Standing Committee
for Economic and Commercial Cooperation
of the Organization of Islamic Cooperation (COMCEC)

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# Proceedings of the 13th Meeting of the COMCEC Poverty Alleviation Working Group

# "Access to Health Services in the Islamic Countries"

**COMCEC COORDINATION OFFICE**
**April 2019**

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# PROCEEDINGS OF THE 13TH MEETING OF THE COMCEC POVERTY ALLEVIATION WORKING GROUP ON

# "Access to Health Services in the Islamic Countries"

(April 4th 2019, Ankara, Turkey)

**COMCEC COORDINATION OFFICE**
**April 2019**

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# Introduction

The 13th Meeting of the COMCEC Poverty Alleviation Working Group was held on 4 April 2019 in Ankara, Turkey with the theme of "Access to Health Services in the Islamic Countries".

The Meeting was attended by the representatives of 15 Member States namely, Afghanistan, Algeria, Benin, Cameroon, Egypt, Indonesia, Iran, Jordan, Kuwait, Malaysia, Oman, Qatar, Saudi Arabia, Tunisia and Turkey. Representatives of the COMCEC Coordination Office, WHO Office for the Eastern Mediterranean, Islamic Development Bank, SESRIC and Doctors Worldwide have also attended the Meeting.[1]

The Meeting began with a recitation from Holy Quran. Afterwards, Mr. Burak KARAGÖL, Director at COMCEC Coordination Office (CCO), and Mr. Andi Zainal Abidin DULONG, Director at Ministry of Social Affairs of Indonesia, as the chairman of the Meeting, made their opening remarks. Afterwards, the representative of the CCO made a presentation on "COMCEC Poverty Outlook". The presentation informed the participants about the state of poverty and human development as well as the overall health situation in the world and in the OIC Member Countries.

The Meeting continued with the presentation of the research report titled "Access to Health Services in the Islamic Countries" which was prepared specifically for the 13th Meeting to enrich the discussions.

The afternoon session began with a policy debate session. The policy recommendations on improving access to health services in the member countries were discussed by the participants. The Room Document, which was prepared by the CCO in light of the findings of the aforementioned research report as well as the answers of the Member Countries to the policy questions, was considered.

Following the moderation session, representatives of Indonesia, Malaysia, Oman, Qatar and Turkey shared the experiences in access to health services in their respective countries.

Finally, the participants listened to the representatives of World Health Organization (WHO), SESRIC and Doctors Worldwide to learn about their experiences in improvement of access to health services.

[1] The list of participants is attached as Annex 4.

## 1. Opening Session

In line with the tradition of the Organization of the Islamic Cooperation (OIC) and the COMCEC, the Meeting started with the recitation from the Holy Quran. Afterwards, Mr. Burak KARAGÖL, Director at the COMCEC Coordination Office welcomed all participants. Thereafter, Mr. KARAGÖL briefly mentioned about the COMCEC and its activities. He also explained the details of the programme of the Meeting.

Afterwards, Mr. Andi Zainal Abidin DULONG, Director at Ministry of Social Affairs of Indonesia, as the chairman of the Meeting, welcomed all the participants to the 13th Meeting of the Poverty Alleviation Working Group. After introducing himself, Mr. DULONG invited Dr. Güneş AŞIK, Sector Specialist from the COMCEC Coordination Office, to make her presentation on Poverty Outlook in the OIC Member Countries.

## 2. COMCEC Poverty Outlook

Prof. Dr. Güneş AŞIK, Sector Adviser from the COMCEC Coordination Office presented the key findings of the COMCEC Poverty Outlook.

In her presentation, Dr. AŞIK explained the state of poverty in the world and in the OIC Member Countries by highlighting key indicators on monetary and non-monetary poverty and gave insight about human development and health outcomes in the OIC. Dr. AŞIK emphasized that poverty goes beyond monetary terms and none of the indicator alone is capable of revealing the true dimension of poverty. Poverty arises not only when people do not have enough monetary resources but it also arises when people are deprived of basic rights such as education, health and security which limit their ability to lead a dignified life.

Dr. AŞIK stated that the most frequently used methods to define poverty are US$1.90 a day poverty line of the World Bank (in monetary terms), or the value of a minimum calorie requirement. Poverty headcount ratio at $1.90 a day is the percentage of the population living on less than $1.90 a day at 2011 international prices.

Then, she briefly informed the participants about the indexes used in the Outlook. The Human Development Index (HDI), produced by UNDP since 1990, measures the achievements in key dimensions of human development: a long and healthy life, being knowledgeable and have a decent standard of living. The HDI is a composite index obtained from life expectancy at birth, mean and expected years of schooling and Gross National Income (GNI) per capita. She added that the Multidimensional Poverty Index (MPI) is also a composite index obtained from health, education, and standard of living indicators but includes additional deprivation measures. MPI was also generated by UNDP in 2010 and it reflects the multidimensional nature of poverty such as sanitation, access to electricity and food. Furthermore, the Global Hunger Index (GHI) is designed to measure and track hunger globally, by country and by region as well as calculated each year by the International Food Policy Research Institute (IFPRI). The GHI highlights successes and failures in hunger reduction and provides insights into the drivers of hunger obtained from undernourishment, child wasting, child stunting and under-five mortality rate indicators.

Dr. AŞIK continued her presentation with poverty situation in the world. The last three decades witnessed a significant global poverty reduction. The global poverty headcount ratio fell to 10% in 2015 from 35.9% in 1990. Regarding income groups, while this ratio was 41.8 percent for upper-middle income countries, 44.8 percent for lower-middle income countries and 60.6 percent for low-income countries in 1990, these ratios fell to 1.7 percent, 13.9 percent and 43.9 percent for these income groups respectively in 2015.

With regards to non-monetary poverty indicators, she first touched upon the HDI. Dr. AŞIK expressed that human development category is strongly correlated with income per capita. 52 out of 59 "very high human development" countries are high-income countries, and the "high human development" category is dominated by upper-middle-income countries. Similarly, "medium human development" category is dominated by lower-middle income countries. In the "low human development category", all of the countries are from low income or lower middle-income groups. Regarding Multidimensional Poverty Index, she stated that the index was calculated for 110 countries in Human Development Report 2018. Trends in MPI show that poverty is on decline, however there is still significant need for progress. Almost 1.3 billion people in these countries live in multidimensional poverty.

Since 2000, significant progress has been made in the fight against hunger. The 2000 Global Hunger Index (GHI) score was 30 for the developing world, while the 2018 GHI score was 20.9. Despite the lower hunger level reflected by the 2018 global GHI score, the number of hungry people in the world remains unacceptably high. According to GHI, 52 countries are still in serious, alarming or extremely alarming situation.

Dr. AŞIK continued her presentation with the state of poverty in the OIC. She pointed out that the OIC represents a highly diverse group in terms of GDP per capita, which varies from 1017 dollars to 128.4 thousand dollars (i.e. Niger and Qatar). The GDP per capita in upper-middle OIC Countries has a diverse pattern. While this indicator is $8,163 in Guyana, it reaches to $29,431 in Malaysia. Malaysia, Turkey and Kazakhstan have high GDP per capita values compared to the rest of the group. In the lower-middle income group, GDP per capita levels vary between $3,694 and $12,284. In the low-income group, GDP per capita levels vary between $1017 and $3,180. One third of these countries have GDP per capita levels, which are lower than $1,600, namely, Niger, Mozambique, Sierra Leone, Comoros, Togo and Yemen. Similarly, the poverty headcount ratio varies remarkably among the OIC Member Countries. The number of people who live under $1.9 a day in the OIC region is approximately 241 million. In terms of monetary poverty, there is no poor in the high-income countries. The poverty rate is generally low in the upper-middle income countries. Lower-Middle income countries display a highly diverse picture and poverty headcount ratio ranges from 1% in Palestine to 53.5% in Nigeria.

As to the multidimensional poverty, Dr. AŞIK stated that according to Human Development Report (HDR) 2018, among the OIC Member Countries, for which multidimensional poverty headcount ratio is calculated, this ratio is highest in Niger and lowest in Turkmenistan.

She continued her presentation with the GHI values of the Member Countries, which range between under 5 and 45.4. None of the OIC member countries experiences an extremely alarming hunger situation and 3 member countries are in an alarming situation while 22 countries are in a serious situation. On the other hand, 9 member countries are in moderate hunger situation and 13 countries are in low hunger situation.

Furthermore, Dr. AŞIK expressed that the world human development index (HDI) average has increased from 0.598 to 0.728 between 1990 and 2017. For the same period, the OIC average rose from 0.505 to 0.632 and remained significantly below the OECD and world average. OIC's HDI values are only higher than those of LDCs. On the other hand, the gap between the OIC and developing countries has enlarged in the last 25 years. In 1990, it was only 0.010 points whereas it has risen to 0.049 points in 2017 implying a more rapid progress in developing countries.

In terms of the components of HDI, Dr. AŞIK stated that in terms of life expectancy and expected years of schooling, OIC's index values are slightly below upper middle income countries and higher than low income and lower middle income countries. However, an important point to note is that the HDI ranking of OIC is not improving as rapidly as the GNI of OIC, meaning that the rise in incomes in OIC is not sufficiently translated into development outcomes. Put differently, HDI score of OIC is lower than what its income per capita implies.

Dr. AŞIK summed up status of the poverty indicators in the OIC region as follows; Monetary poverty is significant in the member countries; however, non-monetary poverty is a bigger problem. Nearly a quarter of the population in the OIC member countries live under multidimensional poverty. She added that progress in the human development varies significantly among the member countries. There is an improvement over time; however, a faster progress is needed.

Finally Dr. AŞIK provided information on the improvements in key health outcomes. Health expenditures as a percent of GDP show significant variation across OIC countries, with high income OIC members exhibiting lower expenditures as a share of GDP on average and lowest income countries on average having higher shares. Dr. AŞIK suggested that this reflects the fact that maintaining a certain level of health expenditures exhausts more of the available resources in low income countries. Across OIC countries, Sierra Leone has the highest health expenditures as a percent of GDP with 18% and Gabon has the lowest, with expenditures equaling 3 percent of GDP.

Dr. AŞIK stated that maternal mortality rates were more than halved in most income groups across the World, but there is still need for significant progress to meet the Sustainable Development Goal (SDG) of 70 maternal deaths per 100,000 live births by 2030. Low income OIC members were able to reduce maternal deaths from 915.3 per 100,000 live births in 1990 to 501.5 in 2015. The reduction in lower middle income OIC countries was from 479.7 per 100,000 live births to 270 during the same period. Dr. AŞIK stated that upper middle income OIC countries is just about to meet the SDG target, with 75.3 maternal deaths while high income OIC countries have already met the target with 12.9 maternal deaths per 100,000 live births.

As for under 5 mortality rate, SDG is 25 deaths per 1000 live births by 2030. High income and upper middle income OIC countries have already met the target with child mortality rates equal to 9.4 and 21.6 per 1000 live births. On the other hand, while recording significant reduction, low income and lower middle income OIC countries still lag behind the targets and the world average with under five child mortality rates equal to 79.3 and 50.3 per 1000 live births. Dr. AŞIK suggested that the improvements across OIC members are encouraging, however, current trends point out that more efforts are clearly needed to improve the health outcomes in low income and lower middle income OIC countries.

**Questions and Comments:**

**Question:** Among the indicators reflecting the poverty situation in the countries, which of the indicators - monetary or non-monetary poverty- are more important?

**Answer:** Dr. AŞIK stated that monetary poverty indicator is insufficient to understand the dynamics in the member countries. Non-monetary poverty indicators such as multidimensional poverty and global hunger index should also be checked to properly grasp the poverty situation in a country.

# 3. Access to Health Services in the Islamic Countries

## 3.1. Overview of Access to Health Services in the World and the OIC

Dr. Tanvir Ahmed, Consultant at Institute of Development Studies, University of Sussex, presented the findings of the research study titled "Access to Health Services in the Islamic Countries".

In his first presentation, Dr. Ahmed mentioned about the concepts of access to health and relevant situation on global, OIC and non OIC member state scale. The session started by explaining that although there have been impressive progress in health worldwide, it varies by regions and by extension other socioeconomic determinants like age, sex, education, income status etc. Dr. Ahmed then continued to explain why health is important for the overall development of people's wellbeing. He explains that health forms the basis of social justice, one of the human rights and is intimately related to economic development through the health and poverty cycle. The cycle demonstrates two dimensions that lead to poor health outcomes for poor people: context and access (to health). The context is related to poor living conditions, housing, sanitation and hygiene, etc. From the health perspective, context is a risk factor for the health of the poor. Access to health services is often restricted for the poor; either due to unavailability of services or lack of purchasing power – especially if services are offered by the private, for-profit sector. Also, facilities accessed by the poor are often overcrowded and understaffed. The lack of access to health service for the poor results in lack of utilization of health services, and lack of knowledge of good practices, which is a direct cause of poor health. On the other hand, poor health leads to lack of productivity and decreased income which risk causing some people to either fall into poverty or to further go down the poverty ladder. This explains why access to health a service is more than just and is a basic component of one's wellbeing.

Dr. Ahmed then discussed the concept of health disparity and how various social determinants like age, sex, education, income status etc. helps to understand the unequal and inequitable

consequences of health. He explained as example that everyday thousands of children die of reasons which are often preventable. It is worse for the children from poor families. And same for the poor regions of the world. Developing countries carries the lion share of the maternal death. If you are a pregnant mother from Afghanistan or Somalia, you have about 48 times higher chance of pregnancy related death compared to a Europe. The richer regions like Europe or North America have more access to trained and formal healthcare compared to Africa or Asia. And then there are perils of being women who have always been victim of illnesses due to socio-cultural and biological reasons coupled with compromised access to healthcare.

Then the methods and materials that has been used to produce the report was explained. The study pursued three strands of inquiry: First, the conceptual discussions around access to health for the poor was summarized. This allowed to answer (1) and to lay the framework to tackle the subsequent questions. Then the analysis of the current status and trends regarding the access to health services in the world and within the OIC, with a special especially on the poor was conducted. A range of existing data on demand for health, physical availability of healthcare, financial access to health, health risk factors and health outcomes to shed light on trends and current situations within the OIC and between OIC and non-OIC member states, at different levels of wealth and for different regions of the world was used for that. Then four in-depth case studies were conducted to better understand how to (or not to) enhance access to health for the poor; Indonesia, Uganda, Turkey, Tunisia. The case studies were selected to represent each OIC region and to provide a variety of situations regarding to past and present health access situations as struggling (first and second) and best (third and fourth) cases. Finally, we draw some common lessons based on the case studies and then suggest recommendations to improve the performance of access to health services within the OIC member states with a specific emphasis on the poor.

Dr. Ahmed then explained that access to health is the ability of a person and/or group to ensure a set of quality health services. He discussed a popular framework which described ability as personal or groups' convenience and/or cost related to one's efforts in ensuring health. According to the framework, the core of access to health a) availability, b) cost (financial affordability), c) geographical accessibility and d) acceptability of health services. Dr. Ahmed criticized the framework as it lacks in two specific aspects among others; a. not enough emphasis on providers' attitude towards service provision and people's perspective of seeking healthcare. Based on the current stand, considering the changing context and rapid growth of technology, the dimensions of access to health is now considered as; a. Physical accessibility (good services are within reasonable reach of everybody), b. Financial affordability (people's ability to pay without financial hardship), c. Acceptability (people's willingness to seek services) and d. Information accessibility was later added to this framework. It is the right of the people to seek, receive and contribute health related information. He then argued that to understand people's perspective of access to health, these dimensions should be viewed in light of people's care seeking dimensions; demand, availability, awareness, utilization of healthcare and related structural factors, i.e. policy landscape.

Dr. Ahmed then provided a brief scenario of global disparity related to access to health and discussed the global response in light of millennium development goals (MDG). He described that, everyday thousands of children die of reasons which are often preventable. It is worse for the

children from poor families. And same for the poor regions of the world. Developing countries carries the lion share of the maternal death. If you are a pregnant mother from Afghanistan or Somalia, you have about 48 times higher chance of pregnancy related death compared to a Europe. The richer regions like Europe or North America have more access to trained and formal healthcare compared to Africa or Asia. And then there are perils of being women who have always been victim of illnesses due to socio-cultural and biological reasons coupled with compromised access to healthcare. Endorsement of MDG has improved the situation to some extent. The major learning from the implementation of the health-related goals of MDG has taught us that; a. targeted international effort and coordinated partnership with stakeholders, b. universal and comprehensive plan and c. effective use of evidence works. Based on wide range of interventions that aims to improve access to health, Dr. Ahmed presented a summarized picture of four types of evidences; a. Investing into small or medium scale initiatives, b. Using more and more evidence (data), c. Ensure intensive participation of all stakeholders and d. financial inclusion-focused initiatives. These were presented as what type of efforts has worked so far to improve access to healthcare by the poor and other vulnerable groups.

Then a brief analysis of various dimensions of access to health was presented by globally, OIC member states (57) and non-OIC member states (160). The OIC and non-OIC states were further categorized as high, upper middle, lower middle- and low-income groups. The analysis showed that various health indicators (i.e. life expectancy, maternal and child mortality, HIV incidence and prevalence, immunization rate, number of health staff, ART coverage, facility birth) as proxy to demand of healthcare, are low in OIC countries and low-income groups. There was high observed variation in outcomes and intra-OIC differences with Sub-Saharan Africa being worse off, the overall higher life expectancy of women than men and maternal mortality rates have fallen, and high-skilled birth attendance is the key to preventing maternal and infant deaths. The physical access to healthcare showed high intra-OIC variation, average health staff ratio has increased; Arab and African OIC groups was better in the past and Asian OIC group has improved and hospital beds ratio has consistently declined in OIC countries. Considering financial accessibility, healthcare expenditure per capita has increased over time; Qatar, UAE and Saudi Arabia are the top 3 spenders with Guinea being in the bottom, Out-of-pocket expenditures have significantly increased; OOP is lowest in Sub-Saharan Africa and South Asia (in general), Countries with low OOP also show low expenditure which might mean poor health infrastructure and services, restricted access etc. and risk of catastrophic expenditure for surgical care is very high particularly in African countries. Wealth disaggregation showed that Access to health by the poor is particularly small in absolute terms and relation to richer populations in countries of the African region. Algeria, Jordan, Kazakhstan, Kyrgyzstan and Turkmenistan are well-covered in terms of access to health care across all economic groups, including the poor. It was observed in most of the countries that very large differences and a relatively 'steady' increase in access to health services with increasing wealth. In case of 'right to information;' most of the OIC member states had outdated data collection systems, lack of trained personnel and appropriate technological equipment, lack of legislative and regulatory framework that facilitates the efficient use of health information systems. There are two major strategic initiatives across the OIC member state which consider improving access to health;

OIC Strategic Health Programme of Action (OIC-SHPA) for 2014-2023 and Middle-Eastern and North-African region (MENA) initiative.

This was followed by a short question and answer session. There were no major disagreement among the participants regarding the contents of the presentation. The session ended with a rich discussion around the complexities of understanding access to health and how can we engage with bottom up approach and people's awareness of services more effectively.

**Questions and Comments:**

**Question:** What would be the determining factor that describes the variation between OIC and non-OIC countries for the indicators mentioned in the presentation and solution to these differences?

**Answer:** Dr. Ahmed stated that since the international database has been used in the research, there is no way to answer easily to this question. However, there is no restriction to make some predictions on them. For example, cultural values are effective in HIV indicators in OIC countries. Compared to non-OIC countries at the same level, OIC countries are doing well. On the other hand, out-of-pocket expenditures in OIC countries are higher than the ones in non-OIC countries. Heavy presence of private sector contributes to this increase. There are countries in the OIC region who are doing good although they suffer from budget constraints. There are mechanisms like COMCEC in the region which can convince governments to act based on the evidence that is listed in these studies.

**Comment:** The primary healthcare and improvement of the infrastructure in primary health care were underlined.

**Question:** It was pointed out that demand for health services is always mentioned, however how the real demand can be measured if the awareness is low is not easy to answer.

**Answer:** Dr. Ahmed agreed with the comment on the importance of primary healthcare and mentioned some good examples such as Turkey to show how bottom-up approach worked well in this case. Dr. Ahmed replied the comment on the awareness by emphasizing how challenging to measure the real demand in the field. Awareness and perception are, for example, two important indicators that display real demand but they have to be measured with the fieldwork and analysis.

**Comment:** Another comment was about the relationship between poverty and health. If the pro-poor policies are promoted then health related problems could also be solved. Economic growth sometimes cannot enable the development in health if it is not pro-poor.

## 3.2. Lessons Learnt from the Selected Case Studies and the Policy Options

In the second part of the presentation, Dr. Ahmed presented the status of access to health care in four case countries. Considering the geographic distribution of the OIC member countries, access to health-wise, two struggling cases, Indonesia and Uganda and two well performing cases, Turkey and Tunisia was chosen to capture the variations in terms of health outcomes and health inequities.

The case studies were conducted using literature review, data analysis and key informant interviews as method and tool.

The Indonesia case study showed that Growing economy and government's aim of universal healthcare coverage (UHC) by 2019 led to an increase in the demand for health services; Life expectancy has increased, both child and maternal mortality rates have decreased, still there is evidence of stunting; height for age, slow progress in controlling infectious diseases, HIV is still high and NCD is on the rise (73% of all deaths). There is considerable evidence of health-related inequality especially geographic distribution and income group wise. The country has improved in terms of increasing facilities and hospital beds ratio but still lagging behind other East Asian countries. There has been number of health initiatives and system strengthening in the country over the years, many of which has specific focus on decentralization. However, increased focus on decentralization has weakened health information systems due to lack of obligation to report to a central level.

Turkey case study shows that there has been significant improvement in health outcomes and related access to healthcare; life expectancy increased (78 yr.), maternal mortality dropped to a sixth (16/100,000 live births), infant, neonatal and under-5 dropped to a fifth. The country has almost achieved UHC; dramatic increase in coverage -99% (75.2 million people), insurance is delivered by the Social Security Institution (SSI) and free for all earning less than 279 TL per month. Further analysis shows that the improved access to health has resulted mostly from expansion of health benefits, infrastructure and human resources, supply of health services, increase in efficiency and decrease in out-of-pocket expenses. All these have been achieved due to its hall mark health initiatives called Health Transformation Program (HTP), Family Medicine Program and Green Card Program. The main areas of further improvement for Turkey appeared to be improving the quality of diagnostic and curative care, Primary health care system –number of staff, skill development, physical and technical resources, community-based prevention and screenings for cancer and chronic illnesses and fiscal sustainability –potential rise of out-of-pocket expenditure.

The Uganda case study shows that in spite of considerable progress in controlling the infectious diseases (HIV, TB, Malaria), the country's overall performance of MDG was poor; only goal achieved was under-5 mortality rate. And there is evidence of marked socioeconomic and geographical health-related inequities; high out-of-pocket expenses and most health centers are found in urban and peri-urban areas. The major challenges for the country in regards to access to health are; 72% lives within 5 km of a health facility; rural and remote areas, 43% of total health expenditure is coming from out-of-pocket, long waiting times, long distance perception also restricts access public health centers, outdated and old health infrastructure; recently adopted DHIS2 as the new HMIS platform, low and frequently non-existent stock of medicines and supplies and lack of trained health staff (doctors, nurses, midwifes per 1,000 ratio was 0.4 in 2017).

The Tunisia case study shows that the country has made remarkable progress in health and related access; fertility rates are low and stable, maternal and infant mortality rates have decreased, life expectancy has risen dramatically, immunization coverage is almost at 100%, HIV/aids is almost non-existent, and Malaria has been officially eliminated. However, the major challenges for the

country are; inequalities in health are observed between different socioeconomic and geographic groups -coastal areas, private sector is growing rapidly contributing to out-of-pocket expenses and fragmented and poorly designed health information systems due to underinvestment.

The main learnings of the case studies can be summarized as; Understanding each context in order to form/reform policies is vital; Turkey and Tunisia is a good example, Importance of political leadership; Indonesia internal concerns were the main drivers of change and progress, Gaps still exist in rural and remote areas –challenge to improve health infrastructure and to attract more high-skilled health workers; Indonesia and Turkey are good examples of achieving this with the right incentives and short-term contracts, Common challenge of tackling emerging NCDs, health insurance is crucial to achieve UHC and secure interest of the poor people, involving private sector rationally and Importance of and current lack of health information systems. Dr. Ahmed concluded the second part of his presentation by making four overarching recommendations; a. Demand and supply side changes need to happen simultaneously, b. Focus on Universal Health Coverage to provide essential services to the most under-served parts of the population, c. Strengthen community-based primary health care in order to reach poor population and d. Create Incentives for skilled health personnel to provide services in rural and remote areas.

**Questions and Comments:**

**Comment:** It was stated that Turkish government now focuses on the improving quality health services and primary healthcare, combatting non-communicable diseases as well as enhancing the infrastructure by city hospitals which have great health campuses with high technology and high bed capacity.

**Comment:** Insurance fund covers only people who work in formal sector in Tunisia. Poor people benefit from free health care in the public facilities. The government has initiated a special program to resolve challenges in health to increase coverage of poor families.

**Comment:** National Health Insurance (JKN) started in January 2014 in Indonesia. Currently, 280 million people are covered by the JKN and the government directly covers 60 percent of them. The growing problem in Indonesia is about middle-income group because informal workers are in this group heavily.

**Question:** Increasing life expectancy also leads to aging population problem and this puts a burden on the social security and health system of the countries.

**Question:** It was asked whether NGOs can help governments to improve and augment the access to health services.

**Answer:** Dr. Ahmed answered, in terms of aging population, by stating that aging problem is not just about health but also a problem of social assistance. It necessitates more financial and human resources. Regarding the NGOs, he responded that they contribute significantly in some countries. If the question of accountability and quality is solved, NGOs should always be on the forefront among other private sector actors.

## 4. Policy Discussion Session

The session was moderated by the Mr. Andi Zainal Abidin DULONG, Director at Ministry of Social Affairs of Indonesia.

At the beginning of the session, Mr. Selçuk KOÇ, Director at the COMCEC Coordination Office (CCO), made a brief presentation on the responses of the member countries to the policy questions on access to health services which were sent to the Poverty Alleviation Working Group focal points by the CCO. He also presented the policy recommendations provided in the room document.

After the presentation, Mr. DULONG gave the floor to all delegations asking their opinions and comments for each policy recommendation. The participants shared their comments on the policy recommendations given in the room document. Based on the intensive deliberations, the participants have highlighted the following policy recommendations:[2]

- Developing a strategy/policy including a well-designed payment and health insurance schemes to achieve universal health coverage
- Strengthening primary healthcare particularly in poorer areas through encouraging skilled health staff to work in rural and remote areas and enhancing integrated health promotion and prevention interventions
- Promoting the engagement of private sector in the provision of safe and quality healthcare in close partnership with public authorities and with well-designed monitoring mechanisms
- Encouraging development and upgrade of health information management systems through designing an online-integrated health information system, allocating required resources to health IT infrastructure and strengthening multi-sectoral coordination mechanism

## 5. COMCEC Project Funding

Mr. Burak KARAGÖL, Director at COMCEC Coordination Office delivered a presentation on utilizing the COMCEC Project Funding (CPF) for the poverty-related projects of the member countries as well as the OIC institutions.

In the beginning, Mr. KARAGÖL informed the participants about the essentials of COMCEC Project Funding. He explained the two instruments of COMCEC Strategy, namely Working Groups and Project Funding. Then, he stated the relationship between Ministerial policy recommendations, Strategy's principles and objectives. He gave details about the activity-based projects and research projects. Lastly, main characteristics of COMCEC Project Funding such as membership to the WGs, partnering with at least two member countries and satisfying the Project Preparation and Submission Guidelines were touched upon.

[2] The Room Document is attached as Annex 3.

Mr. KARAGÖL emphasized the importance of sectoral themes, which should also be considered while submitting project proposals, published on the COMCEC website. He enumerated the supported topics in poverty alleviation cooperation area as followings:

- Developing and implementing nutrition-specific and nutrition-sensitive interventions
- Improving infant and young child feeding practices
- Ensuring universal access to healthcare, safe water and sanitation
- Providing access to safe and nutritious food for all
- Enhancing vulnerable groups' access to education
- Developing political and legal framework for increasing access to inclusive education
- Prioritizing gender equality and equity in access to education
- Mobilizing more financial resources and human capital towards improving the quality of education
- Increasing quality of teachers
- Increasing teaching and learning effectiveness through adoption of information and communication technologies
- Promoting better early-childhood learning opportunities through accessible and affordable pre-primary schooling
- Ensuring progressive universalism for closing the rich-poor gap in learning outcomes
- Involving parents in the monitoring of their children's education and intensifying the parent-teacher interaction
- Developing vocational skills in the OIC member countries
- Increasing access to good health services in the OIC member countries
- Decreasing child and maternal mortality in the OIC member countries

Mr. KARAGÖL continued his presentation with the implementation statistics, both yearly and in sectoral basis, for the last 5 years. Also, he gave the details of the contents and activities of the poverty alleviation projects to be implemented in 2019 by Afghanistan, Nigeria, Suriname, Turkey and SESRIC.

Lastly, Mr. KARAGÖL gave general information about the relevant pages of the COMCEC Project Funding website and mentioned about the timeline for the project submission. He indicated the relevant reference materials in the Online Project Submission System to be used during the project submission period.

# 6. Member State Presentations

In this section, the representatives of Indonesia, Malaysia, Oman, Qatar and Turkey made presentations to inform the participants about policies and programs conducted in their respective countries for improving access to health services.

## 6.1. Indonesia

Mr. Dillon ZUFRI, Social Assistance Specialist, Directorate General for Poverty Alleviation, Ministry of Social Affairs, presented National Health Insurance System Program in Indonesia, focusing on its impact on health access of the poor.

Mr. ZUFRI began his presentation on the history of National Health Insurance in Indonesia, named Jaminan Kesehatan Nasional (JKN). In 1968, Indonesia implemented a similar program, called Askes and Asabri, that insured only segmented population, i.e. civil servants, police and military officers. This program was expanded in 1990s to include formal workers and poor people under different program. This health system was then integrated into a single universal health coverage under JKN in January 2014 ten years later after the law of the National Security System passed. Under JKN, the coverage was scaled up to target 95 percent of population in Indonesia in 2019.

After its 5 years of implementation, JKN has successfully increased the number of people covered. It could be proved by comparing its first year of implementation with the current number of registered members. In its first-year of implementation, JKN recorded the number of people covered reached 133.42 million people. This number almost doubled by early March 2019, when this number reached 218.13 million people. A similar growth is observed by the 'supply-side', i.e. number of affiliated healthcare facilities. In 2014, there are only 18,437 healthcare affiliated within JKN system. This number rose to 27,211 facilities by March 2019.

Mr. ZUFRI continued his presentation on the distribution of insurance schemes by categories. From the chart presented, Mr. ZUFRI pointed out that most of people insured has been subsidized. 96.1 million people out of 218.13 million people who covered by JKN in March 2019 are categorized as subsidized recipients from the national budget (PBI – APBN) and 35.31 million people were subsidized recipients from local budget (PBI – APBD). In other words, more than 60 percent of people covered in the system has been subsidized.

Afterwards, Mr. ZUFRI presented several studies that examine the impact of the implementation of JKN on access to health by the poor. He pointed out the impact of JKN in three perspectives. First, JKN has successfully reduced the inequality between the poor and non – poor in accessing to healthcare (Agustina et.al., 2019; Dartanto et.al., 2015). As a result of this system, there has been an improvement on healthcare utilization of the poor people considerably (Johar, et. al., 2018). Second, JKN has reduced the household expenditure on healthcare. This argument was observed by Agustina et.al. (2019) who shows a decrease in out-of-pocket money for health expenditures after conducting a household survey.

Finally, Mr. ZUFRI emphasized that the implementation of JKN has contributed to reaching '1-digit poverty rate' target set by Government of Indonesia. Since the health expenditure is one of fourteen indicators for measuring poverty in Indonesia, reducing the expenditure of poor people through JKN directly affects downward poverty rate in Indonesia.

## 6.2. Malaysia

Dr. Mohd Safiee b. ISMAIL, Principal Assistant Director for the Ministry of Health of Malaysia presented on Malaysia country profile, the health case system, some achievements, various efforts to achieve universal health coverage, issues and challenges and the way forward.

He firstly provided overall profile of Malaysia which is categorized as a higher middle-income country with USD 10,573 per capita GNI for 2017. The GINI coefficient is at 0.399. 76 percent of the population lives in urban areas.

The Malaysian health care system is a dichotomous system where the public health sector is complemented by private health sector. In terms of SDG and UHC, Malaysia was ranked 55th in 2018 with a score of 70 out of 100. Malaysia is often internationally recognized as having world class healthcare facilities. There has been improvement in the life expectancy and most of mortality rates since independence. However, as some developing countries, Malaysia is still facing various health issues and challenges like the aging population, rapid urbanization, increasing double disease burden, increasing health care costs, higher demand, quality and safety and crisis management.

Malaysia has made some milestones in enhancing universal health coverage. There were 144 public hospitals and specialized medical institutions with 41995 beds, 1060 health clinics and 1803 community clinics in 2017 while in the private sector. There were 187 private hospitals with 13957 beds, over 7000 registered medical clinics and 1992 registered dental clinics. These accounts for more than 80% of the population live within 5km radius of health facilities. To enhance the access to the rest of the population, the government is also providing mobile health clinics (boats and buses) and flying doctor teams.

In order to further improve access to quality healthcare, Malaysia introduced clustering hospitals as an effort to improve sharing of resources and lean healthcare to aim for optimizing resource. Health services at the primary care has also improved markly from predominantly focusing on maternal and child health and outpatient care in 1960s to almost total womb to tomb care from 2010 onwards. The operating hours in some clinics has also been extended until 10 pm.

Dr. ISMAIL also mentioned about the efforts in the provision of step-down care such as the Malaysia Cataract mobile clinic, ambulatory care/daycare services, community mental health clinics, domiciliary care and low birth centre. Various value-added services and innovations were introduced to improve access like mySMS, telephone&take and drive through pharmacy and postal services for drugs. There is also enhancement of public-private partnership via outsourcing services, collaboration on transportation and trainings.

Dr. Ismail also provided information on the financial protection which is another major component in UHC. The public health services in Malaysia provided via general taxation and are highly subsidized. Financial protection is also provided via pension scheme, social security benefits and most recently the PeKa B40 which provides selected health and social benefits for group of population aged 50yrs and above living under lowest 40% total household income in Malaysia. Financial protection is also available within the private sector via employee benefits, Employee Provident Fund and private health insurance.

Dr. Mohd Safiee b. ISMAIL concluded his presentation by stating that Malaysia is highly committed to the international efforts to improve healthcare via advocating SDGs, UHC and the Astana

declaration. These commitments have been incorporated into Malaysian national policies, plans and direction such as in the Vision for health, policies in health and the five-year plan.

## 6.3. Oman

Omani delegate Dr. Badriya AL-RASHDI, Director at Ministry of Health in Oman, made a presentation on the access to health services in her country.

She began her presentation by providing some health statistics in Oman. According to National Center for Statistics and Information (NCSI) estimation, the mid-year Omani population in 2017 results in a sex ratio of 102 males per 100 females. 15.3% and 36.8% of the population are under-5 years and under-15 years, respectively and only 6% are 60 years and over. More than quarter (25.8%) of the total Omani population is females in the reproductive age group (15-49 years). They represent nearly 52.1% of all females and about 42.9% of them are expected to be married. The world health survey (WHS) 2008 displayed that the singulate mean age at first marriage (SMAM) is 29.1 years for males and 26.8 years for females. The rise of the singulate mean age (20.7 for female and 24.7 for male according to 1993 census) might be one of the factors responsible for the decline in fertility rate in Oman. The Total Fertility Rate (TFR) of Omani women was estimated from 1993 census data to be 6.9 and declined to 3.56 according to 2003 census and became 4.0 during 2017. The Crude Birth Rate (CBR) is estimated to be 33.5 per 1000 Omani population during 2017. The CBR indicates a drop of 16.9% over the past twenty two years (1993 CBR= 40.3). This is also accompanied by a decline in the Crude Death Rate (CDR) from 7.3 in 1993 to 2.9 per 1000 Omani population in 2017.

Dr. AL-RASHDI continued her presentation by giving some details about the health system in Oman. In early 1970s, there were only 2 hospitals with 12 beds and 10 clinics and by 2017; Ministry of Health (MOH) is running 49 hospitals. Oman is witnessing a shift in its main health problems from communicable diseases to health problems related to changes in life style and changes in population structure manifested in non-communicable diseases. The Ministry has therefore paid attention in its Five-Year Health Development Plans to developments in secondary and tertiary care. There are, now, a total of 5,039 hospital beds. In its support for primary health care, MOH opened one new Health Center in Dhofar Governorate. This makes the total number of health centers 207 of which 60 are equipped with beds (a total of 98 beds), and twenty-three (23) extended health centers. MOH attempted to strengthen health services outside Muscat Governorate. Therefore an umbrella of health services was established to cover the entire Sultanate. There is a “Governorate Hospital” in each health governorate that provides secondary care (tertiary in some) for the people as an addition to existing facilities.

In 2017 for every 10,000 population, there are 20 doctors and 43.7 nurses in the country as compared to 9.0 doctors and 26.0 nurses in 1990. The nurse-doctor ratio is 2.2 and medical officer specialist ratio is 1.3 in 2017 with increasing number of Omani doctors and nurses. The public sector is further sub-divided into MOH and Non-MOH. The public sectors other than Ministry of Health include Royal Oman Police, Petroleum Development Oman, Sultan Qaboos University

Hospital and Medical Services of Diwan of Royal Court. The private sector data includes information on private clinics, private pharmacies and 21 private hospitals.

With the expansion of health services, there has been a growing trend in the utilization of such services over the years. However, the year 2017 has increase in outpatient visits over last year. Patients' visits to outpatient clinics in Ministry of Health institutions during 2017 were about 15.8 million. Bed occupancy in MOH Institutions over the year 2017 was 69.6 %.

Ms. AL-RASHDI concluded that free primary health care is the gate keeper for all Health servicers in Oman. It includes outpatients, investigations, medications, admissions, and procedures & surgeries. All PHCs is well distributed in the sultanate. Patients are escorted free to secondary and tertiary hospitals.

## 6.4. Qatar

Dr. Mohd ALHAJRI, Director of Department of Health Emergencies in Ministry of Public Health presented a brief outlook about the universal health coverage in state of Qatar.

Dr. ALHAJRI began his presentation by describing Qatar's strong economy and high GDP, which helped the efforts to strengthen the healthcare services provision.

He pointed out that the Universal Health Coverage (UHC) in Qatar is of an advanced status and provides full access to health services for everyone (Citizens and foreigners). Free emergency care services are provided to all, even visitors, tourists.

The government is the main provider health sector and provides well-established promotional, preventive, curative, rehabilitative and palliative services. It meets about 95.6% of health expenditure (2016). A well-coordinated primary healthcare is linked to secondary and tertiary levels with electronic system of referral and shared patient files.

Semi-governmental and private health sector provide a complementary primary and secondary care and represent around 4.4% of health expenditure in (2016).

Dr. ALHAJRI concluded his presentation by stating that the Ministry of Public Health prepares 5 years strategic health plans to improve services and implements new evidence-based approaches and activities. The first plan was NHS1 (2011-2016) and the current one is NHS2 (2018-2022).

## 6.5. Turkey

Dr. Fehmi AYDINLI, expert from General Directorate for EU and Foreign Affairs of MoH Turkey presented the access to health services in Turkey and success achieved in the last decades.

He firstly outlined general overview of demographic conditions of Turkey. Later on, Dr. AYDINLI mentioned about the universal health coverage approach within the scope of Health Transformation Program which started in 2003. The multi-part social security system was combined under one umbrella as the name Social Security Institution (SSI). Thus, 99 percent of the

population was covered in the health insurance system those with low-income groups who were exposed to catastrophic health expenditure firstly.

According to the new system, citizens do not need to make any payment to the health center and the premiums deducted from the income are transferred to the related health centers through Social Security Institution. In addition to this, emergency health services and intensive care services are completely free in the system.

Afterwards, Dr. AYDINLI pointed out that the "Conditional Health Assistance Program" is another social protection practice provided to citizens who are out of the social security system. 35 Turkish Liras per month for general health service, 35 Turkish Liras per month for pregnancy service, 75 pounds once a month for the birth service, and 35 Turkish Liras monthly for puerperality service (for a maximum of two months) are offered as compulsory payment. 1,2 million people have benefited from this program by 2018.

According to the national legislation, health insurance premiums of individuals whose monthly income per capita (as of 2019) are below 852 Turkish Liras are paid by the SSI. Health insurance premiums of families with income per capita above 852 Turkish Liras are deducted from their revenues. The health insurance premium paid in 2018 was 9,1 billion Turkish Liras.

Dr. AYDINLI also shared some statistics and indicators in health area. The share of health expenditures from GDP was 5,2 percent in 2002 and 4,5 in 2017. The share of out-of-pocket health expenditures in total health expenditure was 19,8 in 2002 and 17,1 in 2017. In a 15-year period during which the health system has made significant progress, catastrophic health expenditures (for 10.000 households) fell from 81 to 32.

Thereafter, he shared statistical data on the health services infrastructure. Framework of primary health care, maternal care and child immunization, family medicine, home care services, health emergency services, secondary health care, medical technology infrastructure and the services offered capacity in Turkey, City Hospitals vision, Central Hospital Appointment System (MHRS), Pharmaceutical Track & Trace System, 184 SABİM hot-line and national health human work force capacity were analyzed in the presentation.

Lastly, Dr. AYDINLI provided the data for satisfaction from health services and the increasing trend in health indicators. 71,7 percent satisfaction rate in Turkey for the year 2017 was above the OECD average and it was reminded that comparing with the remaining OECD member countries, it achieved this rate by spending less than others.

# 7. Perspective of International Institutions and NGOs

## 7.1. World Health Organization

Dr. Rayana Ahmad BOU HAKA, Manager at WHO Office for the Eastern Mediterranean, presented the experiences of the WHO in enhancing accessibility of the health services with a presentation titled "Towards Universal Health Coverage in Eastern Mediterranean Region".

Dr. BOU HAKA began her presentation by mentioning 13th General Programme of Work 2019–2023 (GPW 13) of the World Health Organization (WHO). The Programme identifies for the next five years three interconnected strategic priorities and ambitious goals related to the 2030 Agenda for Sustainable Development. This presentation covers mainly the strategic priority of achieving universal health coverage (UHC) and its related goal: to ensure that 1 billion more people benefit from UHC.

UHC cuts across the health-related SDGs and impacts on multiple other SDG targets. Progressively advancing towards UHC is a political choice with important social and economic benefits. UHC has three dimensions, Dr. BOU HAKA mentioned in her presentation; population coverage, service coverage and financial protection. Important progress has been made in developing methods to measure it, but there are still limitations. Currently, UHC measurement focuses on two SDG indicators: 3.8.11 on service coverage and 3.8.22 on financial protection.

Dr. BOU HAKA continued her presentation with the development in the Eastern Mediterranean Region (EMR). EMR is home to over 650 million people living in 22 countries with highly diverse socioeconomic and geopolitical environments. In 2015, average gross domestic product (GDP) per capita in the Region was US$ 12 120. The Region faces emergencies on an unprecedented scale, due to political conflict as well its propensity to epidemic- and pandemic-prone diseases. Almost 30 million displaced persons - more than half of all displaced persons globally - originate from the Region.

In EMR, while some countries have made remarkable progress in generating high-quality data, there is a lack of reliable, timely and comparable information across countries. Challenges include weak civil registration systems, limited population-based surveys, poor quality data from health facilities, lack of disaggregated data, and fragmented data collection systems. Strengthening national health information systems must therefore be a key aim in the context of the SDGs.

Progress in the region is demonstrated albeit with lots of variability and lack of consistency. Several Member States have developed a national vision for UHC or necessary legislation and/or strategies. Despite fiscal challenges, Member States are using public funds and developing prepayment mechanisms towards UHC but the Region as a whole is a low investor in health, accounting for 1.9% of global health expenditure for 8.6% of the world's population in 2015. Insufficient public funding for health, non-existent or dysfunctional prepayment mechanisms and inefficient use of scarce financial resources continue to compromise health system performance in several countries. For the past 15 years, around 40% of health spending in the Region has come from out-of-pocket payments. As a result, around 55.5 million individuals face catastrophic health spending and 7.7 million are impoverished each year (2010).

She stated that the Member States have pursued diverse explicit/implicit service packages. Most countries in emergencies have developed explicit minimum service packages that facilitate resource mobilization. There is a growing understanding that improvements in access to health services without commensurate attention to quality will not lead to the desired population health outcomes. Challenges in improving quality and safety in the Region include insufficient leadership

commitment, low capacities of health professionals and national regulatory authorities, and lack of community engagement and empowerment.

Dr. BOU HAKA concluded her presentation by stating the requirements and different dimensions to achieve UHC. She pointed out that UHC requires that all population groups be covered for all their health needs by services of good quality.

## 7.2. Statistical, Economic and Social Research and Training Center for Islamic Countries (SESRIC)

Mr. Mazhar HUSSAIN, Researcher at SESRIC, shared the experience of SESRIC in the field of access to health and presented the OIC-Strategic Health Programme of Action 2014-2023 (OIC-SHPA).

Mr. HUSSAIN firstly explained the preparation phase of the OIC-SHPA beginning in 2009. Then, he enumerated the main thematic areas of cooperation namely:

- Health system strengthening
- Disease prevention and control
- Maternal new-born and child health and nutrition
- Medicines, vaccines and medical technologies
- Emergency health response and interventions and
- Information, research, education and advocacy.

Afterwards, Mr. HUSSAIN mentioned about the major tools for the implementation of the OIC-SHPA such as twinning programs, study visits, workshops, training of trainers, expert group meetings etc.

Mr. HUSSAIN also provided information on the organizational implementation structure including lead country coordinators and steering committee on health. He enumerated the lead countries as follows: Bahrain, Indonesia, Malaysia, Morocco, Saudi Arabia and Turkey. Each of these countries will be leading in different thematic area.

Mr. HUSSAIN lastly touched upon some programs and networks to be benefitted from during the implementation of the OIC-SHPA. These include IbnSina Programme for Health Capacity Building (IbnSina-HCaB), Occupational Safety and Health Capacity Building (OSHCaB) Programme, Tobacco Free OIC Initiative, OIC Network on Population and Reproductive, Maternal, New-born and Child Health, OIC Ibn Sina Health Alliance of NGOs, OIC Occupational Safety and Health Network (OIC-OSHNET).

## 7.3. Doctors Worldwide

Dr. Safa ŞİMŞEK, Head of Programs and Operations at Yeryüzü Doktorları Derneği (Doctors Worldwide, YYD), presented the experiences of YYD as an international humanitarian organization focused on healthcare and health access that has carried out hundreds of projects in nearly 50 countries to date, ranging from Afghanistan to Syria, Somalia to Gaza, and Uganda to Yemen with support of over 100 thousand donors and volunteers exceeding 15 thousands.

In his presentation Dr. ŞİMŞEK, mentioned about the experiences and achievements accrued by YYD in projects ranging from organizing voluntary medical teams (VMT) establishing medical training programs (MTP) in member countries of the Organization of Islamic Cooperation (OIC). Mr. ŞİMŞEK summarized the most recent projects and cases of Somalia, Yemen, Syria, Palestine and Chad.

Dr. ŞİMŞEK expressed that in low income countries where natural disasters and humanitarian crisis is evident, initially basic primary healthcare services (PHC) should be established and secondary healthcare services should be empowered via MTPs. He also emphasized the importance of involvement of local partners, because by giving services with or via local partners and transferring established value chain to local partners, effected communities are socio-economically empowered.

Dr. ŞİMŞEK lastly expressed the importance of the integration of activities with local shareholders of the project while maintaining global standard of humanitarian aid act. He cited that communication and coordination of shareholders is vital for efficient mobilization humanitarian resources. He also added dilemma of continuity and sustainability must be evaluated with respect to available resources. Also it is emphasized that simpler approaches for humanitarian planning must be adopted. Lastly, he stated that health should be viewed as the component of social culture.

## 8. Closing Remarks

The Meeting ended with closing remarks of Mr. Andi Zainal Abidin DULONG, Chairman of the Meeting and Mr. Burak KARAGÖL, Director at the COMCEC Coordination Office (CCO).

Mr. DULONG thanked all the member country representatives as well as participants from WHO, SESRIC and Doctors Worldwide for their active participation and valuable contributions.

Mr. KARAGÖL also thanked all delegates for their attendance and valuable contributions. He expressed that the main outcome of the meeting is the policy recommendations for the member countries. He stated that these recommendations will be submitted to the 35th Session of the COMCEC as an output of the 13th Meeting of the Poverty Alleviation Working Group.

Furthermore, Mr. KARAGÖL informed the participants that the 14th Meeting of the COMCEC Poverty Alleviation Working Group will be held on September 26th, 2019 in Ankara with the theme of "Child and Maternal Mortality in the Islamic Countries". He stated that as per the usual practice a research report will be prepared on the theme of the Meeting and shared with the focal points in advance of the meeting.

# ANNEXES

## Annex 1: Agenda of the Meeting

**AGENDA OF THE 13TH MEETING OF THE COMCEC POVERTY ALLEVIATION WORKING GROUP**

April 4th, 2019 Ankara, Turkey

***"Access to Health Services in the OIC Member Countries"***

Opening Remarks

1. COMCEC Poverty Outlook
2. Overview of Access to Health Services in the World
3. State of Access to Health Services in the OIC Member Countries and Lessons Learnt from the Selected Case Studies
4. Policy Debate Session on Enhancing Access to Health Services in the OIC Member Countries
5. Utilizing the COMCEC Project Funding
6. Member State Presentations
7. Perspectives of International Institutions and NGOs

Closing Remarks

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## Annex 2: Programme of the Meeting

**PROGRAMME OF THE 13TH MEETING OF THE COMCEC POVERTY ALLEVIATION WORKING GROUP**

**(April 4th, 2019, Crowne Plaza Hotel, Ankara, Turkey)**

***"Access to Health Services in the OIC Member Countries"***

08.30-09.00 **Registration**

09.00-09.05 **Recitation from Holy Qur'an**

09.05-09.15 **Opening Remarks**

09.15-09.35 Outlook of Poverty in the OIC Member Countries

*Presentation: Dr. Güneş AŞIK*
*COMCEC Coordination Office*

09.35-09.45 Discussion

09.45-10.25 Overview of Access to Health Services in the World and the OIC

*Presentation: Dr. Tanvir Ahmed*
*University of Sussex*

10.25-10.55 Discussion

10.55-11.10 **Coffee Break**

11.10-11.50 Lessons Learnt from the Selected Case Studies and the Policy Options

*Presentation: Dr. Tanvir Ahmed*
*University of Sussex*

11.50-12.30 Discussion

12.30-14.00 **Lunch**

**Policy Options for Improving Access to Health Services**

14.00-14.10 Responses of the Member Countries to the Policy Questions on the Policy Framework for Improving Access to Health Services in the OIC Member Countries

*Presentation: Mr. Selçuk KOÇ*
*COMCEC Coordination Office*

14.10-15.30 Discussion

**Utilizing the COMCEC Project Funding**

15.30-15.45 Presentation: *Mr. Burak KARAGÖL, Director*
*COMCEC Coordination Office*

15.45-16.00 Discussion

16.00-16.15 **Coffee Break**

16.15-17.00 **Member Country Presentations**

Sharing Experiences and Good Practices in Improving Access to Health Services

Discussion

**Perspectives of International Institutions and NGOs**

17.00-17.15 Presentation: "Towards Universal Health Coverage in Eastern Mediterranean Region"

*Dr. Rayana Ahmad BOU HAKA, Manager*
*WHO Office for the Eastern Mediterranean*

17.15-17.30 Presentation: "OIC-Strategic Health Programme of Action 2014-2023"

*Mr. Mazhar HUSSAIN, Researcher*
*Statistical, Economic and Social Research and Training Center for Islamic Countries (SESRIC)*

17.30-17.45 Presentation: "Experience of Doctors Worldwide in Access to Health Services in the OIC Region and Lessons Learned from the Field"

*Dr. Safa ŞİMŞEK, Head of Programs and Operations*
*Doctors Worldwide, Turkey*

17.45-17.55 Discussion

17.55-18.00 **Closing Remarks and Family Photo**

## Annex 3: The Policy Recommendations

### POLICY RECOMMENDATIONS HIGHLIGHTED BY THE 13TH MEETING OF THE COMCEC POVERTY ALLEVIATION WORKING GROUP

A policy debate session was held during the 13th Meeting of the Poverty Alleviation Working Group (PAWG). The Working Group came up with some concrete policy recommendations for improving access to health services, especially for the poor, in the OIC and approximating policies among the member countries in this important issue. The policy advices presented below have been identified in light of the main findings of the research report titled "Access to Health Services in the Islamic Countries" and the responses of the Member Countries to the policy questionnaire which was sent by the COMCEC Coordination Office.

***Policy Advice 1: Developing a strategy/policy including a well-designed payment and health insurance schemes to achieve universal health coverage.***

***Rationale:***

Access to health services is critical for human beings. However, access to health without having financial risks is even more challenging. In this respect, universal health coverage is an important asset enabling people's, particularly the poor, access to health services without having a risk of facing any financial hardship. To ensure that all people access to quality health services they need, universal health coverage involves services in promotive, preventive, curative, rehabilitative and palliative health services.

For a detailed analysis and to understand the dimensions of universal health coverage, widely monitored indicators such as life expectancy, maternal mortality and under-5 mortality rate need to be carefully examined. As a key indicator, life expectancy at birth signifies how well a country's health system is working in the provision of preventive, curative, rehabilitative and palliative care. Life expectancy at birth has steadily increased for OIC countries over the period. However, the OIC average is still behind the global average. The same situation is observed in maternal mortality and under-5 mortality rates. In all these indicators, the OIC member countries are quite behind the world average. Moreover, the life expectancy achievements vary remarkably across the member countries.

In this context, there is a strong correlation between access to health services and the welfare of citizens. Universal health coverage, by ensuring that all have access to health, is one of the critical components in achieving Sustainable Development Goals and eradicating poverty. As a way of pooling risks and expanding health service coverage, health insurance schemes are needed to be designed carefully.

***Policy Advice 2: Strengthening primary healthcare particularly in poorer areas through encouraging skilled health staff to work in rural and remote areas and enhancing integrated health promotion and prevention interventions.***

***Rationale:***

As the cornerstone of health systems worldwide, primary healthcare is fundamental for the physical, psychological and social well-being of the people. Strengthening primary healthcare mechanisms increasingly comes to governments' agenda as global experience proves them successful. However, there are ongoing challenges that affect negatively the health status of communities. Non-communicable diseases are on the rise globally. Ensuring sustainable mechanisms for maternal and child health are still challenging for many countries.

Access to primary health care services is a serious challenge in many OIC countries due to inadequate health infrastructure, physical inaccessibility accompanied by the high out-of-pocket spending and/or inadequate health workforce. In this context, interventions that will ensure cost-effective healthcare service are needed to be considered including encouraging skilled health personnel to provide services in rural and remote areas and enhancing community awareness and integrated primary healthcare (promotive and preventive) mechanisms. Moreover, as the key component of primary healthcare, regular screenings need to be performed.

***Policy Advice 3: Promoting the engagement of private sector in the provision of safe and quality healthcare in close partnership with public authorities and with well-designed monitoring mechanisms.***

***Rationale:***

Public financing is crucial to achieve universal health coverage sustainably. In order to ensure financial protection for all people and equitable access to quality health services, the allocation of considerable share in government budget is essential without prejudice to other national plans or priorities. However, considering the budget constraints in many countries, additional domestic resources are needed to be mobilized to achieve universal health coverage. In this manner, private initiatives can play a significant role to complement the public efforts. For example, in order to fill the gaps and shortcomings in public health service delivery (e.g. inadequate human resources and physical infrastructure), the government of Indonesia has started to actively encourage the private sector to contribute to health service delivery. In his framework, the private healthcare providers currently cover up to 60 per cent of health care in Indonesia (in particular hospital care).

On the other hand, there is a need for a well-designed monitoring mechanism. Outdated legislation, lack of enforcement of public health regulations and a widely unregulated private sector may leave consumers unprotected. Therefore, governments would need to put forward effective regulatory schemes to guide private sector and avoid the market failure in order to (i) assess whether private health care services are safe, effective and of good quality, (ii) examine to what extent patients from different socio-economic and socio-cultural backgrounds

can access these services and how barriers could be reduced, and (iii) investigate how private health providers affect the larger health system, e.g. with respect to availability of trained health workforce, the extent to which private providers work with relevant public authorities, and how positive links can be strengthened as well as negative impacts can be mitigated.

***Policy Advice 4: Encouraging development and upgrade of health information management systems through designing an online-integrated health information system, allocating required resources to health IT infrastructure and strengthening multi-sectoral coordination mechanism.***

***Rationale:***

Monitoring key health data is crucial to identify challenges and priorities in providing quality health services. Strengthening health information systems facilitates planning and allocation of resources as well as contributes to accountable and transparent public health management. Integrated health information systems would enable government officials give sound and timely decisions based on reliable data towards enhancing access to health services.

Many OIC Member Countries face challenges regarding health information management such as reporting quality and timeliness, duplication and fragmentation of data collection as well as lack of rigorous validation within different programmes. Some member countries do not have sufficient registration of births and deaths as well as reporting complete and accurate causes of death is lacking. Therefore, allocating required resources to IT infrastructure to enhance a well-designed health information management system with a special emphasis on the poor is needed to be taken into consideration. In this respect, data analysis, which is made at sub-national level to address pockets of poverty, should be ensured. Moreover, in order to ensure uniformity in aggregating data, collaborating with different stakeholders such as statistical departments, relevant ministries and organizations is crucial to achieve a strong multi-sectoral coordination mechanism.

**Instruments to Realize the Policy Advices:**

**COMCEC Poverty Alleviation Working Group**: In its subsequent meetings, the Working Group may elaborate on the above-mentioned policy areas in a more detailed manner.

**COMCEC Project Funding**: Under the COMCEC Project Funding, the COMCEC Coordination Office issues calls for project proposals each year. With the COMCEC Project Funding, the member countries participating in the Working Groups can submit multilateral cooperation projects to be financed through grants by the COMCEC Coordination Office. For realizing above-mentioned policy recommendations, the member countries can utilize the COMCEC Project Funding facility. These projects may include organization of seminars, training programs, study visits, exchange of experts, workshops and preparation of analytical studies, needs assessments and training materials/documents, etc.

## Annex 4: List of Participants

**LIST OF PARTICIPANTS**
**13TH MEETING OF THE POVERTY ALLEVIATION WORKING GROUP**
**4 APRIL 2019, Ankara**

### A. MEMBER COUNTRIES OF THE OIC

**ISLAMIC REPUBLIC OF AFGHANISTAN**

- Mr. MUQADAR SHAH HASHIMI
Director of Economic Policy, Ministry of Economy

**PEOPLE'S DEMOCRATIC REPUBLIC OF ALGERIA**

- Ms. SALIMA OUBOUSSAD
Sub Director, Ministry of National Solidarity, Family, and Woman Condition

**REPUBLIC OF BENIN**

- Mr. MENSAH HYACINTHE MONTCHO
Head of Department, Ministry of Planning and Development
- Mr. FELIX AGBLA
Deputy Executive Secretary, National Council for Aids, Tuberculosis and Malaria Fighting

**REPUBLIC OF CAMEROON**

- Mr. AHMAD MALAM
Sub Director, Ministry of Economy Planning and Regional Development
- Ms. JOELLE NOUNOUCE BOUBA HAMAN
Medical Technologist, Ministry of Public Health

**ARAB REPUBLIC OF EGYPT**

- Mr. AMR SELIM
Deputy Head of Mission, Embassy of Egypt in Ankara

**REPUBLIC OF INDONESIA**

- Mr. ANDI ZAINAL ABIDIN DULONG
Director, Ministry of Social Affairs
- Mr. DILLON ZUFRI
Social Specialist, Ministry of Social Affairs
- Mr. HARYADI SATYA
First Secretary, Embassy of Indonesia in Ankara

**ISLAMIC REPUBLIC OF IRAN**

- Ms. MARYAM MOHAMMADREZA
Deputy General Director, Ministry of Cooperative, Labour, and Social Welfare
- Ms. FAEZEH ZAREI
Head of Social Welfare Indicators, Ministry of Cooperative, Labour and Social Welfare

**HASHEMITE KINGDOM OF JORDAN**

- Mr. LOAY ASSAF
Director, Ministry of Social Development
- Mr. NAJI AL ALWAN
Manager, Ministry of Social Development

**STATE OF KUWAIT**

- Ms. JAMANAH AHMED
Researcher, Ministry of Finance

**MALAYSIA**

- Ms. MAHANI AHMAD HAMIDY
Deputy Director, Ministry of Health
- Mr. MOHD SAFIEE ISMAIL
Principal Assistant Director, Ministry of Health Malaysia

**SULTANATE OF OMAN**

- Ms. MAYA AL HAJRI
Financial Analyst, Supreme Council for Planning –The General Secretariat
- Ms. BADRIYA AL-RASHDI
Director, Ministry of Health

**STATE OF QATAR**

- Mr. SALIH AL MARRI
Asst. Minister of Health, the Ministry of Public Health
- Mr. MOHD AL HAJRI
Director, the Ministry of Public Health

**KINGDOM OF SAUDI ARABIA**

- Mr. ADEL MANSI
Doctor, Ministry of Health

**REPUBLIC OF TUNISIA**

- Mr. NAJET DKHIL GALAI
Director, Ministry of Social Affairs

**REPUBLIC OF TURKEY**

- Dr. SELAMİ KILIÇ
Director General, Ministry of Health
- Mr. YUSUF IRMAK
Head of Department, Ministry of Health
- Mr. MUSTAFA TARLACI
Deputy Director General, Ministry of Family and Social Policies
- Mr. NEVZAT KUNDURACI
Head of Department, Ministry of Family and Social Policies
- Mr. ERCAN DANSUK
Expert, Ministry of Family and Social Policies
- Ms. AYŞE ÇELİKTEN
Expert, Ministry of Family and Social Policies
- Mr. FEHMİ AYDIN
Expert, Ministry of Health
- Dr. HÜSEYİN ÖZBAY
Expert, Ministry of Health
- Mr. AHMED SAİD ALTIN
EU Expert, Ministry of Health
- Mr. HAYDAR RIDVAN CİVAN
Expert, Ministry of Health
- Mr. KADİR ÖZTÜRK
Expert, Ministry of Health
- Ms. YAĞMUR ÖZBUÇAK
Expert, the Turkish Red Crescent
- Mr. YUNUS EMRE TOPÇU
Expert, the Turkish Red Crescent

## B. THE OIC SUBSIDIARY ORGANS

**STATISTICAL, ECONOMIC, SOCIAL RESEARCH AND TRAINING CENTER FOR ISLAMIC COUNTRIES (SESRIC)**

- Mr. MAZHAR HUSSAIN
Senior Researcher, SESRIC
- Mr. TAHIR SYED MAHMUD
Researcher, SESRIC
- Ms. ESMA DEMİRTAŞ
Training Expert, SESRIC

## C. SPECIALIZED ORGANS OF THE OIC

**ISLAMIC DEVELOPMENT BANK (IDB)**

- Mr. ELBASHIER SALLAM
Lead Global Health Specialist, Islamic Development Bank (IsDB)

## D. OTHER INVITED INSTITUTIONS

**WHO**

- Ms. RAYANA AHMAD BOU HAKA
Manager, WHO Office for the Eastern Mediterranean

**INSTITUTE OF DEVELOPMENT STUDIES**

- Mr. TANVIR AHMED
Consultant, Institute of Development Studies, University of Sussex

**DOCTORS WORLDWIDE**

- Mr. SAFA ŞİMŞEK
Head of Programs and Operations
- Mr. AHMET ÇEVİK
Coordinator
- Ms. KAWTAR ALKHAYATI
Coordinator
- Mr. HASAN HAMZA ONAT
Assistant to Manager

## E. COMCEC COORDINATION OFFICE

- Mr. M. METİN EKER
Director General, Head of COMCEC Coordination Office
- Mr. SELÇUK KOÇ
Director
- Mr. BURAK KARAGÖL
Director
- Mr. MEHMET ASLAN
Director
- Ms. GÜNEŞ AŞIK
Consultant
- Mr. ERHAN SIRT
Expert
- Mr. MEHMET AKİF ALANBAY
Expert