DRAFT

Regional Framework for
Reaching the Unreached in the Western Pacific
(2022–2030)

World Health Organization
Western Pacific Region

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Abbreviations

COVID-19	coronavirus disease
GDP	gross domestic product
GHSS	global health sector strategies
PHC	primary health care
TB	tuberculosis
UHC	universal health coverage
WHO	World Health Organization

Executive summary

Reaching the unreached is a global and regional health priority. It is necessary to realize the vision of *For the Future: Towards the Healthiest and Safest Region* – a vision for WHO work with the Member States and partners in the Western Pacific – and the 2030 Agenda for Sustainable Development. It is only through reaching the unreached that it will be possible to achieve a world in which no one is left behind, and everyone can enjoy the highest attainable standard of health and well-being.

Reaching the unreached is everybody's business. It is relevant to all health programmes and health systems strengthening efforts in every country across the Western Pacific Region. It applies to all levels of the health system (national, subnational or local) and all health sector functions. It requires recognizing the complexity of the challenge and developing new ways of working so that systems can routinely identify unreached populations and build services that meet their needs in effective partnerships with those populations.

The coronavirus disease (COVID-19) pandemic exposed the fault lines in health systems and societies, with higher risks and more significant health burdens seen among less-advantaged groups in all countries, impacting global, regional and national disease control efforts. The pandemic highlighted why it is essential to reach the unreached and illustrated that if health systems could routinely reach the unreached, those systems would benefit everybody.

The Western Pacific Region has made remarkable progress towards many health targets, including those for communicable diseases and child and maternal health. However, progress has not equally benefited everyone, and some population groups remain left behind in most countries, even those with robust health systems. Moreover, disruption to the delivery of essential health services during the COVID-19 pandemic is likely to further impede progress towards achieving health targets, particularly for unreached groups.

The Western Pacific Region has experienced rapid economic development and demographic, climatic and societal changes. These pose many challenges that may put those who are unreached at higher risk of poor health and create new unreached populations. These challenges are associated with widening socioeconomic inequities, increased internal and international migration, unchecked urban growth, climate-related disasters, rising sea levels, environmental degradation and ageing populations. On the other hand, economic development and social and technological innovation have created a massive opportunity for building robust and future-proof health systems that support health and development for all.

The *Regional Framework for Reaching the Unreached in the Western Pacific (2022–2030)* aims to support Member States in transforming their health systems and services to reach everyone, everywhere. Reaching the unreached is a dynamic, evolving process that will require innovation. The needs of unreached populations are central to this innovation. Therefore, a system-wide, coordinated approach combining national and global evidence and the capability for local-level adaptation is essential. There will be many pathways to reaching the unreached across the diverse countries and areas in the Region. Finally, the health sector cannot address the challenges of unreached populations alone. It will need to actively engage in multisectoral action and work with communities and civil society

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organizations, including those representing unreached groups, to ensure improved health outcomes for these groups.

Many factors determine who is unreached by the health sector. Across all countries, socioeconomic factors – or the conditions in which people are born, live, grow, work and age – as well as stigma and discrimination, the settings in which people live and work, and the intersections among all these issues influence access to health services and health outcomes. Addressing differentials in access to health services and health outcomes will require understanding how these factors contribute to groups being unreached and to developing strategies so that health systems and services do not continue to leave them unreached.

We need to build people-centred health-care systems and services. They need to be high-quality, equitable, integrated and comprehensive. We must enable all individuals and communities to maximize their health and well-being across the life course. We also should address the historical, social, political, cultural, economic and environmental factors that impact health.

Health system transformation includes building essential capacities for producing the changes required to reach the unreached. The Regional Framework describes these capacities in five action domains. These action domains are applicable at all levels and include:

1. **Political commitment** coupled with governance, financing and legal structures to reach the unreached.
2. **Multi-stakeholder engagement** to support intrasectoral and intersectoral action and cooperation for reaching the unreached.
3. **Data and evidence** to identify unreached populations, monitor and evaluate actions, and continuously learn and improve implementation.
4. **Health service transformation** to reach the unreached, with high-quality, people-centred primary health care and effective community engagement.
5. **Special approaches** to allow quick adaptation to specific challenges or crises beyond the immediate capacity of existing health services.

This Regional Framework provides questions and options to guide reflection and action to progressively build health systems and services that routinely reach unreached populations. It also provides tools and guidelines to support these considerations.

Countries are encouraged to build reaching the unreached into all country health plans and to build system capabilities for routinely identifying and reaching unreached populations.

WHO in the Western Pacific Region will continue supporting countries to reach unreached groups through all health programmes and health systems strengthening activities. In addition, it will help knowledge and information sharing for expediting progress so that no one is left behind.

1. Background

Reaching the unreached is a global and regional health policy priority. At the seventieth session of the World Health Organization (WHO) Regional Committee for the Western Pacific in October 2019, Member States endorsed *For the Future: Towards the Healthiest and Safest Region* – a vision for WHO work with Member States and partners in the Western Pacific. Reaching the unreached was recognized as one of four thematic priorities of *For the Future* that united all Member States around the need for action to realize this vision.[1]

This vision aligns with that of *Transforming our World: The 2030 Agenda for Sustainable Development* endorsed at the Seventieth session of the United Nations General Assembly, which emphasized a new approach to development, challenging Member States to develop new ways of thinking and working to address the complex challenges of development to leave no one behind.[2] This commitment is reflected in World Health Assembly resolutions that call for health systems strengthening for universal health coverage (UHC), with a particular emphasis on those who are most disadvantaged.

In line with *For the Future* and the 2030 Agenda for Sustainable Development, this *Regional Framework for Reaching the Unreached in the Western Pacific (2022–2030)* (see Box 1) acknowledges the human rights of all peoples and is informed by principles that support the progressive realization of these rights, including the enjoyment of the highest attainable standard of health. This Regional Framework also clearly points to the interconnectedness between good health and well-being and all other Sustainable Development Goals and supports health sector collaboration with sectors beyond health to systematize achievement of health for all.

Box 1. Reaching the unreached

Unreached populations can be thought of as those that have no, or limited, access to effective, quality health services and poorer health outcomes than would be expected within their country. This is a situation of health inequity, which is defined as differences in health outcomes and care that are unnecessary, unfair, unjust and avoidable.[a]

The issues that contribute to populations being unreached can be complex, context specific and dynamic and can result in circumstances that impede the achievement of the highest attainable standard of health for everyone in any given country.

This Regional Framework focuses on potential health sector actions to identify and contribute to addressing issues that create unreached populations and to support the goal of reaching everyone, everywhere including through the provision of equitable health care in dynamic and changing settings.

[a] Closing the health equity gap: policy options and opportunities for action. Geneva: World Health Organization; 2013.

1.1 Health affects sustainable development.

Healthy people are necessary for sustainable development, and there is an economic cost to inequity. There is an established relationship between population health, determinants of health (such as education levels, income and gender) and economic prosperity.[3] For example, reductions in morbidity are likely to contribute to an enhanced workforce, improvements in child health are likely to

influence learning ability and have lifelong impacts, and investments in women's health are likely to generate large health, economic, social and environmental gains.[4] The return on investment in health may be higher in low- and middle-income countries where effective, relatively low-intensity interventions can have a big impact on population health.[3] Further, there is growing evidence that health inequities impact economies, with the European Union estimating that health inequities reduce its annual gross domestic product (GDP) by approximately 1.4%.[5] It has also been estimated that between 2003 and 2006, the United States of America could have saved US$ 230 billion in direct medical care costs and US$ 1 trillion in indirect costs by eliminating health inequities for minority populations.[6] The Organisation for Economic Co-operation and Development indicated that improved sharing of the benefits of growth and opportunity is critical to improving equity of health outcomes and fostering social cohesion and sustainable growth, recommending that "if policy-makers want to promote inclusive growth, increasing attention should go to ensuring that health policies benefit the least well-off".[7(p3)]

1.2   Issues impacting reaching the unreached in the Western Pacific

Rapid development in the Western Pacific Region creates significant opportunities and challenges for reaching the unreached. The Western Pacific Region is the most culturally and linguistically diverse of all WHO regions and is experiencing rapid economic growth. GDP per capita has increased 14.8 times from US$ 1435 in 1980 to US$ 21 242 in 2021 (Fig. 1), which is a considerably higher rate than all other WHO regions – with growth across the African Region increasing 4.1 times, the Region of the Americas 4.4 times, the Eastern Mediterranean Region 2.4 times, the European Region 4.4 times and the South-East Asia Region 11.9 times. The speed of this growth varies significantly among countries and has been impacted by the coronavirus disease (COVID-19) pandemic.[8] Many countries in the Western Pacific Region have transitioned to upper-middle-income or high-income status with consequent reductions in donor funding for health sector initiatives.

The **challenge of achieving health for all is heightened by an increasingly globalized world and rapid demographic and societal changes** occurring in many countries. The impacts of these may create additional unreached groups and put those that are unreached at higher risk of poor health. For example, globalization can negatively impact labour standards, exacerbate the vulnerability of migrant workers[9] and increase human trafficking.[10] The Region is also experiencing rapid urbanization (Fig. 2), with the proportion of the population living in urban settings increasing 2.3 times between 1975 and 2020 – from 26.2% in 1975 to 61.5% in 2020. This was the highest level of increase among all WHO regions, with rates in other regions being two times or less over the same period. This creates challenges associated with high levels of population movement and the proliferation of informal urban settlements.

Fig. 1. GDP per capita by WHO region, 1980–2026
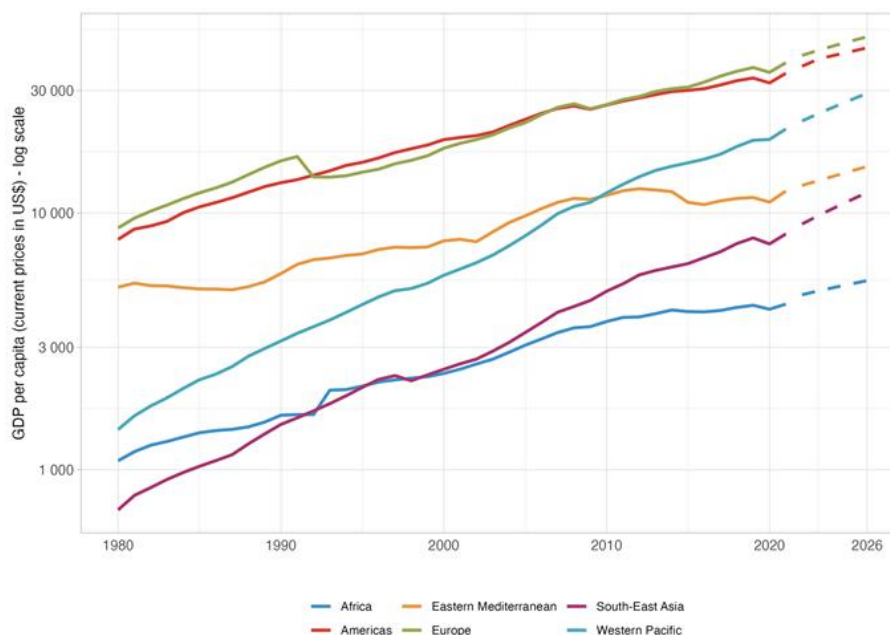
Sources: Gross domestic product (GDP)/current prices per capita were calculated using two data sets:
1) GDP current prices sourced from World Economic Outlook (April 2022). Washington (DC): International Monetary Fund; 2022 (https://www.imf.org/external/datamapper/NGDPD@WEO/OEMDC/ADVEC/WEOWORLD, accessed 14 March 2022).
2) Population data sourced from World Population Prospects 2019. New York (NY): United Nations Department of Economic and Social Affairs; 2019 (https://population.un.org/wpp/Download/Standard/Population/, accessed 1 October 2021). Historical data were used for 1980–2021 and projected data for 2022–2026.

Fig. 2. Proportion of the population living in urban areas by WHO region, 1950–2050
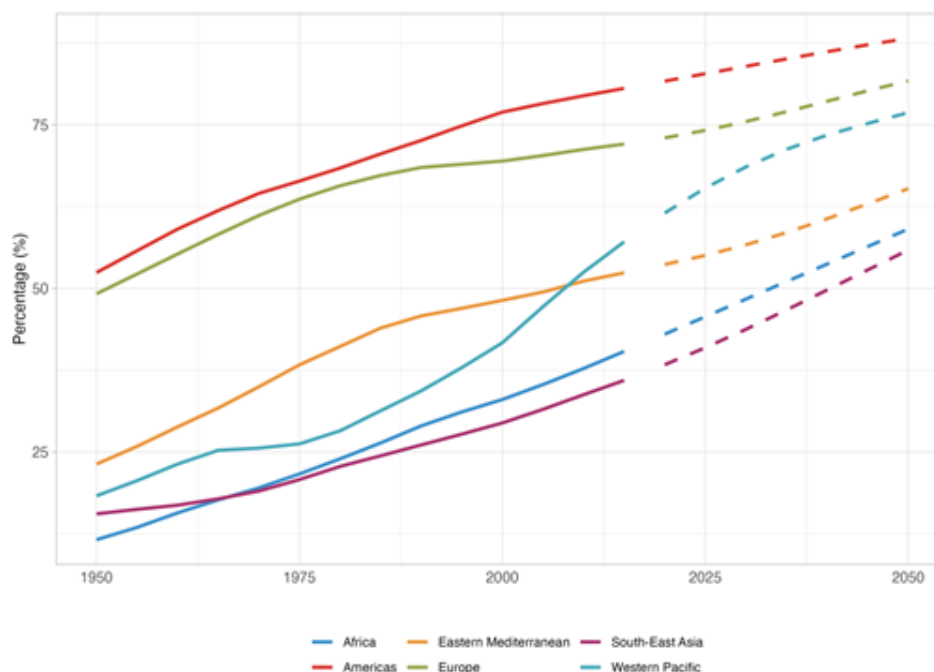
Source: World Urbanization Prospects 2018. New York (NY): United Nations Department of Economic and Social Affairs; 2018 (https://population.un.org/wup/, accessed 25 February 2019). Historical data were used for 1950–2018 and projected data for 2019–2050.

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Many countries and areas across the Region have rapidly ageing populations, and limited time for health system adaptation may result in many older people being without access to the services they need.[11] Six of the world's 10 countries most at risk for disasters due to natural hazards are in the Western Pacific Region – and there are increasing risks for all countries associated with climate change and environmental degradation (Box 2). Pacific island countries and areas are among the most vulnerable to climate change, with some countries and areas already impacted by rising sea levels and an increased risk from climate-sensitive illnesses, such as vector-borne, foodborne and waterborne diseases. The Region also accounts for just over 30% of global premature deaths from air pollution, with many people in urban settings being exposed to ambient air pollution above the recommended levels, and men having a higher mortality rate than women from this exposure. High rates of internal migration, casual cross-border migration and international migration for work are also impacting the Region, as is unchecked urban growth and widening socioeconomic inequities.[11]

Box 2. Climate change and reaching the unreached

- Climate change impacts unreached populations by changing disease patterns in areas with limited access to appropriate health services and facilities or by contributing to disasters that cause some communities to become displaced and unreached. For example, there is a likely link between the increasing incidence of malaria in the Highlands of Papua New Guinea and the rise in temperature and more intense rainfall in these areas since 1997. Health services, including for malaria, have difficulty reaching many of the villages in these areas.[a]
- The Republic of Korea is experiencing increasing intensity of extreme heatwaves in the summer seasons due to climate change, with a related increase in mortality, especially among older people. In many countries, there is also a reported relationship between poverty and mortality from extreme heat.[b]
- Water insecurity, or water stress, is a significant problem in Pacific island countries and areas, elevated by the impact of climate change on rainfall patterns and extreme weather events. Climatic conditions may lead to diarrhoeal illness. In the Pacific, there is a positive correlation between annual average temperature and rates of diarrhoeal disease.[c]

[a] Park JW, Cheong HK, Honda Y, Ha M, Kim H, Kolam J, et al. Time trend of malaria in relation to climate variability in Papua New Guinea. Environ Health Toxicol. 2016;31:e2016003.
[b] Kim SH, Jang JY. Correlations between climate change-related infectious diseases and meteorological factors in Korea. J Prev Med Public Health. 2010;43(5):436–44.
[c] Singh RB, Hales S, de Wet N, Raj R, Hearnden M, Weinstein P. The influence of climate variation and change on diarrheal disease in the Pacific Islands. Environ Health Perspect. 2001;109(2):155–29.

Countries across the Region have made remarkable progress towards many health targets, but progress has not been equitable across the Region or within countries. Excellent progress has been made on HIV, tuberculosis (TB), malaria, neglected tropical diseases, poliomyelitis, hepatitis B, measles, and maternal and infant mortality; however, some groups are still left behind. For example, almost half of the countries and areas in the Western Pacific Region have achieved the global mortality reduction targets for maternal, neonatal and under-5 mortality, but progress in improving newborn survival has lagged. Newborn deaths account for around one half of under-5 deaths, and there are higher mortality rates in this age group in poorer, less educated and rural communities in some countries (Fig. 3). Reducing maternal mortality ratios also remains an ongoing challenge in some countries and for some groups.[11,13] Overall, the impact of inequities is likely to be reflected in all-cause mortality as has been demonstrated in Australia, Japan and the Republic of Korea.[14–16]

Fig. 3. Under-5 mortality rate (per 1000 live births) in the Western Pacific Region by selected demographic characteristics over available years, 2013–2019
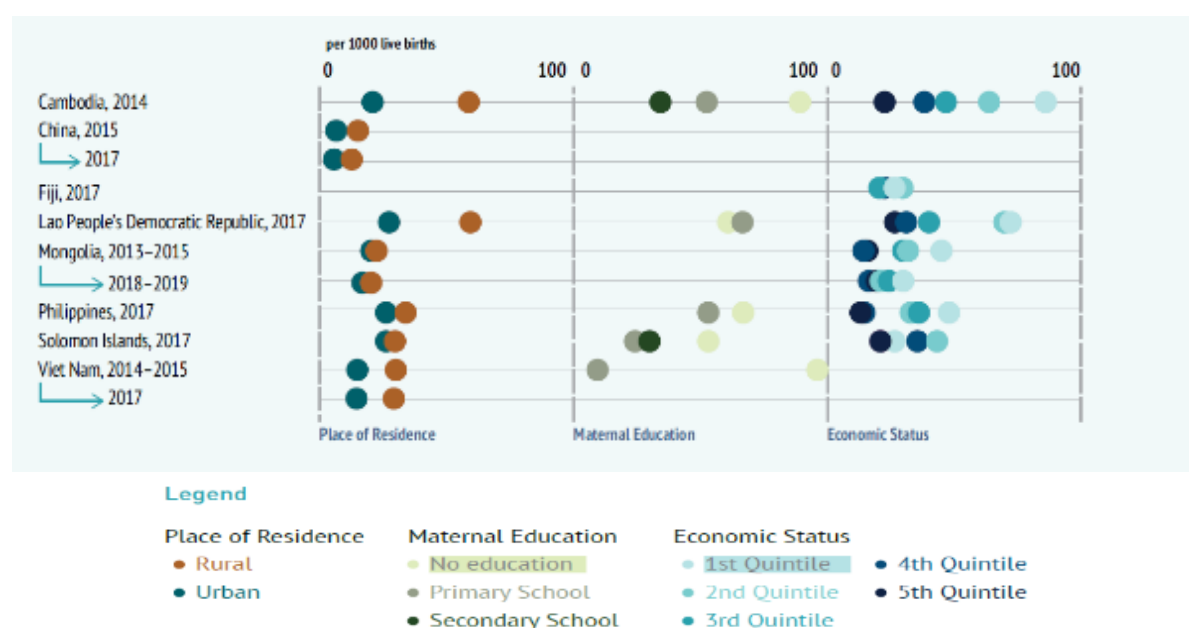
Source: The health-related Sustainable Development Goals: progress report of the Western Pacific Region, 2020. Manila: WHO Regional Office for the Western Pacific; 2021.

In recognizing that progress has not equally benefited all population groups in the Region, countries are now striving to achieve the ambitious global goal of universal health coverage (UHC). As a result, the UHC Service Coverage Index across the Region increased to 80% (between 2015 and 2019), which is higher than the global average of 68%.[17] However, this increase is not uniform, with most Pacific island countries having an index value lower than 60 in 2019.[18] Over the same period time, catastrophic health expenditures in the Region also increased and were the highest of any WHO region, with poorer households likely to be most affected.[17]

Progress towards universal health coverage can mask growing inequity, as those who are more advantaged often benefit more quickly from national strategies than those who are already socially or economically disadvantaged. And the latter can be left behind or lost – even when there is an overall improvement in service delivery or health outcomes. A 64-country study of health outcomes between 1990 and 2011 demonstrated that, despite overall progress towards the Millennium Development Goal targets, relative inequality on some outcome indicators grew in almost half of the countries.[19] Even when services are notionally available, poor quality can negate their effectiveness. In 2016, an estimated 8.6 million deaths across 137 lower-middle-income countries were due to inadequate access to quality care, with 3.6 million of these due to access issues and 5 million due to the poor quality of the health care received.[20]

The COVID-19 pandemic has highlighted inequities and the importance of reaching the unreached to ensure health for all. Much of the health-care and development work across the Region proved helpful in responding to COVID-19. However, the pandemic has also exposed fault lines in health systems and societies. Socioeconomic inequities, high comorbidities, and limited access to preventive measures and health care have created higher-risk patterns and a more significant health burden from COVID-19 among less-advantaged groups in all countries. These factors, in turn,

potentially compromise national, regional and global disease control efforts. For example, overcrowded living conditions make physical distancing unrealistic. Poverty and informal employment with no social protection mean people may need to continue working even when unwell or in contact with those with COVID-19. Fear of incarceration can stop undocumented migrants from accessing appropriate health care.[21–23] Physical distancing measures and other restrictions have also led to social isolation, discrimination, and increased gender-based violence and anxiety disorders.[11] Some groups, such as older people living alone and persons with disabilities relying on family care and support services, have become unreached. Some countries faced reductions in international transportation and supply chains. The downturn in the global economy has compounded these effects, which often differentially impact those who are already less advantaged. In addition, the pandemic has created challenges that are not yet fully understood including the impact of COVID-19 on mental health and post COVID-19 condition, also known as "long COVID".

High pressure on health systems for pandemic responses has also affected the delivery of other health services, further exacerbated by the disruption of supply chains. In 2020, countries reported disruptions of antenatal care, child services, routine immunizations, antiretroviral therapy, diagnosis and treatment of diseases, and mental health and palliative care services. These disruptions may result in an increased need for health services and poorer health outcomes in the future.[11] Global development gains in sexual and reproductive health and rights have also been wound back during the pandemic, with resources being diverted away from family planning, contraception and maternal health services with likely impacts for women and children. [24] The economic consequences of the pandemic may also negatively impact government per capita health spending in some countries, including on essential health services and future emergency responses.[25,26] Conversely, the pandemic has demonstrated how quickly innovations can be developed and scaled up, and how rapidly inequities impacting population health can be addressed. The pandemic also contributed to intensified global and regional collaboration in disease control efforts, a more robust understanding of the need for and implementation of multisectoral action and community engagement, new approaches to health service delivery, increased government provision of social services (including social protection) to unreached populations and expedited digital health uptake. The pandemic has also highlighted the need to ensure health systems are fundamentally resilient.[27]

Health systems that can reach unreached groups will be desirable for everyone. The lessons of the COVID-19 pandemic provide an opportunity for us to "build a new better future" across all populations by creating robust, inclusive and future-proof health systems that effectively support health and development for all.[28,29] Drawing on these lessons points to innovative ways of strengthening systems and services, including actively engaging communities to develop strategies to reach those unreached. Systematically addressing the health needs of unreached populations requires the health sector to understand the political, social, cultural, economic and environmental determinants of health and their influence on access to quality health services. It will require long-term planning and learning from health programmes and initiatives that have successfully reached the unreached, integrating these into existing health systems, and developing new strategies aligned with Member State visions for health system transformation and reform. It also requires enabling and empowering communities and individuals to play an active role in maximizing their health and health care across their lifespans and developing mechanisms that allow them to contribute to the health system and service design.

Central to this challenge is transforming systems and services to enable individuals and communities to be as healthy and safe as possible. This transformation may require a new way of thinking and a broader perspective through which issues are considered – for example, by seeking to understand the services and systems needed through the eyes of communities (see Appendix 1, Vignette V1).

1.3   Understanding why people are unreached by health systems

Multiple factors can contribute to creating populations who are unreached. These include the social determinants of health, stigma and discrimination, as well as the settings in which people live and work. Across all countries, these factors influence access to services and health outcomes. Although some differences in health have biological causes, evidence indicates that up to two thirds of the differences in health status are due to social, economic and environmental factors.[30] For example, gender norms can influence opportunities for education, type of employment, exposure to risk (such as gender-based violence or occupational hazards) and access to social protection. Patterning of this kind can be considered inequitable as they are unnecessary, unfair, unjust and avoidable.[31]

Unreached groups have no or lower access to effective, quality health services and poorer health outcomes than would be expected within their country. Reaching the unreached means reducing inequities associated with the structures that create disadvantage or marginalization,[31] including those that impact access to high-quality health services. Reaching the unreached also means recognizing that assets within the communities should be drawn upon to develop strategies to reach unreached populations. As such, new models of decision-making that demonstrate power-sharing arrangements with the concerned communities may be required.

Three conceptual frameworks help understand the conditions that create unreached populations: 1) the social determinants of health, 2) stigma and discrimination, and 3) settings in which people live and work (Fig. 4).

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Fig. 4.   Factors creating unreached populations: social determinants, stigma and discrimination and settings

> **JOB LOSS**
>
> **HEALTH CONDITIONS**
>
> **FAMILY BREAKDOWN**
>
> **DISASTERS**
>
> **SYSTEMATIC ECONOMIC SHOCKS**
>
> **CIVIL UNREST**
>
> **PANDEMIC**
>
> Economic   Legal
>
> Settings
>
> Intersections dynamic
>
> Stigmatization   Social determinants
>
> **Political**
>
> **Dynamic:**
> May change over time: temporary, cyclical or permanent
>
> **Settings** — for example:
> - Geographical location
> - Humanitarian & refugee settlements
> - Informal settlements
> - Accommodation for migrant workers (documented and undocumented)
> - Prisons
> - Some care settings such as aged care
>
> **Social determinants** — for example:
> - gender/gender diversity
> - Income
> - Education
> - Age
> - Disability
> - Ethnicity
> - Indigeneity
> - Sexuality/sexual identity
>
> **Stigmatization** — for example:
> - People living with HIV
> - People with mental health conditions
> - People who use substances
> - People with disabilities
> - People from specific cultural groups
> - People who are LGBTIQA+

Source: Adapted from Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. Lancet Glob Health. 2018;6(11):e1196-e252.

1.3.1 Social determinants of health contribute to up to two thirds of differentials in health outcomes.

The social determinants of health are the circumstances in which people are born, grow, live, work and age, and the systems put in place to prevent and deal with illness. They include gender, age, sexual orientation, ethnic group, disability and wealth. They can predispose people to a higher exposure to health risks and a greater need, but poorer access to quality health care. A broader set of forces shape these circumstances, including political and governance systems, economic policies, social policies (labour, housing, land, education, health and welfare), culture, and social values, which can result in the stratification of populations. These circumstances can then lead to differences in exposure to health-promoting or health-compromising factors, such as housing, working conditions, nutrition, environmental hazards and stress, which in turn impact health. Poor health, including mental health,

can further entrench disadvantage and impact access to quality care – for example, by compromising employment opportunities and reducing income. Inequities can compound across the life course. For example, access in early life to quality education and skill development impacts employment and income, affecting health and living conditions and outcomes in older age.[32,33] Some types of disadvantage, such as poverty and trauma, can also have intergenerational impacts.[34] Considering social determinants will be critical in the design of health services that reach unreached groups as attention to issues like culture, gender and cost will influence how accessible services are to these groups.

1.3.2 Stigma and discrimination have negative impacts on health and well-being.

Stigmatization is a societal process where a society applies stereotypes to an identifiable subgroup. Once a community applies stereotypes to all members of a subgroup, stigmatizing behaviours (also known as discrimination) towards that subgroup often result. Such discrimination may be related to gender, gender identity, sexuality, ethnicity, race, indigeneity, religion or age. Stigma and discrimination then impact success in many spheres of life such as employment, social relationships, health and health-care experience.[35] People subject to stigma and discrimination can also internalize the negative societal beliefs about their group (self-stigma), further impacting their health and well-being. "Secondary stigma" can be experienced by friends or family members of stigmatized groups or by health-care providers who deliver care to them.[36] This discrimination may have deep historical roots – for example, discrimination experienced by many indigenous peoples. It can also perpetuate through structural and institutional policies and practices. It can result in impacts such as residential segregation, limited access to quality education and housing, and higher incarceration rates – all of which can negatively affect individuals and communities. In addition, stigma and discrimination may lead to poor experience of, and mistrust in, health services and poorly targeted health promotion strategies, the consequence of which can be a denial of the right to appropriate health care.[37–39]

Stigma and discrimination can also be associated with specific health conditions. The drivers of this stigma may vary depending on the health condition and the context. A typical example is the fear of infection through casual contact with people who have an infectious disease. Another example is prejudice about the behaviour of people with mental health conditions. Concerns about productivity due to the poor health of those with chronic conditions or disability are also common. Social judgement and blame for conditions such as obesity, drug use or smoking-related illness are also widespread. A range of factors minimize or exacerbate stigmatizing behaviours. For example, addressing cultural, social and gender norms and improving community knowledge and understanding can influence how health services treat people. Appropriate health and safety policies and equipment can reduce avoidance of people with infectious conditions, and laws can prohibit discriminatory practices. The consequences of perceived or actual stigma and discrimination can include poor access to health services, reduced uptake of testing and treatment, lower adherence to treatment, and reduced resilience.[36]

1.3.3 Settings in which people live can impact access to health and health care.

Health systems can face challenges in providing services to people living and working in some settings. These settings may include people living in remote locations, urban slums and informal settlements, prisons, aged-care facilities, and labour camps, or those who are nomadic or migrants. Often these populations have less access to the conditions that promote good health and well-being (that is, positive social determinants of health) and are more vulnerable to poorer health outcomes.[40–47] As a

result, health services can encounter considerable challenges in providing services to many of these populations.

1.3.4 Unequal power relationships, intersectionality and dynamism all contribute to being unreached.

Unreached populations are dynamic. Individuals can move in and out of particular categories of vulnerability due to shocks such as economic events, illness and pandemics[23] or due to changes to the policies and structures that impact their lives.

There are often intersections between the social determinants of health, stigma and discrimination, and the settings in which people live and work. These can compound disadvantages and impact access to health services. For example, people in prison settings are likely to face a range of other disadvantages and experience discrimination. Also, in many countries in the Region, indigenous peoples experience poorer health outcomes than their non-indigenous counterparts, influenced by both historical and current policies and practices impacting indigenous cultures and traditional lands, as well as discrimination, including racism.[48,49] How much these factors contribute to being unreached by health services depends on the structures and systems – such as government policies, laws and cultural norms – that shape the contexts in which people live and the organization of the systems and services they need.[50]

Unequal power relationships within societies and communities are central to generating and maintaining differential access to social and economic resources,[51,52] continuing stigma and discrimination, maintaining inequitable access to health and other services, and determining who is reached and who is unreached. Working to reach the unreached and to transform health systems so they routinely do this will require change, including changes to power relationships. This change will require strong political leadership and processes that engage both those who are unreached and those who work in the government and sectors such as health, education, industry, justice and social protection (see Appendix 1, Vignette V2 for an example of community participation).[53]

Addressing the complex challenges of leaving no one behind requires Member States, WHO and other partners to effectively transform health-care delivery and public health systems to reach everyone, everywhere and ensure government policies and programmes include attention to reaching the unreached. This Regional Framework aims to support this work.

2.   The Regional Framework

This *Regional Framework for Reaching the Unreached in the Western Pacific (2022–2030)* aims to support countries to take action to ensure their health sectors effectively address the health needs of everyone and collaborate beyond health to impact the conditions that create inequitable health outcomes. It provides tools and strategies to build a future where no one is left behind on the journey towards UHC and to support the realization of the highest attainable standard of health for all.

This chapter outlines the vision, principles and action domains to reach the unreached in the Region.

2.1   Vision

Transformed health-care delivery and public health systems across the Western Pacific Region that routinely reach everyone, everywhere and ensure equitable health outcomes.

2.2   Principles

Five fundamental principles guide the Regional Framework:

1.   Systems approach: Multiple, integrated and coordinated actions are required.
• Multiple, integrated and coordinated actions across social, economic, cultural and health system domains are essential to address the many intersecting causes of being unreached.
• Multiple, integrated and coordinated actions are required <u>within the health sector</u> to align and accelerate actions that support high-quality, equitable, people-centred health-care delivery and equitable health outcomes.
• Solutions need to be evidence based, informed by guidance and policy, and be locally tailored and driven.
2.   Grounds up: The needs of unreached populations are central, and solutions are multiple, context specific and local.
• Effective engagement and empowerment of unreached groups are central to understanding their needs and identifying, monitoring and implementing context-based solutions.
• There is no one solution or set of solutions that meets the needs of all unreached populations, and locally generated solutions can contribute to national policies and approaches.
• Attention to human rights and the progressive realization of the right to health, enshrined in the WHO Constitution, should be fundamental to all strategies to reach unreached populations.
3.   Health beyond the health sector: Diverse stakeholders with varying interests are central.
• The health sector cannot address the challenges of unreached populations alone and will need to engage with and mobilize diverse stakeholders across the government, civil societies, communities and the private sector, where appropriate.
• These stakeholders may have competing interests that require understanding and negotiation – while maintaining a clear focus on the needs of, and improving outcomes for, unreached populations.
4.   Innovation: Reaching the unreached is a dynamic, evolving process.
• Unreached populations are not static, and people can move in and out of being unreached due to shocks, structural changes, illness and life circumstances. There will be subgroups within unreached populations who may have different needs and who experience different and intersecting dimensions of disadvantage.

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- Strategies should recognize and respond to this dynamism, and complex systems may require consultation, experimentation and continuous adaptation.
- A commitment to health equity – or overcoming differences in health care and health outcomes that are unnecessary, unfair, unjust and avoidable – is critical to reaching the unreached.

5. Diverse: There are many pathways to achieve reaching the unreached.

- Given the diversity among Member States, strategies and actions in transforming their health systems and services may differ.
- Each Member State needs to pursue the three intersecting areas of focus for health sector action (described below) to achieve high-quality, comprehensive, integrated and people-centred health systems that equitably and routinely reach everyone across the life course.

2.3 Three intersecting areas of focus for health sector action

There are three key areas where the health sector can take action to reach unreached populations (Fig. 5).

1. **Build high-quality, comprehensive, integrated and people-centred health systems and services that equitably and routinely reach everyone across the life course**, using an inclusive systems approach and identifying opportunities at all levels of the health system to reach the unreached. Actions may differ at each level and depend on the country's context. It also means meaningfully engaging unreached groups in decision-making at national, subnational and local levels.

2. **Enable individuals and communities to maximize their health and well-being across the life course**, actively contribute to improving health systems and services, and play an active role in impacting social, economic and environmental conditions in which they live and work.

3. **Contribute to improving the historical, social, cultural, political, economic and environmental conditions creating unreached populations** by informing and influencing multisectoral action on the determinants of health and institutionalizing joint activity to address these.

Fig. 5.   Three key areas for health sector action to reach the unreached

2.4   Five key action domains that reach the unreached

Five action domains are critical for reaching the unreached (represented in Fig. 6). **Action in all domains requires meaningful engagement with people from unreached groups**.

1. Political commitment coupled with governance, financing and legal structures that support reaching the unreached
Countries have or build political commitment and leadership to reduce inequities in health and health care and also recognize that purposeful policy, legal and financing approaches are needed to reach those unreached. These systems also recognize that initiatives designed to increase access for unreached groups can involve political contestation and organizational reform.[54]
2. Multi-stakeholder engagement
Health systems have leadership and mechanisms encouraging intrasectoral and intersectoral action and cooperation to promote population health and address inequities. Key stakeholders may include governments, unreached communities, civil society and the private sector.

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3. Data and evidence
Health systems collect and use data and evidence to identify unreached populations, monitor and evaluate actions to address them, and continuously learn and adapt from implementation.
4. Transforming health services to reach the unreached
Health services can integrate equitable population-based approaches into public health programmes and clinical service provision. High-quality, people-centred primary health care and effective community engagement should be the platform for this approach.
5. Special approaches
The capability for fast responses to specific challenges or crises impacting unreached populations beyond the immediate capacity of existing health services is maintained.

**Fig. 6.   Five action domains for health sector action to build systems to reach the unreached**

The five action domains are relevant to all levels of the health system. The strategies implemented will differ at each level and depend on the structure of the country's health system. However, action at all levels is required to routinely reach the unreached. The potential impact may be more significant if

there is coordination among the strategies at each level. Fig. 7 illustrates how national, subnational and local levels might contribute to reaching the unreached.

Fig. 7.   Reaching the unreached can be built into all levels of health systems.
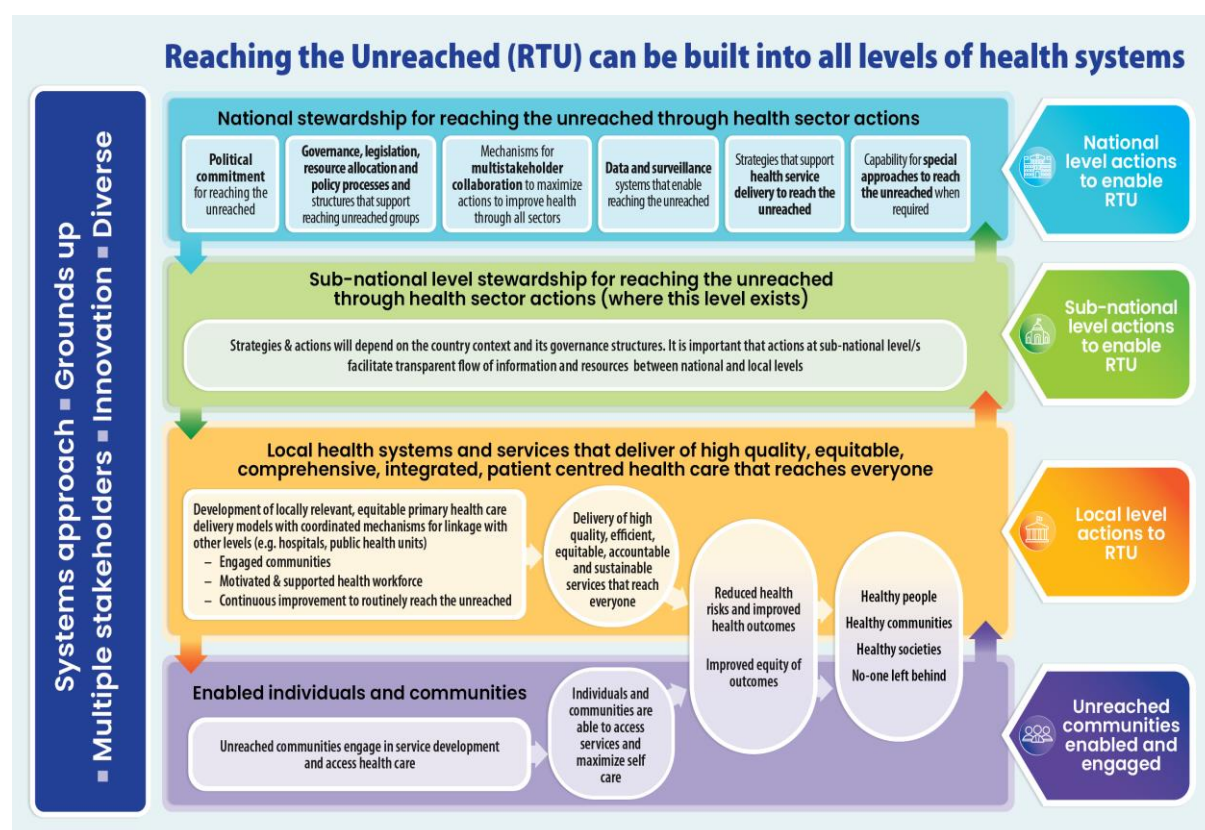
At the **national level**, political commitment, strong governance, legislation, resource allocation and policy processes enable action throughout the health system to reach unreached populations. The multi-stakeholder approach engages key nongovernmental actors and facilitates cross-sector collaboration to address the determinants of health. In addition, a robust national data and disease surveillance system supports identifying those unreached and helps monitor the impact of strategies implemented to reach them.

At the **subnational level,** in countries with this level, a two-way flow of information exists between the national and local levels. Where relevant, the subnational level ensures that the national level recognizes unreached populations and allocates sufficient resources at the local levels. In addition, the subnational level supports the local-level adaptation of national policies and guidance.

Actions at both national and subnational levels will influence action at the **local level**, where there should be the capacity for the development and delivery of high-quality, efficient, equitable, accountable and sustainable services that in turn contribute to improved health and well-being of local populations. There should be capability at the local level for adaptation so that service models appropriate to local populations can be developed and implemented.

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At the community level, populations will be enabled to participate in co-design, and sometimes implementation, of service models that meet their needs, as well as actively engage in their own health and health care.

Clear communication, coordination and feedback loops between levels should be established to ensure barriers to reaching the unreached are effectively addressed and embedded across the whole health system.

Progressively building health systems to reach everyone, everywhere will also require consideration of the best way to achieve this, including through policies that influence both access to health services and the determinants of health. Policy options have been described and include:

- Targeted interventions that specifically focus on addressing health gaps and reaching unreached populations.

- Interventions that are universal and focused on the causes of health inequities. This means they are relevant to all members of a society and are also more likely to improve conditions for those who are the most socially or economically disadvantaged; for example, strategies to reduce catastrophic health expenditures.

- Strategies that have a universal goal, such as UHC, but recognize that additional focus and resources, proportionate to the level of disadvantage, may be required to reach some groups. This is referred to as "progressive" or "proportionate" universalism.[55–59]

Action Domain 1: Political commitment coupled with governance, financing and legal structures that support reaching the unreached

Political commitment is about how different actors prioritize their efforts through their actions, statements and behaviours in their spheres of influence.

Political commitment can include:

- **Expressed commitment**, or public expressions from leaders to support reforms, policies and actions that address inequities.

- **Institutional commitment**, or establishing institutional structures and arrangements to enable the implementation of governance, financing, legal and policy processes that identify and address issues creating unreached populations. This type of commitment includes meaningful engagement of unreached groups in these processes, including decision-making.

- **Allocation of resources** for continued implementation of actions and policies that address inequity, including those for monitoring and evaluation.[60]

The various actors include political leaders, the public sector, the private sector, nongovernmental organizations, indigenous and community groups, religious organizations, and influential citizens. Political commitment is required at all levels both within and outside health systems and is likely to involve various actors working on different types of initiatives at different levels.

It is also helpful for leaders to foster political commitment to address complex issues that create unreached populations at boundaries, such as:

- borders between countries (for example, to address the problems of service delivery for cross-border migrants);
- jurisdictional boundaries between levels in systems (for example, boundaries that may impede action across national and subnational levels for health systems strengthening); or
- between locations (for example, through registration or enrolment requirements that exclude internal migrants accessing services in their new places of residence and work).

Political commitment includes meaningful community engagement of unreached groups in all relevant processes, including decision-making.

Community engagement is a political process involving negotiating and renegotiating power and authority between providers and recipients of services or between political leaders and community members. This engagement aims to develop and maintain meaningful relationships that enable stakeholders to work effectively together to address health-related issues and achieve positive and sustainable health impacts and outcomes. Community engagement occurs across a continuum from simply seeking information from communities to more active forms. These include partnerships where collaborative relationships aim to achieve common goals and where communities (or community members) gain a shared sense of ownership and joint accountability for implementation and outcomes.

Meaningful community engagement may not be easy or comfortable for policy-makers, service providers or communities. However, engaging the community is critical for achieving UHC and reaching the unreached.

Community engagement will require resourcing to support community members in their roles representing their constituencies and to support the changes necessary for organizations due to the engagement process. Importantly, enabling members of groups who may be the most unreached to participate without fear of negative consequences is critical. Those most unreached may include those who are not citizens and those who are unregistered, undocumented or displaced.

For community engagement to contribute to effective change, significant effort needs to go into:

- defining the goals of, and purpose for, engagement;
- working out the most effective strategies to realize the goals;
- considering the extent to which policy-makers and providers are willing to share power and implement change as a result of engagement; and
- building and sustaining relationships of trust over time.

Communities should be engaged from the beginning and enabled to participate in identifying issues, designing required changes, and testing the acceptability and feasibility of proposed solutions. Their role as experts, co-creators and essential stakeholders – bringing knowledge critical to the success of initiatives – should be acknowledged and normalized. This can be facilitated by reorienting from problematizing unreached populations to taking a strengths-based approach. The focus should be on the expertise, strengths, assets and resilience within communities and among individuals that enhance their ability to maintain and sustain health and well-being.[61] This approach may also require allowing for divergent opinions and discussions across stakeholders,[62] and action to hear those whose voices may generally be unheard, such as people with disabilities and older people, so as not to perpetuate existing power, access and outcome inequalities.[63] Some guiding principles are outlined in Box 3.

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Box 3. Action-oriented guiding principles for successful community engagement

- Ensure leadership facilitates and supports community members in their roles and tasks without being too directive or restrictive.
- Create safe spaces and processes where all members – including those from communities and those in professional roles – feel comfortable enough to put forward ideas.
- Involve community members as early as possible, including when identifying and prioritizing their own health-care needs. Consider community members to be experts in the design and implementation of their services.
- Encourage and empower community members to take on governance and decision-making roles within community engagement interventions.
- Acknowledge and address community members' experiences of the power imbalances between them and professionals. This principle includes experiences of discrimination, such as institutional racism and gender-based inequities.
- Offer learning opportunities to community members to develop the skills and confidence to engage.
- Facilitate quick wins to build and maintain momentum among community members and other stakeholders.
- Enable community members to co-develop activities and projects that interest and motivate them, instead of predetermined priorities.
- Ensure a real focus on achieving equity for every decision about conducting meaningful community engagement and determining action to improve health and health care.
- Aim to make representation diverse – for example, include people from different cultural backgrounds and age groups, including those who are often not traditionally invited or involved in improving health and health-care policies and programmes.
- Recognize the intersections between different aspects of people's identities when defining a community so that people with multiple perspectives are engaged; for example, women from ethnic minority groups with disabilities.

Sources: Adapted from Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies. Assessing meaningful community engagement: a conceptual model to advance health equity through transformed systems for health. Washington (DC): National Academy of Medicine; 2022 and De Weger E, Van Vooren N, Luijkx KG, Baan CA, Drewes HW. Achieving successful community engagement: a rapid realist review. BMC Health Serv Res. 2018;18(1):285.

Political commitment is critical to establishing financing mechanisms that ensure equitable service delivery that reaches the unreached.

Investing in the health system is a critical determinant of equity. Ensuring financing mechanisms and decisions are evidence based and protected from political manipulation is important if financing reforms are to achieve the outcome of reaching unreached populations. Financing strategies to support equity include:

- Raising revenues to pay for health services in a progressive way, with people who have more resources paying proportionally more than those without such resources. For example, through a fair tax system or progressive design of prepayment contributions for social health insurance, where the poor are completely subsidized.
- Risk pooling to spread financial risk across the population so that no individual carries the full burden of paying for health care, combined with the redistribution of resources to individuals with the greatest health needs.[64]

- Purposeful allocation of resources to redress inequities in the purchasing power of institutions providing service to different population groups, with those providing services to unreached populations obtaining a higher share of resourcing.65–67
- Strategic purchasing using mechanisms to allocate funding to providers to achieve performance goals for defined populations,20,67 whereby the purchasers, usually health ministries, identify the services/actions most needed for specific populations and incentivize health-care providers to deliver a specified quality and quantity of services to unreached populations.
- A single-payer health insurance system with a unified benefits package.68
- Funding equitable health benefits packages with attention to achieving universal coverage of an agreed, affordable, high-priority package of services.
- Providing incentives to reward improved delivery of high-quality services to unreached populations and/or to achieve improved health outcomes for these groups.
- Aligning external/donor financing to government policies and minimizing the establishment of parallel systems that increase administrative inefficiencies and challenge coherent resource allocations.
- Discouraging reliance on disease-specific donor funding that may prevent the establishment of flexible modalities to reach unreached groups and address all their health needs.
- Ensuring financing for essential health services is maintained in the face of competing priorities such as addressing pandemics and public health emergencies.

In some countries, participatory budgeting has been used as a mechanism to engage communities in the process of deciding how public money is spent and in monitoring the impact of budgeted initiatives.[69] To be effective for reaching unreached groups, attention should be paid to ensuring such processes are gender sensitive, inclusive and enable engagement of representatives from unreached groups.

Political commitment is important in supporting laws enabling equity and supporting reaching the unreached.

While using the law and legal frameworks is potentially a powerful systemic intervention and can assist countries in achieving health equity, creating a new law or substantial amendments to an existing law can be a long, complicated and resource-intensive process. For this reason, it is essential to understand the policy objective for reform and consider what is possible using existing legal frameworks. It is often the case that the required powers exist in legislation, but the authorities are not implementing them adequately. It may be much easier to enforce existing legislation than to seek its review and reform or create new laws.

Successful law review and reform requires careful planning and consideration of the broader reform environment, existing health system laws, and the necessary time and resources for implementation and engagement with all relevant stakeholders. Without such attention, law reforms may not be implemented. This can result in wasted time and resources and potentially weaken the rule of law or undermine population health.

When reviewing and reforming legislation to assist in reaching the unreached, the following elements should be considered:

- including principles such as equity and non-discrimination in public health sector laws;

- establishing a multisectoral mandate for health policy-making;
- ensuring there are laws to support equity-focused data collection and use, with attention to maintaining privacy, confidentiality and rights;
- enabling partnerships in health service delivery;
- establishing health system functions of national and subnational governments;
- setting standards for public and private service providers and for all registered health practitioners;
- including laws pertaining to quality, safety and efficacy of medicines, which may also describe a list of essential medicines;
- ensuring social health insurance laws that provide financing arrangements for access to UHC; and
- incorporating financing laws that enable the collection of funds from employers, premiums from employees and others, and diversion of funds from consolidated revenue for health insurance purposes.

As these areas of possible review and reform often cover several sectors, they are likely to cross areas of portfolio responsibility, such as health, finance, social welfare and emergency management. Changing laws that impact unreached populations may require more than one review or reform effort and may entail ongoing attention as law reform efforts are implemented and lessons incorporated from monitoring and evaluating the impact of these laws. Such monitoring should include reviewing the impact on groups that are potentially unreached.

Another area of considerable scope in countries with strong customary law traditions is the use of such laws to enable primary health care. Customary law that empowers community health workers to undertake basic health functions, sets some local standards for hygiene and sanitation, or assists in referral pathways for small community health clinics presents areas of potential for laws that operate close to communities and are strongly resonant in people's daily lives.

Key points: Political commitment coupled with governance, financing and legal structures that support reaching the unreached
• Governments and decision-makers at all levels in the health system should champion actions to address inequities in health outcomes at every opportunity.
• Unreached communities should be engaged from the beginning in appropriate and meaningful ways in initiatives to ensure that the health system and services meet their needs.
• All policies should ensure attention to equity and support reaching unreached populations.
• Financing strategies that address inequitable access to services should be implemented. These may include equity-focused strategic purchasing, procurement, performance-based financing, equity-focused resource allocation models, risk pooling and health insurance.
• Legal frameworks need strengthening to address inequities where this is relevant, including those that remove barriers to access, such as preventing discrimination.

See Appendix 1, Vignettes V3–V7 for examples illustrating Action Domain 1.
See Appendix 2 for some useful tools for approaching Action Domain 1.

Action Domain 2: Multi-stakeholder engagement

Stakeholders within health systems

Depending on the country's context, various stakeholders will play critical roles within the health sector, including in policy development, financing and service delivery. These stakeholders will have varying interests, power and influence, creating opportunities and tensions. Therefore, successful implementers of health sector reform will need to be aware of and manage six different kinds of politics associated with:

1. interest groups – for example, health provider associations, unions, industry groups, insurers and consumer organizations;
2. bureaucracies – for example, different government departments and agencies that may attempt to protect or expand their authority, interests, budget, personnel or influence;
3. budgets and the processes around budget allocation and expenditure mechanisms;
4. leadership, including the effect that influential stakeholders can have on perceptions of the costs and benefits of policies and actions;
5. beneficiaries, including the end users of the health system; and
6. external actors, including donors and partners, such as international financial institutions, nongovernmental organizations and the private sector.[54,70]

How these stakeholders are engaged and managed is central to the success or failure of health sector reforms, particularly those that aim to meet the needs of unreached groups.[54] There are many mechanisms for such engagement, depending on stakeholders' expertise and potential role.

Annex

Box 4. Successful strategies for enabling multi-stakeholder collaboration

Successful strategies include:

- establishing a shared vision and aligned objectives;
- engaging relevant communities and stakeholders early;
- creating a mix of different partners with diverse backgrounds with strong relationships and trust among partners, and keeping partners engaged and motivated;
- having leadership that inspires trust, confidence and inclusiveness and allows for flexibility when required, for example, in governance and administrative frameworks;
- ensuring coordinated use of policies and actions across organizations and sectors;
- formalizing collaboration agreements and establishing a planned and systematic approach suitable for all partners;
- balancing formal and informal roles, depending on the activity;
- facilitating ongoing capacity-building to strengthen leadership skills for collaboration;
- identifying mutual and joint benefits, or win–win situations;
- ensuring adequate resources, such as trained personnel and funding, and commit to maintaining these over time and distributing them in a transparent and fair way;
- maintaining excellent communication, which is monitored for its effectiveness for different partners and adapted accordingly;
- allocating time for establishing partnerships and working collaboratively;
- using information technology to support organizational connections; and
- drawing on and learning from previous experience, which may include addressing issues that have impeded collaborative action in the past.

Sources:

van Dale D, Lemmens L, Hendriksen M, Savolainen N, Nagy P, Marosi E, et al. Recommendations for effective intersectoral collaboration in health promotion interventions: results from joint action CHRODIS-PLUS work package 5 activities. Int J Environ Res Public Health. 2020;17(18).

Storm I, den Hertog F, van Oers H, Schuit AJ. How to improve collaboration between the public health sector and other policy sectors to reduce health inequalities? - A study in sixteen municipalities in the Netherlands. Int J Equity Health. 2016;15:97.

Adeleye OA, Ofili AN. Strengthening intersectoral collaboration for primary health care in developing countries: can the health sector play broader roles? J Environ Public Health. 2010;2010:272896.

Corbin JH, Jones J, Barry MM. What makes intersectoral partnerships for health promotion work? A review of the international literature. Health Promot Int. 2018;33(1):4–26.

Multisectoral and intersectoral action for improved health and well-being for all: mapping of the WHO European Region. governance for a sustainable future: improving health and well-being for all. Copenhagen: World Health Organization Regional Office for Europe; 2018.

Multisectoral action

The structural and intermediary determinants of health significantly impact the health outcomes of unreached populations. However, most of these determinants are outside the control of the health sector. Instead, they are the responsibility of: non-health government agencies, such as departments of finance, education, social services, housing, corrective services, trade, labour, legal services, migration, commerce and industry; development partners, including a range of United Nations agencies; community and civil society organizations; and others. Therefore, leadership and mechanisms encouraging intersectoral action and cooperation are essential to promote population health and address inequities (Box 4).

Systemic reforms designed to increase health-care access for unreached groups will often be politically contested and involve ethical challenges. The health sector needs to navigate these contests, championing health and driving dialogues to put and keep health, equity and a focus on unreached groups on the agenda, as well as influencing non-health sectors to include considerations of health and health equity in their policies. Health reformers will need the capacity to shape policy agendas to make the unreached visible, critically analyse the root causes of inequity, and understand and negotiate divergent interests and build accountability.

Advocacy may be required to support other sectors to take action. Based on various analyses and systematic reviews, the following advocacy actions have been identified as key roles for the health sector:

- **Establish the dialogue across sectors,** or build on existing dialogues, and facilitate the development of shared understandings of the different terminologies in different sectors.[71–73] This might be facilitated by mobilizing senior political and public health staff in relevant sectors through advocacy and education.

- **Set goals and objectives** that give a clear mandate and link to activities that show measurable results, including establishing equity-based indicators and targets, thereby helping to build confidence across central agencies and providing a sound basis for evaluation.

- **Aim to institutionalize health equity and a focus on reaching the unreached as a central goal of all government policy** to encourage sustainability. This action could involve ministerial-level ownership and coordination of action on health equity, binding targets for ministries or requirements to conduct health equity impact assessments of new policies.[74]

- **Identify win–win strategies** where health equity goals can be realized without diminishing the achievement of strategic goals for the non-health sector.[71,75,76] For example, routinely propose infrastructure that would support adequate access to health care, such as roads, water and power supply, to non-health sectors and support the mobilization of such resources, connecting health goals with existing policies in other sectors.

- **Encourage common responsibilities** such as sharing accountability mechanisms and budgets so that all sectors are equal partners.[74]

- **Support monitoring and reporting** through means such as earmarking funds to pay for an analysis of the impact of all new policies on the social determinants of health.[77]

Key points: Multi-stakeholder engagement

- The health sector has a crucial role in advocating for and supporting multi-stakeholder initiatives to reach the unreached and in institutionalizing health equity as a central goal of government policy.
- Mechanisms and resources to support and continuously strengthen collaboration across sectors and multiple stakeholders within the health sector are critical to achieving health for all.
- Meaningful strategies to engage unreached populations in collaborative initiatives to address their needs are critical.
- Multisectoral efforts to collect, analyse and use data for decision-making, monitoring and action are required.

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> See Appendix 1, Vignettes V8–V15 for examples illustrating Action Domain 2.
> See Appendix 2 for some useful tools for approaching Action Domain 2.
> A series of case studies on Making multisectoral collaboration work published by *The British Medical Journal* in 2018 are also useful.

Action Domain 3: Data and evidence

Access to relevant and reliable information on unreached groups and inequities in health outcomes can help:

- to understand the needs of unreached populations and why they are unreached;
- to understand the impact of intersecting factors on the health of groups – for example, the intersections between gender, ethnicity, socioeconomic status, disability and age;
- to design appropriate interventions;
- to strengthen ongoing monitoring and evaluation to enable policy and practice improvements;
- to assess the impacts of interventions on reaching the unreached, health outcomes and health equity;
- to support learning and adaptation;
- to make evidence-based recommendations to improve the health of those who are unreached; and
- to improve transparency and accountability.

National-level data collection and health information systems in some countries are insufficient, and strengthening them should be integrated into broader health systems strengthening efforts. Currently, national-level data sets may not enable sufficient disaggregation to be useful at local levels, and data at the health service level will generally only provide information about those already being reached. This often means that data to identify unreached populations are not available through routine information systems or data sources used by health services.

Progressively strengthening data design, collection and analysis processes, including those for monitoring, as well as disease and mortality surveillance systems and civil registration and vital statistics, should include consideration of equity to allow the collection of information to facilitate gender- and equity-focused planning, monitoring, evaluation and improvement.[11] It is also recommended to create systems that contain data for use at local levels or relevant to specific population groups. Such processes are likely to involve:

- developing quantitative and qualitative data collection methods to gather information in appropriate ways with and from unreached groups;
- including data fields that enable systematic, useful and ethical "do-no-harm" data disaggregation, for example, by socioeconomic status, sex, ethnicity, indigeneity, disability, gender identity and other equity-related fields;
- ensuring rigorous data governance and management processes that protect the privacy, security and safety of data collection[78]; and
- investing in the capability to collect, analyse, interpret, disseminate, use and report on data, and having resourced and maintained data infrastructure and human resources, along with policies, processes and guides supporting data management and use.[79]

Six essential principles to guide approaches to data collection in ways that support reaching unreached populations outlined by the United Nations cover the following topics[78]:

- participation – of unreached population groups in data collection exercises, including planning, training, data collection, dissemination and analysis of data;
- data disaggregation – to enable data users to compare population groups and understand the situations of specific groups;
- self-identification – populations should be self-defining and individuals should have the option to disclose, or withhold, information about their personal characteristics;
- transparency – data collectors should provide clear, open and accessible information about their operations, including research design and data collection methodology, and data collected by state agencies should be openly accessible by decision-makers, organizations and the public in a timely way; and
- privacy – data disclosed to data collectors should be protected and kept private and the confidentiality of individuals' responses and personal information should be maintained.

There are also calls for enhancing "data sovereignty", with communities, such as indigenous peoples, advocating the right to exercise control over the collection and use of their data. Such efforts will ensure that these data reflect their understanding of health and well-being and progress their interests and aspirations.[80]

Some additional strategies for obtaining useful data to identify unreached populations are contained in Box 5.

Annex

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Box 5. Strategies to identify unreached populations when data are not available through routine sources

- Utilizing existing data as a proxy for those unreached. Such data may include geographic data where maps show areas that are hard to reach, census and survey data that may identify groups at risk (such as people who are poor, have limited education, are unemployed or live in remote areas) or specific service coverage data (such as immunization data). While choosing or using a proxy, the denominator must not hide the groups with low coverage.
- Identifying "zero-dose" children who have not received any primary series vaccines is increasingly used to find the location and characteristics of families that lack access to essential primary health care. There are clear intersections between zero-dose vaccinations and access to services for reproductive, maternal, newborn or child health care.[a]
- Accessing data from other sectors (such as education, transport, social services, and water and sanitation) to identify their unreached populations that may also be unreached by health services.
- Asking additional questions when performing other work, such as conducting a census for bed net distribution.
- Building capability for linking existing data.
- Consulting with civil society organizations and other experts about who they think are being unreached and why, or holding meetings with local communities and advocacy groups, such as village or town meetings.
- Drawing on qualitative and applied research data, including those drawing on indigenous knowledge, such as from communities and front-line service providers.
- Using innovative tools such as geospatial information and mobile phones to support data collection for real-time decision-making.
- Establishing mechanisms to enable unreached populations to identify the kinds of data and data collection methods that would best reflect their health and well-being.
- Commissioning a study designed to gather data on unreached populations.
- Working with other sectors and communities to identify the impact of any conflict in a district or country that may have resulted in refugees, undocumented or stateless people.

[a] MOMENTUM. Commitment to immunizing zero-dose children. Washington (DC): United States Agency for International Development (USAID); 2021 (https://usaidmomentum.org/resource/commitment-to-immunizing-zero-dose-children/, accessed 6 May 2022).

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Key points: Data and evidence

- Through community engagement approaches, unreached groups should advise on and contribute to data collection exercises, including in their planning, dissemination and analysis of data.
- Data collection methods should ensure unreached populations are made visible. Data collected should include useful fields to enable identification of the conditions impacting being unreached and the consequences of this on health outcomes. Fields may include socioeconomic status, place of residence, ethnicity, indigeneity, disability, occupation, sex, religion, education, age, migrant status, caste, gender identity and sexual orientation. The methods and data should ensure the principles of self-identification, transparency and privacy.
- Both quantitative and qualitative data interventions to help identify, understand and monitor unreached populations may pertain to:
  - assessing health needs, knowledge and behaviours;
  - identifying barriers to accessing services;
  - monitoring the quality of services;
  - tracking patient pathways across levels of care to identify issues; and

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- collecting qualitative information to gain an in-depth understanding of issues and perspectives.
- Data sets within the health sector and other sectors should be linked to understand the health impacts of the social determinants of health and the changes in these as interventions are implemented.

See Appendix 1, Vignettes V16–V18 for examples illustrating Action Domain 3.
See Appendix 2 for some useful tools for approaching Action Domain 3.

Action Domain 4: Transforming health services to reach the unreached

High-quality health systems and services are people-centred, integrated, comprehensive and organized around the needs of people rather than focused on specific diseases.[81] They consistently deliver care that improves or maintains health outcomes and responds to changing population needs.[82]

Strong primary health care is critical to systematically reaching the unreached.

Effective primary health care (PHC) is necessary to expedite progress towards UHC and is the foundation for health systems that reach the unreached. PHC has three critical components that align with the three key areas of focus for reaching the unreached:

1. Meeting the health needs of people across the life course through the provision of comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care, with essential public health functions as the central elements of integrated health services.

2. Addressing the broader determinants of health through evidence-informed policies and actions across all sectors.

3. Empowering individuals, families and communities to optimize their health and well-being and to advocate and co-develop policies and services that support this.[82]

In translating this vision to the Western Pacific Region, the draft *Regional Framework on the Future of Primary Health Care in the Western Pacific* outlines five essential characteristics of effective PHC as being[83]: 1) people and community centred; 2) continuous; 3) high quality and equitable; 4) integrated; and 5) innovative. Five strategic actions for enabling such systems include: 1) developing service delivery models tailored to local contexts; 2) empowering individuals and communities to participate in health; 3) building a diverse workforce and provider base aligned with the needs of communities; 4) realigning health financing systems that reduce pressure on the population and make systems financially sustainable; and 5) creating supportive legal, policy and regulatory frameworks.

Creating systems and services that demonstrate the characteristics envisioned for PHC in the Western Pacific Region will be facilitated if there is a focus on reaching the unreached in all health sector transformation strategies and actions, as service delivery will not be equitable when there are groups left behind. Translating this vision into practice will mean being able to routinely identify those who are unreached, to work with unreached groups to understand their needs, to co-design effective service delivery models, and to strive to continuously improve through monitoring, learning and adapting (see Chapter 4).

It will mean attending to both supply-side (service delivery) and demand-side (potential service users) barriers to service access. On the supply side, these include accessibility, approachability, acceptability, availability, affordability and appropriateness of services. An example of a supply-side improvement is

providing services closer to homes, schools and workplaces, rather than just being facility based. On the demand side, drivers include an individual's capacity to perceive a need for health services, to decide to seek these services, to reach and use the services, to be able to pay for the services and to engage with health-care services.[84] (See Appendix 2 for tools to undertake a barrier analysis.)

Creating the envisioned PHC systems and services will mean innovating to develop locally appropriate models, such as through outreach services, community care, home care and self-care to ensure culturally relevant service delivery.[85] It will also mean providing an appropriately credentialed and distributed multidisciplinary and motivated workforce and availability of accessible physical infrastructure and appropriate medicines, products and technologies to ensure effective service delivery.[86] Reaching the unreached may entail additional marginal costs to be budgeted for in health-care planning.

Achieving comprehensive, integrated and people-centred care may be a stepwise process.

Capability for comprehensive and people-centred care will be strengthened when service delivery can be integrated so that a full range of health services can be delivered through the same provider or provider network or by ensuring that individual health workers can deliver or coordinate a broad array of services to clients.[86,87] Achieving integration may be a stepwise process in which the core elements of priority public health programmes are progressively integrated as part of public goods to be delivered by the health system. A challenge for many countries across the Region is how to progressively integrate vertical disease-specific programmes into PHC systems so that:

- health-care delivery becomes more comprehensive, inclusive, coordinated and people centred;
- synergies between programmes are realized, thereby creating efficiencies without diminishing the quality of the services delivered;
- lessons from effective models for reaching unreached populations developed by vertical programmes are incorporated into PHC service delivery; and
- coverage is not reduced as country income levels increase and donor funding for vertical health programmes becomes less available.

Integrating traditional and complementary medicine may also facilitate reaching the unreached as this is an important sector for many communities. WHO, including through the *Regional Framework for Harnessing Traditional and Complementary Medicine for Achieving Health and Well-being in the Western Pacific*, has noted how traditional and complementary medicine has the potential to increase access to care, preserve knowledge and resources associated with therapeutically sound interventions, and ensure patient safety by upgrading the skills and knowledge of traditional medicine providers.[88–90] Collaboration with traditional medicine providers may strengthen the engagement of mainstream health services with unreached populations.[91,92]

Integration is likely to require complementary action across levels in health systems, such as a review of system-wide policies, governance and financing, as well as strategies to support organizational and professional integration and development of service delivery-level protocols, processes and procedures for enabling clinical, service and personal integration around people's needs.[93] Key factors that may impact integration in the short term are summarized in Box 6.

Box 6. Key considerations for integration of vertical programmes into primary health-care systems

1. The context matters.

    The feasibility and potential impact of integration will be influenced by context. Challenges occur when PHC system performance is low relative to vertical programme performance and where the intensity of the health needs of people being addressed by the vertical programme is high. This may point to both the need to strengthen PHC and to progressively build capability for integration as this occurs.

2. Integration may require trade-offs.

    In some cases, integration can improve the reach, quality and sustainability of critical disease-specific services; however, it may also dilute political attention or funding for specific health issues, resulting in slower expansion of coverage than that attainable through a vertical programme. This may mean that some components of a vertical programme need to be maintained – at least in the short term – for example, in the final stages of disease elimination.

3. Integration should go beyond service delivery.

    A range of programme and system components, including planning, financing, supply chain and workforce training, should be developed to support integration efforts.

4. Integration can be incremental.

    A well-functioning health system is a prerequisite for effective integration, so countries can start with programme components that the broader health system is prepared to absorb while investing in system functions that need further strengthening.

Source: Adapted from Chaitkin M, Blanchet N, Su Y, Husband R, Moon P, Rowan A, et al. Integrating vertical programs into primary health care. Washington (DC): Results for Development; 2019.

The role of innovations in supporting reaching the unreached

Business as usual may continue to exclude the unreached. Therefore, innovative approaches are essential. Three important types of innovations that can help reach the unreached are: 1) social innovations, 2) service innovations, and 3) technological innovations.[94] Often, these innovations can help overcome demand-side barriers of cost, distance and time, which may be challenging for the unreached, especially when the risk perception is low (for example, mild or no symptoms of high blood pressure).

Social innovations are collective processes enabling the generation of ideas by people who participate collaboratively to achieve improved well-being.[95] These innovations use the power of local responses to the circumstances that underpin diseases of poverty (the determinants) and highlight the innovations necessary to support and sustain these responses.[96] The social objective behind this innovation emphasizes the engagement of concerned communities.[97] Community-directed programmes provide opportunities for government health services and other social actors, including nongovernmental organizations and for-profit agencies, as well as individuals, to work closely with populations directly affected by such diseases.[96]

Social innovations may include the engagement of local influencers and volunteers (for example, traditional practitioners and community health workers) to provide essential community-based health care, including those for health promotion and disease promotion. Such innovations may also include home-based care and self-care that engages family members and individuals to become self-reliant, for

example, first aid, maintenance therapy and self-monitoring blood pressure. Efforts towards these innovations require empowering communities with health literacy campaigns and providing them with essential tools, such as blood pressure monitors and health screening checklists.

Service innovations include outreach services, mobile clinics and health caravans. Such services are critical in many settings, especially in remote and distant areas, such as remote islands, nomadic populations and ethnic minorities. They may also help groups of people who cannot travel to health facilities due to disability or old age. For instance, an outreach campaign to find people with TB in Cambodia found that the people who benefited more from those services were older people.[98] Also, house-to-house vaccinations against COVID-19 for older people resulted in higher coverage rates than places that relied heavily on mega-vaccination sites in the Philippines.

Well-organized rotations can provide continuous access to outreach health workers and continuity of care for underserved populations. A part of the health workforce that may not prefer permanent relocation may be very interested in serving in remote areas for short periods.

A wide variety of players can provide these services: hospitals or health institutions, professional boards, private companies, nongovernmental organizations or government agencies. The categories of health professionals involved vary from one strategy to another, and modalities to mobilize them also differ, such as voluntary service and financial incentives. Compiling this information provides policy-makers with ways to address the imbalance between adequately served (or even over-served) areas and those where populations have significant difficulties in accessing care.

Technological innovations may use information and communications technology (e-health) to support more people to access care, in particular those who are unable to access fixed facilities.[99,100] However, e-health can also potentially increase health inequalities, particularly for people without good internet access and digital skills.[101] Therefore, the benefits of e-health can only be reached through aligned efforts to expand access to internet and/or mobile telecom services, as well as addressing the digital skills divide. Use of technology to support initiatives to reach unreached populations is increasingly being integrated into health service delivery. Its usefulness has been demonstrated in enabling service provision during the COVID-19 pandemic. However, a health service or system must take care that using digital tools does not either create unreached populations or exacerbate existing unequal access to services.

Digital tools can strengthen service delivery by:

- making information readily accessible to community health workers to support service delivery;
- providing a platform for training and peer learning;
- enabling accurate collection and reporting of data that can be quickly transmitted to central repositories for analysis (for example, to map disease hotspots) and used by community health workers to make data-driven decisions;
- collecting data on health worker activity to inform supervision needs and workforce planning; and
- facilitating efficient payments to rural and remote health workers.

Digital tools can also be used to expedite translation of evidence into practice. For example, WHO has developed a digital platform that provides SMART guidelines that are standards-based, machine-readable, adaptive, requirements-based and testable.[102]

There is also significant growth in the use of digital devices to support self-care defined as the "ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health worker".[103] Self-care aims to support individuals and caregivers achieve greater autonomy and self-determination in their health care. Self-care interventions can include evidence-based and quality devices, diagnostics, drugs and digital products, provided either partially or fully outside formal health services. When quality self-care interventions are integrated well into the spectrum of health services, they can support the individual as an active agent in their own health decision-making, including health maintenance and managing ill health.[103] However, digitally facilitated self-care interventions should be a complement to accessible and quality health services, not a replacement for providing access to services for unreached populations. They should be a positive choice for an individual, not a choice because they have to avoid poor-quality, inaccessible or discriminatory health services.

Recently, the term **"techquity" has been used to refer to ensuring equity in digital health capability and access** at the individual, local and national levels and embracing digital inclusion. Lessons from the use of digital health in the COVID-19 response have informed a recent consensus statement of principles for digital health. These are:

- **Empowerment**: Empower citizens to use mobile technologies to manage their health and prevent disease and continue to support digital skill development, while also increasing internet connectivity.
- **Accessibility**: Monitor and mitigate health inequities by enhancing access to digital health services, including by improving accessibility, training staff, promoting within communities and providing local community-level support.
- **Multisectoral engagement**: Invest in technology and infrastructure to improve access and reduce costs to consumers, including through government and private sector investments and partnerships.
- **Effectiveness**: Ensure that digital transformation can both serve local needs and operate across the wider health-care digital environment and that there is a focus on reaching everyone, everywhere and advancing individual and population health.[104]

Further guidance for integration of digital tools into the health systems includes: focusing on the needs of, and engaging with, end users, including community health workers and community members, in the design of tools for community-based interventions; engaging multiple stakeholders; supporting the implementation of global standards; exploring partnerships to strengthen the digital ecosystem and improve sustainability; and developing infrastructure that will support the integration of a full package of health services delivered at the community level and advance interoperability of tools and systems.[105]

Tailored social and behaviour change communication can increase engagement with unreached groups.

Social and behaviour change communication is the strategic use of tailored communication approaches to promote changes in knowledge, attitudes, norms, beliefs and behaviours. It generally includes

coordination of messages and activities across a variety of channels to reach multiple levels of society.[106] It can require knowledge of local languages and an understanding of local health belief systems and decision-making processes. Social and behaviour change communication appears to be most effective when it is part of a wider, comprehensive strategy and not a single intervention relying on top–down strategies to target a specific disease or behaviour.[107]

A motivated workforce with the skills to reach unreached populations is required.

A motivated, gender- and equity-responsive, and culturally competent health workforce, including all individuals involved in public health and health service delivery, is critical to increasing the accessibility of health services to unreached groups. WHO recommendations to better develop, attract, recruit and retain health workers in rural and remote areas are also applicable for enhancing service delivery to other unreached groups.[108] These include:

- targeted admission, training and rural placement location policies to enrol and train students with rural backgrounds;
- development of health professional education programmes and curricula that reflect the needs of rural and less-advantaged groups;
- enhanced scope of practice and compulsory service requirements in rural and remote areas accompanied by scholarships and bursaries;
- incentives, such as hardship allowances, grants for housing and free transportation, to encourage a high-quality workforce to undertake rural and remote service;
- investment in infrastructure and services in remote areas to provide a good and safe working environment; and
- creation of senior posts in rural areas, support for development of professional networks and use of technologies such as e-health.

In addition, pre-service, in-service and specialized training curricula should include core content on cultural competence, preventing and addressing stigma and discrimination, and effective communication skills, including behaviour change communication. An outcome of all health worker and professional training, including community health workers and volunteers, should be to have graduates who value serving all people, whoever and wherever they are. Adequate health system resourcing to support a workforce that can deliver such services is also required.

Key points: Transforming health services to reach the unreached
• PHC is the foundation of health systems that reach the unreached. These should include models, such as outreach, that address barriers to service access for unreached populations.
• Continuous improvement processes are required to maximize the creation of integrated, people-centred public health and clinical services with effective linkages and referral between health system levels and with other sectors, such as social security.
• Strategies that safely and effectively integrate traditional and complementary medicine can enhance access to culturally appropriate and accessible care.
• New technologies can be effectively harnessed to contribute to reaching unreached populations.
• A workforce skilled in understanding equity and capable of providing culturally safe, non-discriminatory and gender-responsive services is critical.
• It is important to ensure that health communication approaches are accessible, inclusive and understood by groups that need to be reached and do not stigmatize or disempower them.

See Appendix 1, Vignettes V19–V22 for examples illustrating Action Domain 4.
See Appendix 2 for some useful tools for approaching Action Domain 4.

Action Domain 5: Special approaches

There may be contexts where special approaches are required to meet the needs of unreached populations. This may occur when the level of unmet need or the complexity of challenges related to improving service access are particularly high, and it is more likely that an appropriately resourced, specialized service or initiative will be more effective than that possible through mainstream health services. Examples in different contexts have included pandemic and emergency responses, services for indigenous peoples,[109,110] young people,[111] migrants,[112] nomadic people,[44] homeless people[47] and prisoners.[113] Special approaches may also be required to provide services in difficult-to-reach geographical areas, such as the remote Highlands of Papua New Guinea. They may also be required where there are issues to be addressed that may require localized, specific, time-limited or particularly intensive responses, like reaching the last mile for malaria elimination in the forested areas of the Greater Mekong Subregion, eliminating leprosy in the Pacific and addressing neglected tropical diseases.

Purposeful and meaningful community engagement is likely to be a critical element of special approaches to ensure the needs of unreached groups are understood and appropriate strategies generated. Additional resources are also likely to be required, and the strategies and initiatives may be time-bound. Where possible, special approaches should be coordinated with mainstream service delivery – for example, by building on, or coordinating with, PHC services or including additional elements to mainstream service delivery – and over time should contribute to knowledge and strategies for building stronger health systems that reach everyone, everywhere.

Key points: Special approaches
• Special approaches may need to be developed where the level of unmet need or complexity of challenges related to access may be particularly high or where localized or specific responses might be required, such as reaching the last mile in elimination of some diseases.
• Special approaches should be coordinated with mainstream service delivery, where possible, by building on these services and/or adding elements, etc.
• Purposeful community engagement will be critical in developing effective strategies for reaching populations where special approaches are required and additional resources are likely to be needed.
• Over time, special approaches should contribute to knowledge and strategies for building stronger health systems that reach everyone, everywhere.

See Appendix 1, Vignettes V17 and V23 for examples illustrating Action Domain 5.
See Appendix 2 for some useful tools for approaching Action Domain 5.

Annex

3. The path to reaching the unreached: equity-focused continuous improvement

This chapter draws on the frameworks for understanding what factors make populations unreached and on tools to help reach them. It provides examples of the questions that need to be answered along the path to reaching the unreached, as well as links to some validated tools that can be used to obtain this information.

There are many opportunities to develop health systems and strategies to reach unreached populations, and there are many entry points along the path (Fig. 8). These entry points can be found at any level of the health system – national, subnational or local – and may be used within an existing disease control programme or during broader health system reform efforts (Box 7). The journey is not linear, and it requires purposeful, continuous improvement as issues are identified and strategies are designed, tested and adapted. Some solutions may not be as effective as expected when implemented, some may address the needs of some but not all unreached populations, and some circumstances may change and create new unreached populations. This means putting in place practices that enable continuously searching for people who are not being reached, understanding why they are not being reached, and developing strategies to address these situations in partnership with all stakeholders, including affected populations and those from other sectors.

Fig. 8. Path to develop systems and strategies to reach unreached populations
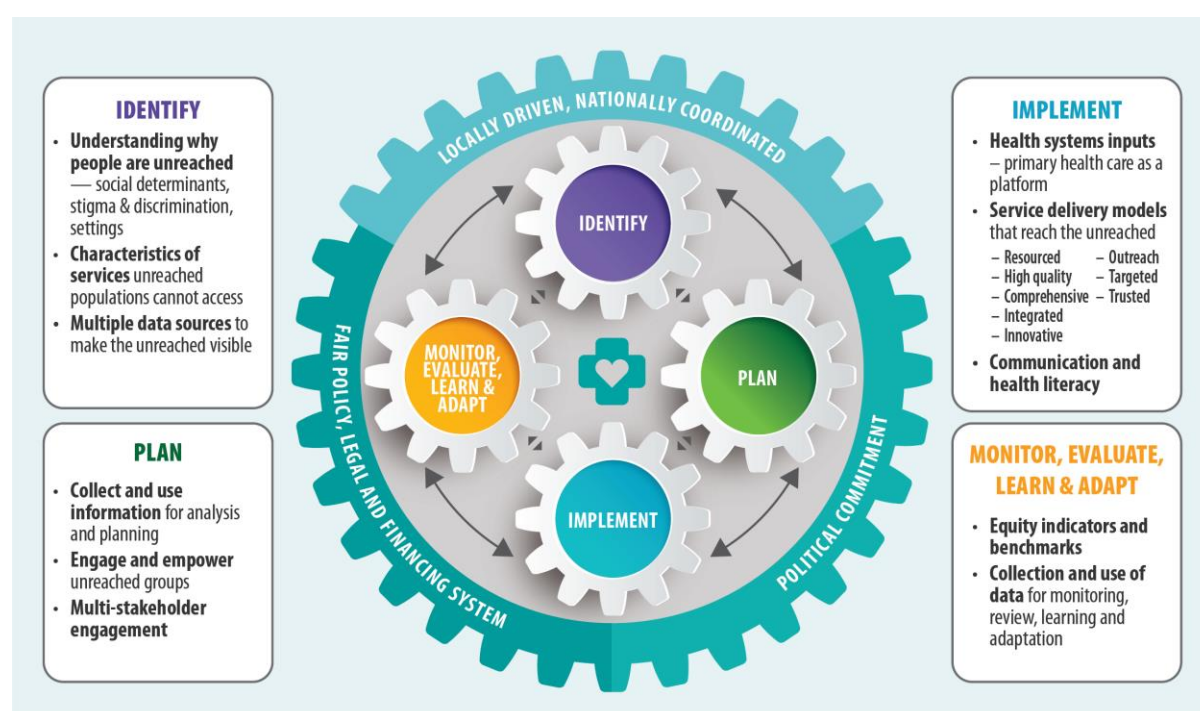
3.1 Steps to reaching the unreached and implementing the Framework

Identifying issues, planning how to address them, implementing solutions/strategies, and ongoing monitoring, learning and adapting are key elements of all health sector policy and programme cycles

and are part of traditional public health practice. The following section provides guidance about how to build reaching the unreached into any of these steps and details some publicly available, useful tools.

Step: Identify who is unreached and the performance of the services in reaching the unreached

The first step in developing health systems and services that leave no one behind is to identify the people and groups who are unreached and understand why they are unreached. This will include understanding how well the existing service delivery system is performing in reaching these groups. It can be difficult to identify unreached populations for many reasons, including that they may be unseen or invisible – for example, because they are discriminated against and may not want to identify or seek services, because they are undocumented and may fear deportation or incarceration, or because data systems are not sufficiently developed to provide the information required to enable identification of unreached groups.

The following are potential entry points for identifying unreached populations (Box 7) and key questions to ask when identifying unreached groups (Box 8).

Box 7. Examples of entry points for identifying unreached populations

- At the beginning of all health reform processes, whether at the national, subnational or local level.
- When developing, reviewing or evaluating health-related policies and programmes at any level in the system.
- When reviewing health services – for example, monitoring data may indicate areas with lower-than-expected coverage. For example, in Papua New Guinea a review of the Demographic and Health Survey data identified low antenatal coverage determined by geographic areas, age groups and educational levels.[a]
- When evidence becomes available – for example, from research investigating whether the needs of some population groups are not met, such as a study on gender and eye health in Cambodia that found that women were less likely to access services even though the rates of cataract among women aged over 50 were higher than those among men.[b]
- When a shock like COVID-19 occurs and some population groups are identified as being more vulnerable or at risk than others. For example, in Singapore during the second wave of the COVID-19 pandemic, migrant workers were identified as experiencing high rates of infection, little knowledge of or access to testing and treatment services, and living conditions that were not conducive to complying with public health measures.[c]
- During continuous reviews of programme implementation – including by seeking feedback from communities and front-line health workers about people who are not accessing services.
- During health service quality improvement processes.
- When advocacy groups raise the unmet needs of the people whom they represent.

[a] National Statistical Office, Papua New Guinea. Papua New Guinea Demographic and Health Survey report 2016-18. Port Moresby and Rockville: National Statistical Office, Papua New Guinea and ICF; 2019.
[b] Neyhouser C, Quinn I, Hillgrove T, Chan R, Chhea C, Peou S, et al. A qualitative study on gender barriers to eye care access in Cambodia. BMC Ophthalmology. 2018;18(1):217.
[c] Han K. Covid forces Singapore to confront conditions for its migrant workers. Lowy Institute; 2020 (https://www.lowyinstitute.org/the-interpreter/covid-forces-singapore-confront-conditions-its-migrant-workers, accessed 30 March 2022).

Annex

Box 8. Key questions for identifying who is unreached

Every health system designer, policy-maker, programme developer or service provider, at the local, district, subnational or national level, should routinely ask the following questions:

1. Who is not being reached through health systems, programmes and services?
2. How do you know who is not being reached, and is additional information required to really understand this? If so, how can this information be collected?
3. Are there subgroups within communities that are particularly difficult to reach, and have you identified all these groups?
4. Why are individuals and groups unreached? A gender analysis is useful in considering this question. Remember to consider the factors creating unreached populations: social determinants, stigma and discrimination, and settings, as well as supply- and demand-side factors in health service delivery.
5. Are there existing mechanisms to engage with unreached communities? If not, how else can they be engaged?
6. Do members of the local workforce have the capacity and capability to actively engage unreached populations?
7. What are the health needs of unreached groups?
8. What services and programmes should be available to unreached populations?
9. What are the local, national and global targets/benchmarks for programmes and services, and what is the gap for unreached populations? Are there specific groups within the community, district or country that have lower-than-expected coverage?
10. How well are existing policies, programmes and services performing with respect to supporting reaching the unreached, for example, on patient-centredness, quality, safety, non-discrimination, cultural competence, accessibility, acceptability and affordability?
11. After a shock, such as a disaster, civil unrest or epidemic, have you reviewed existing data or collected additional data to identify any changes in unreached groups?

It is important to include communities and front-line health workers in answering these questions (see section 2.4 to understand importance of engagement, and how to do this in ways that ensure adequate consultation and collaboration). Qualitative, quantitative and spatial data generated by informal sources, such as community organizations, civil society organizations and community clinics, can also be leveraged.

See Appendix 1, Vignettes V23–V24 for examples of putting this step into practice.
Several pre-existing tools that might be used to support this step appear in Appendix 3.

Step: Plan strategies to reach unreached groups.

In this step, whatever level of the health system, and whether from a health system design, policy, programming or service delivery perspective, a theory of change[*] should be developed. Consideration should also be given to the resourcing required to fully achieve the proposed strategy and how activities will be funded.

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[*] A *theory of change* sets out the hypothesis behind a strategy. It requires being clear about the issues to be addressed and the desired longer-term goals. It then sets out transparent, evidence-based and measurable pathways from inputs to interventions to outcomes, which demonstrate how the goal will be realized. This is aligned with the concept of backcasting, which starts with envisaged longer-term goals and identifies steps required if the goal is to be achieved.

Asking the following questions can help inform the activities in the theory of change (Box 9).

Box 9. Questions for planning to reach unreached populations

From a health service perspective:

1. Who are the community members (and their supporters/carers) and groups that need to be engaged in planning to ensure needs of unreached populations are addressed? How can they be meaningfully engaged and involved in decision-making, including prioritization? What can be done (or changed) to make sure their expertise and assets are used to inform the strategy? Are there existing groups and structures where these groups can be engaged?
2. What needs to be included in plans to ensure health services reach unreached populations?
3. What can be changed in how health services are currently delivered, including mode of delivery, to reach unreached groups while maintaining or improving existing service quality, efficiency and effectiveness?
4. Is it possible to integrate required additional service delivery with existing programmes reaching unreached groups? If so, where are the synergies and what can be shared?
5. Are new service delivery models required to reach unreached groups? If so, what are the features of these models? Are there lessons from programmes that have effectively reached unreached groups?
6. Who can be partners to support the plans and actions? Include consideration of potential health sector partners, donors, development partners and partners from other sectors. Define the roles, responsibilities, rights and obligations of the partners.
7. How can political commitment be fostered to support the planned changes? Are there links to existing laws, conventions, treaties, etc. that can be leveraged?
8. Is the level of unmet need and/or complexity of access for some unreached populations so great that it is more likely that a specialized and resourced service will be more effective than strengthening existing health services?
9. What is the theory of change: is the hypothesis strong and are all stakeholders aligned?
10. How can progress towards reaching the unreached and health equity be monitored? What does success look like?
11. What resources will be required to fully realize this plan and how will it be funded?

From a health system and health system reform perspective:

1. Which stakeholders need to be engaged to ensure appropriate plans are made to reach unreached populations? How will these stakeholders be engaged and involved in decision-making? What will be done (or changed) to make sure the expertise of engaged stakeholders is used to inform the strategy?
2. How can political commitment be fostered to support the planned changes?
3. Are there any legal, governance, cultural or financing barriers to addressing issues for unreached populations? Why? And what needs to be planned to address these?
4. What changes are required in the health system to address the barriers identified as causing populations to be unreached? What does success look like?
5. Are there reforms underway that are or could be adapted to ensure unreached groups are reached and to improve health equity?
6. Are there other sectors the health sector could engage with to plan improvements that would impact the determinants of health for unreached groups?
7. What resources need to be allocated to realize this plan and how will they be financed?

A range of strategies can support effective planning for the needs of unreached populations (Box 10).

Annex

Box 10. Strategies to support effective planning to meet the needs of unreached populations

- Effectively and meaningfully engaging with and empowering unreached populations in the identification of needs and in planning, implementing, monitoring and adapting interventions.
- Conducting an inclusive barrier analysis that systematically identifies issues that prevent unreached groups from accessing services, as well as strategies to overcome these barriers.
- Developing a participatory equity-sensitive theory-of-change map that sets out transparent, evidence-based and measurable pathways from inputs to interventions and outcomes can be useful:
  - o   to make explicit how and why an intervention is hypothesized to work;
  - o   to reach consensus on what is to be achieved and how, the required resources and under what constraints;
  - o   to provide an overarching theoretical framework that enables the identification of knowledge gaps and that facilitates choosing appropriate formative and impact evaluation methods; and
  - o   to facilitate collection of timely and useful information about the progress of the project that can be understood by a diverse range of audiences.

Sources:
Silva MD, Lee L, Ryan G. Using theory of change in the development, implementation and evaluation of complex health interventions: A practical guide. Mental Health Innovation Network; n.d.
Breuer E, De Silva MJ, Fekadu A, Luitel NP, Murhar V, Nakku J, et al. Using workshops to develop theories of change in five low and middle income countries: lessons from the programme for improving mental health care (PRIME). Int J Ment Health Syst. 2014;8:15.

A range of techniques have been developed to enable planning and adaptation in complex systems, and they provide guidance for action on reaching unreached populations. Many of these techniques are based on approaches to human-centred design thinking and facilitate rapid processes for trialling and adapting solutions. For example, agile innovation approaches have been used in a range of health-care settings and contexts, and the steps in this approach are summarized in Appendix 4. Hypothesis-driven approaches also provide useful planning strategies (Appendix 4).

See Appendix 1, Vignette V25 for an example of planning to increase access for a disease-specific programme through expansion of an existing programme.
Several pre-existing tools that can be used to support this step appear in Appendix 3.

Step: Implement strategies to reach the unreached

Based on the theory of change developed in the planning stage, the following questions should be asked (Box 11).

Box 11. Questions for implementing strategies to reach unreached populations at any level

1. Are the policies and procedures required to support reaching unreached groups developed and implemented? Have there been any barriers to implementing these policies and procedures and how are these being addressed? If not, why not and what can be done?
2. Is the health workforce being trained and supported to implement the strategy in the way required so that the unreached are reached? If not, why not and what can be done?
3. Are the infrastructure and logistics required to support the initiative established and operational? If not, why not and what can be done?
4. Are activities occurring as planned and in the right quantity, quality, settings and in a timely manner? Are health promotion activities being included, based on behaviour change and risk communication principles,

and are they culturally appropriate and informed? Are these reaching unreached groups? If not, why not and what can be done?

5. Are the (quantitative and qualitative) data required to measure outputs and outcomes and to measure success in reaching the unreached being collected in a planned and timely way, so that they can be used to improve implementation? Is there adequate capacity to collect, process, analyse, disseminate and utilize results? If not, why not and what can be done?

6. Is funding being provided and used as planned? Is this funding at adequate levels and on time to provide the planned services? Are the multisectoral, including community, resources being provided as planned? If not, why not and what can be done?

7. Are key stakeholders, including community members meaningfully engaged in ongoing refinement and adaptation of the initiative? If not, why not and what can be done?

8. Is there action to strengthen local governance, increase community ownership, optimize the role of community workers and build partnerships? If not, why not and what can be done?

9. Are health sector partners, donor and development partners, and partners from other sectors supporting implementation of service delivery or reforms as agreed? If not, why not and what can be done?

10. Is political commitment at all levels (community, local and national) being maintained and strengthened? If not, why not and what can be done?

11. Is information about the ongoing initiative and its achievements being communicated effectively to unreached communities and other key stakeholders?

12. Are there broader governance, policy, financing and legal issues that impact implementation? If so, how will these be communicated to those with responsibility for them?

See Appendix 1, Vignettes V26–V27 for examples illustrating this step.
Several pre-existing tools that could be used to support this step appear in Appendix 3.

Step: Monitor and evaluate strategies to reach the unreached and enable learning and adaptation

There are many approaches to effectively monitoring the performance of interventions to reach unreached groups, learn from the implementation experience, and adapt systems and programmes to maximize effectiveness. These include rapid review and adaptation, health inequality monitoring,[114] equity-based target setting[115] and use of data to inform continuous quality improvement. Generally, monitoring to enable learning and adaptation requires collection of data and evidence as part of an ongoing process of issue identification, strategy design, planning, implementation, monitoring, review and adaptation,[116] and it should involve unreached populations as partners. It may also be useful to consider how initiatives will contribute to the realization of the agreed indicators outlined in the WHO Results Framework and in particular, the comparison between a specified unreached population and the general population.[117] There are commonly four steps in the adaptive learning and quality improvement approach (Box 12).

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Box 12. Four steps in the adaptive learning and quality improvement approach

1. *What are we trying to accomplish*? Identify what problem or process needs to be improved and set a goal to improve it.
2. *How will we know if the change is an improvement*? Understand the problem and use data to analyse processes and measure outcomes to determine if a change leads to improvement.
3. *What changes can we make that will result in improvement*? Use insight from local stakeholders in the system, creative thinking and others' experiences to develop change ideas or strategies for improvement.
4. *Does the change make an improvement*? Test the change, usually through plan-do-study-act cycles.

Source: Tulloch O. What does 'adaptive programming' mean in the health sector? London: Overseas Development Institute; 2015.

Community-led monitoring is an approach that may be useful in reviewing initiatives to reach unreached populations and increase accountability of the Government and health service providers to the community. Members of directly affected communities are trained, supported, equipped and paid to carry out routine, ongoing monitoring of the quality and accessibility of health services, which can facilitate insights from communities.[118] This approach can also contribute to holding decision-makers accountable for effective service delivery. To be most effective, community-led monitoring should be community led and owned, well organized, and include a focus on generating political will and accountability.[118]

Generally, the monitoring and evaluation step will require using the theory of change (or a hypothesis) about the initiative to identify the data and information that should be collected and reviewed to ensure ongoing learning and adaptation. This will ensure the right strategies are being implemented in the right way to maximize reach of unreached populations. Data should be collected in ways that enable disaggregation to support equity analysis. Potential questions to ask during this step are included in Box 13.

Box 13. Key questions for monitoring and evaluation of strategies to reach the unreached

Key questions for **health services** include:

1. What can be learnt from programmes and services about reaching unreached populations? What is working well? What gaps and issues remain? What needs to be done to address these?
2. Is the strategy producing the desired impacts and outcomes? Are there any unintended consequences that may have enhanced inequities or created new inequities? What needs to be done to address these?
3. What are community perspectives of the changes made and their outcomes? What needs to be done to address these?
4. How can the strategy be improved?
5. Are there opportunities to leverage successful programmes and services to support the provision of additional services and address more health issues?
6. Do the data indicate that the approach could be useful to others wanting to reach unreached groups? If so, how can these data be organized to facilitate translation to other areas, districts or for national uptake?
7. Were the resources allocated appropriate and were they utilized effectively?

Key questions that to ask at a broader **health systems** perspective include:

1. Are the policies and reforms introduced to reach unreached in the health or other sectors achieving the outcomes and impacts envisaged according to the theory of change? If not, why not and what needs to be done?
2. Have there been any unintended consequences that may have created inequities or exclusion due to the reform/s? What needs to be done to address these?
3. Have communities been effectively engaged and empowered through the reform process? If not, why not? What needs to be adapted?
4. Were the resources allocated appropriately and were they utilized effectively?

See Appendix 1, Vignettes 28 and 29 for examples illustrating this step.
Several pre-existing tools that can be used to support this step appear in Appendix 3.

3.2   Conclusions

This chapter has drawn upon the frameworks for understanding what factors make populations unreached and how to reach them. It provides examples of the questions that need to be answered along the path to reaching the unreached and links to some validated tools that can be used to obtain this information. This is an ongoing journey and may require many several iterations to adapt and improve service delivery as not all solutions will meet the needs of everyone, In addition, sudden onset health security threats, economic downturns and disasters may create new unreached populations.

These questions, wherever the entry point – through health programmes or health sector reform efforts, at national, subnational or local levels – provide a good basis for finding successful ways to improve the reach of the health sector so that no one is left unreached. Active engagement with these questions – and alignment with action domains – will enable the wheels to turn so that over time communities will be actively engaged in actions to improve their health and their health services, health systems will be strengthened to reach everyone, everywhere, and the health sector will make a contribution to improving the broader determinants of health and well-being so that the goals of the 2030 Agenda for Sustainable Development are realized and the Western Pacific becomes the healthiest and safest region (summarized in Fig. 9.).

Annex

Fig. 9.   Summary of the Framework for Reaching the Unreached in the Western Pacific

4. Moving forward to reach the unreached in the Western Pacific Region

4.1 Building on global health programme guidance

As countries move towards achieving UHC, much consideration is being given to health systems strengthening and how to ensure no one is left behind. This means building systems based on strong primary health care (PHC) that routinely reaches everyone, everywhere. There are many challenges to this, including that many health gains have been made through implementation of vertical programmes that may be difficult to integrate into broader health systems (Box 6). For reaching the unreached, this presents at least two challenges:

1. Different vertical programmes might be operating in the same catchments and targeting the same populations without coordination, presenting a challenge for delivering comprehensive, people-centred care.

2. Many vertical programmes have established excellent models for reaching unreached populations, but this capability may not be built on to facilitate improvement of mainstream health service delivery due to the focus on specific issues rather than on system development.

All health programmes aspire to reach unreached populations and leave no one behind, and global guidance for all programmes reflects these ambitions. As a result, global guidance contains many common elements to support building effective systems for sustainable implementation of evidence-based interventions for various health issues. These generally align with four key action domains in this *Regional Framework for Reaching the Unreached in the Western Pacific (2022–2030)*: 1) building political commitment, coupled with governance, financing and legal structures that support reaching the unreached; 2) multi-stakeholder engagement; 3) data and evidence; and 4) transforming health services to reach the unreached. The fifth Action Domain – special approaches – is also likely to be relevant to achieving implementation of global guidelines in specific circumstances. This means that the Regional Framework should be applicable to supporting the translation and implementation of all global frameworks across countries in the Western Pacific.

By way of example, *Towards zero leprosy: Global Leprosy (Hansen's disease) Strategy 2021–2030* has a long-term vision of achieving zero leprosy, including zero infection and disease, zero disability, and zero stigma and discrimination. It has four pillars[119]:

- Pillar I: Implement integrated, country-owned zero leprosy road maps in all endemic countries, which includes political commitment for the last-mile reach, surveillance and data management, and partnerships for zero leprosy.

- Pillar II: Scale up leprosy prevention alongside integrated active case detection.

- Pillar III: Manage leprosy and its complications and prevent new disability, where equitable access to services through PHC, an integrated approach and community engagement are recommended.

- Pillar IV: Combat stigma and ensure human rights are respected.

Table 1 highlights the alignment between the four pillars of the Global Leprosy Strategy and this Regional Framework. By way of example, similar alignment can also be seen across other global frameworks (also highlighted in Table 1 with further information provided in Appendix 5), including:

- The *Global Technical Strategy for Malaria 2016–2030*, which envisages a world free of malaria.[120,121]

- The *Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)* with a vision to ensure a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and can participate fully in shaping prosperous and sustainable societies.[122]

- Global Health Sector Strategies on HIV, Viral Hepatitis and Sexually Transmitted Infections (2022–2030) (GHSS), which position the health sector response to these continuing global epidemics as critical to achieving the Sustainable Development Goals.[123]

There is also good alignment between other regional frameworks and this *Regional Framework for Reaching the Unreached in the Western Pacific (2022–2030)*, for example, the *Action Framework for Safe and Affordable Surgery in the Western Pacific Region (2021-2030)* and a draft framework for the prevention and control of cervical cancer that is scheduled to be considered for endorsement by the Regional Committee in October 2022. Further, regional frameworks that have expired and contain guidance that is still relevant to implementation are also well aligned. For example, the *Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)* was developed to support translation of a global strategy into the regional context, yet it remains an active plan to reach the vision of a healthy start for every newborn infant. The Action Plan for Healthy Newborn Infants aligns well with the action domains of the Regional Framework for Reaching the Unreached as outlined further in Appendix 5.

Applying this Regional Framework across health programmes – by focusing on reaching unreached populations and putting these groups at the centre of health planning processes – has additional potential benefits, such as:

- Providing an impetus to strengthen coordination of health service delivery and require improved integration and delivery of health programme interventions through mainstream health service delivery platforms, particularly PHC.

- Enabling discussion at the country level between programmes on key elements for system development where collaboration might produce synergistic effects. For example, building political commitment for addressing stigma and discrimination, or considering how data and surveillance systems may be established to serve multiple programmes, may facilitate action relevant to each of the global strategies identified above.

- Facilitating identification and sharing of best practices and lessons in each of the action domains so that they can then be adopted more broadly.

- Expanding reach to unreached populations through leveraging Member States' commitment to existing global and regional action plans or frameworks, including through the use of recognized and established mechanisms and through processes to renew associated national action plans.

Regular review of existing programmes, including review of their alignment with this Regional Framework, as well as global, regional and national frameworks, will be important to continuously identify opportunities to strengthen health systems to reach unreached populations.

Annex

Table 1. Alignment of global health strategies with the Regional Framework for Reaching the Unreached

Regional Framework for Reaching the Unreached	Global Leprosy Strategy (2021–2030)	Global Technical Strategy for Malaria (2016–2030)	Global Health Sector Strategies (GHSS) on HIV, Viral Hepatitis and Sexually Transmitted Infections, (2022–2030)	Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)
Action Domain 1: Political commitment coupled with governance, financing and legal structures that support reaching the unreached	• Develop integrated, country-owned zero-leprosy road maps, including political commitment for the last-mile reach (Pillar I) • Combat stigma and ensure human rights (Pillar IV)	• Strengthen the enabling environment for more sustainable and equitable results – including political commitment, system strengthening and community engagement (Supporting Element 2)	• Gender equity and human rights, financing, leadership and partnerships (drivers of progress) • Engage empowered communities and civil society (Strategic Direction 4) • Optimize systems, sectors and partnerships for impact (Strategic Direction 2) • Foster innovations for impact (Strategic Direction 5)	• Country leadership, including to promote collective action (Action Area) • Financing for health (Action Area) • Individual potential – including to invest in an individual's development and address barriers with legal frameworks (Action Area) • Community engagement (Action Area) • Accountability (Action Area) • Humanitarian and fragile settings (Action Area)
Action Domain 2: Multi-stakeholder engagement	• Partnerships for zero leprosy (Pillar I)	• Multisectoral action for development of durable solutions (Supporting Element 2)	• Optimize systems, sectors and partnerships for impact (Strategic Direction 2) • Engage empowered communities and civil society (Strategic Direction 4)	• Multisectoral action (Action Area)
Action Domain 3: Data and evidence	• Surveillance and data management (Pillar I)	• Transform malaria surveillance into a key intervention (Pillar 3) • Harness innovation and expand research (Supporting Element 1)	• Generate and use data to drive decisions for action (Strategic Direction 3)	• Research and innovation (Action Area)

Annex

Regional Framework for Reaching the Unreached	Global Leprosy Strategy (2021–2030)	Global Technical Strategy for Malaria (2016–2030)	Global Health Sector Strategies (GHSS) on HIV, Viral Hepatitis and Sexually Transmitted Infections, (2022–2030)	Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)
Action Domain 4: Transforming health services to reach the unreached	• Leprosy prevention and active case detection (Pillar II) • Managing leprosy and its complications and preventing new disability (Pillar III)	• Ensure access to malaria prevention, diagnosis and treatment as part of UHC (Pillar 1) • Accelerate efforts towards elimination and attainment of malaria-free status (Pillar 2)	• Deliver high-quality, evidence-based, people-centred services (Strategic Direction 1)	• Health system resilience (Action Area)
Action Domain 5: Special approaches	• Potentially required for some last-mile actions	• Potentially required to reach some populations		• Humanitarian and fragile settings (Action Area)

4.2 Strengthening action across the Region

For the Future: Towards the Healthiest and Safest Region identified reaching the unreached as one of four thematic priorities and a concern that united all Western Pacific Member States. This Framework reflects the commitment of *For the Future* to strive to reach the unreached and to achieve health for all across the Region. It acknowledges that many countries have been working towards identifying and reaching unreached groups for many years and have gained much knowledge and expertise about doing this. It also acknowledges that in every country there are still groups who are left behind, that new groups are likely to emerge over time as conditions change or there are public health emergencies, and that there is much still to be done.

This Framework envisages a Region where reaching the unreached is routinely built into all health programme and health system planning, development and transformation processes. It acknowledges that this work will be country specific and that there will be a diversity of paths taken by countries to reach the unreached. It highlights that there are many stakeholders in this endeavour at different levels within country health systems and urges engaging them all to maximize the use of available resources, align efforts and create synergies. It recognizes that by working together, Member States and WHO can utilize the opportunities across the Region and expedite progress towards health for all.

4.2.1 Key considerations for Member States

To support this work at the country level, Member States are requested to reaffirm their commitment to health for all, including the provision of equity-focused, quality, people-centred primary health care that is inclusive, culturally safe, empowering and non-discriminatory. Translating this commitment into action is likely to require multiple actions. In this endeavour, Member States are requested to consider:

1. Fostering political commitment at all levels of health systems, and across sectors, to address inequities in health outcomes and to build the capability to amend governance, policy, financing and legal structures so that they support rights to health, freedom from discrimination and access to equitable service delivery.

2. Establishing national and subnational (where relevant) visions for reaching the unreached and using this Framework to support development of local plans according to local context.

3. Leveraging national strategic plans and/or developing specific country plans to support the roll-out of this Framework.

4. Utilizing existing mechanisms, such as those pertaining to human resources, facility licensing, accreditation and quality improvement to support action to reach unreached populations and improve the quality of service delivery to these populations.

5. Taking a leadership role in developing the capacity, capability and mechanisms to enable the effective engagement of unreached groups, including civil society and community-based organizations, within health system governance and decision-making structures at all levels, to support the development of effective strategies to reach these groups.

6. Building a focus on reaching those who are unreached in all health programmes (including health promotion and illness prevention) and health system transformation efforts. This should include

progressively strengthening health systems by building on effective models developed through health programmes.

7. Adopting and resourcing a multisectoral approach to influence all initiatives that have the potential to impact health and its determinants, particularly for those who are unreached.

8. Progressively building routine health information systems that enable the collection of data that can be disaggregated by categories and to a level that supports effective equity analysis and planning. Categories may include gender, socioeconomic status, ethnicity, indigeneity, geographic location, levels of education, disability and age. Additional attention may be required to ensure data pertaining to those who are unreached and who are not appearing in administrative data sets are collected and that privacy and confidentiality are always maintained.

9. Building country capacity and capability to analyse, interpret, disseminate, use and report on data, including for identifying unreached populations and monitoring the impact of interventions to address the needs of these groups.

10. Identifying workforce development needs, designing curricula and supporting training to enable health policy, planning and service delivery to reach unreached populations. Associated capabilities should be incorporated into continuing education and licensing requirements.

11. Ensuring that, as the use of digital technologies in health increases, action is taken to enable these tools to be effectively used to reach unreached populations.

12. Building the capacity of local academic and research institutions to conduct applied research that contributes to improving health outcomes for unreached populations. This might include facilitating new research processes to engage unreached groups and other key stakeholders in all research stages and evaluating the impact of initiatives.

13. Encouraging the recognition of good performance for reaching unreached groups within Member States.

4.2.2 WHO's role in working with Member States

WHO is committed to supporting Member States to reach the unreached through all of their health programme and health system transformation efforts. Priority actions for WHO in working with Member States include:

1. Ensuring reaching the unreached is built into all future regional frameworks and that the guidance in this Framework is used to support the implementation of existing global and regional frameworks.

2. Facilitating cross-programme collaboration to identify where health programmes may work together to reach the unreached and support countries in their efforts in this regard. Further, WHO will support Member States to identify and integrate into health systems key elements of health programmes shown to be effective in reaching the unreached.

3. Building the capability among WHO technical staff to provide guidance on reaching the unreached in all country support activities.

4. Supporting Member States to integrate the recommendations from this Framework into the development of national strategic plans.

5. Building the capability across the Western Pacific Region to strengthen health systems to reach the unreached, meaningfully engage with communities and civil society organizations, work across sectors, and collect and use data that enable equity analysis.

6. Incorporating discussions on reaching the unreached in all high-level and multisectoral policy dialogues and hold these discussions with partners, for example, in collaborations focused on achieving Sustainable Development Goal 3 (ensure healthy lives and promote well-being for all at all ages).

7. Strengthening partnerships with organizations and institutions beyond the health sector to support action on the broader determinants impacting the health outcomes of unreached groups.

8. Supporting the capability of Member States to engage with and reach indigenous populations through evidence-based and informed approaches, developed with indigenous populations.

9. Establishing a Reaching the Unreached Technical Advisory Group to provide ongoing advice on, and review of, regional progress towards reaching the unreached. This Technical Advisory Group (TAG) should include leadership from those representing unreached groups and encourage the establishment of similar groups at the country level.

10. Continuing to support the work of the TAG Alliance to ensure a focus on reaching unreached populations in the work of all TAGs and to accelerate progress through cross-TAG collaboration.

11. Supporting ongoing knowledge exchange across the Region to enable cross-regional learning on effective strategies to reach the unreached.

12. Identifying a process to monitor outcomes and evaluate how Member States' progress will be assessed and reported, leveraging existing data collection and reporting mechanisms, such as those used for the WHO Results Framework, where possible. Also, consider benchmarking efforts to reach the unreached across Member States.

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Appendices

Appendix 1. Examples and vignettes

> Vignette V1. Commissioning health services that respond to Māori visions, principles and definitions of health and well-being

Between 2020 and 2022, the Ministry of Health of New Zealand worked on transforming its approach to commissioning health services for Māori, the indigenous people of Aotearoa New Zealand.

This *mahi* (work) was informed by:

1. the Waitangi Tribunal that is a permanent commission of inquiry that makes recommendations on claims brought by Māori relating to Crown actions that breach the promises made in the Treaty of Waitangi and the Tribunal's inquiry into health services and outcomes for Māori;[1–3]
2. the New Zealand Government's health and disability system review and extensive reform programme led by the Department of the Prime Minister and Cabinet;[4] and
3. an expanding body of *Kaupapa Māori* (Māori philosophical approach) research on how to improve health equity and outcomes for Māori, including the clinical and cultural safety and efficacy of health services and care for *whānau* (families) and communities.

The aim was to build a culturally grounded, holistic approach focused on addressing health and well-being needs within a *whānau* context and to improve equity, access, opportunity and outcomes.

The new *Pae Ora* commissioning framework sits within *Whakamaua: Māori Health Action Plan 2020–2025*[5,6] and is grounded in *Te Tiriti o Waitangi* (the Treaty of Waitangi) principles of *tino rangatiratanga* (self-determination), partnership, equity, options and active protection of *te Ao Māori* (the Māori world).[7] Its core goal is to empower *whānau*, *hapū* (extended kin groups), *iwi* (tribal kin groups) and *hāpori Māori* (Māori communities) to be the decision-makers in their own health and well-being. The framework "flips the script" from the system's top–down focus on individuals within an institutional (providers, funders and commissioners) context by elevating and supporting *whānau* to lead and thrive within their own communities. It also boosts opportunities for joint cross-sector investment that is coherent, connected, *Tiriti* based and *whānau* led, and capable of delivering better outcomes for Māori in broader social and economic environments.

This new approach will begin by deeply understanding what matters to families and their communities and then developing responses accordingly, rather than prioritizing what others have assumed is needed. It means that *whānau* move from passive recipients of care to active players who direct their health and well-being journeys. Service providers, working with *whānau* they serve, will help funders and commissioners understand what information is needed to support continuous improvement instead of compliance, and commissioners will work from a place of humility, seeking to understand how they can influence system conditions to enable innovation and devolution of decision-making to *whānau, hapū*, *iwi* and *hāpori Māori*. Processes that support *whānau* and community co-production of service design, delivery and measures of success are included, as are strategies for capacity-building for individuals, *whānau* and their communities, as well as for enhanced workforce capacity, capability and cultural safety.

At the system level, evidence will be used to inform developing pro-equity and anti-racism policies, research and services to address structural and systemic health and socioeconomic inequities and bias experienced by Māori. Inequities in contexts, such as infrastructure, housing quality and affordability, education, income, and employment opportunities will be factored into funding and design processes. Outcomes will be based on the degree to which the health system delivers on what matters to *whānau* and what works for people, how contexts impact service access and quality, and whether the workforce and infrastructure match demand.

Vignette V2. Indigenous community participation in development of national health plans and policies in Australia

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The Australian Government's *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* details a national policy framework to improve the health and well-being of Aboriginal and Torres Strait Islander people over the next 10 years. The vision is that "Aboriginal and Torres Strait Islander people enjoy long, healthy lives that are centred in culture, with access to services that are prevention-focused, culturally safe and responsive, equitable and free of racism". The Plan was developed in partnership with Aboriginal and Torres Strait Islander people through the Australian Government's Commonwealth Implementation Plan Advisory Group, a subcommittee called the Aboriginal and Torres Strait Islander Health Plan Working Group, and the National Health Leadership Forum. This Plan was released prior to the expiry of the previous plan to ensure links with other new policy frameworks, including an updated *National Agreement on Closing the Gap* (between Indigenous and non-Indigenous Australians in health and education), the *Future Focused Primary Health Care: Australia's Primary Health Care 10 Year Plan 2022–2032*, the *National Preventive Health Strategy 2021–2030*, and the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031*.

The National Aboriginal and Torres Strait Islander Health Plan recognizes the critical role of the Aboriginal Community Controlled Health Service sector, highlights the need for all health services to provide culturally safe care, emphasizes the importance of strengths- and rights-based approaches to health, and embeds the social and cultural determinants of health for Aboriginal and Torres Strait Islander people. The Plan puts Aboriginal and Torres Strait Islander ways of knowing, being and doing at the centre and as a result encompasses a holistic understanding of health and well-being.[8]

Action Domain 1: Political commitment coupled governance, financing and legal structures that support reaching the unreached

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Vignette V3. Reaching the unreached through community engagement for strengthened health governance and COVID-19 responses in the Lao People's Democratic Republic

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The Lao People's Democratic Republic has leveraged unprecedented attention to community health during the COVID-19 pandemic to strengthen governance leadership in engaging local authorities to improve health equity for disadvantaged populations. At the community level, the Ministry of Home Affairs leads an asset-based participatory planning workshop to support the community in identifying solutions to improve community health, while building trust and relationships between community members and health-care providers. Through a sequence of activities, workshop participants and facilitators together identify the factors that impact community health and the existing resources they can utilize. This leads to the development of joint action plans with the health centre, with clear

implementable actions for improved essential health-care access for the most vulnerable and effective COVID-19 prevention and responses.

At the higher municipality level, the Ministry of Home Affairs supports and negotiates with local authorities to identify sustainable funding for the scale-up and continuous support mechanisms. Unlike community health projects before COVID-19, the Ministry of Health positions itself as a technical agency to support local health governance, encouraging a broader intersectoral approach. At the same time, the Ministry of Health develops the capacities of primary health-care providers in providing respectful care to gain trust from the community, as well as clinical capacities to enhance local solutions for local challenges. These three interventions are packaged under one initiative called CONNECT (Community Network Engagement for Essential Health-care and COVID-19 responses through Trust). This is now in the process of being rolled out to each district and province village by local authorities with the aim of reaching the unreached towards universal health coverage.

One of the key lessons learnt is that building ownership and trust at the community and local-authority level and empowering locally led action through collaborative consultation and planning are effective ways of bringing about sustainable change. Some initial outcomes in areas where CONNECT has been implemented include an increase in facility births and antenatal care uptake, improved communication and coordination between village authorities and health centres, and better psychosocial support and decreased stigmatization for families quarantined during COVID-19.

Vignette V4. Laws and policy to enable decision-making and partnership by, for and with Māori to improve health equity in New Zealand

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The *Pae Ora* (Healthy Futures) Bill was passed in the New Zealand Parliament, taking effect on 1 July 2022. It replaces the New Zealand Public Health and Disability Act 2000 (NZPHD Act) and legislates for: the establishment of new public health entities, Health New Zealand, the Māori Health Authority and the Public Health Agency; the strengthening the of Ministry of Health's chief system steward role; and the creation of a new national health system.

The *Pae Ora* legislation incorporates *Te Tiriti o Waitangi* (see Vignette V1) through:

- strengthening the NZPHD Act and providing more detail and provisions on how *Te Tiriti* can/will be met;
- establishing the Māori Health Authority, responsible for the development, planning and commissioning of services to improve Māori health equity, in partnership with Health New Zealand;
- building in specific actions and activities that give effect to the *Te Tiriti o Waitangi* (the Treaty of Waitangi) principles (see Vignette V1);
- explicitly promoting *hauora Māori* (Māori health) and a commitment to Māori health equity;
- establishing and building meaningful Māori–Crown partnerships at all levels of the system;
- enabling a Māori voice that is driven from the ground up, through Iwi Māori Partnership Boards, and firmly embedded into local and regional priorities, plans and the commissioning of services;
- setting expectations jointly to commission Māori health services that foster innovation and draw on locally led Māori solutions, providing greater options for health care;

- supporting greater investment into *hauora Māori* research, evidence and insights, including protection for *mātauranga Māori* (Māori knowledge) and *Rongoa Māori* services (traditional Māori medicine); and
- establishing multiple monitoring mechanisms to measure system performance and openly drive decisions that support equitable outcomes for Māori.

In 2020, the Ministry refreshed its *Te Tiriti o Waitangi* position statement and developed a *Tiriti* framework to guide the country's health and disability system in meeting its obligations under *Te Tiriti*. It provides a mechanism for the system to fulfil its stewardship obligations and the special relationship between Māori and the Crown as envisaged under *Te Tiriti*. The obligations and relationships can be understood as:

- Article I expressed as *Mana whakahaere*: good government
- Article II expressed as *Mana motuhake*: unique and indigenous
- Article III expressed as *Mana tangata*: fairness and justice
- The Ritenga Māori Declaration expressed as *Mana Māori*: cultural identity and integrity.

The principles of *Te Tiriti* as articulated by the courts and the Waitangi Tribunal (see Vignette V1) in the Hauora Report have been adopted and provide a framework for how obligations are met in day-to-day work. The principles are: *tino rangatiratanga*, partnership, active protection, options and equity.[7]

Whakamaua: Māori Health Action Plan 2020–2025 is guided by *Te Tiriti* and informed by system stakeholders, *whānau*, *hapū*, *iwi* and *hāpori Māori*.[5,6] This guides the system to achieve the best health outcomes for Māori, with the overarching aim of *Pae Ora*. Development of this Action Plan was guided by a 12-month engagement process focused on how to make the most meaningful change. Four high-level system outcomes in *Whakamaua* were identified:

- *iwi*, *hapū*, *whānau* and Māori communities can exercise their authority to improve their health and well-being;
- the health and disability system is fair and sustainable and delivers more equitable outcomes for Māori;
- the health and disability system addresses racism and discrimination in all its forms; and
- the inclusion and protection of *mātauranga Māori* throughout the health and disability system.

Vignette V5. Health insurance to support universal health coverage

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The Republic of Korea achieved universal health coverage 12 years after the introduction of mandatory health insurance for employees in large corporations. Political legitimization by the Government and rapid economic growth contributed to the rapid extension of health coverage. In 2000, all insurance funds were merged into a single insurer, which improved the efficiency of pooling and equity in contribution payments.[9]

Vignette V6. Equitable resource allocation between provinces

Every five years, Papua New Guinea's National Economic and Fiscal Commission uses a cost-of-services study to estimate the health sector operational budget, as well as the budget for other sectors, specific to each province for a standard set of activities. This provides a basis for allocating the available

budget equitably among provinces. It considers the relative cost of delivering services in each province and the province's source of revenue, including that from natural resource projects.[10]

Vignette V7: Financing to address inequities

Some 20 years ago, the Cambodian Government recognized that there was insufficient care available for pregnant women, with the maternal mortality ratio (MMR) at 437 per 100 000 live births. To increase retention of staff, especially in rural and remote locations and among unreached populations, the Cambodian Government[11]:

- expanded and strengthened public health infrastructure;
- increased the availability of trained midwives in facilities across the country; and
- provided incentives for midwives who provided delivery services at national hospitals, national centres, referral hospitals, health centres and health posts.

It also reduced financial barriers to health access by issuing the Health Equity Fund Sub-Decree in 2019. The Decree included fee exemptions for women accessing services and free care for the poor.

Deliveries at health facilities increased from 6% in 2002 to 66% in 2012, and by 2010 there was a reduction in the MMR to 206 per 100 000 live births. Cambodia was awarded a special mention for service delivery through the Global Leaders Council for Reproductive Health 2012 Resolve Award.[12,13]

Action Domain 2: Multi-stakeholder engagement

Vignette V8. Housing and homelessness

Homelessness is a result of many intersecting factors, including structural issues such as the availability of housing, employment, social protection and discrimination, as well as factors such as experience of mental health issues, gender-based violence, substance abuse, child abuse and neglect, and natural disasters. There is evidence that providing housing for homeless people reduces their demand for health services. For example, in Australia there was a 44.4% reduction in hospital admissions for homeless people referred with a substance abuse issue one year after obtaining public housing tenancy compared to the previous year.[14,15]

Vignette V9. Transport

Injury prevention is a credible entry point for multisectoral engagement with an equity focus. Viet Nam has a high mortality rate from road traffic fatalities involving two-wheeled vehicles, compliance with helmet use is low, and there are few alternative options for cheap and accessible transport.[16] At the end of 2007, a road safety programme associated with the introduction of a helmet law was developed. Although not introduced as an explicit equity initiative, the programme distributed 50 000 helmets to low-income families, and the programme included school-based awareness and social marketing to change knowledge, attitudes and behaviours on helmet use, with an emphasis on increasing helmet use among children.[17] Within six months of the introduction of the law, significant increases in helmet-wearing were documented in selected provinces – for example, from 27% to 99% in Da Nang. And within three months, surveillance data from 20 urban and rural hospitals noted a 16% decrease in road traffic head injuries and an 18% decrease in deaths.[18]

Vignette V10. Improved well-being and reduced road fatalities

In one Australian state, an initiative to improve Aboriginal peoples' access to obtaining and maintaining a driver's licence improved their mobility and increased employment opportunities. Associated targets included increased life expectancy from improved well-being and reduced road fatalities,[19] as well as reduced incarceration rates due to compliance with vehicle licensing laws.[20]

Vignette V11. Gender-based violence

Based on the findings of the Kiribati Family Health and Support Study in 2010, the Government has established a range of cross-government interventions under the comprehensive *National Approach to Eliminating Sexual and Gender Based Violence in Kiribati: Policy and National Action Plan 2011– 2021*. These actions include: the Elimination of Sexual Gender Based Violence Project, which comprises key government ministries, stakeholders and the church; establishing a Ministry of Women; forming a special domestic and sexual violence unit within the police force; enacting the *Te Rau N TeMweenga Act* (Family Peace Act for Domestic Violence); and developing curriculum and counselling guidelines for schools within the Ministry of Education.[21]

Vignette V12. Nutrition

The *Papua New Guinea National Nutrition Policy 2016–2026* is a collaboration between the departments of agriculture and livestock, community development, education, health, and national planning and monitoring. Equity is one of the policy's key principles. Among strategies to support policy implementation are a Multi-Stakeholder Platform, a civil society alliance, reviews of plans by the national Department of Health and Department of Education with a view to integrating strategies to address nutrition, and enabling complementary laws.[22]

Vignette V13. Partnerships for reaching the urban poor

Reaching the Urban Poor: The Philippine Experience demonstrated how an immunization survey had completely missed including urban-dwelling people living in poverty.[23] Through linking health centres with urban poor communities and supporting communities to collect strategic local data, local actions were facilitated that resulted in vastly increased immunization, family planning and breastfeeding. For example: immunization coverage at 4 months of age in urban poor communities of Paranaque City increased by 30% between 2004 and 2005; in Taguig, there was a fourfold increase in effective family planning use (2005 to 2007); and in Makati city, great improvements in breastfeeding of infants under 6 months of age (from 2% in 2005 to 65% in 2006) were recorded. Linkages were also made with other sectors to address the determinants of poverty, such as income generation and education.

Vignette V14. Partnerships with communities, councils and local governments

The Philippines National Demographic and Health Survey in 2003 found that only 16% of infants aged 4–5 months were exclusively breastfeed. In the same period, the Philippines was one of 42 countries accounting for 90% of under-5 mortality globally. In 2006, almost US$ 100 million was spent advertising infant formula in the Philippines. Despite multiple national initiatives, including drawing on international codes and World Health Assembly resolutions, there were high levels of opposition by the breast-milk substitute industry that actively promoted their products across the country. To counter

widespread misinformation and improve breastfeeding, a community-based peer counselling intervention was developed to target mothers with infants less than 2 months of age who were not exclusively breastfeeding or had difficulty breastfeeding. This was associated with a significant improvement in exclusive breastfeeding practices – for example, the number of infants less than 2 months old receiving mixed feeding decreased by 37%. The initiative became sustainable through engagement of political figures, cities and communities and was scaled up to improve health service delivery for 161 612 people living in low-income communities in the Philippines.[24]

Vignette V15. Tuberculosis and partnership with traditional medicine in Vanuatu

In 2014, Vanuatu reported approximately 110 cases of tuberculosis (TB), and WHO estimated that between 67% and 80% of all TB cases in Vanuatu were detected, with successful treatment of at least 80% of all diagnosed patients. Treatment choices included both traditional and Western medicine, with access and affordability often determining choice of provider. To build stronger TB services, the national health department undertook an assessment of the practices by *kleva* (traditional health providers) to treat lung diseases and their willingness to collaborate with the national TB programme. It confirmed their role in TB treatment – many *kleva* had previously collaborated with the government-funded health-care system – and an almost universal willingness to collaborate with the national TB programme.

One of the steps that will be needed to strengthen the system is to develop a legal framework to enable the engagement of traditional healers as existing laws (Section 18 of the Vanuatu Health Practitioner's Act of 1984, amended in 1985) state that it is an offence for non-registered persons to practise medicine or claim to be registered to practise.[25]

Action Domain 3: Data and evidence

Vignette V16. Urban health in the Philippines

An Urban Health Equity Assessment in the Philippines used a participatory process to develop local definitions of advantaged and disadvantaged barangays – the smallest administrative unit in the Philippines, similar to a village. These definitions varied across the country, but they centred around barangay income, population, household income, presence of slum areas and geographic location. The participatory process was facilitated through both pre-intervention consultations and surveys, with respondents including key officers and personnel from the Department of Health and its Bureau of Local Health Development, the WHO Representative Office in the Philippines, city health offices, local health boards, city mayors and other stakeholders who had been recipients of, or participated in, Urban HEART (Urban Health Equity Assessment and Response Tool) interventions.

The formal organization of local technical working groups was facilitated by an executive order signed by the chief executives of the pilot cities. The composition of the working groups included government officers from health and non-health departments, and in some cases representatives from nongovernmental organizations and community leaders. The multi-agency and multisectoral composition of the working groups facilitated collaboration and coordination in the conduct of the different activities of the programme. The responsibilities of the technical working groups included: review and identification of indicators, data gathering and data analysis, identification of the poorest and richest barangays, identification of response packages to address equity gaps, planning and

implementation of identified projects, and monitoring and evaluation. Prior to data collection, the engagement of stakeholders at the community level through orientation sessions were held to inform them of the objectives and activities of Urban HEART and to gain their buy-in and participation. Barangay-level consultations were conducted to inform communities of their current situation and for them to identify acceptable and feasible programme interventions to address equity gaps.[26]

Vignette V17. Reaching non-citizens in Sabah, Malaysia, during a polio outbreak response with supplementary immunization activities

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In Malaysia, the number of children targeted for vaccination is based on the number of estimated live births, which incompletely captures live births among non-citizens and undocumented migrants. Non-citizens, who tend to change their location frequently to avoid being identified by law enforcement agencies, are also reluctant to seek health care at government health facilities due to cost and fear of being identified and deported. To identify these unreached populations, diverse methods were used to collect data on children requiring immunization. These included:

- triangulation of information from various sources to estimate the size of the non-citizen population in Sabah state;
- engagement of local nongovernmental organizations and local informants (village leaders) to map the location of non-citizen populations during microplanning;
- conduct of house-counting exercises to identify abandoned versus occupied squatter settlements within each health-facility catchment area in high-risk districts;
- separate reporting of supplementary immunization activity coverage data among citizens and non-citizens to closely monitor supplementary immunization activities; and
- intra- and post-campaign rapid coverage assessments to identify missed areas for mop-up activities.

Vignette V18. Data from multiple sources used for decision-making on quality of services in Viet Nam

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In Viet Nam, the Scaling Up Nutrition Civil Society Alliance (SUN CSA – a coalition of international nongovernmental organizations and civil society organizations), Alive & Thrive (an initiative of an international nongovernmental organizations) and the National Targeted Programme for Ethnic Minority Development have worked with a range of stakeholders to advocate the development of Centres of Excellence for Breastfeeding. A hospital can be designated a Centre of Excellence for Breastfeeding by the Ministry of Health if it creates an environment that is breastfeeding-friendly – that is, promotes skin-to-skin contact for newborn babies, ensures that mothers can successfully initiate early breastfeeding, and enables mothers to exclusively breastfeed regardless of whether they delivered vaginally or via caesarean section.

Multiple groups, including independent assessors, pregnant women and women who recently delivered at each facility are involved in conducting a comprehensive evaluation of a hospital's candidacy to become a Centre of Excellence. Accreditation needs to be maintained through a regular accreditation process (every five years), and annual performance monitoring is conducted by provincial departments of health. These processes include assessing supportive supervision (annually) and patient satisfaction via independent call centres (quarterly). Survey data are disaggregated by some equity indicators, including ethnicity. Accreditation status is published in the media and on breastfeeding community social media platforms.[27]

Annex

Action Domain 4: Transforming health services to reach the unreached

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Vignette V19. Data innovations to support malaria elimination in Cambodia

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Cambodia has developed a comprehensive mobile software application for digital malaria surveillance and community health workers (CHWs). It captures data on case management, vector control and stock management components that can be transferred from community to national levels and displayed as data dashboards to support decision-making. CHWs use the app to submit real-time data direct from at-risk communities as messaging is sent to support treatment adherence. The system generates automated notifications of confirmed cases to the provincial and national levels.

Issues that are being addressed include varying CHW capacity, damaged or lost smartphones, data-syncing delays due to poor connectivity, and better integration of the existing information systems into the improved health management information system for sustainability. According to one community-based stakeholder, strengthening real-time reporting of case management data at the community and facility levels, promoting data use at subnational levels, and focusing additional digital health innovations in malaria hotspots have proved useful.[28]

Vignette V20. Strengthening primary health care through health sector reforms in Mongolia

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The vast size of Mongolia, combined with low population density and its nomadic tradition, posed significant challenges for health-care service providers wanting to provide care to herders, border populations, internal migrants, self-employed people, small-scale miners and low-income people. Mongolia has a strong commitment to strengthening primary health care (PHC) and to achieving sustainable development so that Mongolian people lead long healthy lives.

To address health service provision through PHC for unreached populations, the following reforms were initiated:

- strengthening the legal frameworks to ensure PHC is free to all citizens and the responsibilities of PHC are outlined;
- providing a well-defined network of PHC centres with multidisciplinary teams at local levels and in the lowest administrative units; and
- providing outreach services via mobile health services and home visits, enabled through availability of well-developed fibre-optic connections and relatively high use of information technology.

Based on the available data and key stakeholder consultations, the following strategies to strengthen PHC were implemented:

- strengthened capacity of PHC providers to deliver integrated primary care services, including health promotion, prevention, screening, treatment and management for maternal and child health, noncommunicable diseases, communicable diseases, older people, rehabilitation, and emergency care;
- provision of essential medical equipment, tools and mobile health technologies and support for the organization of mobile health service delivery;
- improvement of data recording, data analysis and reporting; and
- advocacy to local and international stakeholders.

These strategies were trialled at a small number of locations, evaluated, and then scaled up based on lessons learnt and adapted to various contexts. By early 2022, the M-health initiative was being implemented in 21 provinces across Mongolia and nine districts in Ulaanbaatar City. In the five years since its introduction in 2016 at 22 primary care facilities, the initiative had expanded to 302 facilities, or 56% of all PHC facilities in Mongolia.

Vignette V21. Local language and cultural needs to be incorporated into TB services in Solomon Islands

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East Kwaio is a remote region on the island of Malaita, Solomon Islands. The region has high rates of TB, low case detection rates and low treatment completion. Atoifi Adventist Hospital is the only hospital and TB service provider in this region. If people come to the hospital with TB, they are usually admitted for the two-month intensive phase of treatment, as there are no community-based TB services. Most people walk or travel by canoe to the hospital because there are no roads. Hoping to improve TB services, local health authorities collaborated with a local community-driven health research group (Atoifi Health Research Group) and local communities to conduct applied research to understand the underlying issues and jointly develop solutions.

They found that the reasons for delays included:

- seeking care from traditional healers;
- challenges faced in accessing health services due to distance, cost and cultural issues;
- social isolation when in the hospital;
- no providers who spoke the local language; and
- the belief that they were old and did not have long to live.

The TB ward was also situated next to the maternity ward, and for cultural reasons, men from mountain hamlets were not meant to see or go near such a woman's space. To do so required seeking permission from, and providing offerings to, ancestors – a ritual that could be very costly. This evidence led to the hospital and community working together to plan and construct a better positioned and culturally safe TB ward and a more culturally appropriate community treatment programme, especially for the unreached populations of the mountain hamlets.[29,30]

Vignette V22. Traditional medicine and mental health

In the Western Pacific Region, it has been estimated that more than 100 million people are affected by mental health issues that account for almost 6% of the Region's total disease burden. Traditional healers form a major part of the mental health workforce in the Region. They contribute to developing more integrated approaches to mental health care that recognize the importance of traditional beliefs and practices and their potential to move the focus from treatment to mental illness prevention, self-healing and community wellness. Various models describe how traditional healers and Western mental health practitioners can work together, including: co-option where traditional healers also deliver Western treatments; collaboration where traditional healers and so-called Western health professionals operate autonomously and cooperate (such as through referrals or joint consultations); and full integration where the two groups work in a hybrid system with integrated treatment approaches.[31]

Annex

Step: Identify who is unreached and the performance of the services in reaching the unreached

Vignette V23. Use of multiple sources of data to identify unreached populations, their needs and preferred service delivery options in Cambodia's malaria elimination programme

Cambodia's Ministry of Health knew that to reach the "last mile" in its quest to eliminate *Plasmodium falciparum* malaria would require provision of promotive, preventive and treatment services to people who had not yet been reached by health services.

To identify who these populations were, why they were not being reached and what accessibility issues needed to be addressed, the Ministry worked with partners – health-care providers in the public and private sectors, community and civil society groups, other sectors, academia and international partners – to gather and analyse qualitative and quantitative data to enable the joint design of appropriate responses. They used data from the existing health information system plus a geographic information system to identify hotspots and to track how disease prevalence changed over time, including with seasons and agricultural cycles. Household mapping was conducted through a village census in close collaboration with community leaders and civil society organizations. They developed a process to support village malaria workers to identify and treat people – mostly men aged between 15 and 49 years who may have undetected and/or untreated parasitaemia. Partnering with national and international implementation research partners enabled the collection of additional in-depth data about unreached populations, including community perceptions of malaria risk and vulnerability, acceptability of prevention and health services, and other access issues. By 2021, implementation of the malaria elimination programme had resulted in malaria incidence dropping to a historically low level.

Vignette V24. Identifying the needs of LGBT populations in Mongolia

An initiative called "Being LGBT in Asia" supported Mongolia to build a knowledge base and develop an understanding of the capacity of lesbian, gay, bisexual and transgender (LGBT) organizations to engage in policy dialogue and community mobilization. It also aimed to build an understanding of the human rights of LGBT people and of the stigma and discrimination they face. The Mongolia National LGBT Dialogue, organized by United Nations agencies and the United States Agency for International Development (USAID), brought together LGBT community members and activists, human rights experts, civil society representatives, government representatives, United Nations agencies, USAID and other development partners. Using a participatory methodology, LGBT organizations and individuals were able to voice their concerns, share experiences, and propose constructive and realistic solutions on issues facing Mongolia's LGBT community within international human rights frameworks.[32]

Step: Plan

Vignette V25. Planning for expansion of a disease control programme to address unreached populations in the Lao People's Democratic Republic

The Ministry of Health in the Lao People's Democratic Republic noted in 2021 that TB treatment coverage was only 30% of the WHO-estimated incidence for that year and that this was lower than the intermediate 2020 target set at 70%. This signalled a need to improve treatment coverage. Additionally, a 2019 joint TB and HIV review recommended strengthening the quality of primary health care at health centres for early detection, referral and care of TB and HIV patients.

Data from the First National TB prevalence survey in 2010 found that the average TB prevalence rate in the adult population was 0.5%, was higher in men than in women, increased with age and was higher in rural than urban clusters. Another survey found a poor yield of symptoms screening and microscopy with 50% missed cases compared to X-ray screening and culture.[33] Implementation research that piloted a systematic screening in 2015 for active TB (active case finding) in the country found that TB prevalence was nearly four times higher among the unreached population: 1.8% prevalence of Xpert positive among all screened by X-ray in three Vientiane municipality prisons and even higher at 2.2% in three southern districts.

Based on this data analysis, as well as WHO and national guidelines, the Ministry developed plans to improve service delivery for two unreached populations: people in prisons and people living in southern districts.

The aim was to: increase access to chest X-ray and Gene Xpert machines at facilities, provide screening services close to where people lived (including in prisons and in villages), engage with local health centre and community volunteers to inform village chiefs and villagers in advance of visits, visit households of people with TB, and improve the quality and acceptability of services by providing on-site coaching and training for province-based active case finding teams, providing equipment and operational costs, and further developing the local TB data system to collect data useful for decision-making.

Step: Implement strategies to reach the unreached

> Vignette V26. Reaching unreached populations through financing and health service packaging reforms in Viet Nam

The Government of Viet Nam has a vision to 2030 that includes having 95% of the population covered by health insurance, a 30% reduction in out-of-pocket health spending as a share of total health expenditure, narrowed gaps across regions in health service utilization and health outcomes, and a 95% patient satisfaction rate with the health services. Data showed that people living in rural, remote and disadvantaged areas were still experiencing health inequities. The analysis identified many specific groups, such as older people, people with disabilities, children, the poor, people from ethnic minority groups, internal migrants, and people with comorbidities such as TB and HIV or diabetes and hypertension who were receiving inadequate levels of care for their conditions.

The Government developed strategies based on this evidence and an analysis of the barriers of health service utilization among unreached groups. The strategies also drew upon best practices from other countries and focused on:

1. Strengthening grassroots health facilities to improve availability and quality of primary health-care services. This strategy introduced health service packages of basic benefits at the grassroots level and included both curative and preventive services, which were further supported by ensuring medicines at the commune health stations, investments for additional equipment and upgrading of health facilities at the grassroots level.
2. Reforming health financing policies by allocating more government budget to primary health care, health prevention and public health, and reforming provider payment methods by applying capitation for outpatient services and diagnostic-related groups for inpatient services.

3. Strengthening health workforce capacity at the grassroots level through rotation of health workers from high-level hospitals to support lower-level hospitals to improve the quality of health service at the lower level in rural areas; providing continuing professional training for grassroots health workers; applying telemedicine for technical support and exchange to build the capacity of lower-level health facilities; and establishing a network of satellite hospitals at the lower levels and building their technical capacity via training, technical capability, infrastructure and facility investment.
4. Implementing communication strategies to improve people's health-care awareness and knowledge and to support positive health-care and care-seeking behaviour, including reducing risk factors.

Vignette V27. Social contracting for HIV services in the Western Pacific Region

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UNAIDS and other global agencies have identified improving health and well-being for people living with HIV involves achieving a long-term positive connection between key populations (such as men who have sex with men, people who inject drugs and female sex workers) and clinical and community services, along with delivery of holistic programmes and services that seek to address the complexity of people's daily lives. Community involvement enables communities to: advocate for services and exercise their rights; deliver services, support health systems and reach those that state facilities cannot; track what works and what does not with a local contextualized perspective; and give a voice to those who need services. This is in line with commitments related to community action of the 2016 Political Declaration on HIV and AIDS, which includes targets such as ensuring that at least 30% of all service delivery is community led by 2030. It also targets that at least 6% of HIV resources are allocated to social-enabling activities, including: advocacy, community and political mobilization; community monitoring; public communication and outreach programmes for rapid HIV tests and diagnosis; human rights programmes such as law and policy reform; and stigma and discrimination reduction.[34]

However, supporting active engagement and partnership in the longer term may require bringing successful community-led programmes under domestic funding mechanisms. One potential mechanism is social contracting where governments contract nongovernmental providers to deliver health services. In the Western Pacific Region, many countries have blended health systems that include a mix of public, nongovernmental/not-for-profit (including faith-based organizations) and private (for-profit and not-for-profit) services. "In relation to HIV, social contracting involves creating space (including laws, regulations and accreditation systems) to include the community-led and community-based organization to be contracted to provide services within this service mix," according to a joint publication by the Australian Federation of AIDS Organizations and UNAIDS.[35]

Step: Monitor and evaluate strategies to reach the unreached and enable learning and adaptation

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Vignette V28. Adding services to existing disease control programme to support reaching unreached populations in Cambodia

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The package of malaria interventions implemented to reach unreached populations such as mobile and migrant workers and forest-goers in Cambodia has proven successful in reducing malaria prevalence. These populations and community health volunteers and staff are asking for more services. The Ministry of Health, supported by development and research partners, is conducting implementation research to redesign the whole vector-borne disease control programme to leverage the success of the malaria programme. The changes that led to reduced malaria prevalence included: employment of

mobile malaria workers; improved health communication strategies in local languages and adapted for literacy levels; continuous mapping of transmission of the disease with targeted test, track and treat outreach activities in a timely manner; and collaboration with the forest-goers to understand their movement patterns and risks. Plans to expand the scope of mobile malaria workers to provide a range of other priority public health services are being developed.

Vignette V29. Engaging multiple sectors to add a specific health initiative into their ongoing activities across Pacific island countries and areas

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To reduce the impact of COVID-19, Pacific island countries and areas identified the need to reach all eligible population groups as quickly and efficiently as possible with safe, high-quality COVID-19 vaccination services. The geographic remoteness and logistical constraints of delivering services in archipelago nations, particularly with limited financing, present a big challenge that needed to be addressed in a strategic way. Parallel to high-level political advocacy for vaccine supply, a whole-of-government approach was mobilized to identify and engage communities (strategic communication), as well as to obtain logistical support for vaccine delivery. Development partners, the private sector, civil society organizations, communities and many other partners collaborated in finding solutions to reach unreached populations. One strategy combined COVID-19 vaccine delivery with the delivery of services and resources needed in communities, such as food rations, water, sanitation and hygiene kits, personal protective equipment, social security assistance, agricultural supplies and education materials. Fiji implemented a strategy combining COVID-19 vaccination with other programmes, such as for outpatient consultations for people with chronic health conditions, delivery of antenatal care and social welfare support services.

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Annex

Appendix 2. Tools to support work on action domains

Action Domain 1: Political commitment coupled with equity enabling governance, financing and legal structures that support reaching the unreached

Resource (with links)	Organization or author
Advocacy toolkit: a guide to influencing decisions that improve children's lives	UNICEF
Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook	WHO
PolicyMaker – to guide strategic political thinking about policy reform and assist with political analysis and policy advocacy	Michael Reich
Urban HEART: Urban health equity assessment and response tool	WHO
Health systems resilience toolkit: A WHO global public health good to support building and strengthening of sustainable health systems resilience in countries with various contexts	WHO
Making decentralization work: A handbook for policy-makers	OECD
Community planning with a health equity lens: promising directions and strategies	National Collaborating Centre for Environmental Health, Canada
Gender mainstreaming for health	WHO
Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care	WHO
Human rights and gender equality in health sector strategies: how to assess policy coherence	WHO
Policy coherence for human rights and gender equality in health sector strategies	WHO
Community engagement: a health promotion guide for universal health coverage in the hands of the people	WHO
Performance-based financing toolkit	World Bank
Allocating public resources for health: Developing pro-poor approaches	DFID Health Systems Resource Centre
A toolkit for ministries of health to work more effectively with ministries of finance	USAID
What's in, what's out: designing benefits for universal health coverage	Centre for Global Development
Transcreation framework for community-engaged behavioural interventions to reduce health disparities	Paper in BMC Health Services Research

Action Domain 2: Multi-stakeholder engagement

Resource (with links)	Organization or author
Health impact assessment (HIA) tools and methods	WHO
Health impact assessment guidance and tools	International Association for Impact Assessment
Health in all policies: training manual	WHO
Health in all policies: background and practical guide	Government of South Australia
Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook	WHO
PolicyMaker – to guide strategic political thinking about policy reform and assist with political analysis and policy advocacy	Michael Reich
Making decentralization work: a handbook for policy-makers	OECD
Community planning with a health equity lens: promising directions and strategies	National Collaborating Centre for

	Environmental Health, Canada
A toolkit for ministries of health to work more effectively with ministries of finance	USAID

Action Domain 3: Data and evidence

Resource (with links)	Organization or author
A human rights-based approach to data: leaving no one behind in the 2030 Agenda for Sustainable Development	United Nations
Health equity assessment toolkit (HEAT)	WHO
Urban HEART: Urban health equity assessment and response tool	WHO
Service availability and readiness assessment	WHO

Action Domain 4: Transforming health services to reach the unreached

Resource (with links)	Organization or author
Operational framework for primary health care	WHO & UNICEF
Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens	WHO & UNICEF
Root cause analysis	University of Chicago
Transcreation framework for community-engaged behavioural interventions to reduce health disparities	Paper in BMC Health Services Research
Gender mainstreaming for health	WHO
Gender and social inclusion toolkit	CIVICUS
Disability-inclusive health services toolkit: a resource for health facilities in the Western Pacific Region	WHO
Disability inclusive development toolkit	Christian Blind Mission
Integrating vertical programs into primary health care: a decision-making approach for policymakers	Results For Development
Using theory of change in the development, implementation and evaluation of complex health interventions: a practical guide	The Centre for Global Mental Health & the Mental Health Innovation Network
Integrated social and behavioural change communication (SBCC) programs implementation kit	Health Communication Capacity Collaborative
Comprehensive package for reducing stigma in health facilities	Health Policy Project
National e-health strategy toolkit	WHO & International Telecommunication Union
The community score card (CSC): a generic guide for implementing CARE's CSC process to improve quality of services	Care
Cross-programmatic efficiency analysis	WHO

Action Domain 5: Special approaches

Resource (with links)	Organization or author
Ageing and health – Regional action plan on healthy ageing in the Western Pacific	WHO
Youth friendly services – Making health services adolescent friendly: developing national quality standards for adolescent-friendly services	WHO
Health of refugees and migrants: regional situation analysis, practices, experiences, lessons learned and ways forward	WHO

Annex

Appendix 3. Useful tools for the path to reaching the unreached

Step: Identify

Resource (with links)	Organization or author
Health equity assessment toolkit (HEAT)	WHO
Urban HEART: Urban health equity assessment and response tool	WHO
Service availability and readiness assessment	WHO
Gender mainstreaming for health	WHO
Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook	WHO
Measuring HIV stigma and discrimination among health facility staff: standardized brief questionnaire – user guide	Health Policy Project

Step: Plan

Resource (with links)	Organization or author
Voice, agency, empowerment: a handbook on social participation for universal health coverage	WHO
Transcreation framework for community-engaged behavioural interventions to reduce health disparities	Paper in BMC Health Services Research
Root cause analysis	University of Chicago
Gender and social inclusion toolkit	CIVICUS
Disability inclusive development toolkit	Christian Blind Mission
Using theory of change in the development, implementation and evaluation of complex health interventions: a practical guide	The Centre for Global Mental Health & the Mental Health Innovation Network
Theory of change – methods and tools for co-producing knowledge	Swiss Academy of Sciences

Step: Implement

Resource (with links)	Organization or author
Advocacy toolkit: a guide to influencing decisions that improve children's lives	UNICEF
Health equity assessment toolkit (HEAT)	WHO
Human rights and gender equality in health sector strategies: how to assess policy coherence	WHO
Policy coherence for human rights and gender equality in health sector strategies	WHO
What's in, what's out: designing benefits for universal health coverage	Centre for Global Development
A toolkit for ministries of health to work more effectively with ministries of finance	USAID
Allocating public resources for health: Developing pro-poor approaches	DFID Health Systems Resource Centre
Primary Health Care Performance Initiative (PHCPI) tools – Compare Tool; Advocacy Tool Kit; and Promising Practices	Primary Health Care Performance Initiative
Integrating vertical programs into primary health care: a decision-making approach for policymakers	Results for Development
Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care	WHO
Proactive population outreach	Primary Health Care Performance Initiative
National e-health strategy toolkit	WHO & International Telecommunication Union

Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook	WHO
Health equity assessment toolkit (HEAT)	WHO
Integrated social and behavioural change communication (SBCC) programs implementation kit	Health Communication Capacity Collaborative
Comprehensive package for reducing stigma in health facilities	Health Policy Project

Step: Monitor, learn and adapt

Resource (with links)	Organization or author
National health inequality monitoring: a step-by-step manual	WHO
Handbook on health inequality monitoring: with a special focus on low- and middle-income countries	WHO
Putting learning at the centre: adaptive development in practice	ODI
What does adaptive programming mean to the health sector?	ODI
Community led monitoring tools	Pepfar Solutions Platform

Annex

Appendix 4. Steps in planning and adaptation using agile innovation methods and hypothesis-driven approaches
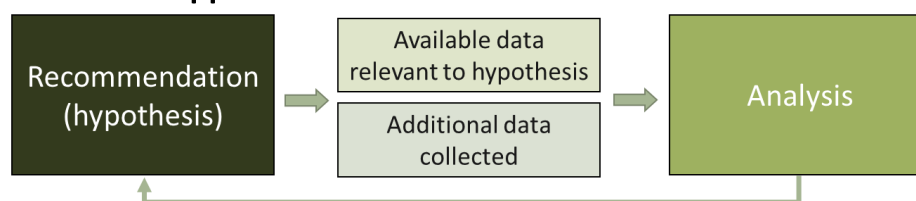
Steps in planning and adaptation using agile innovation methods

1. Confirm demand or define the problem or issue from the perspective of stakeholders.
2. Study the problem or issue – using a range of methods, including available data and collecting information from end users.
3. Scan for solutions involving different stakeholders.
4. Plan for evaluation and identify the conditions that would indicate any intervention should be terminated and not further developed.
5. Ideate and select through generating free-form ideas, building on others early thoughts and stepping outside the confines of present reality to ask "what if" questions. Ideation should be open to many participants, including communities. Evidence indicates that diversity during ideation produces better and more creative ideas.
6. Run innovation development sprints – these are a series of exercises to continuously develop and adapt a potential solution. Rapid prototyping is often advisable to create something that is imperfect but "good enough" to test. Testing allows end users to interact with the solution so that it can be adapted based in real-world situations.
7. Validate solutions through testing and collecting data about the results. This should include monitoring for and addressing unintended consequences, unexpected benefits and emergent behaviours. The innovation is not valid unless it meets the needs of unreached populations.
8. Package valid solutions for further implementation.[*]

Complex problem-solving using hypothesis-driven approaches

The hypothesis-driven approach is a problem-solving method that helps in producing tailored recommendations for complex problems, under conditions of uncertainty. Unlike the "traditional" data-driven approach that starts with gathering and analysing all relevant data to draw conclusions, the hypothesis-driven approach starts with the recommended solution to the problem (Fig. A4.1). Data analysis is conducted in a targeted manner to build a compelling case for the recommendation. If there is insufficient evidence to support the hypothesis, it should be revised and tested again.

Fig. A4.1. Data-driven vs. hypothesis-driven approach

Traditional ("Data-Driven") Approach

| All available data | → | Analysis | → | Recommendation (conclusion) |

Hypothesis-Driven Approach

| Recommendation (hypothesis) | → | Available data relevant to hypothesis / Additional data collected | → | Analysis |

Defining the problem/question

The first step is to identify and clearly define the problem or issue. For example, "people do not know when health services are open" versus "the health services hours are not accessible for people" are different problem definitions and could result in different solutions. To avoid problem definitions that are too vague, do not lead to any action or are built on groundless assumptions, these strategies can be useful:
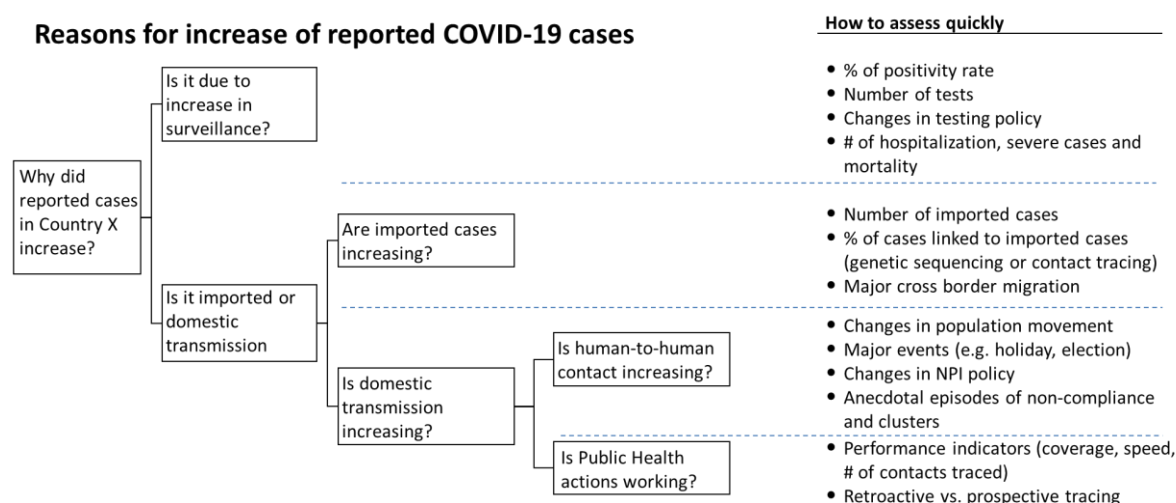
- The "5 Why's" (root-cause analysis): First identify the "pattern" or surface-level symptom, then ask "Why is that?" five times.
- Backcasting: Identify where you want to be, where you are now and the steps to achieve the goal. The gap is the problem.
- 80/20 rule: 80% of the consequences derive from just 20% of the causes. Is the problem identified among the 20%?
- Double-loop learning: Instead of "How can we do what we are doing better?" ask, "Is this current way of working really the most effective way to reach our goals?" Rather than improving techniques and tools of the status quo, question the underlying assumptions of "why" you are solving the problem that way.

Develop and test hypothesis

The next step is to collect the minimum information required to break down the problem, through expert interviews, literature searches, stakeholder knowledge and use of an issue tree (Fig. A4.2). The breakdown should be mutually exclusive and collectively exhaustive to ensure issues are not missed. Based on this, an initial recommendation is proposed (hypothesis). Building a "hypothesis tree" is useful for this, listing out the arguments supporting the proposed recommendation. Then, validate them. Again, expert interviews, including with community members, are useful here alongside targeted data analysis and a literature search.

Annex

Fig. A4.2. Example of an issue tree

Reasons for increase of reported COVID-19 cases

How to assess quickly

- % of positivity rate
- Number of tests
- Changes in testing policy
- # of hospitalization, severe cases and mortality

- Number of imported cases
- % of cases linked to imported cases (genetic sequencing or contact tracing)
- Major cross border migration

- Changes in population movement
- Major events (e.g. holiday, election)
- Changes in NPI policy
- Anecdotal episodes of non-compliance and clusters

- Performance indicators (coverage, speed, # of contacts traced)
- Retroactive vs. prospective tracing

Why did reported cases in Country X increase? → *Is it due to increase in surveillance?* / *Is it imported or domestic transmission* → *Are imported cases increasing?* / *Is domestic transmission increasing?* → *Is human-to-human contact increasing?* / *Is Public Health actions working?*

"Try & learn" approach (human-centred design, lean start-up)

Taking key principles from human-centred design and lean start-up methods, "try & learn" is about putting people at the centre to develop and test potential solutions. In contrast to creating a "perfect, foolproof" plan at the office desk, use an iterative process called the "build-measure-learn" cycle. Solution ideas are based on the unreached populations' realities, needs and motivations. From the potential solution, build prototypes as quickly as possible to confirm the value and relevance of the solution to the stakeholders. If not validated, the solution idea should be improved to address feedback or scrapped. Asking "why" and challenging the value proposition of solution ideas are crucial in ensuring the "right" solutions are offered, rather than repeating what has already been done and improving the speed or scale of status quo approaches (double-loop learning). Of course, these new ideas should be scrutinized and tested with feedback from people.

Prototyping and testing help mitigate risk, as incorrect assumptions are ruled out and ineffective or irrelevant investment of financial, human and social resources into a solution is avoided – for example, finding out a year later that community members cannot access the services. The key is to learn as early as possible to validate major assumptions underlying the solution, directly from stakeholders.

*   Holden R, Boustani M, Azar J. Agile innovation to transform healthcare: innovating in complex adaptive systems is an everyday process, not a light bulb event. BMJ Innovations. 2021;7:499–505.

Appendix 5. Alignment between health programmes and the Regional Framework for Reaching the Unreached

Leprosy

The WHO Western Pacific Region has achieved the target of leprosy elimination as a public health problem (defined as a prevalence < 1 per 10 000 population) since the late 1980s. After the World Health Assembly resolution in 1991 and the introduction of multidrug therapy in the late 1980s, the decline hastened. The number of new cases detected in the Region declined by 73%, from 15 002 in 1991 to 4004 in 2019. The COVID-19 pandemic led to a more than 35% reduction in case notification (2589), largely due to COVID-related restrictions and diversion of resources.

Over the past decade, the number of new cases has remained almost stable, with minor fluctuations. A few Pacific island countries and areas (for example, Kiribati, the Marshall Islands and the Federated States of Micronesia) still carry a high per capita rate of new cases detected. In some other countries (for example China, Papua New Guinea and the Philippines), leprosy as a public health problem has been eliminated at national levels, although hotspots of continuing transmission still exist. China, Papua New Guinea and the Philippines accounted for almost 80% of the total number of new cases in the Region in 2019.

Between 2000 and 2020, four five-year global leprosy strategies have been implemented. They aimed to improve the availability and accessibility of leprosy services, ensure programme sustainability and control morbidity – leprosy elimination as public health problem.

Towards zero leprosy: Global Leprosy (Hansen's disease) Strategy 2021–2030 aims to eliminate leprosy transmission, which is a next step to elimination as a public health problem.[1] The long-term vision of the new Strategy is: zero leprosy, zero infection and disease, zero disability, and zero stigma and discrimination.

The Global Leprosy Strategy has identified the following targets for 2030:

- 120 countries with zero new autochthonous cases
- 70% reduction in annual number of new cases detected
- 90% reduction in rate per million population of new cases with grade-2 disability
- 90% reduction in rate per million children of new child cases with leprosy.

The Global Leprosy Strategy's strategic pillars will contribute to reaching the unreached in the following ways:

- Pillar I (integrated, country-owned zero leprosy road maps) includes political commitment for last-mile reach, surveillance and data management, and *partnerships for zero leprosy,* which are the main action domains of this *Regional Framework for Reaching the Unreached in the Western Pacific (2022–2030).*
- Pillar II (leprosy prevention and active case detection) and Pillar III (managing leprosy and its complications and preventing new disability) align with the service delivery domain of this Regional Framework where equitable access to services through the primary health-care model, an integrated approach and community engagement are recommended.

- Pillar IV (combating stigma and ensuring human rights) falls within the basic principle of this Regional Framework of equitable services and access to social support.

*Translation of the Global Leprosy Strategy to practice*

The Global Leprosy Strategy has been disseminated to national leprosy programmes and partners through various platforms. As a next step, priority countries will be supported in developing zero leprosy road maps wherein the ambitious targets as defined in the Global Strategy will be embedded using the reaching-the-unreached platform as an approach to achieve these. WHO in the Western Pacific Region will also support the implementation of the major interventions of the Global Strategy in priority countries.

Malaria control and elimination in the context of reaching the unreached

The vision of WHO and the global and regional malaria communities is a world free of malaria. WHO's efforts in the Western Pacific Region to support Member States to achieve this vision are aligned with the *WHO Global Technical Strategy for Malaria 2016–2030*,[2,3] which has set ambitious objectives and targets to be measured against 2015 baselines. These objectives include: reduction of the malaria mortality rate and case incidence by at least 75% in 2025 and 90% in 2030; elimination from at least 20 countries by 2025 and 35 countries by 2030; and prevention of re-establishment in all countries that are currently malaria-free.

To achieve these objectives, the Strategy details three core pillars (see figure below): 1) ensuring access to malaria prevention, diagnosis and treatment as part of universal health coverage; 2) accelerating efforts towards malaria elimination and attainment of malaria-free status; and 3) transforming malaria surveillance into a core intervention.

Pillars of the Global Technical Strategy for Malaria 2016–2030
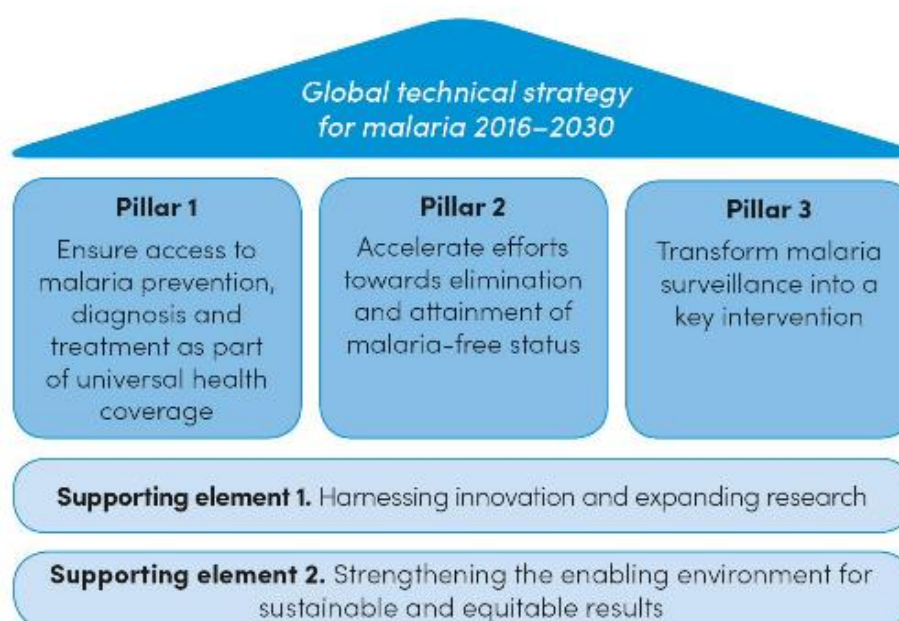
Source: Global technical strategy for malaria 2016–2030, 2021 update. Geneva: World Health Organization; 2021.

The Strategy aligns with this Regional Framework on Reaching the Unreached, particularly in the focus areas of strengthening health systems and services and enabling communities and individuals. Stronger surveillance and more accurate data will support equity analysis and allow for the allocation of resources and design of services to better reach and impact populations most in need. Expanding vector control tools to all individuals at risk, diagnostic testing to every person suspected to have malaria and treatment to all confirmed cases require both strengthening health systems and engaging communities and individuals, particularly to ensure unreached groups are reached.

Each of the nine malaria-endemic countries in the Western Pacific Region have a unique epidemiological context and diverse malaria heterogeneity. National malaria strategies, guided by the WHO Global Strategy, set country objectives and targets and clearly detail how countries will achieve their targets.

National malaria programmes will need to take a more systems-integrated approach without compromising core strategies to prevent and control malaria. WHO will continue to guide programmes with data-driven, innovative approaches. The WHO Mekong Malaria Elimination programme, together with regional efforts, supports Member States to translate aspects of the Global Strategy and the Regional Framework on Reaching the Unreached into action in the Greater Mekong Subregion. The Mekong Malaria Elimination programme was established with the aim of halting the spread of antimalarial drug resistance by eliminating *P. falciparum* malaria. Cambodia and the Lao People's Democratic Republic are adopting innovative strategies including targeted fever screening and treatment and intermittent preventive treatment in forest populations. Efforts made by the programme and countries in the Greater Mekong Subregion have been a major success, demonstrating a 70–90% reduction in *P. falciparum* cases over the past two years.

To accelerate reaching the unreached, WHO will extend this effort to other countries in the Region, particularly in the Pacific. These efforts, along with novel tools such as the malaria RTS,S vaccine to prevent falciparum malaria, aim to provide the tools and understanding of malaria prevention and control that enable individuals and communities to maximize their health and well-being throughout their lives. WHO will continue to develop and disseminate normative guidance, policy advice and implementation guidance to support country action to eliminate malaria in the context of the Regional Framework and through health systems strengthening to reach the unreached. The Organization will provide guidance and technical support to Member States in reviewing and updating their national malaria strategies in line with the priority actions and lead a coordinated global and regional effort to reduce the disease burden by at least 90% by 2030. WHO will work with Member States to develop regional implementation plans, where appropriate.

At the regional level, WHO will support countries in strengthening their national malaria surveillance systems in order to improve the quality, availability and management of malaria data, and to optimize the use of such data for decision-making and programmatic responses and to meet the objectives established in the Regional Framework. It will monitor implementation and regularly evaluate progress towards the milestones and goals set for 2025 and 2030. It will also provide support to countries for developing nationally appropriate targets and indicators to facilitate the subregional monitoring of progress. In line with its core roles, WHO at the regional level will continue to monitor regional and global malaria trends and make these data available to countries and global partners. It will support efforts to monitor the efficacy of medicines, diagnostics and vector control interventions, as well as

maintain global and regional databases as needed for efficacy of medicines, insecticide resistance and other biological threats to malaria control and elimination.

Women's, children's and adolescents' health in the context of reaching the unreached

Sexual, reproductive, maternal, newborn and child health remain unfinished business from the Millennium Development Goals, with targets included in the Sustainable Development Goals (SDGs). These pertain to maternal mortality, newborn and child mortality, sexual and reproductive health, and child malnutrition. (See detailed indicators under each SDG target in the Global Health Observatory database.)

In 2015, the United Nations General Assembly endorsed the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030),[4] which complements the SDGs and seeks to end preventable deaths and promote health and well-being through the life course. The Global Strategy calls for the need to move away from solely focusing on "survive" and ensuring that women, children and adolescents also "thrive". Ensuring universal access to sexual and reproductive health services (including family planning) and rights is a key objective of the Strategy to ensuring women and adolescents "thrive".

The Action Plan for Healthy Newborn Infants in the Western Pacific Region (2014–2020)[5] was developed to translate elements of the Global Strategy into the regional context and remains an active plan to reach the vision of a healthy start for every newborn infant. It details a mission to strengthen the health system and to cultivate an enabling environment where skilled providers of newborn care value and practise Early Essential Newborn Care (EENC) at every birth, clearly including unreached populations.

The goal is to eliminate preventable newborn mortality by providing universal access to high-quality EENC. Targets by 2020 were set for all Member States and include: 1) at least 80% of facilities where births take place are implementing EENC; 2) at least 90% of births in all subnational areas are attended by skilled birth attendants; and 3a) the national neonatal mortality rate is 10 per 1000 live births or less and 3b) the subnational neonatal mortality rate is 10 per 1000 live births or less. Progress towards these targets has been significant. Of nine implementing countries, four had introduced EENC in at least 80% of facilities and four had achieved the neonatal mortality target by 2020. The existing targets will be maintained through 2030, with more emphasis on defining and measuring implementation to ensure it meets quality standards and reducing mortality in high-risk subnational populations.

The Global Strategy and Regional Action Plan for Healthy Newborn Infants are strongly aligned with the Regional Framework for Reaching the Unreached and will be mutually reinforcing through all five reaching-the-unreached action domains. For example, this Regional Framework's focus on using a systems approach to reaching the unreached through improving service delivery, in particular primary health care, will provide leverage to reach women, newborn babies, children and adolescents everywhere through all elements of the health system. In turn, maternal, child, sexual and reproductive health activities provide a platform to reach unreached populations – particularly through actively engaging women, their families and communities in improving health care and prevention. Together, implementation of these frameworks should contribute to improved service quality and accessibility and enhance the survive and thrive agenda for healthier populations.
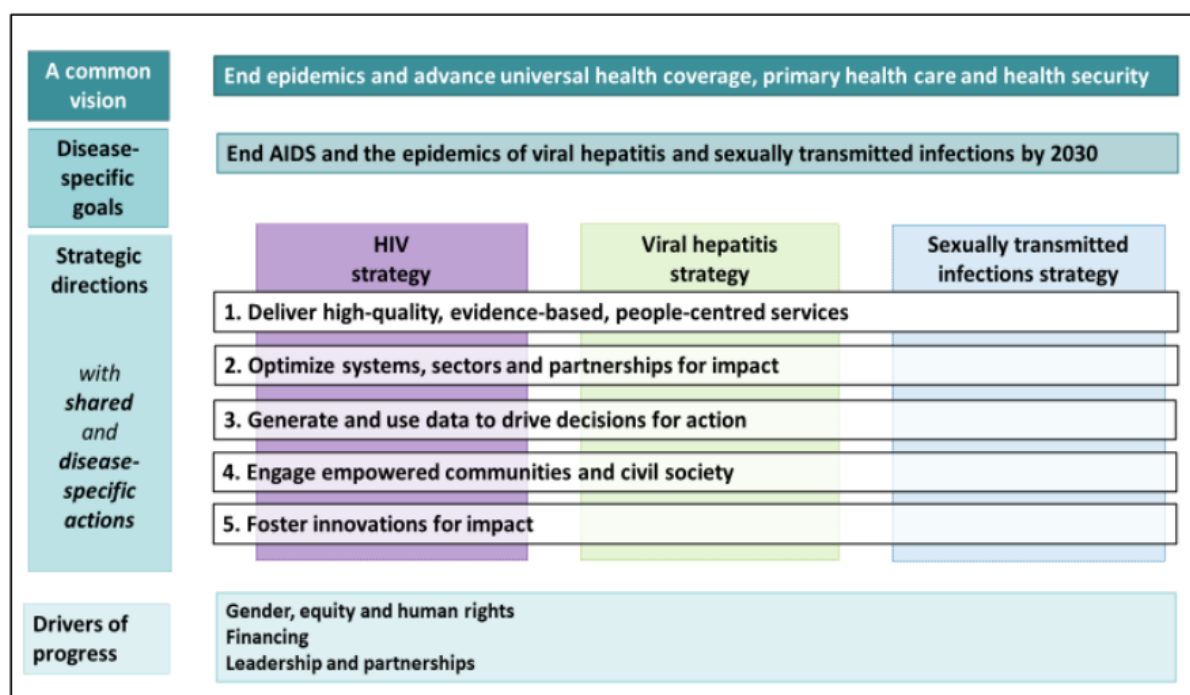
Health sector strategies for HIV, viral hepatitis and sexually transmitted infections

At the Seventy-fifth World Health Assembly, the Global Health Sector Strategies on HIV, Viral Hepatitis and Sexually Transmitted Infections 2022–2030 (GHSS) were noted with appreciation, giving WHO a clear mandate to continue to work with Member States on HIV, viral hepatitis and sexually transmitted infections using the new strategic framework until 2030.[6] The GHSS position the health sector response to these continuing global epidemics as critical to achieving the goals of the 2030 Agenda for Sustainable Development.

The GHSS provide an overall guiding framework with five strategic directions for achieving these goals (Fig. A5.2). Under a universal health coverage framework, as embodied in the Regional Framework for Reaching the Unreached, the GHSS present unique priorities for each disease area, while also leveraging synergies across the three disease areas and other health issues.

The GHSS promote shared approaches across systems, sectors and partnerships to achieve the delivery of services for HIV, viral hepatitis and sexually transmitted infections within national health systems and people-centred services that are accessible through primary health care. Equally important is meaningful community engagement to help address access barriers and reach unreached populations.

Fig. A5.2. Vision, goals and strategic directions of the global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030

Source: Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections for the period 2022-2030.

Each strategic direction will contribute to reaching the unreached, including through:

- Use of evidence-informed guidance and service delivery innovations to accelerate access to, and uptake of, high-quality essential services for HIV, viral hepatitis and sexually transmitted

infections tailored to meet the needs of people in diverse populations and settings, ensuring that no one is left behind (Strategic Direction 1).

- Focus on a systems-oriented approach that promotes synergies across health sector functions and encourages multisectoral responses to social and structural determinants of health to create maximum impact (Strategic Direction 2).

- Generation and use of data for action, disaggregated by: sex, age and other stratifiers to monitor and evaluate progress; guide action, innovation, research and development; and promote data transparency and accountability (Strategic Direction 3).

- Engagement and empowerment of communities and civil society, including affected populations to play a pivotal role in advocacy, service delivery and policy-making, and to address stigma and discrimination and tackle social and structural barriers (Strategic Direction 4).

- Fostering innovations for impact and prioritizing development of new technologies, service delivery models and health system practices that will overcome key barriers to achieving progress against HIV, viral hepatitis and sexually transmitted infections.

The strategies introduce shared and disease-specific indicators and 2025 and 2030 targets to help monitor and drive progress. Countries are called upon to implement the GHSS towards these targets within the reaching-the-unreached framework according to their country contexts and with consideration of the social determinants of health.

References for Appendix 5

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