#UHCPartnership

World Health Organization

Universal Health Coverage Partnership

Annual Report 2020

Implementing a primary health care approach towards universal health coverage in the COVID-19 era

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Universal Health Coverage Partnership annual report 2019. In practice: bridging global commitments with country action to achieve universal health coverage

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Health workers use tree branches for shade during their home-based care visits in Tonga. ©WHO

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“The pandemic has validated the wisdom of our shared vision of health systems and universal health coverage, as central to inclusive and resilient development. As the flagship of this joint vision, the UHC partnership delivers on this ambition.”

Dr Zsuzsanna Jakab, WHO Deputy Director-General

This report covers the calendar year 2020.
It provides a synthesis of country activities and results achieved with the support of the UHC Partnership in all the participating countries.

This synthesis report is, by definition, not exhaustive. It presents a range of country examples related to the major areas of work. It reflects overall activities and results and provides details on how the UHC-P achieved sustainable buy-in of partners and stakeholders at the country level in the different countries concerned.

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Japan – Ministry of Health, Labour and Welfare
Luxembourg – Aid & Development
United Kingdom – Foreign, Commonwealth & Development Office
World Health Organization (WHO)

List of abbreviations

ACP African, Caribbean and Pacific Group of States
ACT Access to COVID-19 Tools
ADB Asian Development Bank
AFHS Adolescent-friendly Health Services (Indonesia)
AMR antimicrobial resistance
ASEAN Association of Southeast Asian Nations
BPHNS Basic Package of Health and Nutrition Services (South Sudan)
CAPA corrective and preventive actions
CARICOM Caribbean Community
CHW community health worker
COVID-19 coronavirus disease 2019
CPS Division of Country Health Policies and Systems (WHO Regional Office for Europe)
CRVS civil registration and vital statistics
CVD cardiovascular disease
CVIC COVID-19 vaccination costing tool
DHIS2 District Health Information Software 2
ECHO Extension for Community Healthcare Outcomes
ECLAC Economic Commission for Latin America and the Caribbean
EPI Expanded Programme on Immunization
FAO Food and Agriculture Organization
FBPIDI Food, Beverages and Pharmaceuticals Industries Development Institute (Ethiopia)
GAP Global Action Plan on Healthy Lives and Well-being for All
Gavi Gavi, the Vaccine Alliance
GBV gender-based violence
GMP good manufacturing practices
GPW13 WHO Thirteenth General Programme of Work 2019–2023
HEOC health emergency operations centre
HFPM health financing progress matrix
HFSP health financing strategic plans
HMIS health management information system
HRH human resources for health
HSSRP health sector stabilization and recovery plan
iAHO Integrated African Health Observatory
IAR intra-action review
ICT information and communications technology
ICU intensive care unit
IHR International Health Regulations
ILO International Labour Organization
IMF International Monetary Fund
IPC infection prevention and control
JEE Joint External Evaluation
JWT Joint Working Team
MDCC multi-donor coordination committee
mhGAP Mental Health Gap Action Programme
NAPHS national action plans for health security
NCD noncommunicable disease
NGO nongovernmental organization
NHA national health account
NHIS National Health Insurance Scheme (Ghana)
NHWA National Health Workforce Accounts
NTD neglected tropical disease
OIE World Organization for Animal Health
PAHO Pan American Health Organization
PCR polymerase chain reaction
PEN Package of Essential Noncommunicable Disease Interventions
PHC Primary Health Care
PHC-A Primary Health Care Accelerator
PHCMI Primary Health Care Measurement and Improvement
PPE personal protective equipment
PVS Performance of Veterinary Services
PWD persons with disabilities
QoC quality of care
QoC Network Network for Improving Quality of Care for Maternal, Newborn and Child Health
SDG Sustainable Development Goal
SFH sustainable financing for health
SHA System of Health Accounts
SIDS Small Island Developing States
SimEx simulation exercise packages
SP-PHC Special Programme on Primary Health Care
SRMNCAH sexual, reproductive, maternal, newborn, child and adolescent health
STEPS STEPwise approach to Surveillance
STI sexually transmitted infection
TB tuberculosis
UHC universal health coverage
UHC-P Universal Health Coverage Partnership
UN DESA United Nations Department of Economic and Social Affairs
UNDP United Nations Development Programme
UNEP United Nations Environment Programme
UNESCO United Nations Educational, Scientific and Cultural Organization
UN-Habitat United Nations Human Settlement Programme
UNICEF United Nations Children's Fund
VCR voluntary national review
WASH water, sanitation and hygiene
WCO World Health Organization country office
WHO World Health Organization

Executive Summary

Although a lot of ongoing and scheduled activities were carried on by the Universal Health Coverage Partnership (UHC-P) in 2020, as soon as coronavirus disease 2019 (COVID-19) was declared a Public Health Emergency of International Concern, the World Health Organization (WHO) and the European Union (EU) – through the UHC-P – have been working hand in hand to ensure that the investments made throughout the COVID-19 response will have a lasting impact towards resilient health systems in building and maintaining country preparedness and health systems that protect everyone, everywhere from the pandemic and future threats to health.

Since the start of the pandemic, the WHO Director-General and the Global Policy Group, comprising regional directors and senior leadership, have led the strategic global public health response to COVID-19. Through the UHC-P, WHO supported Member States for **health emergency preparedness in low- and middle-income countries**, which have weaker health systems and less resilience to respond to crises.

The action is designed to build and maintain sustainable country capacities to **prevent, detect and respond to present and future public health risks, and to address country gaps and needs** through implementation of national action plans for health security (NAPHS). In addition, activities aimed to link NAPHS to national health sector strategic plans and to the COVID-19 Strategic Preparedness and Response Plan.

Mitigation measures, such as lockdowns, **restrict access to health services and lead to deterioration in social and economic conditions that, in turn, have a substantial impact on the mental and physical health of a population**. People living with noncommunicable diseases (NCDs) are more vulnerable to becoming severely ill or dying from COVID-19. Although progress towards achieving the NCD indicators of the UHC-P logical framework has been slow in 2020, key steps have been taken to strengthen collaborative efforts between health systems and NCD programmes.

Health equity needs to be tackled more seriously and the UHC-P is dedicated to building back fairer, healthier societies. COVID-19 has **exposed and amplified health inequalities** due in part to clear socioeconomic and ethnic inequalities. COVID-19 cases and deaths in deprived areas are double those of more advantaged areas. In 2020, the UHC-P placed a special focus on overcoming the gaps related to the lack of inclusion of populations, communities and civil society organizations in COVID-19 committees at country level.

A family being visited by health care providers as part of the Saude na Familia primary health care programme in Timor-Leste. ©WHO/Shobhan

Medical procedure conducted at a hospital in Niger State, Nigeria. ©WHO / Blink Media - Etinosa Yvonne

Since its conception, the UHC-P has built capacities of ministries of health to **lead inclusive, participatory and evidence-informed policy dialogue**. The support of the UHC-P results in mutual trust to strengthen stakeholders' collaboration, while the evidence and data provided bring a shared understanding of needs and policy options to strengthen health system governance.

In order to reach universal health coverage (UHC), **health systems must be oriented towards a primary health care (PHC) approach**, which includes three essential components: multisectoral policy and action; empowered people and communities; and primary care and essential public health functions at the core of integrated health services. An operational framework for PHC has been published in 2020 to propose 14 levers to translate global commitments into operational results. Strengthening PHC to ensure strong health systems foundations and to maintain essential health services was an important focus of the UHC-P in 2020. This point is largely covered in the different chapters of the report.

In addition to disease management, the UHC-P works to ensure **healthy lives and promote well-being** for all at all ages, leaving no one behind. Because many of the factors that threaten health and well-being today lie beyond an individual's control, the UHC-P is committed to supporting Member States to address determinants of health, to promote multisectoral actions to reduce risk factors and to prioritize health in all policies and healthy settings. The UHC-P has been supporting an increasing number of activities related to the third billion of the Thirteenth General Programme of Work 2019–2023 (GPW13), both from an operational perspective at country level and a normative perspective at WHO headquarters and regional offices levels.

In order to monitor implementation of the GPW13, the UHC-P collaborates with dedicated departments in WHO headquarters and with Member States to **improve their health information systems, analytical capacity and reporting for UHC**, including developing comprehensive and efficient systems to monitor health risks and determinants; **track health status and outcomes**, including cause-specific mortality; and **assess health system performance. Good governance and leadership** of a health system both require reliable, timely information, such as whether people are getting the services they need and where resources are going. Information is used in a wide range of situations, such as developing national strategies and plans, monitoring progress against priorities, or responding to public health emergencies.

The UHC-P is recognized to **provide key resources with more than 120 international experts on policy dialogue and catalytic funding** to support collaboration spaces, knowledge production and trainings. The continuous presence of experts in the field allows for close monitoring of the policy dialogue, strengthens the trust relationships with ministries of health, and advances strategic thinking and cross-cutting vision for policy dialogue.

Fig. 1. 2020 Key Milestones

January

- **COVID-19:** WHO Director-General declares the novel coronavirus outbreak a public health emergency of international concern.
- **Regional Office for Europe:** Finalizes recruitment process of health system international policy advisors in six countries (Azerbaijan, Georgia, Kyrgyzstan, Tajikistan, Ukraine, Uzbekistan).

February

- **Meeting:** 4th UHC-P High-level Steering Committee Meeting.
- **Regional Office for Europe:** Establishment of a COVID-19 health systems–strengthening team (including the European Region's UHC-P Joint Working Team) embedded in the coordination structure of the European Regional Office's Emergency Incident Management Support Team.

March

- **COVID-19:** WHO declares COVID-19 a pandemic.
- **Global:** Webinars on social participation for UHC – "Population Engagement and Decision-making", "Representation for Participatory Processes" and "Legal Frameworks. for Participation"

April

- **Meeting:** 5th UHC-P High-level Steering Committee Meeting.
- **Meeting:** 6th UHC-P Multi-Donor Coordination Committee Meeting for UHC.
- **Global:** Webinar on social participation for UHC – "Necessary Capacities for Meaningful Government Engagement with Populations, Communities, and Civil Society".

May

- **Event:** Walk the Talk: The Health for All Challenge.
- **Live monitoring:** Focus on the Eastern Mediterranean Region, including a live survey on impact of COVID-19 on UHC-P-supported activities and next plans.
- **Live monitoring:** Focus on the Region of the Americas.
- **Live monitoring:** Focus on the European Region.

Global Regional COVID-19 Meeting / Event Live monitoring

Fig. 1. 2020 Key Milestones *continued*

June

- **Regional Office for Europe:** New draft law on medical products for price regulation of quality assurance of emergency medicines sent for parliamentary approval in Georgia.
- **Live monitoring:** Focus on the Western Pacific Region.

July

- **Meeting:** 6th UHC-P High-level Steering Committee Meeting.
- **Global:** Stories from the field – Issue 3 (Brazil, Colombia, Haiti, Jordan, Morocco, Nigeria, Republic of Moldova, Timor-Leste, United Republic of Tanzania).
- **Regional Office for Europe:** Finalization of the policy paper "Budgetary space for health in Ukraine" to support the Ministry of Health in budget negotiations for 2021 and provide neutral and timely analysis in the context of COVID-19.
- **Regional Office for the Americas:** Joint report by the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) and the WHO Regional Office for the Americas on ''Health and the economy: a convergence needed to address COVID-19 and retake the path of sustainable development in Latin America and the Caribbean''.

August

- **Regional Office for Africa:** Africa is certified free of wild poliovirus on 25 August 2020.
- **Regional Office for Africa:** Togo eliminates human African trypanosomiasis as a public health problem, becoming the first African country validated by WHO.
- **Regional Office for the Western Pacific:** Virtual meeting with Pacific Ministers – Update from African, Caribbean, and Pacific countries.
- **COVID-19:** (ACP)-European Union (EU) partnership and COVID-19-related work in the Pacific, including Papua New Guinea and Timor-Leste.

September

- **Meeting:** Joint Ministers of Health and Finance Meeting on UHC in Asia and the Pacific: COVID-19 and Beyond attracts high-level attendance from more than 30 Member States across the Eastern Mediterranean, Europe, South-East Asia and Western Pacific Regions.
- **Global:** Stories from the field – Issue 4: Special issue on COVID-19 (Pakistan, Papua New Guinea, South Africa, Suriname, Timor-Leste and Ukraine).
- **Regional Office for Eastern Mediterranean Region:** Online course on "Health Systems Strengthening towards Universal Health Coverage and Health Security – learnings from COVID-19" jointly conducted by the WHO Regional Office for the Eastern Mediterranean and Tabriz University of Medical Sciences, Islamic Republic of Iran.
- **Regional Office for Eastern Mediterranean Region:** Launch of online training resource on "Primary Health Care (PHC) Practice in the Context of COVID-19".

Global Regional COVID-19 Meeting / Event Live monitoring

September

- **Global:** WHO, United Nations Development Programme and United Nations Interagency Task Force on the Prevention and Control of Noncommunicable Diseases launch set of publications, "Responding to Noncommunicable Diseases During and Beyond the COVID-19 Pandemic".[1]
- **Global:** Joint Working Team for UHC (JWT)/UHC-P retreat.
- **Regional Office for the Eastern Mediterranean:** Publication of "Policy dialogue and participation: a new way of crafting a national health financing strategy in Morocco".[2]

October

- **Meeting:** JMinisterial meeting on UHC, commemorating one year after the High-level Meeting on UHC – Measuring progress, challenges and opportunities in the context of COVID-19.
- **Global:** Launch of United Nations policy brief on COVID-19 and UHC.
- **Regional Office for Europe:** Finalization of the "PHC Development Plan Based on Family Medicine Principles in the Republic of Tajikistan for 2021–2025" (approved by the Government in January 2021).
- **Live monitoring:** focus on the Region of the Americas.

November

- **Meeting:** The Seventy-third World Health Assembly endorsed the operational framework for PHC.
- **Meeting:** 7th UHC-P High-level Steering Committee Meeting.
- **Meeting:** 7th UHC-P Multi-Donor Coordination Committee Meeting for UHC.
- **Meeting:** NCD Hard Talks: Making Health Systems Deliver.
- **Live monitoring:** Focus on the African Region.
- **Regional Office for Africa:** WHO, Food and Agriculture Organization (FAO), the World Organisation for Animal Health (OIE), the African Union and Africa Centres for Disease Control and Prevention commemorated the second continental Antimicrobial Awareness Week; heads of regional institutions signed a joint communiqué renewing their commitment to unite against antimicrobial resistance.
- **Regional Office for Europe:** Approval of landmark legislative package for health financing and service delivery reform towards UHC in Uzbekistan.
- **Meeting:** JWT for UHC bimonthly meeting: Health and Migration.

1 Responding to noncommunicable diseases during and beyond the COVID-19 pandemic. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/WHO-2019-nCoV-Non-communicable_diseases-Policy_brief-2020.1, accessed 6 September 2021).

2 Akhnif EL, Hachri H, Belmadani A, Mataria A, Bigdeli M. Policy dialogue and participation: a new way of crafting a national health financing strategy in Morocco. Health Res Policy Syst. 2020;18(1):114. doi:10.1186/s12961-020-00629-2.

Global Regional COVID-19 Meeting / Event Live monitoring

December

- **Global:** Launch of the Special Programme on PHC (SP-PHC) in a high-level meeting of principals between WHO, United Nations Children's Fund (UNICEF) and the Minister of Health of Kazakhstan (conducted on 14 December 2020).
- **Live monitoring:** Focus on the WHO Region of the Americas, and the Eastern Mediterranean, European and Western Pacific Regions.
- **Event:** UHC Day 2020: "Health for All: Protect Everyone".
- **Global:** New WHO strategy for navigating private sector engagement for UHC.
- **Global:** Launch of the Primary Health Care Operational Framework.
- **Event:** NCD Hard Talks: No UHC without an Integrated Approach to NCDs.
- **Regional Office for Europe:** Launch of the talk show series "Let´s Talk Primary Health Care".
- **Regional Office for Europe:** Establishment of the State Health Insurance Fund in Uzbekistan.
- **Regional Office for the Eastern Mediterranean:** Regional roster for health policy advisors and selection in 10 country offices finalized.
- **Regional Office for the Eastern Mediterranean:** Virtual roundtable discussion with directors of the Regional Office for the Eastern Mediterranean to mark UHC Day 2020.
- **Regional Office for the Eastern Mediterranean:** Regional Meeting to Take Forward the Call for Action to Strengthening Nursing and Midwifery Workforce in the Eastern Mediterranean Region.
- **Event:** Series of webinars in the Eastern Mediterranean Region to recognize UHC Day.
- **Regional Office for the Eastern Mediterranean:** Expanding UHC among Refugees and Migrants: Challenges and opportunities in the Eastern Mediterranean Region.
- **Regional Office for the Eastern Mediterranean:** Primary Health Care for UHC in the Eastern Mediterranean Region.
- **Regional Office for the Eastern Mediterranean:** Innovations and Challenges in Maintaining Essential Health Services in the Eastern Mediterranean Region: Country experiences.
- **Regional Office for the Eastern Mediterranean:**Role of Social Participation to Advance UHC and Health Security: Experiences and perspectives from the Eastern Mediterranean Region and beyond.
- **Regional Office for the Americas:** Launch of "The Essential Public Health Functions in the Americas: A renewal for the 21st century".

Global Regional COVID-19 Meeting / Event Live monitoring

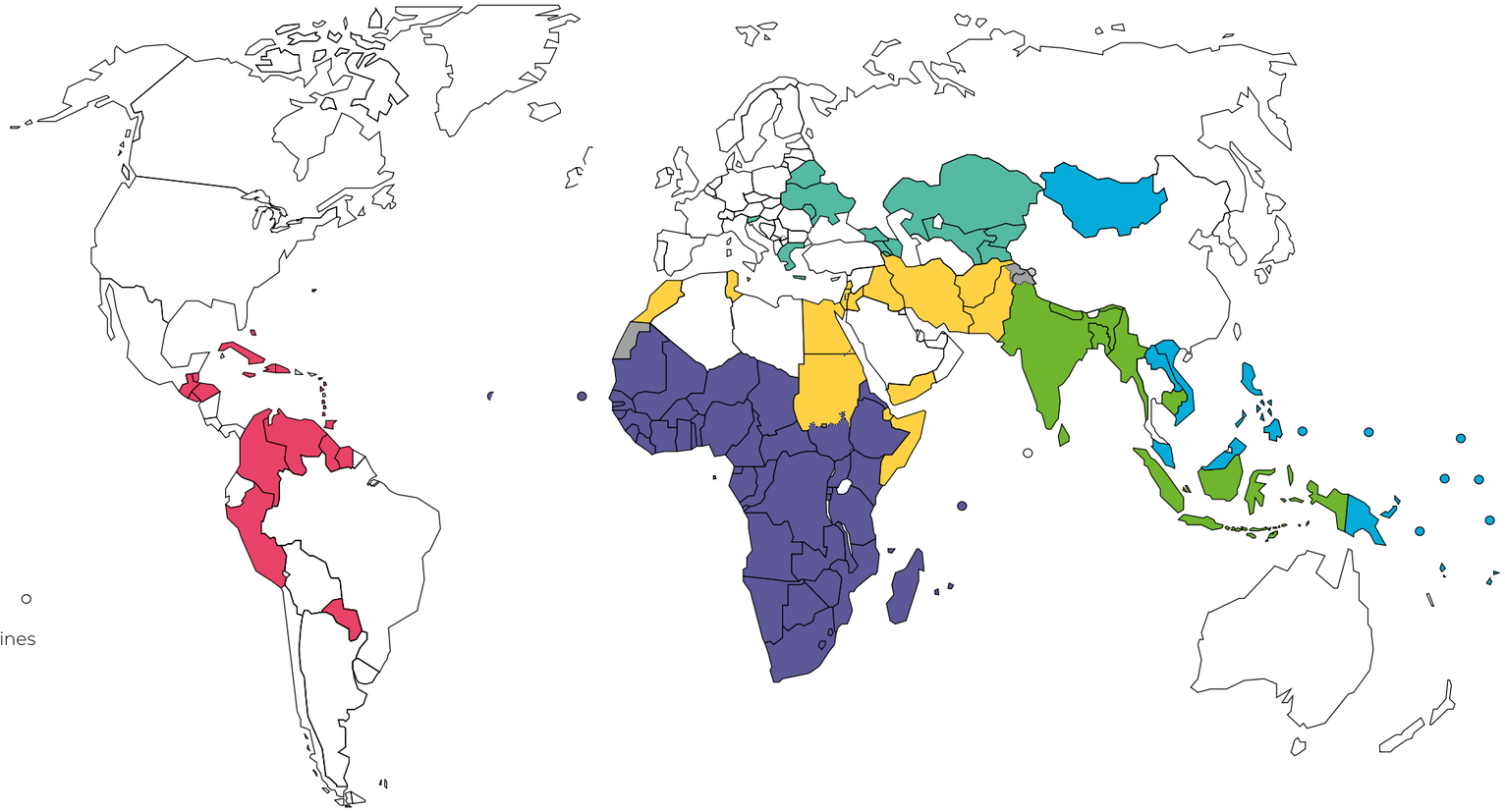
Fig. 2. List of countries and areas supported by the UHC Partnership in 2020

WHO Eastern Mediterranean Region

- Afghanistan
- Djibouti
- Egypt
- Iraq
- Iran (Islamic Republic of)
- Jordan
- Lebanon
- Morocco
- occupied Palestinian territory, including east Jerusalem
- Pakistan
- Somalia
- Sudan
- Tunisia
- Yemen

WHO European Region

- Azerbaijan
- Georgia
- Kyrgyzstan
- Republic of Moldova
- Tajikistan
- Ukraine
- Uzbekistan



WHO Region of the Americas

- Antigua and Barbuda
- Bahamas
- Barbados
- Belize
- Colombia
- Cuba
- Dominica
- Dominican Republic
- Grenada
- Guyana
- Haiti
- Honduras
- Jamaica
- Paraguay
- Peru
- Saint Kitts and Nevi
- Saint Lucia
- Saint Vincent and the Grenadines
- Suriname
- Trinidad and Tobago

WHO African Region

- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cabo Verde
- Cameroon
- Central African Republic
- Chad
- Comoros
- Congo
- Côte d'Ivoire
- Democratic Republic of the Congo
- Equatorial Guinea
- Eritrea
- Eswatini
- Ethiopia
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Madagascar
- Malawi
- Mali
- Mauritania
- Mauritius
- Mozambique
- Namibia
- Niger
- Nigeria
- Rwanda
- Sao Tome and Principe
- Senegal
- Seychelles
- Sierra Leone
- South Africa
- South Sudan
- United Republic of Tanzania
- Togo
- Uganda
- Zambia
- Zimbabwe

WHO South-East Asia Region

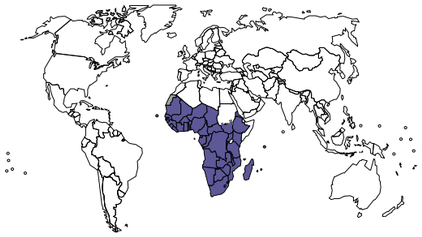
- Bangladesh
- India
- Indonesia
- Myanmar
- Nepal
- Sri Lanka
- Timor-Leste

Not Applicable

WHO Western Pacific Region

- Cambodia
- Cook Islands
- Fiji
- Kiribati
- Lao People's Democratic Republic
- Malaysia
- Marshall Islands
- Micronesia (Federated States of)
- Mongolia
- Nauru
- Niue
- Palau
- Papua New Guinea
- Philippines
- Samoa
- Solomon Islands
- Tonga
- Tuvalu
- Vanuatu
- Viet Nam

Regional highlights



WHO African Region

In early 2020, WHO facilitated a readiness assessment[3] in the African Region, which helped to jump-start support to national authorities in combatting COVID-19 – namely in the development of national COVID-19 preparedness and response plans, the activation of whole-of-government coordination mechanisms, pre-positioning of supplies, and mobilization and training of multidisciplinary responders. Continuous investment was made in readiness capacity-building to comply with the International Health Regulations, including strengthening integrated disease surveillance and response. The Regional Office convened pattern coordination meetings, resulting in the creation of technical working groups through the WHO Emergency Hubs in Dakar and Nairobi.

Forty-one Member States have functional public health emergency operations centres and WHO is providing support to improve the operations of incident management systems. During the 11th Ebola outbreak in Équateur Province in the Democratic Republic of the Congo from 1 June to 18 November 2020, past experiences and lessons learned from previous epidemics were mobilized in the implementation of vaccination for 40 000 people, saving innumerable lives. Massive demands for information to detect acute health events and inform response operations have been managed using agile approaches, new tools, and by leveraging partnerships with academic institutions.

Disruptions to essential services and barriers to quality care access threaten progress in priority areas. The Regional Office has assisted countries to monitor access and utilization, and supported the implementation of a range of approaches to overcome bottlenecks. Countries have received guidance on applying integrated approaches to improve the efficiency and quality of services needed by communities. COVID-19 has reaffirmed the need for action across sectors and for engaging all stakeholders to advance health.

Immense demands have been placed on front-line health workers during the pandemic. Health labour market analyses and health workforce accounts are among the strategies being used to make the case for sustainably addressing workforce shortages. Moving towards achieving the GPW13 mission, strategic support and technical assistance was provided to the 47 countries in the African Region. The interventions included development and implementation of evidence-informed policies and plans, improving the availability of quality health workforce data for monitoring and accountability, strengthening of health workforce education and optimizing health workforce management in the developmental and COVID-19 contexts.

The capacity to diagnose COVID-19 was scaled up rapidly in 2020, going from Senegal and South Africa being the only countries able to do so at the start of the pandemic, to all 47 countries after a few months. Four countries introduced polymerase chain reaction testing for the first time ever with WHO support. With the development of reliable antigen-detecting rapid diagnostic tests, countries are now being urged to scale up access to these easy-to-use tools.

Amid global supply chain disruptions, huge quantities of essential commodities have been procured for African countries using the United Nations Supply Portal, coordinated by WHO. Diagnostic and clinical care capacities have been dramatically scaled up and hundreds of thousands of health workers have been trained in key response areas. Laboratory workforce capacities have also been enhanced through training on diagnostic device selection, national approval, listing and use.

3 Karamagi HC, Tumusiime P, Titi-Ofei R, Droti B, Kipruto H, Nabyonga-Orem J, et al. Towards universal health coverage in the WHO African Region: assessing health system functionality, incorporating lessons from COVID-19. BMJ Glob Health. 2021;6(3):e004618. doi:10.1136/bmjgh-2020-004618.

WHO Region of the Americas

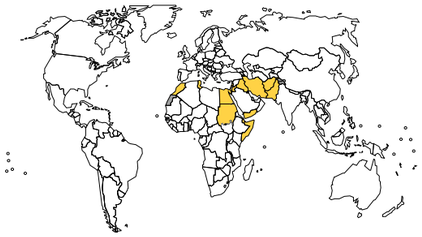
In 2020, the priority of the WHO Regional Office for the Americas was to prepare countries' health systems and services to contain the pandemic. Countries urgently demanded assistance in optimizing and increasing hospital beds and critical care capacity. In response to the pandemic, the Regional Office provided technical support to countries in the reorganization and expansion of hospital services, the adaptation and management of the health services network for the response to the pandemic, and adaptation of the Integrated Health Service Delivery Networks Framework.

During 2020, certain essential services such as the diagnosis and treatment of cancer and other noncommunicable diseases, mental health and immunizations were reported as partially interrupted or impacted in 49% of countries. Consequently, defining and implementing plans to maintain quality essential health services also arose as a central challenge.

A renewed partnership with ECLAC enabled key analytic work to help countries in the Region; a joint report published in July 2020 by ECLAC and the Pan American Health Organization (PAHO) "Health and the economy: a convergence needed to address COVID-19 and retake the path of sustainable development in Latin America and the Caribbean" reveals that economies of the Region will only be reactivated if the curve of contagion of the COVID-19 pandemic is flattened.

The COVID-19 pandemic has demonstrated how the scarcity of medical products can cause disruptions in health care. The Regional Office began work with ECLAC on the analysis of production capacity for medicines and other health technologies, convening ministries of health, science and technology, and industry, as well as the manufacturing sector, with a view to increase regional capacities to improve access within the context of health emergencies.

Caribbean countries boost the capacities of nurses in critical care during COVID-19. Registered nurse, Rehemia Reyes, Head of Adult ICU at the Eric Williams Medical Sciences Complex was a preceptor for the ICU nursing course supported by PAHO. ©PAHO/WHO



WHO Eastern Mediterranean Region

The Regional Health Alliance for the implementation of the Global Action Plan on Healthy Lives and Well-being for All (GAP) in the Region was launched to promote harmonized accountable support to countries to achieve the health-related Sustainable Development Goals. To ensure that primary health care is part of the national COVID-19 response plans, the GAP Accelerator on Primary Health Care partners co-led by WHO and the United Nations Children's Fund (UNICEF) launched the online training on Primary Health Care Practice in the Context of the COVID-19 Pandemic. By the end of 2020, more than 13,000 physicians from the Region had undergone the training.

A series of regional events engaging WHO country offices, development partners and government representatives were organized around UHC Day. The online events/webinars provided an opportunity to countries to co-learn from others' experiences on challenges and innovations undertaken to maintain/restore essential health services; discuss the common denominator and critical ingredients for UHC and health security and their interactions; exchange notes on actions and policies for strengthening health systems contributing to both UHC and health security; discuss the importance of social participation to advance UHC and health security; and review the opportunities and challenges for expanding UHC among refugees and migrants in the Region.

In September 2020, Akhnif et al. published "Policy dialogue and participation: a new way of crafting a national health financing strategy in Morocco" in Health Research Policy and Systems.

The Regional Office finalized a regional roster for health policy advisors and selection in 10 country offices. The majority of the countries made progress on the service delivery of products and services, including development, revision, costing and implementation of the Essential Health Services Package, Primary Health Care Measurement and Improvement Initiative, Quality and Patient Safety activities, and extension of family practice–based PHC models. The second area of progress is products and services related to human resources for health (HRH), including HRH situation analyses, planning, strategy development and implementation, capacity-building, development of regulatory frameworks, and establishment and capacity-building of licensing agencies for health professionals.

Head nurse Hayel Ishtaye looks after a patient in the COVID-19 treatment and isolation centre at Hugo Chavez Hospital, Ramallah, Occupied Palestinian territory. ©WHO/Noor-Tanya Habjouqa

WHO European Region

Since the onset of the pandemic, the Division of Country Health Policies and Systems (CPS) established a team to provide guidance to Member States on health systems strengthening as part of the pandemic response. The team, embedded in the coordination structure of the Regional Office's Emergency Incident Management Support Team, provided support to Member States for rapidly reorganizing service delivery to respond to COVID-19 while maintaining core essential services across the continuum of care. This multidisciplinary Health Systems team included members from several programmes of CPS such as public health, service delivery, or HRH, and included the members of the Regional Office's UHC-P Joint Working Team.

The development of a new regional PHC strategy has provided further impetus for putting PHC at the core of the UHC agenda in the European Region. In addition, the Regional Office has launched a virtual dialogue platform on PHC, "Let's Talk Primary Health Care", to engage regularly with countries´ PHC task forces in regular cross-country dialogues and experience sharing.

Recruitment of health system international policy advisors in six countries through the UHC-P was instrumental to maximizing the catalytic role of UHC-P funding by bringing together relevant stakeholders at country level and ensuring, at the same time, coordination with the WHO Regional Office for Europe. The Region's UHC-P Joint Working Team organized biweekly meetings with the policy advisors to ensure their integration, allow exchange of experiences among them, and provide a vehicle for programmes to channel their content and activities to country level. This was particularly relevant in the context of the pandemic, which required a rapid shift in short-term priorities while keeping long-term and far-reaching transformation on the agenda.

A health worker inside one of the mobile clinics in Azerbaijan. ©WHO Azerbaijan

WHO Western Pacific Region

Strategic partnerships with development partners, such as the Asian Development Bank (ADB), International Monetary Fund (IMF) and World Bank initiated pre-COVID-19 have enabled strong collaborations to support countries in the pandemic response. The Joint Ministers of Health and Finance Meeting on Universal Health Coverage in Asia and the Pacific: COVID-19 and Beyond, convened on 17 September 2020, and attracted high-level attendance from more than 30 Member States across WHO regions of the Western Pacific, South-East Asia, Europe and the Eastern Mediterranean. Ministers reaffirmed the impact of COVID-19 on socioeconomic development and committed to collaborate on appropriate way for countries in the Region to invest in health for the future

The Regional Office collaborated closely with the IMF, World Bank and ADB to understand the impact of the COVID-19 economic crisis on the future fiscal space for governments and international partners to invest in health. This work informed Ministry of Health–Ministry of Finance dialogue to identify the best investments in health that can contribute to growth and poverty reduction. The Regional Office has supported countries to continue to improve financial protection and reduce financial barriers to health care.

The UHC-P's commitment to recruiting policy advisors on health systems strengthening, social determinants of health and NCDs in nine countries and the Pacific subregion played a pivotal role in rapidly responding to the pandemic with longer-term vision of leveraging COVID-19 measures for building a more resilient health system. Repurposed health systems advisors led the surge response to COVID-19 preparedness towards long-term community transmission, including health care delivery to COVID-19 patients, as well as maintaining essential services, including NCDs; contributed to the assessment of bottlenecks in the pandemic response, including vaccines, therapeutics and diagnostics, taking a PHC approach. They were key in sustaining the momentum to advance the UHC agenda in the Region.

Building on the increase in the Government's health budget for PHC services, Mongolia is implementing one of the most notable innovative reforms of the health sector in the Region (during the pandemic). The reform includes decentralization of health-care services, transition into a single purchasing system, prioritization of preventive health examinations, strengthening e-health systems and performance-based financing to further increase access to and quality of health care, and introduction of mechanisms to ensure drug quality, accessibility and price regulation. In addition, the Government of Mongolia has also been taking innovative actions related to model of care in delivering essential health-care services and COVID-19 services through intensified online PHC services and use of modern technologies such as mobile health technology.

©Mandakh Soum Health Centre, Dornogobi Province

Mobile health teams in Mongolia are deployed to rural areas to reach herder families. ©WHO

WHO South-East Asia Region

Adapting to the COVID-19 pandemic and progressing towards UHC and the WHO GPW13 was an imperative for 2020.

Some highlights from 2020 include: the analysis of overall health spending in the Region between 2009 to 2018; technical guidance on product specifications and procurement of emergency medical supplies for COVID-19; regional support to the first-of-its-kind pilot Good Manufacturing Practice online training; normative and technical assistance on infection prevention and control (IPC) throughout the pandemic; a series of seven regional webinars on COVID-19 and the health workforce; mid-term review for the decade for health workforce strengthening; review of progress on traditional medicine from 2014 to 2019; training of over 600 participants on antimicrobial stewardship during COVID-19; and continuous monitoring of UHC in the Region. Further, 20 good practices from the Region on maintaining essential health services during the pandemic were shared with the WHO country offices.

The critical importance of robust primary health care (PHC)-oriented health systems came to the fore as a result of the pandemic. A special issue on "Recalibrating PHC-centred health systems" was launched in the South-East Asia Journal of Public Health. Findings from the review informed the draft PHC Regional Strategy. The PHC Health Workforce was also enumerated for the first time across the Region, highlighting the importance of community and traditional health workers in the Region.

Further, support was provided on disease-specific technical areas (communicable diseases and NCDs), providing norms and standards and strategies (e.g. measles and rubella, HIV, viral hepatitis, malaria, tuberculosis, leprosy and other NCDs, neglected tropical diseases, and sexual and reproductive maternal, newborn, child and adolescent health services), introduction of new vaccines, and building capacity for human resources through online training platforms.

With respect to health emergencies, due to the protracted nature of the COVID-19 pandemic, the WHO Secretariat in the Region encouraged and supported Member States to conduct an intra-action review of COVID-19 lessons learned from the current response and identified priority actions to enhance resilience and further improve health security systems.

Significant achievement during the period included the area of water and sanitation for which, following the COVID-19 pandemic, technical support related to water, sanitation and hygiene (WASH), IPC and COVID-19 supported countries in the Region in monitoring and reporting of basic WASH services in health-care facilities.

A central lesson learned across countries during the period was the need to intensify efforts to strengthen PHC-oriented health systems in each Member State as necessary to respond to the ongoing COVID-19 pandemic and to maintain essential health services for the 2 billion people residing in the Region.

Sub Health Center Hiroli, Dantewada, a primary care centre in Chhattisgarh, India. © Office of Chief Medical and Health Officer, Dantewada

Introduction

The coronavirus disease 2019 (COVID-19) pandemic represents an opportunity for countries to emerge with stronger health systems and to chart a more aggressive path towards achieving health for all.

As soon as COVID-19 was declared a Public Health Emergency of International Concern, the World Health Organization (WHO), through the Universal Health Coverage Partnership (UHC-P), has been working to ensure that the investments made throughout the COVID-19 response will have a lasting impact in building and maintaining country preparedness and health systems that protect everyone, everywhere from the pandemic and future threats to health (see Fig. 1).

COVID-19 has exposed health inequalities and amplified them, revealing clear socioeconomic and ethnic inequalities. COVID-19 cases and deaths in deprived areas are double those of more advantaged areas.[4] In 2020, the UHC-P placed a special focus on overcoming the gaps related to the lack of inclusion of populations, communities and civil society organizations in COVID-19 committees at country level (see Fig. 2).

Moreover, mitigation measures – such as lockdowns – restrain access to health services and involve deterioration in social and economic conditions that in turn affect mental and physical health. In addition, people living with noncommunicable diseases (NCDs) are more vulnerable to becoming severely ill or dying from COVID-19. Health equity needs to be taken much more seriously and the UHC-P is dedicated to building back fairer, healthier societies.

What is universal health coverage (UHC)?

UHC means that all people and communities – with no one left behind – receive the quality services they need, and are protected from health threats, without suffering financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. UHC has been adopted and supported by several World Health Assembly resolutions (WHA58.33, WHA64.8, WHA69.11, WHA71.1 and WHA72.13) and included as one of the three fundamental pillars of the new WHO Thirteenth General Programme of Work for 2019–2023 (GPW13).[5] UHC is a political choice to be made by every nation.

Treading the path towards UHC requires robust policies, political will and strong government capacity to steer the health sector. Policy dialogue can be an important "steering wheel" for governments to drive evidence-informed decision-making. Putting UHC into practice means brokering consensus amongst all relevant stakeholders on health priorities in order to jointly move towards set targets. Those priorities must then be spelled out in national health plans, charting out the country's roadmap towards UHC.

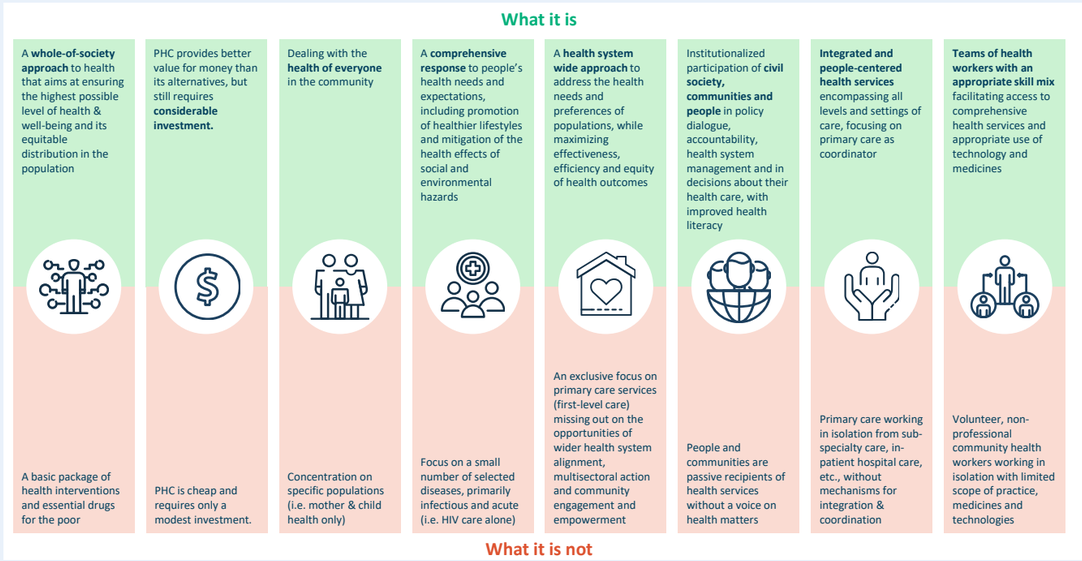
In order to reach UHC, health systems must be oriented towards a primary health care (PHC) approach that includes three essential components: multisectoral policy and action; empowered people and communities; and primary care and essential public health functions at the core of integrated health services. An operational framework for PHC[6] was published in 2020 to propose 14 levers to translate global commitments into operational results. In 2020, we can already see that PHC is increasingly becoming the main strategic approach of UHC-P activities. Fig. 3 is a visual presentation of how experience and recent thinking have shifted the focus and meaning of the PHC movement. This change is intended to widen the scope and perspectives of PHC and make it a whole-of-society approach in dealing with health needs, responses and actors' responsibilities.

4 It's time to build a fairer, healthier world for everyone, everywhere. World Health Day 2021: health equity and its determinants. Geneva: World Health Organization; 2021 (https://cdn.who.int/media/docs/default-source/world-health-day-2021/health-equity-and-its-determinants.pdf, accessed 7 September 2021).

5 Thirteenth General Programme of Work 2019–2023. In: World Health Organization [website]. Geneva: World Health Organization; 2019 (https://www.who.int/about/what-we-do/thirteenth-general-programme-of-work-2019---2023, accessed 6 September 2021)

6 Operational framework for primary health care: transforming vision into action. Geneva and New York: World Health Organization and the United Nations Children's Fund; 2020.

Fig. 3. PHC in practice



Source: Modified from The World Health Report 2008.[7]

What is the Universal Health Coverage Partnership (UHC-P) and how does it support countries?

The UHC-P was created in 2011 to promote UHC, aligned with Sustainable Development Goal (SDG) target 3.8, by supporting policy dialogue and providing technical assistance in order to enable governments to strengthen health systems in governance; access to health products; workforce; financing; information and service delivery; while enabling effective development cooperation (see Box 1). Recently, the UHC-P has developed a specific focus on NCDs to respond to the ever-increasing burden of NCDs on population health and health systems. In the context of the COVID-19 pandemic, the UHC-P is also working on health security, thanks to its flexible and catalytic approach, to build medium-term, sustainable health emergency preparedness capacities while supporting the response to the pandemic, including vaccination, and the continuity of essential services.

As of December 2020, through the UHC-P, WHO scaled up support on UHC to 115 target countries[8] across all six WHO regions covered by 105 WHO country offices (WCOs) (constituting 70% of all WCOs). The UHC-P has grown strikingly from just seven countries in 2011 when it was launched. In terms of results, in 2020, the COVID-19 pandemic pushed countries to focus on the first and second billion of the GPW13 to maintain health services and respond to the emergency. The third billion – promoting healthier populations – remained a smaller focus. More than 120 health policy advisors are deployed at country and regional levels within the frame of the UHC-P. The wide reach of the UHC-P across regions and the on-the-ground support provided by WHO experts are part of its instrumental approach in assisting Member States to achieve UHC.

7 Modified from "Table 1. How experience has shifted the focus of the PHC movement". In: The World Health Report 2008: Primary health care now more than ever. Geneva: World Health Organization; 2008; p. xv.

8 Number of UHC-P countries : 46 in the African Region, 21 in the Region of the Americas, 14 in the Eastern Mediterranean Region, seven in the European Region, seven in the South-East Asia Region and 20 in the Western Pacific Region.

Box 1. UHC-P working principles

A flexible and bottom-up approach
The UHC-P supports countries with flexible funds and agile programming, adapting quickly to evolving contexts and priorities, as in the response to COVID-19, including preparedness, prevention, diagnosis, treatment and vaccination.

In-country technical assistance
A total of 120 long-term senior policy advisors are deployed in countries worldwide to support Member States and ensure approaches and assistance fit for context.

Participatory governance
The UHC-P continues to advocate for policy dialogue and social participation, especially in times of crisis, in order to build and maintain trust and ensure policy adherence.

Prepare and respond to epidemics while maintaining essential health services
The UHC-P supports governments to protect communities from the impacts of COVID-19, maintain essential health services and strengthen country capacities to face future health threats.

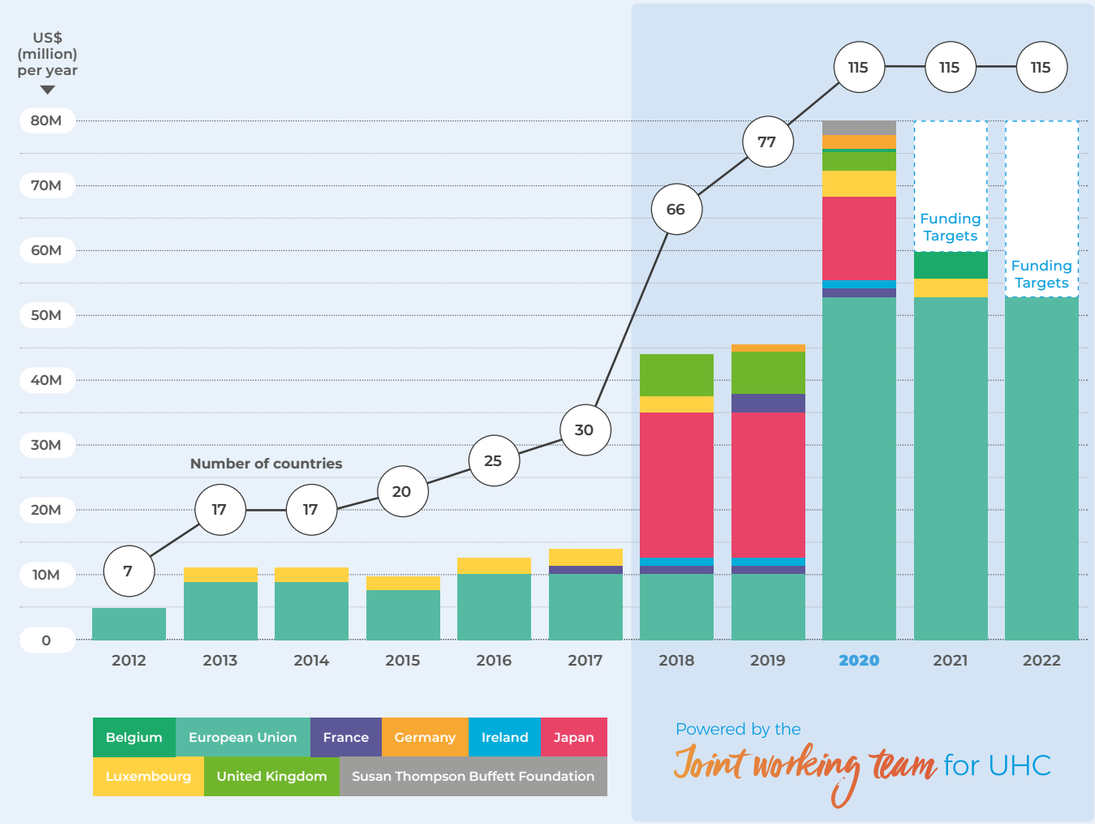
PHC as the foundation of strong health systems
PHC is the foundation of strong health systems and it is central to the COVID-19 response and beyond. It serves as a critical first line of defence during outbreaks, in preventing diseases and improving the health of all communities.

Additionally, the UHC-P supports the development of 63 "WHO public health goods" – an internal concept to the WHO's planning process referring to its technical products on norms/standards, data and research.[9] These products encompass rigorous science- and evidence-based recommendations on matters that affect peoples' health; provide general information and facts pertaining to public health topics; include health information and evidence ranging from global statistics to monitoring data; or introduce innovations, horizon scanning results and research.

The UHC-P channels investments from eight donors (the European Union, Luxembourg, Japan, Belgium, Ireland, Germany, France and the United Kingdom) to ensure **continuity between global commitments and country implementation for health systems strengthening**, ensuring that nobody gets left behind. In addition, the UHC-P is welcoming Canada as a new donor from 2021 and the European Investment Bank shows clear interest in UHC-P activities. Funded activities are supporting WHO workplans across all three levels of the organization (country, regional and headquarters) based on the GPW13, and not as a separate project. Fig. 4 presents the evolution of financial support provided by an increasing number of donors. It is expected that additional contributions from other donors will complement ongoing commitments in 2021 and beyond. Figs. 5 and 6 give an overlook of the UHC-P in numbers.

Fig. 4. UHC-P - JWT - PHC-SP Evolution 2012-2022

UHC-P donor contributions 2012–2022, channelled through the Joint Working Team (JWT) on UHC since 2018



To ensure consistency, the UHC-P developed a specific tailored and bottom-up approach based on country-selected priority areas and country capacities. Financing opportunities are discussed throughout all three levels, but the decision of what needs to be funded is firstly a shared responsibility of regional and country offices. Resources are monitored and tracked through an internal computerized system to follow the distribution by region, country offices and for each donor; the development of workplans for each funding, as well as utilization and distribution at all levels.

The UHC-P benefits from the WHO-wide Joint Working Team (JWT) that brings expertise and coherence to all levels of WHO vis-à-vis UHC. The JWT has been established in the GPW13 and represents an operational arm overseeing the day-to-day management of WHO to guarantee harmony, alignment and integration of efforts geared towards UHC implementation at country level. The JWT continues to ensure the coordination, monitoring and reporting of UHC country, subregional and regional support plans. Moreover, with the specific focus on NCDs and health security, the JWT welcomed additional focal points for these specific issues to ensure greater coordination. Some "NCD Hard Talks" were also organized in 2020 with the support of the UHC-P to discuss and promote solutions for important issues related to NCDs, such as an integrated approach to NCDs or medicines for NCDs.

9 See "Focusing global public goods on impact". In: Thirteenth General Programme of Work, 2019–2023, p. 37.

At the end of 2020, as part of the WHO transformation agenda, the UHC-P and the JWT were merged within the new Special Programme on PHC in order to gain efficiencies through rationalizing the monitoring and reporting work of cross-cutting initiatives. In line with the GPW13, the 2018 Astana Declaration and the joint UNICEF–WHO commitment to support countries on developing and implementing robust PHC strategies, the Special Programme on PHC is destined to boost the achievement of UHC by 2030 by assisting Member States in strengthening PHC.

To improve transparency and mutual accountability, and to ensure systematic monitoring of implementation as well as continuity and stability of efforts at national level, the UHC-P is organized around a strong and high-level internal governance structure supported by world leaders' political commitment. The governance structure of the UHC-P is based on several pillars: the multi-donor coordination committee (MDCC), the UHC-P Steering Committee, the live-monitoring mechanism, the JWT/UHC-P retreat and bimonthly meetings, the communication strategy and operational research.

Fig. 5. UHC-P by the numbers

8 donors

Luxembourg Aid & Development

Belgium partner in development

Irish Aid

Ministère de l'Europe et des Affaires étrangères
Liberté
Égalité
Fraternité

Foreign, Commonwealth & Development Office

US$ 235 million

disbursed to support country-level priorities to date; including **US$ 80 million** in 2020.

Allocation of financial support to country support plans (approximately **60%** staffing versus **40%** activities).

3 levels allocations: **70%** for Country Office, **15%** for Regional Office and **15%** for HQ.

115 health policy advisors globally

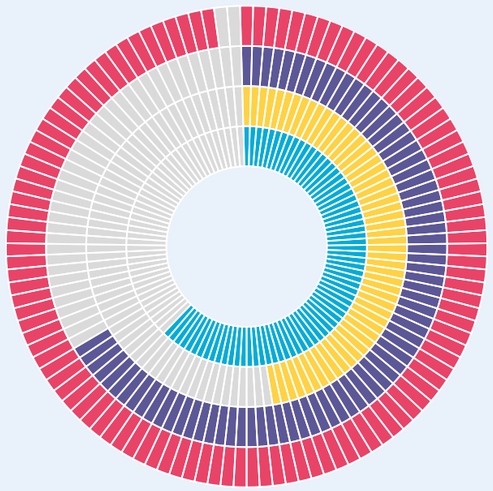
93 country-level health policy advisors in WHO country offices, with **16** under recruitment

22 regional health policy advisors based regionally.

115 countries in the **6** WHO regions

See in the Appendix for all UHC-P activities mapped by country

Fig. 6. UHC-P key thematic areas (number of countries involved)



1st BILLION: 113 countries

2nd BILLION: 78 countries

3rd BILLION: 55 countries

Data and innovation: 73 countries

Fig. 7. Top 10 outputs targeted through the UHC-P

Number of countries that have implemented top 10 GPW13 outputs		
1.1.5	Countries enabled to strengthen their health workforce	80
1.1.1	Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages.	75
1.1.4	Countries' health governance capacity strengthened for improved transparency, accountability, responsiveness and empowerment of communities.	67
1.1.2	Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results.	65
2.1.2	Capacities for emergency preparedness strengthened in all countries.	64
1.2.1	Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage.	63
4.1.1	Countries enabled to strengthen health information and information systems for health, including at the subnational level, and to use this information to inform policy-making.	63
1.2.2	Countries enabled to produce and analyse information on financial protection, equity and health expenditures, and to use this information to track progress and inform decision-making.	52
1.1.3	Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course.	50
1.3.2	Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems.	50

Multi-donor coordination committee (MDCC)

The MDCC provides a visible and transparent mechanism to enable discussions and coordination with the donors on successes and challenges related to the implementation of major activities in the frame of the UHC-P. It met in April and November 2020.

The overall objectives of the MDCC are:

To improve coordination between WHO and donors, by providing a platform to regularly convene, streamline programmes, as well as harmonize and align approaches in order to build synergies and prevent duplication of work.

- To share information in a view to aligning donor investments based on aid effectiveness principles – that is, one plan, one monitoring mechanism, one report, in line with the GPW13 and its priorities for countries.
- To identify priorities and gaps in response with a view to informing future direction of programme-specific funds and other investments in complementarity with other global initiatives.
- The MDCC provides an opportunity to regularly share challenges and successes of WHO UHC country support plan implementation not only with the UHC-P donors but also other stakeholders. Serving a catalytic role, the UHC-P allows stakeholders to come together to adapt and find solutions to address challenges and bottlenecks in progress towards UHC at country level.

High-level Steering Committee

In June 2019, under the guidance of the newly designated Deputy Director-General of WHO, Dr Zsuzsanna Jakab, a WHO internal High-level Steering Committee was put in place. This Committee comprises the Deputy Director-General, the Executive Director of the UHC Life Course Division, all involved Assistant Directors-General and Executive Directors, as well as the Directors for Programme and Management from the six WHO regional offices. In 2020, four meetings were held in February, April, July and November to exchange information on the UHC-P, on resource mobilization and allocation at the three levels of WHO, and to provide global guidance on how to best integrate WHO corporate efforts for optimal support to countries.

The main contribution of the Steering Committee to the UHC-P was improving alignment and coherence of WHO in the field and ensuring strong support from the senior management for implementation of managerial processes to ensure fast recruitment procedures and quick availability of funds at country and regional levels.

Live monitoring

Live monitoring aims to review progress from the WHO country and regional offices on UHC-P-supported activities, lessons learned and updates on future technical work. It provides a unique opportunity for WHO and partners to actively engage in a regular dialogue on the provision of support to Member States to deliver on their UHC goals. Two series of live monitoring sessions were organized in May/June and November/December.

JWT/UHC-P retreat and bimonthly meetings

After the three-level JWT/UHC-P retreat in September 2020, bimonthly meetings – co-chaired by one WHO region and WHO headquarters – were set up to allow deep discussions and exchanges of good practices between the three levels of WHO. The first meeting took place in November 2020 and focused on health and migration.

Communication strategy

A communication strategy has been elaborated to cover the fourth phase of implementation. The targeted single overarching communication outcome of the UHC-P's communication effort is that Member States demonstrate stronger commitment and accelerate action and solidarity to achieve UHC and build more resilient health systems. The implementation of the strategy, which began in mid-2020, has led to greater visibility and representation of the UHC-P at key opportunities, such as WHO's Executive Board sessions, UHC Day and World Health Day, among others.

Regional and country offices have also been more actively engaged in the development and co-promotion of stories from the field, which in many cases involved cooperation from ministries of health and partners, resulting in unified and amplified messaging. UHC-P communications became more agile, responsive and relevant throughout the year, with the development of a special series of stories on COVID-19, supported by newsletters, magazines, feature articles, over 20 videos and several communication toolkits, which were distributed and promoted across high-traffic pages of the WHO website and other digital and social media platforms at global, regional and country level. With more dynamic content and cross promotion, the UHC-P website has seen a gradual increase in visits. In the coming year, a new, more robust website will enable the UHC-P to enhance its presence online and bring more timely and accessible information and resources to its audiences and stakeholders.

Operational research

Two studies have already been launched to understand the role of the UHC-P in health governance strengthening. In 2016, the UHC-P concluded a formal evaluation of its actions that focus on lessons learned with regards to its role (convener, broker, technical assistance provider), strengths (flexibility, bottom-up approach, seed funding, WHO JWT three-levels approach), and weaknesses (roster of technical assistance, difficulties in finding appropriate candidates for the policy advisor positions).[10] Moreover, in 2016, the WHO Regional Office for Africa published a supplement on health policy dialogue in 13 countries in the Region.[11] Lessons learned have informed continued efforts to improve health dialogue in the 47 Member States within the Region. In 2018, a protocol for a realist evaluation of the role of the UHC-P in strengthening policy dialogue for health planning and financing was published[12] and some results have been collected.[13] This study aimed to analyse policy dialogue processes in their context to understand which planning and financing mechanisms have been triggered to enable health systems to move towards UHC.

In 2020, preliminary results were collected and analysed for final publication in 2021. The report will theorize the underlying rationale of the UHC-P, which builds capacities of ministries of health to lead inclusive, participatory and evidence-informed policy dialogue. The support of the UHC-P should result in mutual trust to strengthen stakeholders' collaboration, while the evidence and data provided should bring a shared understanding of needs and policy options. The report will also reveal the necessary conditions for successful policy dialogue such as dynamic local stakeholders, promotion of collaboration as a mode of action, involvement and leadership of the ministries of health and synergy of messages and actions from WHO. The continuous presence of experts in the field is recognized to allow for close monitoring of the policy dialogue, strengthens the trust relationships with ministries of health, and advances strategic thinking and the cross-cutting vision of policy dialogue.

10 Formative evaluation of the EU-Luxembourg-WHO Universal Health Coverage Partnership (UHC-P) 2011–2016. Amsterdam: Royal Tropical Institute of Amsterdam; 2016.

11 Health policy dialogue: lessons from Africa. BMC Health Services Research. 2016;16(Suppl 4).

12 Robert E, Ridde V, Rajan D, Sam O, Dravé M, Porignon D. Realist evaluation of the role of the Universal Health Coverage Partnership in strengthening policy dialogue for health planning and financing: a protocol. BMJ Open. 2019;9(1):e022345. doi:10.1136/bmjopen-2018-022345. Robert E, Rajan D, Koch K, Weaver AM, Porignon D, Ridde V. Policy dialogue as a collaborative tool for multistakeholder health governance: a scoping study. BMJ Global Health. 2020;4(Suppl 7):e002161. doi:10.1136/bmjgh-2019-002161.

13 Zongo S. Le dialogue sur la stratégie nationale de financement de la santé pour la couverture sanitaire universelle au Burkina Faso. Partenariat pour la CSU; 2018 (in French). Robert E. Le dialogue sur la planification sanitaire au Togo. Partenariat pour la CSU; 2019 (in French).

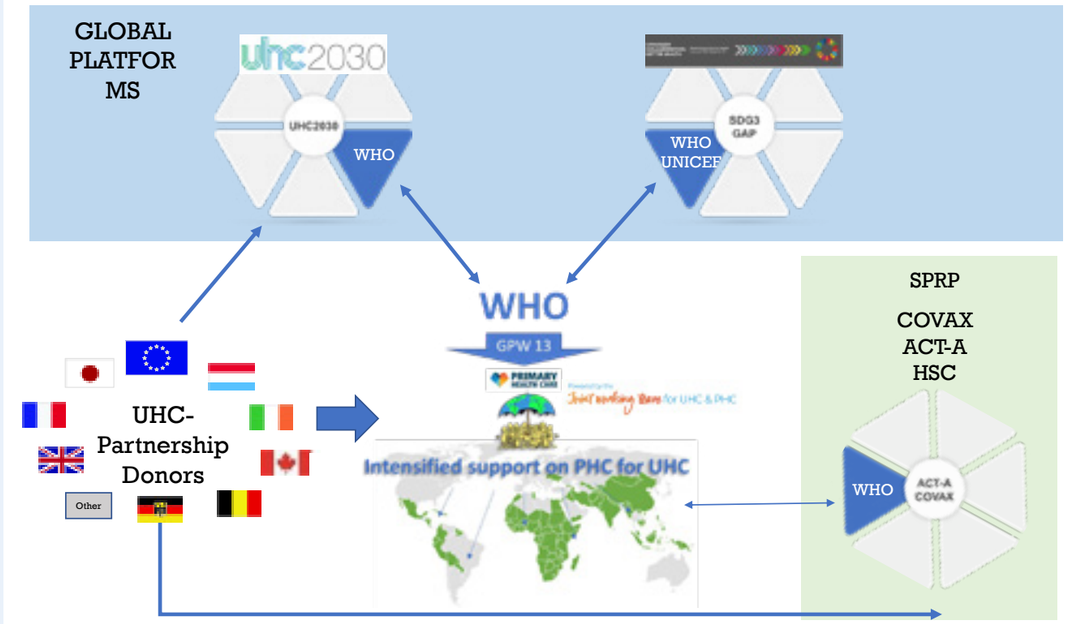
Collaboration with global health initiatives

The UHC-P operates under the global multi-stakeholder platforms of UHC2030 and the SDG3 Global Action Plan on Healthy Lives and Well-being for All (GAP) to promote collaborative working globally and in countries through a PHC approach in order to enhance cooperation effectiveness (Fig. 8). The precursor to UHC2030 was the IHP+, which was transformed into UHC2030 in 2016 to respond to the health-related SDGs. Its mission is to create a movement for accelerating equitable and sustainable progress towards UHC. The SDG3 GAP initiative is described in the following deep dive.

Disease-specific work and health systems strengthening can – and should – be mutually reinforcing. However, this cannot be left to chance. If disease-specific work is to prove effective in building systems while achieving disease-specific results, these dual outcomes must be deliberately planned. Through common goals and targets for health, international partners, governments and civil society improve their alignment and shared accountability.

Finally, fresh initiatives like the SDG3 GAP (see DEEP DIVE: UHC-P and SDG3 GAP PHC Accelerators) or even more recent ones related to the COVID-19 crisis have been included as close collaborators both at global and country levels.[14]

Fig. 8. PHC and the UHC-P in its global environment



ACT-A: Access to COVID-19 Tools Accelerator; COVAX: the vaccines pillar of the ACT-A; GPW13: Thirteenth WHO General Programme of Work 2019–2023; HSC: health system connector; PHC: primary health care; SPRP: COVID-19 strategic preparedness and response plans; UHC: universal health coverage; WHO: World Health Organization

14 Stronger collaboration, better health: Global action plan for healthy lives and well-being for all. In: World Health Organization [website] (https://www.who.int/initiatives/sdg3-global-action-plan, accessed 6 September 2021).

DEEP DIVE

UHC-P and SDG3 GAP PHC Accelerators – collaborating for results

The SDG3 Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP), which was launched in September 2019 at the United Nations General Assembly, is a collaboration of 13 leading humanitarian, development and health agencies to support countries to accelerate progress towards the health-related SDGs. Since its inception, GAP agencies have moved from commitment to laying the groundwork for a decade of delivery and action on the health-related SDGs through stronger collaboration. Implementation of the GAP is grounded in joint support for countries, builds on existing collaborations, and aims to fill gaps in national mechanisms and processes to achieve its aims.

The partnership is organized around four key commitments – Engage, Accelerate, Align and Account:

- **ENGAGE:** Working with countries to identify priorities and to plan and implement together.
- **ACCELERATE:** Acting together to support countries in the accelerator themes and on advancing gender equality.
- **ALIGN:** Harmonizing operational and financial strategies, policies and approaches.
- **ACCOUNT:** Reviewing progress and learning together to enhance shared accountability.

There are seven accelerator areas, each with a global working group, in addition to a working group on gender equality. The seven accelerators are: primary health care (PHC); sustainable financing for health (SFH); civil society and community engagement; determinants of health; research and development, innovation and access; data and digital health; and innovative programming in fragile and vulnerable settings and for disease outbreak responses. GAP agencies work through these accelerators to help countries protect health gains achieved so far, recover from the COVID-19 pandemic with more resilient health systems, and continue their journey towards achievement of the SDGs. The SDG3 GAP serves as a valuable, long-term improvement platform for collaboration among 13 agencies in the multilateral system. The Primary Health Care Accelerator (PHC-A) – co-led by WHO's Special Programme on Primary Health Care (which also hosts the UHC-P) and the United Nations Children's Fund (UNICEF) – is working to ensure country support around implementation of PHC as a crucial pathway towards the road to recovery from the COVID-19 pandemic.

The guiding principles for country collaboration under the SDG3 GAP PHC-A are in line with the core principles of the UHC-P, namely, collaboration that is built on country ownership, using a bottom-up approach, and based on tailored support plans responding to national contexts and priorities.

In order to implement the work of the PHC-A, a consultative process was followed through preliminary engagement with regions. Such initial consultations during the first year of the GAP implementation highlighted the need for mainstreaming PHC, integration with the UHC-P JWT, and requirements for additional funding. A review with regions was carried out in May 2019, in which a selection process was proposed and countries were asked to submit workplans building on their country strategy papers. The criteria for country prioritization and countries selected for initial inclusion in the GAP PHC-A are outlined in Fig. 9.

How the SDG3 GAP PHC-A and the UHC-P are linked in practice

There are currently four main mechanisms through which the SDG3 GAP and the UHC-P are linked:

- **Focal points:** UHC-P policy advisors, as well as the technical and managerial counterparts for the UHC-P, are the main focal points in-country for GAP PHC-A intensified support. Building on the extensive work over several years developed by WHO and bringing in many of the GAP partners, the JWT for UHC has a strong relationship with GAP agencies. The UHC-P works in an integrated manner with the Special Programme for PHC to boost PHC efforts at country level, focusing on country support alongside a number of GAP accelerators, including the PHC-A, SFH Accelerator and innovative programming in fragile and vulnerable settings and for disease outbreak responses.
- **Planning:** One of the primary ways in which the country-level work of the UHC-P and SDG3 GAP come together is through the planning processes. Intensified PHC support through the SDG3 GAP platform is in line with national priorities and follows national planning cycles. To that end, the planning elements of the PHC-A and workplans of PHC-intensified support are built on the existing country support plans and UHC-P plans.
- **Funding:** As noted in Fig. 9, the PHC-A currently focuses on intensified support in 13 countries, using additional funding from the German Federal Ministry for Economic Cooperation and Development that complements UHC-P funding. The list of countries is continuously reviewed and updated as requests for support are received. In some countries, there is additional support for PHC implementation under the UHC-P. One example of a country receiving additional funding for PHC-intensified support is South Sudan, and this involves a larger team to support the Ministry of Health, with a focus on training, equipment, essential package of services, etc. More details on the work of the PHC-A in South Sudan (see DEEP DIVE: PHC-Intensified Support in Fragile, Conflict-affected and Vulnerable Countries) and other intensified-support countries can be found in the 2021 SDG3 GAP Progress Report.[15]
- **Monitoring:** Countries receiving intensified PHC support through the SDG3 GAP platform participate in the regular live monitoring mechanism of the UHC-P. In this way, the UHC-P and SDG3 GAP PHC-A monitoring activities are integrated to jointly review progress on supported activities and engage in regular dialogue related to the activities included in the country support plans.

Fig. 9. Initial selection of intensified-support countries under the SDG3 GAP PHC-A

Criteria for prioritization

- Strong government buy-in and leadership.
- Key health outcomes and major disease control indicators lagging.
- New investment opportunities through rational budgeting cycles or partners' investments.
- Countries facing protracted conflicts, fragile situations and frequent public health emergencies.
- Multiple agencies/partnerships actively supporting.

WHO Region	Number of countries	Countries selected to initiate phased roll-out
African Region	6	Central African Republic, Ghana, Malawi, Mali, North East Nigeria*, South Sudan*
Eastern Mediterranean Region	3	Egypt, Pakistan, Somalia*
European Region	1	Ukraine*
Region of the Americas/ Pan American Health Organization	1	Haiti*
South-East Asia Region	1	Sri Lanka
Western Pacific Region	1	Papua New Guinea

* Fragile, conflict-affected and vulnerable settings.

15 2021 progress report on the Global Action Plan for Healthy Lives and Well-being for All. Geneva: World Health Organization; 2021 (https://www.who.int/initiatives/sdg3-global-action-plan/progress-reports/2021, accessed 6 September 2021).

Country examples of linkages between UHC-P and SDG3 GAP

Mali: Mali has been receiving intensified PHC support under the SDG3 GAP PHC-A over the last year. Building on long-term technical assistance through the UHC-P, both the SDG3 GAP and the UHC-P have worked in a collaborative manner in support of the implementation of the Mali Action Plan, which was established in 2019. Pillar 1 of the Mali Action Plan focuses on PHC, with an emphasis on building a national cadre of community health workers, rehabilitation and digitization of community health centres, and establishing a PHC Centre of Excellence, among other actions.

Somalia: Support for PHC on the road to UHC has been prioritized in Somalia through both the UHC-P and the SDG3 GAP. During a high-level mission on PHC for UHC in January 2020, collaboration between the two platforms supported the roll-out of an essential package of health services, mapping of health services delivery and human resources for UHC, and identification of mechanisms to leverage the humanitarian-development nexus to improve service delivery.

Added value of the SDG3 GAP to the ongoing work of the UHC-P and JWT

JWT focal points are instrumental to ensuring complementary and good collaboration of technical and financial support for PHC at country level. This effort is further supported through the GAP platform, which aims to continuously improve alignment, decrease transaction costs and increase efficiency among partners in the UHC-P and JWT, as well as other multilateral agencies. As shown in Fig. 10, the GAP platform also emphasizes coordination across accelerators, especially at country level, and this is key to ensuring long-term impact. In the context of COVID-19 response and recovery, the GAP presents an opportunity to leverage and align partner organizations around a single PHC support roadmap for long-term systems strengthening and resilience.

Fig. 10. Value proposition of intensified PHC support through the SDG3 GAP

Development partner's intensified' PHC implementation support: Value Proposition	Enhanced visibility and advocacy for PHC
	Increased technical and financial support for PHC
	Better monitoring and supporting of progress on PHC
	Improved access to best practices and knowledge on PHC
	Improved alignment of partner organizations around a single PHC support roadmap
	Decreased transaction costs and increased efficiency of investments on PHC by partner organizations

DEEP DIVE: UHC-P and SDG3 GAP PHC
Accelerators – collaborating for results

A community health worker in Chirirbandar, Dinajpur, Bangladesh, conducts a blood pressure check up. ©WHO Bangladesh/Nuruzzaman

WHO

3 billion strategic priorities

Since its inception in 2011, the UHC-P has been focused on strengthening health systems to make progress on UHC, which is one of the three core strategic priorities of WHO.

The work of ensuring 1 billion more people benefit from UHC is interrelated with WHO's two other strategic priorities, addressing health emergencies and promoting healthier populations as part of the GPW13. Although the majority of the work being reported in this Annual Report at country level is via the UHC priority (section 1), increasingly this work is being recognized in the two other strategic priorities of WHO: Health Emergencies (section 2) and Healthier Populations (section 3).

The following sections of the report are organized for reporting purposes according to GPW13 along the Triple Billion targets (three strategic priorities: sections 1 to 3) and their corresponding outcomes. Linkages to outcomes include access to services (service delivery, leadership/governance and health workforce), health financing and access to essential medicines.

Section 4 focuses on how health information systems make WHO more effective and efficient in providing better support to countries. As per the GPW13 outcomes, section 5 reports on the challenges and lessons learned. Of note, as part of the country-level support provided by the UHC-P, there is concurrent and complementary work on various GPW13 outcomes and outputs. For an extensive list of UHC-P activities by country, see Annex I.

Mobile clinic in Micronesia (Federated States of) providing NCD screening and prevention services using a primary care approach. ©WHO/Yoshi Shimizu

1. UHC

1 billion more people benefiting from UHC

The UHC-P's work on UHC is fully aligned with SDG target 3.8, which focuses on achieving UHC, including access to quality essential health-care services; financial protection; and access to safe, effective, quality and affordable essential medicines and vaccines for all. Equity of access to health services is central to UHC, and by making the initial political choice countries are in fact committing to progressively break down these barriers and expand access to comprehensive services in order to meet the needs of the population. In order to reach UHC, health systems must be oriented towards a PHC approach which includes three essential components: multisectoral policy and action, engaged people and communities, and primary care and essential public health functions at the core of integrated health services. The operational framework for PHC proposes 14 levers to translate global commitments into operational results. In this year's report, strengthening PHC to ensure strong health systems foundations and to maintain essential health services is an important focus.

1.1 Access to services/Improved access to quality essential health services

GPW13 outcome 1.1

Service Delivery *GPW13 output 1.1.1*

Designing essential package of health services and PHC models of service delivery

Throughout 2020, the UHC-P maintained its focus on high-quality, people-centred health services (see Box 2), based on the stated needs of partner countries. To achieve this objective, strengthening PHC as a foundation for UHC and designing essential service packages are key activities of the UHC-P.

For instance, in **Indonesia**, technical assistance was provided by the UHC-P to facilitate successful models of service delivery by conducting situation analyses and proposing updated models of service delivery at the PHC level (see Box 3). In **Jordan**, **Sri Lanka**, **Somalia** and **Tunisia**, the UHC-P supported the development of essential benefit packages and service delivery models for PHC reorganization. In **Sri Lanka**, these two workstreams will be embedded in the PHC reorganization and will effectively support more than 600 primary care institutions by 2023 (around 60% of the PHC curative care units).

In the **WHO Eastern Mediterranean Region**, existing indicators have been adapted to regional realities to create the Primary Health Care Measurement and Improvement (PHCMI) initiative, which enables countries in the Region to evaluate existing health systems and approaches. National profiles for PHCMI were finalized and endorsed by the respective governments of **Egypt**, **Iraq**, **Islamic Republic of Iran**, **Jordan** and **Morocco**. Following these evaluations, countries will be able to use the PHC Operational Framework to decide which PHC levers they can use to move to a PHC model. The **Islamic Republic of Iran**[16] has already moved forward by strengthening PHC as a foundation of UHC to respond to the COVID-19 crisis. This is done through an initiative called "Each home one health post", which is striving to empower families and communities to protect their health while defining an essential benefit package and a clear service delivery model (see Box 4).

This is also what happened in **Georgia** in the **European Region**. In late 2019, a UHC-P mission recommended revising the scope of PHC services to become more preventive and people-centred, expanding the scope of practice of nurses, and redefining the role of specialists in the PHC setting. The stakeholders agreed to focus on integrating vertical programmes and improving outcomes for priority areas: child health, hypertension, cardiovascular disease, chronic obstructive pulmonary disease, type 2 diabetes and asthma. Additionally, based on the findings of the mission, and working in close communication with the Ministry of Health, the team revised the PHC benefit

16 More details (with quotes and images) may be accessed here: https://www.uhcpartnership.net/story-iran/

package in 2020. In **Tajikistan**, WHO provided technical support to the Republican Training and Clinical Centre of Family Medicine for a review of the implementation of its Strategic Plan for the Development of Family Medicine–based Primary Health Care, 2016–2020. Furthermore, WHO supported the elaboration of a new programme for PHC development in 2021–2025. In **Kyrgyzstan**, WHO provided technical assistance to safeguard the existing PHC capacity and position it higher on the political agenda through the production of the "Technical Review of the Healthcare Delivery Optimization Plan for the Kyrgyz Republic", which was subsequently presented to the Minister of Health and Social Development and to the Joint Financiers. In **Uzbekistan**, WHO provided intensive support during the preparatory phase of a new service delivery model that will be piloted in Syr-Darya Oblast from mid-2021 prior to its country-wide implementation. It aims to strengthen PHC to improve its capacity by moving towards multidisciplinary primary care teams; promote a system of medical prevention and patronage based on population risk stratification; and improve primary health-care worker performance monitoring with results-based incentives. In this context, WHO analysed demographic and epidemiological data from all health facilities in Syr-Darya. Moreover, WHO worked closely with the German KfW Development Bank to develop and field test the protocol for a baseline health facility assessment for the pilot, which included an assessment on the continuity of essential health services in the context of COVID-19.

In other examples closer to the field, in **Colombia** the UHC-P strengthened the capacities of basic health teams in hospitals for the provision of health promotion and maintenance services by connecting hospital teams with community health workers from the Wayúu ethnic group/community.[17] In **Haiti**, work on Guidelines for District Health Services informed a PHC-based health system at the first level of care, and increased accessibility, equity and efficiency in health for the communities. In the **West Bank and Gaza Strip**, support was provided by the UHC-P for hospital sector planning.

In the **Eastern Mediterranean Region**, the SDG3 GAP PHC-A partners launched an online training on Primary Health Care Practice in the Context of the COVID-19 Pandemic to ensure that PHC is part of the national COVID-19 response plans. By the end of 2020, more than 13 000 physicians from the Region had undergone the training. The training is available in four languages – Arabic, English, Farsi and French.

Box 2: Peru's strategy for integrated health services networks

Installation of the first 66 Integrated Health Services Networks throughout Peru was achieved during 2020.[18]
The strategy of Integrated Health Services Networks has been strongly welcomed in the country among public health managers and directors because it would enable Peru to overcome fragmentation of its health system.
The process defined by the Ministry of Health will need consistent work for these networks to reach their desired levels of implementation.

In 2018, the 40th anniversary of the Declaration of Alma Ata was celebrated and proposals were drawn up to revive the primary care strategy for the 21st century. With the aim of promoting the recommendations and providing a voice for the people who joined that historical moment, a community of PHC good practices has been set up. In this community, prominent professionals enhanced their capacities to promote the PHC strategy in Peru. The creation of the PHC community of practice and its first public initiatives carried out during 2020 have encouraged the health teams to systematize their actions and disseminate these to emphasize the importance of territorial action and the first level of care in responding to all health priorities.

During 2020 in the midst of the pandemic, the importance of the first level of care, the activation of territorial teams and community action in health was noted. Important regulatory advances and technical recommendations were made, including the approval of a multisectoral health policy by 2030, a new care model, regulations and standards, and the development of support applications. This work, started early, saw its best results during the preparation of the response to the second wave of COVID-19 in the second half of 2020. The Minister of Health, accepting the recommendations channelled through her advisor, Dr Fernando Carbone, founding member of the community of practice, revived the role of the first level and abandoned the hospital-centric approach that had characterized the first stage of the response. The support of pro-PHC actors grouped in the community of practice and institutionally inserted in various instances resulted in budget modifications and reprioritizations for 2021.

17 More details (with quotes and images) may be accessed here: https://www.uhcpartnership.net/story-colombia/.

18 Ministra Mazzetti insta al personal de salud a apoyar recuperación del primer nivel de atención. El Peruano. 12 January 2021 (https://elperuano.pe/noticia/113341-ministra-mazzetti-insta-al-personal-de-salud-a-apoyar-recuperacion-del-primer-nivel-de-atencion, accessed 7 September 2021).

Box 3: *Story from the field – Cameroon*

WHO support to put the health district back on the political agenda of the sector to make better progress towards UHC and the SDGs in Cameroon

The 2018 Astana Declaration commits countries to reaffirming PHC and strengthening district health systems as a success for achieving UHC and the SDGs.

In November 2020, WHO organized a reflection workshop on the health district, leading the Ministry of Health and its stakeholders to reflect on the current capacities of the health district in Cameroon, based on the Astana Declaration orientations (leverage and principles); to consider the methodology to evaluate the functionality of the health district; and to develop a plan for strengthening the health district for its viability.

FACT: The National Health Policy of Cameroon reaffirms the importance of PHC and defines the health district as the operational unit of the national health system, where PHC is implemented. However, the health districts do not have sufficient capacities to ensure the implementation of interventions at operational level in terms of coordination, supervision, control, management and research. As a result, health outcomes are not satisfactory.

WHY IT MATTERS: The health district, through its optimal capacities, ensures the adequate implementation of priority interventions defined in the health policy and materializes the strengthening of the health system for the achievement of UHC and the SDGs. Therefore, each health district must have the human, financial, material, logistical and managerial resources and optimal functional organization to fulfil the roles assigned to it in order to achieve the expected health results.

EXPECTED RESULTS: With the support of WHO, data on the situational analysis of the health system are known, a plan for strengthening the capacities of the health district in Cameroon has been defined with a view to supporting the viability of the health districts by strengthening PHC, and there is improvement and progress towards the SDGs and the UHC.

UHC-P IN PRACTICE: WHO, through the UHC-P funds, is working with the Ministry of Health at different levels – national and subnational – and with other partners to develop a strengthening health district system framework for effective PHC revitalization, which is crucial for moving towards UHC.

Box 4: Story from the field – Mozambique

Expansion of UHC based on community health systems and approach in Mozambique

In 2018, Mozambique received a WHO scoping mission that supported the country to develop a roadmap to accelerate the expansion of UHC. One of the recommendations was the revitalization of the community health subsystem. At the same time, the Government adopted a new agenda of administrative decentralization with impacts on the health sector. In 2020, a new Essential Health Care Package was adopted, which includes interventions at the community level. The current polyvalent health workers are health workers at the community level, but with a vertical focus on communicable diseases. Mozambique's UHC index is 46, still far from a full coverage of essential services.

FACT: The Community Health Subsystem Strategy was defined as one of the four priority flagship programmes for the health sector. It is national in scope and will be implemented gradually over the five-year period 2021–2025, with the start of the pilot that covers six provinces in the first year. The strategy promotes the reconversion of the polyvalent health workers' profile into community health workers (CHWs) and the additional recruitment of other CHWs with a broader and more integrated focus of health interventions at the community level. It also establishes a new form of complementarity between the work of the CHWs and the PHC services.

WHY IT MATTERS: The strategy aims to revitalize health interventions at the community level by training CHWs based on a new profile and with an integrated health-care package, with an emphasis on hard-to-reach populations. The empowerment of communities and local social structures is considered essential to ensure an adequate response to different health needs, through intersectoral and multisectoral collaboration to address the social determinants of health and promote the well-being of communities.

EXPECTED RESULTS: This strategy is expected to improve the UHC index in the country. The Community Health Subsystem expects to reach 55% of the rural population (12 644 088 inhabitants) and 12% of the urban population (1 383 497 inhabitants) by 2025, thus covering around 40% of the total population. For this, the hiring of 16 836 CHWs and 2722 supervisors is expected.

UHC-P IN PRACTICE: WHO, through the UHC-P, has contributed to the development of the Community Health Subsystem Strategy by providing specialized technical assistance. Through the pilot, WHO continues to work with the Government of Mozambique and other actors and partners to empower local communities to build a resilient and more inclusive national health system.

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Maintaining PHC-oriented essential health services during the COVID-19 pandemic

From the beginning of the COVID-19 pandemic, the first level of care was critical in supporting the diagnosis and contact tracing of COVID-19 cases, clinical management of mild COVID-19 cases, and continuity of essential health services. The UHC-P prioritized balancing maintaining the delivery of essential health services (in areas such as NCDs or maternal and reproductive health) with preventing excess deaths from the disruptions caused by COVID-19, as well as supporting partner countries in managing and mitigating the pandemic. It is estimated that between 1 February 2020 and 17 April 2021, there were 621, 370 total excess deaths worldwide due to COVID-19.[19]

In the **Region of the Americas**, 20 out of 24 countries (83%) identified a core set of essential health services to be maintained during the COVID-19 pandemic, and 16 (67%) allocated additional government funding to assuring essential health services. Even though disruptions in service delivery were reported in many countries, only a few countries reported total disruption of services. Advocacy, coordination and negotiation within key global mechanisms – such as the COVID-19 global supply consortium and the three pillars of the Access to COVID-19 Tools (ACT) Accelerator (vaccines, diagnostics and therapeutics) – proved critical to enabling increased access to essential health supplies for COVID-19 for partner countries. However, experiences and lessons learned in 2020 in aspects related to the reorganization of health services, inter-programmatic collaboration, innovations in service delivery modalities – including the use of telemedicine and information and communications technology (ICT) tools – mitigated the impact of the pandemic in some countries, and will be valuable to guide interventions in 2021 and beyond to build resilience in health services.

At country level in the **European Region** (see Box 6), PHC was central to efforts in **Azerbaijan** to respond to COVID-19. The UHC-P supported increasing access to essential health-care services through an improved PHC model; health workforce strengthening; and community engagement through the establishment of a network of health facilities, including outreach services via mobile health clinics to improve access to health-care services. During the pandemic this work played an important role in maintaining the delivery of essential health services (in areas such as NCDs or maternal and reproductive health) to prevent excess deaths from the disruptions caused by COVID-19.

In the **Western Pacific Region** (see Box 7), interim guidance on PHC preparedness and response to COVID-19 was developed to support countries in maintaining essential services. For instance, in **Mongolia**, where this resulted in essential HIV/sexually transmitted infections (STIs) and tuberculosis (TB) services maintained during the COVID-19 pandemic at national and subnational levels, including support for virtual distant patient follow-up, home delivery of antiretroviral and opportunistic infection treatments, hotline and online counselling and provision of personnel protective equipment (PPE). The aim was to ensure the infection prevention and control (IPC) measures were in place while these services were being delivered.

In the **Eastern Mediterranean Region**, resources were being redirected away from essential services in **Pakistan** as rising cases of COVID-19 overstretch the country's health system. The Government made strategic decisions to strengthen PHC so that its limited resources could provide maximum health benefits to its people. WHO and partners prepared an action plan to support the Government in its choice to maintain essential health services – a significant pillar in Pakistan's preparedness and response plan for COVID-19.[20]

In the **South-East Asia Region**, the UHC-P continued to provide technical support to **India** in adapting and monitoring comprehensive PHC and implementation of Health and Wellness Centres, with particular attention to integration of services and continuum of care. For example, support to health systems strengthening in two states, Assam and Chhattisgarh, contributed to comprehensive PHC and led the COVID-19 response in these interventional sites while ensuring essential service delivery during the pandemic. With the direct technical support from WHO in three aspirational districts of Chhattisgarh, 113 out of 158 Health and Wellness Centres were made functional by the end of 2020. The mentorship provided by WHO enabled an increasing number of medical officers and front-line workers to expand the range of essential services delivered. This model of health systems strengthening support is being expanded to other states.

In the **African Region**, the UHC-P supported the rapid assessment of essential sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) services during the COVID-19 pandemic (see Box 5). Results showed that, on average, 50% of all SRMNCAH services were partially disrupted, with routine immunization being the most disrupted of essential SRMNCAH services.

Notwithstanding the challenges posed by COVID-19, strengthening health systems to improve the quality of care (QoC) for essential SRMNCAH services is a priority within the Region. To advance QoC, in 2017, WHO, partners and the governments of nine (up from originally seven) Member States (seven from the **African Region** and two from the **South-East Asia Region**) created a partnership to accelerate the reduction of preventable maternal and newborn illnesses and deaths, and to improve every mother's experience of care. This Network for Improving Quality of Care for Maternal, Newborn and Child Health (QoC Network) is now operational in nine African countries (**Côte d'Ivoire**, **Ethiopia**, **Ghana**, **Kenya**, **Malawi**, **Nigeria**, **Sierra Leone**, **Uganda**, **United Republic of Tanzania**), with additional alignment from other countries not

19 COVID-19 mortality overview. In: National Center for Health Statistics [website]. Atlanta: United States Centers for Disease Control and Prevention (https://www.cdc.gov/nchs/covid19/mortality-overview.htm, accessed 6 September 2021).

20 More details (with quotes and images) may be accessed here: https://www.uhcpartnership.net/story-pakistan/

directly in the Network (**Mozambique**, **Namibia**, **Rwanda**). Since 2017, Network countries have developed national QoC strategies. Originally with a focus on improving maternal and newborn QoC, this focus is now being expanded to improve the QoC for children and young adolescents, and small and sick newborns. These countries continue to be supported to implement quality improvement processes and mechanisms, and in fostering learning that is now being replicated in other Member States. A regional paper was introduced and endorsed at the 70th Regional Committee meeting, entitled "Quality, Equity and Dignity in health services delivery in the African Region: Bridging the quality gap to accelerate progress towards meeting the maternal, newborn and child sustainable development goals targets".[21]

To ensure improved access to and availability of SRMNCAH services, four laws were reviewed and updated: Penal code amendment in **Botswana**; Domestic Violence Bill in **Lesotho**; Evidence and the Indictment Acts to strengthen gender-based violence (GBV) outcomes in **Uganda**; and the Termination of Pregnancy Act in **Zimbabwe**. Six countries (**Chad**, **Côte d'Ivoire**, **Ghana**, **Mauritania**, **South Africa**, **United Republic of Tanzania**) reviewed or developed SRMNCAH policies/strategic plans to inform programme implementation in the next five years. Furthermore, the capacity of more than 10,000 health-care workers and programme managers was built to enable safe provision of quality SRMNCAH services within the pandemic context and continues through webinars.[22]

Various strategies and innovative measures have been implemented at different levels of the health system (health facility and community levels) to counter the disruption of services due to COVID-19 in the six countries. These measures are centred on strategies to optimize service delivery settings and platforms which are intended to reduce congestion at health facilities through self-care practices, dispensing medicines for longer duration, less frequent appointments, task sharing, establishing effective patient flow at all levels to help reduce the need or frequency of visits to health facilities, interventions to build capacity, motivate and retain health workforce, and maintain availability of essential medicines and supplies, as well as improved communication to increase demand for care and alleviate fear and misinformation.

The COVID-19 pandemic provided a unique opportunity to highlight the importance of monitoring and use of data for decision-making. However, challenges related to reluctance in data sharing, data quality, ability to disaggregate and visualize data by equity stratifications, lack of integration of community health data into health management information systems (HMIS) and triangulation of HMIS data with other sources exist as common challenges across countries.

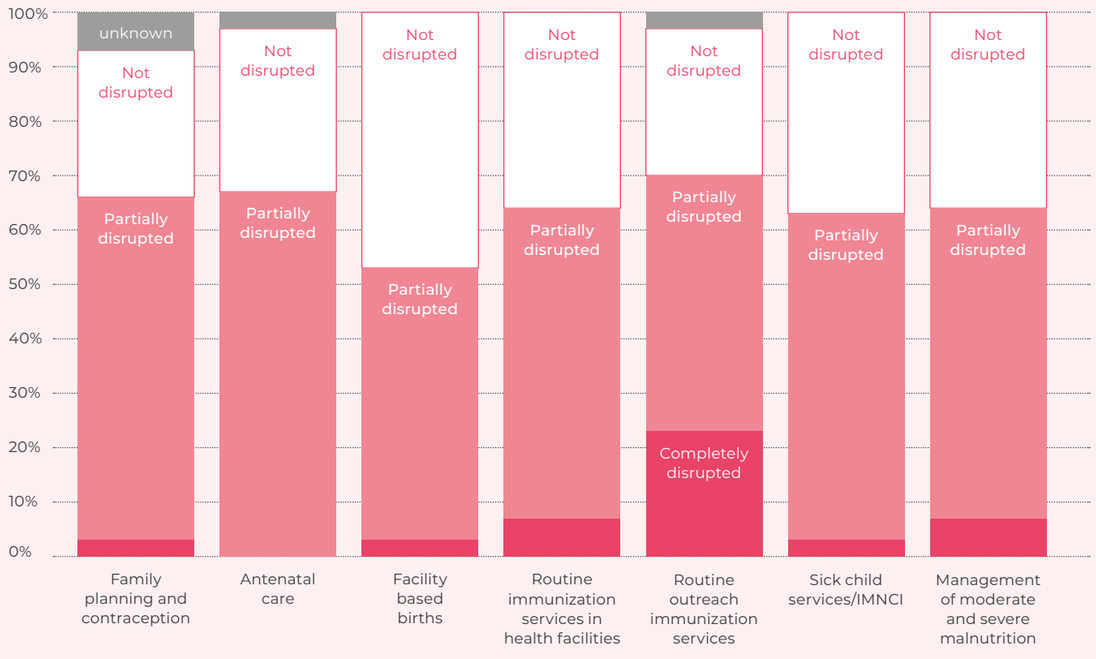
Bernice Ofori-Samuels speaks to a staff member during a postnatal visit at the Ridge Hospital, Ghana. ©WHO/AFRO

21 Regional Committee for Africa. Quality, equity and dignity in health services delivery in the WHO African Region: bridging the quality gap to accelerate progress towards meeting the SDG targets for maternal, new-born and child health: report of the Secretariat. Brazzaville: World Health Organization Regional Office for Africa; 2020 (https://apps.who.int/iris/handle/10665/333738, accessed 6 September 2021).

22 Joint regional webinar series on continuity of maternal and newborn services. 20 July 2020. In: Healthy Newborn Network [website] (https://www.healthynewbornnetwork.org/blog/joint-regional-webinar-series-on-continuity-of-maternal-and-newborn-services/, accessed 6 September 2021).

Box 5: Continuity of essential SRMNCAH services during the COVID-19 pandemic in the African Region

SRMNCAH services disrupted due to COVID-19 in the WHO African Region (WHO Pulse survey, August 2020)



Assessments of the disruption of essential health services were supported in most countries (see Figs. 11 and 12), and a framework for assessing the continuity of essential services supported in **Burkina Faso**, **Eritrea**, **Eswatini**, **Ghana**, **Kenya**, **Lesotho**, **Mali**, **Nigeria**, **United Republic of Tanzania**, **Zambia** and **Zimbabwe**. As part of ongoing technical support in maintaining essential health services during the COVID-19 pandemic, the UHC-P, in partnership with other United Nations agencies, conducted a specific monitoring of continuity of SRMNCAH services for the periods of February–April, May–July, August–December in 2019 and 2020, using data from routine national HMIS. The consequential disruption of services in the already overstretched health systems, and deviation of resources from essential SRMNCAH services have increased the vulnerability of women and children. Pregnant women are particularly vulnerable in this context associated with disruptions in antenatal care, delivery and postnatal services.

The results informed subsequent resource mobilization efforts and identified successes and challenges in ensuring continuity of SRMNCAH services. Moreover, the assessments identified the different measures being taken by countries to modify the planning and delivery of essential health services to ensure continuity, such as:

- Adapting/developing national guidelines, protocols and tools for continuity of SRMNCAH services within the COVID-19 context
- Reorganizing services delivery approaches in line with the COVID-19 context
- Human resources–related measures such as task sharing for community health workers
- Promoting self-care interventions for sexual and reproductive health and rights
- Improving stock management
- Rigorous monitoring of SRMNCAH service provision
- Community mobilization and awareness creation
- Use of digital technologies and programmatic modifications to ensure the continuity of essential health services.

The UHC-P provided additional support to six countries to ensure governance structures were in place to monitor SRMNCAH services; develop policies and actions to maintain the delivery of these services; mitigate reductions in service provision and utilization; and document key policies/strategies, achievements, challenges, lessons learned and next steps to mitigate the indirect effect of COVID-19 on the continuity of essential SRMNCAH services and share their experiences across countries and regions. These experiences and lessons learned will inform planning for future health emergency preparedness and response.

Fig. 11. Innovation and alternative approaches, results of the assessments of the disruption of essential health services

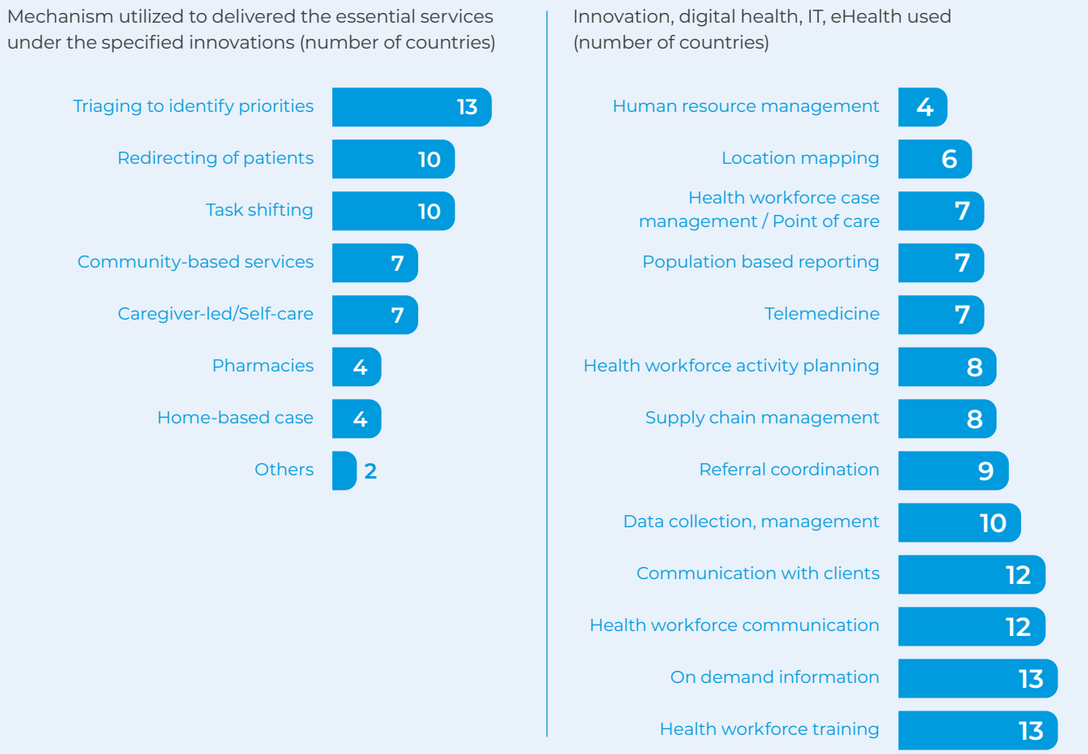
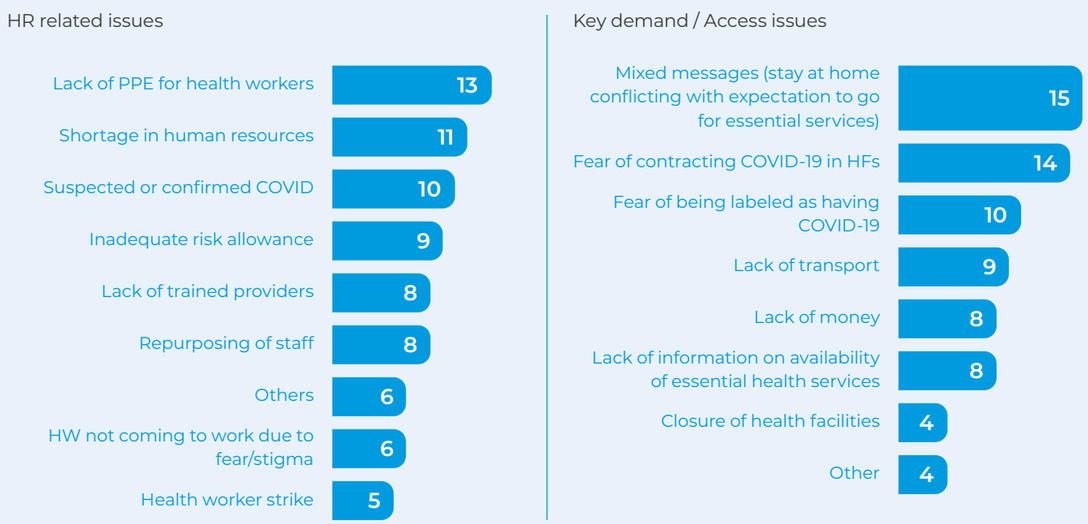


Fig. 12. Main reasons for disruption of SMRNCAH services, results of the assessments of the disruption of essential health services



Box 6: Engagement and collaboration on COVID-19 and PHC at the policy level in the European Region

Since the onset of the COVID-19 pandemic, the WHO Division of Country Health Policies and Systems (CPS) has established a team to provide guidance to Member States on health systems strengthening as part of the pandemic response. The team, embedded in the coordination structure of the WHO European Regional Office Emergency Incident Management Team, provided support to Member States for rapidly reorganizing service delivery to respond to COVID-19 while maintaining core essential services across the continuum of care. This multidisciplinary health systems team included members from several programmes of CPS, such as public health, service delivery, and human resources for health, and included the members of the Regional Office´s UHC-P JWT.

The team, which met on a weekly basis, developed during the first months of the pandemic several lines of products based on **country demands and needs** that were put together in a response mode. The products included a **policy brief**[23] which summarized 16 actions to strengthen the health system response to COVID -19; **technical guidance**[24] on burning issues such as maintaining the delivery of essential health services, creating surge capacity for acute and intensive care, and preventing and managing COVID-19 in long-term care facilities; and **surge planning tools**[25] to support Member States in visualizing acute and intensive care capacity and needs and engage in detailed planning of human resources according to a set of public health and epidemiological variables. The team participated in the establishment, together with the European Observatory, of a **Health System Response Monitor**[26] to collect and organize up-to-date information on how countries are responding to the crisis.

Furthermore, the development of a new regional PHC strategy has provided further impetus for putting PHC at the core of the UHC agenda in the European Region. In addition, the Regional Office has launched a virtual dialogue platform on PHC called “Let´s Talk Primary Health Care”, to engage with countries´ PHC task forces in regular cross-country dialogues and experience sharing.

The UHC-P enabled recruitment of health systems international policy advisors in six countries, which was instrumental in maximizing the catalytic role of UHC-P funding by bringing together relevant stakeholders at country level and ensuring, at the same time, coordination with the WHO Regional Office for Europe. The UHC-P JWT organized biweekly meetings with the policy advisors to ensure their integration, allow exchange of experiences among them, and provide a vehicle for programmes to channel their content and activities to country level, with PHC at its core. This was particularly relevant in the context of the pandemic, which required a rapid shift in short-term priorities while keeping long-term, far-reaching transformation on the agenda.

Box 7: Maintaining essential NCD services during the pandemic in the Western Pacific Region

To ensure the maintenance of essential NCD services during the COVID-19 pandemic, UHC-P staff in the **Western Pacific Region** provided Pacific island countries and areas with guidance documents and webinar sessions emphasizing digital health and telemedicine. The UHC-P support also included conducting clinical audits to assess compliance by health-care workers with screening and treatment guidelines in **Kiribati** and **Fiji** to refine planning. Technical assistance was provided in the roll-out of the WHO Package of Essential Noncommunicable Disease Interventions (PEN) in Fa’a Samoa (the Samoan Way), and six additional villages in Upolu and Savaii have now adopted PEN into their NCD management protocol.

23 Strengthening the health system response to COVID-19: policy brief. Copenhagen: WHO Regional Office for Europe; 2020 (https://apps.who.int/iris/bitstream/handle/10665/333072/WHO-EURO-2020-806-40541-54465-eng.pdf, accessed 6 September 2021).

24 Technical guidance and check lists. In: World Health Organization Regional Office for Europe [website] (https://www.euro.who.int/en/health-topics/Health-systems/pages/strengthening-the-health-system-response-to-covid-19/technical-guidance-and-check-lists, accessed 6 September 2021).

25 Surge planning tools. In: World Health Organization Regional Office for Europe [website] (https://www.euro.who.int/en/health-topics/Health-systems/pages/strengthening-the-health-system-response-to-covid-19/surge-planning-tools, accessed 6 September 2021).

26 COVID-19 Health System Response Monitor (HSRM). In: European Observatory on Health Systems and Policies [website] (https://eurohealthobservatory.who.int/monitors/hsrm/, accessed 6 September 2021).

PHC-oriented services for specific diseases and conditions across the life course

The PHC approach is based on integrated, people-centred health services, which means putting people and communities – not diseases – at the centre of health systems, and empowering people to take charge of their own health rather than being passive recipients of services. However, specific diseases and conditions still need to be addressed through a continuum of health services and not vertical approaches that could hinder the ability of health systems to focus on community health and well-being for all.

Maternal and child mortality

With regards to maternal and child mortality, the UHC-P advisors in the **South-East Asia Region** contributed to the development of national maternal and perinatal death surveillance and response guidelines to prevent future deaths and contribute to the reduction of maternal and newborn deaths. In **Indonesia**, with a set of minimal service standards for PHC already established, the UHC-P support focused on monitoring and evaluating the implementation of each sub-programme at the PHC level and developing a PHC-readiness index, as well as improving PHC's ability to provide better care for antenatal care, delivery, postpartum care, and newborn and child health. Furthermore, the UHC-P initiated adaptation of the latest global recommendations of the Integrated Management of Childhood Illness and Nurturing Care Framework, as well as child growth and development guidelines, into the national policy framework.

In **India**, the UHC-P supported the National Health Systems Resource Centre in revising the national emergency obstetric care training package and operational guidelines, and providing technical inputs to two chapters in the caesarean section guidelines under development. Also, strong coordination has been provided with partner agencies and the Government for communication and joint planning of improved maternal and child nutrition. In **Sri Lanka**, to upgrade maternal mental health interventions and inform COVID-19 control measures, an in-depth analysis of maternal suicides within a cohort of COVID-19 patients was completed.

Cardiovascular diseases

In terms of cardiovascular diseases, the UHC-P also supported implementation of the HEARTS technical package in the **Region of the Americas**, an initiative that seeks to promote the adoption of global best practices in the prevention and control of cardiovascular diseases (CVD) and improve the performance of services through better control of high blood pressure and the promotion of secondary prevention with emphasis on PHC. The HEARTS technical package for CVD management provides standards of clinical practice that guide CVD interventions for hypertension and CVD secondary prevention (including diabetes). This package is being implemented in four countries: **Cuba**, **Dominican Republic**, **Saint Luci**a and **Trinidad and Tobago**. Results show that there has been an overall increase in the number of primary health centres implementing the HEARTS initiative. For example, in the Caribbean countries, the total number of primary health centres implementing HEARTS increased from 2% to 30%, with projections expecting that ultimately 12% to 100% of primary health centres will implement the HEARTS initiative. **Cuba** went from one to 20 polyclinics (12% of total PHC centres), **Dominican Republic** has stayed at 26 implementing PHCs but is expected to increase to 150 centres (11% of total PHC centres), **Trinidad and Tobago** went from five to 35 (30% of total PHC centres) and **Saint Lucia** has implemented it in six wellness centres out of a total of 32, with an implementation plan in development to expand to the entire country. A higher proportion of health facilities report access to essential medications and 12 countries are demonstrating that hypertension control can be improved. For example, in **Trinidad and Tobago**, the initiative expanded from five to 35 implementing sites and a population coverage from 150 000 to over 500 000 people, and with an increase of over 20% at most sites, with one site that moved from a control rate of 16% to 40%.

Ageing

In **Barbados**, the UHC-P supported revision and updates to the National Policy on Ageing, as well as the development of a National Strategic Plan with a Monitoring and Evaluation Framework that has a specific focus on the integrated delivery of health-care services to the elderly and an assessment of the Elderly Services. In the **African Region**, eight countries (**Botswana**, **Burundi**, **Cameroon**, Eritrea, **Gabon**, **Mozambique**, **Rwanda**, Togo) developed healthy ageing strategic plans, resulting in 54% of African Region countries that have by now developed a national policy/strategy on healthy ageing.

Disability

Moreover, the UHC-P supported the rights of persons with disabilities (PWDs) and palliative and rehabilitation service delivery in **Sri Lanka**, advocating to improve the quality of life of PWDs by finalizing the Assistive Product Devices List. The UHC-P also supported the streamlining of rehabilitative services by initiating the development of the National Strategic Plan for Rehabilitation, and improving the quality of palliative care through capacity-building of the health-care workers.

Expanded Programme on Immunization

And finally, in a unique example of country-driven cooperation, the Expanded Programme on Immunization (EPI) programme management capacity and programme ownership were strengthened through implementation of the **Sri Lanka/Timor-Leste** EPI Programme Management twinning partnership, which aims to strengthen immunization systems and knowledge sharing between the two countries.

Leadership and governance

GPW13 output 1.1.4

Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability. Since its creation, the UHC-P has supported policy dialogue as an efficient way to create trust between three categories of stakeholder: the state, health service providers and citizens. This well-documented approach can ensure convergence between these actors and allow the development of evidence-based and inclusive policy.

Informing, reviewing and adopting national health policies

In 2020 in the **Eastern Mediterranean Region**, the UHC-P supported the use of a regional diagnostic and mapping tool regionally and in selected countries (**Afghanistan**, **Egypt**, **Iraq**, **Islamic Republic of Iran**, **Jordan**, **Oman**, **Pakistan** and **Tunisia**) to generate evidence on health systems governance bottlenecks and gaps, and to recommend areas for improvement considering countries' health systems transformation plans. The diagnostic tool reviewed the health systems governance arrangements and institutional set-ups, health policies and plans development processes, as well as relevant national regulatory/legislative measures.

In the **African Region** (see Box 8), the UHC-P was successful in helping countries revise their national health policies towards the attainment of UHC. **Niger** developed a UHC strategic plan that includes heath financing. The **Democratic Republic of the Congo** developed UHC roadmaps for provincial and national levels. Other countries benefited from the UHC-P support to update their legislative frameworks. The Health Code was validated in **Gabon**, whilst the Public Health Bill was drafted in **Lesotho**. In **Kenya** the Food, Drug, Devices and Chemical Substances Bill 2020 was revised, the UHC Health Bill was drafted and the Blood Transfusion bills were finalized.

Mid-term reviews of strategic plans were also supported in **Burkina Faso**, **Eritrea**, **Kenya** and **Liberia**, while annual sector reviews took place in **Burundi**, **Democratic Republic of the Congo**, **Nigeria**, **Togo** and **Uganda**, with UHC-P support. In this context, **Burkina Faso** conducted a Joint Assessment of National Strategies and Harmonized Health Facility Assessment to inform the mid-term review and improve data quality for its COVID-19 response. A Joint Assessment of National Strategies was also elaborated in **Ethiopia** to improve the quality of the draft Sector Transformation Plan II.

In addition, **Burundi**, **Chad** and **Kenya** completed their annual operational plans with the assistance of the UHC-P. Other countries were supported to update programme-level policies. These included: national drug policy and the strategic plans for health promotion, health research, and reproductive health in **Cabo Verde**; assisted reproductive health in **Ghana**; pharmaceutical and laboratory policies in **Niger**; human resources for health in **Nigeria**; and the Community Health Strategic Plan in **Senegal**. All these plans have been built on a consensus between health stakeholders for evidence-based interventions. Furthermore, **Angola**, **Kenya**, **Lesotho**, **Mozambique**, **Sierra Leone**, **United Republic of Tanzania** and **Zambia** were supported to undertake policy analysis to inform their respective national SDG reports.

Mobilizing policy-makers and strengthening policy dialogue for UHC

In 2020, advocacy and engagement with multiple actors remained an important component of UHC-P's work in the **South-East Asia Region**. Against the backdrop of the COVID-19 pandemic that has impacted nations across the world, disrupting lives, economies and societies, International UHC Day 2020 (12 December 2020) advocated for the need to create resilient health systems to end this crisis and build a safer, healthier future for all. In **India**, International UHC Day 2020 was celebrated online with representatives of all 36 states and union territories (see Box 9)..

In **Indonesia**, the UHC-P supported effective health governance through a collaborative model to facilitate the provision of better care at the PHC level. The multisectoral engagement aimed to enhance a more effective partnership between the public and private sectors in providing accessible and equity-based health services, leaving no one behind. One major area of technical support was capacity-building for evidence-based decision-making to the subnational level in a decentralized health system. This project under the UHC-P developed a health data dashboard showing the district-/city-level status of key health indicators, as well as provided evidence-based guidance to subnational health managers through key policy documents and guidelines.

In the **Eastern Mediterranean Region**, technical support was provided to the high-level strategic oversight committee and technical working groups for enhancing coverage of essential health services with a focus on equity in **Afghanistan**; improving governance through institutional transformation planned under the Universal Health Insurance Law in **Egypt**; and health systems governance in the context of decentralization and public–private partnerships in health in **Jordan**. In **Somalia**, following the development of the UHC roadmap in 2019 and strategic recommendations made by the high-level mission, a dialogue on the role of PHC for UHC was initiated. In **Lebanon**, the UHC-P was represented by an expert in health systems governance to support health policy development and operationalization of the Health Policy Observatory when it was established.

Box 8: Story from the field - Sudan

Community dialogues empower disadvantaged populations to decide on their health priorities in Sudan

In the war-torn Darfur region of Sudan, communities are taking an active role in rebuilding their health services and advancing UHC.[27] Through regular community dialogues, they are empowered to identify, prioritize and propose solutions for their health needs, to hold local health authorities accountable, and to act as an early warning system in times of crisis such as the COVID-19 pandemic.

FACT: Many communities in Darfur are, for the first time, sitting down with local health authorities and partners in a series of community health dialogues to discuss priorities and find solutions to the problems the health system faces.

WHY IT MATTERS: Community engagement is a crucial part of ensuring equity and health for all. Many people and communities in Sudan are vulnerable, particularly as many local health facilities were destroyed or damaged during the war.

EXPECTED RESULTS: Communities are setting their own health priorities and are finding solutions to their local problems as they work closely with local health authorities, including re-instigating health committees and supporting local health workers.

UHC-P IN PRACTICE: WHO, through the UHC-P, is working hand in hand with the Ministry of Health, local health authorities and other partners to institutionalize community engagement in the PHC-based health system, crucial in moving towards UHC and peace.

©Community health dialogue session. August 2019. ©WHO/North Darfur Sub-office

27 More details (with quotes and images) may be accessed here: https://www.uhcpartnership.net/story-sudan/.

Box 9: India's communications and advocacy campaign for International UHC Day 2020

In the face of the pandemic, the UHC Day campaign had to evolve to keep in mind restrictions due to COVID-19 mitigation efforts. The event on UHC Day (12 December 2020) was a low-key affair, with a limited number of officials attending the event physically. The event recorded a high representation of state government officials and key stakeholders across the country who attended the event virtually. For this year's campaign, there was a substantial shift towards greater digital engagement through webinars, virtual meetings, and digital and web campaigns.

Campaign highlights and takeaways include:

- Launch of the SDG Dashboard.
- Widespread incorporation of COVID-19-specific messaging and tools, including the production of thousands of Health for All face masks and development of an emoji pack to reach out to a wide audience through digital platforms.
- High-level UHC Day champions (Health Minister, Ministry of Health and Welfare officials, Dr David Nabarro) engaged in the campaign.
- Impact stories on health workers and work done by WHO in partnership with the state government in strengthening PHC featured on the WCO website and amplified through social media networks.
- Advocacy products developed for visibility and reinforcement of key messages.

A number of high-impact promotional features highlighted the key theme – Health for All, Protect Everyone – and established the brand identity of the campaign. These included:

- **Masks** – Masks with messages to reinforce the importance of "health for all, protect everyone" were procured and distributed to front-line workers in the field and the key partners and dignitaries who showed solidarity and their commitment towards UHC by wearing the masks during commemoration of UHC Day 2020.
- **Standees** – A standee cut-out in the shape of a UHC emoji and another with a Hindi message was placed at strategic locations at national health authority offices for high visibility. The QR code to download the emoji pack was printed on the standee.
- **Screen savers, Zoom backdrop, email signature** – These were created using the emoji and theme to reinforce key messages, establish brand identity and create a buzz.
- **Emoji pack** – It was a first for WHO India to have forayed into a completely new method of reaching out to its audience by developing a series of emojis[28] to tap into the ever-increasing popularity of emoji stickers being used widely on social networking sites. These emojis spread the message of "Health for all, Protect Everyone" far and wide.

This initiative generated much traction with and attention from all stakeholders. The emoji pack was shared widely with key partners and field officials through WhatsApp and the website. People were encouraged to use the emojis as a display profile picture in their social media profiles, garnering great visibility. This kind of visibility is very effective in establishing the brand identity, reinforcing messages and delivering high impact. The emoji pack was also shared with the WHO South-East Asia Regional Office and WHO headquarters, and was appreciated for its creativity.

UHC-P staff in India were also successful in mobilizing a Multi-Partner Trust Fund grant for building capacity of health-care workers in responding to the needs of victims of GBV.

Key lessons: Going forward, the dissemination of such creative assets can be done more strategically and weaved into a well-thought-out communications strategy from the health systems team that is reinforced throughout the year rather than only during the commemoration of health days. A more strategic collaboration with key partners can help in much wider outreach. This requires sustained advocacy efforts and highlighting the work through various communication products disseminated across platforms to reach out to the target audience.

28 Universal health coverage. In: World Health Organization Regional Office for South-east Asia [website] (https://www.who.int/india/universal-health-coverage-2020, accessed 6 September 2021).

DEEP DIVE

Health System Governance

From the beginning, health system governance has been at the core of the UHC-P. Through technical assistance, the UHC-P's objective is to promote UHC by fostering policy dialogue on strategic planning and health system governance, developing and supporting the implementation of health financing strategies, and enabling effective development cooperation in countries. But what does it mean at country level?

For WHO, the notion of health system governance was first introduced in 2000 under the term *stewardship*,[29] before being paired in 2007 with the term *leadership* and defined as "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability".[30] In order to translate this concept into practical actions to strengthen the governance of health systems, WHO has recently defined formal and informal governance roles.[31] This conceptual framework expresses the idea that governance includes a legal framework, supported by a strong stakeholders' coalition that is ensured by policy dialogue processes, to give a strategic direction to the health system with the necessary means to implement these policies and capacities to keep governments accountable. Accountability is supposed to be ensured through monitoring and evaluation policies, transparency mechanisms and citizens' participation in the policy-making process.

The first role – de jure governance processes – gathers actions concerning policy development, strategic direction and oversight.
For instance, in the **Region of the Americas**, the core of the regional agenda of health systems strengthening has been constituted since the 1980s by the development of the concept of essential public health functions referring to three core responsibilities of the Ministry of Health: assessment, policy development and assurance. The objective was to define these as fundamental state functions to ensure the stewardship role of health authorities. In 2020, with the support of the UHC-P, a new version[32] based on experiences and lessons learned has been developed to integrate a more holistic vision of public health and address the challenges of the 21st century. This offers an opportunity to help catalyse political commitment and support needed for ensuring UHC, global health security and greater health equity in the Americas.

In addition, the UHC-P continues to provide technical support to develop and implement a strategic policy framework. Technical support was provided in **Tajikistan** to develop its 2021–2030 National Health Strategy and update it in light of the pandemic; in **Republic of Moldova** to define its new National Health Sector Development Strategy 2030; in **Lesotho** to update its National Health Policy and Strategic Plan 2019–2023; and in **Somalia** to develop its National Essential Medicine Policy. In the **African Region**, seven countries were also supported to develop the following national health strategic plans that outline key priorities and strategies for the medium term: Lesotho – National Health Strategic Plan 2019–2023; **Mali** – Programme de Développement Socio-Sanitaire 2019–2023; **Niger** – UHC Strategy and Road Map; **Mauritius** – National Health Sector Strategic Plan 2020–2024; **Ethiopia** – Health Sector Transformation Plan II; **Zimbabwe** – National Health Strategy 2021–2025; and **South Africa** – implementation of the Presidential Health Compact.

The second role is related to preparation for and response to evolving contexts.
For instance, in the **Eastern Mediterranean Region**, with a specific COVID-19 lens, a regional diagnostic and mapping tool was used in several countries (**Afghanistan**, **Egypt**, **Iraq**, **Islamic Republic of Iran**, **Jordan**, **Oman**, **Pakistan** and **Tunisia**) to generate evidence on health system governance, arrangements and institutional set-ups; health policies; plan development processes; as well as bottlenecks and gaps. Results have been used to provide recommendations for improvement while considering countries' health systems transformation plans. Other examples include those in the **Western Pacific Region**, where the UHC-P provided support to Member States in integration policies to manage health emergencies. For instance, **Mongolia** was supported in the development of a law to prevent, fight and mitigate the socioeconomic impact of the COVID-19 pandemic. In the **African Region**, national coordination structures have been established for the COVID-19 pandemic response in order to improve prioritization and reduce duplication, while ensuring that assistance reaches the people who need it most in **Burkina Faso**, **Eswatini**, **Mali**, **Senegal**, **Seychelles** and **South Africa**.

The third role is defined as the management of relationships with all the diverse stakeholders linked to the health sector.
An important tool used by the UHC-P to strengthen this role of the ministry of health is policy dialogue, which can be understood as "a knowledge exchange and translation platform, a mode of governance or a negotiating instrument in international development".[33] Successful policy dialogues require "clear process, a shared understanding of the goals at all levels of the policy dialogue and a policy dialogue approach consistent with the objective".[34] The UHC-P supported many policy dialogues in 2020 to elaborate strategic policy frameworks: in **Republic of Moldova** on COVID-19 challenges and the health insurance system; in **Kyrgyzstan** to support the institutional capacity of the Mandatory Health Insurance Fund; in **Indonesia** on Global Fund requests for TB, HIV, malaria and health systems strengthening; in **Nepal** on human resources for health; in the **West Bank and Gaza Strip** on health financing reform; in the **Western Pacific Region** on physical distancing and COVID-19 treatment; and in the **Region of the Americas** in **Argentina**, **Colombia**, **Grenada**, **Jamaica**, **Panama**, **Paraguay** and **Trinidad and Tobago** on how to better reach domestic violence survivors in the context of the COVID-19 pandemic.

In **Ukraine**, the UHC-P contributed to the high-level policy dialogue on health financing through multiple actions: strengthening the capacity of the Ministry of Health and engaging with members of the National Parliament in health financing, leading regular sessions of the Health Transformation Forum, publication of the joint review of health financing reforms with the World Bank, development of a policy brief on health financing and decentralization reforms, and preparation of an analytical paper on budgetary space for health. **Morocco** was also supported to conduct a policy dialogue to develop a health financing strategy. Once again, the policy dialogue approach has demonstrated how it can support convergence among health stakeholders, allowing more participation and inclusion. This experience has been documented and a publication is available for deeper understanding.[35]

29 Pyone T, Smith H, van den Broek N. Frameworks to assess health systems governance: a systematic review. Health Policy Plan. 2017;32(5):710–22. doi:10.1093/heapol/czx007.

30 Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007.

31 Sriram V, Sheikh K, Soucat A, Bigdeli M. Health Systems Governance Collaborative. Addressing governance challenges and capacities in ministries of health. Geneva: World Health Organization; 2020.

32 The essential public health functions in the Americas: a renewal for the 21st century – conceptual framework and description. Washington, D.C.: Pan American Health Organization; 2020.

33 Robert et al., 2020.

34 Ibid.

35 Akhnif et al., 2020.

Finally, the fourth role is seen as the management of accountability, transparency, participatory and efficiency processes.
These values must be actively managed to ensure that strategic frameworks are based on citizens' needs and reach the most vulnerable. In **Haiti**, many actions have been implemented to strengthen this important role of the Ministry of Health. First, the National Policy for Social Protection and Promotion was adopted by Presidential order in June 2020 with the objective to reduce poverty, inequalities, and economic, social and institutional injustices. This policy aims to build a just social citizenship where the holders of rights to social protection and promotion see their rights realized and their ability to live the desired life improved. Then, in order to increase accessibility, equity and efficiency of health services for the communities, the Ministry of Health was supported to elaborate a national document on the organization of district health services. The selected approach is based on PHC and aligned with the Integrated Health Services Delivery Networks strategy. And finally, to increase engagement among communities in identifying issues and planning solutions for local health problems, the UHC-P collaborated with Médecins du Monde to organize various consultations with youth associations and local leaders. Another good example to illustrate how the UHC-P is strengthening the management of values took place in the **South-East Asia Region**. In collaboration with Management Sciences for Health and the University of Toronto, a policy analysis was conducted on the management of conflicts of interest through the Region to identify policy gaps and provide recommendations to improve transparency and governance in the pharmaceutical sector.

Furthermore, WHO has defined six fundamental hard capacities for ministries of health to ensure their ability to perform these roles:[36] structural capacity (governance architecture); role capacity (appropriate authority or responsibility to make decisions); personal capacity (human resources qualitative capacity); workload capacity (human resources quantitative capacity); performance capacity (tools, infrastructure, finances and equipment); and supervisory capacity (monitoring, evaluation and accountability mechanisms). Finally, soft capacities are also essential to ensure the different roles; these include the abilities to navigate complexity, learn collaboratively, engage politically, be self-reflective and build trust.

Also, as many authors recognized, there is still confusion around the concept of health system governance.[37] In the 2020 framework,[38] WHO proposed to operationalize the conceptual definition and enlarge the main focus of the global health community that had been, until now, essentially targeting health service providers and "the supply of services in relation to norms and standards". Adapted from the *World Development Report 2004*,[39] the framework articulates the relationships between and within three distinct kinds of stakeholders involved in health systems: people, policy-makers and providers. Furthermore, WHO recognized that some missing links[40] relative to formal relations of accountability, relations of power, the exercise of population voice and collective action have emerged in anterior efforts around health system governance.

This new direction on health governance is symbolically illustrated by the foreseen publication in 2021 of a second handbook for UHC on social participation.[41] This new handbook will elaborate on the chapter on population consultation in the first handbook in 2016 on strategizing national health in the 21st century.[42] As a manual from the World Bank stipulated, this kind of governance framework is based on the hypothesis than citizen engagement would reinforce the trust of citizens in their government.[43]

36 Sriram et al., 2020.

37 Barbazza E, Tello JE. A review of health governance: definitions, dimensions and tools to govern. Health Policy. 2014;116(1):1–11. doi:10.1016/j.healthpol.2014.01.007. Meessen B. Health system governance: welcoming the reboot. BMJ Glob Health. 2020;5(8):e002404. doi:10.1136/bmjgh-2020-002404.

38 Sriram et al., 2020.

39 World development report 2004: making services work for poor people. Washington, D.C.: World Bank; 2003.

40 Bigdeli M, Rouffy B, Lane BD, Schmets G, Soucat A, Bellagio Group. Health systems governance: the missing links. BMJ Glob Health. 2020;5(8):e002533. doi:10.1136/bmjgh-2020-002533.

41 Voice, agency, empowerment: handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021.

42 Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization; 2016.

43 Kumagai S, Iorio F. Building trust in government through citizen engagement. Washington D.C.: World Bank; 2020.

DEEP DIVE: Health System Governance

PAHO/WHO supported Suriname in advancing preparedness and response capacities. ©PAHO/WHO

Health workforce

GPW13 output 1.1.5

Health systems can only function with health workers; improving health service coverage and realizing the right to enjoyment of the highest attainable standard of health is dependent on their availability, accessibility, acceptability and quality (see Box 10). The health workforce also has a vital role in building the resilience of communities and health systems to respond to disasters caused by natural or man-made hazards, as well as related environmental, technological and biological hazards and risks. Highlighting the vital role that nurses and midwives play in providing health services at the front lines, 2020 was designated the International Year of the Nurse and the Midwife.

Evidence-based strategies for human resources for health

In the **African Region**, in the context of the African regional framework for the implementation of the global strategy on human resources for health (HRH) – Workforce 2030, the UHC-P supported 10 countries in strengthening HRH governance, conducting situation analyses, and developing policies, costed plans and investment cases for HRH. For instance, **Namibia and South Africa** developed and finalized their national HRH strategic plans, and the **United Republic of Tanzania** developed a draft national HRH strategic plan that will be finalized in 2021. Additionally, **Mali** established an HRH consultation framework and facilitated discussions and identification of the priorities of the HRH department of the Ministry of Health. The UHC-P supported **Mozambique** in building the capacity of human resource managers in the Ministry of Health to develop annual human resource reports and in conducting a mid-term review of the HRH Strategic Plan; supported **South Sudan** in a rapid HRH assessment; as well as **Benin** and **Chad** in conducting HRH investment efficiency studies. Furthermore, health workforce management and regulation were improved in **Eritrea**, **Ethiopia**, **Ghana** and **Sierra Leone**. **Ethiopia** developed a five-year National Motivation, Competent and Compassionate Strategy and its implementation guideline. **Eritrea** finalized and printed the National Registration and Licensing policy, and **Ghana** and **Sierra Leone** developed Schemes of Service for the health sector.

The National Health Workforce Accounts (NHWA) is a system by which countries progressively improve the availability, quality and use of data on health workforce through monitoring of a set of indicators to support achievement of UHC, SDGs and other health objectives[44]. As part of activities to commence the implementation of NHWA, **Kenya** and **Malawi** conducted an orientation of national multisectoral NHWA technical committees comprising ministries of health, and ministries of labour, finance, and education.

Ethiopia obtained government buy-in and commenced preparatory activities towards the conduct of NHWA. **Benin**, **Seychelles and Zambia** finalized their NHWA studies, which improved health workforce data availability for decision-making. For example, Seychelles reported its health workforce data through the NHWA platform for the first time, and used the data to inform a health labour market analysis. NHWA training began in **Mozambique** to integrate the process of NHWA with an existing and functional health workforce observatory. Five countries also conducted health labour market analyses (**Benin**, **Ethiopia**, **Lesotho**, **Mauritania** and **Seychelles**). In Lesotho, the outcome of the health labour market analysis informed a new 10-year HRH strategy and justified a 15% increase in health workforce budgetary increase to absorb 27% of trained but unemployed health professionals. In Ethiopia, the national health labour market analysis partly informed national policy in the Health Sector Transformation Plan II and the Minister of Health requested regional mini-analyses for tailored regional strategies, which is underway. In Seychelles, the results of the health labour market analysis are being used to inform a high-level policy dialogue as part of the health sector strategic planning process. **Benin** conducted an assessment of the staffing needs for health facilities, while the **Gambia** updated the staffing norms of its three service delivery levels.

In the **South-East Asia Region**, the UHC-P supported evidence generation in **India** through a competency assessment study of midwives and nursing educators to document the current status and develop a roadmap for strengthening these services, by developing the midwifery monitoring and evaluation framework. In **Timor-Leste**, after over two years of extensive consultations and partner discussions, the National HRH Strategy was endorsed and launched by the national health authorities in June 2020. In addition, the country is actively engaging as a part of the three-country Systems Thinking initiative (**Botswana**, **Pakistan** and **Timor-Leste**).

In the **Western Pacific Region**, countries in the Region were equipped with timely and practical HRH mapping, analysis and guidance to support timely and evidence-based health workforce policy-making. For example, **Lao People's Democratic Republic** enhanced implementation of a licensing and registration system for the health workforce which has been rolled out at the central and subnational levels, while also reviewing and updating their Health Personnel Development Strategy. This was also the case in the **Region of the America**s, where **Suriname** completed a situation analysis in collaboration with stakeholders and key officials in the Ministry of Health, which will be used to inform the development of a National Strategy for Nursing.

44 National Health Workforce Accounts (NHWA). https://www.who.int/hrh/statistics/nhwa/en/

Health workers in Thailand. ©WHO/P. Phutpheng

DEEP DIVE

Impact of COVID-19 on the Health and Care Workforce: A preliminary synthesis of case studies conducted in the WHO Regions of Africa and the Americas

Background

Health and care workers are at the forefront of the COVID-19 response and as such are highly exposed to infections and deaths, and to different risks such as fatigue, occupational burnout, stress, harassment, and physical and psychological violence. While the COVID-19 outbreak has highlighted existing health workforce challenges, it has also led to new measures to address immediate response needs, including new regulations and new ways of contracting health workers to address limited availability of health personnel. Identifying and understanding these mechanisms will inform decision-makers about strategies to address workforce challenges during emergency situations.

Data reported to WHO confirm a significant under-reporting and very partial coverage of the pandemic's impact on health workers, given that only infections and deaths are included.[45] To better understand the impact, 17 countries from the **African Region**[46] and eight countries from the **Region of the Americas**[47] collaborated with WHO on comprehensively monitoring the impact of COVID-19 on their health workforce, and documenting strategies adopted to address challenges, including in relation to workforce shortages. .

The UHC-P supported survey implementation in eight of the 25 countries. Through UHC-P funding to global goods, the UHC-P is supporting the work on NHWA and on the labour market analyses. These can contribute to the development of health workforce policies and investments for strengthening health systems to better respond to health outbreaks in the future.

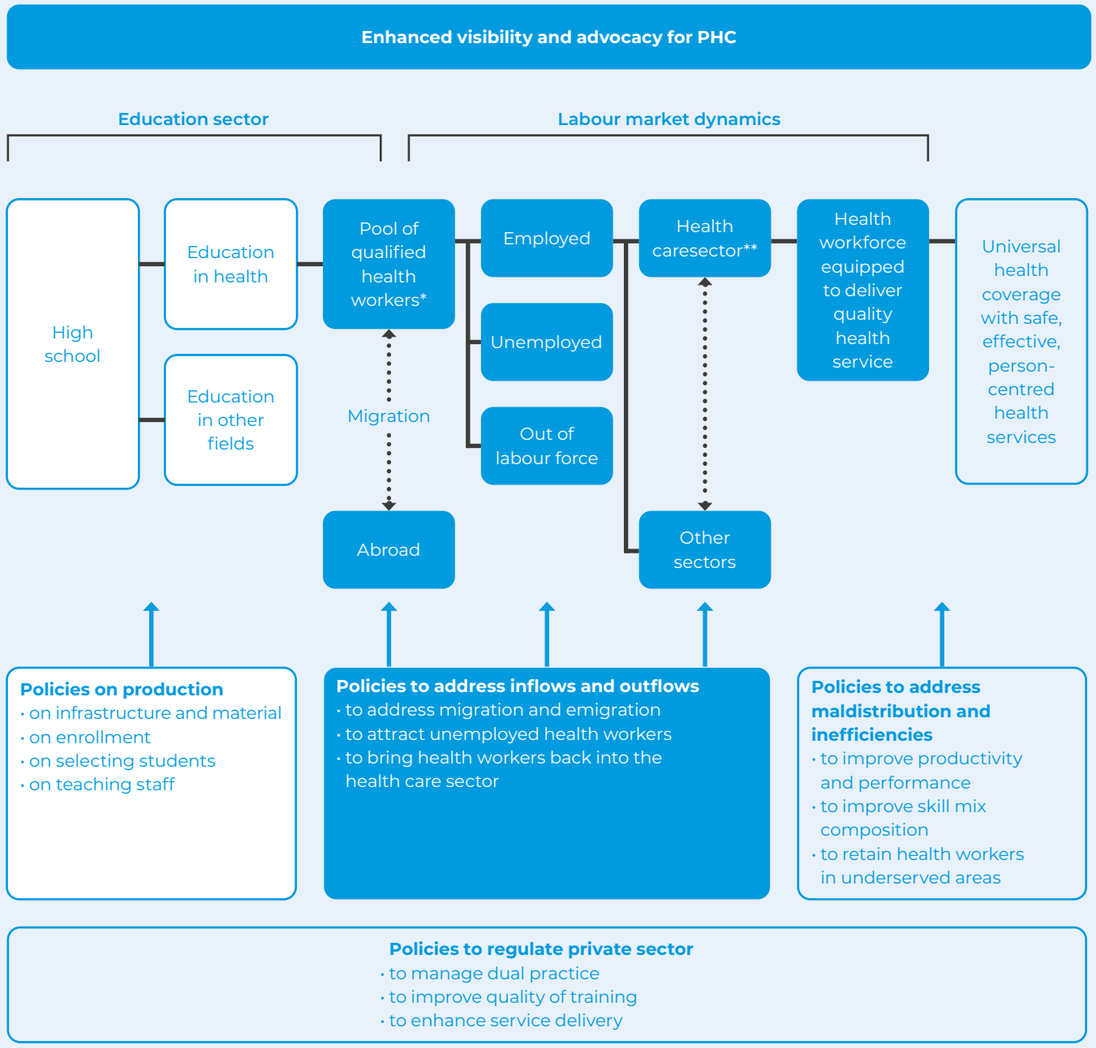
Methods and data sources

The key assessment themes selected for these case studies were based on: (i) an Interim Guidance, developed by WHO in 2020, titled *Health workforce policy and management in the context of the COVID-19 pandemic response;*[48] (ii) the standardized impact measurement framework;[49] and (iii) the Health Labour Market Framework (Fig. 13), which was used as an analysis framework to better understand the various policies and regulations that governments have introduced to manage their human resources for health in the context of their response efforts.

A mixed approach has been adopted consisting of a literature and desk review of existing documents; a review of HMIS and human resources information systems databases, facility surveys and secondary analysis of data. Data were compiled from multiple sources:

- National HMIS and surveillance databases for data on health worker infections and deaths.
- Health facilities survey in **African Region** countries for information on occupational health and safety measures and workload. A total of 126 health facilities were surveyed (77% public; 23% private), of which 35% were in charge of COVID-19 response. Note that this was done only for **African Region** countries.
- Desk review of policies adopted during the pandemic, including reports and grey literature, obtained from ministries of health and service delivery agencies.
- Literature search on regional economic policies impacting countries' decisions.

Fig. 13. Health Labour Market Framework



Source: Global strategy on human resources for health[50]

* Supply of health workers= pool of qualified health workers willing to work in the health-care sector.

** Demand of health workers= public and private institutions that constitute the health-care sector.

45 Weekly epidemiological update on COVID-19 – 30 March 2021. In: World Health Organization [website] (https://www.who.int/publications/m/item/weekly-epidemiological-update-on-covid-19---31-march-2021, accessed 6 September 2021).

46 Angola, Benin, Burkina Faso, Chad, Cote d'Ivoire, Eswatini, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, South Sudan and Togo.

47 Belize, Bolivia (Plurinational State of), Chile, Colombia, Ecuador, Grenada, Jamaica and Peru.

48 Health workforce policy and management in the context of the COVID-19 pandemic response: interim guidance. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/WHO-2019-nCoV-health_workforce-2020.1, accessed 6 September 2021).

49 Weekly epidemiological update on COVID-19 – 30 March 2021.

50 Global strategy on human resources for health: Workforce 2030. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf, accessed 6 September 2021).

Overall data availability and quality

There are some limitations with the results due to data availability and the data sources, which at times varied from one country to another. Due to time and budget constraints, a non-random quote sampling survey has been applied for the primary data collection in facilities in selected **African Region** countries.

Preliminary findings: Impact of COVID-19 on the health workforce

Infections

According to reported data as of 23 May 2021, the cumulative number of health worker infections reported in the **African Region** has reached 112,206 (3.3% of all cases).[51] The data also show significant variations in health worker infections for the **African Region** countries which are part of the study, ranging between 0.1% and 11.28%.

Infections among health workers were more prevalent among nurses, midwives and medical doctors. For example, infections among nurses account for four out of 10 health worker infections. This figure varies from 15% to 59% across the **African Region** countries.

In five of the countries in the **Region of the Americas** (Chile, Colombia, Ecuador, Peru and the Plurinational State of Bolivia), health worker infections represent 3.9% of total infections with a range between 1.6% and 7.5%.[52] In both regions, women were more infected than men because women constitute a larger proportion of the health workforce.

Working conditions – increase in workload

All 25 countries in this study were facing health workforce shortages combined with inequitable distribution before the pandemic. In the **African Region** countries the average health workforce density is less than 1.0 per 1000 population,[53] which is below the density of 4.45 doctors, nurses and midwives per 1000 population to reach the SDGs. For countries in the **Region of the Americas**, the density of medical doctors is between 1.3 and 2.6 per 1000 population, while that of nurses is between 1.3 and 2.6 per 1000 population.[54]

COVID-19 has exacerbated these shortages. The second round of the national pulse survey reported that 66% (of 112 services) of service disruptions were due to insufficient staff availability.[55] The results of this study show that health workers were redeployed or reassigned to the COVID-19 response; absences were also due to infections or because they were identified as contact cases. About 30% of the health facilities sampled in the **African Region** reported an increase in the workload for existing health workers. In addition, 14% of all health facilities reported a temporary closure of certain health services due in part to insufficient staff – for example, reproductive health services, maternal and child health services, or adolescent health services.

51 Weekly bulletin on outbreaks and other emergencies. Week 21: 17–23 May 2021. Brazzaville: WHO Regional Office for African (https://apps.who.int/iris/bitstream/handle/10665/341457/OEW21-1723052021.pdf, accessed 6 September 2021).

52 "Impact of COVID-19 on HRH and policy response in Bolivia, Colombia, Chile, Ecuador and Peru". Washington, D.C.: Pan American Health Organization; forthcoming in 2021.

53 Data compiled from national health statistics yearbooks for all 25 countries for 2017, 2018 and 2019.

54 Organisation for Economic Co-operation and Development, World Bank Group. Health at a glance: Latin America and the Caribbean 2020. Paris: OECD; 2020 (https://doi.org/10.1787/740f9640-es, accessed 6 September 2021).

55 Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic: January – March 2021 – interim report, 22 April 2021. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/bitstream/handle/10665/340937/WHO-2019-nCoV-EHS-continuity-survey-2021.1-eng.pdf, accessed 6 September 2021).

DEEP DIVE: Impact of COVID-19 on the Health and Care Workforce: A preliminary synthesis of case studies conducted in the WHO Regions of Africa and the Americas

Preliminary findings: Policy measures

Countries have taken various measures for surge capacity planning and for protecting their health workers and improving health workers' availability:

Surge capacity planning

It appears that most of the **African Region** countries did not have a tool for estimating the health workforce needs for an effective response to the COVID-19 pandemic. Preparedness and response plans most often provided for capacity-building for health personnel already in place, through continuous training. Retrospective estimates showed that countries underestimated their health workforce needs.

Some of the countries in the **Region of the Americas** used surge planning tools to support a more effective response. This requires timely information on the health workforce by occupational profile and distribution across a country. The information was useful for planning workforce needs by phase of implementation strategy for crisis response and occupational categories, as well as for the different levels of health facility.

Preliminary findings: Measures to protect health workers:

Occupational health and safety

During the first months of the pandemic in the **African Region** (April – June 2020), PPE was not regularly available in health facilities. The average duration of PPE stockouts reached 30 days in most of the studied countries. This situation improved during the first quarter of 2021 (February – May 2021) with increased availability of PPE, improved IPC measures, and additional guidance made available by WHO that led to reducing rates of infections.

Countries in the **Region of the Americas** also faced shortages of PPE during the first months of the pandemic. In addition, many countries introduced legislation (for example, decrees on budget distribution and flexibility to allow direct purchase of PPE) and guidelines (rational use of PPE) to ensure adequate resources to provide availability and access to PPE.

A few countries from the **African Region** have adopted specific incentives to improve working conditions, such as life insurance policy for the health workers in charge of responding to COVID-19. Health insurance has been provided to all health workers involved in the response (in both public or private hospitals).

Some of the countries in the **Region of the Americas** introduced temporary incentives (one-time or regular incentive) to health workers working with confirmed or suspected COVID-19 patients during the emergency, while others increased wages.

Preliminary findings: Measures to maintain or increase health workers' availability

Recruitment processes

For rapid response to needs, most of the countries in both the **African Region** and **Region of the Americas recruited volunteers, retirees** and students instead of filling vacant health posts. The recruitment process was improved by reducing the recruitment period to one month. In the **African Region**, 12 685 health workers were recruited on a temporary basis and 3332 were for long-term recruitment. In the **Region of the Americas**, 73 098 health workers were hired in the five South American countries while the Caribbean relied heavily on the use of volunteers. Additionally, some countries hired students in their last year of studies, facilitated processes to hire foreign health workers, and mobilized retirees.

Deployment and reassignment of the health workforce

In the **African Region**, 3523 health workers, mainly medical doctors, laboratory technicians and nurses, were reassigned to priority response areas. Reassignment decisions were made by the regional authority. Even if the mobility of the staff was not as high as in countries where the pandemic was severe, essential services were disrupted in many facilities. All countries in the **Region of the Americas** reassigned their health personnel towards COVID-19. For some of these countries, the reassigned health workers represented a relatively high percentage of the total health workforce. For example, 16% of the total HRH in Colombia were reassigned to COVID-19. Additional strategies to increase availability of health workers included an increase in working hours and task reorganization.

Training

In the **African Region** countries, COVID-19 management training was provided to all personnel involved in the response, but not necessarily to other personnel in the health facilities who were not involved in the COVID 19 response. In the **Region of the Americas**, training was provided to personnel who volunteered to receive training to acquire new competencies that would allow them to provide the right interventions to people infected by COVID-19 or to provide health services, via telemedicine, to people who cannot come to health facilities.

Conclusion

African Region countries have learned from previous outbreaks (Ebola, Lassa) to quickly establish various committees to make decisions and manage the outbreak. The issue of the availability of PPE was one of the biggest challenges faced by these countries. An important issue that remained unresolved during this pandemic was the shortage of health workers, which has aggravated working conditions during the pandemic. However, the policy responses in terms of rapid recruitment have demonstrated that countries are able to react rapidly and in an innovative way.

The pandemic has highlighted that protecting health workers is key to ensuring a functioning health system and a functioning society. The prevention of COVID-19 infection in health workers demonstrated responsive strategies that integrate technical guidance, training and provision of PPE, access to routine testing and (when needed) recognition of COVID-19 as an occupational disease. Challenges identified in countries in the **Region of the Americas** include job stability and social security for health personnel, as well as guaranteeing training and updating of knowledge for these personnel. A common challenge is to generate mechanisms to absorb the new human resources that were recruited to reduce the shortages that countries had prior to the COVID-19 pandemic, maintaining the implemented salary improvements, which, in turn, depends largely on funding.

It is important to better monitor the impact of COVID-19 on health workers for prompt response, notably, to identify: data to be regularly collected to assess the existing situation; issues impacting the health workforce; competencies and training needs; and health workforce regulations and policies that facilitate recruitment and deployment of additional personnel, and redeployment of existing health workers.

Monitoring and analysis of the impact of the pandemic on the health workforce are essential for continued situational awareness, especially as Member States attempt to balance controlling COVID-19 transmission with ensuring stable economies and livelihoods.

DEEP DIVE: Impact of COVID-19 on the Health and Care Workforce: A preliminary synthesis of case studies conducted in the WHO Regions of Africa and the Americas

Health workers in Nigeria. ©WHO/Blink Media - Etinosa Yvonne

Box 10: *Story from the field – Jordan*

Investing in family doctors to boost PHC in Jordan

Jordan's Ministry of Health is striving to strengthen its PHC system through supporting family doctors at PHC facilities.[56]

FACT: Jordan's Ministry of Health is strengthening its PHC system through training family doctors at PHC facilities to provide more patient-centred care.

WHY IT MATTERS: Family doctors or general practitioners are fundamental to delivery of PHC to communities to promote healthy lifestyles and provide treatment.

EXPECTED IMPACT: General practitioners are providing more effective patient-centred care, communicating better with their patients and prescribing fewer antibiotics. This community-centred approach will increase Jordan's ability to achieve UHC.

IN PRACTICE: The Ministry of Health in Jordan, in cooperation with WHO, launched the Family Medicine Online Diploma, which trains general practitioners to deliver better PHC services.

©WHO/Banan Kharabsheh

Strengthening human resource capacities

Seizing the opportunities arising from in-person training challenges in the context of the pandemic, several countries moved to online training of their health professionals (see Box 11). In the **Region of the Americas**, the UHC-P supported development of an online platform for mentoring migrant health care in **Peru**. This platform also allows online tutoring of foreign health professionals who practise in Peru and need technical support to face the epidemiological, social and institutional realities of the country. Palliative care training also received a UHC-P boost through the Caribbean Extension for Community Healthcare Outcomes (ECHO) programme. This telementoring platform offers an opportunity to health-care professionals to develop knowledge and skills in palliative care through a virtual learning network. A basic virtual course on palliative care, offered in English and Spanish, and available on the Pan American Health Organization (PAHO) Public Health Virtual Campus, was completed by nearly 1000 health providers.

In the **African Region**, to enhance health workforce education, **Togo** provided teaching and learning equipment in 10 training institutions; **Comoros** developed a draft national strategy for pre-service and in-service training; and **Gambia** conducted a training needs assessment and developed a long-term training plan. In strengthening community health worker practice, **Guinea** developed a draft guide for the training of community health technicians, and the **Republic of Congo** finalized their National Community Health Strategy, serving as a scope of practice for community health practitioners in the country. **Eritrea** and **Ethiopia** also developed and finalized their National Continuous Professional Development Guideline.

In the **South-East Asia Region**, **Nepal** also moved to online training with the support of the UHC-P for front-line nursing professionals to improve quality of services. In **India**, UHC-P support to operationalize the midwifery initiative included developing advocacy toolkits for orienting state programme officials and training the 30 midwifery educators, who will be instrumental in scaling up the midwifery programme across the six states.

56 More details (with quotes and images) may be accessed here: https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/jordan/stories_from_the_field_issue3_jordan.pdf.

Box 11: HRH adaptations to the COVID-19 pandemic

The COVID-19 pandemic revealed significant challenges in countries' health systems to respond to health emergencies – and ongoing work pivoted to respond to these challenges. UHC-P funding enabled partner countries to advance good HRH analyses, policies and practices, as well as assisting health leadership in optimizing human resources for COVID-19 response while making certain that essential services were still being provided. **Republic of Moldova** was faced with a shortage of HRH with adequate skills to address the new health needs posed by the COVID-19 pandemic, to which the UHC-P responded by including new requirements for the mobilization of HRH in cases of public health emergencies in the HRH registry. This registry will serve as a tool for decision-makers and will significantly reduce the time required for HRH management and mobilization during public health emergencies.

In **Azerbaijan**, specialists were trained and hospital preparedness teams were assembled to carry out hospital assessment for COVID-19 preparedness and further peer-to-peer training of hospital staff. Trainings were organized to increase hospital preparedness for COVID-19 and to increase the essential health worker competencies to safely identify, triage and manage COVID-19 patients. As a result, rapid scale-up of the essential capacities in 12 hospitals was achieved. In **India**, technical support was provided to four WHO collaborating centres and 20 affiliated hospitals for standardizing data collection and implementing standard treatment protocols for pregnant women with COVID-19 infection, which resulted in documentation of pregnancy outcomes of over 3000 pregnant women with COVID-19. **Haiti** also completed trainings on COVID-19 response at the first level of care for the district health services in the areas of the project, and on the management of pregnant women with COVID-19. This enhanced the interface/collaboration between health professionals and community actors for surveillance and reduction of maternal mortality with attention to protecting essential maternal, newborn and child health services.

The analysis of HRH and COVID-19 in 12 countries of the **Region of the Americas** and the case studies in three countries (**Belize**, **Grenada** and **Jamaica**) highlighted human resource needs and contributions to the COVID-19 response, while in **Dominica** the 2020 cohort of community health workers officially began their training, and those trained in 2019 became essential front-line workers in the fight against COVID-19. **Trinidad and Tobago** – in collaboration with the Ministry of Health, the Caribbean Public Health Agency and the University of the West Indies – developed a virtual training programme: "An introduction to laboratory diagnosis, molecular biology and polymerase chain reaction (PCR) for the COVID-19 laboratory response". The course marked the first time an "on-the-bench" laboratory diagnostics training programme had been delivered virtually through multi-agency collaboration.

The UHC-P also provided regional support for HRH planning to mitigate the impact of COVID-19 to **Angola**, **Benin**, **Burkina Faso**, **Chad**, **Côte d'Ivoire**, **Eswatini**, **Ghana**, **Guinea**, **Guinea-Bissau**, **Liberia**, **Mali**, **Mauritania**, **Nigeria**, **Niger**, **Senegal** and **Togo**. **Mali** and **Seychelles** developed HRH deployment plans as part of their national COVID-19 response. **Liberia**, **Senegal** and **Togo** documented the impact of the COVID-19 response on the health workforce; and **South Africa** strengthened IPC and occupational health and safety practices.

In other countries, such as **Cambodia**, **the Federated States of Micronesia**, **Fiji**, **Kiribati**, **Lao People's Democratic Republic**, **Marshall Islands**, **Mongolia**, **Papua New Guinea** and **Philippines**, the UHC-P supported virtual trainings as well as in-person coaching of health workers on clinical management of COVID-19 cases, IPC and critical care delivered to intensive care units (ICU).

1.2 Reduced number of people suffering from financial hardship

GPW13 outcome 1.2

Health financing is a core function of health systems that can enable progress towards UHC by improving effective service coverage and financial protection. Today, millions of people do not access services due to the cost. Many others receive poor quality of services even when they pay out of pocket. Carefully designed and implemented health financing policies can help to address these issues. WHO's approach to health financing focuses on three core functions: revenue raising, pooling of funds, and purchasing of services. The work supported through the UHC-P in 2020 provides an important foundation for improved quality and access to health services and increased financial protection. Identifying additional means of financing health systems is an important aspect of achieving UHC (see Box 12).

Health financing policies *GPW13 output 1.2.1*

The UHC-P contributed to strengthening countries' capacities for developing and/or implementing health financing reforms towards UHC. For example, in the **African Region**, **Malawi** reviewed the Health Information System Assessment of Central Hospitals Information Management for Strategic Purchasing of Health Services. **Zambia** conducted an assessment on implementation of the National Health Insurance Scheme. **Ethiopia** was able to identify areas for WHO support in its implementation of a National Social Health Insurance, including capacity-building in strategic purchasing, design of the health insurance benefits package and modalities for design, and enforcement/implementation of a mandatory community-based health insurance system. In **Kenya**, the Health Financing Bill was finalized. **Mozambique** was supported to train 15 persons on the OneHealth Costing tool in preparation for costing their extended National Health Strategic Plan (2020–2024). Moreover, a plan was developed in West Africa for a second workshop on universal social health insurance with seven countries (**Benin**, **Burkina Faso**, **Côte d'Ivoire**, **Mali**, **Mauritania**, **Senegal** and **Togo**).

The UHC-P contributed to strengthening countries' capacities for developing health financing strategic plans (HFSP) geared towards the attainment of UHC, in a number of different ways, in response to each country's needs. A draft HFSP was reviewed in **Botswana**; **Mozambique** developed and costed the Global Fund application proposal for HIV/AIDS, TB and malaria along with a health systems strengthening component; **Uganda** developed a costed NHSP, with a component on health financing; in **Sierra Leone**, a health financing system diagnostic was conducted and its new HFSP plan is under development; **Mauritania** developed its health financing strategy towards UHC.

In the **European Region**, the work supported through the UHC-P in **Uzbekistan** has been of paramount importance for the development and approval of a landmark legislative package to support a comprehensive health financing and service delivery reform aimed at improving financial protection and access to quality evidence-based services, with a focus on PHC. The package entailed the establishment of the State Health Insurance Fund, a new national pooling and purchasing agency, funded by general taxes. The fund will guarantee an essential package of health services for everyone, by increasing coverage and reducing financial hardship. The new model brought by the reform will be piloted from July 2021 in Syr-Darya Oblast before its nation-wide roll-out. In **Kyrgyzstan** UHC-P's technical assistance has supported institutional capacity-building and strengthening of governance practices of the Mandatory Health Insurance Fund, resulting in an intention to scale up WHO technical support to strengthen existing governance mechanisms of the fund. **Tajikistan's** health system is to a large extent funded by patients' out-of-pocket payments, while at the same time, chronic illness is widespread and a growing part of the disease burden. An impact budget analysis was completed to initiate the introduction of a small and effective outpatient medicines benefit as a complement to the State Guaranteed Benefit Package so that medicines for common chronic conditions can become as accessible as other primary care services.

WHO has a long history of supporting **Ukraine** in designing and implementing comprehensive health financing reform. In 2020, the UHC-P helped to revise different service packages (descriptions of services, contracting conditions, and provider payment methods and rates), including for mental health, HIV, TB and emergency medical services. The policy paper on budgetary space for health in **Ukraine**[57] supported the Ministry of Health in budget negotiations for 2021 and provided neutral and timely analysis in the context of COVID-19. In **Georgia**, the new PHC costing and payment model was developed to support the phased implementation of the revised PHC benefit package. The new payment model proposes a mixed system of capitated payments, rent allowance and add-on payments for priority services.

Based on analysis of national household budget surveys, in collaboration with the WHO Barcelona Office for Health Systems Financing, local experts from **Georgia** and **Republic of Moldova** produced financial protection reports on the affordability and accessibility of health care, yielding new evidence on financial protection. The reports assess the impact of health financing reforms on the ability of people in these two countries to pay for health care and their risk of experiencing financial hardship, and outlines actionable, evidence-informed policy recommendations to help improve financial protection and move towards UHC.[58]

In the **South-East Asia Region**, a key focus of the work in **Lao People's Democratic Republic** has been to support the National Health Insurance Bureau in organizing two provincial consultations to share outcomes from the assessment on implementation of the National Health Insurance scheme and review and agree on key strategic objectives of the updated National Health Insurance Strategy 2021–2025 with representatives from all provinces. The UHC-P also supported the National Health Insurance Bureau in conducting verification of facility claims in two selected priority provinces to improve implementation of the National Health Insurance scheme.

Box 12: COVID-19 and resource allocation opportunities

The COVID-19 pandemic presented an opportunity to revisit the country health financing situation and additional options for sustainable health financing for UHC in **Sri Lanka**. UHC-P support facilitated these discussions among stakeholders, which included the health and finance ministries and National Planning and Treasury departments as well as development partners and donors. In addition to completing the national health accounts for 2017/2018, the UHC-P contributed to developing the Strategic Preparedness and Response Plan in the country, including costing, to track financial needs for effective managing of the COVID-19 response and vaccination.

To strengthen strategic purchasing in **Republic of Moldova**, the UHC-P supported technical assistance to identify appropriate payment methods for COVID-19 case management, and cost COVID-19 and suspected cases by types of interventions and by severity. The country also developed an analytical report summarizing the results of the National Health Insurance Company Diagnosis-Related Group database for 2020.

Many country responses to COVID-19 involved the rapid budget execution of comparatively large amounts of funding. "Normal" budgeting and expenditure tracking processes had to be adapted and many of these processes can accelerate progress towards UHC. For example, in the **Western Pacific Region**, the UHC-P supported **Papua New Guinea** on the inter-agency financing coordination processes and budget reprioritization to respond to the COVID-19 pandemic while maintaining essential services. The development of a donor tracking tool for the COVID-19 health sector response has been used by the Government to coordinate and monitor investments and has informed their own allocation of government resources.

57 Budgetary space for health in Ukraine: policy document to support budget preparation dialogue for 2021. Health Policy Paper Series No. 20/01. Copenhagen: Regional Office for Europe; 2020 (https://apps.who.int/iris/bitstream/handle/10665/340937/WHO-2019-nCoV-EHS-continuity-survey-2021.1-eng.pdf, accessed 6 September 2021).

58 Goginashvili K, Nadareishvili M, Habicht T. Can people afford to pay for health care? New evidence on financial protection in Georgia. Copenhagen: WHO Regional Office for Europe; 2021 (https://www.euro.who.int/en/countries/republic-of-moldova/publications/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-the-republic-of-moldova-2020, accessed 6 September 2021).

Garam I, Zadnipru M, Doronin V, Matei A, Mosca I. Can people afford to pay for health care? New evidence on financial protection in Moldova. Copenhagen: WHO Regional Office for Europe; 2021 (https://www.euro.who.int/en/publications/abstracts/can-people-afford-to-pay-for-health-care-new-evidence-on-financial-protection-in-georgia-2021, accessed 6 September 2021).

National health accounts and finance tracking *GPW13 output 1.2.2*

The adoption and institutionalization of national health accounts (NHA) – which are a way for countries to monitor health spending across multiple streams – continues to be a priority for the **South-East Asia Region** and the **Western Pacific Region** (see Box 13). NHAs improve the measurement of financial protection and increase the availability of such data for countries to monitor progress made on UHC. In 2020, UHC-P support allowed for the review of the immediate health financing policy responses adopted by countries in the regions in the aftermath of the COVID-19 pandemic, looking at financial access, resource mobilization and allocation, strategic purchasing and public financial management.

In the **African Region**, the UHC-P supported a study on the status of NHA institutionalization using experience from seven countries (**Burkina Faso**, **Cameroon**, **Democratic Republic of the Congo**, **Guinea**, **Malawi**, **Rwanda** and **Uganda**). The report was used to inform the regional guide for NHA institutionalization. Support was also provided to discussions initiated between WHO and the Global Financing Facility for Women, Children and Adolescents on the link between NHA and the Global Financing Facility Resource Mapping and Expenditure Tracking to support enhanced harmonization of the two tools in country processes.

Additional efforts in NHA institutionalization included 15 persons trained in **Mauritius** to produce the 2018/2019 accounts, and reviewing the 2018 NHA accounts studies of **Burkina Faso**, **Côte d'Ivoire**, **Niger** and **Sierra Leone**. NHA training – known as System of Health Accounts (SHA) 2011 – was conducted with teams of 25 members and 40 civil society organization members in **Burkina Faso**, **Comoros**, **Ghana**, **Guinea** and **Mauritania**; 15 students from **Cote d'Ivoire**, **Mali** and **Senegal** were trained in SHA 2011 methodology; 50 managers of priority programmes, such as malaria, TB, immunization, reproductive health, nutrition, HIV/AIDS and neglected tropical diseases (NTDs), were trained on SHA 2011 in **Burkina Faso**, **Côte d'Ivoire**, **Democratic Republic of the Congo** and **Ghana**.

Remote technical support was provided to several countries to launch and conduct a new health account study: **Cabo Verde** (2017-2018), **Central African Republic** (2015–2018), **Gambia** (2017–2018), **Guinea** (2017–2019) and **Mauritania** (2017–2018). **Burkina Faso** conducted immunization expenditures tracking; and COVID-19 expenditures tracking was launched in **Burkina Faso**, **Ghana** and **Senegal**. A virtual workshop on health accounts institutionalization included 32 participants from eight countries (**Benin**, **Burkina Faso**, **Côte d'Ivoire**, **Guinea-Bissau**, **Mali**, **Niger**, **Senegal** and **Togo**) and resulted in a decision to make health accounts compulsory for all Union Economique et Monétaire Ouest Africaine countries. **Kenya** conducted a public expenditure tracking survey to examine flows for health services in the public resources to decentralized levels and front-line providers.

Moreover, the UHC-P identified and analysed survey datasets of financial risk protection in eight countries (**Ethiopia**, **Kenya**, **Malawi**, **Mauritius**, **Namibia**, **Rwanda**, **South Africa** and **United Republic of Tanzania**); UHC-P support was also provided to country financial risk protection analysis and report preparation in four additional countries (**Benin**, **Cameroon**, **Mali** and **Togo**).

In the **Eastern Mediterranean Region**, the UHC-P also provided technical support for the institutionalization of health accounts in several countries and updated NHA were finalized for **Afghanistan**, **Iraq**, **Morocco**, **Pakistan**, **Sudan** and **Tunisia**. PHC expenditures were estimated for **Afghanistan**, **Egypt**, **Jordan**, **Pakistan**, **Sudan** and **Tunisia**; and updated financial risk protection indicators were estimated for **Afghanistan**, **Djibouti**, **Egypt**, **Islamic Republic of Iran**, **Pakistan** and Somalia.

In the **South-East Asia Region**, new NHA studies were advanced in **Bhutan** and **Nepal** (including capacity-building activities to the ministry of health teams), and a cross-country analysis was conducted to produce a regional overview of health spending over the period of 2008–2018. Using the latest available household data, analyses on catastrophic and impoverishing expenditures were conducted in order to produce a report on financial protection in the Region. In the **Western Pacific Region**, with sustained support from the UHC-P and regional and country office support, **Lao People's Democratic Republic** has a clear direction and a set of priorities to improve sustainable health financing and financial protection in the context of the COVID-19 pandemic in agreement with the Ministry of Finance, World Bank, Global Fund and other relevant line ministries.

In the **European Region**, WHO has promoted in **Tajikistan**, under the UHC-P umbrella, the institutionalization of the SHA, which allows the country to track expenditures on health, including household out-of-pocket expenditure. This work will result in quality and accurate data on access and use of health services as well as on health expenditures, including catastrophic health spending. It is the first step in putting in place evidence-based interventions aimed at improving both financial protection and access to health services.

Box 13: Evidence-based health financing policy in Indonesia

Health financing review and improvements has been one of the priority pillars of support to Indonesia. The UHC-P provided three-level organizational support to encourage health financing policies that are pro-poor when designing a basic health benefit package for the national social insurance, and to identify financing options to ensure the implementation of equitable and sustainable health financing strategies towards UHC. This included supporting the national health insurance system towards reforms for improving financial efficiencies and strategic purchasing, and discouraging parallel-track budget allocations to programmes to reduce inequities and financial inefficiencies. Comprehensive analysis on budget allocation and realization on maternal and child health is currently ongoing and expected to result in a policy brief and recommendations for better and equity-based investments on the maternal and child health programme. An in-depth review on catastrophic health spending has been in progress to support the country's efforts in strengthening PHC, especially for management of NCDs and the elder population to ensure their specific needs are met with equality.

A WHO staff with a speaks with a health worker at the National Perinatal Centre in Tashkent, Uzbekistan. ©WHO/Malin Bring

DEEP DIVE

Health Financing Activities under the UHC-P: The development and implementation of the health financing progress matrix (HFPM)

One key challenge in health financing is for countries to assess whether their health financing policy framework is evidence based and supportive of UHC objectives and goals. Quantitative measurements are critical to assessing health financing performance for UHC (through financial protection estimates and health expenditure tracking). However, where and when available, data collection and readiness comes with a time lag of at least two years, and often significantly more. Furthermore, quantitative information provides no direction in terms of policy directions, development and implementation.

WHO developed a set of evidence-based benchmarks, referred to as "desirable attributes" in health financing, built on theory and evidence. These consist of a health financing progress matrix (HFPM), which contributes to a systematic approach in assessing alignment of country health financing policies with global evidence of what works, helping to pave the way towards UHC. A qualitative assessment also provides more timely information to policy-makers, highlighting areas of strength (alignment) and weakness (misalignment), as well as assessment of whether a country is on track in terms of establishing a conducive health financing environment to progress towards UHC goals.

Development process and content

An initial version of the HFPM was developed in 2019 after more than a year of iterative consultation with key health financing experts to validate key areas of focus, the critical features of health financing policy the HFPM should investigate, and to define assessment questions and progress levels (see Fig. 14). It was then field tested in 19 countries and subsequently revised. A second version was released in 2020 based not only on the lessons learned from the piloting stage but also through the expansion of the evidence base that was built upon. The process culminated with the launch of the new assessment guide in December 2020 (including a webinar[59]). The version released in December 2020 is therefore the culmination of almost three years of conceptual development and country testing.

The HFPM assesses and tracks the extent to which a country is developing and implementing health financing policies that improve both access to services and financial protection. The assessment consists of two stages:

- Stage 1 maps the health financing landscape across the health system in terms of schemes and programmes, providing an initial picture of the extent of fragmentation and misalignment across the health system. This picture is further developed by mapping health expenditure data to provide a picture of the relative financial weight or importance of each coverage scheme.
- Stage 2 focuses on the critical elements of a health financing system. It consists of 33 key questions that assess progress towards the 19 desirable attributes, or benchmarks, that cover seven key health financing areas. Four progress levels are defined for each question, defined as "emerging", "progressing", "established" and "advanced", based on criteria considered central to making progress on the specific issues being assessed. These attributes and questions synthesize the lessons learned and the normative work developed by WHO and other organizations, including academia, in health financing over the years; they are "normative statements of 'what matters' in health financing policy and its implementation in order to progress towards UHC".[60] They form the basis of the assessment that signals the direction in which institutions, policy and implementation need to develop in order to make progress towards UHC.

59 Information at: https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix/.

60 Jowett M, Kutzin J, Kwon S, Hsu J, Sallaku J, Solano JG. Assessing country health financing systems: the health financing progress matrix. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337938, accessed 6 September 2021).

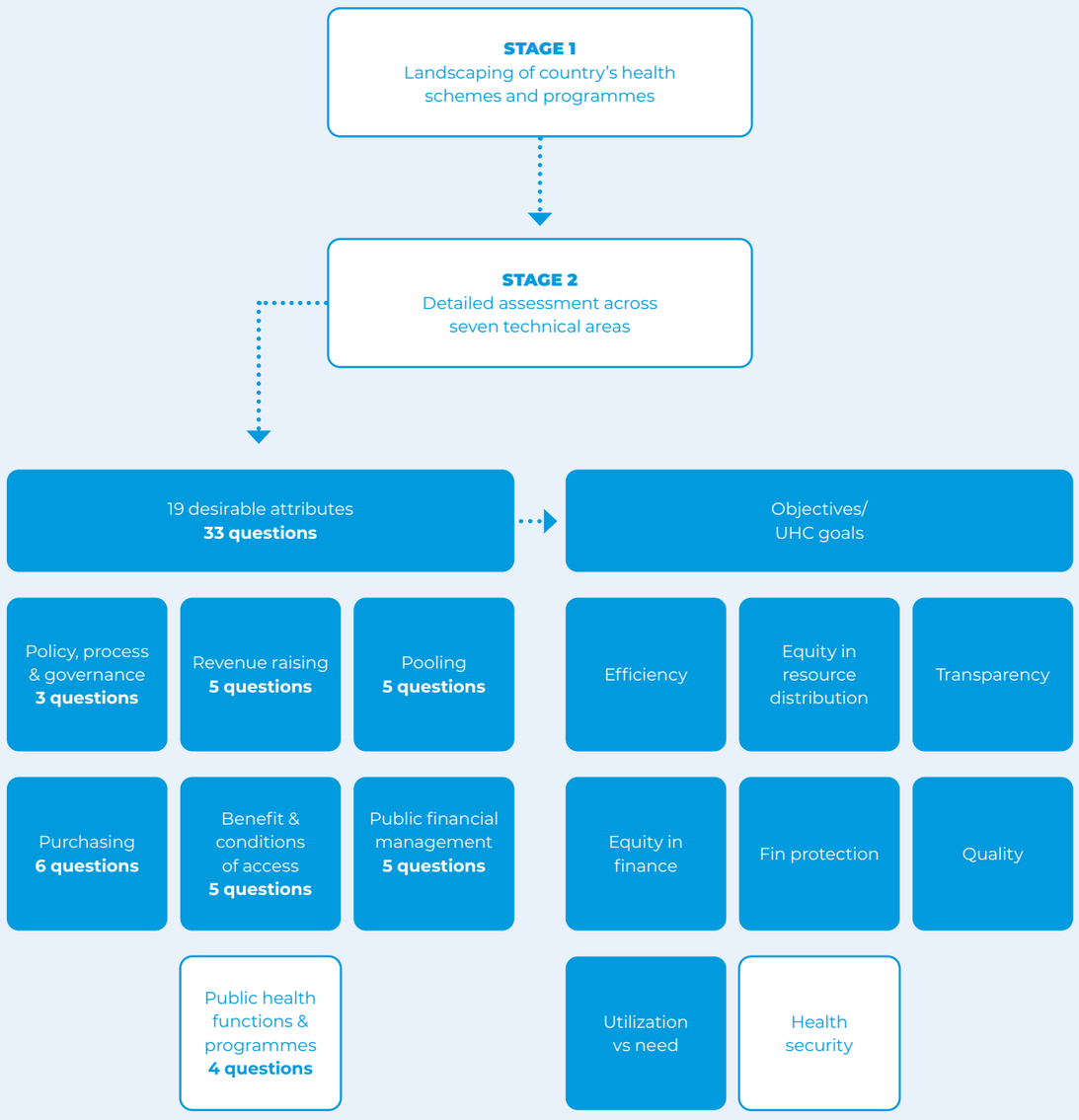
Table 1: Desirable attributes of health financing systems

Table 1 summarizes these key areas and the related desirable attributes.

Health financing policy, process & governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing & provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance, or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits & conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them, and report on spending and outputs
Public health functions & programmes	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives $
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

Source: Jowett et al. (2020).

Fig. 14. Overview of the HFPM assessment



DEEP DIVE: Health Financing Activities under the UHC-P: The development and implementation of the health financing progress matrix (HFPM)

What are the key lessons from the first development phase?

The UHC-P was one of the main channels through which baseline application of the HFPM has been initiated in more than 60 countries. The UHC-P was pivotal in the development phase of the HFPM as the flexibility with which resources can be used offered the opportunity to support a wide range of heterogeneous modus operandi. As of December 2020, assessments were carried out in 19 countries, but many more are ongoing, with an estimated total of 60 countries that have at least started applying the HFPM assessment.

Despite a range of application modalities – both in terms of process and in terms of content as the tool has been iteratively refined – there are key lessons learned that we can draw from that development phase:

- A good number of countries are progressively setting a more conducive health financing system for UHC. Out of the first round of applications among the UHC-P countries, 44% are showing progress in at least one of the 19 attributes of the HFPM.

- In terms of health financing technical areas, key priorities are emerging as assessments have pointed out weak areas, particularly: (a) the need to address gaps and inequalities in population benefits/ entitlements and (b) the need to ensure that budget funds flow to priority services with the appropriate purchasing arrangements.

- In terms of policy process, the way the HFPM was applied was initially quite heterogeneous, with greater guidance and quality control mechanisms and processes released together with version 2.0, detailed in the Country Assessment Guide.[61]

The influence HFPM assessments have on domestic health financing policy dialogue seems to be affected by three key determinants:

- First, the level of engagement of the national authorities in the implementation process. The closer the national authorities supervised the process – in some instances, the ministry of health even took the responsibility to undertake part of the assessment, such as in Afghanistan – the more likely the HFPM will influence the policy framework in health financing. The importance of this engagement needs to be balanced with ensuring that assessments are objective and based on evidence; hence a two-stage external review has been introduced.

- Second, the HFPM does not want to add to the list of numerous health financing assessment tools applied by different partners. On the contrary, it builds on all existing analyses and puts the observations into a single coherent framework which provides a focus on the UHC objectives. The HFPM has been developed as a global good with the aim to further aligning country health financing systems with UHC, and therefore to be gradually accepted as a tool that can serve multiple purposes in a given context. For this to happen, there is a need to continuously promote it in different global health venues, and to continuously refine it with the engagement of a wide range of stakeholders globally, to ensure the production of high-quality, credible, country assessment reports.

- Third, it is important to emphasize the pivotal role of the WHO regional and country offices in the implementation of the HFPM. Not only do they coordinate its implementation, but they must also be the HFPM "promoters", ensuring that results are widely shared and consensus built, and that the HFPM becomes a key instrument to inform the national policy dialogue on health financing over time. The role of country offices is particularly crucial as their capacity to promote the HFPM at the national level will also determine its progressive adoption as a shared assessment tool. In terms of health system expertise and policy entrepreneurship, country offices can help to coordinate the implementation of the HFPM, set the appropriate quality assurance processes, and also seize any window of opportunity to share and discuss the findings of such a health financing system-wide assessment. The example of Ghana (described later in this section) provides a good example of the extent to which the HFPM could influence the national policy dialogue given these two conditions are met.

Following briefings with a number of partner agencies engaged in health financing, a number are starting to use the HFPM to feed into their own internal processes, or as the basis for structuring performance monitoring and evaluation – for example, the Sustainable Accelerator on Health Financing.

61 Country assessment guide: the health financing progress matrix. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/9789240017801, accessed 6 September 2021).

Conclusions

Overall, the HFPM provides a common point of reference for policy discussion, prioritization and monitoring over time, based on a system-wide approach to health financing issues – rather than a scheme-centred or a single-policy focus – which is fundamental to the UHC agenda. In some instances, there are indications (that still need confirmation) that HFPM assessments have contributed to progressively shifting the conversation on health financing issues to what really matters in health financing at country level.

The release of version 2.0, together with clearer guidance on process and the introduction of quality control mechanisms should help to strengthen the buy-in, relevance and institutionalization of the HFPM in national dialogues on health financing. Ghana offers an interesting example of how the HFPM could evolve in the coming years.

The process of implementing the HFPM in Ghana

Following the Minister of Health's approval, WCO Ghana recruited a local consultant, based on experience of the health financing systems in Ghana to support the process.

The first stage of the assessment provided an in-depth descriptive analysis of health coverage schemes in Ghana. Through both published literature and grey literature review, including reports, the various health coverage schemes in the country were identified. Health coverage in the country is mainly through the National Health Insurance Scheme (NHIS); therefore, the legislative instruments that established the NHIS were consulted, namely, the National Health Insurance Act, 2003 (Act 650) and the Revised National Health Insurance Act, 2012 (Act 852). Key features of the NHIS as identified in the acts were described and provided a picture of the health financing architecture in the country.

The second stage of the assessment used the HFPM 48 set questions, following the health financing functions approach. Firstly, a health financing expert with wide experience and knowledge of health financing and the health system of Ghana addressed the various questions under the seven themes. These were: policy development process, revenue raising, pooling revenues, purchasing and provider payment, benefits and entitlements, public financial management, and governance. Quantitatively, respondents were made to rate the progress based on specific questions on a defined scale of 0 to 12. Subsequently, in-depth interviews were conducted to obtain qualitative explanations and details for the questions and ratings. Key persons whose roles in their respective institutions relate to health financing in Ghana were selected from the Ministry of Health, Ministry of Finance, Ghana Health Service, Christian Health Association of Ghana, National Health Insurance Authority. Some of the respondents were also part of the NHA Technical Working Group in Ghana, which played a critical role in the validation exercise.

The various ratings from the respondents were synthesized to obtain the appropriate scores for each of the questions. On the other hand, qualitative data were analysed to identify consistencies and contradictions. Further analysis was done with peer-reviewed literature, annual reports, analytical reports, reviews and relevant documents from government and development partners.

Validation of initial assessment results

At the Health Financing Forum organized by the Ministry of Health which brought together key stakeholders, preliminary results were presented for verification. The final stage involved two health financing experts in academia (from the University of Ghana) who also verified the results of the assessment. Recommendations from the forum informed the finalization of the Ghana report.

DEEP DIVE: Health Financing Activities under the UHC-P: The development and implementation of the health financing progress matrix (HFPM)

Future use

The Ministry of Health regularly reviews its performance. The review process starts from the lowest level of service delivery through district and regional to the national level in the case of the Ghana Health Service. All other agencies of the Ministry concurrently review their annual performances at the national level. Following the agency-specific reviews, the Ministry organizes an assessment ("holistic assessment") of the health sector using an assessment tool developed for that purpose. All these review processes and assessments lead to a Health Summit held in April each year where stakeholders review and validate the assessment report. Recommendations for improvement are made for the current and subsequent years. The holistic assessment report is thus only finalized after the summit when stakeholders' inputs would have been considered and included to enrich the report.

During the November 2019 national Health Financing Forum, stakeholders unanimously recommended the integration of the HFPM into the sector-wide holistic assessment tool. This was once again suggested by participants at the 2021 Health Summit.

The 2021 Aide Memoire has highlighted the need to review the Health Sector Annual Holistic Assessment Tool to align with the Health Sector Medium Term Development Plan 2022–2025; that is, use of a mixed approach for the assessment of health system resilience with special focus on indicators to track sector priorities – regulatory, training, infrastructure, health financing, governance and leadership, etc. There is also an urgent demand for guidance notes to track the performance of the National Health Insurance Authority based on the HFPM.

Institutionalization of HFPM to inform the annual health sector plans

The 2019 HFPM assessment recommended the following interventions. The report of the Health Financing Forum is expected to inform the revision of the health financing strategy to align with Ghana's UHC Roadmap. WHO is supporting this activity in 2021.

- The Ministry of Health should harmonize policies on and related to health financing in Ghana to give a clear and coherent direction to stakeholders.
- The Ministry of Finance needs to release funds in a timely manner to allow effective implementation of health sector strategies.
- Efforts to improve coverage need to be strengthened, especially from the informal sector.
- Measures need to be improved, such as e-claims meant to reduce delays in claims processing and thus reduce delays in reimbursement; in addition to re-examining parameters that inform tariff reviews.
- There is a need for clarity in criteria for determining the benefits package.
- A review of the benefit package to align with UHC reforms is required.
- A comprehensive in-depth evaluation is needed to inform measures that will lead to optimum implementation of the HPFM in the health sector.
- Good governance principles need to be strengthened and institutionalized in the health sector.

1.3 Improved access to essential medicines, vaccines, diagnostics and devices for PHC

GPW13 outcome 1.3

Strengthening regulatory capacities

In the **European Region**, in response to parliamentary commitment in **Georgia** to better regulation of prices of essential medicines, WHO provided comprehensive guidance and inputs for the development of a new Law on Medicinal Products, which creates a framework for price regulation and quality assurance of essential medicines. Discussions were also initiated on assessment of the central procurement system for medicines and medical devices, and UHC-P inputs also informed the reorganization of the National Drug Agency. This has triggered interest in further collaboration with WHO in the area of pharmaceuticals, resulting in a request for additional assistance in improving access to quality pharmaceuticals.

Often when developing and introducing new or amended legislation within an existing governance structure, the move from paper to implementation identifies areas of regulations that may not conform to the objectives, and pilot programmes are helpful in identifying these. The piloting of a new government decree on the introduction of price controls for a selected list of medicines (Additional Drugs package) that are part of universal benefits provided by the Government of **Kyrgyzstan**, exposed some weaknesses of the new regulation, mostly around the collection of reliable information from the manufacturers and distributors. The UHC-P promoted policy dialogues with manufacturers and distributors to find a consensus around how to improve price data sharing. These policy dialogues informed the amendments to the regulation for the next round of approval. The revised draft legislation is pending approval.

In the **African Region**, countries strive to enhance progress to achieve universal access to affordable essential health products of assured quality, as well as to improve their responsible use by health professionals and consumers. **Comoros**, **Congo**, **Eswatini**, **Ethiopia**, **Mali**, **Mauritania**, **Niger**, **Sierra Leone**, **South Sudan**, **United Republic of Tanzania** and **Zambia** reviewed their National Medicines Policies; **Uganda** developed a strategic plan for the pharmaceutical sector development.

The capacities of **Democratic Republic of the Congo**, **Ghana**, **Mauritania**, **Nigeria**, **Togo** and **United Republic of Tanzania** were strengthened on the appropriate selection of essential medicines and devices. The updates of the **Democratic Republic of the Congo**, **Mauritania** and **Togo** national essential medicines lists would guide procurement, prescription and rational use of medicines in these countries. Amid the pandemic, the 47 WHO African Region Member States faced multiple barriers to ensure the continuity of services. They were capacitated with tools and training in forecasting for medicines, laboratory reagents and biomedical equipment. This exercise resulted in the production of needs assessment plans for critical health products. Along the same lines, **Congo**, **Guinea**, **Mauritania** and **Senegal** reinforced their respective national pharmacovigilance systems with the development of national guidelines, tools and formative supervision at district level to promote systematic rational use and assure confidence in the safety of medicines. In this way, patient care and safety are improved. In collaboration with the Union Monétaire Ouest Africaine, **Benin**, **Burkina Faso**, **Guinea-Bissau**, **Mali**, **Niger**, **Senegal** and **Togo** developed and are implementing new community regulatory texts related to postmarketing surveillance of health products, reliance and mutual cognition modus operandi between the national regulatory authorities.

Moreover, six countries (**Benin**, **Ghana**, **Nigeria**, **Sierra Leone**, **Togo** and **Uganda**) were supported to produce strategic information on prevention and detection of, and response to, substandard and falsified medical products; five countries (**Cameroon**, **Nigeria**, **Senegal**, **Uganda** and **United Republic of Tanzania**) included trainings on standard and falsified medical products into the syllabuses of pharmaceutical schools and faculties. **Eswatini**, **Namibia**, **Sierra Leone** and **South Sudan** reviewed their standard treatment guidelines. The deployment of three technical officers on the Inter-country Support Teams to provide assistance on medicines and other health products was instrumental in enhancing UHC-P support to Member States in the **African Region**. The areas related to substandard and falsified medical products, pooled procurement, local manufacturing and the African Medicines Agency benefited from strong WHO advocacy, including from senior management.

Regulation of health products for their quality safety and efficacy is necessary to protect the health of the public to achieve optimum health outcomes. In this regard, medicines regulation was high on the agenda of many countries, including **Botswana**, **Burundi**, **Eritrea**, **Ethiopia**, **Lesotho**, **Rwanda** and **Senegal**. Activities undertaken in this area included development of a strategic plan for the regulatory body; development of tools and guidelines for pharmacovigilance; enhancement of postmarket surveillance for medical devices and in vitro devices to reduce occurrence of substandard devices; development of donation guidelines for medical devices to address challenges related to COVID-19 device donations; procurement of information technology tools (e.g., computers, printers, servers, etc.) for regulatory agency expansion; and electronic registration of medicines and health products, and regulation of manufacturers of PPEs for COVID-19 prevention.

In the **Eastern Mediterranean Region**, the UHC-P provided technical assistance to **Somalia** for the development of a National Essential Medicine Policy. The UHC-P also supported the strengthening of regulatory capacities in **Afghanistan**, **Pakistan** and **Somalia**.

Thanks to the UHC-P, in the **Region of the Americas**, support has been provided in critical areas for the COVID-19 pandemic response such as on therapeutics and regulatory preparedness for the introduction of the COVID-19 vaccine. As a result of this support, leveraged with that of the UHC-P, the Region was able to:

- Provide timely and regular updates to subregional entities and countries on the status of development of candidate vaccines and of the WHO Emergency Use Listing Procedure evaluation process.
- Support the update of the Caribbean Region's Emergency Use Recommendation Procedures as well as its web page and other communication materials.
- Highlight the importance of COVID-19 vaccine safety surveillance through a webinar attended by over 180 people from 17 Caribbean Community (CARICOM) countries.

In **Colombia**, the UHC-P supported strengthening of the response to care for populations in vulnerable situations in migratory contexts and in peace-building processes, through strategies that improve access to health services, medicines and other health technologies. It did so with technical cooperation aimed at strengthening the regulatory authority, and supported the process of technical evaluation of the procurement of medicines and medical devices in the framework of migration and health emergencies.

To further support Member States in the evaluation, revision and updating of formularies and lists of essential medicines and other health technologies in agreement with guidelines and standard procedures, the **Region of the Americas** developed and launched on the PAHO Virtual Campus of Public Health a Virtual Course on Assessment, Selection, Rational Use and Management of Health Technologies in the context of COVID-19.

In the **South-East Asia Region**, WHO developed policies and guidelines to promote best practices to enhance availability, quality, safety and affordability of health products, such as medicines – including traditional medicines – and blood products (see Boxes 14 and 15). The UHC-P supported **Sri Lanka** in developing its National Medicines Policy 2020–2025, **Indonesia** for a report on "Follow on action on 2020 on regulatory aspects in vaccine for COVID19 for market authorization", and **Nepal** in the context of an interim benchmarking assessment (through the WHO Global Benchmarking Tool).

A pharmacy at Fasham Urban Comprehensive Health Centre, Shemiranat District Tehran.
©WHO Islamic Republic of Iran

Box 14: Ensuring safe blood transfusion

In the **African Region**, UHC-P support was provided to **Gabon** to train 12 medico-technical staff of the National Blood Transfusion Services on safe blood donations, including categories of blood donors. **Ethiopia** was supported to develop guidance on transfusion service coordination and **Kenya** undertook a baseline assessment of good manufacturing process (GMP) status in 36 blood establishments, culminating in capacity-strengthening of the blood establishments. **United Republic of Tanzania** also built capacity for blood regulation, whilst in **Togo** national guidelines on the rational use of blood products was developed. All these documents are aimed at improving the availability and proper use of health products within the health-care system.

Ongoing work in the area of blood safety in the **South-East Asia Region** included web-based trainings for regional online haemovigilance training (to ensure blood safety from donor to recipient); online training on the National External Quality Assurance Scheme (**Nepal**); and impact of COVID-19 on blood services of the Member States. The UHC-P provided guidance to partner countries in the Region in implementing a global framework of blood transfusion safety in their national contexts by establishing national standards and submitting data to the Global Database of Blood Safety. In **Haiti**, the UHC-P provided technical support to the National Program for Blood Safety for the promotion of blood donation and safe transfusion.

Box 15: Spotlight on traditional medicine in the African Region

Supporting Member States in developing proactive policies and implementing action plans that will strengthen the role traditional medicine plays in keeping populations healthy is a key objective of WHO's Traditional Medicine Strategy 2014–2023. For example, the WHO Regional Office for Africa, Africa Centres for Disease Control and Prevention and the African Union Commission jointly launched a Regional Expert Advisory Committee on Traditional Medicine for COVID-19 which enhanced coordination, providing independent scientific advice and technical support to Member States on research and development of traditional medicine against the virus. In **Chad**, a draft law on the integration of traditional medicine into the health system was developed.

Ensuring efficient and transparent procurement and supply systems

The availability of quality-assured health products at affordable prices requires efficient procurement and supply management systems in place, good quantification and forecasting systems, and adequate logistics management information systems (see Boxes 16–18). In this area, **Cameroon**, **Madagascar**, **Mozambique**, **Senegal** and **United Republic of Tanzania** assessed their respective supply chain systems; strengthened their capacity in quantification, good storage and distribution practices, monitoring of prices and availability to inform medicine pricing regulation and development of a medicine pricing policy; computerized their logistics management information systems; and expanded supply systems to make medicines available at the primary care level.

Since the beginning of the pandemic, the UHC-P has been supporting capacity-strengthening of the 47 Member States in the **African Region** in forecasting the needs and monitoring the supply and demand of medicines, laboratory reagents and biomedical equipment for COVID-19 response and continuity of essential health services. The pooled procurement initiative for the Small Island Developing States (SIDS) – which include **Cabo Verde**, **Comoros**, **Guinea-Bissau**, **Mauritius**, **Sao Tomé and Principe** and **Seychelles** – gathered momentum with support to streamline activities. This culminated in the signing of the pooled procurement agreement by ministers of health on 29 September 2020, which was a significant step in moving towards the implementation of pooled procurement.

In the **South-East Asia Region**, the UHC-P developed and rolled out an online virtual learning platform to provide knowledge, collaboration, mentorship, training and simulation to make forecasting and the overall health commodity supply chains more resilient. As part of formulating results-oriented and evidence-based health financing policy reforms, the UHC-P supported **Indonesia** to develop a roadmap on a health technology assessment model.

In the **Eastern Mediterranean Region**, the UHC-P provided technical support in **Islamic Republic of Iran** for the ongoing development of the Integrated System for e-prescription, while in **Lebanon**, technical support was provided for accelerating establishment and operationalization of a pharmacovigilance centre, and for rehabilitation and upgrading of the central warehouse.

Box 16: COVID-19 and procurement response in the Region of the Americas

The COVID-19 pandemic has demonstrated how the scarcity of medical products can cause disruptions in health care. In response to the COVID-19 emergency, the UHC-P supported quality assurance processes for the regional procurement of medicines and medical devices, including PPE. Existing capacity and experience in the quality assessment of medicines and vaccines in the **Region of the Americas** was quickly adapted to other health technologies such as in vitro diagnostics and PPE. Combined with existing subregional regulatory initiatives such as the Caribbean Regulatory System and the Central American Mechanism for the Joint Evaluation of Medicines, this catalysed the quality assessments of COVID-19 critical health technologies and provided a platform to quickly engage with the subregions during the pandemic.

UHC-P support allowed for the mapping of existing regulatory routes for authorization, importation and post-deployment monitoring of the COVID-19 vaccine in 16 countries from the **Region of the Americas**, and tools were developed to support COVID-19 vaccine pharmacovigilance with regards to the vaccines' safety data. A list of priority medical devices in the context of COVID-19 was developed and technical trainings were given to 350 participants on COVID-19-related medical devices.

Box 17: Pooled procurement programme for SIDS

The pooled procurement programme of the SIDS (**Cabo Verde**, **Comoros**, **Mauritius**, **Sao Tome and Principe**, **Seychelles**, and lately, **Guinea-Bissau** and **Madagascar**) is an initiative to reduce costs and improve access to quality medicines. SIDS face challenges because of smaller populations and therefore lack negotiating power when buying medicines. Pooled procurement combines several countries into a single unit to purchase medicines, vaccines and other health-care essentials. It is a mechanism that is seen to have a price-reducing effect as it increases the power to negotiate for better prices and good-quality medicines for countries that have challenges with economies of scale. It also allows for greater stability in the supply of medicines and vaccines through pooled resources, and purchasing results in lower unit prices, generating cost savings.

The SIDS Pooled Procurement Initiative started in earnest following the 6th SIDS Health Ministers Meeting held in Seychelles in September 2017 where the health ministers expressed interest in implementing a Pooled Procurement mechanism. WHO made a commitment to support the initiative and host the programme's Secretariat subject to availability of funds and until such a time that the SIDS may be able to take over managing the Secretariat. A technical meeting held in Mauritius in July 2019 provided an opportunity for the SIDS to learn from other pooled procurement initiatives. In 2020, some steps have been taken to move towards the creation and effective implementation of the SIDS pooled procurement programme:

- A pooled procurement agreement and strategy have been developed.
- A SIDS pooled procurement programme advisor has been recruited to support the Secretariat in managing the programme and all technical interactions with the SIDS.
- A priority list of products for pooled procurement has been drawn alongside their specifications, quantities and regulatory requirements, pending consensus by the SIDS.

The advent of the COVID-19 pandemic brought to the fore supply chain weaknesses and has resulted in stockouts and consistent unavailability of products. The SIDS pooled procurement programme is envisaged to remove bottlenecks and improve the procurement and supply management systems in these States.

A mother and her daughter at a health facility in Ghana. ©WHO/Blink Media - Nana Kofi Acquah

Box 18: WCO Ethiopia supports GMP assessment of local medicines manufacturers in Ethiopia

More than 85% of the demand for essential medicines in Ethiopia is currently being met by importation. The availability of essential medicines remains suboptimal at 64%. Ensuring access to affordable, quality-assured and safe medicines through local production has become one of the top priorities and strategic agenda for the Government of Ethiopia. While the Ethiopian Food and Drug Authority applies tighter regulatory follow-up, the Food, Beverages and Pharmaceuticals Industries Development Institute (FBPIDI) provides the necessary capacity-building support for the local pharmaceutical manufacturers to fulfil their corrective and preventive actions (CAPAs) and hence comply with the current GMP requirements.

FACT: Most local pharmaceutical manufacturing firms in Ethiopia lack proper facility layout design and proper management skills, which hinders them from fulfilling the current regulatory requirements that ensure the production and supply of quality-assured medicines. As a result, a GMP roadmap was adopted and implemented.

WHY IT MATTERS: Ensuring the quality of locally produced medicines is one of the critical elements of the local pharmaceutical production strategies in Ethiopia. When local manufacturers comply with the GMP requirements, t hey will be able to produce and supply quality-assured medicines to the local and international market.

EXPECTED IMPACT/RESULT(S): The GMP assessment allows local manufacturers identify and fill the gaps based on WHO GMP guidelines. It also assists the FBPIDI to identify and compile gaps from the manufacturers so that a viable support plan can be developed that will push the manufacturers towards full GMP compliance and hence ensure the production of quality-assured medicines.

IN PRACTICE: The WCO in Ethiopia, in collaboration with the Local Production and Assistance Unit at WHO headquarters, assisted the FBPIDI in preparing a concept note and assessment plan. It also participated in and provided technical assistance during the CAPA implementation and current GMP assessment and report generation process for six local pharmaceutical manufacturers that was conducted over a one-month period.

Addressing antimicrobial resistance

GPW13 output 1.3.5

Antimicrobial resistance (AMR) leads to higher medical costs, prolonged hospital stays, and increased mortality. There is a need to mitigate the effects of AMR as the pipeline for antibiotics and other antimicrobials is reducing over time. The UHC-P has provided technical assistance to the Tripartite (FAO/OIE/WHO) Collaboration, where WHO works in close collaboration with the Food and Agriculture Organization (FAO) and the World Organization for Animal Health (OIE) to promote cross-sectoral collaboration to address risks from zoonoses and other public health threats existing and emerging at the human-animal-ecosystems interface, by providing guidance on how to reduce these risks.

In line with this, **Botswana**, **Burundi**, **Eritrea**, **Ethiopia**, **Lesotho**, **Rwanda**, **Senegal**, **South Africa** and **Zambia** have developed national action plans that seek to establish structures to monitor resistance levels, create awareness, educate the public and promote rational use of antimicrobials through stewardship programmes. Activities include creation of sentinel laboratories and provision of logistics for these sites; definition of norms and standards for AMR surveillance; and national antimicrobial consumption surveys. Similar efforts were undertaken by the UHC-P in **Bangladesh** to provide support in organizing the National Steering Committee meeting and developing the National Action Plan, as well as supporting the national system for monitoring consumption of medical products, especially antimicrobials.

In **Ghana**, the Food and Drug Authority was assessed, supported and formally confirmed to have achieved maturity level 3 in May 2020. To support local production, over 140 regulators were trained on how to embed the antimicrobial response agenda into regulatory inspections and guide the pharmaceutical industry to contribute to the One Health approach for AMR prevention.

DEEP DIVE

Addressing NCDs

Although progress towards achieving NCD indicators (see Fig. 13) has been slow in 2020, key steps have been taken to strengthen collaborative efforts between health system and NCD programmes, with resources mobilized for joint activities and supported by the UHC-P.

A virtual series of global webinars was launched in May 2020 to showcase effective WHO initiatives and foster timely dialogue and experience-sharing on strengthening health systems for impact on NCDs. The "NCD Hard Talks" series acts as a platform to address real challenges and pragmatic solutions through discourse on strategic and technical aspects, with academic perspectives on evidence appraisal, assessment of implementation mechanisms and evaluation of programme impact. Country representatives, donors and global health experts convened for six sessions in 2020, engaging in rich dialogue on topics related to COVID-19 and NCDs, health financing for NCDs, improving access to NCD medicines, optimizing an NCD-ready workforce and delivering NCD services in PHC.

At the regional level, regular virtual meetings have been staged to improve collective communication with and amongst countries. At country level, collaboration between health systems and NCD programmes has been strengthened to enable planning and implementation of joint activities. This has resulted in joint workplans, sharing of needed resources for implementation and joint monitoring. A health systems approach to programmatic implementation for NCDs has been considered across global, regional and country-level activities.

Initial efforts have been made to make progress in planning on joint work within health financing to prioritize NCD services in the National Essential Services Package in **Mongolia**, **Nigeria**, **Senegal** and **Viet Nam**. At the global level, a strategic roundtable was convened in July 2020 to discuss strategic alignment of different initiatives and approaches to the design of priority listing of services, and development and implementation of UHC Benefit Packages with a focus on NCDs. A technical meeting report[62] features an implementation roadmap for global, regional and country strategies. A key component supported by the UHC-P is the forthcoming development of a global good on strengthening NCD service delivery through UHC benefit packages, to guide countries in this priority-setting exercise.

The integration of NCD services in the health system provides a critical entry to strengthening NCD outcomes, with global work underway to develop implementation guidance to support countries (see Annex II). Preliminary planning has commenced to adapt and pilot this guidance in **Papua New Guinea** and **South Africa**, with additional countries to be engaged in 2021.

The results of the 2020 rapid assessment of service delivery for NCDs during the COVID-19 pandemic revealed that 122 out of the 163 countries that responded to the survey were experiencing disruptions in NCD services, with 20% of countries reporting unavailability or stockout of essential medicines, medical diagnostics and health products. In this light, WHO accepted a landmark donation of insulin for people with diabetes, amounting to US$ 1.3 million, which was distributed in 1084 packages with 542 000 vials to 50 low- and middle-income countries. The UHC-P supported the safe delivery of this life-saving medicine by working closely across three levels of WHO and with ministries of health to ensure maintenance of the insulin cold chain through coordinated documentation, green lighting, customs, clearing storage and distribution of the consignments.

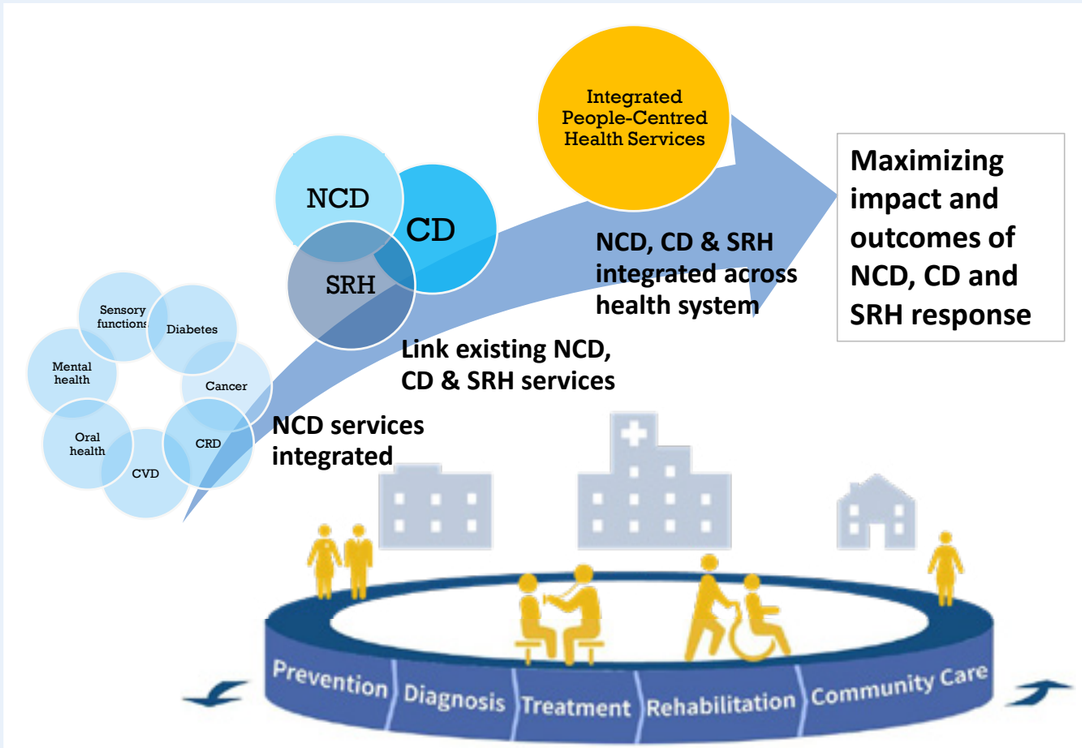
Further work on monitoring of access to and pricing of NCD medicines is underway through implementation of the MedMon application in **Belize**, **Cuba**, **Dominican Republic**, **Ecuador**, **El Salvador**, **Guyana**, **Honduras**, **Iraq**, **Kyrgyzstan**, **Nicaragua**, **Panama**, **Paraguay**, **Peru**, **the Plurinational State of Bolivia**, **Republic of Moldova**, **Sudan**, **Suriname**, **Tajikistan**, **Uzbekistan** and **Venezuela**.

Efforts to strengthen and equip the health workforce to become change agents for NCDs have been taken, with the development of an NCD and leadership capacity-building package to be delivered in **Ethiopia**, **Ghana** and **Nepal**, and at the regional level in **South-East Asia**.

Health information and surveillance in **Burundi**, **Niger** and **Niger** will be strengthened with plans to contribute to the funding of the STEPwise approach to Surveillance (STEPS) survey to collect, analyse and disseminate data on key NCD risk factors. As a result of these collaborative efforts and planned joint activities, there is an expectation of further NCD-focused outputs and impact in subsequent reporting cycles.

62 Strengthening NCD service delivery through UHC benefit package. Technical Meeting Report, 14–15 July 2020, Geneva, Switzerland. Geneva: World Health Organization; 2020 (https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix/, accessed 6 September 2021).

Fig. 15. Maximizing impact and outcomes of NCD, CD and SRH response



CD: communicable disease; CRD: cardiorespiratory disease; CVD: cardiovascular disease; NCD: noncommunicable disease; SRH, sexual and reproductive health

2. Addressing Health Emergencies

1 billion more people better protected from health emergencies

As the COVID-19 pandemic demonstrated, every country is vulnerable to epidemics and emergencies. One of WHO's main goals is to strengthen the resilience of communities and countries through UHC as the foundation for health emergency management.

Since the start of the pandemic, the WHO Director-General and Global Policy Group, comprising regional directors and senior leadership, have led the strategic global public health response to COVID-19. Through the UHC-P, WHO supported Member States for health emergency preparedness in low- and middle-income countries that are most at risk, with weaker health systems. In 2020, the technical assistance provided by the UHC-P played a key role in supporting Member States in the response to the COVID-19 pandemic by supporting the development, costing and implementation of strategic preparedness and response plans.

The action is designed to build and maintain sustainable country capacities to prevent, detect and respond to future public health risks, and to address country gaps and needs through implementation of national action plans for health security (NAPHS). In addition, activities aimed to link NAPHS to national health sector strategic plans and to COVID-19 strategic preparedness and response plans. NAPHS were introduced to help countries identify gaps related to 19 technical areas that should be prioritized for sustainable preparedness and to remedy them. These plans were established to reinforce health systems but also to work through multisectoral interventions. In the three years since NAPHS was introduced, 69 countries have created a plan.

2.1 Legal frameworks and financing for health security

National action plans for health security

In most of the countries with a NAPHS, implementation of activities has been hampered or ineffective due to limited funding, too many planned activities, and the absence of mechanisms to track a stepwise approach to building health security capacity and routinely review activities in the plans. As a consequence, in 2020 the UHC-P supported the prioritization and operationalization of NAPHS in **Nigeria**, **Sierra Leone** and **Uganda**. For instance, in **Sierra Leone**, an operational plan was developed and 52 activities were selected as a priority out of 920 planned activities. Of these priority activities, 40% were unfunded, amounting to a total cost of US$ 1.1 million. The operational plan helped funders understand the country's needs more clearly and provided guidance for external funds to address these gaps.

Moreover, by shifting focus to Sierra Leone's priorities for health security, it is more likely that the Government will maintain this momentum during the COVID-19 pandemic and continue to align domestic resources to build and sustain capacity. NAPHS workshops were also organized in **Botswana**, **Malawi** and **Mali** in 2020 and in the **Central African Republic** in 2021 to start the development of this important health policy.

In the **Western Pacific Region**, countries which had implemented NAPHS for more than five years tended to have fewer COVID-19 cases, although conclusive claims cannot be made on the causal relationship between NAPHS and COVID-19 spread based on the available evidence.

Other policies for health security

With regards to other legal frameworks for health security, the UHC-P has been active in supporting governance and legal-related inputs so they are more "fit for purpose". The UHC-P supported countries in the integration of law in addressing health emergencies, which was found to be needed during the COVID-19 pandemic.

For instance, in the **Western Pacific Region**, **Cook Islands** has been revising its public health act, which will result in future-proofing the nation's legislation against public health threats and emergencies, while strengthening the health system to better protect and promote health throughout the country. The reform, which elevates the role of remote communities and other stakeholders in planning and priority-setting public health interventions, is being used as a blueprint for other countries in the Region, including **Vanuatu**. In the **South-East Asia Region** in **Nepal**, WHO supported the definition of basic health services and emergency health services in 2019. These were approved through public health service regulation in 2020. WHO also supported the development of standard treatment protocols for emergency medical services to ensure quality service delivery at points of service.

The UHC-P also provided guidance on a range of legal dimensions of COVID-19, including through collaborations with academic institutions (see Deep Dive on governance). These major policy and legal reforms have been enacted with comprehensive laws on health, health insurance, medical services and drug regulation. The amendment and development of these laws became priorities during the pandemic, with emphasis given to ensure their alignment with the SDGs and its focus on vulnerable populations. These laws allow governments to make necessary budget adjustments within the approved consolidated state budget.

In **Cambodia**, UHC-P staff supported preparedness for large-scale COVID-19 community transmission through the development and implementation of a Master Plan. The new initiative on local preparedness provides an opportunity to further improve the country's readiness towards the pandemic response in all provinces. UHC-P support helped establish provincial emergency operations centres for COVID-19 (which can be used in the future for other public health emergencies), as well as the design/implementation of regional workshops on provincial preparedness planning, in line with the National Master Plan for COVID-19, identifying key priorities to strengthen local preparedness.

In **Bangladesh**, a health emergency operations centre (HEOC) plan was drafted and approved by the Civil Surgeon of Cox's Bazar. **Timor-Leste** also received UHC-P support in developing HEOC plans, procedures and standard operating procedures, as well as training and simulation exercises on public health emergency preparedness and response, based on the COVID-19 response.

Financing for health security

With the support of the UHC-P to respond to immediate needs, a comprehensive COVID-19 vaccination costing tool was also developed to support countries across the world to access funding through the COVAX facility and support the development of national deployment and vaccination plans for COVID-19. In the **Western Pacific Region**, targeted country assistance was delivered to support budgetary decisions in the health sector for COVID-19 vaccination in 2021 and beyond (e.g. Lao People's Democratic Republic, Papua New Guinea and Viet Nam) and enhance close collaboration in many countries with ministries of finance. Responding to immediate needs, a comprehensive COVID-19 vaccination costing tool (CVIC tool) was developed. CVIC-inspired efforts are another important area where the Region has been able to work more closely in many countries with ministries of finance and the World Bank.

To promote dialogue between countries and partners, the UHC-P also supported resource mapping to assess resources, investments and activities related to health security preparedness in countries. Based on data collected on country needs and partner activities and priorities, these mapping supported monitoring and evaluation of country plans in **Cameroon**, **Chad**, **Cote d'Ivoire**, **Namibia**, **Niger**, **Nigeria**, **Senegal** and **Uganda**. They facilitated the leveraging of COVID-19 actions and investments for building longer-term preparedness and strengthening heath system resiliency through NAPHS. The resource mapping process promoted evidence-based dialogue between governments and partners on addressing gaps and needs, and strengthened collaboration for preparedness. For instance, in **Chad**, the mapping revealed more than US$ 130 million in COVID-19 support from 34 partners. The partner support was heavily focused on the pillars of IPC, logistics and purchasing, and risk communication and community engagement. Little partner support was mapped in some key pillars, especially for laboratories and points of entry.

2.2 Preventing and detecting health emergencies

Reporting on International Health Regulations

The COVID-19 pandemic has underscored the importance of ensuring effective implementation of the 2005 IHR to prevent and prepare for health emergencies. Globally, WHO provided technical support in assessing and strengthening existing IHR capacities as well as monitoring the implementation of the regulations. For instance, with the support of the UHC-P in the **Region of the Americas**, 29 (83%) of the 35 Member States submitted their IHR Annual Report to the Seventy-third World Health Assembly, and specific guidance and training for national focal points were provided for the implementation of international reporting requirements related to COVID-19. In the **African Region**, all 47 countries have been supported to assess their IHR capacities using the State Party Annual Reporting, while 46 countries accomplished JEE assessment since 2016, and 36 countries conducted risk assessment.

Capacity-building for health emergencies

To enhance continued testing of national preparedness capacities, WHO developed COVID-19-specific simulation exercise packages (SimEx) which have been used extensively at country level in **Ethiopia**, **Kenya**, **Mauritius**, **Mongolia** and **Namibia**. For instance, **Namibia** conducted a three-level (national, regional and district) COVID-19 SimEx from March to October 2020, to assess the readiness of the health-care system. More than 2300 participants joined the SimEx through multiple organized exercises. The SimEx has been able to trigger some positive changes in many areas such as case investigation, contact monitoring, referral and management of cases; management of IPC materials and consumables; and COVID-10 protocols and guidelines. With the involvement of partners, the creation of SimEx action plans following the simulation helped to not only address the gaps identified during the SimEx, but also to ensure the resource provision and adequate follow-up. Among impacts seen was a reduction in infection among health-care workers due to enhanced IPC measures.

Furthermore, in the **Western Pacific Region**, a regional programme for IPC systems was established. UHC-P support provided tools to assess and monitor practices in key areas of health facility quality and patient safety, including IPC training curricula, isolation and quarantine facility set-up and training, oxygen capacity assessment, surge capacity, clinical management simulation and coaching tools, and technical recommendations on IPC during cold chain transportation. For example, in **Mongolia**, an IPC simulation exercise resulted in capacity-building for about 10,000 health workers at national and subnational levels, which represent around one health worker trained for every 330 inhabitants. The simulation focused primarily on care pathways and clinical/case management, including IPC measures in referral hospitals and PHC settings.

In **Sri Lanka**, the UHC-P supported extensive training in chemical, biological, radiological and nuclear preparedness and pre-positioned PPE items. Disease surveillance efforts that were enhanced during the COVID-19 pandemic were used as a springboard to upgrade the Sri Lankan national surveillance to a real-time system. The development of a risk communication strategy for COVID-19 was identified as one of the highlights in the country's success in controlling the spread of COVID-19. Coordination between the Disaster Management Centre and other sectors at district level was strengthened and lessons learned in addressing COVID-19 were reflected in its monsoon preparedness plans in March 2020 and August 2020.

In the **South-East Asia Region**, to identify priority actions in order to further improve health systems for health security, the UHC-P encouraged and supported Member States in conducting an intra-action review (IAR) of COVID-19 response to assess what was or was not working well, drawing lessons learned from the current response.

At the global level, in April 2021, an addendum to guidance for country COVID-19 IARs was published to provide additional support for planning and implementing IARs and conducting periodic reviews of national and subnational COVID-19 response. As of May 2021, 61 IARs have been implemented globally by 47 countries.

In the **African Region**, surveys on the impact of the COVID-19 pandemic on the procurement and supply of essential medicines, and on blood supply and demand, identified best practices in Member States as well as gaps, which informed evidence-based decision-making to mitigate the risk of shortage and insufficient investment for building resilient systems. Concerted efforts between WHO and partners facilitated supply of health products at country level. **Mozambique** was supported to build its inspectorate capacity and **Nigeria** to prepare the national supply chains for the deployment of COVID-19 products.

Surveillance system

Teams from the **Western Pacific Region** country offices were also involved in the field response and have vigorously engaged with ministries of health in strengthening surveillance systems. In **Papua New Guinea**, WHO supported the development of surveillance training manuals, standard operating procedures and daily provincial surveillance indicators; training of trainers and health-care workers on medical certification of causes of deaths (two hospitals trained 10 medical doctors in total), medical certification of COVID-19 deaths and verbal autopsy (two districts trained 17 master trainers in total).

In **Solomon Islands**, UHC-P supported the Ministry of Health in building capacity of the National Referral Hospital's laboratory to conduct COVID-19 testing (GeneXpert and qPCR). Technical support included building capacity of surveillance and health information teams to carry out contact tracing effectively; supporting national authorities to develop guidelines for quarantine sites and isolation areas, rational use of PPE, guidelines for reopening schools, and communication strategies.

In **Cambodia**, the UHC-P trained more than 2680 rapid response team members from national to health centre levels on surveillance, contact tracing and specimen collection for COVID-19 using the train-the-trainer method. This resulted in enhanced case detection using multisource surveillance, and supported the management of COVID-19 cases effectively though better surveillance, field investigation and contact tracing (8207 contacts followed up), clinical management and IPC. In **Mongolia**, efforts were made to identify innovative systems for collecting and monitoring data for essential health services and COVID-19-designated services to inform decision-making.

In the **South-East Asia Region**, guidance was provided to develop national standard operating procedures for early detection of COVID-19 cases, contact tracing and outbreak investigation. A regional surveillance strategy, complementary to WHO's global surveillance guidance, was provided to Member States to monitor the pandemic's trends. Moreover, technical support was provided to the COVID-19 information management system and repository for COVID-19 in Cox's Bazar, **Bangladesh**, and a training workshop was held on strengthening the HEOC. Emergency Operations Centre-in-a-Box (HEOC equipment) were also procured and shipped to **Myanmar**, followed by training on the equipment.

Syed Razzaq, technical officer for MIS/IT information management shows data on Pakistan's COVID-19 response. ©WHO/Blink Media - Saiyna Bashir

2.3 Maintaining essential health services while responding to the pandemic

Ensuring the continuity of essential health services

The first pulse survey on the continuity of essential health services[63] and other programme surveys conducted in 2020 demonstrated that the COVID-19 pandemic took a significant toll on health systems in countries, with about 30 countries of the **African Region** reporting partial/complete disruptions to 54% of the 25 health services assessed. Reasons varied, ranging from population fear of visiting the health facilities, to movement restrictions as public health measures in countries, as well as drastic changes in health workforce capacity due to redeployments or infections.

For instance, compared to the same period in 2019 (January to August), in 2020, an extra 1,327,533 and 1,371,267 children under 1 year missed their first dose of measles and BCG, respectively. In **South Africa**, the UHC-P and other partners provided technical support to ensure that there were provincial and district plans to track defaulters and generate sustained demand for routine immunization services. The data indicate that there is an improving trend in the immunization coverage by all antigens from May to August 2020. Moreover, the UHC-P provided technical and financial support to the **Ghana** Health Service and Ministry of Health to ensure continuity of service provision for mothers and children, and immunization performance increased steadily from June to August 2020.

With the support of the UHC-P, many **African Region** countries improved communication to overcome health service disruption, including about where and how to access SRMNCAH and GBV services during the pandemic through the following channels: radio, television, social media, adolescent and youth networks, community platforms, religious platforms, district task force meetings and local channels used by these task forces, and webinars (see Box 19). Other countries decided to provide medicines to patients with chronic diseases with medicines such as antiretroviral therapy for longer periods (three to six months), while **Rwanda** and **Uganda** established COVID-19 treatment/isolation centres, leaving other health facilities to deliver the essential health services. In addition, to ensure implementation of the response to COVID-19, the UHC-P also reinforced capacities of the 47 Member States in the Region in forecasting the needs and monitoring the supply and demand of medicines, laboratory reagents and biomedical equipment for COVID-19 response and continuity of essential health services.

Furthermore, in **India**, in the states of Assam and Chhattisgarh, support in adapting and monitoring comprehensive PHC and implementation of Health and Wellness Centres, with particular attention to integration of services and continuum of care, contributed to leading the COVID-19 response while ensuring essential service delivery during the pandemic. With the direct technical support from the UHC-P in three aspirational districts of Chhattisgarh, 113 out of 158 Health and Wellness Centres were made functional by the end of 2020. The mentorship provided by WHO enabled an increasing number of medical officers and front-line workers to expand the range of essential services delivered.

Health facilities preparedness

UHC-P support provided technical guidance to countries on various aspects of case management and health systems strengthening in emergency situations, including hospital preparedness, repurposing of health facilities for management of mild COVID-19 cases, IPC and health-care capacity monitoring. At the global level, the UHC-P supported the creation of a checklist for rapid hospital readiness and webinars to facilitate the sharing of lessons and opportunities to sustainably scale up health emergency preparedness in hospital settings.

In the **Western Pacific Region**, these activities led to a rapid assessment of hospital preparedness for the COVID-19 response with a focus on ICUs and emergency surgery in **Cambodia**, **Lao People's Democratic Republic**, **Malaysia** and **Mongolia**. In addition, WHO staff working on health systems were fully mobilized and a network of modelling experts was established to support planning in **Malaysia**. In **Lao People's Democratic Republic**, through a health systems approach to COVID-19 and UHC, the UHC-P and the Ministry of Health provided on-site support to all 17 provincial hospitals to set up requirements for safe screening, triage, zoning, referral, patient pathways, use of PPE, environmental cleaning and disinfection, sample collection and clinical management.

Moreover, in the **African Region**, Kenya also conducted the WHO rapid hospital readiness checklist to assess hospital governance, structures, plans and protocols. The objective was to quickly determine the current capacities of hospitals to respond to the COVID-19 pandemic and to identify gaps and major areas that require investment. Results showed their current and surge hospitals' capacities for COVID-19 case management and continuity of essential health services. They highlighted lessons learned, such as the need to strengthen facility surveillance systems, planning and oversight mechanisms, and recommended follow-up assessments at sentinel health facilities.

63 Pulse survey on continuity of essential health services during the COVID-19 pandemic: interim report, 27 August 2020. Geneva: World Health Organization; 2020.

2.4 Multisectoral approach

COVID-19 has highlighted the critical need for whole-of-society and multisectoral approaches to health emergency preparedness and health security. Multiple sectors and different levels of government need to collaborate to prevent, detect and respond to public health threats. A key achievement was the publication in May 2020 of the multisectoral preparedness coordination framework.[64] The framework provides countries, ministries and stakeholders beyond the health sector with an overview of the key elements for multisectoral coordination for emergency preparedness and health security, informed by best practices, country case studies and technical input. The framework provides a clear focus by specifying which non-traditional health sectors need to be engaged.

Policy alignment is an illustrative example of what can be achieved under the UHC-P. For instance, in terms of the One Health approach, **Ethiopia** offers a good example of the necessary holistic and progressive approach used to build collaborative capacities in countries. Gaps were identified in the collaboration between sectors through both Joint External Evaluation (JEE) and Performance of Veterinary Services (PVS) Evaluation. As a result, Ethiopia hosted the International Health Regulations (IHR)-PVS National Bridging Workshop in May 2018, which was attended by 59 participants. Together, the Minister of Health and the Ministry of Agriculture, Livestock and Natural Resources developed a joint roadmap, consisting of 30 prioritized activities that they pledged to implement to strengthen their collaboration and coordination at the human-animal interface. A weakness was, for instance, identified in the lack of collaboration on risk assessment. As a result, a joint risk assessment for Rift Valley fever virus and highly pathogenic avian influenza (H5N8) was conducted in March 2021.

In **Indonesia**, after completing the JEE and NAPHS processes in 2017 and 2018, respectively, the country received a presidential instruction in 2019 aimed at increasing country capacities to prevent, detect and respond to infectious diseases, pandemics, bioterrorism, and other chemical, biological, radiological or nuclear risks and threats. The measure aimed to improve national resilience and provide a framework to instruct how institutions and ministries should collaborate and coordinate across sectoral lines, including at the subnational level, to counteract those risks and threats.

In **Timor-Leste**, many lessons can be learned from the initial response that helped to reduce the country's COVID-19 burden. The COVID-19 multisectoral response plan documents the readjustments and reprioritizations taken to scale up the Government's investments in UHC, strengthen social protection, close gaps in gender and related inequalities, enhance digital connectivity and facilitate recovery of small- and medium-sized enterprises.

Box 19: *Story from the field – Somalia's*

Health for all is Somalia's answer to COVID-19 and future threats to health

Somalia's experience in addressing COVID-19 illustrates how investing in UHC sets a strong foundation for heath emergency preparedness and response. The Government is working to ensure that people can access quality health care without experiencing financial hardship.[65]

FACT: In Somalia, a commitment and strategic approach to UHC has been the bedrock for a strong response to COVID-19. Its UHC Roadmap includes a strategy to prepare for emergency response and recovery.

WHY IT MATTERS: Life expectancy in Somalia is very low, and only 25% of people have access to essential health services. A strong health system and achieving UHC can transform this situation, improving people's overall health and saving lives during emergencies.

EXPECTED RESULTS: Although Somalia is a low-income country, the Government prepared a robust response to COVID-19 to control its spread, raise people's awareness and provide essential care to infected people.

UHC-P IN PRACTICE: WHO supported the Government to develop a roadmap for UHC, as well as its emergency COVID-19 response with surveillance, case management, IPC and strengthening of laboratory capacities.

64 Multisectoral preparedness coordination framework. Geneva: WHO; 2020 (https://www.who.int/publications/i/item/9789240006232, accessed 6 September 2021).

65 More details (with quotes and images) can be accessed here: https://www.uhcpartnership.net/story-somalia/.

DEEP DIVE

PHC-Intensified Support in Fragile, Conflict-affected and Vulnerable Countries – the example of South Sudan

South Sudan has an estimated 11 million people and a life expectancy at birth of 53 years for males and 55 years for females. After more than two decades of war, South Sudan became an independent country in 2011 and descended into civil war in 2013. Since 2018, after five years of war, the country is in a phase of transition, as its Government moves from a core focus of tackling a humanitarian and emergency situation towards reorienting the state's priorities to long-term development of the health sector. South Sudan's health system performance has been significantly affected by the cumulative effects of protracted conflicts which have destroyed livelihoods and left millions in need of humanitarian assistance. The war destroyed both physical and social infrastructure, including the health system, with limited access and coverage of essential health services to the most vulnerable. Only 44% of the population live within a 5-kilometre radius of a health facility and only 68% of health facilities are functional.[66]

As of February 2021,[67] there were 8.3 million people in need of humanitarian assistance, 1.6 million internally displaced persons and 1.4 million malnourished children. In the beginning of the year, 5.8 million people – or 48% of the population – were facing acute food insecurity (IPC phase 3 and above). An active cholera outbreak is affecting eastern counties bordering Ethiopia and vaccine-derived poliovirus type 2 is circulating in the country. In terms of the COVID-19 epidemic, 8,010 cases and 94 deaths have been confirmed.

Collaboration between partners to a build PHC-oriented health system

South Sudan is the first fragile, conflict-affected and vulnerable context country which WHO has supported to develop a health sector stabilization and recovery plan (HSSRP). This allows better bridging between humanitarian, emergencies and development partners and programmes with synergies around the PHC strategic and operational levers.

The ongoing collaboration between partners has resulted in key achievements – for example, development of strategic and technical guidance such as the health financing strategy, the Health Sector Strategic Plan, the basic package for health and nutrition services, and disease control strategies (HIV, TB, hepatitis and NCDs). Sustained efforts to strengthen partners' coordination are vital for progressing towards UHC and health security.

WHO brought catalytic funding and worked jointly across its three levels to support the Ministry of Health in addressing critical gaps in the health system identified in the HSSRP. This financial and technical support is promoting a PHC approach with national stewardship and accountability in four states (Jonglei, Western Bahr el Ghazal, Eastern Equatoria and Central Equatoria).

While the domestic allocation remains very low, the humanitarian assistance is likely to decline with improvements in the political stability in South Sudan. However, health systems foundational issues in terms of health workforce, supply chain, infrastructure, governance and information management remain a critical challenge. This necessitates more progressive support and a collaborative approach to build a PHC-based health system with sustainable capacity to maintain quality and equitable health services and public health emergency risk management. The UHC-P can continue to provide a catalytic role in funding and technical support.

66 Ministry of Health of South Sudan. Primary health care in South Sudan, SDG 3 GAP PHC Accelerator Meeting, December 2020.

67 South Sudan Bi-weekly Humanitarian Situation Report. Issue 04, 15–28 February 2021. Juba: WHO South Sudan Country Office; 2021.

Furthermore, the country has one of the worst health indicators for maternal mortality ratio, estimated at 789 per 100 000 live births. Infant and child mortality rates are 75 and 106 per 1000 live births, respectively.[68] Communicable diseases constitute a significant public health problem. In addition, while NTDs are endemic, NCDs – notably, mental disorders – are on the rise. Inadequate infrastructure such as lack of adequate road network and mobile services, coupled with security issues, hinders outreach activities in the country.

In order to make progress towards UHC, the country has determined three national priorities: rolling out the Basic Package of Health and Nutrition Services (BPHNS) at facility and community levels; the Boma Health Initiative in hard-to-reach communities; and the national health financing strategy. If the COVID-19 situation allows, in 2021, the following outputs are expected: policy dialogue for UHC through a national health summit, human resources policy and strategy, infrastructure standards and norms for the BPHNS, pharmaceutical policy and strategy, improved state and country health facilities management, functional national health observatory, and the operationalization of the national health financing strategy through a public finance management system. The PHC operational levers have contributed to informing the development and implementation of the various guidances and monitoring and evaluation in the health sector. For instance, a Service Availability and Readiness survey was conducted to collect critical health data and measure services availability and readiness. Core capacities of the IHR have been strengthened to prevent the importation of the Ebola virus disease. Furthermore, the country has enhanced polio surveillance and vaccinations to maintain its polio-free status.

WHO has been working tirelessly to harness and sustain targeted support to South Sudan from the three levels of WHO (country, regional and headquarters) and its partners, while building on the past and ongoing humanitarian and development-related investments in the country. Based on jointly identified national and subnational priorities, the WCO focuses on five key strategic areas of work:[69] maternal, newborn and child morbidity and mortality; prevention and control of communicable diseases, NCDs and NTDs; health emergency risk management; health systems strengthening; and environmental and social determinants of health. Strengthening PHC has been identified as a key strategy in taking forward these priorities and improving the associated health services and outcomes, in the context of health system recovery.

The Ministry of Health, with the support of WHO and partners, developed a plan for investments in catalytic actions to foster the recovery, growth and performance of the health system – the HSSRP for the period 2020–2022. Costed at US$ 2.8 billion, it aims to reinforce health governance, mitigate the impact of disruptions, while building foundations for sustained UHC and SDG efforts through cross-sector interventions and aligning all partners under one roadmap for UHC. As the health sector is fragmented and not optimally coordinated with multiple stakeholders and service provider systems, the implementation of the HSSRP should strengthen oversight and coordination mechanisms and performance monitoring systems, as well as improve predictability of funding and sustainability of services. This plan also aims to enhance stewardship and accountability between humanitarian and development programmes.

The HSSRP implementation is also expected to lead to an agreement on standardized and comprehensive incentive structure and non-financial motivators for health workers; implement a real-time human resources information system and support the accreditation of training institutions. There is a need to explore other cost-effective interventions, such as improving the quality of local educational institutions. Currently, the core health workforce density is estimated to be 7.6 per 10 000 (WHO minimum standard is 44.5/10 000) and investments in production of HRH have been limited to a small category of mid-level cadres and overseas training of a few doctors and specialists, which is more expensive. Also, none of the health science institutes is accredited.

In terms of health financing, around 1% of government budget is allocated to health, reducing the Ministry of Health's leadership and influence on resources mobilization, allocation and accountability. Multiple financial flows are not coordinated, resulting in an inefficient use of resources for health. The HSSRP aims

68 South Sudan Basic Package of Health and Nutrition Services (BPHNS), July 2019.

69 WHO, South Sudan annual report 2019.

to secure increased government funding for medical supplies, human resources and infrastructure; improve mapping and monitoring of alignment of external resources to national objectives; harmonize financing of services; and improve the coherence of major funding streams. Moreover, the HSSRP defined other objectives to strengthen the health system, including: harmonization of supply chains; improvement of the procurement process and the pharmaceutical information system; scaling up the District Health Information Software 2 (DHIS2) system; undertaking critical health surveys; mapping, monitoring and introducing innovative approaches for health facilities; and reinforcing service delivery.

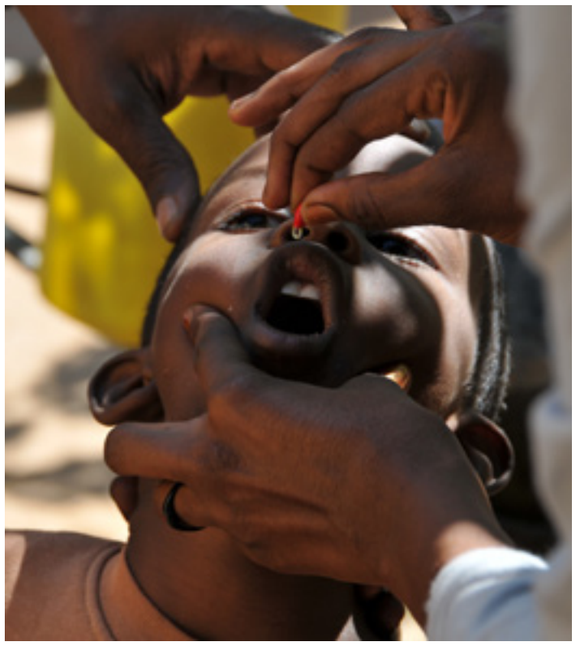
As part of WHO's support, through a year-long funded project, the Ministry of Health is implementing a PHC project in four states (Jonglei, Western Bahr el Ghazal, Eastern Equatoria and Central Equatoria). The project was established following WHO's collaborations with the Ministry of Health and in-country partners, which led to development of the HSSRP. This project aims to address the critical gaps in health systems foundations (across all health system building blocks) to create a more enabling environment for the advancement of PHC. To achieve this aim, an integrated approach is being applied to synergize efforts related to health systems strengthening, emergency preparedness and response, and essential health services delivery, in line with the humanitarian-development nexus. This includes emphasis on health services to vulnerable groups – particularly women and girls – and strengthening the country's capacity for early warning, risk reduction and effective management of public health risks.

The project has gained high-level political buy-in and commitment at the national level. This has been facilitated through continued engagements, coordination and participation of key stakeholders with the resuscitation of the Health Sector Working Group and through the creation of a Health Sector Secretariat with Ministry of Health staff designated as project focal persons. Management tools have been revised for improving health leadership and governance at county and state levels. Two major health facilities (the infectious disease unit and the Juba teaching hospital) have been rehabilitated to improve availability, quality and safety of health services, including primary-level services and maternal and child health. Around 400 community resource persons have been trained to support community surveillance of infectious diseases. Core pipeline drugs for emergency services have also been procured with the project support for distribution to primary care facilities.

Challenges encountered in the implementation of the project include the prevailing security and access concerns, ongoing COVID-19-related restrictions and impacts, and inadequate availability and motivation of suitably skilled staff. Under these realities the project has been able to adapt and provide needed technical and financial support in critical areas for building the capacities of national authorities and health workers. Given the catalytic nature of the project, it has drawn additional support from donors and partners for health systems strengthening. For example, the ongoing work within the scope of this project is informing a complementary initiative to build a PHC foundation in South Sudan as part of the first wave of SDG GAP countries. WHO is continuing to explore with partners options to diversify funding sources to enable adequate and long-term support to the country for sustained progress towards health sector stabilization, recovery and resilience.

DEEP DIVE: PHC-Intensified Support in Fragile, Conflict-affected and Vulnerable Countries – the example of South Sudan

Assessment of nutritional status of a child in an IDP camp in Darfur. ©WHO/South Darfur Sub-office



A child receiving Vitamin A during a Polio vaccination campaign in Darfur region. ©WHO/Sudan

Abu Gao village health centre destroyed during the war in Darfur. ©WHO/North Darfur Sub-office

Community health dialogue session. ©WHO/North Darfur Sub-office

DEEP DIVE

UHC and Migration

The access of refugees and migrants to quality, essential health services are of paramount importance to rights-based health systems, global health security and public efforts aimed at reducing health inequities and achieving the 2030 SDGs. UHC (SDG 3.8) cannot be achieved unless the health needs of refugees and migrants are addressed.

To that end, JWT/UHC-P and WHO's Health and Migration Programme have conducted two bimonthly meetings (November 2020 and February 2021) on health and migration. The programme was established in 2020 to provide global leadership and coordination and policy development on health and migration; set norms and standards and the promotion of a research agenda to generate evidence to support decision-making; monitor trends; strengthen health information systems; provide specialized technical assistance, response and capacity-building support; and promote collaboration, intercountry, interregional and global actions through working across United Nations systems and other intergovernmental and nongovernmental mechanisms.

Inclusion of refugees and migrants in the national health strategies and plans, global, regional and country agendas, partnerships and advocacy

Significant efforts have been made to ensure the inclusion of refugees and migrants in the global, regional and national health strategies and plans. Assessment missions took place to support country assessments in **Ethiopia** and **Niger** to promote the implementation of the Global Action Plan "Promoting the health of refugees and migrants" and the inclusion of refugees and migrants in the national plans. Support also included the response to the COVID-19 pandemic, including refugee and migrant health in the COVID-19 Global Humanitarian Response Plan, and the United Nations framework for the immediate socioeconomic response to COVID-19; promoting equitable access to vaccine for refugees and migrants through developing guidance; and advocating and supporting the development and implementation of national COVID-19 vaccine deployment and vaccination plans.[70] To provide evidence for policy-makers and partners, WHO reviewed all 104 national vaccine deployment and vaccination plans submitted to the COVAX facility and successfully led the global advocacy efforts with partners – such as the International Organization for Migration (IOM); United Nations High Commissioner for Refugees; UNICEF; Gavi, the Vaccine Alliance (Gavi); and the United Nations Network on Migration – for equitable access to COVID-19 vaccination programmes. The majority of countries participating in COVAX at present reported to include refugees, and more countries have included migrants in their national vaccination programmes.

As a member of the Executive Committee of the United Nations Network on Migration and of the Steering Committee of its Multi-Partner Trust Fund, and as co-lead of its Working Group on Access to Services, WHO provides health leadership and strategic direction to the network, particularly as regards the United Nations system response to the COVID-19 pandemic and implementation of the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration. Support has also been provided to regional economic communities and networks to promote refugee and migrant health, including in regional reviews under the latter.

Development of guidance to promote continuity of care and refugee- and migrant-sensitive health systems

To enable health workers to provide quality health services and promote continuity of care for refugees and migrants, the Global Competency Framework for Universal Health Coverage was adapted to define the competency standards in providing health services to refugees and migrants. It specifically informs the development of adapted curricula to support mobile and refugee populations' health needs, specifies the range of services to be provided, and defines occupational scopes of practice. The competency standard is relevant to strengthening the health-care workforce during the pandemic and beyond for better preparedness and building back better.

In the **South-East Asia Region**, for example, targeted programmes for elimination of communicable diseases and specific cross-border management of infections have been strengthened. Last-mile programmes and zero transmission have been maintained through inclusiveness of the migrant population. Building upon the experiences gathered during COVID-19 pandemic, further consultations and coordination with stakeholders will move forward this health agenda for refugees and migrants.

70 United Nations Network on Migration. Enhancing access to services for migrants in the context of COVID-19 preparedness, prevention, and response and beyond. New York: United Nations; 2020 (https://unhabitat.org/sites/default/files/2020/06/final_network_wg_policy_brief_covid-19_and_access_to_services.pdf, accessed 6 September 2021).

In their pursuit towards bridging gaps to equitable access and availability to health services for all communities, particularly refugees and migrants, countries in the **Western Pacific Region** have taken several actions to address barriers to health services affecting refugees and migrants. For example, in **Mongolia**, WHO initiated a subnational health system–strengthening programme, putting UHC and health security at the core. Recognizing that key population groups – including migrant communities – face geographical barriers to accessing health services, they introduced a new model of mobile health services.

In the **Region of the Americas**, in collaboration with partners on the ground and ministries of health, the response on mental health and psychosocial support provided to migrants in diverse settings has been strengthened, particularly through the training of health workers and communities. For example, approximately 10,000 migrants and 1800 health workers benefited from capacity-building workshops on mental health and psychosocial support and targeted communication activities across four different municipalities in **Colombia**. This also includes the development and implementation of a communication strategy in the Wayuu language, targeting returned indigenous populations in the country.

In the **Eastern Mediterranean Region**, a reporting system was developed to monitor the occurrence and trend of COVID-19 among displaced populations in camps and non-camp settings. In support, the UHC-P contributed to the interim guidance note Health system response to COVID-19 in the context of internally displaced persons, refugees, migrants and returnees in the Eastern Mediterranean Region.[71] Technical assistance focused on monitoring the COVID-19 cases among refugees and migrants in the Region and supported countries in enhancing their capacity to capture information from internally displaced persons, refugees, migrants and returnees in routine epidemiological data on COVID-19. In addition, there was continued outreach to partners and monitoring of media outlets to accurately relay timely and accurate information to ensure an accurate and precise response. Furthermore, the UHC-P contributed to developing the situation reports on "Regional COVID-19 Crisis Management Group, Humanitarian Settings and Vulnerable Populations Working Group, Health of Internally Displaced Persons, Refugees, Migrants, Returnees and COVID-19."[72]

Global report on health and migration

Aligned with the WHO transformation agenda of the triple billion targets, as well as key priorities of the WHO Health and Migration programmes across the organization, the first World Report on Health and Migration is the flagship of the WHO Global Programme on Health and Migration. It is a global public health good of the WHO strategic output that commits WHO to help countries to strengthen data, analytics and health information systems to have evidence-informed policies and to have measurable and impactful programmes on the ground to help improve health conditions and henceforth the lives and livelihoods of refugees and migrants. Therefore, the report will provide a basis for the implementation plan of the programme aligned with the WHO results framework.

The World Report intends to establish a global baseline of the health of refugees and migrants. The report is due to be published ahead of the World Health Assembly 2022. It should be noted that this is not intended to be a COVID-19 impact report, but will capture the increased vulnerabilities of refugees and migrants, and demonstrate that our health system is only as strong as our weakest link. This pandemic has shown that if we do not ensure health for all, we do not ensure health security of even the most advantaged, and even the most advanced health systems could be at the brink of collapse. The World Health Report on Health and Migration will contain detailed data and graphics, as well as case studies, stories and other visual features, and aims to be a global reference source, identifying strategies for ways forward, including those related to building back better.

The programme is simultaneously launching the Global Evidence review series on Health and Migration in June 2021, which aims to strengthen the global evidence base through in-depth studies on key topical issues for effective policy-making. The programme is also preparing a strategy on data, evidence and research agenda setting.

71 Health system response to COVID-19 in the context of internally displaced persons, refugees, migrants and returnees in the Eastern Mediterranean Region. WHO Interim Guidance Note. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2020 (https://applications.emro.who.int/docs/EMCSR279E.pdf, accessed 6 September 2021).

72 Regional COVID-19 Crisis Management Group, Humanitarian Settings and Vulnerable Populations Working Group, Health of Internally Displaced Persons, Refugees, Migrants, Returnees and COVID-19. Situation reports. In: World Health Organization Regional Office for the Mediterranean (http://www.emro.who.int/health-topics/corona-virus/situation-reports.html, accessed 6 September 2021).

3. Promoting Healthier Populations

1 billion more people enjoying better health and well-being

Beyond fighting diseases, the UHC-P works to ensure healthy lives and promote well-being for all at all ages, leaving no one behind. Because many of the factors that threaten health and well-being today lie beyond individual control, the UHC-P is committed to supporting Member States to address determinants of health, promote multisectoral actions to reduce risk factors, and to prioritize health in all policies and healthy settings.

Indeed, promoting healthier populations requires collective action to understand and fight health inequities between and within countries. These inequities are the consequences of political economy and resulting inequalities in power, resources and capabilities. The quality of these conditions is often made worse by discrimination, stereotyping and prejudice, which most often affect women and girls, older people, people with disability, or are based on race, ethnicity or sexual identity. Disaggregating data by age, sex, education level and income are essential to identifying inequities in health outcomes and services.

Since conditions in which people are born, grow, live, work and age are fundamental causes of health, actions are entailed outside the health sector through interministerial and intergovernmental collaboration and coordination. Following the Alma Ata and Astana Declarations, the UHC-P support the PHC approach to achieve health for all in the spirit of social justice, and emphasize health as a human right and communitydecision-making in the provision of care. Whether people are healthy or not is determined by their circumstances and environment. Having poor or good health is not an individual choice but a result of political choices. Determinants of health include the social, cultural, economic and physical environment, as well as the person's individual characteristics and behaviours. Such complexity means that measures to promote and protect health and well-being cannot be confined to the health sector alone. To address health challenges and reduce risk factors, the engagement of other sectors is crucial.

3.1 Multisectoral action for NCDs

To lessen the impact of NCDs on individuals and society, a comprehensive approach is needed requiring all sectors – including health, finance, transport, education, agriculture, planning and others – to collaborate to reduce the risks associated with NCDs, and promote interventions to prevent and control them. NCDs are multifactorial and hence their effective control invariably requires a well-coordinated multisectoral response.

In the **South-East Asia Region**, guided by the Regional Strategic Action Plan to Prevent and Control NCDs (2013–2020), the UHC-P provided policy advocacy and technical support to countries in the institutionalization of the development of multi-year and multisectoral NCD action plans along with establishment of multisectoral coordination mechanisms. This support is delivered through close coordination and collaboration with many other collaborative partners such as the World Bank and a range of United Nations organizations (UNDP; UNICEF; United Nations Human Settlement Programme [UN-Habitat]; United Nations Department of Economic and Social Affairs [UN DESA]; United Nations Educational, Scientific and Cultural Organization [UNESCO]; and International Labour Organization [ILO]). In **Sri Lanka**, the UHC-P supported a multisectoral NCD prevention project at workplace and household levels. This project aimed to improve accident and injury surveillance as well as risk identifications through awareness campaigns and targeted interventions carried out by 24 public health inspectors and 85 midwives. In **India**, the UHC-P supported the development of guidelines for prevention and control of NCDs and mental illness at workplaces, based on a situation analysis and on a multi-stakeholder consultative process.

In the **Region of the Americas**, the UHC-P has been able to mobilize partnerships and intersectoral work to prevent NCD risk factors in the Caribbean. One of the key achievements includes the establishment of a formal collaboration with the Caribbean Court of Justice Academy for Law to launch and set into motion a Caribbean Public Health Forum to be scheduled in 2021. A subregional workshop on the use of law to address NCDs in the Caribbean took place in March 2020 in order to set the foundations of the forum. It will aim to promote communication, collaboration and engagement on public health law matters affecting the Caribbean, notably, the use of law to tackle NCDs and their risk factors. For this purpose, the Public Health Forum has a diverse membership, including attorneys-at-law, public health personnel, civil society organizations, academics, government officials, multilateral and bilateral health agencies and distinguished persons renowned for their public health and or public health law backgrounds. In addition, the UHC-P supported the development of a CARICOM front-of-package warning labelling standard through a virtual webinar on this issue and human rights, in collaboration with Healthy Caribbean Coalition, the University of the West Indies and the Caribbean Public Health Agency. In **Trinidad and Tobago**, a social marketing training and a social marketing campaign focusing on NCD risk factors have been implemented. The number of trained Ministry of Health personnel and teams (12 in 2020) is expected to continue to grow in 2021.

The UHC-P has mobilized the United Nations Inter-Agency Task Force on NCDs to support **African, Caribbean and Pacific Group of States (ACP) countries** in multisectoral action for NCDs and mental health as part of broader efforts to strengthen systems for health in the context of COVID-19. Building on its experience in bringing together the United Nations system and partners in over 30 countries, and in line with its 2019–2021 strategy, the Task Force is contributing to the UHC-P through: (1) expanding the UNDP–WHO-led Joint Programme to Catalyze Multisectoral Action on NCDs; and (2) establishing the United Nations Multi-Partner Trust Fund to Catalyze Country Action for NCDs and Mental Health.

Blood sugar screening in Micronesia (Federated States of). ©WHO/Yoshi Shimizu

3.2 Prevention of NCD risk factors

Tobacco and alcohol use, unhealthy diets and insufficient physical exercise are four major risk factors driving the rise of NCDs, which kill 41 million people each year and account for almost 70% of all deaths worldwide.[73]

Tobacco and alcohol

The tobacco epidemic is one of the biggest public health threats the world has ever faced, killing more than 8 million people a year around the world. Over 80% of the 1.3 billion tobacco users worldwide live in low- and middle-income countries, where the burden of tobacco-related illness and death is heaviest. Tobacco taxes are the most cost-effective way to reduce tobacco use and health-care costs, especially among youth and low-income people, while increasing revenue in many countries.

In collaboration with the World Bank and other partners, the **Region of the Americas** organized subregional webinars to promote the use of health taxes as a tool for NCD prevention and additional source of revenues and part of COVID-19 recovery plans, and included national authorities from ministries of health as well as ministries of finance. Representing the first increase since 2016, in October 2020, the government of **Trinidad and Tobago** increased excise taxes on cigarettes, smoking tobacco and waterpipe tobacco by 20%. Decreasing the affordability of such products will result in lower demand and lower consumption, leading to better health.

In the **South-East Asia Region**, countries were supported in implementation of the MPOWER package[74] which uses six proven policy interventions to reduce tobacco-related risk factors. For instance, in **Indonesia**, tax increases have been achieved and tobacco use regulations are being supported at subnational level with an aim to achieve 70% population coverage under smoke-free laws. In **Bangladesh**, tax was raised on some tobacco products and the process of amending the tobacco control law was initiated.

In the **Western Pacific Region, Nauru** raised taxes on alcohol and tobacco by 20% as an evidence-based strategy for NCD prevention and part of the Pacific Ministers NCD Roadmap commitment. This followed a planning session of the multisectoral NCD Taskforce and technical committees, which reviewed the status of alcohol legislation at the end of 2019 in a workshop supported by the UHC-P.

Double burden of malnutrition

Obesity and undernutrition are the two sides of the double burden of malnutrition, and today more people are obese than underweight in every region except sub-Saharan Africa and Asia. Once considered a problem only in high-income countries, overweight and obesity are now dramatically on the rise in low- and middle-income countries, particularly in urban settings. Worldwide, obesity has nearly tripled since 1975 to reach 650 million people. Better nutrition is related to improved infant, child and maternal health, stronger immune systems, safer pregnancy and childbirth, lower risk of NCDs, and longevity.

In the **South-East Asia Region**, the UHC-P guided and technically supported nine countries in initiating an implementation of population-based interventions with focus on restricting marketing of foods and non-alcoholic beverages to children. For instance, capacity was built to establish risk-based food safety systems and strengthen national food control systems.

With the support of the UHC-P, 10 Member States from the **South-East Asia Region** promoted interventions on low-sodium supplements. For example, in **Indonesia**, technical assistance was provided to implement taxation to reduce sugar and salt consumption, and the policy on zero trans-fat industrial foods.

Moreover, in **Sri Lanka**, the national salt reduction strategy has been supported by the UHC-P via a number of activities, for instance: laboratory analysis of salt/sodium in commonly consumed foods in restaurants; analysis of the front-of-pack labels and sale of pre-packed foods prior to implementation of Food Regulation 2019; and the development of an online repository of content of salt, sugar, fats of front-of-pack label images. With the support of the UHC-P, Sri Lanka also launched initial discussions to review its National Strategy for Prevention and Control of Micronutrient 2017–2022 to identify the strategies and interventions to reduce micronutrient deficiencies.

In **Bangladesh**, nutritional guidelines have been developed at the national level and specifically for COVID-19-suspected cases and ICU patients. In **Sri Lanka**, a guide on nutrition for community-dwelling older persons and caregivers, as well as national nutrition quality standards for residential care for older people, have been developed with the support of the UHC-P.

Taxes on unhealthy foods was an important focus of the UHC-P in **Tuvalu** in 2020, resulting in the Ministry of Health prioritizing identifying the availability and accessibility of healthier food as a priority to mitigate the impact of climate change and the persistent double burden of malnutrition.

And finally, with regards to physical activity, guided by WHO's physical activity guideline, **Brunei**, **Mongolia**, **Singapore** and **Pacific island countries and areas** refined the guidance and toolkits on physical activity, developed strategic communication toolkits for physical activity in cities, and developed social media tiles for COVID-19 on physical activity and the #HealthyAtHome campaign.

73 Noncommunicable diseases [fact sheet]. In: World Health Organization [website] (https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases, accessed 6 September 2021).

74 MPOWER. In: World Health Organization [website] (https://www.who.int/initiatives/mpower, accessed 6 September 2021).

3.3 Promoting healthy settings and health-in-all policies

Healthier environment

Healthier environments could prevent almost one quarter of the global burden of disease, which is roughly 13.7 million deaths a year. The COVID-19 pandemic is a further reminder of the delicate relationship between people and our planet. Clean air; stable climate; adequate water, sanitation and hygiene; safe use of chemicals; protection from radiation; healthy and safe workplaces; sound agricultural practices; health-supportive cities and built environments; and preserved nature are all prerequisites for good health.

In the **Western Pacific Region**, a *Regional Panorama on COVID-19 and Groups Living in Vulnerable Situations* has been drafted and captures the latest data among specific vulnerable groups, such as: gender and sexual minorities; indigenous and ethnic minorities; people living in slums and informal settlements; people in rural and remote locations; people experiencing homelessness; people in closed facilities; people with emerging vulnerabilities; refugees; and people with disabilities. The findings and recommendations from this panorama will be incorporated into the social transformation strategy. Recommendations include a call to sustain momentum in achieving UHC by investing in health and social systems that are robust, equitable and gender responsive, ensuring community outreach on COVID-19 is inclusive and accessible, and ensuring that response measures respect human rights and strengthen multisectoral collaboration.

In the **South-East Asia Region**, the regional representatives of FAO, OIE and WHO signed a joint statement and committed to establish and support a Tripartite One Health Coordination Group for Asia and the Pacific to consolidate the multisectoral work carried out over many years in the Asia-Pacific Region on the animal-human-ecosystems interface. They are working increasingly in close partnership with the United Nations Environment Programme (UNEP) to include environmental aspects. In **Indonesia**, the UHC-P has supported several initiatives to support healthy cities and facilitated the discussions on Healthy City actions for local governments in coordination with the Ministry of Health. In collaboration with UNEP, the WCO has been able to facilitate the Asia-Pacific Regional Forum on Health and Environment to increase synergy and close cooperation between countries on health and environmental issues. Moreover, policy discussion to mitigate the health impact due to climate change at the community level and health-care setting was initiated, followed by high-level commitment to implement the Healthy Climate Village Programme nationally.

In **Sri Lanka**, establishment of different types of healthy settings was supported, including healthy cities, healthy villages, healthy workplaces and health promoting hospitals. The Jaffna Healthy City programme engaged more than 10 000 citizens, including children in 10 schools and staff of 10 work settings. Another healthy village, Allawwa, focused on NCD risk assessment and disease prevention, COVID-19 risk prevention and control, which reached approximately 25 000 people. In addition, safe sanitation facilities were provided at 40 key public places and series of orientations on public health and social measures for COVID-19 were conducted. In the selected villages, significant changes in behaviour have been observed – people are more engaged in exercising regularly and monitoring their body mass index; schools are undertaking more physical activity; parents and teachers have formed a group to discuss health issues, including prevention of substance abuse; and village committees have been established to advise, guide and monitor progress. Finally, a health promoting work setting was established at the National Institute of Health Sciences, a key training institute for PHC workers. The aim is to reach approximately 2500 health trainees each year, 1500 of whom will work at the PHC level. WHO has also collaborated with UNICEF in promoting healthy school settings, building on the programme of UNICEF in the other two districts.

Water, sanitation and hygiene (WASH)

Healthy settings also include safe drinking-water, sanitation and hygiene (WASH). Safe WASH is not only a prerequisite to health, but contributes to livelihoods, school attendance and dignity, and helps to create resilient communities. Drinking unsafe water impairs health through illnesses such as diarrhoea, and untreated excreta contaminates groundwaters and surface waters used for drinking-water, irrigation, bathing and household purposes. In 2017, 71% of the global population (5.3 billion people) used a safely managed drinking-water service (located on premises, available when needed, and free from contamination) and 45% of the global population (3.4 billion people) used a safely managed sanitation service.

In the **South-East Asia Region**, technical support related to WASH and IPC was frequently requested by Member States throughout the COVID-19 pandemic. With support from other collaborating partners, technical briefs were developed to adapt IPC and WASH guidelines in order to ensure safe and clean health facilities. Moreover, regular updates were provided to countries on a continuous basis and regional workshops organized. Through its policy advisors, the UHC-P supported countries in monitoring and reporting of basic WASH services in health-care facilities. All 11 countries in the Region participated in reporting on their situations. For stronger visual communication and policy advocacy, fit-for-service dashboards have been developed to show national status of, and improvements in, health-care facility safety and cleanliness, as well as safe services.

In **Indonesia**, the water safety plan and drinking-water quality surveillance have been mandated under the five-year national development plan for 2019–2024 to ensure safe access to drinking-water for the community. Gender, equity and social inclusion have been integrated into the WASH programme with a strong partnership with United Nations agencies and international and national nongovernmental organizations (NGOs) to ensure access of WASH for all strata of population and to achieve quality of care.

In **Timor-Leste,** national standards for WASH in health-care facilities, training curriculum and modules for water quality and climate change have been developed. The UHC-P also supported the national directorate for basic sanitation of the Ministry of Public Works to improve 50 public WASH facilities in Taibesi Market, Dili. This support also included the implementation of two (male and female) public toilets and two handwashing stations as part of COVID-19 response to temporary markets at Dili Central Shopping Centre during Christmas 2020 and New Year celebrations. Furthermore, the UHC-P supported a three-day workshop on developing climate change and health modules and curriculum, as well as a workshop to validate water quality testing, and climate change and health training modules and curriculum; a training curriculum and modules for water quality and climate change were also developed and finalized.

In **Samoa**, WHO actively engaged communities to raise awareness, responsiveness and preparedness towards COVID-19. This engagement afforded the opportunity to deliver hygiene kits to vulnerable families and to assess WASH facilities. It further strengthened partnerships beyond the health sector to provide WASH facilities to vulnerable families and deliver relevant messaging using social media, television and radio during roll-out of the COVID-19 vaccine campaign.

Road traffic conditions

In addition, road traffic conditions are an important element of safe environment and result in the deaths of approximately 1.35 million people around the world each year, and leaving between 20 and 50 million people with non-fatal injuries. The young are particularly vulnerable on the world's roads and road traffic injuries are the leading cause of death for children and young adults aged 5–29. In addition to the human suffering caused by road traffic injuries, they also incur a heavy economic burden on victims and their families, both through treatment costs for the injured and through loss of productivity of those killed or disabled. More broadly, road traffic injuries have a serious impact on national economies, resulting in loss of up to 3% of most countries' annual gross domestic product.[75]

In the **South-East Asia Region**, technical assistance from the UHC-P focused on legislation and public awareness, and was provided to the Association of Southeast Asian Nations (ASEAN) road safety platform to build networking among countries. As a result, nine countries have taken-up strengthening of road safety legislation and raised public awareness on road safety. For instance, in **Indonesia**, the UHC-P has supported the Government to develop a national plan and presidential regulation on road safety for the period 2021–2040 to enforce the priority interventions preventing road safety mortality and morbidity. In **Sri Lanka**, technical support has been provided by the UHC-P for the development, review and implementation of national plans on violence and injury prevention. With regards to police services in the country, a pilot project has been supported in 114 police stations to improve the timeliness and completeness of data, and 190 police officers have been trained to enforce road safety legislation.

In **Thailand**, the country initiated a review of its status against the United Nations Global Road Safety Performance Targets. The findings revealed a good awareness and understanding in most government departments and the implementation of the national strategies by the Government and NGOs. However, the report emphasized the need for fundamental changes to effectively reduce road-related trauma, including the creation of a lead agency with clear responsibilities, more effective inter-agency and intersectoral collaboration between agencies, and better allocation of responsibilities and accountability. The report was presented to highest-level officials of the Road Safety Directing Centre and the Thai Parliament, and discussion on target setting between relevant agencies is ongoing. It will serve as a guide for future action in Thailand.

75 Road traffic injuries [fact sheet]. 21 June 2021. In: World Health Organization [website] (https://www.who.int/news-room/fact-sheets/detail/road-traffic-injuries#, accessed 7 September 2021).

People doing their early-morning-exercise inside Sanjay Gandhi National Park in Mumbai, India. ©WHO/SEARO - Florian Lang

DEEP DIVE

Mental Health

Mental health is an integral part of health and must be considered as more than the absence of mental disorders or disabilities. Determined by a range of socioeconomic, biological and environmental factors, poor mental health is also associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, physical ill-health and human rights violations. An environment that respects and protects basic civil, political, socioeconomic and cultural rights is fundamental to mental health. Without the security and freedom afforded by these rights, it is difficult to maintain a high level of mental health. Mental health promotion should be mainstreamed into governmental and nongovernmental policies and programmes. In addition to the health sector, it is essential to involve the education, labour, justice, transport, environment, housing and welfare sectors.

To strengthen the response to mental health issues, WHO has developed the Mental Health Gap Action Programme (mhGAP).[76] This programme aims to provide evidence-based guidelines and implementation tools to reduce the treatment gap for mental, neurological and substance use disorders, and to enhance the capacity of Member States to respond to the growing challenge presented by these conditions. In this framework, the UHC-P supported mental health service capacity by upskilling eight people in **Kiribati** and **Marshall Islands** and 23 people in **Nauru** as mhGAP trainers.

WHO also established the LIVE LIFE suicide prevention programme,[77] which aims to put countries in the position to reduce suicide mortality by one third by 2030. In 2016, suicide was the second leading cause of death among 15- to 29-year-olds.[78] This programme is focusing on four key strategies: restricting access to means of suicide; responsible media reporting; life skills training; and early identification, management and follow-up. For example, the UHC-P supported integration of the WHO LIVE LIFE strategy into national suicide prevention and control guidelines to ensure that all suicide risk factors are addressed.

In 2020, WHO launched a special Initiative for Mental Health which is underway in seven countries: **Bangladesh**, **Jordan**, **Nepal**, **Paraguay**, **Philippines**, **Ukraine** and **Zimbabwe**. It aims to increase access to mental health services to people around the world by integrating mental health within UHC. Almost all adopter countries have completed mental health situation analyses and have developed country-specific strategies for the implementation. A variety of stakeholders have been engaged through a health system approach, with a particular focus on PHC and other services such as those targeting communicable diseases and NCDs.

As part of the UHC-P and UNDP-WHO-led Joint Programme to Catalyze Multisectoral Action on NCDs, WHO, UNDP and the Task Force have initiated support to multisectoral action for mental health in the **Region of the Americas** and the **African Region**. PAHO, UNDP and the Task Force are supporting the development of mental health investment frameworks in **Guyana** and **Suriname**, building on their growing portfolio of mental health investment case support to countries and leveraging their "Mental health investment case: a guidance note"[79] launched in 2021. PAHO, UNDP and the Task Force are also providing dedicated support on mental health and suicide prevention planning (Guyana and Suriname), mental health and psychosocial support coordination (Guyana, Suriname and **Trinidad and Tobago**) and capacity for suicide surveillance (Guyana, Suriname and Trinidad and Tobago). In the African Region, WHO, UNDP and the Task Force are supporting **Nigeria** to review and strengthen existing acts, regulations and bills on mental health through parliamentarian engagement.

In the **South-East Asia Region**, the UHC-P has contributed to policy development and supported national efforts in Indonesia related to mental health, psychosocial support and suicide prevention. Primary health centre staff capacities have been strengthened to increase access to mental health care and to address risk factors of suicide.

In **Bangladesh**, as a part of the WHO Special Initiative on Mental Health, a situation analysis on mental health was produced and is awaiting final validation by the Government. The costing, editing and designing of the National Mental Health Strategic Plan 2020–2030 is also ongoing.

In the **Western Pacific Region**, the UHC-P provided technical assistance to the mental health programme during the post-cyclone response in **Fiji** and in the post-measles outbreak in **Samoa** by strengthening coordination of activities, disseminating information on evidence-based interventions and promoting staff well-being. **Solomon Islands** and **Tonga** were supported by the UHC-P to develop their first national Mental Health Policies, which provide a vision and high-level strategies for mental health, and which were endorsed by their respective Ministries of Health.

In **Lao People's Democratic Republic**, the UHC-P supported the development of three National Mental Health and Psychosocial Support Guidelines with relevant ministries, including the Ministry of Education and Ministry of Labour and Social Welfare, mass organizations and key partners in the area. The Counselling Guidelines were successfully rolled out in two sites to test the practicality of the guidelines at a community level. Government and stakeholders agreed that the guidelines will supplement enhancement of clinical capacity to manage existing mental health cases at the community and health facility levels.

76 mhGAP Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders. Geneva: World Health Organization; 2008 (https://www.who.int/publications/i/item/9789241596206, accessed 7 September 2021).

77 Live life: preventing suicide. Geneva: World Health Organization; 2018 (https://cdn.who.int/media/docs/default-source/mental-health/suicide/live-life-brochure.pdf, accessed 6 September 2021).

78 Suicide [fact sheet]. 17 June 2021. In: World Health Organization [website] (https://www.who.int/news-room/fact-sheets/detail/suicide, accessed 7 September 2021).

79 United Nations Inter-Agency Task Force on the Prevention and Control of Non-Communicable Diseases. Mental health investment case: a guidance note. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240019386, accessed 6 September 2021).

4. More Effective and Efficient

WHO Providing Better Support to Countries

UHC-P support has shown that factors that contribute to success for providing better support to countries are: focusing on data; advocating for evidence-based strategies; providing strong technical assistance to translate global recommendations into local policies; and supporting national and subnational health systems–strengthening efforts. The availability of internet access and infrastructure in the majority of districts and the high research capacity in countries also contribute to success.

The UHC-P collaborates with countries to improve their health information systems, analytical capacity and reporting for UHC, including developing comprehensive and efficient systems to monitor health risks and determinants; track health status and outcomes, including cause-specific mortality; and assess health system performance. Good governance and leadership of a health system require reliable, timely information, such as whether people are getting the services they need and where resources are going. Information is used in a wide range of situations, such as developing national strategies and plans, monitoring progress against priorities, or responding to public health emergencies.

In this respect, the UHC-P is working closely with the WHO Division of Data, Analytics and Delivery for Impact, which was created to foster a relentless focus on results to deliver on the health-related SDGs and meet the Triple Billion targets, backed by the highest standards of health data.

4.1 Health information and information systems for health

Data, analytics and knowledge management remains a key priority for the **African Region**. As part of cross-cutting actions for data, analytics and knowledge carried out in the Region, an emphasis has been placed on strengthening the integrated African Health Observatory (iAHO), the development of analytical products on health system and sector performance as well as of policy-relevant knowledge products, and the management of functional digital library and information services. In addition, **Mali** was also supported to develop a Health Information System Development Plan 2020–2024.

Leveraging existing polio field surveillance architecture, an **African Region** dashboard for the real-time monitoring of health service continuity was developed to track disruptions in health services in the countries. The dashboard currently displays data from 27 countries, 186 provinces, 1027 districts and 6975 health facilities across the 27 reporting countries, and continues to be updated.

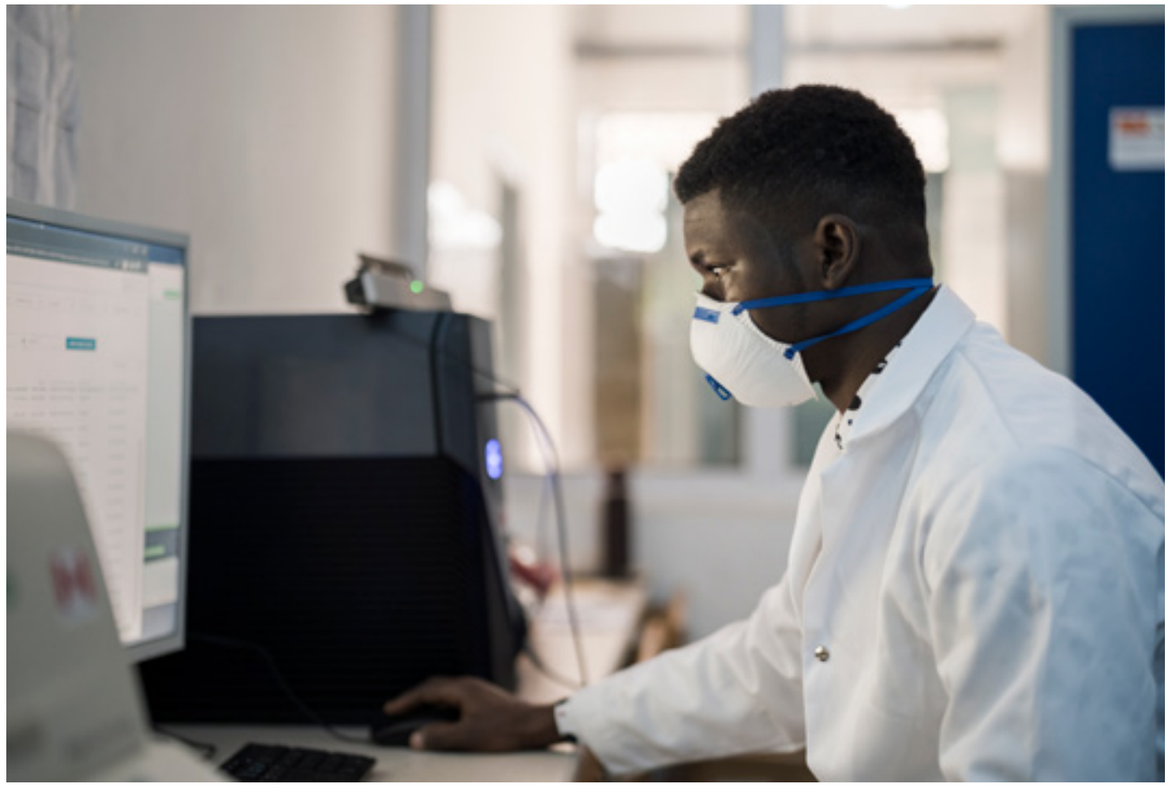
The **African Region** has also invested heavily in supporting countries to implement real-time surveillance processes for health service resilience through Geographic Information Systems. Assessment tools for health service resilience, as well as technical support for analytics and generation of knowledge products on the state of system resilience and overall health system functionality of the 47 Member States, continue to be supported by the UHC-P.

Countries also enhanced HRH data generation within the reporting period. For example, **Eswatini** began to develop a human resource information system, starting with the nursing cadre, and **Democratic Republic of the Congo** and **Kenya** began to develop country health workforce profiles, while **Comoros** and **Mali** completed the development of country health workforce profiles. Support has been provided to **Eswatini** and **Mali** for the review and development of a costed health information system strategic plan.

In the **Region of the Americas**, the UHC-P has supported modelling of underlying health conditions and COVID-19 risk estimates for the Caribbean countries to support the planning for vaccination: PAHO adapted/developed a tool in collaboration with the London School of Hygiene and Tropical Medicines to estimate the population at risk for severe COVID-19 for the Caribbean Region. These estimates were included as part of the Sixth ad hoc Meeting of PAHO's Technical Advisory Group on Vaccine-preventable Diseases to guide countries to develop their vaccination plans.[80]

Countries in the **Western Pacific Region** sought UHC-P support for digital contact tracing, quarantine tools for COVID-19 and telemedicine services, including on legal and ethical dimensions. In the **Philippines**, contact tracing was strengthened as a scalable system, establishing the COVID KAYA mobile application that allows for real-time reporting of suspected, probable and confirmed COVID-19 cases, and becoming the central repository of COVID-19 data, with real-time monitoring, tracking of test specimens, communicating of test results and monitoring of quarantined contacts. In **Lao People's Democratic Republic**, the UHC-P supported the development and roll-out of a tablet-based system to monitor key health resource indicators on a daily basis at all central and provincial hospitals designated for COVID-19, and another tablet-based system for WASH baseline assessment to provide evidence on IPC/WASH capacity in the country. And in **Papua New Guinea**, the Electronic Health Declaration Form has been fully put to use in the Quarantine Monitoring Database in the COVID-19 response.
The analysis of the data confirmed that service delivery (e.g. immunization; maternal, newborn and child health; TB, HIV and malaria) was affected by COVID-19 in March and April 2020, and that there was incomplete reporting from health facilities in the provinces in the second half of 2020. These findings guided the deployment of multi-cluster teams to the provinces for supervision, mentoring and monitoring purposes, which contributed to improvements in testing and reporting rates of some provinces.

In the **Region of the Americas**, in **Suriname**, UHC-P support in the training of health-care providers to directly input patient data into the web-based system and use this data for decision-making on cases has had significant impact on the way patients are managed in hard-to-reach interior areas. A clearer picture of the health status of persons in the interior is now possible because of this patient management information system, and the investment in training under the UHC-P has been critical to showcase the importance of this system and its use for individual, community and national decision-making.



©WHO/Blink Media - Nana Kofi Acquah

80 Sixth ad hoc Meeting of PAHO's Technical Advisory Group (TAG) on Vaccine-preventable Diseases. United States of America (virtual meeting). 16 November 2020. Washington, D.C.: Pan American Health Organization; 2020 (https://iris.paho.org/handle/10665.2/53182, accessed 6 September 2021).

DEEP DIVE

Delivery for Impact

The Thirteenth General Programme of Work, 2019–2023 (GPW13) focuses on making a measurable impact on population health in countries. The results framework tracks the joint efforts of the Secretariat, Member States and partners to meet the Triple Billion targets and the health-related SDGs. It is complemented by the programme budget and annual results reports, to assess the Secretariat's contribution to delivering impact in countries. The WHO results framework is part of a robust impact measurement system comprising the WHO impact measurement, a scorecard for output measurement and qualitative case studies. The WHO impact measurement is based on the SDGs and includes the top-level healthy life expectancy indicator as a summary measure of population health; the Triple Billion targets and related indices; and 46 outcome indicators (39 of which are SDG indicators and remaining are World Health Assembly resolutions indicators).

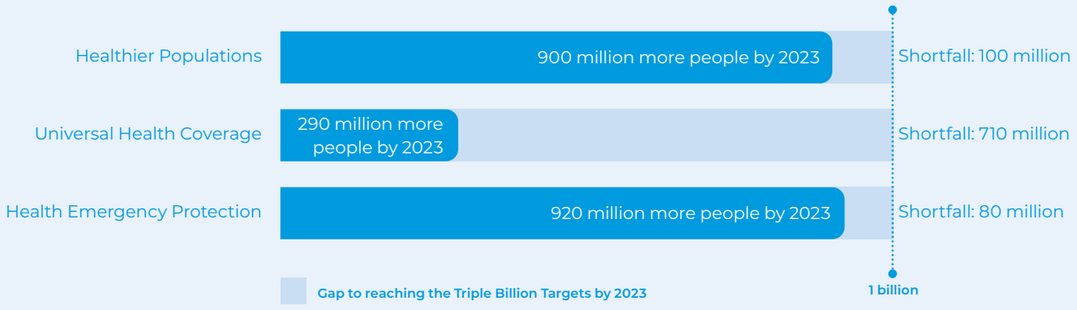
WHO's Transformation Agenda in 2020 continued with a new operating model and new ways of working aligned across the Organization's three levels: headquarters, regional offices and WCOs. A new meeting structure to enhance WHO's ability to deliver on the Triple Billion targets, the "Triple Billion stocktake" was launched in June 2020. Stocktakes are convened as an internal accountability mechanism for WHO Senior Leadership to be updated on progress towards the Triple Billion targets and identify actions to address barriers to progress. Stocktakes involve all three levels of WHO and are chaired by the Director-General with the participation of regional directors and some WCO representatives. The guiding questions of a stocktake are: are we on track and if not, what are we going to do about it?

Regional pre-stocktakes are held to analyse the regional-level trends across and within each of the billion targets, and to identify opportunities for acceleration where it is recognized that the countries are off track in reaching the targets. They are an opportunity for data-driven prioritization in terms of identifying indicators and countries which are showing the least progress or have the greatest potential for acceleration.

The regional pre-stocktakes and stocktakes are also a forum to discuss the interventions necessary to address challenges and accelerate progress, and to make key asks to Senior Leadership to enable acceleration to be achieved. They allow an agile problem-solving and course correction through coordinated follow-up actions taken at three levels of the Organization.

The first Triple Billion stocktake took place in June 2020 and covered each Billion. It was followed by a stocktake on the Healthier Populations Billion in October and then another one in November covering the Health Emergencies and UHC billions. We face a shortfall in trying to reach the Triple Billion targets, as illustrated in Fig. 16.

Fig. 16. WHO Triple Billion dashboard – 2023 projections



Source: Triple Billion dashboard[81]

81 The Triple Billion dashboard. In: World Health Organization [website] (https://portal.who.int/triplebillions/, accessed 7 September 2021).

Universal Health Coverage Billion

- The UHC Billion will be the hardest to achieve – analysis of expected progress by 2023 under a business-as-usual scenario suggests there will be a gap of 710 million people even before disruption caused by COVID-19.
- Low- and lower-middle-income countries are expected to make the most progress during the GPW13. However, this progress is not enough to substantially reduce persistent global inequality in access to services.

Healthier Populations Billion

- Nine hundred million more people are projected to be healthier in 2023 compared to the 2018 baseline.
- The current projected achievement of this Billion is not expected to be equitable. For every person projected to be newly healthier in a low-income country, there will be five newly healthier people in the rest of the world. Additionally, 80% of the anticipated progress is driven by only a few countries.

Health Emergencies Billion

- Prior to COVID-19, estimates showed that the world was on track to achieve 1 billion people better protected from health emergencies by 2023. Latest estimates, including monitoring data from 2020, suggest that whilst progress is being made across all indicators and regions, the current trajectory will fall just short of the target, with 920 million people better protected by 2023.

Although the stocktakes are internal, the Triple Billion Dashboard allows Member States to view progress at the global level across the Billion targets, and access country-specific views on projected progress across all component indicators by 2023. The Dashboard is part of the new measurement tools and mechanisms for using data and ensuring WHO's accountability for results. Progress towards the Triple Billion targets and the SDGs can be achieved only when baselines are defined clearly, targets are set and trajectories for acceleration are identified to guide and drive actions.

Furthermore, in October 2020, eight ambitious countries (**Ethiopia**, **Mauritius**, **Oman**, **Pakistan**, **Paraguay**, **Philippines**, **Sri Lanka** and **Ukraine**) were selected to join the Delivery for Impact Knowledge Hub – a capacity-building initiative designed to support WCOs and Member States to plan for implementation more effectively, apply new problem-solving tools, and drive delivery while showing evidence of impact. This initial cohort of eight countries received additional support from the recently established Delivery for Impact Department to adopt a delivery approach in working towards their strategic objectives. Each country team comprised WCO staff – including health policy advisors – and national authorities. Each team selected their strategic objective and participated in a six-month learning journey in which they learned the fundamentals of the delivery approach and applied that learning to address the challenges faced in the implementation of their health priorities.

In addition, in 2020, WHO ran a pilot project in 33 countries to measure impact and finalize the WHO results framework. Based on the output scorecard, outcomes indicators and Triple Billion targets, this exercise revealed that the results framework is useful and feasible, but will require improved data systems. The result frameworks will also integrate qualitative reports to follow progress, risks, challenges and lessons learned through country case studies. With regards to UHC, the UHC index, which combines measure of health service coverage (SDG 3.8.1) and financial hardship (SDG 3.8.2), will be used to monitor progress.

Case example – Sri Lanka

The country team in Sri Lanka chose to focus on hypertension. Through the Delivery for Impact Knowledge Hub they were able to narrow this focus by identifying a target that was meaningful, measurable and moveable: to reduce the proportion of adults in Sri Lanka who have not been screened for hypertension from 33% to 20%.

With the target firmly established, the team identified success indicators to help review progress towards their target over time and conducted a prioritization exercise to select the most impactful strategies/interventions that will be in the delivery plan.

Strategy 1: Opportunistic hypertension screening at all primary care visits
Provide opportunities to have blood pressure checked f or all people aged 20 years and above to those attending outpatient department services/clinics for any purpose (patient or accompanying person).

Strategy 2: Have the necessary services for (self) screening at different locations (e.g. at workplaces via Healthy Lifestyle Centre staff)
Provide opportunities to have blood pressure checked for all people aged 20 years and above in different workplaces in at least two government and two private institutions each year in a Ministry of Health area.

Strategy 3: Conduct a "Hypertension Week"
Provide opportunities to have blood pressure checked for all people aged 20 years and above at selected public places in a Ministry of Health area every day during a designated "Hypertension Week".

The team applied various problem-solving tools to further unpack this delivery challenge and identify the main barriers to improving hypertension screening. They quickly realized that the main roadblock to ensuring hypertension screening takes place at primary care centres is the lack of staff capacity in the majority of centres as these have just one medical officer, dispenser and one to two support staff serving outpatient delivery needs, healthy lifestyle clinics, antenatal and other clinics. They also identified a need for more physical spaces to make sure patients are screened. Once they were in agreement about the key challenges, the delivery team was able to come up with a set of targeted solutions to address these problems. They agreed on three short-term actions that will enable them to make progress:

- Hold advocacy meetings with all categories of staff at primary care centres on the importance of promoting opportunistic screening.
- Conduct training for effective treatment, to relieve the time taken for consultations and for better planning on stocking medicines.
- Build temporary shelters as waiting areas for patients.

The UHC-P is working closely with the Delivery for Impact Department to identify countries that would benefit from adopting the delivery approach to maximize impact.

DEEP DIVE: Delivery for Impact

A health worker and a patient at Tulagi Clinic, Solomon Islands. The country faces a growing burden of NCDs such as cardiovascular diseases related to diabetes, hypertension, obesity, etc.
©WHO/Blink Media - Neil Nuia

4.2 Data and innovation

There has been a marked increase in the use of digital health as a result of COVID-19 and there have been substantial "spill-over effects" from this increased use of digital health efforts (see Boxes 20–23). For instance, in the **Western Pacific Region**, the UHC-P improved a regional information platform to produce better information for policy-makers to track progress with the Healthy Island Monitoring, SDG and UHC indicators. Technical support from the UHC-P also resulted in ways to embed innovation as a core component of the new normal by identifying effective innovative approaches that can shape the country response. For example, a virtual health assistant (avatar) was developed in 2020 to support older people to leverage innovative channels to promote healthy ageing and self-care relating to COVID-19, with pilots targeted for **Philippines** in 2021.

In **Vanuatu**, the UHC-P supported strengthening the health information system to improve the quality, reliability and timeliness of data available for decision-making. The UHC-P has also contributed to the implementation of key components of the Digital Health Strategy, including the configuration of the electronic **Vanuatu** Health Management Information System to accommodate the new data collections and to integrate and expand the use of the platform for key disease programmes, including malaria, TB, NTDs and EPI. The system will enhance the availability of data for decision-making through automated reporting processes with enhanced visualizations for data analysis.

Furthermore, the UHC-P supported the completion of digital health maturity assessments and digital health country profiles in **Cook Islands**, **Federated States of Micronesia**, **Fiji**, **Kiribati**, **Marshall Islands**, **New Caledonia (France)**, **Niue**, **Solomon Islands**, **Tokelau**, **Tonga**, **Tuvalu** and **Vanuatu**. This has laid the foundation for the strategic planning for digital health information systems in these countries.

In **Indonesia**, the UHC-P supported the development of a digital platform for the National Standard of Adolescent-friendly Health Services (AFHS), and Health Screening tools are in progress with the aim of ensuring AFHS are monitored and improved, and adolescent health status obtained periodically. Moreover, the mobile application for a national TB dashboard was successfully launched in November 2020.

In the **African Region**, in many countries such as **Democratic Republic of the Congo**, **Ethiopia**, **Mozambique** and **Uganda**, digital or mobile health technologies have been used to provide services for communicable diseases, NCDs and SRMNCAH during COVID-19, including health-care provider communication (e.g. WhatsApp groups), health-care provider training (virtual) and health worker activity planning and scheduling.

Health care worker inspects a sample using a microscope in a primary health clinic in Uzbekistan.
©WHO/Anna Usova

Box 20: India's SDG health dashboard

In strengthening country capacity in data and innovation, UHC-P work in the **South-East Asia Region** focused on improving countries' health information systems and use of data and information, monitoring trends with attention to SDGs and GPW13, particularly availability of disaggregated data, improving research systems and innovation, and following health information system norms and standards. In **India**, the UHC-P has built the capacity of 500 medical professionals on medical certification and coding of cause of death in the context of COVID-19, and provided technical support to the National Institute of Medical Statistics for finalizing the publication of a verbal autopsy study comparing methods for assigning cause of death.

The WCO for India partnered with the Ministry for Health and Family Welfare to develop the SDG health dashboard, which was launched by Dr Harsh Vardhan, then Union Cabinet Minister for Health and Family Welfare on UHC Day, 12 December 2020. The UHC Day event witnessed participation of high-level government officials from both federal and state governments, United Nations agencies and development partners, amongst others. The launch video[82] was played during the event to give an overview of the SDG health dashboard to the users and is hosted on the website of the Ministry of Health and Welfare.[83] This dashboard will enable users to store, manage, visualize, explore, monitor and report national and state-level SDG progress.

The SDG health dashboard is currently used by federal and state governments through user credentials that have been shared with the secretaries of health of all the states and heads of all programme divisions within the Ministry for Health and Family Welfare. Upon the recommendations of the ministry, the process of enhancing the dashboard functionality from states to district level use is underway.

WCO India technically and financially supported a national consultation with civil society on SDG 2030. The key challenges, emerging issues, good practices and recommendations from this consultation fed into **India's** Voluntary National Review (VNR) report 2020. The report aims to facilitate sharing of experiences, including successes, challenges and lessons learned, with a view to accelerating the implementation of the 2030 Agenda.

Box 21: District Health Information Software 2 (DHIS2) in the African Region

The UHC-P has supported **Cabo Verde**, **Guinea-Bissau**, **Malawi**, **Mauritius** and **Zambia** to improve their DHIS2, an open-source, web-based platform most commonly used as a HMIS. This includes the assessment of DHIS2 ecosystems, the status of the health information system in general, and the integration of a tracker for integrated disease surveillance and response. Support has also been provided to **Côte d'Ivoire**, **Kenya** and **Mauritania** for the assembly, consolidation and analysis of data to assess the progress and performance of the national health sector strategic plan. In **Côte d'Ivoire** and **Mauritania**, the results have been used to inform the development of a new health sector strategic plan.

In **Chad**, the UHC-P supported a number of activities for strengthening the national health information system, including the deployment of DHIS2; development, validation and dissemination of standards tools for data collection and reporting; and training of health workers at all levels on the tools. **Kenya**, **Uganda** and **United Republic of Tanzania** were supported to develop and begin to roll out an electronic tool for medical certification and coding of cause of death, linked to DHIS2. The tool will improve the availability and quality of mortality data, and also reduce the burden of reporting deaths and causes of death. The plan is to roll out the tool to all the countries in the **African Region** – support to **Eswatini**, **Gambia**, **Liberia**, **Mauritania** and **Namibia** is already in place. **Madagascar** started introducing data on infrastructure and equipment into the DHIS2.

82 See: https://cdn.who.int/media/videos/default-source/covid-19/whatsapp-video-2020-12-15-at-6-36-46-pm-(1).mp4?sfvrsn=48ecb929_6.

83 Website available at: https://sdghealthindia-mohfw.in/.

Box 22: COVID-19 and civil registration and vital statistics systems

COVID-19 has also revealed gaps in the capacity of countries for mortality surveillance and overall capacity of national-level civil registration and vital statistics (CRVS) systems. In line with this, efforts to scale up support to countries in development of roadmaps for CRVS systems strengthening have been supported in all 47 countries of the **African Region**, as well as the development of the African Regional Framework on Mortality Surveillance, in collaboration with Bloomberg Philanthropies, Africa Centres for Disease Control and Prevention, United States Centres for Disease Control and Prevention, and the South Africa Medical Research Council. Support was provided to **Burundi**, **Guinea-Bissau**, **Liberia** and **Nigeria** to conduct an assessment of the status of their CRVS systems. Results of the assessment have informed the development of country roadmaps for improving the availability and quality of data on births, deaths and cause of death.

Box 23: Teleconsultation, an alternative promoted by the private health sector in Mauritius for the COVID-19 period

During the COVID-19 pandemic, the health-care community and private sector in Mauritius are taking an active role in re-engineering their health-care services, advancing care continuity and UHC. Taking a telemedicine approach, an endeavour is being made to provide essential health services during confinement periods in a safe environment. This is an alternative solution promoted by a group of private doctors and entrepreneurs with potential to easing access to health-care services during confinement, increasing efficiencies by reducing cost of care and barriers to access to care, such as waiting times during normal time.

FACT: For the first time in Mauritius private doctors and entrepreneurs have launched two telemedicine services platforms and are providing health services and acting as a marketplace where services of health-care providers such as clinicians, specialists and allied health services are offered to patients.

WHY IT MATTERS: Telemedicine is crucial in ensuring care continuity during confinement or lockdown periods. The alternative offers a tested solution to a systemic problem countries are facing in ensuring services during confinement periods, and will help in overcoming barriers caused by limited physical access to doctors and patients, barriers due to transportation issues, and missed or delayed appointments; it will allay patient fears of physical contact, thereby limiting delay in care-seeking behaviour.

EXPECTED IMPACT/RESULT(S): Telemedicine is expected to be utilized more by patients especially during active phases of confinement or any other disaster. It will ensure easy monitoring of patients remotely with the availability of better newer technologies such as ease of video streaming. Newer challenges would be to ensure services are secure and privacy protected, and to provide an enabling ecosystem for telemedicine to function.

UHC-P IN PRACTICE: WHO, through UHC-P in collaboration with the Ministry of Health and Wellness and other partners, are working towards institutionalization of telemedicine as an alternative approach for services delivery, and with Goals 21 and 25 of the Health Sector Strategy Plan 2020–2024 clearly identifying strategic actions for telemedicine in Mauritius.

5. Challenges and Lessons Learned

The year 2020 will be recognized as a challenging year for health

The COVID-19 pandemic disturbed the delivery of health services, constraining countries to use available resources in the most efficient way. The UHC-P had to quickly adapt and seek ways to provide technical support on a timely basis that could address countries' new realities and needs. Moving forward, as the pandemic remains a major challenge, additional resources and, specifically, additional staff will be required to sustain the delivery of high-quality support to countries, to address the expanded demands.

The realist research[84] has shown that the technical assistance provided by the UHC-P is its greatest added value. In all regions, policy advisors are considered key to facilitating and informing policy discussions while strengthening the leadership and capacities of ministries of health to ensure policy change to move towards UHC. The flexibility to adapt their terms of reference to each context allows the UHC-P to ensure assistance that is fit for context. The role of the UHC-P is essential to ensure that ministries of health have ownership over policy dialogues by promoting a cross-cutting approach, ensuring close follow-up, seizing opportunities to enhance processes and building trusting relationships with health ministries. Financial support to organize exchange platforms and funding to generate evidence are also recognized as key resources provided by the UHC-P to enhance policy dialogue. Moreover, the continuity of UHC-P support is helping countries to yield results in building policy dialogue institutions and strengthening legal and strategic planning frameworks for health.

The realist research also raised some challenges with regards to the UHC-P strategic approach. In the selected case-studies, the UHC-P was able to support policy dialogue when stakeholders recognized the need to collaborate and when it could respond to their needs and interests. However, UHC-P efforts in ensuring operational results from strategic frameworks become hampered when there is low level of mobilization of decision-makers and weak leadership and ownership by ministries of health. These conclusions demonstrate the need to review the paradigm of the UHC-P to ensure that political and social contexts are taken more into account and that the strategic approach to strengthen health systems benefits various health programmes and ultimately improves people's health.

84 Robert E, Zongo S, Rajan D, Ridde V. Contributing to collaborative health governance in Africa: a realist evaluation of the Universal Health Coverage Partnership. [forthcoming in 2021]

5.1 Challenges

Country political and financial commitments to implementation remain an important challenge for health financing strategies and reforms. There is a growing need to identify adequate strategies to go beyond assuming that by supporting countries to develop evidence-based policies, countries will automatically effectively implement them. In the context of the COVID-19 pandemic, the **African Region**, for example, experienced delays in the implementation of health financing reforms, which negatively impacted the progress made towards UHC.

The COVID-19 pandemic posed several challenges for implementation, including a **change in priorities** within the ministries of health to respond to the demands imposed by the pandemic. In the **Region of the Americas**, for example, many activities were postponed, and travel restrictions hampered the start of most planned activities for 2020. Nonetheless, with the financial support of the UHC-P, many countries were able to adapt to new norms and carry out their activities. Different stages of COVID-19 transmission affected absorptive capacity, speed and engagement of counterparts on health systems–strengthening issues, such as in the **European Region**. In many countries, it was a challenge to **adapt to new structures and ways of working**. Virtual connections, for example, yielded varying results in terms of what and how much countries can be supported.

Additional challenges included **constrained engagement with Member States and partners whose absorptive capacity to address non-COVID-19 issues was low**. In the **Western Pacific Region**, for example, health policy advisors repurposed towards COVID-19 response and preparedness contributed to leveraging COVID-19 response to strengthen health systems, including delivery of care and maintaining essential services, notably, NCDs. The challenges of delivering support in the face of **travel restrictions and social distancing measures** were addressed by proactively adopting the use of virtual and innovative modalities.

The pandemic also **affected the regular activities planned at the regional and country levels**, such as in the **Eastern Mediterranean Region**. In **Djibouti**, for example, other epidemics (malaria, chikungunya and dengue) and the large influx of refugees due to the armed conflict in a neighbouring country interrupted planning activity. Moreover, political and social instability, security challenges or fragmentation of interventions continue to pose challenges in **Afghanistan**, **Somalia**, **Sudan** and **Yemen**. Political instability can be illustrated by the high turnover of governmental officials at different levels, which has impeded the continuity of activities in several countries, especially in **Egypt**, **Jordan** and **Pakistan**.

Siparia Health Centre, Trinidad and Tobago. ©PAHO/WHO/Denith McNicolls

5.2 Lessons learned

PHC, UHC and SDG principles have been mainstreamed in the regional guidelines and national health financing policies, strategies and plans under the goal to "Leave no one behind", including the need to take a gender, equity and human rights approach. This has contributed to improvements in countries' progress towards increased and sustainable domestic health financing, as well as more equity in resource allocation, in the **African Region**, for instance. In the **Western Pacific Region**, WHO support for COVID-19 response and preparedness of outbreaks contributed to longer-term health systems strengthening and a foundation to continuously advance UHC in the Region.

Coordination in WHO teams (at the three levels and between the regions) as well as their effectiveness have also increased. For instance, in the **Eastern Mediterranean Region**, a joint review of activities accomplished in 2020 was conducted, resulting in a decision to hold webinars in 2021 with the NCD/mental health and health systems focal points from 14 WCOs and related technical staff. The objective will be to discuss the common activities to be conducted through the jointly developed products and services, and optimal utilization of UHC-P support at the country level, including health policy advisors and activities funding. In the **European Region**, the CPS established, at the onset of the pandemic, a cross-programmatic team to provide guidance to Member States on health systems strengthening as part of the pandemic response. The team, embedded in the coordination structure of the European Regional Office's Emergency Incident Management Team, provided support to Member States for rapidly reorganizing service delivery to respond to COVID-19 while maintaining core essential services across the continuum of care. This team included the members of the UHC-P JWT of the European Region. Since the second half of 2020, the European JWT has organized biweekly meetings with the UHC-P-funded policy advisors to ensure their integration, allow exchange of experiences among them, and provide a vehicle for programmes to channel their content and activities to country level.

The pandemic also demonstrated the importance of the agility of policy advisors on the ground in the surge efforts to support countries to respond to the pandemic, which called on WHO staff to be repurposed to provide critical and additional support to the response at global, regional and country levels. In the **Western Pacific Region**, for example, staff capacity were further developed to be able to better address the growing scope and requests from countries. Corporate support for platforms, resources and analysis in staff learning and development, as well as applying the experience into career development and human resources planning was key to ensuring that the right people were in the right places.

Coordinating and convening key health sectors stakeholders still played a great role in improving country policy dialogue, health policies and plans development and implementation. This has also positively impacted the multisectoral side of health-related interventions. In the **South-East Asia Region**, for instance, these collaborations through regular meetings with key partners such as the World Bank and the IMF, enabled the generation of new evidence on how countries were responding to the COVID-19 crisis and to advocate for much-needed reforms among countries in the Region on health financing for UHC. In the **Western Pacific Region**, WHO's leadership in the COVID-19 response and the trust of Member States in WHO's work translated into an increased number of donors and funding amounts. The Region was able to deliver on Member States' urgent requests to strengthen response and maintain non-COVID-19 essential services, as well as to leverage health systems strengthening that benefits not only the initial response but that will impact health systems in the future. This includes: maintaining the trust of donors to continue building on the gains of the overall health systems–strengthening policies from COVID-19 response and preparedness to continue to advance UHC; and continuing to advocate to donors to invest in the overall Triple Billion goal of GPW13, avoiding earmarking. In the **European Region** the UHC-P-funded policy advisors were instrumental in maximizing the catalytic role of UHC-P funding by bringing together relevant stakeholders (from the health sector and beyond) at country level. The policy advisors, in close coordination with the Regional Office, helped ensure that the key technical priorities – including far-reaching health system reforms in some countries – remained observed amidst a challenging context with competing priorities brought about by the pandemic.

6. Conclusion

and Looking Forward to 2021

While countries adapted quickly using existing resources, as the pandemic remains a major challenge and partner countries look to the UHC-P for continued and expanded technical support, additional resources, and specifically, additional staff, the UHC-P will be required to sustain the delivery of high-quality support to countries and achievement of UHC.

An unprecedented global collaboration formed to respond to the pandemic: the Access to COVID-19 Tools (ACT) Accelerator, with the aim of providing innovative and equitable access to COVID-19 diagnostics, treatments and vaccines. WHO and Gavi co-lead the COVAX pillar, which is focused on ensuring global access to COVID-19 vaccines once they are available, and to guaranteeing fair and equitable access for every country in the world, upholding one of UHC's core principles.

The COVID-19 pandemic highlighted as never before the pressing need to achieve UHC. Recognizing the extraordinary challenges faced by partner countries, this UHC-P Annual Report 2020 demonstrates the successful pivoting of WHO staff at all levels to address the stated needs of WHO Member States to manage the pandemic. The COVID-19 pandemic presented an opportunity for UHC-P staff to quickly adapt and seek ways to provide technical support in a timely manner that would address countries' new realities and needs. The context of the pandemic required a rapid shift in short-term priorities while keeping long-term, far-reaching transformation on the agenda.

This report highlights the efforts of UHC-P staff to ensure that 1 billion more people benefit from UHC, that 1 billion more people are better protected from health emergencies, and that 1 billion more people enjoy better health and well-being, within the context of the COVID-19 pandemic. The report demonstrates that UHC-P contributions and successes in addressing the COVID-19 pandemic vary in breadth and scope depending on the needs of the region and the country, but the underlying thread is that of collaboration and cooperation – across countries, regions and organizations. Although COVID-19 predominated the work functions of the UHC-P, there was continued work on the new approaches, challenges and opportunities based on WHO's GPW13 towards achieving progress towards UHC.

7. Annexes

Annex I

Table of activities by output by country

GPW13 OUTCOMES

- **1.1** Improved access to quality essential health services
- **1.2** Reduced number of people suffering financial hardship
- **1.3** Improved access to essential medicines, vaccines, diagnostics and devices for primary health care
- **2.1** Countries prepared for health emergencies
- **2.2** Epidemics and pandemics prevented
- **2.3** Health emergencies rapidly detected and responded to
- **3.1** Determinants of health addressed
- **3.2** Risk factors reduced through multisectoral action
- **3.3** Healthy settings and Health in All Policies promoted
- **4.1** Strengthened country capacity in data and innovation
- **4.2** Strengthened leadership, governance and advocacy for health
- **4.3** Resources management

	ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									ONE BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES												
GPW13 OUTCOMES	1.1					1.2			1.3					2.1			2.2			2.3			3.1		3.2		3.3		4.1			4.2						4.3			
GPW13 OUTPUTS	1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO African Region																																									
Angola	■	■		■	■		■																						■	■		■									
Benin					■	■	■				■											■																			
Botswana	■			■	■		■				■		■																■		■										
Burkina Faso	■	■	■	■	■	■	■			■			■	■	■			■	■	■	■		■	■					■	■		■			■			■	■	■	■
Burundi	■	■	■	■	■		■		■	■	■		■									■							■	■	■										
Cabo Verde	■	■	■	■	■	■	■			■	■	■	■		■	■																									
Cameroon	■	■	■	■	■	■	■		■				■	■	■	■			■	■		■	■		■	■			■	■		■	■	■	■			■	■	■	■
Central African Republic							■																																		
Chad	■	■	■	■	■	■			■	■	■	■		■	■			■	■	■	■	■	■						■	■	■	■			■				■		
Comoros	■	■	■	■	■	■	■		■				■	■	■	■		■		■		■	■	■		■			■			■						■	■		■
Congo	■	■	■	■	■	■	■		■	■	■	■	■	■	■			■	■	■		■	■						■	■	■	■	■		■			■	■	■	■
Cote d'Ivoire	■	■		■		■	■															■							■												
Democratic Republic of the Congo	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■			■	■	■	■	■	■		■
Equatorial Guinea	■	■	■		■				■	■	■			■	■	■	■	■	■	■	■	■	■	■			■		■	■		■	■			■	■		■		

	ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									ONE BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES												
GPW13 OUTCOMES	1.1					1.2			1.3					2.1			2.2			2.3			3.1		3.2		3.3		4.1			4.2						4.3			
GPW13 OUTPUTS	1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO African Region																																									
Eritrea	■	■	■	■	■				■	■	■		■		■			■		■	■	■	■						■	■		■	■		■	■	■		■		
Eswatini	■	■	■	■	■		■		■	■	■	■	■	■	■	■	■	■	■	■	■	■					■	■	■		■	■	■	■	■			■	■		■
Ethiopia	■			■	■	■	■		■	■	■		■									■						■	■	■		■			■	■	■				
Gabon	■		■	■	■	■	■		■																				■			■									
Gambia	■	■			■	■									■																										
Ghana	■			■	■				■	■	■																														
Guinea	■		■		■	■	■	■		■	■																	■	■												
Guinea-Bissau	■	■	■	■	■		■		■	■	■	■	■	■	■	■	■	■	■	■	■	■		■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	
Kenya	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■					■	■	■	■	■	■	■			■	■	■	■
Lesotho	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■		■	■	■		■	■	■	■	■	■	■	■	■				
Liberia	■	■	■				■			■	■		■		■	■		■	■			■	■		■				■	■					■	■	■				
Madagascar	■	■	■	■		■	■	■	■	■	■	■	■	■	■			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Malawi	■	■	■	■	■	■	■		■	■	■		■	■	■	■		■		■	■	■	■	■	■	■		■	■	■	■	■		■	■			■	■	■	
Mali	■	■	■	■	■	■	■		■				■	■	■			■	■	■	■	■	■		■	■	■		■	■		■	■	■	■	■	■	■	■		■
Mauritania	■	■	■	■	■	■	■		■				■		■			■			■				■				■			■									
Mauritius	■	■	■	■	■		■	■	■				■																■	■					■						
Mozambique	■			■	■	■				■	■																														
Namibia	■			■	■	■	■						■																■												
Niger	■	■	■			■	■		■	■	■		■		■	■		■	■	■	■		■	■	■	■			■		■	■			■						
Nigeria				■		■					■				■							■							■												
Rwanda	■		■				■				■		■									■																			
Sao Tome and Principe	■					■		■																					■			■									
Senegal	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■		■		■	■	■	■	■	■				■			■			■			■	■		■
Seychelles	■																												■												
Sierra Leone				■	■	■	■		■																				■												
South Africa	■			■	■	■	■	■	■				■																■			■									
South Sudan	■			■	■																																				
United Republic of Tanzania	■	■			■	■	■	■	■	■	■				■														■												
Togo	■	■	■	■	■	■	■		■	■	■		■	■	■	■		■	■	■	■	■		■					■		■	■	■		■	■	■	■	■	■	■
Uganda	■	■	■	■	■	■	■	■		■	■		■		■					■	■								■	■		■	■	■	■			■			■
Zambia	■	■		■	■	■		■	■	■	■		■	■		■		■			■	■	■		■	■	■		■	■	■	■	■	■	■	■	■	■	■		■
Zimbabwe	■			■	■	■	■	■		■	■									■									■												

		ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE														ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES										ONE BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING					MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES													
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**						**2.1**			**2.2**			**2.3**			**3.1**		**3.2**		**3.3**		**4.1**			**4.2**							**4.3**			
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO Region of the Americas	Antigua and Barbuda				■		■								■	■					■					■																
	Bahamas	■	■		■	■									■	■	■							■		■				■												
	Barbados	■	■			■		■								■	■				■					■																
	Belize															■																											
	Colombia					■						■																										■				
	Cuba	■	■		■											■																										
	Dominica		■		■	■										■	■				■					■																
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	Grenada		■		■	■										■	■				■					■				■												
	Guyana				■	■	■					■				■	■																										
	Haiti	■	■	■	■			■				■									■											■										
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	Peru	■			■	■	■	■	■																																
	St. Kitts and Nevis	■	■		■			■								■	■				■					■																
	St. Lucia	■	■		■	■										■	■				■																				
	St. Vincent and the Grenadines		■				■									■	■				■										■											
	Suriname		■		■	■	■					■				■	■									■	■			■												
	Trinidad and Tobago		■	■	■	■				■	■				■	■									■		■															

		ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE														ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES										ONE BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING					MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES													
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**						**2.1**			**2.2**			**2.3**			**3.1**		**3.2**		**3.3**		**4.1**			**4.2**							**4.3**			
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO Eastern Mediterranean Region	Afghanistan	■			■	■																																			
	Djibouti						■																																			
	Egypt	■			■		■			■	■																															
	Iraq	■			■	■	■																																			
	Islamic Republic of Iran						■																															■				
	Jordan	■																																								
	Lebanon						■	■							■																												
	Morocco					■	■																																■				
	Occupied Palestinian Territory				■		■																																				
	Pakistan	■				■	■																																			
	Somalia					■		■		■																																	
	Sudan	■	■		■	■	■																																			
	Tunisia				■			■		■	■																																
	Yemen				■																																					
	Azerbaijan	■	■		■																	■																				

		ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE														ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES										ONE BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES													
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**						**2.1**			**2.2**			**2.3**			**3.1**			**3.2**		**3.3**		**4.1**			**4.2**							**4.3**			
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5		2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3		3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2		4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6		4.3.1	4.3.2	4.3.3	4.3.4
WHO European Region	Azerbaijan	■	■		■												■						■																						
	Georgia	■		■			■	■			■						■						■																						
	Kyrgyzstan	■				■	■				■						■						■																						
	Republic of Moldova				■	■	■	■	■								■						■									■			■					■			■			
	Tajikistan	■			■	■	■	■	■		■						■						■																						
	Ukraine	■	■				■	■									■						■																						
	Uzbekistan	■	■	■	■	■	■		■								■						■																						

		ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE														ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES										ONE BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES													
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**						**2.1**			**2.2**			**2.3**			**3.1**			**3.2**		**3.3**		**4.1**			**4.2**							**4.3**			
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5		2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3		3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2		4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6		4.3.1	4.3.2	4.3.3	4.3.4
WHO South-East Asia Region	Bangladesh	■	■	■	■	■	■	■		■	■			■								■	■		■	■	■		■			■	■	■	■	■	■		■		■		■	■	■	■
	India	■			■	■	■	■		■	■																					■	■	■	■	■	■	■	■	■		■	■	■	■
	Indonesia	■		■		■	■			■		■	■			■	■				■	■			■	■	■	■	■			■		■	■	■	■	■				■	■	■	■
	Myanmar					■	■	■																								■														
	Nepal	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■		■	■	■	■
	Sri Lanka	■	■	■		■		■		■		■				■	■	■			■	■	■		■	■	■	■	■	■			■		■	■	■	■	■				■	■		■
	Timor-Leste	■	■	■	■	■	■		■	■	■	■		■		■	■	■		■	■	■	■	■	■	■	■	■	■	■		■	■	■	■	■	■	■	■	■		■	■	■	■

		ONE BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE														ONE BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES										ONE BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES													
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**						**2.1**			**2.2**			**2.3**			**3.1**			**3.2**		**3.3**		**4.1**			**4.2**							**4.3**			
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5		2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3		3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2		4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6		4.3.1	4.3.2	4.3.3	4.3.4
WHO Western Pacific Region	Cambodia	■					■																																						
	Cook Islands		■	■		■			■		■					■	■															■		■	■	■			■						
	Fiji		■	■		■			■		■					■	■															■		■	■	■			■						
	Kiribati		■	■		■			■		■					■	■															■		■	■	■			■						
	Lao People's Democratic Republic	■		■	■	■		■								■																■	■		■	■									
	Malaysia						■																												■	■							■			
	Marshall Islands		■	■		■			■		■					■	■															■		■	■	■			■						
	Micronesia (Federated States of)		■	■		■			■		■					■	■															■		■	■	■			■						
	Mongolia	■	■	■			■																																						
	Nauru		■	■		■			■		■					■	■															■		■	■	■			■						
	Niue		■	■		■			■		■					■	■															■		■	■	■			■						
	Palau		■	■		■			■		■					■	■															■		■	■	■			■						
	Papua New Guinea		■			■															■											■		■											
	Philippines	■	■	■	■	■	■				■											■											■	■	■									
	Samoa		■			■																										■		■										
	Solomon Islands	■									■											■																							
	Tonga		■	■		■			■		■					■	■															■		■	■	■			■						
	Tuvalu		■	■		■			■		■					■	■															■		■	■	■			■						
	Vanuatu		■														■																	■										
	Viet Nam			■																												■											

Annex II.

List of WHO Public Health Goods supported by the UHC-P

DIVISION: Universal Health Coverage / Life Course

UNIT: Maternal, Newborn, Child and Adolescent Health and Ageing (MCA)

GLOBAL GOOD (GG): 2
Guidelines on comprehensive assessment of older people

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE/ACTIVITIES
- Coordinate further development of the integrated care for older people (ICOPE) handbook app, including the digital data platform.
- Develop the ICOPE pilot study protocol and initiate ICOPE implementation pilot study to validate feasibility and acceptability of ICOPE tools.
- Develop survey to collect data on ICOPE implementation readiness using the ICOPE implementation score card.
- Submit the planning proposal for recommendation on intrinsic capacity diagnostic tests and initiate systematic review. Further integrate ICOPE interventions into the UHC Compendium.

2020 PROGRESS
The WHO ICOPE is a community-based approach which will help to reorient health and social services towards a more person-centred and coordinated model of care supporting the optimization of functional ability for older people. WHO has provided several COVID-19 technical guidance for older people, reflecting the ICOPE approach. The ICOPE interventions have been introduced in the WHO UHC Compendium to support countries to provide nondiscriminatory access to good-quality essential health services for older people. Despite the ongoing COVID-19 pandemic, the ICOPE implementation pilot programme has been initiated in selected countries from all regions, by identifying and engaging all stakeholders at the micro, meso and macro levels. The countries for the ICOPE pilot implementation programme have been identified in collaboration with regional offices and country offices. They include Andorra, Brazil, Cabo Verde, Chile, China, France, India, Indonesia, Kenya, Mexico, Pakistan, Qatar, South Africa, Thailand and Viet Nam. The readiness of implementation is being assessed through ICOPE online global surveys to identify barriers and enablers with context-specific considerations, including the existing health system, burden of disease, values and available resources.

GLOBAL GOOD (GG): 4
UHC service package for long-term care

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE/ACTIVITIES
- Evidence review of literature and creation of initial list of interventions as well as meso domains for interventions. Hold an expert advisory meeting with the Global Network on Long-Term Care to discuss domains and interventions.
- Perform a Delphi study to look into missing interventions and interventions applicable to low- and middle-income countries and areas (LMICs) or low-resource settings. The Delphi results and consultations with a set of countries will also look into ordering the priority of interventions to be included in a minimal package.

2020 PROGRESS
Long-term care services are fundamental to improving functional ability and achieving healthy ageing. Through UHC-P support WHO was also able to move firmly ahead in the development process of the UHC service package for long-term care (UHC ICARE package), which will help countries to develop a minimal package of services as part of UHC. UHC-P support has also supported development of the WHO integrated continuum of long-term care. The readiness framework will be a guide for countries when assessing country readiness for long-term care service implementation, and ultimately guide and support countries in fundamental action points when formulating a national strategic plan.

DIVISION: Universal Health Coverage / Life Course

UNIT: Health Workforce (HWF)

GLOBAL GOOD (GG): 329
National health workforce accounts (NHWA) data platform

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
A data management tool that enables countries to record, analyse and visualize health workforce information primarily for their own use. Validated data are publicly available through the NHWA portal.

ACTIVITIES
- Data mining, triangulation, validation and release.
- Generation of data analytics and visuals.
- System maintenance and update.

2020 PROGRESS
The NHWA Online Data Platform facilitates health workforce data reporting and its use in a timely and effective manner. The platform enables countries to record, analyse and visualize health workforce information primarily for their own use. The system integrates data validation and quality assessment features, and offers a wide range of tools to simplify the process of data handling and to present a large amount of data in a customized manner. It also supports assessing the maturity of the human resources for health information systems to generate NHWA indicators. Aggregated data that are validated by countries are publicly available through the NHWA Data Portal available on the link in the next column.

URL FOR 2020 PROGRESS
https://apps.who.int/nhwaportal/

GLOBAL GOOD (GG): 322
Health Labour Market Analysis (HLMA) Guidebook

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
A toolkit composed of a "how-to" handbook explaining why HLMA is important, how to undertake HLMA and how to translate results into policy; and training materials to facilitate conducting trainings on HLMA.

ACTIVITIES
- Literature review.
- Expert meeting to define content.
- Development of draft HLMA Handbook and training material.
- Pre-testing of Handbook and training material.
- Consultation process.
- Editing, publication and dissemination.

2020 PROGRESS
The HLMA Guidebook facilitates the implementation of standardized HLMA to support national authorities to respond to key policy questions on human resources for health. It helps to identify and explain the root causes of health labour market mismatches, such as shortages, surpluses and imbalances in the skills mix and in the distribution of health workers (by geographical areas, types of health workers, levels of care and location of services). Based on this analysis, decision-makers can identify policy options to address challenges or mitigate their effects, and determine the feasibility and conditions of effective implementation of policy recommendations. The Guidebook was launched in September 2021.

GLOBAL GOOD (GG): 327
WHO guideline on HWF development, attraction, recruitment and retention in rural and remote areas

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
An update of the 2010 policy recommendations/guidelines on "Increasing access to health workers in remote and rural areas through improved retention".

ACTIVITIES
- Systematic review.
- Expert meeting.
- Development of draft revised recommendations.
- Consultations: Guidelines Steering Committee, Guidelines Development Group and external reviewers.
- Approval by WHO Guidelines Review Committee.
- Editing, publication and dissemination.

2020 PROGRESS
This updated WHO guideline presents a pathway for reversing both the current and predicted worsening shortage of health workers in rural and remote areas. It presents evidence-based interventions to support national authorities to identify best strategies to develop, attract, recruit and retain health workers in rural and remote areas as means of increasing equitable service coverage. The Guideline was launched in May 2021 and a summary document will be available in six languages.

URL FOR 2020 PROGRESS
https://www.who.int/teams/health-workforce/health-workforce-development/

GLOBAL GOOD (GG): 1363
The Global Competency and Outcomes Framework

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
A document with general and cross-cutting competencies and practice activities to inform the design of curricula and training programmes for health workers, with a pre-service education pathway of 12 to 48 months.

ACTIVITIES
- Literature review.
- Development of draft competency framework.
- Consultations: Global Health Workforce Network education hub, meeting and virtual review.
- Editing, publication and dissemination.

2020 PROGRESS
The Global Competency and Outcomes Framework identifies the requisite competencies towards the achievement for UHC and provides guidance to integrate these competencies into pre-service and in-service competency-based education. The framework is designed to be "adapted and adopted" to define the competency-based outcomes for the role responsibilities, context and priority health services. The main target audience is HWF educators, but the outcomes are also of relevance for licensing and regulatory authorities, and health service and facility managers.

GLOBAL GOOD (GG): 330
State of the World's Nursing report (data/investment case/ regional and country dialogue)

EXPECTED ACHIEVEMENT: 2020

DELIVERABLE
Nursing report.

ACTIVITIES
- Development of the report.
- Consultations.
- Editing, design and printing.
- Report launch.

2020 PROGRESS
The State of the World's Nursing 2020 report describes the global, regional and national nursing workforces of WHO Member States and provides evidence-based policy options for strengthening health service delivery by nurses towards achievement of UHC. Launched 7 April 2020.

URL FOR 2020 PROGRESS
https://www.who.int/publications/i/item/9789240003279

GLOBAL GOOD (GG): 326
International best practices on health personnel regulation and institutional accreditation

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
This review of evidence and lessons learned from international best practices will provide guidance to WHO Member States and all relevant stakeholders on legislative and policy options and processes for strengthening health personnel regulation, covering issues such as licensing and certification, institutional accreditation, performance and discipline matters, medical malpractice, and dual or multiple employment.

ACTIVITIES
- Scoping review of health practitioner regulation across countries.
- Technical Expert Group on Health Practitioner Regulation convened to guide the development for the Global Good.
- Systematic review on health practitioner regulation commissioned to inform the recommendations of the Global Good.

2020 PROGRESS
Planned for 2021.

GLOBAL GOOD (GG):
Strategic Directions for Strengthening Nursing and Midwifery 2021–2025

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
A document that provides 12 policy priorities, on education, jobs, leadership and service delivery, for Member States seeking to strengthen nursing and midwifery to help address population health needs.

ACTIVITIES
- Evidence review.
- Ten virtual consultations, including a consultative process with government chief nursing and midwifery officers.
- Member States consultation.
- Presentation to the Seventy-fourth World Health Assembly.

2020 PROGRESS
The Global Strategic Directions for Nursing and Midwifery 2021–2025 provides 12 policy priorities for Member States seeking to strengthen nursing and midwifery to help address population health needs, in line with the overarching Global Strategy for Human Resources for Health. The draft document is currently available at the link in the next column.

URL FOR 2020 PROGRESS
https://www.who.int/publications/m/item/global-strategic-directions-for-nursing-and-midwifery-2021-2025

GLOBAL GOOD (GG): 325
Bilateral agreements to optimize mutual benefits of health worker migration – a "how-to" guide

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Guidance to Member States, consistent with the WHO Global Code of Practice on International Recruitment of Health Personnel, on the development and implementation of bilateral agreements on health worker migration and mobility, focusing on form, content and processes. The guidance will be informed by the collection and review of existing bilateral agreements and stakeholder interviews.

ACTIVITIES
- Textual analysis of bilateral agreements provided to WHO to inform the guidance.
- Interviews with key stakeholders.
- Technical Expert Group on Bilateral Agreement to guide the guidance development.

2020 PROGRESS
Planned for 2021.

DIVISION: Universal Health Coverage / Life Course

UNIT: Integrated Health Services (IHS)

GLOBAL GOOD (GG): 924
Resilience Toolkit

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
A fit-for-purpose package, logically assembled with technical products and tools, for health systems strengthening, encompassing integration between health systems/services and health security from policy, planning, assessment to implementation and monitoring. This will provide authorities and health services practitioners with operational know-how and tools to maintain and improve the continuity of essential health services in different contextual situations.

ACTIVITIES
- Expert technical consultation within WHO and external authoritative bodies on the conceptual framing of resilience and suggested products for consideration under the Toolkit.
- Rapid scoping review of peer review and grey literature to inform experts' technical reviews and Toolkit development by elucidating the state of resources, gaps and priorities in the public domain.
- Develop, adapt and compile tools and technical resources needed to address the priorities, which will constitute the Toolkit.
- Follow up technical consultations involving global, regional and local experts.
- Trial: This could involve application in a set of countries, followed by further review and update based on country findings.
- Dissemination and application: Updated version of the Toolkit will be made available with support packages for application by countries with partners.

2020 PROGRESS
(1) To inform the design and architecture of the Resilience Toolkit, the team has conducted a series of technical consultations with teams at the WHO headquarters (IHS Department, UHL Division, WHE Division), as well as with colleagues from regional and country offices working on health systems resilience or related areas of work. The aim of these consultations was to seek input in defining the technical scope, conceptual framing and requirements for health systems resilience to be adopted in the Toolkit, while mapping tools and resources to address existing gaps in the global pool of knowledge and practices. In addition, these consultations also sought to identify special considerations for adaptation of the Toolkit to various contexts.

(2) A scoping review was conducted and completed, with the overarching objective to ascertain the existing critical gaps and current priorities in countries, provide an evidence base for the development of the Toolkit, and thus make the package fit for purpose and aligned with country needs. The scoping exercise also aimed to identify existing technical resources that can be relevant to the Toolkit, whilst avoiding duplication with previous efforts.

(3) A "call for technical material" through an online portal was made to various technical teams working on resilience and related areas of work at three levels of WHO. These yielded a collection of material that is directly and indirectly informing the development of the WHO Public Health Goods.

(4) As part of the Toolkit, a review and subsequent report on "Exploring health systems resilience in the context of public health emergencies" has been completed and is undergoing technical consultations. The aim of the review report was to analyse the evolving conceptual framing (including scope and definitions) of health systems resilience, and its application in the context of different types of public health emergencies, such as infectious diseases; acute and protracted conflict; economic stressors; and climate-related disasters; and to apply emerging experiences and lessons from the COVID-19 pandemic.

(5) The team is progressing with the development of the Toolkit, incorporating all feedback received; completion is anticipated before the end of 2021.

GLOBAL GOOD (GG): 888
Guidance to countries and partners on service planning and role delineation, including methods and tools for community health needs

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Guidance on operationalization of health service packages.

2020 PROGRESS
The architecture for the UHC Compendium (formerly Menu) was finalized through consultations across 20 WHO departments. It has been utilized to guide package decision-making processes by providing a structured approach to services across all health areas, which helps to operationalize integrated service delivery. The UHC Compendium architecture was utilized to support Somalia in updating its Essential Package of Health Services, which is being used to develop a normative product that can be operationalized in humanitarian settings, and will support other countries with the development and operationalization of service packages in 2021–2022. Additional guidance and products will be completed in 2022.

GLOBAL GOOD (GG): 870

Quality Toolkit: A co-developed package of technical resources supporting planning, implementation and evaluation of national efforts on quality

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Evidence on implementation and impact of key facility-based interventions to improve patient safety and quality.

2020 PROGRESS
A landscaping exercise conducted a review of over a dozen WHO toolkits to orient the structure and organization of the Quality Toolkit based on prior WHO experience. Internal consultation meetings at headquarters/regional office levels were completed for input into the structure and development of the WHO Quality Toolkit, with particular focus on the WHO Quality Taskforce. Completion of these initial development processes have informed the Design Document for the Quality Toolkit (available on request), which is a mechanism for documenting the creation of the Toolkit as well as to provide an overview of its composition. Input was sought from the design/communications team involved in finalizing the publication of the WHO Quality Planning Guide, which the Quality Toolkit expands upon. Input was also sought from across the organization for populating the content of the Toolkit. A first round review of tools and resources was completed by using a systematic categorization tool. Draft narrative of the Quality Toolkit was developed. Plans for sequential development and release of the Quality Toolkit in 2021 was put in place.

GLOBAL GOOD (GG): 859

Competency Framework for Leadership for Patient Safety

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Competency Framework for Leadership for Patient Safety.

2020 PROGRESS
(1) Leadership Competency Framework for Patient Safety: Extensive literature review was conducted on the (a) competencies important for ensuring patient safety improvements at policy and practice levels; and also on (b) global competency frameworks, national leadership and organizational competency models and frameworks, incorporating patient safety competencies.

(2) Based on the literature review, a draft conceptual framework has been developed which reflects the range of competencies required by leaders at different levels in the health sector, the range of leaders to be targeted for ensuring reduction in avoidable harm due to unsafe health care provision, and key domains of competencies to be developed, including personal attributes, core functions and ability to "execute"/mise-en-place.

(3) A core working group has been constituted for drafting and review of the conceptual framework, which met in April 2021 for the first round of discussions. An external review took place in September 2021, which would be followed by wider consultation and finalization in Q1 2022.

GLOBAL GOOD (GG): 332

Guidance for strengthening monitoring and evaluation (M&E) of national health sector strategies

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Guidance for strengthening M&E of national health sector strategies, with focus on primary health care (PHC) and UHC (revised edition).

2020 PROGRESS
Technical guidance to help countries monitor and evaluate health sector strategies based on a PHC-towards-UHC approach is currently under development with partial contributions from this grant. The guidance will include a conceptual M&E framework and menu of indicators to select, adapt and integrate into national M&E plans based on country context and health system maturity. Based on technical review and consultations with WHO programmes and regions, countries, partners and experts, the document will be published in 2021. Additional supporting tools and guidance will be developed in 2022.

GLOBAL GOOD (GG): 868

Practical guidance for health-care providers and policy-makers on palliative care

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Guidance for strengthening palliative care.

2020 PROGRESS
A technical report was developed on assessing palliative care worldwide. Following requests from Member States, IHS developed a set of indicators to be used by countries for the monitoring of palliative care, including identification of progresses and gaps. Three expert meetings were conducted virtually in 2020, as well as a Delphi process to build a consensus on the most relevant palliative care indicators. The report also includes modalities for the use of indicators in different settings. The launch of the report took place in October 2021; its dissemination was planned to coincide with a number of international events and through institutional collaborations with key partners active in the field of palliative care. Derivative products, including training modules, will be developed in 2022.

About 40 palliative care interventions were included in the UHC Compendium. The UHC Compendium is a database of health services and intersectoral interventions designed to assist countries in making progress towards UHC. The inclusion of palliative care interventions was done on the basis of an essential package for PHC included in the WHO guide on integrating palliative care and symptom relief into PHC published in 2018, taking into account a comprehensive approach to address patients' needs, including physical, psychological and social needs.

DIVISION: Universal Health Coverage / Life Course

UNIT: IHealth Systems Governance and Financing (HGF)

GLOBAL GOOD (GG): 258

Guidance on procedural aspects of using data to support health benefit package selection

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
- A "how-to" guide to developing health benefit packages for UHC.
- Report on Member States survey on how benefit package decisions are made, and what is in benefit packages.

ACTIVITY
- Stakeholder meeting and ad-hoc Technical Advisory Group (TAG) meetings to develop and review guidance document.
- Survey development, translation, analysis and dissemination.
- Proposal for report presented to TAG in June 2021.

2020 PROGRESS
In 2020, a survey on health benefit packages and health technology assessments was developed through consultations across WHO departments. The survey was piloted and translated. The respondent list was updated and the survey was sent to identified respondents. A shell version of a survey website was also developed. As of 21 May 2021, the survey had a 51% response rate (out of 194 Member States) and 77% nomination rate. A survey report/guidance document and associated website will be developed by the end of 2021.

GLOBAL GOOD (GG): 259

Guidance to countries and partners on service planning and rne Health Tool, WHO-CHOICE and Epic: tools to develop economic evidence in support of UHC

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
- Updated health systems modules (governance; logistics; fiscal space projections; human resources; infrastructure, including laboratories; programme budgeting – number of modules depending on the available budget) in the One Health Tool.
- Visualization module for WHO-CHOICE tool.

ACTIVITY
- Development of draft modules on Excel and programming costs (external), and expert group meetings.
- Development of draft visualizations and programming.

2020 PROGRESS
An update of the WHO-CHOICE cost-effectiveness analysis (five papers) has been published in 2021, with a formal launch of the series mid-year. The desktop version of the One Health tool will be converted to a modular online tool; the module for noncommunicable diseases is now being programmed. The request for proposal for the core of the One Health Tool is to be issued mid-year once findings have been ascertained. The Epic tool has also now been reprogrammed to make it more user friendly. It is currently being used for the tuberculosis vaccine investment case, as well as the childhood cancer investment case.

GLOBAL GOOD (GG): 1416

The UHC Menu: An expanded repository of recommended interventions

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
- UHC Menu database.
- UHC Menu database web platform.

ACTIVITIES
- Production and synthesis of evidence pertaining to interventions in the UHC Menu database. This includes the generation and integration of data fields on resource needs/costs, including economic data, into the database for the UHC Menu; country pilots.
- Further develop the UHC Menu web platform to incorporate the full database of interventions and all associated fields, and a data visualization function.

2020 PROGRESS
The UHC Compendium (formerly Menu) was launched in December 2020 during UHC Day. Ongoing work is being done by the technical programmes on collection of the inputs/resources for each one of 3000 actions. It is due for a launch of version 2 on UHC Day 2021. Funding was obtained for selection interface. Additional funding is being sought for the database and improvement of front and back ends and connection to the One Health Tool.

GLOBAL GOOD (GG): 590

How to enhance domestic and development financing for scaling up action on the NCD-related SDGs

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
- WHO flagship book on taxes on alcohol, tobacco and sugary drinks.
- Country reports on the case for more or higher health taxes, developed through coordinated technical assistance (TA), including estimations on health impact.

ACTIVITIES
- Authors' review meetings to finalize text, editing and layout, and printing.
- Establishment and implementation of health taxes workstream under the sustainable financing part of the SDG Global Action Plan for Healthy Lives and Well-being for All (GAP): stakeholder meetings, capacity-building activities, joint country TA to ministries of finance/health, information product.

2020 PROGRESS
First meetings have been held among headquarters (Health Systems Governance and Financing unit and health taxes group), regional offices and country offices to further specify scope of work with health taxes and parliamentarians in Ethiopia, Ghana, Nepal and possibly India/Pakistan. Meetings and communications have also been done to line up partners (World Bank, University of Bergen ..). Legal consultants (one per country) have been selected by WHO, together with the Inter-Parliamentary Union. The Inter Agency Working Group (IAWG) on health taxes and WHO directors related health taxes are meeting regularly. Plan for IAWG portal approved and now for RFP.

GLOBAL GOOD (GG): 257

UHC global monitoring reports: Monitoring of financial protection coverage

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
2021 UHC financial protection report.

ACTIVITIES
Capacity-building workshops, analysis of publicly available household expenditure surveys in collaboration with World Bank; establishment of microdata repository; country consultation.

2020 PROGRESS
Preliminary estimates have been generated. Member States consultation has been completed. Revisions are ongoing based on Member States feedback. Financial protection report is on track, jointly with the World Bank, for launch on UHC Day 2021.

GLOBAL GOOD (GG): 1310

Guidance for the design, implementation and monitoring of health financing for UHC: the Health Financing Progress Matrix (HFPM) (See also Deep Dive, p. 59)

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
HFPM Country Assessments.

ACTIVITIES
- Further development of the HFPM assessment questions to assess health financing for health security, guidance for country assessment, database and visualization interface.
- HFPM country assessment implementation either in long (baseline) or short (annual update) mode, with related dialogue events to feed into enhanced policy development.
- Advanced Global Health Financing Training Course and support to selected regional office and country office training courses to strengthen knowledge and capacities of policy-makers, technical staff of health and finance ministries, and development partners, and to facilitate peer exchange on key health financing issues.

GLOBAL GOOD (GG) 1310: 2020 PROGRESS
During the year a second version of the HFPM was developed, taking the learning from implementation in 19 countries and discussion in numerous conferences and internal workshops; this involved both the technical content of the assessment and the process which governs it. Key areas of work included:

- Worked intensively with a consultant expert to develop clearer guidance on governance arrangements for HFPM; this looked at the entire process, from initiating country assessments, to assessment outputs for countries, the establishment of a Global Knowledge Database, and ensuring that strategic directions are clear. The aim is to strengthen mechanisms and processes which ensure effective oversight and high-quality, defensible assessments. A document summarizing this was produced and shared and discussed with regional offices in a series of webinars. Part of this was to clarify the value proposition offered by the matrix, and to position it relative to other products/assessments, and this was also developed in a document/diagram.
- Developed IT platforms; a data scientist was brought on board to support development of an ecosystem of interconnected products, from data collection tools, database for country assessments, dashboard of supporting indicators backed up by a tailored database structured around the HFPM, and front-end Power BI dashboards, including password-protected areas. Design work involved the architecture connecting all these products.
- Developed and tested a country assessment quality review process.
- Held extensive briefings with regional offices and selected country offices, and also with partner agencies (Gates grantees), Accelerator partners and other experts.
- Developed a Country Assessment Implementation Guide, focusing initially on Stage 1; it became clear during country testing that discussion is required about which schemes/programmes to include in the initial landscaping analysis prior to the main assessment.
- Developed new questions related to health financing and health security.
- Collaborated extensively with the African Union in relation to their development of a Health Financing Tracker to ensure complementarity with the HFPM.
- Provided backup support to new countries implementing or about to initiate the HFPM assessment (e.g. Viet Nam).
- Developed an evidence base to strengthen normative statements of the HFPM.
- Further developed and published a dashboard of background indicators to support the assessment process. This involved pulling data from a series of different sources, including the IHR eSpar country self-assessments database, selected Public Expenditure and Financial Accountability (PEFA) indicators, UHC indicators from the Global Health Observatory and International Labour Organization (ILO) databases (e.g. workforce structure), World Bank/International Monetary Fund (IMF) for economic forecast and debt indicators, and data held in a health taxes database (but never visualized) from a fellow WHO team. Discussions were held with many of these agencies to discuss inclusion. The dashboard will continue to evolve – for example, through the addition of the latest disaggregated information on financial protection.
- Held discussions with several partner agencies engaged in similar initiatives (African Union), or with an interest in the HFPM (Global Financing Facility). At the end of July, a two-day webinar was held with the support of the Global Fund, at which most major international actors in health financing attended, from bilateral and multilateral agencies, academia and individual experts.

GLOBAL GOOD (GG): 1311

Guidance to strengthen engagement between national health and finance authorities on the revenue-raising and efficiency dimensions of sustainable health financing

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Guidance for better public financial management of health resources and services.

ACTIVITIES
- Webinar series on public financial management (PFM)/health (in English and French) for targeted ministries of finance/health officials in countries, including PFM lessons from the COVID-19 crisis, and support to country counterparts to take forward lessons for the post-COVID-19 phase (e.g. simplified spending procedures to the front lines).
- Online training module/podcasts on PFM/health (in English, French, Spanish).
- Guidance book on budget structure reform in the health sector, including aspects related to COVID-19 response (e.g. how to include preparedness and surveillance activities in the design of programme-based budgets) plus dissemination in countries (in English and French).
- Guidance document on implications of integrated service delivery for health budget reforms.

2020 PROGRESS
- A series of PFM webinars was organized to cover PFM issues for a health audience (it consisted of six webinar sessions featuring a range of PFM and health experts, and discussed country policy options to address systemic PFM bottlenecks in health). The webinar series was transformed into video podcasts that are now downloadable on the WHO website.
- A review of PFM modalities was conducted to assess how PFM systems have enabled or hindered an effective budgetary response to COVID-19.
- A series of blogs, short policy notes and seminars (including in partnership with the Health Systems Research Symposium, PEFA Secretariat, Re-build project) was organized in 2020 to share knowledge and lessons.
- Specific attention has been paid to PFM issues for COVID-19 vaccine roll-out with the production of a PFM mapping for vaccination.
- A review was jointly conducted with the IMF to assess pros and cons of extra-budetary funds introduced for the COVID-19 response.
- An online PFM training module was developed to cover the PFM basic concepts for a health audience. In addition, an online training session on PFM was organized in February 2021 as part of the advanced course on health financing delivered by WHO.
- A PFM module of the WHO HFPM was developed to mainstream PFM in health financing diagnostics.
- The guidance book on budget formulation reforms in health has been finalized and is being edited and designed; it will be launched at the upcoming Montreux collaborative meeting on PFM in November 2021. Seven case study reports have been completed on the introduction of programme budgets in health.
- A PFM portal of resources is being developed as a one-stop-shop to access key PFM and health resource materials for COVID-19 players.
- The budget repository has been updated to include budget documentation for 2020 and early 2021.

GLOBAL GOOD (GG): 251

Strengthening strategic purchasing

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
- Guidance note on tailored payment methods to incentivize quality care for NCDs.
- Policy lab and peer learning on strategic purchasing among countries in the African and Eastern Mediterranean regions. Guidance note on health financing/strategic purchasing in decentralized settings.
- Synthesis of country case studies on information management for strategic purchasing and related data analytics to inform policy decision-making.
- Global meeting on strategic purchasing for UHC.

ACTIVITIES
- Organize two policy labs to strengthen knowledge and capacity of policy-makers on strategic purchasing policy instruments, including COVID-19-related aspects: what works, how to adapt it to the country context, how to align with other health financing and health system areas.
- Provide and update global guidance on how to secure strategic purchasing in devolved or federal settings, with particular consideration of lessons from COVID-19 and pandemic preparedness.
- Develop a policy note on improving information management across multiple purchasing agencies to inform decisions with regards to strategic purchasing and health security decisions.
- Develop analytical guidance document to assess information management for strategic purchasing.
- Carry out two case studies to apply the proposed analytical guidance and explore opportunities and challenges towards improved information management for strategic purchasing.
- Carry out two case studies on the enabling and hindering factors for using purchasing agencies' databases, which have been used to inform the response to COVID-19.
- Organize a meeting with scholars, practitioners, academics and civil society actors to share knowledge and experiences on how to better align information systems for purchasing of health services with the wider information systems of a country, leading to a refined global collaborative agenda on the topic focused on country operationalization.

2020 PROGRESS
- A synthesis report was drafted on how devolved setups affect health financing and policy recommendations, based on seven country studies, together with ThinkWell.
- A first draft of the analytical guidance document to assess information management for strategic purchasing was produced in 2020. In 2021, it will be refined through an internal reviewand revised through engagement of different circles of experts to further fine-tune it, before being applied in a set of countries.
- A draft policy note was developed on improving information management. In 2021, it will go through a review process (first round of internal review conducted) and be finalized.
- The Health Governance and Financing team together with regional colleagues published a policy note: How to purchase health services during a pandemic? Purchasing priorities to support the COVID-19 response.
- Our team led a collaborative process to explore modifications of purchasing arrangements as part of the COVID-19 health sector response, looking at benefit design, contracting, payment methods, governance and information systems for monitoring of purchasing performance. On this matter, we undertook a survey via the Collectivity and produced a report summarizing the findings from 31 countries. A shorter blog was also produced in both English and French.
- Based on this, we initiated a collaborative co-learning project with the Collectivity with the purpose of exploring the impacts of the purchasing adjustments made. This project is now underway in 2021 with eight country teams analysing their country developments and drawing lessons from these.
- A draft policy brief on "How can strategic purchasing help improve quality of care?" was produced in 2020. (It is now being finalized and is currently undergoing executive clearance.)
- A draft issue paper on "Digital technologies for health financing: what are the benefits and risks for UHC? Some initial reflections" was produced in 2020. (It is now being finalized and is currently undergoing executive clearance.)
- We disseminated our work on "Health financing in devolved settings" and on "Digital technologies for health financing" at the HSR Dubai virtual symposium.

GLOBAL GOOD (GG): 1362
Tools and guidance to support the strengthening of health institutions for more effective governance for UHC

DELIVERABLE
- UHC Law in Practice survey tool for assessing service access rights and three country case studies.
- Establishment of the Coalition on Anti-corruption transparency in health (formerly ACTA; now called CATCH).
- Advice to Member States on public policy to the private sector in health.

ACTIVITY
Literature review, development of the tool, testing the application of the tool to three countries, completing country assessments using the tool, consultation with national experts, editing, publication dissemination.

2020 PROGRESS
Completed.

EXPECTED ACHIEVEMENT: 2021

ACTIVITY
- Negotiations with United Nations Development Programme, Global Fund and the World Bank to obtain agreement to set up the Coalition, providing the Secretariat for the Coalition during the setup phase.
- Two blogs were published with the Coalition partners on the impact of corruption in the context of the COVID-19 response.
- Drafting of governance documents for the operation of the Coalition in combination with funds received from the SDG Action plan team.

2020 PROGRESS
Completed CATCH is up and running with new funding from NORAD for its operations.

EXPECTED ACHIEVEMENT: 2021

ACTIVITY
Literature reviews, deliberations by our expert group on the private sector, consultation, editing, publication, dissemination.

2020 PROGRESS
In 2019 and 2020 we finished a strategic framework and road map in 2020 and 2021 with a focus on Private Sector Engagement and COVID-19.

EXPECTED ACHIEVEMENT: 2022

URL FOR 2020 PROGRESS
https://cms.who.int/activities/strengthening-private-sector-engagement-for-uhc

DIVISION: Deputy Director General

UNIT: Health and Migration (PHM)

GLOBAL GOOD (GG): 1328
Global Report on Health and Migration

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
National action plans on refugee and migrant health developed in priority countries.

ACTIVITIES
- Support development and implementation of national action plans.
- Collect, assess and disseminate evidence for global guidance on what works and what does not to implement the national action plans and UHC for refugees and migrants in priority countries.

2020 PROGRESS
The global report is under development and well in progress and on track to be published by May 2022.

GLOBAL GOOD (GG): 1328
Global Report on Health and Migration

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
- Global report on health and migration produced and disseminated.
- Accountability/monitoring framework to monitor progress of the GAP implementation developed.
- Guidance on continuity of care and health services for refugees and migrants developed and disseminated.

ACTIVITIES
- Develop key indicators and GAP accountability/ monitoring framework.
- Produce and publish a global progress report on "Health and Migration".
- Develop guidance for enhancing cross-border dialogue, develop platforms for information sharing and exchanges and collaboration, and identify and agree on essential public health packages and functions.
- Develop guidance, tools and training curriculums and materials.
- Produce and promote health records with essential individual health information.
- Support countries with their analyses of unmet need and demand side and barriers.

2020 PROGRESS
Instead of the guidance on continuity of care, a Global Competency Standards for health workers on refugee and migrant health has finally been selected and is under development. It will aim to enable health workers to provide people-centred health services to refugees and migrants, and also promote continuity of care. Another technical product will be developed in 2022 on cross-border collaboration to promote continuity of care.

DIVISION: UHC / Communicable and Noncommunicable Diseases

UNIT: Mental Health and Substance Use (MSD)

GLOBAL GOOD (GG): 521
Guidance and best practices for policy-makers and planners to achieve UHC and promote human rights.

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
Practical guidance on good practice community-based mental health services promoting human rights and recovery.

ACTIVITIES
- Identification of services and networks through multi-language literature reviews, Internet searches and international e-consultation.
- Initial screening against minimum human rights and recovery standards.
- Classification and full screening of services.
- Write-up of overall guidance document.
- International expert review of document.
- Revisions to document based on review.
- Ongoing liaising with service providers and health authorities to edit, fine-tune and finalize service/network of services descriptions.
- Second international expert review.
- Revision and finalization of document.

2020 PROGRESS
Finalized and launched on 10 June 2021.

GLOBAL GOOD (GG): 523
Progress with attainment of SDG health target 3.5 with alcohol and treatment coverage for substance use disorders component

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
Global report.

ACTIVITIES
- Data preparation and analysis from the WHO Global SDG health target 3.5 survey.
- Estimation of alcohol consumption (with adjustment caused by COVID-19), alcohol-related harm and treatment coverage for substance use disorder.
- Consultation process and establishing of advisory and editorial groups.
- Commissioning chapters.
- Developing the report.
- Technical review and editing.
- Layout and production.
- Launch and dissemination.

2020 PROGRESS
Data collection, validation and analysis completed. The findings have been presented and discussed in two meetings of the TAG on alcohol and drug epidemiology (TAG-ADE) and the 3rd Forum on alcohol, drugs and addictive behaviours. The chapters are currently being drafted.

GLOBAL GOOD (GG): 525
Integrated technical packages for substance use disorders

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
Integrated technical package on identification and management of disorders due to substance use.

ACTIVITIES
- Review of existing recommendations, standards, guidelines and identification of elements for an update or elaboration.
- Reviews of evidence for updating selected recommendations. Consultation process.
- Development of an integrated package.
- Technical review and editing.
- Layout, design and publishing.

2020 PROGRESS
Concept and structure developed. Work will intensify after the finalization of GG #523.

GLOBAL GOOD (GG): 535
The Minimum Services Package for Mental Health and Psychosocial Support (MHPSS) in Humanitarian Settings

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Inter-agency minimum service package for emergencies.

ACTIVITIES
- Review existing guidelines for MHPSS in health, education and child protection sectors in emergencies.
- Expert and stakeholder consultations.
- Cost the package.
- Develop training materials.
- Test package in humanitarian settings.
- Publish with United Nations Children's Fund (UNICEF) and United Nations High Commissioner for Refugees (UNHCR).

2020 PROGRESS
- Completed reviews of existing guidelines for MHPSS in health, education and child protection sectors in emergencies.
- Organized online expert consultations and peer reviews of Minimum Services Package (MSP) content.
- Completed draft MSP content for field texting (health, education and child protection).
- Mobilized additional funding to cover general protection (including gender-based violence) components and included additional partner (United Nations Population Fund) in MSP project.

GLOBAL GOOD (GG): 541

Measuring the progress of implementation of the Comprehensive Mental Health Action Plan 2013–2020, including coverage of severe mental health conditions

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE: Mental Health Atlas report.

ACTIVITIES
- Review of indicators and targets and the level of achievement.
- Review of quality and quantity of data received for each of the indicators.
- Consultation with experts on estimation of service coverage.
- Revision of Atlas questionnaire and feedback from regional advisers.
- Development of the online platform and data collection.
- Establishment of data management system and data analysis.
- Preparation and publication of Global Atlas report and country profiles.
- Launch and dissemination.

2020 PROGRESS
- Review of indicators/data quality/targets carried out and discussed with internal and external experts.
- Consultation also included discussion on service coverage estimation for mental health conditions.
- Revision and update of questionnaire and complementary tools completed by April 2020.
- Development of online platform and translations into six languages completed in May 2020.
- Data collection between June and December 2020 (171 participant Member States). Quality check and data processing completed between January and March 2021. Analyses and preparation of report between April and June 2021. Editing, design and peer review July and August 2021. Publication in September 2021.
- Selected countries are being supported in reporting on service coverage by administration of a country walk-through guide that has been developed for the purpose.

DIVISION: UHC / Communicable and Noncommunicable Diseases

UNIT: Noncommunicable Diseases (NCD/ISD)

GLOBAL GOOD (GG): 566

Guidance on how to integrate NCDs into national HIV/AIDS, TB, and sexual and reproductive health programmes
(See also Deep Dive, p. 71)

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
Strategic guidance document.

ACTIVITIES
Systematic review, drafting, technical and expert meetings.

DELIVERABLE
Toolkit.

ACTIVITIES
Region and country field testing, finalization, editing, design, dissemination.

2020 PROGRESS
- The UHC-P supports a holistic approach to health-care delivery with emphasis on treating the whole patient, and not solely the disease, through integrated, people-centred care. Key work has been undertaken to develop evidence-informed and actionable strategic implementation guidance on how to maximize the impact of health services through the integration of NCD service delivery into other programmatic areas and broader health systems. The target audience of this guidance is policy-makers, programme managers and health providers.
- The guidance draws on a considerable amount of qualitative evidence from diverse settings and programmes to enumerate core factors which influence the quality and effectiveness of NCD service integration. These are summarized in nine domains and 21 actions to provide practical guidance on how to introduce and improve NCD service integration. This technical product contains an evidence synthesis, country case studies, templates, tools, models of practice and contextual considerations for country adaptation. The guidance is currently being hosted on the WHO website for public consultation, an exercise which will target end users from countries supported by the UHC-P, including policy-makers, programme managers and health providers, and other key stakeholders. A working group led by the WHO department for NCDs will use inputs from the consultation to further shape and finalize the draft guidance in preparation for country implementation.

GLOBAL GOOD (GG): 1430

Guidance on an approach to prioritize NCDs in national UHC benefit package

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
Guidance on UHC Benefit Package.

ACTIVITIES
Systematic review, drafting, technical and expert meetings, region and country field testing, finalization, editing, design, dissemination.

2020 PROGRESS
Consultant has been hired and work has started with establishing the working group and developing the concept note; draft planned in 2021.

GLOBAL GOOD (GG)

Proposed new GG: Guidance on screening

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
Guidance on NCD screening.

ACTIVITIES
Systematic review, drafting, technical and expert meetings, region and country field testing, finalization, editing, design, dissemination.

2020 PROGRESS
Planned for 2022 but no funds are available.

GLOBAL GOOD (GG)

Proposed new GG: Guidance on integrated chronic care

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
- Guidance on integrated management of NCD, disability and rehabilitation services in PHC.
- Training on integrated management of NCD, disability and rehabilitation services in PHC.
- Country technical support on integrated management of NCD, disability and rehabilitation in PHC.

ACTIVITIES
- Drafting, technical and expert meetings, region and country field testing, finalization, editing, design, dissemination.
- Planning and delivery of training in countries.
- Travel and in-country technical support according to recommendations.

DELIVERABLE
NCD Prevention Training (Oxford University).

ACTIVITIES
Updating of curriculum and programme for NCD Package of Essential NCD (PEN) disease interventions; travel support for staff to facilitate training.

DELIVERABLE
- Community mobilization for NCD prevention and control services training.
- Finalization of training package for community mobilization for NCD prevention and control services.
- Travel support for staff to facilitate training.

2020 PROGRESS
Work has been initiated with consultant hired and concept note developed. It involves alignment with and revamping of Integrated Management of Adult Illness.

GLOBAL GOOD (GG)

GG on recommendations for task sharing

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Supply chain management of NCD medicines and technology.

ACTIVITIES
Technical country work for assessment and support of supply chain management of NCD medicines/technology.

2020 PROGRESS
Systematic review to start in 2021.

GLOBAL GOOD (GG)

Proposed GG product: Guidance for integrating NCD and communicable disease medicines and health products when transitioning countries

EXPECTED ACHIEVEMENT: 2022

2020 PROGRESS
Staff member hired and conceptualization developed and proposition submitted for work to start in 2022.

GLOBAL GOOD (GG)

NCD financing needs tool: Step-by-step guide for countries to identify financial needs and generate realistic estimates and recommendations for scaling up and scaling out NCD services

EXPECTED ACHIEVEMENT: 2022

2020 PROGRESS
Consultant hired and work initiated, with literature review completed and consultation with countries ongoing for development of the tool to be completed in 2021.

GLOBAL GOOD (GG): 686

Global action plan for the implementation of the WHO Special Initiative on climate change and health in Small Island Developing States (SIDS)

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
South-to-South collaboration – Caribbean and Pacific on trade and NCD, access to medicines, climate change and NCD, and COVID-19 and NCD.

ACTIVITIES
- Technical papers on trade and NCD.
- Convene Pacific and Caribbean experts for consensus.
- Dissemination of outcome.

2020 PROGRESS
Data collection in progress.

DIVISION: DDGO

UNIT: Global NCD Platform/UNIATF

GLOBAL GOOD (GG)
NCD and Mental Health Catalytic Fund in line with mandates from Economic and Social Council (ECOSOC) and the World Health Assembly and the WHO Independent High-level Commission on NCD

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
A full-time P5 technical officer to lead advocacy and resource mobilization for the NCD and Mental Health Catalytic Fund.

ACTIVITIES
- Development of policy, strategy and programming papers for the Fund's Steering Group.
- Pump-priming activity at country and headquarters levels to support this work.

2020 PROGRESS
Two consultants have been hired to work on resource mobilization and policy and strategy for the Multi-Partner Trust Fund.

DIVISION: UHC / Healthier Population

UNIT: Nutrition and Food Safety (CC – Healthy Diets)

GLOBAL GOOD (GG): 556
Guidelines on food environment

EXPECTED ACHIEVEMENT: 2021

2020 PROGRESS
Undertaking of systematic reviews:
- Systematic review of implementing fiscal and pricing policies on foods and non-alcoholic beverages in children and adults.
- Systematic review of the effectiveness of nutrition labelling policies.
- Systematic review of the effect of policies to restrict the marketing of foods and non-alcoholic beverages to children.
- Systematic review of the impact of marketing for foods and non-alcoholic beverages on children's eating behaviours, body weight and health: a review of recent evidence.
- Systematic review on effects of policies or interventions that influence the school food environment.

Undertaking of reviews of contextual factors in:
- Fiscal and pricing policies to promote healthy diets.
- Nutrition labelling policies.
- Policies to restrict marketing of foods and non-alcoholic beverages to children.

DIVISION: UHC / Healthier Population

UNIT: Health Promotion 1 – Public Health Law and Policies (LAW)

GLOBAL GOOD (GG): 249
Supporting governments to make effective law and regulation necessary to implement UHC

EXPECTED ACHIEVEMENT: 2020

DELIVERABLE
Database of litigation tracking legal challenges to Member States implementation of health measures to address COVID-19.

ACTIVITIES
- Desk research to identify cases in which government response to COVID-19 is challenged.
- Classification of case law to determine relevance to implementation of NCD best buys and good buys.
- Translation of relevant case law into English.
- Use of case law in provision of specialized technical assistance to Member States.

2020 PROGRESS
- Supported South Africa in litigation concerning restrictions on sale of tobacco products and alcoholic beverages as part of COVID-19 emergency response.
- Conducted scoping research concerning litigation challenging public health interventions to address COVID-19 on grounds relating to protection of fundamental rights.

UNIT: Health Promotion 2 – No Tobacco (TFI)

GLOBAL GOOD (GG): 779
WHO Report on the Global Tobacco Epidemic

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Integrating brief tobacco interventions into NCD prevention and control in primary care in six priority African, Caribbean and Pacific (ACP) countries.

ACTIVITIES
- Country engagement and situational analysis.
- Develop WHO technical tools: update the English version eLearning course (add test and certificate of completion) and develop French version eLearning course (material translation, course creation completion).
- Train-the-trainer workshop on brief tobacco interventions (combination of online and onsite training).
- Action planning workshop for primary care service managers to develop action plans for integrating brief tobacco interventions into primary care in each country.

DELIVERABLE
Reducing infant mortality through tobacco control and stakeholder engagement.

ACTIVITIES
- Headquarters and national consultants.
- Translation of guidance package.
- Evaluation of questionnaires.

DELIVERABLE
Awareness raising/importance of compliance with tobacco control legislation.

ACTIVITIES
- Data analyst hired.
- National consultant hired.
- Translation of surveys.

2020 PROGRESS
Report published on 27 July 2021.

DIVISION: UHC / Healthier Population

UNIT: Health Promotion – Environmental Climate Change and Health (ECH/PHE)

GLOBAL GOOD (GG): 642

Report on water, sanitation and hygiene (WASH)/energy/climate change resilience/chemicals in health-care facility actions and progress towards objectives of global campaign

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Improved awareness, basic environmental infrastructure, and HWF capacities to provide essential environmental health standards in health-care facilities.

ACTIVITIES
Support:
- (1) Global action plan on WASH in Health-care Facilities (including health-care waste management), including promotion of national assessments, standards, road maps/strategies, HWF training and research.
- (2) Global status of energy in health-care facilities.
- (3) Global recommendations and framework on climate-resilient health-care facilities.

2020 PROGRESS
- The report "Fundamentals First: Global Progress Report on WASH in Health Care Facilities" was co-published by WHO/UNICEF and launched in December 2020. The report includes the latest data on WASH access in health-care facilities for 165 countries, progress from 47 countries in implementing the 2019 WASH in health-care facilities resolution, and 30 country case studies of efforts, including addressing WASH and energy, through a climate-resilience approach. As part of the launch of the global progress report, WHO hosted three global think tanks to further discuss country actions, the cost and investment needs and strategic direction.
- Guidance for climate-resilient and environmentally sustainable health-care facilities was launched in September 2020. The aim of this guidance is to enhance the capacity of health-care facilities to protect and improve the health of their target communities in an unstable and changing climate; and to empower health-care facilities to be environmentally sustainable, by optimizing the use of resources and minimizing the release of waste into the environment. This guidance document details the process to be followed and provides suggested interventions to strengthen climate resilience and environmental sustainability around four fundamental requirements for providing safe and quality care in the context of climate change: (1) HWF; (2) WASH and health-care waste management; (3) sustainable energy services; and (4) infrastructure, technologies and products.
- Furthermore, checklists to assess climate change vulnerability in health-care facilities were launched in April 2021. The primary purpose of this document is to support users in establishing a baseline with regards to climate change resilience in health-care facilities and to establish an iterative process for assessing vulnerability in health-care facilities. Tools for measuring the carbon and environmental footprint in health-care facilities are further being developed.
- Development of the Global Status Report on Health Care Facility Electrification has been initiated and the final report is expected in the last quarter of 2021.

GLOBAL GOOD (GG): 1317

Intervention guide for community health and environmental workers on evidence-based action on environmental health

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Guidance on prevention through reducing community health risks by creating healthier environments, including through providing basic environmental health services in the community (e.g. water safety and sanitation safety plans, clean energy, etc.) and health-care facilities.

ACTIVITIES
- Provision of guidance to support service providers involved in community preventive services to address environmental health risks in the community.
- Advocate and build capacity among key stakeholders, working in collaboration with local authorities and professional associations.

2020 PROGRESS
- A final draft of the GG was produced and launched in August 2021.
- The GG is planned to be presented as an online repository of interventions, and contains a large list of guidance on preventive actions that community health workers/health facilities/local health authorities can take in order to implement preventive actions on health and environment as part of UHC's activities. Those interventions are identified with the qualifier "UHC" in the repository.
- The respository also contains practical guidance on cross-sectoral actions, for which the health sector needs to cooperate with other key sectors (e.g. energy, transport) in order to influence policies and actions of those other sectors for being health protective/taking into account the health argument. This repository will feed into/be closely linked with the UHC Compendium of interventions which for now focuses more on clinical interventions.

GLOBAL GOOD (GG): 645

National programmes on occupational health of health workers: A guide for policy-makers in the health system. Providing guidance and examples on the development, implementation and evaluation of national programmes to protect occupational health and safety of all workers and all workplaces in the national health system

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Strengthening countries' capacities to provide safe and decent working conditions in health care.

ACTIVITIES
- Analysis of the experience of pilot countries in developing and implementing national programmes for occupational health of health workers.
- Elaborate a guide for the implementation of the WHO/ILO global framework for national programmes for occupational health of health workers.
- Update WHO/ILO toolkit on work improvement in health-care facilities (Health WISE).
- Develop advocacy and information materials for addressing priority occupational health risks for health workers, such as physicians, nurses, community health workers, emergency responders.

2020 PROGRESS
- WHO, jointly with the ILO, has issued a policy brief on the national programmes for occupational health for health workers and an interim guidance on occupational health and safety for health workers in the context of COVID-19 (both translated to all WHO official languages).
- In addition, WHO developed a checklist for occupational health for health-care facilities and an OpenWHO course on occupational health and safety for health workers (currently in five languages with 64 000 enrolments).
- WHO also convened an expert meeting to review countries' experience in developing and implementing national programmes for occupational health, and organized a number of global webinars.
- WHO is also collecting information from countries about existing national programmes and policy instruments for occupational health for health workers and reporting on a monthly basis through WHO operational update on COVID-19.
- The first draft of the GG #645 "National programmes on occupational health of health workers: A Guide for policy makers in the health system" has been elaborated and planning clearance from Science Division obtained. We are currently recruiting a full-time consultant to revise the draft according to WHO quality assurance requirements for normative and standard-setting products, and to proceed with consultation with stakeholders. The product will be ready by the end of 2021.

URL FOR 2020 PROGRESS
https://www.who.int/publications/i/item/9789240011588

https://www.who.int/publications/i/item/WHO-2019-nCoV-HCW_advice-2021.1

https://www.who.int/publications/i/item/protection-of-health-and-safety-of-health-workers

https://openwho.org/courses/COVID-19-occupational-health-and-safety

https://www.who.int/publications/m/item/weekly-operational-update-on-covid-19---5-april-2021

GLOBAL GOOD (GG): 682

Guidance, tools and information products to support implementation of the Bonn Call for Action to improve radiation protection in health care

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Quality and safety in paediatric fluoroscopy-guided interventions in Latin American and Caribbean countries ("OPRIPALC" is the acronym of its title in Spanish).

ACTIVITIES
- Survey on use of interventional radiology in children.
- Radiation protection training module for health workers.
- Development of methodology for dose data collection/analysis, establishment of preliminary diagnostic reference level DRL) values.
- Technical meeting on operational protocols and quality control of the F-IR systems.
- Identification of medical facilities with the highest patient dose values; potential corrective actions if/as appropriate.
- Development of a report on methodology and results.
- Development of a guidance document on optimization of protection in paediatric interventional radiology and publication of a scientific paper in a peer-reviewed journal. Working language: Spanish.

2020 PROGRESS
- A situation assessment was performed in the 36 enrolled hospitals, including questionnaires about x-ray equipment, HWF, frequency of interventional radiology and interventional cardiology procedures and patient radiation doses. A radiation protection training material for health workers was prepared and a project website was created.
- Data provided by 18 hospitals from nine countries (Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, México, Perú and Uruguay indicate an average of 224 interventional cardiology procedures performed in children per year (range: 2 to 700). Validated data from 128 procedures performed in 20 cardiac catherization rooms of 15 hospitals were analysed. A first set of regional DRLs for fluoroscopy-guided interventions in children was obtained from 63 diagnostic procedures and 65 therapeutic procedures for each of the following patient age groups: < 1 year; 1 to < 5 years; 5 to < 10 years; and 10 to < 16 years.
- The project was presented at an international forum. A technical meeting (webinar) with participating countries was organized in December 2020 and a report was produced in March 2021 describing the methodology, summarizing results, identifying problems/challenges, suggesting solutions and proposing future actions to improve optimization of protection and safety in paediatric interventional practices.

URL FOR 2020 PROGRESS
https://opripalc.org/

https://epos.myesr.org/poster/eurosafe/eurosafeimaging2020/ESI-03445/description

DIVISION: UHC / Healthier Population

UNIT: Health Promotion 3 – More Physical Activity (RUN)

GLOBAL GOOD (GG): 759

Global guidelines on physical activity and sedentary behaviour

EXPECTED ACHIEVEMENT: 2020

DELIVERABLE

Countries demonstrating national action on physical activity through PHC; knowledge base for regulatory and fiscal mechanisms to promote physical activity; support for implementation of best buys for NCDs.

ACTIVITIES

- Development of the updated 2020 global guidelines on physical activity and sedentary behaviour in youth, adults and older adults is on track for launch in Q4 2020; scope extended to include three additional priority populations (pregnant and postpartum women, and people living with chronic disease and disability.
- Guideline Development Group meeting held in February 2020; public consultation conducted in April 2020.
- Submission of draft final guidelines to GRC achieved in June 2020.
- In person multi-country global meeting on guidelines adoption converted to region-by-region virtual workshops; planning and content prepared April/May 2020.
- Western Pacific Regional Office workshop completed that included participation from Western Pacific islands (June 2020); other regions planned in June/July.
- Planning of the global status report has advanced; WHO headquarters and regional office consultation underway.
- Data analysis of NCD 2019 Country Capacity Survey results completed and draft report circulated to regional offices.
- Proposed in-person stakeholder consultation postponed and was held virtually in Q3 2020.
- Project activity continues but is delayed due to COVID-19 response; output deliverable delayed to mid/end 2021. Consultants recruited to complete ACTIVE toolkit on integration of physical activity into PHC services [NCD good buy].
- Progress advanced on completion of ACTIVE toolkits on physical activity mass media campaigns [NCD best buy] and also ACTIVE toolkits on promoting physical activity in schools; through walking and cycling.
- Progress delayed on commencing development of ACTIVE toolkit on national physical activity policy and action plans.

2020 PROGRESS

Guidelines available.

DIVISION: UHC / Healthier Population

UNIT: Social Determinants of Health (SDH)

GLOBAL GOOD (GG): 733

Guidance to support implementation of the draft country framework for action across sectors (HiAP): intervention packages addressing Social Determinants of Health

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE

Implementation Guidance for Action Across Sectors to Improve Health, Equity and Well-Being.

ACTIVITIES

- Appoint the leading WHO collaborating centre for undertaking this work as part of their workplan and develop the concept note and draft framework proposal and outline.
- Convene the first review group of WHO collaborating centres to peer review the direction of the starting proposal.

2020 PROGRESS

- Draft guidance disseminated for review: presented in UHC-P meeting in December 2020.
- Focus group tools developed for working on with regional and
- Testing plan with probing questions on what about the guidance is useful, or what are gaps, are being rolled out currently, with the following components:
  A. African Region: Specific countries in process of transferring funds for local research support of focus group documentation/ implementation support (implementation research): Ghana, United Republic of Tanzania (led by Peter Phori, regional focal point SDH/HiAP).
  B. South-East Asia Region: Regional virtual workshop with national leaders in social determinants and health promotion took place end of August/beginning of September (led by Suvajee Good, regional focal point SDH/HiAP).
  C. European Region: Specific countries including policy laboratory settings: Montenegro, Uzbekistan, Wales (policy laboratory with Collaborating Centre support) (led by Tatjana Buzeti focal point SDH/HiAP).
  D–F. Western Pacific Region, Pan American Health Organization, Eastern Mediterranean Region: Specific countries operational support to capacity assessments for action on SDH while testing: Chile, Colombia, Costa Rica, El Salvador, and eventually Peru, Morocco, occupied Palestian Territories (countries in Western Pacific being confirmed include Philippines and possibly Cambodia).
  G. Connections with NCD and antimicrobial resistance (AMR) sought. Possible connections for involvement of these programmes in Ghana (AMR, NCD), Morocco (AMR), Uzbekistan to be determined (currently holding multisectoral leadership course for AMR), possibly Peru.
  H. Presentation to steering group for testing for usefulness at city level with urban governance special initiative. Testing over the period August September early October. Revision of the guidance by the collaborating centre October/early November. Revised version of the guidance for final second external peer review and internal review November/December 2021.
  Launch publication planned sometime in March/April 2022.

GLOBAL GOOD (GG)

Work for GG #733 will align with GG #584 and #590.

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE

- (1) Framework for Country Action on Health in All Policies a guide for the health sector in multisectoral action.
- (2) Policy briefing on policy coherence for public policies and the determinants of health and health equity.
- (3) Guidance to establish or strengthen national multi-stakeholder dialogue mechanisms for the implementation of national multisectoral NCD and mental health action plans.

ACTIVITIES

- Coordinate the establishment of the interdepartmental working group with engagement process for cross-organizational focal points and advisers (this is the phase we are currently at). Identify the country partners that wish to trial the new implementation guidance in 2021.
- Coordinate the process of development with the development of the in-depth multi-stakeholder guidance and the overall guidance being prepared as: Guidance to establish or strengthen national multi-stakeholder dialogue mechanisms for the implementation of national multisectoral NCD and mental health action plans.

2020 PROGRESS

- Draft guidance disseminated for review: presented in UHC-P meeting in December 2020.
- Focus group tools developed for working on with regional and country collaborators for testing.
- Testing plan with probing questions on what about the guidance is useful, or what are gaps, are being rolled out currently, with the following components:
  A. African Region: Specific countries in process of transferring funds for local research support of focus group documentation/ implementation support (implementation research): Ghana, United Republic of Tanzania (led by Peter Phori, regional focal point SDH/HiAP).
  B. South-East Asia Region: Regional virtual workshop with national leaders in social determinants and health promotion took place end of August/beginning of September (led by Suvajee Good, regional focal point SDH/HiAP).
  C. European Region: Specific countries including policy laboratory settings: Montenegro, Uzbekistan, Wales (policy laboratory with Collaborating Centre support) (led by Tatjana Buzeti focal point SDH/HiAP).
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DIVISION: Access to Medicines and Health Products

UNIT: Health Product Policy and Standards (EMP)

GLOBAL GOOD (GG): 120 – 117
WHO Model List of Essential Medicines and In Vitro Diagnostics

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
National Essential Medicines Lists updated and methodology reviewed.

ACTIVITIES
Support countries to regularly review and update their essential medicines and in vitro diagnostics lists, ensuring inclusion of essential NCD and reproductive, maternal, newborn, child and adolescent health (RMNCAH) medicines and in vitro diagnostics are included, as well as diagnostics for early identification of outbreaks as appropriate per country context.

2020 PROGRESS
Data collection in progress.

GLOBAL GOOD (GG): 118
List of priority medical devices for NCD; list of Medicines for PHC; Interagency Emergency Health Kits

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
National Medical Devices Lists for NCD/PHC updated.
Interagency Emergency Health Kits revised.

ACTIVITIES
Support countries to regularly review and update their essential medicines and in vitro diagnostics lists, ensuring inclusion of essential NCD and RMNCAH medicines and in vitro diagnostics are included, as well as diagnostics for early identification of outbreaks as appropriate per country context.

2020 PROGRESS
Data collection in progress.

GLOBAL GOOD (GG): 132
WHO Secretariat to promote best practices in countries and regional institutions to improve procurement and supply chain efficiency, including for pooled procurement

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Pooled procurement mechanisms and networking of procurement agencies in place.

ACTIVITIES
- Build country capacity for effective procurement of essential medicines, including enhancing access to pooled procurement schemes.
- Support strengthening of in-country supply chain management to ensure timely access to appropriate medicines and technologies health products.
- Support strengthening of regional and subregional expertise and capacities to develop and implement efficient and transparent procurement, fair pricing and reimbursement policies for medicines and health products at country level.

2020 PROGRESS
Data collection in progress.

GLOBAL GOOD (GG): 134
Interagency guidelines for safe disposal and operational principles for good pharmaceutical procurement

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Normative guidelines revised and disseminated.

ACTIVITIES
Support strengthening of in-country supply chain management to ensure timely access to appropriate medicines and technologies health products.

2020 PROGRESS
Data collection in progress.

GLOBAL GOOD (GG): 157
Shortages database

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Set-up of global repository for tracking and responding to global shortages of medicines and vaccines.

ACTIVITIES
Support the introduction and implementation of routine digital real-time stock level monitoring.

2020 PROGRESS
Data collection in progress.

GLOBAL GOOD (GG): 142
Monitoring the availability and predictors of access to medicines, vaccines

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
M&E integrated into national health plans and systems: country profiles, national surveys and assessments.

ACTIVITIES
Strengthen capacity for regular monitoring of availability, pricing and expenditure of medicines and health products at country and regional level.

2020 PROGRESS
Data collection in progress.

GLOBAL GOOD (GG): 146
Drug alert and global medical products alerts

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Interoperability between national, regional and global alert mechanisms improved.

ACTIVITIES
Support use of Global Surveillance and Monitoring Systems for better prevention, detection and response to substandard and falsified medical products.

2020 PROGRESS
Data collection in progress.

DIVISION: Antimicrobial Resistance (AMR)

UNIT: Surveillance, Prevention and Control (SPC)

GLOBAL GOOD (GG): 21
Global AMR Surveillance (GLASS)

2020 PROGRESS: 2022

DELIVERABLE
AMR module developed for DHIS2.

ACTIVITIES
Support the development of an AMR module in the DHIS2 health information system. WHO, in general, supports the use of the DHIS2 platform in countries.

The DHIS2 AMR module will allow surveillance sites (hospitals) to collect information about microbiological samples and patients. These data will be collated at the different echelons of the national health systems in order to produce statistics on AMR..
The DHIS2 will strengthen the use of health information systems: In hospitals, to:
- Improve management of laboratories.
- Improve clinical use of AMR results of microbiological samples.
- Improve the surveillance of AMR in individual hospitals.
- Support development of local actions (such as antibiotic stewardship, treatment guidelines).

At national level, to:
- Support the laboratory capacity.
- Support the national surveillance programme on AMR.
- Support development of national policies to combat AMR.

EXPECTED ACHIEVEMENT
- The Surveillance, Evidence and Laboratory strengthening (SEL) unit within the SPC department has worked closely with the University of Oslo, which has developed an initial DHIS2 AMR module. SEL and University of Oslo have worked on aligning the existing AMR module with the GLASS AMR surveillance methodology to ensure variables are consistent and GLASS datasets can be generated by the DHIS2 AMR module. Specific work has been initiated to ensure data from the WHONET laboratory software can be uploaded into the DHIS2 AMR module.

  Another stream of work has been to integrate WHONET and DHIS2 to provide, in the future, national AMR reporting in DHIS2 for AMR, using the analytical capabilities of WHONET to generate datasets for DHIS2 reports.

DELIVERABLE
Pilot implementation of the DHIS2 AMR module.

ACTIVITIES
Pilot implementation of the DHIS2 AMR module in two countries: Lao People's Democratic Republic and Mali.
WHO is currently supporting these two countries in developing their national surveillance programme for AMR. The respective national AMR surveillance systems count few surveillance sites. In addition, both countries are already using DHIS2 as their national health information system. WHO will support both countries to implement the DHIS2 AMR module in a few hospitals to demonstrate the feasibility of setting up a health information system for AMR from local level to national level.

EXPECTED ACHIEVEMENT: 2022

2020 PROGRESS
Piloting depends on the status of the previous activity. When the integration between WHONET and the DHIS2 AMR module is done, as well as reporting of AMR in DHIS2, the piloting will be initiated in both countries. This is expected to start by the end of 2021.

DIVISION: Polio Transition

UNIT: 953

GLOBAL GOOD (GG): 21
Costing, planning and budgeting tool for surveillance of vaccine-preventable diseases (VPDs) in priority countries for polio transition

EXPECTED ACHIEVEMENT: 2021

DELIVERABLE
WHO supports the development of a costing, planning and budgeting tool for surveillance of VPDs in priority countries for polio transition. Unlike other similar tools, this will not only be a costing tool, but is aimed at guiding country planning and budgeting for surveillance.

The tool will facilitate country national authorities (e.g. public health departments and Enhanced Programme on Immunization [EPI] managers) to estimate the financial resources required (from domestic and, if needed, external sources) to sustain and strengthen VPD surveillance.

Objectives:
- (1) to develop a user-friendly tool and related user manual to facilitate priority countries to cost, plan and budget VPD surveillance activities;
- (2) to assist countries to plan and estimate the resources required to maintain and strengthen VPD surveillance, and to include required budget into their strategic immunization plans and national health plans;
- (3) to provide countries with solid methodologies to estimate costs and budget to be used for advocacy for financing essential functions during (and after) the polio transition process.

ACTIVITIES
- Desk-review literature.
- Consultations with experts on surveillance.
- Development of the methodology.
- Development of beta version of the tool.
- Draft guidance (user manual).
- Pilot in selected countries.
- Finalize tool and guidance.
- Dissemination.

2020 PROGRESS
Several consultations with regional and country offices have been carried out: African Region: Nigeria and South Sudan, and planned for Burundi, Ethiopia, Malawi and Senegal.
Eastern Mediterranean Region: Regional Technical Working Group on Polio Transition, countries TBD.
South-East Asia Region: Bangladesh, India, Indonesia and Nepal.

Consultations aimed to review methods, to identify sources of information and to tailor the methodology to regional and country contexts.

The document on the logical framework for developing the methodology has been drafted, including: scope of VPD surveillance costing; key features of the methodology; modular architecture; costs to be captured; and proposed output tables. The document will be shared to reach consensus on the methods and to align headquarters, regional and country expectations.

Next steps include: Development of beta version of the tool; test the tool in one to two countries; preparation of guidance, including tutorials; finalization and dissemination of the tool.

DIVISION: Emergency Preparedness (WPE)

UNIT: CCI/HAI

GLOBAL GOOD (GG)
Operational tools to build capacities at the International Health Regulations (IHR) human–animal–ecosystem interface

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Improved collaboration between human health and animal health actors.

ACTIVITIES
Support countries to conduct national IHR-PVS (International Health Regulation - Performance of Veterinary Services) national bridging workshops (NBWs) to strengthen collaboration between human, animal and environmental health sectors to control endemic zoonotic, emerging and re-emerging diseases and other public health threats, including COVID-19, in case studies.

2020 PROGRESS
- Total of 43 NBWs have been conducted to date, enabling the development of national road maps jointly endorsed by human health, animal heath and other relevant authorities.
- Implementation of these road maps is facilitated by guidance detailed in the Tripartite (World Organisation for Animal Health [OIE], WHO Food and Agricultural Organization [FAO], WHO) Zoonosis Guide published in 2019 and are facilitated by Tripartite Operational Tools (OTs) developed to facilitate multisectoral coordination for key technical areas, including Joint Risk Assessment OT (28 workshops conducted to date), Multisectoral Coordination Mechanism OT (currently piloted in Khazakstan), Surveillance and Information Sharing OT (currently piloted in Indonesia), and Response Preparedness (in development).

URL FOR 2020 PROGRESS
All road maps available at
https://extranet.who.int/sph/ihr-pvs-bridging-workshop

UNIT: BRD

GLOBAL GOOD (GG)
Global guidance on point of entry screening measures

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE
Strengthened IHR implementation at points of entry.

ACTIVITIES
- Contingency planning for public health events at entry bridges.
- Develop policies and standard operating procedures (SOPs) for public health officers within the points of entry, including referrals to health facilities.
- Establish memorandums of understanding/SOPs to allow entomological surveillance activities at points of entry.
- Strengthening of IHR surveillance capabilities at inbound ports (temperature scanner/temperature arcs for ports and airports).
- Acquisition of means of protection and safety at work in ports of entry and temporary isolation rooms in ports and airports (personal protective equipment, gloves, helmets, identification vests, anti-slip footwear, sprayers for fumigation, flashlights, etc.).

2020 PROGRESS
- With extensive consultations across all relevant departments and WHO regional offices, as well as with the members of the Strategic and Technical Advisory Group for Infectious Hazards (STAG-IH), a document was developed to support countries in contingency planning, mainly around decision-making for calibrating cross-border risk mitigation measures and establishing policies for international travel during the COVID-19 pandemic – WHO Interim Guidance: Considerations for implementing a risk-based approach to international travel in the context of COVID-19, has been published and regularly updated.
- WHO commissioned a rapid review of evidence using a systematic approach to collect studies available up to 13 November 2020 on the public health effectiveness and impact of symptom/exposure-based screening of international travellers in order to provide evidence-based guidance. The review results have been used in the guidance mentioned above to formulate advice on screening as one of the cross-border risk mitigation measures implemented at points of entry.
- Ongoing work: A set of SOPs to support operationalization of surveillance, screening at ground crossings during public health events are in the making, in collaboration with the United States Centers for Disease Control and Prevention (CDC).

DIVISION: Emergency Preparedness (WPE)

UNIT: Multisectoral Engagement for Health Security

GLOBAL GOOD (GG)

Guide for multisectoral preparedness coordination for IHR and health security

EXPECTED ACHIEVEMENT: 2022

DELIVERABLE

Enhanced multisectoral preparedness coordination in ACP countries.

ACTIVITIES

Support countries in multisectoral preparedness coordination for enhanced health security.

2020 PROGRESS

- COVID-19 has highlighted the critical need for whole-of-society and multisectoral approaches to health emergency preparedness and health security. The Multisectoral Preparedness Coordination (MPC) Framework was published in May 2020. The MPC Framework provides countries, ministries and stakeholders beyond the health sector with an overview of the key elements for multisectoral coordination for emergency preparedness and health security, informed by best practices, country case studies and technical input.
- Related accomplishments include the 2020 finalization of the National Civil–Military Health Collaboration Framework or Emergency Preparedness and a joint effort between the MHS Unit and the Inter-Parliamentary Union (IPU) on drafting a handbook on Parliaments' Role in Strengthening Health Security Preparedness.
- The multisectoral engagement work accomplished in 2020 continues into 2021, including the development of an online training package on multisectoral preparedness coordination and the publication of a compendium on country case studies on civil–military health collaboration in the context of COVID-19 and beyond.

Annex III.

List of UHC-P indicators

	Results chain	#	Indicators	Baseline (ref. Year) denominator: 115 countries	Results 2020	Milestones		Targets (2023)	Sources and means of verification	Assumptions
						2021	2022			
General objective	To contribute to countries reaching universal health coverage (UHC)	1	OO1. Coverage of essential health services (SDG 3.8.1/GPW13 indicators, as per the document Methods for Impact Measurement)	3.5 billion (2018, as per WHO GPW13 impact framework)	ASC Index change 3.98 from 2019	-	-	Increase service coverage, as per WHO GPW13 impact framework	WHO reports (World Health Statistics, tracking UHC)	Effective coverage of essential health services (with quality considerations incorporated).
		2	OO2. Proportion of population with large household expenditure on health as share of total household ability to pay (SDG 3.8.2/GPW13 indicator, and related, regionally and country-tailored measures)	12.7% in 2015 (global report on financial protection)	Global and regional rates are updated every two years. A precondition to do this is to update the country-level estimates and related analysis. The latter started in 2020 (see indicator 27)	Establish a pre-COVID-19 global baseline (for 2017 or 2018)	-	No further increase in the % of population incurring large out-of-pocket (OOP) health payments (beyond the catastrophic expenditure threshold) over the period of the grant. Alternatively, for smaller countries or countries with no data, no further increase of OOPs as a proxy for financial protection over the period of the grant.	"WHO/WB, 2019. Global monitoring report on financial protection in health 2019 WHO, 2019. Primary health care on the road to universal health coverage: 2019 monitoring report"	Countries have timely and relevant data available – i.e. two years before the end of the grant.
		3	OO3. 1 billion more people better protected from health emergencies	3 billion (2018; as per WHO GPW13 impact framework)	613.21 million more people are better protected from health emergencies compared to 2018 (334.63 million in 2019)	753.29 million more protected (projection for 2021)	848.62 million more protected (projection for 2021)	4 billion, as per WHO GPW13 impact framework	GPW13 – Emergency preparedness indicator: sub-indicator International Health Regulations (IHR) Annual Report – States Parties Annual Reporting (SPAR) and two other tracer indicators for emergency index	WHO GPW13 Impact Measurements – Countries reporting annually on 13 IHR capacities (SDG 3.d.1) and other statistics for two other tracer indicators (vaccine coverage and detect and respond).
Specific objective(s); Outcome(s)	Strengthened and resilient health systems in targeted countries	4	SO1. Number / % of supported countries in which at least 80% of facilities have a core set of relevant essential medicines available and affordable on a sustainable basis (SDG 3.b.3, GPW13 indicator)	26	Data collection in progress	-	-	Data collection in progress	-	-
		5	SO2. Number / % of countries with systems for monitoring antibiotic consumption at national level	"65 Member States (2015)"	Data collection in progress	-	-	60% of Member States	"Annual GLASS Report Tripartite AMR Country Self-Assessment Survey (TrACSS)"	Countries have the capacity and systems for monitoring consumption and rational use of antibiotics in human health.
		6	SO3. Number / % of countries showing evidence of progress in health financing, with respect to efficiency, equity and sustainability	Number of countries receiving support and conducting baseline assessment	44.30%	30% of countries supported show progress over baseline	40% of countries supported show progress over baseline	50% of countries receiving support in health financing show progress on the attributes defined in the WHO Health Financing Progress Matrix over the period of the grant	Progress Matrix applied in countries receiving health financing support	Countries have the capacity to implement reforms across the health system – for example, in the delivery of quality services. Countries address demand-side barriers. Progress Matrix applied at least twice during the grant period in countries receiving health financing support.
	Strengthened regulatory and support functions of global, regional and subregional bodies	7	SO4. Number of countries making progress on SDG 3.c.1 GPW13 indicator – Health workforce density (measured for the top five occupations – dentists, physicians, nurses, midwives and pharmacists)	0	50/82 with at least two data points and two occupations (see list of countries in attached Excel document)	At least 10 additional countries making progress on health workforce density	At least 10 additional countries making progress on health workforce density	At least 40 countries making progress on health workforce density	National Health Workforce Accounts platform (NHWA)/Global Health Observatory	"Data regularly updated in countries. Countries report their national data to NHWA platform."
		8	SO5. Number of countries making progress on SDG3.c1. GPW13 indicator – Health workforce distribution (using nurses as proxy)	Baseline established (40 countries of the 115 UHC-P countries have submitted one round of data on subnational density of nurses	No country has submitted two rounds of subnational data to measure progress	At least 10 additional countries making progress on distribution	At least 10 additional countries making progress on distribution	At least 40 countries making progress on health workforce distribution.	National Health Workforce Accounts platform (NHWA)/Global Health Observatory	Data regularly updated in countries. Countries report their national and subnational data to NHWA platform.
		9	SO6. Number / % of targeted countries reporting on SDG target 3.8.1	106 (2019)	115	115	115	115	WHO/WB report: Tracking universal health coverage (IS THERE A PUB YEAR FOR THIS?)	Close collaboration between ministry of health and the national statistical office or equivalent institution in charge of the relevant household survey.

	Results chain	#	Indicators	Baseline (ref. Year) denominator: 115 countries	Results 2020	Milestones		Targets (2023)	Sources and means of verification	Assumptions
						2021	2022			
		10	SO7. Number / % of targeted countries showing increased percentage of publicly financed health expenditure by 10%	2017 figure for domestic government health spending as a % of overall government spending	16 countries reported a 10% increase in domestic government health expenditure as a % of general government expenditure among the 119 UHC-P countries (i.e. 14%)	-	-	10% increase in domestic government health expenditure as a % of general government expenditure in at least 30% of the countries receiving support in health financing, by 2023 (8.5–9% by 2022). [NOTE: Revision to text to align precisely to what is in GPW13 measurement framework.]	WHO Global Health Expenditure Database (GHED)	Note that the GHED aims to publish audited expenditure. There is always a two-year lag of reporting because of the data availability (e.g. data released at the end of 2019 had 2017 as the latest year of the data). Thus, while an important measure, caution is warranted in attributing any causal link between WHO activities under the grant (2020–2023) and changes in the indicator (which will reflect the period 2017–2021). However, many of the UHC-P countries were already being supported, so it may be possible to draw links to health financing engagement prior to the current grant and any changes observed during the grant period.
		11	S08. Number of countries with country campaigns for UHC	Baseline (2019) = 68	Provisional: Known UHC Day activities in 40 countries + materials accessed in 169 countries (to confirm)	75	80	Target (2023) = 97 [Rationale = over 50% of United Nations Member States]	-	-
		12	SO9. Number / % of UHC-P-supported countries that have increased their IHR annual reporting score	170	173	9	8	196	IHR SPAR annual reporting questionnaire	Countries submit their IHR SPAR annual reports to WHO.
		13	S10. Number / % of countries enrolled in AMR GLASS and providing data (SDG 3.d.2, GPW13 indicator)	"42 Member States enrolled and 22 Member States providing data (2017)"	87 countries enrolled and 68 Member States providing data (2019)	-	-	50% of UHC-P countries enrolled in GLASS by end of 2023	GLASS Report	Countries enrolled in GLASS and providing data towards the SDG 3.d.2 indicator.
		14	SO11. Number / % of targeted countries that include migration in national health policies, strategies and action plans in place	50	Data will be available in 2022	70	90	100	WHO global benchmarking tool and database	Countries will go back to normal from COVID-19.
		15	SO12. Suicide rate in a given calendar year	9.2 per 100 000 (2019)	Data will be available in 2022	9.2 per 100 000	-	9.1 per 100 000 (TBC)	WHO Global Health Estimates	According to latest WHO Global Health Estimates available.
Outputs	**Output 1 Governance:** Improved coordination and strengthened government leadership to develop robust national health policies, strategies and plans (NHPSPs), and monitor their implementation	16	O1.1. Number / % of supported countries with a comprehensive national health sector policy/ strategy/plan oriented towards UHC, with goals and targets updated within the last five years	69 countries, or 64%	Data collection in progress	-	-	80 countries, or 75%	WHO country office information reviewed by regional offices and headquarters following agreed criteria	-
		17	O1.2. Number / % of supported countries which routinely monitor, review and, when required, update their national health plan (criteria include measuring progress related to noncommunicable diseases [NCDs], preparedness and UHC)	0	Data collection in progress	-	-	32, or 30%	WHO country office information reviewed by regional offices and headquarters following agreed criteria [at least 4 out of 6]	This is a proxy measure for the NCD criterion.
		18	O1.3. Number / % of supported countries with national action plans for health security (NAPHS) that are costed and for which funding has been identified	Seven countries out of 67 that have a NAPHS have been funded (113 have done a Joint External Evaluation)	3	-	-	75% of the countries have NAPHS that are costed and supported	IHR Monitoring, Evaluation and Planning Weekly Update	O1.3 Number / % of supported countries with national action plans for health security that are costed and for which funding has been identified. (IS THIS AN ASSUMPTION? IT IS IDENTICAL TO THE INDICATOR TEXT.)
		19	O1.4. Number / % of supported countries that have engaged in WHO resource mapping (REMAP) for enhanced health security	10 countries have engaged in REMAP	3	-	-	At least 10 additional countries	WHO Strategic Partnership for Health Security and Emergency Preparedness (SPH) Portal	-
		20	O1.4. Number / % of supported countries with an operational, multisectoral national NCD policy, strategy or action plan that integrates several NCDs and their risk factors	74% (2019)	Data collection in progress	-	-	15 additional countries [need country-specific plans]	WHO NCD Country Capacity Survey	Baseline: 74% of countries with operational policy, strategy, or action plan that integrated several NCDs and their risk factors (of 160 that responded to all five surveys – 2010, 2013, 2015, 2017, 2019). All but one was multisectoral (2019).

	Results chain	#	Indicators	Baseline (ref. Year) denominator: 115 countries	Results 2020	Milestones		Targets (2023)	Sources and means of verification	Assumptions
						2021	2022			
Outputs	**Output 2 Medicines:** Policies and systems for access to safe, affordable and effective medicines and good-quality health products and their safe use strengthened	21	02.1. Average number of differences between each country's essential medicines list (EML) and WHO's model list: as a single measure of performance across all countries	0.59	Data collection in progress	-	-	0.62	WHO database on national EMLs	-
		22	"02.2. Number / % of supported countries updating/developing/ implementing medicines pricing policies and monitoring systems"	30%	Data collection in progress	-	-	60%	Facility surveys from MEDMON, reimbursement claim review, national pricing databases, international pricing databases, participation in regional pricing networks	-
		23	O2.3. Number / % of supported countries initiating national priority medical devices list, including essential in vitro diagnostics	5	Data collection in progress	-	-	40	WHO SAV PIDM (Programme for International Drug Monitoring)	-
		24	O2.4. Annual number of reports received by the WHO Global Surveillance and Monitoring system for SF medical products (WHAT DOES SF STAND FOR? BEST TO SPELL OUT)	56	Data collection in progress	-	-	60	WHO global surveillance and monitoring system for SF products	-
	Output 3 Workforce: Education, employment and retention of the health and social workforce strengthened	25	O3.1. Number of countries implementing national health workforce accounts (NHWA) with annual reporting to the NHWA platform	30 with the clarification included; the baseline should be 75 (2012–2016)	86 (2016–2020)	At least eight additional countries	At least eight additional countries	All 114 countries	NHWA platform	Data regularly updated in countries. Countries report their national and subnational data to NHWA.
	Output 4 Financing: Robust national health financing policies developed, and implementation supported	26	O4.1. Number / % of supported countries updating/developing comprehensive health financing strategies, policies or related implementation plans towards UHC	44	41 country offices reported providing support to countries in health financing strategies, policies and implementation plans towards UHC through the UHC-P (of which 29 have shown progress – i.e. 34% of the countries receiving support in health financing are making progress towards more conducive health financing systems); data missing for Pan American Health Organization	At least 30% of the countries receiving support in health financing are developing health financing strategies, policies and implementation plans towards UHC	At least 30% of the countries receiving support in health financing are developing health financing strategies, policies and implementation plans towards UHC	At least 30% of the countries receiving support in health financing are developing health financing strategies, policies and implementation plans towards UHC	WHO mission reports, UHC-P annual activity reports (country, regional and global), national documents and strategies	
		27	O4.2. Number / % of countries supported to complete their national health accounts (NHAs) within the last two years	33 countries completed NHAs in 2019	in 2020, 58 supported countries under the UHC-P have been able to produce primary health care (PHC) expenditure data (from 51 in 2019 – i.e. a 13% increase in the number of countries assisted to produce PHC expenditure data)	-	-	At least a 10% increase in the number of countries assisted to produce NHAs among those receiving health financing support	WHO Global Health Expenditure Database	Timely data are made available. Two-year data generation process; i.e. two-year time lapse between closure of financial period and data publication (e.g. the 2016 NHAs available in 2018).
		28	O4.3. Number / % of supported countries which completed or updated an analysis of financial protection within two years from the time the last relevant survey has been released	In 2019, there were 23 UHC-P countries with an analysis based on a survey conducted in 2015 or more recently, including two based on a 2017 survey (TBD)	Identification of 41 UHC-P countries with (more recent) surveys available to produce (an updated) financial protection analysis and engaged in such work (results available at the end of 2021)	Double the number of countries with a recent analysis featured in a global report	-	At least 40% of countries where survey data are available are supported to complete or update an analysis of financial protection within two years after release	WHO financial protection database	Related to SO4.
		29	O4.4. Number / % of countries supported to introduce or increase taxation of harmful products (tobacco, alcohol, sugar-sweetened beverages [SSBs]) in line with WHO recommendations	95%	Data collection in progress	-	-	At least 10% of countries supported in health financing are assisted for policy dialogue on legislative, fiscal and regulatory policies (e.g. taxation of harmful products) in line with WHO recommendation	WHO NCD Country Capacity Survey	Political environment favourable to such dialogue in the targeted countries. For the baseline: 95% of countries that report having taxes on tobacco (excise and non-excise taxes) (2019).

	Results chain	#	Indicators	Baseline (ref. Year) denominator: 115 countries	Results 2020	Milestones		Targets (2023)	Sources and means of verification	Assumptions
						2021	2022			
Outputs	**Output 5 Information:** Health information systems strengthened; high-quality data available to monitor PHC for UHC progress	30	O5.1. Number / % of countries supported to assess and monitor health systems/PHC performance based on recommended core indicators and methods	15	66	25	30	35	-	-
		31	O5.2. Number / % of countries with surveillance data/information collected via indicator and/or event-based surveillance with regular reporting and immediate notification taking place in a systematic manner	"155 countries 80% of the countries have SPAR capacity indicator C6.1 score >3 (or >41%)"	167	-	-	95% of the countries have surveillance capacity score >3 (or >41%)	IHR SPAR annual reporting questionnaire	Countries submit their IHR SPAR annual reports to WHO.
		32	O5.3. Number / % of supported countries with an NCD surveillance and monitoring system in place to enable reporting against the nine voluntary global NCD targets and mental health	Global baseline: 27%	Data collection in progress	-	-	11 African Region countries supported [need country-specific plans]	NCD Country Capacity Survey	Conducting national risk factor survey used as proxy/measure for this indicator. For the global baseline, 27% of countries conducted survey(s) covering harmful alcohol use, physical inactivity, tobacco use, overweight and obesity, raised blood pressure, raised blood glucose and sodium intake within the past five years (i.e. in 2014 or later) and indicated that the survey(s) were conducted at least once every five years (2019).
		33	O6.1. Number / % of countries supported to implement service packages based on integrated models of care	Four countries (Afghanistan, Ethiopia, Jordan and Yemen)	Seven countries (baseline countries + Pakistan, Somalia and Sudan)	11	17	20	National document and strategies	This indicator is included in the "Astana Operational Framework for PHC" that is currently under consultation to be finalized in 2019. The operational definition for this indicator depends on finalization of this framework. Support should then be provided by the partners supporting the framework for its measurement in countries.
		34	O6.2. Number / % of supported countries that have evidence-based national guidelines/ protocols/ standards for the management of major NCDs through a primary care approach, recognized/approved by government or competent authorities	Global baseline: 48% countries reported having guidelines for four main NCDs (2019)	Data collection in progress	-	-	18 countries [need country-specific plans]	NCD Country Capacity Survey	Utilization of guideline is used as the measure more than the existence of guidelines.
		35	O6.3. Number / % of supported countries for implementation of NCD best buys and good buys intervention	Country baseline to be determined on individual country basis	36	-	-	[need country-specific plans]	NCD Country Capacity Survey	There are 16 best buy interventions to be used as proxy for this and support for any of the 16 would be included.
		36	O6.4. Number of countries supported to implement national quality strategies aligned with national health policies or plans	7	10	15	20	At least 75% of the countries receiving WHO support for national quality directions have developed a national quality policy and/or strategy (aligned with national health policies and plans)	"National documents and strategies WHO and UHC-P annual reports WHO regional reviews"	This indicator should be included as a GPW13 indicator and hence ensure smooth monitoring through WHO country offices and WHO regions.
		37	O6.5. Number / % of supported countries that have developed or updated a digital health strategy	Data to be updated in 2019 with new survey	Data collection in progress	-	-	According to the results of the new survey	"Data reported by countries to the Global Observatory for e-health Latest survey available: 2015–2016"	A new strategy is under development; this indicator may be adapted.
		38	O6.6. Number / % of Member States with national policies/guidelines standards for antenatal care (ANC) consistent with WHO recommendations	58 of 150 (39%) Member States that responded to the survey reported having policy/guideline for ANC that recommends at least eight ANC contacts and that the first contact should occur within the first 12 weeks of pregnancy	Final data to be provided in 2023	Final data to be provided in 2023	"Collection to update data to begin this year Final data to be provided in 2023"	110 Member States with policy/ guideline for ANC that recommends at least eight ANC contacts and that the first contact should occur within the first 12 weeks of pregnancy	Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) Policy Survey responses will be validated against national source documents provided by respondents and further confirmed with national ministries of health.	Combined SRMNCAH Policy Survey was conducted for the first time in 2018–2019 with plans for updated information by 2023. Baseline figures based on responses to survey questions; however, proportions could change based on validation of responses against national source documents.

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