PEOPLE-CENTRED CARE IN LOW- AND MIDDLE-INCOME COUNTRIES

World Health Organization

ACKNOWLEDGMENTS

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BACKGROUND

Putting people at the centre of health services is a core aspect of primary health care.[1] It implies that services are organized around people's needs and expectations, so as to make them more socially relevant and responsive, while producing better outcomes. People-centred care works towards close and direct relationships among individuals, communities, and health workers. It prioritizes people's personal experiences of health and illness, and the circumstances of their daily lives. Patients, families, and communities' perspectives and choices are sought, heard, and respected. Their knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

In numerous high-income countries, health systems are moving towards people-centred approaches. However, in most low-and middle-income countries, this is not happening yet. People-centred care is at least as necessary in low- and middle-income countries where resources are scarce and systems are under pressure to be both integrated and efficient.

Given the importance of these issues, the World Health Organization convened a satellite meeting as part of the Third Geneva Conference on Person-centred Medicine. The conference was co-organized by the International Network for Person-centred Medicine (INPCM), the World Medical Association (WMA), the World Organization of Family Doctors (Wonca), and the World Health Organization (WHO), in collaboration with other major international medical and health organizations, and under the auspices of the Geneva University Medical School.

This special session focused on people-centred care in low- and middle-income countries. The objectives were to better understand how people-centred care can be implemented and scaled-up in low- and middle-income countries; and to identify future priorities and strategies for disseminating this approach in resource-constrained health systems. Presentations highlighted experiences in implementing people-centred services in several low- and middle-income countries: El Salvador, Malaysia, Rwanda, Thailand, and the United Republic of Tanzania.

WHAT IS PEOPLE-CENTRED CARE?

People-centred care is care that is focused and organized around people, rather than diseases. Within a people-centred approach, disease prevention and management are seen as important, but are not sufficient to address the needs and expectations of people and communities. The central focus is on the person in the context of his or her family, community, and culture (see table below).

People-centred care is broader than a closely-related concept, patient-centred care. Whereas patient-centred care is commonly understood[2] as focusing on the individual seeking care—the patient—people-centred care encompasses these clinical encounters and also includes attention to the health of people in their communities and their crucial role in shaping health policy and health services.

Distinguishing features of conventional HEALTH care and people-centred care

Conventional care	People-centred care
Focus is on illness and cure	Focus on health needs
Relationship limited to the moment of consultation	Enduring personal relationship
Episodic curative care	Comprehensive, continuous and person-centred care
Responsibility limited to effective and safe advice to the patient at the moment of consultation	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	People are partners in managing their own health and that of their community

Source: World Health Report 2008, p 43

Core principles of people-centred care include the following.[3][4][5][6][7]

◆ Dignity and Respect. Patients, families, and communities' perspectives and choices are sought, heard, and respected. Their knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.

◆ Focus on the whole person. People-centred care views people as more than their diseases. It sees them in the context of their daily lives, as part of a family and a community, and over the life course from childhood to old age. People's health and well-being are considered from a biopsychosocial perspective, and maximizing quality of life is a paramount treatment objective.

◆ Partnership. Within a people-centred approach, power and responsibility are shared among patients, health workers, and communities. People are enabled to participate, to their level of ability and preference, as partners in their own health and that of their community.

People-centred care is at the heart of the World Health Organization's renewed focus on primary health care. The ultimate goal of primary health care is better health for all. Organizing health services around people's needs and expectations is one of the four key policy directions for achieving that goal, along with moving towards universal coverage, health in all policies, and more inclusive health governance.

As such, people-centred care is not an optional luxury, but both necessary and feasible for all health systems around the world. While most experiences to date have happened in high-income countries, people-centred approaches also have been successfully implemented and scaled up in low- and middle-income countries.

EXPERIENCES IN IMPLEMENTING PEOPLE-CENTRED CARE IN LOW- AND MIDDLE INCOME COUNTRIES

People-centred care is already happening in low- and middle-income countries. Approaches have differed: in some countries, the process has been top-down, starting with a national policy and high-level commitment by government officials. In other cases, people-centred care has been introduced as a small demonstration project and thereafter spread to other parts of the country. Some people-centred approaches cover the entire spectrum of health services, while others are focused on a specific health issue.

A summary of the experiences in El Salvador, Malaysia, Rwanda, Thailand, and the United Republic of Tanzania is provided below. They represent diverse approaches to implementing people-centred care in low-and middle-income countries.

El Salvador

According to WHO estimates, in El Salvador the number of women who die during or immediately following pregnancy (maternal mortality) is 170 per 100 000 live births.[8] Most of these deaths occur among women who are young, poorly educated, or of low socioeconomic status. El Salvador's maternal mortality rate is much higher than the regional average of 99 deaths per 100 000 live births[9]; poor-quality maternal health services combined with significant social and economic disadvantage have been put forward as reasons for this high rate of maternal deaths.

In response to this problem, since 2006 the government of El Salvador, in cooperation with a range of national and international partners, implemented a people-centred approach to improve maternal and neonatal health. Goals included improving access to maternal health services; empowering women, their partners, families, and communities to improve the health of women and newborn; promoting intersectoral participation and networking; and influencing relations between national and local levels of the health system.

> **" We learned that we needed the participation of people and communities at all stages."**
>
> Ms Ana Ligia Molina, Coordinator
> Programme for Empowerment of Women,
> Individuals, Families and Communities,
> El Salvador

Efforts started with team building among different health authorities at national, regional and departmental levels. Within each municipality participating in the programme, committees were formed and comprised of representatives from municipal government, local institutions, nongovernmental organizations, health workers, and the community at large.

A series of community consultations were undertaken. Separate fora were held for women of childbearing age; their mothers, mothers-in-law and grandmothers; their partners; health workers; and community and religious leaders. Recommendations from each of these fora were brought to an inter-stakeholder forum, where consensus was sought on priority problems and the specific ways forward to improve maternal and neonatal health.

The programme has been implemented successfully in eight municipalities to date. Although the consultative process has been the same, each municipality has generated its own set of solutions based on its unique context and priorities. Maternal deaths have dropped to zero since 2006 in 90% of the municipalities involved. More generally, the process of analysis and consensus building has developed community capacity, ownership, and leadership, and has improved relations with health services. Intersectoral links and coordination mechanisms also have been strengthened.

The results of this experience will be used to inform national level policies and plans. In particular, it will again be incorporated into the new national plan for the reduction of maternal, perinatal, and neonatal mortality as well as the plan for social participation.

Malaysia

In Malaysia – a country of 27 million people with limited resources for health – principles of people-centred care have been incorporated into national health policies. A 'person focus' is included among Malaysia's national health service goals. Other national policies and strategies do not carry the explicit label of people-centredness, but are fully consistent with the ideals and principles of people-centred care. These include a focus on wellness, a commitment to the provision of accurate and timely information, empowerment of people for self-management of their health, tailored health services provided close to people's homes, and integrated services throughout the life course. Importantly, primary care services are accessible to all people and almost free of charge. Each patient is charged a nominal fee of MYR 1 (equivalent to US $0.30) for each outpatient visit.

In addition to these broad policy commitments, the Ministry of Health has introduced a set of innovations to improve health-care quality and people-centredness. For example, in the states in East Malaysia, residents in the more rural and remote areas have their own home-based health cards, which allow them to have ready access to their health records and to obtain health care at any facility. Recently, a 'my health e-portal' has been made available online and electronic lifetime health records have been introduced in some of the newer computerized hospitals. Clinic hours have been extended to be more convenient for patients, and home visits are now available in some hospitals for paediatric patients. Pilot projects are underway to assess the usefulness of postal delivery of medications and drive-through pharmacies. To help further assure quality of care, the government has introduced practice guidelines, legislation, credentialing, and privileging. Continuing professional development and systematic mechanisms for patient and family feedback on quality of care are additional measures to improve the quality of services. Efforts have been made to shape the health workplace culture towards greater professionalism, caring, and teamwork.

These and other innovations are meant to improve health care quality and efficiency while simultaneously improving the experiences of patients and families within the health care system.

Rwanda

Rwanda faces an exceptionally large burden of mental disorders. Rates of depression and post-traumatic stress disorder have been reported at levels that far exceed international averages. Much of the country's burden of mental disorders can be traced back to the genocide in 1994, which resulted in the deaths of more than one million people and untold additional disability and suffering.

In response to the burden of mental disorders, the government of Rwanda has taken steps to provide people-centred services for all with mental health problems. It developed its first national mental health policy in 1995. By 2005, mental health was identified within the overall health sector policy as a priority area for intervention. This policy also called for the integration of mental health services in all national health system structures and at the community level.

Mental health services are now decentralized, mainly to district hospitals. Currently, 41 of 43 district hospitals in the country offer mental health services. Care plans are personalized for each individual's unique situation, and health care is provided as close to home as possible. Specially-trained nurses provide a broad range of mental health services under the supervision of a physician. Tools have been introduced to facilitate referral and coordination between the different levels of care. Mental health workers are provided with on-site supervision and participate in regular case review sessions. Importantly, medical students and other health workers in training also receive training and supervision on how to address mental health issues and conditions.

"Families are our partners in the health-care business; everything is done with them."

Dr Yvonne Kayiteshonga, Director
National Mental Health Programme,
Rwanda

Mental disorders are managed from a biopsychosocial and holistic perspective. Affected individuals are seen not only in terms of their disorders, but also in terms of their history, community, and current life circumstances. Families are viewed as key care partners, and community groups are engaged to raise awareness about the extent of mental disorders in the country and to dispel common misunderstandings about their causes and treatability.

A range of capacity building efforts are underway currently. Primary health workers are being trained to provide mental health services that are integrated with general health services. Similarly, community health workers and other community stakeholders are being trained to fight stigma and help support people with mental disorders to join health care facilities and also to reintegrate into society.

Thailand

Until recently, Thailand's health system was based on a conventional care approach that emphasized hospital-based and specialty services over community-based and primary-care services. Whereas hospital medicine flourished, family practice was essentially unknown.

In 1991, a handful of innovators started demonstrating across a range of different health centres that people-centred primary care was both possible and preferable. Key features of their new approach included regular community meetings to hear people's views; systematic use of patient and family records, as well as registries for clinical populations; improved referral systems between the primary health centres and hospitals; strengthened use of home visits; and a payment system that was based on flat rates per illness episode. Importantly, the model also introduced a new way of interacting with people during clinical encounters – emphasizing privacy, listening, and negotiation. Over time, tools were developed to facilitate dissemination of this approach and training was introduced into pre-service curricula of nurses and physicians.

Political will was developed strategically by organizing demonstration visits to family practice health centres. These visits provided a clear vision of what people-centred family practice could achieve. Visits were organized for politicians (the Minister of Health, the Deputy Governor of Bangkok, senators, members of parliament), high officials (the Permanent Secretaries of the Ministries of Health and Interior), representatives of civil society and consumer organizations, and students and health workers. Collectively, these visits helped convince a wide range of leaders – within and beyond the health sector – that a people-centred family medicine approach was both feasible and useful.

> " *I am convinced that if we had not decided to start by showing what could be done, even if that meant learning by doing, and even if we had no formal evidence that what we were going to try would work, we would never have gone so far.*"
>
> Dr Yongyuth Pongsupap, Senior Expert
> Health Care Reform Project,
> Thailand

Following Thailand's universal coverage reforms of 2001, this model of care was adopted by the government as the cornerstone of its new primary care-based health care system. Within one year, the programme spread from 60 health centres covering 600 000 inhabitants, to 1164 health centres covering 12 million people.

A key lesson from the Thai experience is that both technical field work and political pressure are important in facilitating change. Their people-centred family medicine model was developed over ten years before becoming part of the national strategy for universal coverage. During that time, the approach was refined, tools and guidelines were developed and, importantly, the model's visibility was enhanced among political and health leaders. In 2001, when the political movement for universal coverage resulted in national reforms, the people-centred family medicine model was already tried, tested, and known, and was therefore adopted as the means of delivering health care to all.

United Republic of Tanzania

The Morogoro region of the United Republic of Tanzania is the site of a USAID-sponsored project aimed at improving the care of people on antiretroviral therapy (ART) through a people-centred quality improvement approach. Importantly, health care redesign is being shaped by the insights of patients. Six health centres currently are implementing the project and the intention is to eventually cover the entire region of two million residents.

At the outset, the project team identified retention of patients on ART as a major challenge in the region. Baseline assessments revealed that up to 36% of patients missed appointments during a one-month period. Strict adherence to ART is crucial for good treatment outcomes, so this retention gap was alarming.

To understand the issue better, the team convened patients in a focus group to help identify common barriers to keeping health centre appointments, and potential solutions for addressing these issues. The major barriers reported by patients surrounded transportation to and from the health centres, and fear of stigma and discrimination if seen by community members attending an ART clinic. Patients also generated innovative potential solutions, such as dispensing two-month medication supplies to reduce the frequency of required clinic visits, allowing family members to collect ART on behalf of patients, and enhancing the privacy of the ART clinic.

Using patients' ideas, health-care teams introduced changes in the way they organized and delivered ART services. Key changes included those suggested by patients, as well as alterations to the health worker-patient interaction. Before, health workers made the treatment decisions and gave instructions to patients; subsequent changes focused on systematically involving patients in the decision-making and planning of their own care. Initially, many health workers were resistant to making these changes but over time, they saw improvements in the quality of care and their relationships with patients.

The health-care teams monitored their progress so they could see the impact of the various changes. Since the project's inception one year ago, patient and health worker satisfaction has improved and demand for services has increased three-fold in participating health centres. Despite these early gains, the surge in demand for services combined with high staff turnover will be a challenge to the longer-term success of the project. Nonetheless, as a result of this experience the Ministry of Health and Social Welfare is developing quality improvement guidelines and training manuals to facilitate spread of these innovations to other parts of the country.

> "*Patient-centred care facilitates respect of patients' knowledge, values, beliefs and cultural backgrounds, which if incorporated into the planning and delivery of care will lead to better health and increased patient commitment to their care.*"
>
> Ms Faridah Mgunda, Quality Improvement Advisor
> USAID Health Care Improvement Project,
> United Republic of Tanzania

LESSONS LEARNT

The experiences in these five countries illustrate an important point: people-centred care does not happen spontaneously. Rather, it must be fostered by supportive mechanisms. Actions at the levels of the patient-health worker interaction, organization of health care, community, and policy can be used to progressively create people-centred health systems. Political will is key, and can be developed through demonstrating that people-centred care is both possible and feasible in resource-constrained health systems.

Specific facilitating factors were identified from the five presentations and are described below. They do not comprise an exhaustive list of everything that can be done to foster people-centred care, but rather, reflect the practical experiences in these countries.

PERSONAL INTERACTIONS ARE FUNDAMENTAL

People-centred care ultimately manifests through personal interactions among individuals of varying roles and responsibilities. During people-centred interactions, all people – regardless of whether they are in the role of patient, family, community member, or health worker – communicate effectively and share information. Everyone is provided with necessary information and encouraged to participate in joint decision making.

Within primary care settings, health workers, patients, and families collaborate in decision making and goal setting. Health workers also provide information and opportunities for skill-building so that patients and families can self-manage their health and illnesses to the extent possible. This form of education and support occurs on an ongoing basis, not only during one-on-one consultations, but also through group sessions.

> *"Working with and for people is a moral imperative."*
>
> Dr Otmar Kloiber, Secretary General
> World Medical Association

People-centred care also means that health workers work in close relationship with the communities they serve. They interact regularly and systematically with individuals and organizations in the community, such as volunteers, community health workers, self-help groups, community groups, nongovernmental organizations, schools, and employers. Health workers assist communities in making the best use of their potential and ensuring that their voices are heard. They also use community feedback to shape health care delivery and ensure that it is integrated with community-based services.

Although each of the country experiences involved improving some or all dimensions of these personal interactions, a common thread among country experiences was the initial resistance of health workers. They needed to be convinced through their own experience that the systematic participation of patients and communities was useful and ultimately beneficial to quality of care. In Malaysia and the United Republic of Tanzania, for example, health workers thought at first that people-centred services would take precious time from their already overburdened clinical schedules. Eventually, they saw that by making time for quality interactions with patients, they gained time in the form of avoided complications. They also saw improvements in the quality of their relationships with patients. In El Salvador, health workers were initially resistant to the idea that communities had anything useful to contribute about the way maternal health services were organized and delivered. As the project unfolded, however, their attitudes changed and they realized that these perspectives were instrumental in building better care for pregnant women.

HEALTH CARE REDESIGN IS OFTEN NECESSARY

As noted in the World Health Report 2008, putting people first can require significant departures from business as usual. An evolution of health care is often needed.

Continuity of care

Continuity of care is an important aspect of people-centred care, and primary health care teams are best positioned to serve as hubs of coordination. In Rwanda, for example, mental health services are being decentralized to primary health care settings and tools have been introduced to facilitate referral and coordination between different levels of care.

"Primary care is the best approach for making people-centred care a reality."

Dr Salman Rawaf, Professor of
Primary Care and Public Health
Imperial College,
United Kingdom

Supportive guidelines and tools

Guidelines and related tools that promote people-centred care can help to disseminate new ways of working throughout health care systems. This was the case in Thailand, where demonstration project experiences were subsequently synthesized into a series of toolboxes. In the United Republic of Tanzania, guidelines are being prepared to disseminate a people-centred continuous quality improvement method for improving care related to antiretroviral therapy.

Patient and family records

Information systems are important to identify needs, plan care, monitor progress, and assess health outcomes. Individual patient records can be aggregated to provide information about populations, so that useful information exists from the level of the individual seeking care to the entire clinical population or community. In Thailand, for example, individual and family records ensure continuity of information for each individual and also give a comprehensive picture for entire families. Monitoring and evaluation reports are compiled monthly to provide feedback to health centre staff. Residents of Malaysia have their own home-based health cards, which allow them to have ready access to their health records and to obtain health care at any facility. The cards also reduce waiting times. Recently, a 'my health e-portal' has been made available online and electronic lifetime health records have been introduced.

COMMUNITIES ARE VITAL PARTNERS

People-centred care calls for the systematic involvement of communities. They are engaged to identify their priorities and perspectives, and to help generate ideas for ways to improve health care delivery. In the United Republic of Tanzania, for example, patients were convened in a focus group to help identify common barriers to keeping health centre appointments, and potential solutions for addressing these issues. In El Salvador, efforts to reduce maternal deaths started with a series of community consultations, including women of childbearing age; their mothers, mothers-in-law and grandmothers; their partners; health workers; and community leaders.

Communities' involvement is not restricted to identifying needs. Within a people-centred approach, they are integrally involved in policy and service development, implementation, monitoring and evaluation. This is the case in El Salvador, where communities are participating in health care improvement on an ongoing basis.

A strong civil society contributes to more effective, efficient, and accountable programmes and services. In particular, it gives individuals a collective voice to lobby for reform towards people-centred care. In Thailand, for example, a range of civil society organizations advocated successfully for universal coverage, which in turn enabled people-centred care to be scaled-up at national level.

POLICIES INSTITUTIONALIZE CHANGE

A positive policy environment that supports people-centred care is essential to accelerate its scale-up and dissemination. Leadership, workforce training and management, and universal coverage were identified as key policy-level activities to influence people-centred care.

Leadership

Commitment by senior leaders to people-centred care is an important ingredient for successful implementation. For example, Malaysia's Director-General of Health was a champion of people-centred care from the beginning, and this was identified during the meeting as a key reason that people-centred care has been successfully implemented in the country. In Thailand, political will was developed strategically by organizing demonstration visits to family practice health centres. These visits provided a clear vision of what people-centred family practice could achieve. Between January 1999 and December 2001, the health centres received 3294 visitors for one- to two-day demonstrations and 255 visitors for structured 2-week introductory courses in the organization of primary health care. Collectively, these visits convinced a wide range of leaders – within and beyond the health sector – that this approach was realistic and led to higher satisfaction among people. This was a key factor when the country subsequently adopted universal coverage reforms, which required a well-functioning primary health care system for their successful implementation.

Workforce training and management

The health workforce is instrumental in stimulating, creating, and maintaining people-centred care. This requires a multitude of skills, including: identifying and respecting patients' preferences, values, and expressed needs; coordinating continuous and timely care; listening and communicating; providing information and education; and sharing decision-making and treatment management. In addition, the health workforce must be able to move outside formal health care settings, to work with and for their communities. This includes involving community members as active partners in health promotion, and advocating – directly and indirectly – for disease prevention and risk reduction. Communication skills that nurture and maintain community partnerships also are crucial.

This type of care must be learnt. Conventional curricula are increasingly acknowledged as limited because of their fundamental focus on the diagnosis and treatment of acute medical problems in individuals seeking care. Training reform can expand this focus to recognize individuals from a broader perspective, respond to the health needs and expectations of entire communities, and develop related skills for delivering people-centred care. In Malaysia, the government has addressed this issue through introducing continuing professional development and practice standards, credentialing, and auditing. In Thailand, the Health Care Reform Project worked through a subcommittee of the medical council on medical education to develop the curricula that were then adopted by universities for their residency training. In Rwanda, health workers are provided with on-site supervision and participate in regular case review sessions.

Importantly, medical students and other health workers in training also receive training and supervision on how to address mental health issues and conditions.

Opportunities exist for a fundamental rethink of pre-service curricula. People-centred care concepts could be embedded within pre-service education and revisited periodically as students develop their knowledge and skills. International standards in the education of health workers are another potential mechanism for promoting people-centred pre-service education. For those who have already completed their pre-service education, on-the-job training in the form of mentoring, coaching and continuing education can develop their skills.

" We need to reformulate training to focus on people and their perceptions and needs."

Dr Jitendra Trivedi, Professor of Psychiatry
Chhatrapati Shahuji Maharaj Medical University,
India

These and other changes to the wide array of curricula and on-the-job learning require a deliberate effort to mobilize the responsible institutional actors both within and across countries. Local academic institutions and professional bodies can be supported as needed by technical assistance in the form of site visits, distance learning, and twinning arrangements.

Universal coverage

A primary role for people-centred health systems is to ensure universal coverage for the population. Universal coverage implies not only financial risk protection, but also primary care networks that provide people-centred services. Thailand, for example, introduced comprehensive universal coverage reforms in 2001. People pay a flat rate of 30 baht (less than US $1) per disease episode or hospitalization. Any remaining cost is covered by existing financing systems and supplementary funds. In addition, primary care is the first point of contact within the Thai health system. In Malaysia, primary care services are accessible to all people and almost free of charge. Each patient is charged a nominal fee of MYR 1 (equivalent to US $0.30) for each outpatient visit.

MEASURING PROGRESS CONDITIONS SUCCESS

There is a lack of consensus on how to measure progress towards people-centred care. There is an urgent need to define dimensions and indicators that can be used to set targets, monitor progress, and evaluate the effectiveness of interventions. Domains of people-centredness that would be important to consider include the level of the patient-health worker interaction, health care organization and delivery; community participation; and alignment of national health policies, plans, and financing mechanisms. Among other sources of information, it would be crucial to assess people-centredness from the perspective of patients, families, and communities.

EVIDENCE AND INVOLVEMENT BUILD CREDIBILITY

Very little is known about the specific strategies and interventions that are most effective to promote people-centredness. Part of the problem is that research has focused on different aspects of people-centredness and used a range of methods, making studies difficult to compare or generalize. In addition, most – but not all – research on people-centred care has taken place in high-income countries.

Following from an improved understanding of how to measure progress towards people-centred care, the next crucial step would be to strengthen the evidence base for effective policy change. Interventions should be evaluated across a spectrum of indicators, from patient and community perceptions of patient-centredness to health care processes, costs, and health-related outcomes. Importantly, particular attention should be given to developing the evidence base in low- and middle-income countries.

Of particular importance, available and emerging evidence must be communicated in ways that are understandable and useful to end-users. Research is a crucial way of showing decision makers and the broader public why change is needed. It informs decision-making at all levels. It also allows advocates of people-centred care to speak with credibility and confidence, and adds weight to their arguments.

> **"We can't have people-centred care without the people themselves in the role of leadership."**
>
> Dr Janet Wallcraft
> Patient/user consultant,
> United Kingdom

The debate cannot not involve civil society, including consumer organizations and patient organizations. Providers have to be held accountable for providing services that are more people-centred. Such debates create opportunities to hear the collective voice of the people, and also result in increased autonomy and skill development in communities. The involvement of civil society in policy dialogue around the development and negotiation of national health policies, strategies and plans provides opportunities to integrate views of patients, individuals, and communities in decisions that help shape health services and respond to social expectations.

CONCLUSION

The experiences reported during this meeting demonstrate that people-centred care is feasible in low- and middle-income countries. While approaches have differed, all have been able to make service delivery more people-centred in a context of competing priorities and scarce resources.

In many cases, demonstrating what people-centred care means concretely has provided the basis for building political commitment. Demonstration projects have served as the platform for developing people-centred approaches, documenting their feasibility and usefulness, building consensus, and convincing decision-makers of the utility of broader change.

Further demonstrations will be necessary to refine approaches, develop the evidence base, and build political will. It will be important to document the impact of people-centred primary care, in terms of quality of care, cost offset, and importantly, health outcomes. An essential prerequisite will be the development of indicators and tools that can be used to measure progress towards people-centredness.

Pre-service curricula reform, in-service training, and ongoing technical assistance are necessary to prepare the health workforce to assume new roles and ways of working. This not only improves quality of care, but also increases satisfaction among health workers and patients alike.

Community development is required to strengthen their capacity to participate in the planning and implementation of health services. In particular, civil society organizations can enable the people's voices to be heard clearly.

It undoubtedly will take a sustained effort to transform health care in low- and middle-income countries to achieve this vision. It will require champions who are willing to try new ways of delivering health services and promote their experiences to senior leaders within and beyond the health sector. The inclusion of people-centred care in national policies, strategies, and plans will give prominence to key concepts and facilitate their institutionalization in countries' health systems. While much remains to be established, the experiences outlined in this report can serve as a starting point for action.

Annex 1. Meeting programme

9:00 - 9:20   **Opening remarks**

◆ Welcoming words from Dr Carissa Etienne, Assistant Director-General, Health Systems and Services, World Health Organization, Geneva
◆ Welcoming words from Professor Juan Mezzich, President, International Network for Person-centred Medicine

9:20 - 10:20   **Experience with people-centred care in low and middle income countries (I)**

◆ Thailand   Dr Yongyuth Pongsupap (Bangkok) - Senior Expert, Health Care Reform Project
◆ El Salvador   Ms Ana Ligia Molina (San Salvador)- Coordinator, Programme for Empowerment of Women, Individuals, Families and Communities
◆ Malaysia   Dr Azman Abu Bakar (Kuala Lumpur) - Director, Institute for Health System Research, MOH Malaysia

10:20 - 10:45   **Coffee Break**

10:45 - 11:15   **Experience with people-centred care in low and middle income countries (II)**

◆ Tanzania   Ms Faridah Mgunda (Dar es Salaam)- Quality Improvement Advisor, Health Care Improvement Project
◆ Rwanda   Dr Yvonne Kayiteshonga (Kigali)- Director, National Mental Health Programme, MOH, and Dr Achour Ait Mohand (Kigali) - Technical Assistant, National Mental Health Programme

11:15 - 11:30   **Comments on case studies**: Dr Wim Van Lerberghe (Director, Department of Health Systems Strengthening, WHO, Geneva)

11:30 - 1:30   **Roundtable discussion** - future avenues for making healthcare more people-centred in low and middle income countries. Chair: Dr Manuel Dayrit (Director, Department of Human Resources for Health, WHO, Geneva)

Panelists:

◆ Dr Otmar Kloiber (Secretary General, World Medical Association)
◆ Dr Jitendra Trivedi (Professor of Psychiatry, CSM Medical University, Lucknow, India)
◆ Dr Salman Rawaf (Professor of Primary Care and Public Health, Imperial College, London)
◆ Dr Janet Wallcraft (Patient/User Consultant, London)

12:30 - 12:55   **Questions/comments from the floor**

12:55 - 13:00   **Closure of Meeting: Dr Manuel Dayrit**

Annex 2. List of participants

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