GOVERNMENT OF MONGOLIA

MINISTRY OF HEALTH

Resource handbook

Leaving no one behind

in the context of subnational health system strengthening

in **Mongolia**

Resource handbook

Leaving no one behind

in the context of subnational health system strengthening

in Mongolia

GOVERNMENT OF
MONGOLIA

MINISTRY OF HEALTH

Contents

Acronyms

AAAQ	Availability, Accessibility, Acceptability and Quality
ADB	Asian Development Bank
CHWs	Community Health Workers
CSDH	Commission on Social Determinants of Health
EML	Essential Medicines List
G7	Group of 7
HIS	Health Information System
HRBA	Human rights-based approach
HRH	Human Resources for Health
HSS	Health System Strengthening
LMICs	Low and Middle Income Countries
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NCDs	Noncommunicable Diseases
NGOs	Non-governmental organizations
OECD	Organisation for Economic Co-operation and Development
OHCHR	Office of the High Commissioner on Human Rights
OOP	Out of Pocket expenditures
RED	Reaching every District
SDGs	Sustainable Development Goals
SHSS	Subnational Health System Strengthening
STI	Sexually transmitted infection
UB	Ulaanbaatar
UHC	Universal Health Coverage
UN	United Nations
UN CESCR	United Nations Committee on Economic, Social and Cultural Rights
UNDG	United Nations Development Group
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization

Background and introduction

About this handbook

The State Great Hural (Parliament) of Mongolia resolution Approving Mongolia's Sustainable Development Vision 2030 (passed in February 2016) calls for – among other aims – improving the living environment of the Mongolian people to lead a healthy and long life, and increasing life expectancy at birth to 78 years. It sets forth ambitious objectives towards this end, with targets identified for each of the 2016–2020, 2021–2025 and 2026–2030 periods. Like the global Sustainable Development Goals (SDGs), Mongolia's Vision 2030 goals are indivisible and mutually reinforcing, and are underpinned by the principle of "leaving no one behind". The poorest and most marginalized/disadvantaged in society will be the most challenging to reach in efforts towards the Vision 2030, and it is important that a markedly scaled-up focus on leaving no one behind is evident at commencement of the 15-year countdown.

In light of the imperative for action, in 2016–2017, the Ministry of Health of the Government of Mongolia and the World Health Organization (WHO) conducted a series of capacity-building workshops and activities on leaving no one behind in the context of subnational health system strengthening. These activities are in keeping with the commitments represented in the Country Cooperation Strategy for Mongolia (2010–2015), and build on existing work on health system strengthening towards universal health coverage. Capacity-building activities have aimed to support the inclusion of a strong focus on "leaving no one behind" in the health-related subnational planning for the 2016–2020 phase of the Vision 2030.

A long-term State Policy on Health (2017–2026) was approved by Cabinet resolution on 18 January 2017. The policy was developed with technical and financial support from WHO, and with multisectoral, civil society and partner participation.

The Policy has two stages, which are in line with Mongolia's Sustainable Development Vision 2030. The improved awareness of policy-makers regarding universal health coverage and the SDG core concept of "leaving no one behind" – as a result of capacity-building activities conducted in 2016–2017 across the country – has helped to frame the Policy and strengthen the link with national policy implementation at aimag (province) and district levels through inclusion in their 4-year plans. In this regard, the Minister of Health issued an order to revise and update the aimag and district 4-year plans to implement the State Policy on Health and to include specific components/approaches relevant to leaving no one behind, i.e. specifying how to identify and improve effective coverage with health services and financial protection for disadvantaged subpopulations. According to the new law on Development Policy and Planning (2015), local government plans are named "aimag/district subprogrammes for health". Subprogrammes (or subnational plans) were finalized and approved by aimag/district governors during April 2017.

The present handbook accompanies the capacity-building activities being conducted on leaving no one behind in the context of subnational health system strengthening in Mongolia. It was piloted during the last quarter of 2016 through a process involving workshops for more than 100 representatives of authorities from all 21 aimags, 9 districts of Ulaanbaatar, and the Ministry of Health as well as partners. It was subsequently revised during the first quarter of 2017 based on lessons learned from these pilots.

This handbook (and the workshops that accompany it, see Annex 2) specifically aims to:
- describe the importance of considering the heterogeneity of subpopulations and share approaches for identifying

subpopulations that are most at risk of being left behind, drawing from health inequality monitoring and data disaggregation as well as from gender analysis and other sources;
- show how the Tanahashi framework for effective coverage can be used to explore the barriers that disadvantaged subpopulations may face in accessing and benefitting from services and financial protection;
- provide a framework and orientations for considering how health system strengthening can be further undertaken to leave no one behind, including through key measures across the health system building blocks and by ensuring a synergistic system-wide approach;
- identify ways to build aimag/province and district cross-sectoral governance for health for all and to encourage sustained social participation (including of more marginalized/disadvantaged subpopulations);
- identify entry points for enhancing the focus on leaving no one behind in the monitoring, evaluation and review of aimag/province and district 5-year health plans.

The handbook is comprised of a main section with technical orientations on the above aspects, as well as three annexes that can be used by health authorities and partners in the context of strengthening health planning to leave no one behind. The first annex comprises a basic checklist that can be used when formulating subnational health plans from the perspective of leaving no one behind. The second annex comprises the materials used during the workshops that accompany this handbook; it includes the questionnaire sent to aimag/province and district teams before the workshop, the exercises used during workshops, and a generic sample agenda. The third annex contains a collection of WHO and partner resources that can be useful in the planning process from the perspective of leaving no one behind.

The handbook draws on existing WHO materials on health system strengthening towards universal health coverage, the Innov8 approach for reviewing national health programmes to leave no one behind, materials on gender and human rights in health sector strategies, guidance on health inequality monitoring and data disaggregation, instruments for qualitative barrier assessments, and guidance on governance assessments and integrated people-centred health services, among a range of other sources (see References and Annex 3). Following this Mongolia-specific edition, the handbook will adapted for further use globally as part of WHO's country support package on eaving no one behind. The handbook also synergizes with follow-up to the WHO Regional Committee for the Western Pacific resolution WPR/RC66.R2 on Universal health coverage: moving towards better health – an action framework that provides guidance for Member States to accelerate progress towards universal health coverage and some SDGs (WHO Regional Office for the Western Pacific, 2016).

Subnational health system strengthening overview

The Government of Mongolia is committed to strengthening local governance and supporting decentralization. The Government's policy for 2012–2016 has focused on supporting decentralization through the new Budget Law and encouraging citizens' involvement in decision-making through local development funds. Since 2013, the WHO Country Office for Mongolia, in collaboration with the Regional Office for the Western Pacific and other international/national partners, has been providing technical and financial support to aimags/provinces and districts (Ulaanbaatar city) in order to strengthen health systems at subnational level.

On May of 2016, the leaders of the Group of 7 (G7) countries met in Ise-Shima to address major global challenges, and introduced the G7 Ise-Shima Leaders' Declaration. In terms of health, the G7 summit stressed implementing the health-related SDGs targets that ensure well-being at all stages and health security for all individuals, and foster inclusive economic growth for nations. Universal health coverage provides a comprehensive framework that underpins all of the health targets. To achieve universal health coverage, health systems need to be strong, resilient, sustainable and responsive to the current and future needs of the populations they serve. The subnational health system strengthening concepts flowchart (Fig. 1), which underpins the content of this handbook, is aligned with the G7 Declaration's focus on universal health coverage and health system strengthening.

Fig. 1. Subnational health system strengthening concepts flowchart
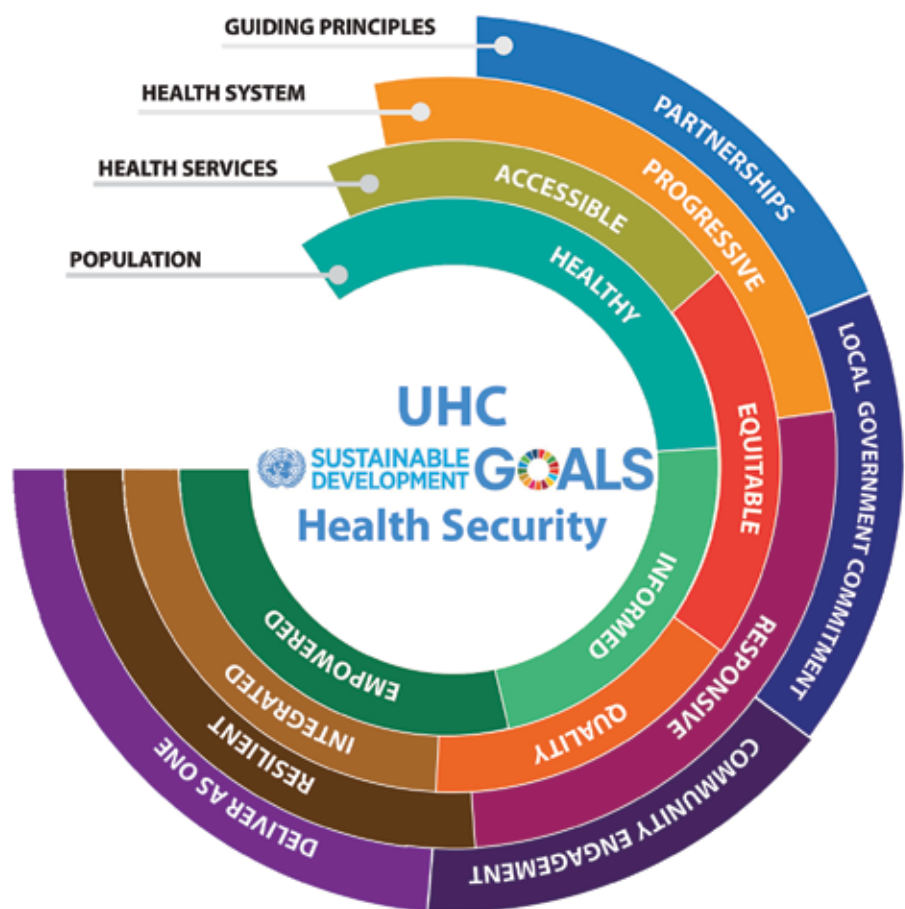
Source: WHO Country Office for Mongolia, 2016(a).

Contributing to the work on subnational health system strengthening now underway in Mongolia, this handbook and the accompanying workshops (see Annex 2) support building know-how and awareness of resources for "leaving no one behind" in the following components and processes linked to the health plans at subnational level:

- conducting situation analyses;
- engaging stakeholders and communities;
- designing and implementing the plan components;
- monitoring and evaluation of the plans.

Health inequities in Mongolia

Universal health coverage means that all people receive the quality essential health services they need, without being exposed to financial hardship (WHO, 2015). Universal health coverage is a goal and health system strengthening is the means to achieve that goal. Studies from Mongolia highlight inequities in access to quality health services and financial protection that remain important to address on the path towards universal health coverage, building on existing gains in this area.

A study by Dorjdagva et al. published in 2015 shows that inequities in health service utilization in Mongolia have increased over time. According to the study, degrees of inequity in tertiary level hospitals and private hospital outpatient services became more pro-rich from 2007/2008 to 2012. Conversely, degrees of inequity in family group practice/soum (subprovince) hospital outpatient services became more pro-poor from 2007/2008 to 2012 (Dorjdagva et al., 2015a). The study highlights that, despite the poor having greater health needs, the rich use more health services except for family group practice/soum hospital outpatient services. This reflects the findings of previous studies (Asian Development Bank, 2008). It also points to the bypassing of primary health care by the rich in order to use more expensive services at higher referral levels or in the private sector, which can contribute to cost escalation, resource waste and inefficiencies (Dorjdagva et al., 2015a). Beyond income-related health inequities, other dimensions of inequity in Mongolia are featured in Box 1, drawing from the 2013 Mongolia health system review (WHO, 2013a). A further study by Dorjdagva et al. (2015b) has also highlighted the importance of considering inequities by education status, as persons with a lower education level experience higher self-reported poor health, among other inequities.

Box 1. Examples of inequities in Mongolia

Although entitlement for health services is universal in Mongolia and population coverage by health insurance was 98.6% in 2011, poor and disadvantaged populations have less access to health and medical care. Those most likely to be excluded from coverage belong to the lowest income group and informal employment sector. Some sources suggest that the uninsured population are mostly unregistered internal migrants coming from rural provinces to the capital city, illustrating that both income and demographic dimensions of health inequity persist.

Primary health care is fully funded by the State and ensures free access to everyone. However, the vast size of Mongolia, combined with low population density and its nomadic tradition, pose real geographical barriers to health care access. These problems of inequitable coverage and access are compounded by the poor quality of rural and remote health care facilities, which are inadequately staffed and insufficiently responsive to the changing health needs of the population. The Government has taken action to improve the civil registration system through social welfare programmes and targeted interventions. This helps rural–urban migrants to be registered and improves access to health services.

According to a situation analysis conducted in Ulaanbaatar by the Ministry of Health and the Asian Development Bank in 2010, only 25% of unregistered residents could obtain health services compared to 62.2% of registered residents. One third of respondents did not access primary health care when needed, due to:

- lack of money (77.5 %);
- lack of health insurance (55.9%);
- geographical distance (31.8%).

In addition, the survey revealed that the proximity of a family group practice/soum hospital, public transport and a pharmacy were further factors influencing access of health care by members of poor and vulnerable households.

Inequities can also be seen in relation to important risk factors. For instance, the proportion of malnourished and/or underweight children is three times higher in poor households compared to non-poor households; 9 out of 10 underweight children are from poor households in rural areas. Among the poor, 48.4% have no access to improved sanitation as compared to 25% among non-poor people. There are also marked differences between men and women for some risk factors. Twice as many young men compared to women and more than half (61.4%) of men aged above 45 years are at high risk of noncommunicable disease. The proportion of current daily smokers is more than eight times higher in males (43%) compared to females (5.2%).

Source: text extracted from WHO, 2013a.

With regard to the financial protection component of universal health coverage, a study by Dorjdagva et al. (2016) using data from the Household Socio-Economic Survey 2012 suggests that 5.5% of households in Mongolia suffered from catastrophic health expenditures that year, when the threshold level for catastrophic expenditure is 10% of the total household expenditure. Dorjdagva et al. (2016) reports that rich households are more likely to suffer from catastrophic payments (also linked to their above-mentioned bypassing of primary health care to access higher and more expensive levels of care). However, the impoverishing effect of health spending is substantial. According to the Health equity and financial report: Mongolia produced by the World Bank in 2012, using a US$ 2 a day poverty line, health spending contributed to a 12% increase in the incidence of poverty and a 14% increase in the poverty gap, which is the ratio by which the mean income of the poor falls below the poverty line. Using the national poverty line of 750 000 tugrik, health spending contributed to a 7% increase in the incidence of poverty and a 9% increase in the poverty gap (World Bank, 2012).

Dorjdagva et al. (2016) states that while almost the entire population has social health insurance, lower income groups are substantially less likely to access specialized health care services at the higher referral levels due to both direct costs (including co-payments, medicines and consultations) and indirect costs (such as for transport and meals). This echoes what has been featured elsewhere, for instance in Nanzad et al. (2011), which cited that 40% of inpatients purchase drugs and injections while hospitalized at secondary level hospitals and that more than 8 in 10 had meals brought from home daily, which pose greater financial burden for lower income groups and those from rural areas.

The above summary draws from various data sources to highlight the different types of health inequity in Mongolia. Inequities are seen in relation to exposure to risk factors, access to health services at different levels of the system, and financial protection. While a much more comprehensive review of existing data is required, this initial synopsis conveys health inequities by a range of often intersecting characteristics, behind which are multidimensional/layered and dynamic processes and pathways. Differences are seen by sex (male/female), highlighting the need to look at the contribution of gender norms/concepts of masculinity, as well as other characteristics such as rural residence, low income, internal migrant status, unregistered status, informal sector employment, and lower education levels.

Critical concepts and glossary

This handbook aims to reinforce the knowledge and capacities of representatives from aimag/province and district governments in relation to practical approaches to "leave no one behind" in subnational health system strengthening efforts. For this, it draws from the fields of equity, gender, human rights, social determinants of health and health system strengthening. It is beyond the scope of this handbook to provide an in-depth overview of any of these fields, but rather it draws from them selectively in relation to subnational planning cycle components (e.g. situation analysis; stakeholder consultation; implementation plans; monitoring, evaluation and review).

There are 12 core underlying concepts and definitions that are critical for understanding when reading this handbook.

1. Universal health coverage and progressive universalism
2. Health equity
3. Integrated people-centred health services
4. Quality
5. Barriers and facilitating factors
6. Health system building blocks
7. Social determinants of health
8. Gender analysis
9. Intersectoral action
10. Social participation
11. Human rights-based approach
12. Subpopulations

Basic descriptions and definitions for each are featured below. These will be explored in more detail in the relevant sections of the handbook.

● Universal health coverage and progressive universalism

Universal health coverage means all people receiving the health services they need, including health initiatives designed to promote better health (such as anti-tobacco policies), prevent illness (such as vaccinations), and to provide treatment, rehabilitation and palliative care (such as end-of-life care) of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship (WHO, 2015a). Universal health coverage is firmly based on the WHO Constitution of 1948 declaring health to be a fundamental human right, and on the Health for All agenda set by the Alma-Ata Declaration in 1978.

Progressive universalism is the concept that more disadvantaged subpopulations benefit at least as much as more advantaged subpopulations in reforms towards universal health coverage (Gwatkin & Ergo, 2011). It reflects a human rights-based approach (see below). This concept refutes prioritizing reforms for expanding coverage and financial protection to the more advantaged subpopulations (e.g. urban middle/upper class) first and leaving for later the more difficult reforms to meet the needs of disadvantaged subpopulations (e.g. rural poor, informal sector workers, internal migrants). Rather, the principle of progressive universalism entails that priority be given to universal health coverage reforms that benefit the more disadvantaged on equal or greater grounds than the more advantaged. It synergizes with the premise that health system strengthening should be done with a view towards building a sustainable universal system, with targeting used as a measure for those who fall through the cracks, and that those with greater needs should receive proportionate services (CSDH, 2008). From a gender perspective, it means that the health system must account for the different needs of women and men, while also taking into account gender norms, roles and relations that may influence health.

● Health equity

Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically, or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential (WHO, 2016a). While health inequity is a normative concept, and thus cannot be precisely measured or monitored, health inequality – observable differences between subgroups within a population – can be measured and monitored, and serves as an indirect means of evaluating health inequity (WHO, 2013d).

● Integrated people-centred health services

Integrated health services are health services that are managed and delivered so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life-course (WHO, 2016L).

People-centred care refers to an approach to care that consciously adopts individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respects social preferences (WHO, 2016L). People-centred care also requires that patients have the education and support they need to make decisions and participate in their own care and that carers are able to attain maximal function within a supportive working environment (WHO, 2016L). People-centred care is broader

than patient- and person-centred care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services (WHO, 2016L).

● **Quality**

Quality is an essential foundation to health for all. Universal health coverage is now a global health priority as part of the SDGs under target 3.8, which focuses on achieving universal health coverage including financial risk protection, access to quality essential health care services, medicines and vaccines for all. The goal of universal health coverage entails making health services more accessible while ensuring the health services provided are of good quality and will not cause harm. The incorporation of quality within every aspect of universal health coverage is essential for the best outcome for patients and populations. When focusing on people-centred health services (see above), quality improves. Quality health care can be defined in many ways, but there is growing acknowledgment (WHO, 2017a) that quality health services should be:

- safe – avoiding injuries to people for whom the care is intended;
- effective – providing evidence-based health care services to those who need them;
- people-centred – providing care that responds to individual preferences, needs and values;
- timely – reducing waiting times and sometimes harmful delays.

To realize the benefits of quality health care, health services must be:

- equitable – providing care that does not vary in quality on account of gender, ethnicity, geographic location and socioeconomic status;
- integrated – providing care that makes available the full range of health services throughout the life-course;

- efficient – maximizing the benefit of available resources and avoiding waste.

● **Barriers and facilitating factors**

Barriers are understood as those factors that hinder the target population from appropriate use of an offered health service or a social guarantee, thus diminishing effective coverage of a health or provision service (Tanahashi, 1978). Similarly, the right to health draws attention to a range of barriers including physical, financial, information and discrimination barriers. It is important to note that there might be gender-based barriers in access to and effective coverage with health services and financial protection.

Facilitating factors are those factors helping the target population to access services or a social guarantee, navigate the pathway/continuum for treatment, and achieve the intended benefits, thus resulting in effective coverage without financial hardship or other adverse social consequences.

● **Health system building blocks**

A health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health (WHO Regional Office for Europe, 2008).

This handbook uses the WHO building blocks framework that describes health systems in terms of six core components or "building blocks": (i) service delivery; (ii) health workforce; (iii) health information systems; (iv) access to essential medicines; (v) financing; and (vi) leadership/governance (WHO, 2010a).

● **Social determinants of health**

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices (WHO, 2015d).

● **Gender analysis**

Gender analysis looks at the differences between men and women in risk and exposure, health seeking behaviour, access and use of services, experiences in health care settings, treatment options and impact of ill-health (WHO, 2011a). It also looks at the interaction between biological and sociocultural factors, and access to and control over resources in relation to health, and identifies appropriate responses to different needs. It asks critical questions to uncover multi-level causes of gender inequality shaped by gender norms, roles and relations, unequal power relations between and among groups of women and men and the intersection of gender with other contextual factors (such as ethnicity, income and age).

● **Intersectoral action**

This refers to actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector. Intersectoral action for health entails health and other sectors working together to inform public policy design and implementation to improve health and well-being, or, at least, not to adversely affect it. Such efforts improve understanding across health and other sectors about the way that the policy decisions and operational practices of different sectors impact on health and health equity (WHO, 2015b).

● **Social participation**

Social participation concerns the participation of civil society and the empowerment of affected communities to become active protagonists in shaping their own health. All persons and groups are entitled to active, free and meaningful participation in, contribution to, and enjoyment of civil, economic, social, cultural and political development in which human rights and fundamental freedoms can be realized. Human rights law recognizes the participation of the population in all health-related decision-making at the community, national and international levels (UN CESCR, 2000).

● **Human rights-based approach**

A human rights-based approach to health focuses attention and provides strategies and solutions to redress inequalities, discriminatory practices (both real and perceived) and unjust power relations, which are often at the heart of inequitable health outcomes (UNDG, 2003). The goal of the human rights-based approach to health is that all health policies, strategies and programmes be designed with the objective of progressively improving the enjoyment of all people to the right to health and other health-related human rights. In working towards the goal of human rights and particularly the right to health, a rights-based approach upholds human rights standards and guiding principles, including but not limited to non-discrimination and equality, participation and inclusion, and accountability (UN CESCR, 2000; UN CESCR, 2003). This handbook draws from WHO's Human rights and gender equality in health sector strategies: how to assess policy coherence (WHO, 2011d) to help underpin the readings and activities with a focus on the human rights-based approach.

● **Subpopulations**

A subpopulation can be defined according to one or more common characteristics. Hence, a subpopulation could be defined only by sex, i.e. "females" or "males", or by income level, education level or residence. To truly understand the dynamics of inequities, however, it can be useful to consider more than one characteristic, e.g. "urban-residence" and "low-education", and then further consider the differences between females and males with these characteristics. Due attention should be given to intersections between characteristics that make some subpopulations more disadvantaged than others.

Part I
Knowing who is being missed

"More than 40 per cent of maternal deaths occur among herder women in remote rural areas where access to medical services is poor"

Ministry of Health, Mongolia, 2007 (in WHO 2013a)

Identifying the subpopulations being missed

Central to the delivery of integrated people-centred health services is an understanding of the population that the health system aims to serve (WHO, 2016d). This includes an explicit focus on the heterogeneity of that population by different social and biological characteristics, as well as the varying health and social needs of the heterogeneous subpopulations. Without a focus on heterogeneity – and a related focus on the contextual social, environmental and biological factors that influence heterogeneity – there is a strong risk that the health system will be unable to respond adequately to health and social needs, including financial protection. This, in turn, will result in stagnation or exacerbation of health inequities. In light of this, aimag/province and district health planners and providers have a central role in truly understanding the heterogeneity within the population, with a particular focus on the subpopulations being missed.

There are different approaches that consider which subpopulations may have greater needs and which may experience inequities in effective coverage with services and financial protection. Methods to do so draw from work on the social production of disease, including Diderichsen's work on how differences in social position account for health inequities (Diderichsen, 2004; WHO, 2010b). The Priority Public Health Conditions Knowledge Network of WHO's Commission on Social Determinants of Health elaborated on Diderichsen's work with a framework that specifically looked at social context and position in relation to differential exposure, differential vulnerability, differential health care outcomes (implied in this is differential effective coverage with services), and differential consequences of ill-health (WHO, 2010c). These types of inequities are described in more depth in Box 2.

Studies have consistently demonstrated the existence of social gradients and differences in disease distribution in populations (CSDH, 2008; WHO, 2016c). Yet, despite the greater health needs of individuals experiencing disadvantage – by income, education or precarious employment, or by ethnicity, sex, gender, etc. – these subpopulations may not express demand, be able to access services or comply with treatments, resulting in lower levels of health service use in relation to their needs (WHO, 2016c). Depending on the country context and health system, there may be situations of low use despite high need due to access barriers. So pervasive is this inequity in access it has been called the "inverse care law" (Tudor Hart, 1971; WHO, 2016c).

In assessing province/district health system performance, it is important to consider differential needs (rates of disease or risk) and differential social circumstances. Equal use across social groups may in reality reflect inequities if use is not appropriate in quantity and quality to differential need (WHO, 2016c). Table 1 can be helpful when considering the current usage rates of subpopulations which have greater or different need. Time should be given to reflect on issues related to effective coverage of interventions (i.e. whether the service the person can access is of sufficient quality and if the system facilitates the necessary referrals). This is because "use" at certain points in the patient pathway may be different for different subpopulations due to, for instance, barriers in accessing specialized care.

Box 2. Linking social position and health inequities through differentials in exposure, vulnerability, outcomes and consequences

Socioeconomic context and position. Social position exerts a powerful influence on the type, magnitude and distribution of health inequities in societies. The control of power and resources in societies generates stratifications in institutional and legal arrangements and distorts political and market forces. While social stratification is often seen as the responsibility of other policy sectors and not central to the health sector per se, understanding and addressing stratification is critical to reducing health inequity. Factors defining position include social class, gender, ethnicity, education, occupation and income. The relative importance of these factors is determined by the national and international context, which includes governance, social policies, macroeconomic policies, public policies, culture and societal values.

Differential exposure. Exposure to most risk factors (material, psychosocial and behavioural) is inversely related to social position. Many health programmes do not differentiate exposure or risk reduction strategies according to social position, although analysis by socioeconomic group would clarify which risk factors were important to each group, and whether these were different from those important to the overall population. Understanding these "causes behind the causes" is important for developing appropriate equity-oriented strategies for health. There is increasing evidence that people in disadvantaged positions are subject to differential exposure to a number of risk factors, including natural or anthropogenic crises, unhealthy housing, dangerous working conditions, low food availability and quality, social exclusion and barriers to adopting healthy behaviours.

Differential vulnerability. The same level of exposure may have different effects on different socioeconomic groups, depending on their social, cultural and economic environments and cumulative life-course factors. Clustering of risk factors in some population groups, such as social exclusion, low income, alcohol abuse, malnutrition, cramped housing and poor access to health services, may be as important as the individual exposure itself. Further, coexistence of other health problems, such as coinfection, often augments vulnerability. The evidence base on the amplifying effects of reinforcing factors is still limited, although it is clear that they exist for low-income populations and marginalized groups. It is important that attempts to reduce or eliminate them identify appropriate entry-points for breaking the vicious circles in which vulnerable populations find themselves trapped.

Differential health care outcomes. Equity in health care ideally implies that everyone in need of health care receives it in a form that is beneficial to them, regardless of their social position or other socially determined circumstances. The result should be the reduction of all systematic differences in health outcomes between different socioeconomic groups in a way that levels everyone up to the health of the most advantaged. The effects of the three upper levels of the analytical framework may be further amplified by health systems providing services that are not appropriate to or less effective for certain population groups or disadvantaged people compared to others.

Differential consequences. Poor health may have several social and economic consequences, including loss of earnings, loss of ability to work and social isolation or exclusion. Further, sick people often face additional financial burdens that render them less able to pay for health care and drugs. While advantaged population groups are better protected, for example in terms of job security and health insurance, for the disadvantaged, ill-health might result in further socioeconomic degradation, crossing the poverty line and accelerating a downward spiral that further damages health.

Source: text extracted from WHO, 2010c.

Table 1. Different usage rates in relation to need

		NEED	
		HIGH	**LOW**
USE	**HIGH**	Appropriate access	**Overuse**
	LOW	Poor access	Appropriate access

Source: WHO, 2016c drawing from White, 1978.

Linked to the above, it is important to consider the conceptualization of need existing in any given subpopulation and the expression of demand associated with such need (WHO, 2016c). Different subpopulations within the target population – even if they have similar needs – may express this need differently due to their educational background, levels of health system literacy, experiences with discrimination, and/or prioritization of meeting basic needs related to food and shelter, among other factors (WHO, 2016c). Likewise, some subpopulations may express more need at certain health service usage points that does not actually correlate with their level of need for those specific services (CDC, 2013; WHO, 2016c). Rather, this can be a reflection of challenges that the subpopulations face in accessing other parts of the system (WHO, 2016c).

Conducting gender analysis is an important part of understanding the differential needs and differential social circumstances of subpopulations in a province/district (WHO, 2011a). Gender analysis looks at the differences between men and women in risk and exposure, health-seeking behaviour, access and use of services, experiences in health care settings, treatment options and consequences of ill-health. Gender analysis asks critical questions to uncover multi-level causes of gender inequality shaped by gender norms, roles and relations (see Box 3), unequal power relations between and among groups of women and men, and the intersection of gender with other contextual factors (such as ethnicity, income and age).

Box 3. Gender norms, roles and relations

Gender norms

Gender norms refer to beliefs about women and men, boys and girls that are passed from generation to generation through the process of socialization. They change over time and differ in different cultures, contexts and populations. Gender norms lead to inequality if they reinforce:

- mistreatment of one group or sex over the other; or
- differences in power and opportunities.

Gender roles

Gender roles refer to what women and men are expected to do (i.e. in the household, community and workplace) in a given society.

Gender relations

Gender relations refer to social relations between and among women and men, boys and girls that are based on gender norms and roles. Gender relations often create hierarchies between and among groups of men and women that can lead to unequal power relations, disadvantaging some groups over others. At a broader level, gender relations also refer to sociopolitical and economic relations to institutions such as the State, corporations and social movements. This includes the collective processes by which power is mobilized and exercised. Gender relations must be understood in relation to systems and processes such as racism, sexism, homophobia (e.g. discriminatory policies), which shape gender and gendered experiences.

Source: WHO (2011a).

Subpopulations can be identified using different stratifiers, including those used to monitor health inequality. Some of the most frequently used stratifiers in monitoring health inequality include (WHO, 2013d; WHO, 2016c):

- income or wealth;
- place of residence (rural, urban, other);
- race or ethnicity;
- occupation (workers/employed, unemployed);
- sex;
- marital status and household composition (single-parent-headed family, children living with grandparents)
- religion;
- education;
- socioeconomic status;
- social class;
- age;
- other characteristics particularly important for the programme and country context (e.g. migrant status, caste, gender identity and sexual orientation).

In accessing data on subpopulations being missed, both quantitative and qualitative sources can be considered. Quantitative data sources include population-based sources (censuses, vital registration systems and household surveys), institution-based sources (resource records, service records and individual records), and surveillance systems (WHO, 2013d). In addition to focus groups and informant interviews, sources of qualitative data may include academic research and "grey literature" such as reports from civil society and nongovernmental organizations, national human rights institutions, human rights treaty bodies and the media, featuring write-ups of views from male and female members of subpopulations with differing health needs who may/may not be getting effective coverage with services and financial protection.

Part II
Considering barriers to effective coverage

Overview of the Tanahashi framework for effective coverage and its links to the dimensions of availability, accessibility, acceptability and quality[1] of the right to health

It is widely acknowledged that a substantial share of health inequities (including differentials in exposure to risk factors, vulnerability, health outcomes and social consequences of ill-health) are due to factors outside the direct control of the health sector (CSDH, 2008). That said, a considerable share is associated with factors that lie in the remit of the health sector, including how the health sector accounts for heterogeneity in needs and demand-side barriers. The health system has a fundamental role in striving towards "leaving no one behind" by ensuring that it does not contribute to or exacerbate inequities. It should be designed in such a way as to ensure availability, accessibility, acceptability and effective coverage with quality services and financial protection, helping to mitigate barriers that may be experienced by different subpopulations. Indeed, understanding the barriers along

health pathways is an important part of providing integrated people-centred health services in ways that reduce health inequity (WHO, 2016d).

The framework proposed by Tanahashi in 1978 examines coverage as a series of dimensions that the beneficiary population must traverse in order to reach effective coverage and obtain the expected benefits (WHO, 2016c). Effective coverage is defined as "people who need health services obtain them in a timely manner and at a level of quality necessary to obtain the desired effect and potential health gains" (WHO, 2015a). Effective coverage is an important concept when considering universal health coverage (Evans, Hsu & Boerma, 2013).

The percentage of the target population with effective coverage depends on the coverage reached in the dimensions

of availability, accessibility, acceptability, contact and, finally, effectiveness (see Fig. 2). The Tanahashi framework aims to identify the target population that is left behind at each step (those left behind are shown by the coverage curve and the box representing those who do not contact the services).

The Tanahashi dimensions of availability, accessibility and acceptability provide a useful framework to assess the enjoyment of the right to health (UN CESCR, 2000). Likewise, the notion of service provision of appropriate "quality" as defined in General Comment No. 14 is also reflected in the Tanahashi framework, with quality-related elements incorporated into the effective coverage dimension and other dimensions (WHO, 2016c).

Fig. 2. Tanahashi framework for effective coverage
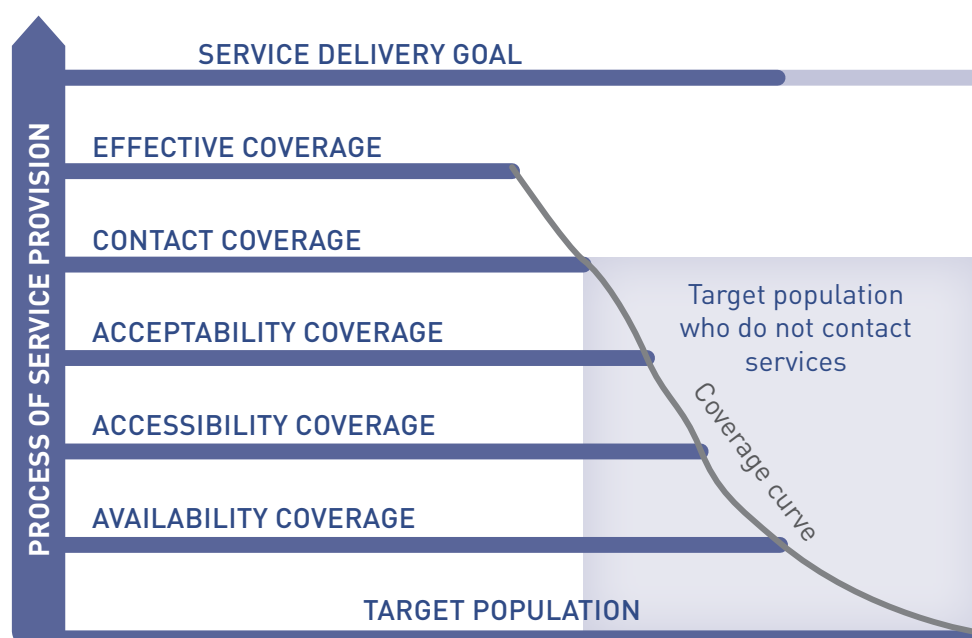
Source: Tanahashi(1978).

---

[1] As per General Comment No. 14 on the Right to the Highest Attainable Standard of Health (UN CESCR, 2000).

The Tanahashi framework is useful for identifying the reasons why some subpopulations are accessing and benefiting, and others are not. It does this by assisting the identification of barriers and facilitating factors that subpopulations experience in relation to accessing and benefiting from services. It can be noted that often both barriers and facilitators are influenced by the health system and the wider context in which people live, work and age, as well as the interface between these (WHO, 2016c). When they are related to the health system, barriers are sometimes referred to as "supply-side bottlenecks"; when they are linked to wider contextual issues, they can be called "demand-side barriers". Often, impediments to effective coverage represent a combined effect of supply and demand constraints (WHO, 2016c). For instance, a person who lives in a rural area may not receive effective coverage because of the rural remoteness and associated transportation issues and the reality that the service provider network is weak in rural areas and there are no adequately equipped rural mobile/outreach units in place (WHO, 2016c).

With regard to gender, it is important to consider how gender norms, roles and relations can result in both supply-side and demand-side barriers; for instance, through lack of availability of same-sex providers or through limited autonomy/decision-making capacity to seek services (WHO, 2011a; WHO, 2016c).

Table 2 provides a non-exhaustive overview of the Tanahashi dimensions, and the types of barriers and facilitating factors that can be associated with each dimension.

Table 2. Dimensions of Tanahashi framework and examples of barriers or facilitating factors

Dimension	Examples of barriers or facilitators
Availability	Resources available for delivering an intervention and their sufficiency, namely: • number or density of health facilities (or outreach services) • availability of services for different diseases/health topics, as appropriate for population burden of disease (men and women, across the continuum) • availability of adequately skilled personnel • availability of necessary inputs (e.g. drugs, equipment)
Accessibility	Geographic: • distance, availability of transport, time for transportation • weather condition, climate (e.g. heavy snow, high mountain area) • road conditions Financial: • direct: out-of-pocket expenditures (e.g. co-payment, medicines) • indirect: opportunity costs (e.g. lost work, child care), transport costs Organizational and informational: • attention schedules/opening times • systems to schedule appointments • administrative requirements for care • appropriate information sources on health topic, services, treatment Discrimination in access
Acceptability	• Cultural beliefs • Gender-responsiveness of services (including same-sex provider where culturally appropriate) • Age-appropriateness of services (e.g. adolescent-friendly) • Extent to which confidentiality is protected and stigmatization avoided • Perceptions of service quality • Discriminatory attitudes by providers (e.g. based on sex, ethnicity, marital status, religion, caste, sexual orientation)
Contact	• Actual contact between the service provider and the user, similar to "utilization"
Effective coverage	• Barriers in treatment adherence (due to unclear instructions, poor patient-provider relationship, mismatch of treatment prescribed with patient compliance ability, adverse social conditions and gender roles/relations preventing follow up by the patient, etc.) • Barriers in provider compliance (which can be related to low levels of training, lack of supportive system requirements, absenteeism or other accountability issues, as well as a weak referral and back-referral system) • Barriers in diagnostic accuracy (which can be linked to insufficient inputs at health centres and in the laboratory network)

Sources: Tanahashi, 1978; UN CESCR, 2000; WHO, 2010c.

Part III
Subnational health system strengthening to tackle barriers

Introduction to health system strengthening with a focus on leaving no one behind

The health system has the responsibility to provide all people with the quality health services they need, independent of sex, ability to pay, social status or other characteristic or condition. By ensuring equitable access to health services and by promoting action across different sectors to improve health and well-being, the health system can directly influence differences in exposure and vulnerability resulting in poor health. The health system has a critical role as a mediating force or buffer against the impacts of an illness or disability on people's lives (WHO, 2010b).
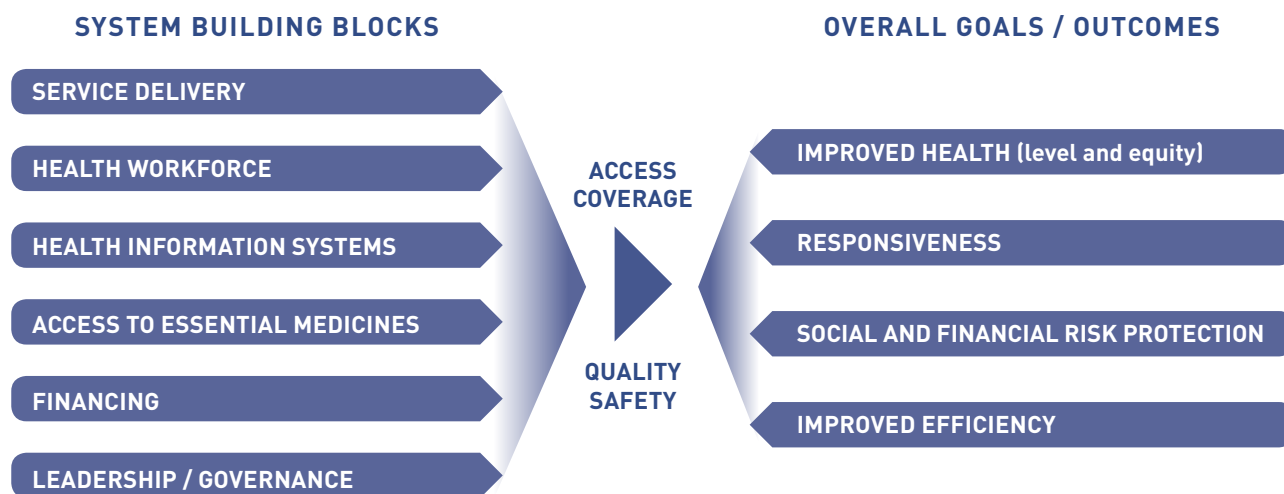
Fig. 3 shows the six building blocks of a health system:

  (i) service delivery;

  (ii) health workforce;

  (iii) health information systems;

  (iv) access to essential medicines;

  (v) financing; and

  (vi) leadership/governance (WHO, 2010a).

In order to leave no one behind in province/district level planning, it is important that specific attention is given to how models of care and each of these building blocks can be strengthened to help overcome the barriers identified in the previous section and reduce health inequities. There are other frameworks applied in health system performance assessment, including those that look at the "control knobs" of financing, organization, payment, regulation and behaviour (Roberts et al., 2004). In this handbook, discussion of these control knobs is synergized with that on building blocks, using the latter as a main frame of reference. The WHO Regional Office for the Western Pacific (2016) has also expanded on the below framework to show the relationship between health system building blocks, attributes and action domains leading to universal health coverage; these relationships are explored in the subsequent subsections.

Fig. 3. WHO health systems framework

SYSTEM BUILDING BLOCKS

SERVICE DELIVERY

HEALTH WORKFORCE

HEALTH INFORMATION SYSTEMS

ACCESS TO ESSENTIAL MEDICINES

FINANCING

LEADERSHIP / GOVERNANCE

ACCESS COVERAGE

QUALITY SAFETY

OVERALL GOALS / OUTCOMES

IMPROVED HEALTH (level and equity)

RESPONSIVENESS

SOCIAL AND FINANCIAL RISK PROTECTION

IMPROVED EFFICIENCY

THE SIX BUILDING BLOCKS OF A HEALTH SYSTEM: AIMS AND DESIRABLE ATTRIBUTES

Source: WHO, 2010a.

Acknowledging that using only the building blocks in assessing performance has its limitations, there is also a need to holistically analyse models of care and identify ways to reorient them to leave no one behind (WHO, 2016L; World Conference on Social Determinants of Health, 2011). Reorienting models of care must consider supply-side and demand-side factors. This involves synergistic and simultaneous actions that span the health system building blocks and address wider determinants of health (WHO Regional Office for Europe, 2010). Reoriented models of care for leaving no one behind prioritize primary and community care services (WHO, 2016L; Carrera et al., 2012). Intersectoral action and social participation are strong features (WHO, 2016L; WHO, 2016b). Reorientation entails a shift from inpatient to outpatient and ambulatory care, and from curative to preventive care, with accompanying greater investment in promotion and prevention (WHO, 2016L). A core defining feature of models of care for integrated people-centred health services is adaptation for overcoming demand-side barriers (including gender norms) and adaptation for cultural preferences in the design and operation of health services (WHO, 2016L).

The below scenarios of two distinct patient pathways provide examples of areas requiring strengthening in order to leave no one behind.

Scenario 1.[2] Dorj, a herder, has quite an unhealthy diet; he smokes and has a stressful life in poverty. Over time, Dorj has developed symptoms of coronary artery disease. He does not realize what these symptoms are, however, so postpones looking for help until he feels quite unwell. When he is finally convinced he may need to seek services, he calls the bagh feldsher (trained mid-level health personnel that work and live in their own ger) who is based at the local health post. The bagh feldsher cannot manage his case effectively due to lack of training combined with insufficiently maintained equipment for tests (the bagh feldsher's main task is to provide health education, ensure immunization coverage, do pre- and postnatal visits, and follow up with discharged patients about their treatment or with patients with chronic disease). So Dorj is referred to the soum health centre. For Dorj, the soum health centre is far away and he must arrange for others to take care of his herd, and given that the time of year is crucial for livestock birthing, he decides to wait to seek care until after the busy period. He tries using some traditional herbs in the meantime, but the symptoms persist. A month later, he goes to the soum health centre (where services are provided free) and is prescribed some medicines. He looks for the medicines in the soum pharmacy and has difficulty finding some of them, and may not be able to afford the price (he asked the pharmacist how much all prescriptions approximately cost and whether they are discounted by health insurance). He feels quite unwell so he purchases some drugs at the soum pharmacy that he can afford, as he knows that once he leaves the soum health centre he will not be able to find the medicines until his next trip there. Dorj returns to his home and herd and takes the medicines for 2 months, and during this time he feels better. Then the medicines run out. He does not have the time or money to go to town again, so goes without the medicines for a while. He starts feeling very unwell and has complications, so his family contacts the bagh feldsher who call the long-distance ambulance service. Dorj is taken by emergency services to the soum health centre. They cannot manage the case, so he is referred for more specialist services and diagnostics to the aimag general hospital. After treatment in the general hospital (during which time his family bring him food and buy his medicines), Dorj is discharged to the care of doctors at the soum health centre. Dorj again faces challenges in accessing the back referral, which is far away, and affording his needed medicines. The illness has been an economic drain on his family over time and has limited his ability to work as a herder. His family considers the option of internal migration to a large town.*

Scenario 2.[3] Tulga is a seasonal internal migrant who lives in the suburban area in during the winter months and at other times works as a part-time truck driver for a coal mining company. There has been rapid population growth in the district due to internal migration. Many people live in overcrowded housing and the area lacks adequate infrastructure including water, sanitation and electrification. Tulga is not registered, and so lacks access to social welfare benefits including social health insurance. As an unregistered person, he is not reflected in the official local authority or family group practice population registries. Tulga had low levels of knowledge about risk factors for sexually transmitted infections (STIs) and had unprotected sex, and so he has contracted an STI. Like many men, due to norms about masculinity and "being tough", he postpones seeking care. Finally, when the symptoms worsen, he visits the family health centre for his area. Consultation is rapid and lacks proper attention, as Tulga is not registered, and he is prescribed some medicines. The consultation is free, in light of a national law indicating that family group practices must provide services regardless of registration status. However, Tulga has to pay for prescribed medications since he is uninsured. As he does not have enough money, he cannot get them. A health worker tells Tulga of the possibility to go to the aimag centre and confirm the diagnosis. Tulga soon has to go back to work in coal transportation for the mining company. He cannot ask his employer for a day off work to go to the aimag health centre for diagnosis and proper consultation, and also does not have money to get there. He speaks with a fellow worker about it, who gives him some different medicines to try (self-prescribed) which do not have an effect. Tulga still has the untreated STI.

---

[2] This scenario has been adapted from the patient pathway featured on page 109 of *Health systems in transition: Mongolia health systems review* (WHO, 2013a).

[3] This scenario has been adapted from the patient pathway featured on page 109 and the information on health care for specific subpopulations on page 127 of *Health systems in transition: Mongolia health systems review* (WHO, 2013a). It also draws from Lhamsuren et al., 2012.

Potential ways in which the health system can be strengthened – with regard to the overarching model of care and synergistically across building blocks – are featured below. This is a non-exhaustive list, but touches on some of the barriers described in the above scenarios and in health systems in many country contexts. The Government of Mongolia, at national and subnational levels, is working to address the issues relevant to the country context through specific interventions (WHO Country Office for Mongolia, 2016; Ministry of Health of Mongolia & WHO, 2014 and 2016).

Service delivery

A health system is comprised of interconnected components that must function together to be effective towards the provision of quality health services and adequate financial protection. Changes in service delivery will have repercussions on, and will require input from, all of the remaining functions. That is, service delivery is closely interrelated with the other building blocks, including financing, and the health system control knobs of organization, payment, regulation and behaviour (WHO, 2007a; Roberts et al., 2004). Equity-enhancing reforms in service delivery cannot be seen in isolation from reforms across the health system as a whole; in fact, evidence suggests that such system-wide approaches are key for progressive universalism.

Integrated people-centred health services

The WHO Framework on integrated, people-centred health services has five strategic dimensions, which are fundamental to the concept of progressive universalism. These are:
1) empowering and engaging people and communities;
2) strengthening governance and accountability;
3) reorienting the model of care;
4) coordinating services within and across sectors; and
5) creating an enabling environment (WHO, 2016L).

In keeping with strategic direction 2, a general recommendation for "leaving no one behind" is to reorient the model of care for integrated people-centred service delivery, including strengthening primary care systems[4] particularly in more disadvantaged communities and ensuring their access to the appropriate (comprehensive) package of health and social services (WHO, 2016L; Roberts et al., 2004; WHO, 2008a; WHO, 2015h). Beyond looking at supply-side issues, and in keeping with the primary health care approach, demand-side constraints must also be addressed.

Important service delivery reforms for leaving no one behind, and which are relevant to the scenarios described (involving Dorj and Tulga), include – but are not limited to – the following approaches.

- A reoriented model of care by expanding quality primary health care – which is person-centred and population-focused – as a first and preferred contact when health needs arise. High-quality primary health care providers are responsible for effectively coordinating individual care across care settings (including hospitals when needed) and provide continuous care across the life-course for individuals, families and populations.

This includes a family and community-oriented approach with a strengthened focus on health promotion, prevention and community participation (WHO, 2016d). It also involves strengthening quality assurance mechanisms (e.g. clinical guidelines adherence, staff management and oversight, facility reviews and other quality-related monitoring) at primary health care level, particularly in disadvantaged areas.

- Adapting service delivery approaches to make them more person-centred. Such person-centred approaches account for social preferences, cultural values and perceptions of illness, as well as help to overcome gender norms, roles and relations that may enhance exposure to risk factors, impact treatment-seeking behaviours or otherwise influence effective coverage with services (WHO, 2011a). Person-centred approaches enhance patients' and their relatives' participation in decision-making. An example of this is interventions for cultural competency, which have the potential to contribute to improvements in associated health care outcomes (Government of Australia, 2015). Related to cultural preferences, adaptations can entail integration of traditional and complementary medicine with modern health systems.

---

[4] Ten shared characteristics of a transformed/strong primary care model can be useful to orient reforms: (1) that care is sought first at primary health care level (e.g. first contact); (2) that service provision is person-centred rather than disease-centred; (3) that services are population-focused and extend to the determinants; (4) that core services are comprehensive and span the continuum to the extent possible; (5) that services are coordinated across care settings and pathways; (6) that services are continuous; (7) that services are delivered through an interprofessional primary care team; (8) that services are family and community oriented as well as (9) participative; and (10) that services are accountable (WHO, 2015h).

- In the context of universal service provision, provision of additional targeted outreach programmes for disadvantaged subpopulations who may fall through the cracks of universal services due to barriers influenced by income, education, residence, gender, income, ethnicity, working conditions or migrant status (WHO, 2016L; CSDH, 2008; WHO Regional Office for Europe, 2010). An example could be targeted measures in geographically remote areas (e.g. mobile health services – see Box 4) (WHO, 2016L).

- Effective methods for managing patient pathways, including efficient referral and back-referral systems backed by case management guidelines that account for potential geographic, financial and other barriers.

- Enhanced integrated service delivery, both within the health sector among care providers and in relation to social services required to address barriers to the health system (e.g. registration) and key determinants of health (e.g. nutrition, early child development, housing and employment). See the section on Governance, and Part IV on intersectoral action.

- Collaborating with stakeholders for health interventions to be delivered in alternative settings in the community. Scenario 2 showed the relevance of workplace health interventions, for example. Although less pertinent to the scenarios described, enhanced school-based interventions may also be a way to engage children (and potentially their families) in health promotion and health education activities.

- Potentially implementing cash transfer schemes as a method to empower disadvantaged communities, increase demand and uptake for health services, and modify health behaviours, while ensuring due attention is given to unintended consequences, financial sustainability and whether conditionality is required (WHO, 2011b).

- Strengthened patient rosters to understand the health needs of the population (to adapt service offer and implement population-based services) and to better meet patients' individual needs including through case management (WHO, 2016d). Patient rostering can enhance social accountability as it establishes a "contract" (even if implicit) between the registered patient (and/or community) and the health provider. Patient rosters can also include weights for social vulnerability, to reflect levels of disadvantage (see Box 4 for a Mongolia-specific example).

Box 4. Two examples of shifting the model of care to better serve disadvantaged subpopulations in Mongolia

Mobile health services

In 2015–2016, the "Improvement of mobile health services as part of the subnational health system strengthening approach in Mongolia" project was implemented through mutual collaboration between the Ministry of Health in Mongolia, WHO and Ministry of Foreign Affairs of the Czech Republic. While the main objective was to contribute to strengthening the subnational health system, project activities were directed towards providing methodological support and improving the legal framework for mobile health services to enhance access to health services for Mongolia's most remote rural subpopulations. One of outputs of the project was the study report "Mobile health services in rural Mongolia", which showed that the actual practices of mobile health provision in remote areas varied. Mobile health services are now almost routine, yet the coverage varies from 16–94%. The study recommends that the Government encourage mobile health services to reach rural remote subpopulations, thus contributing to the goal of universal health coverage by providing methodological, supervisory and financial support in collaboration with all stakeholders.

Following the study recommendation, the Ministry of Health – in collaboration with the project unit and WHO – updated and replaced the previous Ministerial Order for mobile health services (1999) with the new Ministerial Order #A/147 "Provision of healthcare through mobile health services" (29 April 2016). Related capacity-building materials for health workers were developed and trainings conducted. In addition, in 2016, mobile health service provision including application of mobile health (mHealth) technologies was promoted by WHO in five western aimags as well as in another seven aimags and three remote districts of Ulaanbaatar.

In keeping with the leaving no one behind principle, the project "Introduction of mobile health technology at the primary healthcare and community level in Mongolia" was implemented in Songinokhairkhan district (Ulaanbaatar) and Umnugobi province in 2016, with funding support from the Korea Foundation for International Healthcare and the Community Chest of Korea. A total of 14 242 people (including 2826 children aged under 5 years, 2642 children and adolescents aged 5–18 years, and 8774 adults) benefited from this project through receiving integrated health services and screening.

Reaching Every District

The implementation of the Reaching Every District strategy in Bayanzurkh district (Ulaanbaatar) offers important lessons in shifting the model of care from more facility-based services to active community outreach to identify and find people needing services who may be outside the system. For instance, health staff implementing Reaching Every District discovered that district mapping and "sample selection" of communities in high-risk areas were still missing some people. So, they deemed it necessary to go house-to-house in order to detect any vulnerable groups. One health team reported that after this switch in tactic, the team started to find unimmunized children. The increased numbers of families detected who required health and social services was described by the respondents as "unexpected." One nurse is available for each sub-khoroo (or "section"). Under the Reaching Every District strategy, the nurse walked each month through the sub-khoroo identifying new clients (normally dedicating 3 days a month). He/she did not provide services on these walks, but instead requested new clients to attend the health facility or come to the registration office. The person was registered at the health facility or governor's office after getting advice from a nurse, and the information was shared between the family health centre and the civic authorities enabling a newcomer to access basic health and social services in a new or temporary residing area. In addition to meeting community members in their homes, nurses liaised with nongovernmental organizations, section leaders and social welfare and registration staff at the khoroo governor's office to discuss the situation of the socially vulnerable. Nurses transmitted their monthly data to the district level where analysis was conducted on a quarterly basis. Data sheets recorded the names of staff members from the khoroo and numbers of new clients contacted, classified into target groups (e.g. the disabled, temporary residents or unregistered populations, the elderly or orphans without carers, single mothers, the unemployed, school drop-outs, unimmunized children and pregnant women not covered by antenatal care). A district health planner commented that their workload was previously focused on facility care, but that the Reaching Every District strategy had opened up the possibility to work outside the facility in the community.

Source: Lhamsuren et al., 2012; Ministry of Health of Mongolia, 2016; WHO Country Office for Mongolia, 2015, 2016a, 2016b, 2016c, 2017.

In settings with lower levels of public health sector coverage for essential services, authorities may consider outsourcing/subcontracting specific services in order to enhance availability (Chopra et al., 2012; Patouillard et al., 2007). Outsourcing/subcontracting can include single services, such as laboratory services, or complete clinics/primary health centres. Outsourcing can be done through providers including nongovernmental organizations, religious organizations or for-profit companies. While there are potential benefits in terms of enhanced service availability, unless an appropriately robust and well-functioning stewardship function is maintained by national health authorities, outsourcing to for-profit organizations can lead to health care that is driven by profit rather than the patients' best interests, with the risk of lowered quality and providers catering to the wealthiest or creating artificial demand (Patouillard et al., 2007; Roberts et al., 2004). If outsourcing is not properly coordinated with the public health system, there is also a risk of undermining public services and producing system fragmentation (Lagarde & Palmer, 2009). Regulation, management and planning are key in mitigating the potential adverse effects. Reporting/accountability systems need to be in place to ensure that the regulations are respected and that the service provides the desired results, also in terms of its equity impact (Gwatkin, Wagstaff & Yazbeck, 2005; Roberts et al., 2004).

In addition to outsourcing/subcontracting of essential services, partnerships can also be created to expand services that meet the needs of specific subpopulations; an example of this relates to elderly populations (e.g. for home-based care, transportation to health facilities). Again, the regulation, management and oversight of these partnerships are important to ensure accessibility (inclusive of affordability) of services as well as quality and safety, among other factors.

While covered in more detail later in this handbook (see Part V, Enhancing social participation), health service delivery also includes empowerment and measures to enhance agency to claim one's right to health. Participatory, community-based approaches are central to this. It is important that participation be enabled at macro (planning) levels, as well as at meso (service delivery design) and micro (shared decision-making) levels. Communities can also be actively engaged in the co-delivery of services or "community-delivered care", with potentially significant health gains (as seen in Prost et al., 2013, on women's groups addressing neonatal and maternity mortality).

Quality improvement approaches

Likewise, quality improvement approaches can serve as change levers for improving quality of the services rendered at subnational levels. Quality improvement approaches that could be included in operational planning are given below.

- National quality improvement policies and strategies can define the roles and responsibilities of subnational health authorities and health care facilities (such as hospitals, health centres and clinics, both private and public) in the domain of health services quality improvement. These could include the establishment of quality management teams at the different levels of the health system.

- Subnational health authorities and health care facilities can put in place mechanisms to assess patient satisfaction and experiences, and receive and monitor complaints. These could include patient satisfaction surveys, an ombudsman, exit interviews, complaint boxes, and so on. Findings will form the basis from which to identify quality improvement activities.

- Advancing decentralization and de-concentration will require establishment of health governance structures at subnational level (e.g. province and district health boards, hospital boards, health centre management committees). Terms of reference for these governance structures should contain their responsibilities in the domain of health services quality improvement. These include addressing the findings of different patient satisfaction or patient experience assessments, as well as following up on patient grievances and redress mechanisms. Composition of the structures should ensure representation of different groups of stakeholders from government and civil society (including youth, women, traditional and religious organizations) who can play an important role in community engagement.

- Development of mechanisms for accreditation of health care facilities and health workers, and regular conducting of the related assessments as a basis for providing or withdrawing accreditation.

- In the context of the above proposed subnational health services quality improvement structures and responsibilities, much can be learned from targeted quality improvement assessments of subnational health authorities and health care facilities. Lessons and recommendations on the functioning of those structures and their interlinkages can feed into operational planning and possible strategy revisions.

Essential medicines (and technologies and equipment)

The scenarios described (involving Dorj and Tulga) point to opportunities to:

- improve the availability and financial accessibility of medicines at different levels of the public health system, with due attention to the availability of medicines that match the burden of disease most prevalent in the area;
- enhance capacity for overall regulation of medicines;
- assess traditional medicine approaches and providers, including for quality and their liaison with parts of the conventional health system, and to take measures to prevent self-prescription of medicines;
- improve capacity of local health posts (including necessary medical equipment and its maintenance) in rural and remote areas.

Availability and accessibility of essential medicines

Lack of or inadequate availability and access to essential vaccines, medicines and medical equipment is a global health problem, and one that strikes poor and more disadvantaged populations the hardest. WHO publishes an updated list of medicines deemed fundamental for a complete health system; however, in many settings coverage of the medicines is low due to limited availability, high prices and (in some cases) cultural factors (WHO, 2015c; Bigdeli et al., 2012; United Nations, 2015).

In Mongolia, a field study to measure the price, availability, affordability and price components of selected medicines was undertaken in 2012, using a standardized methodology (Ministry of Health, 2012). Findings showed that mean availability of generic medicines was suboptimal: availability levels were 42.8% in the public sector (essential medicines only), 73.0% in the private sector (all medicines) and 60.0% in Revolving Drug Fund outlets

(essential medicines only). Despite being on the essential medicines list, some important noncommunicable disease medicines had low availability in all three sectors and were far below WHO's target of 80% availability. The same study found that in terms of affordability, lowest priced generics had a median price ratio of 2.24 (124% more than the international reference price), with higher rates in the private sector (about 85% higher-priced in the private sector compared to the public sector). With regard to affordability of standard treatment regimes (including those for noncommunicable diseases, which represent a large proportion of Mongolia's burden of disease), some treatments would be unaffordable even when purchasing lowest priced generics (Ministry of Health, 2012).

Globally, medicines make up a large share of out-of-pocket expenses both for patients and health budgets. Saksena et al. (2010) studied 39 low- and middle-income countries and found that consultation only accounted for around 22% of outpatient out-of-pocket expenditures at public providers and 40% at private. The biggest expense was medicines, accounting for 57% of out-of-pocket expenditure at public providers and 45% at private. Out-of-pocket expenditure is regressive and can have negative impacts across the social gradient, posing particular challenges for the poor and near-poor as well as potentially impoverishing some more well-off individuals (Murray et al., 2002). Adding to the problem, patient prices for the lowest priced generics are generally higher in the private than the public sector and, as availability is generally better in the private sector, many patients are forced to pay more (United Nations, 2015).

In many countries, the high price of medicines is due to inadequate pricing policies and governance over the supply chain, including lack of generic medicines

policies, price-setting mechanisms and control of mark-ups. Policies for generics and active purchasing can decrease costs, as can removing taxes and duties, and regulation and monitoring of mark-ups in combination with publicly available lists of medicine prices (WHO, 2010d). Efforts to improve affordability should be combined with measures to enhance public sector availability of medicines appropriate to the local burden of disease. This may mean better selection of medicines, more efficient procurement and supply chain management, and tackling bottlenecks in the supply chain linked to other health system functions; an example would be shortage of funds at health centres and staff issues (e.g. low motivation for improvement, poor recordkeeping and oversight) that influence unreliable and inefficient supply of medicines (Wales et al., 2014). Improved transparency in the pharmaceutical system can empower stakeholders to know their rights with regards to access to affordable medicines of good quality and can improve confidence in government institutions.

In addition to addressing issues of accessibility and availability, it is important to tackle issues linked to inappropriate use of medicines (such as self-medication) as well as substandard and counterfeit medicines (WHO, 2010d). Reducing unnecessary expenditure on medicines, using medicines more appropriately and improving quality control could save countries up to 5% of their health expenditure (WHO, 2010d). Globally, irrational use of medicines is widespread and can include harmful medicine mixtures (polypharmacy), the overuse of antibiotics and injections, failure to prescribe in accordance with clinical guidelines or inappropriate self-medication (WHO, 2010d). Incorrect medication also leads to drug resistance and causes harm through side-effects (WHO, 2010d).

Medical equipment

Medical equipment includes all types of devices used in health care, from tongue depressors to magnetic resonance imaging (MRI) scanners. Medical equipment has been identified as an indispensable component in health care by WHO (WHO, 2007b). Lack of access to medical equipment, either due to its unavailability or lack of maintenance or personnel to use it, is widespread; around 50% of all medical equipment in developing countries is unused (WHO, 2007a). From an equity standpoint, equipment (and the usage thereof) is often expensive and tends to disproportionally benefit the wealthier population, thus driving health inequities (WHO, 2011c).

In rural and remote areas, shortages of necessary medical equipment and insufficient regular maintenance can exacerbate challenges that poorer subpopulations already face in accessing services. To address this issue in Mongolia, the Government and WHO are collaborating for the introduction of mobile health (mHealth) technologies, including wireless-enabled portable medical equipment at primary health care level for prevention and control of major communicable and noncommunicable diseases (WHO Country Office for Mongolia, 2016a). Technologies which are being piloted or for which piloting is planned include android blood pressure monitoring, portable electrocardiography

and portable ultrasound equipment along with information and communication functionalities, data storage, retrieval and utilization for screening, diagnosis and management of chronic noncommunicable diseases as well as antenatal care. This is being done at selected soum and family health centres, including baghs (sub-soums), in selected aimags/provinces and in remote districts of Ulaanbaatar (WHO Country Office for Mongolia, 2016b).

Regulation on medical equipment is present in less than half of all countries (WHO 2013b). From a governance perspective, data on usage and disease burden of affected populations are needed, after which policies for equipment that prioritize prevention and primary health care in respective settings should be created, as with all forms of health system strengthening (WHO, 2011c). Policies need to include improved education on usage and maintenance (in the case of advanced technologies) and platforms for support from the industry (WHO, 2013b).

Infrastructure and maintenance

Other aspects to consider are the infrastructure and maintenance processes needed for the health system to run: reliable supply of electricity, vehicles, communication technologies, improved water supplies and adequate sanitation facilities, as well as reliable systems for

regular maintenance. As with all forms of input into the health system, unreliable supply causes efficiency losses and lowered capacity, translating into lower coverage, which without interventions to prevent it will affect more disadvantaged subpopulations the most. For example, power shortages can render thousands of vaccine doses unusable or risk the outcome of a surgical intervention (Adair-Rohani et al., 2013). A second example is the insufficient number of emergency vehicles and long-distance ambulances in rural and remote areas in many countries. A third example is the lack of water and sanitation in health facilities in many locations globally, which jeopardizes the quality of interventions and health outcomes, exposing patients to unintended risks (WHO/UNICEF, 2015). According to the Joint Monitoring Programme (UNICEF and WHO, 2015), 64% of the Mongolian population has an adequate supply of drinking water and 60% has improved sanitation facilities. In 2013, Mongolia adopted water, sanitation and hygiene (WASH) design requirements for the construction and rehabilitation of health care facilities, using WHO standards as a basis. In addition to infrastructure requirements, the Mongolian standards highlight operation and maintenance processes, health care waste management procedures and infection prevention and control measures (WHO/UNICEF, 2015).

Human resources

In considering the barriers to effective coverage that are experienced by disadvantaged subpopulations, one must consider the role of human resources in the health sector (and linked social sectors) in responding to these, as well as the potential impact of changes in other areas of the system on human resources. Progressive universalism requires a corresponding focus on leaving no one behind in the governance and management of the health workforce, including its stock, skill mix, distribution, productivity and quality (Campbell et al., 2013). The WHO *Global strategy on human resources for health: workforce 2030* (WHO, 2016f) represents an opportunity to design and implement health workforce strategies that address the equity and coverage gaps faced by disadvantaged subpopulations.

Within this context, the scenarios featured earlier (of Dorj and Tulga) highlight the salience of human resource issues to ensure that no one is left behind, including:

- improved capacity of primary health care workers and other local health post staff, including through pre-service and in-service education;
- measures to ensure attraction, recruitment, deployment and retention of the necessary cadre of staff at different levels of district and provincial care, including in rural/remote and other disadvantaged areas;
- engagement of the appropriate cadre of health workers (whether they be local health post staff or culturally competent community workers) in community-based health promotion and prevention;
- improved ability of health workers to provide culturally competent/non-discriminatory and gender-responsive services, through integration of this in pre-service and ongoing training.

Globally, additional and linked approaches to strengthen human resources for leaving no one behind can include (but are not limited to): strengthening governance and stewardship capacity and information systems for human resources for health, optimizing scope of practice and skills mix of the health workforce, addressing migration of health workers, challenging gender discrimination in the workforce, recruiting ethnic minorities into the health workforce, and enhancing the cultural competencies and gender-responsiveness of all health workers. Ideally, these issues will be reflected in a national health sector human resources plan (WHO, 2011d). Governance and stewardship capacity and information systems for human resources for health are particularly important in the context of the development of a national human resources for health strategy, and will influence how the strategy as a whole incorporates a leaving no one behind focus.

Interprofessional primary care teams

Some important barriers to services experienced by disadvantaged subpopulations require improved deployment of interprofessional primary care teams of health workers with broad-based skills, avoiding the pitfalls and cost-escalation of overreliance on specialist and tertiary care. The WHO Global Strategy on human resources for health (WHO, 2016f) recognizes that addressing population needs for the SDGs and universal health coverage requires a more sustainable and responsive skills mix through interprofessional primary care teams, harnessing opportunities from the education and deployment of community-based and mid-level health workers.

A more rational distribution of tasks and responsibilities among cadres of health workers is seen as a promising strategy for improving access and cost-effectiveness within health systems. For example, access to care may be improved by building the capacity of mid-level and "lay" health workers to perform specific interventions that might otherwise be provided by cadres with longer and potentially specialized training (WHO, 2012b). Optimizing skills mix is a means of implementing the principle that care should be provided at the lowest possible effective level, without compromising quality or creating financial inefficiencies. This approach holds potential to release human resources, increase economic efficiency and ultimately increase coverage for a programme (potentially addressing availability barriers) (Byrne et al., 2014; Fulton et al., 2011). Challenges when designing and implementing policy options to optimize the skills mix primarily include the risk of losing quality of care and institutional resistance, including from cadres of professionals who feel their roles are compromised/threatened by the arrangement. Examples of the latter include doctors not wanting to lose profitable and simpler tasks, or nurses that do not consider supervising community health workers as part of their assignment (Callaghan, Ford & Schneider, 2010; Fulton et al., 2011).

Strategies to optimize tasks and roles for the implementation of effective interventions have achieved variable success (WHO, 2012b). This is partly because the effects of these strategies are dependent on varying local health contexts and are shaped by a range of often very different social, political and cultural systems (WHO, 2012b). While many case-studies show that delegating tasks to lower levels of staff has no or even positive impact on quality, there are also cases where the care provided has been inadequate. To tackle this, the tasks selected for delegation must be chosen in accordance to the experience and training of staff; in general, simpler tasks can be delegated more easily. On the same topic, adequate supervision and training is essential for successful outcomes (Fulton et al., 2011).

Community health workers have the potential to increase availability as well as demand and acceptability of services, potentially reducing inequities (Perry, Zulliger & Rogers, 2014; Perry & Crigler, 2014). Community health worker systems also result in financial savings to the health system and yield additional societal benefits, including empowerment of women and increases in income for households of paid community health workers (Dahn et al., 2015). One challenge in the use of community health workers may be that they are recruited, but their role is not officially recognized nor supported through adequate measures. Additional challenges in using community health workers are similar to other forms of task shifting and community-based approaches – a risk of lowered quality of care if the tasks delegated are not chosen correctly and adequate supervision is not given to the health workers. Generally, adequate resources and competence for supervision and management can mitigate these issues (Fulton et al., 2011; Roberts et al., 2004).

A critical first question when considering the introduction of a new cadre, including community health workers, is whether the tasks required (e.g. expanding coverage to those being missed) could actually be achieved by optimizing the number and skills of, and inputs provided to, an existing health cadre without risk of overburdening, compromised quality and/or inefficiencies. Only if the community health worker cadre can fill a unique role with clear added value should the option be pursued. This is because the process of establishing this new cadre requires attention (as part of a coherent national human resources for health strategy) to a range of issues, including: clear

selection criteria for community health workers, clear task definition, accreditation processes, supervision mechanisms and standard procedures for their integration/interaction with other health professionals, ongoing capacity-building and career pathways, adequate reimbursement and incentives, clear indications on how they will access supplies needed for their work, and approaches to enabling their voices to be heard in health sector planning, review and monitoring and evaluation processes (Zulu et al., 2014; Perry & Crigler, 2014; WHO Regional Office for Europe, 2010).

Attention also needs to focus on not creating cadres that are unintegrated or are only partially integrated into the health system. While unintegrated community health workers may have a positive impact on some health indicators in the immediate term, the long-term sustainability implications need to be considered in the context of coherent health system governance (Zulu et al., 2014). Higher levels of integration of this cadre into the official health workforce and existence of human resource policy on community health workers have been cited as factors influencing their performance (Kok et al., 2015). This cadre may also face specific needs with regard to its integration and reinforcing its legitimacy with the target populations. In addition to resistance from other health workers, they may face discrimination based on social, gender and economic status, disease-related stigma by community members, as well as safety and security concerns (Kok et al., 2015; Zulu et al., 2014). The Global Strategy on human resources for health calls for developing a national policy to integrate community-based health workers, where they exist, into the health system so as to enable them to benefit from adequate

health system support and operate more effectively within integrated primary care teams (WHO, 2016f).

Increasing access to health workers in remote and rural areas

While optimization of skills, roles and use of community health workers can enhance accessibility and availability of some health services, it is not a substitute for addressing critical shortages of needed cadre in rural and remote or other disadvantaged areas. Hence, attention needs to be given to effective policies for attraction, recruitment and retention. Lehmann, Dieleman & Martineau (2008) reviews 55 articles for the reasons behind staff shortages in rural, low- and middle-income settings. While low wages, poor working conditions, lack of supervision and lack of equipment/infrastructure were found to be common barriers to staffing, their strongest conclusion was that reasons for leaving/unwillingness to work in a rural area are complex and often largely consist of concerns regarding living conditions and infrastructure (housing, schools, roads, etc.).

WHO provides evidence-based guidance on increasing access to health workers in remote and rural areas through improved retention (WHO 2010e; Buchan et al., 2013); a summary is given in Box 5. The guidelines offer a holistic and intersectoral approach, providing evidence-based recommendations on educational issues (e.g. recruitment of rural students and rural training), regulatory strategies (e.g. mandatory rural service periods), financial incentives and personal/professional support (to make it more attractive) (WHO, 2010e; Grobler et al., 2009).

Box 5. Recommendation areas for increasing access to health workers in remote and rural areas

Education

Recommendations include measures such as targeted admission policies to enroll students with a rural background; placing health professional schools, campuses and family medicine residency programmes outside of capitals/cities; exposing undergraduate students of various health disciplines to rural community experiences and clinical rotations; revising undergraduate and postgraduate curricula to include rural health topics; and ensuring continuing education and professional development programmes that meet the needs of rural health workers.

Regulatory strategies

Recommendations include introducing regulated enhanced scopes of practice in rural and remote areas to increase the potential for job satisfaction; introducing different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practising and reinforce interprofessional primary health care teams in rural and remote areas; ensuring compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives; and providing scholarships, bursaries or other education subsidies with enforceable agreements of return of service in rural or remote areas.

Financial incentives

This involves a combination of fiscally sustainable financial incentives (hardship allowances, grants for housing, free transportation, paid vacations, etc.) sufficient enough to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers, to improve rural retention.

Personal and professional support

Recommedations involve improving living conditions for health workers and their families and investing in infrastructure and services (sanitation, electricity, telecommunications, schools, etc.) as part of a broader rural development strategy; providing a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring; identifying and implementing appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas, and, where feasible, using telemedicine to provide additional support; supporting career development programmes and providing senior posts in rural areas, so that health workers can move up the career path without necessarily leaving rural areas; supporting the development of professional networks, rural health professional associations, rural health journals, etc., to improve the morale of rural providers; and adopting public recognition measures such as rural health days, awards and titles to lift the profile of working in rural areas.

Source: WHO, 2010e.

International migration of health workers

To overcome key barriers to services related to shortage of adequately skilled staff, in some country contexts it is very important to tackle issues of international migration of health workers (Aluttis, Bishaw & Frank, 2014). The WHO Global code of practice on the international recruitment of health personnel (WHO 2010f) stipulates that regulations and international cooperation are necessary to mitigate the negative effects of international migration of health workers on health systems in low- and middle-income countries. The code of practice encourages national governments to recognize the consequences and ethical aspects of unilateral migration. It encourages receiving countries to strengthen the domestic health system and reduce reliance on foreign-trained personnel, cooperate for human-resource sustainability (with emphasis on the emigration side) and facilitate circular/bilateral migration.

Addressing inequalities in the health workforce

Globally, women are currently the main providers of health care including in humanitarian crises and conflict settings. Yet gender biases, physical and sexual violence, and harassment remain important challenges for health workers (WHO, 2016k). Leaving no one behind means tackling gender inequalities within and beyond the health sector, including those experienced by health workers. In fact, addressing gender inequalities in the workforce can improve the capacity of the system to tackle broader inequalities that may be limiting access to services. Increased gender equality in the workforce improves performance by maximizing capabilities of workers. It also improves gender equity in the care provided and health outcomes, thus contributing to reduced gender-related health inequities (Newman, 2014; WHO, 2010g).

Gender discrimination (often against women) in the health workforce takes form as differences in wage, opportunities and consequently representation at higher organizational levels; inability in the system to manage life-course events such as pregnancy; negative stereotypes or stereotyping into certain "caretaking" functions; harassment; and perceptions of lower quality of life among female health workers (WHO, 2010g; Newman, 2014; George, 2007). Typical "female" tasks are also devaluated, as illustrated by a clear inverse relationship between share of female workers in a specific cadre and salary (Newman, 2014). Good human resources for health practices include recognizing the gender diversity of health workforces; acknowledging gender constraints and opportunities; eliminating gender discrimination and equalizing opportunity, starting from entry requirements into pre-service education and all the way through health workforce education, deployment, management and career advancement; making health systems responsive to life-course events; and protecting health workers' labour rights at all levels (Newman, 2014). Policies on sexual harassment and employee abuse may also be relevant (WHO, 2011d). In support of these actions, the High-Level Commission on Health Employment and Economic Growth (WHO, 2016k) specifically called for maximizing women's economic participation and empowerment through institutionalizing their leadership, addressing gender biases and inequities in education and the health labour market, and tackling gender concerns in health reform processes.

Discrimination may also be experienced based on race, ethnicity and other factors, serving as a perceived and real barrier to services. Globally, ethnic minorities (including indigenous people) are often underrepresented in the health workforce, particularly among certain cadre. Besides the direct inequity in terms of lost opportunities for affected individuals, lack of representation of these subpopulations in the health workforce can lead to lowered trust, less adherence to care and lower satisfaction among the underrepresented groups (Cooper & Powe, 2004; Curtis et al., 2012). Addressing this underrepresentation is particularly important at subnational levels where the proportion of the ethnic minority population can be quite high in some geographical areas.

Underrepresentation in the health workforce can be considered a consequence of cross-societal social exclusion; hence, there is a need to address the deeper societal inequities while directly increasing enrolment and completion by ethnic minorities of educational tracks for health careers (Sullivan, 2004; Curtis et al., 2012). This should be coupled with measures (across the system) to ensure that those who enter the health workforce do not experience discrimination, distrust, social exclusion and lack of professional opportunities (Cooper & Powe, 2004; Curtis et al., 2012). Ensuring appropriate representation of ethnic minorities is linked to a wider move towards cultural competency of the health system, in which health professionals – when interacting with each other and with patients – take culture and anti-discrimination into account to enable equitable care to be given regardless of cultural background (Betancourt et al., 2003).

In order to enhance the capacity of the health workforce as a whole to address gender-, income-, ethnicity-, education-linked and other health inequities, training on these should be conducted in pre-service and ongoing education programmes for health staff (WHO, 2011d; CSDH, 2008). Such training can build capacity for the creation of gender-responsive, rights-based and equity-oriented programming that can overcome the barriers experienced by disadvantaged subpopulations.

Financing

From a person-centred perspective, certain factors can influence the perceived and real affordability of services; some subpopulations do not access services or complete treatment as a result, or suffer financial hardship as a result of use (WHO, 2010d; WHO Regional Office for Europe, 2010). These issues include:

- inhibitive or impoverishing formal user fees or informal payments (in-kind or monetary) across different levels of care;
- inhibitive or impoverishing costs of medicines;
- inhibitive or impoverishing costs of laboratory tests and examinations;
- indirect costs of travel and accommodation (or food/supplies while hospitalized);
- opportunity costs, e.g. linked to missed work (more serious for chronic diseases) or child/elderly care;
- barriers to financial protection that are linked to other factors, e.g. lack of registration in local area or of identification/birth certificate, irregular migrant status, barriers imposed by working in informal sector or having a precarious work contract, non-eligibility for social protection benefits due to being missed by means-testing methods, etc.;
- affordability of the health insurance premium, which can disproportionately impact self-employed, unemployed and poor subpopulations.

In response, critical issues relevant to health system financing for progressive universalism include financial protection, equity in financing and use, quality, and efficiency improvements (WHO, 2016e). Transparency and accountability are also important issues for health system financing (which are explored in more detail in the subsequent section on Governance). The following explanations of these concepts are taken from the WHO health financing country diagnostic guidance document (WHO, 2016e).

- *Financial protection* refers to funding health services in a way that protects individuals and
- households from "financial ruin" or adverse effects on their economic livelihood as a consequence of paying for health care. Such adverse consequences are typically, but not exclusively, due to out-of-pocket spending.
- *Equity in finance* is strongly related to the goal of financial protection, but is conceptually distinct. Equity in finance refers to the distribution of the burden of financing the health system across different socioeconomic groups. To be considered equitable, the burden of health financing should be distributed according to individuals' ability to pay.
- *Equity in service use* is enabled by reducing the gap that exists between the need for a health service and the actual use of that service. Financial protection has a role in this since, to reduce the gap, people must not be deterred from seeking treatment because of the feared costs, whether direct or indirect. There must also be awareness by individuals of their need for health services as well an ability to use the required services.
- *Quality* (see the definition in the Introduction) refers to the extent to which health services achieve desired health outcomes or improve health status. Quality is linked to equity in the distribution of resources (financial, physical infrastructure, human resources, equipment, drugs and other medical supplies), and this distribution can be influenced by health financing policy. The effective actual distribution can also be influenced by absorption capacity, particularly in disadvantaged areas.
- *Efficiency improvements* can promote financial protection and equitable utilization of health services. Efficiency implies that resources should not be wasted, but instead that the lowest cost combination of service inputs (e.g. health workers, drugs, etc.) should be

pursued to provide effective and good quality services. It also means that services should be provided at the lowest possible level of the health system (i.e. if a patient can be effectively treated at the primary care level, they should not be treated at a central hospital).

Financial protection and equity in use

In Mongolia, and related to financial protection, the share of out-of-pocket payments in the total health expenditure increased sharply from 12% in 2000 to 35% in 2012 (WHO Country Office for Mongolia, 2016c). Reducing out-of-pocket payments is important for minimizing catastrophic and impoverishing health expenditures. In 2009, an estimated 3.8% of total households in Mongolia experienced catastrophic health expenditures, spending more than 40% of their subsistence income on health (Bayarsaikhan, Chimeddagva & Kwon, 2015). As mentioned in the Introduction, a study by Dorjdagva et al. (2016) using data from the Household Socio-Economic Survey 2012 suggests that about 5.5% of households suffered from catastrophic health expenditures that year, when the threshold level for catastrophic expenditure is 10% of the total household expenditure. Across countries, reducing out-of-pocket payments is a priority in reforms towards universal health coverage; it benefits the poor the most and hence also reflects a progressive universalism approach to reforms (WHO, 2016e). WHO recommends that health systems should predominantly rely on public funding to move towards universal health coverage and decrease inequities (WHO, 2005b; WHO, 2010d; WHO, 2015e).

Medicines and medical supplies account for the largest share of out-of-pocket payments among all quintiles in Mongolia (WHO Country Office for Mongolia, 2016c). Households in the lowest expenditure quintile spent 76% of out-of-pocket payments on medicines in 2012 (WHO

Country Office for Mongolia, 2016c). Reducing out-of-pocket expenditure will therefore require addressing its driving factors, including the irrational use of medicines and pricing practices, as well as insufficient private sector regulation that has contributed to cost escalation and growing pressure on all revenue sources (Bayarsaikhan, Chimeddagva & Kwon, 2015). In addition, consumers may not always be aware of their service benefits and co-payment obligations under health insurance and government health budgets, and this can potentially result in patients paying out-of-pocket even for publicly funded health services and medicines (Bayarsaikhan, Chimeddagva & Kwon, 2015).

With regard to equity in use, benefit incidence analysis can help show whether public funding for health care is more pro-rich or pro-poor. Evidence from Mongolia for 2012 suggests that the highest income quintile benefitted from the public subsidy for health care twice as much as the lowest income group (WHO Country Office for Mongolia, 2016c). According to data from the Mongolia Household Socio-Economic Survey 2012, the poorest 20% of the population received only 13% of government resources spent on health, while the richest 20% received 24% of government spending for the sector. Findings also show that poorer populations mostly use primary health care facilities rather than specialized centres and clinical hospitals at tertiary care level, and that they attend soum and family health centres twice as much as the richest people (WHO Country Office for Mongolia, 2016c). The rich, on the other hand, have greater access to central clinical hospitals and specialized centres (WHO Country Office for Mongolia, 2016c).

Indirect costs

From the scenarios described earlier (of Dorj and Tulga), and also related to

financial protection, the need emerges for strengthened measures to address potentially inhibiting costs of travel/family support/accommodation during referrals to higher levels of care. Indeed, global evidence on why people do not complete treatment for chronic diseases shows that transport costs and lost income can be even more prohibitive than service charges (WHO, 2010d). A study of 39 low- and middle-income countries found that transportation costs made up to 12% of out-of-pocket expenditures, with wide variations between and within countries (Saksena et al., 2010). Tackling indirect costs can be done in different ways and in a staged manner; approaches include strengthening and extension of primary health care, possibly including (or having as intermediate measures) mobile health units, transportation vouchers and cash transfers (e.g. for attending antenatal consultations), acknowledging that the latter intervention requires rather elaborate mechanisms for administration and control (WHO 2010d). WHO recognizes that local, community-based fund-pooling initiatives (for financial protection from direct or indirect costs) may be temporarily beneficial in settings with very weak public health funding, but should not be seen as an alternative to system-wide public funding by authorities in countries like Mongolia, as the impact is usually limited and difficult to scale up, and they risk contributing to fragmentation in financing approaches (WHO, 2015e). Therefore, improving and expanding existing health/social insurance and social assistance programmes, e.g. including coverage of indirect costs such as transport within a benefits package, may be a way to address financial protection without contributing to fragmentation.

Public finance planning, management and use

In relation to health financing for ensuring quality, the scenarios of Dorj and Tulga

highlight the issue of inadequate/insufficient financial allocations to health posts to meet the emerging needs of subpopulations in their designated area. In Scenario 2, the local health centre was overwhelmed by population growth and the number of unregistered persons needing care, which had not been accounted for in financial allocations. Progress for integrated people-centred health services, in particular for the most disadvantaged subpopulations, will not be achieved without improvements in public finance planning, management and use. Alignment of provider payment methods and financial incentives to health service provider performance and results is also required. Recently, the option of moving away from line budgeting and/or fee-for-service payment to mixed payment systems (e.g. partial capitation with some fee for priority services of high effectiveness and public health importance) has been discussed (WHO, 2016d). Through patient rostering where levels of vulnerability (poverty, remoteness, lack of registration) are also accounted for, it may become evident that in some areas health services require additional funds as needs are greater in those areas.

Due attention must be given to absorption capacity for financial allocations in disadvantaged areas, as this can also influence quality. Absorption capacity can be limited in several ways, relating to managerial capacity, insufficient accountability mechanisms in the system, and inefficiencies in infrastructure and governance. Across country contexts, inadequately trained or lack of human resources in administration, planning and management; unstable and weak institutions; and poor infrastructure both in the society (e.g. roads, electricity, water) and in the health sector (e.g. equipment, buildings) can create bottlenecks that limit absorption (Jamison et al., 2006). Avoiding bottlenecks due to inadequate absorption capacity requires a system-wide

understanding of the situation (Gottret & Schieber, 2006). Disadvantaged areas tend to have more of these compounding characteristics than other areas, and hence attention to absorption capacity issues will require deliberate concerted action to maximize the contribution of health financing to delivery of quality services.

When considering what can be done at subnational level to strengthen health system financing for progressive universalism in any given country, it is important to consider the extent of decentralization and the decision-making responsibilities at different levels. Subnational health authorities benefit from knowing the current status of equity in financing and financial protection coverage in their province, and who is being missed and/or is receiving insufficient financial protection in relation to needs. Likewise, subnational health authorities' understanding of national and local health financing arrangements and implications on equity in use and quality (including in relation to absorption capacity issues) can lead to remedial actions both through provincial planning and through advocating for adjustments at national level as necessary. Finally, efficiency improvements as well as transparency and accountability in terms of how funds are spent are areas where subnational health authorities can play a critical role, and should be reflected in planning.

Costing approaches

To leave no one behind in the SDGs, ministries of health and subnational health authorities need to have information and influence over decision-making to ensure the required funds for health. Measures for progressive universalism will entail a shift in what is costed, while also incorporating more equity-oriented, gender responsive and rights-based approaches. WHO has undertaken work to estimate the resources needed to strengthen health systems performance towards the attainment of the health-related SDGs targets (WHO, 2017b). Advanced modelling methods are being applied to look at resource needs, bottom-up by country and year, for 67 low- and middle-income countries for 2016–2030. The analysis will project the costs, estimated health impact and anticipated financing gap for the 67 countries (which are grouped according to their development and health system context i.e. fragile state, foundation, institution and transformation countries). Equity is recognized as a central concept within this analysis, and modelling will account for shifting from a service delivery model towards a close-to-client primary health care model, extending community and outreach strategies and other health system strengthening approaches discussed in this section.

Governance

Leadership and governance involves ensuring that a strategic policy framework exists and is combined with effective oversight and management, coalition-building, regulation, attention to system-design and accountability (WHO, 2014a). Subnational health authorities have a critical role in and within these functions to enable a focus on leaving no one behind. In the context of resilient health systems, the leadership and management capacity of provincial and district teams is particularly important for ensuring system performance, including in relation to coverage, equity and quality of care, as well as in liaising with other sectors to address health determinants (WHO, 2016j). The roles and capacities of subnational health authority management teams can be revised to include implementation of a coherent approach to leaving no one behind, including in relation to understanding the barriers disadvantaged subpopulations face and adapting the system to overcome them (WHO, 2016j).

Fig. 4 (based on Brinkerhoff & Bossert, 2008 and 2013) highlights three categories of actors – politicians and policy-makers, providers, and clients/citizens – and the connections between them that establish the pathways through which health governance becomes operational. This figure can be useful to both national and subnational health authorities when diagnosing underlying incentive and performance problems related to governance, and when looking for leverage points for adopting and managing the changes required for a leave no one behind approach. In this section, the triangle is discussed mainly in terms of relationships within the health sector. Governance for intersectoral action is looked at in Part IV.

The arrows in the figure show the relationships between the actors. The subsections that follow explore these relationships and, selectively, their implications for leaving no one behind, as well as identify some action areas for consideration. In reading through these, it may be useful to keep in mind the need to avoid "one-size-fits-all" good governance prescriptions that may not reflect local context; adapt reforms to existing capacities; recognize that governance has both formal and informal dimensions; and pay attention to sociopolitical differentials and dynamics (Brinkerhoff & Bossert, 2013).

Fig. 4. Health system governance actors and pathways
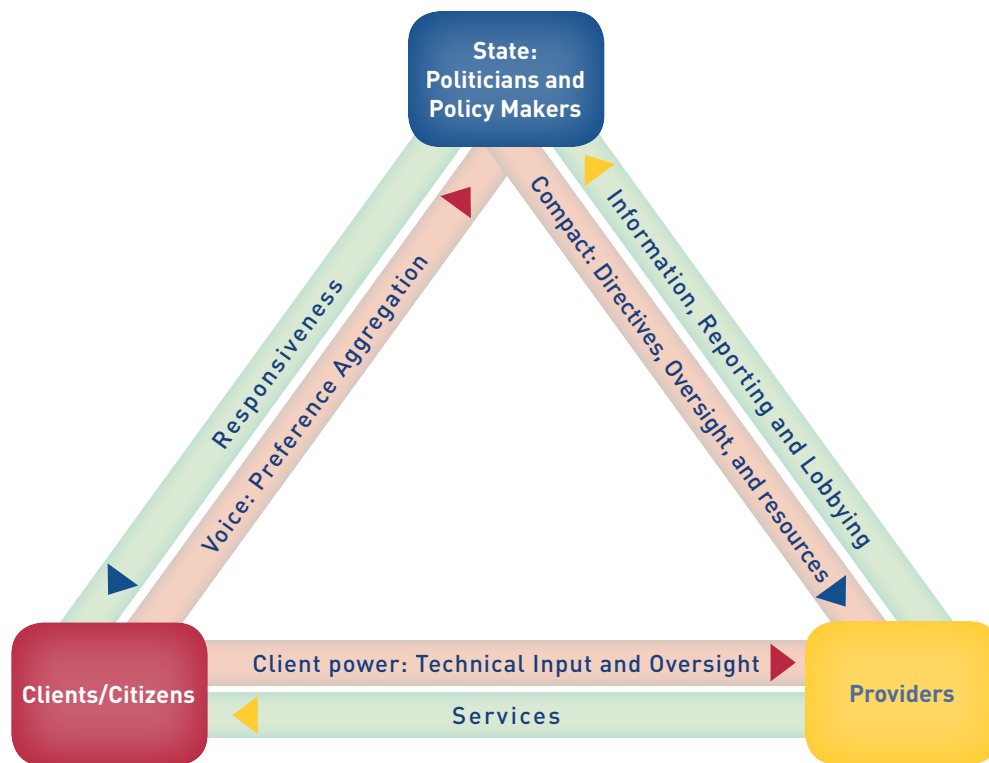
Source: Brinkerhoff & Bossert, 2008, 2013, adapted from World Bank 2004 & 2007.

---

[5] In WHO (unpublished 1). Health system governance actors and pathways in relation to accountability, transparency, participation and information. By: Bigdeli M, Department for Health Systems Governance and Financing, WHO/headquarters.

Currently, WHO is elaborating how – across each set of arrows – the transversal dimensions of accountability, transparency, participation and information can be considered.[5] Accountability refers to the ways in which there can be public scrutiny of the extent to which the health system delivers what is promised or achieves its goals, and the use of public funds (WHO, 2016e). Transparency facilitates progressing towards universal health coverage in that it increases individuals' awareness of their health rights or entitlements, and empowers them to exercise these rights (WHO, 2016e). Participation – in particular social participation – looks at how the population is involved in policy and programming across the cycle of needs assessment, planning, implementation and monitoring and evaluation. The paragraphs that follow take into account the transversal dimensions of accountability, transparency, participation and information in relation to leaving no one behind.

Governance and the relationships between population and state actors

In Fig. 4, the arrow from population (clients/citizens) to state actors highlights the feature of "voice" as an expression of needs, preferences and demands. From politicians to the population, the arrow represents the "responsiveness" feature, indicating the extent to which those needs, preferences and demands are responded to by state actors.

In considering the subpopulations being left behind and barriers that they face in attaining effective coverage, provincial and district health authorities may wish to reflect on how voice and responsiveness are being facilitated through current governance approaches. Are there platforms for enabling social participation of disadvantaged subpopulations so that their needs, preferences and demands can be incorporated into planning

and programming? (This issue will be looked at in detail in Part V, Enhancing social participation). Likewise, are there mechanisms and approaches for ensuring responsiveness? For instance, grievance redress mechanisms can help ensure responsiveness by providing staff with practical suggestions/feedback and assessing the effectiveness of internal organizational processes (World Bank, 2011). Such mechanisms also empower voice through generating public awareness about services and increasing stakeholder involvement, while also leveraging client power and having impacts on deterring fraud/corruption and mitigating risk (relevant to other dimensions of Fig. 4, as discussed below).

Governance and the relationships between providers and clients/citizens

Along the arrow from population to providers, the figure features client/patient power, which can differ between subpopulation groups. With regard to the subpopulations being missed, it is relevant to consider how they – due to their lower socioeconomic position, sex and experience of gender norms, lack of local registration, residence in a marginalized area, or employment in the informal sector – may have fewer resources and capacities for leveraging client/patient power than persons from more affluent/socially privileged backgrounds. In addition to formal mechanisms for leveraging client/patient power (such as grievance redress mechanisms or patient advocacy groups), there may also be informal mechanisms available. In considering reforms, it is important to be cognizant of informal mechanisms and their impact on health equity. For example, informal payments (cash or in-kind) usually imply patients paying providers "under the table" to bypass the queue, to get better care, or to be helped at all. These payments can create economic barriers to services and undermine efforts to leave no one behind.

The reasons behind informal payments are complex. For example, salaries or funding might be too low to live off or to run the health facility, creating a need for informal payments to keep it running (WHO Regional Office for Europe, 2014a). Governance and accountability tends to be weak in settings with widespread informal payments, opening up possibilities of both choosing to pay and choosing to accept (Lewis, 2007). By strengthening awareness of entitlements (through information provision and social participation) and accountability and transparency measures, the informal power relationship changes between patients and health providers. These measures can be coupled with those that address other underlying reasons for informal payments, including insufficient wages or health facility funding.

The arrow from providers to population (clients/citizens) features services. From the perspective of leaving no one behind, governance related to this service dimension incorporates adaptation of service delivery modalities/models of care to account for the heterogeneity of subpopulations. For example, if screening for specific noncommunicable diseases is mandated as part of the universal benefits package, yet rural and remote subpopulations face barriers in accessing this screening when it is facility-based, decisions can be made on modifying the service delivery modality to become more accessible through use of mHealth technologies. Subnational health authorities, given their closer proximity to the population and enhanced capacity for planning based on local population needs, have a key role in enabling operationalization of the integrated people-centred health services approach explained in the previous section (on Service delivery).

Another example of adaptation is ensuring cultural competence of providers and non-discrimination in service provision. This can be incorporated in the way the

health system ensures accessibility of information (e.g. culturally appropriate messages and translation), service delivery organization (e.g. for working with nomadic populations or using community mediators for outreach), links with traditional medicinal approaches, and the existence of complaint mechanisms and patient surveys that address discrimination among other topics (WHO Regional Office for Europe, 2010; WHO, 2011d). All of these should be under the umbrella of a national legal framework on anti-discrimination in the health (and/or public) sector(s) and laws on multiculturalism, for which subnational governments are accountable for implementation.

Governance and the relationships between state actors and providers

Along the arrow from state actors to providers in Fig. 4, policy-makers provide oversight by specifying objectives, procedures and standards; providing resources and support; and exercising control and oversight relative to providers (Brinkerhoff & Bossert, 2013). Oversight encompasses quality assurance/improvement measures such as operating standards, normative guidance, protocols, accreditation, inspections, monitoring compliance, etc. It synergistically encompasses regulation, including of private and voluntary providers. For instance, in many countries, weak regulation of the private sector requires increased attention if policy-makers aim to leave no one behind (Mills et al., 2002; Nishtar, 2009; EQUINET, 2013). Low effectiveness linked to poor diagnosis and treatment practices by some private providers, facilitated by weak regulatory systems, unsatisfactory medical education and a lack of structures for health care consumers to seek redress are examples of the challenges faced (Mills et al., 2002; Nishtar, 2009; WHO, 2005a). Evidence from some countries suggests the poor are more likely to be

impacted by these practices, given that use of private sector services is typically linked with out-of-pocket expenditure and that the quality of services can be lower in poorer or more marginalized areas (e.g. rural or urban peripheral areas) where lower qualified providers operate (Montagu & Bloom, 2010; Das et al., 2012). In addition, lack of regulation on fees charged for services by private providers can result in financial hardship and undermine universal health coverage. That said, if adequately regulated, it is widely recognized that the private sector can help expand coverage and reduce health inequities (e.g. through enhancing availability by expanding access in rural and urban periphery areas) (Lagomarsino, Nachuk & Singh Kundra, 2009; Travis & Cassels, 2006). Hence, an important part of health system governance is gathering intelligence on the characteristics, extent, growth and consequences of the private sector for progress towards universal health coverage, and ensuring adequate regulation so that no one is excluded or has substandard/low-quality services in a mixed system (WHO, 2010h).

Also along the arrows in Fig. 4 between state actors and providers (as well as between population and state actors) is the inherent issue of prioritization. In reforms towards universal health coverage that are underpinned by the principles of progressive universalism and realization of the right to health (WHO, 2011d), authorities face the challenges of expanding priority services, including more people, and reducing out-of-pocket payments in ways that benefit the more disadvantaged subpopulations at least as much as their more advantaged counterparts. Hence, the question of prioritization becomes central in governance processes. In each of these dimensions, national and subnational authorities are faced with a critical choice: which services to expand first, whom to include first, and how to shift from out-of-pocket payments toward prepayment in ways that account for equity

in financing. A commitment to fairness – and the overlapping concern for equity and gender-responsiveness – and to respecting individuals' rights to health care must guide this decision-making (WHO, 2014b). The following three-part strategy can be useful for seeking fair progressive realization of universal health coverage (WHO, 2014b).

1) Categorize services into priority classes. In relation to the burden of disease and with due attention to differences between men and women, relevant criteria include those related to cost-effectiveness, priority to the worse off, and financial risk protection.

2) First expand coverage for high-priority services to everyone. This includes eliminating out-of-pocket payments while increasing mandatory, progressive prepayment with pooling of funds.

3) While doing so, ensure that disadvantaged groups are not left behind. This entails adapting models of care to be responsive to heterogeneity among subpopulations, taking into account inequities linked to barriers and greater/different health needs, and ensuring adequate governance and accountability.

The arrow on Fig. 4 from providers to state actors features information, reporting and lobbying. Key relationships evolve around the provision of information for the purposes of monitoring, transparency and accountability, acknowledging that providers may not be neutral sources of information given their interests (Brinkerhoff & Bossert, 2013). Likewise, information exchange also occurs among providers in this dimension with insufficient state oversight of the equity implications, with some actors having specific interest in maximizing financial gains that may run in contrast to enhancing affordability and accessibility of services to disadvantaged subpopulations.

Globally speaking, a critical issue for governance is lack of transparency – even more so in the agenda to leave no one behind. Evidence suggests that corruption in the health sector has a disproportionate effect on disadvantaged populations (Transparency International, 2006; UNDP, 2011; Vian, 2008). Anti-corruption and transparency measures are relevant to all dimensions of the triangle in Fig. 4, and indeed they are relevant to relationships between state actors and providers as well as among providers. Countries globally, across all income brackets, face related challenges. For instance, a European Commission study on corruption in the health sector – analysing 86 "cases" of corruption in European nations – developed a typology of the six main types of corruption:

  (i) bribery in medical service delivery (informal payments);
 (ii) procurement corruption;
(iii) improper marketing relations (generally between physicians and industry);
 (iv) misuse of high-level positions;
  (v) undue reimbursement claims (insurance fraud); and
 (vi) fraud and embezzlement of medicine and medical devices (European Commission, 2013).

Subnational health authorities have key roles in tackling such corruption issues in their governance reforms.

Governance and economic recession

Particularly in times of economic recession, there may be pressure to make trade-offs that can decrease service coverage and weaken financial protection in response to resource shortages (WHO Regional Office for Europe, 2014b). Governance for avoiding these trade-offs can be particularly challenging in times of economic downturn, which increase people's need for health services but make it more difficult for them to access the services they need (WHO Regional Office for Europe, 2014b). These crises increase fiscal pressures and stretch government resources, and unless governments take action to mitigate impact, this tends to hurt disadvantaged/vulnerable subpopulations (like the unemployed) the most (WHO Regional Office for Europe, 2014b). Governance for mitigating the pressures posed by economic downturn includes: weighing short-term cost-saving measures against longer-term priorities; avoiding arbitrary cuts to coverage, budgets, infrastructure, staff numbers, etc, which are unlikely address underlying performance issues and may cost the health system more in the long term; securing financial protection and access to health services as a priority, especially for the most disadvantaged subpopulations; focusing on promoting efficiency and cost-effective investment in the health system; reviewing the health financing policy design and considering who will be left out by the changing social context and existing approaches to entitlements; and strengthening cross-sectoral cooperation (in particular with social and fiscal policy domains) to address factors outside of the direct control of the health sector (WHO Regional Office for Europe, 2014b).

The potential to use an economic downturn as a chance to introduce needed changes (e.g. efficiency measures) should be harnessed. For instance, the 2010 World Health Report (WHO, 2010d) estimates that 20–40% of all health spending is wasted through inefficiency. Some countries in the European Region have reacted to the recent economic crisis through enhanced financial protection, including extending health coverage to new groups of people and reducing or abolishing user charges, and taking steps to improve efficiency (efforts to strengthen pharmaceutical policy were especially common) (WHO Regional Office for Europe, 2014b).

Governance and change management

Finally, governance to oversee reforms in the health system – including for leaving no one behind and at subnational level – entails a strong approach to "change management". Change management means that special attention needs to be given to issues such as leadership, shared vision across interested stakeholders, sequencing, resources for change, transparency[6], cultural values, and anticipating and mitigating potential unintended results while designing and implementing a reform initiative (OECD, 2008). Resistance can be expected and is part of the change. Marc Roberts gives examples of such resistance: "Redistributing money away from elite institutions to primary healthcare in the periphery will be unpopular with many powerful providers and patients. Enforcing mandatory rural service will not go over well with the children of the elite (who fill the medical schools) nor with their influential parents" (Roberts, 2015). Change management approaches should account for this type of resistance and the political strategies necessary to overcome it, as the skilful orchestration of these will be central in the agenda to leave no one behind.

---

[6] This may entail steps towards increased independent and social auditing, alongside other measures to proactively enhance transparency and the public's access to information on procurement, prioritization exercises and decision-making processes (WHO, 2011d).

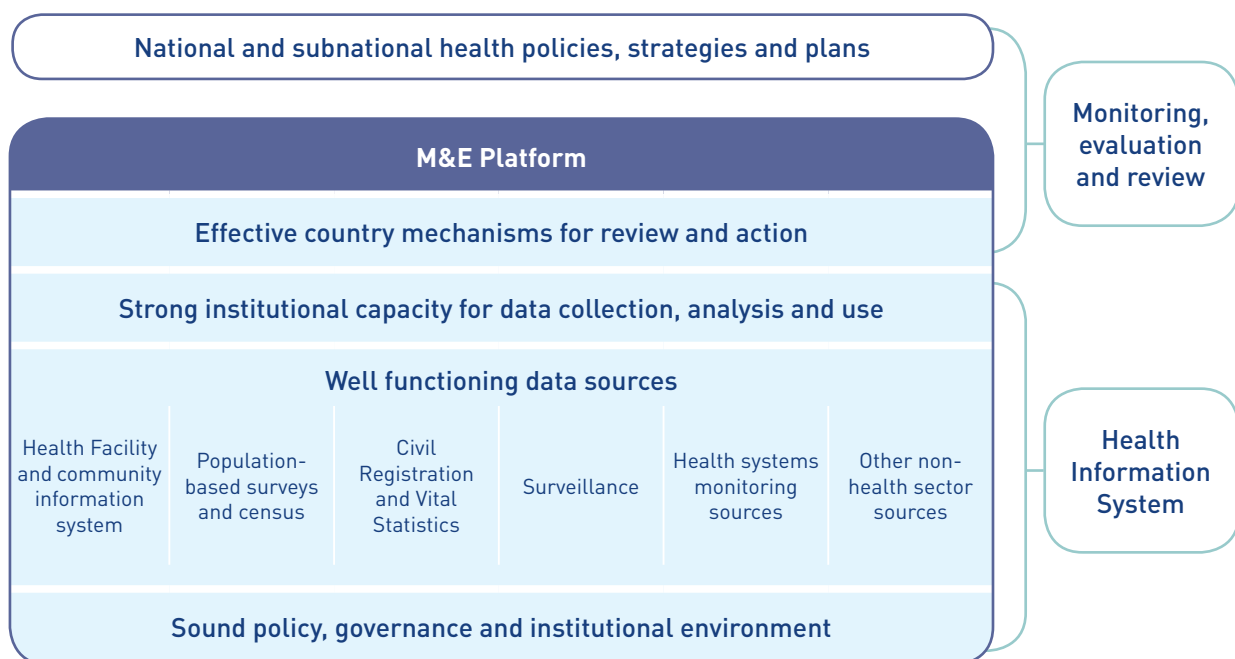# Health information systems and research capacity

Health information system strengthening

Measures to strengthen health information systems in general, across their components and in an integrated way, should be included in health sector planning. These measures can be featured in the national health plan and linked subnational health plans, as well as integrated into the national health information system strategy (and its subnational implementation). The components of health information systems are shown in Fig. 5.

Information is a prerequisite for any kind of health system reform, including reform for leaving no one behind. Data sources to be drawn from in order to understand who is being missed, who has greater health needs, and who is being impoverished as a result of care are highlighted in Fig. 5 (Hosseinpoor, Bergen & Schlotheuber, 2015; WHO, 2013d; WHO, 2016g). Access to relevant and reliable information on who is being left behind enables the design of appropriate interventions and modifications of existing approaches, and is integral to transparency

and accountability. Relevant data can also help secure more investment in equity-enhancing interventions (Nolen et al., 2005). Data in itself is not enough to address inequities; capacity for analysis, interpreting, dissemination/reporting and use is also required (Hosseinpoor, Bergen & Schlotheuber, 2015; Nolen et al., 2005).

Fig. 5. Monitoring and evaluation platform and its links with the health information system

National and subnational health policies, strategies and plans

M&E Platform

Effective country mechanisms for review and action

Strong institutional capacity for data collection, analysis and use

Well functioning data sources

Health Facility and community information system

Population-based surveys and census

Civil Registration and Vital Statistics

Surveillance

Health systems monitoring sources

Other non-health sector sources

Sound policy, governance and institutional environment

Monitoring, evaluation and review

Health Information System

Source: WHO, 2016g.

In the scenarios described earlier (of Dorj and Tulga), it is evident that health information system strengthening could help address the challenges posed in those hypothetical patient pathways, including the following interventions:

- strengthened population-based health surveys that permit assessment of health needs (including risk factors) and enable health inequality monitoring and data disaggregation;
- integration of questions on barriers to services (e.g. on reasons for not seeking care, on gender norms, etc.) into data sources such as surveys;
- implementation and use of regular facility surveys that monitor quality inputs, as part of an approach for accountability and to show in a timely manner the sub-aimag areas/soums requiring greatest attention to enhanced inputs in terms of health facilities and infrastructure, medicines, technologies and other inputs;
- monitoring catastrophic and impoverishing health expenditures and conducting benefit incidence analysis on the extent to which different socioeconomic groups benefit;
- conducting rapid assessments in areas where there are large migratory influxes to understand changing demographics and emerging health needs;
- monitoring key social determinants of health (e.g. rural/remote residence, education, poverty and income levels, internal migrant status);
- conducting patient satisfaction surveys that address responsiveness (and allow for data disaggregation to see differentials by sex, rural-urban, income, education, etc.) as well as qualitative research to understand more specifically why some subpopulations are not accessing services;
- improved facility-based health information management systems that allow for tracking of patients across levels of care (including for back referrals);

- community engagement – including disadvantaged communities – in monitoring activities, with due attention to data protection and privacy;
- overarching improved capacity for analysis and use (including at province level) of equity-relevant data in planning, monitoring and evaluation.

WHO has a range of materials that can support health information system strengthening towards leaving no one behind. These include guidance on and tools for national and subnational health inequality monitoring and data disaggregation (WHO, 2013d; WHO, 2016i; Hosseinpoor et al., 2016), inclusive of tools for data analysis and visualization. Linked to this, WHO has guidance on rapid assessments of health information systems for health inequality monitoring capacity. WHO's financial protection in health calculation tool (WHO, 2016h) collects household survey data to produce and analyse estimates of financial risk protection. Furthermore, WHO has developed the EQuAL framework on monitoring intersectoral factors influencing progress towards universal health coverage (Valentine, Koller & Hosseinpoor, 2016).

WHO's Service Availability and Readiness Assessment (SARA) is a health facility assessment tool designed to assess and monitor the service availability and readiness of the health sector, and to generate evidence to support the planning and managing of a health system (WHO 2015g). Data from SARA can be disaggregated by local level governance unit, which can be crossed with health morbidity and mortality data and/or linked to data on poverty and multidimensional deprivation. Connecting the data in these ways allows insight into facility preparedness in the most disadvantaged areas, by health indicators and by poverty/deprivation.

WHO's AccessMod© (WHO, 2012a) is a toolbox that uses the power of geographic information systems to measure physical accessibility to health care; estimate geographical coverage (a combination of availability and accessibility coverage) of an existing health facility network; and complement the existing network in the context of a scaling-up exercise, or to provide information for cost-effectiveness analysis when no information about the existing network is available.

Data source strengthening

One component of health information system strengthening to leave no one behind relates to data collection. Hosseinpoor et al. (2014) indicated that capacity to conduct health inequality monitoring is largely determined by the performance of the health information system that collects data, analyses data, reports health inequalities and disseminates results. Hence, there is a need to improve mechanisms for the collection, quality and use of data for health inequality monitoring, while taking into account necessary data protection mechanisms (such as ensuring adequate personal identity protection measures, e.g. for data disaggregated by race/ethnicity), as well as building relevant technical competencies.

Table 3 gives an overview of strengths, limitations and possible areas for improvement of selected data sources for health inequality monitoring. The table gives an overview of ways in which the separate sources can be strengthened to better support a focus on progressive universalism and realization of the right to health. The table is just an example, as some important data sources for leaving no one behind (e.g. facility assessments, financial protection data) are missing.

Of particular relevance for subnational health sector plans is the issue of sample sizes when household surveys are used as the source of data: if a sample size is too small to be able to appropriately monitor health inequalities by different stratifiers, options include looking at data from a higher administrative level (e.g. from province instead of district level) and supplementing the data with smaller local studies and qualitative research to understand the local specificities. In this context, improving the routine data system for health inequality monitoring becomes more important.

Table 3. Strengths, limitations and possible areas of improvement of (selected) data sources for health inequality monitoring

Data source	Examples	Advantages	Disadvantages	Possible improvements
Census	National population and household censuses implemented every 10 years	Data cover the entire population (or nearly so), providing accurate denominator for population subgroups	Contains only limited information on health Timing of data collection is not consistent	Include individual or small-area identifiers Include mortality questions, and link them with post-census mortality surveys
Vital registration system (civil registration and vital statistics system)	National birth, death, or marriage registries	Can be used to generate reliable estimates for mortality rate, life expectancy and sometimes cause-of-death statistics Often linked to information on sex, geographical region, occupation, and education	Incomplete in most low- and middle-income countries Does not regularly include information on equity stratifiers, other than sex	Expand coverage Include at least one socioeconomic indicator (note: a human rights-based approach calls for more; see United Nations, 2012) Include cause of death, birth weight and gestational age (when not included)
Household survey	Demographic and Health Survey, Multiple Indicator Cluster Survey, World Health Survey, Study on Global AGEing and Adult Health, Living Standards Measurement Study	Data are representative for a specific population (often national) Contains rich data on a specific health topic as well as living standards and other complementary variables Often repeated over time, allowing for measurement of time trends Conducted in multiple countries, allowing for benchmarking	Sampling and non-sampling errors can be important Survey may not be representative of small subpopulations of interest	Repeat surveys on a regular basis Enhance comparability over time and between countries by harmonizing survey questions Increase sample sizes
Institution-based records (administrative data)	Resource records (e.g. number of hospitals, health workers) Service records (e.g. number of immunizations given) Individual records (e.g. medical charts)	Data are readily and quickly available Can be used at lower administrative levels (e.g. district level)	Data may be fragmented or of poor quality Often data cannot be linked to other sources Data may not be representative of whole population (e.g. those who do not access services may not be covered)	Include individual or small-area identifies Create standardization of electronic records across institutions
Surveillance system	Outbreak disease surveillance Sentinel surveillance Risk factor surveillance Demographic surveillance	Can provide detailed data on a single condition or from selected sites Sentinel surveillance site data useful for correction of over-reporting or underreporting	Not always representative of population Some systems may collect little information relevant to equity stratifiers	Include individual or small-area identifiers Integrate surveillance functionality into larger health information systems with full coverage

Source: WHO, 2013d, as adapted from O'Donnell et al, 2008.

As how the health information system collects data will be important to leaving no one behind, so will how it integrates information in a way that supports integrated people-centred health services that respond to local health needs and population characteristics. This will mean integrating or linking data – as appropriate – from sources such as the public health management information system, a financial management information system, a management information system, a hospital service management information system, and private health sector information system, etc. An integrated health information system is needed to support the effective use of information in decision-making about planning, financial management, resource allocation and implementation of policies and laws (WHO, 2013a).

Box 6 gives an example of work by aimag/ province governments in Mongolia to strengthen health information systems.

Box 6. Example of strengthening the health information system at province level in Mongolia

In Umnugobi aimag, work is underway to strengthen the health information system. Inadequate infrastructure and lack of power supply in some areas have negative impacts on data quality and safety. Consequently, this may result in negative effects on responsive actions.

District Health Information Software version 2 (DHIS 2) is a tool for collection, validation, analysis and presentation of aggregate statistical data, tailored to integrated health information management activities. Two trainings on DHIS 2 were organized in Umnugobi province, and a WHO consultant worked on operationalization of DHIS 2 open software and imported monthly routine aggregated data from all health facilities in Umnugobi for 2014 and 2015 into the DHIS 2 training server. As a result of these initiatives, the province's health department agreed to pilot DHIS 2 in 2016 under the Health System Strengthening Strategy with support from the Ministry of Health, the Center For Health Development, WHO and other partners.

Telemedicine is essential to receive and transmit information in a timely way. Umnugobi province has been implementing the "Mobile Health Technology at the Primary Healthcare and Community Level in Mongolia" project since January 2016, with WHO support. The project introduces mHealth technologies – including wireless-enabled blood pressure devices, portable electrocardiography, and ultrasound equipment – at the primary health care and community levels. Within this project, a software programme on mHealth is being currently developed. It will be integrated into DHIS 2 and H-Info, the latter of which is a national health information system that provides health statistics and indicators for health authorities and partners. In relation to this, WHO Country Office for Mongolia is working with the Center For Health Development to upgrade H-Info and integrate screening and mobile services at primary health care level into the H-Info system.

Source: Extracted from WHO Country Office for Mongolia, 2016a.

Capacity to analyse and report data

Building the capacity of programme staff for analysis, reporting, and dissemination and use of information relevant for leaving no one behind may be a necessary step. For instance, proficiency in analysing health inequality data requires not only technical knowledge of the measures and calculations, but also an awareness of the best practices of how analyses are applied and interpreted (WHO, 2013d; WHO, 2014c). WHO is now working on demonstrating best practices in reporting the results of health inequality monitoring, to introduce innovative and interactive ways for audiences to explore inequality data (Hosseinpoor, Bergen & Schlotheuber A, 2015). Capacity-building resources and normative guidance that provide support to staff have also been made available (see http://www.who.int/gho/health_equity/en).

It is critical that the data relevant to leaving no one behind are incorporated into decision-making, including for resource allocation and financial disbursement (WHO, 2011e). It should be anticipated that these data could meet with resistance from some stakeholders, because they challenge the status quo or could be perceived as a criticism of actions undertaken. Hence, the process of disseminating and starting to use data on inequities can

be accompanied by a strategic change management approach, through which relevant counterparts recognize the joint wins of taking action.

Qualitative sources

In addition to quantitative data source strengthening, qualitative sources are also important in a health information system to produce the necessary intelligence for leaving no one behind. Qualitative sources often provide critical insight into why some subpopulations are more exposed to risk factors, are not accessing services and/or obtaining effective coverage, and are not benefitting from financial protection. Sources may include community monitoring efforts, as well as focus groups and informant interviews (touching on both supply and demand issues). Country reports to human rights bodies on the right to health can also be collected and drawn from. Specific attention should be given to any qualitative data on gender norms, roles and relations that impact health.

Enhancing research capacity

Subnational health plans can also include a focus on building local capacity and partnerships for research on ways to leave no one behind in relation to health.

Nolen et al. (2005) argue that, globally, the resistance to focusing greater efforts on leaving no one behind is more than just a lack of information; in many countries there is often an underlying lack of awareness, and more or less explicit forces in action to retain the status quo. To change this and open up for efficient usage of data, Nolan et al. suggest that research be conducted on the local conditions and dynamics behind stratification and inequities, decision-makers be trained in equity and its relation to health information systems, and public awareness be raised to create a demand for change.

In considering research for leaving no one behind, many questions about progressive universalism and realization of the right to health for all require local answers (WHO, 2013c). At subnational levels, authorities can support the production of research – including studies on barriers experienced by different subpopulations to different levels of care (including gender norms) – as well as be consumers of that information (WHO, 2013c). Increasing partnerships between governments, universities, and international and nongovernmental organizations can contribute to this, backed by comprehensive codes of good research practice.

Ensuring a synergistic system-wide approach

The preceding sections have delineated some of the potential actions that can, depending on the context, be relevant to subnational health system strengthening to leave no one behind. The text was divided by building block, but it is essential to conceptualize the actions needed at province and district level from an interlinked and synergistic systems-wide approach. Fig. 6 shows the relationship between the health system building blocks, and attributes and actions leading to universal health coverage. High-performance health systems are characterized by five attributes: quality, efficiency, equity, accountability, and sustainability and resilience. Achieving universal health coverage requires actions that support the achievements of these attributes (WHO Regional Office for the Western Pacific, 2016). Taking a whole-of-system approach with more integrated service delivery and strengthened primary care is central to leaving no one behind.

Fig. 6. Relationship between health system building blocks, attributes and action domains leading to universal health coverage
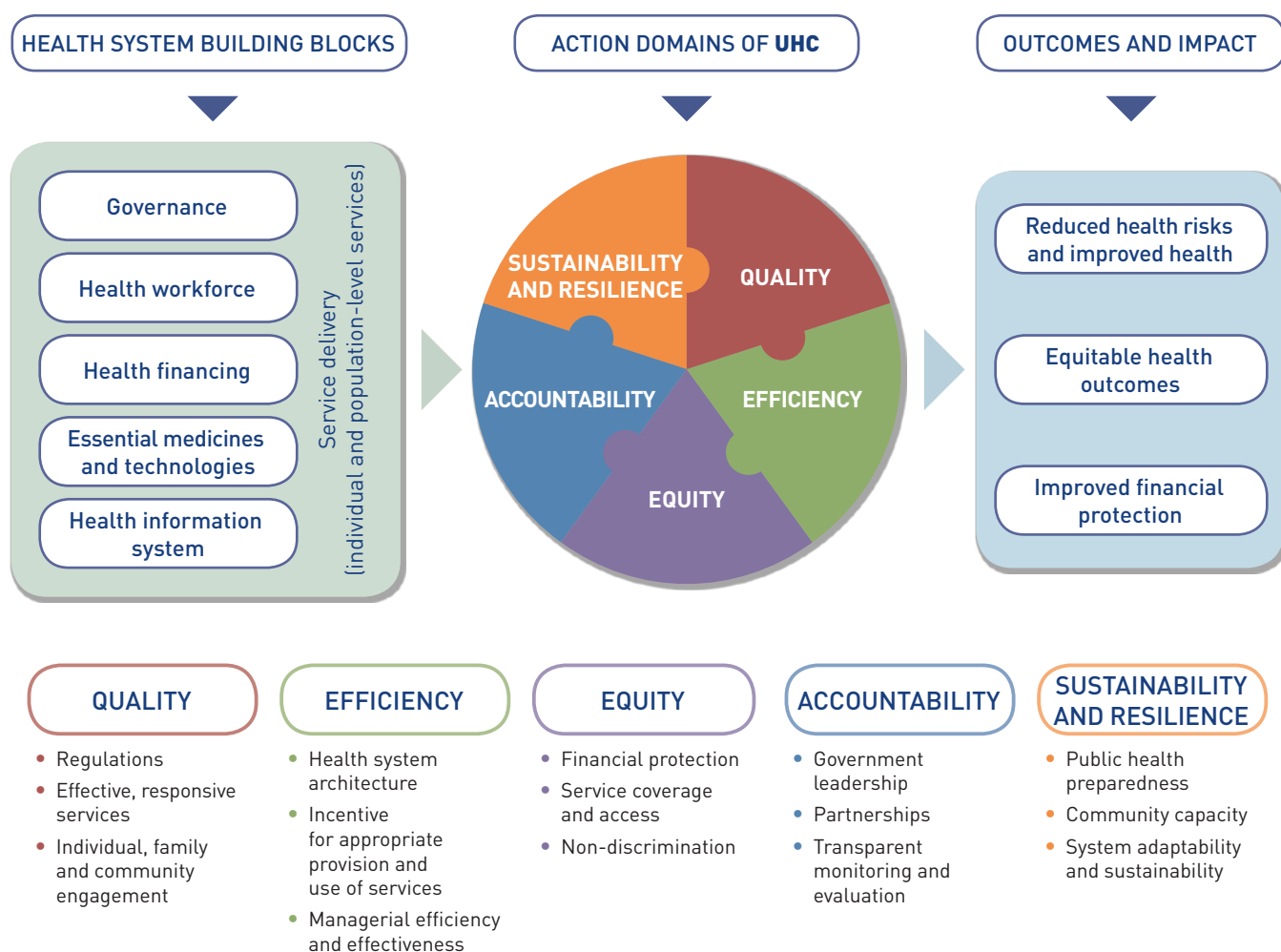
Source: WHO Regional Office for the Western Pacific, 2016.

"Health equity is most certainly not just about the distribution of health, not to mention the even narrower focus in the distribution of health care"

Sen (2002)

Role of social determinants of health

Many of the influences that shape health and the distribution of health inequities are located outside the health sector (WHO, 2008b; WHO, 2016c). As reflected in their definition, health systems include "activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health" (WHO Regional Office for Europe, 2008). Hence, strong stewardship for action on social determinants is an important aspect of health system governance.

Stewardship for action on wider social determinants is encompassed in the third point of what Benzeval, Judge & Whitehead (1995) considers as the health system's

obligations in confronting inequity:

- to ensure that resources are distributed between areas in proportion to their relative needs;
- to respond appropriately to the health care needs of different subpopulations;
- to take the lead in encouraging a wider (beyond the health sector) and more strategic approach to developing healthy public policies at both the national and local level, to promote equity in health and social justice.

WHO advocates that intersectoral action should be a fully integrated component – and indeed, mindset – embedded in national and subnational health planning processes. Without this, health inequities

will likely persist and, as a result, the health of any nation's population will suffer (WHO, 2016g). While the term "social determinants of health" may be relatively new, the idea that health and disease is socially produced and linked to development, gender norms, human rights and other societal factors is not (WHO, 2016c). The work of the WHO Commission on Social Determinants of Health (2005–2008) consolidated the evidence base and raised the profile of this issue (CSDH, 2008). The framework associated with the work of the Commission on Social Determinants of Health, and further refined in its follow-up, is shown in Fig. 7.

Fig. 7. WHO framework on social determinants of health
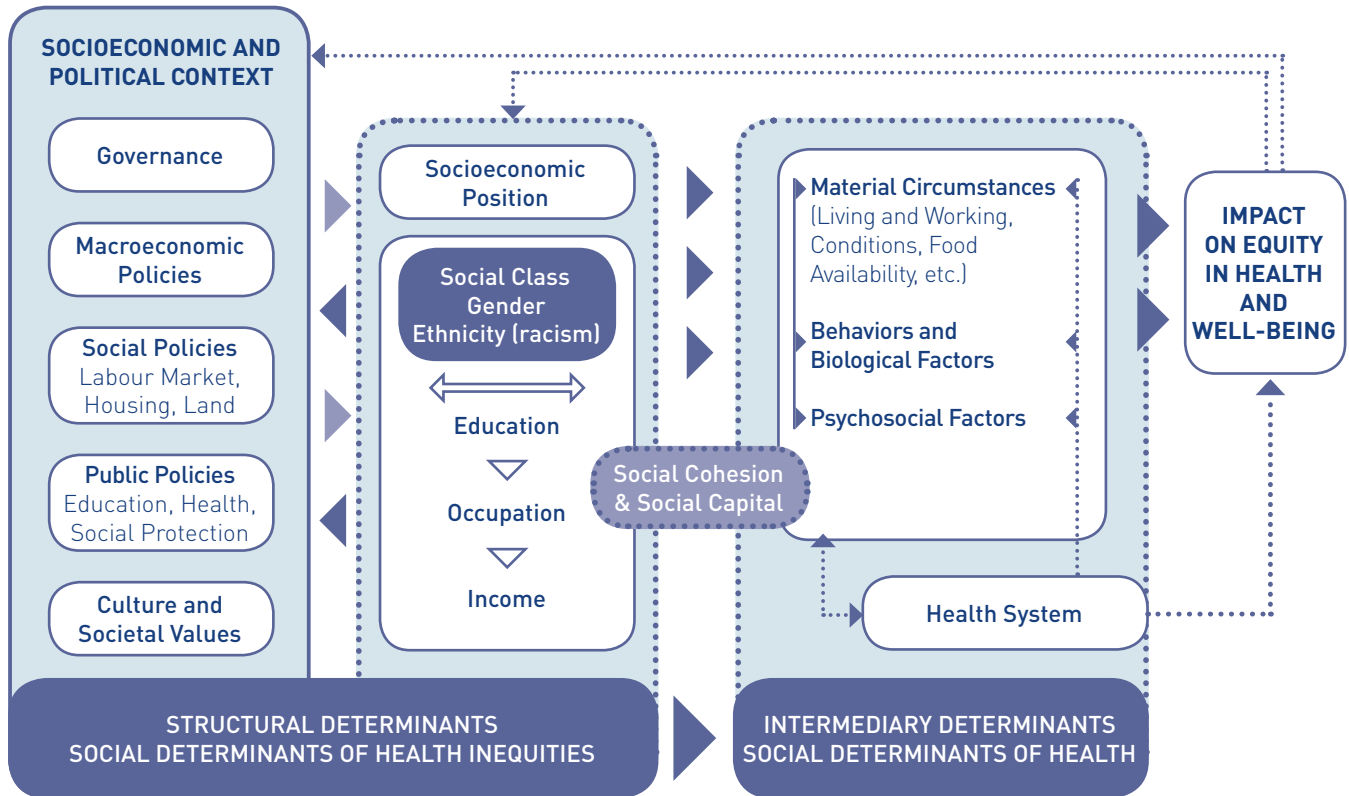
Source: WHO, 2010b.

As shown in Fig. 7, the underlying social determinants of health inequities are structural determinants, which include socioeconomic and political context. These generate stratification, social class and gender divisions in society, and the resulting socioeconomic position of individuals (WHO, 2016c). The socioeconomic and political context includes aspects such as the labour market, the educational system, political institutions and redistributive policies, as well as cultural and societal values including those related to gender norms, roles and relations. These underlying social determinants of health inequities operate through a set of intermediary determinants to shape health outcomes (WHO, 2010b). The main categories of intermediary determinants of health are: material circumstances, psychosocial circumstances, behavioural and/or biological factors, and the health system itself.

Health inequities flow from patterns of social stratification. One must consider the pathways and mechanisms through which the social determinants influence health and health inequity (WHO, 2016c). It is relevant to review again Box 2 on differentials in exposure, vulnerability, outcomes and consequences (see Part I). As described in Box 2, socioeconomic position and sociocultural factors such as gender result in individuals having different levels of exposure to health-damaging conditions and differential vulnerability (WHO, 2016c). They contribute to individuals having differential access to health services and outcomes, and also lead to differences in the consequences of ill-health for individuals from more and less advantaged groups (e.g. inability to work, catastrophic health expenditures, stigmatization). Ill-health may in some contexts exert an effect on socioeconomic position and patterns of social mobility.

The differential accumulation across the life-course of exposures, experiences and social disadvantages that are damaging to health may widen health inequities (WHO, 2016c; WHO, 2010b.)

In some countries, health policies, programmes and interventions can mitigate inequities through focused support to the most vulnerable or more disadvantaged subpopulations (WHO, 2016c). Other actions may address the more structural causes of inequities and intervene across sectors, making it more feasible to eliminate inequities. However, on the other hand, some health policies and programmes may deepen or widen inequities, making them even harder to overcome (WHO, 2016c). For this reason, it is important for health planners (including at subnational level) to understand the "whys" behind inequities, so that measures can be taken to address them.

In conducting gender analysis and in being gender responsive within policies and programmes, it is imperative to understand gender as intersecting with and shaped by other social stratifiers, including ethnicity, socioeconomic status, age, disability, sexual orientation, etc. In addressing the health and health needs of men and women, boys and girls, gender must be understood as relational to such aspects of identity and experience, and not treated as an isolated or static variable. Further, gender and its intersecting social stratifiers are shaped by structures and processes of power (i.e. societal institutions, socioeconomic discrimination, stigmatization) that shape health. This means that a person may simultaneously experience both privilege and disadvantage, depending on place and time. Recognizing these complexities, gender analysis and gender-responsive programming facilitates understanding of, and action on, the multiple factors and processes that shape the health of individuals.

Strengthening intersectoral action and using the Health in All Policies approach

Intersectoral/cross-sectoral action for health entails health and other sectors working together to inform public policy design and implementation to improve health and well-being, or at least not to adversely affect it (WHO, 2016c). Working across sectors requires governments to have "institutionalized processes which value cross-sector problem solving and address power imbalances" (WHO & Government of South Australia, 2010).

These institutionalized processes may be generic and work across multiple determinants of health – like the Health in All Policies approach – or take the form of specific integrated policies.

Subnational Health in All Policies is feasible, but requires facilitation and support by mechanisms and policies at higher levels of government (e.g. governor). This includes providing the leadership, mandate, incentives, budgetary commitment and sustainable mechanisms that support government agencies to work collaboratively on integrated solutions (WHO & Government of South Australia, 2010). Box 7 shows specific tools and instruments supporting intersectoral work, extracted from the Adelaide Statement on Health in All Policies (WHO & Government of South Australia, 2010).

Box 7. Selected approaches, tools and instruments supporting intersectoral action for health at different points in the policy and planning cycle

- Interministerial and interdepartmental committees
- Cross-sector action teams
- Integrated budgets and accounting
- Cross-cutting information and evaluation systems
- Joined-up workforce development
- Community consultations
- Partnership platforms
- Impact assessments
- Legislative frameworks

Source: WHO & Government of South Australia, 2010.

Finally, institutionalized Health in All Policies generally requires a set of supportive and related intersectoral and cross-sectoral components (see Fig. 8) to be put in place. The interaction between levels of government will depend on the specific context for governance.

Embedded social exclusion is an additional policy challenge that needs to be addressed through cross-sectoral action, which may focus on a group of relevant ministries or departments/authorities across government and beyond. A cross-sectoral policy and programming approach tackling "upstream" drivers of social exclusion (e.g. labour policy, migration policy) may be required. National policies that expressly address exclusion, including through intersectoral/cross-sectoral action, will enhance opportunities for integrated service delivery at subnational levels.

That said, attention to manifestations of exclusionary processes on people's daily lives can be delivered by people-centred and adequately resourced cross-sectoral action teams on the ground (WHO Regional Office for Europe, 2010; OECD, 2012; Popay et al., 2008). In its work on social exclusion, OECD (2012) has underlined the importance of integrating social support services around the user, with inputs from different sectors. This same concept is reflected in WHO's approach to integrated people-centred health services (WHO, 2016L). Approaches to social and health service integration have demonstrated as being effective and efficient in promoting health and other benefits; for example, integrated social and medical services tailored to disadvantaged families and delivered by nurses in the home have shown up to 10-fold reduction in child mortality (Howard & Brooks-Gunn, 2009).

Cross-sectoral inputs build the interlinked capabilities of the user, addressing inputs required for accessing social services and tandeming social service use with employment opportunities, school enrollment and social benefits receipt.

Fig. 8. Components of the Health in All Policies implementation process
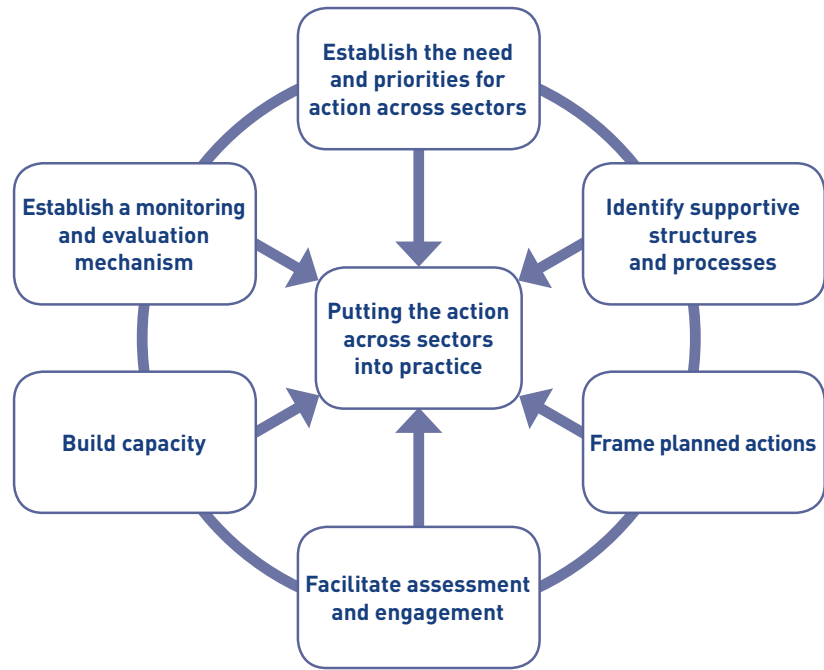
Source: Adapted from WHO & Government of Finland, 2013.

Fig. 9. Example of people-centred service integration across sectors
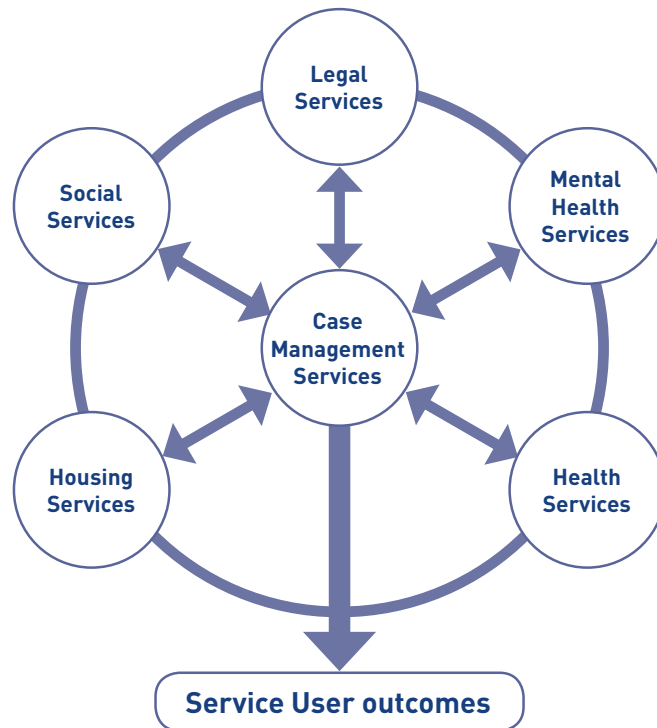
Source: OECD, 2012.

The result can be sustainable social mobility out of the experience of exclusion. Disorganized social systems, including in how services across sectors work together from a person-centred perspective, can be ineffective, waste resources and may result in perpetuated or aggregavated exclusionary processes (OECD, 2012). Fig. 9 provides a visual depiction of integrated social service provision.

A Mongolia-specific example of the relevance of strong intersectoral collaboration for leaving no one behind is related to internal migration (as shown by Scenario 2, in the previous section). Studies suggest that the main barriers to health access for the urban poor relate to interacting effects of poverty, unhealthy daily living environments, social vulnerability and isolation (Lhamsuren et al., 2012). Inadequate documentation is another key factor, hence stressing the importance of a multisectoral approach to alleviate exclusion and improve effective coverage with health services as well as social welfare benefits. A study in Ulaanbaatar found that respondents with proper documentation are 1.94 times more likely to use health services than those without such documentation (Gan-Yadam et al., 2013). Previous estimates have indicated that unregistered populations can constitute up to 20% of the city or district populations (Lhamsuren et al., 2012).

Another example from Mongolia – on mining and health (see Box 8) – highlights the importance of health impact assessments and collaboration with other sectors to reduce negative impacts on environmental health and improve employee conditions.

Box 8. The relevance of cross-sectoral action on mining and health

As miners work in difficult, toxic environments for more than 12 hours a day, their exposure to and risk of developing occupation-related diseases is increased. Being apart from their families for prolonged periods of time, eating out, and living mobile or nomadic lifestyles have further negative impacts on their behaviours and health. In addition, the intense flow of workforce within the mining industry increases the risk of spreading infectious diseases (especially STIs) among the population.

Usually mining companies employ between 500 and 6000 workers, and health service delivery is not well structured and at times uncertain. Doctors and nurses who work at mining sites provide limited primary health care services. An appropriate environment for the provision of health education and screening for risk factors of communicable and noncommunicable diseases among workers and other mobile populations has not yet been established.

Source: WHO Country Office for Mongolia, 2016a; Ministry of Health of Mongolia & WHO – Umnugobi aimag, 2015.

The WHO global publication *Strategizing national health in the 21st century: a handbook* (WHO, 2016g) provides further guidance in its chapter dedicated to intersectoral planning for health and health equity in relation to national health plans (also relevant for subnational plans). The actions it describes can be used within planning processes for health and for other sectors. It specifically describes how to influence other sectors in the planning process to address health determinants. Many of the techniques can also be used to implement a Health in All Policies approach. Likewise, the WHO Regional Office for the Western Pacific publication Health in all policies: report on perspectives and intersectoral actions in the Western Pacific offers region-specific orientations and examples (WHO Regional Office for the Western Pacific, 2013).

Part V
Enhancing social participation

Rationale for enhanced social participation and approaches

Participation is a requirement for the attainment of the highest possible level of health of all people, and is a cross-cutting principle embodied in international human rights treaties and the general comments and recommendations adopted by the bodies monitoring their implementation (OHCHR, 2012; Potts, 2010). As a principle, participation is expected to guide duty bearers (i.e. governments) in their implementation of human rights: "States should encourage popular participation in all spheres as an important factor in development and in the full realization of all human rights" (OHCHR, 2012). Emphasis is given to ensuring that all subpopulations, in particular those who are more disadvantaged, have the opportunity to actively participate. As such, health system governance includes ensuring platforms for social participation in the design, implementation, and monitoring and evaluation of national and subnational health strategies (Potts, 2010).

The WHO Commission on Social Determinants of Health identified participatory approaches as a critical component of a health system that has capacity to tackle health inequities (CSDH, 2008). The Commission called for "organizational arrangements and practices" that involve population groups and civil society organizations (particularly those working with socially disadvantaged and marginalized groups) in decisions and actions that identify, address and allocate resources to health needs. The Framework on Integrated, people-centred health services reinforces this, highlighting the importance of empowering and engaging communities (WHO, 2016L):

This approach will enable communities to voice their needs and so influence the way in which care is funded, planned and provided. It will help to build confidence, trust, mutual respect and the creation of social networks, because people's physical and mental well-being depends on strong and enduring relationships. It strengthens the capacity of communities to organize themselves and generate changes in their living environments.

Social participation concerns the participation of civil society and the empowerment of affected communities to become active protagonists in shaping their own health (UN CESCR, 2000). The goal is to ensure an adequate response to health needs and to empower social groups. Empowerment is "the expansion of assets and capabilities of poor people to participate in, negotiate with, influence, control and hold accountable institutions that affect their lives" (Narayan, 2005; WHO, 2016c). In this definition and others, both individual agency and the institutional environment are relevant (Narayan, 2005). Acknowledgement of these two distinct elements is in keeping with a human rights-based approach to health (WHO & OHCHR, 2001), which emphasizes, among other things:

- empowering people to know and claim their rights;
- increasing the ability and accountability of individuals and institutions that are responsible for respecting, protecting and fulfilling rights.

Governments have responsibility for creating spaces and conditions for participation to allow communities to achieve a greater control over the material, social and political determinants of their own welfare (Potts, 2010; WHO, 2016c). While the need for community empowerment and engagement is widely recognized, the actual process is complex and requires deliberate attention to: the desired functions of, and approach to, participation; a workplan with sustainable resource allocation; and a plan for how inputs will be meaningful and transparently incorporated and reflected across the policy and programme cycles. Incorporating platforms and mechanisms for social participation requires resource allocation, both financial and human, as well as supportive programmatic and policy frameworks. This is especially the case if social participation becomes an integral and ongoing/long-term component of the health sector's way of working.

Various classifications of levels of participation exist; one classification uses a scale from informing, to consulting, to involving, to collaborating, to responsibility in decision-making (IAP2, 2007). Independent of how the levels of participation are classified, it is important to acknowledge that each level corresponds to a different set of activities. Likewise, in practice, the levels of participation may vary across a policy or programme's cycle (WHO, 2016c). For instance, across the phases of needs assessment and planning, implementation, monitoring and evaluation, the levels may differ. There may be some phases where, for example, the level of social participation is more towards "informing", and others where it is more towards "collaboration" (WHO, 2016c). Health authorities should, however, in keeping with a human rights-based approach to participation, consider how to enhance the levels across all stages of the programming cycle.

It is important to consider *who* is participating, and whether the established platforms for participation unintentionally exclude anyone (WHO, 2016c). There may be gender norms, roles and relations that introduce power dynamics and/or limit opportunities for engagement in participatory platforms. Likewise, subpopulations who have lower levels of education and/or are illiterate, live in remote/hard-to-reach areas, have lesser information technology connectivity, are very occupied in meeting basic survival needs and face other adverse daily living conditions, may experience more challenges in participating, even if platforms for this do exist (WHO, 2016c). Health authorities can actively look to promote opportunities for equitable participation by designing mechanisms and platforms that are accessible and appropriate for more marginalized subpopulations, and take into account their daily living conditions and cultural and gender norms.

In considering how subnational health planning and programming can better incorporate participatory approaches, it is useful to consider the following questions (WHO, 2016c).

- What is the desired type of participation and which function would it serve, and from whose perspective?
- Have women and men participated equally – both as beneficiaries and as health sector staff? Do subnational health sector plans consider how gender and other sociocultural norms may impede the participation of women or men, and address them appropriately?
- What is the level or extent of participation (e.g. from informing to empowering)?
- In which phases of the policy and programme cycle does participation take place (e.g. needs assessment, planning, implementation, monitoring and evaluation) and at which levels (e.g. local, district, province, national)?
- How are participatory approaches applied in daily work, and how do they relate to the roles of health personnel?
- Who from within the target population has opportunities to participate (i.e. is there equitable opportunity)?
- What are the mechanisms and resources required by health sector authorities for supporting social participation?

Part VI
Strengthening monitoring and evaluation in subnational health planning to leave no one behind

This section explores ways to strengthen the focus on leaving no one behind in monitoring and evaluation and reviews of subnational health plans. Like a national health strategy, subnational health plans at province and district levels include a strong monitoring, evaluation and review component (WHO, 2011e). Monitoring, evaluation and review are essential functions to ensure that priority health actions outlined in plans are implemented as planned against stated objectives and desired results (WHO, 2016g). As delineated in the WHO guide *Strategizing national health in the 21st century: a handbook* (WHO, 2016g):

- monitoring means bringing all data together to analyse the progress of implementation of activities;
- evaluation builds upon monitoring and assesses whether the desired results of a plan have been achieved;
- based on the evidence gathered through monitoring and evaluation processes, reviews are used to assess overall progress and performance, to identify problems and take corrective actions.

WHO's *Strategizing national health in the 21st century: a handbook* (WHO, 2016g) also identifies important issues with regard to subnational monitoring and evaluation, as given below.

- There should be alignment between national and subnational health plans for the monitoring and evaluation component. Subnational plans' monitoring and evaluation should be coherent with, coordinated with, and form the basis of the national health plan's monitoring and evaluation framework. For coherency, the national health information system strategy (and its subnational implementation) will be integrated in the monitoring and evaluation and review approach in the national strategy and subnational health sector plans.
- Subnational authorities should be involved in review mechanisms and feedback loops for national health plans, and constant interaction between levels is needed for the success, repeatability and reproducibility of monitoring and evaluation and review mechanisms.

- There should be allowance for the status of decentralization in planning, e.g. by complementing the health outcome indicators with political, administrative and fiscal indicators for monitoring and evaluating the performance of subnational planning features.
- The selection of tools and assessment methods should be done in accordance with the features of the health system, enabling consistency and comparability across the different subnational levels. This can be coupled with support (capacity and financial) to subnational levels to be able to analyse and use the data.

As at national level, monitoring and evaluation platforms at aimag/province and/or district levels aim to result in a sound policy and institutional environment; well-functioning data sources; strong institutional capacity for data collection, management, analysis, use and dissemination; and effective mechanisms for review and action (WHO, 2016g). Across all of these, it is critical that there is an emphasis on leaving no one behind.

Designing monitoring and evaluation frameworks for subnational health sector plans that leave no one behind

In the previous sections of this handbook, the subpopulations being left behind, barriers that they face, and action areas for leaving no one behind (in the health sector and beyond, and through social participation) have been discussed. It is now important to consider how these can be reflected in the approach to monitoring, review and evaluation. Fig. 10 identifies generic components of a monitoring and evaluation framework for a national (or subnational) health strategy or plan (WHO, 2011e).

Fig. 10. Common monitoring and evaluation framework and data sources

	Imputs and processes			Outputs	Outcomes	Impact
Indicator domains	Governance	Financing	Infrastructure; Information and communication technologies Health Workforce Supply chain Information	Intervention access and services readiness Intervention quality, safety	Coverage of interventions Prevalence risk behaviours and factors	Improved health outcomes and equity Social and financial risk protection Responsiveness Efficiency
Data collection			Administrative sources Financial tracking system; National health Accounts Databases and records: HR, infrastructure, medicines etc. Policy data	Facility assessments Service readiness, quality, coverage, health status	Population-based surveys Coverage, health status, equity, risk protection, responsiveness	
				Clinical reporting systems		
						Civil Registration
Analysis and synthesis	Data quality assessment; Estimates and projections; In-depth studies; Use of research results; Assessment of progress and performance and efficiency of health systems					
Communication and use	Targeted and comprehensive reporting; Regular review processes; Global reporting					

Source: WHO (2011e).

The task at hand is to enable the monitoring and evaluation framework (and plan, which also links back to the subsection on Health information system strengthening) to contribute to analysis needed for leaving no one behind. For instance:

• knowing who is being missed – does the monitoring and evaluation framework incorporate data disaggregation and health inequality monitoring at outcomes and impact level?

• considering barriers to effective coverage – does the monitoring and evaluation framework have the levels of disaggregation necessary and specific barrier-related measures to identify drivers of inequities within the health sector (e.g. in relation to inputs and outputs) and in other sectors (in relation to key determinants)?

• responses to the barriers – does the monitoring and evaluation framework incorporate process-related indicators that may be helpful in tracing reforms towards leaving no one behind?

While each aimag/province and district will have specific needs for leaving no one behind (drawing from the analysis done in the previous sections), generally

speaking it can be useful if the monitoring and evaluation framework can address issues such as, but not limited to (WHO, 2013d; WHO, 2011d; WHO, 2015a; WHO, unpublished 2; Backman et al., 2008):

- differences in exposure to risk factors, service coverage, morbidity and mortality between subpopulations;
- differences in financial protection between subpopulations;
- differences in vital registration between subpopulations;
- inadequacies in availability, accessibility and quality of services (including outreach/non-facility-based services), infrastructure, medicines, health workforce and technologies/equipment in relation to need by different subpopulations;
- information on quality and responsiveness to non-medical needs (e.g. information on patient rights and entitlements, confidentiality, patient satisfaction);
- information on issues such private providers and traditional/alternative medicine use, as these system dynamics and interfaces may impact subpopulations differently, contribute to inequities, and/or be venues through which to potentially broker partnerships for tackling inequities;
- information on key environmental and social determinants of health and barriers to health (e.g. poverty rates, indirect costs, transport, gender norms and roles);
- information on governance and transparency issues (including functionality of complaint mechanisms, existence and functionality of community engagement and social participation platforms, availability of information in the public domain, completion of audits, etc.).

The above list may seem extensive, but to truly operationalize a focus on progressive universalism and realization of the right to health, these are the types of issues that a health sector plan's monitoring and evaluation framework should address. Often it is suggested that monitoring equity at outcome and impact levels is sufficient. However, this suggestion misses the critical understanding that health inequities, like health itself, are produced through a pathway of mechanisms from within and beyond the health sector; only by understanding the components of the pathway, and modifying them, will those inequities be tackled. As such, measures to monitor a leaving no one behind approach are required across the results chain seen in Fig. 10. An example of this is provided in Box 9.

Box 9. Example of ways to integrate a focus on leaving no one behind at input levelin the monitoring and evaluation framework

In a hypothetical country, a subnational state government identified reducing the health inequities experienced by an ethnic minority population as a priority in their 4-year plan. They included disaggregation of outcome and impact indicators by ethnicity (and other stratifiers), but also wanted to monitor progress at the inputs and processes level. One area that the health plan was going to invest in, as a means for overcoming accessibility and acceptability barriers for this subpopulation, was the health workforce.

The rationale for this was evidence suggesting inadequate numbers of certain cadres (outreach workers), insufficient distribution of adequately skilled health workers in rural areas, the need for same-sex providers to overcome gender-linked barriers, and the need for health workers with certain cultural and linguistic characteristics/competencies to better meet the needs of ethnic minorities. Therefore, to the extent possible at subnational level and through liaison with national level for data collection, it was decided to integrate additional disaggregation of the usual health workforce indicators into the monitoring and evaluation framework, enabling the indicators to provide more insight into the workforce composition by occupation, specialization, sex, rural background, ethnicity and cultural/linguistic competence.

Source: WHO (unpublished 2).

Review processes

The value of a monitoring and evaluation platform depends on the extent to which data are reviewed and used to take action to improve health outcomes. A clear indication that results from a review do influence decision-making is when they are used to guide resource allocation and financial disbursement (WHO, 2016g). Fig. 11 shows an example of a schedule for reviews. It is important to consider how review processes can incorporate the quantitative and qualitative data relevant to leaving no one behind, and be increasingly participatory and transparent in keeping with a human rights-based approach (United Nations, 2012; WHO, 2011d). As shown in Fig. 11, reviews should be periodic and involve a large range of stakeholders (WHO, 2016g).

Fig. 11. Sample schedule for health strategies' progress and performance reviews
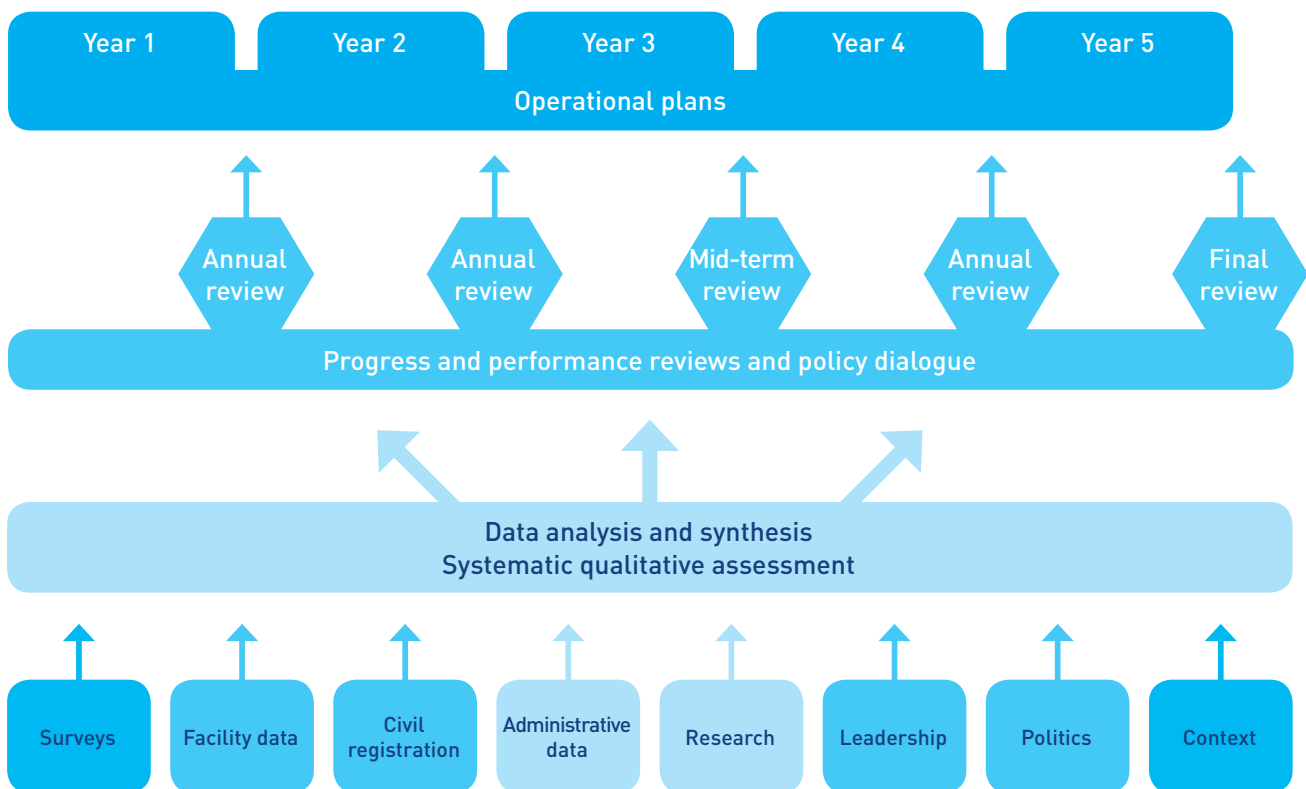
Source: WHO, 2016g.

As demonstrated in the workshops linked to this guide (see Annex 2 – these were conducted in late 2016 to inform subnational health plans in Mongolia), qualitative methods using health pathways can be powerful means of sharing information on where subpopulations are not accessing services (or benefitting less than intended or experiencing impoverishment), what barriers are experienced and how they interact/compound, and areas where the system needs to be strengthened to respond. These solution-focused exercises can contribute to reviews, particularly when done in synergy with and following from an analysis of the latest data on which subpopulations are being missed.

During the review process, feedback loops should be bidirectional, thus allowing local service providers (including those in rural and remote areas) the needed information to address gaps in coverage or quality, and for province and district level analysts to more effectively analyse and interpret data given local context and information needs (WHO, 2016g). Open and transparent data systems are necessary to ensure all stakeholders can participate fully in the review and action planning processes (WHO, 2016g).

Image 1. Example of review of barriers along health pathways

© WHO/Koller, T

Aimag government representatives considering the barriers experienced by low-income rural and remote herder populations along the health pathway for treatment of cardiovascular disease.

References

Adair-Rohani H, Zukor K, Bonjour S, Wilburn S, Kuesel AC, Hebert R et al. (2013). Limited electricity access in health facilities of sub-Saharan Africa: a systematic review of data on electricity access, sources, and reliability. Glob Health Sci Pract. 1(2):249–61 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4168575/).

Aluttis, C., Bishaw, T., & Frank, M. W. (2014). The workforce for health in a globalized context – global shortages and international migration. Glob Health Action 2014, 7: 23611 (http://dx.doi.org/10.3402/gha.v7.23611).

Asian Development Bank (2008). Mongolia: health and social protection. ADB Evaluation Study. (https://www.oecd.org/countries/mongolia/42227662.pdf).

Backman G, Hunt P, Khosla R, Jaramillo-Strouss C, Fikre BM, Rumble C et al. (2008). Health systems and the right to health: an assessment of 194 countries. Lancet. 372(9625):2047–85 (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)61781-X/fulltext).

Bayarsaikhan D, Kwon S, Chimeddagva D (2015). Social health insurance development in Mongolia: opportunities and challenges in moving towards universal health coverage. Int Soc Secur Rev. 68(4):93–113.

Benzeval M, Judge K, Whitehead M, editors (1995). Tackling inequalities in health: an agenda for action. London: King's Fund.

Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O (2003). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports. 118(4):293–302 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf).

Bigdeli M, Jacobs B, Tomson G, Laing R, Ghaffar A, Dujardin B et al. (2013). Access to medicines from a health system perspective. Health Policy Plan. 28(7):692–704 (https://heapol.oxfordjournals.org/content/28/7/692.full).

Brinkerhoff DW, Bossert TJ (2008). Health governance: concepts, experience, and programming options. US Agency for International Development Health Systems 20/20, policy brief. Washington (DC): United States Agency for International Development (USAID) (https://www.hfgproject.org/health-governance-concepts-experience-programming-options/).

Brinkerhoff DW, Bossert TJ (2013). Health governance: principal-agent linkages and health system strengthening. Health Policy Plan. 29(6):685–93 (https://academic.oup.com/heapol/article-lookup/doi/10.1093/heapol/czs132).

Buchan J, Couper ID, Tangcharoensathien V, Thepannya K, Jaskiewicz W, Perfilieva G et al. (2013). Early implementation of WHO recommendations for the retention of health workers in remote and rural areas. Bull World Health Organ. 91:834–40 (http://www.who.int/bulletin/volumes/91/11/13-119008.pdf).

Byrne A, Hodge A, Jimenez-Soto E, Morgan A (2014). What works? Strategies to increase reproductive, maternal and child health in difficult to access mountainous locations: a systematic literature review. PLoS One. 9(2):e87683 (http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0087683).

Callaghan M, Ford N, Schneider H (2010). A systematic review of task-shifting for HIV treatment and care in Africa. Hum Resour Health. 8:8. doi: 10.1186/1478-4491-8-8 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2873343/).

Campbell J, Buchan J, Cometto G, David B, Dussault G, Fogstad H et al. (2013) Human resources for health and universal health coverage: fostering equity and effective coverage. Bull World Health Organ. 91(11):853–63 (http://www.who.int/bulletin/volumes/91/11/13-118729.pdf).

Carrera C, Azrack A, Begkoyian G, Pfaffmann J, Ribaira E, O'Connell T et al. (2012). The comparative cost-effectiveness of an equity-focused approach to child survival, health, and nutrition: a modeling approach. Lancet. 380(9850):1341–51 (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61378-6/fulltext).

Chopra M, Sharkey A, Dalmiya N, Anthony D, Binkin N (2012). Strategies to improve health coverage and narrow the equity gap in child survival, health, and nutrition. Lancet. 380(9850):1331–40. (http://www.sciencedirect.com/science/article/pii/S0140673612614238).

Cooper LA, Powe NR (2004). Disparities in patient experiences, health care processes, and outcomes: the role of patient-provider racial, ethnic, and language concordance (pp. 7–1). New York: Commonwealth Fund. (http://www.commonwealthfund.org/~/media/files/publications/fund-report/2004/jul/disparities-in-patient-experiences--health-care-processes--and-outcomes--the-role-of-patient-provide/cooper_disparities_in_patient_experiences_753-pdf.pdf).

CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization (http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf).

Curtis E, Wikaire E, Stokes K, Reid P (2012). Addressing indigenous health workforce inequities: a literature review exploring 'best' practice for recruitment into tertiary health programmes. Int J Equity Health. 11:13 (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3402985/pdf/1475-9276-11-13.pdf).

Dahn B, Woldemariam AT, Perry H, Maeda A, von Glahn D, Panjabi R et al. (2015). Strengthening primary health care through community health workers: investment case and financing recommendations. New York: Office of the UN Secretary-General's Special Envoy for Health in Agenda 2030 and for Malaria (http://www.who.int/hrh/news/2015/CHW-Financing-FINAL-July-15-2015.pdf?ua=1).

Das J, Holla A, Das V, Mohanan M, Tabak D, Chan B (2012). In urban and rural India, a standardized patient study showed low levels of provider training and huge quality gaps. Health Aff (Millwood). 31(12):2274–84 (http://content.healthaffairs.org/content/31/12/2774.abstract).

Diderichsen F (2004). Resource allocation for Health Equity: Issues and Methods. Washington DC, The World Bank. (https://openknowledge.worldbank.org/bitstream/handle/10986/13619/315940HNP0Chap1enRAforHlthEqtyFinal.pdf?sequence=1&isAllowed=y).

Dorjdagva J, Batbaatar E, Dorjsuren B, Kauhanen J (2015a). Income-related inequalities in health care utilization in Mongolia, 2007/2008–2012. Int J Equity Health. 14:57 (http://equityhealthj.biomedcentral.com/articles/10.1186/s12939-015-0185-8).

Dorjdagva J, Batbaatar E, Dorjsuren B, Kauhanen J (2015b). Explaining differences in education-related inequalities in health between urban and rural areas in Mongolia. Int J Equity Health. 14:154 (https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-015-0281-9).

Dorjdagva J, Batbaatar E, Svensson M, Dorjsuren B, Kauhanen J (2016). Catastrophic health expenditure and impoverishment in Mongolia. Int J Equity Health. 15:105 (https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-016-0395-8).

EQUINET (2013). Regulating the for-profit private health sector in East and Southern Africa. Policy series no.35. Co-published by EQUINET, University of Cape Town Health Economics Unit and TARSC with WEMOS Foundation (http://www.equinetafrica.org/sites/default/files/uploads/documents/Pol_35_finregs.pdf).

European Commission (2013). Study on corruption in the healthcare sector. European Commission – Directorate-General Home Affairs. Luxembourg: Publications Office of the European Union. (https://www.stt.lt/documents/soc_tyrimai/20131219_study_on_corruption_in_the_healthcare_sector_en.pdf).

Evans D, Hsu J, Boerma T (2013). Universal health coverage and universal access. Bull World Health Organ. 91:546–546A (http://www.who.int/bulletin/volumes/91/8/13-125450/en/index.html).

Fulton B, Scheffler RM, Sparkes SP, Yoonkyung Auh E, Vujicic M, Soucat A (2011). Health workforce skill mix and task shifting in low income countries: a review of recent evidence. Hum Resour Health. 9:1 (http://www.human-resources-health.com/content/9/1/1).

Gan-Yadam A, Shinohara R, Sugisawa Y, Tanaka E, Watanabe T, Hirano M, et al. (2013). Factors associated with health service utilization in Ulaanbaatar, Mongolia: a population-based survey. J Epidemiol. 23(5):320–8 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3775525/).

George A. (2007). Human resources for health: a gender analysis. Background paper prepared for the Women and Gender Equity Knowledge Network and the Health Systems Knowledge Network of the WHO Commission on Social Determinants of Health. (http://www.who.int/social_determinants/resources/human_resources_for_health_wgkn_2007.pdf?ua=1).

Gottret PE, Schieber G (2006). Health financing revisited: a practitioner's guide. Washington (DC): World Bank (http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf).

Government of Australia (2015). Cultural competency in the delivery of health services for indigenous people. Issues paper no. 13 produced for the Closing the Gap Clearinghouse. Bainbridge R, McCalman J, Clifford A, Tsey K. (http://www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Our_publications/2015/ctgc-ip13.pdf).

Grobler L, Marais BJ, Mabunda SA, Marindi PN, Reuter H, Volmink J (2009) – reprinted in 2015. Interventions for increasing the proportion of health professionals practising in rural and other underserved areas (review). The Cochrane Library Issue 6 (http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD005314.pub2/epdf/standard)

Gwatkin DR, Wagstaff A, Yazbeck A, editors. (2005). Reaching the poor with health, nutrition, and population services: what works, what doesn't, and why. Washington DC: World Bank (http://siteresources.worldbank.org/INTPAH/Resources/Reaching-the-Poor/complete.pdf).

Gwatkin DR, Ergo A (2011). Universal health coverage: friend or foe of health equity? Lancet. 377(9784):2160–1. doi:10.1016/S0140-6736(10)62058-2 (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(10)62058-2/abstract).

Hosseinpoor A, Bergen N, Koller T, Prasad A, Schlotheuber A, Valentine N et al (2014). Equity-oriented monitoring in the context of universal health coverage. PLoS Med. 11(9):e1001727 (http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001727).

Hosseinpoor A, Bergen N, Schlotheuber A (2015). Promoting health equity: WHO health inequality monitoring at global and national levels.
Glob Health Action. 8:29034 (http://dx.doi.org/10.3402/gha.v8.29034).

Hosseinpoor A, Bergen N, Barros AJD, Wong KLM, Boerma T, Victora CG (2016). Monitoring subnational regional inequalities in health: measurement approaches and challenges. Int J Equity Health. 15:18 (https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-016-0307-y).

Howard K, Brooks-Gunn J (2009). The role of home-visiting programs in preventing child abuse and neglect. Future Child. 19(2):119–46 (https://www.ncbi.nlm.nih.gov/pubmed/19719025).

IAP2 (2007). International Association of Public Participation 2 – Spectrum of Public Participation. (http://c.ymcdn.com/sites/www.iap2.org/resource/resmgr/imported/IAP2%20Spectrum_vertical.pdf).

Jamison DT, Baeza C, Kress D, Maier M (2006). Disease control priorities in developing countries. Chapter 12: Financing health systems in the 21st century. Washington (DC): World Bank (http://www.ncbi.nlm.nih.gov/books/NBK11772/).

Kok MC, Kane SS, Tulloch O, Ormel H, Theobald S, Dieleman M, Taegtmeyer M et al. (2015). How does context influence performance of community health workers in low- and middle-income countries? Evidence from the literature. Health Res Policy Syst. 13:13 (https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-015-0001-3).

Lagarde M, Palmer N (2009). The impact of contracting out on health outcomes and use of health services in low and middle-income countries. Cochrane Database Syst Rev. 7(4):CD008133. (http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008133/full).

Lagomarsino G, Nachuk S, Singh Kundra S (2009). Public stewardship of private providers in mixed health systems: synthesis report from the Rockefeller Foundation—sponsored initiative on the role of the private sector in health systems. Washington, DC: Results for Development Institute. (http://www.resultsfordevelopment.org/knowledge-center/public-stewardship-private-providers-mixed-health-systems-synthesis-report-rockefel).

Lehmann U, Dieleman M, Martineau T (2008). Staffing remote rural areas in middle- and low-income countries: a literature review of attraction and retention. BMC Health Serv Res. 8:19 (http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-8-19).

Lewis M (2007). Informal payments and the financing of health care in developing and transition countries. Health Aff (Millwood). 26(4):984–97 (http://content.healthaffairs.org/content/26/4/984.full).

Lhamsuren K, Choijiljav T, Budbazar E, Vanchinkhuu S, Chang Blanc D, Grundy J (2012). Taking action on the social determinants of health; improving health access for the urban poor in Mongolia. Int J Equity Health. 11:15 (https://equityhealthj.biomedcentral.com/track/pdf/10.1186/1475-9276-11-15?site=equityhealthj.biomedcentral.com).

Mills A, Brugha R, Hanson K, McPake B (2002). What can be done about the private health sector in low-income countries? Bull World Health Organ. 80(4):325–30 (http://www.who.int/bulletin/archives/80(4)325.pdf).

Ministry of Health, Asian Development Bank (2010). Situational analysis of the access to health services of the vulnerable population in UB city. Ulaanbaatar: MOH and Asian Development Bank; 2010.

Ministry of Health of Mongolia (2012). Medicine price, availability, affordability and price component survey undertaken in Mongolia, 2012. Survey manager: Ch. Munkhdelger, Ministry of Health (http://haiweb.org/wp-content/uploads/2015/07/Mongolia-Summary-Pricing-Surveys.pdf)

Ministry of Health of Mongolia (2016). Health ministerial order A/147 on mobile health service. English translation.

Ministry of Health and Sports of Mongolia and WHO (2014). Strategy of health system strengthening in Songinokhairkhan District 2014-2016. Ulaanbaatar (http://www.wpro.who.int/mongolia/publications/NEMUT_english/en/).

Ministry of Health and Sports of Mongolia and WHO (2016). Mid-term strategy on health system strengthening in Umnugobi aimag 2015-2017. Dalanzadgad (http://www.wpro.who.int/mongolia/publications/umnugobi_english/en/).

Montagu D, Bloom A (2010). The private sector and health services delivery in the EAP Region: background report to UNICEF on the role and experiences of the private sector in provision of child health services. (http://www.unicef.org/eapro/3_Market_decentralization_and_Health_Services_delivery.pdf).

MSH (2006). Rural expansion of Afghanistan's community-based healthcare program (REACH): transforming a fragile health system. Cambridge (MA): Management Sciences for Health. (https://www.msh.org/sites/msh.org/files/EOP_Booklet-1.pdf).

Murray CJL, Knaul F, Musgrove P, Xu K, Kawabata K (2002). Defining and measuring fairness in financial contribution to the health system. Geneva: World Health Organization (http://www.who.int/healthinfo/paper24.pdf).

Nanzad O et al (2011). Hospital services costing survey at aimag and district health facilities. Ulaanbaatar: Ministry of Health of Mongolia.

Narayan D (2005). Measuring empowerment: cross-disciplinary perspectives. Washington (DC): World Bank (https://openknowledge.worldbank.org/bitstream/handle/10986/7441/344100PAPER0Me101Official0use0only1.pdf?sequence=1).

Newman C (2014). Time to address gender discrimination and inequality in the health workforce. Hum Resour Health. 12(1):25 (http://www.human-resources-health.com/content/12/1/25#B1).

Nishtar S (2009). The mixed health systems syndrome. Bull World Health Organ. 88:74–5 (http://www.who.int/bulletin/volumes/88/1/09-067868/en/).

Nolen LB, Braveman P, Dachs JNW, Delgado I, Gakidou E, Moser K, Rolfe L et al. (2005). Strengthening health information systems to address health equity challenges. Bull World Health Organ. 83(8):597–603 (http://www.scielosp.org/scielo.php?pid=S0042-96862005000800013&script=sci_arttext).

O'Donnell O, van Doorslaer E, Wagstaff A, Lindelow M (2008). Analyzing Health Equity Using Household Survey Data: A Guide to Techniques and Their Implementation. Washington, DC: World Bank. (https://openknowledge.worldbank.org/handle/10986/6896).

OECD (2008). Managing change in OECD governments: an introductory framework. OECD working papers on public governance, no. 12. France: OECD publishing (http://www.oecd.org/gov/42142231.pdf).

OECD (2012). Integrating service delivery: why, for who, and how? Discussion paper. (http://www.oecd.org/els/soc/Richardson_Patana%20INTEGRATING%20SERVICE%20DELIVERY%20WHY%20FOR%20WHO%20AND%20HOW.pdf).

OHCHR (2012). United Nations declaration on the right to revelopment. Geneva: Office of the United Nations High Commissioner for Refugees (http://www.ipu.org/splz-e/unga14/rtd.pdf).

Patouillard E, Goodman CA, Hanson KG, Mills AJ (2007). Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature. Int J Equity Health. 6:17 (http://www.equityhealthj.com/content/6/1/17/abstract).

Perry H, Crigler L, editors (2014). Developing and strengthening community health worker programs at scale: a reference guide and case studies for program managers and policymakers. USAID/MCHIP (http://bit.ly/1AUBjtS http://www.mchip.net/sites/default/files/mchipfiles/CHW_ReferenceGuide_sm.pdf).

Perry HB, Zulliger R, Rogers MM (2014). Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. Annu Rev Public Health. 35:399–421 (http://www.annualreviews.org/doi/10.1146/annurev-publhealth-032013-182354).

Popay J, Escorel S, Hernández M, Johnston H, Mathieson J, Rispel L (2008). Understanding and tackling social exclusion. Final report to the WHO Commission on Social Determinants of Health from the Social Exclusion Knowledge Network. (http://www.who.int/social_determinants/knowledge_networks/final_reports/sekn_final%20report_042008.pdf).

Potts H (2010). Participation and the right to the highest attainable standard of health. Colchester: Human Rights Centre, University of Essex (http://repository.essex.ac.uk/9714/1/participation-right-highest-attainable-standard-health.pdf).

Prost A, Colbourn T, Seward N, Azad K, Coomarasamy A, Copas A et al. (2013). Women's groups practising participatory learning and action to improve maternal and newborn health in low- resource settings: a systematic review and meta-analysis. Lancet. 381(9879):1736–46
(http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60685-6/abstract).

Roberts MJ, Hsiao W, Berman P, Reich MR (2004). Getting health reform right: a guide to improving performance and equity. New York: Oxford University Press.

Roberts MJ (2015). Equity in health reform. Chapter in: The Palgrave international handbook of healthcare policy and governance, pp 545–60 (http://www.palgrave.com/us/book/9781137384928).

Saksena P, Xu K, Elovainio R, Perrot J (2010). Health services utilization and out-of-pocket expenditure in public and private facilities in low-income countries. World health report, background paper 20. Geneva
(http://www.who.int/healthsystems/topics/financing/healthreport/20public-private.pdf).

Sen A (2002). Why health equity? Health Econ. 11:659–66 (http://onlinelibrary.wiley.com/doi/10.1002/hec.762/pdf).

Sullivan LW (2004). Missing persons: minorities in the health professions, a report of the Sullivan Commission on Diversity in the Healthcare Workforce. (http://www.aacn.nche.edu/media-relations/SullivanReport.pdf).

Tanahashi T (1978). Health service coverage and its evaluation. Bull World Health Organ. 56(2):295–303
(http://www.ncbi.nlm.nih.gov/pubmed/96953).

Transparency International (2006). Global corruption report 2006: corruption and health.
(https://www.transparency.org/whatwedo/publication/global_corruption_report_2006_corruption_and_health).

Travis P, Cassels A (2006). Safe in their hands? Engaging private providers in the quest for public health goals. Bull World Health Organ. 84:427 (http://www.who.int/bulletin/volumes/84/6/427.pdf).

Tudor Hart J (1971). The Inverse Care Law. Lancet. 297(7696):405–12. http://www.sciencedirect.com/science/article/pii/S014067367192410X

UN CESCR (Committee on Economic, Social and Cultural Rights) (2000). General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4 (http://www.refworld.org/docid/4538838d0.html).

UN CESCR (Committee on Economic, Social and Cultural Rights) (2003). General Comment No. 15: The Right to Water (Arts. 11 and 12 of the Covenant), 20 January 2003, E/C.12/2002/11 (http://www.refworld.org/docid/4538838d11.html).

UNDP (2011). Fighting corruption in the health sector: methods, tools and good practices. New York: United Nations Development Programme (http://www.undp.org/content/dam/undp/library/Democratic%20Governance/IP/Anticorruption%20Methods%20and%20Tools%20in%20Health%20Lo%20Res%20final.pdf).

UNDG (2003). The human rights based approach to development cooperation towards a common understanding among UN agencies. New York: United Nations Development Group (https://undg.org/wp-content/uploads/2016/09/6959-The_Human_Rights_Based_Approach_to_Development_Cooperation_Towards_a_Common_Understanding_among_UN.pdf).

United Nations (2012). Human rights indicators: a guide to measurement and implementation. New York and Geneva: UN Office of the High Commissioner on Human Rights (http://www.ohchr.org/Documents/Publications/Human_rights_indicators_en.pdf).

United Nations (2015). Millennium Development Goal 8: taking stock of the global partnership for development. MDG Gap Task Force report 2015. New York: United Nations (http://www.un.org/en/development/desa/policy/mdg_gap/mdg_gap2015/2015GAP_FULLREPORT_EN.pdf).

UNICEF and World Health Organization (2015). Progress on Sanitation and Drinking Water – 2015 update and MDG assessment. Geneva (http://www.who.int/water_sanitation_health/monitoring/jmp-2015-update/en/).

Valentine N, Koller T, Hosseinpoor A. (2016). Monitoring health determinants with an equity focus: a key role in addressing social determinants, universal health coverage, and advancing the 2030 sustainable development agenda. Glob Health Action. 9:34247 (http://www.tandfonline.com/doi/full/10.3402/gha.v9.34247).

Vian T (2008). Review of corruption in the health sector: theory, methods and interventions. Health Policy Plan. 23: 83–94 (http://heapol.oxfordjournals.org/content/23/2/83.full.pdf).

Wales J, Tobias J, Malangalila E, Swai G, Wild L (2014). Stock outs of essential medicines in Tanzania – a political economy approach to analyzing problems and identifying solutions. Overseas Development Institute and Twaweza. London (http://twaweza.org/uploads/files/Stock-outs%20of%20essential%20medicines%20in%20Tanzania%20-%20ODI%20&%20TWA%20-%20final%20March2014.pdf).

WHO Country Office for Mongolia (2015). Mobile health service in rural Mongolia, study report, 2015. English translation.

WHO Country Office for Mongolia (2016a). Country Programme on Subnational Health System Strengthening in Mongolia. [Web page]. WHO Representative Office for Mongolia. Ulan Bataar,
(http://www.wpro.who.int/mongolia/mediacentre/releases/subnational_health_system_strengthening_in_mongolia/en/).

WHO Country Office for Mongolia (2016b) [webpage]. Country Programme on e-Health and m-Health (http://www.wpro.who.int/mongolia/mediacentre/releases/20160218_e-health_m-health/en/).

WHO Country Office for Mongolia (2016c). Achieving UHC: health services utilization and catastrophic health payments in Mongolia. Policy brief [unpublished].

WHO Country Office for Mongolia (2016d). Introduction of mobile health technology at the primary healthcare and community level in Mongolia. Project report, 2017. English translation.

WHO Country Office for Mongolia (2016e). Training handbook on mobile health service and mHealth, 2016. Mongolian version.

WHO Country Office for Mongolia (2016f). Improvement of mobile health services as part of the sub-national health system strengthening approach in Mongolia. Project report. English translation.

WHO Country Office for Mongolia (2017). Introduction of mobile health technology at the primary healthcare and community level in Mongolia. Project video. English (https://www.youtube.com/watch?v=C6OxrbXExs0&t=6s).

WHO Regional Office for Europe (2008). The Tallinn Charter: health systems for health and wealth. Copenhagen (http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf).

WHO Regional Office for Europe (2010). Poverty, social exclusion and health systems in the WHO European Region. Copenhagen (http://www.euro.who.int/__data/assets/pdf_file/0004/127525/e94499.pdf).

WHO Regional Office for Europe (2014a). Framework for addressing out-of-pocket and informal payments for health services in the Republic of Moldova. Vian T, Feeley FG, Domente S. Copenhagen. (http://www.euro.who.int/__data/assets/pdf_file/0009/256158/Framework-for-addressing-out-of-pocket-and-informal-payments-for-health-services-in-the-Republic-of-Moldova.pdf?ua=1).

WHO Regional Office for Europe (2014b). Economic crisis, health systems and health in Europe: impact and implications for policy. Thomson S, Figueras J, Evetovits T, Jowett M, Mladovsky M, Maresso A et al. Copenhagen (http://www.euro.who.int/__data/assets/pdf_file/0008/257579/Economic-crisis-health-systems-Europe-impact-implications-policy.pdf).

WHO Regional Office for the Western Pacific (2013). Health in all policies: report on perspectives and intersectoral actions in the Western Pacific. Regional report. Manila (http://www.wpro.who.int/topics/social_determinants_health/health_in_all_policy_report.pdf).

WHO Regional Office for the Western Pacific (2016). Universal health coverage: moving towards better health – action framework for the Western Pacific Region. Manila (http://iris.wpro.who.int/bitstream/handle/10665.1/13371/9789290617563_eng.pdf?sequence=1).

WHO (2005a). Working with the non-state sector to achieve health goals: making health systems work. Working paper no. 2. Geneva (http://www.who.int/management/working_paper_2_en_opt.pdf).

WHO (2005b). Resolution WHA58.33. Sustainable health financing, universal coverage and social health insurance. In: Fifty-eighth World Health Assembly, Geneva, 16–25 May 2005. Resolutions and decisions, annexes. Geneva (WHA58/2005/REC/1; http://apps.who.int/gb/ebwha/pdf_files/WHA58-REC1/english/A58_2005_REC1-en.pdf).

WHO (2007a). Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva (http://www.who.int/healthsystems/strategy/everybodys_business.pdf).

WHO (2007b). Resolution WHA60.29. Health technologies. In: Sixtieth World Health Assembly, Geneva, 14–23 May 2007. Resolutions and decisions, annexes. Geneva (WHASS1/2006–WHA60/2007/REC/1; http://apps.who.int/gb/ebwha/pdf_files/WHASSA_WHA60-Rec1/E/cover-intro-60-en.pdf).

WHO (2008a). The world health report 2008: primary health care (now more than ever). Geneva (http://www.who.int/whr/2008/en/).

WHO (2008b). Health equity through intersectoral action: an analysis of 18 country case studies. Geneva (http://www.who.int/social_determinants/resources/health_equity_isa_2008_en.pdf).

WHO (2010a). Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva (http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf).

WHO (2010b). A conceptual framework for action on the social determinants of health. Social determinants of health discussion paper 2 (policy and practice). Solar O, Irwin A. Geneva (http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf).

WHO (2010c). Equity, social determinants and public health programmes. Editors Erik Blas and Anand Sivasankara Kurup. Geneva (http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf).

WHO (2010d). The world health report: health systems financing: the path to universal coverage. Geneva (http://apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf).

WHO (2010e). Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. Geneva (http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf).

WHO (2010f). WHO Global code of practice on the international recruitment of health personnel. Geneva (http://www.who.int/hrh/migration/code/WHO_global_code_of_practice_EN.pdf).

WHO (2010g). Gender, women and primary health care renewal: a discussion paper. Geneva (http://apps.who.int/iris/bitstream/10665/44430/1/9789241564038_eng.pdf).

WHO (2010h). Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services: report by the Secretariat. Geneva (A63/25 (http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_25-en.pdf).

WHO (2011a). Gender mainstreaming for health managers: a practical approach. Geneva (http://www.who.int/gender-equity-rights/knowledge/health_managers_guide/en/).

WHO (2011b). Public health agencies and cash transfer programmes: making the case for greater involvement. Social determinants of health discussion paper 4 (policy and practice). By: Forde I, Rasanathan K, Krech R. Geneva (http://www.who.int/social_determinants/publications/9789241503075/en/).

WHO (2011c) Development of medical device policies. WHO Medical Device Technical Series. http://apps.who.int/medicinedocs/documents/s21559en/s21559en.pdf

WHO (2011d). Human rights and gender equality in health sector strategies: how to assess policy coherence. Geneva (http://apps.who.int/iris/bitstream/10665/44438/1/9789241564083_eng.pdf).

WHO (2011e). Monitoring, evaluation and review of national health strategies: a country-led platform for information and accountability. Geneva (http://www.who.int/healthinfo/country_monitoring_evaluation/1085_IER_131011_web.pdf).

WHO (2012a) [website]. Modelling physical accessibility to health care and geographic coverage (AccessMod©). Geneva (http://www.who.int/ehealth/resources/accessmod/en/).

WHO (2012b). WHO recommendations: optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (OPTIMIZEMNH). Geneva http://apps.who.int/iris/bitstream/10665/77764/1/9789241504843_eng.pdf

WHO (2013a). Mongolia health system review. (Health systems in transition, Vol. 3 No. 2). Geneva: WHO (on behalf of the Asia Pacific Observatory on Health Systems and Policies) (http://www.wpro.who.int/asia_pacific_observatory/hits/series/Mongolia_Health_Systems_Review.pdf).

WHO (2013b). Second WHO global forum on medical devices: priority medical devices for universal health coverage. Geneva (http://www.who.int/medical_devices/global_forum/2ndgfmd_report.pdf?ua=1).

WHO (2013c). The world health report 2013: research for universal health coverage. Geneva (http://www.who.int/whr/2013/report/en/).

WHO (2013d). Handbook on health inequality monitoring: with a special focus on low- and middle-income countries. Geneva (http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf).

WHO, Government of Finland (2013). Health in all policies: Helsinki statement. Framework for country action. Geneva. (http://apps.who.int/iris/bitstream/10665/112636/1/9789241506908_eng.pdf?ua=1).

WHO (2014a) Health systems governance for universal health coverage: action plan. Geneva (http://www.who.int/universal_health_coverage/plan_action-hsgov_uhc.pdf).

WHO (2014b). Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage. Geneva (http://apps.who.int/iris/bitstream/10665/112671/1/9789241507158_eng.pdf?ua=1).

WHO (2014c). Monitoring health inequality: an essential step for achieving health equity. Geneva (http://apps.who.int/iris/bitstream/10665/133849/1/WHO_FWC_GER_2014.1_eng.pdf?ua=1).

WHO (2015a). Tracking universal health coverage: first global monitoring report. World Health Organization, World Bank. Geneva (http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf?ua=1).

WHO (2015b). Health in all policies training manual. Geneva (http://apps.who.int/iris/bitstream/10665/151788/1/9789241507981_eng.pdf).

WHO (2015c). WHO model list of essential medicines (April 2015). Geneva (http://www.who.int/medicines/publications/essentialmedicines/EML_2015_FINAL_amended_NOV2015.pdf?ua=1).

WHO (2015d). People-centred and integrated health services: an overview of the evidence. Interim report. Geneva (http://apps.who.int/iris/bitstream/10665/155004/1/WHO_HIS_SDS_2015.7_eng.pdf?ua=1&ua=1).

WHO (2015e). Raising revenues for health in support of UHC: strategic issues for policy makers. Health financing policy brief no.1. Geneva (http://apps.who.int/iris/bitstream/10665/192280/1/WHO_HIS_HGF_PolicyBrief_15.1_eng.pdf?ua=1).

WHO (2015f). Anchoring universal health coverage in the right to health: what difference would it make? Policy brief. Geneva (http://apps.who.int/iris/bitstream/10665/199548/1/9789241509770_eng.pdf?ua=1?).

WHO (2015g). Service Availability and Readiness Assessment (SARA): an annual monitoring system for service delivery. Implementation guide. Geneva (http://apps.who.int/iris/bitstream/10665/183119/1/WHO_HIS_HSI_2015.5_eng.pdf?ua=1).

WHO (2015h). Building primary care in a changing Europe. European Observatory on Health Systems and Policies. Kringos DS, Boerma WGW, Hutchinson A, Saltman RB, editors. Copenhagen (http://www.euro.who.int/__data/assets/pdf_file/0018/271170/BuildingPrimaryCareChangingEurope.pdf?ua=1).

WHO (2016a) [website]. Health impact assessment (HIA). Glossary of terms used. (http://www.who.int/hia/about/glos/en/).

WHO (2016b) [website]. Social determinants of health. Geneva (http://www.who.int/social_determinants/en/).

WHO (2016c). Innov8 approach for reviewing health programmes to leave no one behind. Geneva (http://apps.who.int/iris/bitstream/10665/250442/1/9789241511391-eng.pdf).

WHO (2016d). IPCHS call for action: people-centred health services for people-centred development. Geneva. (http://www.who.int/servicedeliverysafety/areas/people-centred-care/call-for-action/en/).

WHO (2016e). Health financing country diagnostic: a foundation for national strategy development. McIntyre D & Kutzin J. Geneva (http://apps.who.int/iris/bitstream/10665/204283/1/9789241510110_eng.pdf?ua=1&ua=1).

WHO (2016f). WHO global strategy on human resources for health: workforce 2030. Geneva (http://apps.who.int/iris/bitstre am/10665/250368/1/9789241511131-eng.pdf?ua=1).

WHO (2016g). Strategizing national health in the 21st century: a handbook. Schmets G, Rajan D, Kadandale S, editors. Geneva (http://www.who.int/healthsystems/publications/nhpsp-handbook/en/).

WHO (2016h) [website]. WHO's financial protection in health calculation tool – extranet portal. Geneva (https://extranet.who.int/frpcalc/).

WHO (2016i). Health Equity Assessment Toolkit (HEAT). Geneva (http://www.who.int/gho/health_equity/assessment_toolkit/en/).

WHO (2016j). Building resilient sub-national health systems: strengthening leadership and management capacity of district health management teams. Technical workshop report. Freetown, Sierra Leone (http://www.who.int/csr/disease/ebola/health-systems-recovery/dhmt-report.pdf?ua=1).

WHO (2016k). Working for health and growth: investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth. Geneva (http://apps.who.int/iris/bitstream/10665/250047/1/9789241511308-eng.pdf?ua=1).

WHO (2016L). Framework on integrated, people-centred health services: report by the Secretariat. In: Sixty-ninth World Health Assembly, Geneva, 23–28 May 2016. Provisional agenda item 16.1, A69/39. Geneva (http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf).

WHO (2017a) [webpage]. Why quality UHC? Geneva (http://www.who.int/servicedeliverysafety/areas/qhc/quality-uhc/en/).

WHO (2017b) [Web site]. Q&A: Sustainable Development Goals Health Price Tag. World Health Organization, Geneva (http://www.who.int/features/qa/sdg-price-tag/en/).

WHO (unpublished 1). Health system governance actors and pathways in relation to accountability, transparency, participation and information. By: Bigdeli M, Department for Health Systems Governance and Financing, WHO/headquarters.

WHO (unpublished 2). Monitoring equity-oriented progress towards UHC – drawing from the fields of social determinants of health, gender equality and human rights. Unpublished working document for project working meeting (September 2013).

WHO, Government of South Australia (2010). Adelaide statement on health in all policies: moving towards a shared governance for health and well-being. Adelaide (http://www.who.int/social_determinants/publications/isa/hiap_statement_who_sa_final.pdf).

WHO/UNICEF (2015). Water, sanitation and hygiene in health care facilities: status in low-and middle-income countries and way forward. Geneva (http://apps.who.int/iris/bitstream/10665/154588/1/9789241508476_eng.pdf?ua=1).

World Bank (2011). How-to notes. Feedback matters: designing effective grievance redress mechanisms for bank-financed projects. Part 1: the theory of grievance redress. (http://documents.worldbank.org/curated/en/342911468337294460/pdf/639100v10BRI0F00Box0361531B0PUBLIC0.pdf).

World Bank (2012). Health equity and financial protection report: Mongolia. Washington (DC): World Bank (http://documents.worldbank.org/curated/en/383181468122679132/pdf/724500WP0HEFPr09012020120Box371917B.pdf).

World Conference on Social Determinants of Health (2011). Rio political declaration on social determinants of health. Rio de Janeiro (http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf?ua=1).

Zulu JM, Kinsman J, Michelo C, Hurtig A (2014). Integrating national community-based health workers programmes into health systems: a systematic review identifying lessons learned from low- and middle-income countries. BMC Public Health. 14:987 (http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-987).

Acknowledgements

Acknowledgements

About the context for this work

In keeping with the Country Cooperation Strategy (2010–2015) for WHO and the Government of Mongolia, the WHO Country Office for Mongolia started working on subnational health system strengthening during the summer of 2013, building partnerships with many development partners for placing universal health coverage and health security at the centre of subnational health system strengthening. In the next phase, the WHO Country Office for Mongolia initiated pilot implementation of district health system strengthening in Songinokhairkhan district of Ulaanbaatar city and aimag health system strengthening in Umnugobi aimag from 2014 to 2016. Based on the results of the pilot implementation phase, and also demands from the remaining local governments and in coordination with the national authorities, WHO Country Office for Mongolia supported the expansion and scale-up phase from 2016 onwards.

The WHO Country Office for Mongolia aligned the subnational health system strengthening activities with the SDGs (including the target on universal health coverage) and the related principle of "leaving no one behind". The three levels of WHO collaborated with national authorities during 2016 to organize three technical workshops and build the capacity of health professionals from all 21 aimags and Ulaanbaatar city's 9 districts.

The WHO Country Office for Mongolia, together with other health partners, supported the development of the State Policy on Health, 2017–2026, by the Ministry of Health, Mongolia. WHO's collaborative technical support on subnational health system strengthening in alignment with the SDGs, universal health coverage and health security has been included in the State Policy on Health. The WHO Country Office for Mongolia supported the Ministry of Health on the development of its subprogramme for the implementation of the State Policy on Health at the aimag and district levels by organizing follow-up regional technical workshops on leaving no one behind and making supervisory and monitoring visits to the aimags and districts of Ulaanbaatar.

Now in Mongolia, the core principle of the SDGs – leaving no one behind – is at the centre of aimag and district level health planning processes. The Ministry of Health and all its departments of health at each aimag and district of Ulaanbaatar city have taken ownership and leadership of this process of incorporating leaving no one behind, universal health coverage and health security at the centre of their health sector strategies and plans.

Annexes

Checklist for reviewing subnational health system strengthening 5-year plans

Mongolia leaving no one behind checklist for the review of subnational health system strengthening plans

Introduction

This checklist can support review of the draft subnational health system strengthening 5-year plans that are being done by all 21 aimags and the 9 districts of Ulaanbaatar. The checklist is divided into five domains.

1. Leaving no one behind in the needs assessment and situation analysis.
2. Leaving no one behind in the plan's core implementation areas.
3. Leaving no one behind in the monitoring and evaluation (M&E) framework and health information system strengthening.
4. Budgeting/financing the health plan.
5. Leaving no one behind in the policy dialogue and consultation processes informing the aimag or district plan.

The final section is dedicated to leaving no one behind through coherence with other plans (including national level) and partnership agreements.

Checklist

Domain 1: Leaving no one behind in the needs assessment and situation analysis

A. Have trends in health and trends in differences between subpopulations been assessed?[7]

B. Are the proposed core indicators for the new National Health Plan reflected (as well as any additional indicators especially important for the aimag or district), and have they been disaggregated[8] by relevant stratifiers (e.g. male/female, rural/urban, education level, income, age, state/district and others)?

C. Have data sources on barriers to health services been drawn from? This may include qualitative sources designed to get community input.

D. Linked to the above question, have data on financial protection, including on impoverishing and catastrophic expenditures and on indirect costs, been integrated into the situation analysis?

E. Are health programme evaluation findings on coverage gaps and implementation bottlenecks considered, with special attention to findings from disadvantaged areas within the aimag or district?

F. Are data on wider health system performance issues, including on quality, considered (e.g. assessments of facilities, human resources, the laboratory network, referral systems)?

G. Has an analysis of programmatic integration (across the health programme intervention packages, e.g. reproductive, maternal, neonatal, child and adolescent health, noncommunicable diseases, mental health and substance abuse, communicable diseases, etc.) been done, with a special view to the effectiveness of integration for the most disadvantaged subpopulations?

H. Does the situation analysis include data on key social and environmental determinants of health, as well as on gender roles, norms and relations most relevant to the aimag or district context?

I. If a considerable proportion of services are provided through the private or third sector, are data on this featured, also with a view towards these entities' impact on equity?

---

[7] See WHO Health Inequality Monitoring: http://www.who.int/gho/health_equity/assessment_toolkit/en/

[8] If disaggregated survey data are not available at aimag or district levels, they can be given by aimag or district groupings (e.g. western aimags).

Domain 2: Leaving no one behind in the plan's core implementation areas

A. Are the objectives focused on health system strengthening to overcome performance deficiencies (e.g. inadequate models of care at primary health care level with limited outreach capacity, weak referral network, insufficient training and inputs to frontline staff, insufficient availability and affordability of medicines) and other barriers experienced by disadvantaged subpopulations?

B. Are the underlying principles listed reflecting progressive universalism, i.e. that disadvantaged populations benefit at least as much as more advantaged subpopulations in reforms towards universal health coverage? The plan should have a view towards progressively improving the health system to enable universal health coverage.

C. Do the implementation plans (under each objective):
    a. Reflect ways to ensure full effective coverage (across a continuum of care) for disadvantaged subpopulations by overcoming barriers?
    b. Address adverse social consequences (impoverishment, stigmatization) of service use, including from indirect costs or lack of confidentiality, respectively?
    c. Reflect adaptations in delivery approaches to account for gender norms, roles and relations?
    d. Avoid fragmentation in the health system or verticalization of programming?

D. Is there an appropriate inclusion of population-wide health promotion (e.g. salt reduction strategies, enforcement of anti-tobacco legislation, air pollution regulation and enforcement, water supply quality improvements), and mechanisms indicated to strengthen intersectoral action for these?

E. Are there prevention activities (including those conducted through community outreach) included for generating demand, improving health literacy and knowledge of rights, obligations and entitlements, and conducting basic screening among disadvantaged subpopulations (e.g. this may include using social health workers to conduct outreach)?

F. Are there mechanisms or entry points for community engagement as part of the implementation of the plan?

G. Are there mechanisms to empower health professionals across the levels of the aimag or district health system, in particular those on the frontline, for implementation of activities indicated in the plan?

Domain 3: Leaving no one behind in the monitoring and evaluation (M&E) framework and health information system strengthening

A. Is there a clear M&E framework with inputs, outputs, outcomes and impact, and linked data sources?

B. Is there coherency between the M&E framework and the National Health Plan? The core pillars and main indicators should be integrated.

C. Does the M&E approach reflect use of disaggregated data, as well as equity-oriented targets (i.e. for reducing inequities in facilitating performance, coverage, morbidity and mortality in disadvantaged parts of the aimag or district)?

D. Is data source mapping done in relation to the M&E requirements?

E. Does the plan identify ways to strengthen aimag or district health information systems (including the quality of data sources, as well as data analysis and use, and creation of an integrated health information platform with regular reporting)?

F. Does the plan identify a research institute with capacity/mandate to do health inequality analysis and/or qualitative studies relevant to the needs of disadvantaged subpopulations?

Domain 4: Budgeting/financing of the health plan

A. Since the 5-year plan will be used to advocate at aimag and district levels for funding allocations:
- Is a review of current funding gaps in relation to system needs featured, showing how funding gaps influence system performance (in particular in the most disadvantaged parts of the aimag or district)?

B. Does the health plan feature a budget with costings per objective and indications of potential funding sources?

C. In case the most disadvantaged parts of an aimag face challenges in absorbing the budget annually allocated, are there measures in place to enhance management for appropriate and transparent absorption capacity?

D. Are ways to ensure cost savings and improve efficiencies (e.g. adjustments to essential medicines management to introduce cost savings, such as innovative ways to procure safe, quality, and lower cost drugs) featured?

E. Are ways to improve governance for transparency and accountability mentioned, e.g. strengthening of grievance mechanisms, improving transparent procurement approaches and their planning, making more transparent hiring practices, enhancing social accountability mechanisms, using findings from patient satisfaction surveys, and ensuring availability of health information in the public domain?

Domain 5: Leaving no one behind in the policy dialogue and consultation processes informing the aimag or district plan

Each aimag and district can be encouraged to include in their plan a description of the process to develop the plan, responding to the following questions:

A. Did the consultation process for the plan include mechanisms to get input from disadvantaged subpopulations (e.g. those with less formal education, no internet connectivity, living in remote areas) as well as staff who are on the frontline?

B. Did the process include consultation with other sectors to address key determinants of health inequities (social protection, environment, etc.) as well as with private and third sector providers?

C. Were specific measures taken to ensure the avoidance of conflicts of interest in decision-making processes related to the action plan?

D. Is the process and rationale for prioritization of action areas delineated, and does it reflect basic criteria for equity and fairness on the path to universal health coverage?[9]

---

[9] http://www.who.int/choice/documents/making_fair_choices/en/

Additional consideration: Leaving no one behind through coherence with other plans (including national level) and partnership agreements

This section looks at policy coherence issues. Policy coherence will facilitate adequate resource allocation and a supportive/enabling policy environment for the aimag and district health plans. In the feedback sessions on the aimag and district plans, national and subnational levels can be encouraged to pay attention to coherency issues (including the questions below).

a. Which aspects of health system strengthening will be particularly important to synergize with the National Health Plan and other national strategies and plans[10], so that the actions at aimag and district levels are reinforced?

b. Which aspects of the health plan require coherency (including with other sectors) through the Aimag Development Plan?

c. Which implementation areas will be particularly important for aimag-to-aimag exchange and district-to-district exchange (as well as potential cost sharing) in the context of implementing the plan?

d. How do the actions in the plan relate to the United Nations Development Assistance Framework (UNDAF) and other partner cooperation strategies, and which areas in particular will be important for partnerships?

e. If partnership needs are identified, what is the approach indicated for sustainability and national/subnational financing in the longer term?

---

[10] These may include the new national health financing strategy, new human resources for health strategy and new health information strengthening strategy, to ensure a supportive national policy environment.
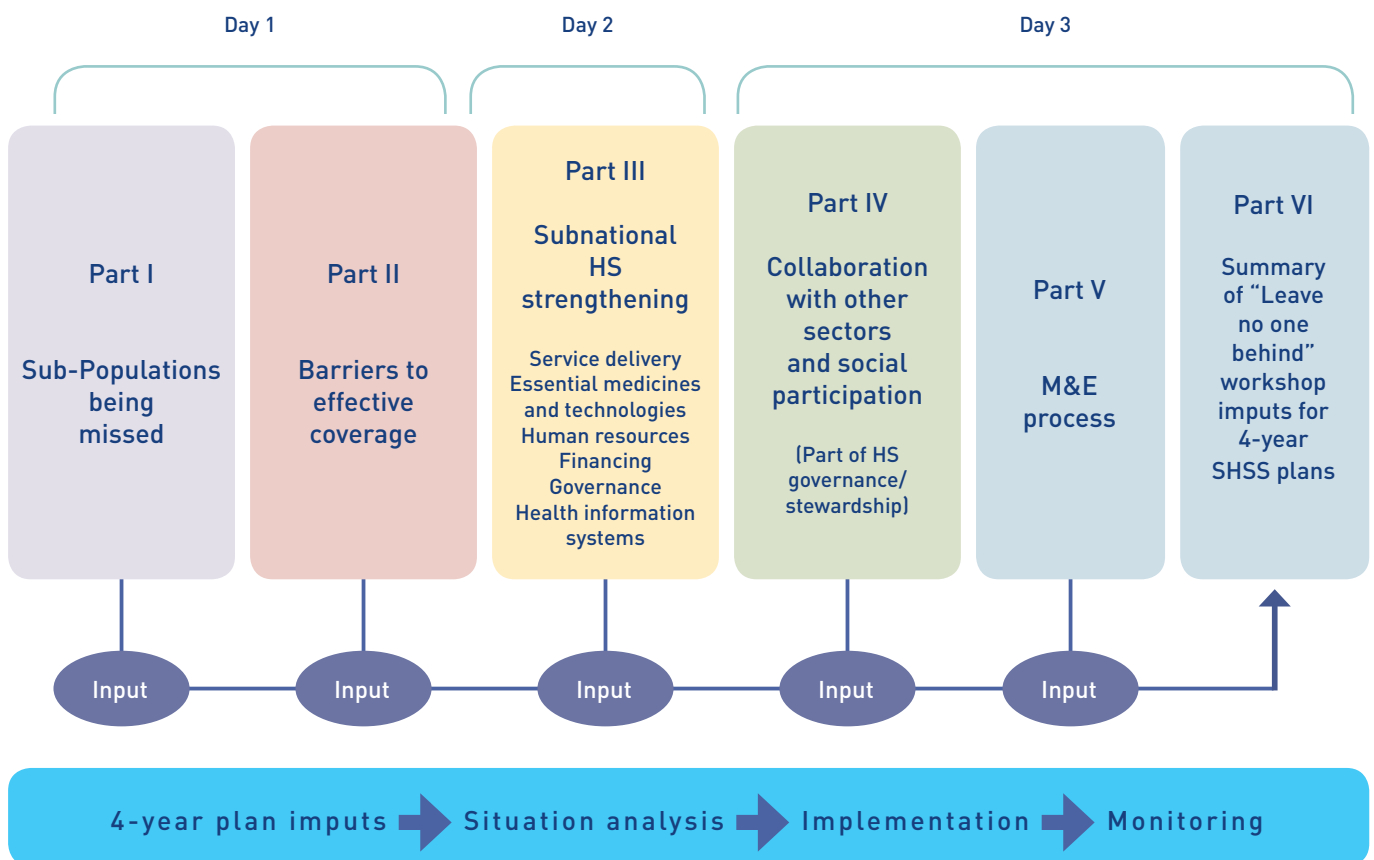
Annex 2

Materials to support review workshops using this handbook

The present handbook accompanies other capacity-building activities to support the inclusion of a strong focus on "leaving no one behind" in health-related subnational planning for the 2016–2020 phase of the Vision 2030. These capacity-building activities include workshops with aimag and district authorities. This annex comprises the materials that were used during the workshops conducted in the last quarter of 2016. It includes the workshop overview, the questionnaire sent to aimag/district teams before the workshop, the exercises that they completed during the workshops, and a generic sample agenda.

Workshop overview

The components of the capacity-building workshop on leaving no one behind in the context of subnational health system strengthening are featured in the figure below. As you can see, they match the components of the handbook. Workshop participants should be encouraged to read this handbook before and during the activities, as well as afterwards, as a resource for more information.

Workshop process

Day 1		Day 2	Day 3		
Part I Sub-Populations being missed	**Part II** Barriers to effective coverage	**Part III** Subnational HS strengthening Service delivery Essential medicines and technologies Human resources Financing Governance Health information systems	**Part IV** Collaboration with other sectors and social participation (Part of HS governance/ stewardship)	**Part V** M&E process	**Part VI** Summary of "Leave no one behind" workshop imputs for 4-year SHSS plans
Input	Input	Input	Input	Input	

4-year plan imputs ➡ Situation analysis ➡ Implementation ➡ Monitoring

Questionnaire to send aimag/district teams before 3-day workshop

Please work together with other representatives from your aimag or district to complete this questionnaire prior to the workshop.
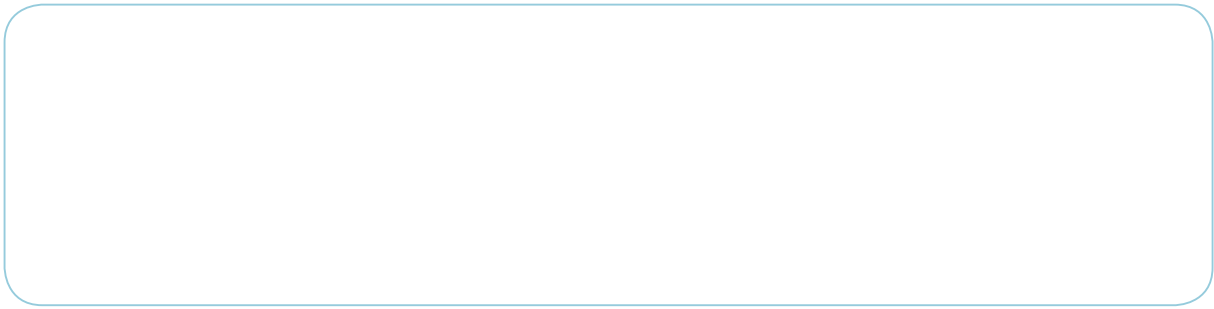
1) Please document the top 10 leading causes of death (per 10 000 population) for your aimag or district.

2) Please list the main sources of information in your aimag or district on health inequalities. Health inequalities are observable differences between subgroups within a population; they can be measured and monitored, and serve as an indirect means of evaluating health inequity[11]. Please bring to the workshop any existing relevant reports that you might want to draw from during the working group exercises.
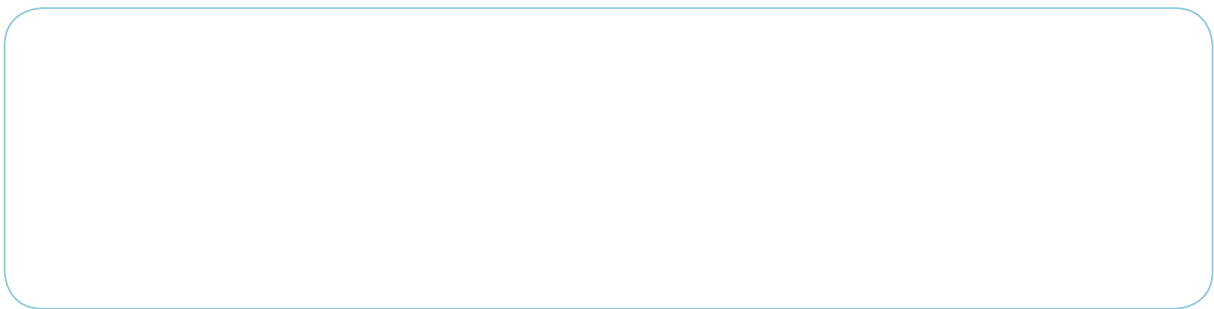
3) Please list the main sources of information in your aimag or district on barriers to services experienced by different subpopulations. Please bring existing relevant reports with you to the workshop.

---

[11] For more information, see WHO (2013). *Handbook on health inequality monitoring: with a special focus on low- and middle-income countries. Geneva.* http://apps.who.int/iris/bitstream/10665/85345/1/9789241548632_eng.pdf
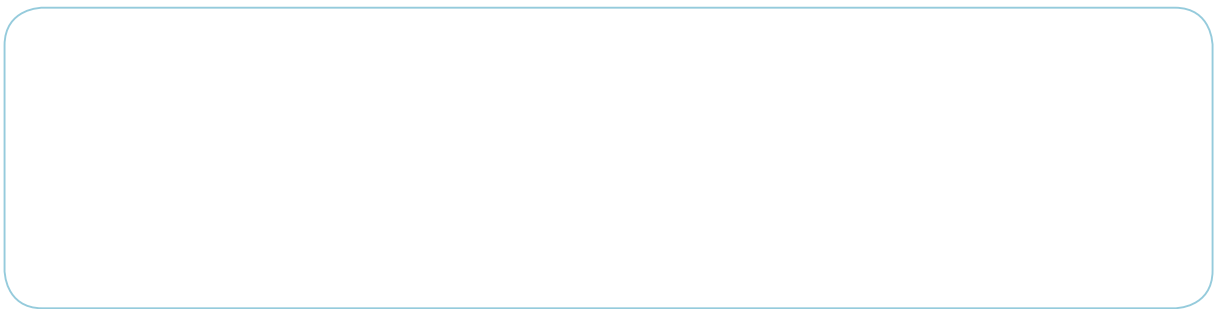
4) If health sector performance assessments (in part or comprehensively) have been done in your aimag or district, please list the reports/publications below and bring them to the workshop. These will be drawn from when identifying supply-side issues that may disproportionately impact disadvantaged subpopulations.
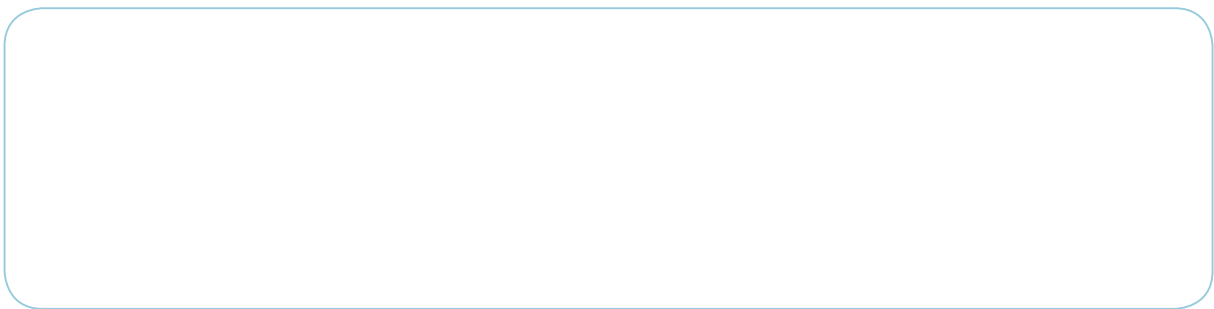
5) In your aimag or district, what are the main social and environmental factors (the responsibility for which lie outside of the health sector) that are influencing health, in particular the health of the more disadvantaged subpopulations?

6) For your aimag or district, please document below the greatest challenges and opportunities experienced by the health sector in working with other sectors.

7) For your aimag or district, please document below the greatest challenges and opportunities experienced by the health sector in fostering social participation.

8) In your aimag or district, please give examples of gender norms, roles and relations that influence health.

Definition	Generic example that is harmful to health	In your aimag or district
Gender norms refer to beliefs about women and men, boys and girls that are passed from generation to generation through the process of socialization.	Gender norms that associate masculinity with risk-taking and disregard of pain/injury may lead to hazardous behaviours by men and boys on roads. As a result, in many countries men are more likely to die or be injured in road traffic crashes.	
Gender roles refer to what women and men are expected to do (i.e. in the household, community and workplace) in a given society.	In some societies, women tend to be seen as responsible for household tasks including cooking. As a result, women can be more exposed to indoor air pollution from cooking fuels.	
Gender relations refer to social relations between and among women and men, boys and girls that are based on gender norms and roles.	Unequal power relations between women and men can contribute to differential vulnerabilities to certain health conditions (e.g. gender-based violence).	

9) For the next 5 years in your aimag or district, what are the emerging health sector priorities for "leaving no one behind" in efforts to ensure that all people have access to the necessary health services, across the continuum of care, without the risk of experiencing financial hardship?

10) For the next 5 years in your aimag or district, in which ways do you envisage strengthening your health information system to enable a focus on leaving no one behind?

Exercises to use in 3-day workshops*

*It should be noted that these exercises are not meant to replace the in-depth assessment and analysis of these issues that should be undertaken in the planning process. However, they are meant to spark ideas and reflections that can later be drawn on for development of a fuller assessment.

Corresponding text – "Health inequities in Mongolia" and Part I: Knowing who is being missed

Exercise 1. In pairs, or in your aimag or district team, please read the content in the Background on "Health inequities in Mongolia". Discuss your thoughts on how/if these types of differences between subpopulations exist in your aimag/district. Take notes below and be ready to share (a few pairs/teams will be called on to share).

Exercise 2. In your aimag or district team, please reflect on differences in health between subpopulations in your aimag/district and which subpopulations are being "left behind". In doing so, think about subpopulations that have higher exposure to risk factors and experience accumulated vulnerability (the latter means exposure to multiple risk factors at once and/or presence of co-morbidities that enhance vulnerability to ill-health). Reflect on those subpopulations that may have lesser access to and utilization of health services, despite their higher needs. Think about which subpopulations have higher mortality and morbidity rates. Also consider which subpopulations may be more at risk than other groups in adverse social circumstances (such as impoverishment, losing one's job, etc.) as a result of illness. Sometimes it comes instinctually to focus on only the most disadvantaged (e.g. streetchildren or homeless persons), but be sure to think across the social gradient – for instance, that people in the lowest and second-lowest wealth quintiles may also have lower health status than more affluent people.

For this exercise, you can use the following list of characteristics to reflect on which subpopulations may be being left behind:
- income or wealth;
- place of residence (rural, urban, other);
- occupation (workers/employed, unemployed);
- sex;
- marital status and household composition (single-parent-headed family, children living with grandparents);
- education;
- age;
- other characteristics particularly important for the programme and country context (e.g. migrant status, caste, race/ethnicity, religion, gender identity and sexual orientation).

Write below your team's reflections on which subpopulations are being left behind in progress towards better health in your aimag or district.

Corresponding text – Part II: Considering barriers to effective coverage

Exercise 3. This exercise supports you in identifying different types of barriers that disadvantaged subpopulations may experience in your aimag/district. Start by taking a few minutes to review Part II on considering barriers to effective coverage. Then complete the table, below, for barriers experienced by the main subpopulations that you identified as "being left behind" in Exercise 2. Please also consider barriers related to gender norms, roles and relations.

Subpopulations being missed (from Exercise 2)	Barriers *(considering the different relevant Tanahashi dimensions)*

Corresponding text – Part III: Subnational health system strengthening to tackle barriers

The following exercises aim to explore health system strengthening measures that can address barriers experienced by the subpopulations being left behind.

Exercise 4. Please fill out the table below, considering how service delivery can be strengthened in your aimag/district to overcome barriers being experienced by disadvantaged subpopulations and reduce health inequities.

Barriers identified (from Exercise 3)	Ways in which service delivery can be strengthened to address barriers	Expected impact on disadvantaged subpopulations in your aimag/district

Exercise 5. Please fill out the table below, considering how human resources can be strengthened in your aimag/district to overcome barriers being experienced by disadvantaged subpopulations and reduce health inequities.

Barriers identified (from Exercise 3)	Ways in which the health workforce/ human resources can be strengthened to address barriers	Expected impact on disadvantaged subpopulations in your aimag/district

Exercise 6. Please fill out the table below, considering how essential medicines, technologies and inputs can be reinforced in your aimag/district to overcome barriers being experienced by disadvantaged subpopulations and reduce health inequities.

Barriers identified (from Exercise 3)	Ways in which essential medicines, technologies and inputs can be reinforced to address barriers	Expected impact on disadvantaged subpopulations in your aimag/district

Exercise 7. Please fill out the table below, considering how financing can be strengthened in your aimag/district to overcome barriers being experienced by disadvantaged subpopulations and reduce health inequities.

Barriers identified (from Exercise 3)	Ways in which financing can be reinforced to address barriers	Expected impact on disadvantaged subpopulations in your aimag/district

Exercise 8. Please fill out the table below, considering how governance can be strengthened in your aimag/district to overcome barriers being experienced by disadvantaged subpopulations and reduce health inequities.

Barriers identified (from Exercise 3)	Ways in which governance can be strengthened to address barriers	Expected impact on disadvantaged subpopulations in your aimag/district

Exercise 9. Please fill out the table below, considering how health information systems can be strengthened in your aimag/district to provide information needed to overcome barriers being experienced by disadvantaged subpopulations and reduce health inequities.

Barriers identified (from Exercise 3)	Ways in which the health information system can be strengthened to address barriers	Expected impact on intelligence about disadvantaged subpopulations in your aimag/district

Exercise 10. While there are separate exercises for each building block, it is important to acknowledge that they are all synergistic and interrelated, and that a systems-wide approach will be required. To support conceptualization of a synergistic and interlinked approach, please complete the table below summarizing your findings.

In which ways are the suggested health system strengthening measures synergistic and mutually reinforcing in overcoming barriers experienced by disadvantaged subpopulations? Are there any that should be done before the others in order to ensure a smooth flow of reforms (i.e., please expand on staging considerations).
Are there any potential unintended consequences of the suggested measures and how could these be mitigated?

Corresponding text – Part IV: Working with other sectors to address health determinants and overcome barriers

Exercise 11. Please review Fig. 7 showing the WHO framework on social determinants of health (in Part IV). Consider the structural and intermediate social determinants influencing the health of the disadvantaged subpopulations that you identified in the previous exercises. Consider how these social determinants influence the barriers that you identified (in Exercise 3). Then think of the sectors – other than health – that have a responsibility in addressing those social determinants. Please list the top three in the table below.

Name of sector	Why does that sector matter for overcoming barriers and improving the health of disadvantaged subpopulations in your aimag/district?	What specific action by the sector is required for this?
1.		
2.		
3.		

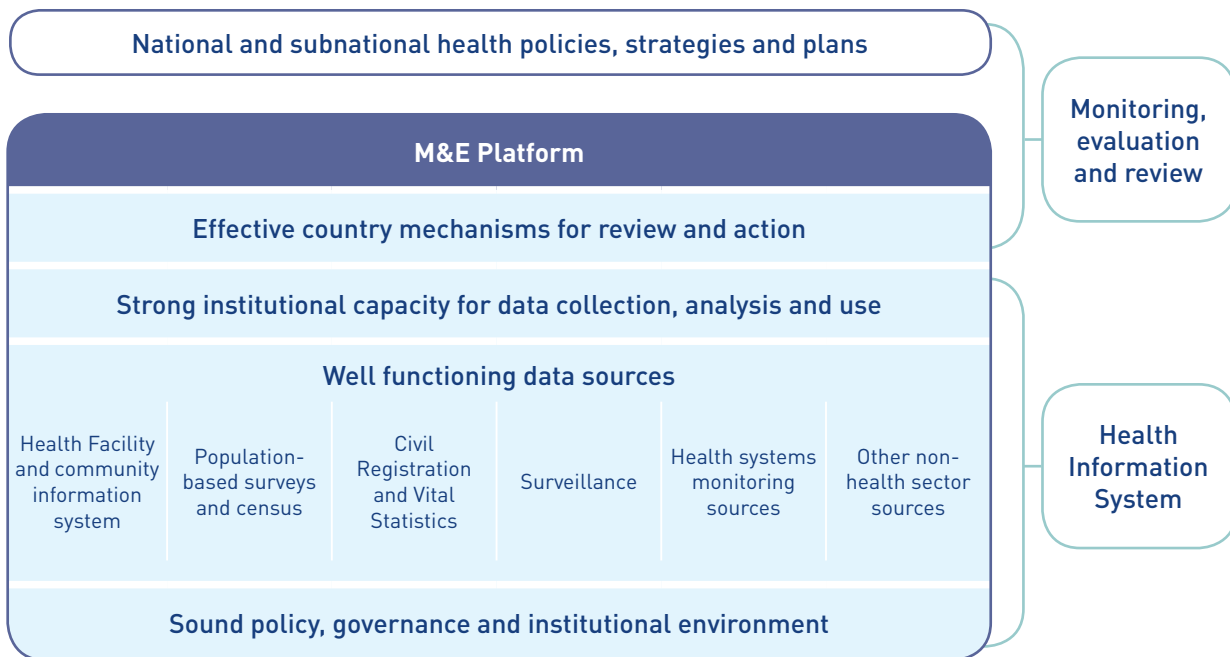**Corresponding text – Part V: Enhancing social participation**

Exercise 12. Please complete the table below on improving social participation of disadvantaged subpopulations in decision-making regarding their health. Participation is a principle of a human rights approach to health, and can enhance service effectiveness, gender-responsiveness and equity.

In your aimag or district, how would social participation of disadvantaged subpopulations be particularly important for overcoming barriers experienced by them? Which barriers?
What kind of mechanisms for social participation could be created?

Corresponding text – Part VI: Strengthening monitoring and evaluation in subnational health planning to leave no one behind

Exercise 13. Please consider how the monitoring and evaluation framework and annual review processes for your aimag or district 5-year plan could, among other items:

- draw from health inequality monitoring, benefits incidence analysis, data on financial protection coverage, and area-disaggregated data from facility assessments;

- draw from (qualitative and quantitative) data on access barriers experienced by disadvantaged subpopulations and gender analysis;

- include information on key environmental and social determinants of health;

- feature data on quality and responsiveness to non-medical needs (e.g. information on patient rights and entitlements, confidentiality, patient satisfaction);

- feed in other research findings relevant to leaving no one behind;

- be participatory – to what extent are disadvantaged communities engaged;

- provide information on governance and transparency issues, including functionality of complaint mechanisms, existence and functionality of community engagement and social participation platforms, availability of information in the public domain, etc.

National and subnational health policies, strategies and plans					
M&E Platform					
Effective country mechanisms for review and action					
Strong institutional capacity for data collection, analysis and use					
Well functioning data sources					
Health Facility and community information system	Population-based surveys and census	Civil Registration and Vital Statistics	Surveillance	Health systems monitoring sources	Other non-health sector sources
Sound policy, governance and institutional environment					

Monitoring, evaluation and review

Health Information System

Generic agenda for 3-day workshop to accompany the handbook

Day 1

Registration at 08:00

Opening session

09:00–09:30	Opening remarks by appropriate national and subnational authorities and partners
09:30	Roundtable introductions of all participants, introduction of co-facilitators
09:45	Group photo
10:00	Coffee and tea break

Session I: Identifying subpopulations most at risk of being missed or benefitting

10:15	Western Pacific regional perspectives on leaving no one behind in the SDGs, as per the "Universal health coverage: moving towards better health" action framework
10:40	Presentation on health inequalities in Mongolia by representative from the Ministry of Health
11.00	Working in pairs with someone from a different aimag/district (who you do not know), read the background section on health inequities in Mongolia, and discuss your thoughts on how/if these types of inequities exist in your aimag/district
11:30	Feedback to the audience from a few of the selected pairs
12:00	Power walk[1]
12:45	Concepts when considering subpopulations being left behind • What are health inequities and what frameworks can help to understand them? • Why are data on health inequalities important when you are doing your situation analysis for the 5-year plans? • What is gender, and how do gender norms, roles and relations influence health? Comments from the audience, questions and answers (between each component)

Lunch at 13:20–14:00

---

[12] See page 53 for instructions – http://apps.who.int/iris/bitstream/10665/44516/1/9789241501071_eng.pdf

14:00	Introduction to group work
14:10	Teams work together to discuss the subpopulations being missed in their aimags/districts, and how they can reflect these in the situation analysis for their plans
14:40	Reportback of a few teams and discussion in plenary – local consultant (facilitation) and country office staff (translation)

Session II: Exploring the barriers that disadvantaged subpopulations may face in accessing and benefitting from services

15:00	Presentation on the Tanahashi framework for effective coverage and the availability, accessibility, acceptability and quality (AAAQ) of the right to health
15:20	Interactive plenary component using Tanahashi dimensions (with local consultant and co-facilitators)
15:40	Discussion by teams of the main barriers to effective coverage experienced by disadvantaged subpopulations in their aimags/districts, and how to include data on barriers in their situation analysis – write answers on flipcharts
16:10	Sharing by two aimags/districts of their answers and discussion
16:20	Coffee and tea – pick it up and be ready to take it to your group work
16:30	Explanation of group work using patient pathways (overlaying barriers experienced by disadvantaged subpopulations)
16:40	Group work – divide all participants into three groups: • one patient pathway for a noncommunicable disease • one patient pathway for a communicable disease • one generic patient pathway Each group will select *one disadvantaged subpopulation* for which to do this exercise (as an example). Patient pathways will be posted on a wall and group members will have to overlay barriers on top of the pathways using post-it notes.
17:20	One representative from each group reports on barriers for disadvantaged subpopulations in relation to the patient pathways Discussion in plenary
17:45	Close of day

Day 2

Session III: Strengthening subnational health systems for moving towards universal health coverage and leaving no one behind

08:30	Opening of Day 2: • recap of the previous day • overview of Day 2
08:45	Presentation on universal health coverage and leaving no one behind
09:15	Group exercise on health system strengthening to overcome barriers identified in the patient pathways (using post-it notes, on the patient pathways depicted on the walls)
09:45	Reportback from group work
10:00	Presentation on health system strengthening approaches to leave no one behind, by health system building block • Slides on service delivery approaches to leave no one behind • Examples from Mongolia and/or other countries
10:30	Group work on service delivery approaches to tackle the barriers that they identified in their aimag/district
11:00	Coffee and tea break
11:15	• Slides on human resource strengthening to leave no one behind • Examples from Mongolia and/or other countries
11:35	Group work on human resource strengthening approaches to tackle the barriers that they identified in their aimag/district
12:00	• Slides on essential medicines, technologies and basic infrastructure/equipment strengthening to leave no one behind • Examples from Mongolia and/or other countries
12:25	Group work on essential medicines, technologies, and basic infrastructure/equipment strengthening to tackle the barriers that they identified in their aimag/district
12:55	Reportback of two aimags/districts on what they have proposed so far – keeping a link (during reporting) to how the suggested changes will help overcome the barriers experienced by disadvantaged subpopulations (and mentioning how these changes across building blocks are synergistic towards the intended aim of leaving no one behind)
13:15	Lunch (45 minutes)

14:00	• Slides on financing approaches to leave no one behind • Examples from Mongolia and/or other countries
14:30	Group work on strengthening financing approaches to tackle the barriers that they identified in their aimag/district
15:00	• Slides on subnational governance strengthening to leave no one behind • Examples from Mongolia and/or other countries
15:25	Group work on governance strengthening to tackle the barriers that they identified in their aimag/district
15:55	Reportback of two aimags/districts on what they have proposed so far – keeping a link (during reporting) to how the suggested changes will help overcome the barriers experienced by disadvantaged subpopulations (and mentioning how these changes across building blocks are synergistic towards the intended aim of leaving no one behind)
16:15	Coffee and tea break
16:25	• Slides on subnational health information system strengthening to leave no one behind • Examples
16:40	Group work on health information system strengthening to tackle the barriers that they have identified in their aimag/district
17:10	Reportback of two aimags/districts on what they have proposed so far – keeping a link (during reporting) to how the suggested changes will help overcome the barriers experienced by disadvantaged subpopulations (and mentioning how these changes across building blocks are synergistic towards the intended aim of leaving no one behind)
17:30	Facilitator comments and reflections on synergistic actions across the building blocks (not to look at health system strengthening in siloed approaches) – using the WPRO universal health coverage framework.
17:40	Close of Day 2 All aimag/district teams should have completed answers through Exercise 9 in the workshop template, and should be asked to complete Exercise 10 as homework that evening.

Day 3

08:30	Opening of Day 3 • Recap of the previous day • Overview of Day 3
08:45	• Presentation on social determinants, intersectoral action and social participation in relation to leaving no one behind • Example • Introduction to group work for Session IV
09:15	Parallel group work for Session IV on intersectoral action to leave no one behind – aimag/district teams will be split into three groups (i.e. there will be a representative from each aimag/district in each group) and they will gather around the three boards with patient pathways (and barriers experienced by subpopulations being missed)

Intersectoral action groups	*Social participation* group
In relation to the patient pathway on noncommunicable diseases and the generic patient pathway, participants discuss the following: • Name of partner sector • Why does that sector matter to reducing the barriers to health services experienced by the subpopulation being left behind? • What is the specific action of the sector required for overcoming barriers and where would these actions fit on the patient pathway? The participants then write their answers regarding specific actions up on cards and place in the correct place along the patient pathway.	In relation to the patient pathway on communicable diseases, participants discuss the following: • How would social participation be particularly important to overcoming barriers along the patient pathway? • What kind of mechanisms for social participation could be created? The participants then write their answers on cards and place in the correct place along the patient pathway. Underpinning this discussion should be reflection on how social participation can be reflected across the cycle of situation analysis, planning, implementation, and monitoring and evaluation for the health topic addressed by the patient pathway.

10:00	• Reportback of groups (5 minutes each) • Introduction to work to complete their aimag/district exercise template on findings for social participation and intersectoral action
10:20	Coffee and tea break
10:30	Aimag/district teams work on completing the sections on social participation and intersectoral action in their exercise templates for the 5-year plans, focusing on which measures they could include to help overcome barriers experienced by disadvantaged subpopulations

Session V: Strengthening monitoring and evaluation to leave no one behind

11:00	• Presentation on monitoring and evaluation of subnational health sector plans, and reflecting a "leave no one behind" approach • Examples • Introduction to group work for Session V
11:30	Group work on monitoring and evaluation to leave no one behind – findings put into exercise template
12:30	Reportback of some of the aimag/district groups and discussion in plenary

Lunch at 13:00–14:00

Session VI: Identifying entry points for enhancing the focus on "leaving no one behind" in the design, implementation and monitoring and evaluation of the health-related 5-year plans

14:00	• Participants should be working in their aimag/district teams • Group work to finalize inputs into the exercise template and prepare for presentation (participants will have filled the template during the course of the workshop). This extra time is given to complete slides and make additional ones on next steps that will be implemented once they return to their aimags/districts. Facilitators may want to give guidance for these additional slides, depending on the context.
16:00	Reportback via peer review and exchange • For reportback, aimag/district teams will be paired and have to report to each other and co-facilitators their full template contents • First aimag/district in the pair presents, followed by Q&A across teams and by co-facilitators Coffee and tea will be served at 16:30 and participants are asked to pick it up and return to groups • Second aimag/district in the pair presents, followed by Q&A across teams and by co-facilitators
17:00	Plenary discussion on points emerging from the peer review Reflections on core criteria for a leaving no one behind approach in subnational plans, and next steps
17:30	Closing • Closing address by authorities and partners • Certificates • Feedback/evaluation of workshop

Resources for more in-depth work

Please see reference list for web links to publications.

WHO (2011). *Gender mainstreaming for health managers: a practical approach.* Geneva.

The manual is a user-friendly guide aimed to raise awareness and develop skills on gender analysis and gender responsive planning in health sector activities. The manual is conceptually structured to move from awareness to action throughout a 3–4 day workshop to reduce gender-based inequities in health. Core WHO gender analysis tools are introduced in this participatory training manual, including:
- Gender Analysis Matrix (GAM)
- Gender Analysis Questions (GAQ)
- Gender Responsive Assessment Scale (GRAS)
- Gender Assessment Tool (GAT)
- Gender and health planning and programming checklist

WHO (2011). *Human rights and gender equality in health sector strategies: How to assess policy coherence.* Geneva.

This tool is meant to support countries as they design and implement national health sector strategies in compliance with obligations and commitments. The tool focuses on practical options and poses critical questions for policy-makers to identify gaps and opportunities in the review or reform of health sector strategies as well as other sectoral initiatives. The tool aims to operational a human rights-based approach and gender mainstreaming through their practical application in policy assessments.

WHO (2013). *Handbook on health inequality monitoring: with a special focus on low- and middle-income countries.* Geneva.

WHO developed this handbook to act as a resource for those involved in spearheading, improving or sustaining monitoring systems. The handbook was principally designed to be used by technical staff of ministries of health to build capacity for health inequality monitoring in Member States; however, it may also be of interest to public health professionals, researchers, students and others. The users of this handbook should have basic statistical knowledge and some familiarity with monitoring-related issues.

Videos on health inequality monitoring: http://www.who.int/gho/health_equity/videos/en/

WHO (2016). *Innov8 approach for reviewing national health programmes to leave no one behind.* Geneva.

Innovat8 is an eight-step approach for reviewing national health programmes to leave no one behind. Innov8 responds to the practical question of "how" to move from having data on inequalities to making actual changes in programmes to ensure no one is left behind. Made specifically for health programmes, and with technical staff from ministries of health in mind, Innovat8 uses a stepwise approach to analyse the subpopulations being missed by the programme, identify the barriers they face, define the potential drivers of the barriers in the health sector and beyond, and look at the role of intersectoral action and social participation.

WHO (2015). *WHO global strategy on people-centred and integrated health services: interim report.* Geneva

The WHO global strategy on people-centred and integrated health services is a call for a fundamental paradigm shift in the way health services are funded, managed and delivered. This document delineates the five strategic directions of the strategy.

WHO (2014). *Health systems governance for universal health coverage: action plan.* Geneva

WHO developed this document to assist countries as they move closer to universal health coverage. The document outlines a plan of action for the work of the Department of Health Systems Governance and Financing in the area of health system governance and leadership, focusing particularly on governance for universal health coverage.
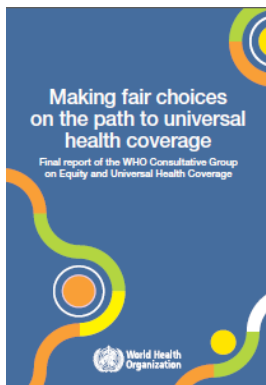
WHO (2014). *Making fair choices on the path to universal health coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage.* Geneva.

This report addresses the key issues of fairness and equity that arise on the path to universal health coverage by clarifying these issues and by offering practical recommendations for how countries can manage them. The report also describes three dimensions countries must advance in order to achieve universal health coverage. The report is relevant for a wide range of actors (e.g. institutions, groups and individuals, within and outside government, locally, nationally, and internationally) and particularly for governments in charge of overseeing and guiding the progress toward universal health coverage. More specifically, the report can be particularly useful for policy-makers and technical advisors in health ministries.

WHO (2016f). *WHO global strategy on human resources for health: workforce 2030.* Geneva.

The Global Strategy on Human Resources for Health: Workforce 2030 is primarily aimed at planners and policy-makers of WHO Member States, but its contents are of value to all relevant stakeholders in the health workforce area, including public and private sector employers, professional associations, education and training institutions, labour unions, bilateral and multilateral development partners, international organizations, and civil society.

WHO (2010). *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations.* Geneva.

This document proposes 16 evidence-based recommendations on how to improve the recruitment and retention of health workers in underserved areas. The evidence-based recommendations relate to the movements of health workers within the boundaries of a country and focus solely on strategies to increase the availability of health workers in remote and rural areas through improved attraction, recruitment and retention. It also offers a guide for policy-makers to choose the most appropriate interventions, and to implement, monitor and evaluate their impact over time.

WHO (2016). *Health financing country diagnostic: a foundation for national strategy development.* Diane McIntyre and Joseph Kutzin. Geneva.

This document provides step-by-step guidance on how to undertake a situation analysis of a country's health financing system and considers a number of issues, including the current level, mix and sources of funding for the health sector and institutional arrangements for health financing. It also assesses the performance of the system against the objectives and goals of universal health coverage. The diagnostic is written for ministries of health and other actors responsible for developing and implementing health financing policies, as well as those in an advisory role.

WHO (2017). *Developing a national health financing strategy: a reference guide.* Kutzin J, Witter S, Jowett M, Bayarsaikhan D. Geneva.

Guide lays out the conceptual approach, principles and a set of issues which need to be addressed in order to ensure the development of a comprehensive and coherent health financing strategy.

WHO (2015). *Health in all policies: training manual.* Geneva.

This manual is a training resource to increase understanding of the importance of Health in All Policies (HiAP) among health professionals and policy-makers in public health institutes, universities, nongovernmental organizations, and government and intergovernmental organizations. The material included forms the basis of 2- and 3-day workshops which: build capacity to promote, implement and evaluate HiAP; encourage engagement and collaboration across sectors; facilitate the exchange of experiences and lessons learned; promote regional and global collaboration on HiAP; and promote dissemination of skills to develop training courses for trainers.
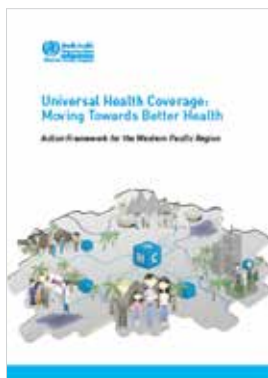
WHO Regional Office for the Western Pacific (2016). *Universal health coverage: moving towards better health – action framework for the Western Pacific Region.* Manila

This document details an action framework that provides guidance for Member States to accelerate progress towards universal health coverage and some SDGs. The framework supports countries to develop their own universal health coverage road maps by tailoring a group of interconnected actions as part of their national health policy and planning processes. In developing its own road map, each Member State should assess its progress towards universal health coverage, identify gaps, select entry points and opportunities for change, cultivate an enabling environment and intersectoral collaboration across government and for stakeholder engagement, ensure financial sustainability, and continue to monitor and evaluate progress. Member States at all levels of development can take steps to advance universal health coverage.

UNICEF's EQUIST platform

http://www.equist.info/

EQUIST is an approach and an online platform designed to help health policy-makers and programme managers to sharpen health plans and policies and make decisions about how to strengthen their health systems, with a focus on reproductive, maternal, neonatal, child (and adolescent*) health issues. EQUIST's explicit aim is to give access to stakeholders at national and subnational level to the best available global evidence, data and tools in a logical and user-friendly manner. The goal of EQUIST is to help devise strategies and approaches to reduce health disparities between the most marginalized mothers and young children and the better-off. The tool was designed principally for developing countries – those suffering from the highest levels of child and maternal mortality and malnutrition – as well as middle-income countries with remaining pockets of excluded populations.

* Adolescent modules are forthcoming.

WHO (2016). *Strategizing national health in the 21st century: a handbook.* Geneva

This handbook is designed as a resource for providing up-to-date and practical guidance on national health planning and strategizing for health. It establishes a set of best practices to support strategic plans for health and represents the wealth of experience accumulated by WHO on national health policies, strategies and plans.

IntegratedCare4People

Following on the endorsement of the Framework for integrated people-centred health services, which includes a focus on vulnerable and marginalized subpopulations, IntegratedCare4People is an online network of practitioners and organizations (launched in 2016).

http://www.integratedcare4people.org/

The Call for action on integrated people-centred health services is primarily intended for national and subnational health authorities to support them in translating the Framework on integrated people-centred health services approved by the World Health Assembly in May 2016 into their national and subnational settings. It provides orientations for implementation, highlighting strategies and policy levers for service delivery transformation. It is complemented by a series of technical documents, including an assessment and planning toolkit, position papers and policy and practice briefs that will be released during late 2017.

IHP+ has transformed into the International Health Partnership for universal health coverage 2030. Since IHP+ began in 2007, partner agencies and countries have worked together to produce a range of tools, guidelines and frameworks to support the work that takes place at country level.

https://www.internationalhealthpartnership.net/en/tools/

Global Learning Laboratory for Quality Universal Health Coverage (WHO)

The WHO Global Learning Laboratory (GLL) for Quality Universal Health Coverage aims to gather people from across the globe, representing various disciplines, within a safe space to share knowledge, experiences and ideas; challenge those ideas; and spark new ways of doing, all to strengthen approaches towards achieving quality care for all placing people at its centre. The GLL is organized around three areas. First, national quality policy and strategy, which allows consideration of the multiple disciplines that lead to strong comprehensive, yet focused, policies and strategies. Second, specific technical areas – e.g. WASH and maternal and child health – that need to be considered carefully in achieving quality universal health coverage. Third is the heart of the GLL, the role of compassion in quality universal health coverage, acknowledging the human spirit that drives quality from both the health system and community.

https://extranet.who.int/dataform/627224?lang=en

WHO (2015). *Service Availability and Readiness Assessment (SARA): an annual monitoring system for service delivery.* Geneva

The Service Availability and Readiness Assessment (SARA) is a health facility assessment tool designed to assess and monitor the service availability and readiness of the health sector and to generate evidence to support the planning and managing of a health system. Data from SARA can be disaggregated by local level governance unit, which can be crossed with health morbidity and mortality data and/or linked to data on poverty and multidimensional deprivation. Connecting the data in these ways allows for insight into facility preparedness in the most disadvantaged areas.
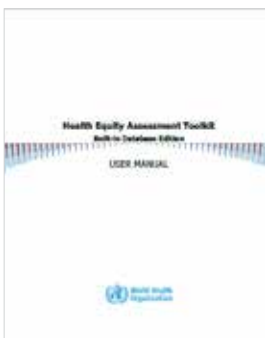
WHO (2016). Health Equity Assessment Toolkit (HEAT). Geneva

The Health Equity Assessment Toolkit (HEAT) is a software application for use on desktop or laptop computers and mobile devices (minimum screen size of 7.9 inches recommended). It was developed to facilitate the assessment of within-country health inequalities.

The Health Equity Assessment Toolkit is available in 2 editions:
- HEAT, Built-In Database Edition, which comes pre-installed with the Health Equity Monitor database.
- HEAT Plus, Upload Database Edition, which allows users to upload and work with their own database.

WHO (2012). Modeling Physical Accessibility to Health Care and Geographic Coverage (AccessMod©). Geneva.

AccessMod© is a toolbox that uses the power of geographic information systems to:

- measure physical accessibility to health care;
- estimate geographical coverage (a combination of availability and accessibility coverage) of an existing health facility network;
- complement the existing network in the context of a scaling-up exercise or to provide information for cost-effectiveness analysis when no information about the existing network is available.

WHO (2017). *National health inequality monitoring: a step-by-step manual.* Geneva.

The manual was designed as a highly accessible, practical reference to encourage and strengthen the practice of health inequality monitoring. Additionally, the manual aims to foster regular reporting of inequalities across diverse health topics, and promote greater integration of health inequality considerations in policies, programmes and practices.

The manual is organized according to a flow chart, which shows the steps and sub-steps of the health inequality monitoring cycle, with key questions and itemized checklists of data requirements, analysis/reporting activities and/or decision points. Relevant examples and resources, including sample table templates and recommended readings, are provided for further exploration.

WHO Regional Office for the Western Pacific (2013). *Health in all policies: report on perspectives and intersectoral actions in the Western Pacific. Regional report.* Manila

The report looks at what, why and how intersectoral action for health and, where possible, HiAP approaches have been implemented to address the social determinants of health. The report aims to explore lessons applicable to working intersectorally on public policies, which lies at the heart of a HiAP approach. It describes what it takes to develop and implement intersectoral action for health across the Region.

WHO and ITU (2015). *A handbook on how to implement mTobacco Cessation.* Geneva

A handbook describing procedures to implement national mHealth programmes on tobacco cessation. It lays out five core components: operations, content development, technology support, programme promotion, and monitoring and evaluation.

WHO and ITU (2015). *A handbook on how to implement mDiabetes.* Geneva

A handbook describing procedures to implement national mHealth programmes on prevention and management of diabetes. It lays out five core components of implementing an mHealth for tobacco cessation programme: operations, content development, technology support, programme promotion, and monitoring and evaluation. The handbook aims to support countries in successful implementation of a mHealth for diabetes programme.

MOVING TOWARDS HEALTH IN ALL POLICIES:
A COMPILATION OF EXPERIENCES FROM
AFRICA, SOUTH-EAST ASIA AND
THE WESTERN PACIFIC

WHO (2013). *Moving towards health in all policies: a compilation of experience from Africa, South-East Asia and the Western Pacific.* Geneva.

The document compiles case-studies of intersectoral action from Asia and Africa. These cases were compiled in the lead-up to the 8th Global Conference on Health Promotion, which took place in Helsinki, Finland, and which focused on HiAP. The cases are viewed with a common lens that interrogates how they address determinants of health and promote health equity, and whether they are potential strong cases with respect to the way they deal with intersectoral relations.

PRACTISING A HEALTH IN ALL POLICIES APPROACH—
LESSONS FOR UNIVERSAL HEALTH COVERAGE AND
HEALTH EQUITY

A policy briefing for ministries of health based on experiences from
Africa, South-East Asia and the Western Pacific

WHO (2013). *Practising a Health in All Policies approach – lessons for universal health coverage and health equity.* Geneva.

The policy brief summarizes the framing of HiAP approach and describing the links between universal health coverage and HiAP. It builds on the cases examined in the compilation of experiences from Africa, South-East Asia and the Western Pacific. Specifically, integrated services in schools and in the context of mental health are highlighted in two cases.

Health in All Policies
a manual for local government

Local Government Association (2016). *Health in All Policies: a manual for local government.* London.

This manual brings together the arguments for a HiAP approach with practical suggestions for development at the local level. It was written for the context of England and the United Kingdom, but provides useful insights for local actors in other countries.

ANNEX
DRAFT FRAMEWORK FOR COUNTRY ACTION
ACROSS SECTORS FOR HEALTH AND HEALTH EQUITY

WHO & Government of Finland (2013). *Helsinki Statement. Framework for Country Action.* Geneva.

The framework for country action was originally developed at the 8th Global Conference on Health Promotion. The subsequent revised framework was approved by the World Health Assembly in May 2015 and can be referred to in the annex of resolution WHA68/17. The framework identifies seven components of action requiring institutionalization for HiAP.

WHO (2016). *Recovery toolkit: supporting countries to achieve health service resilience.* Geneva
http://www.who.int/csr/resources/publications/ebola/recovery-toolkit/en/

The recovery toolkit is a library of guidance resources in a single place which can be quickly and easily accessed, to guide action. A key purpose of the toolkit is to support countries in the reactivation of health services which may have suffered as a result of emergencies.

WHO (2016). *Guidelines for core components of infection prevention and control programmes.* Geneva

http://www.who.int/gpsc/ipc-components-guidelines/en/

These new guidelines on the core components of infection prevention and control programmes at the national and facility level will enhance the capacity of countries to develop and implement effective technical and behaviour modifying interventions. They form a key part of WHO strategies to prevent current and future threats from infectious diseases (such as Ebola), strengthen health service resilience, help combat antimicrobial resistance and improve the overall quality of health care delivery.
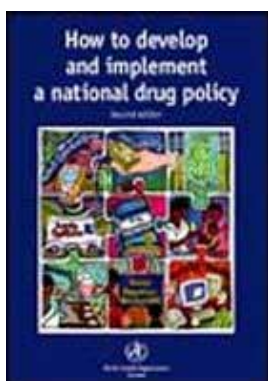
WHO (2001). *How to develop and implement a national drug policy, 2nd ed.*
Updates and replaces Guidelines for developing national drug policies (1988). Geneva

http://www.who.int/medicines/areas/policy/emp_ndp2nd/en/

Resolution WHA28.66 requested WHO to develop means to assist Member States in formulating national drug policies. It also urged WHO to assist countries in implementing strategies, such as the selection of essential drugs and appropriate procurement of quality drugs based on health needs, and in providing education and training in various elements of pharmaceutical programmes.