

Message from

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At the

***International Symposium on Regional Network
Development for the Future of Primary Health
Care and Teaching Imperatives***

***17-18 June 2010
Bangkok, Thailand***

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***Speech by:*
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- Professor Piyasakol Sakolsatayadorn, President, Mahidol University
- Dr Surin Pitsuwan, Secretary General, ASEAN
- Dr Supattra Srivanichakorn, Director, AIHD
- Distinguished participants, Honorable guests, Ladies and gentlemen:

I would like to thank the organizers of the meeting for inviting me to talk on this important subject. In light of the current efforts worldwide to revitalize PHC, the subject for this symposium is indeed timely. PHC has served as the main strategy for the attainment of health for all during the past more than 30 years.

PHC has been the key approach to “equity” and “social justice” in health. PHC is the important tool for public health actions; the actions that help ensure reaching the “hard-to-reach” or reaching the “unreached”.

As we all know, however, the world is yet to attain the goal of health for all. This goal is the attainment of the level of health that can permit all people to lead a socially and economically productive and satisfied life. In pursuit towards this goal, a substantial progress had been achieved during the past 3 decades.

By average, people today live longer; their life expectancy at birth has increased. Their illness and death had gradually declined; this is especially in developing countries. In general, people look healthier today, than they did 30 years ago. However, with new and emerging health challenges, much more needs to be done to attain health for all goal.

Distinguished participants, the principle of HFA/PHC has significantly effected change in the ways health policies are developed and it has affected the ways health programmes are planned and implemented. With HFA/PHC principle, health development work had gone much farther from the realm of health sector.

The integration of “health concerns” into national development policies in all sectors had been promoted. Based on PHC approach, health systems had been reformed to take into account works of other sectors that have bearings on health and well being of people. Worldwide, there had been many documentations on the success story of PHC implementation.

In SEAR, there are also several of such documentations. Basic minimum needs programme in Thailand, Posayandu development scheme in Indonesia, Ayador health development project in Myanmar, and Mongar health development initiative in Bhutan.

At the same time, there have been “global changes” in all spheres during the past three decades. There have been deteriorations of environment and eco system worldwide. The global climate has changed to become global warming. There have been frequent outbreaks of new and emerging infectious diseases etc.

These events have profoundly affected people's health, either directly or indirectly. Therefore, in 2008, WHO called for worldwide revitalization of PHC to ensure its continued relevance to the changing health needs of people. This call was made, when the 30th anniversary of Alma Ata Declaration on PHC was globally celebrated.

In SEAR, a high profile regional meeting on revitalizing PHC was held as part of that celebration. As far as health of the world population is concerned, we may say that this period is the second phase of PHC movement. During this phase, PHC needs invigoration, innovation and reorientation.

PHC, which is a "social movement", has to adapt to the dynamic of "social change". "Social determinants of health" must be the cornerstone of today's development of PHC. Along these lines of thought, in SEA Region, there are a number of ideas to revitalize PHC; Strategic Road Map Initiative in Thailand; Development of Community Health Clinics in Bangladesh; Development and deployment of ASHA (Assistant Social Health Activist) in India; Community-based health development (SISCa) in Timor-Leste; etc.

Among other support to these initiatives, WHO has provided platforms for Member States to share information and to learn from each other in the development process that can lead to effective cooperation between and among Member States. This intercountry cooperation is one way to help nurture PHC development in a uniform and sustained manner to ensure effective information exchange, and successful intercountry cooperation; networking of relevant "institutions", both within and outside countries, is necessary.

The idea of regional networking in PHC as being initiated by AIHD is commendable indeed. It will help ensure the relevance and effectiveness of PHC development in the Region. At the Regional Meeting on Revitalizing PHC in 2008, an idea to develop a network of “PHC innovations” was broached. That network development involves the Thai Ministry of Public Health and the Quality of Life Foundation, Thailand.

WHO has been supporting that effort, which is now on-going. Networkings in PHC as initiated by the QoLF and AIHD should coordinate their activities to ensure complementarity. I understand that this PHC network development, which is being initiated by AIHD will focus the attention to PHC “quality improvement” through R&D and experience sharing.

With this perspective in view, I would like to underline the important role of “academic and research institutions” that can help generate evidence necessary for innovations in PHC development.

These institutions can also help in assessing or evaluating the impact of PHC interventions. Certainly, “community health workers” have indispensable role to play in this R&D process. Important contributions to PHC development also came from people in community, local government, civil society, voluntary organizations; and others.

Ladies and gentlemen; once the PHC network is formed, we have to ensure its sustained functioning in long term. This is a formidable challenge. We have to plan now how to organize an effective managerial back up to the network functioning. Networking requires spirit of coordination and cooperation among the institutions concerned.

In principle, the networking must be beneficial to all institutions involved; individually and collectively. There must be means and ways to firmly bind these institutions together, in both technical and managerial terms. These institutions need to play their respective roles as “equal partners”, sharing “responsibility”, and sharing “credit” in a fair manner.

Once again, I highly commend AIHD for its effort in organizing this important international symposium - the symposium on PHC Network Development. The outcome of the symposium will bring us a long way forward towards PHC “quality improvement”. The symposium will significantly contribute to the “revitalization” of PHC in SEA.

Ladies and gentlemen, before I conclude, let me touch on some challenges in PHC. We may say that these challenges are the unfinished agendas, as far as PHC development is concerned. Since the Alma Ata Declaration 30 years ago, not all aspects of PHC principle have been implemented or successfully implemented.

Therefore, some of the challenges in PHC 30 years ago are still our challenges today. In this connection, I would like to remind us of the following, PHC is “health care for all people by all people” – HFA through AFH, PHC is “people’s health care systems”, by people for people, PHC is for both rich and poor; for both rural and urban, PHC is not second-grade care or low quality care, but, it is quality health care for all.

PHC is not exactly the same as PC. PHC is more than PC, which is the first level of government health care delivery systems. To remind, PHC is an important tool for public health actions to reach the unreached. We are yet to really achieve universal coverage of health care, through reaching the unreached.

Wide gaps in health among population groups are still persisting. PHC should be primarily considered as the development endeavours rather than the provision of health services. Education and empowerment of people are principal strategy of PHC, which needs Change agents – community health workers, community health volunteers.

Demystification of health knowledge, health technology, that is appropriate for use by people in community, social control of health technology, HFA/PHC movement is considered as a ‘social reform” in health area.

Ladies and gentlemen, these challenges are important areas for education, research and development in PHC. The relevance of PHC to the today’s and tomorrow’s health development will continue. However, the word “PHC” may be changed to something.

A lot remains to be done in the development and implementation of PHC approach which is the key to equity and social justice in health. These are encouraging challenges in the today’s changing health scenario and needs. With strong determination and unwavering commitment, let us discharge our full potentials in facing these challenges towards the attainment of HFA in SEA.

With these words, ladies and gentlemen, I wish the meeting all the best and all success.

Thank you.