



**World Health
Organization**



Strategizing national health in the 21st century: a handbook
Chapter 1

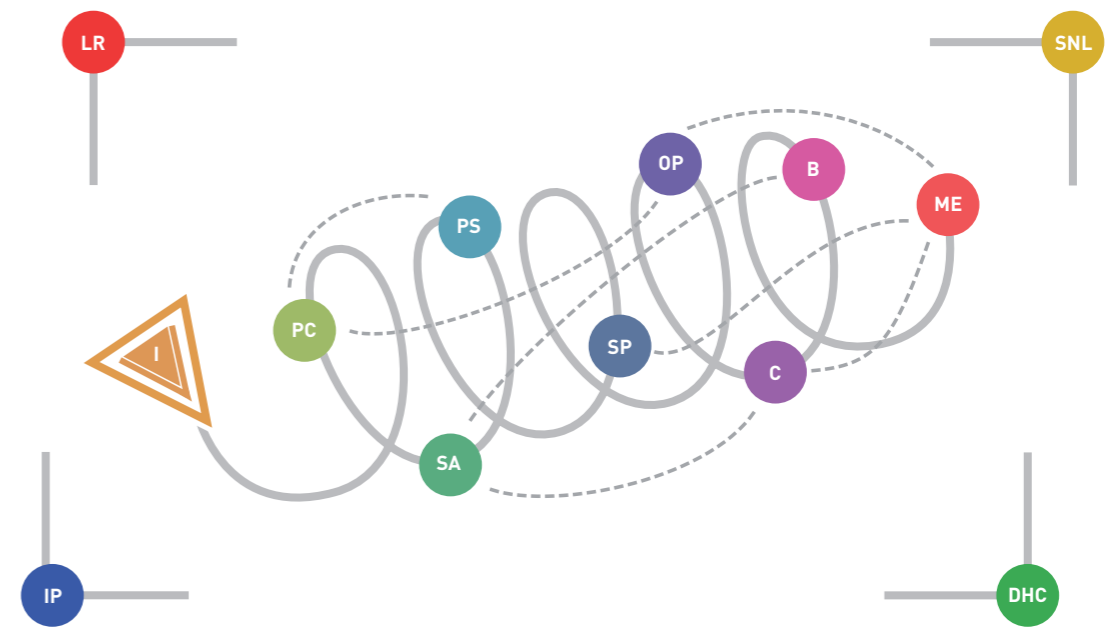
Introduction

Gerard Schmets

Sowmya Kadandale

Denis Porignon

Dheepa Rajan



I	CHAPTER 1 Introduction: strategizing national health in the 21st century
PC	CHAPTER 2 Population consultation on needs and expectations
SA	CHAPTER 3 Situation analysis of the health sector
PS	CHAPTER 4 Priority-setting for national health policies, strategies and plans
SP	CHAPTER 5 Strategic planning: transforming priorities into plans
OP	CHAPTER 6 Operational planning: transforming plans into action
C	CHAPTER 7 Estimating cost implications of a national health policy, strategy or plan
B	CHAPTER 8 Budgeting for health
ME	CHAPTER 9 Monitoring and evaluation of national health policies, strategies and plans

Cross-cutting topics relevant to national health planning

LR	CHAPTER 10 Law, regulation and strategizing for health
SNL	CHAPTER 11 Strategizing for health at sub-national level
IP	CHAPTER 12 Intersectoral planning for health and health equity
DHC	CHAPTER 13 Strategizing in distressed health contexts

Introduction

Gerard Schmets
Sowmya Kadandale
Denis Porignon
Dheepa Rajan



WHO Library Cataloguing-in-Publication Data

Strategizing national health in the 21st century: a handbook / Gerard Schmets ... [et al].

Contents: 13 individual chapters

1. Health Policy. 2. National Health Programmes. 3. Health Planning. 4. Handbooks. I. Schmets, Gérard. II. Rajan, Dheepa. III. Kadandale, Sowmya. IV. World Health Organization

ISBN 978 92 4 154974 5 (NLM classification: WA 540)

© World Health Organization 2016
All rights reserved. Publications of the World Health Organization are available on the WHO website (<http://www.who.int>) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; email: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications – whether for sale or for non-commercial distribution – should be addressed to WHO Press through the WHO website (http://www.who.int/about/licensing/copyright_form/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

The named editors have overall responsibility for the views expressed in this publication. The named authors alone are responsible for the views expressed in each chapter.

The document has been produced with the financial assistance of the European Union and the Grand Duchy of Luxembourg. The views expressed herein can in no way be taken to reflect the official opinion of the European Union nor the Grand Duchy of Luxembourg.

Graphic design by Valerie Assmann.

Suggested citation: Schmets G, Kadandale S, Porignon D, Rajan D. Chapter 1. Introduction. In: Schmets G, Rajan D, Kadandale S, editors. Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016.

Contents

Acknowledgements	iv
1.1 Rationale for this handbook	1
1.2 Context in the 21st century	2
1.2.1 Sustainable development goals, strengthening health systems and universal health coverage	2
1.2.2 The fiscal gap and the importance of domestic resources	6
1.2.3 A whole-of-government and a whole-of-society approach to policy dialogue	8
1.2.4 Different contexts, different countries, different strategies for strengthening a health system	14
1.3 NHPSPs in the 21st century	17
1.3.1 Good practice for the development of robust NHPSPs	17
1.3.2 Dynamic 21st century process	27
1.4 The handbook scope and content	29
1.4.1 Scope	29
References	33

Acknowledgements

We would like to give special thanks to Agnes Soucat for overall guidance.

Thanks are also due to Alyssa Muggleworth Weaver for overall background research support.

Information and graphs for boxes were provided by Maryam Bigdeli, Jim Campbell, David Clarke, Carmen Dolea, Edward Kelley, Marie-Paule Kieny and Nuria Toro Polanco.

English language editing was provided by Dorothy van Schooneveld and Thomson Prentice.

We gratefully acknowledge financial support from the European Union and the Grand Duchy of Luxembourg.



1.1 Rationale for this handbook

The global health environment is becoming increasingly complex. Social, demographic and epidemiological transformations fed by globalization, urbanization and ageing populations pose challenges of a magnitude that was not anticipated three decades ago. In addition, recent global health security threats such as the Ebola virus disease or Zika virus outbreak, and the growing mismatch between the low performance of health systems and the rising expectations of societies, are increasingly becoming a cause for political concern. This often leads to countries prioritizing, or re-prioritizing, efforts towards strengthening health systems, moving towards universal health coverage (UHC) and implementing the idea of health in all policies.¹

Countries recognize that these calls for efficiently strengthening health systems and improving health security must be translated into robust, realistic, comprehensive, coherent and well balanced health policies, strategies and plans. In the post-Millennium Development Goals (MDGs) era, they also recognize that in pluralist, mixed, public-private health systems, these policies, strategies and plans have to relate to the entire health sector and cannot be limited anymore to “command-and-control” plans for the public sector.

Functional health systems that deliver high quality services to the population are the main priority for governments. Achieving this requires permanent, well-structured and dynamic processes, with a true consensus between the demand and supply of services, as well as between governments, services providers and the population. A solid, evidence-informed *policy dialogue* is the only real way to achieve this in the 21st century.^{2,3,4}

Furthermore, it is now widely understood that national health policies, strategies and plans (NHPSPs¹) extend much beyond “health care”, i.e. clinical personal services, and cover the broad public health agenda, including disaster preparedness, risk management and the International Health Regulations, encompassing action on the social determinants of health and the interaction between the health sector and other sectors in society.

In the face of both these gradual and acute changes over the past decade, NHPSPs, and more importantly the process of developing the NHPSP, need to be adapted and given a different focus. This handbook attempts to address that need.

In the context of the Paris, Accra and Busan principles of effective development cooperation, it is also widely recognized that in countries that receive significant external aid, NHPSPs are increasingly seen as crucial for making aid more effective.

It is recognized that, during the MDGs era, plans or policies did not always fulfill their promises; this was often because of design deficiencies or implementation failures. It was common to observe that national plans were not inclusive, not comprehensive enough, often imbalanced and incoherent with the wide variety of health problems to be tackled. Often, there was a disconnect between national plans and the broader national development policies or policy frameworks, health financing strategies and macroeconomic policies.

¹ The terms “policy”, “strategy” and “plan” are used interchangeably by WHO, following a WHO Global Policy Group meeting and decision in 2009.

1.2 Context in the 21st century

1.2.1 Sustainable development goals, strengthening health systems and universal health coverage

Strategizing means designing plans and policies to achieve a particular goal related to the health of a nation.

This handbook aims to make the case that strategizing – meaning designing plans and policies to achieve a particular goal related to the health of a nation – is absolutely critical in the 21st century. It is not only recommended by the Member States of the World Health Organization (WHO), but is also feasible for all countries in all settings.

This handbook builds on the experiences gathered by WHO and its partners during the MDGs era. It presents the way of developing NHPSPs from a new pluralistic perspective, and it advocates for policy dialogue as a means to ensure inclusiveness and the participation of both service providers and the population in debates and the decision-making process with the government, as well as in the follow-up, monitoring and evaluation of NHPSP implementation.

As the world shifts from the MDGs to the Sustainable Development Goals (SDGs), governments are afforded a tremendous opportunity to better engineer the development of their countries. This is particularly relevant in the health sector, as countries make progress towards universal health coverage (UHC), i.e. *ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.*⁵ In other words, this entails reducing the gap between access, need for and use of services, improving quality, and improving financial protection (see Fig. 1.1).

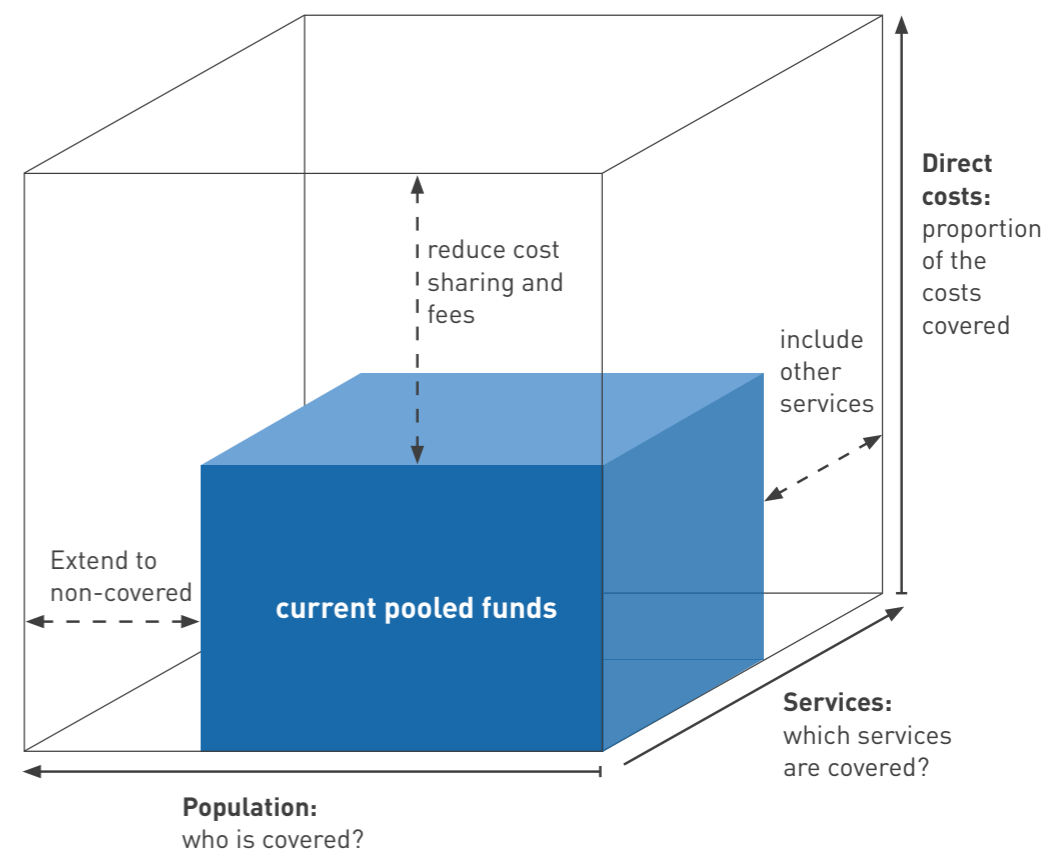


Fig. 1.1 Moving towards UHC⁶

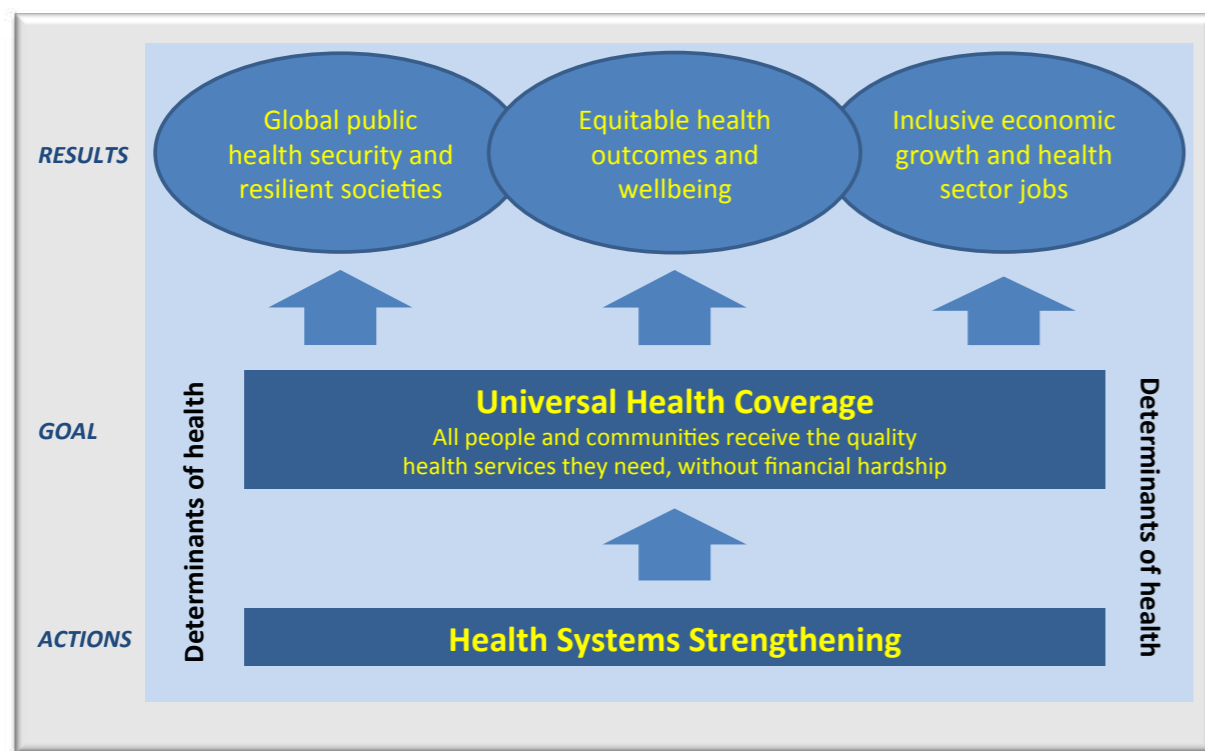
UHC will only be achieved by its target date of 2030 if consistent and comprehensive health systems are developed, ones which are able to deliver on health outcomes and the well-being of the populations they serve. In particular, strong health systems are essential to ensure both individual and global public health security. As sharply illustrated during recent health emergencies in West Africa, or natural disasters in Nepal and the Philippines, health systems must also be prepared to guarantee the health security of the population and the resilience of societies.

Health system strengthening (HSS) efforts thus must be scaled up immediately. HSS is the process of identifying and implementing the changes in policy and practice in a country's health system (institutions, people and actions), so that the country can respond better to its health and health system challenges.⁷ HSS implies mobilizing or better prioritizing the allocation of financial resources for health, as well as building the capacities of health systems in a variety of institutional, economic, fiscal, and political contexts.

Strategizing for health relates to SDG 3 but also to other SDGs such as SDG 1 (Poverty), SDG 4 (Education), SDG 5 (Gender equality) or SDG 8 (Inclusive economic growth and decent jobs).

Health systems and their strengthening are seen as the foundational set of policies, institutions, actions, approaches and tools, required to achieve the goals of UHC and the SDGs. Attaining these goals will, in turn, make essential contributions to global health security and resilient societies, equitable health outcomes and well-being, and inclusive economic growth—a dynamic further illustrated in Fig. 1.2 below. Realistically, strategizing for health needs to build on solid financial evidence and a stable financial perspective, as discussed in the next section.

Fig. 1.2 A framework for UHC as part of the SDGs



Adapted from a presentation by Kiemy, MP, Category Network Meeting, Geneva, January 2015

Box 1.1

Key concepts for the HSS agenda

- ▶ **A health system** is the aggregate of all public and private organizations, institutions, and resources mandated to improve, maintain or restore health. This includes both personal and population services, as well as activities to influence the policies and actions of other sectors to address the political, social, environmental, and economic determinants of health.
- ▶ **Health system strengthening** is the significant and purposeful efforts to improve the performance of existing health systems.
- ▶ **Resilience** reflects the ability of health systems and institutions and societies to absorb disruptions, adapting and responding as needs evolve and the wider context changes. Resilience is a dynamic objective, captured over time as systems progressively build capacities to effectively respond to future shocks.
- ▶ **Health security** has two separate dimensions—individual and collective. Improving individual health security aims at reducing individual vulnerability to health risks through trusted access to safe and effective health services, products, and technologies. Collective health security at the global level involves reducing the vulnerability of societies to health threats that spread across national borders.
- ▶ **Universal health coverage:** all people and communities receive needed quality health services (including prevention, promotion, treatment, rehabilitation, and palliation) without financial hardship.

1.2.2 The fiscal gap and the importance of domestic resources

NHPSPs need to be guided by better and more efficient use of existing domestic resources, and by a very strategic and very well reflected allocation of the expected additional future domestic resources. This requires increased accountability of all concerned stakeholders, with strong policy dialogue at the highest level.

Estimates of the resources required to strengthen health systems point to a stark financial gap. In 2015, WHO estimated that the minimum investment required in the health sector for countries to attain the SDGs by 2030 is USD 55 billion per year.ⁱⁱ Of this annual amount, according to the Taskforce on Innovative International Financing for Health Systems, between two thirds and three quarters— USD 40 billion—must be spent on HSS efforts.⁸

The global HSS gap of USD 40 billion per year demands additional resources, as well as a realignment of existing resources. One cannot expect that this gap, mainly located in low and middle income countries, will be covered by external aid. Indeed, in 2013, the total combined amount of funding for HSS from all international sources was just over USD 2.3 billion, whereas funding for disease-specific programmes such as HIV/AIDS, tuberculosis or malaria amounted to USD 34 billion.⁹ It is unrealistic to expect a twenty-fold increase in external aid for HSS to reach the required annual funding targets. Consequently, this gap will need to be covered by domestic funding (government and household contributions).

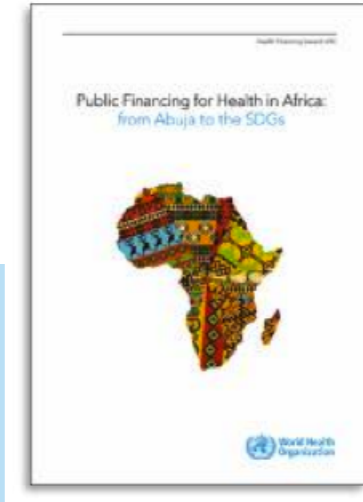
As echoed in the 2015 Addis Ababa Action Agenda,¹⁰ the growing use of domestic resources for financing the health sector signifies that governments must make smart choices in

determining how and where investments are made. In 2013, domestic resources represented 75% of total health spending in fragile states and low-income countries, and more than 95% in middle-income countries.¹¹ Notably, however, these domestic resources are often not optimally distributed, neither geographically nor among various income quintiles. Out-of-pocket expenditures remain unacceptably high.ⁱⁱⁱ This trend also suggests the need to reduce fragmentation and duplication among the different programmes, thereby increasing efficiency within and outside the health sector.

These issues of misallocation and inefficient use of domestic resources in many low- and middle-income countries underline the crucially important role of better strategizing and planning domestic resources in order to improve the health and well-being of populations. NHPSPs need to be guided by a better and more efficient use of existing domestic resources, and by a very strategic and very well reflected allocation of the expected additional future domestic resources. This requires increased accountability of all concerned stakeholders, with strong policy dialogue at the highest level. As discussed in the next section, to achieve these objectives, strategizing national health in the 21st century clearly needs to be inclusive of all relevant actors and sectors.

ⁱⁱ WHO estimates 2016, based on the 2009 Financing for Development Conference.

ⁱⁱⁱ In 2013, out-of-pocket expenditures represented 49% of total health expenditures in this group of countries, while public expenditures represented only 39% of total health expenditures.



Box 1.2

Why are sound NHPSPs so important? The evidence from Africa

In the 2016 WHO report Public financing for health in Africa: from Abuja to the SDGs,¹² WHO concluded that **“For every USD 100 that goes into state coffers in Africa, on average USD 16 is allocated to health, only USD 10 is in effect spent, and less than USD 4 goes to the right health services.”** The authors assessed that four key areas need to be addressed to overcome this situation: (1) the de-prioritization of health in the context of increasing revenues; (2) funding inconsistency and the lack of predictability of both domestic and external resources for health; (3) budget underspending; and (4) misallocation of resources.

The development of sound health policies and strategies through intersectoral (whole-of-government) and intrasectoral

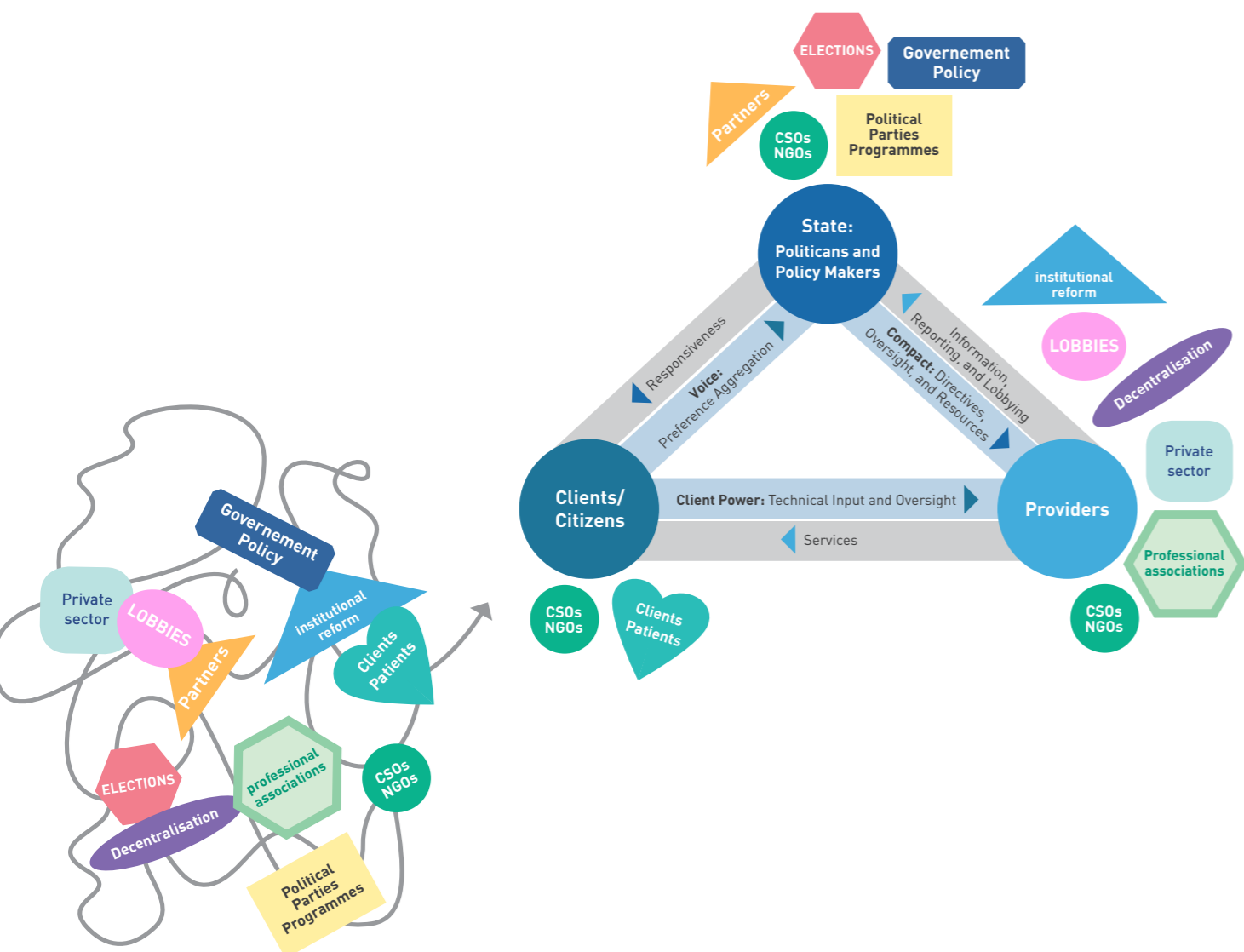
inclusive policy dialogue with all health stakeholders (whole-of-society) is the way forward. In other words, to address the above-mentioned key issues, robust NHPSPs that reflect the vision, formalize the agreements, and put implementation aspects down on paper, need to be developed. They must be well prioritized and reflect the needs and the demand for health services, with resource allocation orientated towards UHC objectives. They need to clearly specify health sector goals and be anchored in strong political agreements to improve consistency and predictability. NHPSPs must be well translated into operational plans and budgets that will allow for full implementation. They also need to be well monitored and transparently evaluated for increased accountability and transparency.

1.2.3 A whole-of-government and a whole-of-society approach to policy dialogue (see Box 1.3)

Linked to the evolution of democratic and human right values in national debates, and supported by more rapid, real-time communication offered by the media in the age of the internet, governance has evolved towards a whole-of-government and a whole-of-society approach: improving health and well-being is no longer the role of the public health sector only, and no longer only under the purview of

the ministry of health (see Box 1.4). In other words, all sectors are part of the UHC road to success, and all stakeholders, beneficiaries, providers and the state must be involved in its design, implementation and follow-up. By thus taking on an increased role in defining the “what” and the “how”, health actors accept increased responsibility and accountability for delivering results on agreed targets.

Fig. 1.3 Structuring the policy dialogue¹⁴



Box 1.3

Policy dialogue: a fundamental process for the development of truly “whole-of-society” and “whole-of-government” NHPSPs?¹³



Policy dialogue can be defined as the “set of formal and informal exchanges aimed at facilitating policy change, influencing policy design and fostering further processes for decision-making where stakeholders of the different health system levels participate and contribute”. It is an iterative inclusive process connecting the technical to the political, addressing the aspirations of the people, involving multiple stakeholders aimed at questioning and changing formal or informal policy, strategy and plans or addressing specific health issues to have maximum (public) health impact through a face-to-face and interactive discourse.

In the health sector, the entry points for policy dialogue can be very diverse. The entry point may be an issue that has arisen in the course of a policy process that provokes dialogue, often (but not always) due to the sensitivity or the wide-reaching consequences of the policy. It can be the emerging need for reforms, national or sub-national political debates, technical challenges, or even operational problems related to health systems or disease control activities. Examples of such entry points are health system reform, fiscal policy, health financing strategies, coordination of stakeholders within and outside of the health sector, health accounts, human resources for health, service delivery models, and drug pricing strategy, among many others.

Ideally, a robust policy dialogue leads to key policy decisions with the buy-in and ownership of a wide range of stakeholders – this is crucial because policy implementation is directly dependent on buy-in from at least those stakeholders who are involved in implementation. Stakeholder ownership is invaluable and is, among other things, a consequence of having a voice in the policy process. It includes any communication (informal consultations, electronic correspondence, corridor meetings, among others) or contact between people who are ultimately contributing in some way, shape, or form to a process which culminates in a policy decision. Policy dialogue provides a means to enhance mutual understanding of problems and to expand trust between partners by providing a platform to clarify expectations and agree on commitments. Policy dialogue also offers a way to increase accountability, more effectively implement policies, and more rapidly respond to barriers or challenges that are ideally addressed in a collective and collaborative manner.

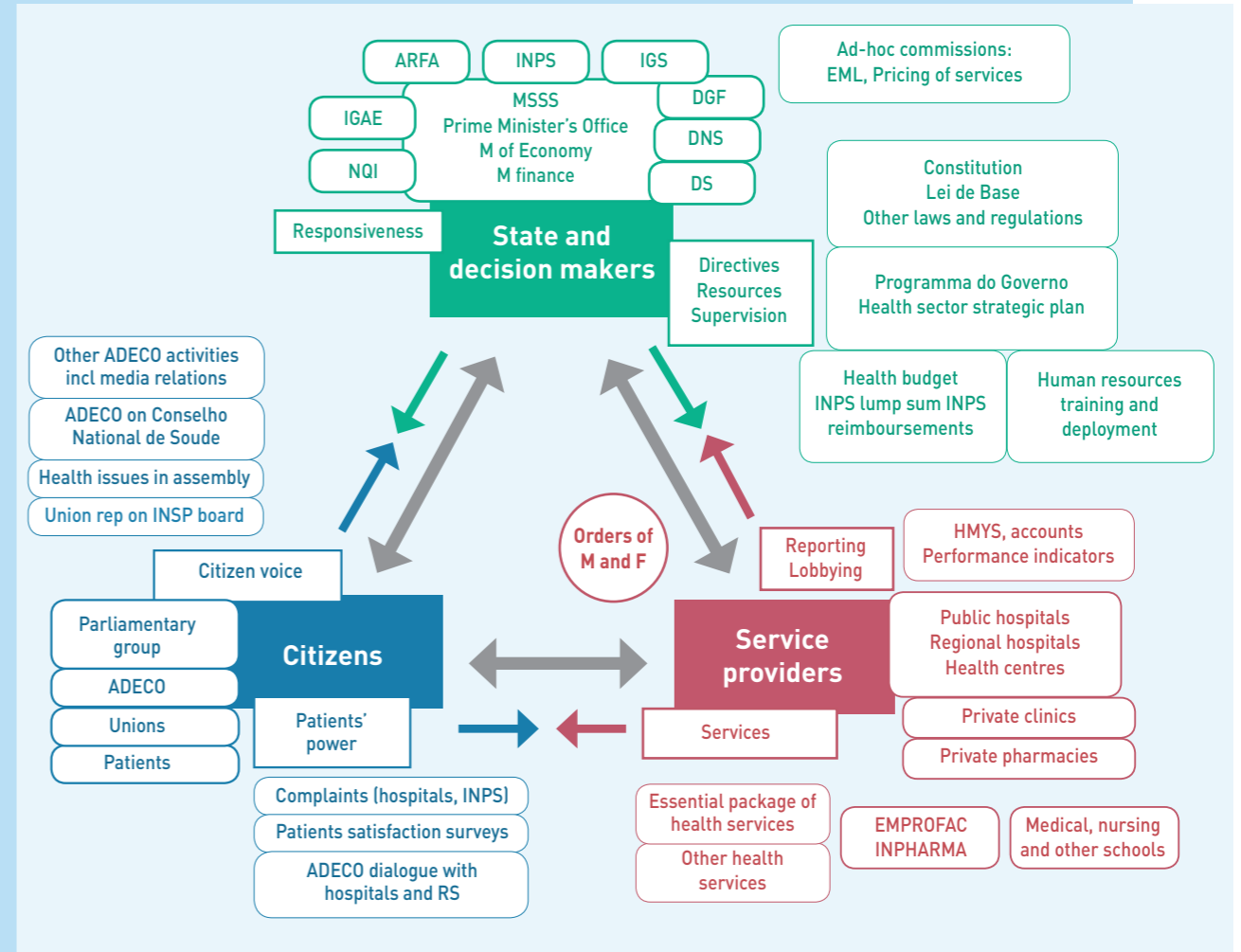
Ensuring continued participation of all the actors necessitates innovation to allow dialogue outside the formal frameworks and spaces that constitute formal dialogue processes.

Recent policy dialogue processes at country level have demonstrated that flexibility is key to supporting strategic interventions. A Ministry of Health should be capable to adapt its policy orientations to the evolution of the national situation as well as to the transformation of the outside world.



Box 1.4

Overview of health system governance in Cabo Verde 2016¹⁴



How do participation and inclusiveness play out in practice? A recent analysis of health stakeholders and major health governance issues in Cabo Verde demonstrates the sheer plethora of actors involved in the health sector. The graphical and visually “busy” representation above makes it strikingly clear how overwhelming the health policy arena can be. The illustration

elucidates how complex a simple stakeholder analysis can be, with multiple actors, multiple interests and a multiplicity of relationships and connections between them. It also drives home the point that the health policy playing field is no longer necessarily dominated by the public sector, and that participation and inclusiveness must be structured and managed.



© WHO /Stéphane Saporito

The national and in some cases international stakeholders need to agree on baselines and targets, on methods and strategies to achieve the targets, on plans to implement the strategies, on mechanisms and process to monitor and correct strategies in a dynamic environment where external conditions will guide and reshape initial strategies to keep the objectives on track all along the journey.

They will need to be present at all levels, wherever a decision-making process is needed. In highly decentralized countries, it may mean a pluralistic participation in various facility boards or other steering, management or health committees. In all cases, it is clearly a dynamic process that needs to be sustained: in order to be effective and ensure accountability, this policy dialogue is not a “one shot” exercise; it is a permanent process to guide countries towards UHC (Box 1.5).

Box 1.5

Using crises to improve health planning

The 2014-15 Ebola Virus Disease (EVD) outbreak in West Africa exposed significant gaps in the health systems of the affected countries. Prior to that period, Sierra Leone had embarked on a series of efforts to improve national health planning: the National Health Sector Strategic Plan 2010-2015, which provided the overarching framework for informing the strategic orientations of the country; the Joint Programme of Work and Funding 2012-2014, which aligned interventions to key sector priorities; the Basic Package of Essential Health Services 2010-2015, which provided the platform for guiding delivery of health services and a Results and Accountability Framework 2010-2015, which articulated the monitoring and evaluation requirements to support health services management. With the EVD epidemic, the implementation of many of these measures was hindered. However, the post-Ebola environment has provided a fertile ground for improved national health planning, incorporating the lessons learnt from the past as well as during the outbreak to enhance the health and well-being of the population. The Government of Sierra Leone, with support from partners, has identified a

series of targeted, prioritized interventions across all sectors to revitalize the country. In health, this has meant a sustained effort in the 6-9 month period following Ebola to tackle patient safety and revive essential services, while in the medium-term 10-24 months, there have been identified key result areas to reduce maternal and child mortality, maintain a ‘resilient zero’ – i.e. no new cases of Ebola, and provide care to EVD survivors. These prioritized interventions have enabled the Government and partners to rationalize limited resources, allowing for focused planning, budgeting and monitoring.

Similarly, the lessons from Tunisia illustrate the impetus crises can provide to strengthen planning processes. During the post-revolution period, in 2012, the Government launched a “societal dialogue”, which was instrumental in providing the basis for sector’s health priorities.^{IV}

These two experiences – from Sierra Leone and Tunisia – highlight the growing recognition by countries to move towards innovative ways of better planning for health, particularly, as they emerge from challenging situations.

^{IV} For more information, please see chapter 2 “Population consultation on needs and expectations” in this handbook

1.2.4 Different contexts, different countries, different strategies for strengthening a health system

Context is of prime importance in national planning and policy dialogue.

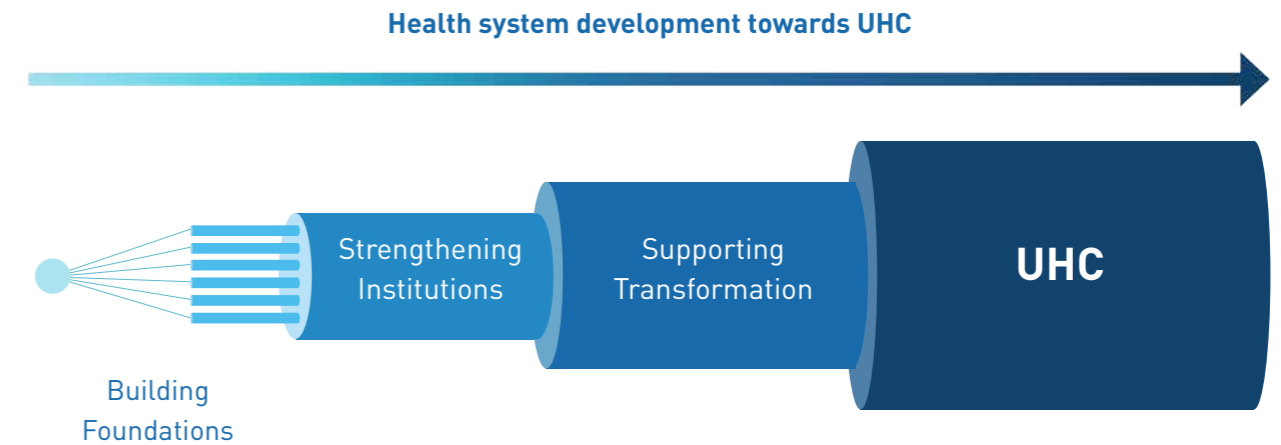
In national planning and policy dialogue, context is of prime importance and thus blueprint approaches are unlikely to provide sufficient support. Fortunately, enough knowledge has been accumulated to identify good practice elements. Experience shows that the policy dialogue for building comprehensive NHPSPs is as much a political process as a technical one. The balance between vision and policy, and operational detail and implementation arrangements, varies considerably from country to country, as well as within the same country over time.

Some countries are more advanced in the process, while others are still facing fatal gaps that need to be addressed in order to improve population health. The way systems are strengthened will be different in every country context, and subsequently reflected as such in each NHPSP. WHO has categorized three broad country contexts from the specific vantage point of strengthening health systems as a means to achieve UHC (see Fig. 1.4).

These are further described below, and are pertinent with regard to the NHPSP content.

1. Strategy 1: “F”: Strengthening health systems **foundations** in least-developed and fragile countries with poor health system performance and negligible fiscal space to increase public spending on health.
2. Strategy 2: “I”: Strengthening health systems **institutions** in least-developed countries where the health system foundations are in place.
3. Strategy 3: “T”: Supporting health systems **transformation** in countries with mature health systems where reaching UHC and health security is still challenging.

Fig. 1.4 Health systems contexts and the WHO FIT strategies¹⁶





1.3 NHPSPs in the 21st century

1.3.1 Good practice for the development of robust NHPSPs

The various contextual factors summarized above have translated into a renewed focus on strengthening countries' capacity to strategize their health and develop robust, efficient, evidence-informed NHPSPs that can:

- ▶ respond to growing calls for strengthening health systems as a means towards achieving UHC;
- ▶ guide and steer the entire pluralist health sector rather than being limited to command-and-control plans for the public sector alone;
- ▶ go beyond the boundaries of health systems, addressing the social determinants of health and the interaction between the health sector and other sectors in society;
- ▶ be used as the key element for governmental negotiations regarding fiscal space and budget execution;
- ▶ be used, mainly in countries with "foundational" problems, where external aid plays a significant role, as the key element to improve development effectiveness.

The current context favours getting more value from NHPSPs, with a growing expectation that they will be informed by a realistic assessment of capacities and a bold vision of the future,

with much more emphasis on stakeholder accountability. In addition, in a globalized world, expectations are growing that NHPSPs will support the development of resilient health systems leading to more security, more equity and more health.

Based on this, elements of good practice for developing robust national health policies, strategies and plans are outlined below.¹⁷

(a) UHC as an overarching vision

While UHC is generally accepted as an overall objective to strive for, in practice this means that all debates and discussion take place with the following in mind:

- ▶ ensuring coverage of the population – leaving no one behind;
- ▶ ensuring financial health protection and avoiding catastrophic expenditures;
- ▶ providing a comprehensive package of high-quality integrated and people-centred health services (see Box 1.6).

A robust, efficient, evidence-informed NHPSP should be able to guide and steer the entire pluralist health sector, and form a key element for fiscal space and budget negotiations in government.

Box 1.6

Framework on integrated people-centred health services

Globally more than 400 million people lack access to essential health care. Longer lifespans and the growing burden of long-term chronic conditions requiring complex interventions over many years are also changing the demands on health systems.

Adopted by Member States at the World Health Assembly in May 2016, the Framework on integrated people-centred health services (IPCHS) aims to address these issues by calling for a fundamental shift in the way health services are funded, managed and delivered. The Framework presents a compelling vision of a future in which all people have access to health services that are provided in a way that is coordinated around their needs, respects their preferences, and is safe, effective, timely, affordable, and of acceptable quality. It proposes five interdependent strategies:

(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.

Developed as a universal vision – the Framework can be adapted to all countries whether high-, medium- or low-income, with mature or fragile health systems.

Related links:

WHO Website on IPCHS:

<http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>

Integratedcare4people web platform:

<http://www.integratedcare4people.org>

Box 1.7

The International Health Regulations

The International Health Regulations (IHR (2005)) represent a binding international legal agreement involving 196 countries, including all the Member States of WHO. The purpose and scope of the IHR (2005) is to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.

The IHR (2005), which entered into force on 15 June 2007, establish the procedures that WHO and States Parties must follow to uphold global public health security. Under the IHR (2005), States Parties are required to assess and notify to WHO public health events that may constitute a public health emergency of international concern, on the basis of defined criteria, which include the seriousness of the event, its unusual or unexpected features, the risk of its international spread and the risk of international travel or trade restrictions.

WHO is obliged to request verification of events that it detects through its surveillance activities with the countries concerned, who must respond to such requests in a timely manner. Notifications and information are communicated by a National IHR Focal Point to a WHO IHR Contact Point which, together, establish a unique and effective communications network between countries and with WHO. States Parties are further required to ensure that their national health surveillance and response capacities meet certain functional criteria, and to report annually to the World Health Assembly on the implementation of the IHR.

Building synergies between IHR core capacities, strengthening health systems and essential public health functions is key to ensure a coordinated and effective response to global public health threats.

WHO website on IHR: http://www.who.int/topics/international_health_regulations/en/

(b) The international context

An NHPSP should be compliant with the International Health Regulations¹⁸ (Box 1.7), the Global Framework Convention on Tobacco Control¹⁹ as well as other WHO recommendations or UN resolutions.

One recent example is the United Nations Secretary-General's 2016 High-Level Commission on Health Employment and Economic Growth (see Box 1.8); the co-chairs, French President Francois Hollande and South African President

Jacob Zuma, in their speech to the UN General Assembly in September 2016, invited "all stakeholders to join ... in implementing ... [the] ten recommendations [of the Commission's final report] and to integrate these in their national, regional and international plans. We need to align our efforts with other related plans if we are to achieve the Sustainable Development Goals."

sectors and the national development plan; with programme-specific or sub-sector plans; with the epidemiological and socioeconomic context; and with the available current and estimated future resources.

- ▶ Scenarios and policy directions should move towards universal coverage, shifting health-care delivery towards integrated people-centred health services,²⁰ protecting and promoting the health of communities and building capacity to deal with future challenges.
- ▶ Intersectoral mindset should be fostered, implying that governments and other stakeholders proactively address the determinants for health inequities by identifying and promoting intersectoral action as an integral and vital component of the national health planning process.
- ▶ The associated costs and resource mobilization implications should be carefully considered.
- ▶ Attention should be devoted to the leadership and governance arrangements for implementing the strategy in terms of the role of various institutions and stakeholders, regulatory and legal frameworks to ensure sustainability, working with other sectors, dealing with the donor community and monitoring performance.

Policy formulation must be based on broad and inclusive consultation in order to ensure balanced and coherent choices of what to address by priority in the given context.

Box 1.8

High-Level Commission on Health Employment and Economic Growth

The High-Level Commission on Health Employment and Economic Growth was launched by the UN Secretary-General in March 2016 with the aim of stimulating and guiding the creation of 40 million new jobs in the health and social sector, and to reduce the projected shortfall of 18 million health workers, primarily in low- and lower-middle income countries, by 2030. The Commission, chaired by the Presidents of France and South Africa, submitted its report *Working for health and growth: Investing in the health workforce* to the UN Secretary-General on 20 September 2016. The Commission is a strategic political initiative that lends momentum to implementation of the WHO Global Strategy on Human Resources for Health: Workforce 2030.

The Commission's vision is an expanded, transformed and sustainable health workforce that will deliver benefits across the Sustainable Development Goals (e.g. poverty elimination, good health and well-being, quality education, gender equality, and decent work and economic growth). The Commission proposes six recommendations to transform the global health workforce to address SDG needs, focusing on the following areas: job creation, gender equality, education training

and competencies, health service delivery and organization, technology, and crisis and humanitarian settings. An additional four recommendations, in the areas of financial and fiscal space, partnerships, international migration, and data, information and accountability, are presented as enabling factors for this transformation.

Stressing the urgency for action, the Commission identifies five immediate actions to be taken between October 2016 and March 2018, aligned with national, regional and global processes. These include accelerated actions on technical and vocational education and training, labour mobility, national health workforce accounts, and enhanced accountability. Moreover, ILO, OECD, and WHO, the Vice-Chairs of the Commission, are tasked with bringing together relevant stakeholders by the end of 2016 to develop a five-year implementation plan to give effect to the Commission's ten recommendations. All stakeholders are invited to integrate the Commission's recommendations in their national, regional and international plans.

WHO website on the Commission: <http://www.who.int/hrh/com-heeg/en/>

(c) Comprehensive, balanced and coherent NHPSP content

The emphasis given to policy, strategy formulation and planning must be based on a broad and inclusive consultation on what affects the health sector, in order to ensure balanced and coherent choices of what to address and what not to address in the given context. The following range of elements and structures deserve consideration.

- ▶ A comprehensive analysis should be undertaken of current and future challenges in the health sector, ideally covering: stakeholder positions; social determinants of health and health needs; demand for services and social expectations; health system performance and shortfalls, including the system's ability to respond and anticipate.
- ▶ NHPSP content should be well-balanced in terms of finances and inputs, as well as depth of analysis on the principal health issues of the country. In other words, each strategic direction needs to be developed with the same level of detail as the others, and with a level of resources that rightly corresponds to its extent and scope. On finances, this implies that the resources and costs necessary to implement the NHPSP is reasonable and within the given fiscal space for health.
- ▶ Coherence should be assured with: other

(d) Sound process

As explained in Box 1.3, policy dialogue is more likely to lead to better results, such as improved service delivery and better outcomes, if it is inclusive of all relevant social, technical and political stakeholders in and beyond the health sector. The quality of the process of policy dialogue is crucial to formulating the goals, values and overall policy directions that will guide strategy

formulation, planning and decision-making. The process must support consensus building at different stages of the planning process, including situation analysis, priority-setting, NHPSP design, implementation and review. A sound process encompasses mechanisms for obtaining feedback on implementation, and initiating corrective measures, as well as high-level endorsement of these policy directions. Smart timing is crucial for alignment with broader development frameworks and country political and institutional cycles.

(e) Realism

NHPSPs are more likely to be implemented if they are realistic and compatible with the health sector's capacities, resources and constraints. They are more likely to lead to sustained results if political commitment and policy directions are translated into legal frameworks. They are more likely to be effective if the link between strategic and operational planning is sufficiently flexible to allow for adaptation to unforeseen economic, political and health events. Finally, greater commitment is likely to be achieved if the concerns of the people who are at the forefront of implementation are adequately reflected.

(f) Linkage with operational plans

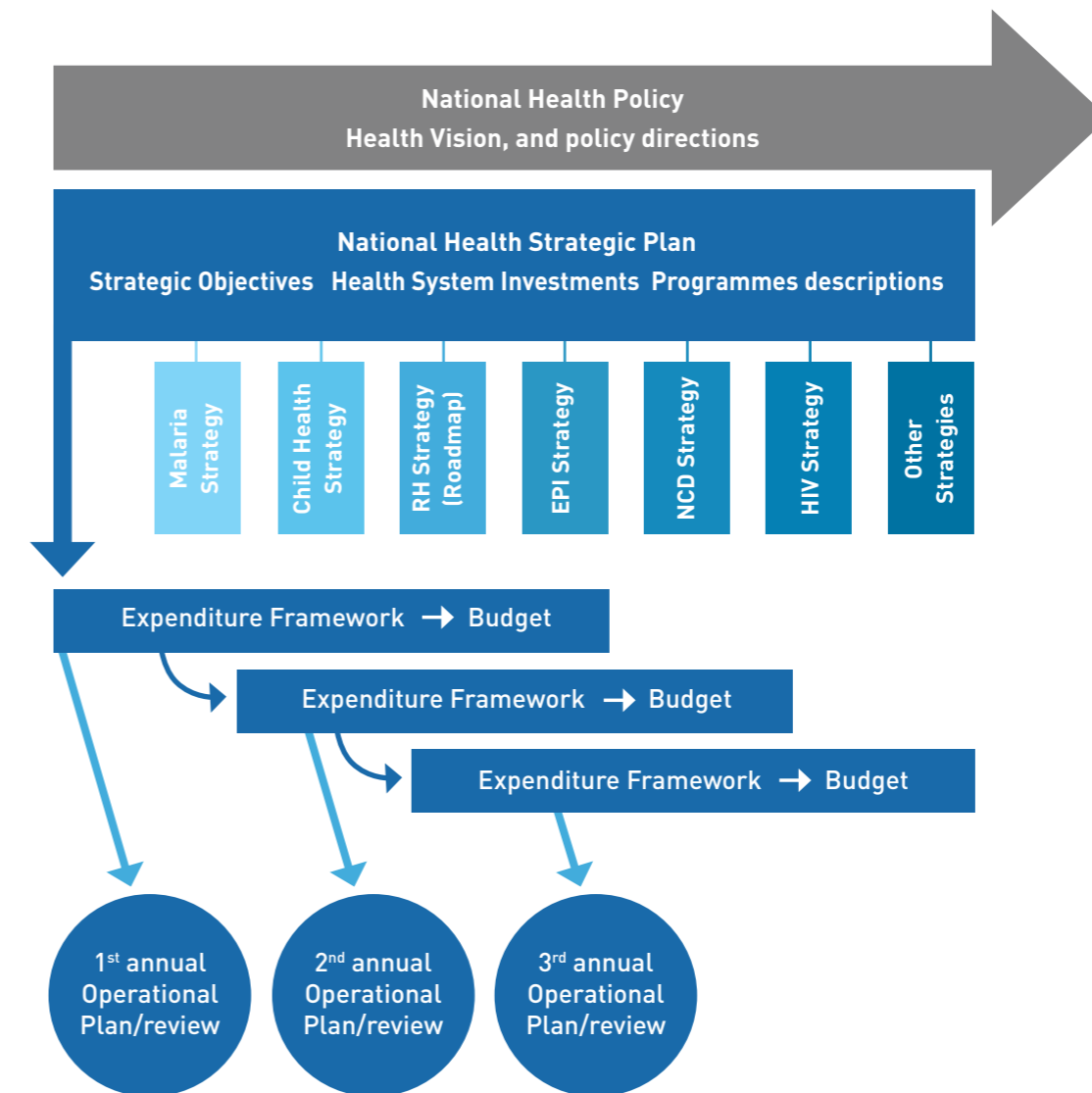
NHPSPs must be linked to regional or district-level operational plans. The extent of linkage depends on the level of detail in the NHPSP and the degree of autonomy at decentralized level. Some countries choose a more centralized approach with explicit, tight links between the national and sub-national plans;

the advantage is coherence between the plans at different levels, but this may be at the price of being overly controlling and insufficiently adaptable to context. Other countries opt for a more decentralized approach leaving much more freedom of interpretation at decentralized levels; this allows for flexibility and creativity, but may affect coherence. Many countries link the national strategic plan with operational plans through rolling medium-term plans and expenditure frameworks.

(g) Linkage with programmes

The extent to which NHPSPs address the concerns and operational plans of the country's disease-specific or life-cycle programmes varies greatly. In many countries the disconnect to the NHPSP leads to imbalance or lack of coherence between health sector planning efforts and subsequent problems in implementation. The causes are complex and include: (i) inadequate situation analysis and priority setting; (ii) the programme's operational planning is often conducted in a different arena, with different constituencies and with different planning cycles; and (iii) donors' earmarking of funds, leading to fragmentation, competition for scarce resources, and imbalances in national priority-setting. Balance and coherence can be improved by ensuring realistic assessments of how programmes can draw on shared resources and capacities, and of the impact they will have on these shared resources and capacities, and by adequate reflection of programme concerns in the comprehensive NHPSP. Ideally, the integration of programmes in the national planning need to be fully harmonized and aligned, as expressed in Fig. 1.5.

Fig. 1.5 Integration of programmes in NHPSPs



NHPSPs must be linked to regional or district-level operational plans.

(h) Linkage with the political agenda

The policies, strategies and plans for the health sector have major political and budgetary implications, well beyond their direct implications

for the public sector. Eventually they have to be endorsed as part of the government programme. As health takes increasing political space in how

Box 1.9

Health Data Collaborative

The Health Data Collaborative (HDC), launched in March 2016, is an inclusive partnership of international agencies, governments, philanthropies, donors and academics, with the common aim of improving health data. The approach is to ensure that different stakeholders in national, regional and global health are able to work together more effectively to make better use of resources, and by doing so help to accelerate impact of investments and improvements in country health information systems. The Health Data Collaborative aims to put the IHP+ principles of country ownership and alignment into practice by translating them into a joint operational plan that specifies concrete collective actions at country and global levels.

The work of the Collaborative is facilitated by a small core team hosted within WHO with dedicated focal points within key partner institutions.

One of the first countries where this is being operationalized is Kenya. In to support of the health ministry's leadership in integrating monitoring and evaluation (M&E) systems into a unified, more efficient framework, global

health partners are now working together to harmonize their financial and technical resources to ensure they are in line with country priorities.^v During a four-day meeting in Nairobi in May 2016, various stakeholders signed a joint statement of commitments to support a unified "One M&E Framework" and launch the Kenya Health Data Collaborative.

The MoH has drafted a detailed costed roadmap to be implemented by technical working groups focused on data analytics, quality of care, a new national health data observatory, civil registration and vital statistics, and informatics. This collaborative approach is expected to strengthen Kenya's health information system through a united front supporting and investing in one national M&E plan.

HDC Website:
<http://www.healthdatacollaborative.org/>



countries view their future, the legitimacy of, and political commitment to, the sector's policies, strategies and plans depends on integration with the broader national development dialogue. In order for arguments to carry the most weight, they need to make the linkage by insisting on the role of health as a factor of development, rather than relying solely on statements about expected health benefits.

(i) Strong accountability

Strengthening the institutional base for progress and performance review, information use and accountability is essential. This requires considerably improving the quality of the situation analysis on which policies, strategies and plans are based; bringing coherence and balance to priority-setting; facilitating the adoption of a single country-led monitoring and evaluation framework; facilitating alignment of international partners (see Box 1.9); and ensuring accountability through progress and performance reviews integrated with country planning processes.

(j) Sustainability

Some countries have been striving to develop more inclusive approaches to policy dialogue. However, in most countries, the process remains largely unsystematic. In some cases, this situation is partly due to a high turnover of planners, which constrains the skill base and the institutional memory. In others, this relates to successive waves of externally driven priorities and reform agendas. There is a need to increase the robustness of the process through a combination of: investing in institutional and individual capacities for conducting meaningful

policy dialogue; promoting the framework for guiding the policy dialogue process; assisting with better synchronization of planning cycles and better guidelines for programme planning; and helping to broaden the policy dialogue beyond the public sector and to align national health strategies with national development plans and financial policy cycles.

(k) Redefining the role of the Department of Planning, Ministry of Health

In the 21st century, the role and functions of the MoH Department of Planning needs to evolve from a pure planner's role to a planning and brokering role, from a top-down approach to a bottom-up approach and from a monolithic to an inclusive pluralistic approach.

This department must have adequate human resources and budget to fulfill its new role, to enable the regular convening of different stakeholders for a true bottom-up and pluralistic process.

This department must also be well-connected to all modern forms of media to ensure transparency and proper communication to the citizens. Regular communication requires dedicated staff time and a budget as well which must be foreseen. In countries where resources are scarce, this might need additional support from donors.

The EU-Luxembourg-WHO Universal Health Coverage Partnership is an example of a targeted approach to support ministries of health to more smoothly transition to its more modern convening & brokering role (see Box 1.10)

In the 21st century, the role and functions of the MoH Department of Planning needs to evolve from a pure planner's role to a planning and brokering role, from a top-down approach to a bottom-up approach and from a monolithic to an inclusive pluralistic approach.

^v Please see chapter 9 "Monitoring, evaluation and review of national health policies, strategies and plans" in this handbook

Box 1.10

EU-Luxembourg-WHO UHC partnership

The focus on national health planning and universal health coverage has gained momentum on the global agenda during the last few years, leading to more intensified WHO country support for health planning, health financing and policy dialogue.

In 2011-2012 the European Union, the Government of Luxembourg and the World Health Organization entered into a collaborative agreement to support policy dialogue on national health policies, strategies and plans (NHPSP) and universal health coverage (UHC).

The Partnership was made operational in 28 countries by 2016, with a diverse and numerous set of activities directly supporting health policy, health financing and effective development cooperation at country level. Seed monies are provided to all countries to actively foster inclusive policy dialogue and ensure a stronger convening and brokering role for ministries of health.

The Partnership is an integral part of WHO's support to countries' endeavours to steer towards universal health coverage, with a lucid recognition that it can only happen if ministries of health take on their new and

changing role with confidence. The Partnership provides dedicated WHO Country Office staff to accompany MoH in this ambition, acknowledging that the new MoH role will take time to become the norm.

For example, in Moldova, the WHO Country Office and MoH jointly organized a series of policy dialogue events over the course of 5 years 2012-2016. These events focused on specific topics highly relevant to universal health coverage. The topics were pushed high on the policy agenda through the inclusive dialogue process supported by the Partnership. Examples of some of these topics are: strengthening public health services, performance-related pay and service delivery access.

Currently, the Partnership targets the following countries: Burkina Faso, Burundi, Cape Verde, Chad, Democratic Republic of the Congo, Guinea, Guinea-Bissau, Kyrgyz Republic, Lao PDR, Liberia, Mali, Morocco, Mozambique, Niger, Republic of Moldova, Senegal, Sierra Leone, South Africa, South Sudan, Sudan, Tajikistan, Timor-Leste, Togo, Tunisia, Ukraine, Viet Nam, Yemen, Zambia.

UHC Partnership web site:
www.uhcpartnership.net

1.3.2 Dynamic 21st century process

The renewed interest in using NHPSPs to enhance health sector performance and improve the health and well-being of populations differs substantially from the planning approaches employed in the 1980s and 1990s (see Fig. 1.6). Indeed, the poor performance of health systems in many countries, as well as the rising expectations of citizens regarding their health, are increasingly becoming causes of political concern, which in many countries lead to reforms to put in place integrated and people-centered health services, UHC and health in all policies.

That being said, this handbook advocates for a final element of good practice: moving away from a command and control planning process towards a process focused on dialogue and debate (Fig. 1.7), and from a more static planning cycle mainly owned by department of planning of the ministry of health towards a dynamic, flexible, open and pluralist planning process towards UHC, owned by the community of stakeholders.

This handbook advocates for a planning process focused on dialogue and debate which is dynamic, flexible, open and pluralist.



Fig. 1.6 1980s and 90s technocratic planning process

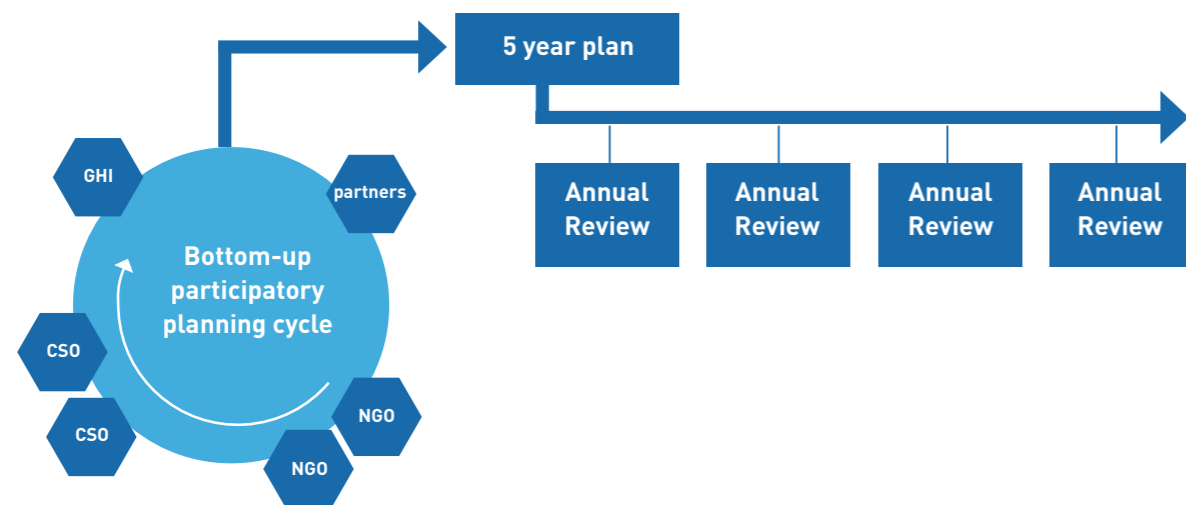
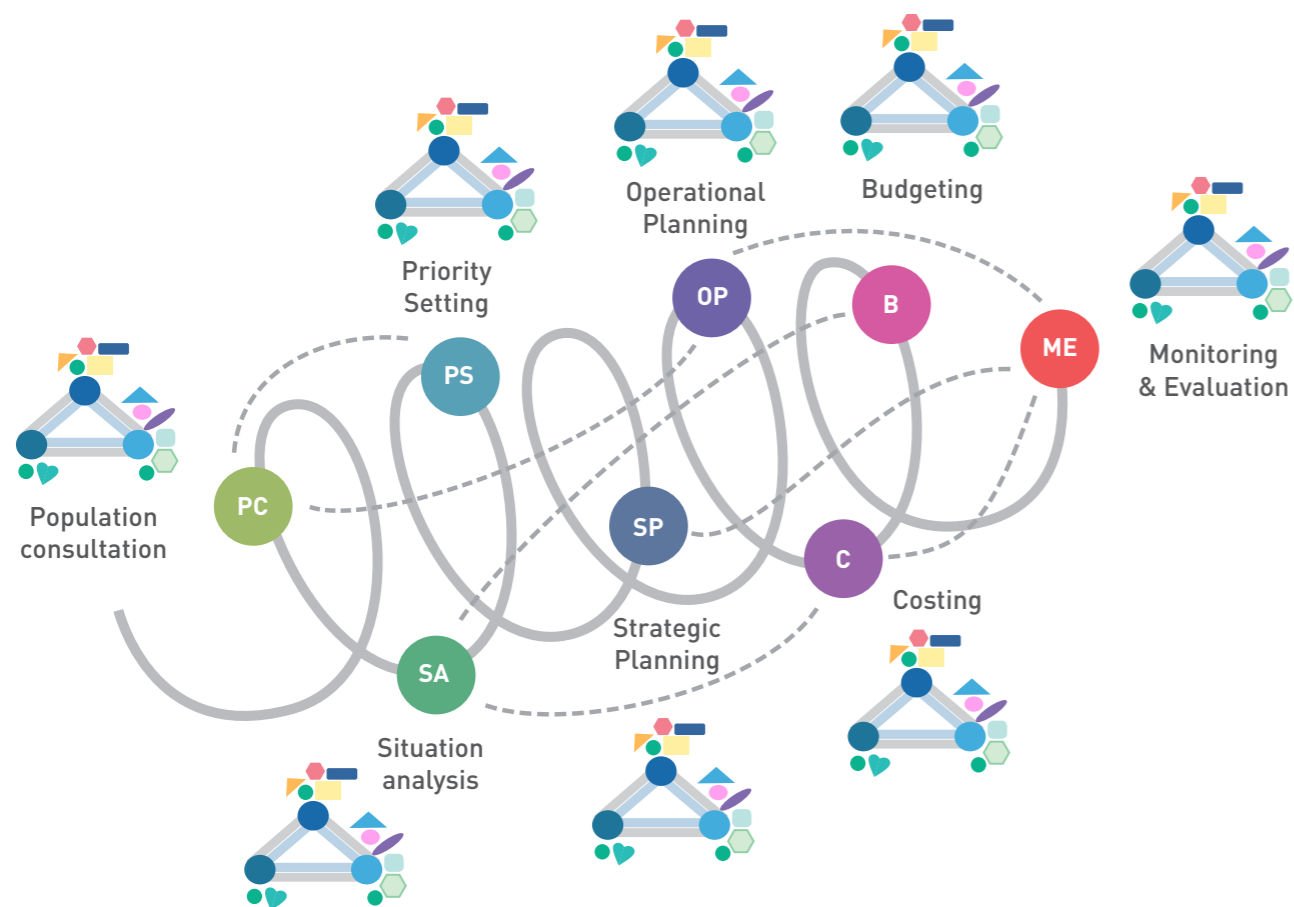


Fig. 1.7 A dynamic policy dialogue-led process



1.4 The handbook scope and content

1.4.1 Scope

The handbook covers the main steps of a **national health plan**, defined for the purposes of this book as a medium-term national strategic plan of approximately 3–7 years. The handbook is not intended to serve as a classical technical planning textbook, but rather seeks to capture the **innovative realities** of national planning at the country level, taking into account the **policy dialogue process** in ensuring the success of the plan. It takes the health plan as a living, dynamic document, with all its associated sub-plans, that guides overall strategic reforms in a country rather than as a static, monolithic paper.

Furthermore, the handbook provides a concrete, **practical** picture of the different aspects of planning and develops on existing work, literature reviews and country experiences. By building on **multisectoral** participatory approaches, while covering all the key elements of national health planning, the handbook links the conceptual with the pragmatic – thereby, for the first time, consolidating essential guidance to countries in one place. It emphasizes the role of democratic structures and the importance of political will, while reflecting the significance of international legally binding treaties.

Lastly, recognizing the prominence of vertical disease programmes and global health initiatives in certain settings, the handbook gives feasible advice in tackling such issues, drawing on country case studies.

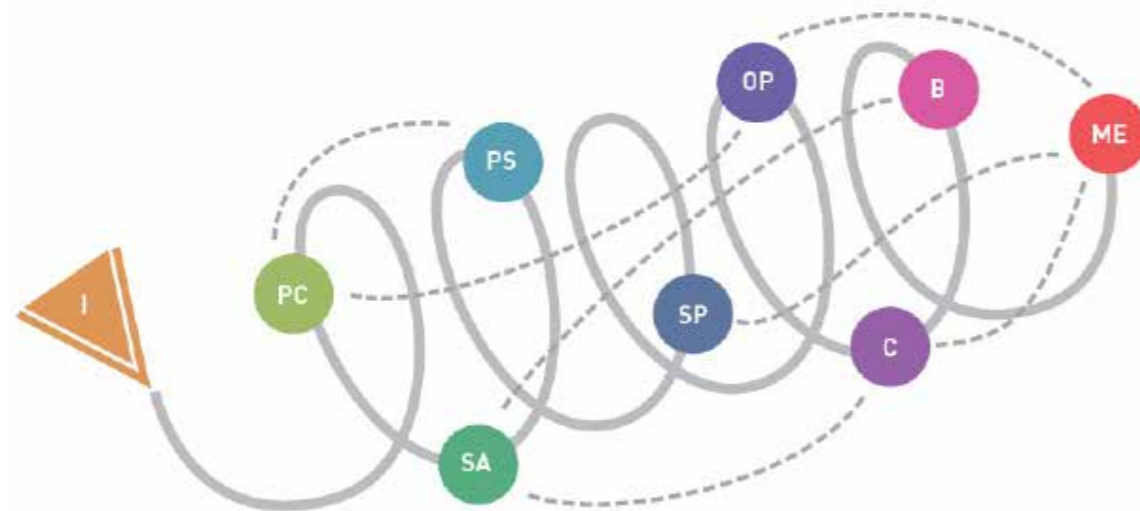
The target audience of the present handbook is health ministries and other relevant stakeholders involved in national health planning.

1.4.2 Content

Although national health planning is often viewed as linear or cyclic in nature, in reality, it is a complicated, difficult, challenging process (as illustrated in Fig. 1.8). Therefore, the handbook can be read in its entirety, but each chapter is also stand-alone, so it can be easily understood and used by relevant stakeholders. There is a clear conducting line among the chapters, with the main concepts reinforced.

This handbook links the conceptual with the pragmatic by building on multisectoral participatory approaches, consolidating essential guidance to countries in one place.

Fig. 1.8 National health planning in action



In Chapter 2 “[Population consultation on needs and expectations \(PC\)](#)”, Rohrer and Rajan make a strong case for including citizens’ voices in planning processes, providing concrete ways in which people can be engaged during the development of a national health plan. The chapter outlines the aims of a population consultation, its specific added value to national health planning, and how to undertake a consultation from the methodological and conceptual perspectives.

In Chapter 3 “[Situation analysis of the health sector \(SA\)](#)”, Rajan emphasizes the comprehensive nature of undertaking a detailed health sector assessment, taking into account different methodological options while ensuring broad stakeholder input. The latter is especially highlighted, since a balanced analysis will include technical analysis as well as opinions, viewpoints and experiences of health system users.

Similarly, in Chapter 4 “[Priority-setting for national health policies, strategies and plans \(PS\)](#)”, Terwindt, Rajan and Soucat guide the reader through the critical choices that must be made to determine the strategic directions of the national health plan. Priority-setting being a shared responsibility between the ministry of health (MoH) and the entire health stakeholder community, a case is made for a structured and inclusive exercise elaborated upon in the chapter.

In Chapter 5 “[Strategic planning: transforming priorities into plans \(SP\)](#)”, Terwindt and Rajan provide guidance on developing a relevant NHPSP that is referred to, consulted and used. Steps are proposed to manage the NHPSP development process, and common challenges and mistakes are pointed out with suggested solutions.

This leads to “[Operational planning: transforming plans into action \(OP\)](#)”, Chapter 6, by Shuey, Bigdeli and Rajan, where implementation issues linked to strategic planning are explored. They make the case that operational plans should not be under the sole remit of professional planners or managers. The best operational plans, and certainly the ones most likely to be implemented, are those that are developed with the people who will carry them out.

In Chapter 7 “[Estimating cost implications of a national health policy, strategy or plan \(C\)](#)”, Stenberg and Rajan provide guidance on costing options for a NHPSP. They advocate for a process of estimating costs as a crucial step within the NHPSP formulation process, as it allows decision-makers to consider the extent to which policy objectives and strategic orientations are feasible and affordable.

In Chapter 8 “[Budgeting for health \(B\)](#)”, Rajan, Barroy and Stenberg examine health budgets, national budgeting processes and fiscal space for health. This chapter discusses the specific role of the MoH and other health sector stakeholders within the budgeting process and examines how they can provide timely inputs.

The main “cycle” of national health planning concludes with Chapter 9 “[Monitoring, evaluation and review of national health policies, strategies and plans \(ME\)](#)” by O’Neill, Viswanathan, Celades and Boerma. This chapter outlines how monitoring, evaluation and review require an integrated approach that builds on a single country-led monitoring and evaluation platform.

In addition, four cross-cutting chapters provide guidance on critical issues that influence all stages of national health planning.

In Chapter 10 “[Laws, regulation and strategizing for health \(LR\)](#)”, Clarke explores how regulation represents a key means by which a government gives effect to its health policy preferences, especially through the exercise of a government’s law-making powers.

Given the significance of sub-national structures and functions in health planning, Rohrer unpacks the key elements of “[Strategizing for health at sub-national level \(SNL\)](#)” in Chapter 11, going through each step in the health policy and planning cycle. The chapter aims at supporting policy-makers with specific recommendations strategizing for health in a decentralized system.

Blas, Roebbel, Rajan and Valentine tackle the work across sectors to address health determinants in Chapter 12 “[Intersectoral planning for health and health equity \(IP\)](#)”. They outline the need and practical action for including intersectoral planning for health and health equity as a mindset within the overall process of strategizing for health.

Finally, in Chapter 13 “[Strategizing in distressed health contexts \(DHC\)](#)”, Pavignani and Colombo consider the challenges posed by policy and strategy formulation in health systems under stress, highlighting the main differences with these processes in more stable environments.

The chapters contain country illustrations throughout the document along with, where relevant, annexes on relevant tools, documents and references.

References

- 1 See resolution WHA62.12, Primary health care, including health system strengthening (http://www.who.int/hrh/resources/A62_12_EN.pdf?ua=1, accessed 11 October 2016).
- 2 Rajan D, Adam T, El Husseiny D, Porignon D, Ghaffar A, Schmets G. Policy dialogue: what it is and how it can contribute to evidence-informed decision-making. Geneva: WHO; 2015 (Briefing Note; <https://www.researchgate.net/publication/297698707>, accessed 11 October 2016).
- 3 Nabyonga-Orem J, Dovlo D, Kwamie A, Nadege A, Guangya W, Kirigia JM. Policy dialogue to improve health outcomes in low income countries: what are the issues and way forward? BMC Health Serv Res. 2016;16(4):217 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4959394/>, accessed 11 October 2016).
- 4 Dovlo D, Nabyonga-Orem J, Estrella Y, Mwisongo A. Policy dialogues: the “bolts and joints” of policy-making: experiences from Cabo Verde, Chad and Mali. BMC Health Serv Res. 2016;16(4):216 (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4959380/>, accessed 11 October 2016).
- 5 Universal health coverage. In: Health systems (website). Geneva: WHO; 2016 (http://www.who.int/healthsystems/universal_health_coverage/en/, accessed 11 September 2016).
- 6 World Health Report 2010, (<http://www.who.int/whr/2010/en/>, accessed 11 September 2016).
- 7 Health Systems Strengthening Glossary G-H. In: Health systems (website). Geneva: WHO; 2016 (http://www.who.int/healthsystems/hss_glossary/en/index5.html, accessed 11 September 2016).
- 8 Taskforce on Innovative International Financing for Health Systems. Constraints to scaling up and costs: working group 1 report. Geneva: International Health Partnership; 2009 (http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results___Evidence/HAE_results___lessons/Working%20Group%201%20Technical%20Background%20Report%20%28World%20Health%20Organization%29.pdf, accessed 11 October 2016).
- 9 Flows of global health financing. Seattle (WA): Institute for Health Metrics and Evaluation; 2015 (<http://vizhub.healthdata.org/figh/>, accessed 11 October 2016).
- 10 United Nations General Assembly. Resolution 69/313. Addis Ababa Action Agenda of the third international conference on financing for development. 27 July 2015 (http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/313, accessed 11 October 2016).
- 11 Global health expenditure database (GHED). [online database] Geneva: WHO; 2016 (<http://apps.who.int/nha/database>, accessed 11 October 2016).
- 12 Public financing for health in Africa: from Abuja to the SDGs. Geneva: World Health Organization; 2016 (Health Financing toward UHC; http://www.who.int/health_financing/documents/public-financing-africa/en/, accessed 11 October 2016).
- 13 Rajan D, Adam T, El Husseiny D, Porignon D, Ghaffar A, Schmets G. Briefing Note: Policy dialogue: What it is and how it can contribute to evidence-informed decision-making. Geneva: World Health Organization; 2015 (Briefing Note; <https://www.researchgate.net/publication/297698707>, accessed 11 October 2016).
- 14 Original design, adapted from World Development Report 2004: Making services work for poor people. World Bank; 2004. and Brinkerhoff D, Bossert T. Governance: concepts, experience and program options. Bethesda: Health Systems 20/20 Project; 2008
- 15 adapted by Bigdeli M and Clarke D, from World Development Report 2004: Making services work for poor people. World Bank; 2004. and Brinkerhoff D, Bossert T. Governance: concepts, experience and program options. Bethesda: Health Systems 20/20 Project; 2008
- 16 Foundations Institutions Transformation. World Health Organization; 2016.
- 17 Health systems strengthening: improving support to policy dialogue around national health policies, strategies and plans: report by the Secretariat to the Sixty-fourth World Health Assembly. Geneva: WHO; 2011 (Document A64/12; http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_12-en.pdf, accessed 12 October 2016).
- 18 International Health Regulations (2005), Second Edition. Geneva: WHO; 2008 (<http://www.who.int/ihr/publications/9789241596664/en/>, accessed 11 October 2016).
- 19 WHO Framework Convention on Tobacco Control. Geneva: WHO; 2005 (<http://www.who.int/fctc/en/>, accessed 11 October 2016).
- 20 Framework on integrated, people-centred health services: report by the Secretariat. Sixty-ninth World Health Assembly. Geneva: WHO; 2016 (Document A69/39; http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1, accessed 12 October 2016).

