REPORT

SECOND HEALTH SECTOR DEVELOPMENT TECHNICAL ADVISORY GROUP (HSD TAG) MEETING ON PRIMARY HEALTH CARE IN THE WESTERN PACIFIC REGION

MANILA, PHILIPPINES
5-7 DECEMBER 2001
NOTE

The views expressed in this report are those of the participants in the meeting and do not necessarily reflect the policy of the World Health Organization.

This report has been prepared by the World Health Organization Regional Office in the Western Pacific for those who participated in the Second Health Sector Development Technical Advisory Group Meeting on Primary Health Care in the Western Pacific Region which was held in Manila, Philippines, from 5 to 7 December 2001.
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Keywords: Primary Health Care / Health Services / Health Planning / Western Pacific
SUMMARY

The primary health care (PHC) approach has been strongly advocated by WHO since 1978. Improvements to PHC are considered fundamental for increasing access to health care and reducing the burden of disease in the population. However, a review of the PHC approach is warranted to ensure it remains relevant in the context of the changing global health challenges.

The Second Health Sector Development Technical Advisory Group (HSD TAG) meeting served as a forum for the regional review of PHC, contributing to WHO’s future strategy and policy on PHC both globally and in the Western Pacific Region.

The TAG strongly supports the definition and concept of PHC as set out in the 1978 Declaration of Alma Ata. Over the last 23 years much has been accomplished, and continues to be accomplished, by WHO and the Member States in applying the principles and developing programmes in keeping with the Health for All strategy and the PHC approach. The TAG recommends that WHO should:

1. Strengthen, re-energize and actively promote PHC strategies and programmes to meet new health challenges, placing strong emphasis on the philosophical, whole system and strategic aspects of PHC and focusing even more on the needs of disadvantaged and marginalized populations particularly women and children, and to prevent and contain potential negative health impacts of globalization;

2. Rearrange its policies, structures and processes, including programme funding, to give added emphasis to locally integrated community development approaches and reduce the current dependency on vertically organized and targeted approaches;

3. Maintain its technical assistance to Member States to help them in all PHC settings and at all levels:
   - to develop appropriate evidence-based tools and approaches to facilitate the gathering, analysis, sharing and use of information, including documenting PHC experiences and engaging in formal evaluation processes, in support of improved decision-making, in particular at the community level, to achieve quality PHC services;
   - to develop measures pertaining to the rights to health care, social justice and equity as key components of quality PHC;
   - to support leadership and governance;
   - to improve capability and capacity for policy-making and organizational development;
   - to encourage the long-term development of the PHC workforce, particularly frontline community health workers;
   - to explore with countries ways and means of more equitably and efficiently funding PHC while developing PHC financial management systems;
   - to improve the member states capability and capacity for intersectoral action; and
➢ to develop frameworks to help face the many operational and practical challenges deriving from the implementation of PHC; and

4. Provide strong leadership both within and beyond the health sector and internationally, in support for the role that PHC could and should play in the fight against poverty and its social and health consequences.
1. INTRODUCTION

1.1 Objectives

The objectives of the Second Health Sector Development Technical Advisory Group (HSD TAG) Meeting on Primary Health Care in the Western Pacific Region were

a) to identify, validate, draw lessons from and conclusions on good practices in primary health care (PHC) implementation necessary in the context of emerging challenges and wider development in the Western Pacific Region;

b) to identify effective interventions for the improvement of major sub-systems which influence the implementation of PHC such as financing of health services, availability of drugs and rational drug use, human resources development and retention, health seeking behaviour;

c) to provide recommendations on WHO's future strategy and policy on PHC, and to identify WHO's role in supporting countries developing PHC; and

d) to provide recommendations for action in the Western Pacific Region in relation to PHC, including the identification of resources to support priority activities on PHC and ways in which WHO's Regional Office for the Western Pacific could improve coordination with development partners.

1.2 Participants

A total of 34 participants attended the meeting: four Technical Advisory Group (TAG) members, 14 technical advisers, three observers, and 13 members of the Secretariat.

It was proposed and agreed that the office-bearers of the meeting should be as follows:

Chairperson       Dr Phua Kai Hong
Vice-Chairperson   Dr Natsag Udval
Rapporteur        Dr George Salmond

The agenda and list of participants are attached as Annexes 1 and 2.

1.3 Organization

The Second HSD TAG Meeting on Primary Health Care in the Western Pacific Region met in Manila, Philippines, from 5-7 December 2001. Annex 3 includes the programme of activities.
1.4 Opening Ceremony

In opening the meeting, the Regional Director, Dr Shigeru Omi, explained that WHO has initiated a Primary Health Care Review Project. The review will provide a clear description of good practices and an articulation of WHO policy in primary care as a component of health policy and systems, to contribute to improvements in health status for populations. Improvement to the PHC approach is fundamental for increasing access to health care and reducing the burden of disease in the population. PHC has been strongly advocated by WHO since 1978. However, a review of the PHC approach is warranted to ensure it remains relevant in the context of the changing global health challenges.

The WHO global review process involves a report from each WHO region, to be completed by the end of 2001. These reports will then be used as part of a global review scheduled for the first quarter of 2002.

The Second HSD TAG Meeting will serve as a forum for the regional review of PHC, thus contributing to the global agenda, and will focus on regional activities, including recommendations for policy, donor coordination and resources allocations for priority actions on PHC. The regional review report will incorporate the HSD TAG discussions and other relevant materials.

2. PROCEEDINGS

2.1 Workshop documentation and process

The following documents were used to assist the workshop deliberations:

- A PHC review issue-raising document prepared by WHO Geneva;
- A presentation on ‘Quality of Primary Health Care’ by Dr Aviva Ron; and
- A PHC review and synthesis of reports from 20 countries in the Region presented by Dr Marjolein Jacobs.

The workshop was facilitated by a consultant and staff from WHO Geneva, who are participating in all the regional reviews of PHC.

In the light of these deliberations the TAG makes the following observations, draws some general conclusions, and suggests ways the WHO’s PHC strategy and associated programmes may move forward. These insights are then consolidated in a set of recommendations.

2.2 Primary health care as a concept

The TAG strongly supports the definition and concept of PHC as set out in the 1978 Declaration of Alma Ata. The Declaration was a landmark achievement in moving the health sector globally away from an exclusive focus on medical treatment facilities and services and towards seeing health sector activity as an integral part of social and economic development. At the time this was an important, new and exciting paradigm shift. It captured the imagination and engaged the energies of health systems globally.
Over the last 23 years much has been accomplished, and continues to be accomplished, by WHO and Member States in applying the principles and developing programmes in keeping with the Health for All strategy and the PHC approach. PHC is now embedded in the discourse about health and development, at all levels, and has now become the prevailing orthodoxy and a central pillar of conventional health wisdom. This said, the diffusion and implementation of PHC strategies and approaches have been slow in most countries and have opened up new problems, such as how to operate an effective decentralized system or how to deal with a broadening number of stakeholders. The political rhetoric, at all levels, has not always matched the reality of PHC on the ground.

The concept of PHC has four interacting components. It is an overarching philosophy and strategy embodying the idea of health for all. It is a level of care, and it is a set of activities. As an overall concept it is not easily grasped and is confusing to many. In some countries, it is a difficult concept to explain and to market.

The TAG sees the philosophical component of PHC as being of paramount importance. The key to this philosophy is a broad total health system approach to health and the provision of health services.

Health care is not just about doctors and drugs; it is about people acting for their own well-being.

Health care is not just the obligation of governments; it is the responsibility of society as a whole.

Health care is not just fighting disease; it is about dealing with the constant changes in social systems and institutional structures.

Health care is not just about delivering and using services; it addresses all factors affecting health status.

The idea of PHC as a level of care has advantages and disadvantages. It focuses on front line services but it does tend to distract attention from the philosophy of a total health systems approach which is applicable at all levels and in all countries. PHC is as much about hospitals as it is about front line community services.

Over the past two decades the freshness and compelling passion of the PHC idea has faded somewhat. From being an exciting revolutionary idea in the beginning, it is accepted now as health sector orthodoxy in most countries, even if this acceptance is not always reflected in appropriate action. Despite this, the TAG also noted that PHC is far from being disregarded, and a number of countries in this Region have active PHC reforms underway; however, there are concerns that fewer resources are being directed specifically to PHC.

The TAG believes that PHC, in all of its dimensions, is in need of modernization. It needs to be redesigned and re-energized urgently to meet the many challenges of the modern world. In this regard, WHO could develop frameworks to help Member States face the many operational and practical challenges deriving from the implementation of PHC.
2.3 **PHC in the modern world**

Health systems globally face increasingly rapid change and enormous challenges. Of paramount importance are the changes associated with ‘globalization’. These impact in all areas - economic, technical, social, cultural, and in the physical environment. As a consequence of globalization the world’s resources are rapidly being accumulated by already prosperous countries, organizations and people. The poor are being further marginalized and disadvantaged. In keeping with prevailing market ideologies publicly funded health care is in many countries being eroded by rapidly expanding unregulated and uncontrolled private provision, further disadvantaging the poor.

Other challenges discussed by the TAG were:

- rising health care costs, especially out-of-pocket health costs;
- increasing public expectations;
- growing epidemics of non-communicable disease;
- the impact of HIV/AIDS and other infectious diseases;
- population ageing;
- rising levels of violence, particularly against women and children; and
- the often disruptive effects of repeated rounds of health systems restructuring.

To meet these challenges the TAG is firmly of the view that the prime focus of WHO’s PHC strategy must be on the needs of marginalized and disadvantaged populations. To this end, the PHC concept should include greater emphasis on the rights to health care, social justice and inequality in all its dimensions. Such a broadening of the focus would link WHO’s PHC effort more directly with the efforts of other sector strategies to reduce world poverty. The TAG believes that WHO’s PHC strategy and programmes should be strengthened, repositioned and actively marketed in this broader context. However, care should be taken not to associate PHC again with poorly resourced, ineffective first line services for the marginalized.

2.4 **Diversity, complexity, context and community**

The modern world is characterized by diversity and complexity. In such a world few PHC problems are amenable to a ‘one size fits all’ approach. Linear mechanical models have limited application - indeed chaos theory may provide more useful insights into observed behaviour. To be applicable, decisions must be context specific and where possible be ‘owned’ by the local decision-makers. Guidance and technical support from higher levels or from outside of the system may be helpful, particularly when resources are involved, but such involvement should not undermine, over-ride or otherwise compromise local decision-making.

PHC has a key role to play in health improvement in civil society. Engagement and commitment by local communities can contribute, in a whole variety of ways, to health improvement. By identifying, mobilizing and committing their own resources, communities can not only build an enhanced sense of collective purpose and social solidarity and improve their capacity for self-help, but also can advocate more effectively for, and use, outside resources. To enable the empowerment of communities, WHO should do more to promote and improve the self help capability and capacity of communities.
In the past, WHO has achieved considerable success with vertically targeted, organized and funded programmes, particularly in areas such as communicable disease and environmental health. In most areas some vertical targeting is helpful but it must be complemented by context specific approaches aimed at the horizontal, often intersectoral integration of service provision in local settings. Given the challenges now facing the PHC approach, greater emphasis should be placed on, and more resources devoted to, context specific, local, horizontal, integrating approaches with less emphasis on top down, centrally driven vertical programmes. More attention should be given to philosophical frameworks such as the Ottawa Charter on Health Promotion and to ‘Healthy Cities’ and ‘Healthy Islands’ initiatives which draw on broadly-based, integrated, multi-disciplinary and multi-sectoral approaches. In this context small, action-orientated, local initiatives can be both effective and efficient in achieving desired outcomes. WHO should pay more attention to these ‘cross-cutting’ approaches, if necessary at the expense of some vertically targeted programmes.

2.5 New tools for a new era

PHC approaches and strategies often fail, either because of a lack of political will or because of the non-availability of adequate tools for planning, policy-making and organizational development. Sometimes this may be due to a lack or inappropriate use of resources. But, conceptual matters aside, there is much that WHO could do to assist Member States to improve their tools, their capability and capacity for PHC decision-making.

2.5.1 Information for evidence based decision-making

All policy deliberations should start with careful analysis of the relevant evidence available. Evidence-based decision-making tools are becoming increasingly sophisticated and powerful. However, their use can also be time consuming, require special knowledge and skills, and be very expensive. WHO could help countries with the development and use of appropriate evidence-based approaches to evaluate health sector performance, in terms of both process and outcomes, and to improve decision-making.

Different sorts and presentations of evidence are required by countries at different stages of development, and at different levels across health systems. WHO could help by assisting countries to gather, analyze and use appropriate information in support of PHC decision-making in all of these different settings.

Unfortunately, information support for PHC decision-making and for the assessment of quality is deficient. The processes needed for the gathering, analysis and sharing of information differ at different levels of the health system. Information requirements at community level differ markedly from those of an institutional board of directors. For instance, in working with communities much greater use could be made of local history, story telling and case studies. WHO could assist in teasing out and meeting these information needs.

2.5.2 Quality dimensions of PHC

Quality has been defined as the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are concurrent with professional knowledge.

Customary dimensions of quality are safety, effectiveness, efficiency, consumer responsiveness and access.
The TAG supports the proposition in Dr Ron’s paper that quality is a fundamental component of PHC. At the least it should reflect measures pertaining to the appropriateness and outcomes of care. Tools to assist in the making of such measures are increasingly available.

Quality improvement is a major preoccupation of health services around the world at this time.

The TAG supports the further development and use of quality improvement measures in PHC. To the existing quality paradigm it would add the dimensions of social justice, right to health care and equity in all aspects of health care delivery.

In pursuit of quality improvement, WHO could promote the proposition put forward by the TAG that social justice, right to health care and equity be included as integral dimensions of quality in PHC. It could also lead the way in developing ways to measure these dimensions. The TAG sees this as one way in which WHO could lead the way towards refocusing and re-energizing the PHC concept.

2.5.3 Leadership, governance, stewardship and advocacy

Leadership is required in all areas and at all levels for PHC to advance. Leadership is not the exclusive preserve of top managers but should be encouraged and cultivated across the sector and between sectors.

As well as inspiring leadership the sector requires good governance and capable and honest stewardship as described in the 2000 World Health Report. It also requires leaders, governors, managers, clinicians and other health workers who are ready, willing and able to advocate for PHC.

WHO should play an active role in support of all of the above leadership functions.

2.5.4 Policy development and organizational performance

PHC strategies often fail because of lack of knowledge, skills and experience in policy-making and implementation and other aspects of organizational performance. Competence, capability and capacity in all of these areas should be encouraged. WHO has a significant role to play in these areas.

2.5.5 Human resource management

The human resource needs of PHC is an area of particular neglect. The types of short-term fixes often used are no real solution, and could well be more expensive in the long run. In general the current workforce is ill equipped to meet current and future PHC demands. Problems exist with the division of labour and in recruitment, training, deployment, career development and other aspects of human resource management. Often there is lack of congruence between what competencies are required to deliver high quality care and what is taught in educational institutions. Relationships between PHC provider organizations and academic institutions are cause for concern in many places. The appropriate recruitment, training, deployment, retention and on-going support of front-line community health workers is of great concern in most countries. There is considerable scope for the WHO to play informing and facilitating roles here.
2.5.6 Financing PHC

Financing PHC is an area of major concern. Under-funding is a universal complaint. In most countries existing resources are inappropriately used, and often wasted.

To relieve pressure on public funding, in recent years many countries have looked to increasingly introduce user charges and to extend pre-paid health insurance schemes. The principal effect of both of these measures has been to deprive disadvantaged populations of access to needed care.

The under-funding of publicly funded and provided services has encouraged rapid expansion of largely unregulated private provision in many countries. Such provision is often expensive and ineffective, and may be dangerous.

The TAG is firmly of the view that PHC provision, particularly to marginal and disadvantaged populations, should be largely funded out of either general taxation, dedicated taxes or social insurance. It is also of the opinion that all prepaid health insurance schemes should cover PHC and well as hospital care.

WHO could help by providing expert help in exploring and designing better systems to finance and regulate PHC. This includes technical help in the design and operation of PHC financing and financial management systems. Such help may well benefit from the involvement of epidemiologists, historians, anthropologists and other social scientists, as well as health economists and health systems managers.

2.5.7 Intersectoral action

In the past most health systems have been based on vertical bureaucratic and programme structures, have been inward looking and top down in terms of decision-making. Future systems are more likely to be designed as networked arrangements which are outward looking and largely independent well-designed information systems, shared understanding, cooperation and trust for concerted action.

From its inception, emphasis has been placed on the intersectoral aspects of PHC. In the complex modern environment this is even more important. Intersectoral action is often context specific. WHO could assist Member States by mapping intersectoral possibilities and processes and by ensuring that intersectoral experiences are documented and shared.

2.5.8 International action

WHO has a key role in encouraging, facilitating and generally supporting the PHC programmes of Member States. This is seen as a strong leadership function. Intervention, either alone or with development partners, by way of vertical programs may be necessary from time to time but such interventions should, to the extent possible, be tailored to fit with the host country’s PHC strategy and integrated work programme. The same is true for other agencies such as the World Bank.
At higher levels, when social justice, rights to health care and equity issues are at stake, WHO should facilitate interaction with the other relevant stakeholders in the UN system. It should seek to expand the boundaries of partnerships in health and develop programmes with civil society groups. This is particularly pertinent in the fight against poverty and its social and health consequences. This could be exciting new territory for WHO and its Member States. It could be the spark needed to re-ignite the global passion for PHC.

3. RECOMMENDATIONS

3.1 Recommendations

The TAG makes the following recommendations on WHO’s future strategy and policy on PHC both globally and in the Western Pacific Region. The TAG recommends that WHO should:

1. Strengthen, re-energize and actively promote PHC strategies and programmes to meet new health challenges, placing strong emphasis on the philosophical, whole system and strategic aspects of PHC and focusing even more on the needs of disadvantaged and marginalized populations particularly women and children, and to prevent and contain potential negative health impacts of globalization;

2. Rearrange its policies, structures and processes, including programme funding, to give added emphasis to locally integrated community development approaches and reduce the current dependency on vertically organized and targeted approaches;

3. Maintain its technical assistance to Member States to help them in all PHC settings and at all levels:

   ➢ to develop appropriate evidence-based tools and approaches to facilitate the gathering, analysis, sharing and use of information, including documenting PHC experiences and engaging in formal evaluation processes, in support of improved decision-making, in particular at the community level, to achieve quality PHC services;

   ➢ to develop measures pertaining to the rights to health care, social justice and equity as key components of quality PHC;

   ➢ to support leadership and governance;

   ➢ to improve capability and capacity for policy making and organizational development;

   ➢ to encourage the long term development of the PHC workforce, particularly front-line community health workers;

   ➢ to explore with countries ways and means of more equitably and efficiently funding PHC while developing PHC financial management systems;

   ➢ to improve the Member States capability and capacity for intersectoral action; and
to develop frameworks to help face the many operational and practical challenges deriving from the implementation of PHC; and

4. Provide strong leadership both within and beyond the health sector and internationally in support for the role that PHC could and should play in the fight against poverty and its social and health consequences.

3.2 Review and report on recommendations made by the TAG at its first meeting (2000). (Refer also to Annex 4)

Recommendations included:

1. Constituency building with health professionals and people who receive health care and create advocacy for improved health care.

WHO country offices have been and are being strengthened on health systems concepts and problems, health and poverty, health and development issues. A position paper to foster collaboration with nongovernmental organizations has been developed.

2. Focus on the health care needs of the poor and the disadvantaged populations.

This has being undertaken through several collaborations with disease programmes which often deal with poorer or more disadvantaged populations, such as the malaria, tuberculosis, reproductive and adolescent health programmes. Some training modules for health workers on gender and poverty are being developed. Research on the impact of disaster on poverty is about to be published.

3. Health sector development work should be comprehensive, integrated and relevant to disease programmes.

Cross cutting work has been undertaken on essential public health functions, safe and rational use of injections, laboratory improvements, training on safe motherhood and sexually transmitted infections, costs studies of diabetes and tuberculosis treatments. Legislative support to Member States in a number of issues as well as support in drug management for disease programmes have been offered. A gender mainstreaming programme has been initiated.

4. Brokering and facilitating role in integrating interventions in collaboration with national agencies and international partners.

This has been implemented mainly through country offices, specifically on Poverty Reduction Strategy Papers. WHO collaborated on health care financing with Asian Development Bank in numerous countries.


This aspect has been addressed through the development of strategies and tools for the improved management of equipment and health technologies as well as through the development of health legislation.

6. The Situation Analysis for Policy Making approach should be intensified. Health data should be disaggregated into poor and disadvantaged populations. Development of policy options should address the rapid demographic changes and urbanization of the Region.
This has been implemented in several Pacific islands countries, in Laos and several Chinese provinces. The format of the Country Health Information Profiles has been amended to enable desegregation into indicators by sex. Other efforts focused on birth and death registration and on curriculum modules on noncommunicable diseases and violence against women.

7 Intensification of successful programmes

The Essential Drugs Programme has been expanded. A regional strategy on traditional medicine has been developed.

8 Next TAG meeting

Although this has not been practical for the 2001 meeting, it is proposed to hold a future TAG meeting in one of the Member States.
ANNEX 1

AGENDA

Day 1
1. Opening ceremony
2. Presentation "Primary Health Care (PHC) Global Perspective"
3. Methods and dynamics of the workshop
4. Group Work I: PHC and health challenges
5. Feedback from Group Work I
6. Presentation: PHC and quality of care
7. Group Work II: PHC and health systems

Day 2
8. Brief summary of Day 1
9. Feedback from Group Work II
10. Group Work III: PHC and broader health development
11. Feedback from Group Work III
12. Presentation "Regional PHC review: 20 Country Reports"
13. Group Work I, II, III and Western Pacific Region (WPR) country reports: key messages
14. Next steps: PHC review, global level

Day 3
15. Brief summary of Day 2
16. Discussion "Next Steps: WHO and PHC in the WPR"
17. WPRO Health Sector Development (HSD) TAG on PHC recommendations
18. Report on the previous HSD TAG meeting
19. Closing ceremony
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ANNEX 3

PROGRAMME OF ACTIVITIES

DAY 1 – Wednesday, 5 December

0800-0830 : Registration

0830-0930 : Opening ceremony
- Opening remarks from the Regional Director
- Self-introduction
- Primary Health Care (PHC) global perspective
- Designation of officers
- Administrative announcements

0930-1000 : Group photograph and coffee break

1000-1015 : Overview of the agenda
Methods and dynamics of the workshop

1015-1215 Group Work I: PHC and health challenges

1215-1330 : Lunch break

1330-1430 : Feedback from Group Work I
Presentation and discussion on PHC and quality of care

1430-1700 Group Work II: PHC and health systems
(including a coffee break, when convenient)

1830 : Dinner hosted by WHO/WPRO Regional Director

DAY 2 – Thursday, 6 December

0830-0915 : Brief summary of Day 1
Feedback from Group Work II

0915-1130 Group Work III: PHC and broader health development
(including a coffee break, when convenient)

1130-1215 : Feedback from Group Work III
Introduction to the documentation display

1215-1330 : Lunch break

1330-1500 : Regional PHC review: 20 country reports

1500-1530 : Coffee break
Annex 3

1530-1615 : Group Work I, II, III and Western Pacific Region (WPR) country reports: key messages

Next steps: PHC review, global level by WHO headquarters

DAY 3 – Friday, 7 December

0830-1000 : Brief summary of Day 2

Whole forum: Next steps: WHO and PHC in the WPR

1000-1030 : Coffee break

1030-1200 : TAG recommendations related to PHC and health sector development (HSD) in the Region

Report on previous HSD TAG meeting

1200-1230 : Closing ceremony
ANNEX 4

REVIEW AND REPORT ON RECOMMENDATIONS MADE
BY THE TECHNICAL ADVISORY GROUP AT ITS FIRST MEETING IN 2000

A. Recommendations on the work of Health Sector Development (DHS), WPRO

1. DHS/WPRO should work on constituency building with health professionals and people who receive health care and create advocacy for improved health care.

As this can best be done through WHO Country Offices with appropriate support and materials, we have:

- Collected and distributed resources on health systems, health and poverty and health in development to the country offices for use in policy dialogue with Ministry of health and other counterparts.
- Developed and circulated a concept paper on working with NGOs, as a basis for increased collaboration with NGOs.
- Started work on a resource manual on basic health system development concepts and issues, to strengthen WHO Country Office capacity in health systems work.

2. In all its health sector development work, DHS/WPRO should focus on the health care needs of the poor and disadvantaged populations.

- More work in collaboration with disease control units, such as Stop TB and Roll Back Malaria, Reproductive health and adolescent health.
- Toolkits being developed to integrate poverty and gender issues into health worker training.
- Study underway on the impact of disasters on poverty in three countries: Philippines, Viet Nam and Cambodia. These studies carried out in partnership with local NGOs.

3. The technical assistance given by WPRO in the broad context of health sector development should be comprehensive and integrated, dealing with multiple components of health systems and their relevance in disease programmes.

In addition to the above, DHS has initiated cross-division work in several areas including:

- Review of essential public health functions in 3 countries, to assess the implications of broader health sector reform on priority public health areas.
- Working group on safe and rational use and disposal of injections in all areas.
- Improvement in laboratory management and practice in all areas.
- Increased focusing of training to meet priorities related to health problems: safe motherhood, STIs.
- Initiating integration of system factors into on-going work of disease control areas.
Annex 4

Study of costs of diabetes care to promote better resource allocation

Review of financing of personal health care (Stop TB)

Focus on legislative tools in several areas: health professionals, health facilities, food safety

Review of drug management, drug resistance and rational use of drugs in disease control programmes, such as Stop TB, HIV/AIDS and malaria.

- Work has been started on developing a gender mainstreaming strategy for WPRO

4. WPRO should take on a brokering or facilitating role in integrated interventions, in collaboration with national agencies and international development partners.

- Support review of PRSPs, through WHO country offices.
- Intensive work with the Asian Development Bank in several countries, mainly in health care financing.

5. DHS/WPRO should develop a programme that would help countries benefit from state of the art mechanisms to improve quality.

- Work done to develop strategies and tools for countries to better manage medical equipment and devices
- Work to strengthen the capacity of member states in health legislation

6. The extension of health information to a situation analysis for policy approach as developed by DHS/WPRO should be intensified. The information should be disaggregated to allow for analysis of health data related to poor and disadvantaged population sectors and enable the Member States to determine if government policy regarding health system development is closing health gaps between population groups.

- SAP extended to additional countries in the Pacific Islands, and started in Laos and six provinces in China.
- The format of the Country Health Information Profiles (CHIPS) has been amended to enable disaggregation of indicators by sex
- Intensive work started to improve basic health information, beginning with birth and death registration, particularly for the Pacific Island Countries.

7. Noting the demographic changes in the Region, mainly rapid ageing and urbanization, DHS/WPRO should initiate the collection of information and the development of policy options to help countries deal with these challenges, especially for those people who have inadequate resources to meet their basic needs.
Annex 4

- This area is covered by SAP.

- The curriculum integration toolkit will contain a module on ageing, non-communicable diseases, violence against women, in addition to the modules on poverty and gender.

8. In health system areas in which WHO has demonstrated success, work should be intensified and expanded, e.g. formulation of national drug policies include traditional medicines.

- Work on rational drug prescribing and use, drug procurement strategies in more countries/sub-regions.

- In addition to the above, a regional strategy on traditional medicine has been developed.

B Recommendations related to the future work of the TAG

9. The work of the TAG should continue with its existing composition, meeting at least once a year. The meetings may be held in selected Members States.

Next year – we will try to hold the meeting in one of the member states.

10. In the interim, the TAG members should be willing to communicate with DHS/WPRO regarding development and opportunities for increasing knowledge and experience in the relevant fields through national and international events and networks. The TAG may also hold electronic discussions on selected topics of interest.

- There has been considerable contact between DHS and TAG members.

11. Future meetings should deal with specific topics within the broad context of health sector development. For such meetings, additional experts may be invited.

- And therefore, this second TAG meeting is on Primary Health Care.