e) 戦略的なリサーチ／デヴェロップメント (R/D) プランへ、他のstakeholderの参画を求めること。（この項目について、わが国として政策的に協力できるものと認識する。）

E. 結論

上記結果と考察を畢竟すると、a)顕微鏡技師の人材の流出に歯止めをかける方法を探る、b) 顕微鏡技師の QA-system 強化に金を使う、c) Self-sustainable な対策手法へのスイッチを探る、d）R/D の投入により、ファンディングのマネジメント強化や、人材の確保・育成に rationale を構築する、ことが重要である。

5．保健人材育成と保健システム強化に関するケース分析に関する研究

研究要旨：

貧困僻地における末端医療機関及び村落ボランティアにおける保健人材の Capacity Building を効果的にはかるために、Supportive supervision を導入するとともに、村落保健ボランティアと末端保健医療機関とのコミュニケーションの改善のために携帯電話による改善を図った。昨年度までの基礎調査においては村落ボランティアの教育歴の低さが阻害要因となる可能性があることが指摘されたが、導入を実施した結果、村落保健ボランティアからの保健医療情報の報告率は 50%から 80%に上昇し、コンサルテーションや通達等にも積極的に使用されたことが分かった。Supportive supervision についても導入は容易であり、導入後 3 年間ラオス僻地郡においてヘルスセンタースタッフの退職はみられていない。今後は本研究成果を活用して、この取り組みの普及・応用を積極的に行っていきたい。

A. 研究目的

貧困僻地における末端医療機関及び村落保健ボランティアにおける保健人材の Capacity Building を効果的にはかるために人材管理システムを開発し、その効果を評価した。

B. 研究方法

１．ラオス国貧困僻地郡（サバナケット県セポン郡）において保健村落ボランティア（VHV）とヘルスセンターの Capacity Building を図るために、携帯電話を用いたコミュニケーション強化を導入した。コミュニケーションの改善として、報告率を指標として評価するとともに 147 名の VHV のうち定例トレーニングに参加した 98 名を対象に、フォーカスグループ討議を実施してコミュニケーションの改善について質的な解析を行った。

２．ラオス国貧困僻地郡及びミャンマー国全域において末端医療機関の看護士もしくは助産士の人材管理システムの一つとして Supportive Supervision を導入し、その効果を評価した。ラオスにおいてはヘルスセンタースタッフの人材管理において導入し、定着率の推移から効果を評価した。ミャンマーにおいては、継続現任教育の研修管理に Supportive Supervision を導入することによってそのシステムの確立についてのケース・スタデイーを行った。

C. 研究結果

１．ラオスにおける研究で、VHV の教育歴とヘルスセンターと村落の距離が、保健医療情報の報告率に影響をあたえている因子としてあげられた。これらを改善するために携帯電話を VHV へ配布しヘルスセンターとのコミュニケーションの改善を図った。この結果、保健医療情報の報告率は５０%から８０%へと改善した。また VHV を対象としたフォーカスグループ討議では「携帯電話の使用は、県や郡のコールセンターとのコミュニケーションよりも末端保健医療機関であるヘルスセンターの間で主に改善され信頼感が構築された」との意見がみられた。また携帯電話は報告のみならず、コンサルテーションや通達にも積極的に使用されたことが分かった。

２．ラオス・サバナケット県セポン郡の 10 のヘルスセンター・31 名の全スタッフ（有資格看護士）において、現任教育の場で Supportive Supervision を導入した。この結果 2010 年から新たに配属になった看護士 8 名を含めて、2012 年 1 月の時点で Drop Out Rate は０%であった。ミャンマーにおいては JICA Basic Health Staff プロジェクトで 17 州／管区のうち 8 箇所の州／管区を選択し、その中の 8 箇所のタウンシップにおいて研修管理システムを導入した。2010 年には Supportive Supervision の導入を図るため、現状の研修管理システムについて 8 箇所の州／管区担

当者に半構造化質問紙を用いたインタビューを行い、EPI（拡大予防接種事業）等の縦型プログラムでは導入されているが、研修管理に関しては導入されていないことがわかった。また特記すべきこととして、未導入であるにも関わらず担当者の Supportive Supervision の実施についての自己効力感は高かった。2011 年には導入１年後の評価を、キーインフォーマントインタビューを用いて、質的に解析した。ＢＨＳスタッフに対する Supportive Supervision を直接実施するモデルタウンシップにおいては、プロジェクトで作成された研修管理の Supportive Supervision に対するハンドブックが有用であり、且つ研修管理に Supportive Supervision を導入していることがわかった。Supportive Supervision の認識を改めて確認したとの発言もあった。しかしながらプロジェクトの進展が遅いこと、またソフトの支援だけでＰＣ等の器材等の支援が得られない等が言及された。

D. 考察

１．2010 年には、ラオスにてマラリア対策や母子保健の縦型プログラムにて VHV に要求されている報告様式は複雑であることが影響していると考えられることを指摘した。2011 年には Global Fund による国家プロジェクトにおいて新たに VHV に求められるフォームが改編されたため、携帯電話による報告項目と順番を整理し紙ベースでの報告と混乱が生じないように改善を行った。しかしながら報告事項は依然として多岐にわたり VHV の理解できるであろう報告項目とは乖離している現状は改善されていない。県からは中央に再三にわたってこの点実を報告しているにもかかわらず改善されず改編されるごとに逆に複雑になっていく。Community Base の事業を導入して VHV を保健人材として末端での治療・予防活動に巻き込んでいくほど、予算執行の報告は詳細に透明性を求められている。これは依然として国家プロジェクトといっても Funding Agency に対して透明性を確保することが大前提として中央では討議されていることが、末端での実現性と乖離した報告システムを導入することが続いてしまっていることが現実であろう。

２．ラオスの貧困僻地、ミャンマーの全国規模の研修管理においても、Supportive Supervision の導入は容易であり、現時点での Supervision システムについての疑問が、管理者側にもあったと考えられる。ラオスにおいて新人８名のうち６名は都市部出身であったが、現時点まで継続的に勤務していることは Supportive Supervision の導入の影響とも考えられる。ヘルスセンターの強化は県主導で行っており、本研究もこれにあわせて行われたため、今後中央への成果の還元を行う予定である。

またミャンマーでは全国レベルの研修管理への導入が進展した一方、このような保健システム強化のソフトの導入は、機材等のハードの導入に比較して時間を要し管理者にとってはかえって業務の増大をもたらしモチベーションをも増大させるとはいえないことがわかった。研修管理強化というプロジェクトベースでなく、保健システム強化全体の計画のなかでハードの導入とシンクロさせて末端に導入していくことが困難ではあるが必要ではないかと考えている。このためには、中央の膨大な計画の調整ではなく、末端の保健システム強化全体のマイクロプラン作成をプロジェクトベースのものも含んで作成することが実現可能な対応策かと考える。

E.　結論

ラオス及びミャンマーの貧困僻地での人材管理システムに、携帯電話によるコミュニケーションの改善および Supportive Supervision の実施を試みたが導入が有効であることが確認された。

６．途上国における生活習慣病対策に関する研究

研究要旨：

生活習慣病は先進国に留まらず途上国においても年々、その疾病負担が増大している。ところが途上国における生活習慣病対策のための保健人材は極めて限られており、そのような状況下でも実現可能な対応策を検討する必要がある。そこで本研究では、保健人材不足の中でも実践可能なヘルスプロモーション・モデルの作成を目的として、生活習慣病が主な死因となっているスリランカで調査を行った。昨年度までの調査によって、家族の生活習慣を母子保健の決定要因として位置づけ、公衆衛生助産師がその対応能力を身につけることによって生活習慣病対策を進めることが現実的であるとの示唆を得た。本年度は、公衆衛生助産師の生活習慣病対策への活用を検討するため、公衆衛生助産師に対する調査を準備した。具体的には、カウンターパートとの討議、調査票の作成、調査場所の選定を完了し、現在コロンボ大学の倫理審査を受けているところである。本研究結果をもとに、今後生活習慣病対策のための保健人材養成について、具体的な提言が可能である。

A. 研究目的

生活習慣病の課題は、先進国に留まらず途上国においても年々その深刻度を増している。ところが途上国における生活習慣病対策のための保健人材は極めて限られており、その状況下でも実践可能な新たな対応策を検討する必要がある。

スリランカは、GNP per capita などの経済指標は高くはないが、周辺諸国と比べて乳幼児死亡率が低いなど健康指標が良好な国の一つである。スリランカの死亡原因のうち最も多いのは、心血管系疾患、次いでがん、脳血管障害と続く。これらの生活習慣病による死亡者数はいずれも感染症の死亡者数よりも多い。途上国は多くのいまだ感染症による死亡が多いのに対し、スリランカの死亡原因は先進国型に近い傾向を示しており、スリランカで生活習慣病予防のためのヘルスプロモーション・モデルを検討する意義は大きい。

これまでの我々の調査から、家族の生活習慣を母子保健の決定要因として位置づけ、公衆衛生助産師がその対応能力を身につけることによって、生活習慣病対策を進めることが現実的であるとの示唆を得た。そこで本年度は、公衆衛生助産師の生活習慣病対策におけるこれまでの経験や生活習慣病対策に関与することに対する考え方・意識を調べ、公衆衛生助産師の通常業務に負担とならない形での公衆衛生助産師の生活習慣病対策への活用を検討することを目的とした。

B. 研究方法

１）カウンターパートとの討議

本研究に興味を持っているアチャラ・ウペンドラ医師（ケラニア大学医学部公衆衛生学教室　講師）をカウンターパートとして、倫理委員会への申請や調査票の作成、調査場所の選定など調査の準備を進めた。

２）調査票の作成

以下の１１項目からなる自記式調査票を作成した。

① これまで、母親から、生活習慣病（肥満、高血圧、糖尿病など）について質問を受けたことがあるかどうか
② 昨年、母親から、生活習慣病について質問を受けたことがあるかどうか
③ 受けた質問の内容
④ 生活習慣病対策に関する助言を行うことに自信を持っているかどう。
⑤ 母親から要望がなくても、生活習慣病対策について助言を行ったことがあるかどうか
⑥ 昨年、母親に対して、生活習慣病対策について助言を行ったことがあるかどうか

⑦ 助言を行った内容
⑧ 生活習慣病対策に関するトレーニングを受けたいかどうか
⑨ 生活習慣病対策に関する質問を母親から受けた場合に自分が対応するべきかどうか。
⑩ 妊婦や乳幼児の受動喫煙に対する考え方
⑪ 生活習慣病対策に関与する意識

3）調査場所の選定

コロンボ近郊のヌワレニヤ（Nuwaraeliya）郡の医療行政を管轄している係官から、本郡における調査の許可を得た。本郡の公衆衛生助産師（約100名）を対象に、調査を実施する予定である。

（倫理面での配慮）

琉球大学疫学研究倫理委員会から、研究の倫理承認を得た。現在、コロンボ大学の研究倫理委員会の審査を受けている。

C. 研究結果

現在、コロンボ大学からの倫理承認を待っているところである。倫理承認が得られ次第、調査が進められるように準備は完了した。

これまでのところ、ケラニア大学医学部公衆衛生学教室およびヌワレニヤ郡の医療行政を統括する係官らスリランカ国の公衆衛生専門家からは、公衆衛生助産師が生活習慣病対策に関与することについて、否定的な意見はあがって来ていない。

D. 考察

現在進めている調査は、公衆衛生助産師の生活習慣病対策に関与したこれまでの経験（母親から質問を受けたり母親に対して助言したりした経験）と生活習慣病対策に参加することに対する考え方や意識を調べるものである。これから行う調査によって、多くの公衆衛生助産師が生活習慣病対策に関与した経験があり、かつ積極的に生活習慣病対策に関与したいと考えていることが判った場合は、公衆衛生助産師に対して生活習慣病対策に関する講習会などの介入を検討している。生活習慣病対策に積極的に関与したいと考えない、あるいは時間的な制約のため関与できないという意見が公衆衛生助産師の間で多数を占めた場合は、公衆衛生助産師が母親等に対してパンフレットを配布するなど軽微な介入を検討する。

日本の農村部を中心に取り組まれてきた地域における高血圧・脳卒中対策の経験より、スリランカにおいても母子保健活動を担ってきた公衆衛生助産師が生活習慣病対策を担うことによって、対策のコストを抑えつつ、成果を挙げることが期待される。母子保健サービスに加えて新しい領域の保健サービスに取り組むことへの心理的抵抗も根強いことが一部で伝えられているものの、生活習慣病の予防あるいは早期発見のため公衆衛生助産師が習得すべき基本的技能とサービス提供のあり方に関する基礎データを当事者から得ておくことは、既存の母子保健システムを生活習慣病予防対策としても有効に機能し得るモデルに改変するにあたって有用であろう。

E. 結論

公衆衛生助産師を活用した生活習慣病対策モデルの構築のために、公衆衛生助産師を対象とした調査の準備をほぼ完了した。今後は、調査の結果に基づき、公衆衛生助産師を活用した生活習慣病対策モデルの構築を進める。

F. 研究発表

別ファイル参照

G. 知的財産権の出願・登録状況

なし

global health workforce alliance

HRH Funding: a "checklist" for Global Health Initiatives

Campbell, J., Wilde D., Bernard, J., Buchan, J., Corner, B., Dieleman, M. Friedman, E.A., Harbick, D., Jimba, M., Kasungami, D., Martineau, T., Mullen, Z., and Oulton, J.

Human Resources for Health (HRH) is rightly prominent on the global health agenda as the countdown to 2015 and the achievement of the Millennium Development Goals (MDGs) grows in resonance. The global health community has made strides in generating evidence, sharing knowledge, and reaching agreements on how to advance HRH policy and achieve results[i].

The upcoming rounds of Global Health Initiative (GHI) funding decisions offer scope to further develop country HRH programming and put commitments into practice to improve health systems. HRH experts and practitioners recognize this window of opportunity and have been engaged in debate on how to support the development and review of proposals to GHIs to integrate and implement evidence-based, best practice and/or innovative HRH solutions within disease-focused funding channels.

A growing international consensus on the role of GHIs

The establishment in 2006 of the Global Health Workforce Alliance (the Alliance) and collaborative agreements such as the *Kampala Declaration,* the *Agenda for Global Action*[ii] (2008), and the *Venice Statement on Maximizing Positive Synergies between health systems and Global Health Initiatives*[iii] (2009) have been key steps in clarifying HRH challenges and the role that GHIs can play in wider health systems strengthening and the achievement of the health MDGs.

The Alliance documents have received political backing at the highest possible level, with G8 official communiqués in both 2008[iv] and 2009[v] recognizing the challenge at hand:

G8 Communiqué on Africa and Development - 8 July 2008

- The G8 members will work towards increasing health workforce coverage towards the WHO threshold of 2.3 health workers per 1000 people
- We will also support efforts by partner countries and relevant stakeholders, such as the GHWA in developing robust health workforce plans and establishing specific, country-led milestones
- We take note of the *Kampala Declaration* and *Agenda for Global Action*

G8 Declaration. Responsible Leadership for a Sustainable Future - 8 July 2009

- In order to advance the goal of universal access to health services, especially primary health care, it is essential to strengthen health systems through health workforce improvements
- We reaffirm our commitment to address the scarcity of health workers in developing countries, especially in Africa and we note the 2008 *Kampala Declaration* and the *Agenda for Global Action* launched by the GHWA

The Venice Concluding Statement[1] acknowledges that "the impact of global health initiatives on health outcomes and health systems, though variable, has been positive on balance and has helped to draw attention to deficiencies in health systems", yet recognises that there is an "urgent need **to develop and strengthen the health workforce** through increased education and training as well as **strategies to sustain and retain all categories of health workers**".

The Venice Recommendations[vi] (see below) provide the foundations for 'a new paradigm in global public health – one in which more consistently productive and constructive interactions between Global Health Initiatives (GHIs) and country health systems will mean better value for money and better health outcomes'.

[1] As agreed at a WHO convened meeting in Venice (June 22–23) between countries represented by ministries of health, Global Health Initiatives (the Global Fund to fight Aids, Tuberculosis, and Malaria, Global Alliance for Vaccines and Immunisation, World Bank Multi-country AIDS Program, and the US President's Emergency Plan for AIDS Relief), UN agencies, academia, and civil society.

The Venice Recommendations for Maximizing Positive Synergies between health systems and Global Health Initiatives.

BE BOLD
Infuse the health systems strengthening agenda with the sense of ambition, the scale, the speed, and the increased resources that have characterized the GHIs

SET TARGETS
Agree on clear targets and indicators for health systems strengthening

ENHANCE LEADERSHIP
Promote country capacity for strong national planning processes and better alignment of resources with national planning processes

ENGAGE COMMUNITIES
Promote the meaningful involvement of civil society organizations in the governance of health systems and the delivery of health services

IMPROVE EVIDENCE
Improve evidence-based decision making in health by building the capacity of countries to generate and use knowledge

These principles are further supported by many of the entities that are in effect the service providers and intermediaries that contribute to health system building and strengthening within the setting of increased aid flows to the health sector. The *NGO Code of Conduct for Health Systems Strengthening*[vii], that has been joint developed by a number of leading health sector NGOs as a response to this changing working environment, places great importance on HRH elements. Furthermore, in recognising that vertical programs and selective approaches have at times exacerbated inequities in health systems and ignored underlying determinants of health, it pledges to "advocate with donors to support general health systems strengthening in the service of comprehensive national priorities".

GHI 'buy-in': opportunities for HSS and HRH synergies

Against this backdrop of growing consensus around the building blocks necessary to sustainably strengthen health systems in the South, the imminent rounds of GHI funding offer a timely opportunity to put the agreed principles into practice. 2009 must be the year to move from 'words to deeds, resulting in concrete progress on the ground'[viii]

In addition to the relevance of the initiatives and declarations listed above, GHIs such as the GFATM, GAVI and PEPFAR have developed substantial research, monitoring and evaluation documentation to guide future funding strategies. They acknowledge the importance of wider health systems strengthening in addition to their vertical disease-specific concerns - as demonstrated by elements such as the GAVI HSS policy[ix]. THE GFATM Five Year Evaluation, as per Finding 3 of its synthesis report[x] presented to the Board in May 2009, also notes that "the weaknesses of existing health systems critically limit the performance potential of the Global Fund. However, the increasing focus on health systems strengthening among Global Fund partners presents a unique opportunity to collectively address these issues".

- **GFATM**: The Technical Review of Round 9 Proposals is due to take place from 23 August – 4 September 2009. Following the Mid-Term Review of the Second Voluntary Replenishment in April 2009[xi], total donor contributions available for grants in the 2008-2010 replenishment cycle are now expected to reach at least US$ 9.5 billion at current exchange rates – with an anticipated US$0.9 billion for future rounds in 2008-2010[xii]. Decisions on Round 9 funding will take place at the 20th Board Meeting in November 2009.
- **PEPFAR**: The Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act (H.R. 5501)[xiii] (the 'PEPFAR Reauthorisation') was signed into law on 30th July 2008. It authorises a total budget of US$ 48 billion for the 5-year period 2009 - 2013. President Barack Obama has since pledged to carry through this law[xiv], indicating that PEPFAR's country operational programming should increase from the $US3.94 billion in Fiscal Year 2009[xv].

- **GAVI**: The GAVI Alliance Board is due to meeting in Hanoi, Vietnam on 17-18 November 2009. This should prove an opportunity to react to the GAVI Health Systems Strengthening Evaluation results, due in September, and to profile future funding replenishments.

The HRH Exchange Community of Practice

With these GHI funding opportunities in mind, the Alliance's *HRH Exchange* Community of Practice has recently undertaken a moderated online discussion on the topic of 'Essential HRH Elements in Funding Proposals'. Over 9 days from 3-12 August 2009, the *HRH Exchange* – consisting of over 290 community members from 61 countries - deliberated over the key aspects that could guide HRH programming within GHI funding proposals – both in their development and their subsequent evaluation by the respective technical teams within the individual GHI procedures.

It was quickly established that it was certainly not the place of the *HRH Exchange* to undermine the guidelines or procedures of the GHIs, or question the leading role of the planning authorities of national governments. An agreement was reached that the place of the Community of Practice was to provide specialist input of a practical nature that could prove of value to the stakeholders involved in the GHI funding rounds.

A varied but moderated and focused discussion covered the nature of linkages between GHIs and wider health workforce plans and needs, and health systems as a whole. Specific HRH issues high on the agenda included workforce equity, cadre levels, skill-sets, excellence in training, geographical distribution, inclusive processes, productivity and efficiency of current staff, health worker migration, working conditions and incentives. The importance of reliable data and information systems and monitoring and evaluation of policy implementation was also deemed key to future advances.

Comment on all of these issues fed into the development of a tool that it is hoped will prove useful to GHI funding rounds in the near future. This tool takes the format of a *'checklist'* below that has been developed in accordance with the 'weight' of Exchange discussion dedicated to each theme (with point 1 having been the subject of the most comment etc.). The *checklist* is not intended to act as a pass/fail measure, i.e. certain questions may be less relevant to particular proposals, but instead as an additional resource for GHI stakeholders that may serve to:

- highlight key questions
- inform proposal development
- guide a process of critical appraisal
- prompt interaction and discussion
- increase support and funding for evidence-based, and/or innovative, HRH solutions that are coordinated with a country's overarching health plan

As participants and advisors in the HRH Exchange we thank all those who contributed to the online discussion and trust the checklist will have a positive impact on future HRH programming.

HRH funding – A 'Checklist'

1. Process - Design

Does the funding proposal demonstrate alignment with the country's health and HRH plans (as available or in development) and is there evidence that a broad range of stakeholders (i.e. line ministries, civil society, private sector, trade unions, training institutions, communities including marginalized members/groups) have been engaged in/signed on to its development?

2. Process - Implementation / Human Resource Management Capacity

Does the funding proposal demonstrate evidence that stakeholders (i.e. line ministries, civil society, private sector, training institutions, communities) are committed to its future implementation: respecting government policies; supporting national and sub-national capacity to coordinate and oversee implementation, and; addressing the change management processes that may/will result?

3. Evidence / Baseline

Does the funding proposal articulate the baseline from which it works and the evidence on which it is premised?

4. Monitoring and Evaluation

Is there evidence of a strong and inclusive approach to monitoring and evaluation (i.e. to 'Train, Retain and Track'), commensurate with the promotion of a country's own M&E Framework and Management Information Systems, which will enable the measurement of results, improved workforce surveillance, cost-effectiveness and active learning?

5. Access, Equity & Gender

Does the proposal (and if possible each intervention) include specific measures to increase access to the health workforce (especially for people that currently have the least access), advance equitable distribution, and address the specific dynamics to enable improved access for women, children and marginalized groups (e.g. ethnic minorities)?

6. Performance / Efficiency

Is the intervention supportive of improving the efficiency, effectiveness and performance of the workforce, in its current or future workplace and are any proposed incentives aligned with government policy?

7. Sustainability

Does the proposal take account of expressed needs, short-term/intermediate results and the long-term sustainability of the intervention as part of the evolving health plan, implementation and financing, recognizing that it might not yet be possible to identify the source(s) for long-term funding implications (beyond the grant period) of the proposal?

8. Synergy

Will the intervention maximise its impact on wider initiatives to strengthen the health system and does it capitalise on the comparative advantage of the funding stream from which it seeks financing?

9. Health cadres

Where an intervention targets a particular health cadre, does it take account of the respective professional association and/or regulatory body (if existing) and the longer-term strategic plans of these organizations as part of the country health plan?

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[xiv] "Statement by the President on Global Health Initiative", The White House Briefing Room, 5 May 2009. Available at: http://www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/

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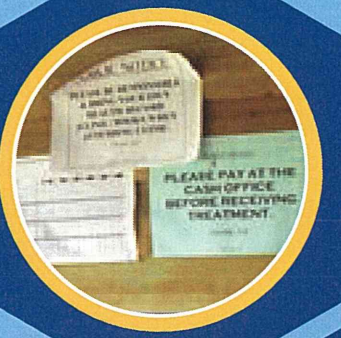
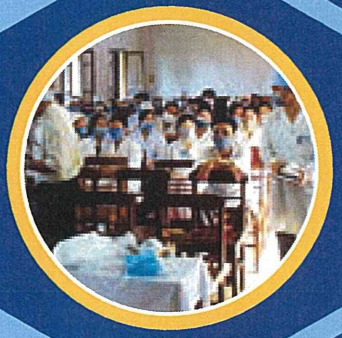
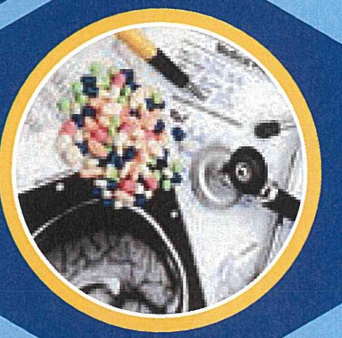
Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care

Self-determination • Scientific Soundness • Equity • Personal Responsibility • People-centredness • Community Protection • Self-reliance • Social Justice • Universality • Participation •



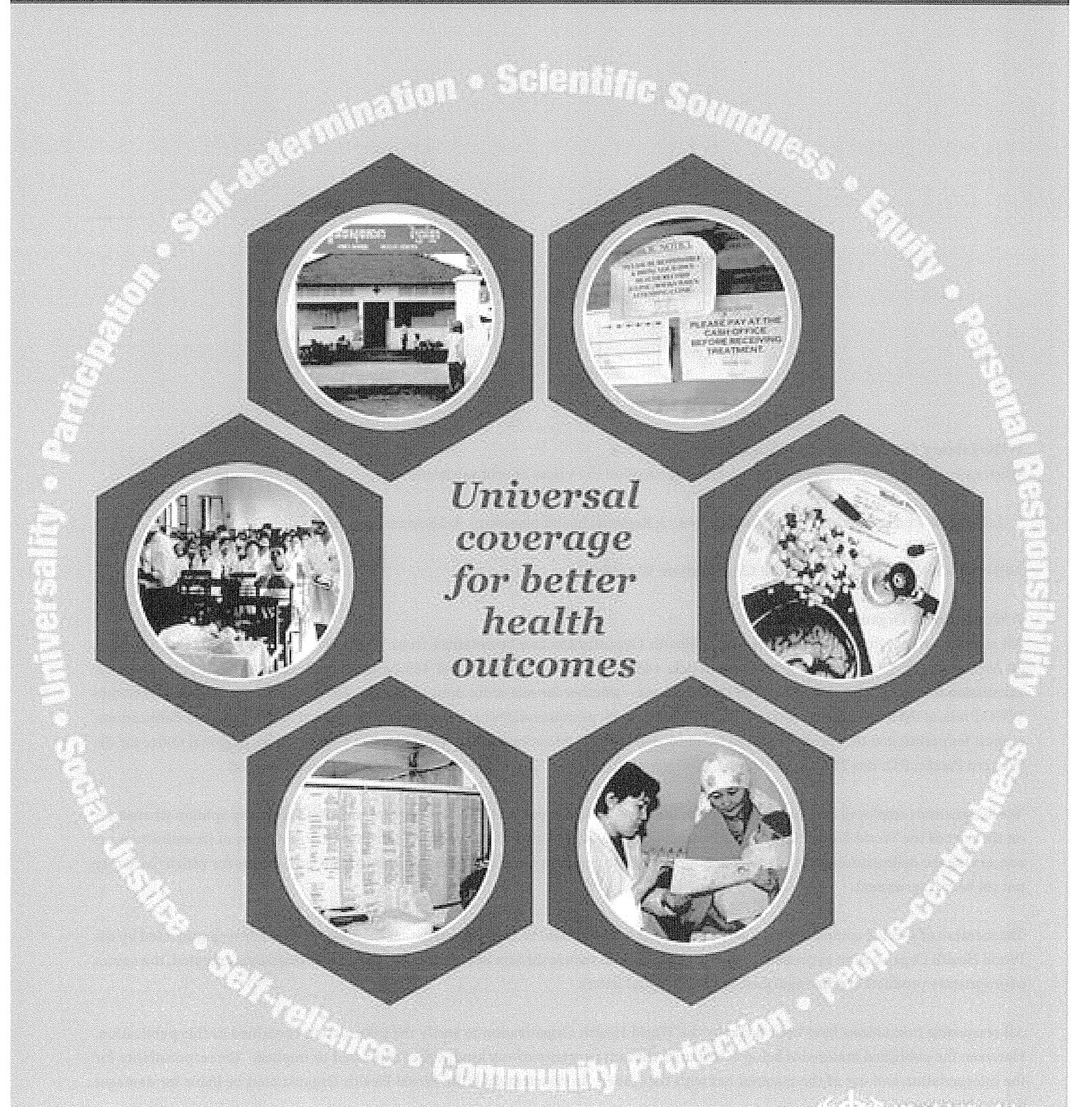


Universal coverage for better health outcomes



World Health Organization
Western Pacific Region

Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care



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Contents


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Foreword

Health systems throughout the Western Pacific Region are under stress. Strong and effective health systems are needed to achieve sustainable improvements in health outcomes and other important health goals, such as the health-related Millennium Development Goals. The *World Health Report 2008* reaffirmed the values of primary health care in achieving equitable and accessible health systems. By adopting the *Western Pacific Regional Strategy for Health Systems Based on the Value of Primary Health Care,* the Member States of the Western Pacific Region have identified equity, social justice, universality, people-centredness, self-determination, scientific soundness, personal responsibility, participation, self-reliance and community protection as key values for their health systems.

There is sufficient evidence to show that health systems based on the values of primary health care do better at achieving the four goals of health systems: improved health and health equity, universal coverage with financial risk protection, responsiveness to the population's desires for health services, and efficient use of resources.

This strategy provides evidence-based guidance and options for Member States on organization and use of resources related to each of the health system building blocks including the connections between them. It is necessary to look at health systems in a holistic fashion.

Strategy alone is not enough. Moving from strategy to action is even more important. Robust planning processes and sound management practices at all levels of the health system are crucial.

The Member States of the Western Pacific Region and their health systems are diverse. Each Member State will determine its own path towards the vision of 'Universal Coverage for Better Health Outcomes' defined in this strategy. WHO is committed to assist them in that endeavour.

Shin Young-soo, MD, Ph.D.
Regional Director


Universal
coverage
for better
health
outcomes

Executive Summary

The WHO Constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being". Effective and efficient health systems contribute to the progressive realization of that right. Health systems do better at attaining that standard if they are underpinned by core values such as equity, social justice, universality, people-centredness, community protection, participation, scientific soundness, personal responsibility, self-determination and self-reliance. Values such as these have been a part of the primary health care agenda since they were articulated in the *Declaration of Alma-Ata* adopted at the International Conference on Primary Health Care in 1978. Although there are wide variations in political, social and health systems both globally and within the Western Pacific Region, there is an increasing body of evidence that proves adherence to these core principles or values leads to better health systems and better health outcomes.

Evidence-based statements about international norms for health systems may help national leaders navigate among competing interests in the health sector. The *Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care* provides guidance that may assist national decision-makers overseeing the design and implementation of health systems adapted to their particular situations.

The people of the Western Pacific Region deserve to live their lives in the highest state of health possible. While there can be no guarantee of individual health, all people have a right to quality health services that are available, accessible, affordable and acceptable.

The four goals of a health system are:

(1) health, both the absolute level across the entire population and equity across socioeconomic groups;
(2) social and financial risk protection in health;
(3) responsiveness and people-centredness;
(4) efficiency.

Thirty years after the *Declaration of Alma-Ata*, a worldwide process of reflection on primary health care (PHC) culminated in *The World Health Report 2008: Primary Health Care, Now More Than Ever*. It concluded that countries that have organized their health systems on PHC principles have achieved better health outcomes in relation to the funds expended than those countries with health systems that are not based on PHC values. The report also found that the goals and values of PHC are as valid as they were in 1978.

Primary health care is closely related to but not synonymous with primary care. A strong primary care system is the foundation for a health system based on PHC values, but secondary and tertiary services that connect to the primary care system are also vital.

Four areas of reform, policy and action that foster the development of PHC-oriented health systems are described in *The World Health Report 2008*: (1) universal coverage intended to improve health equity and financial risk protection; (2) service delivery that is people centred, responsive and supports universal coverage; (3) leadership aimed at making health authorities more reliable and accountable to those they serve; and (4) public policy implemented across all sectors in ways that promote and protect the health of communities and individuals. People and their participation remain at the centre of PHC. Different countries and areas have plotted their own paths towards PHC implementation using different routes and concepts, such as universal coverage or "Healthy Islands" initiative.

A whole-of-system approach based on the values of primary health care is proposed as the most effective and sustainable way of strengthening health systems. The WHO framework of six building blocks for health systems strengthening is used as a tool to analyse health systems, although other frameworks are available. The important issue is that health systems are analysed holistically. Key issues in each of the six building blocks include:

(1) **Leadership and governance** – policy frameworks and health planning, managing the health sector, accountability and transparency, generating and interpreting information, building coalitions outside the health sector, and aid effectiveness.
(2) **Health care financing** – increasing investment and public spending, aid effectiveness, efficiency, prepayment and risk pooling, provider payment methods, safety nets, evidence for policy-making, and monitoring and evaluation.
(3) **Health workforce** – preparing the workforce with sufficient numbers, skill mix and quality with appropriate deployment; enhancing