Reaching those who are left behind: Health, the SDGs and the role of Universal Health Coverage – next steps in South-East Asia Region

Report of the Regional Consultation, 30 March – 1 April 2016, New Delhi, India

World Health Organization
Regional Office for South-East Asia

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1. Introduction

The year 2016 is a time of significant change in thinking about how governments can accelerate improvements in people's health and in development in general. The 17 Sustainable Development Goals (SDGs) were adopted in late 2015, and encourage an integrated approach to sustainable development, with a focus on the most vulnerable. The health goal (SDG3) is broad: *'Ensure healthy lives and promote well-being for all at all ages'*. It is framed as a contributor to and beneficiary of progress on many other SDGs. Many questions are being raised. What do the SDGs mean in practice for improving health? What role can Universal Health Coverage (UHC) play in advancing the health goal? What can national (and local) governments and their partners do to accelerate progress? Does it mean changing priorities, or is it more about ***how we work*** on those priorities?

The objectives of the consultation therefore were to:

- Discuss how the SDGs can be an opportunity to accelerate progress in health in the South-East Asia Region (SEAR);
- Examine the role of UHC in achieving health SDG targets;
- Identify next steps for advancing UHC in SEAR, in the context of the SDGs.

The programme (Annex 1) was organized around four main thematic areas:

- Who is still being left behind?
- Improving frontline services and access to care, from birth to old age;
- Improving financial protection;
- Measurement and accountability for progress on UHC and the health SDGs.

There were 130 participants from all 11 SEAR Member States: from governments, WHO, other international development partners, nongovernmental organizations and academia (Annex 2).

In the opening session, Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region, and Dr Anarfi Asamoa-Baah, WHO Deputy Director-General, highlighted changes in development thinking in the last 15 years, which are now reflected in the SDGs. The key differences between the Millennium Development Goals (MDGs) and the SDGs were clearly set out: the SDGs include all countries, not just 'developing' countries; the emphasis is now squarely on an integrated approach to development, which will require big cultural shifts in how individuals and institutions work; sustainable development is not possible with international development assistance alone, and domestic and international funding have to be considered together; there is a much greater emphasis on equity in the SDGs, which means new approaches to reaching those being left behind will be needed, rather than simply doing more of the same. They noted that the key idea of UHC is that all people receive the care they need, without incurring financial hardship. It therefore provides a strong underpinning for the SDG call to leave no one behind.

All presentations are available at: http://www.searo.who.int/entity/uhc2016

2. Concluding key messages

1. **The challenge:** The goal of SDG3 is to leave no one behind, but 130 million people still lack access to one or more essential health services; at least 50 million people are impoverished because of health-care costs.
2. **The SDGs are ambitious**, **but they provide an opportunity** to accelerate improvements in health. They require new ways of working and emphasize the need for integration. This is not easy and it will take time to develop new approaches.
3. **UHC underpins the SDG health targets:** UHC focuses on leaving no one behind and fosters more integrated action across the health targets. UHC is a useful and tangible way of taking the health SDGs forward.
4. **Averages disguise inequities:** Better information is needed on who is being left behind and why. Everyone needs to be counted; new techniques and information as well as communication technologies (ICT) offer opportunities to do this better.
5. **There is much happening already:** SEAR countries are taking action on different aspects of UHC – on extending services to more people; on extending the range of services; and on extending financial protection. No country is starting from zero.
6. **Progress towards UHC will be gradual:** by increasing the range and reach of services available; reducing out-of-pocket (OOP) payments; creating better systems for monitoring; and more effective accountability. Progress can be difficult but possible. It is important to have a clear sense of where you want to get to, and then take things step-by-step.
7. **Countries are unique but share similar challenges** – and sometimes similar solutions. There is much to be gained by sharing experiences. Tackling new challenges means widening the scope of services to include noncommunicable diseases (NCDs), mental health and disability; addressing ageing populations; ensuring more resilient health systems in a region repeatedly affected by natural disasters; and harnessing new technologies.
8. **There is a need for better linkages within the health sector** to make progress and use resources equitably and efficiently.
9. In the spirit of the SDGs, **stronger linkages between health and other sectors are needed,** for example, to improve access to medicines and the health workforce. In addition, exclusion will not be properly tackled without addressing determinants of health.
10. This meeting is part of **a continuing conversation**. The strength of the meeting was the range of points of view represented from within the health sector. National consultations on the implications of the SDGs for health are being scheduled in a number of countries in the Region, and are the critical next step.

3. Summary of discussions: key issues and next steps

3.1 Who is being left behind?

Key issues

In SEAR, at least 130 million people still lack access to one or more essential health services, and 50 million people are impoverished as a result of health-care spending. The analysis of available data for SEAR, using the same indicators as the 2015 WHO/World Bank global UHC monitoring report, also revealed significant inequalities in coverage for 'MDG services' by income, education and urban/rural location. These are well known. The same analysis is not yet possible for NCD service coverage, but coverage is generally considered to be lower.

Box 1. Where are we now? The evolving situation in SEAR

- 130 million people in SEAR still lack access to one or more essential health services
- 50 million people in SEAR are impoverished as a result of health-care spending
- From 2015 to 2030, the number of people aged 60+ will rise from 186 million to 312 million
- The number of people over 60 years will outnumber under-fives by 2020.

In addition to exclusion from specific services, exclusion from health care more generally by different population groups was discussed. Those at higher risk of exclusion include ethnic minorities; migrants, mobile populations and refugees; people whose behaviours, identities or health conditions are stigmatized – such as sex workers or people with HIV; women in some cultures and also the urban poor. Insufficient information was a prominent theme: we still do not know enough about who is being excluded, and averages disguise huge inequities: *'Everyone counts but we do not count everyone'.*

Conclusions and next steps

- Those left behind in health care are commonly excluded on many counts in society, and there are no easy 'off-the-shelf' responses. Whatever happens, excluded groups should not be treated as if it is 'their fault'.
- Better and more disaggregated data are essential if the visibility of excluded groups is to improve. So are more imaginative ways to collect data, because formal information systems will continue to be insufficient.

3.2 Improving frontline services and access to care, from birth to old age

Four interrelated topics were discussed; across all, action is needed to achieve sustained improvements in access to care when needed, from birth to old age.

Expanding access to a broader range of services, to address changing needs

Key issues

Countries continue efforts to address the *'unfinished MDG agenda'*. At the same time, many are beginning to expand their range of frontline services to include NCDs. Multiple approaches were identified that included: bundling of health services; redesigning work processes and finding new ways to use health workers; introducing more community-based care including mobile and outreach services; team-based care; partnerships with NGOs and the private sector; revising free medicines policies; more use of strategic purchasing; and more explicit accountability of both public and private providers. Improved quality of care in frontline services – public and private – was seen as critical if use of frontline services – which are often bypassed – is to increase. More harmonized approaches to quality improvement would be beneficial.

Conclusions and next steps

- Frontline services will remain key to reach those left behind, and to respond to new health needs as reflected in the SDGs and UHC.
- Fresh thinking on alternative frontline service delivery models is urgently needed in SEAR; this will include addressing links with/referrals to and from secondary care, and quality of care.
- Expanding access to care involves multiple interventions; it requires political leadership, effective governance and explicit change management strategies.
- Partnerships with NGOs and the private sector may help address some aspects of exclusion, and these actors need to be brought into discussions.
- More syntheses of experience with service delivery models, with evidence of their effectiveness in addressing gaps in care, and providing value for money, would be useful.

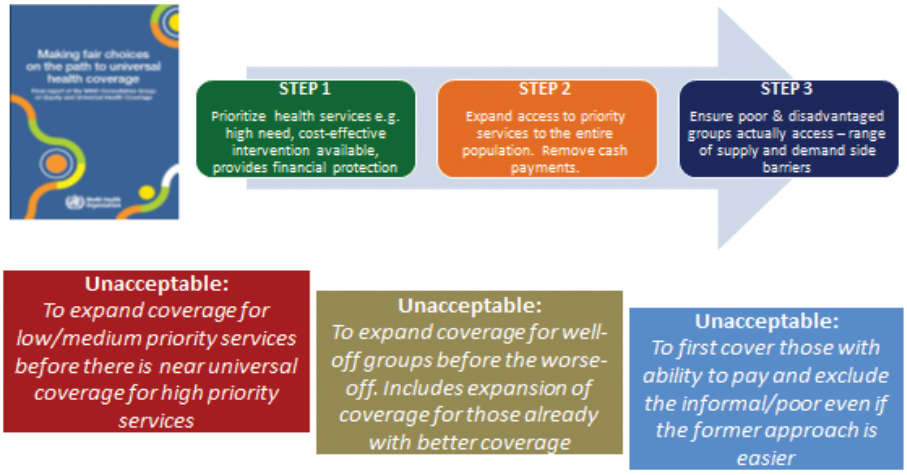
Priority setting to benefit the most needy

Key issues

Adopting the SDGs, and within that UHC, does not mean that everyone is entitled to any care they want. Choices have to be made for the use of public funds. In practice we all do priority-setting all the time, though it is neither always systematic nor transparent. In real life, policy-makers' room to manoeuvre for reprioritization within public budgets can also be limited. However, priorities can be set in a more systematic way and then implementation and results monitored**.** The selection of new technologies and medicines for public funding in Thailand is one practical example of a systematic process. In any priority-setting exercise, a special focus is needed on disadvantaged population groups. Major criteria to be used are affordability, equity and feasibility (including current capacity to deliver interventions).

'Value for money is not only to ensure efficient use of health resource but also for ethical justification of using public money' (Siriwan)

Box 2. Approach to priority-setting: some ideas



Source: Matthew Jowett; WHO. Session 5- Priority Setting: Linking resources to benefits for the most needy

Conclusions and next steps

- There is a need to increase understanding of priority-setting processes in the Region, so that decisions are incorporated into budget allocation processes and then ultimately reflected in access to needed services. WHO will review different priority-setting exercises, and share findings with Member States.
- Priority-setting exercises, as part of a wider policy process, are only useful if they will change how resources are allocated. Prior to any priority-setting exercise, a brief assessment of the feasibility of applying the findings should be done; during the exercise, that practical perspective also needs to be maintained.

Maintaining momentum on health workforce strengthening

Key issues

To address gaps in health services and advance UHC, concerted action is needed on human resources for health (HRH), remembering that the health workforce is a means to an end, not an end in itself. There is a pressing need to rethink HRH strategies to take into account not only quantity and quality, but also competencies and skill mix to meet changing health needs. The Decade for Strengthening Human Resources for Health in SEAR 2015–2024 provides a realistic timeframe for progress, and reflects political commitment. Countries are taking many actions in health workforce education, retention and reorientation of work processes and of cadres. Many national stakeholders and international development agencies are involved. But more action is needed, including addressing the nonclinical health workforce.

Box 3. Links between the health workforce and the rest of the health system

Source: Diah S. Saminarsih, Session 7 – Towards Sustainable Health in Indonesia. Improving frontline services: Maintaining the momentum on health workforce strengthening

Conclusions and next steps

- HRH discussions must be linked to those on service delivery, including community-based health services.
- The high-level action – and intersectoral action – needed to make progress on health workforce reform is still limited in many countries.
- Regional HRH events will be used to take forward discussions from this consultation: the first review of progress on the Decade in April 2016; meetings of regional networks SEARAME and AAAH[1] in late 2016, and the WHO South-East Asia Regional Committee in September 2016.

Improving access to medicines

Key issues

Medicines are a major source of OOP spending and so closely tied to impoverishment, especially as noncommunicable diseases increase. There are many areas where action can be taken: in medicines selection; better monitoring and transparency in medicines pricing, availability and use; opportunities for small countries to leverage approaches of bigger countries in procurement, and regulation of quality; efficiency gains from merging parallel procurement systems; developing policies that include all players – public, private and NGOs; having HRH policies that explicitly include people trained to manage medicines.

1 SEARAME and AAAH stand for South-East Asia Regional Association for Medical Education and Asia-Pacific Action Alliance on Human Resources for Health, respectively.

Box 4. How access to medicines has been improved

- ***Improving procurement and distribution of essential medicines in Bhutan.*** Bhutan is a small mountainous country, with good but not universal access to essential medicines. In 2014, two challenges persisted: poor responses from medicine manufacturers to tenders for low-volume procurement of certain medicines and insufficient transport. To improve procurement, Bhutan implemented a fast-track registration policy for 72 drugs, and obtained 'nonquoted' items directly from its procurement office based in India. To improve distribution, it expanded the fleet of trucks. As a result, availability of essential medicines improved from 96% in 2014 to 98% in 2015.
- ***Using policy and information technology in Sri Lanka.*** A wide network of health facilities exists in Sri Lanka. However, increased demand and changing prescribing patterns have revealed inefficiencies in the supply of medicines. In response, a new medicine supply management information system (MSMIS) was introduced. Sri Lanka also introduced a Drug Regulatory Act, and now convenes monthly institutional drug and therapeutics committee (DTC) meetings. As a result, availability of NCD drugs at primary care facilities improved from around 44% to 62% in 2015.
- ***Improving affordability of high-priced medicines in Thailand***. Thailand already has a good national medicine policy and qualified pharmacists managing medicines. Current challenges are affordability of high-priced medicines, orphan drugs and drug security. To improve affordability, a national committee implemented a strategic plan with centralized procurement, price negotiation, supply management, cost-effectiveness and impact evaluation. The National Health Security Office monitors drug use. The set of interventions has helped to reduce the cost of high-priced medicines.

Conclusions and next steps

- Improve information – by using/adapting existing survey tools for medicine prices and availability, and medicine management.
- Make more information publicly available, e.g., on quality testing, antibiotic use and antimicrobial resistance.
- Explore creation of a regional database on pricing information.
- Use the emerging SEAR regulators' network as a forum to discuss the regulatory issues raised in this consultation.

3.3 Improving financial protection, and implementing financing reform

Key issues

Financial protection means ensuring that no one faces financial hardship when seeking health care. This is measured by estimating the number of people who are impoverished or face catastrophic levels of spending due to health-care costs. This, of course, does not capture those who do not even seek care because they cannot afford to, for example, because of transport costs to a facility, or consultation fees.

The main cause of impoverishment is OOP payment, which is still high in many countries in SEAR. The main causes of impoverishment from OOP expenditures are medicines (especially for NCDs) and inpatient care. Better understanding of determinants of OOP payments is still needed.

There is growing experience within and beyond the Region with policies to increase financial protection – how these have been financed; what structural changes were introduced, such as merging of several insurance schemes; and other changes that also need to be considered, such as strategies to manage cost containment and access to care in remote areas.

Box 5. Implementing financing reform: international experience

Most financing reforms aim to reduce OOP expenditures. Increasing funding for health is a common entry point to financing reform; efficiency is another objective. Efficiency in spending varies across health systems globally. Even at low levels of funding, there is significant variation in health outcomes at the same level of spending, demonstrating that effectiveness in existing spending is important: both more money for health *and* more health for the money are required.

The design and implementation of reform requires good political management as well as evidence. When embarking on financing reform, the arguments to build the case for more money for health differ from country to country. In China, the benefits of reducing OOP expenditures for health were argued in terms of achieving sustainable *domestic* economic growth – as opposed to export-driven growth.

Culture and values are key in shaping health financing options. For instance, in places such as Taiwan, Japan, and the Republic of Korea , health is perceived as a good for personal consumption, and in those countries, some OOP expenditure is to be expected. It is also important to understand the needs and address the demands of different political constituencies.

Conclusions and next steps

- There is a need to better understand who is being impoverished, why and how financial protection policies are working. It is important that countries measure their progress on financial protection, including both indicators plus a measure of unmet need. Service utilization indicators, therefore, need to be disaggregated by gender,

income and geography. Research should in turn be used to trigger changes in policy, including benefits design and resource allocation.

- Medicines must be included in discussions on benefit packages. The vulnerabilities of the informal sector must also be explicitly addressed.
- Financial protection is not just a financing issue; governments need to improve quality of public services and enhance the regulation of private providers.
- SEAR countries should update health financing policies based on evidence-based health financing system diagnostics. These exercises require the use of an analytical framework that helps identify the root causes determining how a system is performing.
- The biregional SEARO-WPRO health financing policy workshop in July 2016, in which the Asian Development Bank (ADB) and the World Bank are also involved, is designed to support countries currently designing and implementing health financing reforms.

3.4 Measurement and accountability for progress on UHC and the SDGs

Key issues

In terms of SDG and UHC monitoring, the overall SDG indicator framework was adopted by the Inter-Agency Expert Group on SDG Indicators of the UN Statistical Commission in March 2016. For health, the SDG3 indicators are mostly derived from existing internationally agreed indicators. For UHC, a service coverage index consisting of 16 indicators has been agreed, for many of which data are already available; the financial protection indicator requires further discussion.

The challenge remains how to minimize the data collection and reporting burden, while maximizing the quality and use of data for policy and planning. There is a need to distinguish between what one wants, versus needs or affordability. SDG and UHC monitoring processes need to be aligned with national M&E frameworks and indicators. The emphasis in SDG monitoring discussions is on developing more flexible, comprehensive and integrated approaches to monitoring, setting national rather than global targets and having more disaggregated data to track inequity. New ICT developments and information platforms such as DHIS2, already widespread in SEAR, will help. The importance of distinguishing monitoring from accountability, as they are not the same, was emphasized.

Box 6. SDG3: overview of country data availability

	Indicator topic	Country data availability	Disaggre-gation	Comparable estimates	Source estimates
3.1.1	Maternal mortality	Fair	Poor	Annual	UN MMEIG
3.1.2	Skilled birth attendance	Good	Good	In prep.	UNICEF, WHO
3.2.1	Under-five mortality rate	Good	Good	Annual	UN IGME
3.2.2	Neonatal mortality rate	Good	Good	Annual	UN IGME
3.3.1	HIV incidence	Fair	Fair	Annual	UNAIDS
3.3.2	TB incidence	Fair	Fair	Annual	WHO
3.3.3	Malaria incidence	Fair	Fair	Annual	WHO
3.3.4	Hepatitis B incidence	Poor	Poor	In prep.	WHO
3.3.5	Neglected tropical diseases at risk	Fair	Poor	Annual	WHO
3.4.1	Mortality due to NCD	Fair	Poor	Every 2-3 years	WHO
3.4.2	Suicide mortality rate	Fair	Poor	Every 2-3 years	WHO
3.5.1	Treatment substance use disorders	Poor	Poor	Not available	UNODC, WHO
3.5.2	Harmful use of alcohol	Fair	Poor	Annual	WHO
3.6.1	Deaths road traffic injuries	Fair	Poor	Every 2-3 years	WHO
3.7.1	Family planning	Good	Good	Annual	UNPD
3.7.2	Adolescent birth rate	Good	Good	Annual	UNPD
3.8.1	Coverage index UHC	Good	Fair	In prep.	WHO, World Bank
3.8.2	Financial protection	Fair	Fair	In prep.	WHO, World Bank
3.9.1	Mortality due to air pollution	Fair	Poor	Every 2-3 years	WHO
3.9.2	Mortality due to WASH	Fair	Poor	Every 2-3 years	WHO
3.9.3	Mortality due unintentional poisoning	Fair	Poor	Every 2-3 years	WHO
3.a.1	Tobacco use	Fair	Good	Annual	WHO
3.b.1	Access to medicines and vaccines	Poor	Poor	Not available	WHO
3.b.2	ODA for medical research	Fair	n.a.	In prep.	OECD , WHO
3.c.1	Health workers	Fair	Poor	Not available	WHO
3.d.1	IHR capacity and emergency preparedness	Fair	n.a.	n.a.	WHO
6.1.1	Drinking water services	Good	Good	Annual	WHO, UNICEF
6.2.1	Sanitation services	Good	Good	Annual	WHO, UNICEF
7.1.1	Clean household energy	Fair	Fair	In prep.	WHO
11.6.1	Air pollution	Good	Good	Annual	WHO
13.1.1	Mortality due to disasters	Fair	Poor	Every 2-3 years	WHO
16.1.1	Homicide	Fair	Fair	Every 2-3 years	WHO
16.1.2	Mortality due to conflicts	Fair	Poor	Every 2-3 years	WHO, UNPD

Source: WHO

Conclusions and next steps

- Several countries are already reviewing and updating their national health system monitoring frameworks to reflect the health SDG indicators.
- The *Measurement and Accountability for Health (MA4H) Call to Action*, which is supported by M&E and health information experts from all SEAR Member States, and international development partners, provides a useful framework for continued action in the Region. It focuses on improving and aligning investments in M&E; strengthening institutional capacity; ensuring that countries have a well-functioning information system; and increasing community participation for greater accountability.

Key URL Links for SDG Monitoring are as follows:

- http://unstats.un.org/sdgs/
- http://unstats.un.org/sdgs/iaeg-sdgs/metadata-compilation

4. Concluding remarks on discussions and next steps

- The **national consultations on health and the SDGs** that are being planned in countries are an essential next step to help 'demystify' the SDGs and begin to frame actions to support their implementation. With such a broad agenda, setting priorities will be important, and progress will be gradual. WHO will support these consultations.
- **Discussions have been practical and focused on implementation.** Next steps related to improving access to frontline services, financial protection and monitoring of progress and results need to be followed up by countries, WHO and other partners in this consultation. Some – such as comparing medicine prices – can be considered low-hanging fruit. Others, such as strengthening the health workforce, are complex but can benefit from the political momentum generated by the commitment to the *Decade of Strengthening HRH in SEAR*.
- **More sharing of good practice is needed in all areas, especially on *how* to make progress,** e.g., on community engagement; working with private providers; financial protection; new ways for health to create effective linkages with other sectors; and greater accountability for results. Involvement of other partners will be essential.
- There are many events over the coming one to two years that can reinforce and build on this consultation. One important event will be the **Ministerial Roundtable on the SDGs and UHC at the SEA Regional Committee in September 2016**.

Annex 1
Programme

Day 1: 30 March 2016	
0900–0945	Opening Session Master of Ceremonies: Ms Kaveri Mukherji **Key note speakers** The Sustainable Development Goals: a new narrative for health in a fast changing Region *Dr Poonam Khetrapal Singh, Regional Director, WHO South-East Asia Region* A global perspective on the implications of the SDGs for achieving better health *Dr Anarfi Asamoa Baah, Deputy Director-General, WHO HQ* Consultation objectives, programme and participants: *Dr Phyllida Travis, Director, Health Systems Development, WHO SEARO* Meeting conventions, time keeping: Master of ceremonies
0945–1030	GROUP PHOTOGRAPH, POSTER MARKET PLACE, BREAK
1030–1100	**Session 1. The short story of Universal Health Coverage** *Chair: Dr Senendra Upreti, Chief Specialist, Ministry of Health, Nepal* Presentation: *Dr David Evans, Dr Matthew Jowett, WHO*
1100–1230	**Session 2. Setting the scene: Where are we now? Who is still being left behind?** Moderator: *Dr Andrew Cassels* Who is being left behind? Regional overview of gaps in health service coverage and financial protection: *Dr Phyllida Travis* Panel discussion of who is being left behind, and why. *Ms Diah Saminarsih, Special Advisor to the Minister of Health, Republic of Indonesia, for Promoting Partnerships and the SDGs; Ms Sheeza Ali, Director-General Health Services, Republic of Maldives; Shri Manoj Jhalani, Joint Secretary Policy, MoHFW, India (TBC);* *Dr Ishtiaq Mannan, Save the Children Fund.* Plenary discussion of who is left behind, and why. Summing up: Moderator
1230 – 1400	LUNCHEON

1400–1530	**Session 3. Improving frontline services: what has been the experience in SEAR with expanding coverage to 'those left behind' Part 1** *Co-chairs: Professor Vinod Paul, AIIMS, India;* *Dr Navaratnasamy Paranietharan, WHO Representative, Bangladesh* Introduction Professor Vinod Paul Extending services for the unfinished MDG priorities, and for new priorities such as NCDs and an ageing population: *Nepal; India (TBC); Bhutan* Future strategic directions to accelerate improvements in MNCH in SEAR, and possible relevance to other health services: health workforce; community engagement; quality; accountability: Professor Vinod Paul Panel reflections on expanding access to care for those being left behind: *Professor Syed, BRAC University; Ms Nel Druce, DfID; Dr Rajesh Pandav, WHO Representative Timor-Leste; Mr S P Kalaunee, Possible Health; Dr Roderico Ofrin, Director, HSE, WHO SEARO.* Plenary discussion and introduction to group work
1530–1600	BREAK
1600–1730	**Session 4. Improving frontline services: Part 2** **Group work** to discuss two questions: • Challenges, opportunities and current directions in expanding frontline services • Next steps on how to make desired changes happen • Plenary feedback on questions, concluding with ideas about how to move ahead: *what next and how?* Concluding remarks: Chairs
1830–2030	Reception hosted by Regional Director, WHO SEAR
Day 2: 31 March 2016	
0900–1045	**Session 5. Priority setting: linking resource allocation to benefits for the most needy – what have we learned?** *Chair: Dr Somsak Chunharas, Executive Vice President, National Health Foundation, Thailand* Introduction: Dr Somsak Chunharas Issues in priority setting from international experience, *Dr Matthew Jowett, Senior Health Financing Specialist, WHO* Approaches to priority setting: experience from Thailand, Sri Lanka, Myanmar (TBC). Plenary discussion: experience and lessons learned: ideas on how to move ahead: *what next and how?* Concluding remarks: Chair
1045–1115	BREAK

1115–1245	**Session 6. Improving frontline services: improving affordability, quality, availability and use of medicines in SEAR** *Co-chairs: Mrs Vini Mahajan, Principal Secretary Health, Punjab (TBC); Dr Nata Menabde, Executive Director, WHO Office at the United Nations* Introduction: Chairs Recent global and regional developments and strategies to improve affordability and availability of medicines, *Dr Margaret Ewen, Health Action International; Dr Kathy Holloway, Regional Adviser Essential Medicines, WHO SEARO* Improving access to medicines: experiences from Bhutan, Sri Lanka, Thailand Plenary discussion on experience; ideas on how to move ahead: *what next and how?* Concluding remarks on what next and how: Co-chairs
1245–1400	LUNCHEON
1400–1530	**Session 7. Improving frontline services: maintaining the momentum on health workforce strengthening** *Co-chairs: Dr Palitha Abeykoon, Professor James Buchan* Introduction: Overview of health workforce issues and responses in SEAR, *Dr Palitha Abeykoon.* Key enablers and barriers to health workforce strengthening: highlights from global experience, *Professor James Buchan*. Country experience: Republic of Indonesia; State of Kerala, India. Panel reflections on how to accelerate progress, and who should be involved: Prof Rita Sood, SEARAME; *Dr Piya Hanvoravongchai, Chulalongkorn University; Mr Christopher Herbst, World Bank (provided input)* Plenary discussion Concluding remarks on what next and how? Co-chairs
1530–1600	BREAK
1600–1730	**Session 8. Expanding financial risk protection: what have we learned about how to do this? How to move ahead?** *Co-chairs: Professor Soonman Kwon, Asian Development Bank; Dr Jihane Tawhilah, WHO Representative, Indonesia* Introduction: Chairs Current status; main causes of impoverishment, and policies to improve financial protection: experience from Bangladesh, India, Indonesia, Thailand. Plenary discussion on progress, challenges, opportunities to improve financial protection *Concluding remarks on ideas on what next and how? Co-chairs*

Day 3: 1 April 2016	
0900–1030	**Session 9. Health financing reforms for UHC in the real world: what works?** *Co-chairs: Prof Siripen Supakankunti, Chulalongkorn University; Dr Henk Bekedam, WHO Representative, India* Introduction:Co-chairs Common issues and challenges in health financing in Asia: Professor Soonman Kwon, ADB International experience with health financing reform: Dr Matthew Jowett, WHO Panel debate on financing reform – *getting started, making progress* – with policy practitioners Concluding remarks: Co-chairs
1030–1100	BREAK
1100–1230	**Session 10. Measurement and accountability for progress on UHC and the health SDG: what's new globally and in SEAR? How to move ahead?** *Co-chairs: Ms Sheeza Ali, Director-General, Health Services, Republic of Maldives; Dr Thushara Fernando, WHO Representative, Democratic People's Republic of Korea* Introduction: Chair Overview of SDG monitoring approach, and other global and regional developments, *Mr Mark Landry, Regional Adviser Health Trend Assessment, WHO SEARO* Country experience in strengthening monitoring and accountability: Sri Lanka, Bangladesh 'At-table' discussions on future approaches to strengthen monitoring and accountability: people, systems and priorities, *what next and how?* *Concluding remarks on what next and how: Chairs*
1300–1400	LUNCHEON
1400–1530	**Session 11. Bringing it together, looking ahead: what next, to reach those still being left behind? Part 1** *Co-chairs: RD Dr Poonam Khetrapal Singh; DDG Dr Anarfi Asamoa Baah* *Facilitator: Dr Andrew Cassels* Introduction: summary of key ideas raised in preceding sessions Panel discussion: reflections on ideas, emerging priorities and processes; what next and how? Group discussions of priorities for action after the meeting, *focusing on what next, how, and whom to involve?*
1530–1600	TEA

1600–1730	**Session 12. Bringing it together, looking ahead: what next, to reach those still being left behind? Part 2 and closing.** *Co-chairs: Dr Poonam Khetrapal Singh, Regional Director, WHO SEAR, and Dr Anarfi Asamoa Baah, Deputy Director-General, WHO HQ* *Facilitator: Dr Andrew Cassels* Group report back to plenary *Plenary discussion and agreement on priority next steps in the South-East Asia Region*

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