during the period July to October 2022 to inform the launch of ILP in August 2023. The process of national scale-up is ongoing, with Puskesmas Plantungan initiating ILP in November 2023.

Problem statement and objectives

PHC in Indonesia was fragmented across vertical programmes, with coverage of only selective disease priorities. Fragmentation was evident across health system building blocks (that is, human resources for health, information systems, supply chain); there was disconnection across levels of care and within the community; and challenges existed in service delivery due to geographical constraints. Moreover, despite the recognition of need and government desire to introduce preventive and promotive interventions, puskesmas (community health centres) continued, in practice, to focus on curative services as linked to professional background and training of staff. There was an urgent need to scale up primary health care rapidly using an approach that would make it much more integrated and comprehensive, in a cost-effective manner.

The Vision of ILP

The ILP initiative is more than a programme. It represents a transformative vision aimed at integrating fragmented health care services, improving data systems, and enhancing the quality of care through redefining and standardizing health care roles across 10 000 puskesmas, 25 000 pustus (health subcentres or auxiliary puskesmas), and 300 000 posyandus (integrated health posts). Unlike the previous model of care in Indonesia, which was programme centred, ILP shifts to a life cycle approach that emphasizes promotive and preventive health across every stage of life. While the earlier system often resulted in siloed and disjointed care, ILP fosters a more cohesive and comprehensive health care experience across the continuum of care, addressing the entire spectrum of health needs. As necessary, the initiative extends services closer to communities, reaching down to the village, hamlet and household level.

Context, process, outcomes

Puskesmas Plantungan, located in the most remote area in the highlands of Kendal Regency, Central Java, provides an important example of "how" Indonesia's recently launched ILP is being realized. This health care centre, which serves a population of approximately 34 759 people, has long faced the challenge of delivering services to a geographically isolated population. Before ILP implementation, health care services in this region were limited and fragmented, with disconnection from lower-level and higher-level facilities and the community itself.

Central to the ILP transformation undertaken by Puskesmas Plantungan was a 20-day period during which the head of puskesmas and team understood the ILP approach and guidelines, restructured processes within and outside health structures, and mobilized communities in four villages to enable the change. The following steps taken during this 20-day period were critical to

implementation of ILP in Puskesmas Plantungan:

- Notification and understanding of the ILP guidelines.
- Mapping of existing human resources for health (roles, capacities) and available facilities (readiness).
- Internal socialization of staff within the puskesmas, to both orient to new vision and tools (for example, electronic medical records) and co-develop implementation processes.
- Official announcement of the ILP implementation and local meetings with all puskesmas staff.
- Cross-sectoral socialization, both formal and informal, to build support for ILP implementation. Strong support from the village head, village organization, and local government was essential to ensure funding for kaders (community health workers), building maintenance of posyandu, and wi-fi and internet connection for pustu. Informal socialization was particularly important to build trust and co-ownership.
- Development of supporting documents, including technical and puskesmas regulations for ILP implementation.
- Cross-sectoral meetings with head of subdistrict and village leadership, with commitment to support two pustu and 24 posyandu in four villages.
- ILP implementation was initiated in four villages in December 2023, with scale-up to all 12 villages covered by Puskesmas Plantungan by January 2024.

Three main shifts are evident through ILP implementation in Puskesmas Plantungan. First is a shift in focus from a disease-specific programme to a life cycle-based approach, with focused attention on strengthening promotive and preventive care. Services have been prioritized and standardized based on the burden of disease estimates in each age group. The enhanced set of services provided are organized into five distinct clusters: management, maternal and child health, adult and elderly care, infectious disease control, and cross-cluster support. Across these five clusters emphasis is on disease prevention and promotion, as follows:

- Routine immunization for an expanded set of 14 immunizations, including human papillomavirus (HPV) vaccine, pneumococcal conjugate vaccine (PCV) and rotavirus.
- Improving maternal and child health, with a focus beyond antenatal care and to include ultrasonography-supported breast cancer screening and neonatal screening for congenital heart disease.
- Screening for the highest cause of death in each category (thus giving greater focus to noncommunicable diseases), with 14 priority diseases across age categories. These screenings are progressively rolled out. Flowcharts showing the standard care pathways for follow-up to each of these screenings are in place.

The second shift brings health care close to the community through strengthening of a unified health network that reaches into villages, hamlets and home visits, with standardization of the services that are to be delivered at each level. At the most peripheral level are home visits by kaders (community health workers); as coordinated through hamlet-based posyandus. Posyandus are operated by village committees with a focus on community empowerment in health. Above these at the village level are the pustu, which earlier had one midwife or nurse and have been further strengthened to include both a midwife and a nurse. The puskesmas is located at the subdistrict level and has close to 50 staff, including two doctors, one dentist, 12 nurses and 20 midwives. Once a patient enters a puskesmas or a supporting facility like a pustu or PKD (village health post), they receive holistic care that comprehensively addresses their health concerns. This includes

thorough screenings and evaluations. If further monitoring is necessary, follow-ups are planned and home visits extended as needed. Structural strengthening of each level was accompanied rapidly, training the staff to be able to deliver these services.

The third essential shift is strengthening local area monitoring through digitalization and a village-level health situation dashboard. The village dashboard serves as an important monitoring and accountability mechanism, with puskesmas and the pustu conducting weekly reviews to ensure that the entire population is covered.

The full support from village officers has been crucial in sustaining these services. Village funds are allocated to maintain and upgrade the infrastructure of pustu and PKD facilities. Additionally, these funds are used to cover internet costs in villages to facilitate real-time data collection and communication, ensuring efficient monitoring and coordination of health care services, as well as transportation expenses for kaders, who support posyandu services and conduct home visits.

Progress at the level of puskesmas and below requires support from other pillars of Indonesia's Health System Transformation. One of these pillars is Indonesia's broader Digital Health Transformation Roadmap. Central to this effort is the Satu Sehat platform, which connects over 23 500 health care facilities, facilitating seamless data flow and comprehensive patient care. The transition to electronic medical records is also expected to simplify administrative tasks, allowing more efficient and compassionate patient care, while easing the burden on reporting work by health care workers.

Another pillar is improving resilience of pharmaceutical and medical devices by transitioning to domestic production of 14 routine immunization vaccine antigens, and the top 10 medicinal raw materials and top 10 medical equipment by volume and by value. Transformations in secondary care, emergency response, health workforce and health financing are also recognized as necessary parallel measures to ensure the successful scaling up of ILP nationwide.

Active assistance, continuous monitoring, and supportive supervision from the Ministry of Health, provincial health office, district health office, and local government are also crucial components for the successful implementation of ILP at Puskesmas Plantungan.

Learning and continuing challenges

The story of Puskesmas Plantungan is a testament to the power of collective effort towards a shared vision, as enabled through processes of both technical and social participation. The transition was challenging. Health workers, who had long focused on curative services, had to adapt to a model that prioritized preventive and promotive care. The introduction of electronic medical records represented a significant shift, requiring new skills and approaches. Moreover, village leaders and community members had to be both socialized to the reforms and mobilized for active contribution in reviving facilities and engagement that was dormant.

Local leaders, health care providers, and residents united to overcome the challenges and ensure the success of the initiative. The robust processes undertaken, formal and perhaps even more importantly informal, for involvement of the community in actively shaping ILP implementation has been fundamental to the early success evident in Puskesmas Plantungan. The processes and collaboration have fostered a sense of ownership and pride, making the health care system a vital part of the community's identity.

Moreover, by ensuring comprehensive care and follow-up, including home visits, ILP has touched all layers of society, making health care a shared responsibility and a common good. As the ILP continues to expand, the lessons from Plantungan will guide other provinces and districts in Indonesia, as well as other low- and middle-income countries, in developing a feasible roadmap for progress towards the goal of achieving universal health

coverage. The journey is only beginning, but the path laid out by Puskesmas Plantungan provides an example of the possible.

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Case Study 2

Integrated capacity-building for primary health care in Faafu Atoll, Maldives

Credit: WHO Maldives

Organization and scale

Pilot intervention in Faafu Atoll, with expansion to 10 atolls (current phase) and in final phase to all of Maldives. Organized by Ministry of Health, Government of Maldives.

Timeline

Launched in September 2022, with expansion to 10 atolls planned in 2024, ongoing.

Problem statement and objectives

There is a constitutional commitment to ensure progressive realization of the right to health (physical, mental and a healthy environment) for all citizens of Maldives. A PHC workforce team is in place in all the 188 inhabited islands, but these teams did not have the capacities to provide the comprehensive set of services at primary care level. Given the dispersion of teams, it is challenging to build the skills of the PHC team and then follow up with the supportive supervision and mentoring required.

Context, process, outcomes

Maldives is an archipelago with a population of about 515 132 people dispersed across about 188 inhabited islands grouped into 20 administrative atolls, which are spread over a diameter of close to 800 kilometres. The population of most islands ranges from 300 to 5000. The Faafu Atoll comprises five islands and total of 4869 residents.

Maldives delivers health care through a tiered system. At the base level, there are 164 island centres distributed throughout the islands,

catering to basic health care needs and addressing everyday medical issues. Moving up the tier, there are 14 atoll hospitals strategically located in atoll capitals. These hospitals offer a broader range of services, including specialty care and diagnostic facilities to meet more diverse health care requirements. For more complex cases and specialized treatments, there are six regional hospitals serving clusters of two to four atolls, along with central hospitals providing the highest level of care nationwide. Additionally, private health care facilities are primarily concentrated in the central region, delivering specialized outpatient services and some advanced tertiary care options. Health care is free for all Maldivians in the public facilities, whereas in the private sector there is a co-payment system. Emergency referral is covered under an insurance scheme, but when patients bypass the referral system and directly come to central level during non-emergencies, they cover the cost of transportation and accommodation.

Each island has a PHC team consisting of at least one medical doctor, one nurse and one community health worker (CHW). The CHW is a public health worker with a training in PHC of two and half years leading to a diploma in primary care. There are two distinct types of CHWs in Maldives: the family health worker and the community health worker. Both categories of CHWs are official government employees with formal salaries, employed by the Ministry of Health and fully integrated into civil service structures. CHWs are stationed either at the public health unit within the atoll hospital or at the island level within the health centre. Their responsibilities encompass a wide range of public health services, preventive measures, and curative interventions, including the provision of reproductive health services to the community.

Earlier these PHC teams provided a very selective package of basic care. For specialized care, persons had to go to the regional or central hospital and find a place to stay. Primary health centres would be underutilized and bypassed, with more patients travelling to the capital for health care. Preventive and promotive care at the primary level was weak. All these gaps became a huge problem during the COVID-19 pandemic, leading to the decision to revitalize PHC. With the revitalization of PHC, the costs of care could be brought down, and the level of foregone care or unmet needs would also decrease. The central challenge of revitalization was to expand from the earlier very selective packages to a much more comprehensive approach, which in practical terms meant the inclusion of priority noncommunicable disease and mental health services into the PHC set of assured services.

The Faafu Atoll pilot intervention for building PHC capacity had five major components:

- the introduction of an electronic PHC registry, based on which a functional data-based monitoring system was built;
- a training programme that addressed the needs of all team members, including doctors, nurses and CHWs, to move to the larger package of services and make use of the registry;
- the introduction of standard treatment protocols and care pathways for a much larger package of services;
- more effective community engagement;
- effective referral arrangements as required to support the primary level of care.

The primary health care registry was built up on a DHIS-2 platform. This could previously provide aggregate information, but now it could also capture health details of individuals as needed. This therefore became a major tool to monitor population coverage, service delivery and outcomes.

The introduction of standard treatment protocols guided health care providers and helped training, monitoring and supply logistics. The care pathways developed informed the flow of individuals within the facility while accessing care. The referral pathway informed the providers where a case was referred to when there was an indication. There has been an improvement in supply chain management

to ensure the larger list of essential medicines and diagnostics are in place in every PHC facility. Laboratory samples are sometimes transported by ferry or boat to the atoll hospital from the PHC facilities and results are provided to the PHC facility online. Patients do not need to travel unless their physical presence is needed. Though currently transportation is largely by ferry, there is ongoing work on the introduction of drones.

Earlier there was little clarity on when to and when not to refer, and often the referred person had considerable expenditure (during non-emergencies) in transport to the main national referral hospital and, when in the city, would need to get an appointment, which could be several days away, resulting in expenses and inconvenience related to the stay. This changed with the designation of a facilitator in each island who would ensure an appointment before patients began their journey. Further, the costs of care were covered by social health insurance, which provides universal coverage for secondary and tertiary care, and which has been in place since 2014. Cost of transportation was however covered only in emergencies.

Maldives has a Decentralization Act (2010) by which the administration of each island has primary responsibility for the delivery of PHC. In each island there is a community-based island development organization, which assists and supports the work of government in community engagement. They also carry out CHW training and assists in other public health measures.

The immediate results were a 95% empanelment of the entire population in the system, over 95% of diabetics receiving regular services, and increased coverage for all chronic illnesses. In the next phase, Maldives plans to leverage the use of e-learning platforms. This would enable the staff across the regions to complete training in a self-paced, self-learning approach. Digital platforms could also measure and reward performance. Telemedicine is also another frontier.

Learnings and continuing challenges

The revitalization of primary health care is a good example of learning from the COVID-19 crisis and building back better afterwards. There were already PHC teams in place in the islands, but with minimal capacity and very selective packages of care and with less focus on curative care. Revitalization required a huge expansion in their capacity to deliver services. Maldives took an integrated approach – integrating noncommunicable diseases and mental health into the selective packages instead of introducing them as vertical programmes, integrating the training of the different members of the workforce as a team, and integration of care across levels. While the high degree of population dispersion and isolation made it obligatory for them to choose this path, many countries that also have geographical areas with such dispersion will find these lessons useful. The lesson is also that training is only one element of capacity-building. There are many more elements that must accompany it to enable PHC teams to deliver all the services expected of them and for the PHC approach to lead to better health outcomes. The process of a pilot whereby one develops the tools and the understanding to inform scale-up is also noteworthy. The development of a step-by-step guide for PHC revitalization based on this learning is especially notable.

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Case Study 3

Reskilling and organization of the health assistant cadre for comprehensive primary health care, Bhutan

Credit: WHO Bhutan

Organization and scale

All Bhutan, organized by Ministry of Health, Government of Bhutan.

Timeline

2021 to ongoing.

Problem statement and objectives

Previously, there were many types of front-line workers, each with functions and skills in a limited area. This was consistent with the earlier understanding of selective primary health care. The shift to comprehensive health care services required a broader and more integrated set of skills and functions in the peripheral providers.

Context, process, outcomes

Currently, in Bhutan there are 32 hospitals, 23 ten-bedded hospitals and 185 primary health centres. Further, these health facilities are supported by the network of 53 subposts and 550 outreach clinics. Together they serve the entire population of about 700 000. Most primary health centres individually cater to about 1500 to 2000 population. The distribution of the health workforce is linked to the

type of health care facility, which in turn is linked to the catchment population. The numbers and types of staff for each category of health facility are calculated at a minimum level as indicated in the service standards. The primary health centres have two to three health assistants and they are at the forefront of providing services for the community. The norm is for a primary health centre to be staffed by one female and two male health assistants and one caretaker, but in practice most would have only two health assistants. There are also health assistants in hospitals, based in community health units. In all there are about 390 health assistants working in primary health centres, subposts, and satellite clinics, and 210 working in community health units of hospitals.

In 2019, the government decided to move from selective to comprehensive PHC. In the same year, a pilot project – Service with Care and Compassion – was designed to take medical services for people living with noncommunicable diseases to their doorstep. To achieve this, a human resources for health strategy was developed for multiskilling of health assistants, thereby enabling them to provide comprehensive PHC. As part of this upgrade, health assistants in Bhutan were required to have a basic education of 12th standard with a science background. Previously, a 10th standard in any subject was adequate. This was followed by a three-year Diploma in Health Sciences from Khesar Gyalpo University of Medical Sciences of Bhutan. The diploma licenses them to perform public health programmes and treatment of minor illness in the community. The previous focus had been limited to reproductive and child health care and the major communicable diseases. Most of the health assistants in employment were of the earlier period and now, in the context of a rising burden of noncommunicable diseases, they had to be multiskilled through in-service programmes for addressing emerging public health needs, including mental health.

To guide this transformation, in 2020, the Bhutan Ministry of Health developed a Competency-Based Framework for Health Assistants with the objective of defining clear roles and responsibilities of health assistants aligned to service delivery needs, and strengthening training and development. The framework first agreed upon the three major roles of health assistants, and 26 key competencies under eight competency areas. The framework also identified 107 behavioural indicators under the competency areas. The development of the framework involved a rigorous, consultative and inclusive process with key stakeholders.

Based on the Competency-Based Framework for Health Assistants, a training needs assessment was conducted using interviews, focus group discussions and a survey. The survey questionnaire had both closed and open-ended questions on over 100 indicators. This was used to develop the training programme.

In parallel to the revision of training for health assistants, PHC performance measurement tools were developed. After training there was the challenge of ensuring performance. One tool of performance measurement was the service delivery indicator health survey. This is a nationally representative, facility-based survey measuring PHC service delivery. Currently, the Bhutan service delivery indicator survey has included clinical competency assessment to measure PHC workforce competencies. Performances can also be monitored through the electronic patient information system, which was launched in 2023. In addition, Bhutan with support from WHO is currently working on a performance management system for the PHC workforce and a scheme to motivate and retain health workers. To promote retention as well as improve performance, a technical working group is mapping the workload, outcomes, competencies and different payment mechanisms.

Learnings and continuing challenges

Bhutan already had an adequate density of primary care facilities staffed by a cadre of health assistants who had three-year training. They did not need a new cadre to make the shift to more comprehensive

services. The emphasis was on an organization of health services such that instead of patients coming to the health facility, care is delivered as close to the community as possible, and prescription refills are also made available. This in turn required an increase in the number of health assistants from two to three, a team-based approach to care delivery, an increase in their skills through a well planned programme of assessing competencies required and the existing gaps, and training to close the gaps. In parallel, Bhutan is currently introducing performance measurement. These measures taken together aims to lead to a revitalization and universalization of PHC across Bhutan.

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Case Study 4

Deploying mid-level health care providers at scale for achieving comprehensive primary health care, India

Organization and scale

Nationwide programme by the Ministry of Health and Family Welfare, Government of India, in partnership with state governments.

Timeline

From 2018 to present.

Problem statement and objectives

The National Health Policy 2017 committed India to a roadmap towards universal health coverage, based on moving from a selective primary level care approach to a comprehensive primary health care approach. However, the existing network of subcentres and primary health centres were staffed and oriented for delivery of a very selective package of health care. A strategy was required to provide the necessary skills in these 150 000 planned centres by the 2022 deadline, which was only four years away.

Context, process, outcomes

In February 2018, the Government of India announced that 150 000 health and wellness centres (HWCs)[2] would be created by transforming existing health subcentres and primary health centres to deliver comprehensive PHC. The key elements in this transformation includes multiple

2 Though they were termed HWCs at the time of conception, the current terminology is ayushman arogya mandir.

reforms spanning all aspects of the health system, such as expanded service delivery, increased human resources, financing, access to medicines and diagnostics, community participation, infrastructure, information technology systems, partnerships and continuum of care.

Key to the operationalization of Ayushman Bharat HWCs as centres for the delivery of comprehensive PHC has been the introduction of a new non-physician cadre of mid-level health care providers who are officially designated as community health officers (CHOs).

The role of mid-level health care providers is very closely related to the objectives of comprehensive PHC itself. The mid-level health care provider is responsible for delivering an expanded package of 12 sets of services through the HWCs[3]. They are also the managers for HWCs in their day-to-day activities and provide leadership to the primary care team working at the subcentres that are upgraded to HWCs.

The challenge was to generate these non-physician clinical care providers on such a scale and within a limited timeline. Earlier efforts had focused on introducing a three-year graduation programme to be undertaken by university colleges (Chhattisgarh) or government medical colleges (Assam). But the process was slow and on too small a scale, and further was legally contested by the medical associations. Non-physician clinical care providers had been proposed in policy since 2011 as one of the measures to overcome the problem of getting physicians to work in primary care settings in rural and remote areas. However, it was only after the adoption of the National Health Policy 2017 and the report of the 2017 Task Force for Roll-Out of Comprehensive Primary Health Care that this challenge was taken up in earnest.

The next option that was considered was to provide a six-month training for ayurveda and later unani (of the Indian System of Medicine or AYUSH) physicians and deploy them as CHOs. The possibility of doing this through the Indira Gandhi National Open University was considered. This too faced the problem of creating a separate training structure as existing institutions were all unable to take on the scale of this new commitment.

What finally worked was to provide the three-year trained nurses (general nurse midwife) and the four-year trained nurses (BSc Nursing) with an additional six-month training and then qualify them as CHOs. This approach faced less resistance. Further, it would be possible to integrate the CHO curriculum into existing basic and post-basic nursing programmes. In certain states (such as Jammu and Kashmir), the CHO course was also offered to traditional medicine practitioners of ayurveda and unani.

The Ministry of Health and Family Welfare collaborated with the Indian Nursing Council to create a six-month Certificate Course in Community Health to deliver the necessary competencies. Leveraging existing nursing institutions to train service providers to meet future human resources for health needs saved time and costs of additional training, was easier to scale up and was more sustainable. Given the major expansion of nursing education capacity in the previous decade, and the much more limited scale of expansion of nursing positions in government service, the availability in the labour market of nurses was relatively high, even in underserviced states.

The reason why these nurses, now with additional certification, were so easily absorbed was that the central government undertook to finance this additional cadre. Hitherto the subcentre had only one auxiliary nurse midwife, and after establishment of the National Rural Health Mission in 2005 many states opted for two auxiliary nurse midwives, who were paid for by the central government. There was also a position of a male worker, but this was to be paid for by the states. In many states, this position of the male worker was no longer functional and in

3 The 12 packages of services include care in pregnancy and child-birth; newborn and infant health care; child and adolescent health care services; family planning, contraceptives and reproductive health; communicable diseases; acute simple illness and minor ailments; noncommunicable diseases; eye and ENT problems; basic oral health; elderly and palliative services; mental health ailments; and emergency medical services.

most of the states, vacancies against requirement were over 60%. So, the introduction of the CHO with central government financial support was quickly taken up across states.

An important subsequent challenge was how ensure that the HWC team were indeed providing a more comprehensive set of services within a system that had been accustomed to providing only a very selective package. A further innovation – performance-linked payments to the HWC team – was introduced with the core objectives to improve motivation levels, strengthen quality of services, enhance accountability for population health outcomes and serve as a mechanism to identify performance and skill gaps of the primary level health care team. The performance-linked payments are provided on a monthly basis for the HWC team, that is, the CHO, two multipurpose workers, and accredited social health activists (ASHAs) as per the population of the area being served by the subcentre. The performance is assessed through existing information systems using a set of selected core indicators focused on both service delivery processes and outcomes (for example, the number of outpatient department cases in a month, the proportion of pregnant women registered who received antenatal care, the proportion of children aged up to 2 years who received immunization, the proportion of those aged above 30 years who were screened for hypertension, diabetes, and oral cancer, village health and nutrition days held, monthly health committee meetings held). Selected indicators, as suggested by the Ministry of Health and Family Welfare, are indicative of implementation of service packages and community interventions in the HWCs. There are predefined ceilings to the maximum incentive allocation for each team member. Importantly, the Ministry of Health and Family Welfare has given the state governments flexibility to have their own set of indicators, monitoring mechanisms and modalities. Operationalization of performance-linked payments at scale has not been easy and further refinement is under way.

Outcomes from scaling up mid-level health care provision were immediate. From a pre-existing situation of zero to three outpatients per subcentre, the upgraded HWC could average 30 to 50 outpatient visits per day. Maternal care and immunization were strengthened, both because of an additional nurse and because the earlier auxiliary nurse midwives could now focus on reproductive and health care services. Absences were coped with better. And most importantly, care for noncommunicable diseases was introduced for the first time at this level. This mostly took the form of screening for hypertension, diabetes and cancers of the breast, cervix and oral cavity. Better performing states have built up referral links, leading to the start of treatment plans after confirmation of diagnosis and medication access and follow-up at the HWC. The disease control programmes also benefited. The mid-level health care provider was also empowered by the National Free Drugs and Diagnostic Service Initiative, which advocated the provision of 14 diagnostic tests and 106 medicines at the ayushman arogya mandir (subcentre) level, as a measure of reducing out-of-pocket expenditure and making public health services affordable. Though service delivery for all 12 sets is yet to be achieved, much progress in that direction has been made.

Learnings and continuing challenges

The policy decision to go from selective to comprehensive health care required two changes in the structure and functioning of the primary health centre. The first was to upgrade every health subcentre to the previous level of primary health centres, so that each primary care team catered to about 5000 population instead of 25 000, as previously. The second was to modify the composition of the PHC workforce by introducing a mid-level health care provider known as the community health officer (CHO). The introduction of a mid-level health care provider cadre required new norms for their entry qualifications, training, certification, deployment and incentive environment, and this had to be done keeping in

mind the requirement for a nationwide scale-up in a period of just five years. It is interesting to compare this experience with how other countries operationalized the transition from selective to comprehensive care.

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Case Study 5

Capacity-building for community health officers: NHSRC–Christian Medical College mentoring programme, India


Credit: CMC, Vellore, India

Organization and scale

India, to all its 120 000+ community health officers (CHOs) positioned at health subcentre level (in rural areas).

Timeline

2021 to ongoing.

Problem statement and objectives

While pre-service and in-service training is essential, it is not sufficient to ensure that mid-level health care providers or CHOs have the required skills for the large number of functions and services expected of them. They require on-the-job mentoring – however, but organizing this at scale is a challenge.

Context, process, outcomes

With the adoption of the National Health Policy 2017 for universal health care through the Ayushman Bharat initiative, India is in the process of upgrading all its subcentres and primary health centres, which previously provided very selective packages of primary health services to health and wellness centres (HWCs), so that they now provide comprehensive PHC.

A new cadre of mid-level health care providers designated as CHOs was introduced at health subcentre level (in rural areas). This cadre was created by imparting a six-month PHC competency-based training to largely nursing graduates and also AYUSH (ayurveda, yoga and naturopathy, unani, siddha, and homeopathy) graduates in a few states (though in Jammu and Kashmir, a few unani graduates were also permitted). By December 2022, as per the National Health Systems Resource Centre (NHSRC) report, over 120 000 CHOs were in place. However, this pre-service qualification was not adequate to ensure all the required clinical, public health, and managerial skills. The Common Review Mission reports of 2021 had pointed out that they required more role clarity and skills. To address this challenge, a system to mentor them was envisaged. Mentoring, in contrast to

training, is relationship based, going beyond skills development to all-around personality development and support.

A specifically designed and scalable CHO Mentoring Project was developed to address this. A partnership was established between the Christian Medical College, Vellore's Distance Education Unit, and the NHSRC, India, with the support of the Ministry of Health and Family Welfare and respective states. Those institutions had already worked together to provide in-service family medicine training to medical officers in primary health centres.

The mentoring programme aims to nurture leadership qualities and enhance public health, managerial, and clinical skills among CHOs. It also aims to orient CHOs to lead teams at HWCs. Beyond this, the training also emphasizes ethics, values and social responsibility, and provides the orientation required to establish linkages with local self-government institutions, village health committees and community-based organizations. The curriculum also includes formative and summative assessments for mentors and those being mentored. As conceptualized and articulated in government documents, this is to be delivered throughout the country on an online platform utilizing an application coordinated virtually by a team of master trainers, national mentors, and state mentors.

First, an e-learning online platform was developed to train state mentors on mentoring CHOs. The learning package encompasses skills and competencies required for CHOs through problem-based self-learning modules, which include interactive teaching methods. It also has a component for training to become mentors through weekly synchronous live groups and personal mentoring sessions by national mentors. Following a three-month training period, state mentors are assessed and certified. Following this, they are allotted CHOs by the respective states. The CHOs are mentored through a six-month national mentor-observed mentoring period followed by a three-month independent mentoring period, which can be sustained beyond the project.

The state mentors are taught to mentor using the structured GROW coaching model. Both the state mentors and the CHOs document their feedback following each personal mentoring session, which helps identify measurable objectives for mentoring. The mentors enquire about problems the CHOs face professionally and personally impacting work. They guide CHOs to arrive at solutions rather than leaving them to find solutions themselves. In the first six months, the mentors spent 22 hours weekly in mentoring and, subsequently, 11 hours per week.

For sustainability and scalability, the state mentors were identified and competitively selected from the existing health cadre, who have a good understanding of Ayushman Bharat HWCs, experience in training CHOs, and an aptitude for mentoring. The desirable educational qualification for state mentors was either an MBBS/BAMS degree or MSc Nursing with two-year experience, or a BSc Nursing with five-year experience. As a pilot, 25 national and 1000 state mentors were identified and trained to mentor 36 000 CHOs. State mentors were to be paid 100 rupees per CHO mentored per month with an additional 50 rupees per CHO per month be paid as a performance-linked incentive based on predefined indicators.

The CHOs also undergo weekly formative assessments and some mid-course and end-of-course summative assessments before certification. In addition to these assessments, certification criteria include participation, attendance in group mentoring sessions, demonstration of skills, and personal mentoring calls attended. A formal evaluation is currently planned by the NHSRC. Other models of CHO mentoring that have been developed (for example, Postgraduate Institute of Medical Education and Research Chandigarh) will also be evaluated.

Learnings and continuing challenges

While introducing a new workforce, there is a need for high-quality mentoring to support them. The expectation that the PHC medical officers would undertake this role could be misplaced. In reality, such measures often fail due to multiple factors like time, skills, orientation, and lack of motivation among the PHC medical officers to undertake this role. Creating mentors with the necessary skills and motivation to bring quality assurance and rigour into the mentoring programme is a considerable challenge requiring a higher level of resources and efforts. The challenge has been met by a careful process of identifying and developing mentors, standardization of the mentoring process, and the development of content and assessment protocols. A recognized limitation lies in the exclusive focus on CHOs for mentoring purposes. Currently, the NHSRC is considering development of PHC team competencies to feed into associated mentoring process.

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Case Study 6

PHC team for the provision of family health care approach, Timor-Leste

Organization and scale

Nationwide programme, undertaken in Timor-Leste by the Government of Timor-Leste.

Timeline

From 2015.

Problem statement and objectives

Given the scarcity of human and financial resources, and the difficulties of finding skilled health professionals to work in newly emerged low-resource settings, the country faced challenges developing the optimal team for providing PHC.

Context, process, outcomes

Timor-Leste restored its independence in 1975 following 400 years of Portuguese and 25 years of Indonesian presence. Upon independence, Timor-Leste inherited an estimated 23 doctors for its population of over a million people, with very limited public health infrastructure. The role of the private sector is small in Timor-Leste and limited to the capital city, Dili.

The country began an active programme to build up its human resources for health. Many candidates were sent for training to Cuba, where they had to learn one year of Spanish and then 4.5 years for medical graduation. The focus was on PHC. Later, one medical college, with faculty support from the Cuban Medical Brigade, and a national hospital were established in the country. The programmes for midwives and nursing are largely conducted in Tetum, the national language, and since the nursing staff has a continuity with

the days of Indonesian control, the staff are also familiar with the Indonesian Bahasa language. The official languages are Tetum and Portuguese; there is limited use of English.

The country has one national hospital for tertiary care; five referral hospitals for secondary care; about 70 community health centres, each catering to about 20 000 population, and about 350 health posts, each catering to about 300 to 500 families. The community health centres and the health posts constitute the primary level of care, which also includes a programme of community outreach through monthly health camps.

Under the flagship programme Saude na Familia, a multidisciplinary team is placed for provision of comprehensive care through a family health care approach. Under this approach, care provision is provided not only for those who are ill, but also for those who are healthy or with any risk factors, or those with co-morbidities or disabilities. The multidisciplinary team include a doctor, nurse, midwife and CHWs, who are known as family health promoters (promotora saude familia or PSF). Each team is responsible for about 300 to 500 families, and in its initial design the entire team provides regular doorstep services. It is interesting to reflect on the parallels between this structure and the Brazilian Family Health Programme, which is also known as Saude na Familia. This is not coincidental. Timor-Leste is a former Portuguese colony like Brazil, where Portuguese is still spoken. There is a strong sense of solidarity with Brazil, Cuba, Portugal and their achievements.

Recently, to ensure role clarity and team efficiency, the Ministry of Health developed clear job descriptions for the PHC workforce teams, including for doctors, nurses and midwives and the newly introduce cadre of PSFs. Health care service delivery is guided by the essential services package for primary care developed in 2022.

The roles and responsibilities of the PSFs include four major domains: informer, educator, mediator and motivator. There were places where they could be caregivers, but for the most part the effort was to use them as link workers and mobilizers to generate demand and ensure that the persons who required services reached the facility or outreach centres. Typically, they do not prescribe or dispense medication. There is about one such PSF per village (suco) and there are in all about 2200 villages. The PSFs are seen as volunteers and receive incentives from selected national programmes. A major revitalization of this cadre is under way, including the potential provision of additional and more secure incentives.

For community engagement a platform called the mothers' support group has also been created. This successfully engages, educates and empowers women of various age groups. The mothers' support groups are effective in ensuring community participation; this is in large part due to the support provided to this community-level institution through the PSFs, who provide counselling, demonstration, mother and child support, case identification and referral of malnourished children.

While the effectiveness of midwives in service delivery is considered to be good, there are major constraints due to the lack of infrastructure and frequent interruption in supplies. Many facilities face problems with respect of water, electricity and sanitation. Though medical doctors are trained for PHC, the system struggles to retain them in rural and remote areas and about one third of posts are vacant or face absenteeism. Systems of in-service training and competency building are required.

On paper there is a three-tier, well defined list of essential services, including a comprehensive list of services for PHC. In practice, services comprise relatively selective care that prioritizes maternal health, immunization and tuberculosis control. The country has done well with malaria elimination and is now waiting for certification of this achievement. But other vector-borne diseases, notably dengue, are still problematic. It is however for noncommunicable diseases, especially hypertension, diabetes and cancers, that much more requires to be done. Thus, achieving comprehensiveness in primary-level care

is very much work in progress, supported by the recent government priority given to strengthening integration in service delivery.

The lack of specialist support at secondary and tertiary levels is a challenge. Tertiary care for cancers and cardiovascular diseases is limited, with overseas referrals for advanced illnesses to the neighbouring countries of Singapore, Malaysia and Indonesia, where treatment is costly, and this consumes close to 10% of the health budget.

Learnings and continuing challenges

The Timor-Leste case study underscores the importance of adopting a doorstep, close-to-community approach, ensuring accessibility and comprehensive care delivery. Clarity in roles and responsibilities, achieved through detailed job descriptions, particularly in reintroducing the PSF role and strengthening community linkages, emerges as a critical factor. Moreover, the study highlights the significance of adapting lessons from other low- and middle-income countries (such as Brazil and Cuba) to suit the local context. Building on learning to date, Timor-Leste developed the 2024 National Integrated Health Service Policy to address gaps in delivery of comprehensive PHC through family health teams.

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Case Study 7

Performance incentives linked to quality and outcomes, Thailand

Organization and scale

Nationwide, organized by National Health Security Office and Ministry of Public Health, Government of Thailand.

Timeline

2013 to now.

Problem statement and objectives

Whereas financing is based on the quantum and mix of services, the quality of care delivered is not visible to the financing mechanism. There was a need to incentivize providers to achieve a much more effective population-based coverage for comprehensive PHC.

Context, process, outcomes

In 2002 Thailand established the Universal Coverage Scheme, which provides health coverage for all those who are not covered by public health insurance schemes for civil servants and formal sector employees. This is close to 80% of the population. Central to the Universal Coverage Scheme is that every Thai citizen is registered with a network of comprehensive PHC providers, and this registration is an entitlement to receive free health services for all essential health care needs, including preventive and promotive services. Comprehensive PHC is financed through payments from the National Health Security Office (NHSO) to a local governance system called contracting units for primary care (CUPs). A CUP includes a district hospital plus all the primary health care centres

under supervision of the hospital, known in Thailand as health-promoting hospitals (HPHs). A district in Thailand usually has a population of about 30 000 to 100 000, and each of these HPHs or primary health centres serves a population of about 3000 to 5000. The term primary care providers refers to the entire CUP, which is the district hospital plus the HPHs under it.

For improving the quality of care, Thailand has implemented pay for performance, as adapted from the United Kingdom's Quality and Outcomes Framework (QOF), for primary care providers. The first pilot was in 2013. There was an earlier effort in 2011, which was not satisfactory, so a revised version was implemented in 2013. QOF incentivizes PHC providers (CUPs) to improve primary care quality in key areas, namely health promotion and disease prevention; primary health care services; organizational development and management; and services targeted to local needs. There are two types of QOF indicators: core or central indicators, used at the CUP level throughout the country; and local indicators, developed by regional health boards, consisting of the regional NHSO, senior officers at provincial health offices and regional, provincial, and district hospitals, and HPH representatives. Together they are scored for 1000 points. Based on the score a QOF budget is allocated to each CUP, those with a higher score getting more.

The core indicators comprise nine quality measures in use in 2014, as shown in Table 4.

Table 4: Core indicators by category

Category 1: Quality and performance of health promotion: (3 core + 1 local) (> 200 points)
1.1 Percentage of pregnant women receiving first antenatal care before 12 weeks
1.2 Percentage of pregnant women receiving antenatal care 5 times
1.3 Percentage of coverage of cervical cancer screening in women aged 30 to 60 years within 5 years
1.4 Local indicators, decided by regional or provincial office
Category 2: Quality and performance of primary care services: (4 core + 1 local) (> 200 points)
2.1 Proportion of outpatient visits in primary care units to outpatient visits in hospital
2.2 Percentage of hospital visits due to asthma
2.3 Percentage of hospital visits due to short-term complications of diabetes
2.4 Percentage of hospital visits due to short-term complications of hypertension
2.5 Local indicator, decided by regional or provincial office
Category 3: Quality and performance of primary care services (2 core + 2 local) (> 100 points)
3.1 Percentage of people who have access to a physician
3.2 Percentage of registered primary care units
3.3 and 3.4 Local indicators, decided by regional or provincial office
Category 4: Quality and performance of services targeted to local needs: decided by Ministry of Public Health (> 200 points)

The core indicators cover mother and child services, communicable diseases and noncommunicable diseases, as well as systems indicators. The local indicators that are established by the Ministry of Public Health would often cover public health priorities, such as the case detection rate for tuberculosis, clinical examination for breast cancer, cervical cancer screening (Pap smear/HPV DNA test), or administrative priorities. These indicators are dynamic and change over the years in consultation between the NHSO, Ministry of Public Health, its regional and provincial offices, and the regional NHSO. Mostly, new indicators, especially for disease prevention and health promotion, are added.

The assessment is done on an annual basis using

patient care databases. This means that the data for performance scoring emerge from the routine entry of service delivery data into the database, and denominators are derived from the Universal Coverage Scheme database. One principle has been that the scoring should not require any additional data collection.

The scores are computed by the district hospital and the HPH that govern the CUP. Once computed, they are sent to the provincial office, which verifies the data and forwards them to the Ministry of Public Health and NHSO. In principle, the total points achieved are then converted into a financial value, which is allocated to the CUPs as a different process from the allocation to individual facilities or PHC teams at CUPs through the NHSO. It is then the responsibility of CUPs to allocate the funds received to the respective facilities, which are the district hospitals and the HPHs. The guidelines for this allocation are specified by the Ministry of Public Health, with some room for the district hospital to negotiate with the HPHs and make adjustments at the district level. These negotiations are via the CUP Board meeting.

The CUPs are allowed to spend the money earned through the QOF on any aspect of care provision, including improving amenities for the providers or patients and capacity-building activities. They cannot be used as individual payments over and above salaries. They can however be used for hiring contractual staff and overtime requirements.

Since 2017, the QOF payment system transitioned to an area-based prevention and promotion payment model, while maintaining similarities to the original QOF structure. The NHSO allocates area-based prevention and promotion funds to CUPs in alignment with national health policies or health needs of certain districts. Conversely, the prevention and promotion fee schedule is contingent upon the performance of HPHs. Enhanced funding is available through electronic claims for HPHs that achieve higher coverage rates in services related to health promotion and disease prevention.

Learnings and continuing challenges

One evaluation is available, but this is from the early implementation phase. The most positive finding was that this QOF was introduced as learning by doing, and feedbacks from evaluation and implementers was expected to feed into improving implementation. While the QOF was welcomed as useful to give attention to priorities, several problems were noted and recommendations were made. These could be listed as:

- Improve data reliability-related issues for scoring.
- Increase technical and stakeholder consultation in the design of indicators.
- Better norms for the distribution of the QOF fund within the facilities of the CUP.
- More engagement of the peripheral facilities in the process, so that the incentives work at that level also.
- Performance is often better because baselines and access to resources are better; the requirements of equity may require more allocation of funds to the poorer-performing CUPs because their challenges are greater.
- To avoid increasing inequities, the QOF budget should be additional to the capitation fee-based ambulatory care budget, not derived from earmarking a sum for QOF within that budget.
- The QOF payment in a small district and HPH population is a very small amount, especially if the facilities are far from the village, and does not act as a great incentive. It becomes a burden to a small district where a limited workforce is available.

It is important to note that while QOF is at times presented as an example of pay for performance, it is essentially a form of measuring performance and providing additional resources in turn.

Note: There have been changes in core indicators in the past few years. For example, screening for cervical cancer has changed to an HPV DNA test kit. Thailand added hepatitis B and C in screening for early detection of hepatocellular carcinoma, and the FIT test for colonic cancer is also standard for cancer screening in 2024.

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Case Study 8

Common Review Mission: monitoring for building a learning adaptive system, India

Credit: NHSRC, India

Organization and scale

Nationwide, organized by the Ministry of Health and Family Welfare with technical support of the National Health Systems Resource Centre (NHSRC).

Timeline

Initiated in 2007, conducted annually since then.

Problem statement and objectives

The National Health Mission is one of the most extensive public health system strengthening programmes in the world built on a primary health care approach There was a need to build the National Health Mission as a learning system so as to constantly monitor and generate information on the implementation and use it creatively, adapt and evolve the programme, making course correctives as necessary and feasible.

Context, process, outcomes

The framework of implementation of the National Health Mission (earlier known as the National Rural Health Mission) was approved in 2005. The National Health Mission is an arrangement for financing state governments in India to strengthen their public health systems to provide equitable, affordable and quality health care. It addresses the entire district health system and is not limited to the primary level. Within the framework set by the central Ministry of Health, state governments draw up an annual programme implementation plan that is then discussed, finalized and financed jointly by the central and state governments. The

approved programme is a composite of many activities and schemes, and the priorities and roll-out differ across states. One of the challenges that the National Health Mission faces is its ability to assess the progress of the programme in diverse contexts and use such evidence to constantly improve programme design and implementation.

The annual Common Review Mission (CRM) undertaken by the Ministry of Health and Family Welfare, with the technical assistance of the NHSRC, is one of the key institutional mechanisms through which the progress of the country's National Health Mission is monitored. Its objective is to monitor the implementation status of the National Health Mission on its very many components, analyse strengths and challenges with respect to health system strengthening, identify trends in the progress of key indicators attributed to coverage, equity, quality and affordability at state, district, subdistrict, and community levels, document innovations and best practices, evaluate readiness of states to undertake implementation of new initiatives, and review the progress and coordination mechanism with various partners. The terms of reference of the CRM mechanism are dynamic and have evolved with the expanding mandate of the National Health Mission. For instance, aligned with the National Health Policy's vision (2017) to leverage HWCs to deliver comprehensive PHC that is universal, free, and closer to the community, the terms of references have also prioritized the assessment of the roll-out, operationalization, and uptake of HWCs.

The states, union territories and districts for CRM are chosen purposively. Representatives of high-focus, non-high-focus, north-eastern, and hilly states are included in each CRM round, and there is also focus on including the most challenging districts within the states. The selected teams visit at least one well performing and one poorly performing district in the identified states.

To get a comprehensive understanding of the status of the continuum of care, facilities from all tiers of the public health system are targeted for review – district or subdistrict hospitals, community health centres, block primary health centres, HWC centres (both rural and urban) and subcentres. All Common Review Missions are collaborative efforts of a multidisciplinary team of government functionaries, public health experts, civil society members and development partners to reflect and examine the changes achieved under the National Health Mission. On average, 170 such experts constitute the mission distributed in 12 to 15 teams. The team includes government officials, such as representatives of the Ministry of Health and Family Welfare, other ministries such as the Ministry of Women and Child Development, public health experts from the NHSRC, state health systems resource centres, other national research-based organizations and members of academia. The inclusion of external stakeholders enhances the robustness, objectivity, and accountability of the CRM mechanism, and the varied backgrounds of the members ensure a multidisciplinary approach to the review.

Each team visits one state, and about 15 states are visited in all. In each state at least two districts are visited. In each district a selection of health care facilities at different levels are visited and the infrastructure and work in progress is observed, the documents examined, and the providers interacted with.

The first meeting is usually a state or union territory briefing, followed by visits to the districts, and ending with state or union territory debriefing by the teams. The field visits follow a bottom-up approach where the team conducts interviews and focus group discussions with community members and the CHWs first. This is followed by visits to different health facilities. All the findings are finally presented to the state- and district-level health teams, including suggested corrective measures. Positive team practices of individual PHC teams are also highlighted at the national level.

The administrative coordination is undertaken by the Ministry of Health and Family Welfare with support from the NHSRC. The review by CRM

teams is accompanied by a critical analysis of secondary data collected at the national level and provided by the state. An annual exercise, the CRM has completed 15 rounds thus far.

The NHSRC is itself a unique institution situated at the confluence between research and practice. It is the institutional memory of the programme and one of the most important sites where learning merges with planning and the development of policy and strategy. Its role is advisory to the National Health Mission, but it is also charged with capacity-building in the states and ensuring the change management that has to go along with the introduction of new initiatives.

An analysis of CRM reports shows that much of the report is simple a description of what is happening as against what was expected to happen and as per the guidelines issued. But this in itself has great importance for a country so large, as it is difficult to keep track of how the same programme plays out in different provinces and districts. The CRM is not a source of quantitative data or statistical analysis. The study of each district and of each state, including of vertical programmes, is developed with a strong health system perspective. The first level of interpretation of such qualitative data as are gathered is not whether the programme is working, but rather to what extent is the programme effective, and in what circumstances. Then, at the next level of interpretation, there is a deliberative process, where the analysis is based on conversations of the visiting teams with the providers, of the central officers and team with state and district officers, and of the team members amongst themselves. This is often about trying to understand why the guidelines could not be implemented. This level of inquiry draws upon the experiential knowledge at each of these levels. Finally, there is another level that looks at whether the guidelines were themselves appropriate and what has been learned about priorities. The recommendations therefore are not only to the implementing states but also to the policy-makers themselves. A simple guiding principle is that if the majority of sites visited are unable to implement a guideline, it is the guideline itself that must get reviewed.

It would not be easy to measure what impact CRMs themselves make. But practitioners would aver that many of the developments of strategy have their roots in the CRM. The CRM teams document a number of interesting innovations that address widespread problems with greater success or adapt to context. They also point out collateral or unintended benefits, as well as unintended adverse effects of initiatives or new gaps that have opened up. These get shared, replicated and eventually scaled up. The annual Best Practices Summit, coordinated by the Knowledge Management Division of the NHSRC, further helps systematize such knowledge acquisition and scaling up.

This learning adaptive characteristic becomes more apparent if we compare the main strategies on play with the original design documents of the National Health Mission. Thus, many of National Health Mission's great success stories, such as the Dial 108 ambulance services, or the scaling up of special newborn care units to every district and taluk hospitals, or the introduction of Janini Shishu Suraksha Karyakram (the newborn child protection programme) or ASHA help desks, evolved by learning in the course of the programme implementation. The CRM is not the only source of such learning, but it is by far the most extensive and systematic of the learning mechanisms that the National Health Mission has put in place. Its strength is both in its participatory and in its reflective character.

In recent years, since the adoption of the National Health Policy of 2017, the policy thrust has changed and now the focus of the programme is in moving from selective to comprehensive health care based upon a network of 150 000+ Ayushman Bharat HWCs. These are the earlier subcentres and PHCs now upgraded to provide a comprehensive set of 12 categories of services. There are many new challenges in doing so, and though all have made progress few have achieved the goal. There is also the challenge of pandemic preparedness in the

post-COVID-19 scene. But the basic institutional design of the CRM is robust and it has been able to quickly adapt to this need. A major focus of the CRM for 2022 was on the Ayushman Bharat HWC scheme, and this has helped in improving the quality and effectiveness of the scheme's implementation.

Learnings and continuing challenges

All PHC programmes struggle with the challenge of monitoring. Monitoring based on numbers reported on digital monitoring systems or evaluation studies that generate data tell us about outputs and outcomes. One can identify poor progress, but one cannot determine why. The problem becomes even more complex when we are dealing with health systems and not only singular vertical programmes. Health systems are rightly termed as complex-adaptive systems and they require a different approach to monitor and evaluate. It is also not easy to find evidence to support recommendations, which are statements on what should be done for the future. Learning from positive deviances in the programme does help. But above all we need participatory, non-threatening approaches where there is a dialogue with providers at every level, instead of a top-down inspection.

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Case Study 9

Public–private partnerships under the Universal Coverage Scheme in Bangkok City and scale-up, Thailand


Credit: WHO SEARO

Organization and scale

Initiated in Bangkok Metropolitan Area with national scale-up under way; organized by Bangkok Metropolitan Authority, Ministry of Public Health, National Health Security Office (NHSO), and Health Professional Councils, Government of Thailand.

Timeline

Since 2019 with nationwide scale-up in process as part of Universal Coverage Scheme "Treats All Diseases" to "Treatment Anywhere" reform.

Problem statement and objectives

Of an approximate 48 million persons registered in the Universal Coverage Scheme, 6 million are in Bangkok City. Recognizing significant unmet need in Bangkok, with average outpatient visits half of the national average, and from the lessons learned during the pandemic that gaps in PHC also impacted COVID-19 response, the NHSO and Bangkok Metropolitan Authority introduced a number of PPP initiatives. Unlike in rural areas, there is a high density of private providers in urban areas, accounting for 50% to 70% of all health care utilization. But it has been difficult to recruit and retain them as providers in the Universal Coverage Scheme and orient them to PHC. The public hospitals are often overcrowded and not convenient for patients with chronic illnesses. The Bangkok Health Administrative Office is separate from the Ministry of Public Health, and the city has a different system, especially for secondary and tertiary care. Most Bangkok residents are unaware of their primary care doctors or health centres.

Moreover, they may have had Universal Coverage Scheme insurance coverage but it is registered in their hometown in another region. Therefore, they may not be entitled to public health facilities near their workplace. Bangkok also has its local NHSO that operates differently from the other 12 regional NHSO offices.

Context, process, outcomes

In most of Thailand over 95% of providers are public facilities. The domination of public providers is not a result of the law but because public provision was much more cost-effective than available alternatives. It is only in urban areas, especially Bangkok, that the coverage of public facilities is inadequate and private providers were available. Even here, when it came to primary health care, the availability of private practitioners contracting with the Bangkok NHSO was limited.

Further, public hospitals are overcrowded with primary-level care seekers, which brings pressures on the hospital, and is also very inconvenient for the service users, many of whom are elderly people with chronic illnesses. During the COVID-19 pandemic it became essential to find a way of delivering medication for chronic illnesses close to home and without patients coming to the public hospitals. Therefore, in a pilot programme, Thailand partnered with private clinical establishments to maximize the use of private sector resources to benefit public health. Referred to as “new way public health service units” or “innovative health service units”, these private partnership units include pharmacies and nursing clinics, medical technology clinics, physical therapy clinics, general medicine clinics, Thai traditional medicine clinics, dental clinics, and mobile dental care for vulnerable groups such as inmates and children in detention centres. Learnings from this period have helped improve, scale up and stabilize these partnerships. Of these, the partnerships with pharmacies are well established.

We present the partnerships with private pharmacies in detail and comment on the others as well.

Partnerships with private pharmacies

The NHSO partnered with the Pharmacy Council of Thailand and retail drug stores to expand the role of pharmacists in primary care, with approximately 500 pharmacies participating. This was being scaled up to 1500 pharmacies in 2023. The partnership aims to increase people’s access to primary care by tapping the opportunity of private pharmacies in Thailand and turning them into entry points of care. This partnership has drawn from and built upon the experience of the United Kingdom’s National Health Service. Universal Coverage Scheme beneficiaries can request free consultation with pharmacists in pharmacies registered under this scheme and get free consultation and medicines for treating 16 common illnesses. These include headache, dizziness, joint and muscle pain, fever, cough, sore throat, stomach ache, constipation, dysuria, irregular leukorrhea, and skin and eye irritation. Patients can also see doctors at hospitals and then pick up their prescribed medication from pharmacies partnering with the NHSO without waiting at the hospital’s pharmacy section.

To join the partnership, pharmacists at the drug stores must pass the training offered by the Pharmacy Council of Thailand. Not only the individual pharmacists but the drug stores too have to pass the checklists of good pharmacy practice standards set by the Ministry of Public Health and register in the list of “quality pharmacies”. After both pharmacists and pharmacies have passed, each pharmacy will receive a certificate and a sticker printed with “My Quality Pharmacy”, which will be attached in front of their stores.

Except for the 16 common illnesses, pharmacies always dispense free medicines only against prescriptions from an empanelled provider or facility. If such a prescription is not there, medicines have to be paid for. Most prescriptions are e-prescriptions, from the facility to the linked pharmacy.

The access of pharmacies to the required medicines can take three forms. They could be given supplies from the Department of Health, which are then dispensed free to the patients. Or for some medicines they procure their stock at prices specified, and the NHSO reimburses them. Or they could despatch the drugs to the homes of the patients using a health volunteer or "health rider" who would be paid about 30 baht per delivery. Since the riders are from the locality, they know the homes very well. Many health volunteers are working as health riders. Pharmacies themselves are paid in a lump sum and 180 baht per customer visit. Payments are against digital filing of claims and are paid digitally.

Pharmacists are required to refer the patients to hospitals if their symptoms become more severe. Telemedicine consultation is available as part of the scheme for some networks. It need not be only individual pharmacies. A set of 200 pharmacies are part of a retail pharmacy chain owned by one firm.

Similar engagement has taken place with laboratory technicians in private laboratories for diagnostic services, though the scale of engagement is less and some of the laboratories could be for more specialized tests. Another set of partnerships is with nurses in private nursing care centres for individual level preventive and promotive services, which would include antenatal care, immunization, access to contraceptives and some other services. The scale of engagement is less and it is focused on specific areas.

In the preceding year there has also been a roll-out for physiotherapists in physical medicine centres and for Thai traditional medicine. This has been slow, because payment rates and mechanisms for payment have to stabilize. There are also challenges of identification of necessary care and formulation of protocols of care and of course of budgets.

A PHC manager has been identified for each district of Bangkok to strengthen cooperation across government, public and private sectors. One major area of partnerships is with private medical health care providers. While private providers make a relatively small contribution to health care service provision in Thailand; their role in Bangkok is significant. In Bangkok, private facilities provide 50% to 70% of all health services that Universal Coverage Scheme members utilize. The Social Security Office and the NHSO are involved in contracting with private health facilities to fill gaps in service provision, notably in urban areas in Bangkok. Before entering into a contractual agreement, the NHSO's service inspection unit evaluates applicants registering as main contracting units or referral units based on nationally set standards and guidelines developed jointly by the NHSO, the Ministry of Public Health, and relevant stakeholders. Health service providers that do not meet these assessment criteria are unable to enter into a contract, while facilities that fail annual inspections face dismissal or non-renewal of their contracts. In addition to new entry and renewal requirements, the NHSO also conducts unannounced surprise visits to health facilities, typically targeting those suspected of non-compliance based on document audits, complaints from Universal Coverage Scheme members, and random user checks.

Many of the contracted private sector units may have only one medical officer and two nurses. This is effective as a dispensary and for screening. The services they provide would not match the comprehensive care package of CUPs in rural areas. Nor is primary health care organized in the form of CUPs, with a district hospital linked to several health promotion hospitals. Other than objective factors, one subjective determinant is that health care governance in Bangkok is not under Thailand's Ministry of Public Health, but with a health department under the Bangkok Metropolitan Authority. As the system evolves and the pressure on secondary hospitals mounts, one route to achieving more effective preventive and promotive services and routine medication follow-up services is through partnership with allied providers. Another new initiative to close the primary-level care gaps in Bangkok City is its telemedicine and mobile units initiative.

The Bangkok Metropolitan Administration launched a telemedicine programme at Ratchaphiphat Hospital with mobile units deployed across the metro to expand health services. The telemedicine sandbox model was launched in conjunction with the Bangkok Metropolitan Administration's Medical Service Department, the Health Department, district offices, the NHSO, private medical centres and community networks. This provides clinical care for patients with 42 diseases and symptoms often reported in outpatient wards. Consultations span 10 to 15 minutes; with medicines delivered to patients within 24 hours. The objectives are increased accessibility to people as well as helping in reducing hospital crowding. In this model, Ratchaphiphat Hospital acts as the "mother ship" linking with 69 public health centres across that city. The centres are partnering with community clinics and drug stores in its network, allowing easy health access to community residents. This programme has therefore to be read in conjunction with the different types of PPPs described earlier.

Learnings and continuing challenges

There are two important learnings from these PPPs. First, where comprehensive primary care cannot be provided from a single facility with a team and the population is vast and shifting, a network of different types of care providers can help ensure that the legal guarantee to meet the minimum standards of health services laid down is fulfilled. And second, all the contracting done is free of market pressures where clinical or public health decisions are linked to monetary gain or loss. It is a system of private ownership but acting under clear and explicit public administration, whereby the health care is delivered without any user fees. It also builds on two decades of experience in contracting and financing district health systems for primary health care in the public sector.

The challenge of delivering comprehensive primary health care in a large city like Bangkok, and across other provinces, lies in the fragmented nature of the health care system. This fragmentation makes it difficult to ensure continuity of care, including services such as home health care, annual health check-ups, prevention programmes, and health promotion initiatives. While PPPs are beneficial for curative care and ongoing medication provision, they do not offer a comprehensive approach to health care. This experience underscores the need to analyse and strategize for the future, particularly in Bangkok, where the majority of doctors are specialized and primarily based in hospitals.

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Case Study 10

Bangkok public health and digital health volunteers, Thailand


Credit: WHO

Organization and scale

Bangkok City, Thailand, by Bangkok Metropolitan Administration.

Timeline

2021 till now.

Problem statement and objectives

Rural areas have had the benefit of village health volunteer programmes for decades. The volunteers are linked to well defined community institutions and communities whose characteristics are well known. Though they existed in Bangkok too, all of those aspects were far more limited and had to be expanded rapidly to support the COVID-19 response. Another challenge was the digital divide – despite the widespread use of digital devices in health care, many of the more marginalized sections were excluded. In this theory of change the lack of digital literacy was holding back the underprivileged from fully benefiting from modern technology and maximizing their potential in the digital economy.

Context, process, outcomes

One of the strengths of the Thai primary health care system is its village health volunteer force of over 1.07 million volunteers. In most areas there is one volunteer for about 15 to 20 households. These village health volunteers are people from the community, who are therefore trusted by the local

population. They help to create the appropriate healthy practices and health-seeking behaviours, navigating through the complex and dynamic health system to support the population and health care providers. They are the real "first responders" in Thailand. They are trained to respond to health emergencies and must be prepared to perform their duties when health crises occur, as they did when the COVID-19 pandemic occurred. Each village health volunteer is clearly linked to local administration organizations, local health officers and community leaders, as well as supported human resources, budget and instruments. Thailand also celebrates a National Public Health Volunteer Day annually to recognize the contribution of the village health volunteers.

In contrast, the number and functionality of volunteers is lower in Bangkok City, accounting for about 15% of the population, and there have also been less clear linkages with the government institutions. It has proved difficult to define the catchment or service areas and the characteristics of the population in each, especially internal and international migrant communities and other marginalized sections of the population.

The first step therefore was to rapidly increase the number of public health volunteers. Subsequent to the increase during the COVID-19 years, Bangkok has now approximately 15 000 public health volunteers, with an average of one volunteer per 41 households. The number is planned to be increased further, bringing the average closer to that of other provinces.

A related but distinct initiative was the introduction of digital volunteers in Bangkok City. A total of 494 candidates from the 2000+ communities in the city were selected by the Bangkok Metropolitan Administration's Social Development Department to become the city's community development volunteers (technology aspect). Their main objective is to promote digital literacy among underprivileged people. They provide knowledge and train locals on how to use digital technology to access government services and other benefits, especially among the underprivileged, the poor and the marginalized. Another important role is to gather information on the characteristics of each community and help establish a central city database with updated information on each community's demographic, urban layout, economic status, and digital literacy status.

Each volunteer is allocated work in one community, usually their own respective community, in the first phase of the project. If it proves to be a success, the city will expand the project to cover all of its over 2100 communities.

The digital volunteers are encouraged to coordinate with other city officials who have been closely working with communities in public health, social development and urban planning in collecting vital information. There is a budget of 200 000 baht per community to tackle urgent local problems that they are facing. Each community must establish a committee to consider which project the budget would go towards. The city is also planning to adjust its regulations to allow the allocation of a budget that is appropriate to the size of communities – large, medium, or small – and will give consideration to communities that have yet to officially register with the authority to receive the budget.

The volunteers undergo an orientation session and learn about the programme's objectives and procedures. They receive training from the Bangkok Metropolitan Administration's Social Development Department.

One of the highlights of the digital literacy initiative is the VHV Online programme. An application AorSorMor Online (VHV Online) was developed as a collaboration between the Department of Health Service Support and Advanced Info Service Public Company Limited (AIS). This public health application was awarded an International Telecommunication Union and United Nations prize. It focuses on sustainable development of all sectors, since community public health is necessary for local communities, especially those who are marginalized. It will inform and

communicate with volunteers and promote liaison with the primary care team for better performance and communication.

VHV Online and the digital literacy programme is not limited to urban areas. It is also being taken to scale in many districts, especially in the context of crisis management. The aspiration is to use it develop integrated health management communities into "happy communities": healthy, happy and wealthy. Features introduced during the COVID-19 pandemic and since are used to examine mental health and related factors in communities using an online mental health questionnaire prescribed by the Department of Mental Health, to strengthen disease surveillance and prevention in communities, and to support communities' role in health management.

Learnings and continuing challenges

All countries in the Region have CHWs and are working on ways to increase their engagement with community institutions on public health concerns, and how to use digital technologies to advance these objectives. While there are now many reports and evaluations of Thailand's village health volunteer programme, there is little on these developments in Bangkok City. Though these are still early days for the public health volunteer programme in Bangkok City and for the even more aspirational digital literacy initiative, these should be followed closely to learn from them and see how sustainable they are, and what improvements in outcomes result. The specific challenges of marginalized populations, including undocumented migrant workers, also need to be followed.

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Case Study 11

ULAMA: engaging elderly in the planning and implementation of the Healthy City Programme of Wajo Regency, Indonesia

Credit: Wajo Regency, Indonesia

Organization and scale

South Sulawesi Province of Indonesia, by Wajo Regency Government; as part of broader Healthy City/Regency Programme led by Ministry of Health and Ministry of Home Affairs, Government of Indonesia.

Timeline

2011 till now.

Problem statement and objectives

There is a need to find more effective ways of mobilizing volunteers and engaging with communities for urban health and building healthy cities.

Context, process, outcomes

Wajo Regency is one of the urban administrations in Indonesia that has been active in the Healthy Cities movement in the country. Wajo Regency is an autonomous district in South Sulawesi Province, on the sea coast about 200 kilometres north of Makassar, the provincial capital. Its population of 400 000 is mainly of Buginese ethnicity and is largely involved in agriculture and fisheries. Indonesia has in all about 500 districts; under the Constitution, there is considerable decentralization to the provinces and districts. Administration is by an elected committee led by the regent.

Indonesia began implementing the WHO-initiated Healthy Cities approach in 2009. The Healthy Cities approach was adopted as a national programme,

namely the Healthy City/Regency Programme (Programme Kabupaten/Kota Sehat or KKS), which is jointly led by the Ministry of Health and Ministry of Home Affairs. Wajo has been a part of this programme since 2011. The Healthy City Forum is a nongovernmental body formed in every city and regency in Indonesia as the channel for community participation in Healthy City implementation. It consists of representatives of nongovernmental stakeholders, including academia, health professional organizations, journalists, and informal community leaders. The work of the Healthy City Forum is categorized across nine thematic areas, each with its own indicators:

1. Healthy and self-reliant community
2. Healthy public facilities
3. Healthy schools and health promoting schools
4. Healthy markets
5. Healthy tourism
6. Healthy roads and road safety
7. Healthy workplaces
8. Social security (poverty reduction, protection against domestic violence)
9. Disaster mitigation and preparedness.

Each of the above areas of intervention has a department in charge and indicators against which progress is measured. Wajo Regency is one of the best performers in this programme, having consecutively earned the highest Healthy City award from the national government in the past 10 years. It is known for its success in community engagement across all these sectors.

Wajo Regency has four hospitals, two of which are regional or provincial government hospitals and two are private. It has 23 primary health centres (puskesmas). The primary health care system has a focus on reduction of maternal and infant deaths, reduction of tuberculosis prevalence, and community promotion and prevention activities and health education. These interventions cannot be done by the government alone. They require a level of trust and rapport that comes better from change-makers within the community.

One unique feature in this city's programme is the active participation of the retiree community group, most of them in the age group 55–70 years. This is the only city in Indonesia to have taken this initiative. The organized participation of retirees is recognized as a major contributor to these achievements. Retirees are a subgroup of elderly who are educated, experienced, have the community's trust and have free time. As for urban communities in general, young people in Wajo are so busy with work and family life that they are hardly available to contribute to community activities, whilst the elderly are commonly discounted from social ventures. Involvement of the elderly in a social programme not only made use of their energy and knowledge, it was also perceived as one effective route to better elderly care, helping them remain more independent, purposeful and creative. Instead of being seen as a burden they were perceived as an asset. This programme is known as ULAMA – an abbreviation of Usia Lanjut Masih Aktif, or Active Elderly.

The development of this approach was rather spontaneous, with one senior recently retired officer taking the initiative. That senior citizen, now aged 73 years, remains active in leading the programme. Wajo Regency Government responded favourably and took forward the initiative to engage all the retiree community groups, aged 55 years and older, who are willing to volunteer their time and thoughts as member of the Healthy City Forum. At the district level there are now 45 ULAMA members, and they are represented on the District Advisory Committee. They are also part of the advisory committees in 23 puskesmas, which are at the subdistrict administrative level, and they are part of the 190 village groups at the village level. To become an ULAMA member one is recruited either by formal invitation or by the elderly coming forward to volunteer. Then the mayor of the city, or the corresponding head of the subdistrict or village administrative head, gives the applicant a formal appointment letter as an ULAMA member, which is

an honorific position that they retain for three years. There is annual verification and renewal.

There is an office in the Healthy City administration for the ULAMA volunteers. This office also arranges for free health screening and other services as required for the elderly.

The ULAMA members work closely with the Healthy City Forum and health facilities. Their main roles are to empower the community to recognize the need to protect and promote their health; to act as an advocate for community health needs in the city's development planning and budgeting; and to mobilize community support for the implementation of government programmes to address the determinants of health. This they do across all the nine governance areas.

The ULAMA members organize or participate in community meetings to discuss various situations that impact the health of the local population with the purpose of looking for solutions and mobilizing participation. These are then taken up during the annual city development planning process as proposals from the local village community and from the advisory committees at every level.

One of the main deliverables of the programme is to ensure the attainment of a minimum health knowledge standard. Also included in the main priorities for intervention are elimination of child labour, prevention of child marriage, prevention of school dropout, and prevention of nutritional stunting. These are areas with an immediate impact on health, but they entail behaviour changes that must happen within communities. The elderly have the respect of and stature in the community to promote these changes.

Wajo's ULAMA model has been presented globally in the WHO European Healthy Cities Network Annual Meeting (Copenhagen, Denmark, January 2023) and the International Federation on Ageing 16th Global Conference on Ageing (Bangkok, June 2023)

Learnings and continuing challenges

This is a unique story. Here the elderly are both the subjects and objects of the programme. In the process of contributing to a healthy city they remain active, and this along with elderly services keeps them healthy. Their work focuses on community-level behaviour changes that are very important and have an immediate impact on health but cannot be done by government alone. They also increase access to and utilization of public health services. This is an idea with great potential for replication.

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Case Study 12

The Jaffna Healthy City Project, Sri Lanka

Credit: WHO Sri Lanka

Organization and scale

Jaffna City, Northern Province, Sri Lanka. Organized by Jaffna Municipal Council with the Department of Health Services and Department of Education, Northern Province, University of Jaffna, with the guidance of WHO (organized collectively as the Jaffna Healthy City Coordination Committee).

Timeline

2020 to ongoing.

Problem satement and objective

Jaffna is a city in the north of Sri Lanka with an estimated population of approximately 85 000 residents, within a district of approximately 600 000 population. After the end of civil conflict, Jaffna experienced rapid economic growth, with increased urbanization. The city is currently grappling with a range of challenges related to urbanization, including water supply, drainage, solid waste management, traffic congestion, crime, and alcohol, tobacco, and drug use, with adverse health effects for Jaffna city's population. There was the need for an integrated urban health programme, with a focus on multisectoral action for public health, including all elements of prevention and promotion.

Following a series of discussions across sectors, the Jaffna Healthy City Project was launched in 2020 to support the overall health and wellness of Jaffna residents in a sustainable manner through adoption of the WHO Healthy Cities concept. The Jaffna Healthy City Project has five major thematic domains: COVID-19 prevention, solid waste management, physical activity, water, sanitation and hygiene (WASH), and healthy foods.

The Healthy Cities concept is notable for an in-built process of monitoring and learning, as stipulated in the WHO South-East Asia Region Healthy City Network Assessment Framework, with a preliminary assessment based on 13 prioritized indicators of social determinants of health and a

comprehensive assessment based on a set of 45 indicators, across the five domains of activity.

The case story presents the approach and process of implementing the Healthy City project in Jaffna, including preliminary assessment across 13 priority indicators and early learnings from the comprehensive assessment conducted in mid-2024.

Context, process, outcomes

Following a series of discussions across sectors, the Jaffna Healthy City Project was launched in 2020 to support the overall health and wellness of Jaffna residents in a sustainable manner through adoption of the WHO Healthy Cities concept. The project was jointly initiated in July 2020 through organization of the Jaffna Healthy City Coordinating Committee, including the Jaffna Municipal Council, Provincial Department of Health Services, Provincial

Table 5: Jaffna's score based on set of 13 prioritized indicators of social determinants of health, 2021

S.No.	Indicator	Level 0	Level 5	Jaffna 2021
1	Crime rate (per 1,00,000 population)	> 100	0-20	214 (level 0)
2	Road traffic death rate (per 100 000 population)	> 40	0-5	23 (level 2)
3	Average range of moderate-intensity physical activity for adults (18-64 years)	Inactive No activity above baseline	High: >300 minutes a week	NA
4	Percentage of households that receive solid waste collection, transportation, and landfill disposal services	< 50%	90-100%	58.5% (level 2)
5	Safety in work environment, equipment and safety procedure provided/ mandated in workplace	No safety procedure nor equipment provided	High safety enforcement and workforce awareness, all equipment in place	NA
6	Unemployment rate	> 20%	2-3%	4.7% (level 3)
7	Percentage of population using at least basic drinking water services	< 90%	98-100%	100% (level 5)
8	Percentage of population using at least basic sanitation services	< 70%	95-100%	94% (level 5)
9	Percentage of population with access to electricity	< 90%	98-100%	100% (level -5)
10	Presence and design of public spaces (space for walking, recreation etc)	Public spaces are not designed for all. No development plan in place.	Everyone is satisfied with all public space usage and willing to help each other out.	Level 2
11	Average travel time to the nearest health facility	> 120 min	< 10 min	Level 4

12	Levels of social security and insurance coverage	No social security nor social health insurance is available.(retirement, disability, survivors)	Social security AND social health insurance provide all three benefits for all citizens, regardless of work years.	Level 3
13	Health Information Accessibility	No health information provided in any circumstance.	Provide updated and useful health information in different formats at different times.	Level 3

Department of Education, University of Jaffna, and WHO. The Jaffna Healthy City Coordinating Committee additionally cooperates with a range of local non-governmental and private sector actors, as well as the United Nations Children's Fund (UNICEF).

With the guidance of WHO, a joint technical assistance plan was developed among development partners that was aligned with national priorities and the regional Healthy Cities initiative. A core aspect of the design was a preliminary assessment based on 13 indicators of social determinants of health, which grades achievement in each indicator into five levels, from 0 (lowest grade) to 5 (highest grade). Jaffna's scores on the preliminary assessment are provided in Table 5. The indicators speak to the importance of multisectoral collaboration to improve health and well-being in an urban context. Importantly, the Jaffna Healthy City Coordinating Committee, supported by the University of Jaffna, identified reasons for poor performance and collectively developed recommendations, at policy and community level, for improvement.

The Jaffna Healthy City Project began with identification of three settings and three thematic areas of intervention. The settings were the city schools, workplaces and public spaces. The thematic areas were food, physical exercise and the urban environment. The challenge was to ensure that these multisectoral interventions are well integrated and follows the principle of "PHC as a whole-of-society approach to health", with a focus on empowerment of communities and primary prevention.

For the work in schools, the agencies supported revision of regulations at 10 schools with more than 8000 students and nearly 500 teachers reached to develop an environment more supportive of healthy choices. Healthy diets were encouraged, and excessive sugary drinks discouraged through appropriate health communication. A programme to promote frequent engagement in physical activities was launched. WASH facilities within these schools were prioritized, and the programme promoted gender equality to boost the attendance and well-being of female students and empowered girls and women by addressing barriers to equal opportunity for female students. One of the key activities to achieve this was school workshops on menstrual health and hygiene in Jaffna City to raise awareness on menstrual hygiene and puberty.

At the workplaces, the focus was on the promotion of healthy eating habits, keeping physically fit and occupational safety. Interventions in public spaces involved an effort to reintroduce the culture of cycling, with the aim of reducing motorized vehicles as a mode of transport. Sustainable waste management was a major focus, which was promoted in all settings.

To further assess Jaffna's progress in becoming the first Sri Lankan city to join the South-East Asia Healthy Cities Network, a comprehensive assessment across 45 indicators, with associated dialogue with the Municipal Council, Jaffna Healthy City Coordinating Committee, and broader stakeholders, was conducted in mid-2024. Discussions focused on strengthening the quality of safe water and sewage systems, the need for walkable environments and active spaces, and timely public services responsive to needs.

Challenges identified related to obtaining the data and information required, securing broader participation, and reaching the most vulnerable. Initial recommendations highlight the need to prioritize investment in water and sewage treatment systems across all development projects, as well as the continued need for strengthening coordination across government, private sector and community groups.

Learnings and continuing challenges

The WHO Healthy Cities initiative, with a focus on addressing social determinants of health, aligns directly with the revitalized movement for advancing PHC in the urban context. The launch of the Jaffna Healthy City Project supported coordination of a range of governmental, nongovernmental, private, academic and community groups as aligned to the overall vision of advancing health and wellness for the city's population. It also raised the place of health in the city's political and social agenda.

The Healthy City processes of structured assessments with measurable indicators, as well as associated review and dialogue, is itself of value in advancing momentum towards addressing social determinants of health. Despite continuing challenges, there are some major success stories in this area, making it crucial to learn from ongoing efforts such as the initiative undertaken by the Jaffna Healthy City Project. As in the rural context, success relies on processes for ongoing programme review, active learning, and participatory decision-making.

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Case Study 13

Government Pharmaceutical Organization for universal access to essential medicines, Thailand

Organization and scale

Nation-wide, Govt of Thailand

Timeline

1966 to present.

Problem statement and objectives

For universal health coverage to be affordable for low- and middle-income countries, access to essential supplies, especially medicines, must be as low cost as possible without affecting quality, and must be distributed according to health needs. In most countries, medicines have to be purchased from external or global markets, and increases in prices seriously limit how much care can be provided within available budgets. Low-cost medicines often have problems with regard to quality. Supply chains are not reliable and at times of crisis they can be disrupted.

Context, process, outcomes

Universal health coverage requires that patients are able to access medicines without financial hardship. Since the poorer sections of the population can seldom afford the medicines required for most serious illnesses, it becomes the responsibility of the state to provide these essential medicines free of charge through public services or publicly administered services, supported by reformation of health financing to allocate budgets for medicine. Thailand, through keeping the cost of medicines low, shows how universal health coverage can be delivered in a much more affordable way. Thailand's total expenditure on health is approximately 4% of

gross domestic product (GDP), and its public health expenditure is only 3% of GDP as of 2020. The establishment of the Government Pharmaceutical Organization (GPO) under the Ministry of Public Health and the GPO Act of 1966 was Thailand's main route to addressing this challenge.

The main responsibility of the GPO is to manufacture medicines and pharmaceutical products to support the country's public health and organize their distribution to serve the national public health policy. This includes maintaining the price level of pharmaceutical products and medical supplies necessary for Thai society to ensure people's accessibility.

Currently the GPO manufactures around 300 medical products within the country, of which about 200 are in public sector units and others in collaboration with private sector entities. The GPO has enabled the country to be self-sufficient in the production of medicines, especially for newly emerging diseases and specific diseases that would otherwise require expensive drugs. The GPO makes and sells four categories of products: medicines; antiretrovirals; chemicals, test kits and natural products; and preventive medicines. Besides Thailand, it markets its products internationally, including Nigeria, Ghana, Bhutan, Somalia, Myanmar, Sri Lanka, Malaysia, Cambodia, and Viet Nam.

The GPO has an advanced quality assurance system in place for controlling, monitoring and supervising production to meet the appropriate quality requirements at all stages of the production process. The production process includes receiving raw materials, packaging materials and their correct dispensing, manufacturing, packaging of the finished pharmaceutical products, and transporting and distributing the products to consumers. The GPO is committed to producing products in accordance with good manufacturing practice standards, the Pharmaceutical Inspection Cooperation Scheme, and the rules and regulations of international conventions, as well as the evaluation of the European Medicines Agency. These regulations use consumer protection principles in the quality, safety and efficacy of the products, as well as having a basis in the scientific and rational standards of quality risk management.

Multiple stakeholders are involved in the central procurement process. The key stakeholders include the Thai Food and Drug Administration, which focuses on quality and good manufacturing practice; the Health Intervention and Technology Assessment Programme and International Health Policy Programme, which focuses on cost-effective analysis; the GPO, which focuses on price negotiation; the National Essential Drugs Committee; and health care providers.

The GPO gives Thailand significant leverage in its price negotiations with foreign drug suppliers. But even that is not adequate to ensure accessibility. The GPO was permitted to produce efavirenz and two other patented medications by having sought compulsory licensing under the provisions of the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement).

The GPO operates a vendor-managed inventory system for effective distribution. All the special access items, such as high-cost medicines and orphan drugs, are centrally procured by GPO and directly delivered to health facilities using the vendor-managed inventory system. The system is also authorized to cut the purchasing budget by reducing the redundant distribution in warehouses at the regional and provincial levels and overstock at the hospitals.

At the facility level, a pharmaceutical and therapeutics committee has been established in each subdistrict hospital for steering drug selection into hospital formulary and formulating an annual procurement plan for medicines and medical supplies based on specific context and hospital requirements. The plan must be annually submitted to the Office of the Permanent Secretary, Ministry of Public Health. There is a GPO outlet at each health care facility managed by pharmacists. All medicine requirements for inpatients and outpatients are dispensed from these pharmacies with no fees of any sort. However, dispensing drugs is only against

prescriptions, and these are all e-prescriptions. It is not mandatory to dispense only from the GPO outlet, and one can purchase from other outlets if the medicines are more affordable and of better quality. But in practice the advantages of such local purchase would be marginal.

The GPO distributes last mile delivery of drugs through multiple channels to ensure access to essential medicines to all Thai citizens. As an illustration, peritoneal dialysis fluid is delivered to the homes of renal failure patients directly through the Thailand Post Company Limited and, in cases of emergency, antidotes are delivered directly to clinics within 24 hours for patients who have been poisoned by food, chemicals or natural residues.

The GPO also has its own research and development institute. The GPO has established a research fund to provide adequate, appropriate, flexible and effective funding for research and development.

Learnings and continuing challenges

One of the key challenges in achieving universal health coverage and comprehensive PHC is ensuring that there is adequate access to essential medical technologies. This includes medicines, diagnostics, vaccines, devices and preventive technologies. Domestic manufacture with public sector production taking the lead has helped Thailand address this problem. It does not have the same lead in innovation and development, but with regard to patented drugs, or where technology is not in place, to ensure affordability in both public and private sector health care the government needs to step in for pooled procurement and, where necessary, make use of WTO TRIPS Agreement flexibilities.

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Case Study 14

State role in manufacture and supply of medicines at affordable cost for primary health care, Bangladesh


Credit: WHO SEARO

Organization and scale

Nationwide, Ministry of Health and Family Welfare, Government of Bangladesh.

Timeline

1983 to now.

Problem statement and objectives

Making universal access to affordable medicines a reality and ensuring health security in times of crisis.

Context, process, outcomes

The Essential Drugs Company Limited (EDCL), established in 1983, is a 100% state-owned Pharmaceuticals Company in Bangladesh under the Ministry of Health and Family Welfare. It mainly undertakes the task of producing quality medicines under the essential medicines list and supplying the same to the public health institutions, including community clinics, as well as nongovernmental and international organizations. This has played an important role in keeping the prices at affordable levels. One specific advantage of such a public sector entity is that it provides considerable

health security in times of crisis. At the time of the COVID-19 pandemic, when there were disruptions in the global supply chain, Bangladesh had to rapidly scale up personal protective equipment and maintain supplies of essential medicines. The presence of the EDCL enabled this.

The EDCL currently manufactures some 120 products out of 285 products in Bangladesh's essential drug lists. The entire manufacture is for the supply of public hospitals and public health centres. This includes publicly administered and contracted services, such as those provided through nongovernmental organizations (NGOs). EDCL is able to manufacture over 80% of all medicines consumed at the PHC level. The remaining 20% are newer medicines for specific disease control programmes, usually procured with international institutional support. At the tertiary hospital level about 50% of the medicines are from EDCL. The prices of the medicines are based on a cost-plus system and negotiated administratively to ensure the lowest possible prices while ensuring sustainability of manufacture.

All the manufacture of medicines by EDCL takes place in four government factories and through five private sector units that are contracted in. Two of the government manufacturing units at Madhupur and Khulna are exclusively for condom production, and one is for intravenous fluids and penicillin. There are also two new pharmaceutical units under construction, which will be geared to manufacture of more recently introduced medicines. A vaccine manufacturing unit has also been established.

One important feature of EDCL is that it has its own transport and stock delivery mechanism for all the 120 medicines it manufactures. This mechanism delivers the medicines directly to the over 14 000 community clinics that are spread countrywide. It is a less expensive and more reliable system for supply chain management of primary care consumables.

EDCL has a robust quality assurance system with administrative oversight by the Director-General of Drug Administration.

Domestic manufacture is only one part of the conditions required for universal access to medicines. EDCL is complemented by the Systems for Improved Access to Pharmaceuticals and Services programme (supported by the United States Agency for International Development), which aims to ensure access to quality pharmaceutical products and effective pharmaceutical services through system strengthening approaches, including strengthening procurement and supply chain systems throughout the Ministry of Health and Family Welfare. There is also a programme to strengthen the supply chain and eliminate stock-out. An electronic logistics information management system (eLIMS) is able to track information, including stock status, inventory transactions, donations, and consumption, and allows tailored reports accessible by all stakeholders, including policy-makers and suppliers. The portal is currently rolled out across nation and training was provided to all end users through the Director-General of Health Services.

Learnings and continuing challenges

Bangladesh has built institutions that are able to manufacture and deliver essential medicines of good quality without interruption to its entire primary health care services. Countries that have taken this approach include Sri Lanka and Thailand, which are both well recognized as delivering good health outcomes at much lower per capita public health expenditure compared to other similar countries. Such an institutional basis also ensures health security and sovereignty in times of a health crisis, such as a pandemic. Domestic public sector manufacturing capacity in the pharmaceutical sector is a necessary condition for pandemic preparedness and response for the future. However, continuous modernization and expansion of the existing capacity remains a significant challenge.

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Case Study 15

Local government in primary health care and community engagement, Nepal


Credit: WHO SEARO

Organization and scale

Nationwide; Federal, Provincial and Local Governments.

Timeline

2015 till date.

Problem statement and objectives

To ensure decentralization of health care and community participation.

Context, process, outcomes

Nepal's Constitution adopted federalism as a key principle, providing considerable powers and functions to local governments. The Constitution also established health as a fundamental right and stipulated public health as a concurrent function amongst all three levels of government. The country has federal government, seven provinces and 753 municipalities. The urban municipalities are headed by a mayor and deputy mayor and the rural by a chairperson and deputy chairperson.

Ministry of Finance has devolved the budget across different levels of government, with a portion to provincial governments and a significant share allocated to local and the federal government. A considerable portion of the health budget is directed towards hospital grants, with another part earmarked for capital construction. The funds are released to local levels as conditional grants for public health priority programs including basis health service delivery. In addition, the local administrative units can raise funds to meet local budget needs. A feature of this decentralization is

that all levels of governments must work together for health agenda as the concurrent function. There are mechanisms of coordination committees at all levels.

By the Local Government Operations Act (2017), it is solely the local government's task to deliver basic health care services to the community. The Act makes local governments responsible for registering, licensing, and monitoring primary-level hospitals, including private health facilities and their community outreach activities. Local governments can and do make additional laws and top up additional services to the defined list of the basic health services.

Each municipality should also have basic health centres at the ward level and basic hospital (5/10/15 bed hospital) at the municipality level. There are approximately 98 medicines listed to deliver the defined list of basic health services.

Aligned to the PHC approach, health facilities in Nepal have health facility management committees to manage funds, human resources, and health programmes, based on the principle of health sector decentralization. Each health facility management committee comprises of nine to 13 representatives. In order to ensure everyone has a voice in health facility management, membership includes the health facility in charge, the municipality chairperson, and elected members, including school teachers, female community health volunteers, and at least one of each of the following: Dalit, Janajati (an ethnic group), and female representatives. The health facility management committee contributes to regular monitoring and feedback mechanisms. The municipalities provide land for operations of basic health centres and health facilities.

The types of health facilities across the country have been devolved to three levels of government based on levels of services and management capacity. However, most provincial hospitals located in the provincial headquarters that have more than 200 beds are directly administered by the federal government.

The main strength of decentralization is a much higher level of support and ownership by local communities with respect to the public health facilities. Decentralization also helps to strengthen infrastructure and human resource gaps. This is enabled by the transfer of funds and human resources and related powers to the municipalities. Municipalities can raise additional funds at the local level. Decentralization helps deal with variations in demand for services and improves efficiency in addressing many local barriers and problems, which local entities understand well. The municipalities are also a major platform for convergence across sectors.

All of these factors come to great advantage when dealing with emergencies. This was seen both in the COVID-19 response and during the earthquake emergency. Local bodies feel accountable for the response and can mobilize resources to work together, with the technical support from provincial and federal governments. During the COVID-19 pandemic there were instances of provincial and district administrations, as in Koshi Province, paying for and supporting a hospital dedicated to COVID-19, and ensuring that the entire administration, including the police force, to support the required public health action.

Despite these efforts, there are certain challenges. There is disparity in capacity and motivation across local levels. In such a situation, the federal and provincial governments have a major role to play. Federal government intervention is facilitated by an effective health management information system based on the DHIS2 digital platform, which measures and displays different levels of service provision. When it comes to interventions, the delegation of powers is not always clear, and disagreements can occur. The local governments manage health workforce through contractual recruitments where existing health workforce from public services is not sufficient to meet the local needs. The health workforce adjustment in the federal context, to an extent, fragments accountability.

The other set of problems relates to operation of basic hospitals, which require a considerable degree of technical, health workforce and logistic support with strong referral mechanisms. There are considerable problems for continuity of care. Unlike basic health services, the current policy envisions secondary and tertiary care as being largely provided through health insurance, which brings further challenges. As one official put it: "This level of decentralization is recent, and it is still on a learning curve. Currently the communities are enjoying their new-found freedom and this has brought a lot of positive energy and motivation. They are also beginning to recognize that everything cannot happen at the local level, and there has to be a development of institutional capacity and technical support at all levels."

Learnings and continuing challenges

Nepal's recent experiences with decentralization have involved a considerable amount of energy and community engagement, but it is also faced with several challenges, the more so as the programme extends beyond basic health services to address continuum of care with well-defined referral mechanism to the higher levels of care. The strengths of decentralization have been greater community ownership and the remediation of many gaps in local capacity. However, there is uneven development across municipalities, and it remains a challenge to assure the right to health for all. The linkages and continuity between federal, provincial and local levels with regard to health care and administration still require focused attention, consistent with principles of cooperation, co-existence and coordination as envisioned in the constitution.

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Case Study 16

Kerala Palliative Care Programme with involvement of local government (panchayat), India


Credit: NHSRC, India


Credit: NHSRC, India

Organization and scale

Scaled up to the entire state; organized by local self-government in collaboration with State Directorate of Health Services and National Health Mission Kerala.

Timeline

Initiated in mid-1990s, current design and statewide scale-up in the last decade.

Problem statement and objectives

Kerala is facing the problems of a rapidly ageing population and increasing chronic illnesses. There is a need to find solutions suitable for a low-resource setting for palliative care for the chronic and severely ill, for terminal patients and for elderly persons who require additional support at the home. A network of homes for the elderly and palliative care is at this moment neither affordable nor desirable.

Context, process, outcomes

Palliative care was introduced in Calicut, Kerala, in 1993 by an NGO, the Pain and Palliative Care Society, based on Calicut Medical College. Palliative care became a community movement later through the project Neighbourhood Network in Palliative Care, which aimed at empowering the local community to care for the bed-bound patients in their area. Local governments started involving with this community movement in 2004. The government introduced a Palliative Care Policy in April 2008, following which the programme gained momentum through local self-government departments and health departments.

The Kerala palliative care model involves a community-led approach with panchayats (local governments) taking a leadership role in operations,

funding, and supervision. Community involvement and ownership are considered as the key attributes of sustainability of the Kerala palliative care model. In this model, the major part of care is at the primary care level.

Currently the programme is integrated with the state government flagship scheme Mission Aardram, launched in 2017 with the primary objective of re-engineering primary health centres into family health centres to provide people-friendly services. A critical strategy of the Mission was the involvement of local self-governments, or panchayats, in monitoring and ensuring comprehensive health services.

The resources for the day-to-day functioning of palliative care come both from the state budget and from the community as microdonations, contributing to the sustainability of this initiative. A revised Palliative Care Policy 2019 is the state's guide for action.

The definition of palliative care is not limited to terminal illness. The programme reaches out to cancer patients who are terminally ill or on home care, as well as to chronic kidney disease patients on conservative care or on dialysis or after transplantation, and to those who are recovering from stroke or other paralysis and those who are bed ridden and immobile due to old age (most often) or some illness. To give an example, we provide the details of the pattern of health care utilization in one village panchayat that was visited. This village panchayat takes care of 236 persons registered under it for palliative care. This panchayat has a population of 23 500, and the 236 palliative care service users constitute about 1% of the population. The 236 persons includes 147 cancer patients and about 100 bed-ridden patients, many of whom have hemiplegia or paraplegia, and 71 chronic kidney disease patients. Of the 71 chronic kidney disease patients, nine have had kidney transplantation, 15 are on chronic dialysis and the remaining 47 are on conservative management. Chronic obstructive pulmonary disease and heart failure also contribute. (Inconsistencies in the data presented may result from several patients having co-morbidities.)[4]

At the primary care level, structured home visits are organized by a trained community nurse once or twice a month. This nurse is paid by the panchayat. Other team members include health department staff, trained ASHA workers, and field staff of the primary health centre. There are also local volunteers, under the supervision of the primary health centre medical officer. Medicines are also paid for by the panchayat. Panchayat raj institutions (local government bodies) each spend about 1 million to 1.5 million Indian rupees per year under the decentralized planning scheme for palliative care activities.

Patients in a primary-level palliative care programme often need higher skill levels of care. Patients with end-stage cancer may require a colostomy or tracheotomy. Many may require morphine. A nurse with higher levels of training supported by a medical officer with additional training on palliative care who are stationed within the block (a cluster of panchayats) are available to provide this care. These secondary units are also coordinating and monitoring the activities of primary palliative care units in their area through training and quality improvement programmes. Much of the geriatric care is subsumed into this palliative care. Tertiary-level palliative care focuses on various trainings for professionals (doctors and nurses) as well as students and volunteers in nearby hospitals, which act as a referral sites.

The scheme also provides for preparation of a participatory plan, strengthening the neighbourhood network of palliative care, and partnership with NGOs and community-based organizations.

This programme can only be understood in the context of Kerala state's excellent decentralization of primary care services to the village panchayats. Panchayats have the funds, the personnel, and the power to undertake palliative care activities. Village panchayats are spending 2.5 million to 10 million Indian rupees to ensure adequate functioning of the health care facilities under their governance,

4 Field study report by Professor T. Sundararaman, January 2020.

and even higher sums are spent by block and district panchayats. Examples of expenditure include supplemental staff, supplemental medicine, enhancing local health infrastructure, and panchayat projects.

The panchayat project is an interesting concept. Panchayats can propose projects of their choice for state funding. A fair number of such proposals relate to health services. They can be location specific and innovative. Examples include projects for noncommunicable disease prevention with a focus on developing gymnasiums and promoting exercise; tribal health and tribal nutrition projects; teaching cycling to adolescent girls; supplying cots to tribal households; and provisions for geriatric care. A few projects, such as the Palliative Care Project, are mandatory, and for this purpose approximately 1 million to 1.5 million rupees per year are earmarked.

This high level of public participation and ownership has to be supported by adequate technical knowledge and supplies, as delivered by the health services acting in partnership.

Learnings and continuing challenges

This is a unique primary care programme, not only in India, but across the countries of the South-East Asia Region. It provides for community-based palliative care, led by local governments and professionally supported by the health system. This gives major scope for planning and innovation at the local government level and helps address the problem of matching public financing with local participation and planning. Presently, local self-governments are involved in the functioning of the family health centres, and have autonomy of operation to act as coordinators and involve other departments, organizations, and panchayats. Their involvement is also leveraged to address the social determinants of health. Finances to implement the transformation of primary health centres to family health centres are sanctioned through the panchayats, and they also contribute to the Mission by using the discretionary funds available to them, or by mobilizing resources for improved infrastructure and additional human resources. Thus, panchayats are partially responsible for hiring PHC workforce teams. As a convergent body for different departments, including the health department, local self-governments are expected to budget for, implement, manage, monitor, and evaluate primary care services to ensure access to care.

It is also an important example of why and how low- and middle-income countries must find innovative solutions if they choose to move from selective to comprehensive PHC, and most such solutions require high levels of community engagement.

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Case Study 17

Intersectoral platform for community action on health and determinants: Swasthya Panchayat Yojana, Chhattisgarh, India

Organization and scale

State of Chhattisgarh, organized by local self-government, State Health Resource Centre, and National Health Mission.

Timeline

2007 till now, with a scale-up in 2017.

Problem statement and objectives

A key challenge was to address inequity and marginalization within the very heterogeneous village communities, while promoting convergent action on the proximate social determinants of health. The objective was to strengthen the community role in PHC through a structured process of planning, monitoring, dialogue and grievance redressal.

Context, process, outcomes

Swasthya Panchayat Yojana (Healthy Panchayat Plan) was initiated in Chhattisgarh in 2007 with the purpose of promoting community action on the social determinants of health. The village health, sanitation and nutrition committees (VHSNCs) had been constituted under the National Rural Health

Mission and provided with a modest fund of 10,000 rupees per year. The initiative aimed to enable and engage communities to plan for their own health and then take up intersectoral action to improve it.

With regard to the programme features, the initiative was built on the capacity that existed in form of the Mitanin CHW programme. The State Health Resource Centre, a hybrid civil society–government agency, stewarded the CHW programme as well as the Swasthya Panchayat initiative. Mitanin CHWs had generated trust in the communities through their work since 2002. The Swasthya Panchayat initiative sought to expand the scope beyond CHW action by also involving the local elected bodies (panchayats) in planning and action on social determinants of health. In order to plan, the communities needed the capacity to assess the situation of their health and its determinants. Tools were created through which community volunteers could collect the data and analyse where their panchayat stood on key indicators. Panchayats were encouraged to take up local action to resolve the gaps. The assessment was repeated annually to reflect the progress achieved, and the well performing panchayats were recognized in public events. The supportive supervision structure of the CHW programme was deployed to facilitate the above processes.

The initiative is integrated with the VHSNCs under the National Health Mission. VHSNCs involved multiple local groups with the panchayat representatives and Mitanin CHWs in leadership roles. The planning process and tools of Swasthya Panchayat evolved to allow monthly monitoring of health determinants and continuous planning and action instead of the earlier annual process. In all there were 29 indicators to be compiled quarterly. The first nine indicators were on nutrition for children aged below 5 years, with special focus on the functioning of the anganwadi (integrated child development) programme. The next 10 related to outreach activities under the primary level of health care. The next three related to social security – the functioning of the public distribution system for food security, the employee guarantee scheme and pensions for elderly. The next three related to school education, including retention of girls in schools, teacher attendance, and mid-day school meals. Ensuring and maintaining access to safe drinking water and prevention of mosquito breeding sites were another two indicators. Combating gender-based violence was also a key theme for action and had its own indicator. Importantly, each indicator represented an area of intervention; nor was action limited to only what was measured. In the domain of health services, action was focused on primary care and outreach services for reproductive and child health and control of communicable diseases. Along with demanding better services from government, there was a significant component of collective action by communities on prevention of diseases, especially source reduction for vector control. Based on these scores, the best-performing three panchayats under each administrative block would be given a modest cash award, which came with considerable local recognition. In all there are 11 000 panchayats across 146 development blocks. To score all panchayats and declare block-level results is therefore a considerable challenge.

The next level of community action under Swasthya Panchayat Yojana is the VHSNC cluster meeting. The VHSNC consists of members from one village, whereas each VHSNC cluster consists of people from five to eight VHSNCs. Some local issues are resolved at the village or local level but there are certain common issues that require a larger group to apply enough pressure on the service providers and administration, and VHSNC cluster meetings provide that platform to the communities. The VHSNC cluster can be considered as a federation of VHSNCs. Each month, a meeting is held in one of the villages, with a rotation basis so that each village has the privilege of hosting a cluster meeting. The cluster meeting or federation meeting is facilitated by Swasth Panchayat Samanvyak. It was felt on many occasions that beneficiary visits to the janpad office or block development office for redressal of grievances had failed to reach the concerned officials. To support this action further,

the Swasth Panchayat Samanvyak spends one day at block level, especially in the janpad office or block development office, as a helpdesk facilitator to support the beneficiaries in (a) writing applications, (b) guiding the beneficiary to reach the concerned officials, and (c) advocating on behalf of beneficiary before the officials. This supportive action is known as "janpad sampark" work. "Monitoring members" – two from each government scheme – are assigned with the task of visiting the service sites each month to physically review the schemes and presenting the findings of their review during the VHSNC meeting.

The initiative further evolved with Jan Samwad (Public Dialogue) events occurring in every rural block annually. The village-level groups were horizontally integrated as larger bodies with greater clout to resolve problems. They learned how to escalate action to block or district headquarters when a problem could not be solved through village-level action. These consultations would lead to formulation of village health plans, which would be reviewed and presented in the annual block-level health assembly. In all there are 19 180 such village plans that are drawn up each year. To support the increasing volume of work, the State Health Resource Centre developed a cadre of facilitators known as Swasthya Panchayat coordinators.

The initiative has been successful in enhancing the communities' voice in several domains and improving their access to many services and programmes. The initiative has been sustained for more than 15 years now and continues to impact the determinants of health, as evident from indicators derived from National Family Health Surveys. Chhattisgarh became one among the top state in India in reducing child malnutrition and the rate of stunting among children aged under 3 years, in improving the nutrition status of women, in reducing spousal violence, and in reducing the proportion of marriages involving underage (below 18 years age) girls, all of which were themes addressed by Swasthya Panchayat. Village health assemblies have helped sustain the quality and diversity of supplementary feeding, have raised issues such as the lack of functional toilets for girls in schools, and have ensured that food supplements reach children aged below 3 years in the community.

The panchayats played diverse roles in the initiative – in responding to people's demands as the local implementation arm of the government for many programmes, as allies of the community in petitioning government for better services, as organizers of communities in taking up collective action on disease prevention, and as legitimate leaders of the community when supporting CHW action on gender-based violence.

Learnings and continuing challenges

The Swasthya Panchayat initiative is a unique example of a convergent platform of community action for health that has been sustained for nearly two decades on a statewide scale of around 20 000 villages. A key lesson from the initiative is that community engagement is feasible and fruitful. The facilitation support provided by the support structure of the CHW programme and the stewardship of State Health Resource Centre are examples of the roles necessary in replicating such initiatives. The ability to evolve and introduce layers of mutually supporting interventions as demonstrated by the Swasthya Panchayat initiative can be the key to success of community engagement programmes. The partnership between the CHW programme, the intermediary village health committees and the elected panchayats was the key to the success achieved in intersectoral action, as was the considerable investment in capacity-building and support.

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Case Study 18

Grievance redressal with civil society engagement, Thailand


Credit: WHO

Organization and scale

Nationwide under Universal Coverage Scheme, National Health Security Office (NHSO) and Ministry of Health, Government of Thailand, with civil society organizations.

Timeline

2009 till now.

Problem statement and objectives

There is a robust grievance redressal system and many forms of community participation but the challenge was to bring these together in a manner that remedies the issues being addressed.

Context, process, outcomes

Under the National Health Security Act of 2002, the government not only has to ensure mechanisms that protect the right to access good-quality care, but also has the duty to register complaints and take necessary action for compensation and correction if any rights are violated. These rights could be related to loss or injury from a deficient service (under article 41 of the Act); the violation of a health service standard (under article 57 of the Act); or a rights violation including denial of an entitled service, or not receiving convenient service, or being asked to pay for a free service or pay above the prescribed standard fee (under article 59 of the Act). In such circumstances a preliminary compensation is due for a loss or injury without having to establish a perpetrator, because often the failure is at the systemic level and not on an individual service provider.

Most grievances are likely to be related to miscommunication rather than malpractice.

Redressal efforts provide emotional relief to both providers and patients without engaging in adversarial procedures. The process has helped reduce litigation against health care providers over the past decades.

There are many channels to register a complaint. The most commonly used and widely known channel is the NHSO call centre 1330, which provides information to Universal Coverage Scheme members and receives and manages complaints. There is also an NHSO customer centre at every participating health service facility. As of 2019 there were 886 such NHSO customer service centres, including 36 non-Ministry of Public Health hospitals. There are awards for excellence in services, and effective centres are upgraded into consumer protection service centres, which have the power to investigate complaints and prescribe a course of action. Another channel for filing grievance is through the provincial public health office. The team there would assist with the documents and provide counselling for the family.

In 2009, the NHSO formally established independent, free-standing complaint-receiving units in collaboration with civil society organizations (CSOs) who had been helping to educate the public and facilitating rights management locally. As of 2019, there were 122 such CSO-partnered independent community-based complaint-receiving units covering all 77 provinces in the country.

These units do far more than receive complaints. They also help defuse conflict in cases of loss or injury. In 2019, about 70% of field complaints were resolved by the unit, and 14% were referred to relevant higher committees, while 16% received appropriate compensatory assistance at that level itself. Most of these CSOs are local NGOs that have strong ties with the community in addressing grievances locally and informally before escalating to the formal systems in place. This acts as an effective mechanism in settling grievances in a more amicable manner and with more immediate outcomes. It also helps the community understand the problems that the providers face, with an opportunity to reach out to them and provide support, for which there are provisions. In return the providers also get to hear community views without rancour thanks to the mediation of the local NGOs. The entire process supports community monitoring in a non-threatening, cooperative framework.

The formal protocol for addressing the complaints through any of the three channels is the same. First, the matter is entered in a database. This is followed by gathering preliminary information and a decision is made as to further referral, based on claimant desire or the process for preliminary compensation. Following this, the complaint is referred to the provincial office where a decision is to be taken. Here there is verification of facts, usually a process of mediation or negotiation, which is part of the official protocol, and finally a judgement. In most cases there is a time limit of 30 days for the decision. It has been found that many of the complaints are related to a misunderstanding of the system or miscommunication between providers and patients. A non-confrontational discussion often not only solves many complaints, but also has the potential to build solidarity between the community and providers. Mediation by community organizations that have a close positive relationship with both is especially helpful.

Most of the community-based complaint-receiving centres are also tasked with giving information on the Universal Coverage Scheme to the people (referred to as people's health security centres). There are 146 such centres. By rule these must have their own infrastructure and must not be located in the hospital or a place of government, and must not be under the line authority of the government or any of its agencies. There is also a civil society network for health, which networks with and supports these people's health security centres. People's health security centres also join the important movements that lead to development

of new benefits packages, such drug compulsory licensing and many newer disease-specific benefits packages.

Learnings and continuing challenges

All countries in this region are engaged in different forms of community engagement for increasing accountability of public health services and publicly administered services. All countries are also working on grievance redressal systems that ensure that violations of patient rights are acknowledged and redressed. Both of these measures are perceived as essential to improve public health and PHC performance. Thailand's positive practice provides a framework for grievance redressal and consumer protection, which builds from an inquisitive and mediation-based approach instead of an adversarial legal approach. This framework provides important space for community engagement. Though by nature much of this activity could be confrontational, special efforts are taken to design measures that build trust between communities and providers, reducing antagonism and misunderstanding while also ensuring speed in redressal. Though the word accountability is seldom used in descriptions, the main outcome is clearly a very high level of accountability and solidarity. It shows that the health system has an accountability to the population that is more effective, timely and compassionate to both providers and the complainants as compared to a formal adversarial, and often slow, legal process.

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Case Study 19

Bangladesh Health Watch: taking voices of the grass roots to policy-makers, Bangladesh

Organization and scale

Nationwide, organized by civil society network with secretariat at BRAC University's James P. Grant School of Public Health.

Timeline

2006 till now.

Problem statement and objectives

To ensuring accountability of services and health rights through the role of civil society in monitoring health policies, programmes and indicators and advocating necessary change.

Context, process, outcomes

Bangladesh Health Watch was established in 2006 with the aim of improving the health of the people through monitoring progress in the health of the population and health systems and playing a catalytic role in making lasting changes in the health sector. Bangladesh Health Watch is a civil society advocacy and monitoring network dedicated to improving the health system in Bangladesh through a critical review of policies and programmes and recommendation of appropriate actions for change. Its mission statement states: "Building a functional platform through which citizens and all other relevant stakeholders of the country can get their voices heard and thereby influence policies and programmes impacting citizen's health."

Bangladesh Health Watch's structure consists of a 13-member working group comprising senior public intellectuals working in different nongovernmental health and academic organizations. It has an eight-person advisory group, many of whom are pioneers of action for health rights in Bangladesh. Most importantly, it has an active secretariat, with 12 full-time staff, which is housed in the BRAC University's James P. Grant School of Public Health.

In 2019, Bangladesh Health Watch decided to revisit its objectives and strategies for the current health scenario. The strategy was developed through participation of key members of the working group and external third-party participants and endorsed by the working group. This strategy was the basis for designing a project "Making Bangladesh's health care systems more responsive and participatory", as supported by the Swedish International Development Cooperation Agency.

The main objectives under this revised strategy are:

- creation of a platform for voicing concerns;
- facilitating creation of evidence for changing policies and practices;
- dissemination of new knowledge and information;
- engagement with stakeholders, mainly the Government of Bangladesh, for policy change;
- optimal use of technology to collect feedback, disseminate information and generate debate.

Bangladesh Health Watch has eight regional chapters comprising civil society members to monitor health service situations at the local level and act as the bridge between service seekers and providers. Regional chapters operate through eight district health rights forums, eight upazila health rights forums and two union health rights forums. Alongside there are district health rights youth forums to support the health advocacy programmes of the district health rights forums.

The objectives of the regional forums are to monitor the health service situation in their regions and maintain close contact with local bodies as well as health facilities, collect opinions and give space for people's voices. Regional forums can initiate actions to mitigate the issues unearthed, propose solutions, and follow up on implementation, as well as bringing up any significant observation from those subregions for discussion and action at the regional or national level.

These objectives were well expressed by its convenor Dr Ahmed Mushtaque Chowdhury. To quote: "To achieve the Sustainable Development Goals of 2030 and be a developed country by 2041, it is necessary to increase the budget in the health sector. This requires the best use of allocations in the health sector, accountability, equity, and people's participation. Bangladesh Health Watch and District Health Rights Forum are acting as civic forums, which will solve some of the problems locally on the one hand and provide an opportunity to highlight local realities in national policy-making on the other."

The various activities of Bangladesh Health Watch consist of policy advocacy, research and capacity-building. There are also annual reports and publications that Bangladesh Health Watch brings forward. Bangladesh Health Watch at the national level also has a number of thematic groups that deliberate in specific areas. A short course on some of the core health rights themes for duty bearers was conducted in 2021 and 2022.

The fact that this platform and many of the organizations that constitute the platform often take a critical stand on government policies or the role of external aid agencies could be a source of friction and tension. However, this is mitigated to a large extent through reports being evidence based and constructive in nature.

One of the recent achievements was the publication and dissemination of the book "Bangladesh: 50 years of advances in health and challenges ahead". The publication highlights how tremendous progress in health outcomes has been made at such low cost. In its conclusion, it calls for "bold innovations, expansion of public health expenditure, developing a strong and accountable PHC system, professionalizing the CHW cadre, encouraging research and the use of

evidence in decision-making", with a strong role for civil society.

Learnings and continuing challenges

Social participation is accepted as essential for progress towards universal health coverage, based on a PHC approach. Yet most such approaches limit themselves to either providing last-mile linkages or holding peripheral workers accountable. However, community action needs to go along with community-informed change in national health policy development and approach to implementation. The existence of platforms such as Bangladesh Health Watch have an important role in realizing the vision of PHC and health for all by reflecting perspectives and concerns of communities in national policy development and implementation.

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Case Study 20

Nongovernmental organization role in providing primary health care: Gonoshasthaya Kendra, Bangladesh


Credit: WHO

Organization and scale

Initiated in Savar upazila with extension to 15 districts of Bangladesh; organized by civil society.

Timeline

1971 to present.

Problem statement and objectives

The NGO challenge is to provide affordable health services to the poor and marginalized, in complementarity with government services and without reliance on external funding, while also contributing to policy development. The case study of Gonoshasthaya Kendra is included to honour the recent passing of its founder, Dr Zafrullah Chowdhury, whose work informed development of the 1978 Alma-Ata Declaration and subsequent call for "health for all".

Context, process, outcomes

Bangladesh has a rich history of NGO engagement in health service delivery, potentially greater in scale than other low- and middle-income countries. The pioneering NGOs of the post-independence period include Bangladesh Rural Advancement Committee (BRAC), Grameen Bank, Gonoshasthaya Kendra (GK), CARITAS, Family Planning Association of Bangladesh, Rangpur Dinajpur Relief Service, Bangladesh Women's Health Kendra, Naripokho, and many others. In all there are estimated to be over 2000 such NGOs. BRAC, with about 60 000 full time staff is the largest NGO in the world, acting in many health and development sectors. The large

NGO presence has made an important contribution to Bangladesh's better health outcomes compared to similar countries and at lower public health expenditure. While many models have been historically dependent upon external financing, there are also many models of such civil society intervention that are designed to reach the poor based on resources raised domestically with high levels of cross-subsidy. GK is one important example of this, with both PHC programmes and effective secondary care in support.

The origins of GK date back to the Bangladesh Field Hospital, which was built on the border with India (Tripura state) to treat those wounded in the liberation struggle of 1971. After the establishment of Bangladesh, GK registered itself as a public charitable trust and started a hospital and an integrated field health programme in Savar upazila, on the outskirts of Dhaka. Today the programme has spread to 31 unions in 17 upazilas of 15 districts. In each upazila there is a GK-run health centre, each catering to about 100 000 population and linked to that are two or three health subcentres, each catering to about 30 000 population. In all there are 25 health subcentres per district. There is also a CHW programme. GK's community health programme, including cooperative health insurance and a strong CHW role, was one of the inspirations for the 1978 Alma-Ata Declaration.

GK manages two 150-bed hospitals, one in Savar, where it is also a medical college hospital, and the Gonoshasthaya Nagar Hospital in the Dhanmondi area of Dhaka. Both hospitals have close to 100% bed occupancy, with over 500 outpatient visits daily. In addition, the Dhaka hospital does a remarkable 300 haemodialysis patients daily, contributing to affordability not only for the poor but also for middle-income patients.

The GK hospital also has an outreach service in the form of a mobile clinic that visits nearby slums four or more days of the week. Seven slum areas are visited every week. This mobile clinic has one doctor, two nurses and one laboratory technician. It does blood grouping, blood sugar, rapid antigen test for COVID-19, and tests for anaemia.

The hospital has no external funding support. It is sustained by user fees and topped up with individual one-time small donations and bank loans that take care of capital costs. The hospital has a clear pro-poor focus. The clearest expression of this is in its graded system for user fees, with a cross-subsidy built into it. This is made possible through the Gonoshasthaya Health Insurance Scheme. The process of registration involves sorting individuals into six economic categories: very poor, poor, lower middle class, middle class, upper middle class and rich. The registration fee varies from 200 taka, which can be waived for the very poor, to 3000 taka for the rich. But more importantly, every other fee – from consultation s to surgical fees, to investigation fees and the fees for dialysis – all are graded into these six levels. This cross-subsidy approach also extends to the primary care services. At the same time, GK clearly articulates that it supplements, but never competes with, government health systems. "GK's primary focus is to work with the government, so that its innovative schemes, if found result yielding, can easily be adopted by the government." It works with local governments and undertakes implementation of national programmes in the villages where it operates. GK also plays a major role in the response to any health or humanitarian crisis with involvement of the local community.

Another noteworthy initiative of GK has been to set up three pharmaceutical manufacturing units: one for antibiotics, one exclusively for paracetamol and a third for other allopathic formulations. GK has been a major force to promote rational drug policies and self-sufficiency and health security with regards to essential medicines. GK also plays a major role in medical and technical education, leading to the creation of a suitably skilled human resource base for the nation.

Learnings and continuing challenges

Bangladesh's approach to universal primary health care has always had NGO and civil society involvement as one of its strengths. NGO-organized

service delivery supplement public health services, reaching out to communities and geographies and addressing health issues that otherwise may be neglected. Unlike other NGOs, GK highlights the importance of domestic financing. Here, while capital costs may be through donations or grants, running costs are completely recovered through user fees, with strong cross-subsidy for the poor. Given pro-poor focus in service delivery, GK has also emerged as an important advocate – nationally and internationally – of strengthening health services as public goods. GK provides a good example of a private not-for-profit organization advancing the vision of comprehensive PHC and health for all.

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CHAPTER 5

Learnings from the case stories

Strengthening public health services or publicly administered health services is a challenge across countries of the South-East Asia Region. Within this, strengthening PHC has its own particular set of operational challenges. Each Member State in the South-East Asia Region has responded, at subnational as well as national levels, to this challenge through a diversity of actions. This report is a modest effort to document some of these efforts, with the aim of enabling collective learning.

Given the wide dimensions of strengthening PHC, the South-East Asia Regional PHC Forum undertook to categorize the required interventions into a number of broad thematic areas, of which four are represented in this report: (a) human resources for health, with a focus on PHC teams; (b) urban primary health care; (c) quality, with a focus on access to essential medical products; and (d) community engagement.

This selection of case studies documents various models and practices, largely related to innovations in public policy and public administration, but also inclusive of two case studies that relate specifically to civil society action. The story of Integrasi Pelayanan Kesehatan Primer (also Integrasi Layanan Primer, ILP) implementation in Indonesia cuts across public policy, public administration, and the process for civil society engagement.

Of the first eight case studies, seven have a strong focus on human resources for health. The first two of these describe how the shift from selective to comprehensive services goes beyond just increasing numbers and skills of human resources to transforming the organization of health care itself. The next four case studies relate to the composition of the PHC team and how it had to be transformed with capacity-building of this workforce to play an expanded role. The seventh and eighth case studies describe monitoring performance of a health system as different from monitoring individual providers and programmes. What is common in most of the countries is that there is shift taking place from selective to comprehensive packages of care. The earlier workforce composition and policies built for selective primary care that addressed only some elements of reproductive and child health and two or three disease control programmes is unable to cope with this shift. The case studies also impress the need to focus on a PHC team rather than on individual providers.

In the case studies of ILP from Indonesia and the capacity-building pilot in Faafu Atoll in Maldives, the shift from selective to comprehensive services requires integrated action on five fronts: introduction of standard treatment protocols, clarity on care pathways and referral mechanisms, a team-based training programme for the primary care team, more effective community engagement, and the introduction of an electronic health care registry.

In India the shift to comprehensive care has taken the route of the upgrading of subcentres (Ayushman Bharat HWCs) alongside that of PHC centres; central to the upgrading of the subcentres has been the introduction of mid-level health care providers. To envision and deploy a new cadre of about 120 000 mid-level health care providers between 2018 when the policy was adopted and the 2022 deadline for full operationalization was indeed a unique challenge; and this is the story we tell. Here is a story of a policy decision overcoming different forms of resistance and then a story of strategy choice to find the fastest and most practical way of reaching the objective. This rapid scaling up worked. But one consequence of the accelerated pace was that the quality of output could be varied. This led to new approaches being developed to impart the mentoring support required for such a huge new workforce. The difference between training and mentoring is an important difference, and through our case stories, we tell the story of positive practice in this area. The lesson is that when programmes get scaled up there is a need for tremendous attention to detail and for rigour, so as to ensure the necessary outcomes. If well planned and articulated mentoring can be done on such a scale, it surely is possible to replicate this in most contexts for other cadres, including the primary health care teams as a whole.

In Timor-Leste on the other hand, the context is a country situation where there was some presence of midwives but very few other human resources for health available. Timor-Leste had to start generating the doctors, nurses and CHWs they needed, and accepted the help of distant Cuba for the task. There is also the problem of multiple languages in use. Timor-Leste began with the concept of a doctor-nurse-CHW team, all of whom make home visits and manage clinical care, rediscovering for itself the logic of the PHC team and how work allocation within the team must proceed, and the important and differential roles that each member of the team must play.

Bhutan and Maldives are low-population countries that had already deployed a primary care workforce of good quantity and skills mix and had a good density of health posts and centres. So going comprehensive meant redefining their roles in terms of services provided and thereby redesigning their skills requirements. They achieved this transition through changes in entry qualification and in-service training. The Bhutan example is notable for the rigour and level of participation it has put into identifying the competency gap, developing training materials to close the gap, and putting in place performance measurement. Most countries

have done this, though perhaps not with the same rigour. But Maldives, through its Faafu Atoll pilot, goes further to conceptualize capacity-building as far more than training, linking it to a primary care registry for work documentation and monitoring, team building with training programmes addressing all team members, improved community engagement, and, most importantly, improved systems of referral and continuity of care. Currently, Maldives is in the phase of scaling up, and which has its own challenges.

We observe a few general patterns in the cases examined, including that PHC teams require CHWs (understood as lay workers selected from the community with frequent repeated training), often mid-level care providers (understood as non-physician clinical care providers with capacities for public health functions), and nurses, midwives and medical doctors who may be posted at the most peripheral facility or one phase above. All require training based on good competency gap analysis, but the bigger challenge is to organize good systems of on-the-job mentoring. While this need has been recognized for mid-health professionals, the front-line health workers would benefit from mentoring arrangements. All PHC teams also require systems of medical and specialized support.

All countries have monitoring systems in place, often related to digitalization of data, as well as individual performance records and some system of rewards. The case studies we select in this area are different and notable. The Common Review Mission (India) is a form of monitoring but it differs in being, qualitative, participatory, and systemwide. Its focus is not on the numbers, with relevant numerical data obtained from other sources. Nor is its focus on individual programmes, but rather on the whole health system. The Common Review Mission gives particular attention to processes, that is, how guidelines are implemented in practice and where they require to be modified. While data-based measurements can tell us whether an expected output is being realized, the Common Review Mission is more useful in helping analysis of why there are gaps, and why some districts and states are doing better compared to others. If it is our commitment is to shape health systems as learning adaptive systems, then the Common Review Mission has the potential to be one of the most important tools in that direction. Further, it has to be housed in an institution whose objective is to catalyse internal learning and adaptation (in the case of India, the National Health Systems Resource Centre).

Payment for performance is a highly recommended strategy for change. However, identifying examples that make an impact is difficult. Thailand's Quality of Care Framework is a case apart. It is team based and performance based; the measures of performance are population based and relatively comprehensive; and the indicators are dynamic, locally identified, and cover different accountabilities. One needs to reach a level of system maturity before attempting such an ambitious intervention.

The second thematic area that this collection of case studies covers is urban PHC. Here most countries are seized with similar problems. First is the challenge of service delivery in a context when urban populations have increased out of proportion to urban PHC delivery systems. In most nations, urban private hospitals and general practitioners have grown rapidly. While this creates a perception of plenty there are significant exclusions, there are huge out-of-pocket expenditures, and preventive and promotive care remains unattended to. Population-based preventive care is difficult to establish as – unlike in rural areas – there is no clear service area and fixed target population in a mutual relationship with the primary care team. Expanding primary care infrastructure is a problem due to constraints in acquiring land for this purpose. Public–private partnerships are often projected as the way out, but since the problems are not related to ownership but design, they seldom offer sustainable solutions. The other major challenge before urban health that all countries are grappling

with is how to engage the urban community and how to address the large impact that adverse social determinants make in the urban environment.

While a range of operational examples are present in the South-East Asia Region PHC Forum, we selected two important and recent examples from Bangkok, Thailand, that go beyond dispensary-type care provision to deepening partnerships in urban settings. Bangkok Metropolitan Authority is not under the Ministry of Public Health, but its health care finances draw from the health budget through the NHSO office. Whereas in rural Thailand, and even in most of its urban areas, over 95% of providers are public providers, in Bangkok City, private providers dominate. In this context, there has been a major new effort to contract in pharmacies to fill in the gaps of access. This goes along with contracting in physiotherapists, nursing services and medical doctors. The terms of contracting, the services expected of each and their integration into the larger system are described in the case study. The other related case study, again from Bangkok, discusses how public health volunteers have been introduced and, along with these, an innovative subgroup called digital volunteers whose applicability extends to both urban and rural areas. One function they perform is community mapping and delineation, while another is digital literacy to overcome the digital divide; together, hopefully all these measures will help reach the unreached. The recognition that Bangkok City has a segment of population who are too marginalized to reach routine services, and innovative ways are required to reach this section, should be a learning of particular interest to every metropolis in the Region.

When it comes to intersectoral public health intervention, the progress of Healthy City, Jaffna, Sri Lanka, and the example of Wajo Regency, Indonesia, could inspire us and deepen our understanding of this approach. The Healthy Cities initiative is a WHO initiative being rolled out across the Region, and there are more than 70 cities on the list. Jaffna is an important case study as 13 clear indicators are in place, with baseline readings on all indicators, and clear action points to address the gaps. In Wajo Regency, the interventions are across nine governance areas. Their unique contribution is to make organized and systematic use of the retired and elderly community to improve community engagement to promote access to care and address social determinants while also improving the health of the elderly. The elderly are no longer a burden on the health system but an asset for its strengthening.

In a third thematic area, the South-East Asia Regional PHC Forum set out to capture learning from operational approaches to ensure access to essential medical products, but the material before us makes for a different reading. Most countries report improved supply-side management through digitized inventories. But in addition, three countries – Bangladesh, Sri Lanka and Thailand – report state intervention in the manufacture, procurement and supply chain management of essential drugs and diagnostics as one of their achievements. By themselves these may not be remarkable, but we note that across these countries progress is being made in universal health coverage with relatively low public expenditure on health care as a proportion of GDP. Is there a correlation between this and the fact that almost all the medical supplies in use in the public sector are manufactured or procured by these central agencies? We need to explore this relationship further, but for now we present two of these three as case studies for reflection.

In our fourth and final thematic area on community engagement, we present six case studies – two on local self-government, two on community-level organizations working in alliance with the state, and two where civil society organizations act through advocacy and independent service delivery to promote the adoption of universal and comprehensive approaches to primary health care. We begin with the case study of Nepal where, following the adoption of a new Constitution, the

country went into an accelerated decentralization phase where extensive powers and functions, including all basic health care, were passed onto village and urban units of local self-government. This enabled closure of gaps in infrastructure and human resources, and better quality of local monitoring and support to providers. Systems of measurement of performance against indicators were also incorporated. The challenge faced was that many functions and health services, for technical reasons, could not be decentralized and needed to be organized and delivered at provincial and national levels. This included procurement of equipment and supplies and the delivery of many secondary and tertiary care services. The links between the primary-level care delivered by the facilities under the rural or urban municipality and the higher level of services, where access is facilitated by publicly funded insurance programmes, remain challenging. Technical capacity to support innovation is also a challenge.

In India, the state of Kerala has similar decentralization of health care to local self-governments. This has been in place for over two decades, with a relationship between technical support, financing and local governance that has developed over that period. What is important in successful local governance is putting in place an appropriate set of rules and building capacities for execution. This case study shows how this has led to an innovative and effective approach to deliver palliative care with a high level of community ownership and participation. In the case study from Chhattisgarh, India, the main institution for community engagement is the village health, sanitation and nutrition committee (VHSNC). The objective of the engagement is to ensure effective delivery of all health-related public service entitlements and inclusion of marginalized sections of society. Again, success has depended on bringing together technical support, financing and the framing of appropriate rules.

One of the major purposes of community engagement proposed is ensuring accountability of providers and grievance redressal. In the Thailand case study, we present a system of grievance


Credit: WHO SEARO

redressal and accountability, that is built into the legal framework and implemented through formal institutions of governance working synergistically with community-based civil society organizations. The involvement of the latter ensures that a sense of mutual understanding and solidarity is retained in the process of addressing grievances that otherwise could become adversarial between the community and the providers. The Thai approach also seems to lead to a faster redressal of disputes.

We finally close with two well known examples of civil society action: one of advocacy and another of service delivery to reach the poor. Though these are apparently two very different domains of intervention, in practice most organizations involved in Bangladesh Health Watch are also involved in service delivery. NGO programmes engaged in delivery of health care services, such as Gonoshasthaya Kendra (GK), are sites of innovation and new thinking, which when adopted by policy-makers often lead to substantial improvements in policy and strategy.

Finally, we must not forget that the source for inspiration and conceptualization of the modern PHC movement, through both governmental and NGO experimentation, started from countries of the South-East Asia Region. Through inclusion of the case story of GK, with reference to its founder Dr Zafrullah Chowdhury, we honour the rich history of PHC and health for all in the WHO South-East Asia Region.

CHAPTER 6

Conclusion


Credit: WHO SEARO

This selection of case studies is purposively drawn. It is not meant to be representative of countries or programmes. The case studies, through narrative description ("case stories"), illustrate how some common problems of universalizing comprehensive primary health care can be addressed in the context of low- and lower-middle-income countries. This case study approach is not meant to replace more detailed studies using experimental or quasi-experimental designs or structured sample surveys where required. However, qualitative studies also have an important place in advancing collective learning.

In each of the four thematic areas we have looked for examples where we tell a story of how policy-makers or implementers, when facing a barrier to implementation, evolved an innovative approach to addressing this problem. Necessarily the approach taken was context and path dependent. Tracing this relationship of context–mechanisms–outcomes (C–M–O) and relating it to the programme theory or theory of change is the heart of the realistic evaluation methodology that we used across the case studies. Case studies are part of qualitative methodologies that allow us to collect information about a strategy or institutional reform when data points are far too many and varied for a sampling

approach. It could be combined with quantitative measurements of outcome, but for the most part, the outcomes measured are themselves processes that are better described through a qualitative approach.

We hope that this set of 20 case studies or "case stories" will support the sustained advocacy, political commitment and efforts towards decentralization, and associated systems of learning, that strengthening PHC requires. We also hope that this report helps South-East Asia Region Member States and the broader global community to reflect on the enabling legal mechanisms, institutional structures, policy developments, use of technologies and community engagement that would help them strengthen PHC.

The biggest benefit of this entire exercise, in our view, is the shaping of our health systems as learning adaptive systems. It is not only this set of case studies, but the entire process for their development, that is important. The creation of the South-East Asia Region PHC Forum and its working groups, the work involved in collection of operational examples, the development of case studies, and the follow-up to these case studies, all taken together contribute to the creation of a learning environment. This is an environment where policy-makers and practitioners, researchers and activists all interact and all benefit in the pursuit of our shared objectives of primary health care as the cornerstone for universal health coverage and health for all.

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Annexes

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