Regional Workshop to Strengthen Primary Health Care in the South-East Asia Region, Bangkok, Thailand, 28-30 Nov 2022

Meeting Report
Regional Workshop to Strengthen Primary Health Care in the South-East Asia Region,

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### Abbreviations and Acronyms

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<th>Abbreviation</th>
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<tr>
<td>CHW</td>
<td>Community Health workers</td>
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<tr>
<td>CPHC</td>
<td>Comprehensive Primary Healthcare</td>
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<tr>
<td>DHIS</td>
<td>District Health Information Software</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information Systems</td>
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<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>IPC</td>
<td>Infection prevention and control</td>
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<tr>
<td>NCD</td>
<td>Non-Communicable Diseases</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NQAS</td>
<td>National Quality Assurance Standards</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
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<td>RC</td>
<td>Regional Committee</td>
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<tr>
<td>RCCE</td>
<td>Risk Communication and Community Engagement</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SEAR</td>
<td>South-East Asia Region</td>
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<tr>
<td>SEARO</td>
<td>South-East Asia Regional Office</td>
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<tr>
<td>SOP</td>
<td>Standard operating procedure</td>
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<td>UHC</td>
<td>Universal Health Coverage</td>
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<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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Executive Summary

Primary health care (PHC) is well recognized as the most inclusive, effective and efficient approach to ensure people’s health and wellbeing. Covid-19 and subsequent economic challenges have further emphasized the importance of strengthening PHC-orientation of health systems in the WHO South-East Asia Region (SEAR). Member States in the SEA Region are at various stages of PHC-orientation of their respective health systems. All Member States have expressed commitment to strengthen PHC orientation of health systems in the process of ‘building back better’.¹

In December 2021, responding to Member State request, WHO SEARO and Ministers of Health in the Region together launched the South-East Asia Regional Strategy for Primary Health Care, 2022 – 2030 (“SEAR PHC Strategy”) on UHC Day. Building on lessons learned during Covid-19, the SEAR PHC Strategy elaborates a set of 7 values and 12 inter-dependent strategic actions, to guide, support and monitor PHC-oriented health system transformation in the Region. The SEAR PHC Strategy was developed conscious of significant and intensifying development and implementation partner PHC-specific activity in the Region, with opportunity for greater collaboration and synergy.

Notably, at the 75th South-East Asia Regional Committee, Member States further adopted the Resolution “Enhancing social participation in support of Primary Health Care and Universal Health Coverage” (SEA/RC75/3), which:

¹ RC 74 Declaration by the Health Ministers of Member States at the Seventy-fourth Session of the WHO Regional Committee for South-East Asia on COVID-19 and measures to ‘build back better’ essential health services to achieve universal health coverage and the health-related SDGs.
- **Endorsed the South-East Asia Regional Strategy for Primary Health Care: 2022-2030**

- **Called upon international agencies to provide synergized support to SEAR Member States in their effort to reorient health systems to comprehensive primary health care;**

- **Urged Member States to strengthen national capacities in PHC implementation and monitoring, including through participation in regional knowledge and experience-sharing mechanisms and activities; and**

- **Requested the 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.**

**Regional Workshop to strengthen Primary Health Care in South-East Asia Region**

The Regional PHC workshop was organized as the first PHC-focused, physical meeting since the pandemic. The specific objectives of the Regional PHC Workshop were to:

- Share progress and challenges in PHC-orientation, including with respect to delivering essential service packages, across SEAR countries;

- Identify and refine Regional PHC Monitoring Indicators and approach;

- Launch the regional knowledge and experience sharing mechanism, with sharing of operational learning from Member States and partners; and

- Identify priority action to advance national PHC-orientation and specific areas of technical support from WHO and partners, including through operationalizing the South-East Asia Regional Strategy for Primary Health Care: 2022-2023 and SEAR PHC Forum.
Over a hundred participants actively participated during the three-day workshop. The participants included Member State representatives from 9 SEA Region countries\(^2\), including executive level policy makers, PHC directors, and directors at provincial and district level. The meeting also included senior representatives from key PHC related partners active in the Region, including bilateral partners, international agencies, international financing institutions, philanthropies, implementing agencies, academic institutions, and members of civil society organizations. (See Annexure A- Agenda; Annexure B- List of Participants).

The Regional PHC workshop facilitated interaction across meeting participants, enabling knowledge exchange on operational level challenges and solutions to address key PHC-related bottlenecks. The Regional PHC workshop also saw the collective launch of the SEA Regional PHC Forum (See Annexure C- TOR SEAR PHC Forum); and enabled a site visit to view the District Health System in operation in Bang Pa-in District, Thailand.

The Regional Workshop was formally opened by the WHO Representative, Thailand; Director General, Health Service Support Department, Ministry of Public Health, Thailand and Director UHC/Health System, with opening remarks on behalf of the WHO SEARO Regional Director. All the inaugural speakers emphasized the need and relevance of PHC oriented health systems to advance UHC, health security, and the health-related SDGs (See Annexure D, for WHO SEARO Regional Director, Opening Remarks).

\(^2\) Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand, Timor -Leste.
A major focus on the first day of the Regional PHC Workshop was presentation by all Member States on their national priorities/direction, areas of demand for support and areas of support to others based on a pre-shared template under the Market Place Session (Member State presentations are available through the SEAR PHC Forum website, SEAR-PHC-Forum (sharepoint.com)). This was followed by a plenary discussion, with matching of need and availability of operational support (See Table I: Member State Market Place: Matching Request for Demand with Available Support).

The other key emphasis on the first day was an intensive discussion on monitoring PHC-orientation and performance, including the principles to guide the selection of indicators and capacities to both collect and use utilize information. The participants were split into three working groups to discuss specific domains, importance of PHC monitoring and strengthening of country level capacities in this area was highlighted across countries and meeting participants, with agreement to work collectively as part of the SEAR PHC Forum.

Building on the first day’s discussions, a World Café and plenary discussions were held in the following identified priority areas: Human Resource for Health, Urban PHC, Quality in PHC, and Governance, with focus on community engagement and empowerment. The World Café facilitated open discussion, with meeting participants sharing initiatives, challenges, and recommendations for priority areas under these four themes.

The second day of the Regional PHC Workshop also saw the formal launch of the SEA Regional PHC Forum for PHC-Oriented Health Systems (“SEAR PHC Forum”) with a strong commitment from Member States and Partners to co-create a regional knowledge and experience-sharing mechanism. Reflections and interests of SEAR member states and partners as well as the way forward for the SEAR PHC forum were discussed. Based on the themes developed during the world café and the
discussions held thereafter, seven potential thematic groups were formed for action through the mechanism of the SEAR PHC Forum. The identified thematic groups are as follows:

- PHC workforce; Urban PHC; PHC Quality, with focus on medical products; Community engagement; PHC monitoring; PHC Service delivery; and PHC investment case.

Participants volunteered themselves to the various thematic working groups, including in lead capacity and agreed to collectively capture operational learning in the thematic areas. Participants also discussed the need for messaging from the thematic working group, and especially for the PHC investment case, that resonates at the political level and with senior policy makers. The timeline for the SEAR PHC Forum and thematic working groups was shared, with government representatives from Sri Lanka putting themselves forward to host a planned follow up meeting of the SEAR PHC Forum in Q4 2023 in Sri Lanka.

The Regional PHC Workshop was also notable in facilitating organization of informal bilateral meetings across meeting participants, based upon potential areas of innovation and support: i.e., Indonesia learning from the Thailand PHC Act, India’s CHW programme.

The workshop concluded with a study visit by participants to Bank Pa-in District Site Visit, Ayutthaya Province, Sub-district hospital visits and home visits. The field visit gave the participants a first-hand exposure and learning experience as to how Thailand manages PHC at the District and Sub-District level and the role of all stakeholders in the PHC landscape of the country. The workshop was formally closed by the Director, UHC/Health System WHO SEARO at Bang Pa-In Palace.
The following areas of action were agreed:

1. SEAR PHC Forum partners to jointly support development of **Thematic Working Group papers** that capture operational and potentially undocumented experience/learning of identified priorities, with relevance for other SEAR countries, with the aim of finalizing by October 2023, including both virtual and physical convening.

2. WHO SEARO and partners to strengthen the **SEAR PHC Forum coordination website** to enable knowledge exchange and collaboration across Member States focal points and partners on identified areas.

3. SEAR PHC Forum partners to jointly support development of a **Regional PHC monitoring approach**, including core and progressive indicators, and required capacities for strengthening PHC measurement and utilization with focus on strengthening performance, accountability and supporting advocacy.
Introduction

Primary health care (PHC) is well recognized as the most inclusive, effective and efficient approach to ensure people’s health and wellbeing. Covid-19 and subsequent economic challenges have further emphasized the importance of strengthening PHC-orientation of health systems in the WHO South-East Asia Region (SEAR).

At the SEAR level, substantial deliberations have taken place on lessons learnt from the pandemic and opportunity to “build back better”. At the 74th session of the WHO Regional Committee for South-East Asia in 2021, the Ministers of Health of the Region committed to reorient health system towards PHC to achieve UHC, the health-related SDGs and health security. Moreover, they underlined in the Ministerial Declaration “the imperative and a once-in-a-century opportunity” to advance transformation toward resilient primary health care-oriented health systems in the Region.

In December 2021, responding to Member State request, WHO SEARO and Ministers of Health in the Region together launched the South-East Asia Regional Strategy for Primary Health Care, 2022 – 2030 (“SEAR PHC Strategy”) on UHC Day. Building on lessons learned during Covid-19, the SEAR PHC Strategy elaborates a set of 7 values and 12 inter-dependent strategic actions, to guide, support and monitor PHC-oriented health system transformation in the Region. The SEAR PHC Strategy was developed conscious of significant and intensifying development and implementation partner PHC-specific activity in the Region, with opportunity for greater collaboration and synergy.

Notably, at the 75th South-East Asia Regional Committee, Member States adopted the Resolution “Enhancing social participation in support of Primary Health Care and Universal Health Coverage” (SEA/RC75/3), which:
• **Endorsed the South-East Asia Regional Strategy for Primary Health Care: 2022-2030**

• **Called upon international agencies to provide synergized support to SEAR Member States in their effort to reorient health systems to comprehensive primary health care;**

• **Urged Member States to strengthen national capacities in PHC implementation and monitoring, including through participation in regional knowledge and experience-sharing mechanisms and activities; and**

• **Requested the 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.**

To help operationalize the SEAR PHC Strategy, in March 2022, WHO had convened a two-day virtual regional meeting at which participants similarly recognized the need to systematically capture implementation-related learning and innovation and achieve greater synergy in partner support.

In this backdrop, the Regional PHC workshop was the first physical meeting on PHC to bring together key stakeholders to discuss, debate and take joint actions to drive PHC oriented transformation of health systems. The 'Regional PHC Workshop', brought together over a hundred participants, including senior level policy makers from Member States, as well as key academic, development and implementation partners in the Region. The three-day inter-active workshop enabled discussion on specific PHC-related bottlenecks and examples of operational initiatives to overcome these barriers. The Regional PHC Workshop also saw launch of the SEA Regional PHC Forum for PHC-Oriented Health Systems (“SEAR PHC Forum”), as requested by 75th RC, with strong commitment from Member States and Partners to engage in a regional knowledge and experience-sharing mechanism.
Following country presentations, areas of Member State demand for support and areas where Member States innovations/initiatives could benefit others were mapped to guide cross-learning and priorities of the SEAR PHC Forum.

World Café and Plenary discussion were held in the following identified priority areas: Human Resource for Health, Urban PHC, Quality in PHC, and Governance, with focus on community engagement and empowerment. Following further discussion, and as part of the launch of the SEAR PHC Forum, 7 thematic working groups, and associated immersion questions, were prioritized for the capture of operational and implementation-focused learning. The meeting further enabled operational learning for meeting participants through organization of site visit to Ba Pa-in District and learning from Thailand’s operation of its’ District Health System.

The Regional PHC Workshop, including launch of SEAR PHC Forum, seeks to support the region to both capture “tacit” implementation-focused learning in the Region and strengthen synergy in our action.
Objectives

General Objective:

To advance progress in reorientation of health system toward stronger primary health care in SEAR, including through launch of the South-East Asia Regional Partners Forum for PHC.

The specific objectives of the workshop were:

1. Share progress and challenges in PHC-orientation, including with respect to delivering essential service packages, across SEAR countries;

2. Identify and refine Regional PHC Monitoring Indicators and approach;

3. Launch the regional knowledge and experience sharing mechanism, with sharing of operational learning from Member States and partners; and

4. Identify priority action to advance national PHC-orientation and specific areas of technical support from WHO and partners, including through operationalizing the South-East Asia Regional Strategy for Primary Health Care: 2022-2023 and SEAR PHC Forum.
Discussions and Key Deliberations

The Regional Workshop to strengthen PHC in SEAR was formally opened by the WHO Representative, Thailand; Director General, Health Service Support Department, Ministry of Public Health, Thailand and Director UHC/Health System WHO SEARO, who presented remarks on behalf of the Regional Director. All the inaugural speakers emphasised the need and relevance of PHC-oriented health systems to accomplish UHC, health security, and the health-related SDG targets by 2030.

The Director General, Health Service Support Department, Ministry of Public Health, Thailand discussed the Thailand PHC model and how the Village Volunteers played a key role during COVID-19 as the torch bearers of primary health care. The WHO Representative, Thailand discussed that while the “Why and What” of strengthening Primary Health Care is well recognized; it is the “How” that requires greater focus. He underlined the need of ‘collective energies’ for supporting member states in their PHC priorities. He also highlighted and appreciated the unprecedented energy, innovation, and cooperation shown by member states at the time of crisis during COVID-19. The Director UHC/Health System WHO SEARO gave the opening remarks welcoming the participants on behalf of the Regional Director and elucidated on the key four objectives of the workshop. He also emphasised that the region recognizes PHC as the most cost effective and equitable approach to meet the many health challenges of today as well as well as tomorrow and to ensure that the PHC oriented transformation to happen in a co-ordinated way aligned with national priorities avoiding duplication and fragmentation and in a manner that maximizes impact.

The keynote address was given by Deputy Secretary General, National Health Security Office, Thailand on ‘Thailand experience in UHC and Investment for Primary Health Care’. She put forth that Thailand’s journey towards UHC was a result of long-standing investment in health system focusing on PHC led by the Ministry of Public Health, Thailand. The adoption an innovative Human Resource Strategy which
includes local recruitment, local training and placement helped retention of health workforce in Thailand. The re-orientation towards family health care approach, motivation through financial and non-financial incentives such as social recognition and enhanced working and living environment of the workforce were key elements in strengthening PHC oriented systems in Thailand. The Senior Advisor (PHC), WHO Head Quarters (on behalf of Director, PHC Special Programme, WHO HQ) spoke on ‘Health system reorientation toward Primary Health Care: A global perspective’. He discussed that currently there exists a window of opportunity to strengthen PHC than ever before due to commitment from all stakeholders and the increase in investment, technical partnerships, and joint research endeavors from WHO in strengthening the PHC scenario across countries is bringing out tangible outcomes.
Regional Workshop to strengthen PHC in the SEAR: Meeting Report
The workshop then progressed with the Regional Advisor, HRH, WHO SEARO setting up the context and background for the workshop. He highlighted about the challenges faced by the SEAR countries which widened the inequity in the region. He specifically mentioned about the World Bank Report, 2022 which cited the current economic situation in the region as the ‘biggest reversal of poverty’ since World War II. In this context, he urged the participants the need for reconceptualization and operationalisation of PHC in SEAR context with multi-stakeholder engagement. This was succeeded by the Coordinator, Integrated Health systems, WHO SEARO laying the objectives, meeting protocols and expectations of the workshop and an introduction to the segment of Market Place.
The major focus on the first day was presentation by all member states on their national priorities/ direction, areas of demand for support and areas of support to others based on a pre-shared template under the Market Place Session. The Market Place started with presentation from Sri Lanka wherein they described the ‘Policy on Healthcare Delivery for UHC (2018), placing of family physicians in apex hospitals to look after the OPD facilities and enabling continuum of care for chronic diseases, designating nearest hospital as 'best hospital' and the revision of essential packages post COVID-19. The areas they demand for support includes 'make PHC attractive to patients', tools and mechanisms to strengthen community support systems and leveraging digital technologies. Sri Lanka also acknowledged the efforts by USAID for supporting with telemedicine equipment and informed about their plan to establish a Human Health Record Management System all over the country including the primary care set up. The areas they put forth that could benefit other countries include Integration of Non-Communicable Diseases, Institutionalize and Strengthen Learning Health Systems and decentralisation reforms through District Health System. Sri Lanka also has briefed their plan to consider Public-Private Partnership (PPP) in PHC. Sri Lanka is also trying to study best practise in community engagement since they considered that as an area of challenge in their PHC system.
India shared progress on the ‘Ayushman Bharat’ Health and Wellness Centers (HWC) initiative. India also spoke to embarking on an ambitious target of achieving 50% compliance of all public health facilities to India Public Health Standards and 50% facilities for National Quality Accreditation Standards compliance. Representative from government of India informed that they are spending 54% of their health budget for PHC against the target of 67%. They discussed refinements post-COVID, which includes decentralised planning, allocation and implementation of health grants through the 15th Finance Commission through local governments, strengthening public health infrastructure including PHC, diagnostic services network with Integrated Public Health laboratories and setting up of critical care blocks in all districts and creation of Ayushman Bharat Digital Mission (ABDM) wherein every citizen of country is to have a unique health ID. The areas of demand for support as informed by India include integration of NCDs with strategies to improve tracking of treatment adherence for NCDs in rural & urban areas, technical guidance to improve interoperability of various IT portals, ensuring continuum of care across all tiers of public healthcare and capacity building of PHC workforce teams on new packages under PHC and improvement of quality-of-service delivery. The areas they put forth that could benefit other countries include their model of community based PHC
based on the culture of wellness and holistic well-being, tele-medicine program and the India Hypertension Control Initiative (IHCI) which received the UN Inter Agency Task Force on the Prevention and Control of NCDs. India briefed on the challenges they are facing after provision of funds directly to urban and rural local bodies and emphasised the importance of further capacity building in this regard to the local body staff since they are dealing healthcare for the first time. India discussed on the importance of having a unique ID for ensuring continuum of care with both forward and backward linkages and emphasised on having minimum variables to be collected by the field staff for ensuring sustainability of the portals from their experiential learning.

The Thailand team started with explaining their PHC system and health service reform under the Primary Health System Act 2019. The areas of demand for support include building capacity for health management of provincial administrative organization, training course for family doctor and team to learn about the experience of other countries and accreditation of primary care unit for strengthening quality of PHC. The areas they put forth that could benefit other countries include training course for the Village Health Volunteers (VHV), PHC
financing through the Universal Coverage Scheme and their innovative Urban PHC models.

Bhutan shared development related to health governance transformation, revision of National health Policy, formulation of National Health Bill, digitization efforts and strengthening critical health infrastructure going on in the country. The areas of demand for support include enhanced financial assistance particularly to the health and social sectors, Innovative strategies to sustain healthcare financing, Innovative Financial Protection Strategies to strike a realistic and logical balance between public and private spending, Performance Payment for HRH to realize PHC aspirations. The three key operational actions or innovations that have enabled advancement of PHC at national / subnational level; and would benefit others in the region include ‘the Principles of State Policy as mentioned in the Constitution of the kingdom of Bhutan, Bhutan Health Trust Fund and Strong auditing and anti-corruption regulations and institutions across the public sector. Bhutan also informed that they would like to learn about how they can successfully introduce performance-based incentives from neighbouring countries in the best sustainable way. Bhutan also requested WHO and other partners to re-start the FETP scholarship and other
fellowships which could help public health professionals from the country to build capacity among young health workforce.

Bangladesh initiated the presentation by mentioning the major milestones they have achieved in the last five decades in health sector. The areas of demand for support include strengthening PHC in Urban area, developing regulations around provision of PHCs through private sector, strengthening public health facilities infrastructure, HR, medicines, and diagnostic services and effective gate keeping mechanisms, collaboration with countries that successfully strengthened HR capacity at the primary level of health system and rural retention, advocacy for increasing resource allocation to primary health care, health promotion, disease prevention and strengthen capacity of Community Health Workforce through innovative technologies, upgrade their skillset and incentive for motivation. The key operational actions or innovations that have enabled advancement of PHC for the country include launch of Community Clinics to provide PHC at community level in hard-to-reach area through a Community Health Care Provider (CHCP) after 12 week’s training, DHIS-2 based continuous monitoring for ensuring Essential Health Services.
Nepal started the presentation with the recent policy changes in health sector which include Public Health Service Act 2018 and Regulation 2020, Right to Safe Motherhood and Reproductive Health Act 2018 and Regulation 2020, National Health Policy 2019, National Health Sector Strategy (2015-2020) and 15th five-year plan (2019/20-2023/24). The Government’s commitment towards the plan to expand primary hospital at each municipality and basic health centre at ward level, implementation of Standard treatment protocols and guidelines across all national public health programs for quality assurance and setting ‘Minimum service standards’ of health care facilities to deliver quality health services and ranking of facilities based on that are some current national priorities of Nepal. Nepal also mentioned about deployment of more than 50,000 female community health volunteers for serving national public health priorities programs to the remote and vulnerable community. One of the major refinement from policy level post COVID-19 is the ‘Nepal Health Sector Strategy (2022-2030)’ that has been developed to address emerging health needs post – pandemic. The three areas of demand requested by Nepal include application of innovative strategies and tools to address urban needs and referral mechanism, Investment for PHC Workforce with motivational/incentive
package and sustainable technical / financial strategies to ensure accessibility of affordable quality health services as per constitutional mandate. The areas of support to others as mentioned by Nepal include implementation of Minimum Service Standards across health care facilities to ensure readiness of quality health care service delivery, mobilization of Female Community Health Volunteers and mothers’ groups for National Public Health Priorities Programs to advance primary health care and the political will and commitment to advance PHC as envisaged by Constitution of Nepal.

Timor-Leste initiated by mentioning the door-step health services through the re-vitalized ‘Family Health Program’ (Saude-na-Familia) and the Essential Service Packages which got revised latest in 2022. As post COVID refinement strategy, Timor made transformational strengthening of critical care services (in secondary care) including emergency services. The areas of demand support as mentioned by Timor include In-service mechanisms to improve practical skills of health workers; improved procurement to prevent stock-outs; bio-medical (and diagnostic) maintenance, learning from successful approaches to strengthen public health management capacities for health managers and from successful countries for strengthening the CHW program. The areas of support to others as briefed by the country include
openness for learning from good practices in other countries, integration across disease programs and strong PHC workforce team (with one medical doctor, 2 Nurses, one mid wife and one health volunteer). Timor also spoke to 9 areas of integration with 54 selected indicators.

Maldives initiated the discussion with explaining the national policy which mentions on provision of access to affordable, all-inclusive and quality health care services to all its citizens. Maldives also mentioned on the new primary healthcare specialist program for doctors in collaboration with Royal College of General Practitioners International - South Asia. The areas of demand for support required include capacity development at individual, institutional and system level, tools and equipment for the lifestyle modification and strengthening PHC in urban setting. The areas of support to others as briefed by the country include establishment of pharmacies in the island through outsourcing of medical supplies and consumables, sample transfer mechanism operated through ferry, establishment of telemedicine, drone base transfer of medicines and samples and the ‘Asandha Insurance scheme’. Maldives also mentioned that all their resorts also have a clinic with a medical doctor and nurse as mandatory requirement. During the discussions, it was highlighted that Maldives were able to bring down the household expenditure from about 50% about
10 years to almost 10% now. Two of the challenges raised by Maldives was about the trade-off between primary care and tertiary care, wherein most of the tertiary care is being provided outside the country and 70% of their healthcare professionals being expatriates.

Indonesia started by explaining the 2020 – 2024 ‘National Medium Term Development Plan for improving health services towards UHC, with emphasis in strengthening PHC through encouraging promotive and preventive efforts, supported by innovation and technology utilization. Indonesia also set the ‘Minimum service standard’ by ministry of home affairs with 12 indicators to ensure every individual received standard essentials health services. Another important policy is about financing support from the central government to district through special fund allocation to fill the financing gap of implementing PHC. As refinements post pandemic, the country pursued into Health System Transformation through 6 transformation pillars including most importantly PHC transformation. Indonesia is also set stage to revise their health law and the ministerial decree for PHC as well as reorienting the model of care from program-based service delivery in PHC to life cycle approach including mental health. The areas of support which was put forth by the country include how to institutionalise community health workforce, Policy,
implementation and financing system on community based mental health service and de-institutionalization, engagement of private health services, technical support for establishing a public health laboratory system, learning management and delivery system for PHC workforce and exchange from other countries on health promotion/education strategy (including at school and work setting). The areas of support as discussed by Indonesia include structure and approach of community engagement and empowerment, expansion and implementation of assured set of services by life cycle and Integrated service delivery system at the Primary Health Centre (Puskesmas) which is currently being piloted.

WHO country office staff in Myanmar followed by sharing key priorities of the Ministry of Health, including the new National Health Insurance Law (UHC) to be developed by Ministry of Health for financial protection and accessible to quality health care as well as the review and development of the HRH strategic plan 2023-27. to be developed.
Following country presentations, the collective lessons learned under areas of Member State demand for support and areas where Member States innovations/initiatives could benefit others were mapped to guide cross-learning and priorities of the SEAR PHC Forum (Table I).
### Table I: Member State Market Place: Matching Request for Demand with Available Support

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<th>Priority area requested by Member State for Support</th>
<th>Member State identified area of potential support to others</th>
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<tr>
<td>Capacity</td>
<td>Scholarship</td>
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<td>Motivation-retention</td>
<td>Performance</td>
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<td>Distribution</td>
<td>Performance</td>
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<td>CHWs</td>
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<td>Intersectoral collaboration (private, NGO)</td>
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<td>Commitment</td>
<td>Migrant issues</td>
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<td>Governance</td>
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<td>community engagement</td>
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<td>Decentralization</td>
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<td>minimum standard</td>
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<td>Health in All</td>
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<td>anti-corruption</td>
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<td>Health Financing</td>
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<td>Investment</td>
<td>graduation</td>
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<td>Innovative financing</td>
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<td>Health Information systems</td>
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<td>Digital transformation</td>
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<td>Interoperability of platform</td>
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<td>use of information</td>
<td>learning</td>
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<td>Research</td>
<td>Learning</td>
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<td>Research</td>
<td>learning</td>
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<td>Specific areas</td>
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<td>community clinic model</td>
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<td>Hypertension Model</td>
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<td>Continuum of care</td>
<td>gatekeeping</td>
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<td>Health promotion-Wellness</td>
<td>life course</td>
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<td>Urban PHC</td>
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<td>Trust /Utilization</td>
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<td>quality</td>
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<td>integration (NCD, etc.)</td>
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<td>Mental Health</td>
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<td>Medicines and diagnostics</td>
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The other key emphasis on the first day was an intensive discussion on monitoring PHC-orientation and performance, including on the principles to guide selection of indicator, capacities required and regarding the core indicators to prioritise. The session started with Dr Viroj Tangcharoensathien, Secretary General of International Health Policy Program (IHPP), giving a detailed presentation on PHC performance monitoring indicators especially under 4 areas for monitoring (Governance, Inputs, Processes, outcomes). The indicator list as suggested by him is given below in Table II.

Table II: PHC Performance monitoring indicators

<table>
<thead>
<tr>
<th>AREAS FOR MONITORING</th>
<th>INDICATORS</th>
<th>SOURCES OF DATA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOVERNANCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governance</td>
<td>1. Multi sectoral collaboration and community engagement</td>
<td>• Health facility survey</td>
</tr>
<tr>
<td>Information</td>
<td>2. Percent PHC having functioning health and management information system</td>
<td>• Health facility survey</td>
</tr>
<tr>
<td>system for policy</td>
<td></td>
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</tr>
<tr>
<td><strong>INPUTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHC facilities</td>
<td>3. PHC facility per 100,000 population</td>
<td>• Routine administrative data</td>
</tr>
<tr>
<td>Financing</td>
<td>4. Government PHC spending as % of government health expenditure</td>
<td>• National Health Account</td>
</tr>
<tr>
<td>Health workforce</td>
<td>5. Absenteeism rate, % PHC health workforce</td>
<td>• Unannounced visit⁴</td>
</tr>
<tr>
<td></td>
<td>6. PHC workforce density per 10,000 population (SDG 3.c.1)</td>
<td>• National health workforce account</td>
</tr>
<tr>
<td>Medicines, medical</td>
<td>7. Percent PHC that essential medicines are available (SDG 3.b.3)</td>
<td>• Health facility survey</td>
</tr>
<tr>
<td>supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WASH amenities</td>
<td>8. Percent of PHC that have basic WASH amenities</td>
<td>• Health facility survey</td>
</tr>
<tr>
<td><strong>PROCESSES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHC functions</td>
<td>9. Level of implementation: a) Service provision, b) Multisectoral actions for health, c) Community empowerment</td>
<td>• Health facility survey</td>
</tr>
<tr>
<td>defined by Astana</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHC service provision</td>
<td>10. Service mixed provided by PHC, including public health function</td>
<td>• Health facility survey</td>
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### Regional Workshop to strengthen PHC in the SEAR: Meeting Report

#### and surveillance of diseases

<table>
<thead>
<tr>
<th>Patient safety</th>
<th>11. Percent of PHC comply with IPC guidelines</th>
<th>• Health facility survey</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OUTCOMES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to PHC</td>
<td>12. PHC visits per capita per year</td>
<td>• National household surveys (Integrate utilization questions)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health workforce</th>
<th>5. Attendance rate, % PHC Health workforce</th>
<th>Unannounced visit</th>
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<tbody>
<tr>
<td>6. PHC workforce density per 10,000 population (SDG 3.c.1)</td>
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<td>PHC service provision</td>
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</table>
The major discussion points raised by the participants after the presentation include:

1. global health security agenda and one health as part of inter sectoral convergence may be added
2. PHC workforce density in urban areas to be decreased
3. PHC visits per capita based on family is a better option than individual
4. Extent in which values like equity, solidarity, participation can be measured as part of PHC monitoring
5. Competency of health workforce (on new guidelines, information etc.) may be added
6. Multi-sector collaboration to be separated from community engagement
7. one health approach may be added as an indicator
8. Source of data: whether all health facilities to be selected or sample data
9. Qualitative aspect of PHC to be measured (eg: quality of HMIS)
10. Per capita visit: whether it indicate access or indicating failure of system in crisis
11. Sub-national and national set of indicators based on member state’s priorities and context

The WHO team then presented a brief introductory presentation to set the context and discussed on the current updates on the PHC measurement. The key considerations which were discussed by the SEARO team include values guiding PHC measurement (bottom-up approach, people centeredness, accountable to communities, making invisible visible and equity aspect, rural vs urban boundary of PHC, public vs private consideration and prioritisation of communities, providers and managers).

The participants were split into three working groups to discuss on the three main domains as mentioned below to come up with solutions / recommendations.

1. Which principles should guide the selection of indicators?
2. Which (core and progressive) indicators to prioritize:
   - to monitor PHC performance; to monitor PHC orientation.
3. Which capacities required to capture and use data?

The first group discussed that there should not be any additional data collection burden on the government in creating the measurement framework and index and the available information in the routine information systems and existing surveys to be used (but no new surveys to be carried out). The other guiding principle put forth by the group was that, the values and principles enshrined in government policies and priorities should reflect in the measurement framework. The values like equity, patient centredness, community participation and perception should come up in the guiding principle and common policies should come out in
this measurement framework. There needs to be a focus on processes and outcomes rather than just inputs and the group also felt that the indicator selection should reflect political commitment. The measurement framework should use data from both public and private sector and the core values in the WHO PHC strategy should be reflected in the measurement. The group also put forth the idea to have a set of core indicators and then an extended set of indicators and finally the group felt to consider local relevance and context as an important guiding principle. The frameworks that are globally relevant may not be hence not nationally relevant and those which are nationally relevant may not be sub nationally relevant- so the best option is to have several levels to construct the measurement framework and indicators- a core set and an extended set. This also reflects to have several levels of aggregation. The group also felt that having a separate monitoring framework and index may not be useful altogether because of fragmentation and hence to use the health systems framework and to insert the relevant PHC indicators within that. The monitoring framework should also reflect the PHC approach which means that there should be focus on preventive and wellness as well along with curative care. During the discussion it was emphasised to have data for indicators and having data elements for integration and to look into the feasibility of selection should also be added as a guiding principle.

The second group discussed based on the 29 selected indicators in the SEAR PHC strategy – discussing that the domains can be core but measurability may be kept optional based on country’s priorities and requirements. The core indicators selected among the 29 set of indicators include:

1. Existence of national health policy oriented to PHC and universal health coverage
2. Government PHC spending as percentage of government health expenditure
3. Sources of expenditure on health (and PHC specific)
4. Existence of supportive supervision system
5. Health facility density/ distribution (including primary care)
6. Service package meeting criteria + Percentage of facilities offering services according to national defined service package
7. Outpatient visits
8. Availability of essential medicines
9. Existence of policy, strategy or plan for improvement of quality and safety
10. Availability of basic water, sanitation and hygiene (WASH) amenities
11. Percentage of facilities compliant with infection prevention and control (IPC) measures
12. National e-health strategy
13. Completeness of birth registration and death registration
14. Existence of effective surveillance system and regular system of population-based health surveys
15. Priority setting is informed by data and evidence + Perceived barriers to access (geographical, financial, sociocultural)

The team also discussed that this is a work in progress and based on the stage of maturity of the system, we have to come up with new way of measuring the indicators and then moves into another way of measuring it, understanding the nuances associated with it.

The third group discussed on strengthening existing data systems and need for a focal point for data systems. Capacity to capture and use of data needs to be strengthened, structurization and data standardisation, data flow system and framework, logistics, infrastructure readiness, resolving existing information gaps by inter sector collaboration for inter-operability, unique ID creation, data auditing on regular basis were the other major points discussed by the team. There was an important point discussed on ‘once only data collection’ of line lists and the aggregate numbers should be arrived from the same rather than having multiple
portals of entry for same data sets. The challenges of line listing in full structure and shape was also highlighted during the discussion. The importance of PHC monitoring and strengthening of country capacities in this area, with important role for WHO, was further recognized across countries and meeting participants at the end.
On Second day under the segment of ‘World Café’ four thematic groups were formed among the participants to address four important under each thematic area. The thematic group include Human Resource for Health, Urban PHC, Quality in PHC, and Governance, with focus on community engagement and empowerment. The World Café brought in rich discussions and each group shared a variety of initiatives, challenges, and priority areas under the theme in addition to specific recommendations in each of the topic areas.

The first thematic presentation was on addressing two questions - ‘how to ensure quality in PHC’ and how to measure quality in PHC. The group discussed on focusing on the structural elements and ensuring the basics of quality at first which include adequate health workforce, diagnostics, devices, data, before going into the other aspects of quality. In terms of measuring quality, the team discussed on standards, guidelines, SOPs etc. but to measure those factors the team emphasised on the feedback from the communities themselves. The team then discussed on defining quality parameters from providers and users perspectives:
Providers:

- Clinical standard, skill development and technical capacity, system support.
- Think quality is finding fault in them- culture of quality/accountability

Users:

- timeliness, cleanliness, friendliness, integrity and honesty, safety, availability of diagnostics facilities /willingness to provide service with care and compassion

The team discussed on giving equal priority to process and outcome indicators other than structural. The major steps /processes as discussed by the team for ensuring quality include:

- Accreditation/licensing
- Monitoring and supervision
- Effective and relevant trainings
- standard setting, guidelines, SOPs/clinical protocols /policies
- Establish flexible mechanism to set context specific interim quality standards to address quality in hard-to-reach areas.
- Ensure continuous quality assurance/ patient safety/IPC through frequent facility assessment and evaluation systems.
- Ensure accountability/regulation-by internal and external independent bodies to address corruption/absenteeism
- Use of digital tools to monitor quality/structure
- Matrix of Quality Indicators including the outcome/timeliness
- Social audit to measure community satisfaction
- Buildup competencies and establish Clint feedback systems
- Adequate/complete and quality health information.
- Institute motivation systems to empower service provider and facility performance
- Strengthen clinical governance/clinical audit: report adverse events and readmissions
- Citizen’s charter- rights for service and feedback
- Avoid blame culture and respond – principle of “DO NO HARM”
- Pay for performance to meet target quality indicators
- Ensure standards for specific inputs such as HR/HF/Medicine’s/HIMS/ community engagement both in service delivery and setting service standards.
- Financing and HR for PHC: resource allocation for PHC, including emergency services in PHC
- Paradigm shift- move away from service delivery and the facility-based standards towards community need and expectations
- Supportive policy/political commitment/ leadership/ technical capacity to invest and drive the quality agenda in PHC

In the discussions, it was suggested to classify the quality parameters into input, outcome and process based and the region can put up a minimum standard benchmark and allow the individual country to put up their own country specific targets. Rather than inputs alone, quality was discussed to be seen as a function of ‘behaviour change’. There was also a brief discussion on a research paper recently published, which mentions that two-third of all the diagnosis in PHC are wrong and among them 98% of the time the management which we provide is not aligned with the standard treatment guidelines.

The second world café discussion was on Urban PHC and the thematic question was on how to build robust PHC for urban settings. The need to have a detailed situation analysis (SWOT) to understand the of urban PHC more holistically and then to create an investment case for urban PHC is the first and foremost aspect
in case of Urban PHC strengthening as discussed by the group. The group discussed that different urban settings would have different kinds of regulations. There needs to be effective linkage on intergovernmental coordination between local bodies, provincial and national government. The team also discussed on need to have a regulatory body to regulate private hospitals and pharmacies in the urban sector and needs to have partners coordination towards PHC and strengthening gate keeping role through GP contracting, engaging NGO, urban dispensaries. In terms of financing, there was the discussion on inequitable distribution of primary care resources to urban area in comparison to rural area which needs to be addressed. The role of PPP, health insurance for urban population and other innovative financing models for urban settings came up in the discussion by the team. The team suggested to look into the community participation model through a different lens based on the urban context and need for effective BCC strategies to bring in perception change towards urban public health facilities. There needs to be different modalities for outreach and reaching out to marginalized population in urban context. In terms of service delivery, the team discussed to have a defined referral pathway like clinic within hospital, community clinics at ward level, need of unique ID and telemedicine. The equity aspect should be addressed through different pathways and mechanisms in urban settings to address the needs of homeless people, slum population, migrants etc. During the discussions, it was emphasised that the quality of clinical care in urban areas is more important than rural area- not just from ethical point of view but from a practical point of view. The different strata of society in urban area needs also to be included (and not urban poor) when we discuss about urban PHC as well as need for health promotion and prevention in context of Urban PHC was other important thoughts which was discussed. There was also the discission on designing systems where everybody could come and access care but at the same time the needs and demands of the marginalized community to be prioritised more and the system hold itself responsible for that. The accountability
cannot be fixed to the public systems for the entire urban population and denominators for indicators to be selected keeping that context on the background.

The thematic group on ‘Human Resources’ stressed on importance of defining the PHC team as the first modality and cited the ‘Bhutan example’ of having multi-skilled and multi-disciplinary team for PHC and Indonesian example of ‘Family medicine practitioners’ concept’. The demarcation of clear job responsibilities, ethic/value, regulatory mechanism are fundamental for monitoring PHC team performance. The need of team composition, adequacy, competency and multi-skilling were important in building a strong PHC team. The need for enabling engagement with wider group of workers including private, NGOs and the capacities that are needed to built around all sectors was discussed. There was a big discussion around the conflict that is happening within the teams linked to differential in power, responsibility etc. Bhutan gave the example how they assess the organisation, the department and individual together for better performance monitoring. The importance of community monitoring for strengthened PHC team performance was also emphasised by the team and the Tamil Nadu (India) example of Self-Help Group members monitoring PHC performance and the community clinic model of Bangladesh was discussed in this regard. Another important aspect on attraction, retention and motivation of workforce especially in remote areas was discussed and the idea of having a counselling as part of the posting process and trying to reflect the local culture and bringing people from local communities being fundamental to this. The need of adequate financial and Non-financial incentives in retention of workforce was discussed - Compensation (Salary/non-salary); Accommodation, Transport, Fuel, Communication tools are important aspects in this regard. The need for recognition (Team, Individual), Support mechanisms, Career Pathways, supportive monitoring and mentoring are also central for retention and motivation of PHC team. The Tamil Nadu example of ‘Mentor Staff Nurse’ was discussed wherein a trained mentor nurse will visit the facilities and provides hand hold training and mentoring to junior nurses. Training was another important fundamental aspect and need for
simplified digital tools for data collection, decentralised training institutes, self-learning modules were discussed for bringing in effective capacity building across PHC workforce. The Maldives example of having option for ‘work from home’ to do the non-clinical works using digital technology was cited but many of the countries were not in favour for the same in their country’s context. The discussion on Performance based incentives highlighted that it has to be large enough to actually make some difference in decision making. The PBI has to be a reflective of population needs rather than top-down approach and need for creation of evidence and data to support whether the PBI mechanism is actually working or not was also discussed. The threat of overdoing the ASHA workers and adding more work to them in the name of PBI was also discussed during the course of discussion. There was emphasis on taking care of the health of the health workforce and the need for having health insurance schemes for health workforce in NGO and non-public sector as well. The necessity for training PHC workforce to address the need of diverse community like LGBTQ, persons with disabilities was also highlighted. The Director, HSD highlighted the importance of aligning the PBI in a way it influences the behaviour of the provider.

The fourth thematic group discussed on ‘How to promote community engagement, empowerment and accountability in strengthening PHC’. The initial point was how the tripartite relation between population, Government and providers can be strengthened and made accountable to each other. The group also discussed on importance of community mobilization and ownership as part of community engagement and empowerment, role of both public and private sectors in partnering and strengthening community but with vigilant in the role of private sector in governance. The next point was on regular advocacy and lobbying on the policy dialogue to the policy makers as well as with the local governments so that they can internalize community participation in the true sense. The team then discussed on the dynamics between rural versus urban community, homogenous groups versus heterogenous and the equity lens through which we should look into the community
participation. The need of decentralisation, considering geography, local contexts, culture etc. were also highlighted by the thematic group. The various existing networks of community engagement like community support groups, mother support groups, SHG, faith groups and the mechanisms like public hearing, social audits and strengthening health facility management committees were discussed as measures to strengthen community engagement. The group discussed need of placing legal perspective for community engagement to ensure that it happens in right sense and need for independent audit mechanism. The importance of cross learnings and sharing from different countries and contexts and not having a single blanket approach was highlighted. The need to simplify procedures which turns out be the barriers and need for two-way traffic (oriented, informed, engaged) and importance of multi-sector approach was also deliberated by the group. Indonesia cited the example to go beyond community engagement to planning, designing, documenting through a bottom-up mechanism. Other points discussed were linkage of community volunteers with service provider and community, accountability mechanisms, transparency, responsibility, trust and need for digitization to strengthen community engagement. During the discussion it was highlighted the importance of a community person within the accountability setting and need for community in planning, monitoring and taking ownership, community oriented pre-service training.
The second half of the second day started with the launch of the SEAR PHC Forum to drive PHC-oriented transformation of health systems through implementation-focused knowledge management and synergized support for achievement of the SDGs. The establishment of the SEAR PHC Forum as the outcome of the conference will bring in focus on strengthening implementation-related learning, synergy, and action among the member states. The SEAR PHC Forum aims to identify and facilitate translation of high-impact and scalable solutions on areas of expressed need by SEAR Member States, as guided by implementation-related learning and context-relevant research and advance joint and/or strengthened synergy of partner programmatic activities and greater regional collaboration in support of identified national health priorities; and enable joint advocacy for strengthened Primary Health Care Investment in the Region. The SEAR PHC Forum will also leverage operational learning from relevant knowledge platforms, including the World Bank’s Joint Learning Network for UHC and the Access Health/Rockefeller Foundation’s Global Learning Collaborative for Health System Resilience, and through the WHO PHC Implementation Solutions initiatives.
The major principles laid down by the forum include National governments being in the lead and Representatives from ministries of health, through participation in the Advisory Committee, will guide the overall direction and work of the SEAR PHC Forum. The knowledge management and synergized support will prioritize implementation-focused learning and activity. The SEAR PHC Forum will operate with a flexible and efficient governance system, with aim to facilitate a self-organizing,
self-evolving and self-sustaining forum that adds value to countries and partners. The SEA Region Member State focal points, as nominated through respective Ministries of Health, will play a key role in guiding the overall deliberations of SEA Region PHC Forum and the Advisory Committee will include representatives from SEA Region Member States, WHO, USAID, UNICEF, Asian Development Bank, World Bank, European Investment Bank, Gates Foundation, Global Fund, GAVI, Access Health/Global Learning Collaborative, and representatives of relevant partner institutions. The Advisory Committee will identify thematic areas and leads, as well as support preparation and content of regular convening of the SEAR PHC Forum. The Advisory Committee will, as relevant, also seek to guide and enable joint research, programmatic and advocacy actions in support of national PHC-related priorities. WHO SEARO supported by USAID and JHPIEGO, and other interested partners, will serve as coordination focal points of the SEAR PHC Forum, with responsibility for day to day operation of the Forum as consistent with its’ mandate and as guided by the Advisory Committee. The composition of the coordination group could be modified as per the guidance of the Advisory Committee.

In the next session, during the reflections and interests by SEAR member states and partners, USAID initiated the discussion on need for member state and partners collaboration and a road map in terms gaps in PHC implementation in countries, the actions required and the commitments from each member state, implementing partners and funding partners to achieve the desired outcomes. USAID emphasised that there is no better time than now to accelerate the PHC transformation and the need to sustain the momentum that arose because of the tremendous gaps that came out of the COVID response. The need for cross learning from other countries to build in equity into our systems and how to ensure that we are being responsible to the needs of those who are being served by the system and those that are left behind was also highlighted by USAID.
UNICEF explained how the approach of PHC should be reframed based on new diseases, disease patterns, new technologies etc. In SEAR context, access is not the key issue, but quality is the area that has to be focused on. The importance of PHC in context of zero dose vaccination was also highlighted by UNICEF. The need for putting up more resources and offering quality services under PHC is the key to create public trust as discussed by UNICEF.
Access Health informed about the importance of Government to Government, Public to private and between civil society partnerships for strengthening PHC. The health care provisioning from people’s requirement and perspective, compiling knowledge of various stakeholders, addressing gaps from knowledge to learning and then to implementation or country specific impactful action demands the need for a secretariat (PHC forum) to overall guide and coordinate this with technical partners.

The DG from Indonesia suggests for a stronger participation from the research community in the PHC forum and requested WHO together support from partners to get grants for research in PHC. In response, the Director HSD mentioned about the Lancet Commission on PHC in SEAR doing key research including urban PHC, CHW etc.

The BMGF highlighted the importance of PHC especially in context of the pandemic and the need to look at PHC as a sustainable and effective partnership between people and the health system. They highlighted that as we go into delivery of PHC encompassing services beyond maternity care, the region still has sub national areas which needs emphasis on this aspect and need to learn from the
mistakes of our past as we expand to an effective comprehensive primary health care. The use of digital technology should need a serious examination from the lens of equity and quality of care. There also needs a rethinking in terms of financing and BMGF urged the PHC forum to develop tools to track financing flows, particularly from district to service delivery points where PHC is being offered. The final point by BMGF was importance of multi-sectoral convergence-its enabling factors and barriers as a critical part of PHC.

The representative from India stressed the need for more advocacy wherein more financial resources can be pooled in to convince the political leadership to invest more in PHC. India briefed on the four health working groups created as part of G-20, one among which is PHC strengthening and UHC through digital health. The member state, Bhutan committed on learning and generation of evidence and knowledge for the benefit of all member states in the region.
The People’s Health Movement (PHM) emphasised about the importance of learning from the past successes as well as failures especially in digitization, urban planning etc. The PHM also underlined the need of advocacy and need of capacity building in the non-government side as an important tool in strengthening social participation.

The ADB Representative discussed that the goal of the forum is aligned to the ADB strategy 2030 and mentioned that every country at different stages of UHC is having the same fundamental or foundation which is ‘PHC’. The challenges posed by NCDs and climate change was discussed in context of PHC. ADB also underlined the importance of integrated care, digital technology, private sector, urban PHC, quality and HRH in context of PHC. The Director, HSD also added and acknowledged ADB for the substantial hike in funding in health sector to about 6-10% from 1-2% earlier.

The representative from Sri Lanka explained about the health sector reforms being carried out in PHC settings in the country as well the strategic plan for PHC and assured that this will accelerate the PHC transformation in the country. Sri Lanka requested development partners to help them with costing, advocacy, research and capacity building.
The European Union representative briefly discussed on the formulation of a new global health strategy being developed by them where PHC is kept as the foundation for countries to achieve UHC. The EU also congratulated the SEAR for its PHC strengthening efforts and extended full support to the PHC forum.

The representative from Nepal urged the partners to support them with innovations to cater PHC services in remote and hard to reach areas with digital tools. Nepal also discussed on importance of mental health services as part of PHC and urged support from partners for the same as well. The member State Bangladesh urged support for digital health, NCD surveillance system, health system reforms, national services standard and integration of NCD, CDs in PHC.

PATH briefly mentioned on the work they are doing in PHC implementation in both rural and urban settings in India and the lessons they learned during this course. The role of PATH in helping other countries to co-create national and local interventions in context of NCDs, climate change, AMR, emerging barriers to health equity was also discussed. PATH assured to share their learning from COVID in establishing community-based surveillance systems, deployment of diagnostics, robust vaccine coverage, private sector engagement to other countries in SEA region.
PATH also extended support in sharing their living lab initiative, wherein they use inclusive innovation and human centred design approach to address some of the most intractable challenges in health sector to member states.

JHPIEGO emphasised on sharing of best practises as well as on learnings which has not worked and also urged their support in sharing their learning to all member states. The Lancet PHC consortium team gave a brief introduction of the major topics which they are working under the Lancet series on PHC. The lancet collective discussed on importance of learning from each other and importance of looking into PHC systems for the future health demands.
The final session was on the operational part of the PHC forum. The forum decided to have a workable number of thematic areas to get desired results. Finally, the reflections and interests by SEAR member States and partners as well as the way forward and actions for SEAR PHC forum were discussed. Based on themes developed during the world café as well as the discussions held thereafter seven potential thematic groups were formed with one country taking up position of lead member state and partnering agency taking up the position of co-ordinating partner. This includes: PHC workforce; Urban PHC; PHC Quality, with focus on medical products; Community engagement; PHC monitoring; PHC Service delivery; and PHC investment case. The thematic groups will seek to address specific implementation-focused questions capacity building need, and adaptation and adoption of solutions/technologies, as identified by the Advisory Committee, in support of Member State priorities. There was an elaborate discussion which succeeded with all stakeholders actively giving their inputs.

Maldives stressed upon the importance of political commitment and the importance of evidence-based decision making as a culture that must be accepted within the country at political level. Hence, the advocated the forum to having
working group which can create research or evidences on evidence based policy making and how to promote those in the countries.

The Honorary Chief Scientist and Advisor, Pothikrit Institute of Health Studies discussed on having ‘access to medical products and diagnostic services’ rather than medical products alone and may be club it with the Quality thematic area. The WHO HQ team was mentioning to align the thematic based on WHO Health system building blocks, but not restricting to it and emphasised on ‘model of care’ as an important process. The Director Special Program on PHC discussed that PHC is a political commitment and how citizens need to be empowered to demand for more and better health from elected officials at the time they cast their vote. This is where the community-based organizations, NGOs and Civil society should play the key role in supporting the same. She underlined the importance of bringing health in the major political discourse and as part of the election agenda.

Joint Secretary Policy from India discussed need to address medical products and diagnostics separately and need to have standard list of drugs and diagnostics, to have new models of supply chain management for both drugs and diagnostics, research on point of care diagnostics and health technology evaluation for better faster and more reliable results in diagnostics.

The Timor Leste re-emphasised the importance on advocacy and need for advocating politicians and the need to include that as one thematic area. USAID discussed to bring in EPHF, one health and AMR under one theme which are pressing issue under PHC. The team decided to add that along with service packages at PHC theme. There was discussion to include pre-service education also under PHC workforce theme. The Indonesian team discussed to add role of other sectors and actors and whole of Govt. approach under one theme.

The member from Lancet series emphasised on having representatives from public, other sectors and selected politicians to be part of the forum to have
sustained advocacy strategies. She also advocated to have similar country level PHC forum to carry out these activities at country level. The forum discussed and decided that the lead member state can be a country for better ownership and development partners can be co-ordinating partners and co-leads.

Finally, it was decided that WHO SEAR to support development of Thematic Working Group papers in collaboration with interested Member States and Partners, with aim for finalization by October 2023.

The member states were requested to officially nominate the focal point to WHO SEARO in consultation with the respective Governments. It was decided to have advisory committee meeting at least once in 6 months and thematic groups to meet as appropriate either physically or virtually. The seven thematic groups along with the key immersion question arrived after the deliberations with lead state and co-ordinating members as discussed in the meeting is mentioned in Table III.
### Table III: The Seven Thematic Groups identified during launch of the SEAR PHC Forum: Capturing Operational and Implementation-focused learning in SEAR

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<th>SI No</th>
<th>Thematic Group</th>
<th>Key focus area(s) discussed during the Regional SEAR Workshop</th>
<th>Immersion Question</th>
<th>Lead Member State</th>
<th>Coordinating Partner</th>
<th>Member States and Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PHC workforce</td>
<td>• Defining the PHC team</td>
<td>Select approaches that have optimized performance of PHC workforce teams to address growing and changing population health needs?</td>
<td>Sri Lanka</td>
<td>JHPIEGO</td>
<td>Bangladesh, Bhutan, India, Indonesia, Maldives, Timor-Leste John Hopkins University, PATH, People’s Health Movement (PHM)</td>
</tr>
<tr>
<td>SI No</td>
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<td>2</td>
<td>Urban PHC</td>
<td>• Gate keeping mechanisms for robust urban PHC&lt;br&gt;• Disorganized and fragmented urban PHC with weak referral linkages and community structures&lt;br&gt;• Urban PHC financing Models and investments in Urban PHC&lt;br&gt;• Challenge of convergence across sectors in urban settings&lt;br&gt;• Innovative models for different settings, including use of digital technology, for Urban PHC.&lt;br&gt;• Increasing challenge of boundary across rural, urban and peri urban settings and associated approaches&lt;br&gt;• Presence and appropriate use of private sector</td>
<td>Innovative models (including gatekeeping approach) to support PHC in urban settings in SEAR</td>
<td>India</td>
<td>PATH/USAID</td>
<td>Bangladesh, Bhutan, Thailand, Access Health, Johns Hopkins University</td>
</tr>
<tr>
<td>SI No</td>
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</tbody>
</table>
| 3     | PHC Quality / Medical Products | • Structural elements and ensuring basics of quality  
• Defining quality parameters from Providers and users Perspectives  
• Bridging access and affordability through Quality care at PHC  
• Relation between quality, trust and availability  
• Institutionalizing quality assurance mechanisms from inputs to processes  
• Quality as a function of ‘behaviour change’  
• Access to quality medical products (including medicines, vaccines and diagnostics) as entry door to addressing quality in PHC | What are the national/ sub-national approaches that have strengthened access to and quality of medical products in PHC? (as part of broader quality improvement)?  
Or  
Examples of models and approaches for measuring and strengthening quality improvement in PHC? | Sri Lanka | PATH | Bangladesh, India, Indonesia |
|       |                              |                                                                                                                               |                                                                                   |                  |                      | Access Health, JHPIEGO, Johns Hopkins University |
| 4     | Community Engagement         | • Community Engagement, Mobilization, Empowerment and Accountability- various models and practices  
• Sustained advocacy, political commitment and decentralisation                                                                 | Identification of local models and practises in SEAR member states that have supported Community Engagement, Mobilization, Accountability, Empowerment | Bangladesh | People’s Health Movement (PHM) | Indonesia, Maldives Sri Lanka |
<p>|       |                              |                                                                                                                               |                                                                                   |                  |                      | Access Health, |</p>
<table>
<thead>
<tr>
<th>Sl No</th>
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<th>Coordinating Partner</th>
<th>Member States and Partners</th>
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</thead>
<tbody>
<tr>
<td>5</td>
<td>PHC Monitoring</td>
<td>• Guiding Principles for selection of PHC monitoring&lt;br&gt;• Data and Indicators for Monitoring PHC Performance&lt;br&gt;• Capacities required to capture and use data</td>
<td><strong>Identification of priority indicators (core and progressive) and associated necessary capacities to monitor PHC performance and PHC orientation?</strong></td>
<td>Bhutan</td>
<td>UNICEF</td>
<td>Bangladesh, Nepal, Sri Lanka, Timor-Leste, Johns Hopkins University</td>
</tr>
<tr>
<td>6</td>
<td>PHC Service Delivery</td>
<td>• Multiple priorities that must be addressed through Service delivery models&lt;br&gt;• Building health system resilience through PHC&lt;br&gt;• Integrating Essential Public Health Functions through multi-sectoral</td>
<td><strong>Describe innovative approaches in the organization of referrals to ensure continuity of care across levels of care?</strong></td>
<td>Indonesia</td>
<td>USAID</td>
<td>Bangladesh, India, Sri Lanka, PATH</td>
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<tr>
<td>SI No</td>
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<td>7</td>
<td>PHC Investment</td>
<td>• Importance of developing a PHC investment case&lt;br&gt;• A policy brief for region adapted to the needs of senior policy makers, politicians&lt;br&gt;• Mechanisms to efficiently and equitably allocate, purchase and spend finances to improve access to health services and reduce OOPE (achieve UHC)</td>
<td>What are the key elements and data requirements to build a compelling ‘PHC Investment case’ for SEAR?&lt;br&gt;• Incorporate examples of arguments/evidence that have been successful at national/subnational level.</td>
<td>Thailand</td>
<td>Access Health</td>
<td>Bangladesh, Indonesia, Maldives, Johns Hopkins University</td>
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</table>

Secretariat: WHO SEARO, USAID / JHPIEGO / PATH
Director Health System, WHO SEAR provided a timeline for steps forward to operationalize the SEAR PHC Forum, including advisory group and full SEAR PHC Forum group meetings in 2023. Of note, representative from Government of Sri Lanka volunteered to host the 2\textsuperscript{nd} SEAR PHC Forum Meeting in Sri Lanka in Q4 2023. The Director, Special Program on PHC, WHO HQ closed the meeting by congratulating WHO SEARO to come up with an inclusive platform to discuss PHC based on WHO core values of equity, solidarity and patient centredness and assured all support from the WHO HQ.

The workshop also facilitated Informal Bilateral meetings across Member State policy makers, based upon potential areas of innovation and support, which were of important utility: e.g.: Indonesia learning from Thailand PHC Act; from India CHW programme and medical education regulatory reforms.

The Regional PHC Workshop concluded with a study visit by participants to Bank Pa-in District Site Visit, Ayutthaya Province, Sub-district hospital visits and home visits. The field visit gave the participants first-hand learning experience on how Thailand is managing PHC at the District and Sub-District level and role of all stakeholders in PHC scenario of the country. The workshop was formally closed by Director, UHC/Health System WHO SEARO at Bang Pa-In Palace.
Actions Forward and Road ahead

The following areas of action were agreed:

1. SEAR PHC Forum partners to jointly support development of Thematic Working Group papers that capture operational and potentially undocumented experience/learning of identified priorities, with relevance for other SEAR countries, with the aim of finalizing by October 2023, including both virtual and physical convening.

2. WHO SEARO and partners to strengthen the SEAR PHC Forum coordination website to enable knowledge exchange and collaboration across Member States focal points and partners on identified areas.

3. SEAR PHC Forum partners to jointly support development of a Regional PHC monitoring approach, including core and progressive indicators, and required capacities for strengthening PHC measurement and utilization with focus on strengthening performance, accountability and supporting advocacy.
## Annexure

### Annexure – A: Programme Agenda

#### 28 Nov 2022: Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 – 9:00</td>
<td><strong>Registration and Market Place Set-up</strong></td>
<td>Master of Ceremonies: Dr. Teeranee Techasrivichien, WHO Country Office, Thailand</td>
</tr>
<tr>
<td>9:00 – 9:15</td>
<td><strong>Inaugural Session</strong></td>
<td>• Dr Jos Vandelaer, WHO Representative, Thailand</td>
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<td>• Dr. Sura Wisedsak, Director General, Health Service Support Department, Ministry of Public Health, Thailand</td>
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<td></td>
<td></td>
<td>• Mr Manoj Jhalani, Director UHC/Health System WHO SEARO</td>
</tr>
<tr>
<td>9:15 – 9:45</td>
<td><strong>Keynote speakers</strong></td>
<td>• Dr Lalitaya Kongkam, Deputy Secretary General, National Health Security Office, Thailand</td>
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<td></td>
<td>• Dr Denis Porignon, Senior Adviser (Primary Health Care) on behalf of Director, PHC Special Programme, WHO HQ</td>
</tr>
<tr>
<td>9:45 – 10:00</td>
<td><strong>Healthy break</strong></td>
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<tr>
<td>10:00 – 10:15</td>
<td><strong>Technical and Administrative information</strong></td>
<td>• Mr. Pankaj Bisaria, WHO SEARO</td>
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<td></td>
<td>• Mr. Ibadat Dhillon, WHO SEARO</td>
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<td></td>
<td></td>
<td>• Dr. Thamarangsi Thaksaphon, WHO SEARO</td>
</tr>
<tr>
<td>Time</td>
<td>Topic</td>
<td>Speaker</td>
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<tr>
<td>10:15 – 12:30</td>
<td><strong>Member State Market Place</strong>&lt;br&gt;• National priorities/direction&lt;br&gt;• Areas of Demand for Support&lt;br&gt;• Areas of Support to Others&lt;br&gt;<em>(Based on pre-shared template)</em></td>
<td>• Member State Representatives&lt;br&gt;(Moderated by Dr Thamarangsi Thaksaphon, WHO SEARO)</td>
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<tr>
<td>12:30 – 13:30</td>
<td>Lunch</td>
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<tr>
<td>13:30-14:30</td>
<td><strong>Plenary Discussion on collective lesson learned from Market Place</strong></td>
<td>• Dr Thamarangsi Thaksaphon, WHO SEARO</td>
</tr>
<tr>
<td>14:30 – 17.00 (With working tea)</td>
<td><strong>Monitoring PHC-performance and orientation</strong>&lt;br&gt;• Overview presentation&lt;br&gt;• PHC monitoring for improved performance, Reflection from Thailand and the Region&lt;br&gt;• Plenary discussion on approach, capacities, and indicators.&lt;br&gt;• Working Groups</td>
<td>• Mr. Ibadat Dhillon, <em>WHO SEARO</em> &amp; Dr. Adrjana Rietsema <em>UNICEF ROSA</em>&lt;br&gt;• Dr. Viroj Tangcharoensathien, <em>IHPP, MOPH Thailand</em>&lt;br&gt;(Moderated by Mr Manoj Jhalani, <em>WHO SEARO</em>)</td>
</tr>
<tr>
<td>17:00 – 17:15</td>
<td><strong>Key Takeaways and Wrap Up of Day 1</strong></td>
<td>• Mr Manoj Jhalani, <em>WHO SEARO</em></td>
</tr>
</tbody>
</table>
# Regional Workshop to strengthen PHC in the SEAR: Meeting Report

## 29 Nov 2022: Day 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker</th>
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</thead>
<tbody>
<tr>
<td>9:00 – 9:15</td>
<td>Recap and Introduction to World Café*</td>
<td>Dr Thamarangsi Thaksaphon, WHO SEARO</td>
</tr>
<tr>
<td>9:15 – 11:45</td>
<td>World Café on four Priority Thematic Areas*</td>
<td>Café managers</td>
</tr>
<tr>
<td></td>
<td>• Round I (9.15-9.45)</td>
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<td></td>
<td>• Round II (9.45-10.15)</td>
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<td></td>
<td>• Round III (10.15-10.45)</td>
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<td></td>
<td>• Round IV (11.00-11.30)</td>
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<td></td>
<td>(Coffee &amp; tea break between 10.45-11.00)</td>
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<tr>
<td>11:45 – 12:30</td>
<td>World Café Report back and plenary discussion*</td>
<td>Café Managers</td>
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<tr>
<td></td>
<td>(Moderated by Dr Thamarangsi Thaksaphon, WHO SEARO)</td>
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<tr>
<td>12:30 – 13:30</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>14:30 – 14:45</td>
<td>Overview of the SEAR PHC Forum*</td>
<td>Mr Manoj Jhalani, WHO SEARO</td>
</tr>
<tr>
<td></td>
<td>• Opportunity, Expectations and Timeline</td>
<td></td>
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<tr>
<td>14:45 – 15:00</td>
<td>Launch of the SEAR PHC Forum*</td>
<td>Launch as a group</td>
</tr>
<tr>
<td>15:00 – 16:00</td>
<td>Reflections and Interest from Partners</td>
<td></td>
</tr>
<tr>
<td>16:00 – 17:00</td>
<td>Discussion on the governance, functioning and action of the SEAR PHC forum*</td>
<td>Moderated by Dr Thamarangsi Thaksaphon, WHO SEARO</td>
</tr>
<tr>
<td>17:00 – 17:30</td>
<td>Way forward and Actions for SEAR PHC Forum*</td>
<td>Mr Manoj Jhalani, WHO SEARO</td>
</tr>
</tbody>
</table>

* Denotes availability for virtual participation (link to be shared). Please note that virtual participation will not be possible for the Member State Market Place and District Site Visit.
# 30 Nov 2022: Day 3, District Health System, Bank Pa-in District Site Visit

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>07:00 am</td>
<td>Depart to <strong>Bang Pa-in District</strong> Hospital, Phra Nakhon Sri Ayutthaya Province</td>
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<tr>
<td>7:00 – 09:00</td>
<td><strong>Activities on the bus</strong></td>
<td>• Facilitated by Dr. Wilailuk Wisasa, National Health Security Office, Thailand</td>
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<td>- Overview of the field trip program, and a brief presentation about</td>
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<td></td>
<td>“Managing PHC at the District Health System”</td>
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<td></td>
<td>- Group Discussion</td>
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<tr>
<td>9:00 – 9:30</td>
<td><strong>Arrive at Bang Pa-in Hospital</strong></td>
<td>• Bang Pa-in Director or Ayutthaya Province Chief Medical Office, Ayutthaya Provincial Public Health Office</td>
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<td></td>
<td>- Welcoming speech from Bang Pa-in Director or Ayutthaya Province Chief Medical Office, Ayutthaya Provincial Public Health Office</td>
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<tr>
<td>9:30 – 10:00</td>
<td><strong>Presentation on “Roles of all stakeholders in PHC in District Health System”</strong></td>
<td>• Dr Thapakorn Jitanoon, Director of Bang Pa-In</td>
</tr>
<tr>
<td>10:00 – 11:00</td>
<td><strong>District Hospital tour</strong></td>
<td>• Break out groups</td>
</tr>
<tr>
<td>11:00 – 12:30</td>
<td><strong>Subdistrict Health Promoting Hospital and Home visits</strong></td>
<td>• Break out groups</td>
</tr>
<tr>
<td>12:30 – 13:00</td>
<td><strong>Lunch</strong></td>
<td></td>
</tr>
<tr>
<td>13:00 – 14:00</td>
<td><strong>PHC Regional Workshop Closing at Bang Pa-In Palace</strong></td>
<td>• Mr. Manoj Jhalani, WHO SEARO</td>
</tr>
<tr>
<td>14:00 – 15:30</td>
<td><strong>Study visit Feedback and Site Visit Discussion (on the bus)</strong></td>
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<tr>
<td>15:30</td>
<td><strong>Arrive at Hotel</strong></td>
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</tbody>
</table>
## Annexure – B: List of Participants

### Participants from Member Countries

#### Bangladesh

1. Dr Abdul Alim  
   Assistant Director & Program Manager  
   Planning & Research  
   DGHS, Dhaka, Bangladesh  
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2. Dr. Ashiqur Rahman  
   Deputy Program Manager  
   Upazila Health System Strengthening & Referral System  
   UHC, DGHS, Dhaka, Bangladesh  
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#### Bhutan

3. Mr Singye Dorji  
   District Health Officer  
   Pemagatshel Dzongkhag Administration  
   Ministry of Health  
   Thimphu, Bhutan  
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4. Mr Tandin Dendup  
   Dy. Chief Planning Officer  
   Policy and Planning Division  
   Ministry of Health  
   Thimphu, Bhutan  
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5. Mr Mongal Singh Gurung  
   Sr. Research Officer  
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6. Mr Sangay Thinley  
   Chief HR Officer  
   Human Resource Division  
   Ministry of Health  
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#### India

7. Mr Vishal Chauhan  
   Joint Secretary, National Health Mission  
   Ministry of Health & Family Welfare  
   Government of India  
   New Delhi, India  
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8. Mr Harsh Mangla  
   Director, National Health Mission - I  
   Ministry of Health & Family Welfare  
   Government of India  
   New Delhi, India  
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9. Mr Adwait Kumar Singh  
   Deputy Secretary  
   National Health Mission-IV  
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#### Indonesia

10. Dr Maria Endang Sumiwi, MPH  
    Director General for Public Health  
    Directorate General of Public Health  
    Ministry of Health Republic of Indonesia  
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11. Dr Upik Rukmini, MKM  
    Chief of Clinical Standardization Working Team  
    Directorate of Primary Health Services  
    Ministry of Health Republic of Indonesia  
    Health Policy Agency, Jakarta, Indonesia  
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12. Dr. Rima Damayanti, M.Kes  
Health Administrator  
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13. Dr Febrima Wulan Adriani S,SKM, MPH  
Working Team of Pregnant Women  
Children and Adolescent Behavior  
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14. Dr Devi Senja Ariani, SE, MKM  
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15. Prof. Rizal Demanik  
Deputy for Training, Research and Development of BKKBN  
The National Population and Family Planning Board (BKKBN)  
Jakarta, Indonesia  
Email:

16. Mr Hadrian Marta, S.STP., M.Si  
Health Analyst  
Director of Synchronization of Regional Government Affairs III  
Ministry of Home Affairs  
Jakarta, Indonesia  
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17. Mr Sidayu Ariteja  
Junior Planner  
Directorate of Health and Community Nutrition  
Ministry of National Development Planning (BAPPENAS)  
Jakarta, Indonesia  
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18. Mr Hassan Mohamed  
Deputy Director, Health Protection Agency  
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19. Ms Ramla Wajeeh  
Assistant Director  
Regional and Atoll Health Services Division  
Ministry of Health  
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Email: ramla@health.gov.mv

20. Mr Shuaib Ismail  
Community Health Officer  
F. Atoll Hospital  
Ministry of Health  
Male, Maldives  
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21. Ms Aminath Shadha  
Projects Officer  
Policy Implementation and International Relations Division  
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22. Dr Anup Bastola  
Director (Curative Service Division)  
Department of Health Services (DoHS)  
Ministry of Health and Population  
Kathmandu, Nepal  
Email:

23. Mr Gyan Bahadur Basnet  
Sr Public Health Administrator (Officiating Director)  
Health Directorate Province 1  
Ministry of Health and Population  
Kathmandu, Nepal  
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24. Dr Rabin Khadka  
Officiating Director  
Health Directorate, Karnali Pradesh  
Ministry of Health and Population  
Kathmandu, Nepal  
Email: khadkarabin6000@gmail.com
<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
<th>Email Address</th>
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<tbody>
<tr>
<td>25.</td>
<td>Mr Ravi Kanta Mishra</td>
<td>Senior Public Health Officer</td>
<td>Ministry of Health and Population</td>
<td><a href="mailto:ravimishra2007@gmail.com">ravimishra2007@gmail.com</a></td>
</tr>
<tr>
<td>26.</td>
<td>Mr Baikuntha Raj Regmi</td>
<td>Section Officer</td>
<td>Ministry of Health and Population</td>
<td><a href="mailto:baikuntharaj.reg@gmail.com">baikuntharaj.reg@gmail.com</a></td>
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<td></td>
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<td>Kathmandu, Nepal</td>
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<td>Sri Lanka</td>
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<tr>
<td>27.</td>
<td>Dr G.S.P. Ranasinghe</td>
<td>Director/Primary Health Care</td>
<td>Ministry of Health</td>
<td><a href="mailto:gspr2019@gmail.com">gspr2019@gmail.com</a></td>
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<td></td>
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<td></td>
<td>Colombo, Sri Lanka</td>
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<tr>
<td>28.</td>
<td>Dr. S. Sridharan</td>
<td>Deputy Director General (Planning)</td>
<td>Ministry of Health</td>
<td><a href="mailto:drsri94115@gmail.com">drsri94115@gmail.com</a></td>
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<td>Colombo, Sri Lanka</td>
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<td>29.</td>
<td>Dr Chandima Sirithunga</td>
<td>Provincial Director of Health Services</td>
<td>Ministry of Health</td>
<td><a href="mailto:csiritunga@yahoo.com">csiritunga@yahoo.com</a></td>
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<td>/Southern Province</td>
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<td>Colombo Sri Lanka</td>
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<tr>
<td>30.</td>
<td>Dr Umashankar</td>
<td>Regional Director of Health Services/</td>
<td>Ministry of Health</td>
<td><a href="mailto:rdhsmtv@gmail.com">rdhsmtv@gmail.com</a>; <a href="mailto:iysuma@yahoo.com">iysuma@yahoo.com</a></td>
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Annexure – C: TOR SEAR PHC Forum

South-East Asia Regional Forum for Primary Health Care-Oriented Health Systems
(SEAR PHC Forum)

Capturing learning, fostering synergy, and driving action

Terms of Reference
Context

Robust primary health care-oriented health systems have long been recognized as the most equitable and efficient approach for achieving UHC and the health-related SDGs. The direct and indirect impact of COVID-19 pandemic and subsequent economic challenges in the Region have only further highlighted the importance of PHC-oriented health systems to rapidly mounting a response to health emergencies while maintaining essential health services.

The WHO South-East Asia Region, encompassing 11 Member States and a quarter of the world's population, has been especially affected by the COVID-19 pandemic and subsequent economic challenges. In addition to the direct impact on morbidity and mortality, successive waves of the COVID-19 pandemic have disrupted essential health services and exposed gaps in health systems across the South-East Asia Region resulting in excessive indirect morbidity and mortality. The pandemic and subsequent economic challenges have also contributed to a decline in economic growth, increased rates of extreme poverty, a rise in debt burden across several countries, and reversed or stalled progress in health service delivery. The most vulnerable in the Region have been the most affected.

Simultaneously, demands of health systems in the Region have increased. Priorities for strengthening of surveillance, laboratory, and public health intelligence capacities; equitable delivery of emergency response-related tools; strengthened preparedness and response functions; as well as continued expansion and extension of health services must all be met in a context of constrained resources.

Recognizing the above challenges, at the 74th session of the WHO Regional Committee Meeting, Ministers of Health in the Region committed to reorient health system towards PHC, including through increased public investment, as the primary approach to simultaneously ensure health system resilience and the achievement of UHC and the health-related SDGs. Moreover, through the Declaration of Health Ministers (SEA/RC/74/R1), SEAR Ministers emphasized a once-in-a-century opportunity to enable such transformation and the value of a SEA Regional PHC Strategy to guide, support, and monitor PHC-orientation of health systems.¹

³ See Declaration by the Health Ministers of Member States at the Seventy-fourth Session of the WHO Regional Committee for South-East Asia on COVID-19 and measures to 'build back better' essential health services to achieve universal health coverage and the health-related SDGs
The South-East Asia Regional Strategy for Primary Health Care: 2022-2030 was launched on UHC Day in December 2021, with participation of Ministers of Health from across the Region. The SEAR PHC Strategy elaborates a set of seven values; 12 interdependent strategic actions; and proposes a selection of monitoring indicators. The SEAR PHC Strategy further identifies that WHO SEARO will bring together regional best practices and innovations to support progress across the strategy’s 12 strategic actions, as well as convene and leverage capacities of partners in alignments with nationally defined PHC priorities.

The SEAR PHC Strategy was developed conscious of significant and intensifying development and implementation partner PHC-specific activity in the Region, at times occurring in an uncoordinated manner. A meeting for operationalization of the SEAR PHC Strategy was held on March 2020⁴, with focus on identification of national health stakeholder priorities and associated dialogue with development, implementation, and academic partners.

Representatives of SEAR Member States and partners active in the Region highlighted the need and opportunity to systematically capture implementation focused-PHC learning and innovation, with focus on cost-effective models; to improve synergy in support at national and sub-national level; and collectively advocate for PHC investment and strengthening, with the SEAR PHC Strategy a unifying frame. There was strong support from meeting participants for establishment of a regional forum for development, knowledge, and implementation partners to convene regularly to share, synergize, and support PHC-related implementation.

Notably, at the 75th South-East Asia Regional Committee, Member States adopted the Resolution “Enhancing social participation in support of Primary Health Care and Universal Health Coverage” (SEA/RC75/C), which:

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

⁴ See Meeting Notes, Operationalizing the South-East Asia Regional Strategy for Primary Health Care, Regional Meeting (virtual), New Delhi, India, 28-30 March 2022. Moreover, as conducted by Indonesia in advance of the March PHC meeting, WHO Country Offices can play an important role in convening partners and Member State to ensure the Platform delivers benefit to Member States.
• Called upon international agencies to provide synergized support to SEAR Member States in their effort to reorient health systems to comprehensive primary health care;
• Urged Member States to strengthen national capacities in PHC implementation and monitoring, including through participation in regional knowledge and experience-sharing mechanisms and activities; and
• Requested the 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.**

The establishment of the SEAR PHC Forum responds to the request from Member States of the South-East Asia Region, with focus on strengthening implementation-related learning, synergy, and action.

The SEAR PHC Forum is consistent with the vision and approach of the SDG 3 Global Action, including its’ PHC accelerator, which leverages partnership across 13 multilateral organizations. The SEAR PHC Forum aims to further extend sharing and coordination across additional development, implementation, and academic partners active in the Region.

The SEAR PHC Forum will also leverage operational learning from relevant knowledge platforms, including the World Bank’s *Joint Learning Network for UHC* and the Access Health/Rockefeller Foundation’s *Global Learning Collaborative for Health System Resilience*, and through the WHO PHC Implementation Solutions initiatives.

**Vision**

To drive PHC-oriented transformation of health systems through implementation-focused knowledge management and synergized support for achievement of the Sustainable Development Goals.

**Objectives**

The establishment and operation of the SEA Regional Forum for PHC-oriented Health Systems will:

i. Facilitate knowledge and experience sharing on positive practice, and strengthened collaboration across Member States and partners in the Region;

ii. Identify and facilitate translation of high-impact and scalable solutions on areas of expressed need by SEAR Member States, as guided by implementation-related learning and context-relevant research;
iii. Advance joint and/or strengthened synergy of partner programmatic activities and greater regional collaboration in support of identified national health priorities; and
iv. Enable joint advocacy for strengthened Primary Health Care Investment in the Region.

Activities

i. Regularly organize knowledge and experience sharing on positive practice, including sharing of relevant information and data, among Member States and PHC-related partners on specific thematic areas, as linked to expressed SEAR Member States interest, the SEAR PHC Strategy, and Partner activities and priorities.
   - Thematic areas will seek to address specific implementation-focused questions capacity building need, and adaptation and adoption of solutions/technologies, as identified by the Advisory Committee, in support of Member State priorities.
ii. Compile and regularly update landscape of Member State and PHC-related actors, initiatives and tools available in the Region to address Member State demands including through development of a knowledge portal.
iii. Advance joint research and/or programmatic activities to support PHC-orientation in Member States, including strengthening capacities at national and sub-national levels for monitoring PHC-orientation and performance.
iv. Jointly communicate and advocate, including through convening and coordination at leadership level, for strengthening of PHC-related capacities and investments across SEAR Member States.

Governance

Note: The description below provides an overview of the general governance structure of the SEAR PHC Forum, including description of membership, Advisory Committee, Thematic Groups, and Coordination Group. Operational details for the SEAR PHC Forum will be further developed.

The South-East Asia Regional Forum for PHC-oriented health systems will follow three overarching principles:
1. National governments are in the lead. Representatives from ministries of health, through participation in the Advisory Committee, will guide the overall direction and work of the SEAR PHC Forum.
2. Knowledge management and synergized support will prioritize implementation-focused learning and activity.

3. The SEAR PHC Forum will operate with a flexible and efficient governance system, with aim to facilitate a self-organizing, self-evolving and self-sustaining forum that adds value to countries and partners.

Engagement in the SEAR PHC Forum will include SEAR Member States and PHC-relevant development partners, including SDG 3 GAP partners; implementation partners, including private sector; and knowledge partners, including academic and research and civil society institutions.

SEA Region Member State focal points, as nominated through respective Ministries of Health, will play a key role in guiding the overall deliberations of SEA Region PHC Forum. Regular convening of nominated focal points will enable key priorities, needs and challenges of SEAR Member States to guide deliberations and actions of the Advisory Committee and Coordination Group.

The Advisory Committee of the SEAR PHC Forum will be composed of individuals and institutions to capture regional representation of PHC-relevant development, knowledge and implementation partners. The Advisory Committee will include representatives from SEA Region Member States, WHO, USAID, UNICEF, Asian Development Bank, World Bank, European Investment Bank, Gates Foundation, Global Fund, GAVI, Access Health/Global Learning Collaborative, and representatives of relevant partner institutions. The Advisory Committee will identify thematic areas and leads, as well as support preparation and content of regular convening of the SEAR PHC Forum. The Advisory Committee will, as relevant, also seek to guide and enable joint research, programmatic and advocacy actions in support of national PHC-related priorities.

WHO SEARO supported by USAID and Jhpiego, and other interested partners, will serve as coordination focal points of the SEAR PHC Forum, with responsibility for day to day operation of the Forum as consistent with its’ mandate and as guided by the Advisory Committee. The composition of the coordination group could be modified as per the guidance of the Advisory Committee.

Members of the coordination group will also seek to identify opportunities to link technical activity and learning to broader opportunities for strategic communication, advocacy and leadership, through engagement and regular convening at senior leadership levels.
Annexure D: Regional Director’s message to the Regional Workshop to Strengthen Primary Health Care in the South-East Asia Region, Bangkok, Thailand, November 28-30, 2022

Distinguished Representatives of the South-East Asia Region, senior advisors, experts, partners, delegates and colleagues,

Although our Regional Director, Dr Poonam Khetrapal Singh, would have very much liked to attend this important meeting, she is unable to due to prior commitments. It is therefore my pleasure to deliver this message on her behalf.

Quote:
Good morning and welcome to this Regional Workshop to Strengthen Primary Health Care (PHC) in the South-East Asia Region. My sincere gratitude to the Government of Thailand for enabling us to witness the District Health System in Operation, promoting our Region-wide culture of shared learning, synergy and action.

And my thanks to all present – Member State representatives, partners and experts -- for participating in what is the first in-person meeting in this crucial area of work. Today, and over the course of this three-day meeting, you will:
First, share progress and challenges in your efforts to reorient health systems towards quality, accessible and affordable PHC;
Second, jointly define our Regional PHC monitoring approach, indicators, and required capacities, to improve performance and ensure accountability to those we serve;
Third, participate in the launch of the South-East Asia Regional Forum for PHC-Oriented Health Systems, an innovative new platform to enable Regional knowledge and experience-sharing;
And fourth, identify priority areas of action to accelerate national PHC orientation and how best WHO and partners can support.

In achieving these objectives, you will build on a wave of momentum. Since 2014, the Region has sought to achieve universal health coverage (UHC) as a Flagship Priority, recognizing that increased coverage, quality and affordability is critical to accelerate progress in all areas of health.
In 2021, amid the COVID-19 response, the Region unanimously adopted the Declaration on COVID-19 and measures to build back better essential health services to achieve UHC and the health-related Sustainable Development Goals.

The Declaration explicitly recognizes the role of quality, accessible and affordable PHC in the delivery of essential health services in both steady-state and emergency scenarios, and in the achievement of UHC and health security.

In December that year, the Region launched its new Strategy on Primary Health Care, which is based on the values of universality, equity, solidarity and accountability, and focuses on 12 inter-dependent strategic actions.

To help operationalize the Strategy, in March 2022, WHO convened an online Regional meeting at which participants recognized the need to systematically capture implementation-related learning and innovation, and achieve greater synergy in partner support.

Finally, in September this year, at the Seventy-fifth Session of the Regional Committee, Member States unanimously adopted a key resolution on enhancing social participation in support of PHC and UHC.

Through the Resolution, Member States committed to strengthen capacities in PHC implementation and monitoring, and also requested the Regional Office to establish and strengthen knowledge and experience-sharing mechanisms, including by mobilizing development, implementation, and academic partners. This we have done, and with you, this we will achieve.

Because I am certain you are aware: Amid the ongoing COVID-19 response and recovery, demands on health systems across our Region have intensified -- demands that must be met amid significant resource constraints, even as we advocate for countries to not just sustain but even increase expenditure on health.

Our challenges are immense, but let us agree: The glass is more than half full. The last few years have witnessed unprecedented energy and innovation in health. This includes:

First, the establishment of new platforms for whole-of-government and whole-of-society action to protect, promote and support health.
Second, renewed Region-wide attention to and approaches for community and private sector collaboration and engagement.

Third, an array of initiatives to optimize the existing health workforce, including regulatory flexibilities and operational adaptation, especially at the community level. Importantly, such initiatives have included not just doctors and nurses, but community health workers, traditional medicine practitioners, allied and paramedical staff, students and retired professionals.

And fourth, unprecedented expansion in the use of digital technology and cutting-edge innovations to deliver quality, accessible and affordable health care to all individuals and communities, whoever they are, and wherever they live.

Together, we must grasp this once-in-a-century opportunity to accelerate PHC transformation across our Region. But crucially, let us agree: We must do so in a manner that is coordinated, is aligned with national priorities, and which avoids duplication and fragmentation.

In other words, in a manner that maximizes impact. Member States must lead, and partners must support.

Together, we must rely on and be steered by shared learning, synergy and action, focused not just on the ‘what’, but the ‘how’. No more can there be ships in the dark, moving roughly together, but never quite reaching port. Our objectives are simply too important, our responsibilities too great.

I once again thank the Government of Thailand and wish you productive, engaging and successful deliberations to reorient health systems towards quality, accessible and affordable primary health care, to achieve universal health coverage, health security and Health for All.

Unquote.
I echo that sentiment and look forward to coming discussions. Thank you.