

REGIONAL ACTION AGENDA on

# Achieving the Sustainable Development Goals in the Western Pacific





# **Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific**

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# FOREWORD

A new era in global health and development began in 2016. The 2030 Agenda for Sustainable Development came into force, after its adoption by world leaders in 2015. This new holistic vision of global development calls on countries to achieve 17 interconnected and interdependent Sustainable Development Goals (SDGs) and leave no one behind.

The SDGs build on the Millennium Development Goals (MDGs), but they go much further. While the Western Pacific Region made remarkable progress under the MDGs, gains did not benefit all groups equitably.

The SDGs reflect a new understanding that today's health and development challenges are increasingly complex, integrated and interlinked. They require more integrated and inclusive strategies to achieve economic, environmental, political and social development that leaves no one behind.

The SDGs place more demands on Member States and WHO. Member States may build on information systems, policies, reporting and coordination arrangements. At the same time, however, they must go beyond business as usual to develop new ways of working that address the underlying determinants of quality of life. They must work across all sectors and stakeholders to achieve the vision of sustainable development for everyone.

At the sixty-seventh session of the WHO Regional Committee for the Western Pacific in October 2016, Member States endorsed the *Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific*. We stand ready to support Member States – at all levels of development – in their efforts to achieve the many health-related targets of the SDGs.

Working together, we can make the vision of sustainable development a reality for all of the nearly 1.9 billion people who call the Western Pacific Region home.



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

# ABBREVIATIONS

<b>AMR</b>	antimicrobial resistance
<b>APSED</b>	Asia Pacific Strategy for Emerging Diseases
<b>CRVS</b>	civil registration and vital statistics
<b>DHBs</b>	district health boards
<b>GDP</b>	gross domestic product
<b>FETPs</b>	field epidemiology training programmes
<b>HiAP</b>	Health in All Policies
<b>ICT</b>	information and communications technology
<b>ISDS</b>	investor–state dispute settlement
<b>IHR</b>	International Health Regulations
<b>JEE</b>	joint external evaluation
<b>M&amp;E</b>	monitoring and evaluation
<b>MAPS</b>	mainstreaming, acceleration and policy support
<b>M&amp;E</b>	monitoring and evaluation
<b>MDGs</b>	Millennium Development Goals
<b>MFA</b>	Medical Financial Assistance
<b>NHIS</b>	National Health Insurance Service
<b>NHID</b>	National Health Insurance Database
<b>NCD</b>	noncommunicable disease
<b>OOP</b>	out-of-pocket
<b>SDGs</b>	Sustainable Development Goals
<b>SDH</b>	social determinants of health
<b>TB</b>	tuberculosis
<b>UHC</b>	universal health coverage
<b>UN</b>	United Nations
<b>WHO</b>	World Health Organization





## EXECUTIVE SUMMARY

*The Sustainable Development Goals (SDGs), adopted by the General Assembly of the United Nations in 2015, aim “to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment”. The 17 SDGs build on the Millennium Development Goals (MDGs), which had guided development efforts for the preceding 15 years.*

Member States achieved significant successes with the MDGs, but the gains did not equitably benefit all groups in society. The gains under the MDGs were realized in a large part due to programmatic approaches focused on specific disease and health issues. Less emphasis was placed on the connections between these issues and the broader social determinants of health. To accelerate progress on the unfinished MDG agenda and achieve the SDGs, more integrated and inclusive strategies are needed, giving priority to the most disadvantaged groups to ensure that no one is left behind. SDG 3 exclusively addresses health, but health in the SDGs goes beyond SDG 3, with core health issues also residing in other goals. All the SDGs influence – and are influenced by – health. Universal health coverage (UHC), defined as all people and communities having access to quality health services without suffering the financial hardship associated with paying for care, is a specific target in the SDGs as well as the platform that brings together programmes and actions for health and development. The SDGs envisage collaborative partnerships across sectors of government, diverse stakeholders and communities to address today’s wide-ranging and interconnected health and development challenges.

*This Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific aims to guide Member States as they embark on SDG implementation. Much progress has already been achieved. Member States can rely on information systems, reporting and coordination arrangements, and policies and programmes that*

are already in place. Achieving the SDGs also involves significantly new ways of working that go beyond business as usual – and newer roles and capabilities for the health sector in working across government and stakeholders. The action agenda suggests practical actions to achieve the change in mindset that is needed.

The action agenda builds on and aligns with existing global and regional strategies, World Health Assembly and Regional Committee resolutions, as well as broader United Nations mandates and guidance. The regional framework *Universal Health Coverage: Moving Towards Better Health*, endorsed by the WHO Regional Committee for the Western Pacific in October 2015, provides a broad foundation for action. The *Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific* is not prescriptive, nor is it intended to be followed in a linear or sequential manner. Rather, it presents a menu of options and strategies that Member States may consider for achieving the SDGs. Member States will need to review and renew their own national plans and priorities to incorporate the SDGs. The health sector is the primary audience for this action agenda. It suggests ways in which the health sector may identify and respond to priority health needs in their specific contexts by strengthening health systems to achieve UHC and health in the SDGs, as well as through attention to the economic, environmental, political and social factors that may create or perpetuate ill health, especially among disadvantaged groups.

## An action agenda

### The action agenda is organized in four sections

#### Section 1

Section 1 concerns the aims countries are trying to achieve and how they will know whether they have succeeded. It suggests actions and provides guidance to help countries identify for themselves those targets and indicators that have the highest priority in their own social and economic contexts. Member States need to reinforce national strategies to advance UHC and health in the SDGs through a robust review process with a range of stakeholders that will guide action and will develop high-quality standardized information systems and cross-sectoral information to track progress, as well as the capacity to analyse and use such information to refine policy- and decision-making.

## Section 2

Section 2 outlines policy and programme priorities to ensure that no one is left behind in the context of health in the SDGs. It suggests actions and provides guidance on equity-focused policies and actions that are needed within health and across sectors to advance UHC. It suggests ways to reduce barriers to access, addressing the social determinants of health equity and meeting the needs of disadvantaged populations. Partnerships across sectors on mutually beneficial outcomes can improve outcomes, especially for disadvantaged groups. This involves the health sector strengthening its focus on access barriers and health literacy, and countering stigma and discrimination, as well as collaborating more with other sectors, linking with social development and advancing progressive financing for social protection.

## Section 3

Section 3 discusses actions and provides guidance on how Member States can achieve their priorities by effectively working across sectors, including by creating enabling conditions and institutional arrangements for intersectoral action and embedding health equity within national planning and reporting and international action. The section also draws attention to the need for constructive relationships with stakeholders beyond government. Lastly, it calls for meaningful participation by affected communities in policies, programmes and actions to address their health needs.

## Section 4

Section 4 suggests actions and provides guidance on how the health sector can develop its capabilities to effectively advance health in the SDGs. The health workforce needs to build its ability to understand the goals and drivers of other sectors and of the social determinants of health equity, and to influence and collaborate on shared concerns through partnerships that advance mutually beneficial policies and actions. It also means strengthening the health sector's capacity to engage and work with a broader range of stakeholders, including parliamentary bodies, the judiciary, local government, community and religious leaders, civil society, development partners, and affected communities on shared priorities and problems. Institutional mechanisms and processes are needed that develop and sustain such capabilities, now and in the future.

## Suggested areas of action

### Overview of guiding questions, action domains and suggested actions

Area of action	<b>1. What are countries aiming to achieve, and how will they know?</b>
	<b>1.1 Country-led selection of health goals, targets and indicators</b>
	a. Review and revise country-based monitoring frameworks to advance UHC and action on health in the SDGs
	b. Ensure indicators are fit for purpose
	c. Make the best use of existing data collections
	<b>1.2 Robust monitoring and review process</b>
	a. Conduct equity-focused national- and local-level reviews
	b. Use evidence to inform policy development and evaluation
	<b>1.3 Adequate information capacity</b>
	a. Strengthen links between information systems within and beyond the health
b. Sector-build capacity to gather and use information strategically	
c. Standardize information and harness communication technologies	
Area of action	<b>2. What are the policy and programme priorities for leaving no one behind?</b>
	<b>2.1 Equity in health services</b>
	a. Minimize access barriers
	b. Collaborate across health programmes on shared social determinants
	<b>2.2 Realizing win–wins through collaboration across sectors</b>
	a. Stimulate social development
	b. Promote healthy urbanization
c. Protect the health of the environment	
<b>2.3 Financing strategies for promoting equity</b>	
a. Strengthen public financing for health and social equity	
b. Improve access to social protection	

**3. How will countries put their priorities into effect?****3.1 Collaboration across government**

- a. Create enabling conditions for intersectoral action
- b. Structure institutional arrangements to support intersectoral action
- c. Embed measures of health equity within planning and reporting across sectors
- d. Shape international relations to enable action on health

**3.2 Engagement of stakeholders beyond government**

- a. Sustain constructive engagement with stakeholders beyond government
- b. Strengthen partnerships for programme and service delivery
- c. Build advocacy coalitions for action on the social determinants of health

**3.3 Participation of affected communities**

- a. Include affected communities in policy consultations
- b. Empower affected communities to participate

**4. How can the health sector drive the agenda?****4.1 Capabilities for knowledge exchange**

- a. Build the knowledge base on the social determinants of health
- b. Understand the priorities and processes of other sectors
- c. Understand perspectives and needs of communities

**4.2 Leadership skills to navigate the policy system**

- a. Strengthen the capability to engage other sectors in policy-making
- b. Strengthen the capability to mobilize political and financial support
- c. Strengthen the capability to use policy levers effectively

**4.3 Institutional capacity for present and future challenges**

- a. Raise the priority of health in the national development agenda
- b. Establish rules and incentives for improving performance and sustaining progress
- c. Train the health workforce to be facilitators and champions for health equity

## The way forward

### Member States

The SDGs challenge Member States to think differently about health and development, while tackling the unfinished business of the MDGs. Member States will review and renew their national plans and priorities to advance UHC and strengthen action on health in the SDGs. The interdependent nature of the SDGs requires multisectoral and multistakeholder partnerships for shared action on the range of factors that shape health and well-being. Member States need to ensure that their policies and actions centre on the needs and expectations of people and communities, focus on health equity, and marshal political and social support for such policies and actions. This involves embedding the SDGs in national plans and information systems, identifying gaps and targeted entry points, and building capacity to lead, design, implement and evaluate progress on evidence-based and equity-focused policies and actions, as well as engaging across sectors and with old and new stakeholders on health in the SDGs. The choice and sequencing of strategies will depend on the socioeconomic situation, governance, resources, expectations and political landscapes of various Member States.

### WHO in the Western Pacific Region

WHO is committed to supporting Member States in developing and implementing their national health policies, strategies and plans and implementing the SDGs as part of their national planning and policy development, including those to advance UHC and promote health and well-being for all. WHO will engage in technical collaboration to build national capacity for equity-focused policy and programme design, data collection and analysis, and multisectoral and multistakeholder collaboration. WHO will work with Member States to promote high-level communication and advocacy, and social and political mobilization in support of the SDG agenda, as well as to foster country-led regional peer learning and cooperation. WHO will convene diverse stakeholders, providing platforms for information exchange and the engagement of parliamentarians, mayors and other leaders.



# I. Introduction

## Background

In September 2015, the General Assembly of the United Nations adopted the 2030 Agenda for Sustainable Development. Member States pledged their commitment to 17 “bold and transformative” Sustainable Development Goals (SDGs) and 169 targets intended “to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment” (**Appendix 1**). The SDGs were built upon the foundation of the Millennium Development Goals (MDGs), which had helped to guide development efforts for the previous decade and a half. The MDGs articulated eight great challenges: eradicating extreme poverty and hunger; achieving universal primary education; promoting gender equality and empowering women; reducing child mortality; improving maternal health; combating HIV/AIDS, malaria and other diseases; ensuring environmental sustainability; and creating a global partnership for development.

Remarkable progress was made over the 15 years of the MDG blueprint, but it was also recognized that the gains did not equally benefit all groups in society and that many programmes neglected to build on the connections between the goals. For development to benefit all, more integrated and inclusive strategies were called for. The SDGs, which apply to all countries at all stages of development, were formulated recognizing that health is influenced by the broader cultural, economic, political and social environment and in turn influence security and economic, political and social development. For individuals, and for the population as a whole, good health underpins productivity, sustainability and the economy. If the MDGs were eight balls of yarn of different colours, the SDGs are a tapestry woven from many strands, all indivisible and creating a template for development over the next 15 years.

The WHO Constitution defines health not merely as the absence of disease but as a state of complete physical, mental and social well-being. National development plans in the Western Pacific Region have long recognized that health and sustainable development are interdependent. The Sustainable Development Agenda echoes this. While SDG 3 aims to “ensure healthy lives and promote well-being for all at all ages”, core health targets are also embedded in other goals (**Fig. 1**). More broadly, health is influenced by

**FIGURE 1.** Health in other SDGs

	<b>SDG 1</b> Extreme poverty Vulnerability to economic, social and environmental shocks and disasters	
	<b>SDG 2</b> Malnutrition	
	<b>SDG 5</b> Violence against women and girls Sexual, reproductive health and rights	
	<b>SDG 6</b> Safe and affordable drinking-water Sanitation and hygiene	
	<b>SDG 8</b> Safe and secure working environment	
	<b>SDG 11</b> Housing and basic services Air quality, waste management in cities	
	<b>SDG 13</b> Climate-related hazards and natural disasters	
	<b>SDG 16</b> Violence Legal identity	

and contributes to all other goals and targets as well. The SDGs call for an integrated approach to “just, rights-based, equitable and inclusive” action to address today’s challenges and promote growth, social development and environmental protection for all. This places equity at the centre, with particular focus on disadvantaged groups that are typically excluded from social benefits such as a good education, health care and economic participation while facing higher burdens of disease and disability. Achieving health in the SDGs so that no one is left behind, a central tenet of the SDGs, requires whole-of-system, whole-of-government and whole-of-society approaches, bringing together various government sectors, civil society, academia, development partners and communities.

This *Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific* builds on and aligns with existing global and regional strategies, World Health Assembly and Regional Committee resolutions, as well as broader United Nations mandates and guidance on the SDGs. The regional framework *Universal Health Coverage: Moving Towards Better Health*, endorsed by the WHO Regional Committee for the Western Pacific in October 2015, provides a broad foundation for action. UHC – defined as all people and communities having access to quality health services without suffering the financial hardship associated with paying for care – is a core part of the SDG agenda, bringing together disparate health and development efforts. It is an overarching vision for health systems development and for achieving equitable and sustainable health outcomes (**Appendix 2**). It emphasizes the connections between individual- and popu-



lation-based services, between treatment and care on one hand and promotion and prevention on the other, and between health and other sectors. It also draws attention to the social determinants of health and the needs of disadvantaged population groups, especially those who have been left furthest behind in health gains and access to services. Whether the urban or rural poor, older people, people with disabilities, indigenous populations, migrants, refugees, ethnic minorities, or those excluded and stigmatized by society, they are at chronic risk of being bypassed by the very services they most need and isolated from the mainstream of economic and social opportunity.

## **Purpose of the action agenda**

Building on these mandates and the vision embedded in the SDGs, this document is written to guide Member States as they review and renew their own national plans and priorities. It is not prescriptive, and suggested actions are not necessarily to be pursued in a linear or sequential order. Rather it suggests options for Member States to consider in making the transition from the MDGs to the SDGs based on their own contexts, resources and entry points. The action agenda urges broader thinking about the complex matrix of factors that shape health in different environments. It also suggests ways of identifying and responding to the most pressing needs of communities in order to ensure no one is left behind by addressing those economic, environmental, political and social factors that perpetuate illness and which exclude and disadvantage some population groups.



## II. Achievements, challenges and opportunities

### Achievements during the MDG era

Health has been central to the MDGs as an explicit focus of three of the eight goals and linked with, or influenced by, the other five goals. Progress was achieved through concerted efforts on specific strategies, informed by solid technical knowledge and supported by considerable resources (**Appendix 7**). The MDGs mobilized political commitment and policy support and were backed by monitoring and evaluation (M&E) frameworks.

Overall, countries in the Western Pacific Region made significant progress towards the MDGs (Appendix 7). Many countries have experienced rapid economic growth. The annual gross domestic product (GDP) doubled in the Philippines in the two decades after 1990, and in China alone extreme poverty was reduced tenfold. The prevalence of underweight and undernourished (stunted) children in this period decreased fivefold and the estimated maternal mortality rate fell by two thirds. Over 90% of all women today have access to a skilled birth attendant. Since 2000, 15 million patients were treated and cured of TB, and reported HIV incidence decreased in Cambodia, Malaysia, Papua New Guinea and Viet Nam. A major effort on vector control, diagnosis, treatment and such initiatives as the distribution of insecticide-impregnated bednets saw noteworthy progress in reducing the incidence and mortality from malaria. Almost all of the population of the Region now has access to sources of improved drinking water.

### Lessons learnt and challenges ahead

Despite these gains, there were inevitable shortcomings in the implementation of the MDGs. Among these are the problem of health and disease programmes working separately from each other, weak health systems, poorly directed funding and a “one-size-fits-all” approach. Even where MDG targets were achieved at the population level, not all groups benefitted equally (**Appendix 8**). For example, income inequality increased in Fiji, China, Mongolia and Viet Nam despite economic growth. Some 900 million people in the Western Pacific still live on less than US\$ 2 a day. An estimated one third of people in

the Lao People's Democratic Republic and one fifth of those in the Philippines are living in poverty. A further 105 million people suffer financial catastrophe and over 70 million are impoverished each year because they have to pay for health care that they cannot afford. Out-of-pocket (OOP) expenditure is one third of the total health expenditure in some countries in the Region, with Cambodia, the Philippines, Singapore and Viet Nam being among the highest.

Stark inequities persist in health and in access to care in countries of the Region. The majority of deaths in children under 5 years occurs in the poorest households. Only one in five people with multidrug-resistant tuberculosis (TB) is diagnosed, one in eight treated and one in 16 cured. Just over one third of those in need were receiving antiretroviral therapy, and those key populations most affected by HIV infection are disproportionately in need of testing and interventions. The proportion of urban dwellers living in slums in 2009 was two fifths in the Philippines and just over one third in Viet Nam. Chronic rural–urban inequities persist in, for instance, access to safe drinking water and sanitation. These and other shortfalls are the “unfinished business” of the MDGs.

In addition to those targets yet to be achieved, there are new and emerging challenges that are highlighted in the SDGs. Obesity in children has emerged as a major concern. Globally, noncommunicable diseases (NCDs) are increasing, with the highest numbers of deaths between 2010 and 2020 predicted in the Western Pacific. An estimated 250 million people in the Region live with a disability, with the numbers expected to increase as populations age and with the increase in chronic health conditions. Road traffic injuries and deaths most affect the young (15–44 years) and the poor, with over 90% of road deaths occurring in low- and middle-income countries. Every year, environmental risk factors such as air, water or soil pollution, climate change, and ultraviolet radiation are responsible for more than 3.5 million deaths in the Region, many in low-income countries. On average, over 200 disease outbreaks and related events every year are detected in the Western Pacific Region through WHO's emerging disease surveillance system. Nineteen out of 27 countries have achieved core capacity requirements to detect, assess, notify and report events, and to respond to public health risks and emergencies of national and international concern in line with the International Health Regulations (2005), or IHR (2005).

## **Tackling the SDGs: a focus on the social determinants of health**

The SDGs target all countries, regardless of income level. The SDG “tapestry” weaves together a more complex picture than was portrayed by the MDGs by endeavouring to

capture the many ways in which equitable and robust development is shaped by factors that are linked to each other. Poverty, food security and agriculture, health, education, water and sanitation, energy, employment and economic growth, inequality, the human habitat, climate change, and natural resources, as well as just, accountable and inclusive societies and global partnerships, are all integral to the 2030 agenda. Whether explicit or not, health underpins or is affected by all of these factors. In this sense SDGs highlight the influence of the social precursors of good health and hence the broader front on which improvements in health must be tackled. This includes universal access to basic health care, social and material resources, basic infrastructure, and navigating the political and governance landscapes.

Access to health and other social services is influenced by the material circumstances of individuals and families and such factors as housing, information, food, productive work, safe water, transport and sanitation. Exposure to risk factors is not evenly distributed across populations, but reflects entrenched inequities. The SDGs call for greater combined efforts to improve living conditions and therefore the social determinants of health. These interact with each other. For example, gender inequalities typically result in lower school enrolment rates for girls than for boys. In turn, poor education results in poorer health outcomes for girls and women themselves, and for their children and families. Similarly, disability, marginalization or ethnicity can compound gender-based disadvantage and further limit access to health and social services.

Achieving the SDGs means tackling barriers to access to health services, whether financial, physical, geographic, educational or cultural, especially those faced by socially excluded and disadvantaged groups. In this context, UHC does not stand apart from or in parallel to efforts in specific health programmes. Rather, it constitutes a platform on which to bring health and development efforts together, whether related to the unfinished MDG agenda or newer health challenges and their determinants. It is a whole-of-system approach to improving health system performance and sustaining health gains. It focuses attention on people and communities, calling for health systems that are of good quality, efficient, equitable, accountable, resilient and responsive to the needs of diverse population groups, including in particular those left furthest behind.

But ensuring health and well-being for all is a broad goal that the health sector cannot achieve on its own. Understanding the drivers and advocating effectively for social and economic change more broadly is central to progress on the SDGs. The interplay between multiple social, economic, environmental and political factors, coupled with the rapid pace of change in the Western Pacific Region, highlights the importance of identifying critical junctures where action can be most effective. Partnerships between health and other sectors can result in multiple benefits. For example, tackling air pollution, a growing challenge in the Region, is a shared interest for both the health and

the environment sectors. Educating girls has “downstream” benefits for their health, employment, food security, delaying childbearing, exposure to sexually transmitted diseases, the health, education and nutrition of their own children, and their personal health knowledge and care.

Progress also requires strong institutional and governance structures. These vary significantly across the Region and pose challenges for accountability and governance. Institutional fragmentation and unsustainable financing strategies are common challenges. Multiple stakeholders and partners are involved in selecting targets and pursuing strategies across various sectors and levels of government, which makes communication and agreement on priorities particularly complex, especially where services and programmes are decentralized and central guidance and oversight is weak.



## III. An action agenda

This *Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific* is intended to guide Member States as they consider the implications of the SDGs for national plans and priorities and set their own strategic goals and targets, including those which are likely to have the greatest impact on health and reach the most excluded and disadvantaged population groups. The agenda addresses four guiding questions in four sections (**Fig. 2**).

### Section 1

Section 1 relates to the aims countries are trying to achieve and how they will know whether they have succeeded. Countries will need to identify for themselves those targets and indicators that have the highest priority, in light of the country realities, characteristics, challenges and capacities. To measure and report on the SDGs and ensure that policies and actions are informed by evidence, countries will need robust monitoring and review processes and to ensure that timely and high-quality data and information are available to planners and practitioners.

### Section 2

Section 2 addresses what countries need to do to ensure that no one is left behind. Equity-focused policies and initiatives will be needed across all programmes to address common barriers to access and to meet the needs of disadvantaged populations. In addition, given the interconnected nature of the SDGs, and the importance of action on the social underpinnings of health and health equity, policies and action will be needed that can ensure beneficial outcomes for different sectors. Ensuring health equity also means that countries will need to put into place progressive financing mechanisms to promote social equity.

### Section 3

Section 3 discusses how Member States can implement their priorities by working across sectors of government, including by creating enabling conditions and institutional

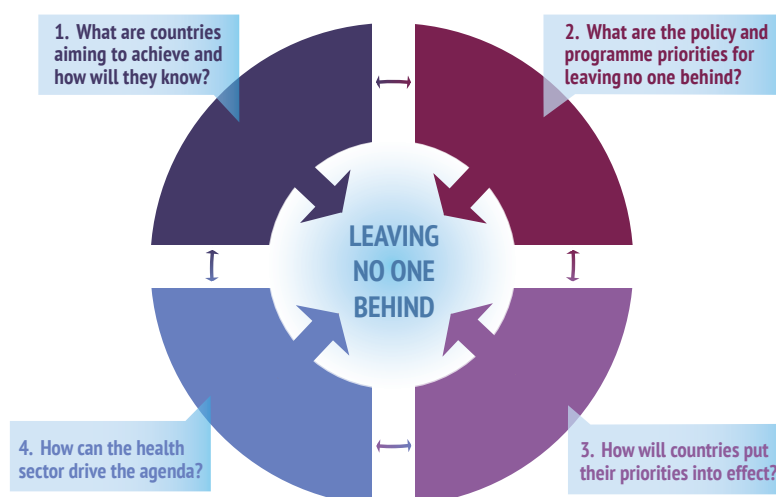
arrangements for intersectoral action and embedding health equity within national planning and reporting and international action. The section also suggests ways to build constructive relationships with stakeholders beyond government. Lastly, it calls for fostering the participation of affected communities in policies, programmes and actions.

## Section 4

Section 4 considers how the health sector can develop or build upon the skills needed to drive this new agenda. It discusses the capabilities needed to educate and inform those in other sectors and to influence and collaborate on shared concerns through partnerships that advance mutually beneficial policies and actions. It also means strengthening the health sector's capability to engage and work with new stakeholders. Institutional mechanisms and processes are needed that develop and sustain such capabilities, now and in the future.

The appendices include a list of SDGs (**Appendix 1**), an overview of the regional action framework on UHC (**Appendix 2**) and the Framework for monitoring SDGs and UHC in the Western Pacific Region (**Appendix 3**). A list of regional and global strategies and plans, determinants and stakeholders (**Appendix 4**), examples of relevant instruments of international law (**Appendix 5**) and decision tools for action on SDGs (**Appendix 6**) are also provided. An analysis of regional progress during the MDGs (**Appendix 7**) is presented, as is an overview of evidence on leaving no one behind and the underlying determinants in the Western Pacific (**Appendix 8**).

**FIGURE 2.** Framework of the SDG action agenda in view of achieving the SDGs



## SECTION 1

# 1. What are countries aiming to achieve, and how will they know?

## Background

The SDGs are intended to be owned and led by Member States. There is no defined path that should be taken. Rather, Member States will need to select which of the 169 targets they want to achieve over the next 15 years and the order of precedence. They will plan, design and stage interventions based on national and local contexts and their most-pressing challenges. To target interventions most effectively, countries need to have means of setting priorities, analysing data and monitoring what is being achieved.

In the Western Pacific Region, the capacity to generate, process and analyse data reliably is highly variable. At one end of the spectrum countries such as Australia, Japan, New Zealand, and the Republic of Korea have health information systems that provide timely, comprehensive and diagnostic data that make it feasible to target resources and provide windows on how well services and programmes are meeting their goals.

On the other hand, countries such as Cambodia, the Lao People's Democratic Republic and Viet Nam are evolving with "pockets" of donor-funded health information systems. The information arrangements in these countries are often fragmented. There is limited collection and use of data and a lack of ownership and uniformity in definitions and guidelines. In small island states in the Pacific, limitations of staffing, geographic isolation and reliable technology require different approaches to the monitoring and surveillance of health indicators and to creating a culture where information is seen to be an essential tool for management. The SDGs underline the importance of timely, high-quality data, translating information into policy and action and using it to assess progress and guide planning. Without trustworthy data it is difficult to know where to focus attention, in what order to tackle health challenges, where to invest resources, and how to determine what will make a difference.

One of the successes of the MDGs was the consensus on clearly defined targets and goals that could be monitored at local, provincial, national, regional and global levels, with clear divisions of responsibility. Progress on the SDGs similarly will require valid indicators and a robust, transparent and participatory review process. Tracking progress also raises some new challenges. The SDGs recognize that the goals, targets and indicators



are linked and that action on one affects action on others. This calls for a cross-sectoral approach to monitoring that links health with other national information systems in ways that capture the social determinants of health and a health-in-all-policies perspective. The SDGs also place emphasis on equity-focused monitoring and the collection, analysis and use of disaggregated data to capture and target those who live in poverty, are disadvantaged or invisible to the programmes and services that they most need.

## Suggested areas of action

### **Action 1.1** Country-led selection of health goals, targets and indicators

In March 2016, the United Nations Statistical Commission agreed on a set of 230 global indicators for measuring progress on the SDGs to be considered by the United Nations General Assembly in September 2016.<sup>1</sup> Based on these global indicators, the WHO Regional Office for the Western Pacific has developed a *Framework for monitoring SDGs and UHC in the Western Pacific Region (Appendix 3)*. The framework includes a list of selected health and health-related indicators, reflecting health targets under the SDG health goal, as well as targets from other goals. Based on the framework, countries are encouraged to undertake country-led monitoring adapted to their own contexts, populations and priorities. This includes the selection of targets and indicators that are fit for purpose and align with existing data collections to minimize the reporting burden.

#### ***a. Review and revise country-based monitoring frameworks to advance UHC and action on health in the SDGs***

- Select goals and targets based on the country context and national priorities, building on current progress and national socioeconomic development plans.
- Identify indicators that track the progress of selected goals and targets across the spectrum, from the social determinants of health to health programmes and services, health outputs and health outcomes.
- Monitor progress, including with regard to equity, on the selected indicators both at the national and local levels and for different population groups using stratifiers of income, sex, age, race, ethnicity, migratory status, disability and geographic location, or other characteristics where available and as relevant, based on country context.
- Adopt a shared and centrally collated system for data collection and standardization so to avoid data being held in “silos” within health or other sectors and stakeholders.

1. For more information, please see: UN Statistical Commission. Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators. E/CN.3/2016/2/Rev.1. New York: United Nations Economic and Social Council; 2016 (<http://unstats.un.org/unsd/statcom/47th-session/documents/2016-2-SDGs-Rev1-E.pdf>, last accessed 1 August 2016).

***b. Ensure indicators are fit for purpose<sup>2</sup>***

- Use globally agreed definitions to support standardized collection and analysis of data that enables both within and cross-country comparisons.
- Match indicators to key policy and implementation questions, and strengthen the understanding of the linkages between health determinants, interventions and impacts.
- Apply SMART (specific, measurable, achievable relevant, and time-bound) criteria to indicator development.

***c. Make best use of existing data collections***

- Review existing data collections, identify gaps, and strengthen and build on these resources before developing new collections.
- Validate and use existing data sources in health and other sectors and stakeholders (for example administrative data, facility data, survey data, patient records, financial reporting and other internal management records) to track the indicators and streamline data systems to reduce duplication and redundancy in the information being collected.
- Improve utilization of existing administrative data collections, including civil registration and vital statistics (CRVS), for monitoring and reporting by using checklists to standardize procedures and by developing new data architecture, including unique patient identifiers.
- Apply information technologies and innovative methods to data collection, processing and sharing and for the development of potential data sources, such as the use of electronic health records, national data warehouses and big data.

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***District health information software in the Lao People's Democratic Republic***

*In 2013, the Ministry of Health in the Lao People's Democratic Republic replaced the existing spreadsheet- and paper-based processes for the Health Management Information System (HMIS) with an open-source web-based district health information software (DHIS2).*

*The new system generates consolidated information based on data entered directly into DHIS2 by health facilities and offices nationwide. The system has improved the timeliness, transparency and accuracy of information, through mechanisms such as validation rules that verify the quality of data entry, and has enabled district- and province-wise analysis.*

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2. WHO Framework for monitoring SDGs and UHC in the Western Pacific Region could serve as reference to support Member States in developing their own monitoring framework. For details, see Appendix 3.

The Ministry of Health's ownership of DHIS2 implementation has helped make a difference. A ministerial decree standardizes data recording, reporting and management procedures. The national HMIS plan, developed under the umbrella of the national health plan and HMIS development roadmap, guides funding decisions based on identification of sources and gaps. Annual implementation reviews provide directions for the next planning cycle. A national core team, comprising Ministry of Health departments and development partners, manages planning and activities. Clear terms of reference developed for the central team and provincial and district task forces guide the alignment of reporting flows and linking of functions. Training has built skills in all provinces and districts on health information and DHIS2 operation.

Today, trained staff from 18 provinces, 147 districts and central-level hospitals can report and access the reported data at the facility level for their use. Managers can access data from facility, district and national levels to inform planning. DHIS2 has become a common platform and data warehouse for data from/on HMIS, selected programmes, human resources for health, health insurance, and major studies such as the service availability and readiness assessment, the Lao Social Indicator Survey and the Multiple Indicator Cluster Survey. The platform generates products ranging from the national health statistics report, other programme reports and the MDG report to the UHC and MDG dashboard.

Source: Ministry of Health. UHC and MDG In: Health Management Information System [website]. Vientiane: Lao People's Democratic Republics; 2016 (<https://hmis.gov.la>, accessed 5 July 2016).

## **Action 1.2** Robust country monitoring and review process

Better data are not an end in itself but rather a vital resource for country policy and programme review. It is central to effective management and public accountability. A review process is important not only to monitor progress but also to facilitate a common understanding among partners and stakeholders of what is working and what is not, and to encourage joint responsibility for results.

### **a. Conduct equity-focused national- and local-level reviews**

- Review regularly the national monitoring framework, assess evidence of overall progress and identify gaps and bottlenecks at national, subnational and local levels.
- Use disaggregated data to assess the progress of different population groups, for example indigenous peoples, people in rural and remote areas, culturally and linguistically diverse groups, socioeconomically disadvantaged groups, older people, etc. to inform strategies that address health equity and UHC.<sup>3</sup>

3. For more information on UHC, please see the Regional action framework on Universal Health Coverage: Moving Towards Better Health. Manila: WHO Regional Office for the Western Pacific; 2016 and the summary included in Appendix 2.

- Make clear, concise information available on publicly accessible information platforms and report on SDG progress in order to increase transparency and community participation and to promote the accountability of government, donors, and development and nongovernmental partners.
- Contribute to the regional SDG monitoring and reporting process every two years and regional thematic analyses every five years, taking into account linkages between health and related variables.

***b. Use evidence to inform policy development and evaluation***

- Draw upon the experience and knowledge of a range of sectors and stakeholders (for example civil society, research institutes, universities, government agencies, development partners and donors) in indicator development and reviews of progress.
- Evaluate the impact of health policies and action and use these evaluations and practical experiences to inform and refine strategies.

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*Healthy Islands monitoring framework and indicators*

*In 1995, the Pacific health ministers declared their vision of Healthy Islands in the Yanuca Island Declaration. It embodies a comprehensive and integrated approach that has served as a unifying theme to protect and promote health in the Pacific by addressing priority health issues, including noncommunicable diseases and lingering and emerging and re-emerging infectious diseases.*

*A Healthy Islands Monitoring Framework was developed recently to support progress monitoring. It comprises 52 mandatory indicators (36 core and 16 complementary indicators) and 26 optional indicators, from which countries can select based on national priorities and reporting systems. The indicators were identified based on specific criteria, including the availability of subregional and national information to assess 20-year trends, as well as of agreed collection methodologies or secondary data sources, and the ability to chart progress on the Healthy Islands descriptors and the five elements of the Healthy Islands vision.*

*The framework provides institutional mechanisms and opportunities to better measure, report and share data, including on indicators for the five Healthy Islands elements and priority actions. It enables the use of regional health governance mechanisms to regularly report progress and share success stories to build national capacities.*

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*Source:* WHO Western Pacific Regional Office. Eleventh Pacific Health Ministers Meeting: 15–17 April 2015, Yanuca, Fiji [website]. Manila: Philippines; 2016 ([http://www.wpro.who.int/southpacific/pic\\_meeting/2015](http://www.wpro.who.int/southpacific/pic_meeting/2015), accessed 5 July 2016).

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### *Collective monitoring and evaluation of IHR core capacities*

*Member States have agreed on the International Health Regulations (IHR 2005) as the legal framework to detect, prepare for and respond to public health threats and report on events that may constitute a potential public health emergency of international concern. The IHR monitoring and evaluation (M&E) framework enables countries to evaluate their preparedness and core capacity to respond to hazards based upon a whole-of-society approach. Member States' progress is reported against SDG Target 3d. Since 2005, the Asia Pacific Strategy for Emerging Diseases (APSED) has served as a regional action framework for health security. It guides Member States in strengthening their IHR core capacities.*

*APSED's M&E approach includes regular country stakeholder planning and review, national workplan development and implementation, development and sharing of progress reports between partners, and annual Technical Advisory Group meetings. Since 2010, several Member States, including Cambodia, the Lao People's Democratic Republic, Mongolia and Viet Nam, have established national planning and review processes.*

*The APSED M&E approach is based on principles of accountability, ownership, partnership, flexibility and system strengthening. It builds on the IHR M&E framework through annual reporting, exercises, and joint external evaluation (JEE). The JEE process, developed by WHO and partners, provides a mechanism to overcome challenges in multisector and multi-stakeholder collaboration. This strategic approach to M&E enables continuous improvement and strengthens public health emergency preparedness.*

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## **Action 1.3 Adequate information capacity**

The effectiveness of health and related interventions, and the best use of resources, depends in part on the quality of the information available. Investments in improving data availability, quality and analysis are essential to support monitoring, reviews and decisions. Where there are gaps, a plan should be developed to address these and meet future data needs. This may include supporting the use of information and communications technology (ICT) to enable the aggregation and transfer of data at the health facility, provincial and national levels, reporting of disease outbreaks through mobile technologies, telemedicine, unique identifiers, electronic patient records, etc. The development and use of innovative technologies requires, however, technical expertise, informed and supportive country leadership, and strong governance.

### ***a. Strengthen links between information systems within and beyond the health sector***

- Review and revise national information plans taking a whole-of-systems approach, avoiding fragmented efforts and strengthening data linkage and information sharing.

- Strengthen systems and capacity for equity-focused data collection and analysis and their use in refining policies and targeting programmes to reduce health inequities and tackle the social determinants of health.
- Track indicators for health, including equity, and its determinants by using data from a range of sources across health and other sectors, including facility data, population-based surveys, surveillance data, civil registration and vital statistics, and relevant data from stakeholders beyond government.
- Work with development partners, donors, the informal sector and other stakeholders to strengthen oversight and leadership in data collection and management and to align stakeholders and investment to support national health information systems.

***b. Build capacity to gather and use information strategically***

- Develop a health sector workforce that can use information to fill knowledge gaps and inform decision-making.
- Develop a policy workforce that can identify relevant knowledge gaps and commission needed research, as well as skilled “brokers” who can link research, policy and action.
- Foster a culture of decision-making that draws upon health information to make funding, programme and service-delivery decisions.
- Use foresight methodologies and trend analysis to strengthen planning.

***c. Standardize information and harness communication technologies***

- Agree on consistent national, and where feasible regional, information standards to ensure that systems and data collections can “talk” to each other to improve comparison, sharing, exchange, use and re-use for different purposes.
- Improve the timeliness of information, including real-time access where possible and maximize information flows at the facility and local levels to improve services and programmes.
- Use information and communication technologies, applications and platforms, for example, open source software, big data, eHealth and mHealth as an enabler to achieve the SDGs and to scale up interventions in different national and subnational contexts.

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### *Fiji's National Data Repository*

In 2015, the Fiji Ministry of Health and Medical Services developed a National Data Repository, a web-based cataloguing system serving as a single data warehouse to document, store and widely disseminate for all public health data and metadata in Fiji and maximize their use in policies and programmes. The ministry is working to document and disseminate the data and metadata collected under various initiatives over the last 10 years. The portal enables health managers, practitioners, analysts and researchers to browse, search, compare and download health survey data as well as routinely reported health facility and administrative data. It and promotes equitable access and helps ensure continued viability, transparency and use of international standards in data collection.

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Source: Ministry of Health and Medical Services. Fiji National Data Repository [website]. Suva: Fiji; 2016 (<http://www.health.gov.fj/fjindr/index.php/home>, accessed 5 July 2016).

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### *Big data and the Korean National Health Insurance Service*

The Republic of Korea's National Health Insurance Service (NHIS) is the nonprofit single insurer for all those in the Republic of Korea. In providing health and long-term insurance, reimbursing fees to institutions and conducting health screening for all those in the Republic of Korea, a large body of computerized longitudinal data has become available in the NHIS on various health dimensions, including pathophysiological status, health behaviour, health conditions, and service use and fees. The data are representative of all those in the Republic of Korea.

The NHIS has set up the National Health Information Database (NHID), which integrates these data through individual identification linkages. Analyses of these big data, such as the following, have produced evidence to inform public health policy:

- Identifying causality and predicting risk by linking health-screening data with medical history and socioeconomic status.
- Creating an evidence base on health risk and disease by region and workplace to develop customized services in communities and workplaces.
- Developing an accurate health–disease index and surveillance system to target chronic diseases, based on information on use of services by chronic disease patients.

The data are being used to address pressing health issues, including the low birth rate, an ageing population and the chronic diseases burden. Future plans include integrating the NHID with other public health data (for example, electronic medical records) and climate, pollution and spatial network data.

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Source: WHO Regional Office for the Western Pacific. Regional Meeting on Maximizing the Potential of Health Insurance Data Systems to Support Universal Health Coverage, Manila, Philippines, 1-2 December 2015: meeting report. Manila: Philippines; 2015 (<http://iris.wpro.who.int/handle/10665.1/13139>, accessed 5 July 2016).

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## Additional guidance

Deciding on what should be done and in what order, using reliable information to plan and give priority to interventions, is important for all countries. To track the progress of SDGs, all countries should ensure a focus on equity.

For countries with limited financial and human resources, a monitoring framework and indicators might focus on high-burden health issues and MDGs yet to be achieved. Complementary indicators would then target local needs and priorities. The review of SDG and UHC indicators should be combined with other reviews, such as those of national development or the health system, as well as a broad range of stakeholders and representatives of communities consulted and involved.

For countries facing socioeconomic transition, the focus should be on current health priorities and the changes in health and its determinants including new and emerging diseases, NCDs, health promotion campaigns, environmental impacts, etc. Health equity and the principle of leaving no one behind should be central to monitoring frameworks and reviews. Information transparency and social and community engagement and participation are key to improving both focus and accountability.

For high-income countries, while some of the SDG targets may already be achieved, targets relating to UHC, NCDs, health emergency responses and similar issues may be priorities. Whatever the prosperity of the broader population, these countries will also have minority, indigenous, rural and remote, and other socioeconomically disadvantaged groups whose needs should be given high priority. Overall, the use of a suitable, country-specific framework and data repositories to assess progress and inform policies and services should be common practice whatever the social and economic context.



## SECTION 2

# 2. What are the policy and programme priorities for leaving no one behind?

## Background

Leaving no one behind is a core principle of both UHC and the SDGs. Social and economic inequality together magnify inequities in health. Poor health and well-being are a result of the unequal distribution of power and resources such that poverty, poor education, a lack of local services, gender, housing and other factors together entrench and amplify poor health. The SDGs purposefully highlight health equity and the socioeconomic basis of health.

Integrating an equity focus will accelerate progress by focusing attention and services on those with the greatest burdens of disease and illness. It underlines the need to reduce barriers to access faced by disadvantaged groups. There are also opportunities for health programmes and services to work together to address shared determinants of health for priority groups. Addressing health equity goes beyond the health sector. It requires different sectors to complement and work with each other. When multiple sectors and stakeholders coalesce around common interests, the potential exists for win–wins (co-benefits) in the realization of multiple goals. Best buys for partnerships across sectors include policies and interventions in education and early childhood development, agriculture, urban development and infrastructure, and the environment and social protection.

## Suggested areas of action

### Action 2.1 Equity in health services

Integrating equity into national policies and plans means purposefully reorienting health programmes and services around the needs of those who are on the margins of society. Disadvantaged groups often face more and higher barriers in their access to

essential health services. Overcoming these barriers is critical to improve their health and decrease avoidable and unfair health differences between them and other population groups. Attention to the underlying social factors that foster or exacerbate multiple health conditions provides an opportunity for joint action by health programmes and services to better reach disadvantaged communities.

**a. Minimize access barriers**

- Reduce physical, geographic and information barriers to access by:
  - applying UHC<sup>4</sup> and people-centred principles in designing health services and facilities, including enabling access for people with disabilities;
  - adopting strategies such as targeting or use of information technology to reach the most disadvantaged groups and areas, including mobile and rural populations;
  - tailoring services and information to accommodate language, income and education; and
  - working with communities and providers to strengthen health literacy and encourage the cooperative creation of solutions.
- Eliminate discrimination in access to health services, by:
  - addressing structural and legal barriers to access to services, including those relating to household registration and citizenship; and
  - reducing bias and prejudice among health workers and fostering cultural respect, understanding and the ability to work effectively across different cultures.
- Design and adapt services for various social settings, cultural contexts and local needs and improve the acceptability of services for defined population groups, for example, through:
  - addressing community stigma based on health-related status, for example sexually transmitted infection, TB, mental illness, disability, etc.;
  - ensuring privacy and confidentiality; and
  - implementing culturally and gender-sensitive and people-centred practices.

**b. Collaborate across health programmes on shared social determinants**

- Undertake collective planning and action on social determinants of health, risk factors and sources of vulnerability for disadvantaged groups that are shared by multiple health programmes.
- Provide incentives for changes in the ways health services are provided that encourage a move from the customary approach of separate disease-specific programmes to

4. For more information on actions to accelerate progress towards UHC, please see the Regional action framework, *Universal Health Coverage: Moving Towards Better Health*. Manila: WHO Regional Office for the Western Pacific; 2016 and the summary included in Appendix 2.

- joint action and pooled funding to address common social determinants of health and sources of vulnerability for disadvantaged groups.
- Implement community- or place-based approaches that bring together various health service and programme interventions and tailor them to local and community needs.

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### *Targeted approaches in the Philippines national malaria control programme*

*To achieve nationwide malaria elimination by 2020 in the face of shrinking resources and a resurgent epidemic, the Philippines national malaria control programme conducted a stratified analysis, which showed that, as of 2015, an estimated 14 million Filipinos were at risk of contracting malaria, most living or working in the 53 malaria-endemic provinces, particularly in rural, forested areas. At-risk groups identified included charcoal makers, loggers, subsistence farmers, development project workers, displaced populations, migrant workers, mobile indigenous peoples, military personnel and other armed groups. These groups posed a range of challenges to malaria prevention and treatment, including weak access (due to rural location, nomadic lifestyles and poverty), low acceptability of interventions such as long-lasting insecticide bednets (due to cultural beliefs), language barriers and low health literacy. Rising prevalence found in children under 5 years and pregnant women, pointed to gaps in programme implementation.*

*In response, the programme, with WHO and partners such as the Global Fund to Fight AIDS, Tuberculosis and Malaria and Pilipinas Shell Foundation, adopted an equity-focused subnational strategy that targets resources and interventions to high-risk groups in endemic areas. The new stratification criteria enabled categorization of malaria-endemic areas, earlier detection and treatment in targeted priority groups and areas. Health promotion and intersectoral collaboration, including with cross-border partners, were intensified, local capacities strengthened and complementary spraying used where cultural practices limited bednet use. As a result, malaria was reduced by three quarters between 2000 and 2011; by 2013, one third of provinces had eliminated malaria.*

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*Source:* Department of Health - National Center for Disease Prevention and Control. Malaria Control Program. In: Health Programs [website]. Manila: Philippines; 2016 (<http://www.doh.gov.ph/malaria-control-program>, accessed 5 July 2016). Ministry of Health Philippines and the World Health Organization and the University of California, San Francisco. Eliminating Malaria: Case-study 6 – Progress towards subnational elimination in the Philippines. Geneva: The World Health Organization; 2014.

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### *Whānau Ora: a cross-government initiative in New Zealand*

*Whānau Ora is a New Zealand cross-government initiative to empower families to take control of their own futures. It was introduced in 2010 after a taskforce on whānau-centred (family-centred) initiatives recognized that health and social services were not serving Māori whānau well. Whānau Ora involves an innovative whānau-rather than individual-centred approach that empowers whānau to achieve better outcomes. It puts whānau at the centre of decision-making about their service, opportunity and access needs, and builds capacity to achieve their goals. Families work together in whānau groups to identify their needs and develop plans, which may range from improving health outcomes to gaining new skills or getting a job. Health, education, social development, justice, housing and other social services, as well as community and Iwi (tribe) agencies, work together to respond to these identified needs.*

*In the April–June 2015 quarter, nearly 5000 whānau (including Māori, Pacific and other families) in New Zealand were receiving whānau-centred services across 62 providers. The initiative is led by Te Puni Kōkiri, the Ministry of Māori Development. Multiple agencies, including the ministries of health and social development, jointly implement its cross-government work programme. A Whānau Ora Partnership Group, comprising representatives from the National Iwi Chairs Forum and government partners, provides strategic leadership, sets direction and priorities, and monitors progress, based on a Whānau Ora outcomes framework, with indicators to achieve accelerated progress towards health equity for Māori and Pacific families and Whānau Ora in the next four years.*

*Activities are selected on criteria that support working in a whānau-centred way, reflect known health issues for Māori and Pacific families, and provide a mix of interventions and changes to baselines for priorities that can be achieved within four years. The Ministry of Health focuses on five indicators in the framework: mental health, asthma, oral health, obesity and tobacco. It regularly reports on the performance of general practices in Whānau Ora collectives (groups of providers that aim to improve access to health and social services), based on 11 indicators strongly linked to major causes of morbidity and mortality for Māori. The last published report, covering the year ending September 2015, showed the Whānau Ora sample was performing as well as or better than the national sample in five of the 11 indicators. This is promising, given the typically high health needs of patients enrolled in general practices in Whānau Ora collectives.*

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*Source:* Further information and sources: Report on the Performance of General Practices in Whānau Ora Collectives as at September 2015. Wellington: New Zealand Ministry of Health; 2016 (<http://www.health.govt.nz/publication/report-performance-general-practices-whanau-ora-collectives-september-2015>, accessed 2 August 2016). Whānau Ora at a glance [online]. Wellington: Te Puni Kōkiri, New Zealand Ministry of Māori Development; 2016 (<http://www.tpk.govt.nz/en/whakamahia/whanau-ora>, accessed 2 August 2016). Whānau Ora programme [online]. Wellington: New Zealand Ministry of Health; 2015 (<http://www.health.govt.nz/our-work/populations/Māori-health/whanau-ora-programme>, accessed 2 August 2016).

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## **Action 2.2** Realizing win–wins through collaboration across sectors

Achieving better health and equity lies beyond the capacity of the health sector alone. The SDGs emphasize working collaboratively with other sectors and stakeholders (see **Appendix 4** for an illustrative mapping of health programme areas and their related priority sectors and stakeholders). Evidence suggests a number of best buys for partnerships between health and other sectors where the potential for mutual benefits or win–wins is greatest. When multiple stakeholders cooperate to address shared interests, there is potential to magnify benefits and advance the goals of all sectors through shared responsibility across sectors.

### ***a. Stimulate social development***

- Mobilize social sectors and other partners through joint action for social equity, including:
  - a comprehensive package for early childhood development, including primary education for all, concentrating first on disadvantaged groups;
  - education for women and girls and initiatives for women and men, boys and girls to transform gender norms that are harmful to health, safety and development;
  - healthy school environments including access to adequate and safe food, water and sanitation;
  - improved working conditions for men and women in the formal and informal sectors based on internationally agreed standards to reduce their exposure to physical and psychosocial hazards;
  - working arrangements that include family leave, employment and social protection, breastfeeding at work, and support for family and child care;
  - actions to tackle forced labour, including forced child labour and human trafficking and improve access to basic services for refugees and migrants; and
  - coordinated responses and basic services for disadvantaged population groups, including integrated services for older people and people with disabilities.

### ***b. Promote healthy urbanization***

- Work with urban and infrastructure planners and service providers to promote health and safety, especially for those in low-income communities, and in megacities and dense urban spaces.
- Assure adequate housing, shelter, water and sanitation, electricity and other basic services and upgrade urban slums.
- Provide access to safe spaces and community settings free from violence, with particular attention to women and girls and other disadvantaged groups and incorporate these into urban design.

- Invest in and regulate for safe and accessible transport, road infrastructure and education to reduce injuries and road traffic accidents, and improve road and rail access to health and other facilities and services.
- Support cities and rural areas to prepare, respond to and recover from disasters.

***c. Protect the health of the environment***

- Strengthen mechanisms and processes to protect the environment from water, air, land and soil pollution and protect biodiversity and ecosystems.
- Monitor environmental health risks and take steps to mitigate them, especially for disadvantaged population groups.
- Raise awareness of and take steps to mitigate the impact of climate change on population health, including by fostering resilient health systems.
- Assess the health and health equity impacts of proposed infrastructure, mining and other industrial projects.
- Boost local food production and sustainable agricultural and fishery practices and consumption.
- Improve systems for food safety and food security, especially for low-income communities and other disadvantaged groups.
- Build “green” health and public facilities and advocate environmentally beneficial principles and stewardship across all sectors.

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***Climate change in the Pacific***

*Recognizing the particular vulnerability of Pacific island countries and areas to climate change, with impacts on community infrastructure, ecosystems, fisheries, agriculture and human health, the Pacific heads of government designated the Secretariat of the Pacific Regional Environment Programme to coordinate the region’s response.*

*The goal of the Secretariat’s Climate Change Strategic Priority is to strengthen capacity of all members to respond to climate change based on increased awareness and understanding of the potential impacts on communities and livelihoods, by improving policies, implementing practical adaptation measures, enhancing ecosystem resilience and achieving low-carbon development. The 2006–2015 Pacific Islands Framework for Action on Climate Change recognizes that success depends on political will of stakeholders and national and local partnerships along with regional coordination.*

*The Secretariat leads regional action through the biannual Pacific Climate Change Roundtable, the Pacific Islands Framework for Action on Climate Change and the Council of Regional Organizations of the Pacific (CROP) CEOs Working Group on Climate Change.*

The Pacific Climate Change Portal compiles information on projects and partnerships by country, agency and topic.

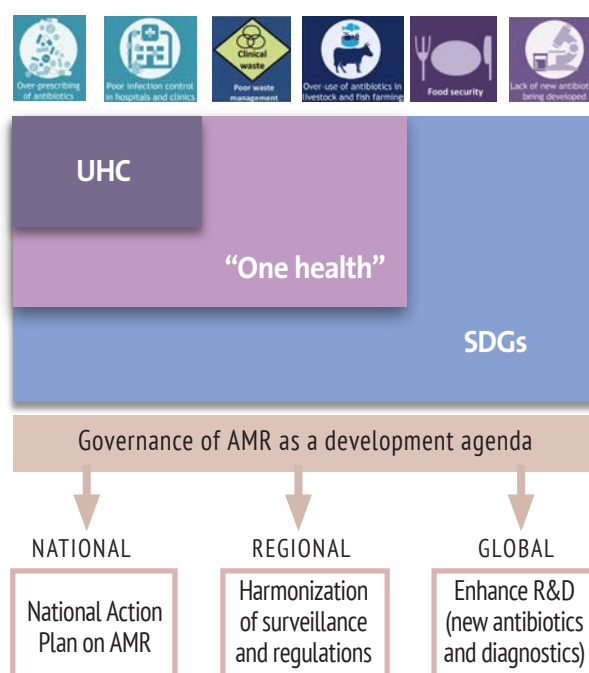
Source: Secretariat of the Pacific Regional Environment Programme. About Us [website]. Apia: Samoa; 2016 (<https://www.sprep.org/about-us>, accessed 5 July 2016). Secretariat of the Pacific Regional Environment Programme. Pacific Islands Framework for Action on Climate Change 2006-2015. Apia: Samoa; 2007 ([http://www.sprep.org/climate\\_change/pycc/documents/PIFACC.pdf](http://www.sprep.org/climate_change/pycc/documents/PIFACC.pdf) Accessed 5 July 2016). Secretariat of the Pacific Regional Environment Programme. Pacific Climate Change Portal [website]. Apia: Samoa; 2016 (<http://www.pacificclimatechange.net/>, accessed 5 July 2016).

### Framing antimicrobial resistance (AMR) in the context of the SDGs

The rise of antimicrobial resistance (AMR) threatens our ability to treat infections and ultimately the achievement of the SDGs. It is a global health challenge that requires collaboration across sectors and stakeholders.

The Biregional Technical Consultation on Antimicrobial Resistance in Asia, held in Tokyo, Japan, in April 2016, stressed the importance of tackling AMR as a development issue through systems strengthening and effective national, regional and global governance mechanisms for multi-sectoral collaboration.

The resulting Communiqué of Tokyo Meeting of Health Ministers on Antimicrobial Resistance in Asia signed on 16 April 2016 situates AMR within universal health coverage, One Health and the broader SDGs (especially SDGs 2, 3, 12 and 17; see figure). Resilient health systems can contain AMR in the human sector. The One Health approach enables sustainable action across the human, animal, agriculture and environment sectors. Integrated action on AMR through collaborative governance helps achieve the SDGs.



Source: Ministry of Health, Labour and Welfare, Japan. Communiqué of Tokyo Meeting of Health Ministers on Antimicrobial Resistance in Asia. Tokyo: Japan; 2016 (<http://www.mhlw.go.jp/file/06-Seisakujouhou-10500000-Daijinkanboukokuksaika/0000122127.pdf>, accessed 5 July 2016).

## Action 2.3 Financing strategies for promoting equity

The goal of social equity is to enfranchise socially excluded and disadvantaged groups. Universal access to public services and infrastructure is critical for a country's development as well as the health and well-being of its citizens. This requires sustainable, innovative, transparent and evidence-based approaches to mobilizing and allocating resources.

### *a. Strengthen public financing for health and social equity*

- Advocate policies that are informed by evidence and demonstrate the social returns of investing in health equity.
- Increase fiscal space for the social sector, including through progressive taxation, for example earmarked tax on tobacco and alcohol, and sugary beverages.
- Make public spending more efficient and equitable, including by tackling corruption and conflicts of interest.
- Target disadvantaged groups so that they benefit from public investment and interventions with the greatest potential impact.

### *b. Improve access to social protection*

- Implement measures that provide a minimum level of social protection from poverty and social exclusion.
- Link health financial protection mechanisms with broader social protection mechanisms.
- Tackle financial barriers to access to essential health and social services and medicines, and reduce the out-of-pocket payments that lead to financial hardship or impoverishment of individuals and families.

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### *A financial assistance scheme in China*

*China's Medical Financial Assistance (MFA) scheme promotes affordability of basic medical services and thereby acts as a safety net for urban and rural poor households, by helping with enrolment in basic medical insurance and providing extra reimbursements for out-of-pocket (OOP) medical expenses, such as deductibles and co-payments.*

*The scheme was started for rural areas in 2003 and expanded to urban areas in 2005. By 2008 it became nationwide. The Ministry of Civil Affairs (MOCA) leads implemen-*



tation, with the ministries of finance, human resources and social security and the National Health and Family Planning Commission. It is funded through government and social donations. It provides financial assistance to urban poor households on the “five guarantees”: food, clothing, medical care, housing and burial expenses. In rural areas, the people’s communes assist older people, those with disabilities, widows, orphans and the poor, mostly with hospital admission expenses, and sometimes outpatient services.

Those registered with MOCA pay only OOP expenses at designated hospitals, with other expenses settled directly with the hospitals by MFA. Enrollees not registered with MOCA pay expenses at the time of use and seek reimbursement afterwards. Between 2009 and 2014, the scheme has amassed over CN¥ 100 billion, covering over 100 million person-times. A 2015 policy document for improving financial assistance for critical and serious illnesses, combines the urban and rural medical assistance systems to create a comprehensive system protecting the health rights of citizens by reducing health-care costs and promoting use of needed services.

### Taxation and earmarking for better health

Member States of the WHO Western Pacific Region are using a range of methods to increase fiscal space for health, including taxation and earmarking. Many have set up health promotion foundations to promote health and well-being and prevent disease. An overview of approaches and institutions in selected countries is provided below.

STATE / COUNTRY	Organization	Legislation	Funding sources
<b>COOK ISLANDS</b>			
<b>Purposes of the Act/Fund</b> The Ministry of Finance and Economic Management has allocated a portion of additional revenue from increased tobacco taxation to the Ministry of Health for NCDs. The Ministry of Health has used the revenue to fund tobacco control initiatives, including smoking cessation services.	Ministry of Finance and Economic Management, Ministry of Health, Government of Cook Islands	Not legislated; agreement between Ministry of Finance and Ministry of Health	Tobacco taxes
<b>MALAYSIA</b>			
<b>Purposes of the Act/Fund</b> 1. To develop the capacity of organizations, including those that are health related and community based, for health promotion. 2. To plan and implement health promotion programmes and activities for the benefit of the community, with a particular focus on youth.	Malaysian Health Promotion Board	Act 651 of the Malaysian Parliament 2007	Triennial allocation from Government based on application by the Board. (a)

STATE / COUNTRY	Organization	Legislation	Funding sources
<b>MONGOLIA</b>			
<p><b>Purposes of the Act/Fund</b> Tobacco and alcohol control through:</p> <ol style="list-style-type: none"> <li>1. health promotion project and programme implementation;</li> <li>2. supporting activities to prevent diseases caused by tobacco smoking and alcohol consumption;</li> <li>3. organization of information, education and communications (IEC) activities on tobacco and alcohol control and its monitoring;</li> <li>4. increasing the supply of necessary drugs, equipment and techniques to assist in smoking cessation and treatment of alcohol abuse;</li> <li>5. research into economic impacts on health of tobacco and alcohol use;</li> <li>6. improving and increasing access to health and social welfare services for those suffering from alcohol abuse;</li> <li>7. supporting activities of individuals, nongovernmental organizations and legal entities that are actively involved in alcohol control and prevention activities; and</li> <li>8. supporting activities to promote the health of the general population.</li> </ol>	Mongolian Health Promotion Foundation	Mongolian National Law on Government's Special Fund	Government budget
<b>NEW ZEALAND</b>			
<p><b>Purposes of the Act/Fund</b> The agency leads and supports activities to:</p> <ul style="list-style-type: none"> <li>• promote health and well-being and encourage healthy lifestyles;</li> <li>• prevent disease, illness and injury;</li> <li>• enable environments that support health and well-being and healthy lifestyles; and</li> <li>• reduce personal, economic and social harm.</li> </ul>	New Zealand Health Promotion Agency <a href="http://www.hpa.org.nz">www.hpa.org.nz</a>	New Zealand Public Health and Disability Amendment Act 2000	Funded from Vote Health, the levy on alcohol produced or imported for sale in New Zealand and part of the problem-gambling levy
<b>PALAU</b>			
<p><b>Purposes of the Act/Fund</b> Allocates 10% of taxes on alcohol and tobacco to NCD prevention (specifically for the NCD Fund that supports efforts of the National Coordinating Mechanism for NCDs.</p>	National Coordinating Mechanism for NCDs	RPPL 9-57	Tobacco and alcohol taxes
<b>PHILIPPINES</b>			
<p><b>Purposes of the Act/Fund</b> The law mandates that 15% of revenues from excise taxes on tobacco products be used for programmes promoting alternatives for tobacco farmers and workers in tobacco-producing provinces. The law also requires that 80% of the remaining revenues be allocated for the UHC programme under the National Health Insurance Program and 20% of medical assistance and health enhancement facilities programmes.</p>	Earmarking of tobacco and alcohol taxes for health	Republic Act 10351 or the "Sin Tax" Reform Law	Incremental revenues from excise tax on alcohol and tobacco products; the law restructured taxes on tobacco and alcohol products to generate additional revenue

STATE / COUNTRY	Organization	Legislation	Funding sources
<b>REPUBLIC OF KOREA</b>			
<p><b>Purposes of the Act/Fund</b></p> <ol style="list-style-type: none"> <li>1. To support developing the National Health Promotion Plan based on the National Health Promotion Act.</li> <li>2. To operate training programmes for health-care professionals.</li> <li>3. To plan and evaluate research regarding health promotion.</li> <li>4. To carry out initiatives related to health promotion programmes assigned by the Ministry of Health, Welfare and Family Affairs.</li> </ol>	<p>Management Centre for Health Promotion  <a href="http://mchp.hp.go.kr">http://mchp.hp.go.kr</a></p>	<p>National Health Promotion Act 1995 (revised 2006)  Regulations of Ministry of Health, Welfare and Family Affairs (enacted 2005)</p>	<p>Mainly funded from the Ministry of Health, Welfare and Family Affairs budget</p>
<b>SINGAPORE</b>			
<p><b>Purposes of the Act/Fund</b></p> <p>To promote health by forming sustainable partnerships with other government agencies, the community, private and corporate entities to implement programmes to all age groups (children, youth, adults, elderly) in various settings (schools, community, workplaces, health-care institutions). These programmes encompass health promotion (in smoking control, nutrition, physical activity, mental health, NCDs and communicable disease prevention and management), screening for chronic diseases (for adults), health screening for children (weight/height status, myopia, hearing status, scoliosis, dental) and immunization.</p>	<p>Singapore Health Promotion Board  <a href="http://www.hpb.gov.sg">www.hpb.gov.sg</a></p>	<p>Health Promotion Board Act 2001</p>	<p>Mainly funded from Ministry of Health budget</p>
<b>VICTORIA, AUSTRALIA</b>			
<p><b>Purposes of the Act/Fund</b></p> <ol style="list-style-type: none"> <li>1. To fund activity related to the promotion of good health, safety or the prevention of disease.</li> <li>2. To increase awareness of programmes for promoting good health in the community through the sponsorship of sports, the arts and popular culture.</li> <li>3. To encourage healthy lifestyles in the community and support activities involving participation in healthy pursuits.</li> <li>4. To fund research and development activities in support of these activities.</li> </ol>	<p>The Victorian Health Promotion Foundation (VicHealth)  <a href="http://www.vichealth.vic.gov.au">www.vichealth.vic.gov.au</a></p>	<p>Tobacco Act 1987</p>	<p>Initial funding via tobacco levy (Tobacco Act 1987); funded now by direct grant from central state government</p>
<b>WESTERN AUSTRALIA</b>			
<p><b>Purposes of the Act/Fund</b></p> <p>To provide grants and sponsorships to advance health promotion through health promotion programmes and research, as well as sports and arts activities.</p>	<p>West Australian Health Promotion Foundation (Healthway)  <a href="http://www.healthway.wa.gov.au">www.healthway.wa.gov.au</a></p>	<p>Tobacco Products Control Act 2006 , (replaced Tobacco Control Act 1990)</p>	<p>Regulated annual transfer from Treasury (formerly a percentage of tobacco tax)</p>

STATE / COUNTRY	Organization	Legislation	Funding sources
<b>TONGA</b>			
<p><b>Purposes of the Act/Fund</b></p> <ol style="list-style-type: none"> <li>1. To support activities, facilities, projects or research programmes related to the promotion of good health, safety and the prevention and early detection of diseases.</li> <li>2. To keep statistics and other records relating to the achievements of the foundation.</li> <li>3. To provide advice on matters referred by the Minister to the foundation and matters that are relevant to the operation of the foundation.</li> </ol>	<p>Tongan Health Promotion Foundation (TongaHealth) <a href="http://www.tongahealth.org.to">www.tongahealth.org.to</a></p>	<p>Health Promotion Foundation Act 2007</p>	<p>Funds will be appropriated by Legislative Assembly and may include appropriate revenue measures as agreed by Minister of Finance and Minister of Health from time to time. It will also accept bequests, donations or grants made or any other income or payment due to the fund.</p>

(a): The Treasury of Malaysia has deemed that there is no provision to directly divert tobacco tax to the Board and noted political and religious limitations to earmarking taxes on tobacco and other “health-damaging goods”.

## Additional guidance

The optimum pathway for strengthening equity-focused approaches to health in each country will depend on its history, political and cultural landscape, economy, available resources and aspirations. As a starting point, countries may wish to identify concrete steps to incorporate an equity focus into their existing national health policies, strategies and plans.

Countries focused on the unfinished goals of the MDG agenda will need to evaluate their health programmes and services through an equity lens to identify those marginalized and disadvantaged population groups that have been left behind and to improve the effectiveness of interventions. Lessons learnt can inform action on other emerging health priorities, building a strong foundation for collaboration with other sectors and stakeholders in future.

Some focus of some countries will be on sustaining gains achieved during the MDG era. Where a focus on equity has already been institutionalized and collaborative partnerships across sectors are in place, the focus can be on expanding and institutionalizing cooperation, and addressing more complex health priorities. National development plans can be useful for identifying entry points, and in agreeing on steps that can be taken immediately as well as strategies to scale up successful programmes.

Other countries will be able to rely on more advanced systems and resources to intensify or redirect targeted health initiatives and programmes and to review and develop policy in partnership with other sectors and stakeholders. Targeted efforts will be needed to identify, engage and address the needs of those groups that have not benefited from economic and social gains and to which key services have not yet been able to reach.

The most appropriate pathways will need to balance available resources with maximizing effectiveness in leaving no one behind.

## SECTION 3

# 3. How will countries put their priorities into effect?

## Background

Working effectively across government will mean unaccustomed ways of thinking and working for many in government and beyond. While the health sector can play its part in removing the barriers and creating incentives for intersectoral collaboration, this will require informed leadership, novel strategies, policies and funding principles that encourage and reward cooperation.

The structures of government, parliaments, the bureaucracy and nongovernmental bodies, and therefore the opportunities for influence and advocacy, vary from country to country. Whatever their characteristics, all offer a variety of potential avenues for persuasion and collaboration. These may include cabinet and parliamentary committees and secretariats, interdepartmental working parties and committees, and various forms of public, stakeholder and industry forums and engagement. These bodies provide multiple avenues for support, sharing evidence, setting goals and targets, coordination, advocacy, monitoring and evaluation, policy guidance, financial support, legal mandates and implementation.

## Suggested areas of action

### Action 3.1 Collaboration across government

#### *a. Create enabling conditions for intersectoral action*

- Identify high-level and committed leadership to foster dialogue, mobilize efforts and guide action.
- Set shared goals for action with relevant sectors and stakeholders (**Appendix 4**) that address key challenges confronting the different sectors.
- Seize windows of opportunity as entry points for intersectoral action.
- Build trust among government officials and nongovernmental stakeholders, for example nongovernmental organizations, the for-profit private sector and academia,

to encourage cooperation and recognition of the strengths, expertise, roles and responsibilities of each.

***b. Structure institutional arrangements to support intersectoral action***

- Engage legislative and executive branches of government to assess if legislative reform is required to achieve health equity.
- Orient and build the capacity of incoming parliamentarians and public servants from other sectors on intersectoral action for health equity.
- Convene intersectoral and intergovernmental forums to orient government sectors around priorities and action where shared commitment and consensus on issues already exists.
- Promote local government participation and ensure that local government authorities are sufficiently resourced and empowered to fulfil their responsibilities.

***c. Embed measures of health equity within planning and reporting across sectors***

- Integrate health equity goals, strategies and indicators into the planning and reporting of other sectors and design complementary programmes, policies and regulation at national and subnational levels.
- Pursue budget allocations for programmes that produce benefits for health, including joint budgeting or pooled funding across government ministries and tiers of government.
- Generate and disseminate evidence, including the results of health and health equity impact assessments and joint reviews, to advocate for collaborative action and modelling to better understand, plan, anticipate and address the social determinants of health.
- Design tailored programmes and policies across government for disadvantaged population groups and health issues.

***d. Shape international relations to enable action on health***

- Improve the integration of health equity in overseas development assistance policy and programming.
- Work with relevant sectors to protect public health in the negotiation of trade and other international and bilateral agreements.
- Participate in the development of internationally agreed conventions and standards that respond to the needs of disadvantaged population groups and adopt these standards in domestic legislative frameworks as appropriate to the local context (Appendix 5).

- Engage with other countries and regional organizations to share information and promote coordination across borders on such issues as migration, environmental risks, climate change, and infectious disease surveillance and response.

### Examples of intersectoral governance structures

Many policies and programmes affecting health originate outside the health sector. Therefore, population health can be achieved only through intersectoral action, such as through a Health in All Policies (HiAP) approach. The table below provides a conceptual framework showing how different governance structures can foster HiAP, each having its own profile in terms of intersectoral actions.

How intersectoral governance structures can support Health in All Policies			Governance actions									
			Evidence support	Setting goals and targets	Coordination	Advocacy	Monitoring and evaluation	Policy guidance	Financial support	Providing legal mandate	Implementation and management	
Intersectoral governance structures	Government level	Cabinet committees and secretariats										
	Parliament level	Parliamentary committees										
	Bureaucratic level/ (civic service)	Interdepartmental committees and units										
		Mega-ministries and mergers										
	Managing funding arrangements	Joint budgeting										
		Delegated financing										
	Engagement beyond government	Public engagement										
		Stakeholder engagement										
		Industry engagement										

Adapted from: McQueen D, Wismar M, Lin V, Jones CM, Davies M (Eds). Intersectoral governance for Health in All Policies. Structures, actions and experience. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies; 2012.

### International trade agreements: opportunities or threats for public health?

International trade agreements can advance or hinder public health objectives. For example, promoting equitable access to medicines can potentially serve both commercial and public health interests. Much depends on the design and implementation of the agreements. Such agreements can include investor–state dispute settlement (ISDS) mechanisms. These mechanisms enable private entities to make claims against governments outside of domestic court systems. ISDS mechanisms may deter countries from introducing and implementing public health policies where they have



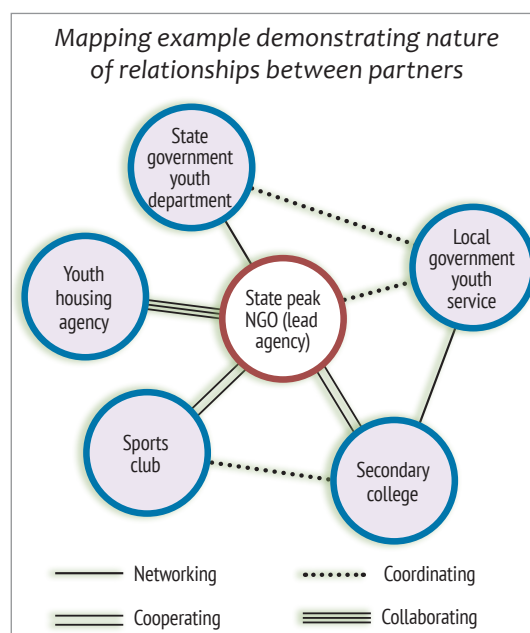
concerns about potential litigation. There are precedents for these sorts of claims in relation to public health issues. For example, in 2012, Philip Morris challenged the Australian Government’s plain packaging laws. The claim was made under a bilateral trade agreement between Australia and Hong Kong SAR (China) and relied on an ISDS-type mechanism. Learning from this experience and based on similar concerns expressed during negotiations, the Trans-Pacific Partnership Agreement excludes tobacco control measures from the relevant ISDS mechanism. This exclusion limits the ability of companies to bring claims against governments in relation to policies that aim to decrease tobacco use, such as plain packaging laws.

Source: WHO Regional Office for the Western Pacific. Regional Meeting on Maximizing the Potential of Health Insurance Data Systems to Support Universal Health Coverage, Manila, Philippines, 1-2 December 2015: meeting report. Manila: Philippines; 2015 (<http://iris.wpro.who.int/handle/10665.1/13139>, accessed 5 July 2016).

### VicHealth partnerships analysis tool

To improve the potential success of partnerships for health, VicHealth, the Victorian Health Promotion Foundation in Australia, has developed a partnerships analysis tool to help organizations working through partnerships to better understand the value of partnerships, reflect on existing partnerships, and explore ways to strengthen partnerships. The tool helps organizations assess, monitor and maximize the effectiveness of their partnerships. Building effective partnerships is especially relevant for achieving the SDGs, since they are interconnected and require action across sectors and stakeholders. The tool helps users discuss issues and ways forward through various activities, including a checklist defining features of successful partnerships.

Source: Victorian Health Promotion Foundation. The partnerships analysis tool. Melbourne: Victoria; 2011 ([www.vichealth.vic.gov.au](http://www.vichealth.vic.gov.au), accessed 5 July 2016). NGO = nongovernmental organizations.



### *Dedicated units in health ministries for intersectoral action*

*Health ministries have sometimes created units dedicated to intersectoral action. For example, South Australia's Department of Health established a small Health in All Policies (HiAP) unit to support collaboration with other government agencies on health and well-being, with a particular focus on the social determinants of health. The Department of Health uses a HiAP approach as a way to encourage all sectors to consider the health impacts of their policies and practices and how a healthier population can contribute to the goals of other sectors.*

*Such units can ensure dedicated time and resources for intersectoral work. However, they may take responsibility away from other parts of the ministry, or become marginalized if seen as being too distant from the ministry's core business. Strategies to enable their success include staffing the unit with highly technically competent and politically aware staff, maintaining an outward focus as the role of the unit and cultivating ownership of the unit by the relevant minister or political body.*

*Source: Scott Greer and Anna Maresso (2012) 'Intersectoral Problem Solving by Interdepartmental Units and Committees' Eurohealth, Vol 18 No 14, 11-13. Department of Health, Government of South Australia (2011). The South Australian approach to Health in All Policies: background and practical guide, Version 2.*

## **Action 3.2 Engagement of stakeholders beyond government**

Stakeholders beyond government, such as nongovernmental and civil society actors, traditional community leaders, professional and faith-based organizations and the for-profit private sector, play significant and diverse roles in improving health. In the Western Pacific Region they account for a large and increasing proportion of health-care delivery itself, as well as the supply and distribution of medicines and health products, health financing, workforce education and training, and health promotion and prevention. Other roles include the promotion of employee well-being, corporate social responsibility initiatives, the reduction of NCD risk factors, such as tobacco, alcohol, and high-sugar and high-salt foods, the delivery of development assistance, and as part of an active civil society by supporting accountability and community engagement. Governments need to enlist the cooperation of these organizations and have well-mapped engagement strategies in place supported by policies and legislation to protect the public interest and promote equity. It is essential to build trust, to support coalitions and alliances, and to combine forces to plan and act collectively and effectively for the greater good.

### ***a. Sustain constructive engagement with stakeholders beyond government***

- Develop a clear policy framework for the engagement of stakeholders beyond government with a principal focus on protecting the public interest.

- Collect information and undertake analysis of the contributions and programmes of nongovernmental stakeholders as part of routine health system monitoring, evaluation and research.
- Enable and support the constructive involvement of civil society in health including its role in health service delivery, health promotion and awareness raising, policy advocacy, dialogue and development, resource mobilization and allocation, monitoring of health service quality and responsiveness, and research and evidence generation.
- Create a platform for promoting coordination, dialogue and knowledge sharing on specific health issues with other stakeholders and sectors and jointly map out strategies for addressing specific goals.

***b. Strengthen partnerships for programme and service delivery***

- Design and implement adequate regulation of health services and commodities, including traditional medicine to promote quality and equity.
- Introduce safeguards against undue influence by the for-profit private sector or other vested interests in health-related decision-making, including management of real, perceived or potential conflicts of interest, and ensure that the public good is put before commercial interests.
- Contract stakeholders beyond government where appropriate to expand affordable health services and programmes to areas with limited access, and enforce transparent public tendering and accountability based on quality, expertise, outcomes and cost.
- Create subsidies and incentives to encourage stakeholders beyond government to provide health care and provide access for disadvantaged populations.
- Provide education and training on health programme and service delivery to non-governmental agencies and organizations.
- Build public–private partnerships for health to bring together different skills and resources for strengthening service delivery, catalysing private support and improving coordination.

***c. Build advocacy coalitions for action on the social determinants of health***

- Implement measures to prevent and address NCDs, drawing upon evidence of the most cost-efficient and effective interventions.
- Safeguard citizens from environmental risks to health, in particular in relation to extractive and other industries operating in remote and inaccessible areas.
- Exercise leadership in promoting corporate social responsibility and the introduction of voluntary or mandatory standards of responsible practice that include health equity considerations.

- Build trust and support coalitions and alliances of diverse organizations with a common goal of supporting agenda setting and the implementation of programmes or services.

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### *The power of partnerships: lessons from Papua New Guinea*

Following a 2010 audit by the Global Fund to Fight AIDS, Tuberculosis and Malaria, which revealed irregularities in the administration of grants to Papua New Guinea, it became apparent that the grants for malaria, tuberculosis and HIV/AIDS were at risk. In response, the national Government decided to transfer the management and fiduciary responsibility of the grants to the nongovernmental sector. Papua New Guinea received approximately US\$ 200 million from the Global Fund between 2004 and 2014. The principal recipients for the current grants, totalling US\$ 65 million in 2015–2016, are Rotarians Against Malaria and Population Services International for malaria, World Vision International for tuberculosis, and a foundation established by the largest company in the country, Oil Search, for HIV. The principal recipients and sub-recipients funded under the grants, including church and other civil society organizations, work closely with the Government. The challenges of funding and running programmes and ensuring the supply of drugs and other commodities across a country of 800 languages and large tracts of land in mountainous and coastal areas inaccessible by road are huge. A multistakeholder body, the Country Coordinating Committee, oversees grant implementation.

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### *Working in partnership on NCDs in Guam*

The Guam Non-communicable Disease Consortium was formed in 2010 in response to the declared regional state of emergency due to the NCD epidemic in the United States Affiliated Pacific Islands. It is a community-based organization with over 200 members from 50 different agencies whose mission is to “lead, collaborate with and empower individuals, families and communities in working towards a non-communicable disease-free Guam”. With support from the Department of Public Health and Social Services, the consortium meets monthly to discuss plans for improving health in the island state. It has seven action teams, working respectively on alcohol prevention and control, nutrition and obesity, physical activity, tobacco prevention and control, data and surveillance, policy and advocacy, and communications. The Consortium is led by the Executive Committee that consists of the action team leaders, coalition leaders, and the administrator of the Bureau of Community Health Services. It was a key collaborating partner in the development of the Guam Non-Communicable Disease Strategic Plan 2014–2018, and is a lead organization and key resource for its implementation. Through its work, the consortium has proven that collaboration across sectors, as well as leveraging voice, maximizing resources and aligning of priorities and activities, is an effective way to address NCDs. The consortium has

*also been successful in promoting collaboration among diverse stakeholders while breaking down “silos”, implementing cross-cutting and overarching strategies, and leveraging limited resources.*

Source: Guam Department of Public Health and Social Services and the Non-Communicable Disease Consortium. Guam Non-Communicable Disease Strategic Plan 2014-2018. Guam; 2013 (<http://dphss.guam.gov/article/2014/06/30/guam-non-communicable-disease-strategic-plan-2014-2018>, accessed 5 July 2016). Live Healthy Guam. NCD Documentary: Live Healthy Guam. Guam; 2015 (<https://www.youtube.com/watch?v=c9gggkwq84I>, accessed 5 July 2016).

### **Action 3.3** Participation of affected communities

Involving affected communities in decision-making is not only a basic principle of human rights and democratic governance, it also bolsters the use and effectiveness of health programmes and interventions. There is a wide spectrum of participatory approaches and techniques, from information to consultation, involvement, collaboration, and empowerment (**Table 1**). The more complex and controversial the action, the more important is the investment in participation to build consensus and facilitate ownership. Efforts to foster participation also underline the importance of strengthening technical and financial resources and the capacities of affected communities to enable their active, free and effective participation.

#### ***a. Include affected communities in policy consultations***

- Give voice to disadvantaged groups, community groups and civil society organizations by institutionalizing participation from health policy development and implementation to assessment and review.
- Mandate representation from diverse groups in decision-making bodies, including those for health programmes and projects.

#### ***b. Empower affected communities to participate***

- Take active steps to counter stigma and discrimination against disadvantaged groups that discourage their participation.
- Build the confidence, knowledge and understanding of affected communities so that they can contribute to policy development, programme delivery and research.
- Facilitate community access to the technical, technological and financial resources needed for effective participation.
- Report publicly on progress, feed information and results back to communities in ways that are readily understood, and solicit their advice and leadership in overcoming road-blocks, adverse consequences or unanticipated problems in the delivery of services.

**TABLE 1.** Overview of participatory approaches and tools

UNDERLYING AIMS	
Information	To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.
Consultation	To obtain public feedback on analysis, alternatives and/or decisions.
Involvement	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.
Collaboration	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.
Empowerment	To place final decision-making in the hands of the public.
EXAMPLE TECHNIQUES AND TOOLS	
Information	Printed information (fact sheets, posters, flyers) Online information (websites; newsletters, social media pages) Information hotlines Open houses/information kiosks Press and media engagement Art exhibitions/performances
Consultation	Public meetings/hearings/ comments or town-hall meetings Comment/feedback forms Focus groups Surveys and interviews (in person, by phone or online) Citizen performance report card
Involvement	Participatory assessments (including mapping and forecasts) Public and consensus workshops (World Café, charrettes, roundtables, etc.) Deliberative polling
Collaboration	Participatory planning and budgeting; Citizen advisory committees Community task force Social partnership agreements Consensus building Joint decision-making and audits/reviews; Joint steering committees
Empowerment	Citizen juries and referendums Ballots Delegated decision-making

Sources: International association for public participation, IAP2 Spectrum of Participation, 2014; World Bank, Participation sourcebook, 1995. World Bank, Empowerment and poverty reduction, 2002. WHO WPRO, Integrating poverty and gender into health programmes (foundational module on poverty), 2006.

### Community empowerment in Samoa

Launched in the late 1990s as part of the Healthy Islands initiative, the Aiga ma Nu’u Manuia (Healthy Homes, Healthy Villages) programme in Samoa uses traditional social structures to promote village health. Village women’s committees identify community health and social needs and mobilize their communities to work to address them. It has tackled issues ranging from primary health care, health promotion and disease prevention to hygiene and sanitation at the grassroots level. Led by a multi-sectoral steering committee and coordinated by the Ministry of Women, Community and Social Development, the programme has been implemented in 183 villages across the

country. It has facilitated entry from different ministries on a range of activities that have increased self-reliance and empowered communities to identify, manage and seek appropriate support for community development.

Source: Ministry of Health. National Health Promotion Policy 2010-2015. Government of Samoa. Apia: Samoa; 2010.

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### *Strengthening the voice of consumers and affected communities in Australia and New Zealand*

The Consumers Health Forum (CHF) of Australia, the national body representing the interests of health-care consumers, works to achieve safe, quality and timely health care for all Australians, supported by accessible health information and systems. It began with “A petition of reform addressed to the Minister” in May 1985 that asked that public participation be formally built into the national health administration. Following a review of community participation, government funds were allocated to establish a health forum of representatives of community groups. CHF actively contributes to health policy in Australia through submissions to national inquiries; conducting projects in topical policy areas; providing position statements on areas of concern for health consumers; meeting with key stakeholders including government, health professionals and industry bodies; and providing media comment on current health policy issues. CHF is an independent, not-for-profit national organization, although it receives government funds for certain projects, such as the Our Health, Our Community initiative.

New Zealand has a formal system for ensuring community voices in health-care decision-making. The New Zealand Public Health and Disability Act 2000 requires district health boards (DHBs) to involve Māori and other population groups in planning and delivery of health and disability services to “reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand”. The act includes the specific objective for DHBs to work in partnership with Iwi (tribe) and Māori communities to improve health outcomes for Māori. Publicly elected community representatives make up the majority of the boards that govern each DHB. This provides accountability, ensuring community views are represented, and consultation with community groups about their health needs is undertaken. The Minister of Health must also ensure that Māori membership of the governing board is proportional to the Māori population resident in each DHB area, with a minimum of two Māori members on each board. Each DHB must also establish a Community and Public Health Advisory Committee, including Māori representation, to advise on health improvement measures.

Source: Consumers Health Forum of Australia. About CHF [website]. Deakin West: Act; 2016 ([www.chf.org.au](http://www.chf.org.au), accessed 5 July 2016). Ministry of Health, New Zealand. NZ Health System: District Health Boards. Wellington: New Zealand; 2014 (<http://www.health.govt.nz/new-zealandhealth-system/key-health-sector-organisations-and-people/district-health-boards>, accessed 5 July 2016). New Zealand Public Health and Disability Act 2000. Reprint as at 30 April 2016 (<http://www.legislation.govt.nz/act/public/2000/0091/latest/DLM80051.html>, accessed 5 July 2016).

## Additional guidance

Countries are likely to have existing governance structures and mechanisms that can support intersectoral action to address health equity. A useful starting point for all countries would be to review these mechanisms, identify key sectors that need to be involved, including stakeholders beyond the government, and identify representative(s) who can exercise influence and help to open doors for targeted initiatives and actions.

Where new governance structures or mechanisms are required, countries may focus on integrating a stronger focus on equity within health and other sectors. As a starting point it can be effective to pursue the most promising and straightforward interventions, the so-called low-hanging fruit, in order to ensure early successes that generate confidence and can then be built upon.

Where countries are working with new partners, a useful first step can be to develop issues-focused pilot projects that help build sustainable partnerships, goodwill and collaboration, with the prospect of bringing joint projects to scale. The greater the specificity in establishing pilot projects, the more conducive they are to monitoring and evaluation, and the more easily they can be achieved and scaled up.

It is essential to engage stakeholders and have a clear framework that is well understood by all involved to help create parity in care and services. Countries that have existing mechanisms for engagement may wish to review the lessons learnt and explore options for accelerating progress.

For all countries, it is essential to put in place approaches that foster the confident participation of affected communities, including disadvantaged population groups. A key entry point is identifying who is “missing” and whose engagement would help to broaden the debate and bring other voices to the table.



## SECTION 4

# 4. How can the health sector drive the agenda?

## Background

The health sector has the explicit responsibility for improving population health and health equity and will need to champion this agenda. However, working across sectors and stakeholders is challenging. Within the Western Pacific Region, the health sector does not always have an influential voice in setting social and economic priorities despite the fact that health spending often represents upwards of 10% of a country's GDP. Short-term commercial and economic considerations can outweigh longer-term health objectives. This is commonly the case in international and regional trade negotiations, national economic development planning and local industry investment, as well as community, family and individual decision-making in both developed and developing countries. The SDGs envisage a health sector that can engage, support, advocate and lead effective action on social determinants of health, as well as its traditional domains of health planning and service delivery.

Significant progress has already been made in the Western Pacific Region. The regional action framework on UHC identifies a wide range of intersectoral strategies for improving health system performance, and therefore health outcomes and equity. The Region also has a long history of improving health through action on the social determinants of health across a broad spectrum, for example in tobacco control in Australia, China and the Philippines, the healthy diet campaigns in the Pacific island countries, environmental protection, climate change forums and healthy city initiatives. The Region has made progress in embedding health in the policies of other sectors, although health-related entry points are not always easy to identify. Lessons from these experiences can be adapted and expanded to address the SDGs.

To lead policy and action on the health-related SDGs across sectors, health authorities and workers will need to expand their repertoire of skills as well as strengthen existing knowledge and capabilities. Equally important is the health sector's institutional capacity to evaluate the quality and accessibility of programmes and monitor their performance.

## Suggested areas of action

### Action 4.1 Capabilities for knowledge exchange

Tackling the health-related SDG goals requires more than traditional professional and technical health expertise. It requires an understanding of health within the broader framework of its social determinants and the complex process of policy-making. Successful participation in the development of policy demands timely and reliable intelligence not only at the government level, but also at the levels of communities, families and individuals. The SDGs call on the health sector to build and support knowledge exchange.

#### *a. Build the knowledge base on social determinants of health*

- Stay updated on innovative interventions and novel approaches to addressing the social determinants of health both across the globe and in the Region and on evidence of the benefits of investment in health to overall national development.
- Collaborate with research institutions, and draw on data repositories to understand, track and tackle trends in the social determinants of health.
- Undertake intervention research that is practical and participatory to ensure timely translation of research findings into policy and practice.

#### *b. Understand the priorities and processes of other sectors*

- Learn about the goals, language, institutional arrangements, operations and budgetary mechanisms of other sectors such as finance, education, urban development, labour, social welfare, agriculture and environment.
- Know the process and the arguments for economic development through trade including international, regional and bilateral trade agreements and their potential impact on health.
- Identify shared concerns and goals, the most effective role for the health sector (to lead, facilitate, collaborate, etc.), entry points for partnership and the implications for multisectoral action of key social factors.
- Study and share international experiences and promote regional knowledge exchange.

#### *c. Understand perspectives and needs of communities*

- Engage with communities through health promotion strategies in the activities of health services at all levels.

- Consult communities and document their perspectives and priorities in order to better understand their needs and expectations and incorporate these into policy and programme design.
- Understand how communities make decisions about health care, disease prevention and health promotion on their own behalf.

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### *Building and strengthening institutional capacity for knowledge exchange*

*In the last two decades, many Member States, both developed and developing, have set up institutions designed to help translate evidence into policies. For example, the Health Strategy and Policy Institute in Viet Nam was established in 1998 by the Ministry of Health through a prime-ministerial decree. The China National Health Development Research Center (formerly known as the China Health Economics Institute), established in 1991 under the leadership of the Ministry of Health (now the National Health and Family Planning Commission), is a national think tank providing technical consultancy to health policy-makers. Similarly, Malaysia established the Institute for Health Systems Research in 2002. The Sax Institute, established by the New South Wales Health Department, is another such example in Australia. These institutions are typically independent from any university or research group, and much closer to key decision-makers. These institutional platforms help embed research and evaluation in policy-making and implementation, building partnerships between researchers and policy-makers, and promoting joint production of evidence. The SDGs provide opportunities to learn from and strengthen these structures further.*

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## **Action 4.2 Leadership skills to navigate the policy system**

The health sector is called upon to play a range of roles in a multisectoral approach to policy-making. These include leading, convening, coordinating, engaging, advocating, participating, supervising and monitoring. Influencing policy requires deep knowledge, engagement and skill. It requires the health sector to involve others in its deliberations and planning, as well as participating in policy development with other sectors where health issues are relevant.

### ***a. Strengthen the capability to engage other sectors in policy-making***

- Strengthen relationships with key ministries, particularly planning and finance, and build the capacity to articulate the importance of health to social and economic development and to other sectors' responsibilities.

- Build expertise in health diplomacy and the political process to influence and shape global and regional initiatives that have an impact on health.
- Be able to identify and negotiate solutions that advance the shared interests of different sectors.

***b. Strengthen the capability to mobilize political and financial support***

- Build capabilities for effective engagement with:
  - parliamentarians and their committees directly and indirectly related to health and its social determinants in order to enhance their role in legislative development, adoption of budgets and accountability for health outcomes;
  - the judiciary to ensure legal interpretation and action fosters public health interest and does not undermine health equity;
  - mayors and local government representatives to champion health and well-being in human settlements; and
  - community and religious leaders, and influential figures in civil society, academia and the political spheres to enlist their support.
- Negotiate common goals with donors and encourage evidence-based targeting of development aid.

***c. Strengthen the capability to use policy levers effectively***

- Use governance mechanisms, such as processes for the development of laws and joint budgets, to facilitate multisectoral and multistakeholder collaboration.
- Provide sound and persuasive evidence of the social and economic benefits of investing in health to advocate for resources from both public and private sources.

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*Cities as drivers of sustainable urban development*

*The Western Pacific Region is rapidly urbanizing in the face of sustained economic growth and development. However, many cities have grown faster than their capacity to provide adequate infrastructure and services, including safe housing, water and sanitation, and health. The reliance on motorized transport, insufficient waste management, outdoor and indoor air pollution, unhealthy food environments and lack open green spaces for physical activity are threatening health and overall well-being of urban populations. Climate change, disasters and migration pose additional risks.*

*The fulfilment of the urban health agenda is crucial to achieving progress towards the SDGs, and cities are in a strong position to drive change. WHO recognizes the need to shift urban health action from “reactive to proactive” so that countries and cities can strengthen their ability to plan, anticipate and mitigate current and emerging urban challenges. It has taken a series of steps to support this transition. In the late*

1980s, WHO initiated the Healthy Cities initiative as an integrated and multisectoral approach for tackling urban health issues. The approach aims to improve the physical and social environments and expand community resources to support healthy lives. Healthy Cities promotes collaboration among various sectors, fosters community participation and maximizes the effectiveness of local governance. In 1995, at their first meeting, the Ministers of Health for the Pacific Island Countries developed the Healthy Islands initiative to create a unified vision for health protection and health promotion. In 2003, the WHO Regional Office for the Western Pacific launched the Alliance for Healthy Cities to offer cities a platform to communicate and share experiences in addressing urban health challenges. A Healthy Cities Toolkit was developed to provide local governments with actions for implementing good governance, policy coherence, reducing inequalities and fostering innovation. The Regional Framework for Urban Health in the Western Pacific (2016–2020): Healthy and Resilient Cities, endorsed by the Regional Committee for the Western Pacific in 2015, presents a context-specific approach for local governments to improve urban health.

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### **Action 4.3 Institutional capacity for present and future challenges**

While reforms are often initiated by a champion or strong leader, without institutional adaptation few reforms would succeed or last. Institutional change involves rules, plans, mechanisms and incentives as well as the formal and informal relationships between organizations and people. It involves all levels of agencies and service providers, and the individuals who lead and staff them.

#### ***a. Raise the priority of health in the national development agenda***

- Create common goals that link health and social and economic development with strong political commitment.
- Articulate the responsibilities of institutions at all levels within the health sector for achieving SDGs.
- Secure sufficient domestic funding for essential public health functions and for scaling up effective interventions.
- Promote the efficient use of available resources focusing on the most cost-effective evidence-based interventions and actions.

#### ***b. Establish rules and incentives for improving performance and sustaining progress***

- Review rules, policies, guidelines and reporting to ensure effective collaboration across sectors.

- Create incentives to foster a culture of effective collaboration.
- Establish measures of performance for effective engagement across sectors and stakeholders.
- Pool funding to enable joint action on shared concerns and priorities.

***c. Train the health workforce to be facilitators and champions for health equity***

- Provide opportunities for health policy-makers and planners to gain experience or exposure to other sectors.
- Institutionalize preservice training that builds the knowledge and skill base of health workers to collaborate across sectors and stakeholders.
- Build multidisciplinary and multisectoral teams through continuing education and on-the-job training for health authorities, health professionals and community health workers.

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### *Global health diplomacy training in China*

*China is now a key player in global health diplomacy and has been hosting courses on global health diplomacy since 2009. The courses aim to develop capacity in the Region on global health diplomacy and promote China's participation in global health negotiations. Four courses have been held, bringing together over 150 participants from a range of countries (Australia, Brunei Darussalam, Cambodia, China, Indonesia, Japan, Malaysia, Mongolia, Papua New Guinea, Philippines, Samoa, Singapore, Thailand, Tonga and Viet Nam). Diplomatic and health professionals explore common interests in health as a foreign policy issue, key concepts and priorities in global health, and global health governance structures. The courses focus on learning by sharing through examples and lessons drawn from other countries, South–South Cooperation and past global health negotiations, such as International Health Regulations (2005), the WHO Framework Convention on Tobacco Control and the Pandemic Influenza Preparedness Framework.*

Source: Course Summaries for China 2013, 2012, 2010 and 2009. Past Courses. In: Executive Courses [website]. Geneva: The Graduate Institute; 2016 (<http://graduateinstitute.ch/home/research/centresandprogrammes/globalhealth/training/executive-courses/past-courses.html>, accessed 5 July 2016).

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### *Strengthening public health surveillance and response capacity*

*Public health workers need to strengthen their skills to sustain public health surveillance and response. Field epidemiology training programmes (FETPs) help achieve this goal through on-the-job mentorship and training. Eight countries in the Region, including Australia, China, Japan, Republic of Korea, Malaysia, Philippines, Singapore*

and Viet Nam, have implemented the standard two-year FETP; a shorter, modified version has been organized in Cambodia, the Lao People's Democratic Republic, Mongolia and Papua New Guinea. The FETP's value has been demonstrated by the involvement of graduates in responses to major public health events. For example, fellows and graduates of the Mongolian FETP (MFETP) played a critical role in investigating the first and second waves of a measles outbreak, in March 2015 and early 2016, respectively.

Regional training on event-based surveillance and risk assessment and Western Pacific Surveillance and Response journal writing workshops helped graduates build on MFETP skills. Nearly all MFETP graduates from the first five cohorts found public health sector jobs. They have been leading national planning and review for public health system strengthening. National and local response capacity has been improved through field exercises, hands-on laboratory trainings, coordinated risk assessments and outbreak response reviews. To ensure its sustainability, the Ministry of Health has formally integrated the MFETP into its annual plan and budget and expanded its scope to noncommunicable diseases, veterinary, environmental health and maternal and child health and is moving towards sub-national implementation.

MFETP field projects have resulted in national guideline and policy development and revision. As FETPs are embedded in health systems, they enable the development of regional networks of graduates, strengthen leadership and the robustness of regional surveillance systems, facilitate the sharing of experiences and enhance safety and resilience, in line with IHR (2015).

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### *Health and multisectoral action in selected national development plans*

Almost all Member States in the Western Pacific Region, at all levels of development, engage in systematic and multisectoral national socioeconomic planning, which is in most cases approved by national legislatures. An analysis of selected national plans and policies developed between 2010 and 2016 shows that Member States have articulated their strategies for sustainable development in terms of inclusive growth, in different ways.

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**CAMBODIA** – With the aim of “further expanding achievements gained in Third Legislature of the National Assembly, the Rectangular Strategy – Phase II”, Cambodia developed its National Strategic Development Plan 2014–2018. It combines four key elements: “ensuring an average annual economic growth of 7%” that is “sustainable, inclusive, equitable and resilient to shocks”; “creating more jobs, especially for youth”; “achieving more than one percentage point reduction in the poverty rate annually” including “placing high priority on the development of human resources and sustainable management, and use of environmental and natural resources”; and “improving institutional capacity and governance... to better serve the people”. There is an emphasis on human and social development with priorities placed on poverty,

equity, education and health. With strengthened focus on monitoring and evaluation, accountability is emphasized at national and subnational levels.

*Sources:* Ministry of Planning. Guidelines for formulating National Strategic Development Plan (NSDP) 2014–2018. Royal Government of Cambodia. Phnom Penh: Cambodia; 2013. National Strategic Development Plan 2014–2018. Royal Government of Cambodia. Phnom Penh: Cambodia; 2014.

**LAO PEOPLE’S DEMOCRATIC REPUBLIC** – The Eighth National Socioeconomic Development Plan of Lao People’s Democratic Republic aims to “enhance the well-being of the people and the prosperity of the country”. It was “designed as a results-oriented plan...with 3 Outcomes, each with a set of Performance Targets.” The three outcomes are, respectively: “sustained, inclusive economic growth with economic vulnerability reduced to level required for LDC (least developed country) graduation and consolidated financial, legal and human resources to support growth”; “human development enhanced to LDC graduation criteria level and achievement of off-track MDGs through the provision and use of services which are balanced geographically and distributed between social groups”; and “reduced effects of natural shocks as required for LDC graduation and sustainable management of natural resource exploitation”. Each outcome has a number of specific outputs required to be achieved, with a total of 20 outputs. These include enhanced food security, access to high-quality education and high-quality health care and enhanced social welfare. An additional three cross-cutting themes (local innovation, gender equality, and enhanced effectiveness of public governance and administration) are also identified.

*Source:* Ministry of Planning and Investment. Five-Year national Socio-Economic Development Plan VIII (2016–2020). Vientiane: Lao People’s Democratic Republic; 2015.

**MALAYSIA** – The theme of the 11th Malaysia Plan is “anchoring growth on people”. Development was “guided by the Malaysian National Development Strategy, which focuses on rapidly delivering high impact on both the capital and people economies... the people economy is concerned with what matters most to the people, which includes jobs, small businesses, the cost of living, family well-being and social inclusion”. It has “six strategic thrusts to help Malaysia stay ahead of the challenge and opportunities of the fast-changing global and political landscape”. These are enhancing inclusiveness towards an equitable society; improving well-being for all; accelerating human capital development for an advanced nation; pursuing green growth for sustainability and resilience; strengthening infrastructure to support economic expansion; and re-engineering economic growth for greater prosperity. The strategic thrust on “enhancing inclusiveness” aims to have balanced geographic growth. The strategic thrust on “well-being for all” aims at having equal access to quality health care and affordable housing. There are also “six game changers, which are innovative approaches to accelerate Malaysia’s development that... will fundamentally change



the trajectory of the country's growth". One of these game-changers is "uplifting B40 (bottom 40%) households towards a middle-class society". "Collectively these improvements will ensure that everyone, regardless of gender, ethnicity, socio-economic status and geographic location, can live in a truly harmonious and progressive society that bears the mark of an advanced economy and inclusive nation".

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*Source:* Economic Planning Unit, Prime Minister's Department. Eleventh Malaysia Plan 2016-2020: Anchoring growth on people. Federal Government of Malaysia. Kuala Lumpur: Malaysia; 2015.

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**PHILIPPINES** – With an overarching aim "in pursuit of inclusive growth", the Philippine Development Plan 2011–2016 recognizes the current inadequacies in the level of human development with a failure of inclusive growth. The plan acknowledges that, in order for inclusive growth to be achieved, there must be a reduction in poverty and increased employment. The Philippine Development Plan 2011–2016 proposes three broad strategies to remedy this, namely high and sustained economic growth, equal access to development opportunities, and effective and responsive social safety nets. Equal access to development opportunities proposes better education, primary health care and nutrition, and other basic social services. The Philippine Development Plan 2011–2016 emphasizes the importance of "good governance and the Rule of Law... social development... peace and security". "Through this plan [they] aim to pursue rapid and sustainable economic growth and development, improve the quality of life of the Filipino, empower the poor and marginalized and enhance [their] social cohesion as a nation... to give the Filipino people a better chance of finally finding their way out of poverty, inequality, and the poor state of human development".

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*Source:* National Economic and Development Authority. Philippine Development Plan 2011-2016: In pursuit of inclusive growth. Philippine Government. Manila: Philippines; 2011.

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**PAPUA NEW GUINEA** – With an overarching goal of "a high quality of life for all Papua New Guineans", the Papua New Guinea National Strategic Plan is guided by the goals of the constitution – "integral human development; equality and participation; national sovereignty and self-reliance; natural resources and environment; and Papua New Guinea ways". It aims to deliver "quality education for all and a world class health system" and "prosperity to rural areas with extension of transport, utilities, education, health and business opportunities" among other things. The plan is implemented through four five-year Medium-term Development Plans and is formulated with a conceptual framework with clear establishment of forward and backward linkages within the economy, of policies and whole-of- government operations. The Medium-term Development Plan aims to build "the foundations for prosperity" and share that prosperity among all Papua New Guineans for "broad based and inclusive growth". It includes a monitoring and evaluation framework with indicators and targets and

*specifically identifies the cross-cutting sectors of youth, gender, HIV/AIDS, vulnerability and disadvantaged groups.*

*Sources:* Department of National Planning and Monitoring. Development Strategic Plan 2010-20130: Our Guide to Success. Government of Papua New Guinea. Port Moresby: Papua New Guinea; 2010. Department of National Planning and Monitoring. Medium Term Development Plan 2011-2015: Building the foundations of prosperity. Government of Papua New Guinea. Port Moresby: Papua New Guinea; 2010.

**SAMOA** – *The Strategy for the Development of Samoa 2012–2016 continues the longer-term goal of “Improved Quality of life for All” with the theme for the strategy being “Boosting Productivity for Sustainable Development”. Fourteen key strategic outcomes are identified under four priority areas. The priority areas are economic sector, social policies, infrastructure sector, and the environment. Under social policies are the outcomes of healthy Samoa, improved focus on access to education, training and learning, and social cohesion. Strategic areas and key performance indicators are identified for each strategic outcome. “The government’s continuing economic goal is to rebuild macro-economic resilience and encourage inclusive growth.” In addition, “a health system...based on health promotion and comprehensive primary health care orients its structures and functions towards the values of equity and social justice, solidarity and the right of every human being to enjoy the highest attainable standard of health, without discrimination.”*

*Source:* Ministry of Finance. Strategy for the Development of Samoa 2012-2016: boosting productivity for sustainable development. Government of Samoa. Apia: Samoa; 2012.

**VIET NAM** – *The Viet Nam Socio-Economic Development Plan has the overall objectives of rapid sustainable economic growth, ensured social welfare and social security with continual improvement in the material and spiritual life of the people, enhanced diplomatic activities, and defence and maintenance of independence, sovereignty, unification, territorial integrity and political security. “Sustainable and effective growth must come along with social progress and equality, natural resource and environment protection, [and] socio-political stability”. Both economic and social indicators and targets are set that emphasize focus on reducing inequalities with prioritization of the most disadvantaged areas and population groups and reducing the rich–poor gap, improving budget allocation, access to and quality of education and health-care services, and social protection mechanisms.*

*Sources:* Ministry of Planning and Investment. Viet Nam Sustainable Development Strategy for 2011-2020. In: Socialist Republic of Viet Nam Government Portal [website]. Hanoi: Viet Nam; 2012 (www.chinhphu.vn). Ministry of Planning and Investment. Socio-Economic Development Plan for the 2011-2015 Period. In: Socialist Republic of Viet Nam Government Portal [website]. Hanoi: Viet Nam; 2011 (www.chinhphu.vn).

## Additional guidance

Countries are likely to have existing governance structures and mechanisms that can support intersectoral action to address health equity. A useful starting point for all countries would be to review these mechanisms, identify key sectors that need to be involved, including stakeholders beyond the government, and identify representative(s) who can exercise influence and help to open doors for targeted initiatives and actions.

Where new governance structures or mechanisms are required, countries may focus on integrating a stronger focus on equity within health and other sectors. As a starting point it can be effective to pursue the most promising and straightforward interventions, the so-called low-hanging fruit, in order to ensure early successes that generate confidence and can then be built upon.

Where countries are working with new partners, a useful first step can be to develop issues-focused pilot projects that help build sustainable partnerships, goodwill and collaboration, with the prospect of bringing joint projects to scale. The greater the specificity in establishing pilot projects, the more conducive they are to monitoring and evaluation, and the more easily they can be achieved and scaled up.

It is essential to engage stakeholders and have a clear framework that is well understood by all involved to help create parity in care and services. Countries that have existing mechanisms for engagement may wish to review the lessons learnt and explore options for accelerating progress.

For all countries, it is essential to put in place approaches that foster the confident participation of affected communities, including disadvantaged population groups. A key entry point is identifying who is “missing” and whose engagement would help to broaden the debate and bring other voices to the table.



## IV. The way forward

### Background

The SDGs place renewed demands on Member States and on WHO in the Western Pacific Region. They also provide a valuable platform for advocacy and action. They challenge for Member States – regardless of income level – and the international community more broadly is to change the ways they think about policy and programme development and to adopt more critical perspectives. The integrated nature of SDGs assumes a move away from programme “silos” to shared and multifaceted action on the underlying factors that shape community health and welfare. Their indivisibility means the SDGs will help to shed light on the circumstances and needs of those in the shadows and on the consequences of social and economic marginalization.

The way forward builds on existing global and regional instruments, action plans and frameworks as well as broader United Nations guidance on the SDGs. For example, the United Nations Development Group’s guidance on implementation lays out a mainstreaming, acceleration and policy support (MAPS) framework (see accompanying box).

The following principles may guide next steps in countries:

- Working to improve the effectiveness of programmes by ensuring they are centred on people and communities rather than driven by the interests of bureaucracies and service providers.
- Ensuring a focus on health equity and on reaching those who bear the heaviest burden of illness and suffering but have the most limited access to the resources and services they need.
- Working across sectors and stakeholders to build consensus and mobilize joint action.
- Identifying priorities and enlisting political support.

The agenda is not prescriptive. It is a starting point rather than a definitive guide. Its purpose is to promote discussion on options to accelerate progress towards the SDGs. Countries will need to select the appropriate mix of actions among the menu of suggested options, based on their own contexts. **Appendix 6** outlines a couple of decision tools that may be useful to Member States in identifying priorities and translating political commitment into action.

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## *Mainstreaming, acceleration and policy support (MAPS) for implementing the 2030 Agenda*

*Mainstreaming, acceleration and policy support, or MAPS, is the approach developed by the United Nations Sustainable Development Working Group to guide coordinated and coherent support by the United Nations System to Member States, through country-level mechanisms such as United Nations country teams. Mainstreaming refers to integration of the 2030 Agenda for Sustainable Development into national, subnational and local development plans and budget allocations. Acceleration refers to targeting resources to areas identified as priorities in the mainstreaming process. Policy support refers to making available in a timely and cost-efficient manner the skills and expertise of the United Nations development system. The elements of partnership, that is development (engaging additional partners, including, for example, parliamentarians, nongovernmental organizations or the media), accountability (strengthening monitoring and review frameworks) and data (strengthening the capacity to collect and analyse information), cut across all three components.*

Source: MAPS: Mainstreaming, Acceleration and Policy Support for the 2030 Agenda. UNDG Concept note. New York: United Nations Development Group; 2016 (<https://undg.org/home/undg-mechanisms/sustainable-development-working-group/country-support/>, last accessed 10 August 2016).

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## **Member States will:**

- Learn from the MDGs and build on existing structures, plans and experiences, while broadening efforts to meet the expanded scope of the SDGs.
- Understand and develop plans to fill gaps at the national level in information, equity, services and capacity.
- Strengthen or set up national accountability mechanisms for regular monitoring and review of progress with a broad range of stakeholders based on selected country-specific indicators and targets.
- Ensure that national health policies, strategies and plans address how health programmes will meet equity goals, especially by focusing on primary health care and disadvantaged groups.
- Understand community expectations and strengthen social and political mobilization and awareness to catalyse action on the SDGs.
- Adopt as necessary a staged approach, starting with health sector capacity, moving on to selective partnerships with other sectors, and building governance mechanisms for institutionalizing collaboration between sectors.
- Pursue regional and international cooperation to share knowledge of successful policies and initiatives that address health and its determinants.
- Encourage development partners to consider pooling, combining and aligning programme efforts for greater efficiency and equity.

### **WHO in the Western Pacific Region will:**

- Continue to support Member States in developing national health policies, strategies and plans and in implementing the SDGs as part of their national planning and policy development.
- Support national capacity-building on SDG and UHC monitoring and evaluation, health information systems and information analysis, and in particular equity analysis, as well as information systems consolidation and linkage.
- Build on existing mechanisms and common agreed indicators, to support the development of a country-led learning platform that reports to the Regional Committee for the Western Pacific on a periodic basis.
- Support planning in countries by convening diverse stakeholders, including government agencies, stakeholders beyond government and development partners.
- Support communication, advocacy, social and political mobilization on the SDGs, including by supporting the establishment of a regional platform to engage with parliamentarians and foster political understanding and action.
- Use WHO country cooperation strategies to identify entry points, priorities and options to achieve the health-related SDGs in all Member States.

## Conclusion

The achievements during the MDG era were significant, but it is widely acknowledged that progress was uneven, many of the poorest and marginalized people were left in the wake of national economic progress, and the focus was often narrow rather than expansive and inclusive. Learning from the successes and failures, the architects of the SDGs sought the views, concerns and aspirations of a much broader global public and a mandate for a more encompassing vision.

The outcome is a detailed, comprehensive and complex blueprint that will challenge all involved in its translation and implementation in different country contexts. Its strengths, however, are its emphasis on collaboration and joint action to solve shared problems, on collective accountability and the public interest, on the eradication of poverty and tackling the determinants of health, and notably on the primacy of reaching those left furthest behind.

The Member States of the WHO Western Pacific Region – developed and developing countries – exemplify a long-standing commitment to the well-being of their citizens. But they also face the challenge of reaching the most disadvantaged and working with these communities and families to transform their life chances. Member States will draw upon and adapt the SDGs in light of their own priorities, profiles, problems and plans, as well as their socioeconomic context and political environment. These guidelines are intended as a map for reference on the journey and a contribution to their endeavours.



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## VI. Glossary

### Acceptability

Acceptability, one of the four elements of the right to health, requires that all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned. It is part of a human rights-based approach to health that provides strategies to reduce the inequalities, discriminatory practices and unjust power relations that often lie at the heart health inequities and ensures that health policies and programmes progressively improve the enjoyment of all people to the right to health.

(Adapted from WHO (2015). Health and human rights. Retrieved from: <http://www.who.int/mediacentre/factsheets/fs323/en>).

### Access barriers

Access barriers are factors that constrain the timely use of needed health services. They cover the dimensions of availability, geographic accessibility, affordability and acceptability. Along these dimensions, barriers to access can stem from factors that weaken people's ability to use the services (demand-side factors), such as distance, costs of transport or lost wages in seeking care, information, sociocultural and gender-related norms, and user's preferences or trust in the services. They can also stem from features of the health system itself that hinder timely use (supply-side factors), such as service location, cost of services, waiting times or provider attitudes. Access barriers are distributed along a social gradient and are faced disproportionately by socially excluded and disadvantaged groups, despite their typically higher need for health services.

(Adapted from Jacobs B, Ir P, Bigdeli M, Annear P and Van Damme W. Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries. *Health Policy and Planning* 2012;27:288–300).

### Best buys

As used in this Regional Action Agenda on Achieving the Sustainable Development Goals in the Western Pacific, best buys refer to those partnerships between sectors for which good evidence is available on the mutual benefits or win–wins.

### Big data

Big data are data sets that are so large and complex that they cannot be analysed using traditional methods or applications. They are analysed computationally and can reveal patterns, trends and associations, especially relating to human behaviour and interactions. Big data offer the potential for predictive analysis and, thereby, better decision-making.

(Adapted from Wikipedia. (n.d.). Big data. Retrieved from: [https://en.wikipedia.org/wiki/Big\\_data](https://en.wikipedia.org/wiki/Big_data)).

### Capacity-building

Capacity-building is the development of knowledge, skills, commitment, structures, institutions, systems and leadership to enable effective and healthy public policies.

(Adapted from WHO. (2015). Health in All policies training manual. Retrieved from: [http://who.int/social\\_determinants/publications/health-policies-manual/en](http://who.int/social_determinants/publications/health-policies-manual/en)).

### Civil society organization

Civil society organizations are non-state, not-for-profit, voluntary organizations formed by people from the community, but excluding political parties and commercial firms. This includes a wide range of organizations, networks, associations, groups and movements independent from government. They sometimes unite to advance common interests through collective action. Some definitions also include certain businesses (e.g. media, private schools, for-profit associations), however by definition, all civil society organizations are not affiliated with government and would be expected to have mandates to benefit society and those in need.

(Adapted from WHO. (n.d.a). Glossary of globalization, trade and health terms. Retrieved from: <http://www.who.int/trade/glossary/en>).

### Co-benefits

See win–wins.

### Community

A community is a specific group of people, often living in a defined geographical area, who share a common culture and are arranged in a social structure according to relationships. Members of a community gain their personal and social identity by sharing common beliefs, values and norms.

(Adapted from WHO, (n.d.). The WHO Health Promotion Glossary. Retrieved from: <http://www.who.int/health-promotion/about/HPG/en>).

### Cultural respect in health care

Cultural respect enables providers to deliver services that respect and respond to the health beliefs, practices, and cultural and linguistic needs of diverse patients. It can potentially increase the responsiveness and acceptability of health services, thereby reducing access barriers that contribute to health inequities.

(Adapted from NIH. (n.d.). Cultural respect. Retrieved from: <https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication/cultural-respect>).

### Disadvantaged groups

Disadvantaged, marginalized and vulnerable groups are groups of people who, due to factors outside their control, do not have the same opportunities as the general population and are at a higher risk of poverty and social exclusion. Depending on the context, these may include unemployed people, refugees, indigenous peoples or those from ethnic minorities, internally displaced people and migrants, the homeless, those struggling with substance abuse, people with mental illness and disabilities, isolated older people and children.

(Adapted from WHO. (n.d.). Health Impact Assessment (HIA), Glossary of terms used. Retrieved from: <http://www.who.int/hia/about/glos/en>).

## Discrimination

Discrimination in health is any negative judgement about a person or group made on the basis of ethnicity, sex, language, religion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status or opinion that limits their access to health care or the underlying social determinants of health. Discrimination can mean poorly targeted health programmes or restricted access to services. Discrimination means that those with equal need are not treated equally. Overcoming discrimination demands objective, reasonable criteria intended to rectify inequities in health.

(Adapted from WHO. (2015). Health and human rights. Retrieved from: <http://www.who.int/mediacentre/factsheets/fs323/en>).

## Disability

Disability is a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives. It is an umbrella term, which includes impairments, activity limitations and barriers to their full and effective participation in society on an equal basis with others. Overcoming the limitations faced by people with disabilities requires interventions to remove these barriers.

(Adapted from WHO. (2011). World report on disability. Retrieved from: [http://www.who.int/disabilities/world\\_report/2011/report/en](http://www.who.int/disabilities/world_report/2011/report/en)).

## eHealth

eHealth is the use of information and communication technologies (ICT) for health. Examples include treating patients, conducting research, educating the health workforce, tracking diseases and monitoring public health.

(WHO. (n.d.). eHealth. Retrieved from: <http://www.who.int/topics/ehealth/en>).

## Equity analysis

Equity analysis refers to quantitative or qualitative analytical techniques that help in measuring, quantifying or understanding health inequities. Analysing health data according to social, demographic, economic or geographical factors can reveal differences among subgroups that overall averages may mask, and thereby help identify vulnerable populations to whom health policies and programmes should be targeted. Health equity analysis provides the evidence base for equity-oriented interventions and is a key component of mainstreaming gender, equity and human rights as well as equity-oriented progress towards universal health coverage.

(Adapted from WHO. (n.d.). Global health observatory: health equity. Retrieved from: [http://www.who.int/gho/health\\_equity/about/en](http://www.who.int/gho/health_equity/about/en)).

## Foresight methodologies

Foresight methodologies are methodologies that contribute to sound, forward-looking decision-making in the face of uncertainty. They are based premise that the future is still in the making and can be actively influenced or even created. Foresight methodologies permit governments to plan for undesirable but possible and probable scenarios, while developing policies that capitalize on the transformational possibilities of preferred futures. Participatory and inclusive foresight methodologies can create spaces for dialogue and negotiation

between a range of stakeholders, perspectives and futures by tapping into the distributed, often tacit, knowledge “in the room”.

(Adapted from UNDP Global Centre for Public Service Excellence. (2014)). Foresight: the manual. Retrieved from: <http://www.undp.org/content/undp/en/home/librarypage/capacity-building/global-centre-for-public-service-excellence/foresightmanual.html>).

### **Governance**

Governance is the exercise of economic, political and administrative authority to manage a country’s affairs at all levels. It comprises the mechanisms, processes and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences. Good governance characteristics and principles include: consensus-orientation, participation, rule of law, effectiveness and efficiency, accountability, transparency, responsiveness, equity and inclusiveness.

(Adapted from UNESCAP. (n.d.). What is good governance? Retrieved from: <http://www.unescap.org/sites/default/files/good-governance.pdf>).

### **Green**

A product or service that is not harmful to the environment or that has positive environmental attributes or objectives.

### **Health diplomacy**

Health diplomacy brings together the disciplines of public health, international affairs, management, law and economics, and focuses on negotiations that shape and manage the policy environment for health. The relationship between health, foreign policy and trade is at the cutting edge of global health diplomacy.

(Adapted from WHO. (n.d.). Global health diplomacy. Retrieved from: <http://www.who.int/trade/diplomacy/en>).

### **Health equity**

Health equity is the absence of avoidable or remediable differences in health among groups of people, whether defined socially, economically, demographically, or geographically. Equity differs from equality, which pertains to ensuring that everyone has equal access to opportunities. Equity, on the other hand, is about ensuring fair outcomes, often through proactive measures like affirmative action in favour of those who are disadvantaged.

(Adapted from WHO. (n.d.). Equity. Retrieved from: <http://www.who.int/healthsystems/topics/equity/en>).

### **Health equity impact assessment**

Health equity impact assessment is a tool to help decision-makers systematically assess the potential impact of policies, programmes, projects, or proposals on health equity in a given population with the aim of maximizing the positive health equity benefits and minimizing the potential adverse effects on health equity (Measurement and Evidence Knowledge Network of the WHO Commission on Social Determinants of Health, WHO, 2007). The WHO Commission on Social Determinants of Health noted that equity is not typically integrated into health impact assessments and recommended that health equity impact assessments be institutionalized and capacity built among health policy-makers and planners to use them systematically.

(Adapted from WHO. (2008). Closing the gaps. Final report of the WHO Commission on Social Determinants of Health. Retrieved from: [http://www.who.int/social\\_determinants/thecommission/finalreport/en](http://www.who.int/social_determinants/thecommission/finalreport/en)).

### **Health impact assessment**

Health impact assessment (HIA) is a means of assessing the health impacts of policies, plans and projects in diverse economic sectors using quantitative, qualitative and participatory techniques. HIA helps decision-makers make choices about alternatives and improvements to prevent disease/injury and to actively promote health.

(Adapted from WHO. (n.d.). Health impact assessment. Retrieved from: <http://www.who.int/hia/en>).

### **Health information system**

A system providing information support to decision-making at all levels of the health system. It incorporates information generated by both population- and institution-based data sources, as well as data collection, processing, reporting, and use of the information.

(Adapted from: WHO Regional Office for the Western Pacific. (2004). Developing Health Management Information Systems a practical guide for developing countries. Retrieved from: [http://apps.who.int/iris/bitstream/10665/207050/1/9290611650\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/207050/1/9290611650_eng.pdf?ua=1). Health Metrics Network.(2009). Guidance for the Health Information Systems (HIS) Strategic Planning Process. Retrieved from: <https://www.k4health.org/toolkits/hrh/guidance-health-information-systems-his-strategic-planning-process>).

### **Health information system plan**

A plan or strategy which outlines the overall set of strategic interventions defined for addressing the problems affecting all the priority health information system components along with the implementation activities and necessary resources required.

(Adapted from: Health Metrics Network. (2009). Guidance for the Health Information Systems (HIS) Strategic Planning Process. Retrieved from: <https://www.k4health.org/toolkits/hrh/guidance-health-information-systems-his-strategic-planning-process>).

### **Health literacy**

Health literacy refers to the skills, confidence, motivation and ability of individuals to gain access to, understand and use information in ways that promote and maintain good health. Health literacy improves access to health information and the capacity to use it effectively to improve their own, their families' and their community's health.

(Adapted from: WHO. (1998). The WHO Health Promotion Glossary. Retrieved from: <http://www.who.int/health-promotion/about/HPG/en>).

### **Health promotion**

Health promotion includes strengthening the skills and capabilities of individuals (enabling people to increase control over and improve their health), and action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health.

(Adapted from: WHO. (1998). The WHO Health Promotion Glossary. Retrieved from: <http://www.who.int/health-promotion/about/HPG/en>).

### **Health sector**

A wide variety of actors and organizations that is held politically and administratively accountable for the health of the population at various levels.

(Adapted from WHO. (2015). Health in All policies training manual. Retrieved from: [http://who.int/social\\_determinants/publications/health-policies-manual/en](http://who.int/social_determinants/publications/health-policies-manual/en)).

### Health service

Health services are any services (i.e. not limited to medical or clinical services) that contribute to improved health or to the diagnosis, treatment and rehabilitation of sick people.

(Adapted from WHO. (n.d.). Health systems: Health Systems Strengthening Glossary. Retrieved from: [http://www.who.int/healthsystems/hss\\_glossary/en](http://www.who.int/healthsystems/hss_glossary/en)).

### Health system

Health systems encompass: (i) All the activities whose primary purpose is to promote, restore and/or maintain health; and (ii) the people, institutions and resources and policies intended to improve the health of the population and protect people from the cost and burden of ill health through activities planned and provided to improve health.

(Adapted from WHO. (n.d.). Health systems: Health Systems Strengthening Glossary. Retrieved from: [http://www.who.int/healthsystems/hss\\_glossary/en](http://www.who.int/healthsystems/hss_glossary/en)).

### Health workforce

Health workers are “all people engaged in actions whose primary intent is to enhance health”.

(Adapted from WHO. (2006). World Health Report. Working together for health. Retrieved from: <http://www.who.int/whr/2006/en>).

### Intersectoral action

Intersectoral action refers to the coordinated efforts of two or more government sectors, including across different levels of governance (national and subnational). Whole-of-government, health in all policies (HiAP) and healthy public policies are similar terms used in the literature.

(Adapted from WHO. (2015). Health in All policies training manual. Retrieved from: [http://who.int/social\\_determinants/publications/health-policies-manual/en](http://who.int/social_determinants/publications/health-policies-manual/en)).

### Knowledge brokers

Knowledge brokers are intermediaries (organizations or people) that facilitate knowledge exchange between and among stakeholders, including researchers, practitioners and policy-makers by developing relationships and networks with, among and between producers and users of knowledge and by providing links, knowledge sources and knowledge itself, (e.g. technical know-how, market insights, research evidence) to them.

(Adapted from Wikipedia. (n.d.). Knowledge brokers. Retrieved from: [https://en.wikipedia.org/wiki/Knowledge\\_broker](https://en.wikipedia.org/wiki/Knowledge_broker)).

### Knowledge translation

Knowledge translation encompasses the processes to convert scientific knowledge to socially beneficial actions, often through behaviour change of stakeholders and actions of decision- and policy-makers. Its scope includes knowledge dissemination, communication, technology transfer, ethical context, knowledge management, knowledge utilization, two-way exchange between researchers and those who apply knowledge, implementation research, technology assessment, synthesis of results within a global context, development of consensus guidelines and more.

(Adapted from WHO. (n.d.). EVIPNet Country Knowledge Translation Platforms. Retrieved from: [http://www.who.int/evidence/resources/country\\_reports/KTP/en](http://www.who.int/evidence/resources/country_reports/KTP/en)).



## **mHealth**

mHealth, a component of eHealth, is medical and public health practice supported by mobile devices, such as mobile phones, patient-monitoring devices, personal digital assistants and other wireless devices, involving the use of a mobile phone's capabilities for voice and short messaging service (SMS), general packet radio service (GPRS), third- and fourth-generation mobile telecommunications (3G and 4G systems), global positioning system (GPS), and Bluetooth technology.

(Adapted from WHO. (2011). mHealth: New horizons for health through mobile technologies: second global survey on eHealth. Retrieved from: <http://apps.who.int/iris/handle/10665/44607>).

## **Multisectoral/ intersectoral/ whole-of-government approach**

A whole-of-government or multisectoral approach refers to the coordinated efforts between two or more government sectors. This can include such partnerships as information-sharing arrangements or joint programmes. Such coordination and integration is often centred on overarching societal goals rather than the specific objectives of one sector.

(Adapted from WHO. (2015). Health in All policies training manual. Retrieved from: [http://who.int/social\\_determinants/publications/health-policies-manual/en](http://who.int/social_determinants/publications/health-policies-manual/en)).

## **Multistakeholder/ whole-of-society approach**

A whole-of-society or multistakeholder approach refers to coordinated efforts by multiple stakeholders within and outside of government (including the private sector, civil society or communities).

(Adapted from WHO. (2015). Health in All policies training manual. Retrieved from: [http://who.int/social\\_determinants/publications/health-policies-manual/en](http://who.int/social_determinants/publications/health-policies-manual/en)).

## **Nongovernmental organizations**

Nongovernmental organizations are organizations not affiliated with government. The term is used to describe non-profit making, non-violent organizations that seek to influence the policy of governments and international organizations and/or to complement government services (such as health and education). They usually have a formal structure, offer services to people other than their members, and are, in most cases, registered with national authorities. Nongovernmental organizations vary greatly in their size, scope of activity and goals. They may operate nationally, or internationally, or they may be small community-based organizations (CBOs) that aim to mobilize, organize or empower their members and others, usually in a local area.

(Adapted from WHO. (2004). A glossary of terms for community health care and services for older persons. Retrieved from: [http://www.who.int/kobe\\_centre/ageing/ahp\\_vol5\\_glossary.pdf](http://www.who.int/kobe_centre/ageing/ahp_vol5_glossary.pdf)).

## **Participation**

All people and groups are entitled to active, free and meaningful participation in, contribution to, and enjoyment of civil, economic, social, cultural and political development in which human rights and fundamental freedoms can be realized (UNDG, 2002). Human rights law recognizes the participation of the population in all health-related decision-making at the community, national and international levels (CESCR, 2000). Participation is one of the human rights principles that needs to be considered when applying a human rights-based approach

to health. Adequate and sustainable financial and technical support, including investment in empowerment of rights-holders, is essential to enable meaningful participation.

(Adapted from UN Committee on Economic, Social and Cultural Rights. (2000). General Comment 14 on the right to the highest attainable standard of health. Retrieved from: [www.refworld.org/pdfid/4538838do.pdf](http://www.refworld.org/pdfid/4538838do.pdf). UNDG. (2002). UN Statement of Common Understanding on Human Rights-Based Approaches to Development Cooperation and Programming. Retrieved from: <http://hrbportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies>).

### People-centred care

Care that is focused and organized around the health needs and expectations of people and communities rather than on diseases. Whereas patient-centred care is understood as focusing on the individual seeking care (the patient), people-centred care encompasses these clinical encounters and also includes attention to the health of people in their communities and their crucial role in shaping health policy and health services.

(Adapted from WHO. (n.d.). Health systems: Health Systems Strengthening Glossary. Retrieved from: [http://www.who.int/healthsystems/hss\\_glossary/en](http://www.who.int/healthsystems/hss_glossary/en)).

### Primary care

Primary care is the first level of care generally encountered by individuals. This is through a health-care provider or practitioner such as primary care physicians, general practitioners or practice nurses.

(Adapted from WHO. (n.d.). Health systems: Health Systems Strengthening Glossary. Retrieved from: [http://www.who.int/healthsystems/hss\\_glossary/en](http://www.who.int/healthsystems/hss_glossary/en)).

### Social determinants of health

Social determinants of health refer to the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

(Adapted from WHO. (2008). Closing the gaps. Final report of the WHO Commission on social determinants. Retrieved from: [http://www.who.int/social\\_determinants/thecommission/finalreport/en](http://www.who.int/social_determinants/thecommission/finalreport/en)).

### Social equity

Social equity is a commitment to promote fairness, justice and equity in the formation and implementation of public policy. This includes the fair, just and equitable distribution of essential social services such as social protection, education, subsidized housing and food, and health care.

(Adapted from Melbourne Social Equity Institute. (n.d.). What is social equity [website]. Retrieved from: <http://www.socialequity.unimelb.edu.au/what-is-social-equity>).

### Social equity

Social equity is a commitment to promote fairness, justice and equity in the formation and implementation of public policy. This includes the fair, just and equitable distribution of essential social services such as social protection, education, subsidized housing and food, and health care.

(Adapted from Melbourne Social Equity Institute. (n.d.). What is social equity [website]. Retrieved from: <http://www.socialequity.unimelb.edu.au/what-is-social-equity>).

### **Stakeholders beyond government**

As used in this action agenda, the term encompasses a broad scope of different actors, organizations and partners, such as nonstate, nongovernment and civil society actors, professional and faith-based organizations, politicians and parliamentarians, academic and research organizations, foundations and businesses. A stakeholder is a person or group who has an interest or concern in a process of issue.

(Adapted from WHO. (2015). Health in All policies training manual. Retrieved from: [http://who.int/social\\_determinants/publications/health-policies-manual/en](http://who.int/social_determinants/publications/health-policies-manual/en)).

### **Sustainable development**

Development that meets the needs and aspirations of the present without compromising the ability of future generations to meet their own needs.

(Adapted from World Commission on Environment and Development. (1987). Our Common future. Appendix to document A/42/427 on Development and International Co-operation: Environment. Retrieved from <http://www.un-documents.net/wced-ocf.htm>).

### **Universal health coverage**

Universal health coverage means that all people and communities receive the health services they need. This includes health promotion, treatment, rehabilitation and palliation of sufficient quality to be effective while at the same time ensuring such care does not cause financial hardship.

(Adapted from WHO Regional Office for the Western Pacific. (2016). Universal Health Coverage: Moving towards better health. Action framework for the Western Pacific. Retrieved from: [https://iris.wpro.who.int/%2Fbitstream/%2Fhandle/%2F10665.1/%2F13371/%2F9789290617563\\_eng.pdf%3Fsequence%3D1&usg=AFQjCNElj7cjabX\\_Sdifohng4F8FYnZ6Ew&cad=rja](https://iris.wpro.who.int/%2Fbitstream/%2Fhandle/%2F10665.1/%2F13371/%2F9789290617563_eng.pdf%3Fsequence%3D1&usg=AFQjCNElj7cjabX_Sdifohng4F8FYnZ6Ew&cad=rja)).

### **Whole-of-government approach**

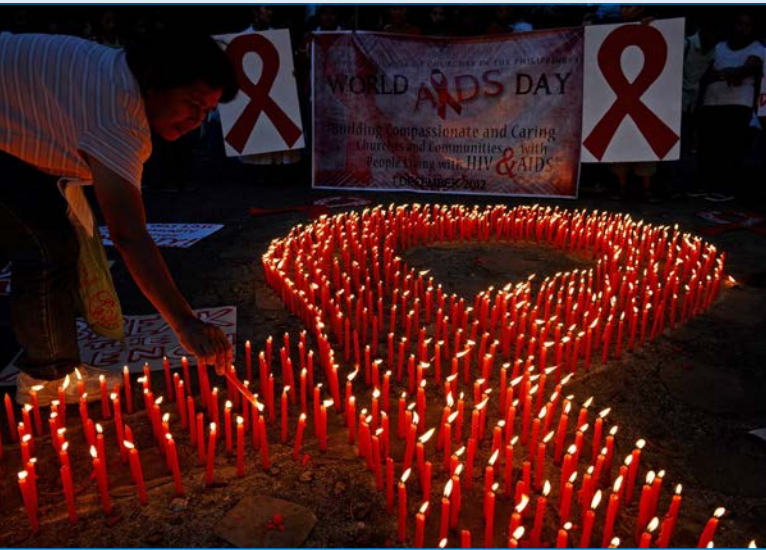
See multistakeholder approach.

### **Whole-of-society approach**

See multisectoral approach.

### **Win–wins**

Win–wins are co-benefits, i.e. mutual benefits shared by all engaged parties and stakeholders benefit. For example, the action agenda outlines a number of issues where collaboration between the health sector and the partner sectors (e.g. education, environment) results in benefits for both sectors.






















## VII. Appendices

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## Appendix 1

### List of Sustainable Development Goals (SDGs)

	<b>Goal 1</b>	End poverty in all its forms everywhere.
	<b>Goal 2</b>	End hunger, achieve food security and improved nutrition and promote sustainable agriculture.
	<b>Goal 3</b>	Ensure healthy lives and promote well-being for all at all ages.
	<b>Goal 4</b>	Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.
	<b>Goal 5</b>	Achieve gender equality and empower all women and girls.
	<b>Goal 6</b>	Ensure availability and sustainable management of water and sanitation for all.
	<b>Goal 7</b>	Ensure access to affordable, reliable, sustainable and modern energy for all.
	<b>Goal 8</b>	Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.
	<b>Goal 9</b>	Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation.
	<b>Goal 10</b>	Reduce inequality within and among countries.
	<b>Goal 11</b>	Make cities and human settlements inclusive, safe, resilient and sustainable.
	<b>Goal 12</b>	Ensure sustainable consumption and production patterns.
	<b>Goal 13</b>	Take urgent action to combat climate change and its impacts.
	<b>Goal 14</b>	Conserve and sustainably use the oceans, seas and marine resources for sustainable development.
	<b>Goal 15</b>	Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss.
	<b>Goal 16</b>	Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.
	<b>Goal 17</b>	Strengthen the means of implementation and revitalize the global partnership for sustainable development.

Source:

Sustainable Development Goals. In: Sustainable Development Goals knowledge platform [website]. New York: United Nations; 2016 (<https://sustainabledevelopment.un.org/sdgs>, accessed 12 August 2016).

## Appendix 2

# Universal Health Coverage: Moving Towards Better Health

In October 2015, the 66th session of the World Health Organization Regional Committee for the Western Pacific adopted resolution WPR/RC66.R2 endorsing the Western Pacific regional action framework on *Universal Health Coverage: Moving Towards Better Health*.

The resolution recognizes universal health coverage (UHC) as a critical foundation for the achievement of the Sustainable Development Goals (SDGs) and for realizing good health outcomes for everyone. It urges Member States to: (1) use the action framework to develop country-specific road maps as part of the national policy and planning process tailored to their contexts; (2) exercise government leadership in multisectoral approaches and commit sufficient funding to implement national policies and plans to advance UHC; and (3) establish mechanisms to monitor the progress of UHC and evaluate the impact of associated policies.

### Attributes and action domains to move towards UHC

The framework encompasses five health system attributes for UHC (quality, efficiency, equity, accountability, and sustainability and resilience, as well as 15 action domains). The suggested actions provide a framework for countries to customize their approach to UHC.

HEALTH SYSTEM ATTRIBUTES	ACTION DOMAINS FOR UHC
<b>1. QUALITY</b>	<ul style="list-style-type: none"> <li>1.1 Regulations and regulatory environment</li> <li>1.2 Effective, responsive individual and population-based services</li> <li>1.3 Individual, family and community engagement</li> </ul>
<b>2. EFFICIENCY</b>	<ul style="list-style-type: none"> <li>2.1 Health system architecture to meet population needs</li> <li>2.2 Incentives for appropriate provision and use of services</li> <li>2.3 Managerial efficiency and effectiveness</li> </ul>
<b>3. EQUITY</b>	<ul style="list-style-type: none"> <li>3.1 Financial protection</li> <li>3.2 Service coverage and access</li> <li>3.3 Nondiscrimination</li> </ul>
<b>4. ACCOUNTABILITY</b>	<ul style="list-style-type: none"> <li>4.1 Government leadership and rule of law for health</li> <li>4.2 Partnerships for public policy</li> <li>4.3 Transparent monitoring and evaluation (M&amp;E)</li> </ul>
<b>5. SUSTAINABILITY AND RESILIENCE</b>	<ul style="list-style-type: none"> <li>5.1 Public health preparedness</li> <li>5.2 Community capacity</li> <li>5.3 Health system adaptability and sustainability</li> </ul>

Source:

Universal Health Coverage: Moving Towards Better Health. Action Framework for the Western Pacific Region. Manila: WHO Regional Office for the Western Pacific; 2016.

## Appendix 3

### Framework for monitoring SDGs and UHC in the Western Pacific Region

The WHO Regional Office for the Western Pacific has prepared this Framework for monitoring SDGs and UHC in the Western Pacific Region (monitoring framework) as a guide for countries in their efforts to collect, analyse and validate data that support their own monitoring and review of progress towards the SDGs and universal health coverage (UHC) as they relate to health over the next 15 years.

The SDG agenda broadens the MDG health agenda to include potentially a range of issues such as: noncommunicable diseases (NCDs), mental health and substance abuse, UHC and access to quality health care, hazardous chemicals and pollution, global health security, the health workforce, access to health commodities, research and development, and health financing. UHC is not only a key component of SDGs, but it also serves as a common platform for all health targets. There is also an explicit focus on equity and serving the hardest-to-reach populations to ensure that no person is “left behind”.

The monitoring framework and indicators build on the United Nation’s identified SDG goals and targets<sup>5</sup> and the Western Pacific Region framework, *Universal Health Coverage: Moving Towards Better Health*,<sup>6</sup> adopted by Member States in October 2015.

Guidance on metadata, including definitions, disaggregation and measurement, and analysis and reporting will be detailed in a subsequent technical document.

#### Purpose of regional monitoring

At the regional level, the purpose of a monitoring framework and common indicators is two-fold: firstly, it allows monitoring of progress against health and health-related targets in a region; and secondly, it provides an opportunity for within- and across-country comparisons of trends, successes, challenges and opportunities, and such comparisons between population groups using equity- and gender-based metrics.

Countries are expected to select country-specific goals, targets and indicators guided by their national health policies, priorities, strategies and capacity for implementing their national monitoring framework.

Enhanced coordination between health and other sectors will be required to monitor cross-cutting health and health-related issues. Data on the determinants of health must be captured alongside traditional health information system data, for example longitudinal measurement of behaviour changes, such as handwashing, exercise and safe sexual practices. Both new and existing national statistical systems will require strengthening to increase the capacity to not only collect, process, analyse and use data within and beyond the health sector, but support equity-focused monitoring and analysis. Core to monitoring SDG and UHC progress will be the ability to make improvements or changes to strategies as data are generated and lessons are learnt.

5. For more information, please see: UN Statistical Commission. Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators. E/CN.3/2016/2/Rev.1. New York: United Nations Economic and Social Council; 2016 (<http://unstats.un.org/unsd/statcom/47th-session/documents/2016-2-SDGs-Rev1-E.pdf>, last accessed 1 August 2016).

6. Universal Health Coverage: Moving Towards Better Health. Action Framework for the Western Pacific Region. Manila: WHO Regional Office for the Western Pacific; 2016.



## Framework development

The WHO Regional Office for the Western Pacific developed a monitoring framework to reflect the breadth of the SDG agenda, one that sees health not only as ensuring health lives and promoting well-being for all at all ages, but one in which health and its determinants influence, and are influenced by, other goals and targets.

The monitoring framework is based on the conceptual framework in **Figure 3.1**. The conceptual framework identifies four tiers: health impact through the life course, determinants of health, UHC, and health system resources and capacity. Together, these four tiers reflect that individual and population health needs over the life-course are influenced by the determinants of health (socioeconomic, environmental, behavioural), UHC (financial protection, service coverage and accessibility), and health system resources and capacity (quality and safety, resources and infrastructure, responsiveness and people-centeredness). Equity is considered to be integral to each of the four tiers. UHC acts as a unifying platform, without it, health gains will not be sustained and the SDGs cannot be achieved.

## Indicators for monitoring SDGs and UHC in the Western Pacific Region

Based on the defined monitoring framework, a set of indicators was carefully identified from the SDG indicators, existing global collections for health indicators<sup>7</sup> and other indicators collected by various programmes. Consideration was also given to the *Healthy Islands monitoring framework*, a subregional framework approved by health ministers of Pacific island countries. Existing data were leveraged to minimize the reporting burden.

This indicator set will be used for monitoring progress of SDGs and UHC through country comparisons across the Region. Countries are encouraged to collect, compile, use and share related information for better policy development and information exchange between countries and the region.

The monitoring framework is comprised of 26 indicators under SDG Goal 3 and 17 indicators from other SDGs (**Table 3.1**). In addition to the two composite indicators monitoring UHC under SDG 3, 42 additional indicators have been identified to track the progress of UHC and the health system over time and across the spectrum – from health inputs, processes, outputs and outcomes.

The indicators are essential to ensure development goals are met across various population groups. The ability to make improvements as data is generated and lessons are learnt will be key to monitoring of SDG and UHC delivery at multiple levels (national, subnational and local), both for learning and evidence-based decision-making.

## Availability of indicators for monitoring SDGs and UHC

Based on a review of current data collections, the availability of indicators and the frequency of collections were analysed (**Table 3.2**).

**Fifty regularly collected:** these indicators can be collected via routine administrative systems and programme collections on an annual basis, biennial basis or through regular survey collection, such as census or special household surveys, and as such, would only be updated every three to five years, depending on survey cycles.

7. These indicators are drawn from: WHO Global Reference List of 100 Core health indicators. Geneva: World Health Organization; 2015 ([http://apps.who.int/iris/bitstream/10665/173589/1/WHO\\_HIS\\_HSI\\_2015.3\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/173589/1/WHO_HIS_HSI_2015.3_eng.pdf) accessed 27 July 2016) and Universal health coverage: moving towards better health. Regional action framework. Manila: WHO Regional Office for the Western Pacific; 2016.

**Thirty-two irregularly collected:** these indicators are currently collected intermittently or through specific-purpose survey collections, observatory data, the criminal justice system, and/or public health and civil registration. These indicators require a systematic strategy for data collection. A few of these also require methodological work to ensure comparability.

**Three not collected:** these indicators are part of the new SDG agenda and have not previously been collected. The methodology and indicator construct are still being developed.

## Data collection for monitoring SDGs and UHC

The majority of the indicators have been generated from various data sources, such as facility data, administrative data and survey data. During the SDG era, information gaps and challenges to fulfil the indicator requirements and level of disaggregation will need to be addressed. A whole-of-systems approach, broader engagement with stakeholders from various sectors, strengthened civil registration and vital statistics (CRVS) systems, and new methodologies and innovative approaches are required.

Of the 43 identified SDG indicators, 15 are collected and reported by other United Nations agencies, such as UNICEF, IGME, UNAIDS, the United Nations Office on Drugs and Crime, OECD, UN-WOMEN and UNFPA. These indicators include: number of deaths, missing people and people affected by disasters, proportion of ever-partnered women and girls subjected to violence by intimate partner, number of countries with laws and regulations that guarantee women access to sexual and reproductive health care, etc.

Of the 42 identified UHC indicators, all are collected and reported by WHO, 30 are collected by health intervention programmes, such as HIV, TB, malaria, etc., while 12 are from nonprogramme collections, such as administrative data, estimates and/or modelling, as well as CRVS data, including life expectancy at birth, total current expenditure on health as percentage of GDP, bed occupancy rate, stillbirth rate, coverage of services for severe mental health disorders, death registration coverage, health facilities with functioning water services, health facilities with functioning sanitation services, and average length of stay.

Efforts need to be made to compile indicators that are collected by various United Nations agencies and programme collections based on the monitoring framework. Special arrangements based on the existing collection mechanism will be introduced to address the remaining indicators for which there is no routine collection mechanism.

## Disaggregation

The SDGs emphasize equity-focused programmes and, therefore, monitoring efforts should support and the collection, analysis and use of disaggregated data to target those at risk of being left behind. Progress on SDGs should not only be monitored at the aggregate level, but also at the subnational and local levels and for various population groups, disaggregated, where relevant, by income, sex, age, race, ethnicity, migratory status, disability and geographic location, or other characteristics.

It is recognized that the identified stratifiers cannot be universally applied to all data collections and the identification of stratification variables can pose major analytical and operational challenges. A number of these variables are not currently captured in administrative collections. Household surveys are the best source for the identified stratifiers. Health facility and administrative data are useful to identify geographic differences, district and subdistrict.

WHO will prioritize indicators that can be disaggregated to the greatest extent possible, including those from internationally compiled household surveys. These surveys will also need to bolster the collection of data relating to disability and ethnicity, and will improve the quality and comparability of spatially disaggregated data, and can be a good starting point while work is undertaken to strengthen statistical systems and refine additional or alternative indicators for the future.

Further guidance on disaggregation for each indicator and equity-based analyses will be outlined in a subsequent technical document.

## **Collection and monitoring**

The WHO Regional Office for the Western Pacific will work with countries to proactively collect existing data from countries, which is published data from various sources such as websites, annual reports and programme reports. The collected data will be cleaned, validated and provided to countries for review and clearance. Where there are data gaps, countries will have the opportunity to address these.

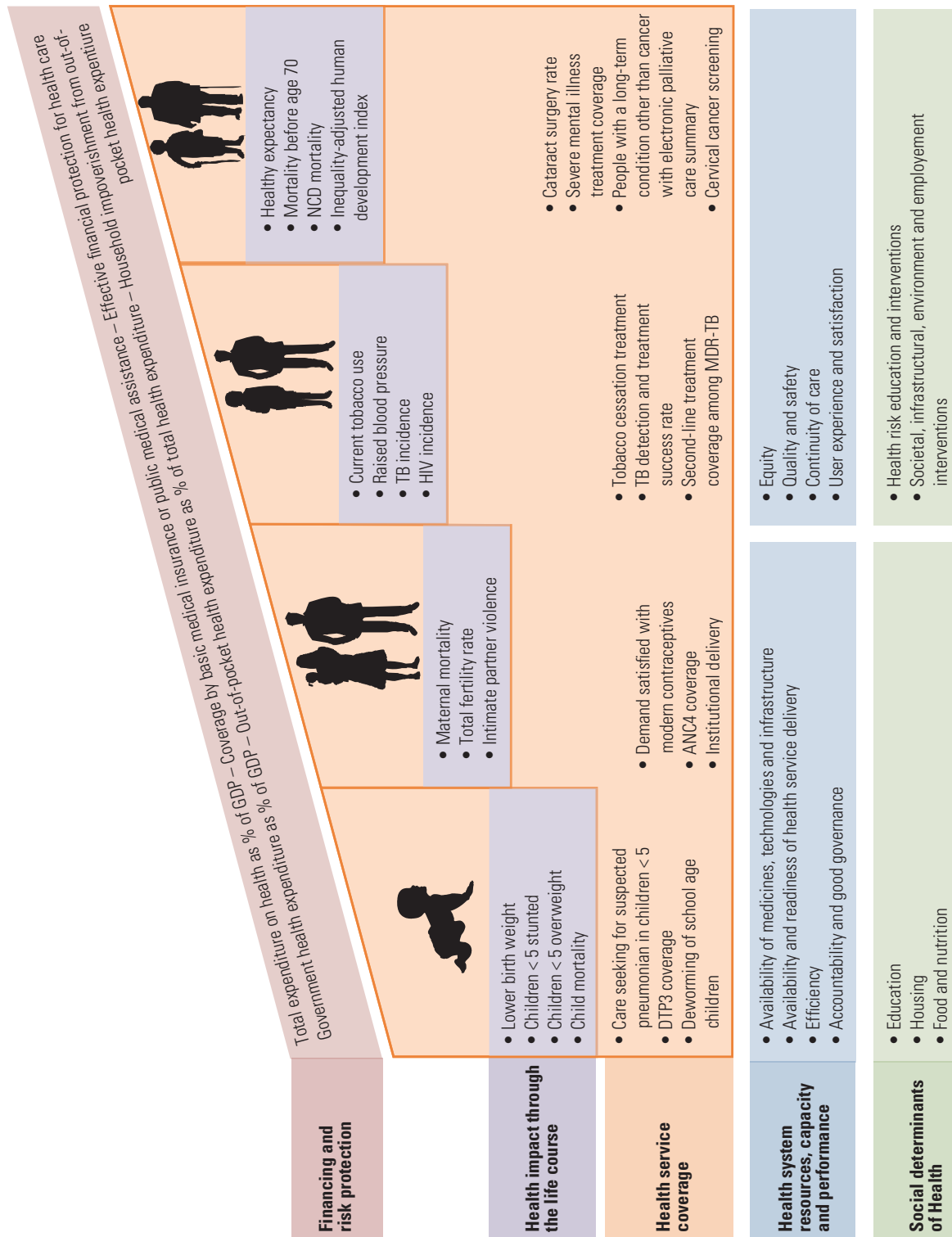
The collected data will be analysed based on the monitoring framework and published to support the development of a country-led learning platform that reports to the WHO Regional Committee for the Western Pacific on a periodic basis. Additionally this data will be used to initiate discussions on priority health issues within the Region. Based on data availability and identified priorities across the Region, a subset of SDG indicators could be monitored and reported on more frequently.

A regional SDG progress report will be conducted by the Regional Office every two years and a regional thematic in-depth report every five years, taking into account linkages between health and related benefits. These will be based on the baseline data and country progress reviews.

Countries are encouraged to use this monitoring framework and indicators as a reference to undertake their own regular monitoring and review. SDG progress should be reviewed at the national, subnational and local levels to inform evidence-based policies and programmes.

The WHO Regional Office of the Western Pacific will work with countries to prepare detailed metadata, identify tracer indicators and operational arrangements to support the collection and monitoring of the indicators. Additionally, support will be provided to countries to improve the quality and timeliness of data and information, engagement with national statistical offices, and encourage country investments to improve data availability and address future data needs.

**FIGURE 3.1** Conceptual Framework for monitoring SDGs and UHC in the Western Pacific Region



Note: this figure does not include all abbreviated indicators from Table 4.1, it includes some determinant factors from outside the proposed WHO collections (marked with \*) to illustrate the breadth of the monitoring framework, e.g. part of targets in goals on poverty, education, climate change, cities, etc.

**TABLE 3.1** WHO Western Pacific Region SDG and UHC indicators

<b>TARGET</b>	<b>SDG 3 Indicators (Ensure healthy lives and promote well-being for all at all ages)</b>
3.1.1	Maternal mortality ratio
3.1.2	Proportion of births attended by skilled health personnel
3.2.1	Under-5 mortality rate (deaths per 1000 live births)
3.2.2	Neonatal mortality rate (deaths per 1000 live births)
3.3.1	Number of new HIV infections per 1000 uninfected population, by sex, age and key populations
3.3.2	Tuberculosis incidence per 1000 population
3.3.3	Malaria incidence per 1000 population at risk
3.3.4	Hepatitis B incidence per 100 000 population
3.3.5	Number of people requiring interventions (preventive chemotherapy) against neglected tropical diseases
3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease
3.4.2	Suicide mortality rate
3.5.1	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
3.5.2	Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
3.6.1	Death rate due to road traffic injuries
3.7.1	Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods
3.7.2	Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group
3.8.1	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious disease, noncommunicable diseases and service capacity and access, among the general and the most disadvantaged population)
3.8.2	Fraction of the population protected against catastrophic/impoverishing out-of-pocket health expenditure
3.9.1	Mortality rate attributed to household and ambient air pollution
3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)
3.9.3	Mortality rate attributed to unintentional poisoning
3.a.1	Age-standardized prevalence of current tobacco use among persons aged 15 years and older
3.b.1	Proportion of population with access to affordable medicines and vaccines on a sustainable basis
3.b.2	Total net official development assistance to the medical research and basic health sectors
3.c.1	Health worker density and distribution
3.d.1	International Health Regulations (IHR) capacity and health emergency preparedness

**TABLE 3.1** WHO Western Pacific Region SDG and UHC indicators (*continued*)

<b>TARGET</b>	<b>Selected health-related SDG Indicators</b>
<b>1.3.1</b>	Percentage of the population covered by social protection floors/systems disaggregated by sex, and distinguishing children, unemployed, old-age persons, persons with disabilities, pregnant women/newborns, work injury victims, the poor and the vulnerable
<b>1.5.1</b> <b>11.5.1</b> <b>13.1.2</b>	Number of deaths, missing persons and persons affected by disaster per 100 000 people
<b>2.2.1</b>	Prevalence of stunting (height for age <-2 SD from the median of the WHO Child Growth Standards) among children under 5 years of age
<b>2.2.2</b>	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5, disaggregated by type (wasting and overweight)
<b>5.2.1</b>	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner, in the last 12 months, by form of violence and by age group
<b>5.2.2</b>	Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner, in the last 12 months, by age group and place of occurrence
<b>5.6.2</b>	Number of countries with laws and regulations that guarantee women aged 15–49 access to sexual and reproductive health care, information and education
<b>6.1.1</b>	Percentage of population using safely managed drinking water services
<b>6.2.1</b>	Percentage of population using safely managed sanitation services, including a handwashing facility with soap and water
<b>11.6.2</b>	Annual mean levels of fine particulate matter (i.e. PM2.5 and PM10) in cities (population weighted)
<b>16.1.1</b>	Number of victims of intentional homicide per 100 000 by age and sex
<b>16.1.2</b>	Conflict-related deaths per 100 000 population (disaggregated by age group, sex and cause)
<b>16.1.3</b>	Percentage of the population subjected to physical, psychological or sexual violence within the past 12 months
<b>16.2.1</b>	Percentage of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month.
<b>16.2.2</b>	Number of victims of human trafficking per 100 000 population, by sex, age group and form of exploitation
<b>16.2.3</b>	Percentage of young women and men aged 18–24 years who experienced sexual violence by age 18
<b>16.9.1</b>	Percentage of children under 5 whose births have been registered with civil authority, disaggregated by age

**TABLE 3.1** WHO Western Pacific Region SDG and UHC indicators (*continued*)

TARGET	UHC Indicators
	Life expectancy at birth
	Total current expenditure on health as percentage of gross domestic product
	Seat-belt wearing rate
	Helmet wearing rate
	Bed occupancy rate
	Caesarean section rate
	Immunization coverage rate for diphtheria-tetanus-pertussis (DTP3)
	Immunization coverage rate for measles
	Stillbirth rate (per 1000 total births)
	Case rate of congenital syphilis (per 100 000 population)
	Exclusive breastfeeding rate in infants 0–5 months of age
	Incidence of low-birth weight among newborns
	Prevalence of anaemia in children aged 6–59 months
	Anaemia prevalence in women of reproductive age
	Age-standardized prevalence of overweight and obesity in persons aged 18+ years
	Age-standardized prevalence of raised blood pressure among persons aged 18+ years
	Age-standardized prevalence of insufficiently physically active persons aged 18+ years
	Percentage of children under 5 years of age with suspected pneumonia taken to a health facility
	Antiretroviral therapy (ART) coverage (%)
	Second-line treatment coverage among multidrug-resistant tuberculosis (MDR-TB) cases
	Cervical cancer screening
	Coverage of services for severe mental health disorders
	Death registration coverage
	Current expenditure on health by general government and compulsory schemes as a percentage of current expenditure on health
	Use of assistive devices among people
	Newborns receiving essential newborn care
	30-day hospital case fatality rate – acute myocardial infarction (stroke)
	Patient experience
	Health facilities with functioning water services
	Health facilities with functioning sanitation services
	Average length of stay
	Dengue mortality

**TABLE 3.1** WHO Western Pacific Region SDG and UHC indicators (*continued*)

TARGET	UHC Indicators
	Mortality rate attributable to hepatitis B virus and hepatitis C virus infection
	Institutional delivery
	Age-standardized prevalence of current tobacco use among persons aged 13–15 years
	Service utilization (outpatient visits)
	Cataract surgical rate and coverage
	Post-operative sepsis as a percentage of all surgeries
	Hospital readmission rates
	Proportion of the population utilizing the rehabilitation services they require
	HIV testing coverage (%) among people living with HIV
	Viral suppression among people on antiretroviral therapy (%)

Note: These indicators have been identified by WHO to track progress of UHC and health systems in the Region.



**TABLE 3.2** Availability of WHO Western Pacific Region SDG and UHC indicators

INDICATORS		
HEALTH (SDG 3) INDICATORS	HEALTH-RELATED (OTHER SDGS) INDICATORS	UHC INDICATORS
<b>REGULARLY COLLECTED</b>		
<b>13</b>	<b>6</b>	<b>31</b>
<b>Examples include:</b> <ul style="list-style-type: none"> <li>maternal mortality ratio; proportion of births attended by skilled health personnel</li> <li>neonatal mortality rate; under-5 mortality rate;</li> <li>health worker density and distribution</li> </ul>	<b>Examples include:</b> <ul style="list-style-type: none"> <li>population covered by social protection floors/systems</li> <li>prevalence of stunting</li> <li>prevalence of malnutrition</li> <li>population using safely managed drinking-water services</li> <li>children under 5 years whose births have been registered with a civil authority</li> </ul>	<b>Examples include:</b> <ul style="list-style-type: none"> <li>life expectancy at birth</li> <li>total current expenditure on health as % of GDP</li> <li>caesarean section rate</li> <li>immunization coverage rate for DTP3</li> <li>stillbirth rate</li> <li>exclusive breastfeeding rate</li> </ul>
<b>IRREGULARLY COLLECTED</b>		
<b>10</b>	<b>11</b>	<b>11</b>
<b>Examples include:</b> <ul style="list-style-type: none"> <li>hepatitis B incidence</li> <li>adolescent birth rate</li> <li>mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease</li> </ul>	<b>Examples include:</b> <ul style="list-style-type: none"> <li>annual mean levels of fine particulate matter in cities</li> <li>number of victims of intentional homicide</li> <li>conflict-related deaths</li> <li>children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers</li> </ul>	<b>Examples include:</b> <ul style="list-style-type: none"> <li>coverage of services for mental health disorders</li> <li>service utilization (outpatient visits)</li> <li>cataract surgical rate and coverage</li> <li>use of assistive devices among people</li> </ul>
<b>NOT COLLECTED</b>		
<b>3</b>		
<b>Examples include:</b> <ul style="list-style-type: none"> <li>coverage of essential health services</li> <li>mortality rate attributed to unintentional poisoning</li> <li>total net development assistance to the medical research and basic health sectors</li> </ul>	N/A	N/A

## Appendix 4

### List of regional and global strategies and plans, determinants and stakeholders

Primary SDG/target	Global or regional strategy	Determinants	Key sectors for collaboration	Key stakeholders for collaboration
<b>PROGRAMME</b>				
<b>1. COMMUNICABLE DISEASES</b>				
<b>1.1 HIV AND HEPATITIS</b>				
<b>SDG3/3.3</b>	WHA69.22: Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021	Quality education (SDG4) Peace, justice and strong institutions (non-discrimination and participation) (SDG16) Gender equality (SDG5) Reduced inequalities (SDG10) Partnerships (trade) (SDG17)	Ministries of: Health; Education; Justice; Finance; Foreign Affairs	Line ministries professional groups, civil society organizations (CSOs), affected communities, city/local governments, private sector
	WPR/RC66.R1: Viral hepatitis	Clean water & sanitation (SDG6) Quality education (SDG4)	Ministries of: Health; Education; Justice; Finance; Environment; Public works; Foreign Affairs	
	WHA69.22: Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021	Peace, justice and strong institutions (non-discrimination and participation) (SDG16) Reduced inequalities (SDG10) Partnerships (trade) (SDG17)	Ministries of: Health; Education; Justice; Finance; Foreign Affairs	
	WHA69.22: Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections, for the period 2016–2021	Quality education (SDG4) Peace, justice and strong institutions (non-discrimination and participation) (SDG16) Gender equality (SDG5) Reduced inequalities (SDG10) Partnerships (trade) (SDG17)	Ministries of: Health; Education; Justice; Finance; Foreign Affairs	
<b>1.2 TUBERCULOSIS</b>				
<b>SDG3/3.3</b>	WHA67.1: Global strategy and targets for tuberculosis prevention, care and control after 2015 WPR/RC66.3: Regional Framework for Action on Implementation of the End TB Strategy in the Western Pacific 2016	No poverty (SDG1) Zero hunger (SDG2) Decent work and economic growth (SDG8) Reduced inequalities (SDG10) Sustainable cities and communities (SDG11)	Ministries of: Social Welfare; Labour; Justice in charge of urban development	Line ministries city/local governments, funding and technical partners, professional societies, nongovernmental organizations (NGOs) and CSOs, patients, families and affected communities
<b>1.3 MALARIA</b>				
<b>SDG3/3.3</b>	WHA68.2: Global technical strategy and targets for malaria 2016–2030 WPR/RC67.R53: Regional action framework for malaria control and elimination in the Western Pacific (2016–2020)	No poverty (SDG1) Quality education (SDG4) Decent work and economic growth (SDG8) Industry, innovation, infrastructure (SDG9)	Ministries of: Health; Education; Environment; Economics; Labour; Irrigation	Line ministries migrant workers and mobile populations, city/local governments, CSOs, private sector, donors, partners

Primary SDG/target	Global or regional strategy	Determinants	Key sectors for collaboration	Key stakeholders for collaboration
<b>1.4 NEGLECTED TROPICAL DISEASES</b>				
<b>SDG3/3.3</b>	WHA66.12: Neglected tropical diseases WPR/RC63P4: Regional action plan for neglected tropical diseases in the Western Pacific (2012 – 2016) WPR/RC67R5: Regional Action Plan for Prevention and Control of Dengue (2016)	No poverty (SDG1) Food (SDG2) Quality education (SDG4) Clean water & sanitation (SDG6) Sustainable cities and communities (SDG11)	Ministries of: Health; Education; Environment; Economics; Agriculture/ Animal Health/Fisheries; Rural development; Irrigation	Line ministries affected communities, city/local governments, CSOs, private sectors, academia, donors, partners
<b>1.5 VACCINE-PREVENTABLE DISEASES</b>				
<b>SDG3/3.3</b>	WPR/RC65.R5: Regional framework for implementation of the global vaccine action plan WPR/RC64.R5: Hepatitis B control through vaccination	Quality education (SDG4) Peace, justice and strong institutions (non-discrimination and participation) (SDG16) Partnerships (SDG17)	Ministries of: Health; Education; Finance	Line ministries CSOs, affected communities
<b>SDG3/3.2</b>		Quality education (SDG4) Peace, justice and strong institutions (non-discrimination and participation) (SDG16) Partnerships (SDG17)	Ministries of: Health; Education; Environment/ Public works; Finance	Line ministries CSOs, affected communities
<b>SDG3/3.8</b>	WPR/RC65.R5: Regional framework for implementation of global vaccine action plan	Quality education (SDG4) Clean water & sanitation (SDG6) Reduced inequalities (SDG10) Peace, justice and strong institutions (non-discrimination and participation) (SDG16)	Ministries of: Health; Education; Environment/ Public works; Finance	Line ministries professional groups, CSOs, communities/patients
<b>2. NONCOMMUNICABLE DISEASES</b>				
<b>2.1 NONCOMMUNICABLE DISEASES</b>				
<b>SDG3/3.4</b>	WHA69.6: Prevention and control of noncommunicable diseases: responses to specific assignments in preparation for the third High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable diseases in 2018 WHA66.10: Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs (Global action plan for the prevention and control of NCDs 2013 – 2020) WPR/RC64.R6: Regional Action Plan for the prevention and control of noncommunicable diseases (2014 – 2020) WPR/RC66.8: Regional framework for urban health in the Western Pacific 2016 – 2020: healthy and resilient cities	Zero hunger (SDG2) Partnerships (trade) (SDG17) Sustainable cities and communities (SDG11)	Ministries of: Health; Trade/Commerce; Urban Development; Transport; Education	Line ministries city/local governments, private sector, academia, CSOs

Primary SDG/target	Global or regional strategy	Determinants	Key sectors for collaboration	Key stakeholders for collaboration
<b>2.1 NONCOMMUNICABLE DISEASES (continued)</b>				
<b>SDG3/3.4/3.a</b>	WPR/RC65.R2: Regional Action Plan for the Tobacco Free Initiative in the Western Pacific (2015 – 2019) WHA56.1: WHO Framework Convention on Tobacco Control (FCTC)	Quality education (SDG4) Gender equality (SDG5) Reduced inequalities (SDG10) Sustainable cities and communities (SDG11)	Ministries of: Health; Finance; Trade; Customs and Taxes; Education; Tourism; Justice	Line ministries professional groups, CSOs, communities/patients, youth
<b>2.2 MENTAL HEALTH AND SUBSTANCE ABUSE</b>				
<b>SDG3/3.4</b>	WHA65.4: Global burden of mental disorders and the need for comprehensive, coordinated response WHA66.8: Mental Health Action Plan 2013–2020 WPR/RC65.R3: Regional agenda for implementing the mental health action plan in the Western Pacific (2013–2020)	No poverty (SDG1) Quality education (SDG4) Gender equality (SDG5) Reduced inequalities (SDG10) Sustainable cities and communities (SDG11) Peace, justice and strong institutions (SDG16), Partnerships (SDG17)	Ministries of: Health; Education; Labour; Justice; Welfare; Finance	Line ministries CSOs, NGOs, media, academia, labour groups
<b>SDG3/3.5</b>	WHA63.13: Global strategy to reduce the harmful use of alcohol	No poverty (SDG1) Quality education (SDG4) Sustainable cities and communities (SDG11) Partnerships (SDG17)	Ministries of: Health; Education; Finance; Trade; Justice	Line ministries CSOs, NGOs, youth, private sector
<b>2.3 VIOLENCE AND INJURIES</b>				
<b>SDG3/3.6</b> <b>SDG5/5.2</b> <b>SDG11/11.2</b> <b>SDG16/16.1</b> <b>SDG16/16.2</b>	WPR/RC66.R2.4: Violence and Injury Prevention (regional action plan) WHA69.5: WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children	No poverty (SDG1) Quality education (SDG4) Clean water and sanitation (SDG6) Reduced inequalities (SDG10) Partnerships (SDG17)	Ministries of: Health; Transport; Police; Social Affairs; Women and Children; Justice; Finance; Education; Planning and Development; Urban Development; Labour	Line ministries professional peak bodies, CSOs, NGOs, communities, private sector (transport, automotive, energy)
<b>2.4 DISABILITY AND REHABILITATION</b>				
<b>SDG1/1.3</b> <b>SDG3/3.8</b> <b>SDG4/4.5</b> <b>SDG4/4.a</b> <b>SDG8/8.5</b> <b>SDG10/10.2</b> <b>SDG11/11.2</b> <b>SDG11/11.7</b> <b>SDG16/16.7</b> <b>SDG17/17.18</b>	WHA67.7 WHO global disability action plan 2014–2021: better health for all people with disability WHA58.23 Disability including prevention, management and rehabilitation	Quality education (SDG4) Decent work and economic growth (SDG8) Reduce inequalities (social, economic and political participation of people with disability) (SDG10) Accessible cities, water and public spaces (SDG11) Peace, justice and strong institutions (non-discrimination) (SDG16) Partnerships (disability disaggregation of data) (SDG17)	Ministries of: Health; Social Affairs/Welfare; Justice; Planning/Development; Education; Labour; Economics & Finance; National Statistical Offices	Individuals with disability and their families; CSOs (disabled person's organisations and disability service providers); UN agencies; bilateral donors; international organisations; local/provincial governments; professional bodies; private sector

Primary SDG/target	Global or regional strategy	Determinants	Key sectors for collaboration	Key stakeholders for collaboration
<b>2.5 NUTRITION</b>				
<b>SDG2/2.1; 2.2</b>	WHA55.23: Global strategy on diet, physical activity and health	No poverty (purchasing power) (SDG1)	Ministries of: Health; Education; Agriculture; Environment/Public Works; Finance; Trade/Industry	Line ministries CSOs (especially also consumer protection), private sector (including small holder farmers), cities/local communities, settings (schools, work sites, market places, etc.), professional groups, academia
<b>SDG3/3.2; 3.4</b>	WHA55.25: Global Strategy on Infant and Young Child Feeding	Zero hunger (SDG2)		
<b>SDG6/6.1</b>	WHA58.3: IHR (2005) – chemicals/pesticides in foods	Good health & well-being (SDG3)		
<b>SDG11/11.3</b>	WHA65.6: Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition	Quality education (SDG4)		
<b>SDG12/12.3</b>	WHA66.10: Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of NCDs (Global action plan for the prevention and control of NCDs 2013–2020);	Gender equality (SDG5)		
<b>SDG14/14.4;</b>	WHA68.19 Outcome of the Second International Conference on Nutrition	Clean water and sanitation (SDG6)		
<b>SDG15/15.9</b>	WHA69/8 Report of the Commission on Ending Childhood Obesity.	Affordable and clean energy (for cooking, refrigeration) (SDG7)		
	WHA69.8 Report of the Commission on Ending Childhood Obesity.	Decent work and economic growth (earning opportunities to help households rise out of poverty) (SDG8)		
	WHA69.8 Decade of Action on Nutrition	Reduced inequalities (SDG10)		
	WPR/RC63.R2: Scaling up nutrition in the Western Pacific Region	Urban environment (urban food systems) (SDG11)		
	WPR/RC65/10: Action Plan to Reduce the Double Burden of Malnutrition in the Western Pacific (2015-2020)	Responsible consumption and production (product diversification; food quality) (SDG12)		
	WPR/RC64.R6: Regional Action Plan for the prevention and control of non-communicable diseases (2014–2020)	Climate action (change/food security/emergencies/disasters) (SDG13)		
	WPR/RC65.R6: Emergencies and disasters (Regional framework for action for disaster risk management for health) – Nutrition in emergencies	Life below water (marine resource sustainability, – fisheries) (SDG14)		
	WHA58.3: IHR (2005) – chemicals/pesticides in foods	Life on land (use of ecosystems – improved diet quality) (SDG15)		
	WPR/RC62.R5: Food Safety strategies	Peace, justice and strong institutions (conflict/destruction leads to food insecurity) (SDG16)		
	WPR/RC35.R15: Drinking water quality	Partnerships (trade/food trade/FENSA) (SDG17)		
	WHO/SDE/WSH/05.06 HQ Water quality/water safety plans			
<b>3. PROMOTING HEALTH THROUGH THE LIFE COURSE</b>				
<b>3.1 REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH</b>				
<b>SDG3/3.7,</b>	WHO/RHR/04.8: Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets, 2004	No poverty (SDG 1)	Ministries of: Health; Education; Social/Women's Affairs; Finance; Trade; Justice	Line ministries councils for women (committees for CEDAW, International Covenant on Economic, Social and Cultural Rights), professional groups, CSOs, NGOs, communities/patients
<b>SDG5/5.6</b>	Regional Framework for Reproductive Health in the Western Pacific, 2013	Quality education (SDG4)		
		Gender equality (SDG5)		
		Reduced inequalities (SDG10)		
		Peace, justice and strong institutions (non-discrimination and participation) (SDG16)		
		Partnerships (trade) (SDG17)		

Primary SDG/target	Global or regional strategy	Determinants	Key sectors for collaboration	Key stakeholders for collaboration
<b>3.1 REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH (continued)</b>				
<b>SDG3/3.1, 3.2</b>	WPR/RC39.R10: Maternal and child health Global Strategy For Women's, Children's and Adolescents' Health (2016–2030), 2015 WHO/RHR/15.03: Strategies toward ending preventable maternal mortality (EPMM), 2015 WHA67.10 Every Newborn: An Action Plan to End Preventable Deaths, 2014 WPR/RC64/9: Regional Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020), 2013 WPR/RC56.R5: Child Health	No poverty (SDG-1) Zero hunger (SDG 2) Quality education (SDG4) Gender equality (SDG5) Clean water and sanitation (SDG6) Reduced inequalities (SDG10) Peace, justice and strong institutions (non-discrimination and participation) (SDG16) Partnerships (trade) (SDG17)	Ministries of: Health; Education; Environment; Agriculture; Social/Women's Affairs; Finance; Trade; Justice	Line ministries councils for women and children (committees for CEDAW, CESC, the Convention on the Rights of the Child – CRC), professional groups, CSOs, NGOs, communities/patients
<b>3.2 AGEING AND HEALTH</b>				
<b>SDG2/2.2, SDG3/3.4, 3.8, SDG11/11.2</b>	WHA69.3: The global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life WPR/RC64.R3: Regional framework for action on ageing and health in the Western Pacific (2014–2019)	No poverty (SDG1) Reduced inequalities (SDG10) Sustainable cities (SDG11) Partnerships (trade) (SDG17)	Ministries of: Social Affairs; Social Protection/Labour/Pension; Urban Development	Line ministries professional groups (including health workers), CSOs and older people's associations, communities, UN partners
<b>3.3 GENDER, EQUITY AND HUMAN RIGHTS MAINSTREAMING</b>				
<b>SDG5/5.1, 5.2, 5.3 SDG3/3.8 SDG8/8.7 SDG16/16.b</b>	WHA69.5: WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children WHA60.25: Strategy for integrating gender analysis and actions into the work of WHO	No poverty (SDG1) Quality education (SDG4) Gender equality (SDG5) Reduced inequalities (SDG10) Peace, justice and strong institutions (SDG16)	Ministries of: Health; Women's Affairs; Social Affairs; Justice	Line ministries professional groups (including health workers), communities/CSOs, NGOs, UN partners (especially United Nations Entity for Gender Equality and the Empowerment of Women – (UN Women), United Nations Population Fund (UNFPA), United Nations Children Fund (UNICEF) and Office of the United Nations High Commissioner for Human Rights (OHCHR)
<b>3.4 SOCIAL DETERMINANTS OF HEALTH</b>				
<b>SDG1/1.3, 1.5 SDG3/3.8 SDG8/8.5, 8.8 SDG10/10.2/ 10.4/10.7 SDG11/11.1</b>	WPR/RC66.R2: Universal Health Coverage: Moving Towards Better Health (regional action framework); WHA67.12: Contributing to social and economic development: sustainable action across sectors to improve health and health equity; WHA65.8: Social determinants of health	No poverty (SDG1) Quality education (SDG4) Gender equality (SDG5) Reduced inequalities (SDG10) Sustainable cities (SDG11) Partnerships (SDG17)	Ministries of: Health; Planning; Finance	Line ministries multisectoral mechanisms, city/local governments, CSOs, NGOs

Primary SDG/target	Global or regional strategy	Determinants	Key sectors for collaboration	Key stakeholders for collaboration
<b>3.5 HEALTH AND THE ENVIRONMENT</b>				
<b>SDG1/1.5</b> <b>SDG3/3.3, 3.8,</b> <b>3.9</b>	WHA45.31: Health and environment WHA46.20: Global Strategy for Health and Environment	No poverty (SDG1)	Ministries of: Health; Environment; DRM; Meteorology; Education	Line ministries municipal governments, community organizations, non- profit organizations, for-profit organizations, labour unions, academia, WHO Collaborating Centres
<b>SDG6/6.1, 6.2,</b> <b>6.3, 6.4</b>	WHA64.24: Drinking-Water, Sanitation and Health	Good health and well-being (SDG3)	Ministries of: Health; Environment; Education; Public works	
<b>SDG12/12.4,</b> <b>12.5</b>	WHA67.11: Public health impacts of exposure to mercury and mercury compounds: the role of WHO and ministries of public health in the implementation of Minamata Convention WHA68.8: Health and the environment: addressing the health impact of air pollution	Clean water and sanitation (SDG6)	Ministries of: Health; Environment; Public works; Urban development; Rural development	
<b>SDG13/13.1,</b> <b>13.2, 13.3</b>	WPR/RC44.R9: Regional Strategy on Health and Environment	Clean energy	Ministries of: Health; Environment; Transport; Energy	
<b>SDG14/14.2</b> <b>SDG17/17.3</b>	WPR/RC56.R7: Environmental Health WPR/RC59.R7: Protecting Health from Climate Change	Decent work and economic growth (SDG8)	Ministries of: Health; Environment; Labour; Agriculture; Public works	
		Industry, innovation and infrastructure (SDG9)	Ministries of: Health; Environment; Education; Public works; Science & Technology	
		Sustainable cities (SDG11)	Ministries of: Health; Environment; Education; Public works; Transport	
		Responsible Consumption and Production	Ministries of: Health; Environment; Industry	
		Climate action (SDG13)	Ministries of: Health; Environment; DRM; Meteorology; Education; Energy; Public works; Science & Technology	
		Oceans	Ministries of: Health; Environment; Tourism	
		Partnerships	Ministries of: Health; Environment	

Primary SDG/target	Global or regional strategy	Determinants	Key sectors for collaboration	Key stakeholders for collaboration
<b>4. HEALTH SYSTEMS</b>				
<b>4.1 NATIONAL HEALTH POLICIES, STRATEGIES AND PLANS</b>				
<b>SDG3/3.8</b>	WPR/RC66.R2: Universal Health Coverage: Moving Towards Better Health (regional action framework)	Quality education (SDG4) No poverty (SDG1) Reduced inequalities (SDG10) Decent work and economic growth (SDG8)	Ministries of: Finance; Social Welfare; Health Insurance Agency; parliamentarian.	Line ministries, professional groups, academia, CSOs, private sector, parliamentarians
<b>4.2 INTEGRATED PEOPLE-CENTERED HEALTH SERVICES</b>				
<b>SDG3/3.8</b> <b>SDG3/3.c</b>	WHA69.24: Framework on integrated, people-centred health services WHA63.16: WHO global code of practice on the international recruitment of health personnel, 2010 WPR/RC66.R2: Universal Health Coverage: Moving Towards Better Health (regional action framework) WPR/RC62.R4: Regional Strategy for Traditional Medicine (2011-2010) WPR/RC58.R4: People centred care framework 2007 WPR/RC57.R7: Regional strategy on human resources for health 2006 – 2015, Global/health workforce 2030	Quality education (SDG4) No poverty (SDG1) Reduced inequalities (SDG10) Decent work and economic growth (SDG8)	Ministries of: Health; Social welfare; Education Education Development Centres	Line ministries professional groups, academia, CSOs, educational institutions, National Institutes of Public Health, WHO collaborating centres
<b>4.3 ACCESS TO MEDICINES AND OTHER HEALTH TECHNOLOGIES AND STRENGTHENING REGULATORY CAPACITY</b>				
<b>SDG3/3.8</b> <b>SDG3/3.b</b>	WHA67.20: Regulatory system strengthening for medical products WHA67.21: Access to biotherapeutic products including similar biotherapeutic products and ensuring their quality, safety and efficacy WHA 67.22: Access to essential medicines WHA 67.23: Health intervention and technology assessment in support of universal health coverage WHA67.25: Antimicrobial resistance WPR/RC66.R2: Universal Health Coverage: Moving Towards Better Health (regional action framework) Regional framework for action on access to essential medicines in the Western Pacific 2011 – 2016 WPR/RC65/8: Expanded Program on Immunization: Regional framework for implementation of the global vaccine action plan in the Western Pacific WPR/RC65/7: Antimicrobial resistance	No poverty (SDG1) Hunger (SDG 2) Quality education (SDG4) Decent work and economic growth (SDG8) Industry, innovation and infrastructure (SDG9) Responsible consumption and production (SDG12)	Ministries of: Health; Finance; Education; Agriculture; National Medicines Regulatory Authority; Intellectual Property Office; Procurement agency; Health Insurance Agency; networks Health Technology Assessment Agency	Line ministries policy-makers, regulators, pharmaceutical industry, agricultural industry, health-care workers, regional and global



Primary SDG/target	Global or regional strategy	Determinants	Key sectors for collaboration	Key stakeholders for collaboration
<b>4.4 HEALTH SYSTEMS INFORMATION AND EVIDENCE</b>				
<b>SDG3/3.b</b> <b>SDG17/17.8</b>	WPR/RC66.R2: Universal Health Coverage Moving Towards Better Health (regional action framework)		Ministries of: Health; Foreign Affairs; Evaluation; National Statistics Office	Line ministries professional groups, communities, statisticians, local health managers, health workers, etc.
<b>5. PREPAREDNESS, SURVEILLANCE AND RESPONSE</b>				
<b>5.1 ALERT AND RESPONSE CAPACITIES</b>				
<b>SDG3/3.d</b>	WPR/RC56.R4: Asia Pacific Strategy for Emerging Diseases WPR/RC60.R6: Asia Pacific Strategy for Strengthening Health Laboratory Services (2010–2015) WPR/RC61.R5: Asia Pacific Strategy for Emerging Diseases WHO's Emergency Response Framework WHA64.5: Pandemic Influenza Preparedness Framework WHA58.3: IHR (2005) WHA69.30: Reform of WHO's work in health emergency management: WHO Health Emergencies Programme	No poverty (SDG1) Water (SDG6) Decent work and economic growth (SDG8) Industry, innovation and infrastructure (SDG9) Settlements (SDG11) Climate action (SDG13) Life below water (SDG14) Land (SDG15)	Ministries of: Health; Environment/Public works; Trade/Industry; Education; Foreign Affairs; Defense; Agriculture; Finance	Line ministries city/local governments, CSOs, private sector; communities, NGOs, UN agencies, bilateral and multilateral agencies
<b>5.2 EPIDEMIC- AND PANDEMIC-PRONE DISEASES</b>				
<b>SDG3/3.3</b>	WPR/RC56.R4: Asia Pacific Strategy for Emerging Diseases WPR/RC60.R6: Asia Pacific Strategy for Strengthening Health Laboratory Services (2010-2015) WPR/RC61.R5: Asia Pacific Strategy for Emerging Diseases WHO's Emergency Response Framework WHA64.5: Pandemic Influenza Preparedness Framework WHA58.3: IHR (2005) WHA69.30: Reform of WHO's work in health emergency management: WHO Health Emergencies Programme	No poverty (SDG1) Clean water and sanitation (SDG6) Industry, innovation and infrastructure (SDG9) Settlements (SDG11) Climate action (SDG13) Life below water (SDG14) Land (SDG15)	Ministries of: Health; Environment/Public works; Agriculture; Education; Trade/Industry; Foreign Affairs; Defense; Agriculture; Finance	Line ministries city/local governments, CSOs, private sector, communities, NGOs, UN agencies, bilateral and multilateral agencies
<b>5.3 EMERGENCY RISK AND CRISIS MANAGEMENT</b>				
<b>SDG3/3.d</b>	EB138.2.3: WHO response in severe, large-scale emergencies WPR/RC65.R6: Western Pacific Regional Framework for Action for Disaster Risk Management for Health WHO's Emergency Response Framework WHA58.3: IHR (2005) WHA69.30: Reform of WHO's work in health emergency management: WHO Health Emergencies Programme	Zero hunger (SDG2) Gender equality (SDG5) Reduced inequalities (SDG10) Settlements (SDG11) Climate action (SDG13)	Ministries of: Health; Finance; Environment; Public works; Trade/Industry	Line ministries city/local governments, CSOs, private sector, communities, NGOs, medical teams (national and foreign), United Nations Central Emergency Response Fund (CERF), Office for the Coordination of Humanitarian Affairs (OCHA), UNICEF

Primary SDG/target	Global or regional strategy	Determinants	Key sectors for collaboration	Key stakeholders for collaboration
<b>5.3 EMERGENCY RISK AND CRISIS MANAGEMENT (continued)</b>				
<b>SDG13/13.1</b>	EB138/23: WHO response in severe, large-scale emergencies WPR/RC65.R6: Western Pacific Regional Framework for Action for Disaster Risk Management for Health WHA58.3:IHR (2005) WHA69.30: Reform of WHO's work in health emergency management: WHO Health Emergencies Programme	Affordable and clean energy (SDG7) Reduced inequalities (SDG10) Responsible consumption and production (SDG12) Life below water (SDG14) Life on land (SDG15)	Ministries of: Health; Environment; Trade/Industry; Agriculture	Line ministries city/local governments, CSOs, private sector, communities, NGOs
<b>SDG10</b>	EB138.2.3: WHO response in severe, large-scale emergencies WPR/RC65.R6: Western Pacific Regional Framework for Action for Disaster Risk Management for Health WHO's Emergency Response Framework WHA58.3: IHR (2005) WHA69.30: Reform of WHO's work in health emergency management: WHO Health Emergencies Programme	Zero hunger (SDG2) Settlements (SDG11) Climate action (SDG13) Reduced inequalities (SDG10) Gender equality (SDG5)	Ministries of: Health; Finance; Environment; Public works; Trade/Industry	Line ministries city/local governments, CSOs, private sector, communities, NGOs, medical teams (national and foreign), CERF, OCHA, UNICEF
<b>SDG5</b>	EB138/23: WHO response in severe, large-scale emergencies WPR/RC65.R6: Western Pacific Regional Framework for Action for Disaster Risk Management for Health WHO's Emergency Response Framework WHA58.3: IHR (2005) WHA69.30: Reform of WHO's work in health emergency management: WHO Health Emergencies Programme	Sustainable cities and communities (SDG11) Health (SDG3) Zero hunger (SDG2) Quality education (SDG4) Decent work and economic growth (SDG8) Reduced inequalities (SDG10) Gender equality (SDG5)	Ministries of: Health; Environment; Public works; Agriculture; Education; Trade/Industry	Line ministries city/local governments, CSOs, private sector, communities, NGOs, UNICEF, Food and Agriculture Organization of the United Nations (FAO)
<b>5.4 FOOD SAFETY</b>				
<b>SDG2/2.1</b>	WPR/RC62.R5: Western Pacific Regional Food Safety Strategy (2011-2015) WHA63.3: Advancing food safety initiatives: strategic plan for food safety including foodborne zoonoses 2013-2022 WPR/RC55.R6 (2004) Food Safety WPR/RC52.R2 (2001) Food Safety WHA 53.15 (2000) Food Safety WPR/RC56.R4: Asia Pacific Strategy for Emerging Diseases WPR/RC60.R6: Asia Pacific Strategy for Strengthening Health Laboratory Services (2010-2015) WPR/RC64.R5: Asia Pacific Strategy for Emerging Diseases (2010) WHA 58.3: IHR (2005) WPR/RC65.R6: Emergencies and disasters (Regional framework for action for disaster risk management for health)	Zero hunger (SDG2) Good health and well-being (SDG3) No poverty (SDG1) Decent work and economic growth (SDG8) Climate action (SDG13) Responsible consumption and production (SDG12) Life below water (SDG14) Life on land (SDG15) Industry, innovation and infrastructure (SDG9)	Ministries of: Health; Agriculture, livestock and fisheries; Industry; Education; Trade; Environment	Line ministries food industry associations, education institutions, farmer associations, UN agencies (FAO, World Bank, United Nations Industrial Development Organization – UNIDO), chambers of commerce

## Appendix 5

### Examples of relevant instruments of international law

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WHO Framework Convention on Tobacco Control (2003)

International Health Regulations (2005)

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International Covenant on Economic, Social and Cultural Rights, and International Covenant on Civil and Political Rights (1966)

International Convention on the Elimination of All Forms of Racial Discrimination (1965)

Convention on the Elimination of All Forms of Discrimination Against Women (1979)

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)

Convention on the Rights of the Child (1989)

Convention on the Rights of Migrant Workers (1990)

Convention on the Rights of Persons with Disabilities (2006)

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Geneva Conventions I–IV and its Protocols

Convention relating to the Status of Refugees, 1951

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Abolition of Forced Labour Convention, 1957 (No. 105)

Minimum Age Convention, 1973 (No. 138)

Worst Forms of Child Labour Convention, 1999 (No. 182)

Equal Remuneration Convention, 1951 (No. 100)

Discrimination (Employment and Occupation) Convention, 1958 (No. 111)

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World Trade Organization agreements, including:

- Multilateral Agreements on Trade in Goods
- General Agreement on Trade in Services
- Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS)

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United Nations Framework Convention on Climate Change, 1992 (UNFCCC)

Kyoto Protocol, 1997

Paris Agreement, 2015

Vienna Convention for the Protection of the Ozone Layer & Montreal Protocol on Substances that Deplete the Ozone Layer, 1989

Convention on Biological Diversity (CBD)

## Appendix 6

### Decision tools for action on SDGs

#### Sequencing

Deciding what to do first and what to do later, how best to stage programmes and interventions, or what is affordable and will have the greatest impact is a complex process. A sequencing matrix can be useful in deciding what should be done in the short term and longer terms, which actions can start immediately, and which need more time and preparation. Row 1 of the matrix (DO row) would include priorities for which action will be needed. Row 2 of the matrix (START row) indicates issues that may be less pressing or that need to come later but on which preparation can start.

	NOW	LATER
DO		
START		

For example, Country X may decide that the unfinished MDG agenda in child health can be readily achieved with a little additional effort or expense (Do/Now cell). In contrast, it may choose to work on malnutrition (SDG 2, Target 2.2) but implement this subsequently (Do/Later cell). It might decide to start convening key sectors around issues of mutual interest, for example initiating partnerships with the education sector on healthy school environments and designing programmes (Start/Now cell). Other initiatives such as engaging sectors and stakeholders on marketing of food could be held over until later (Start/Later cell).

#### Portfolio

A portfolio matrix can help in making decisions about what actions should have the highest priority based on their risk, as well as how strong their returns or benefits are. The columns indicate the level of benefit from the action, whether high or low. The rows indicate the degree of risk of failure, whether high or low. Actions that fall in the “high return/low risk” cell would be high priorities. Conversely, those in the “low return/high risk” cell would be low priorities. Setting priorities would depend on a careful assessment of the related political, economic and socioeconomic factors that would promote or hinder successful implementation.

		RETURN	
		HIGH	LOW
RISK	HIGH		
	LOW		

For example, if Country X wishes to reduce noncommunicable disease risk factors, increasing people’s awareness about healthy diets and physical activity may be a low risk but low return option. If the government is able to stand up to the tobacco lobby, increasing the tobacco tax may be a high return/low risk strategy. If the food industry is politically powerful, tackling marketing to children may be a high return/high risk option. If people are accustomed to the existence of bicycle lanes in the country’s larger cities, re-zoning to promote physical activity might be both low return and high risk.

## Appendix 7

# Reaching the Millennium Development Goals (MDGs) in the Western Pacific: successes and challenges

The linkages between health and development were acknowledged by the Millennium Development Goals (MDGs), established following the United Nations Millennium Summit in 2000. Health has been at the centre of these efforts, being integral to three out of eight goals.

Progress towards the MDGs on the whole has been remarkable, including for example, poverty reduction, education improvements and increased access to safe drinking water. Progress on the three health goals and targets has also been considerable. Globally, the HIV, tuberculosis and malaria epidemics were, to different degrees, arrested, and child and maternal mortality decreased, despite falling short of the MDG targets (Table 7.1).

### Regional achievements 2000–2015

- Many countries have experienced rapid economic growth. The annual GDP between 1990 to 2014 increased in China from 3.9% to 7.3%, in the Philippines from 3% to 6.1%, and in Mongolia from –3.2% to 7.8%.<sup>(1)</sup> In China alone, poverty gap at US\$ 1.90 a day reduced from 24.4% in 1990, to 2.7% in 2010.<sup>(2)</sup>
- The under-5 mortality rate decreased from 52 to 14 deaths per 1000 live births between 1990 and 2015.<sup>(3)</sup> Seven countries and areas in the Region – Australia, Brunei Darussalam, Cambodia, Japan, Macao SAR (China), Mongolia and the Republic of Korea – have been verified as achieving measles elimination.<sup>(3)</sup> The prevalence of underweight among children under 5 years decreased from 13.5% in 1990 to 2.6% in 2014.<sup>(4)</sup> The number of chronically undernourished (stunted) children under 5 has decreased from 54.4 million (1990) to 8 million (2014).<sup>(4)</sup>
- The estimated maternal mortality ratio decreased by 64% between 1990 and 2015.<sup>(5)</sup> The skilled birth attendance rate has increased to 96%, with 21 of 31 countries and areas having a rate of 90% and above.<sup>(5)</sup>
- Regionwide implementation of global strategies on TB cured over 15 million patients since 2000, and reduced the disease burden by 58% since 1990.
- During 2001–2014, HIV prevalence and incidence decreased in Cambodia, Malaysia, Papua New Guinea and Viet Nam.<sup>(6)</sup>
- All 10 malaria-endemic countries in the Region made significant progress through improved vector control, accurate diagnosis, effective treatment and sound programme management. Eight countries reached the target on reducing incidence and nine the target on mortality.<sup>(6)</sup>
- Almost 100% of the population uses an improved drinking-water source, up from 71% in 1990.<sup>(7)</sup> Some 705 million people have gained access to an improved drinking-water source since 1990.<sup>(7)</sup> About 79% of the Western Pacific Region population now uses an improved sanitation facility, which is 2 percentage points higher than the MDG target.<sup>(7)</sup>

The SDGs, and specifically SDG 3, incorporate some unfinished agendas (targets on maternal and child mortality, communicable diseases, etc.), which continue on from the MDGs. The SDGs also include new or previously neglected agendas (targets on noncommunicable diseases, mental health, and health systems and UHC). Crucially, health in the SDGs goes beyond SDG 3. Several health targets can be found in other goals, for example nutrition in SDG 2, violence against women in SDG 5 and birth registration in SDG 16. The SDGs also place greater emphasis on a broader range of determinants of health, including poverty reduction, reducing inequality, climate action and migration).

**TABLE 7.1** Regional overview of progress on MDG targets related to health, in percentage

MDG TARGETS	INDICATORS	Target	Global	AFR	AMR	SEAR	EUR	EMR	WPR
<b>Target 1.c:</b> Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Per cent reduction in proportion of underweight children under 5 years of age, 1990–2015	50	44	35	63	49	85	39	82
<b>Target 4.a:</b> Reduce by two thirds, between 1990 and 2015, the under-5 mortality rate	Per cent reduction in under-5 mortality rate, 1990–2015	67	53	54	65	64	65	48	74
	Measles immunization coverage among 1-year-old children <sup>a</sup> , 2014	90	85	73	92	84	94	77	97
<b>Target 5.a:</b> Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	Per cent reduction in maternal mortality ratio, 1990–2015	75	44	44	49	69	63	54	64
	Births attended by skilled health personnel <sup>b</sup> , 2013	90	73	54	96	59	99	67	95
<b>Target 5.b:</b> Achieve, by 2015, universal access to reproductive health	Antenatal care coverage: at least one visit, 2013	100	88	81	99	84	99	79	95
	Unmet need for family planning, 2015	0	24	55	19	27	28	42	10
<b>Target 6.a:</b> Have halted by 2015 and begun to reverse the spread of HIV/AIDS	Per cent reduction in HIV incidence, 2000–2014	> 0	45	59	28	50	-16	< -50	27
<b>Target 6.c:</b> Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	Per cent reduction in incidence of malaria, 2000–2015	> 0	37	42	78	49	100	70	65
	Per cent reduction in incidence of tuberculosis, 1990–2014	> 0	17	1	49	17	14	12	48
<b>Target 7.c:</b> Halve, by 2015, the proportion of people without sustainable access to safe drinking water	Per cent reduction in proportion of population without access to improved drinking-water sources, 1990–2015	50	62	38	62	74	67	39	84
	Per cent reduction in proportion of population without access to improved sanitation, 1990–2015	50	31	7	47	32	28	54	54

Legend:  Half way  Met or on track  Insufficient progress

Note:

- AFR, African Region; AMR, Region of the Americas; SEAR, South-East Asia Region; EUR, European Region; EMR, Eastern Mediterranean Region; WPR, Western Pacific Region.
- a: Target for measles immunization coverage was set by the World Health Assembly.
- b: Target for births attended by skilled health personnel was set by the International Conference on Population and Development.

Source:

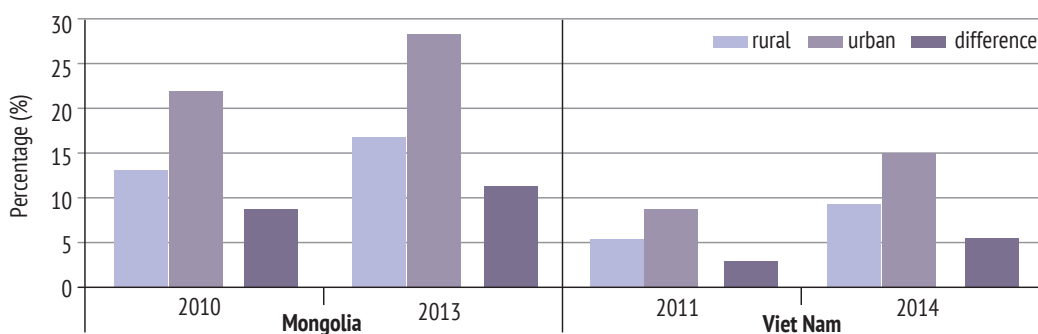
Table 1.1 Global and WHO regional status of the health-related MDGs. In: Health in 2015. From MDGs to SDGs. Geneva: World Health Organization; 2015.

## From MDGs to SDGs: focusing on health disparities

The SDGs place renewed emphasis on the linkages between goals and the need for integrated, collaborative and participatory approaches to sustainable development and to “leaving no-one behind”. This is especially relevant in the Western Pacific Region, which has significant and growing differences in health and well-being, both among and within countries and areas (Fig. 7.1). Thus, a greater focus on identifying and acting on disparities across population groups is a defining characteristic of the SDG agenda – not only as a matter of fairness and social justice but also as critical to sustainability.

**FIGURE 7.1** Growing inequities over time by residence and wealth quintile, selected countries, Western Pacific Region

**FIGURE 7.1a** Percentage of women aged 15–49 tested for HIV and informed of result in the past 12 months, by place of residence, 2010–2015

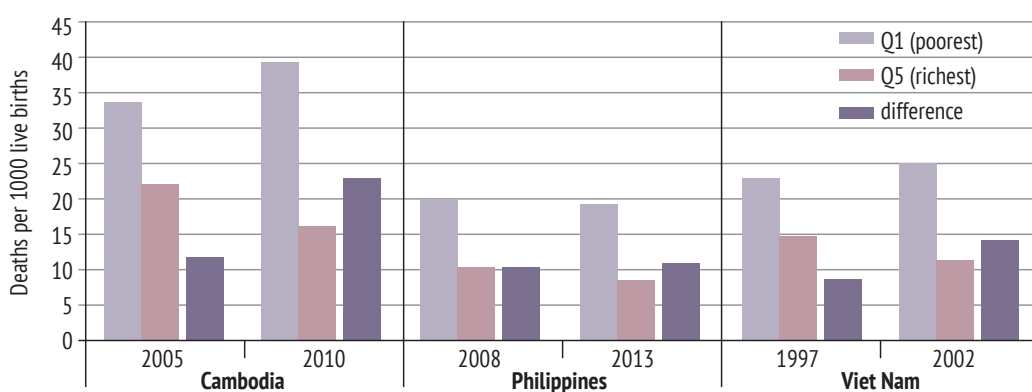


Sources:

Mongolia: Social Indicator Sample Survey-2013: Multiple Indicator Cluster Survey Final Report. Mongolia: National Statistics Office; 2015. Mongolia: Child Development-2010 survey: Multiple Indicator Cluster Survey – 4 Final Report. Mongolia: National Statistics Office; 2013.

Viet Nam: Multiple Indicator Cluster Survey 2014 Final Report. Ha Noi, Viet Nam: General Statistics Office, UNICEF; 2015. Viet Nam: Multiple Indicator Cluster Survey 2011 Final Report. Ha Noi, Viet Nam: General Statistical Office (GSO); 2011.

**FIGURE 7.1b** Neonatal mortality rate (deaths per 1000 live births), by wealth quintile (Q), 1997–2013



Source:

Neonatal mortality rate (per 1000 live births). In: World Bank Data [online database]. Washington, DC: World Bank Group; 2016.

## References

1. World Development Indicators: GDP Growth (annual %). In: World Bank [online database]. Washington, DC: World Bank Group; 2016. (<http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators#>, accessed 3 June 2016).
2. World Development Indicators: Poverty gap at \$1.90 a day (2011 PPP). In: World Bank [online database]. Washington, DC: World Bank Group; 2016. (<http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators>, accessed 3 June 2016).
3. MDG 4: Reduce child mortality. In: Achieving the health-related Millennium Development Goals in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific; 2016 (forthcoming).
4. MDG 1: Eradicate extreme poverty and hunger. In: Achieving the health-related Millennium Development Goals in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific; 2016 (forthcoming).
5. MDG 5: Improve maternal health. In: Achieving the health-related Millennium Development Goals in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific; 2016 (forthcoming).
6. MDG 6: Combat HIV/AIDS, malaria and other diseases. In: Achieving the health-related Millennium Development Goals in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific; 2016 (forthcoming).
7. MDG 7: Ensure environmental sustainability. In: Achieving the health-related Millennium Development Goals in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific; 2016 (forthcoming).

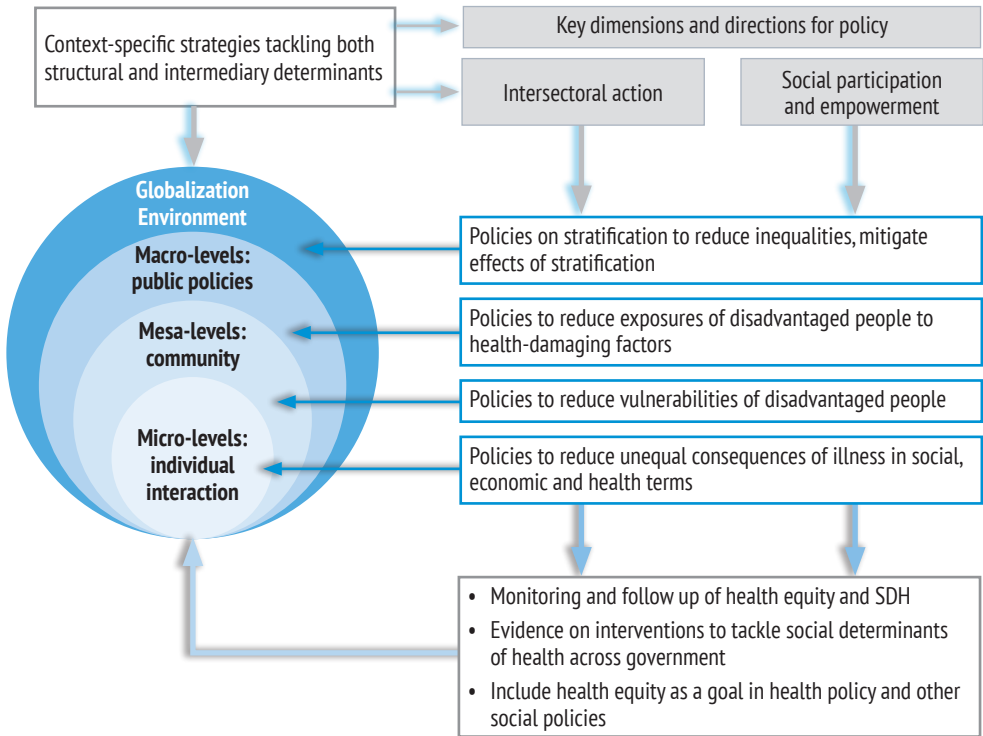


# Appendix 8

## Health equity and its determinants in the Western Pacific Region

Health inequities have continued to pose challenges to health and development efforts in the Western Pacific Region. For example, compared to urban regions, women in rural areas have reduced access to skilled health personnel at their deliveries in Cambodia (72% cf. 95%), the Lao People’s Democratic Republic (31% cf. 80%) and the Philippines (68% cf. 85%).<sup>(1)</sup> Social gradients in health burdens persist in the Western Pacific Region, with the gaps in TB prevalence between the highest- and lowest-income households being as high as 5% in China and 9% in the Philippines.<sup>(2)</sup> Health and health equity are significantly determined by social, economic and environmental factors, including access to health care (Fig. 8.1).

**FIGURE 8.1** Framework for action on social determinants of health



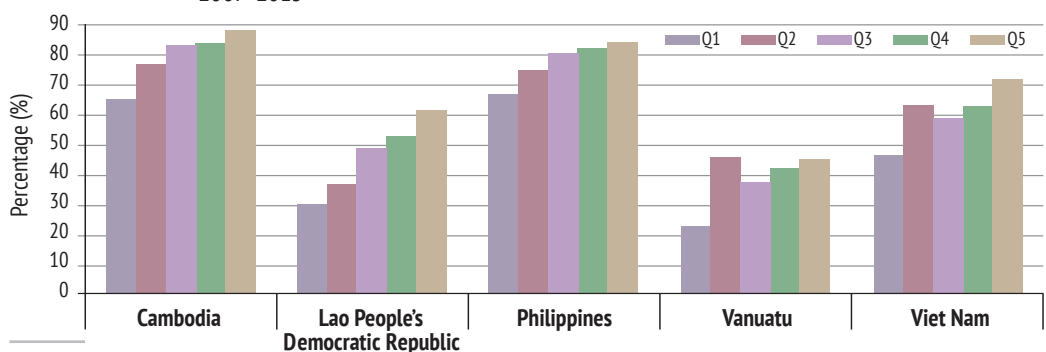
### Improving access to the health-care system

Despite their poorer health, people from poorer or socially excluded households are less likely than others to receive the health services they need. For example, children from the poorest households are often least likely to be vaccinated (Fig. 8.2a). Out-of-pocket payments reduce the use of services, particularly for those from the poorest households. For example, out-of-pocket payments amount to more than 30% of total health expenditures in selected countries in the Region, with Cambodia, the Philippines, Singapore and Viet Nam being among the highest (Fig. 8.2b).

Similarly, data suggest rural–urban differences in access to health services, drawing attention to the geographic barrier in access to health services. For example, compared to those in urban settings, women living in rural areas are less likely to have access to antenatal care (Fig. 8.3).

**FIGURE 8.2** Financial barriers in access to health services, selected countries, Western Pacific Region

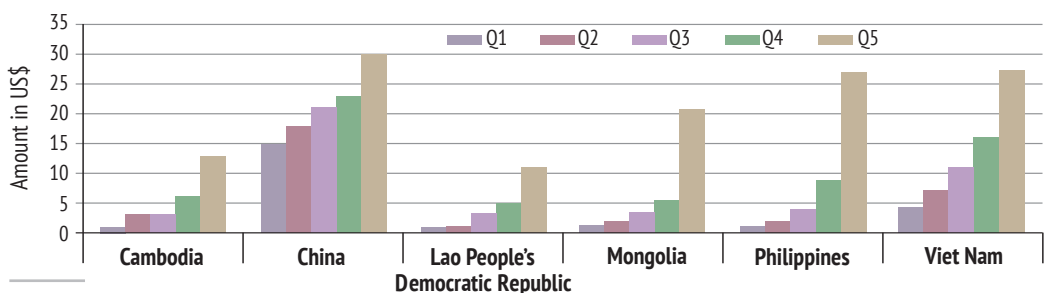
**FIGURE 8.2a** Percentage of children with full immunization coverage, by household wealth quintile (Q), 2007–2013



Source:

Health Equity Monitor: Full Immunization Coverage among one-year-olds by Economic Status. In: Global Health Observatory data Repository [online database]. Geneva: World Health Organization; 2016. (<http://apps.who.int/gho/data/view.main.94200>, accessed 30 May 2016).

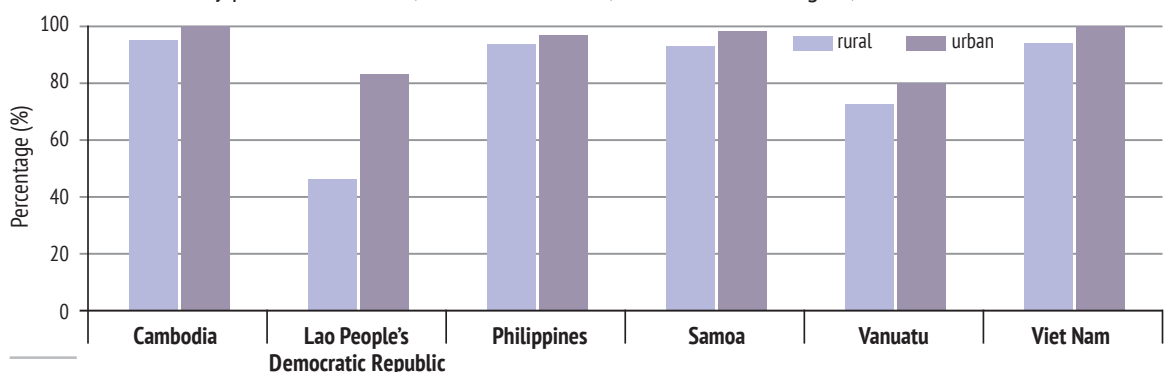
**FIGURE 8.2b** Monthly household out-of-pocket expenditures by income quintile (Q), 2007–2010



Source:

Chu A, Xu K, James C, et al. Universal health coverage: health service utilization and financial burden of health payments in six Asian countries. WHO Regional Office for the Western Pacific Manuscript. Manila: WHO Regional Office for the Western Pacific; 2014.

**FIGURE 8.3** Percentage of women receiving antenatal care at least once from a skilled provider, by place of residence, selected countries, Western Pacific Region, 2011–2014



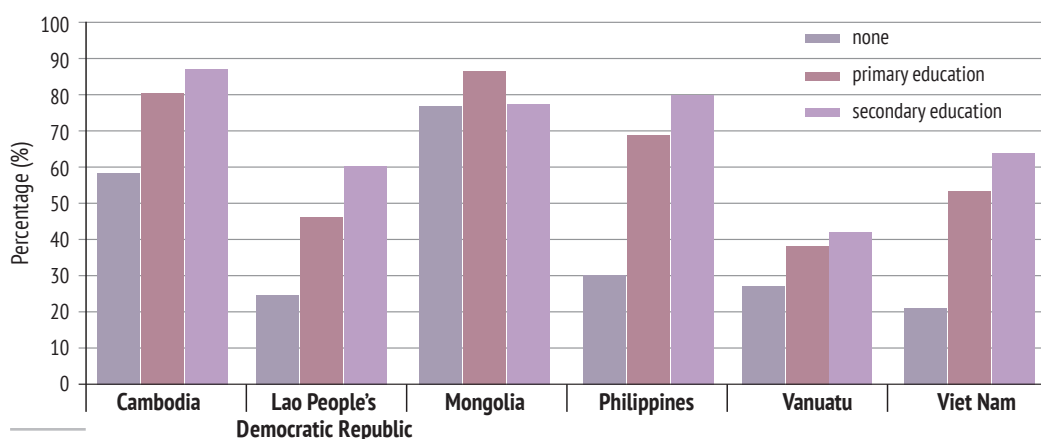
Source:

Maternal Health: Antenatal Care Coverage. In: UNICEF global databases 2015 based on DHS, MICS and other nationally representative surveys [online database]. New York: UNICEF; 2015 (<http://data.unicef.org/maternal-health/antenatal-care.html>, accessed 2 June 2016).

Rural–urban differences can also interact with gender-related barriers. Data from the Region show how women and men’s access to services differs. For example, in some countries of the Region, women have more access to antiretroviral drugs than men (Fig. 8.4a). At the same time, boys are more likely than girls to receive full immunization in the Region (Fig. 8.4b). Gender norms can also discourage or even prevent the use of health services. For example, fear and stigma often prevent women from seeking sexual health care and treatment for ill-health or injuries resulting from intimate partner violence. Violence against women and girls remains a major public health challenge in the Region.

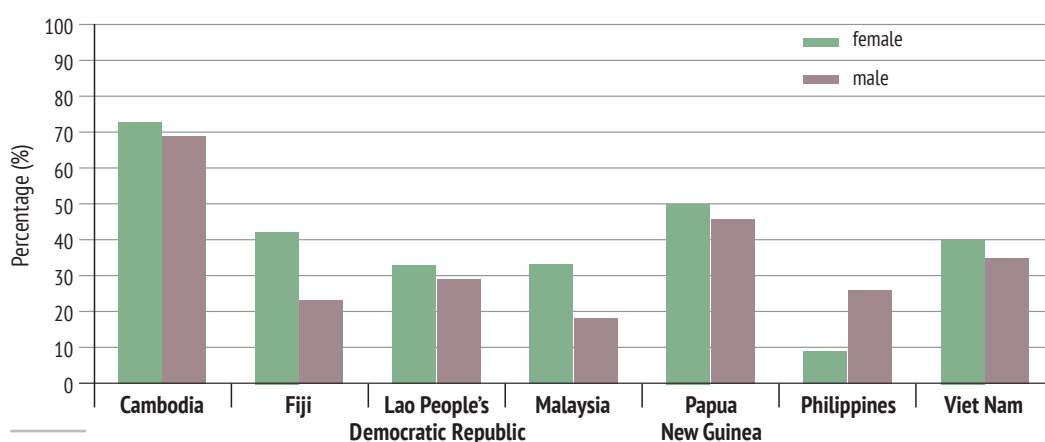
**FIGURE 8.4** Gender-related barriers to health services, selected countries, Western Pacific Region

**FIGURE 8.4a** Full immunization coverage among 1 year-old children, by maternal education, 2007–2013



Source: Health Equity Monitor: Full Immunization coverage among one-year-olds by Maternal Education. In: Global Health Observatory data Repository [online database]. Geneva: World Health Organization; 2015 (<http://apps.who.int/gho/data/node.main.HE-1589?lang=en>, accessed 30 May 2016).

**FIGURE 8.4b** Access to antiretroviral drugs, by sex, 2014



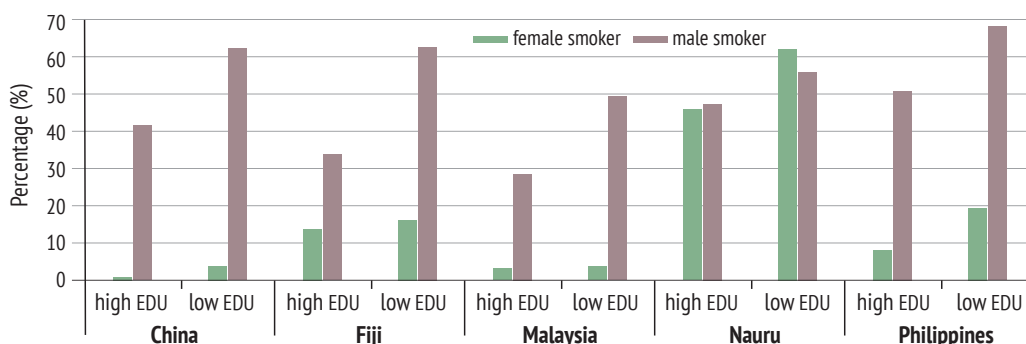
Source: Gender Statistics: Access to Anti-retroviral drugs, male and female. In: World Bank Data [online database]. Washington, DC: World Bank Group; 2016 (<http://data.worldbank.org/data-catalog/gender-statistics>, accessed 31 May 2016).

### Population risk factors

Exposure to risk factors is not evenly distributed across population groups. Differences in risk factor exposure – for example differences in smoking rates by sex and education level (**Fig. 8.5a**) – are important in explaining differences in disease prevalence. Similarly, the rate of underweight children in many settings varies significantly by rural/urban location and household income, with children from rural and poorer households being consistently worse off with adverse consequences for their health across the life course (**Fig. 8.5b**). Since 1990, the double burden of obesity and undernutrition has emerged as a growing problem. Although the number of chronically undernourished (stunted) children under 5 years of age has decreased from 54.6 million (1990) to 8 million (2014), there were 6.2 million children under 5 who were overweight in 2014. (3)

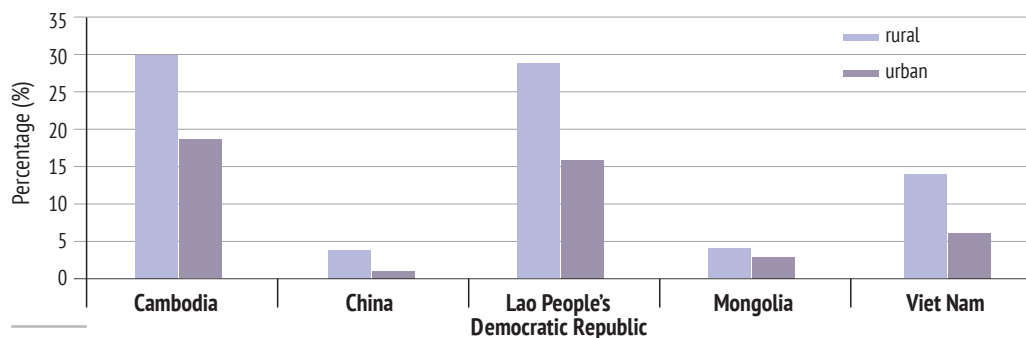
**FIGURE 8.5** Distribution of risk factors, selected countries, Western Pacific Region

**FIGURE 8.5a** Percentage of current smoker by sex and education (EDU) attainment, 2002–2006



Source: Noncommunicable disease risk factors and socioeconomic inequalities-what are the links? A multicountry analysis of noncommunicable disease surveillance data. Manila: WHO Regional Office for the Western Pacific; 2010.

**FIGURE 8.5b** Rural-urban differences in the percentage of underweight prevalence among children under 5 years, 2008–2012

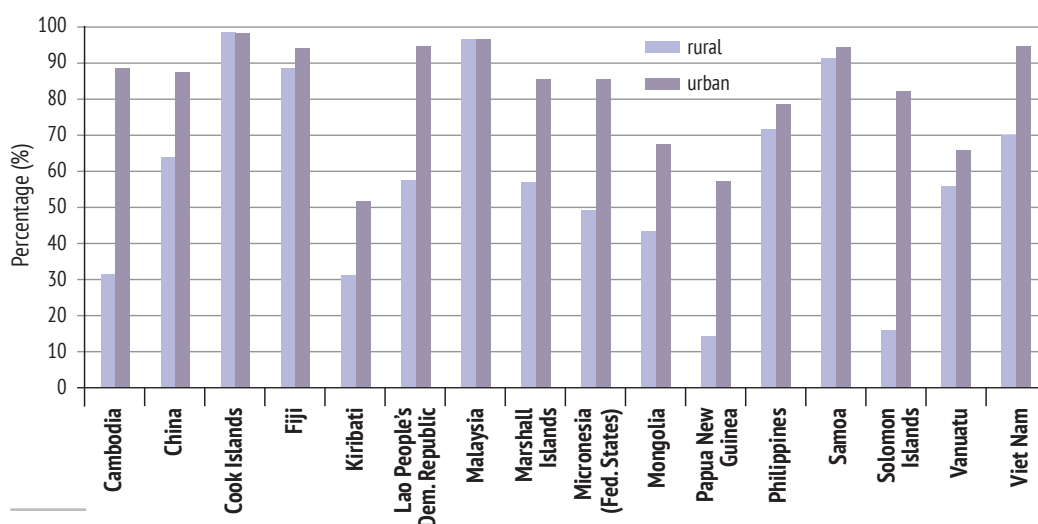


Source: Every Child Counts: The State of the World's Children 2014 in Numbers. New York: UNICEF; 2014 ([http://www.unicef.org/publications/index\\_71829.html](http://www.unicef.org/publications/index_71829.html), accessed 30 May 2016).

The material circumstances of families and communities are also key determinants of their health status. For example, access to improved drinking water and improved sanitation varies by rural or urban residence across the Region (**Fig. 8.6**). Access to adequate water and sanitation is associated with a lower risk of waterborne diseases including diarrhoea, cholera, dysentery, typhoid and hepatitis A.

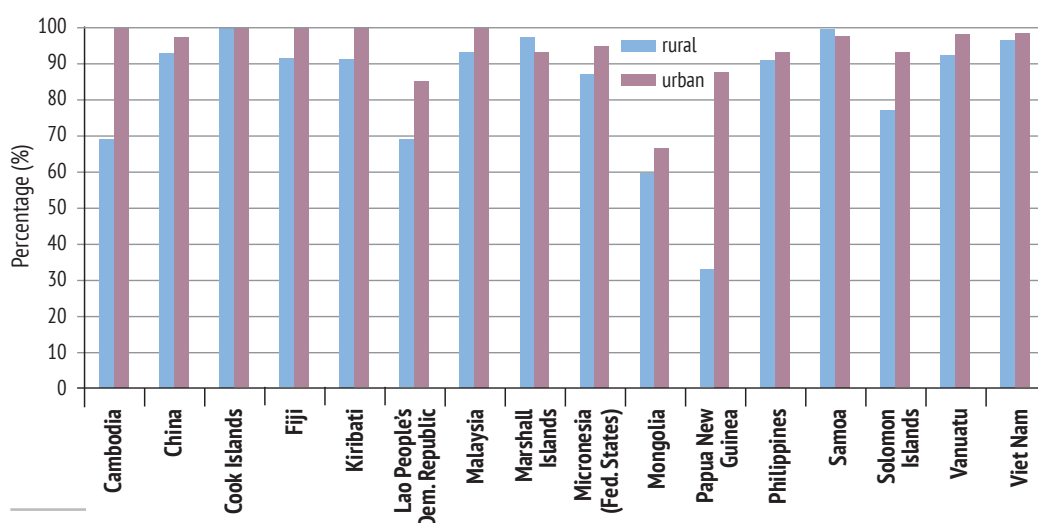
**FIGURE 8.6** Differential access to water and sanitation, selected countries, Western Pacific Region

**FIGURE 8.6a** Proportion of population using an improved sanitation facility, by residence type, 2015



Source: Public Health and Environment: Population using improved sanitation facilities. In: Global Health Observatory data Repository [online database]. Geneva: World Health Organization; 2015 (<http://apps.who.int/gho/data/node.main.167?lang=en>, accessed 30 May 2016).

**FIGURE 8.6b** Proportion of population using an improved drinking-water source, by residence type, 2015

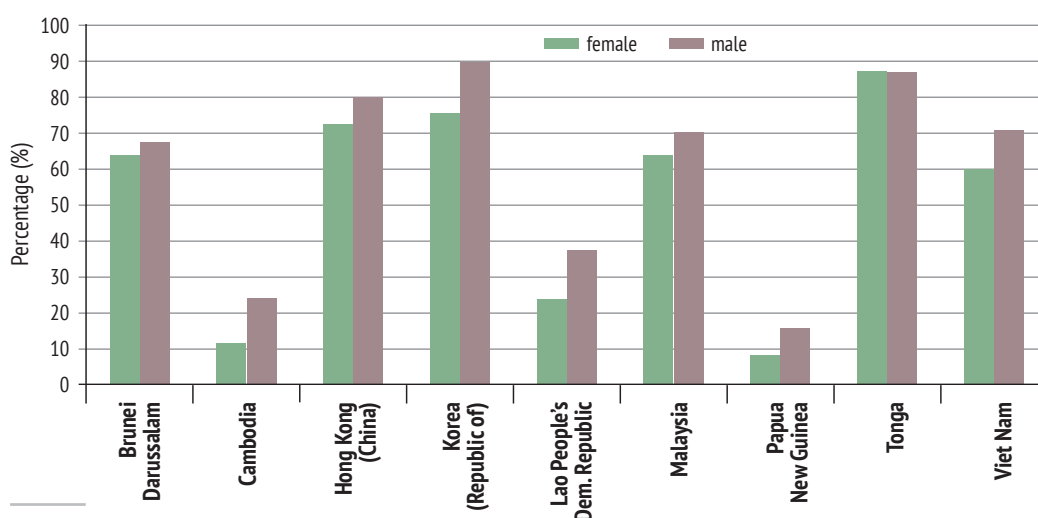


Source: Public Health and Environment: Population using improved drinking-water sources. In: Global Health Observatory data Repository [online database]. Geneva: World Health Organization; 2015 (<http://apps.who.int/gho/data/node.main.167?lang=en>, accessed 30 May 2016).

The social determinants of health (SDH) operate independently, but also interact with each other. For example, gender inequalities result in typically lower school enrolment rates for girls than boys and poorer health outcomes (Fig. 8.7a). Older age groups have higher levels of illiteracy, and across the Region older men have higher literacy rates than older women, with low- and middle-income countries showing the widest gender gaps (Fig. 8.7b). As women live longer than men, they are more likely to face poverty and deprivation in old age, exacerbated by lower rates of education, employment and well-being over the course of their lives.

**FIGURE 8.7** Education, employment and health, selected countries, Western Pacific Region

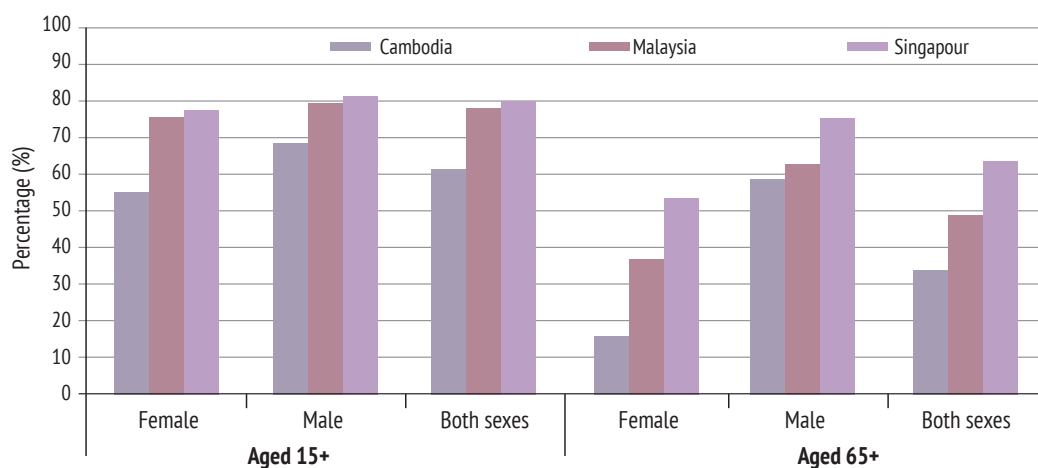
**FIGURE 8.7a** Percentage of population with at least secondary education, by sex, 2005–2014



Source:

Statistical Appendix: Table 5: Gender Inequality Index. In: Human Development Report 2015: Work for Human Development. New York: United Nations Development Programme; 2015 [http://hdr.undp.org/sites/default/files/2015\\_human\\_development\\_report.pdf](http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf), accessed 30 March 2016).

**FIGURE 8.7b** Rates of literacy in adult population aged 15+ and 65+, by sex, 2009–2010



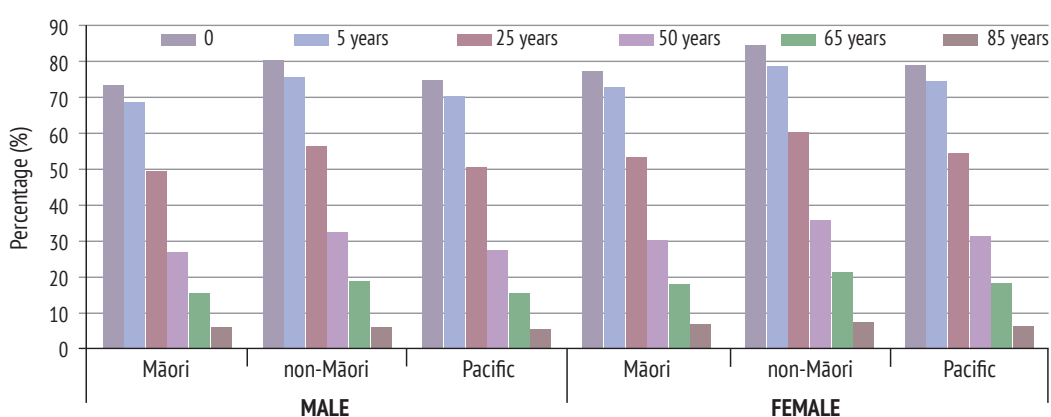
Source:

Literacy rates among adult population (15+) and elderly population (65+), male and female. Canada: UNESCO Institute for Statistics [online database]; 2015 (<http://data.uis.unesco.org/>, accessed 30 May 2016).

Other determinants such as ethnicity interact with gender and age. For example, in New Zealand, life expectancy among non-Māori people is higher than Māori and Pacific populations, with female Māori being higher than male Māori (Fig. 8.8a). In Australia, life expectancy varies by sex and ethnic group, with Aboriginal and Torres Strait Islanders being consistently worse off (Fig. 8.8b).

**FIGURE 8.8** Ethnicity and health, Western Pacific Region

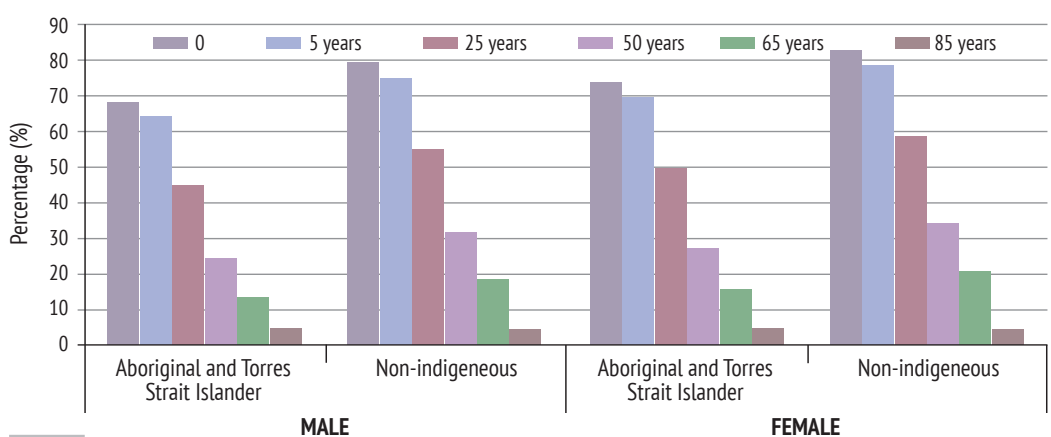
**FIGURE 8.8a** Life expectancy in New Zealand, by ethnic groups and sex, 2012–2014



Source:

Source: New Zealand Period Life Table 2012–2014. New Zealand: StatisticsNZ [online database]; 2015 ([http://www.stats.govt.nz/browse\\_for\\_stats/health/life\\_expectancy/NZLifeTables\\_HOTP12-14.aspx](http://www.stats.govt.nz/browse_for_stats/health/life_expectancy/NZLifeTables_HOTP12-14.aspx), accessed 31 May 2016).

**FIGURE 8.8b** Life expectancy in Australia, by ethnic groups and sex, 2010–2012



Source:

Life Tables for Aboriginal and Torres Strait Islander Australians. Australia: Australia Bureau Statistics [online database]; 2013 (<http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3302.0.55.0032010-2012?OpenDocument>, accessed 31 May 2016).

## Social, economic and political contexts

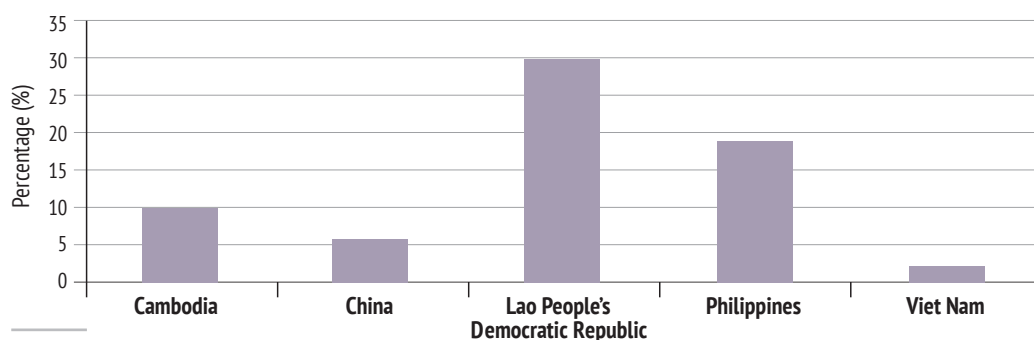
It is the structural drivers of the conditions of daily life at the global, regional, national and local levels that drive health inequities. A household's income is an important determinant of its capacity to meet the basic needs of its members, such as food, water, education and health services. However, many countries in the Region continue to have high levels of income inequality. The Gini index<sup>8</sup> is one measure of income inequality within countries (Fig. 8.9). Between 2002 and 2012, the Gini index increased in the Lao People's Democratic Republic from 34.7 to 37.9. Slight increases were also noted in Viet Nam (37.3 to 38.7) and Mongolia (32.9 to 33.8).<sup>(4)</sup>

The drivers and conditions of poverty include more than low income. They include a lack of economic opportunities, low levels of education and poor health outcomes, as well as lack of access to resources, services and skills. Poverty typically overlaps with and reinforces other types of social exclusion, such as those based on gender, ethnicity, race, age or geographical location. Ten per cent of the population in Cambodia, 19% in the Philippines and 30% in the Lao People's Democratic Republic live below the income poverty line of purchasing power parity (PPP) of US\$ 1.25 per day (Fig. 8.9).

When looking at the Human Development Index (HDI),<sup>9</sup> which is a composite measure combining indicators of life expectancy, educational attainment and income, it is important to note that a country's overall index can conceal the fact that various groups within the country have very different levels of development. The Inequality-adjusted Human Development Index (IHDI) reveals how inequality hampers development, when compared to the unadjusted HDI. As figure 8.9c shows, the level of human development in every country is lower when adjusted for inequality.

**FIGURE 8.9** Socioeconomic environment, macroeconomic trends, selected countries, Western Pacific Region

**FIGURE 8.9a** Percentage of population living below income poverty line, PPP US\$ 1.25 a day, 2010–2013



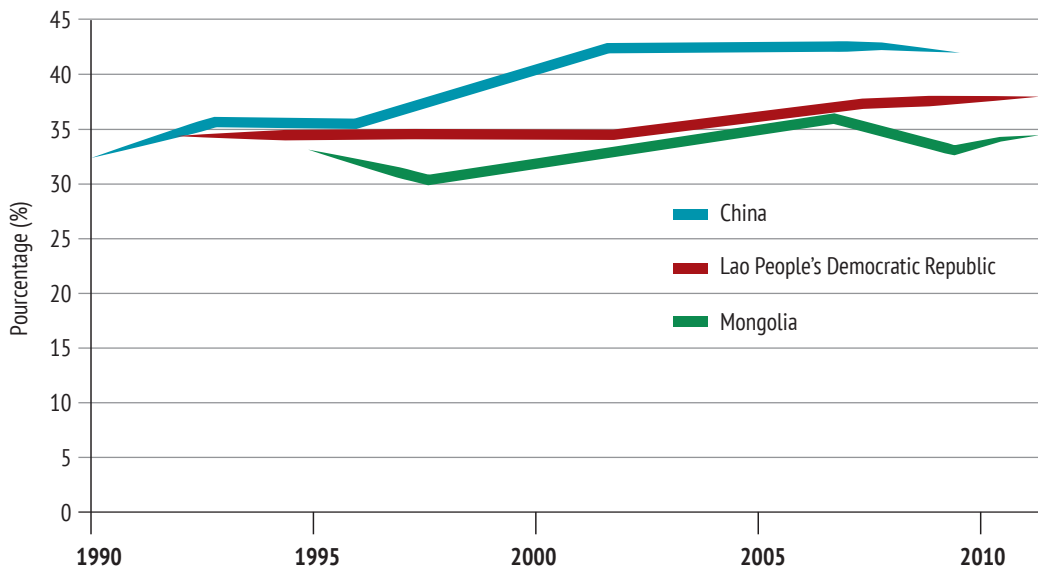
Source:

Statistical Appendix: Table 6: Multidimensional Poverty Index: developing countries. In: Human Development Report 2015: Work for Human Development. New York: United Nations Development Programme; 2015 ([http://hdr.undp.org/sites/default/files/2015\\_human\\_development\\_report.pdf](http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf), accessed 30 March 2016).

8. The Gini index or coefficient is a measure of income inequality within countries. It ranges from 0 to 100, with 0 representing perfect equality and 100 perfect inequality.
9. The Human Development Index (HDI) is a composite measure of overall human development in a given country by combining three key dimensions of human development (a long and healthy life, being knowledgeable, and having a decent standard of living). The Inequality-adjusted Human Development Index (IHDI) goes beyond averages by aiming to capture the distribution of development achievements. It thus takes into account the human development cost of inequality, or the loss to human development due to inequality. The IHDI is equal to the HDI if perfect equality exists, but falls below the HDI when inequality rises.



FIGURE 8.9b Gini coefficient index, 1990–2012



Source:

World Development Indicators: GINI Index (World Bank Estimate). In: World Bank Data [online database]. Washington, DC: World Bank Group; 2016 (<http://databank.worldbank.org/data/reports.aspx?source=world-development-indicators>, accessed 30 May 2016).

FIGURE 8.9c HDI compared to inequality-adjusted HDI, 2014



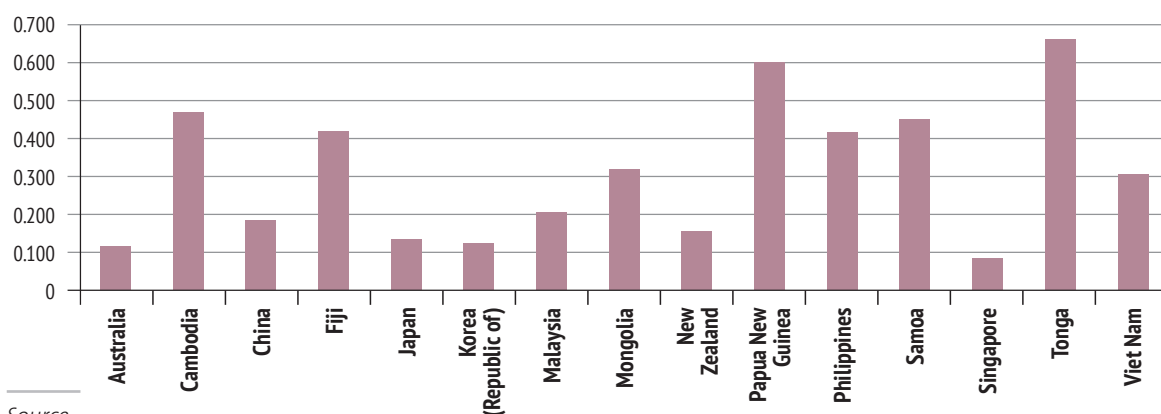
Source:

Statistical Appendix: Table 3: Inequality-adjusted Human Development Index. In: Human Development Report 2015: Work for Human Development. New York: United Nations Development Programme; 2015 ([http://hdr.undp.org/sites/default/files/2015\\_human\\_development\\_report.pdf](http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf), accessed 30 March 2016).

Gender inequality, a significant determinant of health status, remains a challenge in the Western Pacific Region, as elsewhere. Women lag behind men in almost every social and economic indicator of well-being. For example, the Gender Inequality Index (GII)<sup>10</sup> varies widely across countries of the Region, from a low of 0.088 in Singapore, indicating high levels of equality, to a high of 0.666 in Tonga, showing substantial gender inequality (Fig. 8.10).

The environment is another key determinant of health. For example, the total deaths attributable to joint effects of both household and ambient air pollution was significantly higher in 2012 among the Region’s low- and middle-income countries (2.8 million deaths) than among its high-income countries (68 000 deaths).<sup>(6)</sup> In the same year, the environment-related disease burden was estimated to be 25% in countries not members of the Organisation for Economic Co-operation and Development (OECD), and 13% in high-income OECD countries.<sup>(5)</sup>

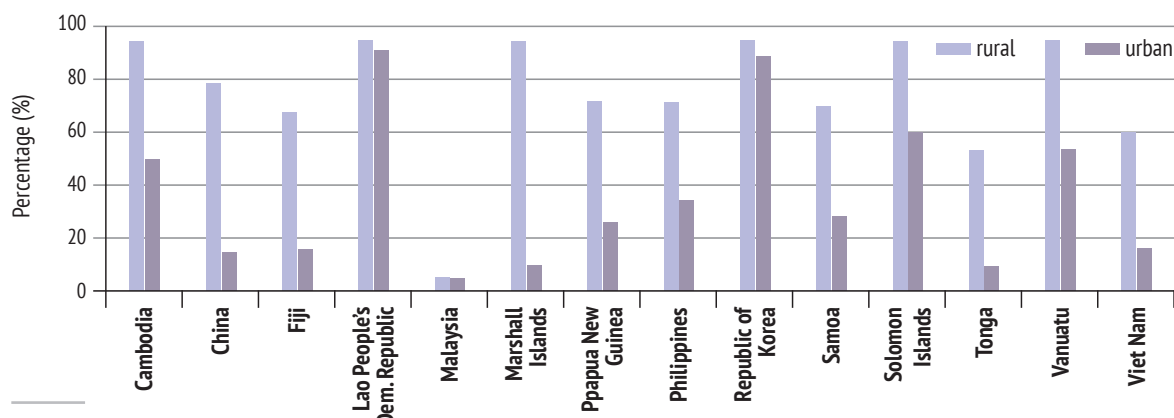
**FIGURE 8.10** Gender inequality index, selected countries, Western Pacific Region, 2014



Source:

Statistical Appendix: Table 5: Gender Inequality Index. In: Human Development Report 2015: Work for Human Development. New York: United Nations Development Programme; 2015 ([http://hdr.undp.org/sites/default/files/2015\\_human\\_development\\_report.pdf](http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf), accessed 30 March 2016) ([http://hdr.undp.org/sites/default/files/2015\\_human\\_development\\_report.pdf](http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf), accessed 30 March 2016).

**FIGURE 8.11** Percentage of population using solid fuels, by place of residence, selected countries, Western Pacific Region, 2013



Source:

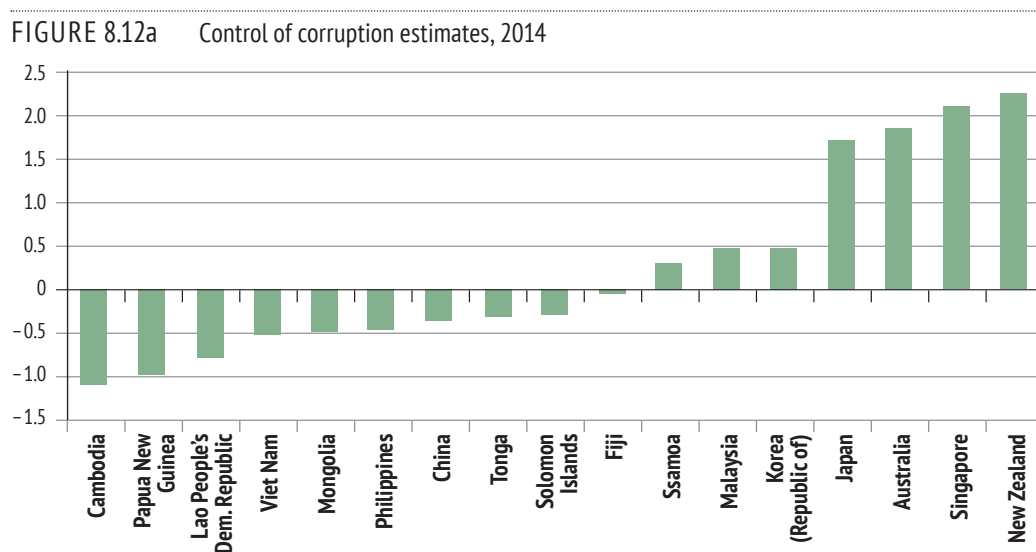
Public Health and Environment: Population using solid fuels. In: Global Health Observatory data Repository [online database]. Geneva: World Health Organization; 2015 (<http://apps.who.int/gho/data/view.main.1701>, accessed 30 May 2016).

10. The Gender Inequality Index is a composite measure of gender inequality in a country that combines discrimination in health, education and the labour market, with 0 representing perfect equality to 1 representing perfect inequality.

Achieving the SDGs requires maximizing opportunities for gains in health, through partnership between health and other sectors. For example, it is in the interest of both the health and the environment sectors to tackle air pollution and climate change. Climate change exacerbates and worsens environmental conditions in all settings, resulting in floods, droughts, cyclones, heatwaves and other extreme weather events. These changes go beyond the control of one sector, or even one country. In 2012, environmental risk factors such as pollution of air, water or soil by chemical or biological agents, climate change, and ultraviolet radiation are responsible for more than 3.5 million annual deaths in the Region.<sup>(5)</sup> This burden is unequally borne by the low- and middle-income countries, exacerbating problems those countries already faced.

The SDG agenda also raises the question of whether institutional and governance structures are adequate to the challenges (Fig. 8.12). Considerable variation exists in arrangements for accountability and governance. Institutional fragmentation and unsustainable financing options are particular challenges. Multiple stakeholders and partners will need to be involved in addressing the SDGs across various sectors and levels, which makes implementation particularly complex, especially in decentralized settings.

**FIGURE 8.12** Indicators on accountability and good governance, selected countries, Western Pacific Region



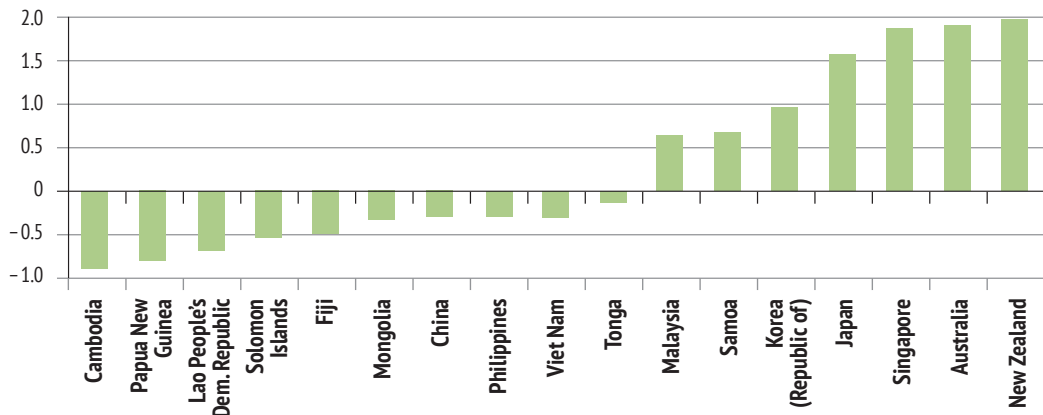
Adapted from:

Worldwide Governance Indicators: Control of Corruption Estimate. In: World DataBank [online database]. Washington, DC: World Bank Group; 2015 (<http://databank.worldbank.org/data/reports.aspx?source=worldwide-governance-indicators&preview=on#>, accessed 31 May 2016).

Note:

Control of corruption estimates capture perceptions of the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as “capture” of the state by elites and private interests. Estimates give a country’s score on the aggregate indicator, in units of a standard normal distribution, i.e. ranging from approximately – 2.5 to 2.5. Source: Kaufmann, Daniel, Aart Kraay and Massimo Mastruzzi (2010). “The Worldwide Governance Indicators: Methodology and Analytical Issues”. World Bank Policy Research Working Paper No. 5430 ([http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1682130](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1682130)).

FIGURE 8.12b Rule of law estimates, 2014



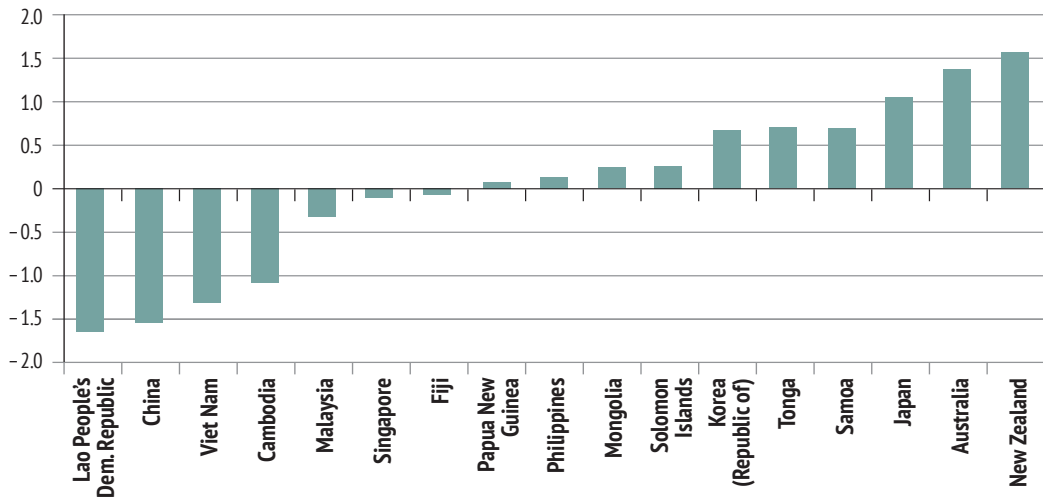
Adapted from:

Worldwide Governance Indicators: Rule of Law Estimate. In: World DataBank [online database]. Washington, DC: World Bank Group; 2015 (<http://databank.worldbank.org/data/reports.aspx?source=worldwide-governance-indicators&preview=on#>, accessed 31 May 2016).

Note:

Rule of law estimates capture perceptions of the extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence. Estimates give a country's score on the aggregate indicator, in units of a standard normal distribution, i.e. ranging from approximately -2.5 to 2.5. Source: Kaufmann, Daniel, Aart Kraay and Massimo Mastruzzi (2010). "The Worldwide Governance Indicators: Methodology and Analytical Issues". World Bank Policy Research Working Paper No. 5430 ([http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1682130](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1682130)).

FIGURE 8.12c Voice and accountability estimates, 2014



Adapted from:

Worldwide Governance Indicators: Rule of Law Estimate. In: World DataBank [online database]. Washington, DC: World Bank Group; 2015 (<http://databank.worldbank.org/data/reports.aspx?source=worldwide-governance-indicators&preview=on#>, accessed 31 May 2016).

Note:

Voice and accountability estimates capture perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media. Estimates give a country's score on the aggregate indicator, in units of a standard normal distribution, i.e. ranging from approximately -2.5 to 2.5. Source: Kaufmann, Daniel, Aart Kraay and Massimo Mastruzzi (2010). "The Worldwide Governance Indicators: Methodology and Analytical Issues". World Bank Policy Research Working Paper No. 5430 ([http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1682130](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1682130)).

## Universal health coverage as a unifying platform

UHC – defined as all people and communities having access to quality health services without suffering financial hardship associated with paying for care – is the overarching vision for health systems development. It is a platform that can bring health and development efforts together with a common purpose. Endorsed by the WHO Regional Committee for the Western Pacific in October 2015, *Universal Health Coverage: Moving Towards Better Health* is a regional action framework that has been developed to support countries in realizing this vision of better health through UHC. It outlines shared principles of UHC and reflects the values of the WHO Constitution, the Health for All agenda set by the Alma-Ata Declaration in 1978 and multiple World Health Assembly resolutions. The action framework emphasizes a comprehensive, whole-of-system approach and multisectoral collaboration in reducing health risk factors and improving health outcomes. There is no one-size-fits-all formula to achieve UHC, as health systems necessarily reflect their social, economic and political contexts, as well as historical decisions about national priorities. Fifteen action domains are outlined across the five essential health system attributes – quality, efficiency, equity, accountability and sustainability and resilience. These attributes are reflected in health policy objectives across the Region, while the actions echo country, regional and global experiences.

## Moving forward

Achieving the SDGs will mean building on the lessons learnt from the MDGs. To strengthen accountability, good data, robust review processes and strong analysis remain critical to monitor progress and refine actions. However, the SDGs also introduce new topics, perspectives and emerging challenges for health and its determinants. Lessons learnt from the MDG era highlight the need for strong partnerships across sectors, across stakeholders and across affected communities. The SDGs respond to lessons learnt, calling for changes in strategy, both in the health sector and beyond. The overarching principle of leaving no one behind and the linkages between diverse targets and goals require collaboration across sectors, between stakeholders and with communities. It also calls for a changed role and capabilities for the health sector to inform, influence and institutionalize action that has a direct or indirect benefit for health.

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