Primary Health Care and Urban Health

Brian Chin
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ADB Health Sector Group
Training Workshop on Health Systems

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Overview

- Primary Health Care (PHC)
  - Alma-Ata Declaration
  - What is PHC and why is it important?
  - Four avenues of reform for PHC
- Urban Health
  - Background
  - ADB interventions in Bangladesh and India
  - Urban Health frameworks
  - Healthy Cities

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Background

- Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 1978
- Expressed need for urgent action by all governments, all health and development workers, and the world community to protect and promote primary health care

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Alma-Ata Declaration

- ***<u>Health</u> is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity***
  - is a fundamental human right
  - attainment of the highest possible level of health is a most important world-wide social goal that requires the action of other social and economic sectors in addition to the health sector
- **Governments have a responsibility for the health of their people** by the provision of adequate health and social measures

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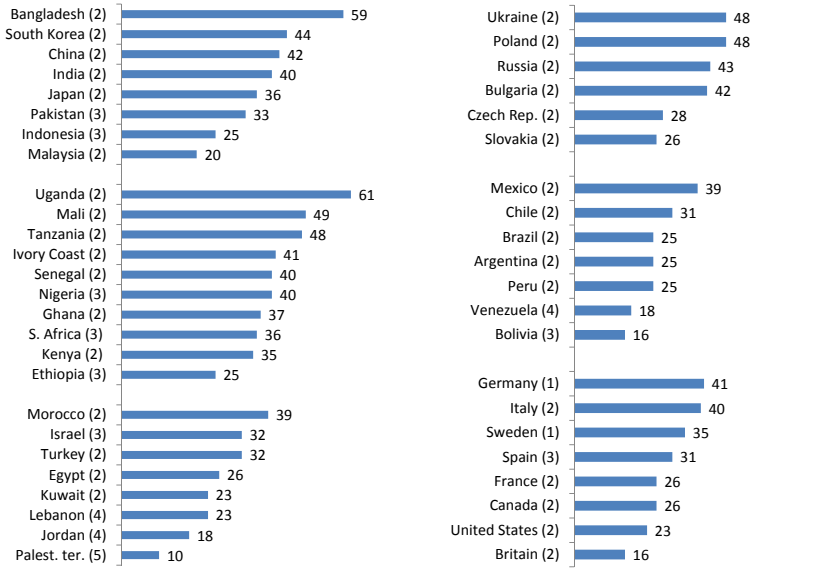
Health is among the top personal concerns



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Kaiser/Pew Global Health Survey (2007). A Global Look at Public Perceptions of Health Problems, Priorities, and Donors.

What is PHC and why is it important?

- ***<u>Primary health care</u>: Essential health care made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development***
  - Forms an integral part of the country's health system
  - First level of contact of individuals, family, and community with the national health system bringing health care as close as possible to where people live and work
  - Constitutes the first element of a continuing health care process
  - Reduces inequality in health status particularly between developed and developing countries as well as within countries

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Components of PHC

1. Provides the full range of promotive, preventive, curative and rehabilitative services
2. Incorporates health education and essential services
   - Food supply
   - Nutrition
   - Safe water and basic sanitation
   - MCH including family planning, immunization
   - Prevent and control of endemic diseases
   - Provision of essential drugs
3. Multi-sectoral coordination
   - Agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors

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Components of PHC (cont'd)

4. Community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources
5. Strong referral systems to support comprehensive health care for all, giving priority to those most in need, and efficient health systems
6. Trained health workers, including physicians, nurses, midwives, auxiliaries and community workers, as well as traditional practitioners, to work as a health team and to respond to the changing health needs of the community

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World Health Report 2008: Primary Health Care Now More Than Ever

- Experience shows a primary health care approach is the most efficient, fair, and cost-effective way to organize a health system
  - Better use of existing interventions could prevent 70% of the global disease burden
- When countries at the same level of economic development are compared, those where health care is organized around primary health care produce a higher level of health for the same investment
- People-centered approach to health that makes prevention as important as cure
- Calls for a return to primary health care to steer health systems towards better performance

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Goal of PHC

- The ultimate goal of primary health care is better health for all
- *World Health Report 2008* identifies key elements to achieving the goal:
  - reduce exclusion and social disparities in health (universal coverage reforms)
  - organize health services around people's needs and expectations (service delivery reforms)
  - integrate health into all sectors (public policy reforms)
  - pursue collaborative models of policy dialogue (leadership reforms)

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PHC reforms necessary to refocus health systems towards health for all

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WHO (2008). The world health report 2008 : primary health care now more than ever.

I. Universal Coverage

- Inequities persist in health outcomes, in access to care, and in what people have to pay for care

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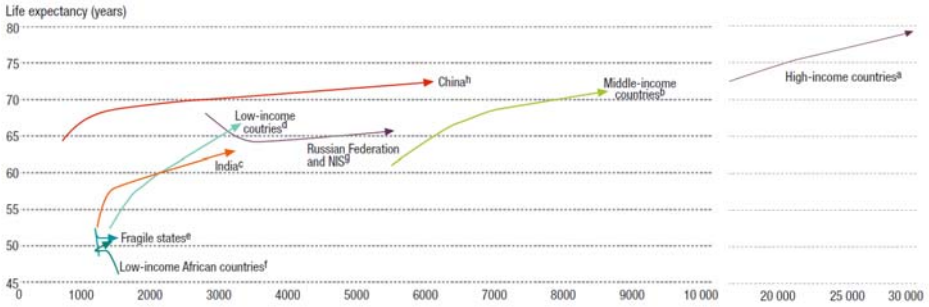
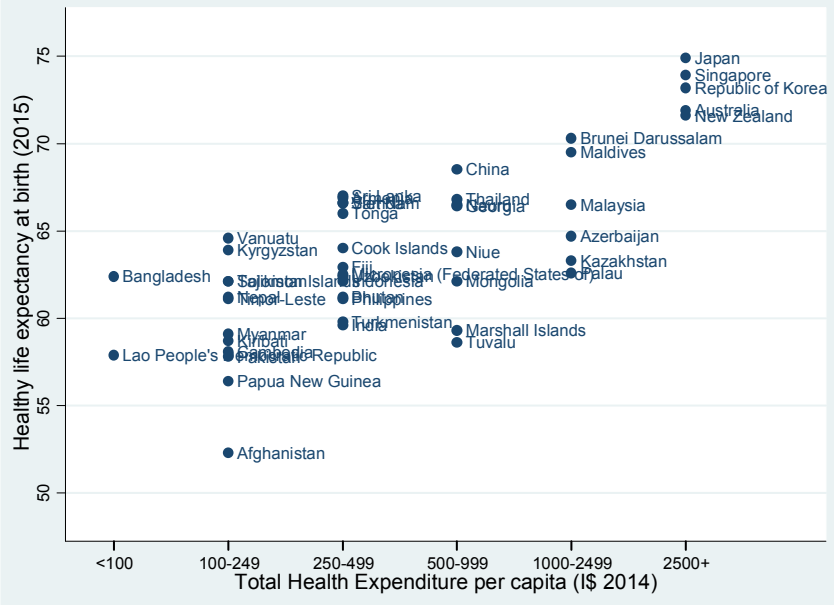
Trends in GDP per capita and life expectancy at birth in 133 countries grouped by 1975 GDP, 1975–2005



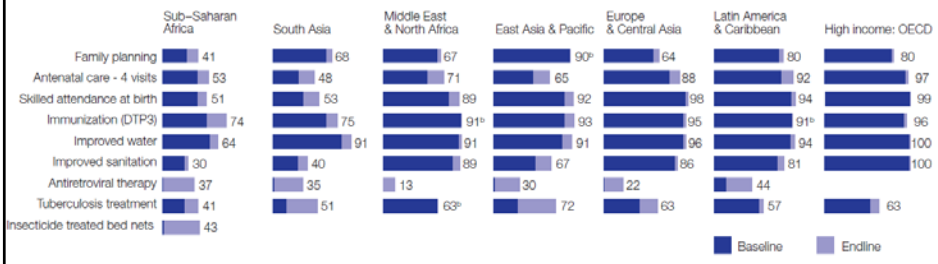
WHO (2008). The world health report 2008 : primary health care now more than ever.

Wide variation in returns to health in Asia and the Pacific



WHO Global Health Expenditure Database; WHO Global Health Observatory.

Regional coverage in 2000 and 2013 for essential health services



WHO (2015). Tracking universal health coverage: first global monitoring report.

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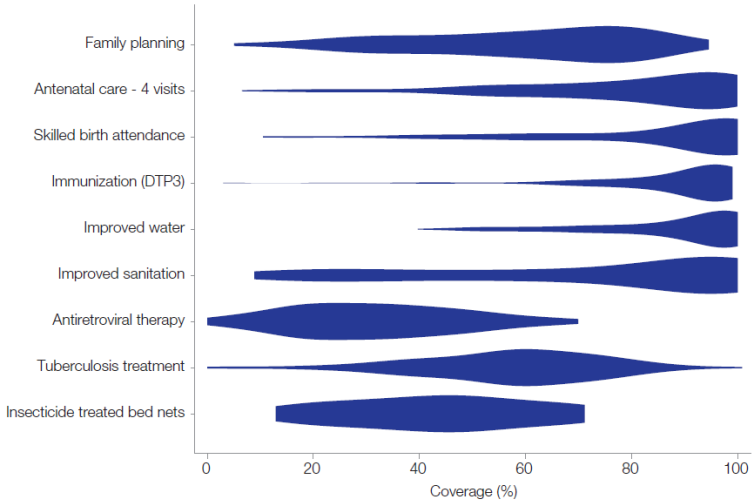
Country distributions of current coverage for essential health services



WHO (2015). Tracking universal health coverage: first global monitoring report.

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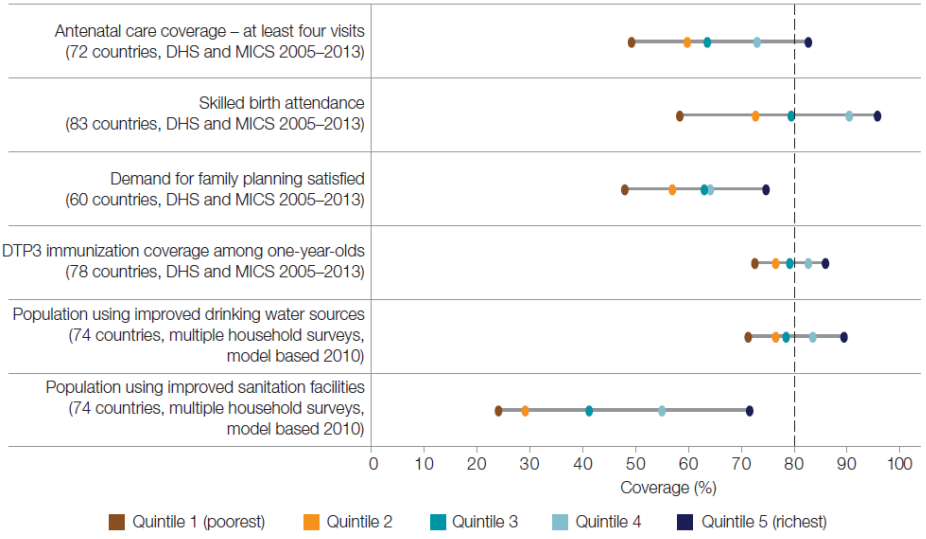
Median coverage of selected interventions by wealth quintile, in low- and middle-income countries



WHO (2015). Tracking universal health coverage: first global monitoring report.

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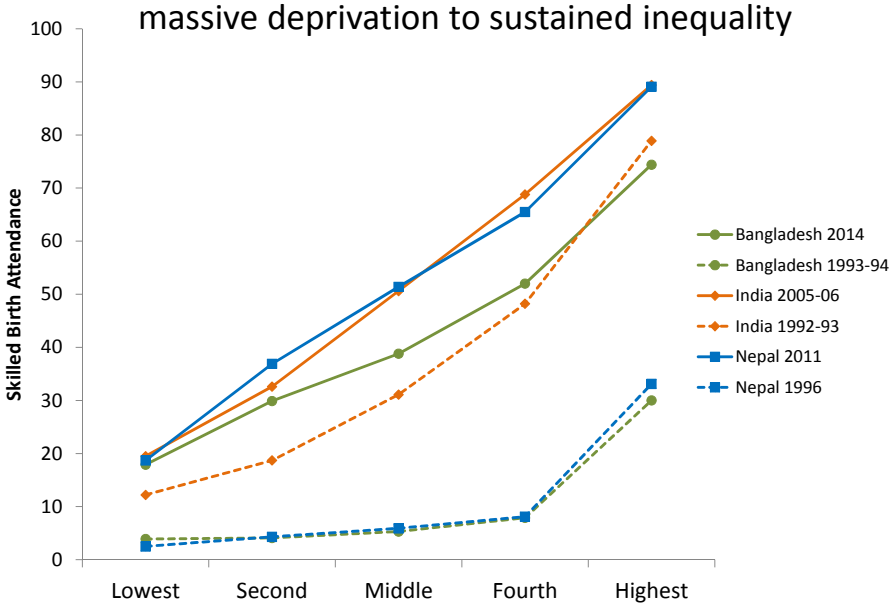
Changing patterns of exclusion: massive deprivation to sustained inequality



Demographic and Health Surveys. statcompiler.com

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II. Service Delivery

- *How primary care brings promotion and prevention, cure, and care together safely and effectively at the interface between the population and the health system—"putting people first"*

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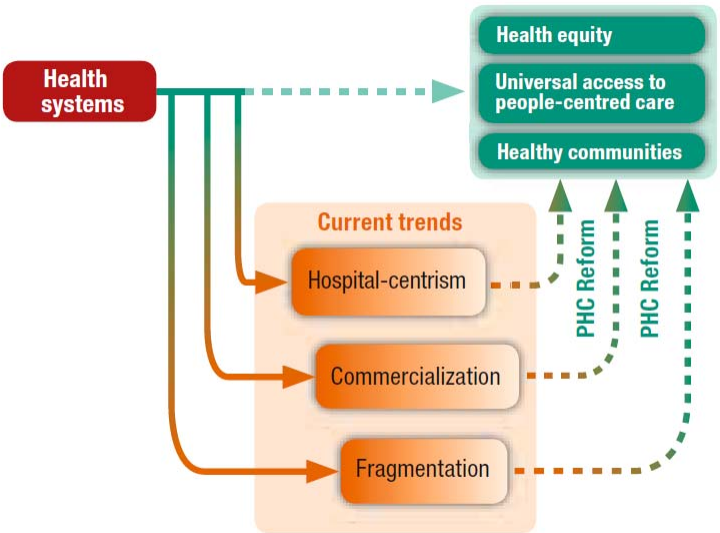
How health systems are diverted from PHC core values



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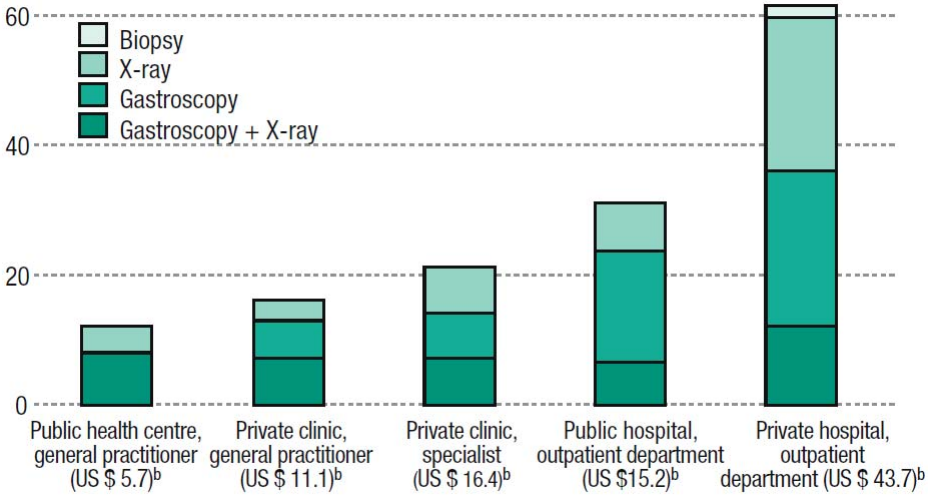
WHO (2008). The world health report 2008 : primary health care now more than ever.

Unnecessary investigations prescribed for patients presenting with a minor stomach complaint, Thailand[a,b]



[a] Observation made in 2000, before introduction of Thailand's universal coverage scheme

[b] Cost to the patient, including doctor's fees, drugs, laboratory and technical investigations

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WHO (2008). The world health report 2008 : primary health care now more than ever.

Distinguishing aspects of care

Conventional ambulatory medical care in clinics or outpatient departments	Disease control programmes	People-centred primary care
Focus on illness and cure	Focus on priority diseases	Focus on health needs
Relationship limited to the moment of consultation	Relationship limited to programme implementation	Enduring personal relationship
Episodic curative care	Programme-defined disease control interventions	Comprehensive, continuous and person-centred care
Responsibility limited to effective and safe advice to the patient at the moment of consultation	Responsibility for disease-control targets among the target population	Responsibility for the health of all in the community along the life cycle; responsibility for tackling determinants of ill-health
Users are consumers of the care they purchase	Population groups are targets of disease-control interventions	People are partners in managing their own health and that of their community

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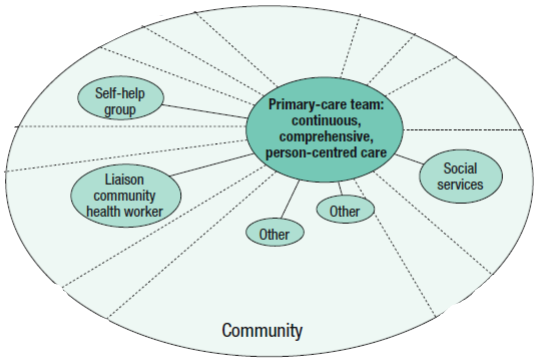
WHO (2008). The world health report 2008 : primary health care now more than ever.

Primary care as a hub of coordination



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WHO (2008). The world health report 2008 : primary health care now more than ever.

Contribution to quality of care and better outcomes

- Person-centeredness
  - Improved treatment intensity and quality of life
  - Better understanding of the psychological aspects of a patient's problems
  - Improved satisfaction with communication
  - Improved patient confidence regarding sensitive problems
  - Increased trust and treatment compliance
  - Better integration of preventive and promotive care
- Comprehensiveness
  - Better health outcomes
  - Increased uptake of disease-focused preventive care (e.g. blood pressure screen, mammograms, pap smears)
  - Fewer patients admitted for preventable complications of chronic conditions
- Continuum of care
  - Lower all-cause mortality
  - Better access to care
  - Less re-hospitalization
  - Fewer consultations with specialists
  - Less use of emergency services
  - Better detection of adverse effects of medical interventions

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III. Public policies

- **Systems policies** – alignment and arrangement of health systems' interdependent building blocks (infrastructure, human resources, essential medicines, information, technologies and financing) to support universal coverage and effective service delivery
- **Public-health policies** – addressing priority health problems through cross-cutting prevention and health promotion
  - Technical policies that guide PHC
  - Alignment of priority health programs with PHC
  - Public health initiatives (controlling and preventing disease, altering behavior and lifestyles)
  - Rapid disease outbreak response capacity
- **Policies in other sectors** – contributions to health made through intersectoral collaboration, "health in all policies"
  - Health content of school curricula
  - Industry's policy towards gender equality
  - Food safety and consumer goods
  - Road safety
  - Disaster emergency preparedness

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Adapting to new health challenges

- Globalization
- NCDs
- Aging
- Road Traffic Accidents
- Climate change
- Urban Health

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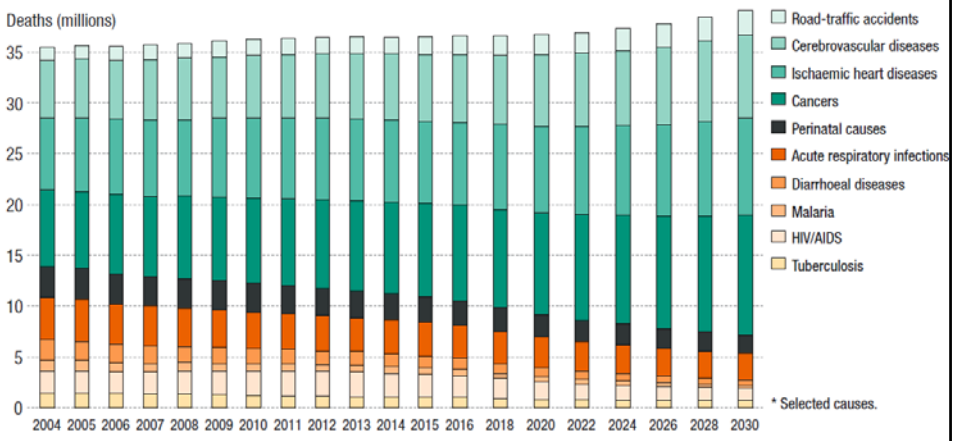
Increasing share of NCDs and injuries



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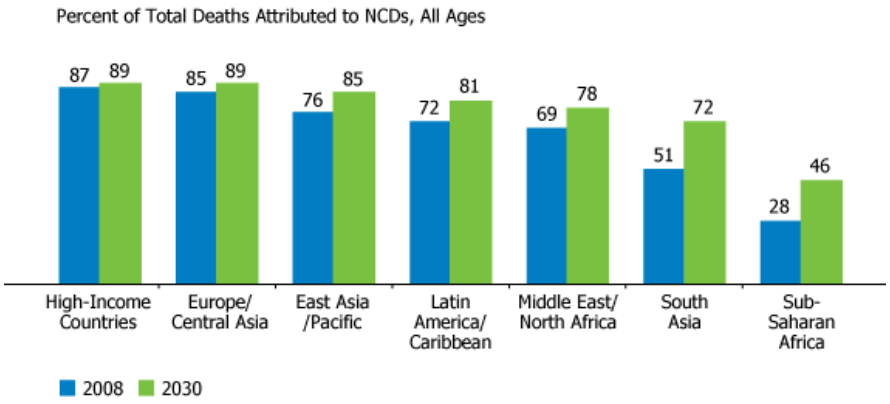
WHO (2008). The world health report 2008 : primary health care now more than ever.

NCDs account for a growing share of total deaths, especially in developing regions



Nikolic, Stanciole, and Zaydman (2011). Chronic Emergency: Why NCDs Matter. World Bank Health, Nutrition and Population Discussion Paper.

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IV. Leadership and Effective government

- Governments as brokers for PHC reform
  - Plays a strong role in leading with financial leverage to steer public health care reforms
  - Relies on "mediation" and collaborative policy dialogue
- Effective and informed policy dialogue
  - Information systems, innovations, sharing lessons
- Building a critical mass of capacity for change
  - Hands-on engagement with major sector program/national programs and planning exercises
  - Build critical alliances and partnerships; coaching
- Managing political process: from launching reform to implementation
  - Respond to changing health system demand and challenges
  - Show relevance, health/social/political returns and costs, and affordability

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Primary care in well-resourced contexts is oversimplified in resource-constrained settings

1. **primary care provides a place to which people can bring a wide range of health problems** – it is not acceptable that in low-income countries primary care would only deal with a few "priority diseases"
2. **primary care is a hub from which patients are guided through the health system** – it is not acceptable that, in low-income countries, primary care would be reduced to a stand-alone health post or isolated community-health worker
3. **primary care facilitates continuous relationships between patients and clinicians, where patients participate in decision-making about their health**; **and builds bridges between individual, family and community health care** – it is not acceptable that, in low-income countries, primary care would be restricted to a one-way delivery channel for priority health interventions

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Primary care in well-resourced contexts is oversimplified in resource-constrained settings (cont'd)

4. **primary care opens opportunities for disease prevention and health promotion and early detection of disease** – it is not acceptable that, in low-income countries, primary care is solely about treating common ailments
5. **primary care requires teams of health professionals** – it is not acceptable that, in low-income countries, primary care is low-tech, non-professional care for the poor
6. **primary care requires adequate resources and investment to provide better value for money** – it is not acceptable that, in low-income countries, primary care is financed through out-of-pocket payments on the assumption that it is cheap and affordable for the poor

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Urban Health

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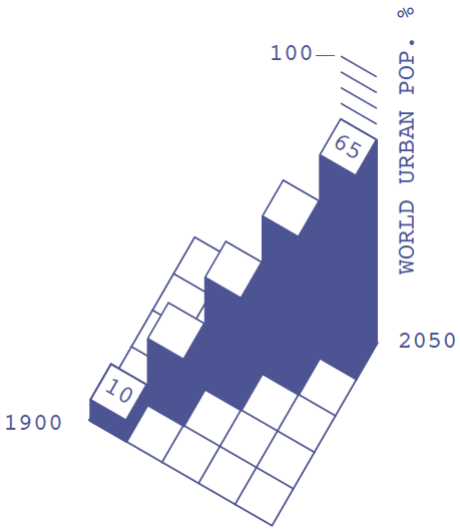
By 2050, 6.3 billion people, or 65% of the world population will live in urban areas



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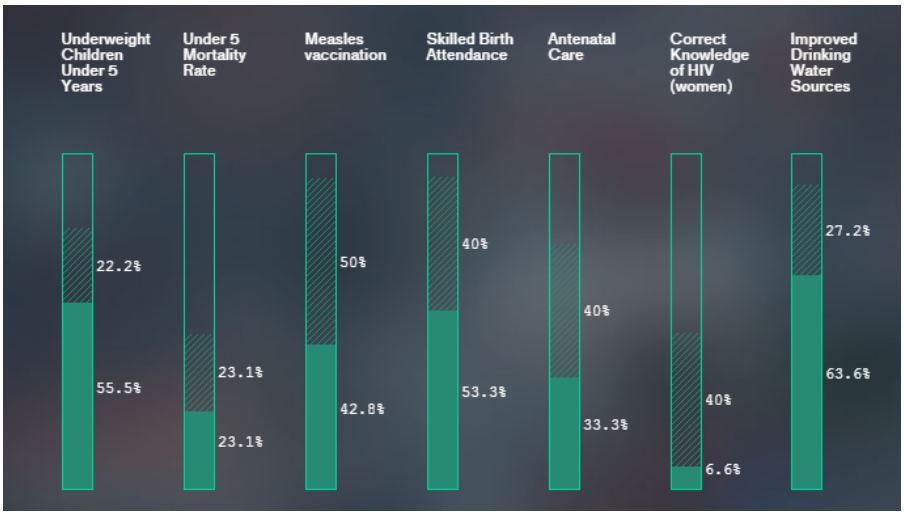
MDG Progress in Urban Areas



Solid bars: % of urban populations meeting MDG target; Striped bars: meeting target within 25%

WHO-UN Habitat (2016). Global report on urban health: equitable, healthier cities for sustainable development.

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Urban environment linked to SDGs

I. Cities free of preventable diseases
   1. Reduce health inequity for sustainable development
   2. Advance universal health coverage in cities
   3. Leverage the urban advantage to tackle communicable diseases
   4. Non-communicable diseases: overcome the new urban epidemic
   5. Tackle 21st century malnutrition

II. Cities planned for people
   6. Provide safe water and sanitation for all
   7. Design healthier, more sustainable cities
   8. Transform urban mobility
   9. Improve health in the home
   10. Ensure safety in the city

III. Renewed focus on urban governance
   11. Participatory decision making
   12. Public-private partnership
   13. Coordinated policies and actions across multiple sectors

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WHO-UN Habitat (2016). Global report on urban health: equitable, healthier cities for sustainable development.

Key challenges to universal health coverage in urban areas

1. Weak urban health systems

- *Inadequate urban primary health facilities; weak and fragmented delivery of health services and referral system, community outreach, and reaching the vulnerable*
- *Underutilized primary health facilities with limited scope of services lead to overloaded secondary and tertiary hospitals*

2. Urban environments

- *High population density; high communicable disease infection rate; highly mobile population increases health security risk*

3. Unregulated private sector and limited financial protection

- *Wide range of private health providers in urban areas, often unregulated with limited quality, accountability, and reliability; operating in parallel to the health system*
- *High out of pocket expenditures*

4. Weak convergence with other sectors

- *Higher concentration of wider health determinants (water, sanitation, nutrition, education, financial and physical access to health) although uncoordinated*
- *Misalignment of 'funds, functions and functionaries' regarding integration of primary health care and public health functions*

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Key challenges to universal health coverage in urban areas (cont'd)

5. Poor and vulnerable population bear disproportionate burden

- *Poor living conditions and hazardous environmental exposures*
- *Lack of patient satisfaction, limited trust in public system, limited community participation*

6. Health information systems are unable to capture data on urban poor

- *Urban poor are often 'hidden' within urban health statistics*
- *Critical health intelligence is needed to identify the sub-groups who are being covered by specific health services and their health status, and those who are left out*

7. Limited Innovations and Institutional Capacity

- *Weak incentive systems for creative solutions and sharing these practices*
- *Weak capacity for program management, guidance, and stewardship*

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Urban slum in Dhaka

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Urbanization in Bangladesh

- One of the top countries with rapid urbanization and highest population density
- Urban population was 8.78% in 1974 and increased to 34.3% in 2015
- It is assumed, population of the country will be 197 million by 2040, more than half will be living in the urban areas
- About 75% urban population growth due to rural-urban migration and 25% due to natural population increase

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Urban Poor of Bangladesh: Some Facts

- Urban poverty has been increasing by migration of the rural poor to urban areas
- One-third of city corporation population lives in slums
- Two-thirds of the population living in slums are migrants
- Access to essential services by urban poor is inadequate
- 30 percent houses are earth floorings
- 13 percent slum households have improved sanitation
- 32 percent women living in slums have no education
- Median age at marriage below 16.5 years in the slums

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Bangladesh Urban Health Survey 2013

Bangladesh Urban Health Challenges

- No PHC structure in cities under Ministry of Health
- Urban Local Bodies have responsibility but no significant role
- Private sector expensive for the poor
- Only NGOs provide door to door service

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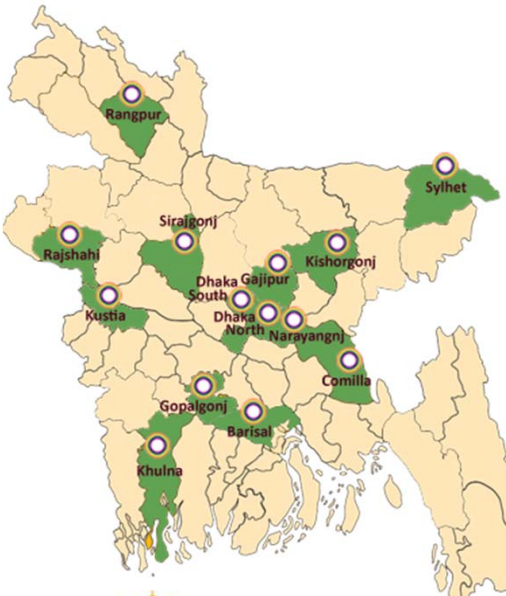
Urban Primary Health Care Services Delivery Project, Bangladesh (2012-2017)



UPHCP BANGLADESH ADB SWEDEN UNFPA

UPHCSDP

2012-2017

- Development Partners: ADB, Sida, UNFPA
- Total Budget: $81 million
- Catchment population around 8 million in 10 City Corporations and 4 district municipalities
- 32 posts in Project Management Unit (PMU)
- 11 Individual Consultants in PMU
- 78 posts in 14 Project Implementation Units (PIU)
- 2,710 manpower in 25 partner NGOs

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Major Activities

- Delivering PHC services through selected NGOs
- Construction of 12 Comprehensive Reproductive Health Care Centers (CRHCC) and 26 Primary Health Care Centers (PHCC)
- Capacity development
- Behavior Change Communication and Marketing
- Monitoring & Evaluation
- Conducting Operational Research

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Services

Essential Services Delivery (ESD) package

✓Maternal health care	✓Child health care
✓Reproductive health care	✓Family planning
✓Nutrition	✓Adolescent health care
✓Limited curative care	✓Communicable disease control
✓Laboratory service	✓Health education
✓Medicine	✓Ambulance service

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Tiers of Service Delivery

Satellite Clinic	PHCC	CRHCC
Headed by a Paramedic provides door-step services • Immunization • Family Planning • Nutrition • Routine checkup • Minor curative care • Health Education • Referral to PHCC Manpower : 3	Headed by a Medical doctor provides all services of ESD package except delivery service Open 6 days in a week 9 am – 4 pm except holidays Only outdoor service Manpower : 10	A team of 7 Medical Doctors including 2 Specialist Physicians (Gyn and Pediatrics) 10-15 beds Provides EmOC including NVD and C-section Ambulance service Open 24/7 Manpower : 32

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Role of Different Organizations

Local Government Division	Ministry of Health and Family Welfare	City Corporation and Municipality Health Department	Partner NGO
Executing Agency through Project Management Unit Provides Administrative and technical supports with the help of project staff & Consultants Coordination with Ministry of Health	Provides technical supports Logistics for Family Planning and vaccination through field offices under the Ministry Coordination with LGD, DPs and other organizations at Ministry Level	Implementing Agency Monitoring and Supervision at local level Coordination with other actors through Partnership Committee headed by Mayor	Providing quality services based on ESD+ package by engaging skilled manpower Ensuring financial sustainability through user fees from non-poor Provide free services to the poor

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Other Providers and Services

USAID –DFID NGO Health Service Delivery Project	▪ Provides all clinical and outreach services of ESD package both urban and rural areas ▪ No permanent infrastructure ▪ No collaboration with ULBs ▪ No sustainability plan
BRAC Community based MNCH program (MANOSHI Project) funded by Bill & Gates Foundation	▪ Provides community based maternal and child health care in city corporation slum areas by Health Workers ▪ Provide NVD by Trained Birth Attendants at community level ▪ No clinic

There are many other actors, most of them provide non-clinical or fragmented service, advocacy and technical support

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Achievements

- Established partnership among ULBs and selected NGOs for delivering PHC services
- Increase coverage of PHC services for the poor
- Enhanced ULB's role to deliver PHC services
- Established a permanent network of 8 CRHCC buildings and 134 PHC buildings
- Established urban PHC sustainability fund in city corporation and municipalities
- Introduced regular quality monitoring system of urban PHC service delivery standard
- Developed a National Urban Health Strategy
- Conducts service related operational research

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Achievements (cont'd)

- The project covers 14% urban population of the country
- Highly gender responsive with around 80% female clients and 68% female staff
- Established referral system for better care
- Established incentive scheme for health workers to promote institutional delivery
- Established 'rainbow' service branding logo for easy identification of health centers

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Service Standards

- Medicine only from pre-qualified pharmaceuticals
- At least 10% of NGOs recurrent cost allocated for medicine
- Laboratory service in each CRHCC and PHCC
- Unified record keeping system in all facilities
- HMIS and web-based data entry system
- Unified accounting system using Tally software
- Standardized guidelines for quality assurance
- Ambulance service in each CRHCC

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Reaching the Poor

- All services including medicine are free for the members of red card holder households
- Outreach workers of satellite clinics play important roles in expanding coverage of PHC service
  - ✓ Through home visit
  - ✓ Home based service delivery
  - ✓ Health education and motivation
  - ✓ Ensure referral linkage
  - ✓ Builds linkage with and confidence of the poor clients

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Overall Project Impact

Contributing to reduce

- Under -5 mortality rate
- Maternal mortality rate
- Total fertility rate
- Child malnutrition rate
- Out-of-pocket expenditure

Contributing to increase

- Access to essential health care by the poor
- Institutional delivery and emergency obstetric care
- Use of modern contraception
- Full basic immunization services
- Overall health status of the urban population

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Outreach Activities



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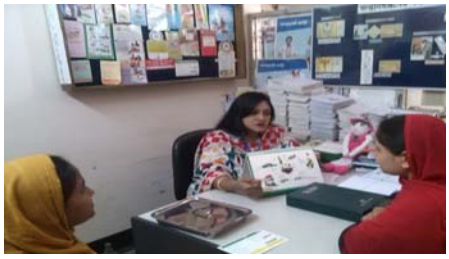
Clinical Services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Clinical Services




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Clinical Services




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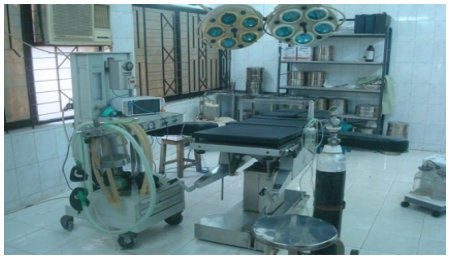
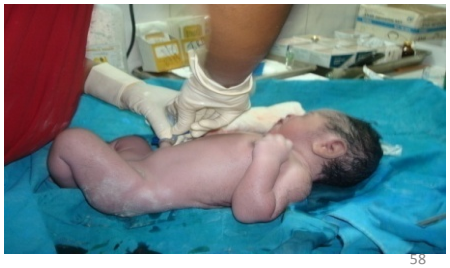
Emergency Obstetric Care



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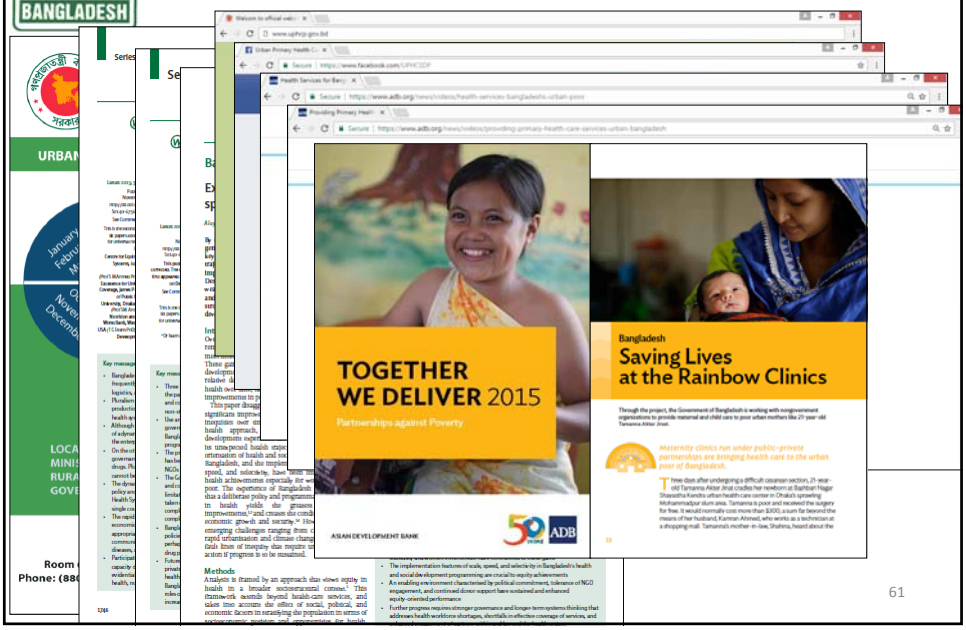
Infrastructure




Capacity Development



Information Dissemination



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India: Supporting National Urban Health Mission

Six of the world's 50 megacities are in India. Estimated that 31% of its population lives in urban areas and 17% lives in slums

- Expand **primary care service** access in urban areas across India through: strengthening city planning and mapping of existing service delivery points and vulnerable populations; constructing **urban primary health centers**; building capacity of **outreach workers** (urban ASHAs), urban local bodies, and health staff
- Support **quality essential service** delivery through strengthening quality assurance mechanisms including patient satisfaction and local stakeholders groups
- Identify and scale up **innovations and partnerships** to support states plan for sustainable service delivery in urban areas
- Strengthen **health management information system** and reporting mechanisms
- **Capacity development framework** including knowledge platform for sharing good practices and innovations and twinning arrangement for strengthening capacity of public health managers

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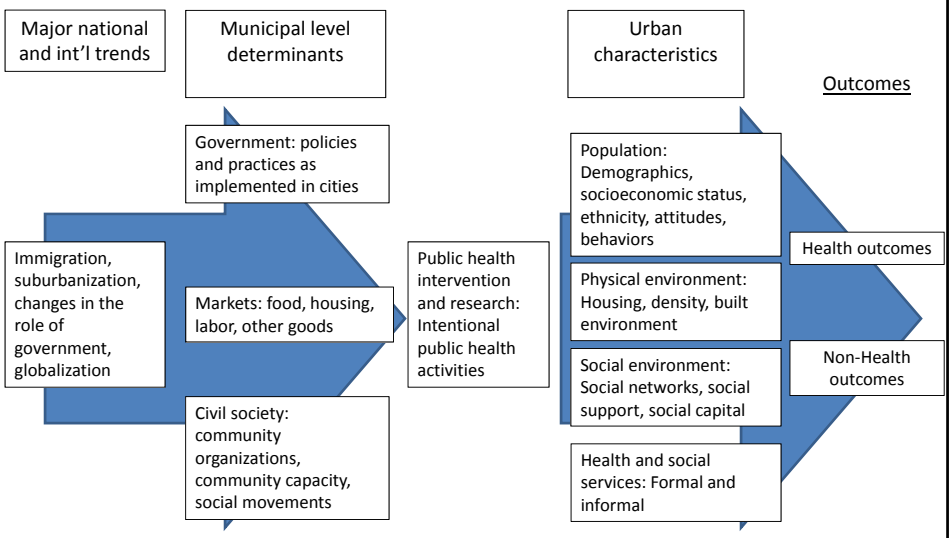
Conceptual Framework for Urban Health



Enduring Structures: e.g., economic systems, religion, government, culture, geography

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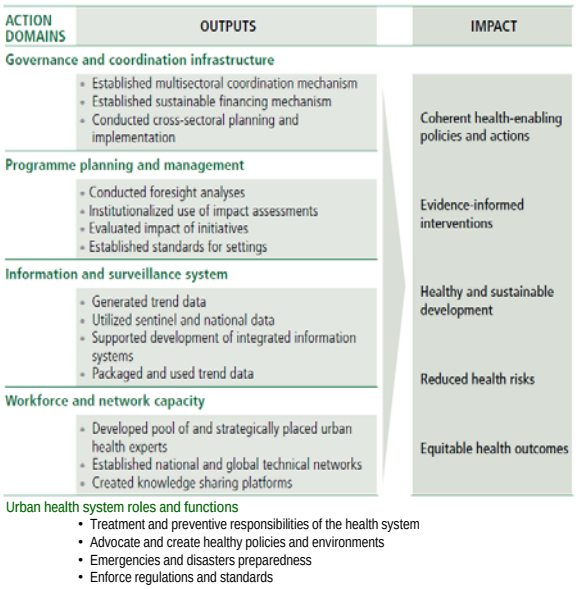
Vlahov, Boufford, Pearson and Norris (2010). Urban Health: Global Perspectives.

WPRO Urban Health Framework 2016-2022



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WHO (2016). Regional Framework for Urban Health in the Western Pacific 2016–2020: Healthy and Resilient Cities.

Healthy Cities: Summary

- In 1986, the first Healthy Cities programs were launched in developed countries (Canada, USA, Australia, many European nations)
- Ottawa Charter on Health Promotion in 1986 paved the way for the healthy settings approach that encouraged people to take control over influences on their health and life in the places where they live, learn, work and play
- In the early 1990s, WHO developed guidelines for healthy cities and established a program to support Member States
  - Good models were soon seen in Australia, China, Japan, Malaysia, the Philippines, and the Republic of Korea
- Based on the guidelines and implementation strategies of initial successes, cities
  - start with the organization of a multi-sectoral healthy cities committee
  - undertake a situational analysis
  - develop a vision
  - make a public policy statement
  - implement a work plan to improve quality of life

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Healthy Cities defined

- A **healthy city** is continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and developing to their maximum potential
- A **resilient city** is prepared and adaptable to changing conditions and can withstand extreme stresses, survive and recover without devastating losses, diminished productivity or quality of life, and without requiring much external assistance
- A Healthy City aims to:
  - to create a health-supportive environment
  - to achieve a good quality of life
  - to provide basic sanitation & hygiene need
  - to supply access to health care

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Healthy Cities: Areas of progress

1. **Effective national advocacy** made it easier to obtain political and financial support for the expansion of Healthy Cities
2. **Easy to take action on social determinants of health at the local level** by working with key sectors: transport, communications, education, tourism, municipal authorities, faith-based groups, academia, medical and health care, and economic development
3. **Health promotion mobilizes stakeholders in local settings** through local policies and regulations
   - Healthy food in schools, tobacco-free temples, road safety, smoke-free cities, salt reduction strategies, age-friendly cities, and baby-friendly hospitals
4. **Leadership development programs and cross-national and city-to-city learning** was key to adoption of Healthy Cities
   - Activities helped identify local problems such as the prevention and control of NCDs
   - Recognition by WHO drew the attention of national policy actors and decision-makers to urban health issues

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Healthy Cities: Areas for improvement

1. **Unmet challenges to create dynamic linkages** between settings and between cross-cutting issues
   - Was less effective in addressing health inequities
2. **Predominantly a "response" strategy** that facilitates a strategic shift from public health approaches that target individuals at risk to population approaches that address structural and political determinants of health
   - Has potential to become a **proactive platform** to anticipate, mitigate, and adapt to new health challenges
3. **Urban health leadership has been more prominent at the local level** than at other levels of governance
   - Requires strategic approach and more intensive focus on **leadership development**
4. National level engagement could be improved through **cross-sector policy dialogue on new and emerging urban health challenges** (e.g., dengue, flooding, HIV and sexually transmitted infections, and foodborne disease)
5. Application of **disaster risk reduction and disaster risk management for health approaches fit well** in the context of climate change, natural and human-induced disasters, and environmental degradation

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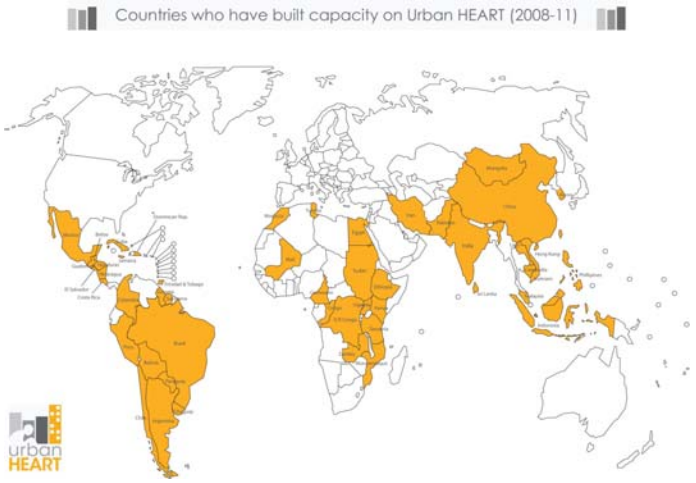

- **Urban Health Equity Assessment and Response Tool (Urban HEART)** is a decision-support tool used by local communities, program managers, and municipal and national authorities to identify and reduce health inequities in cities
  - better understand the unequal health determinants, health risks, and health outcomes faced by people belonging to different socioeconomic groups within a city
  - use evidence to advocate and plan health equity interventions
  - participate in intersectoral collaborative action for health equity
  - apply a health equity lens in policy-making and resource allocation decisions

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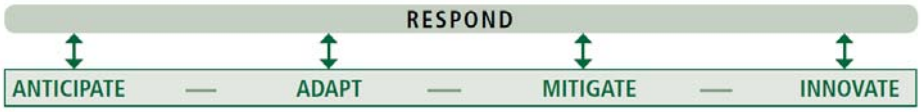
Proactive approach to urban health



- "Whole-of-system approach" to urban health governance
- Ever-changing urban environments pose threats to health
- Climate change and disasters in urban areas have profound health impact
- Disadvantaged and vulnerable groups need to be considered
- Urban areas also confer health advantages
  - smaller carbon footprint
  - efficiently concentrate and organize life-sustaining resources (water, sanitation, education and health)
  - economic and livelihood opportunities
  - transport and communication
  - innovations

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Additional resources

- **Resources**
- WHO African Region Healthy Cities
- WHO Region of the Americas Healthy Cities
- WHO Eastern Mediterranean Region Healthy Cities
- WHO European Region Healthy Cities
- WHO South-East Asia Region Healthy Cities
- WHO Western Pacific Region Healthy Cities
- Urban Health Equity Assessment and Response Tool (Urban HEART)
- **Networks**
- Alliance for Healthy Cities
- International Healthy Cities Foundation
- Making Cities Work (USAID)
- WHO Regional Office for Europe - Links to all national network sites

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