



Who services primary health care and how can they be effectively and equitably created, motivated and maintained to provide good PHC services?

An excerpt from the PMAC 2008

The Prince Mahidol Award Conference in 2008 was co-organized by Prince Mahidol Foundation, Royal Thai Government, World bank, and taken place on 30 January—1 February 2008. This year's theme "*Three Decades of Primary Health Care: Reviewing the Past and Defining the Future*" was to commemorate 30th anniversary of PHC.

The Parallel Session 1 on "*Who services primary health care and how can they be effectively and equitably created, motivated and maintained to provide good PHC services?*" was the session that AAAH was involved, particularly on country case studies on HRH and PHC/CHC. The PHFI was commissioned by AAAH to synthesis case studies.

There are 5 speakers, including Dr. Manuel M. Dayrit from WHO-HQ who gave a presentation on primary health care and human resources for health, reviewing the past and defining the future; Professor Srinath Reddy from PHFI who also is AAAH steering committee member gave a presentation on a synthesis of country case studies; and the result of the synthesis was present at the conference. Professor Miriam Were from NACC and AMREF who presented a synthesis of African experiences; Dr. Sultana Khanum from WHO-SEARO; who gave a presentation on health workforce development for revisiting the PHC approach; and Dr. Badara Samb from WHO-HQ who gave a presentation on task shifting; rational redistribution of tasks among health workforce teams. Participants actively discussed after the presentation.

There are seven key recommendations developed from the session, as follow:

1. Build up partnership for health, involve all concerned stakeholders: public, private, communities, civil society, local authorities: to communicate and plan for an effective health care system and health workforce.
2. System design must be context specific and culturally, politically, and economically appropriate. CHW's must be rooted in the community and can serve a transformative role.
3. Reorientations of health professional attitude towards primary health care and broaden the scope of health workforce to cover volunteers, traditional healers, and care takers at community level.
4. Integrate community services into the main stream health system and recognize the roles of community volunteers as well as provide technical support: training, supervision, equipment to community volunteers.
5. Clear definition of roles, supervisory structures, referral patterns, and incentive packages for health workers at all levels. Pure volunteerism is not sustainable in many situations.
6. Consider implementing task-shifting according to the country context. Key factors need to be in place: standardization of tasks, high quality initial training and technical support. Properly implemented task-shifting can be done without adverse or even positive impact on quality, cost, patient outcomes, and patient satisfaction.
7. A range of appropriate motivation to retain health professionals in rural should be in place, with measures to motivate community health workers as well as community volunteers.