Issue 1, April 2021

Primary Health Care Matters

Articles, news & updates, resources on primary health care by The India Primary Health Care Support Initiative

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KEY IPSI UPDATES

Launch of IPSI Webinar Series - Public Health Matters in February 2021

Join us on Wednesday 21st April 2021 for our third webinar, Cost of scaling-up comprehensive primary health care in India: Implications for universal health coverage

Johns Hopkins India Health System Institute is offering eight online courses between 7th - 19th of June 2021 as part of the annual Health Systems Summer Institute offered by JHU's Health Systems Program. Click here to visit the IPSI fellowships page for eligibility requirements, application process and more information.

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The India Primary Health Care Support Initiative is pleased to share the first issue of *Primary Health Care Matters.* This Series presents commentaries on primary health care and health systems, IPSI news & updates, and related content on primary health care and health systems.

A little over a year ago, in March 2020, India went into one of the most stringent lockdowns in the world in an effort to contain the spread of COVID-19 and buy time to strengthen existing health system resources to manage an outbreak. Twelve months, and a brief respite from the pandemic later, COVID-19 is back with its second and third waves in India and globally, even as the world scrambles to prevent, identify and manage COVID-19 cases, alongside efforts to vaccinate people against the disease. Global cooperation led to the rapid development of many vaccines which can prevent COVID-19, and yet the inequities in vaccine access remind of the deep inequities which continue to exist in access to care for COVID-19, and indeed reflect the inequitable access to health care in general. This series also launches on World Health Day – a day to mark the anniversary of the First Health Assembly in 1948, and now commemorated annually by creating awareness on health issues. This past year has reaffirmed the important role of primary health care health emergencies, in ensuring health care services to some of the most vulnerable, and its critical role in health security and resilient health systems. This year's World Health Day theme is *Building a fairer, healthier world*, and PHC is critical towards achieving a fairer and healthier world.

The *Primary Health Care Matters* series is an effort to create a space for dialogue, and evidence for policy on primary health care. We welcome your comments, thoughts, and feedback. Enjoy your reading!

World Health Day 2021

Building a fairer, healthier world – World Health Day 2021

By Dr. Anand Krishnan
Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi

Achieving equity in health care is an important goal of most primary health care (PHC) system reforms. Equity in healthcare means that it should be provided solely on the basis of "need" and not on other extraneous considerations like – social or economic situation, gender etc. Social and structural factors play important roles in the development of disparities in health and health care. Research has identified low education, living in a disadvantaged area, and low socioeconomic status, as factors contributing to inequality in access to and utilization of health care.

Equity of health care has been divided into three domains: equal access to health care for people in equal need; equal treatment for people in equal need; and equal outcomes for people in equal need. However, need is not easy to define. Needs may be 'normative need' (defined by an 'expert') or 'felt need' (what people think they need assuming that they are knowledgeable); 'expressed need' (service utilisation). As not all 'felt need' gets turned into 'expressed need', there will be people who experience "unmet" need.

Equity could be either horizontal (equal treatment for individuals/groups with similar levels of need) or vertical (differential treatment of individuals/groups according to their need). Understanding the equity of primary healthcare services requires us to map, understand, and analyse the reasons for existing equalities using appropriate indicators to monitor access, treatment, and outcomes. If we do not measure inequities, then we have no chance of addressing them.

Primary health care is one of the most efficient ways of closing the equity gap and addressing the needs of those most disadvantaged. The central attributes of primary care are eminently suitable to address inequities: first contact with the health system (accessibility), people-centered comprehensive care (preventive, promotive, curative, and rehabilitative), continuum of care (including referrals towards secondary and tertiary care). Another cardinal feature of PHC is its engagement with the community and the bottom-up approach while promoting increased social cohesion and empowerment. Strong primary health care systems are critical component towards building a fairer, healthier world.

An introduction to the India Primary Health Care Support Initiative

The India Primary Health Care Support Initiative was established in July 2020 under a grant from the Bill & Melinda Gates Foundation. Led by the Johns Hopkins Bloomberg School of Public Health and the All India Institute of Medical Sciences, Delhi, IPSI aims to create a PHC focused ecosystem in select states by pursuing three "pillars":

Building capacity:
Aims to build technical capacity through courses, advance trainings, workshops, and exchange visits related to primary health care, focused on state health departments, and supporting organizations.

Implementation research on PHC
Aims to conduct short- or medium-term research studies to help program managers and decision makers improve implementation of PHC programs.

Evidence informed PHC policies
Aims to generate evidence from research and global best practices and promote its use for effective PHC policies.

Find out more about our project, partners, and team members on our *website*

Social Protection in the Time of COVID-19

Krishna D. Rao
Johns Hopkins Bloomberg School of Public Health

Pandemics are highly inequitable. They impose a disproportionate burden of morbidity and mortality on countries and people at the lower end of the income distribution. Moreover, as in the case of COVID-19, control efforts through social distancing and population lockdowns have brought additional deprivations on vulnerable populations. In low- and middle- income countries (LMIC) and elsewhere, the slowdown in economic activity has resulted in rapidly rising unemployment, particularly in the informal sector, where the majority of workers are employed and without adequate social safety nets. The effects of COVID-19 and population lockdowns will have short and long term effects on health, human capital, and income of vulnerable populations. It is now increasingly clear that economically vulnerable groups are being forced to sacrifice disproportionately more for the better health of society. To mitigate the deprivation due to COVID-19 it is necessary for government safety net programs to provide long term support focused on specific vulnerable populations.

The association between pandemics and poverty is well known. The 1918 Spanish flu left around 500 million people infected and at least 50 to 100 million deaths worldwide. Poor countries bore the brunt of the pandemic. Between 1918 and 1920, India, which at that time was under British rule, had an estimated loss of *18 million lives or 6% of the population*, the highest anywhere. In contrast, the United States, where the flu might have originated, experienced only *675,000 deaths*. Similar, social inequities are seen in the current COVID-19 pandemic. In New York City COVID-19 related mortality is disproportionately *higher among Latino's and blacks*. Deaths and illness due to COVID-19 are both an emotional and economic shock. Deaths, particularly of earning family members, represent a huge financial loss to vulnerable households, which can take a long time to recover from. Further, those who are unable to work due to contracting COVID-19 will experience substantial income losses; this will be particularly challenging for daily wage earners and poor households. Such productivity losses have been reported to be as large as *half the income* of the poorest households. While inequities in COVID-19 morbidity and mortality are yet unknown in low and middle-income countries, given that the social conditions there are much more conducive to epidemic spread, the pandemic will likely disproportionately affect economically vulnerable households.

Pandemics affect the economic well-being of survivors long after they are over. Studies from several low and middle-income countries and elsewhere have reported that exposure to tropical diseases and poor nutrition in-utero or during early childhood have long lasting effects on future cognition, educational achievement, and *adult income*. A study on the Spanish flu in the United States reported that individuals who were in-utero during the pandemic, as adults displayed reduced educational attainment, increased rates of physical disability, lower income, and greater dependence on social security payments, compared with *birth cohorts just before and after the pandemic*. For example, children born to infected mothers were 15% less likely to graduate from high school, their annual wages were approximately 5–9 percent lower, and disability rate was 20% higher at age 61, compared to birth cohorts not affected by the flu. Importantly, these effects were greater in socially vulnerable populations such as women and non-whites. The long term inter-generational effects of the flu will affect the economically vulnerable disproportionately. As such, relief programs need to have a long time horizon.

Irrespective of the extent to which COVID-19 inflicts financial hardship on vulnerable households, it is certain that COVID-19 control measures such as social distancing and population lockdowns will profoundly affect their economic well-being and health. Globally, so far, around 2.6 billion people *have been put on lockdown due to COVID-19* control measures. In LMICs, like elsewhere, the collapse of economic activity has affected employment and livelihoods on a massive scale. The International Labor

Organization estimates that more than 25 million jobs will be lost globally, *a large share being in LMICs*. The workforce in LMICs is largely in the informal sector with limited access to paid or sick leave, or social safety nets. The loss of employment is already playing out in dramatic ways - in India thousands of migrant workers started fleeing cities because they found themselves without any income after the lockdown was announced; in Bangladesh, 1 million garment *workers have lost their jobs* due to the population shut down. Large scale unemployment is also seen in more prosperous countries such as the United States, and Spain.

The loss of livelihoods due to COVID-19 control measures will affect the health of economically vulnerable populations in both the short and long term. For poor households, the health effects due to loss of livelihood will result in greater emotional stress, lower food and health care consumption. Further, the closing of schools due to the lockdown has deprived many children of their only nutritious meal through school-feeding programs. The health effects on pregnant women and children are particularly important because of their long term effects.

Governments in LMICs have announced a range of social protection measures to address the economic hardship faced by vulnerable households. These limited-time interventions have relied on existing safety nets and typically include – providing free or subsidized food, direct cash transfers, extending unemployment insurance for those in the formal sector, providing microfinancing loans or *restructuring existing loans*. The effectiveness of these safety nets will depend on the adequacy of the relief package, how well they reach the poorest groups, and efficiencies in delivery system. It is important to note that these measures are one-off measures intended only for a short period of time. However, the economic and health deprivation caused by COVID-19 will have long term effects. Addressing the long term health and economic effects of COVID-19 is much more challenging. It will require extending relief measures for a longer duration to at least a few years and expanding the benefit package. To prevent human capital deprivation in the future, both long and short term relief measures will need to target specific populations like pregnant women and young children. As noted in studies on the effect of 1918 Spanish flu and tropical diseases more broadly, exposure to infectious disease and poor nutrition during pregnancy and early childhood affect children's future cognitive ability, educational attainment, productivity, and income. Protecting vulnerable households from the short and long term consequences of COVID-19 will be expensive and require sustained political commitment.

Pandemics affect the economic well-being of survivors long after they are over. The COVID-19 outbreak will affect economically vulnerable populations in LMICs in multiple ways in both the short and long term. Recent government actions in this direction are helpful but they are focused on the short-term. As such, governments need to take a long term view of mitigating the many economic and human capital effects of COVID-19 and its control measures.

Addressing chronic and noncommunicable diseases through primary health care

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Globally, noncommunicable diseases (NCDs) are responsible for *about 70% of all deaths*, resulting in nearly 15 million premature deaths globally i.e., deaths between the ages of 30 and 69 years. The majority of these deaths at 85% occur in low- and middle-income countries (LMICs). NCDs such as cancer, CVD, CRD, diabetes and mental health – can result in a cumulative output loss of US$ 47 trillion over the period 2011-2030 i.e. nearly *75% of the global GDP* in 2010. CVDs and mental health diseases are the two main *contributors to the global economic burden* of NCDs. In India and other South-East Asian countries, NCDs affect a relatively younger population as compared to the western countries.

In LMICs, PHC for NCDs can support constrained health system in the prevention and management of NCDs. This is especially critical in the case of management of chronic conditions which might require frequent access to health care services and monitoring. In addition, often chronic conditions need to adopt a continuum of care approach, and primary health care services can be a critical component of the health system in meeting these needs of NCD care.

A primary health care approach to NCD management can play a key role in the prevention, screening, and management of NCDs and chronic care conditions. This may include community health workers involved in surveillance of NCD risk factors and also disease in the population; health promotion – from tobacco cessation to messaging on harmful alcohol use, encourage physical activity and better diet to also messaging on accessing health services and management of NCD in primary care settings.

Evidence from countries such as New Zealand, Mexico, countries of the OECD, England and Wales show that reduction in cause-specific premature mortality from asthma, cancer and CVD is attributed to treatment and *improvements in primary care*. Community engagement is key to ensuring better acceptance and adhering to preventing and treatment measures on NCDs. In Thailand, a primary care system based on community participation started in 1985 through the recruitment of health volunteers, establishment of health centres and a drug cooperative system. Strong health infrastructure, competent staff, and secured budget boost PHC capacity to address NCD prevention, case management, referral, and rehabilitation. Community engagement through *village health volunteers* improves NCD awareness, enrolment in screening and adherence to interventions.

Efforts have also been made to outline pathways for NCD management in primary health care. Evidence based guidelines can lay the foundation for effective NCD management at the primary health care level with the necessary adaptations for local or country needs. For example, the WHO has recommended the *Package of Essential Noncommunicable Disease Interventions* (WHO PEN) for primary care in low-resource settings. The components include protocols for clinical diagnosis guidance on essential medicines and diagnostic technologies and indicators to monitor the programme. WHO PEN lays emphasis on using a people-centred approach to care, ensure continuity of care to improve patient outcomes, whilst making efficient use of limited resources.

Integrating NCDs in primary care offers a cost effective, affordable, and equitable model of care that can reduce morbidity and mortality from NCDs. Scaling up coverage of evidence-based interventions for NCDs in primary care could play a major part in reaching the SDG target to reduce premature mortality from NCDS by one third by 2030 through prevention and treatment. There is a need to review the current PHC strategies to adapt to the changing epidemiology of diseases, changing demographic and emerging health conditions. To meet the needs of the planned and ongoing PHC reforms, it is also crucial to build the capacity of health system at all levels with the ultimate goal of improving the quality of care and achieving Universal Health Coverage.

Financing for Primary Health Care

Harsha Joshi
India Primary Health Care Support Initiative (IPSI)

The year 2020 brought global attention to public health and health systems. Faced with the COVID-19 pandemic, governments across the world are prioritizing the health sector and its resource requirements. In India, recent developments such as the 15th Finance Commission (FC) report, and the Union Budget 2021-22 indicate increased government attention to the health sector. Importantly, there is a renewed focus primary health care reforms and increased financing for primary health care.

Efforts to increase financing for the health sector, including primary health care are being made against the backdrop of the COVID-19 pandemic – which saw even the strongest of health systems struggle to cope. Primary health care systems emerged as being integral to the COVID-19 response globally, and it its role in future health system resilience and security.

Focus on Primary Health Care post-2020

The union budget of India was presented on the 1st of February 2021. The Budget 2021-22 announced a new scheme for the health sector – Pradhan Mantri Aatma Nirbhar Swasth Bharat Yojana (PMASBY). At the same time, the 15th Finance Commission (FC) report was also tabled in the parliament.[1] The core of the 15th FC grant's support and significant proportion of PMASBY funds is for supporting the Ayushman Bharat-Health and Wellness Centre initiative (AB-HWC), India's new flagship comprehensive primary health care initiative.[2]

15th Finance Commission

The 15th FC report highlights the challenges in India's health care system and views strengthening the primary health care system as a key solution to a stronger health system. For example, the *report states*, "*primary health care should be the number one fundamental commitment of each and every State and that primary health expenditure should be increased to two-thirds of the total health expenditure by 2022*". Following the suggestion by union health ministry regarding allocation of funds, the 15th FC has recommended Rs. 1,06,606 Crores of grants-in-aid support to health sector over the five-year period, which is 10.3% of total grants-in-aid support by FC. This also represents a shift from the previous 14th Finance Commission which presented a combined grant to states and local bodies for drinking water and sanitation, education and health. Moreover, Rs. 70,051 Crores out of this grant (two-thirds of total health grant) are to be released to local governments towards primary health care system strengthening (Table 1).

Table 1. 15th FC Health Grants through Local Governments

	Sub-components	Amount (Rs. Crore)
1	Urban HWCs	24,028
2	Building-less sub centres, primary health centres, community health centres	7,167
3	Block level public health units	5,279
4	Support for diagnostic infrastructure to the primary healthcare facilities	18,472
5	Conversion of rural sub centres and primary health centres to HWCs	15,105
	Total	**70,051**

Source: *15th Finance Commission- Chapter 7, Main Report*

[1] The finance commission provides recommendations on distribution of tax revenues between the Union and the States and amongst the States themselves for period of five years.

[2] Government of India launched the AB-HWC initiative in 2018 to provide comprehensive primary health care through upgraded primary health care facilities (sub centres in rural area and primary health centres in rural and urban area). Till date (as on 31st March 2021), 74,283 AB-HWCs (source: AB-HWC portal, MoHFW) have been operationalized as against the target of 1,50,000 HWCs to be established by December 2022.

Union Budget 2021-22

This year's health sector budget presented a 137% increase over last year's health budget estimates. The 'Health and Wellbeing Expenditure' amounting to Rs. 2,23,846 Crores, as announced by Finance Minister in her *budget speech* includes other heads in addition to the health ministry such as the budget of the Ministry of AYUSH, Department of drinking water and sanitation, COVID-19 vaccination funds and 15th FC grants for health and sanitation. Thus, there are no additional heads within the health ministry's budget and other existing heads have been included in this 137% increase. This can be misleading in judging the changes in government health expenditure.

There has only been a marginal increase in funds for primary health care in the union budget. Broadly, funds for National Health Mission can be considered as funds for primary health care within the MoHFW budget as NHM aims to build district health systems and to strengthen the primary health care service delivery. However, here we consider AB- HWC initiative funds as indicative for primary health care financing as it is more directly linked. Funding for AB-HWCs has increased over the years (Table 2). These *funds are allocated* for infrastructure, human resources, diagnostics, and IT equipment for upgradation of health facilities to HWCs. The actual expenditure for years *2018-19* and *2019-20* has been reported as 100%, though there is a need to further examine this.

Table 2: Funds for AB-HWC from 2018-19 to 2021-22

Revised Estimates 2018-19	Budget Estimates 2019-20	Budget Estimates 2020-21	Budget Estimates 2021-22
1200 Cr	1600 Cr	1600 Cr	1900 Cr

Source: *Expenditure budget volume, Ministry of Finance*

Pradhan Mantri Aatma Nirbhar Swasth Bharat Yojana (PMASBY)

During the union budget (2021-22) speech, the Finance Minister announced a new centrally-sponsored scheme – the Pradhan Mantri Aatma Nirbhar Swasth Bharat Yojana (PMASBY) which has an outlay of Rs. 64,180 Cr. over six years. The *scheme will support states*, in addition to NHM funds, for building primary, secondary, tertiary health systems and strengthening of national institutions. One of the sources of funding for this scheme is by the *Asian Development Bank* under a results-based lending program, with *central and state governments also contributing to the funding*. Further details of the scheme, including the mechanisms of fund flow are unclear yet. It is expected that the PMASBY will support following aspects of the primary health care system:

a. Building health infrastructure (primary health care facilities) in rural areas in the seven high focus states and three north-eastern states.

b. Upgradation of 11,024 urban primary health care centres to HWCs.

c. Establishing block public health units at 3382 blocks in 11 high focus states.

What is the current Primary Health Care financing status and what do these announcements mean for Primary Health Care financing?`

Separating expenditure on primary health care from the total health expenditure, is not always clear. Allocation and expenditure on primary care and health system strengthening initiatives for building primary health care systems have been used as measures for understanding primary health care financing.

In India, the National Health Accounts (NHA) provides estimates for expenditure on primary care. *In 2016-17*, (the most recent NHA estimates) out of a total current health expenditure, 45.2% was spent on primary care.[3]

[3] As per National Health Accounts 2016-17 report, expenditure on primary care includes the following- 1) Expenditures under preventive care under all healthcare providers, 2) All expenditures at Sub Centers, Family planning centers, primary health centres, dispensaries (CGHS, ESIS, etc., private clinics) except for those incurred for specialized outpatient care and dental care. Expenditures for general outpatient curative care at all healthcare providers including related diagnostic and pharmaceutical expenditures apportioned from where ever relevant, 3) Expenditures under all pharmaceuticals and other medical nondurable goods, therapeutic appliances and other medical goods purchased directly by the household, 4) Expenditures for inpatient curative care at all ambulatory centers including expenditures related to childbirth at Sub Centers, 5) Expenditures under rehabilitative care at offices of general medical practitioners, 6) Expenditures under all long-term care and Expenditures under patient transportation.

Government expenditure on primary care was 52.1% of current government health expenditure, which is significantly less compared to the *National Health Policy goal* of 66-67%. The trend has nearly been the same since 2013-14. An increase in primary care expenditure can be expected after the launch of AB-HWC initiative in 2018 followed by further increase after 2020.

Funds for primary health care are routinely provided through the NHM and include central and state government contributions. The Centre's share is released to state health societies. In a remarkable change to this fund flow suggested by the 15th FC, the grants are to be directly allocated to the local government bodies across the district, block, and village levels. Learning from the key role played by Panchayats in COVID-19 management, the Commission has engaged more deeply at the level of the local government for health sector planning, and extended resources to them to strengthen primary health care. Panchayati Raj Institutions are to be involved as supervising agencies in the primary health care institutions. This recommendation will go a long way in strengthening community participation and the management of primary health care systems.

Another observation on PHC financing is on the overlaps in sub-components proposed to be funded by 15th FC grants, PMASBY and the existing NHM functions. 15th FC grants and PMASBY, both are supporting HWCs in rural and urban areas and block public health units. Although prioritization of primary health care is an affirmative step, this overlap indicates limited coherence in resource allocation planning. The timelines for allocation of resources for AB-HWC also need to be aligned with the AB-HWC target timelines (till 2022), as the 15th FC grants and PMASBY funds are provided over the duration of five (till 2026) and six years (till 2027) respectively. This would require changes in budgetary allocations through PMASBY and NHM.

Greater allocation of resources to primary health care is a measure of the relative prioritization of this important investment in human development and the health sector by policymakers. The increase in funding is a much-needed step towards strengthening AB-HWCs. Alongside it is important to strengthen other aspects of the health system such as capacity building of health workers, ensuring continuum of care, improving quality of care and investment in related social sectors. Together this will contribute to enhancing the wellbeing of people and building a strong primary health care system in India.

IPSI COURSES

Courses for Capacity Building

Strengthening institutional capacity within States to build stronger primary health care systems is one of the aims of the IPSI project. Two short courses for state program officers are currently being designed in partnership with the All India Institute of Medical Sciences, New Delhi under the capacity building component of IPSI. These are (a). Future Primary Healthcare Systems; (b). Implementation Research.

The training on 'Future Primary Health Care Systems' aims to foster thinking on primary health care system models, to develop understanding and practical competencies for key essential public health functions. Learning from global and Indian primary health care experience and models will be integral to the content of this course.

The short course on 'Implementation Research' aims to develop understanding about implementation research among the program managers. This will enable program managers to build to articulate relevant research questions and collaborate with researchers and to use the generated evidence to strengthen delivery of health services and program implementation.

An initial needs assessment has been conducted to understand the status and requirements of state program officers before designing the course modules. In person interviews were conducted with 16 state program officers at Haryana and Rajasthan for this in March 2021. The exercise helped us identify areas of study of relevance for our target group, preferred mode of study, and identify appropriate stakeholders for the course.

Needs assessment for capacity building initiatives at Haryana State Health Department

Courses are designed to be delivered through didactic lectures, examination of case studies, group-based discussions, and skill-building sessions to make it participatory. IPSI will support the cost of training for the development of these course, and participation. Trainees will be provided with a Certificate of Participation from partner academic institutions after successful completion of the course.

Click here to download our course brochures

Johns Hopkins India Health System Institute

IPSI Global Health Scholars Program offers scholarships for short-term courses to eligible candidates interested in enhancing their competency in the field of primary health care. The program is currently accepting applications for the India Health Systems Institute (IHSI). IHSI is a new initiative by the Health Systems Program in the Department of International Health at the Johns Hopkins Bloomberg School of Public Health (JHSPH), and the India Primary Health Care Support Initiative (IPSI). The IHSI features fully online courses designed specifically for participants from India and are taught by leading faculty at JHSPH. The Institute is offering eight courses between the 7th to the 19th of June 2021:

- Evaluation of District-Level Primary Health Care Implementation in Low-and Middle-income
- High Performing Organizations in LMIC Settings
- Design and Implementation of Incident Management Systems in Low- and Middle-Income

- Global Health Entrepreneurship: from Ideas to innovations
- Essential Skills for Women's Leadership in Global Health
- Introduction to Household Surveys for Evaluation of Primary Health Care Programs in Low- and Middle- Income Resource Settings
- Introduction to Design and Implementation of Digital Health Programs in LMIC Settings
- Modeling and Simulation for Health Workforce Analysis

The IPSI Global Health Scholars program will sponsor the fees for one IHSI course per scholar. **Last date for applications is May 15th, 2021**

Click here to visit the IPSI fellowships page for eligibility requirements, application process and more information.

IPSI UPDATES

Launch of Public Health Matters – IPSI Webinar Series

IPSI Webinar 1: Primary care in the COVID-19 response: Global Experiences

On the 24th of February 2021, the India Primary Health Care Support Initiative (IPSI) launched its online webinars series 'Public Health Matters'. The first virtual panel discussion was on Primary care in the COVID-19 response: Global Experiences. The panel, moderated by the IPSI Director Krishna D. Rao, comprised of health system experts from different countries. Mr. Manoj Jhalani, Director, Department of UHC/Health Systems & Life Course, WHO SEARO started the session with a discussion on the response to COVID-19 from countries in the SEARO region. Dr. Anand Krishnan, Professor Centre for Community Medicine, and member of the AIIMS team (IPSI National Partner) introduced the response to the disease outbreak in India. Dr. Titiporn Tuangratananon, Research Fellow IHPP, Ministry of Public Health Thailand gave an overview of the primary health system in Thailand – and how its structure served to respond to the COVID-19 health emergency. Lastly, Professor David Bishai from the Johns Hopkins Bloomberg School of Public Health brought in a wider global health perspective to the discussions.

Click *here to watch the webinar* on Primary care in the COVID-19 response: Global Experiences

IPSI Webinar 2: A tale of two cities: urban primary health care and the COVID-19 response in Rio and Mumbai

The second IPSI webinar focused on the response to COVID-19 at the primary health care level in urban areas in two BRICS countries – India and Brazil. Dr. Padmaja Keskar, who recently retired from the Greater Mumbai Municipal Corporation, India brought in her experience in the COVID-19 response at the critical initial few months of the outbreak. Dr. Claudia Pereira, associate professor, Fiocruz introduced the audience to the experience of the COVID-19 response in Rio.

Click *here to watch the webinar* on urban primary health care and the COVID-19 response in Rio and Mumbai

RESOURCES

Readings

The significance of primary health care for building back better: lessons from COVID-19

"The coronavirus disease 2019 (COVID-19) pandemic, with its overlapping public health and economic emergencies, is a global reminder of the importance of addressing social and environmental determinants of health and inequality, and investing in health systems oriented towards primary care, all of which are components of a primary health care (PHC) approach."

Strengthening primary health care in the COVID-19 era: a review of best practices to inform health system responses in low- and middle-income countries

"Successful PHC strengthening initiatives required substantial reform across all four of the framework's strategic levers – political commitment and leadership, governance and policy, funding and allocation of resources, and engagement of communities and other stakeholders. Importantly, strategic reforms must be accompanied by operational reforms; the strongest evidence of improvements in access, coverage and quality related to service delivery models that promote integrated services, workforce strengthening and use of digital technologies. Strengthening PHC is a "hard grind" challenge involving multiple and disparate actors often taking years or even decades to implement successful reforms. Despite major health system adaptation during the pandemic, change is unlikely to be lasting if underlying factors that foster health system robustness are not addressed."

Read the full issue of the WHO South-East Asia Journal of Public Health here

PRIMASYS: a health policy and systems research approach for the assessment of country primary health care systems

"There is no one-size-fits-all model of a country-level PHC system, and countries have implemented diverse models, adapted to and conditioned by their respective social, economic and political contexts. This paper applies advances in the field of health policy and systems research (HPSR) to propose an approach to the assessment of country PHC systems, using a compendium of 70 elements of enquiry requiring mixed quantitative and qualitative assessment. The approach and elements of enquiry were developed based on a review of policy and guidance documents and literature on PHC and HPSR and were finalized as part of a consultation of experts on PHC. Key features of the approach include sensitivity to context, flexibility in allowing for in-depth enquiry where necessary, systems thinking, a learning emphasis, and complementarity with existing frameworks and efforts. Implemented in 20 countries to date, the approach is anticipated to have further utility in a single country as well as in comparative assessments of PHC systems."

Events

IPHACON 2021

The 65th Annual National Conference of the Indian Public Health Association will take place between the 24th to 26th of September 2021. The conference is being organised by the Department of Preventive and Social Medicine, JIPMER International school Of Public Health, and the Indian Public Health Association.

Early Bird Registrations ongoing for the 14th International Health Economics Association Congress

The biennial Congress will be hosted virtually in 2021.

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