WHO-SEARO Global Digital Health Strategy (2028 2033)

Multi-Stakeholder Consultation Webinar

1. Webinar Details

Host Organization	ICMR - National Institute for Research in Digital Health and Data Science (ICMR-NIRDHDS)
Co-organizer	World Health Organization, South-East Asia Regional Office (WHO SEARO)
Date	Saturday, 4th April 2026
Time (with Time Zone)	2:00 PM 4:00 PM IST (Indian Standard Time)
Mode	Online Zoom Webinar
Number of Participants	Approximately 45 participants across breakout sessions
Participant Profile	Government officials, Academic and research institutions, Public health practitioners, Digital health technologists, Civil society representatives, Development sector partners (from India and across the South-East Asia Region, including Maldives)

2. Opening Addresses and Plenary Presentations

The webinar commenced with a structured plenary session that set the strategic, contextual, and country-level framing for the subsequent breakout discussions. Three addresses anchored this segment.

2.1 Welcome and Context Setting Dr. Anurag Agrawal

Dr. Anurag Agrawal, Dean, Trivedi School of Biosciences, and Head, Koita Centre for Digital Health, Ashoka University, delivered the opening remarks. Dr. Agrawal situated the consultation within the broader challenge confronting health systems globally: the imperative to move forward on digital transformation not merely because technology permits it, but because coherent, evidence-informed planning demands it. He emphasized that the real work of strategy-making lies

in understanding what outcomes we are genuinely seeking, and then designing systems digital and otherwise in service of those outcomes, rather than the reverse.

Dr. Agrawal underscored that the value of such consultations lies in the discipline of documenting thinking across a diverse group of stakeholders and building a shared understanding of both the possibilities and the constraints. He conveyed a sense of urgency tempered by realism, noting that effective digital health transformation requires not just ambition, but structure, evidence, and sustained institutional commitment. His remarks set a tone of purposeful inquiry for the session, encouraging participants to engage critically and concretely with the themes at hand.

2.2 Overview of the Global Digital Health Strategy (2020 2027) and the Path to 2028 2033 Dr. Karthik Adapa, Regional Advisor, Digital Health and AI, WHO SEARO

Dr. Karthik Adapa, Regional Advisor for AI and Digital Health at WHO SEARO, provided a substantive overview of the existing Global Digital Health Strategy and the process by which the successor strategy for 2028 2033 is being developed. He opened by acknowledging the significance of participants joining on a Saturday, and reflected on the range of expertise in the room, a breadth that, he noted, was itself a testament to how far digital health had penetrated across sectors.

He traced the evolution of digital health policy at the global level, from early eHealth resolutions through to the current strategy, which was launched in 2020 with the goal of ensuring that digital technologies contribute effectively to stronger, more equitable health systems. He noted that the current strategy has been extended through 2027, and that the 78th World Health Assembly saw member states formally request the development of a new strategy for the period 2028 2033, with over sixty member states explicitly highlighting the importance of digital health, AI, and digital capacity in their interventions.

He outlined the structural achievements of the current strategy period, including the development of national digital health strategies in approximately 120 countries globally eight of ten countries in the South-East Asia Region among them as well as WHO's normative guidance work and the establishment of the Global Institute on Digital Health, launched during India's G20 Presidency. He also acknowledged the persistent gaps: fragmented systems, weak interoperability, uneven digital infrastructure, limited workforce capacity, and the challenge of ensuring that digital health strengthens rather than silos health systems.

On the emerging priorities for the next strategy, Dr. Adapa identified several areas that member states and regional consultations have consistently surfaced: a stronger emphasis on Digital Public Infrastructure and shared standards for health data exchange; the governance of emerging technologies including AI, with particular attention to ethics and regulation; and the continued need for capacity building and regional collaboration. He described the regional consultation series of which this webinar formed a part, noting that it was the fifth such consultation in the SEAR series. Outputs from the regional consultations would feed into a zero draft of the strategy, with a

final draft anticipated by end of July 2026, before the document moves into formal intergovernmental consultations.

Dr. Adapa was direct about what the webinar was expected to achieve: structured, actionable input on key lessons from the 2020 2027 period, identification of gaps in governance, financing, interoperability, equity, and workforce capacity, and concrete recommendations for what the 2028 2033 strategy should prioritize. He closed by reiterating the significance of participants' contributions, which would form part of the substantive regional input feeding directly into the global strategy drafting process.

2.3 Country Reflections Ms. Moonima Abdullah, Deputy Director General (Medical), Ministry of Health, Maldives

Ms. Moonima Abdullah, Deputy Director General Medical, Ministry of Health, Maldives, offered a candid and detailed reflection on the Maldives' digital health journey. Her presentation was notable for grounding the consultation in a concrete country context, illustrating both the promise and the very real constraints of digital health implementation in a small island developing nation.

Ms. Abdullah began by situating the Maldives within its distinctive geography: a population of approximately half a million people dispersed across 1,100 islands, of which only 16 percent are inhabited, organized into 21 atolls. This geographic reality, she explained, shapes every aspect of health service delivery. Specialist services remain concentrated in the capital, Male, forcing patients to travel often at considerable cost for care that cannot be provided locally. Referrals abroad, primarily to India and Sri Lanka, are common for conditions the health system cannot manage domestically, and these cross-border care episodes are rarely integrated into the national record systems.

The Maldives, she noted, does not lack digital systems. The country operates a range of platforms: the VINAVI portal, the national health financing scheme AASANDHA for managing payments and claims, the GAMON system for birth and death registration, DHIS2 for national reporting and programme-specific modules, and hospital-level health information systems in the major facilities. The problem, as she put it plainly, is not the absence of systems but their fragmentation. Data remains siloed, undermining clinical decision-making, care continuity, and the ability to derive value from the significant investments already made.

She described the Maldives 2.0 initiative, launched by President Dr. Muizzu in 2024, as the national framework guiding the next phase of digital transformation across eight strategic pillars. Health sits under Pillar 7, alongside finance and education, signalling that digital health transformation is understood as a priority national agenda rather than a standalone sectoral initiative. Cross-pillar enablers digital identity (Pillar 1), open data sharing and governance (Pillar 2), cybersecurity (Pillar 3), a modern legal framework for digital trust (Pillar 4), and secure digital infrastructure (Pillar 5) each carry direct implications for health system digitalization.

At the heart of the Maldives digital health ecosystem, she explained, lies the unique health identifier, which is essential for linking personal health records across facilities and levels of care. Around this, the country is building a Health Information Exchange, a data repository, and a terminology master to ensure consistency in how clinical and public health data is defined and used.

In her reflections on the global strategy, Ms. Abdullah was specific about what the Maldives and similar small island states need from the next iteration. While the current strategy provides a sound global foundation a shared vision for people-centred, interoperable digital health aligned to universal health coverage it offers limited practical guidance for contexts like the Maldives. She called for more context-specific implementation toolkits adaptable to country-level realities, the positioning of telemedicine as a core service delivery model rather than a supplementary tool, stronger attention to AI governance, ethics, and safe adoption, and sustained emphasis on capacity building. Her closing message was direct: the next strategy must be more practical, more context-sensitive, and genuinely responsive to the diversity of country situations across the region.

4. Summary of Discussions by Thematic Area

Following the plenary presentations, participants were organized into three breakout rooms, each tasked with deliberating across four thematic areas: Governance, Leadership and Equity; Digital Public Infrastructure, Interoperability and Data Systems; Workforce Capacity and Competencies; and Sustainable Financing, Partnerships and Ecosystems Enablement. Each group was assigned a facilitator to guide discussion and a rapporteur to document key findings. The synthesis below draws from the slide-based presentations shared by each group upon reconvening in the main session, as well as notes from the plenary discussion.

Theme 1: Governance, Leadership and Equity

Key Regional Gaps Identified

- Governance structures for digital health remain fragmented across the region. Administrative challenges in establishing dedicated digital health units persist in several member states, including gaps in clearly defined leadership mandates.
- In federal health systems, particularly India, the constitutional positioning of health as a state subject creates coordination complexity: national policies and digital health frameworks exist but their implementation across states remains uneven, and alignment between central and subnational governing bodies is often weak.
- One Health integration linking human health, animal health, climate and environmental monitoring remains largely aspirational at the digital governance level, with few operational mechanisms to coordinate across sectors.

- Low digital literacy among beneficiary populations, compounded by the design of digital health tools that do not adequately account for limited-literacy users, creates structural equity barriers. Technology is frequently built for the already-connected, rather than for those who most need services.
- Multi-stakeholder convergence remains inconsistent. Governance structures do not adequately incorporate clinical professionals, health technology professionals, and patient representatives at the design and accountability stages. Inclusion at design particularly of marginalized communities and minorities is not yet standard practice.
- Data governance for AI systems raises specific concerns: anonymization practices for patient data entering AI training pipelines are inconsistent, accountability frameworks for data misuse are weak, and transparency in AI-based health information systems is limited.
- Government scheme awareness remains low among intended beneficiaries, exacerbated by the absence of dedicated personnel to guide citizens in navigating eligibility and entitlements under digital health platforms.

Priority Actions Proposed (2028 2033)

- Establish dedicated digital health governance units within ministries, with clearly defined mandates, leadership accountability, and cross-sectoral coordination mechanisms.
- Develop structured, legally grounded data protection frameworks with implementation capacity-building components, ensuring that existing laws are understood and operationalized at the institutional level.
- Mandate inclusion of clinicians, health technology professionals, and community representatives in digital health governance bodies and product design processes.
- Prioritize proactive, targeted digital literacy programmes for marginalized and minority communities, designed to bring populations onto digital platforms rather than waiting for self-initiated engagement.
- Create structured referral pathways and dedicated beneficiary navigation support under national digital health schemes to improve awareness, access, and uptake.
- Develop and promote equitable access frameworks for digital skills and tools that explicitly address socioeconomic and geographic determinants of digital access.

Illustrative Examples / Country Reflections

The Maldives, as elaborated in the plenary, highlighted the challenge of governance in a geographically dispersed small island context, where coordinating digital health across 21 atolls with varying infrastructure and capacity requires bespoke governance models. The country's Maldives 2.0 framework, with health embedded in a multi-pillar national digital transformation agenda governed at the highest political level, was cited as a constructive example of aligning health governance with a broader national mandate. Participants from India noted the particular challenge of India's health federalism, where state governments hold primary responsibility for

health delivery but depend on central frameworks for digital health architecture and policy direction.

Theme 2: Digital Public Infrastructure, Interoperability and Data Systems

Key Regional Gaps Identified

- Interoperability remains poorly implemented across the region despite the existence of multiple frameworks and standards. The gap between policy articulation and ground-level implementation is significant, with different data collection formats, incompatible pipelines, and a mix of paper-based and digital systems persisting simultaneously.
- Health data continues to exist in silos across facilities, programmes, public and private providers, and administrative levels severely limiting the clinical and public health value that can be derived from existing data assets.
- Representative, population-level data is largely absent. Current data capture mechanisms do not adequately cover all geographic areas or demographic groups, creating blind spots in the evidence base for policy and planning.
- The DPI-AI intersection requires more granular thinking: there is insufficient clarity about at which layer of the AI or digital health stack DPI should be integrated, and what interoperability means for different actors it is not a single concept but a multi-dimensional one depending on who needs to exchange what data with whom.
- Government and private sector actors alike continue to doubt the value of interoperability, partly because the business case what interoperability delivers for each type of actor has not been clearly articulated or demonstrated.
- Data privacy and security concerns remain inadequately addressed, particularly as health records are increasingly shared across platforms and as AI systems begin consuming patient-level data at scale.
- Training and digital literacy among data entry personnel the frontline workers who populate health information systems is insufficient, resulting in data quality degradation at the point of entry.

Priority Actions Proposed (2028 2033)

- Develop and enforce national data standards for health information systems, applicable to both public and private providers, with mandatory minimum data sharing requirements articulated in government policy.
- Build the evidentiary and value case for interoperability for each category of actor, making explicit what interoperability delivers for government health agencies, private providers, insurers, and patients respectively.

- Design data entry interfaces and tools for usability by frontline health workers, prioritizing simplicity and workflow integration over technical sophistication. The quality of AI and data systems ultimately depends on the quality of data entered at the primary level.
- Invest in intranet-based and cloud-based national health data architecture, with defined standards for data storage, terminology, and exchange.
- Mandate data sharing from the private sector, which accounts for the majority of healthcare delivery in several SEAR countries, through central government policy with enforceable accountability provisions.
- Situate data collection as a life-course endeavour, capturing records from birth onwards in a consistent, nationally standardized format that enables longitudinal tracking of individual and population health outcomes.
- Conduct structured training for all healthcare personnel engaged with digital health platforms, aligned with the actual clinical workflows into which these systems are integrated.

Illustrative Examples / Country Reflections

India's Ayushman Bharat Digital Mission (ABDM) was referenced as an example of how a national digital health strategy can catalyze structured, standards-based digital infrastructure, including the unique health identifier and federated health record architecture. However, participants also noted that even within ABDM, implementation gaps persist: coordination between public and private providers is inconsistent, data sharing from private players remains limited, and the coexistence of paper-based systems in many facilities continues to undermine interoperability efforts. The Maldives similarly illustrated the challenge of fragmented digital health systems across geographically dispersed facilities, noting that despite having numerous digital platforms in operation, effective data exchange between them remains limited.

Theme 3: Workforce Capacity and Competencies

Key Regional Gaps Identified

- The region faces a structural shortage of trained digital health professionals, compounded by the challenge of retaining skilled personnel, particularly in rural and remote areas where digital health implementation is often most challenging and most needed.
- Task shifting assigning digital health data entry and management responsibilities to frontline workers such as ASHA workers or nurses is occurring without adequate support structures, resulting in overburdening already stretched health workers and, in some cases, compromising service quality.
- There is no structured, system-level strategy for workforce development in health informatics. Capacity building initiatives tend to be programme-specific, short-term, and

inadequately evaluated. Modular training exists but quality assurance and regular up-gradation mechanisms are weak.

- Language and cultural barriers compound digital literacy challenges across the region's linguistic diversity. Digital health tools and training programmes are predominantly in English, creating adoption barriers in states and countries where regional languages dominate.
- Healthcare workers including physicians are already overburdened. The addition of digital health systems and data entry requirements, without commensurate workflow redesign or incentive structures, risks deepening resistance to adoption.
- Acceptance of AI in clinical practice is uneven. There is limited clarity among practitioners about what types of AI are being deployed, for what clinical tasks, and what the expected role of the human clinician is in conjunction with the AI system.
- Regulatory bodies such as AICTE and UGC have not yet developed systematic guidance on health informatics competencies for medical and allied health education, creating a gap in pre-service preparation.

Priority Actions Proposed (2028 2033)

- Develop a structured, system-wide workforce strategy for digital health, encompassing pre-service education, in-service training, and continuous professional development, with clear competency standards and quality assurance mechanisms.
- Engage regulatory bodies (AICTE, UGC, and equivalent national bodies) to embed health informatics and digital health competencies into medical, nursing, and allied health education curricula.
- Design training programmes around the specific roles, contexts, and digital health use cases of different cadres of health workers, rather than applying uniform training across all staff levels.
- Empower frontline workers beyond ASHA workers to include community health officers, ANMs, and other primary health workforce members with appropriate digital tools, point-of-care diagnostics, and low-power, handheld solutions suited to remote and resource-limited settings.
- Use digital technologies themselves to reduce administrative burden on clinical staff, enabling data entry automation, e-pharmacy integration, and digital referral tracking that reduce rather than add to workload.
- Design and implement structured change management processes to build motivation and readiness for digital health adoption, with attention to incentive structures and enabling conditions for meaningful engagement.
- Conduct implementation science studies on digital health adoption in real clinical settings, generating evidence on what works, for whom, and under what conditions.

Illustrative Examples / Country Reflections

India's Revised National Tuberculosis Elimination Programme (RNTEP) was cited as an instructive example of how digital health systems, when well-integrated into clinical workflows with clear patient identification, tracking from diagnosis through to treatment completion, and strong community health worker support, can achieve meaningful longitudinal patient management at scale. Participants highlighted CCAMP (Centre for Cellular and Molecular Platforms) as an example of an institutional mechanism that hand-holds digital health and AI solutions through the development-to-scale pipeline, representing a model worth learning from and potentially replicating. The Maldives' experience of having frontline survey data confirming that health workers are supportive of technology use when adequately equipped was also noted as an important positive signal.

Theme 4: Sustainable Financing, Partnerships and Ecosystems Enablement

Key Regional Gaps Identified

- Financing for digital health in the region is predominantly project-based and donor-driven, with limited structural integration into government health budgets. Once project funding cycles end, innovations frequently stall at the prototype or pilot stage, unable to scale without continued external support.
- There is a significant gap between research and development investment and operational scale-up. The timeline from R&D to a finished, field-tested digital health product is long and often resource-constrained, resulting in solutions that do not reach the populations they were designed for.
- Public-private partnerships in digital health are inadequately governed. Existing partnership frameworks do not provide clear accountability structures, data sharing obligations, or mechanisms to align private sector incentives with public health objectives.
- National health insurance and government health scheme frameworks have not been updated to integrate predictive and preventive digital health measures, remaining primarily structured around episodic, curative care financing.
- Evidence of real-world adoption and impact of digital health technologies is limited. The market is saturated with solutions, but the evidence base for what delivers measurable health outcomes particularly for government procurement and scale decisions is thin.
- The nomenclature and classification of digital health in budgeting and planning processes is inconsistent, creating difficulties in tracking expenditure, linking financing to outcomes, and making the case for sustained investment.
- Rural digital infrastructure gaps continue to constrain the reach of digital health investments, as solutions designed for connected environments cannot function effectively in settings with unreliable connectivity and power.

Priority Actions Proposed (2028 2033)

- Shift from donor-driven to government-led health financing models for digital health, with dedicated budget lines at central and subnational levels and mechanisms to attract blended financing from CSR funds, impact investors, and development finance institutions.
- Develop outcome-linked financing instruments for digital health, where disbursements and contracts are tied to demonstrated health system performance improvements rather than input metrics.
- Establish central regulatory and procurement frameworks for evidence-based digital health technologies, ensuring that only validated solutions are adopted at scale, and that evidence generation is built into the adoption process from the outset.
- Create collaborative innovation teams comprising physicians, engineers, public health practitioners, and researchers to ensure that digital health solutions are designed in response to identified needs, not in search of problems to justify existing technology.
- Strengthen and scale mechanisms like ICMR's MedTech Mitra programme, which provide structured hand-holding for digital health and MedTech solutions from conception through to market-ready scale-up.
- Reform public-private partnership governance frameworks for digital health, establishing clearer accountability structures, minimum data sharing obligations, and mechanisms to protect public health data sovereignty.
- Position telemedicine and AI-enabled point-of-care diagnostics within health financing frameworks as reimbursable service delivery modalities, not supplementary tools, to create sustainable demand-side incentives for adoption.

Illustrative Examples / Country Reflections

Participants pointed to India's ICMR MedTech Mitra programme as a concrete example of an institutional mechanism designed to bridge the gap between innovation and scale, providing technical, regulatory, and commercialization support to digital health and medical technology developers. The challenge of sustaining AI-based screening programmes beyond initial research funding was raised by multiple groups, illustrating the structural financing gap that afflicts even promising innovations. The Maldives highlighted the costed implementation roadmap embedded in its digital health blueprint as an approach to aligning government budget cycles and development partner support around shared priorities, offering a model for countries seeking to move from ad hoc project financing toward more structured investment planning.

5. Pre-Webinar and Post-Webinar Rapid Prioritization Surveys

5.1 Pre-Webinar Survey

Participants were invited to complete a structured pre-webinar survey at the start of the session, shared via the Zoom chat interface. The survey comprised seven sections and approximately twenty questions, covering participants' institutional roles, their assessments of progress and gaps under the current Global Digital Health Strategy (2020 2027), and their initial priorities for the successor strategy. Questions were primarily open-ended, allowing participants to articulate their perspectives in their own terms.

The survey was designed to ensure that inputs could be captured from participants across the full spectrum of institutional contexts represented in the room, and to provide the organizing team with a baseline of perspectives ahead of the breakout discussions. Participants were encouraged to complete the form concurrently as the session progressed. The survey data will be analysed and incorporated into the consolidated regional report that ICMR-NIRDHDS will prepare for submission to WHO SEARO as part of the formal input process for the strategy development.

5.2 Post-Webinar Rapid Prioritization Survey

Following the plenary synthesis by each breakout group, participants were invited to complete a post-webinar rapid prioritization survey, also shared via the chat interface. This survey was specifically designed to capture structured prioritization inputs on the themes and recommendations that had emerged across the three breakout discussions.

The rapid prioritization survey was framed as a mechanism to translate the qualitative richness of the breakout discussions into structured, quantifiable regional input. Participants were asked to rank and rate the priority actions and cross-cutting themes identified during the session, enabling the organizing team to identify areas of strongest consensus and differentiate between high-priority and secondary actions. The survey was estimated to take no more than five minutes to complete and was positioned explicitly as a direct contribution to the strategy drafting process: responses would be incorporated into the host webinar report and transmitted to WHO SEARO as part of the formal regional consultation outputs.

The results of both surveys will be analysed alongside the qualitative synthesis from the breakout sessions and the plenary discussion to produce a comprehensive regional input document. This will form part of the structured evidence base that WHO SEARO and WHO Headquarters will draw upon in developing the zero draft of the Global Digital Health Strategy (2028 2033).

6. Cross-Cutting Themes

Several issues surfaced with notable consistency across all four thematic areas and across all three breakout groups. These cross-cutting themes are not reducible to any single thematic area but

instead cut horizontally across the systemic challenges that digital health transformation must address in the South-East Asia Region.

Institutional Capacity and Governance: Across every thematic discussion, the adequacy of institutional structures or their absence emerged as a recurring concern. Whether the question was interoperability governance, workforce development strategy, or financing accountability, groups consistently returned to the need for stronger, more clearly mandated institutions with defined roles, adequate resourcing, and mechanisms for cross-sectoral coordination.

Data Quality and the Human Element: The quality of health data was identified as foundational to virtually every other objective, and the human element in data quality the frontline worker entering data, the clinician using the system, the policy analyst interpreting the outputs was repeatedly emphasized. Technology alone cannot resolve data quality problems; the conditions under which people interact with digital systems matter as much as the systems themselves.

Context-Specificity and Local Adaptation: Groups repeatedly cautioned against the assumption that solutions that work in one setting will transfer directly to another. The diversity of the South-East Asia Region across geography, health system structure, digital infrastructure, language, and institutional capacity means that context-sensitivity must be a design principle, not an afterthought, in both the global strategy and in the tools and frameworks that flow from it.

Accountability and Transparency: The accountability gap in digital health for data governance, for AI systems, for public-private partnerships, for financing outcomes was a persistent concern. Participants identified weak accountability frameworks as enabling both data misuse risks and poor implementation performance. Stronger, enforceable accountability mechanisms were seen as a prerequisite for the scale and sustainability of digital health transformation.

Equity and Inclusion by Design: The risk that digital health deepens rather than reduces health inequities was raised across multiple discussions. Geographic, socioeconomic, linguistic, and literacy-related disparities in digital access mean that digital health systems, if not explicitly designed for equity, may disproportionately benefit already-advantaged populations while leaving the most vulnerable further behind.

7. Areas of Consensus

Several positions commanded strong and consistent agreement among participants across institutional backgrounds, geographic contexts, and thematic areas of focus.

- Workforce capacity and training are non-negotiable prerequisites for effective digital health transformation. No group contested this; all three breakout rooms independently elevated it as a priority. There was broad consensus that training must be modular, context-sensitive, regularly updated, and evaluated and that it must be embedded in sustainable institutional arrangements rather than delivered as one-off project activities.
- Interoperability is foundational, but its implementation requires political and policy commitment, not just technical standards. Participants agreed that the technical frameworks for interoperability exist; the binding constraints are governance, political will, and the articulation of a clear value proposition for both public and private actors.
- Evidence-based adoption of digital health technologies must become the norm. There was strong agreement that the proliferation of digital health solutions in the market, without commensurate evidence of real-world effectiveness, creates risks for health systems and wastes scarce public resources. Centrally governed, evidence-linked procurement and adoption frameworks were broadly endorsed.
- Financing must shift from project-based to systemic. Participants across groups agreed that donor-driven, time-bound project financing is insufficient to sustain digital health transformation at scale. Long-term, government-led financing with clear budget lines, blended financing mechanisms, and outcome-linked instruments is needed.
- The next global strategy must be more practical and implementation-oriented than its predecessor, providing concrete toolkits, country-adaptable frameworks, and mechanisms for peer learning and technical assistance, particularly for small and medium-sized health systems.

8. Divergences or Unresolved Questions

While the level of agreement among participants was high on many fundamentals, several areas of tension or unresolved complexity were also apparent.

- The appropriate balance between centralization and decentralization in digital health governance remains contested. In federal or quasi-federal health systems, particularly India, the question of whether digital health policy and procurement should be centrally mandated or state-governed creates genuine tension. Health as a state subject creates constitutionally grounded decentralization pressures that are difficult to reconcile with the interoperability and standardization objectives that a national digital health architecture requires.
- The role and responsibilities of the private sector in digital health remain underspecified. While there was agreement that private sector data sharing is essential given that private providers account for the majority of health service delivery in several SEAR countries,

the mechanisms, limits, and incentives for such sharing are contested. The degree to which government can mandate rather than negotiate private sector compliance is context-specific and legally complex.

- The pace and scope of AI integration in clinical decision-making prompted divergent assessments of readiness. Some participants highlighted the transformative potential of AI at the point of care, including through low-power handheld diagnostic devices in resource-limited settings. Others emphasized the risks of premature adoption, particularly given limited validation of AI tools in regional clinical contexts, weak regulatory frameworks for AI in health, and the potential for algorithmic bias to deepen inequities.
- Task shifting and the boundaries of frontline worker roles in digital health were not fully resolved. While there was agreement that frontline workers should be empowered with better tools, there was divergence on how far their digital health responsibilities should extend, what the appropriate division of labour is between different cadres, and how overburdening risks should be managed.

9. Consolidated Regional Summary

Key Regional Priorities for SEAR

The consultation surfaced a clear and coherent set of regional priorities. The South-East Asia Region faces a shared challenge: significant investments have been made in digital health infrastructure and policy over the 2020 2027 strategy period, but the benefits of these investments remain unevenly distributed, and the foundations governance, workforce, interoperability, and financing remain insufficiently consolidated to support the next phase of transformation.

The region's heterogeneity is both a strength and a challenge. It encompasses countries at vastly different stages of digital health development, with dramatically different geographic, demographic, and institutional contexts. Any successor strategy must be calibrated to this diversity, offering frameworks flexible enough to be adapted to contexts as different as India's federal health system and the Maldives' dispersed island setting, while still providing enough structure to ensure coherence and interoperability across the region.

Strategic Directions for 2028 2033

The consultation pointed toward several strategic directions that should animate the next global strategy as it pertains to the South-East Asia Region.

- Consolidate before expanding. The priority should be ensuring that existing digital health investments deliver the value they were designed to deliver through stronger governance, better interoperability, and more effective workforce engagement rather than adding additional systems and tools on top of fragmented foundations.

- People first. Digital health transformation is fundamentally a human transformation. The conditions under which health workers, patients, and communities engage with digital health systems their literacy, motivation, workload, and trust will determine whether digital investments translate into better health outcomes. The next strategy should position people, not technology, at the centre of its architecture.
- Evidence and accountability. The next strategy should establish stronger norms for evidence-based adoption and outcome-linked accountability at every level from procurement to implementation to financing.
- Equity as design principle. Reducing the digital divide within and across countries should be an explicit strategic objective, with equity metrics built into the implementation and evaluation frameworks for the next strategy period.

Recommendations to Inform the Next Global Digital Health Strategy

- Embed context-specific implementation guidance within the global strategy, including adaptable toolkits for small island developing states, federal health systems, and countries with significant rural-urban digital divides.
- Establish global norms for AI governance in health, covering clinical validation requirements, data anonymization standards, transparency obligations, and regulatory frameworks that member states can adapt to their national contexts.
- Position telemedicine as a core health service delivery modality in the strategy, with financing and implementation guidance commensurate with its centrality, particularly for geographically dispersed populations.
- Create structured mechanisms for South-South learning and peer exchange within the SEAR region, enabling countries to learn from each other's implementation experience and avoiding redundant work across similar contexts.
- Build monitoring and evaluation frameworks into the strategy from the outset, with clear health outcome metrics not just digital adoption metrics that allow member states and WHO to track whether digital health is translating into improved health system performance and population health outcomes.