
To meet the unmet

Preparing for health equity challenges in
WHO South-East Asia Region



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REGIONAL OFFICE FOR

**World Health
Organization**
South-East Asia

To meet the unmet: Preparing for Health Equity Challenges in WHO South-East Asia Region

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FOREWORD



Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. UHC includes the full spectrum of essential and quality health services, from health promotion and prevention, to treatment, rehabilitation and palliative care across the life-course. UHC is central to improving population health and well-being and enhancing human capital for sustainable social and economic growth. It is essential to achieving the 2030 Sustainable Development Agenda, and since 2014 has been a Flagship Priority in the WHO South-East Asia Region.

Health inequity, unmet need and forgone care are major challenges in achieving UHC globally and in the South-East Asia Region. The most concerning aspect of health inequity is unmet health need, which occurs when people who need health services do not use or are unable to use them.

Globally and in the Region, unmet need is more common among disadvantaged groups, who are disproportionately vulnerable to poor health status, higher health risks, and less access to health system resources.

This publication, 'To meet the unmet: preparing for health equity challenges in the WHO South-East Asia Region,' aims to help policy makers, health system designers, academics and health professionals across the Region build fairer, more equitable health systems. It does this by documenting progress and challenges in meeting unmet need, and by identifying ways forward to address health inequity at sub-national, national and Regional levels.

The publication contains 25 case studies that include all Member States, and which address a range of challenges, including groups with geographical hardships, lower socioeconomic status and less education; women and children; the elderly; ethnic and gender-based minorities; migrants and refugees; and people living with diseases and health conditions. And it supplements 'The Platinum Decade: Accelerating health for billions,' launched during the Seventy-sixth Session of the WHO Regional Committee for South-East Asia in 2023.

I urge all stakeholders to appropriately leverage this document to accelerate health equity, building on the Region's steady and sustained progress towards UHC, the Flagship Priority and Sustainable Development Goal target that underpins all others.

A handwritten signature in black ink, reading "Poonam Khetrpal Singh".

Dr Poonam Khetrpal Singh
Regional Director
WHO South-East Asia Region



EXECUTIVE SUMMARY

Health inequities are unjust and avoidable systematic differences in the health status and access to health resources of different population groups. Health inequity manifests itself at all levels as differences across countries, within countries, between communities, and within population groups. Health inequities arise from social determinants of health, or social and environmental conditions in which people are born, grow, live, work and age; they do not occur randomly or by chance, and are largely beyond an individual's control. These social determinants include a person's education, income, access to social and health services, and good nutrition, access to healthy housing and environment factors.

A common phenomenon in all countries: the lower an individual's socioeconomic position, the higher their risk of poor health. Because of its impact on population health and socioeconomic development, enhancing health equity, therefore, is an overarching goal of health system and universal health coverage (UHC).

The most worrying aspect of health inequity is the unmet health need, which is generally defined as people who need health services but do not use, or are unable to use, them for whatever reasons. Unmet need consists of two components; firstly, forgone care which occurs when someone who realizes the needs for services but is unable to access the services expressed; and secondly unexpressed (or un-realized) demand for health care. Unmet health care needs can result from various barriers, from both supply and demand sides of health care, and beyond the health system. Monitoring unmet need and understanding the reasons or forgone

care are key components for monitoring and achievement of UHC.

Health inequities, expressed as discrepancies in health outcomes and access to health care, as well as unmet health needs, are a top agenda in the South-East Asia Region. Evidence shows that disadvantaged population groups are disproportionately vulnerable to poor health status, higher health risks and less access to health system resources. These groups include those having geographical hardships (island and rural); those with lower economic status, less education; women and children; the elderly; ethnic and gender-based minorities; migrants and refugees; and people living with diseases and health conditions. Twenty-five case studies in this document reflect a common direction from all Member States of the Region in tackling health inequities and addressing health needs of marginalized population groups. Besides strengthening of health system components and harnessing digital health, common success factors include a strong political commitment with a common understanding of the capacity of health systems, and coordination mechanisms across agencies and across levels.

To promote health equity and address the unmet need in the Region, five action areas are needed to tackle three groups of major challenges. These are (i) challenges in health system capacity; (ii) challenges in addressing social, economic and environmental determinants of health inequity; and (iii) challenges in monitoring and tracking progress. The five action areas are:

1. Strengthening system governance, partnership and accountability
2. Realizing UHC through people-centred health system strengthening
3. Ensuring actions beyond the health sector
4. Capitalizing innovations and technologies

5. Enhancing the capacity for monitoring and evaluation.

The WHO Regional Office for South-East Asia is always ready to support Member States in improving health equity through evidence-informed actions and strengthening system capacity, as well as augmenting health leadership beyond the health sector.

Chapter 1

Introduction



“A Nation’s greatness is measured by how it treats its weakest members”

~ Mahatma Gandhi

1.1 Health equity: what and why?

As a fundamental human right, health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.¹ To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs and to change or cope with the environment. Health therefore is seen as a resource for everyday life, not the objective of living.²

Differences in health status within and across societies are expected. Inequity and inequality in health are sometimes confused, but they are not interchangeable. Health inequality simply refers to uneven distribution of health or health resources. In contrast, health inequities refer to systematic unfair, unjust and avoidable differences in health outcomes, or in the distribution of health resources, between different population groups. Health inequities arise from social conditions in which people are born, grow, live, work and age; they do not occur randomly or by chance, and are largely beyond an individual’s control. Resulting from

poor governance or unmerited exclusion, health inequities go against the principles of social justice; and therefore could be addressed by the right mix of policies. On the other hand, different government policies, depending on their nature, can either improve or worsen health and health equity.

Health inequity manifests itself at all levels as differences across countries, within countries, between communities, and within population groups. The COVID-19 pandemic has exposed and exacerbated health inequities in every country; people worst affected by the COVID-19 pandemic and consequences are those least able to withstand it. Evidence demonstrates that older people, people with pre-existing poor health conditions, people without access to health and social welfare, migrants, informal workers, ethnic minorities, and socially discriminated people are those who suffered the most from COVID-19 morbidities, mortalities, and unintended negative consequences.

Health inequities contribute to overall poor health of the population. Addressing health inequity therefore is a responsive function of the health system. There is ample evidence that social factors, including education, employment status, income level, gender and ethnicity have a marked influence on how healthy a person is. The lower an individual’s socioeconomic position, the higher their risk of poor health.

1 <https://www.who.int/about/governance/constitution>

2 <https://www.paho.org/en/documents/ottawa-charter-health-promotion>

Enhancing health equity is regarded as an overarching goal of the health system.³ Health inequities are perhaps the most important challenge for universal health coverage (UHC) in ensuring that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. Aggregated information on national UHC progress often conceals disparities across population groups.

Health inequities have a significant financial cost to societies and persistent inequities slow socioeconomic development, through deficiencies in human capital, and societal burden from health-care cost and lower productivity. Because population health is a fundamental asset for sustainable development to every society, the burden of disparities lowers the nation's overall health status and resources. Advancing progress towards health equity, on the other hand, could enhance national security, social cohesion, and produce economic and other benefits.

1.2 Unmet need: the neglected significance of the health system

The most worrying aspect of health inequity for UHC achievement is unmet need including forgone care. Those who face barriers in access to health care they need, often forgo their health concerns which result in undesirable outcomes. These are key aspects for UHC monitoring as it reflects the gaps of access to care. Unmet health need is generally defined as people who need health services but do not use them for whatever reasons. Individuals with true unmet needs are those who have the potential to realize a health benefit from a given service, which may differ from perceived need due to a variety of social, cultural, and economic

factors.⁴ Unmet need therefore has two components; expressed (or realized) and unexpressed (or un-realized) demand for health care. The first component of unmet need is referred to as forgone and it occurs when someone who realizes the needs for services is unable to access the services due to a range of barriers.

Unmet health-care needs can result due to various and complex reasons. Availability of services, geographical accessibility, affordability, quality, convenience, cultural and context relevancy, and trust are among major factors underpinning unmet need. Assessing unmet need allows us to understand the extent to which individuals have health needs over their life-course, yet do not receive quality services in sufficient quantity to alleviate the burden of disease or ill-health. There is, however, no universally accepted definition of unmet need and forgone care. Wide variations in the prevalence of unmet needs between and within countries were reported.⁵

Evidence leads to a few key observations. Firstly, countries with higher service coverage are likely to report lower unmet need; secondly, higher prevalences of unmet need have been reported among populations with vulnerabilities, such as people with economic and geographical difficulties, and people with particular health demands including those with disabilities and the elderly. Barriers to accessing health care are more commonly and disproportionately experienced by disadvantaged population subgroups such as the poorest, least educated, and those living in rural areas. Fig. 1.1 shows the

3 <https://www.who.int/publications/i/item/9789241563444>

4 Shengelia, Bakhuti, et al. "Access, utilization, quality, and effective coverage: an integrated conceptual framework and measurement strategy." *Social science & medicine* 61.1 (2005): 97-109.

5 Multi-country cross sectional and longitudinal studies to quantify unmet needs for health and social care among older people. Kobe: World Health Organization Centre for Health Development)

household survey data from low- and middle-income countries (LMICs) from 2011 to 2021 on inequalities according to household economic status, education and place of residence for different barriers to accessing health care. These findings support expectations that advancing service coverage strategized to people with vulnerabilities would lead to reductions in unmet health-care needs and therefore promote universal health coverage (UHC).

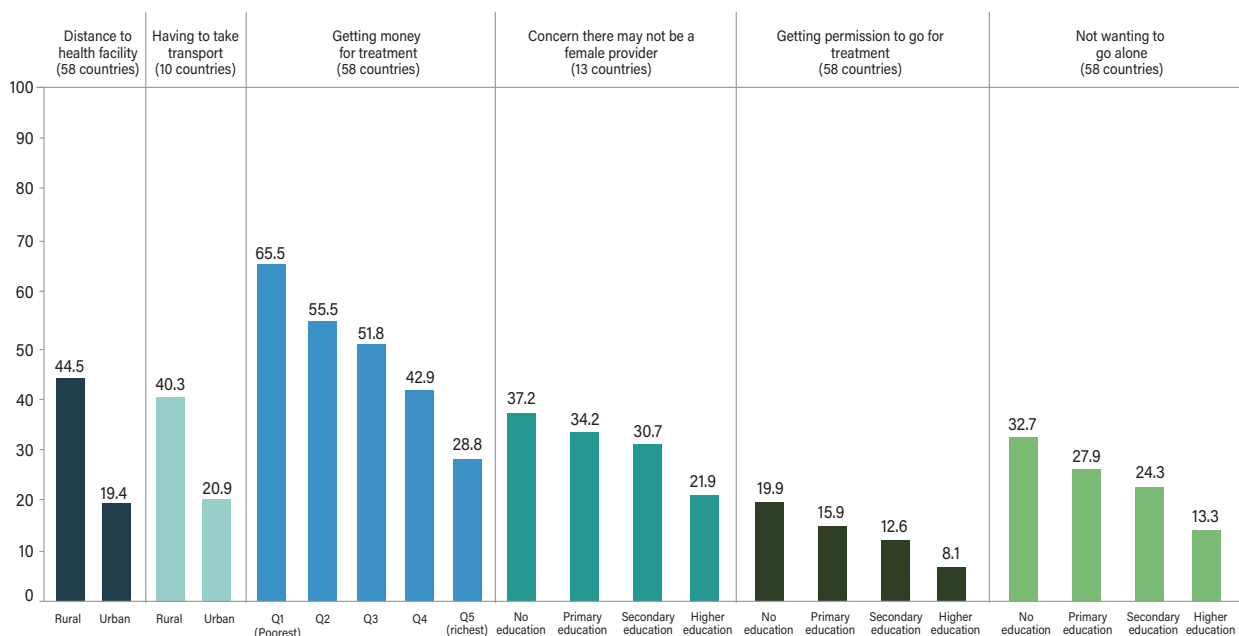
Understanding the reasons why individuals do not receive services or forgo care provides insights as to the barriers people face when engaging with the health system. Monitoring health inequities, especially on unmet need, is essential to identify and track disadvantaged populations to promote equity-oriented policies, programmes and practices. It is crucial to understand and address the full range of key barriers, both supply and demand sides. New ways to

collect quality data on access barriers need to be developed and implemented, including strengthening national health information systems to obtain disaggregated data on access barriers. Some Member States of the South-East (SE) Asia Region have put unmet need data in monitoring access to care by vulnerable populations or specific diseases [such as Thailand].⁶

Health vulnerabilities, such as poor health statuses and limited access to health care, are dynamic and often results of multiple factors and conditions. Setting determinants (such as geographical hardship and migration), demographic conditions (e.g. poverty, ethnic, sexuality), and social

6 Thammatacharee N, Tisayaticom K, Suphanchaimat R, Limwattananon S, Putthasri W, Netsaengtup R, et al. Prevalence and profiles of unmet healthcare need in Thailand. BMC Public Health. 2012;12:923

Fig. 1.1. Reasons for forgoing health care among females aged 15–49 years (household surveys, 2011–2021)



Notes: Circles indicate countries – each country is represented by multiple circles (one for each indicator and subgroup). Horizontal black lines indicate the median value (middle point of estimates).

Source: Demographic and Health Surveys (DHS), accessed via the WHO Health Inequality Data Repository, 2023 (<https://www.who.int/data/inequality-monitor/data>). Reported in the 2023 Global Monitoring Report on UHC

stigmatization (such as discrimination and prohibitive conditions) complexly interact and intersect with each other in the phenomenon of unmet need, forgone care and health inequity.

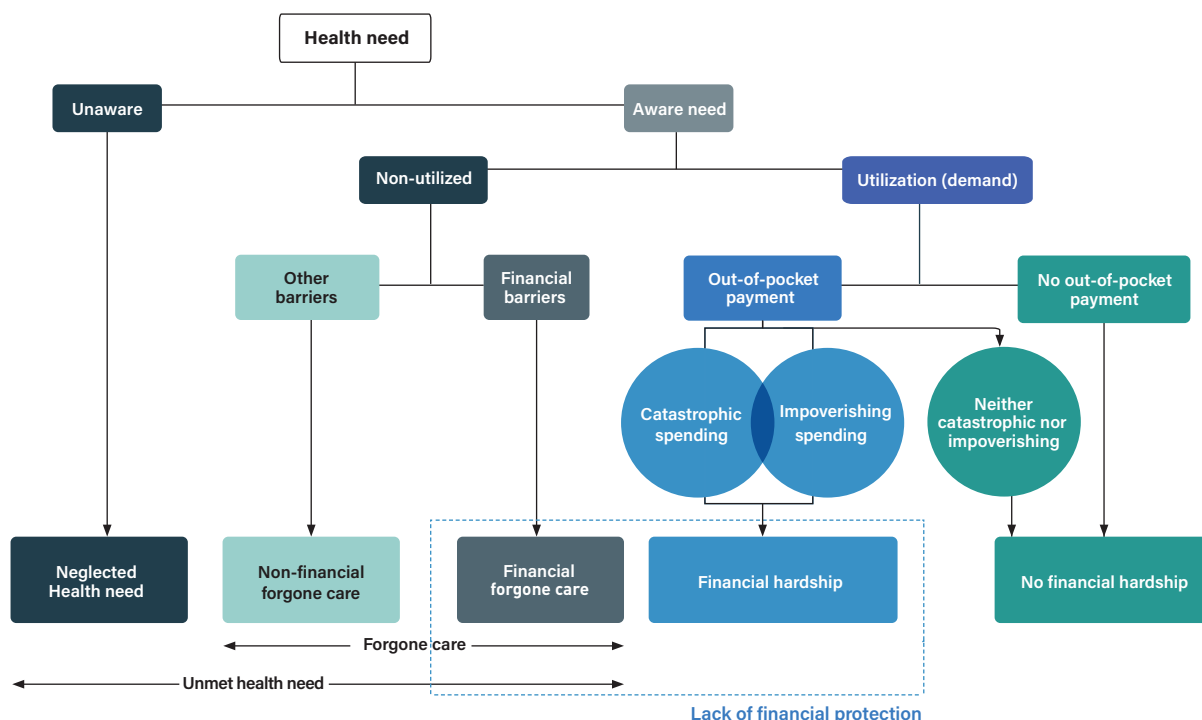
There has been an increasing interest in measuring and monitoring unmet need and forgone care as means to promote equity in service coverage and financial protection, and provide insights as to how access to effective services might be improved. Similar to the definition, different measurement frameworks for unmet need and forgone care have been used for different purposes. The unrealized or unexpressed demand of unmet need makes it extremely difficult to measure, with respect to many health interventions. Comparatively, measurement for forgone care, a dimension of unmet need that aims to capture the inability of an individual to fulfil their perceived health service needs, is relatively easier. The reasons for forgone care are often assessed to describe the systematic barriers to accessing care of sufficient quality.

At the global level, routine reporting systems are not designed to capture unmet need and financial protection, and therefore data availability would be a major limitation to its adoption as a proxy to achieving UHC. Despite these limitations, advances to measuring unmet needs and forgone care and understanding the reasons for the same are key to ultimately achieving UHC.

1.3 Addressing the root causes of health inequities and unmet needs

Health of population is largely affected by social determinants of health; or conditions in which people are born, grow, live, work, play and age; access to resources and power; as well as biological determinants. Similarly, health inequities are the product of both “intermediate” and “structural” determinants of health. These social determinants include a person’s education, income, access to social and health services, and good nutrition, access to healthy housing and environment factors.

Fig. 1.2. Conceptual diagram for unmet need, forgone care and health financial hardship



Source: Adapted from WHO Global monitoring report on financial protection in health 2021⁷, by Thamarangsi T.

7 <https://www.who.int/publications/i/item/9789240040953>

As shown in Fig. 1.3, intermediary determinants including living circumstances, behaviours and practices, complexly interact based on a broader context of structural determinants, such as culture, resource and power distributions and economic and political system. People’s living conditions are often made worse by sociocultural factors including discrimination, stigmatization, stereotyping and prejudices.

Equity is the absence of unfair, avoidable or remediable differences among groups of people. It is only achievable when everyone can attain their full potential for health and well-being. And because health and health equity are determined by the conditions in which people are born, grow, live, work, play and age, as well as biological determinants; prevention and reduction of health inequity require actions beyond the health sector boundary, identifies strategic actions from key sectors, including housing, food and nutrition, education, environment, transportation, and economic

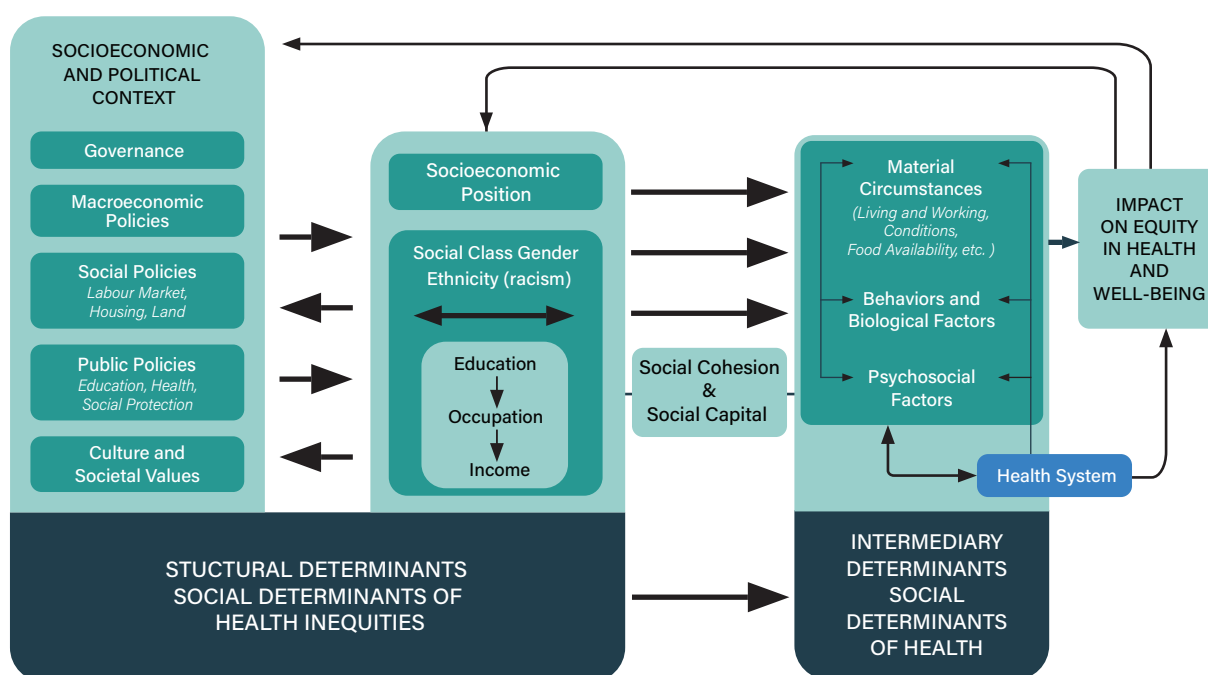
and commercial sectors.⁸ In addition, WHO recommends three specific actions for the health sector to promote health equity: (i) to prioritize the primary health care (PHC) approach; (ii) to ensure availability and use of disaggregated data by age, sex, education and income; and (iii) to enhance capacity in working with other sectors.

1.4 Structure of this report

The report aims to promote achievement of UHC through building a fairer health system in the WHO SE Asia Region. It complements the major publication ‘The Platinum Decade: Accelerating health of billions-WHO South-East Asia Region’, especially on the chapter of UHC. This report would benefit policy-makers, health system designers, academics, health professionals and practitioners in their collective effort in reducing health inequities through UHC strengthening.

8 WHO Health equity and its determinants, World Health Day 2021

Fig. 1.3. Conceptual framework for action on social determinants of health



Source: Solar O, Irwin A. A conceptual framework for action on the social determinants of health. *Social Determinants of Health Discussion Paper 2 (Policy and Practice)*.

In chapter 2, the report provides evidence on the status of health inequities in terms of health outcome, resources and practices. In chapter 3, this report documents progresses in addressing current and future health inequities with a focus on multiple manifests of vulnerabilities and multiple components

of the health system. Synthesizing from the 25 country case studies and literature review leads to the analysis of system challenges and identifying the way forward and recommendations form the last part of this report.

Chapter 2



Situation of health inequities in the WHO South-East Asia Region

“Reducing health inequities is an ethical imperative. Social injustice is killing people on a grand scale”⁹

The population in the Region are today living a longer and healthier life compared to decades ago. On average between 2000 and 2019, life expectancy at birth increased from 62.2 years to 69.9 years for males and 64.6 to 73.1 years for females. Importantly, in terms of healthy life-expectancy (HALE), the 2019 estimates shown in Fig. 2.1 (darker bars) indicate that females (61.9 years) appear to enjoy an extra year of healthier life expectancy than males (61.1 years). However, these estimates also show that females suffer an excess loss of about 2.4 years (11.2 minus 8.8) in lost HALE compared to males, indicating that females have a higher proportion of years lived with disability.

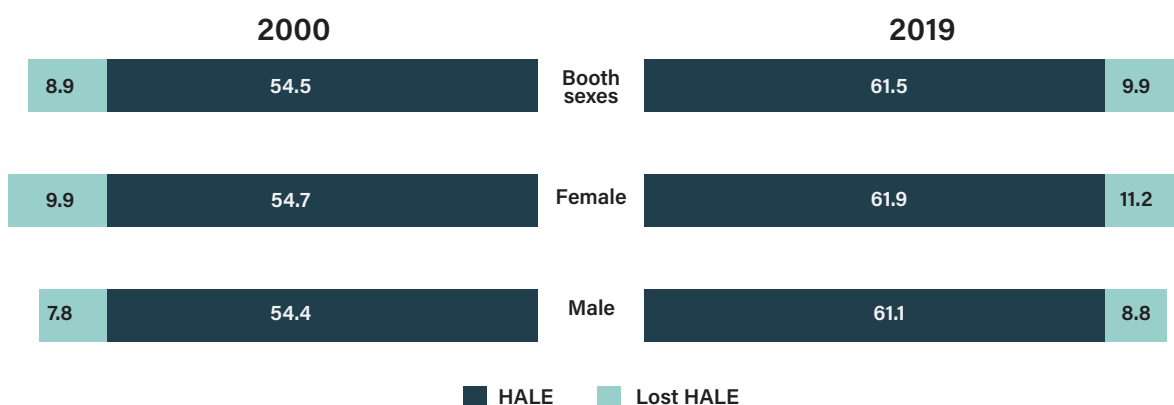
In terms of country-specific findings, Fig. 2.2 provides an insights on the variability and the order of magnitude of improvement in life expectancy comparing males and females. By the latest 2019 estimates, the highest life-expectancy is that of females in Maldives and Thailand (80+ years) compared to males lower life-expectancy (<70 years) in DPR Korea, India, Indonesia, Nepal, Myanmar and Timor-Leste.

2.1 Preventing maternal deaths

Countries of the SE Asia Region have made tremendous progress in the reduction of maternal deaths. A remarkable reduction of 68.5% was noted in maternal mortality ratio

9 <https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1>

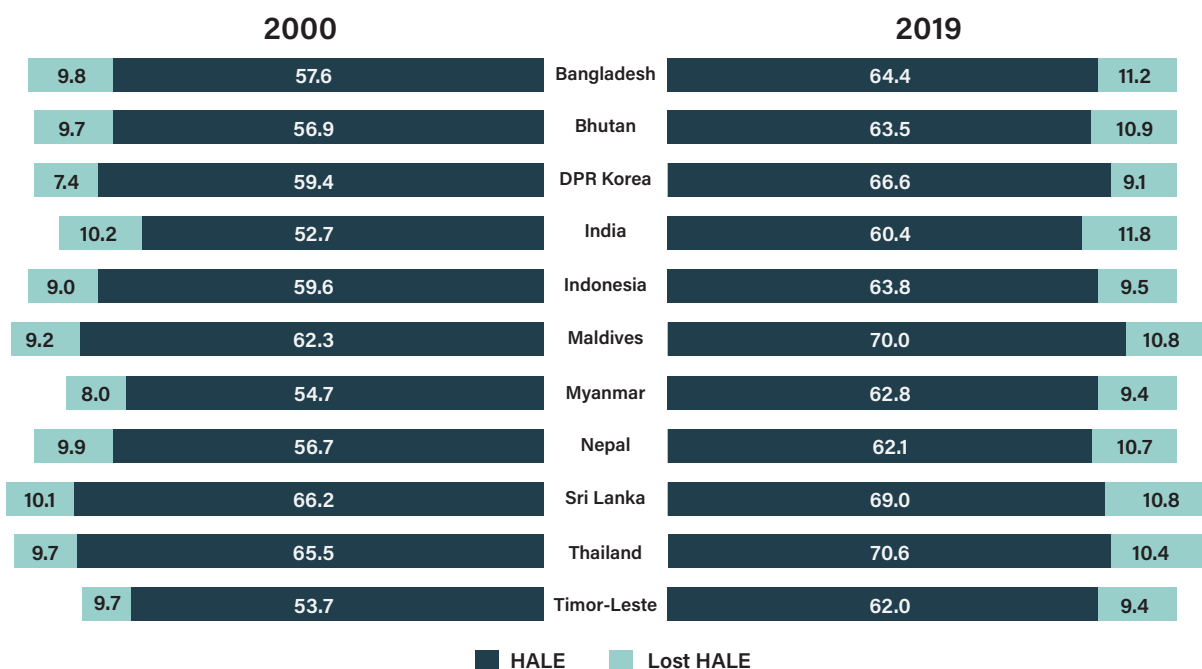
Fig. 2.1. Life-expectancy and healthy life-expectancy (HALE) for the SE Asia Region, 2000 and 2019



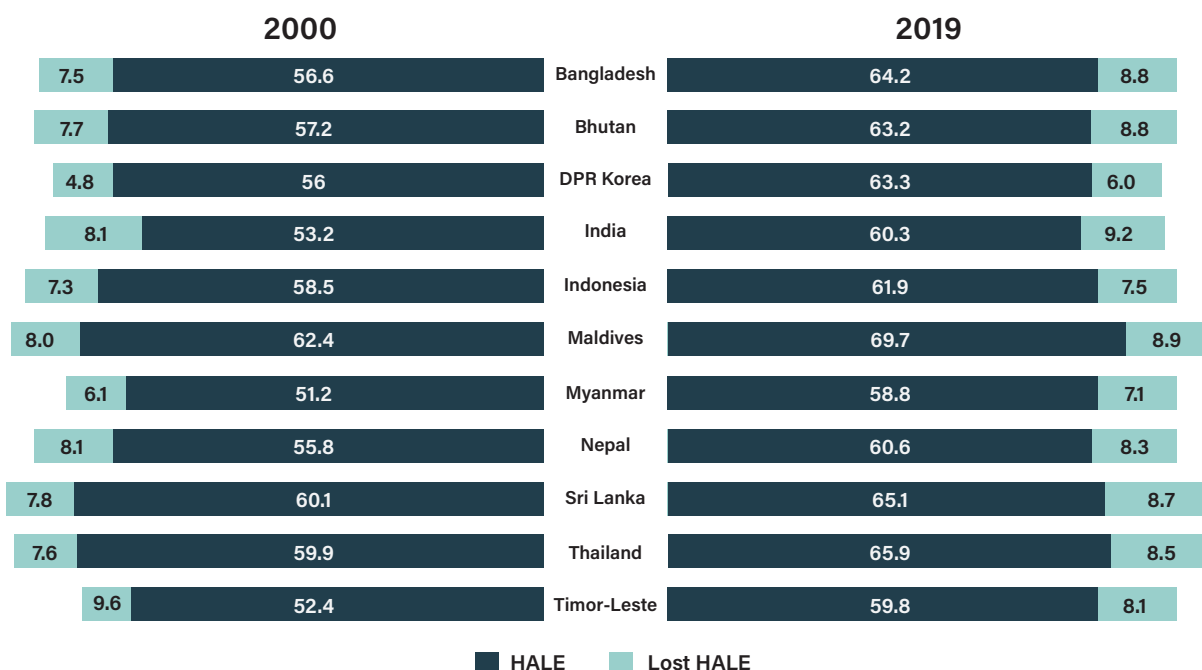
Data source: WHO Global Health Observatory (GHO), accessed 21 November 2023

Fig. 2.2. Life-expectancy and healthy life-expectancy (HALE) among countries in the SE Asia Region, 2000 and 2019

Female



Male



Data source: WHO Global Health Observatory (GHO), accessed 21 November 2023

(MMR) between 2000 and 2020. Seven of 11 countries of the Region have achieved MMR that is less than 140 per 100 000 live births, and by 2030 all 11 countries will achieve the same position, i.e. they will be below the global SDG upper ceiling of 140 per 100 000 live births for MMR. Maternal deaths occur primarily because

of complications during and following delivery and childbirth. These complications are preventable and/or treatable. Access to health services such as antenatal care, delivery by skilled birth attendants and postpartum care can reduce pregnancy-related complications and prevent maternal deaths.

Although service coverages have improved among the disadvantaged subgroup, variation in coverages continues to be better in the advantaged subgroup, compared with the disadvantaged subgroup. For instance, the proportion of the population using clean fuel for cooking is nearly 50% higher among those living in urban areas, compared with those living in rural areas. These comparisons underscore the importance of going beyond a national average to advance health equity.

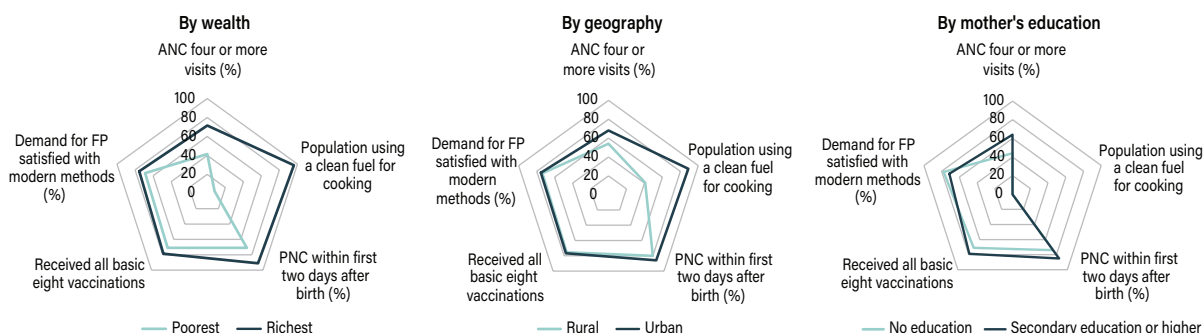
At the national level, there are clear differentials in access by care by place of residence. For example, the percentage of institutional deliveries show that those living in rural areas have – on average – lower

access than those in urban areas. Strikingly, Fig. 2.4 shows that the percentage of institutional deliveries for the urban poor is similar to, or worse than, those living in rural areas in all but one of the seven Member States. Suboptimal access to essential health care today is no longer a problem limited to those living in remote and rural areas only.

2.2 Inequities in reducing child mortality

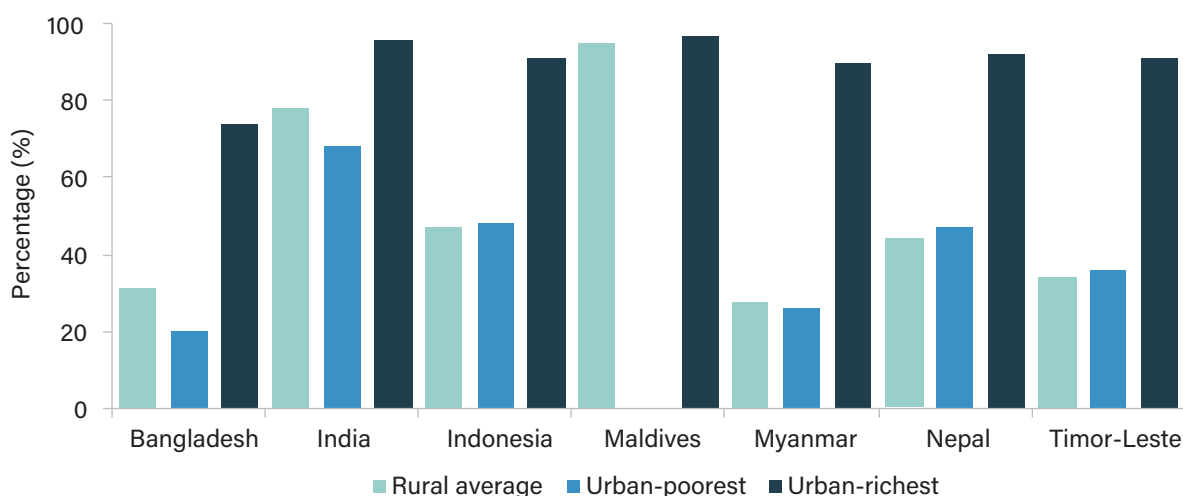
In the past two decades, the Region has witnessed a 65% decline in under-five mortality rate (U-5MR) from 84 deaths per 1000 live births in 2000 to 29 deaths per 1000 live births in 2021. Despite the decline,

Fig. 2.3. Variation in service coverage in the SE Asia Region by income, residence and mothers' education



Data source: Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2023 update

Fig. 2.4. Variation in institutional deliveries in selected countries of the SE Asia Region by place of residence, 2021



Data source: Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2021 update

inequity in under-five mortality is evident by sex, place of residence, maternal education, and household wealth quintiles across the SE Asia Region countries (Fig. 2.5). Critically, inequity by wealth and maternal education are most prominent. Children belonging to poorer households and/or children whose mothers have no education tend to have higher risk of death before age 5 years than those belonging to richer households and/or whose mothers have more education.

2.3 An entrapped burden of tuberculosis (TB) infections

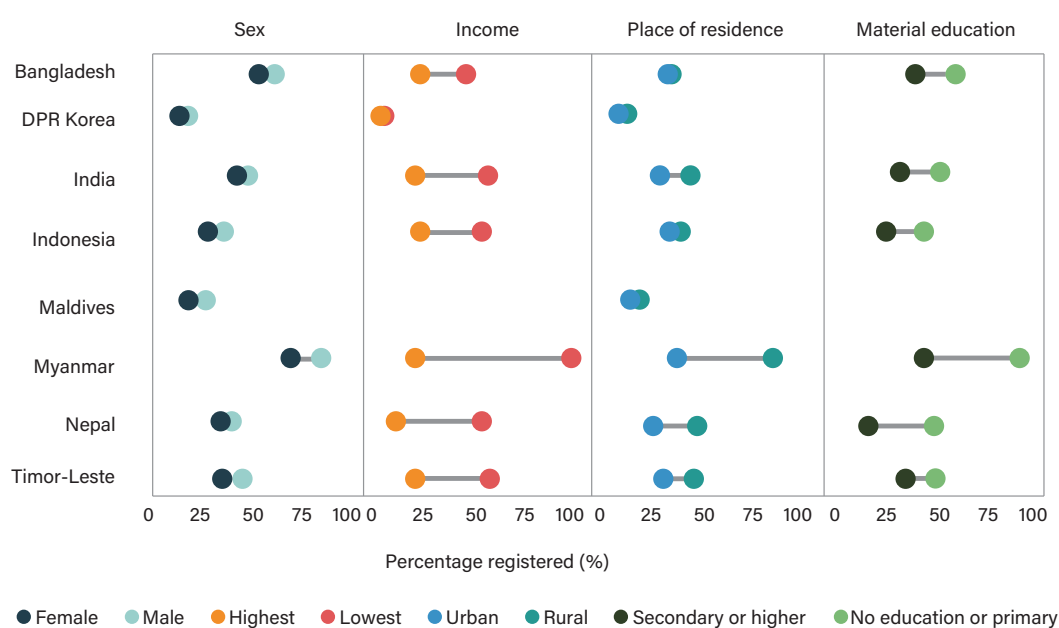
The Region has a high burden of TB infections, accounting for 45% of the TB incidences globally. An estimated total of 4.8 million people had TB in 2021, which is equivalent to a TB incidence rate of 234 cases per 100 000 population. The COVID-19 pandemic temporarily reversed the gains the Region had made with a slight increase in TB incidence between 2019 (223 per 100 000 population) and 2022 (234 per 100 000 population). Even more disturbing is the fact that in 2021, the

Region suffered an increase of 8.6% in TB mortality rates, compared with the rates in 2015. Although TB can affect anyone, regardless of age or sex, the highest burden is found among adult men, who accounted for more than half of all TB cases in 2022. More seriously, the gap in case detection and reporting are higher among males than females in the Region (Fig. 2.6).

2.4 Disparities in households' access to basic handwashing facilities with soap and water

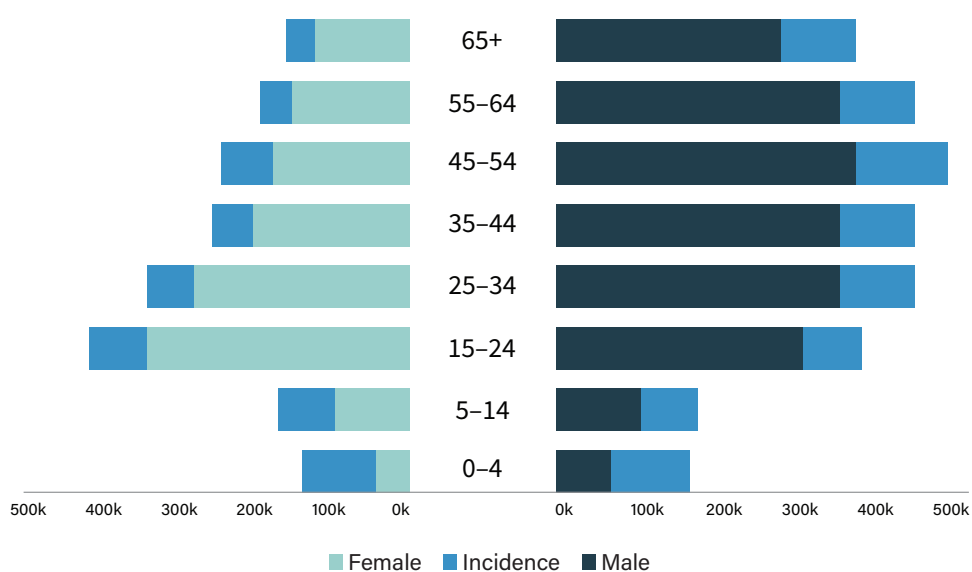
Access to basic handwashing facilities within households is fundamentally important for the prevention of infectious disease and is considered as a key tracer indicator in the infectious diseases' subindex of UHC 3.8.1 on essential service coverage. In terms of availability, access to basic handwashing facilities with soap and water has the widest variability between countries of the Region ranging from 39% to 98%. Additionally, with the exception of Maldives and Thailand, countries in the SE Asia Region show great

Fig. 2.5. Under-five mortality (per 1000 live births) in countries of the SE Asia Region by income, place of residence, wealth, and mother's education, 2016–2021



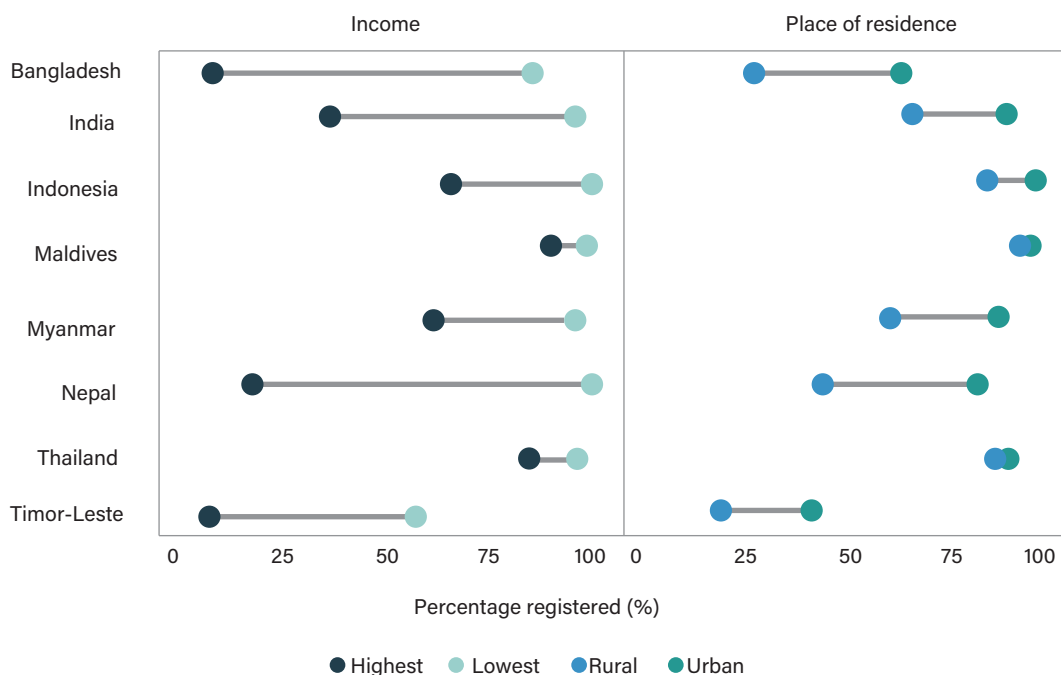
Data source: DHS/MICS, 2016–2021

Fig. 2.6. TB incidence and case notification by age and sex, 2022



Data source: Global Tuberculosis report, 2023

Fig. 2.7. Disparities in the access to handwashing facilities with soap and water, by place of residence and wealth, 2016–2022



Data source: DHS/MICS 2016–2022

disparities in access to basic handwashing facilities between households in urban and rural areas and those belonging to richer quintile compared to those who are poorer (Fig. 2.7).

2.5 The rising trends of noncommunicable diseases (NCDs)

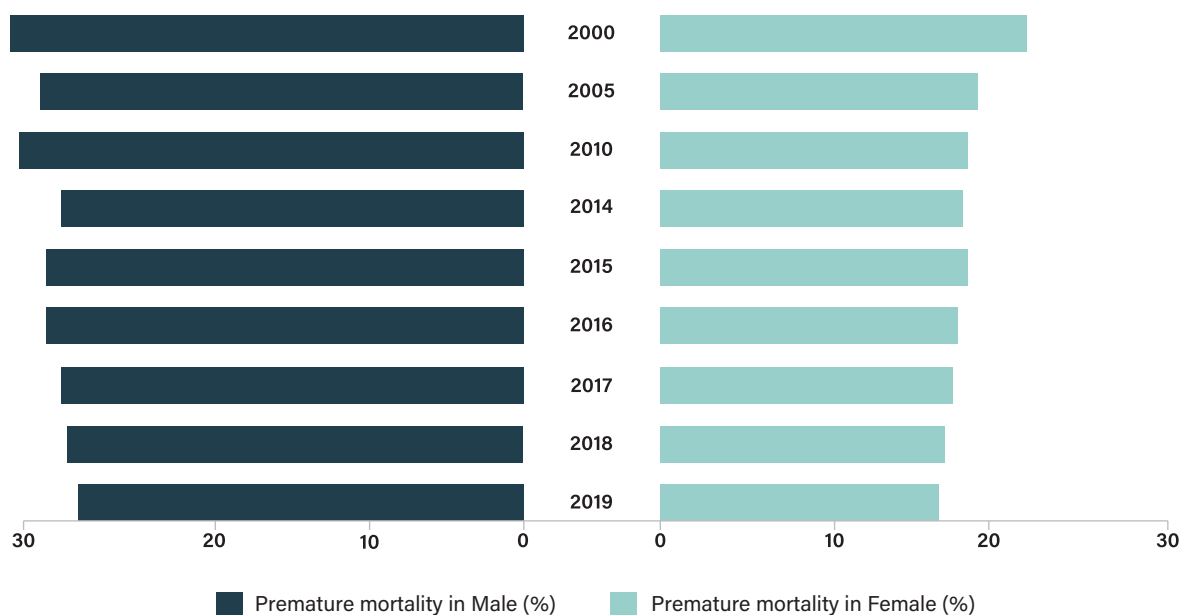
NCDs are responsible for 69% of all deaths in the Region, accounting for an estimated

8.5 million deaths annually mainly due to four major causes (cardiovascular diseases, cancer, diabetes, and chronic respiratory diseases). Of these, 52.4% of deaths are premature, i.e. before 70 years. Unequivocally, there is a strong and persistent variation in the proportion of premature mortality due to

four major NCDs by sex – males show the higher proportion of premature mortality compared to females (Fig. 2.8).

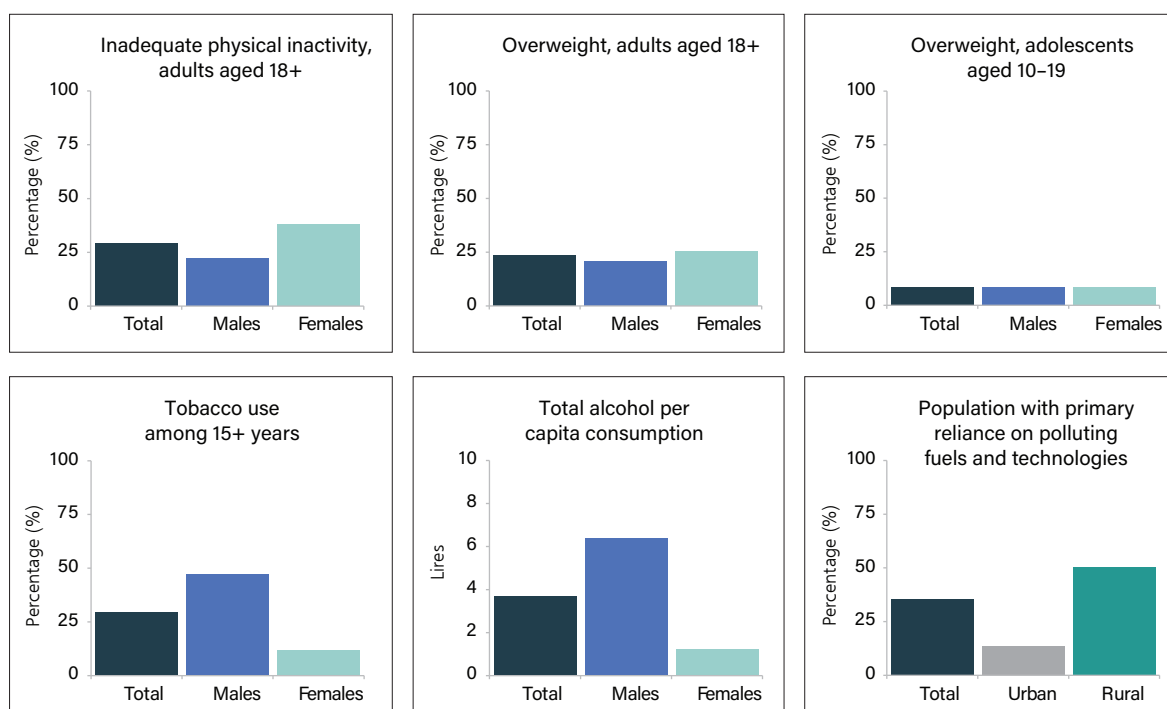
In terms of risk factors related to NCDs, Fig. 2.9 shows that the prevalence of tobacco use, and the prevalence of alcohol consumption is higher

Fig. 2.8. Premature mortality due to four major NCDs, by sex



Data source: WHO Global Health Observatory, 2023

Fig. 2.9. Prevalence of NCD risk factors, by sex, in Member States of the SE Asia Region



Data source: Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2023 update

among males than females in all countries of the Region. Importantly, the magnitude of the difference between males and females shows wide variability. Indonesia has the highest difference in the percentage of tobacco use between males and females (58%). Timor-Leste has the highest difference in the percentage of alcohol consumption between males and females (41.7%). Conversely, there is no clear pattern nor a significant difference in the prevalence of raised blood pressure between males and females (25.8% vs 24.2%) (2015).

Variations in the NCD risk factors were also examined by place of residence and showed no clear evidence of a difference in the prevalence of tobacco nor alcohol use. There is however an unequivocal sex differential in tobacco use between males and females – the prevalence of tobacco use is four times higher among males compared to females. However, since the year 2000, the Region has witnessed a sharp decline in tobacco use

for both sexes mainly attributed to stronger tobacco control supported by improved tobacco surveillance mechanisms.

2.6 Suicide in the SE Asia Region

Encouragingly, the average age-standardized suicide mortality declined by a third in the Region – from 15 per 100 000 to 10 per 100 000 population between 2000 and 2019. However, the suicide mortality rate among males remains 1.2 times that of females. Fig. 2.10 shows that between 2000 and 2019, the estimated deaths from suicide in the age group 35+ years had increased, while it has significantly decreased in age groups lower than 35 years.

2.7 Ensuring universal access to birth registration

The Region continues to witness inequity in access to birth registration by wealth quintile (Fig. 2.11). Children under-five years

Fig. 2.10. Estimated number of deaths by suicide by age and sex in the SE Asia Region, 2000 and 2019

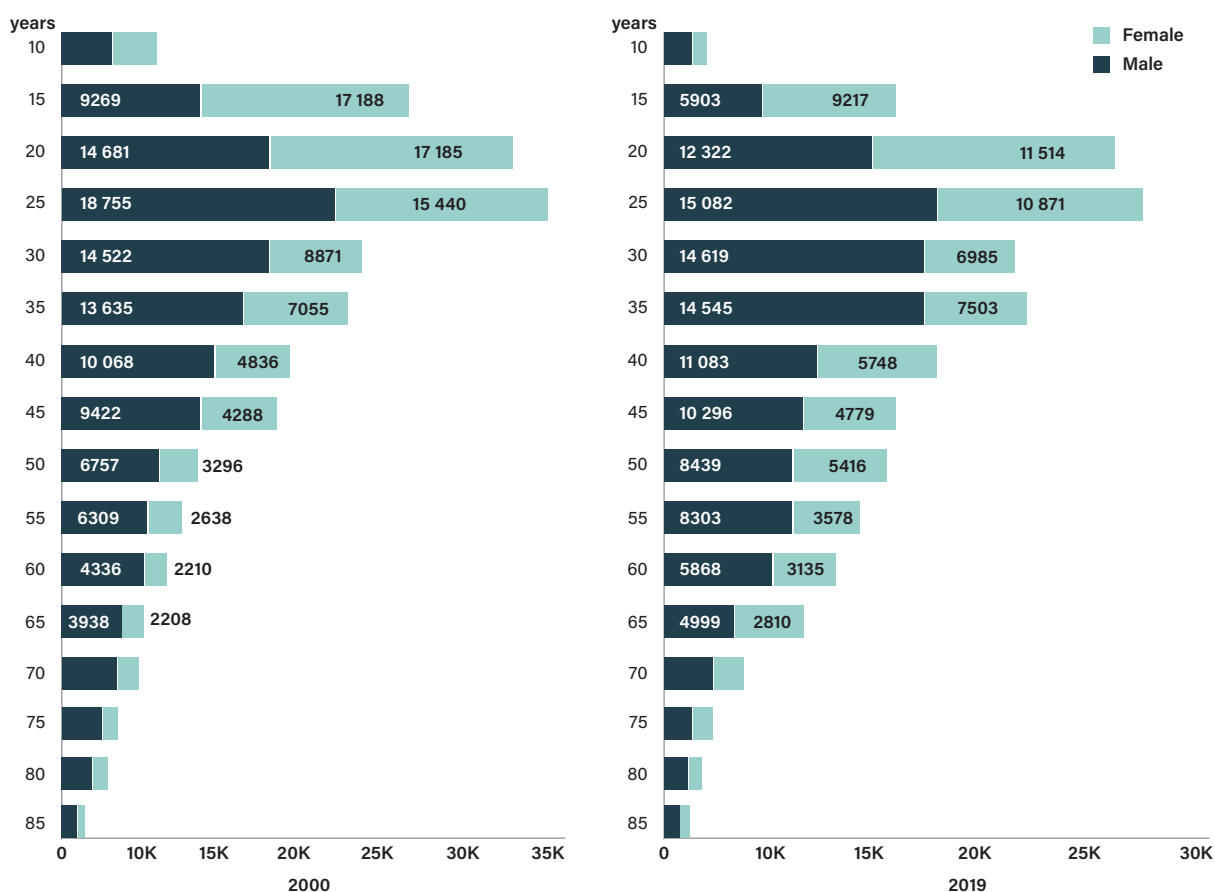
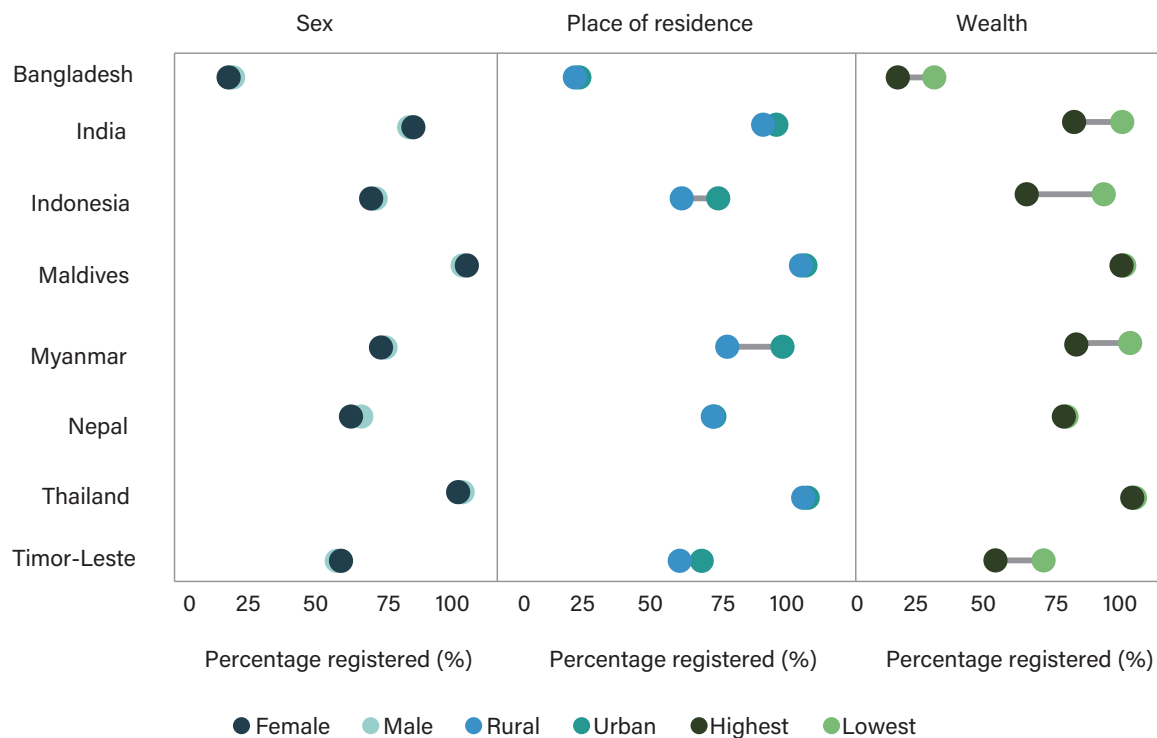


Fig. 2.11. Percentage of birth registered by sex, place of residence and wealth (2016–2022) among selected countries of the SE Asia Region



Data source: DHS/MICS 2016–2022

of age belonging to richer (highest) wealth quintile are more likely to have their birth registered compared to those belonging to the poorest (lowest) wealth quintile. Although children under-five residing in rural areas have slightly lower proportion of birth registered than those residing in urban areas; however, the differential is of very small magnitude. Encouragingly, the proportion of births registered by sex is similar across all countries of the Region. It is important to understand where the equity gap in birth registration lies so that targeted intervention and programmes can take place to increase awareness on the importance and right to birth registration and to ensure universal access to birth registration.

2.8 Inequities in financial protection

Encouragingly, pre-pandemic patterns estimates showed that the total population both impoverished and further impoverished due to out-of-pocket (OOP) health spending

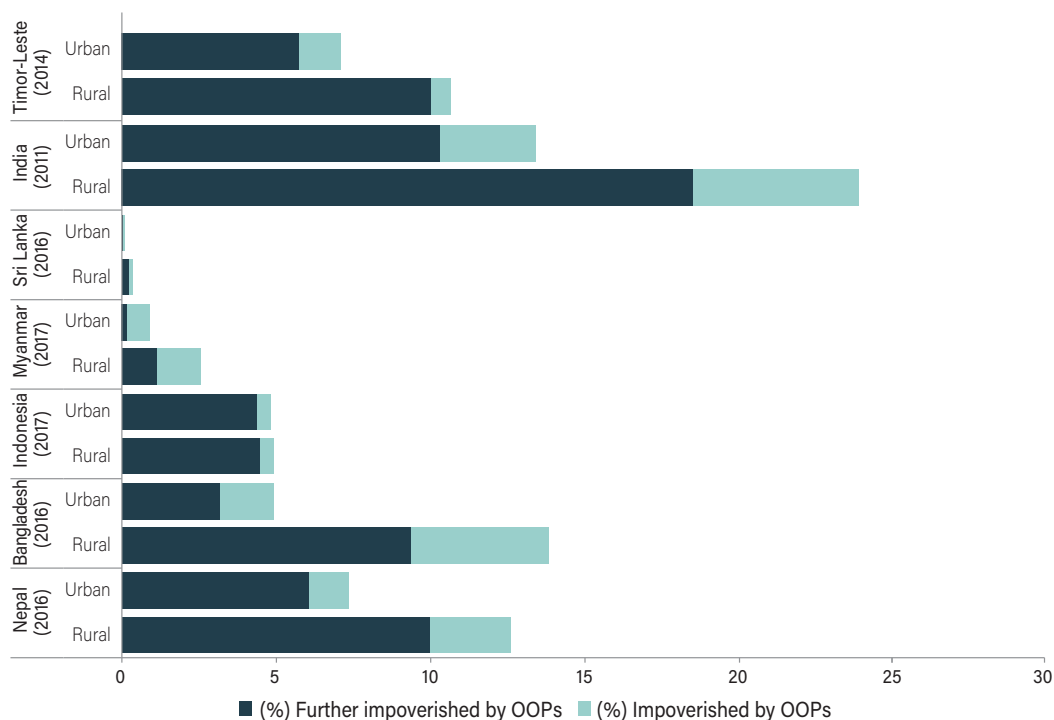
(living with less than PPP\$ 1.90 a day per person) decreased drastically in the Region from almost 30% in 2000 to about 6% in 2017. Within that pattern, disparities show that the percentage of those impoverished and further impoverished due to OOP was consistently higher among rural residents than urban ones, but with varying relative differences within countries (Fig. 2.11). Sri Lanka (2016) had the lowest rural percentage at 0.3%, which was still three times higher than the urban proportion. Myanmar (2017) and Bangladesh (2016) were among the countries with the highest rural/urban disparities in the incidence of impoverishing OOP health spending. It was followed by India (2011) and Nepal (2016) (Fig. 2.12).

Overall, people in the poorest and near poor consumption quintiles faced the highest rates of financial hardship in countries with impoverishing health spending exceeding 2% (Fig. 2.13). Incidence rates in the poorest (Q1) consumption quintile ranged from less than 20% of the population incurring financial

hardship due to OOP health spending in Myanmar (2017) and Timor-Leste (2014) to over 45% in Nepal and Bangladesh (2016). By contrast, in the richest consumption

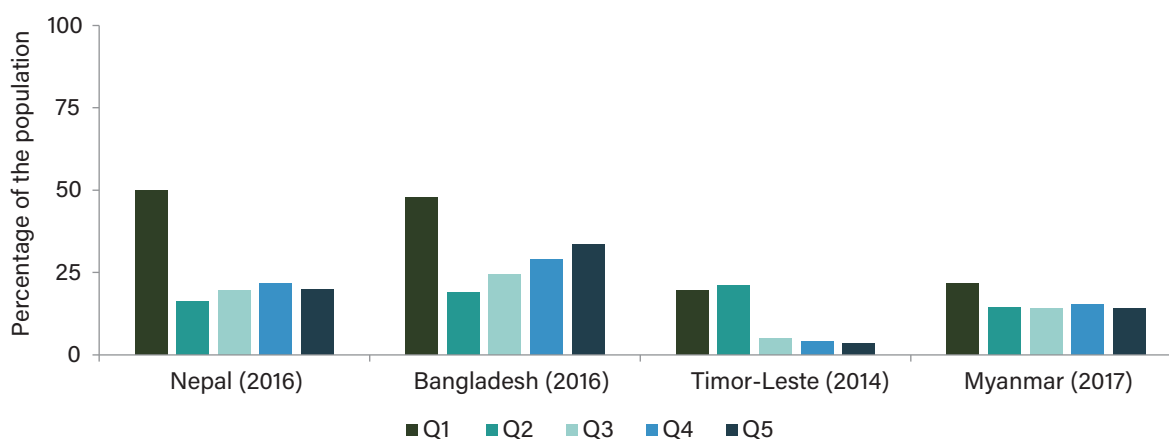
quintile (Q5), the incidence did not exceed 15%, except in Bangladesh (2016), where the rate was high at 34.2% even in the richest consumption quintile (Fig. 2.13).

Fig. 2.12. Incidence of impoverishing due to health spending at the extreme poverty line (PPP\$ 1.90 per day) by areas of residence



Data source: Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2022 update

Fig. 2.13. Incidence of financial hardship across per capita consumption quintiles, among selected countries in the SE Asia Region, 2014-2017



Data source: Monitoring progress on universal health coverage and the health-related Sustainable Development Goals in the WHO South-East Asia Region: 2022 update

Chapter 3



Progress in addressing unmet need in the WHO South-East Asia Region: 2014–2023

“Great political leaders recognize the importance of Universal Health Coverage, not only in improving the health of their people, but also in stimulating economic growth and reducing inequalities in society”

~ Gro Harlem Brundtland

In realizing the UHC vision to promote access to quality health care without financial negative consequences, addressing the needs of disadvantaged population is the key. The Regional Flagship set a clear strategic priority across all 11 Member States of the WHO SE Asia Region to strengthen primary health care (PHC) as a foundation for UHC achievements. This needs improvement of all health system building blocks to address complex demands from different population groups.

Based on WHO Health system building blocks, this chapter describes concrete efforts to address health inequity through the facilitation of access-to-care among people with vulnerabilities in the SE Asia Region. Conducted between 2014 and 2023, these innovative case studies are pathfinder by their nature. Evaluation of their sustainable achievements is challenging, partly due to lack of comprehensive assessment. The chapter also synthesizes key factors for these initial accomplishments.

3.1 Strategic start: health system governance and leadership

Leadership and governance involve ensuring that strategic policy frameworks exist and

are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. They are therefore the underpinning of all needed efforts to change rules and norms that shape roles and responsibilities, incentives and interactions of all health system components to better address health inequities. Governments play a major role in setting the governance arrangements through a broad range of legal, policy, planning and monitoring instruments. Health service providers, both public and private, communities, and citizens, and sectors beyond the health system boundary constitute actors in health governance.

Putting vulnerable populations in planning and resource allocation is key for a fair health system. Case studies from Sri Lanka show how to use existing health system infrastructure, especially PHC system, in addressing needs of neglected populations such as children with developmental disorders and orphans. Timor-Leste has shown its leadership to address social determinants of health at key life stages. Maldives and Bangladesh government reflect the value of inclusive COVID-19 response, by extending the policy coverage

to migrants and refugees. And lastly, the case of Service with Care and Compassion Initiative from Bhutan reflects the human

face of benefit from collaboration across sectors and good governance.

Box 1. Support Infection Prevention and Control for the forcibly displaced population in Cox's Bazar district, Bangladesh

Cox's Bazar, Bangladesh, is the largest refugee camp in the world. More than 890 000 refugees have gathered in makeshift or spontaneous settlements. Poor nutrition, communicable diseases, injuries and other concerns such as mental health pose immense public health challenges. The COVID-19 pandemic has led to a drastic and profound shift in the routine disease-prevention behaviour, especially in fragile and vulnerable settings to contain the spread of infections. Overcrowded and poor living conditions in the camps contribute to the high risk for the spread of infectious diseases.

Through the guidance and leadership of the Ministry of Health (MoH), Bangladesh and WHO-led health sector, implementing partners have established infection prevention and control (IPC) committees and selected IPC focal points in all health facilities in the Rohingya camps. Many local and international nongovernmental organizations (NGOs) have also appointed IPC focal points in all facilities.

All IPC focal persons in the refugee camps received IPC training from WHO and the host community facilities. Starting from 43 doctors and nurses in May 2020, the 4-day master training programme has been attended by over 3600 health and care workers eventually, including workers from host community health-care facilities. A monthly scorecard was established in the facilities for the visualization of IPC implementation by each health-care facility.

Based on the evidence captured through the IPC scorecard system, significant improvements were recorded in IPC in health-care facilities in the refugee camps. The monthly scorecards displayed in health-care facilities have been an incentive in promoting accountability and tracking progress of IPC measures. WHO, together with partners, have been working on developing a central dashboard for the visualization of IPC in health-care facilities in the Rohingya camps, which could be accessed globally.



Box 2. Protecting one and protecting all: the COVID-19 DHIFAAU campaign for migrant-friendly and equitable access to vaccine in Maldives

Migrant workers, documented and undocumented, are key to Maldives' economy. The number of migrant workers in Maldives has significantly increased from 2422 in 1985 to 180 000 in 2020, with approximately 63 000 being undocumented.¹⁰ With the size of approximately one third of the resident population, Maldives' disease-prevention programme cannot achieve any goal without successes of control in migrant populations, legal and illegal alike.

The Government of Maldives implements COVID-19 response programme with no discrimination to the migrant population, including comprehensive risk communication strategies, COVID-19 prevention and testing. Isolation and treatment services were available to all regardless of their geographical location within Maldives.

More importantly, an all-inclusive, free of cost, COVID-19 vaccination campaign was rolled out by the government and partners by using innovative approaches to overcome an array of barriers and hurdles. Migrants were inoculated irrespective of their nationality, documentation status (registered and unregistered), language barriers, gender and socioeconomic status. To overcome hurdles relating to geography, disabilities and mobility, the COVID-19 vaccination 'DhifaaU' Campaign (*in Dhivehi 'Protection'*) and outreach was also carried out in every atoll, bringing immunization closer to migrants' places of work and residence.

The DhifaaU campaign uses both conventional and innovative means to ensure the outreach to migrants nationwide. Vaccination registration/appointment and information, education and communication (IEC) desks were set up at parks and other locations frequently visited by migrants. Digital health technologies allow the government to produce and disseminate multimedia information and advocacy materials in multiple languages, to ensure vaccine acceptance and uptake. To facilitate a smoother and stigma-free registration process for migrants, unique identifiers were provided for individuals without identification or passports, allowing them to receive COVID-19 vaccination free of cost and free of hurdles. This inclusive approach continues to be implemented to this day, ensuring the health and well-being of the migrant workforce in Maldives.



¹⁰ https://www.ilo.org/wcmsp5/groups/public/---dgreports/---inst/documents/publication/wcms_776391.pdf

Box 3. Leave no child behind: how Sri Lanka covers neglected future

The Sri Lankan maternal and child health programme has been regarded as a global health success; children morbidity and mortality rates significantly declined over decades. However, Sri Lanka has been encountering with system challenges to maintain the declining trend and addressing the challenges of groups with specific needs. This case study shows how Sri Lankan government has improved care to children with special health needs and orphans.

A. Including childhood developmental delay and disability early intervention through IncludDe

In low- and middle-income countries (LMICs), children with developmental disabilities are challenged with receiving optimal health, educational and social support to reach their potential. Experience in violence, discrimination and other forms of abuse are disproportionately high. Their caregivers are often stigmatized, isolated and impoverished.

Care for children with developmental disabilities has been integrated into the overall child health programme in Sri Lanka. The Nurturing Care Framework (NCF) for Early Childhood Development launched in 2018 by WHO, UNICEF and World Bank is a unified platform to construct the foundation for all child's lifetime learning and engagement, leaving no children behind.

The Ministry of Health (MoH) has taken leadership in introducing the Inclusive Early Childhood Development (IncludDe) campaign with support and engagement from developmental partners, and parent groups. WHO has been instrumental in introducing developmental screening, and designing care pathways in providing care services for these children in a systematic way. Three screening and care pathways, namely 'Public Health', 'Neonatal Care' and 'Primary Care', were introduced to identify and refer children with developmental disabilities for early interventions. Series of guidelines on including care pathways for early detection and management; multisectoral services; guideline on identification, evaluation and management of children with autism, cerebral palsy and other neurological disorders were developed and disseminated.

The Family Health Bureau, MoH in collaboration with the Provincial Directorates of Health and WHO had demonstrated the success of this campaign in two pilot districts. Hospital-based neonatal intensive care teams, and premature baby unit teams and PHC teams were empowered to identify children with developmental delays and start early interventions.



Training of parents on early intervention for children with developmental delay

Photo credit: Child Developmental Unit, Family Health Bureau, Ministry of Health

The training packages include care environment, as well as a referral and follow-up process. Identified as an integral component, the campaign addresses the need to enhance specific parental skills, especially through adaptation of WHO Caregivers Skills Training (WHO-CST) Tool to the local context, with support from WHO in training master trainers on this tool.

B. Who cares for children in the care system in Sri Lanka

Parents take care of children at home, who cares for children without home?

In the Sri Lankan context, institutional care is the fate of many children who have been abandoned by their parents. There are more than 21 000 children living in orphanages in Sri Lanka. Living conditions for children in some of these homes is less than satisfactory, which lack sufficient staff to provide the attention needed by the children there. Evidence shows that knowledge and skills of caregivers related to adolescent sexual, reproductive health, mental health and dealing with adolescents are suboptimal. The preparation for these children to reintegrate with society is also suboptimal. The MoH has worked with Departments of Probation and Child Care Services, WHO and partners, including representative from youth groups in advancing health services for these children and adolescents through existing PHC services. This cooperative effort has led to the development of minimum care package of health services and strengthened the monitoring and evaluation system. Next, the MoH will scale up and enhance capacities of PHC teams in providing child and adolescent-friendly health services to children and adolescents in the care system – with the aim of supporting them to reach their maximum potential.



Health staff training on early identification and intervention for children with developmental delays

Photo credit: Child Developmental Unit, Family Health Bureau, Ministry of Health

Box 4. Pocket money for the start of life: Timor-Leste's programme to promote healthy pregnancy and early childhood development

Rampant poverty-related conditions make it difficult to start a healthy life in Timor-Leste. Forty-two per cent of the population are living below the poverty line with very high prevalence of acute malnutrition (8.6%) and stunting (47%) in children under 5 years of age.¹¹ The 'Bolsa da Mãe Jerasaun Foun' programme (or 'pocket money for mothers programme') is a social assistance initiative introduced by the Timor-Leste government with the primary goal of supporting pregnant women and children in early years of life. This financial assistance programme targets pregnant women and children aged 0–3 years, providing them with a monthly financial subsidy. Initially set at \$15 per month for pregnant women and \$20 per month for each child in 2022, the amounts are subject to annual adjustments based on inflation rates and will continue until the child attains six years of age. There are additional supplements of \$10 per month for children with chronic disease, disability or special needs.

11 Timor-Leste Food and Nutrition Survey, 2020

The programme aims to improve maternal and child health, promote health and nutrition, combat stunting, and alleviate poverty for vulnerable families. The assistance is key to promote early initiation and complete antenatal care during pregnancy, improve nutrition during the antenatal period and provide supplementary nutrition support for growth and development of children during the formative years of life. This intervention intends to encourage the consumption of diverse and nutritious foods to ensure optimal nutrition during the critical period of pregnancy and early childhood development.

The programme was launched in July 2022 in three (of the 13) municipalities in the country: Ainaro, Bobonaro and the Special Administrative Region of Oe-Cusse Ambeno (RAEOA). The programme is planned for expansion to four more municipalities in 2023.



Taur Matan Ruak, former Prime Minister of Timor-Leste, hands over the bank booklet to a mother and child

Box 5. Bhutan's Service with Care and Compassion: a life-changing initiative

Bhutan is among the first countries of the Region to adopt the WHO package of essential noncommunicable (PEN) disease interventions for primary health care (PHC). The Ministry of Health (MoH) with support from WHO adapted PEN into the pilot project 'Service with Care and Compassion Initiative (SCCI)', starting from four districts in 2018. To promote tailored approaches for people's needs, the SCCI generates greater resolve through active interplay between communities and the health system, involving tripartite partnership – MoH, Khesar Gyalpo University Medical Sciences of Bhutan and District Health Authorities.

The initiative was later scaled up to cover most districts in the country. Benefits such as, team-based care, efficient referral pathway, timely medicine refills, laboratory follow-ups are evident. In recognition of Bhutan's efforts towards prevention and control of noncommunicable diseases, the MoH was awarded the prestigious United Nations Inter Agency Task Force and WHO Special Programme on Primary Health Care Awards in 2022.



Beyond numbers and awards, the SCCI has brought change to people with special demand, home-bound patients – bedridden due to chronic diseases. The life of Mr Jitshuen Dorji has been challenged with congenital paraplegia for both lower limbs. In 2019, Mr Jitshuen was diagnosed with chronic hypertension, which led to his enrolment under home-bound care of the SCCI.

Mr Jitshuen's story is the story of independence of this 40-year-old who received social support from his family, and community and health-care professionals to pursue the tailoring course, organized by the Disability People's Organization and Ministry of Labor and Human Resources in 2021. With a strong heart and strong support, Mr Jitshuen sets an example of social reintegration and health policies that can turn once disabled into this able owner of a tailoring shop in his hometown.

3.2 Backbone: human resources for health

Central to attaining UHC, health systems can function only with health and care workers; improving health service coverage and realizing that the right to the enjoyment of the highest attainable standard of health is dependent on their availability, accessibility, acceptability and quality. Health and care workers include physicians, dentists, pharmacists, nurses and midwives, and also laboratory technicians, public health professionals, community health workers (CHWs), and all other support workers who help deliver services.

Since the adoption of the Decade for Strengthening Human Resources for Health, 2015–2024, the SE Asia Region has recorded many successes.¹² These include increase in

the density of doctors, nurses and midwives in the Region, as measured as SDG 3.C target, by over 30% from 2014 to 2020. Nine countries are now above the first WHO threshold of 22.8 doctors, nurses and midwives per 10 000 population, compared with six in 2014. Three countries are also above the second WHO threshold of 44.5 doctors, nurses and midwives per 10 000 population.

Experiences from Member States of the Region show that every human resource for health counts in addressing the unmet need, regardless of their profession or institution. CHWs have contributed to many public health achievements, including COVID-19 response. Case studies from India and Bangladesh confirm this story. The Bridging the Healthcare Divide Project reflects Indonesia's effort to to match local demand from the services of physicians who were trained abroad.

Box 6. Community health workers and comprehensive primary health care in Bangladesh

As in many other countries, community health workers (CHWs) in Bangladesh are the main driver at the first point of contact of the rural communities, home of 70% of the total population. Physical presence of CHWs at the community level is essential for access to care for rural and hard-to-reach disadvantaged and vulnerable people. Ample evidence repeatedly confirms that CHWs can contribute to promote healthy behaviours and literacy, expand service coverage, strengthen linkages between communities and health services; and thus promote UHC achievements, but only when they are trained, supervised, equipped with supplies, and motivated.

12 <https://www.who.int/publications/i/item/9789290209881>

At present, the Government of Bangladesh is in the process to realize the full potential of CHWs in advancing national health priorities. A comprehensive review of CHW programmes at multiple platforms, both public and private, and strategic capacity-building, are key to strengthen PHC and improve health system resilience. A new national CHW strategy and action plan to enhance their optimal performance would be a gateway to a modern Bangladesh rural health system.



A CHW attending a patient in a rural area

Box 7. Community health officers – the upgraded driving force for health and wellness centres in India

In 2018, the Government of India did a total face-lift of comprehensive primary health care (PHC), by upgrading primary health centres and sub-health centres across the country into 156 000 Ayushman Bharat – health and wellness centres (HWCs). A bold move was to introduce the first batch of more than 90 000 mid-level community health officers (CHOs) to HWCs nationwide. This was hailed as one of the largest health workforce reforms in recent times.

The findings from a comprehensive study conducted by WHO India in the states of Assam and Chhattisgarh in 2020–2021 confirm that this mid-level cadre of health-care providers is key for access to comprehensive PHC of the population. CHOs developed and used the population-based household lists and registration mechanism for all individuals and families to ensure equitable coverage and address issues of marginalization for those residing within the catchment area of an HWC. At HWCs, these mid-level CHOs are capable of providing good quality essential services, including pregnancy and childbirth, neonatal and infant health care, as well as screening, monitoring, and care for diabetes and hypertension. For public health functions, an assessment in Assam shows that most of frontline CHOs had played significant roles in community surveillance to identify, isolate and manage suspected cases and delivering services to those in need during the COVID-19 pandemic.

High community acceptance and trust given to CHOs, a majority of whom are females, are key for access to basic health services. CHOs contribute to achieving health equity and UHC.



Box 8. Bridging the healthcare divide: Indonesian specialists returning home

In the sprawling archipelago of Indonesia, the distribution of health workers has long been a challenge, with many remote areas facing difficulty in accessing quality health care. Indonesian specialist doctors, graduated from abroad, have been identified as a source of augmenting system competency to address these gaps.

The specialist doctor adaptation programme is a series of activities designed to adjust the competencies, abilities, attitudes and behaviours of specialist doctors to meet the national health system's standards in Indonesia. The new re-orientation mechanism has transformed the once delayed and academic-based practice into a direct participation to the reality of health service facilities.

In this ground-breaking programme, physicians with various specialty experience were placed in 16 public hospitals across Indonesia, especially in areas that lacked specialist doctors. This initiative is a significant step towards transforming HRH, ensuring the availability of competent health-care providers where they are most needed, and enhancing quality of health services. The success of this programme signifies a promising future for Indonesian health care, where the integration of diaspora talent helps in building a more equitable and efficient health workforce for the benefit of all citizens.



A doctor Mia (centre) is examining a patient in Hemuge village, Wamena, Papua, 18 February 2023 (WHO/Rosa Panggabean)

3.3 Redesign the system for equitable availability of and access to health products

Medicines and health products are a fundamental part of health care. Spending on medicines remains the most pressing concern for out-of-pocket (OOP) expenditure, leading to health impoverishment in the Region. An estimated 40% of health budgets in LMICs are spent on medicines. UHC can be achieved only when there is affordable access to safe, effective and quality medicines and health products, both modern and traditional.

Like elsewhere, Member States of the SE Asia Region face a range of obstacles to provision of affordable, quality products to the needy population. These obstacles include shortages and stock-outs of essential medicines, poor procurement and irrational use, waste, substandard and expired medicines, and the growing problem of substandard and falsified medical products. Other contributing barriers include under investment in national capacity on supply chain and regulatory systems, limited capacity in managing international trade, as well as inadequate information system on medicines.

Access to quality health products requires a systems approach, including supply chain management. Unambiguous national policies and boosted capacity of the system are prerequisites for the success, as shown in the Indonesia's attempt to

make available plasma-derived medicinal products. Boosting local production capacity and registration of traditional medicine products to the national essential drugs list are key leverages in the DPR Korea case study.

Box 9. The "Achilles" project to assure safety and availability of blood products in Indonesia

The availability of plasma-derived medicinal products (PDMPs) has never matched its demand, Indonesia has relied on imported PDMPs from abroad for long.

Since 2009, Indonesia has joined the WHO "Achilles" project, aiming to improve the quality of blood components for transfusion and plasma for fractionation. Identified as a strategic partner, the project put early efforts in strengthening the Indonesian Food and Drugs Agency (FDA), as the national blood regulatory authority for quality of blood products. The FDA has been key for the development of Good Manufacturing Practice (GMP) Standard for blood establishments, as well as a new blood regulatory framework, as part of the national health system transformation.

A clear goal was set for the local plasma contract fractionation in 2024. So far, 20 blood centres nationwide have been GMP-certified and enabled to provide approximately 200 litres of recovered plasma that can be fractionated to become PDMPs.

In line with the WHO guidelines, the FDA, Indonesian Red Cross and WHO have cooperated to conduct a series of activities to promote quality and safety of plasma as well as increase the volume of quality plasma for fractionation. These include the recent workshops in 2023 on 'Strengthening the Blood Services Consolidation' and 'Testing and analysis for ensuring the quality of PDMPs'



Photo credit: Indonesian Red Cross

Box 10. Promoting access to traditional medicinal products in DPR Korea

DPR Korea has had a long and rich experience in integrating traditional 'Koryo medicine' into the national health system. Since 1977, Koryo medicine services have been available at all levels of public health facilities, together with modern medical services. Currently, Koryo medicine accounts for half of overall services at PHC facilities.

Local production from local medicinal plants makes these products available and accessible. To promote seamless integration, 37 traditional medicinal products have been included in the national essential medicine list as of 2019. These Koryo medicinal products are used in DPR Korea for a variety of health conditions, including cardiovascular, gastrointestinal, gynaecological, respiratory, dermatological and mental disorders.

Traditional medicine has played an important role in disease prevention and health promotion as well as in management of various diseases for the local community.

Traditional medicine guidelines and information have been developed and disseminated by the government. Knowledge, literacy and trust also contribute to the popularity of traditional medicine, both for curative and preventive/promotional aspects.



3.4 Better measurement through strong health information systems

Monitoring health situations and trends underpins evidence-based decision-making in every facet of health systems strengthening. Good governance and leadership of a health system requires reliable, timely information through well-function health information systems (HIS), which can generate information to enable decision-makers to identify problems and needs, make evidence-based decisions on health policy and allocate scarce resources optimally. Health information is vital for all actors at all levels involved in health care and service delivery, national health and development policy planning, to regional and global agenda such as UHC.

The lack of robust and effective HIS often results in a significant gap between what

actors know and what they need to know to improve the health of the population. WHO commits to improve the availability, quality, analysis and use of health information from different sources for better measurement and accountability for health. Strengthening governance, capacity, interoperability and sustainability of national HIS, civil registration and vital statistics (CRVS) systems are key mechanisms. Meanwhile, national investment and capacity are crucial for sustainability of HIS.

Collaboration from stakeholders is often overlooked in HIS strengthening. Case studies from Indonesia (Box 11) and Nepal (Box 12) show how bottom-up approaches can improve availability and accuracy of information, and thus sharpen public health actions to address the needs. Another Nepal case study (Box 13) shows why strengthening capacity of information authority is crucial in a crisis.

Box 11. The Verbal Autopsy Initiative in challenging terrains to strengthen CRVS in Indonesia

Civil registration and vital statistics (CRVS) is crucial to any robust health information system (HIS). However, poor quality of data on cause of death is common in low- and middle-income countries (LMICs).

Since 2015, the Indonesian Ministry of Health (MoH) has been strengthening the CRVS system. The Verbal Autopsy Initiative (VA) was launched in five selected districts in 2021, including Kepulauan Sula District of North Maluku Province, a typical remote island region, with geographical hardships.

Capacity-building activities involved training sessions for health-care personnel from primary health centres, hospitals and the health offices within the district. Data analysis was carried out on the collected VA data, involving 644 deaths recorded in the year 2021. The initiative yielded several positive outcomes, including improved regulations through the issuance of regional head decrees and well-structured reporting procedures, and enhanced abilities of health-care professionals, as well as better cooperation across agencies. The experience underscores how the VA Initiative can improve the quality of HIS, which is key to address the demand of disadvantaged populations and addressing health disparities. By empowering local health-care personnel and refining data processes, this VA project holds the potential for replication in other low-resource settings.



A health worker from a local health centre conducts verbal autopsy in a village, Kepulauan Sula district (Photo credit: MoH/Yusleli Usman)

Box 12. Bottom-up approach to improve maternal mortality data in Nepal

An accurate estimate of maternal mortality ratio (MMR) is crucial to track the progress on SDG target 3.1. In the absence of accurate and comprehensive information, maternal mortality had been for long in the unknown and controversial zone; thus our public health interventions had been on the blind mode. The Nepal Ministry of Health and Population (MoHP) is now working to make this lacuna a history.

In collaboration with the National Statistics Office, the MoHP launched the Maternal Mortality Study Project in 2021. This is the first integrated national effort to estimate the MMR and determine the cause of death. Conducted after the National Population and Housing Census, this project employ census enumerators to collect data on live births and deaths of women of reproductive age (WRA) in the past 12 months. In case of possible pregnancy-related deaths, the verbal autopsy was conducted by health workers in line with the WHO classification of conditions.

The project involved rigorous training, fieldwork, and data management; with engagement from all three tiers of the government and development partners, as well as health-care workers from all levels. The project tallied 653 pregnancy-related deaths, of which 622 complied with maternal death criteria. The national MMR was estimated to be 151 per 100 000 live births accounting for 4.8% of total deaths among WRA. The study also showed that preventable causes of maternal deaths, especially non-obstetric complications are key for these mortalities. The study resolved the longstanding issue on conflicting data on maternal mortality and established the feasibility of upscaling it elsewhere.



Province level training of trainers on maternal mortality data at Pokhara, Gandaki Province, 2021

Box 13. The Information Management Unit to support COVID-19 response in Nepal

Information is important in normal times, but extremely important in a crisis. The declaration by WHO and the Government of Nepal for COVID-19 as a public health emergency made everyone realize the need for accurate information. Disaggregated information, by subnational level governance and service delivery structure, is in demand to report COVID-19 situation updates, response actions including availability of clinical services.

Warranted by the pandemic situation, after a year of onset of COVID-19 in Nepal, the government established the Information Management Unit (IMU), responsible for data collection, management, and analysis. With support from WHO, the IMU App was developed to accumulate paper-based and paper-less data sources, and turn them into a generic data management platform, handled by skill-mixed professionals.



Senior citizens after COVID-19 vaccination with certification from IMU (WCO Nepal), 2021

The IMU platform had become a main tool to manage availability of beds, medicines and critical equipment, as well as for reimbursement for COVID-19 care. The IMU App had provided big support to the national COVID-19 vaccination programme, including vaccination certification, and for the public to fulfil various administrative requirements.

As a lesson learnt from COVID-19, there is a need to strengthen the information system before the times of crises. The development of a continuous Integrated Disease Surveillance System is an opportunity to backstop the IMU as active vigilance to sense the emergencies.

3.5 Harnessing digital health

Digital transformation of a health system can be disruptive. Information and communication technology (ICT) presents new opportunities and challenges for the achievement of all 17 Sustainable Development Goals. Strategic and innovative use of digital and cutting-edge ICT will be an essential enabling factor towards ensuring UHC. ICT has proven potential to enhance health outcomes by improving access to and quality of care, reducing costs, promoting health literacy and skills among populations; as well as for promoting evidence-based knowledge, skills and competence to health and care workers.

Digital health should be an integral part of health priorities and should benefit people in a way that is ethical, safe, secure, reliable, equitable and sustainable. It should be developed with principles of transparency, accessibility, scalability, replicability, interoperability, privacy,

security and confidentiality. Despite the considerable progress made by some countries, application of digital health to improve the health of populations remains largely untapped. Countries still require institutional support for the development and consolidation of national digital health strategies and the implementation of their plans, which usually requires considerable resources and capabilities.

The e-Sanjeevani case study in India (Box 14) shows that a telemedicine platform can not only turn the right-to-health concept into reality with boosted access to health care for millions of those in need, but also enhance the quality and continuum of essential health services. The pilot project from Maldives (Box 15) confirms that digital health is no longer a luxury at the PHC level, but when used in an integrated way, the Primary Health Care Registry can address health needs of everyone regardless to their nationality and legal status.

Box 14. e-Sanjeevani: the game-changer for access to quality care in India

Advances in information and communication technology (ICT) brings countless opportunities to bridge gaps in the access to care, especially in rural and remote communities. The Ministry of Health and Family Welfare, India took a significant step forward for telemedicine, through the launch of e-Sanjeevani, the new official National Telemedicine Service platform, in November 2019.

This e-Sanjeevani programme aims to provide equitable and quality care and strengthen continuum of care amidst geographical and socioeconomic challenges. This free-of-cost communication also supports Ayushman Bharat Digital Mission in developing the integrated digital health infrastructure of India. The first mode of e-Sanjeevani is the 'hub-and-spoke provider-to-provider platform,' designed for tele-consultation especially between those frontliners, health and wellness centres (HWCs) and physicians at upper levels of care. The e-Sanjeevani OPD platform, the second mode, enables patients to connect with providers even from their homes.

The e-Sanjeevani is arguably the world largest telemedicine platform. As on mid-2023, more than 114 million patients have availed e-Sanjeevani services. With 57% and 19% of beneficiaries as females and the elderly, respectively, e-Sanjeevani has been a game-changer to address health inequity in access to health among vulnerable populations in India. WHO is providing technical support for upscaling the programme coverage, with collaboration from state and district officials, physicians at the secondary/ tertiary hub, and on-ground HWC teams.



Box 15. Establishment of primary health care digital information system in Faafu Atoll, Maldives

With strong commitment on UHC, the Government of Maldives ensured accessible health-care services with financial protection, on every inhabited island. Bringing health care closer to the communities, this pledge to upgrade health system capacity to provide in-demand services, especially for noncommunicable diseases (NCDs). Digital health technologies present an opportunity to address the remaining key challenges, including capacity to provide people-centred care through a life-course approach, as well as interconnectedness of the health information system.

The Ministry of Health (MoH), Maldives and WHO launched a pilot project to strengthen integrated NCD services and the information system at the PHC level in Faafu Atoll. The newly developed digital health platform, 'Primary Health Care Registry,' facilitates effective empanelment, screening, follow-up and continuity of care for the entire population. The comprehensive 'Island Health Profile Database' plays a crucial role in NCD prevention and control, including early detection, identifying population-level risk factors, and ensuring timely management within the island communities. By empaneling all residences, the project supports inclusive services to all walks of life, including undocumented migrants, vulnerable groups, and minorities.

The Primary Health Care Registry is a software owned entirely by the MoH, and is developed on the District Health Information System (DHIS2); a free open-source software platform. WHO has played a significant role in supporting capacity development and has provided relevant training modules to the MoH, ensuring a smooth transfer of the registry's responsibilities. Additionally, this platform facilitates the integration of other DHIS2 modules, such as Child Growth Development, and Antenatal and Postnatal Care. This integration contributes to a comprehensive health information system fundamental to address health demand at the entire life-course.

Following three months of implementation, 93.6% of the target population has been empaneled. Commendably, 96.6% of the empaneled population has also been screened. This initiative demonstrates achievement in enhancing data accessibility and ultimately improve health outcomes for all individuals of the Maldives, leaving no one behind.



Photo credit: Ministry of Health, Maldives

3.6 Invest more and invest smarter: health financing

Health financing is a core function of health systems that can enable progress towards UHC by improving service coverage and financial protection. Health financing policies ensure that financial resources are effectively and equitably allocated and that different population groups, especially those least able to pay. Carefully designed and implemented health financing policies can help to promote access to quality care and address impoverishment due to expenditure on health. Limited resources must also be efficiently managed and administered to ensure that the policy delivers the best value for money in delivery of health services.

In the past decade, Member States of the Region have shown progress in health financing including expansion of government

health expenditure through better revenue raising, pooling of health funds, and improvement in service purchasing. The SE Asia Region is still the region with the highest proportion of out-of-pocket (OOP) spending on health. Millions of people live with the threat that at any time catastrophically high household expenditure could push them into poverty.

The case study from India (Box 16) shows that strengthening is a political choice that could change destinies of millions of lives. Similar is the case of restructuring of health financing and benefit packages in Indonesia (Box 17) for patients living with diseases and their families. Meanwhile, the Thailand case study (Box 18) shows the mixed use of compulsory, semi-compulsory and voluntary insurance schemes to ensure access to health care and public health services for legal and illegal migrants.

Box 16. The world largest health financing reform in India

Since 2008, the Government of India has been implementing the government-subsidized health insurance reform for improving equity in access to services with financial hardship protection, by various programmes of the Central and state governments. The overhaul change, however, came in 2018 through the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY). This is the world's largest health protection scheme, which provides health coverage to over 600 million beneficiaries, identified mainly by parameters of those living below the poverty line.

Since 2019, WHO has supported the state governments to improve access to and service coverage, under and beyond the scope of PMJAY. One such initiative is the design, implementation and review of efforts to integrate the PMJAY with pre-existing state health insurance schemes and health financing pools. By maximizing risk and fund pooling, this integration magnifies population coverage to enable people living above the poverty line and informal employment segments.

A recent study in selected states by WHO shows that this integration could yield 70–100% population coverage, a huge boost to 40% of PMJAY-covered population living under the poverty line.¹³ The study also reports improved equitable access to services, for poor and non-poor in both rural and urban settings, and a more harmonized benefit package for all, as well as improved system efficiency.



Box 17. Reform of the single-payer scheme and harmonized benefit packages in Indonesia

The National Health Insurance (Jaminan Kesehatan Nasional/JKN) programme in Indonesia has been a beacon of hope for patients and families nationwide. The programme's vision of promoting health equity led to its transformation into a single-payer system, consolidating various insurance schemes. This critical step eradicated disparities in health-care coverage and streamlined administrative processes, resulting in a more efficient and inclusive health-care system.

Considering a transformative example for people living with tuberculosis (TB), the single-payer system with harmonization of benefit packages has brought standardized and equal access to diagnosis and treatment for all Indonesians, regardless of their location or socioeconomic status. It also simplified the process of seeking medical assistance, ensuring

13 World Health Organization. Country Office for India. (Forthcoming, 2023). Review of Defragmentation of Publicly Subsidized Health Insurance Schemes.

comprehensive care throughout the nation. Diagnostic services, medication and follow-up care are now available without discrimination; this initiative also provided much-needed financial relief to affected families.

The strides made by JKN in expanding access to health care for individuals living with diseases exemplify its commitment to addressing health inequities and improving the lives of all Indonesians. As the programme continues to evolve, it remains a testament to Indonesia's dedication to the well-being of its people and a success story for achieving UHC.



Patients wait to register at Christina Marta Tiahahu PHC in Ambon Citu, Maluku, Indonesia (WHO/Nyimas Laula)

Box 18. Towards universal health coverage for migrants in Thailand

Following the success of UHC for Thai citizens, the government in 2002 put efforts in extending coverage to migrants, through two public insurance schemes. As of 2019, 68% of registered migrants are enrolled under these two schemes.¹⁴

The Social Security Scheme (SSS) targets documented/legal migrants working in the formal employment sector. The SSS is a compulsory scheme with tripartite contribution, from migrant workers and employers and the government. The benefits of SSS include medical care, preventive health services and social benefit package.

The Migrant Health Insurance Scheme (MHIS) targets all other migrants. It is a semi-compulsory scheme, designed for migrant workers and their dependents, not covered by and eligible for the SSS. Annual fees range from US\$10 to US\$55 depending on age. The benefits of this MHIS cover annual health check-up, outpatient and inpatient medical care, health promotion and disease prevention services.



14 2019 Towards universal health coverage for migrants in Thailand. In Thailand Migration Report 2019 (B. Harkins, ed.)

In addition to the public scheme, undocumented migrants living in border areas are eligible for a voluntary community health scheme, M-FUND, run by the Dreamlopmments Foundation.

With a monthly fee starting at US\$3 for each healthy individual and higher for people with chronic diseases, the M-FUND service covers outpatients and inpatients with the ceiling of 5000 and 45 000 bath per month, respectively.

Despite these three schemes, a big proportion of migrants, especially unregistered, are uninsured. Increasing scheme coverage to migrants by simplifying the registration process and enhancing marketing with incentives is a government priority.

3.7 Redesign health service models for better outreach

For health care and coverage to be truly universal, it requires a shift towards health systems designed for people, with people. Current health services may not be fit for the collective demand, especially, when considering changes in the demographic and epidemiological patterns. A substantial share of the population in the SE Asia Region still lacks access to essential health services; meanwhile available health care is too often fragmented, disconnected and not of good quality. Poor coordination and a lack of integration across providers and programmes, as well as predominance of curative care models, are common bottlenecks.

A renewed focus on service delivery through an integrated and people-centred lens is critical for reaching underserved and marginalized populations to ensure that no

one is left behind. Integrated people-centred health services (IPCHS) are a key feature of robust and resilient health systems and are critical for progressing towards UHC. IPCHS ensures access to coordinated and comprehensive services and care with quality, addressing health need through people's life-course with dignity, and through competent and motivated health and care workers.

Case studies from Myanmar (Box 19) and Nepal show the possibilities of applying low-cost, high-impact public health interventions at the PHC level to address once ignored issues such as safe abortion and epilepsy. Case studies from Bhutan (Box 20), Sri Lanka and Timor-Leste reflect that the simple truth of redesigning service models with collaboration across sectors can dramatically change the situations for those hard-to-reach populations, including ethnic, gender-based minorities, and those living with geographical hardships.

Box 19. High quality with low-cost care for people living with epilepsy in Myanmar

In most low- and middle-income countries (LMICs), demand of people with mental and neurological diseases (including epilepsy) have been neglected in terms of resource, capacity and attention. Epilepsy, one of most common neurological conditions, leads to negative consequences to lives of patients and families. Evidence suggests that early detection and proper treatment can change this life-course, and that this can be conducted with little cost at the PHC level. A study in 2014 estimates that prevalence of epilepsy ranges from 0.83 to 1.9 per 1000 population, but most importantly only 5% of people with epilepsy had access to treatment.¹⁵

15 WHO, 2018 Myanmar Epilepsy Initiative – Piloting the WHO programme on reducing the epilepsy treatment gap 2013-2017, Myanmar [https://cdn.who.int/media/docs/default-source/mental-health/myanmar-epilepsy-initiative.pdf?sfvrsn=6b2b2126_2#:~:text=In%20Myanmar%2C%20it%20is%20estimated,not%20receive%20the%20care%20]

The Myanmar Epilepsy Initiative (MEI) started as a pilot project in 2013 and gradually rolled out with WHO support, aiming to tackle the epilepsy burden and to scaling up integrated epilepsy care into PHC in Myanmar. The MEI runs on multiple implementation modalities to expand and sustain integrated care to these vulnerable patients, amidst of challenges and limited resources. The MEI uses WHO mhGAP guidelines in training multidisciplinary primary care workers.

The project ensures adequate and sustainable availability of anti-seizure medicines. A comprehensive monitoring and evaluation system was established to provide a clear understanding of the availability of anti-seizure medication in rural health centres, the use of epilepsy services, and patient outcomes. The MEI shows that epilepsy care is feasible and cost-effectively integrated into the primary health system in a low-resource setting.



Epilepsy service provision by a health assistant at a primary health care facility

Box 20. Gender-sensitive health-care services in Bhutan

Lesbian, gay, bisexual and transgender (LGBT) may particularly suffer from various forms of discrimination and social exclusion, and face health disparities leading to high magnitudes of many physical and mental health problems. Although evidence is sparse, it is known that LGBT in Bhutan are among the most marginalized and underserved populations in the health system.

Life story of Tshering: Tshering knew at age five that her gender was not what people expected of her, but did not have the words for it at such a young age. Growing up, she felt different, and she decided to seek health care. Tshering's experiences with the health-care system have been mixed, including being a victim of stigma and discrimination by health professionals. Fortunately, she was referred to the Adolescent Friendly Health Services where she received the right type of support including counselling, conducted by health professionals who were familiar with gender-related care.



Photo credit: Humans of Thimphu

While she enjoys free access to the service at the National Referral Hospital, Tshering pointed out a key barrier in the form of competency of health workers to address the need of LGBT people, some emerged from a lack of proper vigilance. Beyond health care, Tshering was involved in advocacy efforts within her community through the PrideBhutan, an organization to promote the rights of the LGBT community.

Box 21. Bring services to demand: expansion of safe abortion in Nepal

Despite being recognized as a core component of UHC, sexual and reproductive health and rights is one of the neglected areas in practice. The Sexual and Reproductive Health and Rights (SRHR) project was launched in Nepal in 2019, with the aim to support the government in achieving universal access to sexual and reproductive health care with a focus to reduce maternal mortality. During its first four years, the SRHR initiative had been a key factor in establishing the institutional governance mechanism, through a steering committee and technical working committees, to provide a common platform to advance the SRHR agenda. The project was successful in endorsing and implementing the guidelines of the National Safe Abortion Services (SAS) up to the local level.

Since its inception, SRHR has boosted the expansion of SAS services including to remote areas with marginalized populations, through service certification process at all provinces, including at the local level across the country. Between September 2021 and July 2022, 136 new certified facilities and 300 new providers were listed at the provincial/ local level with the support of provincial SRHR officers. Additionally, the project was essential for strengthening workforce competency SRHR services, including in pre-service education of medical, nursing and midwifery students. With the support of WHO Nepal, 10 simulation laboratories were established at eight medical institutions and 170 faculty members were trained in simulation-based education.



Box 22. Promoting child health in minority plantation communities in Sri Lanka

Plantation communities are descendants of Indian migrants who came to Sri Lanka during the colonization era to work in tea estates. Around a million of 250 000 families suffer from health disparities. Living with poor facilities, their health conditions and socioeconomic statuses are not on par with others. Lack of basic sanitation and education, difficult terrain, language barriers and poor access to health are key issues. The nutritional status of

under-five children in the estate sector were poorer than the national average figures. Rates for stunting and underweight are 83% and 45% higher than national figures, respectively.¹⁶

Tackling this complex agenda requires actions beyond the health sector. WHO has been working with the Plantation Human Development Trust (PHDT) and the relevant stakeholders of the Ministry of Health (MoH) to improve the capacity of community development officers (CDOs) and plantation family welfare officers (PFWOs), trained as health promotion agencies with a focus on nutrition and psychosocial development, especially in the COVID-19 recovery phase.

The PHDT has identified several pain points of previous programmes, such as low engagement and disconnected support. Health of pre-school children has been recognized as a no-man's-land among early childhood care and development teachers and grassroots health staff.

Pilot projects were conducted in 73 PHDT regions covering 118 plantation communities. One PHDT staff member from each region was empowered. Fifty-three out of 73 trainees have been identified as high-achieving community members with the capacity to train others. These are key workforce for the expansion of the programme to further 84 communities. Improvement in once-malnourished children and attendance to child development centres were the initial success stories of this initiative.



Box 23. Timor-Leste's Saude Na Familia programme for better community health care

Timor-Leste is constitutionally committed to deliver health care to its people through a democratized public health system that is free at the point of delivery. The reality, however, is that 70% of the population lives in rural and hard-to-navigate small, scattered and remote villages, often isolated by difficult mountainous terrain and poor road connectivity. This geographical challenge severely affects access to health care, health-seeking behaviour and contributes to unmet need.

To realize this commitment, the Government of Timor-Leste launched its flagship family health programme, "Saude na Familia" (SnF) on 22 July 2015. Over the years, the SnF programme has emerged as the main approach to reach such vulnerable populations and provide holistic health services at the doorstep of people through a multidisciplinary team in an integrated manner. By bridging the gap between communities at the grassroots and

16 Sri Lanka Demographic and Health Survey 2016

health-care facilities, the SnF is aimed at strengthening the overall health-care system and addressing health disparities and unmet need.

Modelled on the successful Cuban model, the SnF brings comprehensive PHC services down to the household level, through regular domiciliary visits, clinical consultations, screening, treatment, referral, and follow-up. This initiative is conducted by a team of multidisciplinary professionals; teams of physicians, nurses, midwives, public health officers, nutritionists and community health workers (CHWs). The SnF teams register and maintain a health profile for every individual and family, including the wider social determinants of health.



A health-care worker from the SnF examines a child in Ermera municipality

3.8 Integration of public health functions to primary health care system

Disadvantaged population groups do not only suffer from access to care, but also on public health functions, such as disease prevention and eradication and health-promotion activities. Improved integration of public health functions to the health-care system is critical to optimize the potential of the health system to address broad health demand of the population. Promoting a comprehensive PHC system that can carry essential public health functions to population has been a policy agenda of many countries in recent times.

Many governments have implemented structural and financial reforms to move away from fragmented provider-centred models of care and have reoriented them based on principles of integration to ensure that everybody has access to a continuum

of care that is responsive, coordinated and in line with people's needs throughout their life. Integrated health services, based on strong primary care and public health functions, directly contribute to enhanced and equitable well-being and quality of life, which in turn bring important economic, social and individual benefits. Integrated care contributes to improved access to services, better adherence to health programmes and overall improved health outcomes.

A case study from Maldives shows that the integration of comprehensive leprosy eradication activities into PHC with a clear policy direction and goal to be among the world's first leprosy-free countries. Meanwhile, a case study from the Tamil Nadu State of India (Box 24) shows the possibility to change the tragic course of life of one of the most neglected groups, such as the homeless people with mental illness, and not only for health care but also for their social reintegration.

Box 24. Comprehensive care for mentally ill homeless in Tamil Nadu, India

Approaches to mental illness usually focus on tertiary specialized care, which hardly address the mental health needs on ground. The Government of Tamil Nadu State pioneered in establishing Emergency Care and Recovery Centres (ECRCs) to holistically address the needs of homeless people with mental health conditions. This initiative established and designated care centres in 10 districts, each with 50-bed capacity and equipped with comprehensive physical and mental services and cares for wandering mentally ill persons. Individuals at the centres are also provided shelter, rehabilitation, vocational training and social reintegration services. ECRCs also provide 'inclusive living options' with personalized supportive services, particularly for those who are unable to return to their families or live independently and are at risk of long-term institutionalization in psychiatric facilities.

Since January 2021, more ECRCs have been set up in districts in collaboration with nongovernmental organizations (NGOs) and support from district administration. From October 2018 to January 2023, nearly 1768 homeless with mental health conditions have enjoyed benefits from ECRCs, out of which 432 have been reunited with their families and societies.

A clear example of leaving no one behind, this innovative best practice addressing the once-ignored health and social needs of the vulnerable and voiceless population was later emulated by multiple states in India and appreciated by the Ministry of Health and Family Welfare, India.



Box 25. Maldives strives for 100 leprosy-free islands: progress, challenges, and the road ahead

Maldives was listed as a highly-endemic country for leprosy with a prevalence rate of 96.64 per 10 000 population until the year 1982.¹⁷ The introduction of multidrug therapy (MDT) in 1982 marked a turning point. Subsequently, the Maldives made significant strides in combatting the disease. Within a span of 15 years, registered prevalence of leprosy decreased to less than one case per 10 000 population. After achieving elimination of leprosy as a public health problem, the status has been sustained and the disease burden was reduced in the next two decades.¹⁸

Challenges in leprosy control, however, remain, including geographical complexity, population concentration and mobility in the Greater Male' area, and a large share of the migrant population.

17 National Guideline for Leprosy Management 2021, Health Protection Agency, WHO Maldives.

18 Framework for Zero Leprosy in the Maldives: 100 Leprosy Free Islands by 2023, Ministry of Health, WHO Maldives

These achievements in leprosy control and commendable track record of eliminating infectious diseases in the past, together with availability of health-care facilities in every inhabited island supported by Aasandha social insurance scheme, have led Maldives towards pursuing its goal of achieving zero leprosy by 2030 and reach the last mile of leprosy elimination.

The Maldivian government, in collaboration with WHO, has developed a comprehensive five-year Zero Leprosy Roadmap. This roadmap encompasses crucial elements such as surveillance, testing, screening, treatment, community engagement, and effective monitoring on all islands. Social discrimination and isolation, especially in small communities, may deter affected individuals from seeking help. To combat this, the Health Protection Agency conducted community awareness and advocacy campaigns to destigmatize leprosy. Aiming to leave no one behind in its efforts to eliminate leprosy, plans are under way to provide disability care services for individuals affected by leprosy and incorporate leprosy care into PHC for the entire population, including migrants.

These initiatives reflect the country's determination to become among the world's first leprosy-free nations.



Photo credit: Ministry of Health, Maldives

3.9 Summary

This chapter unfolds 25 praiseworthy case studies in the SE Asia Region to address the need and demand of various disadvantaged population groups; some of these were once totally neglected by the health system. These path-finding initiatives remind us of three key common factors for success. These are: firstly, clear and strong political commitment with common understanding and dedication along with implementation. Secondly, the capability of the health system,

primary health system in many cases, as well as public awareness and support – how society is addressing such health issues, are decisive conditions for achievement and sustainability of such programmes. Lastly, all of these case studies require good coordination across agencies and across levels of health care, most cases cannot even start without strong efforts from non-health agencies. Leadership qualities beyond the health sector boundary are evident in many case studies above.

Chapter 4



Challenges in addressing health inequity and unmet needs

“Of all the forms of inequality, injustice in health is the most shocking and inhumane.”

~ Martin Luther King Jr.

The primary goal of a health system is to improve both the level and distribution of health outcomes. Health equity, defined as absence of unfair, unjust and avoidable differences among population groups, includes but not limited to disparity in health outcome status such as morbidity and mortality parameters. It also covers discrepancies in access to and possess of health care, services, information, resources, power and ability to improve and protect health and well-being. Health equity has been recognized as a health system strengthening agenda for long. Health equity is an essential component of the vision on health as fundamental human right and health for all, where everyone can attain their full potential for health and well-being. Such remediable differences are still widespread across and within countries. Health gradients have been repeatedly reported across population groups of different social, economic, demographic, health conditions, as well as geographical and ethnic categories.

Unmet need is the most concerning aspect of health inequity. Inability to access health care resulting from one or more barriers, regardless of the perception of health need, limits the potential benefit from services when and where they need the most, and

could exacerbate negative consequences for individuals, families and public. Forgone care defines the lack of services among those who perceive demand, but the domain of unmet need also includes unattended health need without recognition of those who may require it.

The COVID-19 pandemic and its consequences revealed weaknesses and gaps of the health system, including its capacity to address health inequities. Differences are evident in access to prevention and care including diagnosis and vaccination, infection and death, as well as the ability to cope and recover, across socioeconomic gradients.

Effective tackling health inequities and unmet need is a long-term, continuous and sustained whole-of-society and whole-of-government multisectoral collaboration and commitment. While the health sector is a decisive element, much of collective actions need to take place beyond the health system boundary. From the lesson learnt from the SE Asia Region, three groups of major challenges remain, including challenges in health system strengthening, challenges in addressing root causes of health inequities, and challenges in monitoring and tracking progress.

4.1 Challenges in health system capacity

Universal health coverage is achieved when effective services are available for all, when they are accessible without financial barriers. UHC does not mean only to promote quality service to those who have access to health care, but also to non-consumer populations. Access to care can be limited for a variety of reasons, including limited availability or affordability of services, inadequate capacity to provide quality services, service models that are not friendly enough to lifestyle of populations, and a lack of trust. Policies therefore need both to address financial barriers to care and to promote an adequate supply and distribution of health workers and health-care services throughout the country.

Every component of health systems plays a significant role in promoting outreach to those disadvantaged population groups and unmet needs. So do the different sectors and levels of health-care facilities and public health authorities; they may be public or private providers, community or super-tertiary health care, and national or local governments.

Among these diversities, a comprehensive PHC system, when strengthened, is the integrated platform, most cost-effective and equitable approach to address most of health-care demands. While strengthening secondary and tertiary care levels also helps addressing these gaps, investment in comprehensive PHC is the most critical strategy to promote health equity. All the 25 case studies in chapter 3 reconfirm the role of PHC to attend the needs of vulnerable populations.

- **Need for improved health system governance**

Addressing unmet needs is not a short process. Health system leadership, especially its capacity to promote multisectoral coordination is a must. Political determination, synergized commitment

and shared understanding across actors are key prerequisites for an effective way forward. Resource allocation is the political commitment in action. Financial resources, especially domestic sources to PHC, are the main vessel for the equity-promoting health system. International financial assistance may complement, but not replace public budgets in the long run. Fiscal spaces to reduce OOP expenditure, the most important hurdle to care-seeking, require continuous and sustainable commitment over succeeding political authorities.

Stewardship for constructive and synergized contributions from all health-care providers, public and private, has not gained attention it deserves. Polarization and unhealthy competition of health-care providers may hamper health equity, further divide those who have and do not have access.

- **Inadequate social participation/ community engagement for people-centred health care**

People-centred health care starts with engagement from the people and community. Social participation in the health system, particularly in policy decision-making at all levels, is essential for the system accountability framework, and ensuring the attention to health demands of key population groups. Demands of disadvantaged and voiceless population groups are fragmented in nature, and need to be organized. Community engagement, especially of those disadvantaged, seems not to be a mandatory checklist in health system strengthening. Their voices are too often unheard in health policy forums.

Centralized and provider-focused health system and government authorities are facing difficulties in attending to special demands of those marginalized populations in various circumstances. Addressing their needs requires more than technicality and resources; it's the trust and tailored approach to their context, conditions and realities. Engagement and ownership of

civil society organizations, the private sector, communities, local authorities and representatives of vulnerable people are key to fine-tuning the policy and practices, beyond promoting system accountability.

- **Lack of resources and capacity of primary health care system**

Despite the frequent call for health systems reorientation towards primary health care, investment to PHC might not be politically popular in reality. The global phenomenon is the chronic under-investment of the PHC system. Shortage and imbalance of workforces at the PHC level, some with high mobility, are common in the Region. Availability and access to PHC in many urban settings are far inferior to rural counterparts. The absence of people-centred PHC in cities, with the rise of urbanization, hides the reality of the health situation, ignoring the health demand. Apart from the inadequate capacity to provide quality functions, vulnerabilities of PHC in the Region also include a lack of resilience to climate changes and environmental degradations. Shortage of water supply, energy and sanitation services including infectious waste management, all restrain the system's capacity.

The collective capacity of the PHC system is much more than just the addition of capacity of individuals. Equipping PHC personnel with training, guidelines, standards and health products and technologies may not be sufficient for those neglected populations. Successes in vertical health programmes in the past, such as maternal and child health, may not guarantee capacities in dealing with more complicated situations and contexts, especially considering the increasing expressed and non-expressed health demands. It is worth mentioning that the roles of the PHC system to provide essential public health functions have been found wanting during and following the pandemic era.

The PHC system is not just delivery of primary care of primary level

health infrastructure. The concept of comprehensive PHC is the most important, but also the most misunderstood. The Alma-Ata Declaration and the subsequent Declaration of Astana reaffirm the three pillars of PHC; provision of primary front-line care; community engagement and empowerment; and multisectoral actions at root causes. The reality is, however, that the PHC system does not strike a balance over these pillars, too focusing on provision of primary care while neglecting others. Adding to this imbalance, the implementation of PHC concept solely relies on government-run infrastructures, and does not adequately recognize the roles of private sectors, civil society and community organizations, and even secondary and tertiary health infrastructures.

- **Underutilized technology, policy and service innovations**

One synthesized lesson from the case studies in chapter 3, innovative approaches have edged advances in addressing health demands of vulnerable populations, while just more of business-as-usual may not. In-demand innovations to promote health equity do not limit to just ICT, such as applications of digital health domain. Social and policy innovations, such as the redesign of community health workers or partnership platforms; as well as practice innovations—new way to provide health services better, such as doorstep delivery, all help closing the gaps.

The down realities of these such ICT, policy and social, and service innovations are firstly underused, despite their potentials. Secondly, such good practices from chapter 3 are usually sporadic, not systematically nurtured. This poses questions about the system's capacity to create innovation-enabling ecology and learning health system. Inter-countries and intersectoral knowledge and experience-sharing platforms may facilitate in bringing innovations to benefit the needs of neglected populations.

4.2 Challenges in addressing determinants of health inequity and unmet needs

Healthy people are a prerequisite, means and end-results for sustainable development; and there is an economic cost to inequity. Changing values of health inequity to society are obvious, in particular the attention on the interconnectedness between health and broader socioeconomic–environmental development agenda. Unequal power, prohibitive relationship, intersectionality, stigma and discrimination of those unmet needs and forgone care must be addressed by law and societal infrastructure context, as well as by the health system

Health equity, unmet needs and negligence from the health system are largely stemmed and determined by the conditions in which people are born, grow, live, work, play and age – so-called social determinants of health (SDH). In any societal ecology, structural determinants, including political, legal and economic factors, together with sociocultural norms, shape the distribution of power and resources, and thus affect health and well-being of all walks of life. Environmental conditions, such as climate changes and air pollution, can severely impact the existing inequities.

The challenges of achieving health for all are heightened by an increasingly globalized world and rapid demographic and societal changes occurring in many countries. Countries depend on others in a complex interconnectedness. For example, globalization can negatively exacerbate the vulnerability of migrant workers. The importance of digital divide, gaps in access to modern ICT, has flared up in the COVID-19 response and post-pandemic period.

- **Realizing interconnectedness between health equity and socioeconomic development**

With recognition of the complex interconnectedness between health and

other systems, emerging health-related actors have mushroomed unprecedentedly at all levels; from local to global. However, capacity of governments to provide health system stewardship, especially in coordinating stakeholders, are limited. These limited capacities include in promoting constructive roles and oversight of other sectors, including private providers, pharmaceutical and health products, civil society and communities. Multisectoral coordination mechanisms for many health programmes such as cross-ministerial committees, do exist, but may not function well in many settings in the Region.

Decentralization movements, happening strongly now in many countries of the SE Asia Region, demand for more contribution and engagement from, and stronger capacity, of subnational governments and communities. The lack of robust participatory space (mechanisms), especially in the policy-making process, leads to limited voice from disadvantaged populations.

- **Mindset on health beyond the health sector**

Everyone knows that tackling health inequity requires actions outside the health sector. WHO has been an active advocacy platform for SDH, calling for leadership for health and well-being across sectors (such as Health-in-All-Policies, Whole-of-Government, Whole-of-society); as well as with technical tools including health impact assessment. Such campaigns and tools have not been extensively materialized especially in the long term and at large scale. These stakeholders may have competing interests that require understanding and negotiation – while maintaining a clear focus on improving health outcomes for marginalized and unreached populations.

The narrow paradigm of a health system for (only) health problems, rather than a fundamental component of human capital and socioeconomic development need urgent attention. This might be the result from too much technicality and arrogance of

the health system with inadequate attention to the political dimension. Despite the agreed principles of universality and inseparability, the centrality of health to other SDGs has not been fully explained.

- **Accountability framework**

The lack of a robust accountability framework is a common pain point for health system governance. This is particularly relevant in ensuring coordinated actions conducted outside the health sector. An accountability framework starts with, but goes beyond good monitoring and evaluation on situations, inputs, implementation and outputs. It also includes vigorous review platforms to turn data and information into meaningful messages; as well as the mechanisms to warrant in-demand actions taken.

Challenges in the accountability framework begin with the lack of monitoring and evaluation mechanisms to track situations and progress of those disadvantaged populations. Similarly, imperfect coordinating mechanisms and fragmentation of health and health-related actors hamper this accountability framework. These situations make health inequity and unmet need merely a public health agenda, to be responsible to the health sector in isolation.

4.3 Challenges in monitoring and tracking progress on health inequities and unmet needs

Good data and measurement provide the basis for political actions and accountability on the determinants of health and the improvement of health equity. Where good data exist, measurement and analysis can serve as powerful inputs in the design and evaluation of interventions. An effective policy is one which achieves both absolute and relative improvements in the health of the poorest groups or across the social gradient. Policy-makers in low- and middle-income societies are commonly trapped in the vicious cycle; among the situations of lack of quality data, poor utilization of data

and underinvestment for the information system.

The national representative and aggregated data, in many cases, may disguise the reality of distribution of health outcomes as well as access to care and health system resources in any society. As discussed in chapter 2, available evidence confirms the discrepancies in health statuses and access to health care across many social gradients, and that marginalized groups are the most suffering categories, including wealth, education, geographical hardship, urban poor, ethnicity, the elderly, those with disabilities, people living with diseases, migrant and social classes. The evidence shows the importance of measuring the pattern of inequality accurately as an input in policy formulation, intervention planning, resource allocation and investment.

However, a good information system needs a disaggregated approach that takes into account the whole of the gradient in health equity in a society, not only the most disadvantaged. Availability of quality health information is already an issue in most low- and middle-income societies. Disaggregated data by social gradients and evidence on most marginalized population groups, especially long term and regularly measured, are rare for health systems in the Region. This calls for visionary investment and planning for a better health information system.

- **Long-term investment and capacity-building**

The current health information systems in most LMICs have not been designed or adequately strengthened to measure how well the expressed and non-expressed health needs of disadvantaged populations have been addressed. Data on health outcome disparities are relatively easier to track than forgone care and unmet need, which might be already too difficult for the existing capacity. Visionary commitment for long-term investment on, and capacity-building of a strong health information system with

a focus on both level and distribution of health outcomes across social gradients, as well as access to health care, is crucial. Unfortunately, this is not a common case in reality.

Measuring health equity and unmet needs requires more than software, hardware and peopleware. The whole ecosystem and system interoperability are essential for availability and utilization of evidence to tackle inequities and attend the demand of neglected populations.

• **Technical difficulties in monitoring health inequity, forgone care and unmet need**

Assessing forgone care and unmet need has never been an easy process, partially due to the lack of internationally agreed definitions and tools. Population-based household surveys of health needs and access to health care, for example the Health Needs Assessment method, is the common method to calculate forgone care, yet it is costly and requires technical expertise. Routine data at health-care facilities may reflect health needs of those individual patients having access

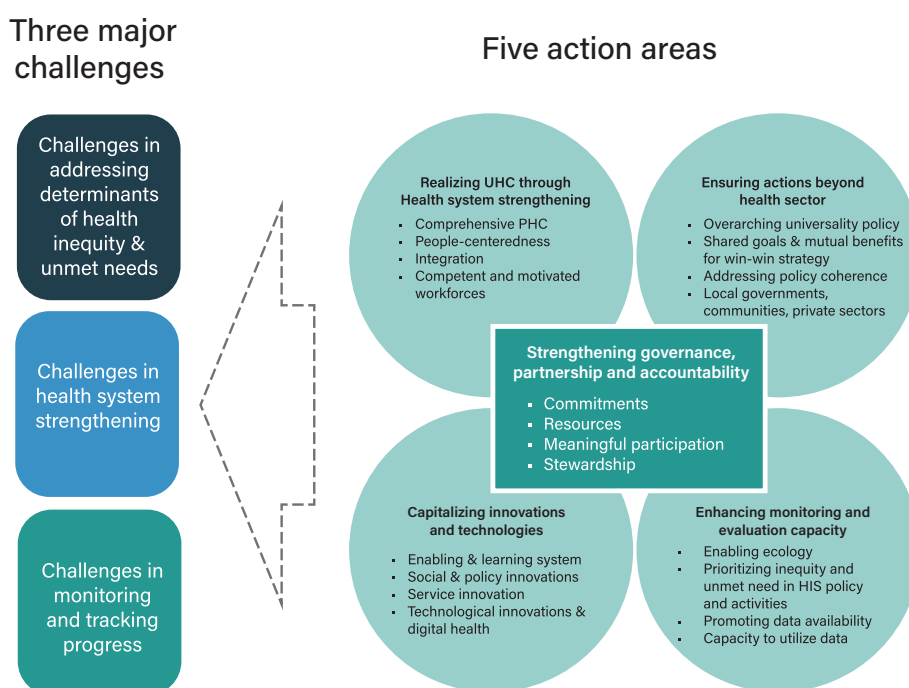
to the health-care system, but not the wider health needs of the community and society. Small-scale research and higher feasibility may give some circumstantial factual but not the whole scenario. The non-expressed unmet need may not be comprehensively quantified through a single survey.

Monitoring health inequities among social gradient needs a strategic approach, starting from identification of target population groups. Because stigma and discrimination are common issues for these marginalized groups, the data-gathering process must be carefully designed to be culturally appropriate and friendly enough while keeping the data validity intact.

• **Utilization of imperfect data**

The shortage of accurate and comprehensive data should not curb or delay actions to tackle health inequities. Current less-than-perfect evidence should be utilized at all levels, for planning and resource allocation, while the information system should be strengthened. Shared understanding and commitment among policy-makers, technocrats, academics and practitioners

Fig. 4.1. Three major challenges and five action areas



is a crucial starting point. Registered data in health-care facilities, although not representing the whole society, is better than a shot in the dark.

With the call to reduce health inequities through addressing the social determinants of health, all countries should promote data sharing across sectors. One step towards intersectoral actions, access to data from other sectors, such as education or social welfare systems, and to link these data together, could improve targeted

interventions to attend health demand of marginalized groups. Policy-makers, programme managers and relevant sectors, from national to community levels, can also better analyse local data in order to develop, implement and evaluate solutions with the appropriate sectors and levels involved. The effects of policies and programmes on inequities need to be measured, monitored and evaluated. As shown in many case studies of chapter 3, demonstrating success is likely to be a key element in building broader political support for upscaled actions and further investment.

Chapter 5



Reach the unreached to meet the unmet

“But if you’re asking my opinion, I would argue that a social justice approach should be central to medicine and utilized to be central to public health. This could be very simple: the well should take care of the sick.”

~ Dr Paul Farmer

Though countries in the WHO SE Asia Region have demonstrated many successful initiatives as discussed in chapter 3, urgent whole-of-society commitment is required to tackle health inequity and unmet need in the Region. Reaching the unreached is everybody’s business. Actions within the health sector boundary are at best a cosmetic improvement, as root causes of health inequities stem from social, economic, political and environmental determinants of health. Strategic and effective approaches on health inequity require holistic and system thinking, taking into consideration the complex interrelatedness of components of health and societal systems while taking into account sensitive issues such as stigmatization and cultural suitability.

The health sector however still has a crucial role in advocating for and supporting multi-stakeholder initiatives to reach the unreached and in institutionalizing health equity as a central goal of government policy, as well as the service provider and monitoring functions. It is relevant to all health programmes and health systems strengthening that efforts at all levels should recognize the importance and complexity of health needs of disadvantaged populations. This is to ensure that health systems can

provide services to meet both expressed and unexpressed needs of those populations.

Synthesized from the concepts, situations and experiences in the SE Asia Region, given below are five groups of actions to tackle three major challenges and advance the whole-of-society reach to those unmet needs.

5.1 Strengthening system governance, partnership and accountability

Lessons learnt from the 25 case studies confirm that political commitment, shared goals, and partnership across sectors are prerequisites for success. A clear common vision on inclusive society or universalist policy should be the entry point. Political commitments include individual commitment, such as expressions from leaders, institutional commitments in the form of arrangements and allocation of resources and investment for programme implementation as well as monitoring and evaluation systems. Commitments from various stakeholders, including private and community, are required at all levels both within and outside health systems. It is also helpful for leaders to synergize political

commitment to address complexity of health inequity and unmet needs, including some sensitive issues. Laws and regulations are essential for the equity-promoting ecosystem. Review and reform of legal frameworks in many cases could be a powerful game-changer.

Meaningful participation from actors entails functioning and coordinating mechanisms. The formal business-as-usual structures, such as cross-agencies committee, may face limitations in this complex and complicated issues of inequities. Establishment of shared vision and objectives, roles and responsibilities are healthy entry points for partnership and collaboration across sectors. Engagement and ownership of the community are key processes to forge meaningful partnerships and ensure the response to the concerns of those marginalized groups. While community engagement is critical for achieving UHC, it however requires resources and participatory spaces, as well as capacity of government to facilitate partnership and contribution.

One of the in-demand leadership is the government's capacity to conduct stewardship for positive engagement and contribution from other sectors. An effective accountability framework to ensure actors conduct right actions rightly need to be developed and/or strengthened. Collaborative planning, monitoring, review and decision-making with involvement from stakeholders are crucial components of the accountability framework.

Ensuring health inequity as an agreed priority by ensuring adequate and sustainable financial support is perhaps the most critical commitment. Financial strategies go beyond just raising the revenue to pay for health services of the vulnerabilities, but also cover strategies to promote risk and fund pooling, and risk sharing, progressive allocation and purchasing, harmonizing benefits and standards, and most importantly enhancing

investment and capacity-building. A system-wide approach including by synchronizing overseas development supports with the national strategy and plan to avoid fragmentation of funding may be central in some settings.

5.2 Realizing universal health coverage through people-centred health system strengthening

High-quality health systems and services are people-centred, integrated, comprehensive and organized around the needs of people, rather than focused on specific diseases. UHC is a powerful social and health equalizer. A strong comprehensive PHC system is critical, equitable and cost-effective foundation to systematically address health needs of the population in any society; therefore it is necessary to expedite progress towards UHC. Despite adopted over four decades ago, the three pillars of PHC according to the Alma Ata Declaration are still valid today; these are: (i) provision of essential health services; (ii) community engagement; and (iii) addressing health determinants through multisectoral collaboration.

Transforming the PHC-oriented health system towards the expressed and unexpressed needs of marginalized populations requires groundwork from both the supply and demand sides. On the supply side, these include coverage, availability, accessibility, trust and affordability of services, as well as quality and safety. Chapter 3 reminds us that strengthening of any health system blocks from workforces to information; yields positive outcomes; and even better outcomes if these improvements are coordinated. Many case studies show that providing essential health services beyond conventional health care facilities, such as community, school, and workplaces, can extend the reach. On the demand side, works to be done are around realizing the right to health care to empower the

community and disadvantaged populations to perceive and utilize essential services. Tailored communication activities, such as local languages and an understanding of local health belief and culture systems, are a strategic approach to empower and promote health literacy for neglected population groups.

Common barriers are how to progressively integrate vertical disease-specific programmes into PHC systems; and synergize programmes for system efficiency without diminishing the quality of the services. Putting health inequity at the core of the health system planning and monitoring is a necessary starting point. Capacity of the health system to provide comprehensive and people-centred health care, including essential public health functions, needs long-term strategic investment and integrations across the full range of health services. Particularly relevant to the SE Asia Region, integrating traditional and alternative medicinal practices could be an effective approach, as they are currently used and trusted by the population.

Despite advances in technology, health-care delivery still has labour-intensive procedures. Human resources for health (HRH), especially in the PHC system, are therefore the backbone to deal with health needs of unreached populations. Availability, distribution, cadre-mixed and competency of health professionals are crucial determinant of the health system. In many settings, however, production and development of health workforces tend to focus on specialized higher levels of care rather than PHC. Human resources at both for-profit and not-for-profit private sectors may not be fully utilized. Meanwhile, community health and social workers, including voluntary-based workers from community, may help in boosting up availability and capacity, as well as trust and acceptability of the health system.

5.3 Ensuring actions beyond the health sector

Evidence repeatedly confirms two key messages; firstly, social determinants of health play a major role in health inequity, discrimination, access to health care and unmet needs; and secondly, actions in all areas of public policy affect both the level and distribution of health, positively or negatively.

In reality, policy-makers may focus on the policy of some government sectors which create a high impact on health of disadvantaged populations. Rural development and transportation sectors could ease access to health care in settings of geographical hardships. While urbanization is common in the Region, evidence informs that investments in healthy city programmes produce high returns for economies. The Commission on Macroeconomics and Health documented this and it has been reaffirmed in recent studies. For example, a study indicates 5–46 times social economic return on investment on water supply and sanitation in the least-developed areas.¹⁹ Migrants and labour employment policies undeniably have an impact on inclusiveness of migrant workers and refugees. In the era of growing economic interdependence and trade liberalization, the national capacity needs to be urgently strengthened to address impacts on population health from movement of goods, services, capital, technology and labour across borders. The NCD epidemic as well as health impacts from climate changes usually have commonly widen health inequities, while populations in the lower socioeconomic status encounter disproportionate consequences and have relatively less ability to cope with and recover from such consequences.

19 Haller L, Hutton G, Bartram J. Estimating the costs and benefits of water and sanitation improvements at global level. *J Water Health*. 2007;5:467–480.

Local governments, municipalities and communities are integrating platforms for policies of multiple sectors. They can contextualize and augment policies and resources to best fit with local circumstances. They thus play a major role in addressing health needs, particularly those un-expressed needs happening outside health-care facilities.

Cross-sector actions include actions of the private sector, civil society organizations, and international agencies. The private sector influences the social, physical and cultural environments through business actions and societal engagements; for example, supply chains, labour conditions, product design and packaging, research funding, lobbying, preference shaping and others. In many societies, the private sector is the biggest employer, and thus influences health and well-being of their formal and informal employees and families.

The Sustainable Development Agenda can serve as an agreed framework to facilitate policy coherence and integration across government sectors. Meanwhile, the Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), endorsed by WHO and other UN agencies, may help in promoting harmonized actions among international partners.

- **Advocacy actions to promote actions across sectors may include the following:**
- Establish/reaffirm overarching universality policies with a focus on population health and well-being as the key to unlock long-term socioeconomic growth, which can bridge the policy consistency across sectors. These actions include setting up the national agenda on social inequity and mainstreaming/ institutionalizing health equity and unmet needs, as the central goal.

- Establish a participatory space and promote dialogue across sectors for shared understandings on roles and responsibilities. Identifying mutual benefits from the beginning for the win-win strategies might be an effective approach to promote buy-in across sectors. For example, an early childhood development policy does not only tackle malnutrition but also benefit education performance. The women empowerment policy can drive both poverty reduction as well as reproductive health agenda simultaneously.
- Focusing on long-term collective benefits, rather than short-term gains, may help to avoid competing policy priorities and demands, driven by government sectors with different values and interests. It may also help in maintaining the policy direction across consecutive governments amidst political instability.
- Regular and participatory review of situations and operations, as part of an accountability framework, and leading to collective decision for actions in need.

5.4 Building on innovations and technologies

The initial successes in developing and utilizing innovations and technologies for the benefit of marginalized populations, shown in chapter 3, need to be further upscaled. Member States of the Region show smart use of all three types of innovations, also in combination: (i) policy and social innovations; (ii) service innovations; and (iii) technological innovations. A health system, when strengthened, can use these innovations in addressing barriers at both demand and supply sides of health care; for better and easier access with lower cost and higher quality.

Social and policy innovations are new ideas to mobilize and use resources for better

achievement, particularly for population health and well-being. These innovations include the use of financial, human and technical assets for local responses to address health inequities and determinants. Ownership and engagement of individuals, local leaders and influencers are key for the setting up and maintenance of such innovations. Innovative financing mechanisms for health, common targets across ministries, self-help group, social participation for health, health volunteers are exemplars of the social and policy innovations.

Service innovations, including outreach services and mobile clinics, are critical in many geographical settings, as well as to people living with diseases and conditions having difficulties for access-to-care. Telemedicine, home health care, delivery of medicines at home, community vaccination and home care have been some good practices during the COVID-19 pandemic. Resource-sharing across institutions, task-shifting and task-sharing approaches, as well as performance-based incentives may help in encouraging the outreach to those vulnerabilities; they might also address the imbalance of demand and supply in some settings.

Technological innovations, including digital health, use ICT to enable access to care. The COVID-19 pandemic has been a powerful accelerator for digital health technology and application. ICT and digital health can strengthen service delivery by promoting data availability including through data collection and registration, making information more accessible, building up capacity of health workforces, situation reporting, as well as facilitating purchasing and payment transactions. Some remaining concerns are the digital divide, which may expand the gaps across population groups with different access to and skill on digital health, as well as data safety and confidentiality. Governments therefore should play the role of both a facilitator and regulator

to maximize the benefit of digital health and technological innovations.

Policy-makers need to strategize the way to promote the use of available innovations to address the unmet need and health inequities. Making the health system a learning system and strengthening an enabling ecosystem can fast track the upscaling process.

5.5 Enhancing capacity for monitoring and evaluation

Access to data and information can enable the health system to provide evidence-based and appropriate interventions. Robust data architecture is the key to promote accountability across sectors. This can stimulate targeted investments in underserved areas or responsive adaptation of existing policies. Academia and other actors can utilize publicly available data systems to generate additional research evidence as well as collaborate with the government to fill knowledge and service gaps and ensure that policies are contextually appropriate. However, information about health demands of unreached populations is hardly available through routine sources and registration.

Health inequities should be prioritized as central to the health information system. Progressively strengthening data design, collection and analysis processes should take into consideration social gradients and health needs of vulnerable populations. Collection of disaggregated data should be made compulsory for all health-related surveys; while quantitative and qualitative studies should be promoted, especially on barriers to health care. Engagement of disadvantaged population and communities, transparency of process and data privacy are also important for the sustainability of a strong health information system. The integrated health information platform and inequity measurements should be supported by the best available digital technologies,

underpinned by appropriate legal frameworks, which can improve processes of public health surveillance and health data management to promote evidence-informed policies.

As important as the availability of quality data is the capacity to utilize data for formulation of policy and intervention planning, and adjusting practice to match complex and complicated health needs of vulnerable population groups. A mindset on evidence-based policies and practices is a must. Production and use of data at all levels, including at the local and community levels, must be fortified.

Strengthening and enabling the ecosystem for the health information system for health inequities covers strong data governance mechanisms, country-owned leadership, technology-enabled and supported by a network of experts in data generation, analysis and use. All of the above actions along the data lifecycle, from production to utilization, require investment. Technical capacity and human resource competency, as well as institutional capacity, need to be rapidly scaled up to support translation of data into evidence for routine decision-making.

