#UHCPartnership

World Health Organization

Universal Health Coverage Partnership annual report 2021

Health systems strengthening and health emergencies beyond COVID-19

Universal Health Coverage Partnership annual report 2021: health systems strengthening and health emergencies beyond COVID-19

ISBN 978-92-4-006715-8 (electronic version)
ISBN 978-92-4-006716-5 (print version)

Suggested citation. Universal Health Coverage Partnership annual report 2021: health systems strengthening and health emergencies beyond COVID-19. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

Cover: Midwife Bahja and her children are beneficiaries of a new health-care centre in Abu Gaw, Sudan. The village's original health centre was destroyed during the armed conflict in 2004 which also drove residents, including Bahja, to flee. Since 2018, about 8000 people have returned to the village from displacement camps. The community identified rebuilding the health centre as a priority through a series of community health dialogues with health authorities, which was facilitated by WHO with support from the UHC Partnership. © WHO / Lindsay Mackenzie

World Health Organization

Universal Health Coverage Partnership annual report 2021

Health systems strengthening and health emergencies beyond COVID-19

Health workers in Kharkiv, Ukraine moved their patients and equipment to the bomb shelters to be able to maintain health services during the war. © WHO / Anne Pellichero

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Drought and food insecurity have impacted health in northern Kenya. © WHO / Billy Miaron

This report covers the calendar year 2021.
It provides a synthesis of country activities and results achieved with the support of the Universal Health Coverage 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.

Acknowledgement of donors and partners

The Universal Health Coverage Partnership is supported and funded by:

Belgium – Development Cooperation
Canada – Global Affairs Canada
European Union – DG INTPA thematic unit G4 and geographic directorates A, B, C
France – Ministère de l'Europe et des Affaires étrangères
Germany
Ireland – Irish Aid
Japan – Ministry of Health, Labour and Welfare
Luxembourg – Aid & Development
United Kingdom – Foreign, Commonwealth & Development Office
World Health Organization

List of abbreviations

AAR after-action review

ADB Asian Development Bank

AMR antimicrobial resistance

COP26 2021 United Nations Climate Change Conference

COVID-19 coronavirus disease 2019

CRVS civil registration and vital statistics

CVD cardiovascular disease

DCP3 Disease Control Priorities 3

DRG Diagnosis-related Group

DHIS2 District Health Information System

EPHFs essential public health functions

EPHS essential package of health services [Pakistan]

EPI Expanded Programme on Immunization

EU European Union

EVD Ebola virus disease

FFS fee-for-service

GAVI Gavi, the Vaccine Alliance

GFF Global Financing Facility

Global Fund The Global Fund to Fight Tuberculosis, HIV and Malaria

GPW13 WHO Thirteenth General Programme of Work for 2019–2023

HEOC Health Emergency Operations Centre

HLMA Health Labour Market Analysis

HRH human resources for health

iAHO Integrated African Health Observatory

ICD-10/11 International Classification of Diseases (10th/11th Revision)

IDSR integrated disease surveillance and response

IHR International Health Regulations 2005

IHRIS Integrated Human Resources Information System

IPC infection prevention and control

IS4H Information Systems for Health [Bahamas]

IT information and communications technology

JEE Joint External Evaluation

JWT WHO Joint Working Team on PHC and UHC

KPI key performance indicators

MDCC Multi-Donor Coordination Committee

mhGAP WHO Mental Health Gap Action Programme

MHIF Mandatory Health Insurance Fund [Kyrgystan]

MHPSS mental health and psychosocial support

NAPHS National Action Plan for Health Security

NBW National Bridging Workshop

NCD noncommunicable disease

NDoH National Department of Health [Papua New Guinea]

NGO nongovernmental organization

NHA National Health Account

NHSP National Health Support Project [Pakistan]

NHWA National Health Workforce Account

OOP out-of-pocket

oPt occupied Palestinian territory

P4P pay for performance

PAHO Pan American Health Organization

PEN Package of Essential Noncommunicable Disease Interventions

PFM public financial management

PHC primary health care

PHCMI Primary Health Care Measurement and Improvement

PHEOC Public Health Emergency Operations Centre

PHIO provincial health information officer [Papua New Guinea]

PHSM public health and social measures

ROM Results-Oriented Monitoring

RRT rapid response team

SCORE Survey Count Optimize Review Enable

SDG Sustainable Development Goal

SDG3 GAP SDG3 Global Action Plan for Healthy Lives and Well-being for All

SIDS Small Island Developing State

SPH Strategic Partnership for Health Security and Emergency Preparedness

SSB sugar-sweetened beverage

STAR Strategic Tool for Assessing Risks

TB tuberculosis

UHC universal health coverage

UHC-P Universal Health Coverage Partnership

UHI Universal Health Insurance [Egypt]

UNICEF United Nations Children's Fund

USAID United States Agency for International Development

WHO World Health Organization

WISN WHO's Workload Indicator of Staffing Need

Executive summary

For over a decade, the Universal Health Coverage Partnership (UHC-P) has progressively reinforced, via a flexible and bottom-up approach, the World Health Organization (WHO) strategic and technical leadership on universal health coverage (UHC), with more than 130 health policy advisors deployed in WHO country and regional offices. The UHC-P Annual report 2021 captures a return to a broader focus to achieving UHC, at a time when the world is learning how to manage the continuing health threat posed by the coronavirus disease 2019 (COVID-19) while also moving forward with putting policies and interventions in place to achieve UHC.

This broader focus on UHC built on lessons learned and awareness of the health systems gaps exposed by the pandemic. For example, in 2021, there were concerted and high-level efforts to develop a collaborative agenda for health systems strengthening based on primary health care (PHC) for UHC and health security. This will ensure that the investments made throughout the COVID-19 response will have a lasting impact towards the creation of resilient health systems, and in building and maintaining country preparedness and health systems that protect everyone, everywhere from the pandemic and future threats to health.

In this year's report, strengthening PHC to ensure strong health systems foundations and to maintain essential health services was an important focus for the first billion. This included highlighting the progress made in developing essential health services and benefit packages and strengthened essential public health functions in countries, advances in health financing approaches, and the importance of tracking and training human resources for health.

As recent years have shown, the increasing frequency and severity of climate-related hazards – combined with the added challenge of vector-borne diseases (Ebola, Zika, dengue, Chikungunya, COVID-19) – impose heavy human and economic tolls, and burden health-care systems. This report demonstrates how the UHC-P has supported achieving UHC for the second billion, and its dedication to working with countries to prepare for health emergencies and to take actions to ensure that those affected by health emergencies – especially the most disadvantaged – have access to essential life-saving health services and public health interventions.

Beyond fighting diseases, the UHC-P works to ensure healthy lives and promote well-being for all at all ages, leaving no one behind.

As a nurse at a health centre in Tobago, Rafuel (left) participated in a chronic disease self-management course implemented by PAHO/WHO with the support of the UHC Partnership. © WHO / Alasdair Bell

A mother brings her son for a blood test at a health facility for women and children in Abu Shouk internally displaced people camp in North Darfur.
© WHO / Lindsay Mackenzie

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 an individual's control, the UHC-P is committed to supporting Member States to address determinants of health, to promote multisectoral actions to address the burden of noncommunicable diseases (NCDs), to reduce risk factors, and to prioritize health in all policies and healthy settings, to achieve UHC for the third billion.

As the past two years have shown, good governance and leadership of a health system requires 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 in developing national strategies and plans, monitoring progress against priorities, and responding to public health emergencies. The UHC-P ensured collaboration 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, and assess health system performance. This systematic monitoring of implementation and results ensures clear accountabilities.

In 2021, the UHC-P has strengthened its anchorage in the Special Programme on Primary Health Care, established by WHO to achieve healthy lives and well-being for all, by building people-centred, resilient and sustainable PHC-based health systems. The Special Programme on PHC offers an agile, flexible, integrated and multidisciplinary platform to connect WHO's three billion strategic priorities (healthier populations – UHC – health emergencies) as well as country office, regional office and headquarters work on PHC. This WHO department also ensures the leadership for PHC at the global level, with, for instance, the coordination, alongside the United Nations Children's Fund (UNICEF), of the Global Action Plan for Healthy Lives and Well-being for All, or with the formulation of a PHC course for health professionals in the frame of the WHO Academy.

In addition, following the Seventy-fifth World Health Assembly, WHO committed to increase its budget for intensified PHC support to Member States and called for a radical reorientation of health systems towards PHC. After the publication of the PHC Measurement Framework and Indicators in 2022, the Special Programme on PHC will support countries to reorient their health systems with the publication of consolidated country case studies on PHC. These case studies contain diverse evidence and lessons learned across different settings for PHC implementation, that will also benefit the future work of the UHC-P.

By combining policy dialogue and technical assistance, the UHC-P has provided tailored and bottom-up support for each country's road map towards achieving UHC.

The year 2021 was an important year as we began to see a shift from activities that were mainly direct responses to the COVID-19 pandemic, to a return to ongoing and scheduled activities that support countries' plans for achieving UHC. The UHC-P's support for the continuous presence of more than 120 experts in the field allows for close monitoring of policy dialogues, strengthens the trust relationships with national authorities, and works towards overcoming the gaps related to the lack of inclusion of populations, communities and civil society organizations that the COVID-19 pandemic has exposed. By combining policy dialogue and technical assistance, the UHC-P has provided tailored and bottom-up support for each country's road map towards achieving UHC.

Fig. 1. UHC-P 2021 timeline

January

- **Webinar:** NCD Hard Talks: From Declarations to Actions: Political will to fight NCDs.
- **Webinar:** The European Union and Collective Action for Universal Health Coverage.
- **Regional Office for Africa:** COVID-19 vaccination begins between January and April, with mass vaccination campaigns being carried out in most countries. All countries but Eritrea begin COVID-19 vaccination. Countries develop and update their vaccine deployment plan to address challenges of distribution, improve access, and mitigate vaccine hesitancy, which is widely experienced in many of the African Region countries.

February

- **Regional Office for South-East Asia:** Lessons from COVID-19 are captured in the February 2021 special edition of the *WHO South-East Asia Journal of Public Health* (Volume 10, Supplement 1) in the article, "Recalibrating PHC-centred Systems for UHC in the New Normal: Lessons from COVID-19".
- **Regional Office for Europe:** Webinar series: Let's Talk Primary Health Care.
- **Webinar:** NCD Hard Talks: Reducing Risks, Averting Deaths! Leveraging systems for NCD prevention.
- **Meeting:** UHC-P 8th High-level Steering Committee and Multi-Donor Coordination Committee Meeting for UHC.
- **Live monitoring:** Focus on the South-East Asia Region.
- **Global:** Stories From the Field – Issue 5 (60-second summaries).
- **Meeting:** Bimonthly meeting of the Joint Working Team on Health and Migrations.

March

- **Regional Office for the Western Pacific:** The joint Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) "PHC for UHC Mission to Pakistan" takes place during the first week of March 2021. This mission falls under the Regional Health Alliance and GAP accelerators on Primary Health Care (PHC) and Sustainable Financing and is attended by representatives from federal and provincial governments; WHO; Gavi, the Vaccine Alliance; the Global Financing Facility; the Global Fund to Fight Tuberculosis, AIDS and Malaria; joint United Nations Programme on HIV/AIDS; United Nations Population Fund; UNICEF; the World Bank; and other local and international development partners and civil society organizations.
- **COVID-19:** Two grants agreements are signed between WHO/UHC-P and the Government of Canada to support efforts to end the acute phase of the COVID-19 pandemic.
- **Webinar:** NCD Hard Talks: Shifting the Paradigm: NCDs, economics, and the push toward wellbeing.

Global events Regional events Accountability mechanisms

Fig. 1. UHC-P 2021 timeline *continued*

April

Regional Office for Africa: A WHO mission titled "Re-imagining the Health System in Sudan: Health system strengthening for UHC and health security" visits Sudan from 3 to 10 April.

Region of the Americas: Webinar 1 on "Accessing access barriers to achieve universal health in the era of COVID-10" is held on 23 April.

Regional Office for Europe: The first ever regional report – "Spending on Health in Europe: Entering a new era" – is published analysing health spending in 53 countries in the Region from 2000 to 2018.

Webinar: NCD Hard Talks: Data-driven Action on NCDs for Impact.

Meeting: Bimonthly meeting of the Joint Working Team: PHC on the road to UHC (part 1).

May

Regional Office for Africa: A Regional Consultation on Climate Change and Health is organized in collaboration with WHO headquarters and the Global Climate and Health Alliance.

Regional Office for the Americas: Webinar 2 on "Monitoring universal health in the era of COVID-19" is held on 18 May.

Live monitoring: Focus on the Regional Office for the Eastern Mediterranean where sessions are conducted with WHO country offices in Egypt, Lebanon and Tunisia presenting.

Regional Office for Europe: UHC-P participates in the 33rd meeting of the Commonwealth of Independent States (CIS) Health Council, dedicated to the role of PHC during the COVID-19 pandemic.

Regional Office for South-East Asia: WHO report titled *Crisis or Opportunity? Health financing in times of uncertainty: Country profiles from the South-East Asia Region* is published.

Global: WHO launches *Voice, Agency, Empowerment – Handbook on Social Participation for Universal Health Coverage*.

Meeting: Seventy-fourth World Health Assembly is on "Strategic Briefing on Primary Health Care for Universal Health Coverage".

Webinar: NCD Hard Talks: Digital Solutions for NCDs: COVID-19 and beyond.

Live monitoring: Focus is on Region of the Americas.

Global events Regional events Accountability mechanisms

Fig. 1. UHC-P 2021 timeline *continued*

June

Regional Office for Europe: First edition of the "Tailored Training and Mentorship Programme on Strengthening PHC Performance Measurement and Management" is launched with the participation of Georgia, Ukraine and Uzbekistan.

Regional Office for Europe: Country vignettes for Azerbaijan and Georgia for the series "Transforming Primary Health Care During the Pandemic" are published.

Meeting: High-level event is held on "The role of primary health care in the COVID-19 pandemic response and leading equitable recovery".

Webinar: NCD Hard Talks: Awakening the Giant: Public–private partnerships, a potent tool for NCD impact.

Global: Stories From the Field – Special Issue on Small Island Developing States.

Global: Newsletter of the WHO Special Programme on PHC – Issue 2.

Live monitoring: Focus on the European and Western Pacific Regions.

Meeting: Small Island Developing States Summit for Health.

A team of health workers in Fiji. © WHO

July

Regional Office for the Americas: Webinar 3 on "Policy development from an integrative perspective" is held on 12 July.

Regional Office for Europe: New country-specific analyses on financial protection for Georgia with complementary web story and video launched about the impact of out-of-pocket payments for medicines on individuals and families.

Webinar: NCD Hard Talks: Maximizing Purchasing and Pricing Power: Does pooled procurement work for NCD medicines?

Global: Stories From the Field – Issue 6 (the Caribbean, India, Mongolia, Sudan, Uzbekistan and Zimbabwe).

Meeting: 9th Multi-Donor Coordination Committee for UHC.

Global events Regional events Accountability mechanisms

Fig. 1. UHC-P 2021 timeline *continued*

August

Global: Stories From the Field – Issue 6 (60-second summaries).

September

Regional Office for the Americas: Webinar 4 on "Improving the quality of care in the delivery of health services" is held on 17 September.

Regional Office for Europe: The resolution "Realizing the potential of primary health care: lessons learned from the COVID-19 pandemic and implications for future directions in the WHO European Region" is approved at the 71st session of the Regional Committee for Europe.

Regional Office for South-East Asia: The report *Crisis or Opportunity? Health financing in terms of uncertainty* is published with country profiles and a review of health financing policy responses to COVID-19.

Regional Office for South-East Asia: The report *Monitoring Progress on Universal Health Coverage and the Health-related Sustainable Development Goals in the WHO South-East Asia Region* is published with annual monitoring of UHC and the health-related Sustainable Development Goals (SDGs).

Regional Office for South-East Asia: During the 74th session of the Regional Committee, ministers of health from the South-East Asia Region identify the urgency for and commit to seize a once-in-a-century opportunity to reorient health systems towards comprehensive PHC through increased public investment. Ministers issue a declaration on COVID-19 and measures to "build back better" essential health services to achieve UHC and the health-related SDGs.

Webinar: NCD Hard Talk: What in the World is NCD Integration and How to Do It?

Meeting: Annual Retreat of the Joint Working Team for PHC and UHC.

Meeting: Bimonthly meeting of the Joint Working Team: PHC on the road to UHC (part 2).

October

Regional Office for the Western Pacific: A high-level panel discussion on PHC is convened during the Seventy-second session of the Regional Committee, involving ministers of health from New Zealand, Singapore, Tonga and Vanuatu. This reaffirms the commitment of the Member States to strengthen PHC in the Region and gives a clear mandate to the Regional Office to develop a regional framework to guide countries in designing and undertaking PHC reform.

Global: WHO publishes a position paper on building health systems resilience for UHC and health security during the COVID-19 pandemic and beyond.

Webinar: NCD Hard Talk: How COVID-19 has Affected NCD Control in Cities.

Meeting: 10th High-level Steering Committee and Multi-Donor Coordination Committee Meeting for UHC.

Global events | Regional events | Accountability mechanisms

Fig. 1. UHC-P 2021 timeline *continued*

November

Regional Office for the Americas: Webinar 5 on "Right to health, social participation and the strengthening of the essential public health functions" is held on 19 November.

Regional Office for Europe: A WHO high-level Health System Mission visits Jordan, focusing on "Re-shaping the Health Sector in Jordan: Towards optimizing the role of the Ministry of Health".

Regional Office for the Western Pacific: The annual UHC Technical Advisory Group (TAG) meeting and the second TAG Alliance meeting are held in November 2021 to discuss ways to capitalize from identified lessons and opportunities from the COVID-19 pandemic to transition from the "new normal" to the "new future" of health. These meetings set forth the future direction and identified joint activities that increase technical and political advocacy to integrate health agendas with a UHC lens towards strong health systems.

Regional Office for the Western Pacific: On 23–24 November, 23 Member States from 13 Pacific island countries and areas convene in a virtual meeting along with observers, temporary advisors and members of the Secretariat for the Sixth WHO Pacific Islands Mental Health Network meeting, to share good practices, create a vision for mental health and initiate country planning steps.

Regional Office for Europe: The fifth edition of the WHO Barcelona course on health systems strengthening for improved tuberculosis prevention and care is published.

Webinar: NCD Hard Talk: Comprehensive Diabetes Management.

Results-Oriented Monitoring: The UHC-P is the object of the external monitoring system of the new Directorate-General for International Partnerships of the European Commission. The report highlights the high relevancy of the intervention because of its flexible and bottom-up approach based on a menu of activities, which ensures a well-framed response to the current needs of ministries of health.

Blood sugar screening in Samoa. © WHO

Global events Regional events Accountability mechanisms

Fig. 1. UHC-P 2021 timeline *continued*

December

Regional Office for Africa: The 1st International Conference on Public Health in Africa (CPHIA2021) takes place virtually.

Regional Office for the Americas: Webinar 6 on "Measurement and strengthening of the EPHF: the experience of countries in the Region of the Americas" is held on 8 December.

Regional Office for the Eastern Mediterranean: WHO leads activities to mark UHC Day at Dubai Expo 2020 on 12 December. In more than 170 years of the World Expo history, the Dubai Expo is the first to be held in the Middle East, Africa and South Asia Region, and is also the largest with the participation of 192 nations.

Regional Office for the Eastern Mediterranean: The WHO Eastern Mediterranean Region Special Issue (2018–2021) on "Stories From the Field" is published on UHC Day 2021; the stories in this publication demonstrate the depth and breadth of work that WHO, through the UHC-P, is undertaking to achieve Health for All by All in the Eastern Mediterranean Region; they document the results of collaboration with governments, communities and our partners.

Regional Office for the Eastern Mediterranean: A Regional Training Course on Humanitarian-Development-Peace Nexus for Health is jointly organized by the Health Systems in Emergencies Lab and the Center for Conflict and Humanitarian Studies.

Regional Office for South-East Asia: The ministerial launch of the "South-East Asia Regional Strategy for Primary Health Care: 2022–2030" takes place on UHC Day. The Strategy seeks to guide, support and monitor PHC-oriented transformation of health systems across the Region.

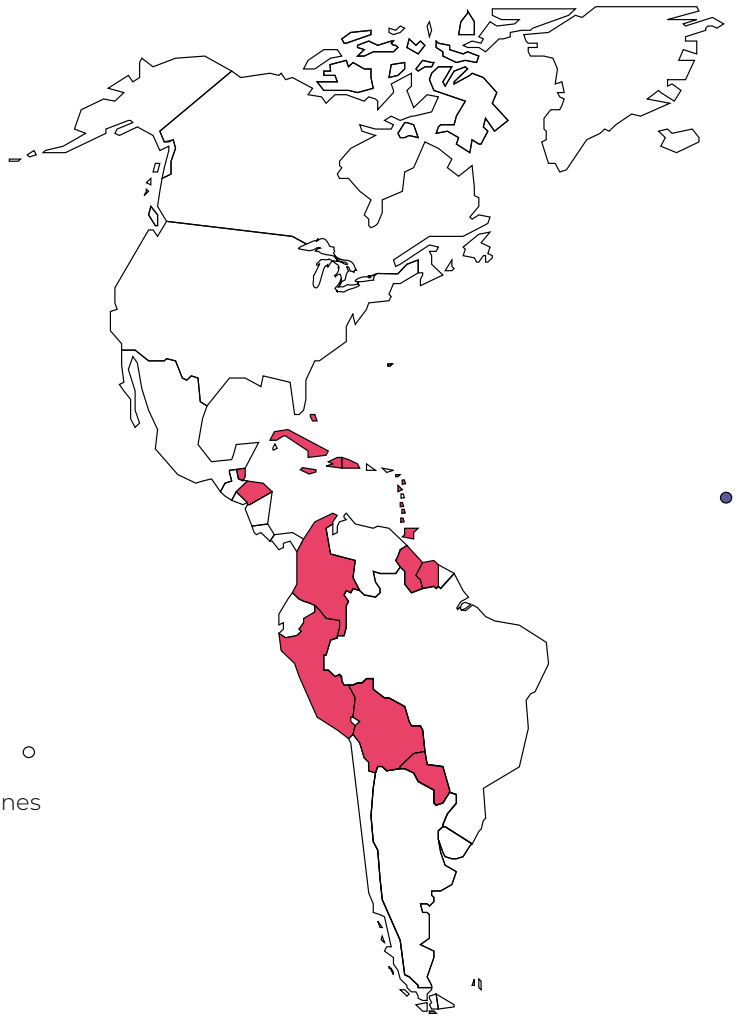
Live monitoring: Focus on the Americas, Eastern Mediterranean, Europe, South-East Asia and Western Pacific Regions, plus support from Canada to WHO country support plans.

Global: Stories From the Field – Special Issue on the Eastern Mediterranean Region (highlights on Egypt, Islamic Republic of Iran, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, the occupied Palestinian territory, Somalia, Sudan, Syrian Arab Republic and Tunisia).

Scene at the waiting area of hospital in Lahore, Pakistan.
© WHO / Blink media – Saiyna Bashir

Global events Regional events Accountability mechanisms

Fig. 2. List of countries and areas supported by the UHC-P in 2021



WHO Region of the Americas

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

WHO African Region

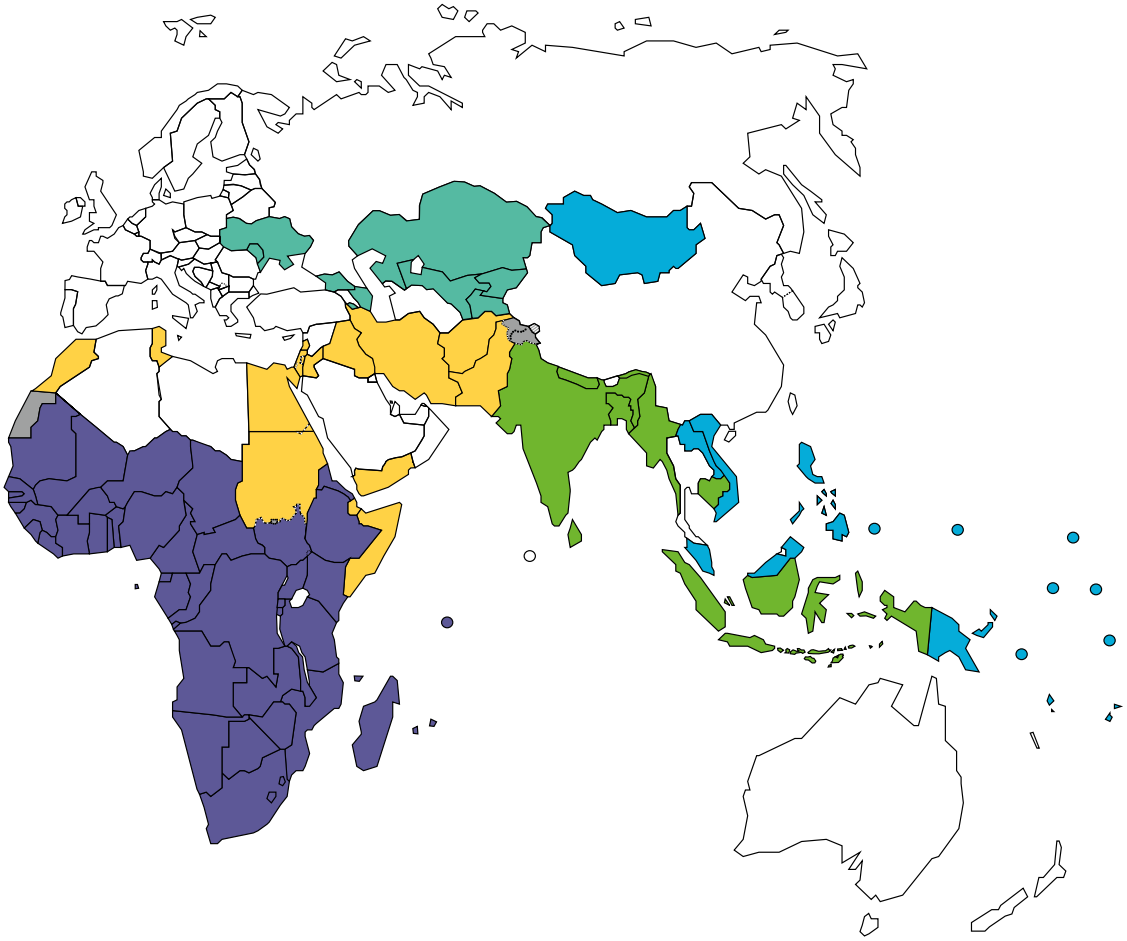
- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cabo Verde
- Cameroon
- Central African Republic
- Chad
- Comoros
- Congo
- Côte d'Ivoire
- Democratic Republic of the Congo
- Equatorial Guinea
- Eritrea
- Eswatini
- Ethiopia
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- 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 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 South-East Asia Region

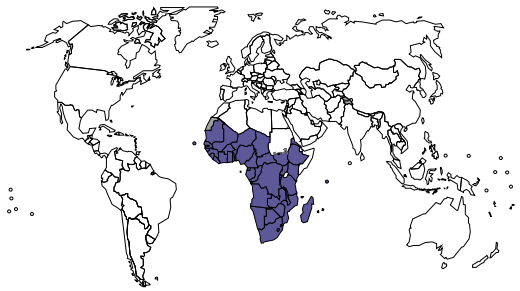
- Bangladesh
- India
- Indonesia
- Myanmar
- Nepal
- Sri Lanka
- Timor-Leste

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

Not Applicable

Regional highlights



WHO African Region

Towards the path to the 2021 United Nations Climate Change Conference (COP26), the Regional Office for Africa co-organized, co-chaired and facilitated the regional consultation on climate change and health in collaboration with WHO headquarters and the Global Climate and Health Alliance, with the participation of **Ethiopia**, **Ghana**, **Madagascar**, **Mozambique** and **Sao Tome and Principe**. Countries have been assisted to prepare national case studies on climate change and health that fed WHO's COP26 Special Report on Climate Change and Health. The Regional Office also participated actively in the COP26 Health Programme on building climate-resilient and sustainable low-carbon health systems, with 19 Member States submitting their signed commitments towards this goal.

In 2021, with UHC-P support, **ministries of health in the African Region** benefited from WHO-facilitated analysis of the 2020 health-care expenditures that helped track, in particular, the COVID-19 response public spending. This evidence-based budgeting data and information introduced a greater degree of certainty in health investment and advocacy decisions in the African Region.

The development of mental health investment cases in **Kenya**, **Uganda** and **Zimbabwe** has also enabled engagement of various stakeholders, in several sectors of government. The first implementation of recommendations is already demonstrating some improvements in the health of the population suffering from mental illnesses. In addition, following the establishment of global and regional strategic documents, many activities have been implemented, such as data collection on COVID-19 and mental, neurological and substance use disorders; review of the intersectoral global action plan on epilepsy and other neurological disorders; dissemination of mental health and psychosocial support (MHPSS) tools and guidelines; and implementation of the WHO-UNICEF joint programme of work focusing on a minimum services package for MHPSS in north-east **Nigeria** and **South Sudan**.

A mobile team provides nutrition screening and other health services under a the shade of a tree in Marsabit, Kenya. The area is facing one of the worst droughts in recent decades. © WHO / Billy Miaron

WHO Region of the Americas

The essential public health functions (EPHFs) approach of the Pan American Health Organization (PAHO) was applied across 12 countries in the Caribbean and Latin America. Thanks to the UHC-P, technical support was provided to **Bahamas**, **Dominican Republic** and **Suriname** for implementation of the initial phases of the EPHFs approach. These included situation analyses of the health system, including progress towards UHC and institutional mapping, as well as measuring of institutional capacities for implementation of public health actions. The results will be the main input for developing action plans to strengthen institutional capacities and technical cooperation plans. In addition, PAHO worked on developing a set of tools for training health authorities and implementing teams on the renewed EPHFs assessment. These included a virtual course, which has been launched in 2022, and a virtual platform to facilitate EPHFs assessments.

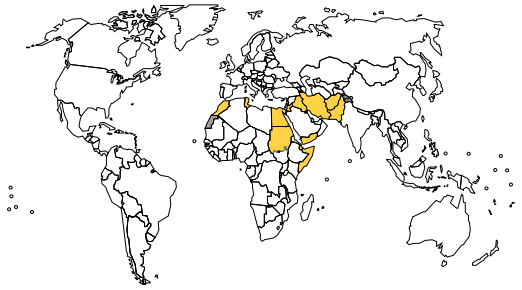
With regard to health financing, studies on burden of disease and fiscal space and a health financing system profile were developed in **Barbados**, while a costing and efficiency study of selected facilities was elaborated in **Saint Kitts and Nevis**. Two health financing progress matrixes (HFPM) assessments were successfully completed in **Antigua and Barbuda** and **Barbados**.

Financial protection indicators in health were estimated for **Grenada** and **Saint Kitts and Nevis** using the household budgetary survey databases for 2006/2007 and 2007/2008, and were subsequently presented to national authorities.

In addition, the Regional Office Department of Noncommunicable Diseases (NCD) and Mental Health, with the support of the UHC-P, developed an analysis to estimate the population at risk for severe COVID-19 due to underlying health conditions in **12 Caribbean** countries. The results were used for shielding strategies, vaccination planning and the planning of NCD programmes. The analysis contributed to protecting the gains, preventing setbacks, and fostering the progress reached in areas related to NCDs and their risk factors.

Lastly, the Regional Office Department of Public Health Emergencies supported countries in improving their preparedness capacity by working on the development and adaptation of strategic risk assessment training materials; the training workshops on strategic risk assessment for the Caribbean; and an online training course on the Multi-Hazard Response Framework.

Malaria control programme in Suriname. © WHO/PAHO



WHO Eastern Mediterranean Region

Committed leadership and strong political support stand out as major strengths for PHC strengthening in the Region. Family practice–based model of care has been implemented to a varying scale in several countries. However, it has been felt that the same model may not be suitable for all contexts; there are missed opportunities in identifying roles, functions and linkages between service delivery platforms; community engagement is ad hoc and lacks sustained mechanisms for social accountability. Although there has been recent attention towards multisectoral action and policy, regular engagement between health and other social sectors is missing.

Through the regional initiative for developing PHC-oriented models of care in selected Eastern Mediterranean Region countries, WHO – in close collaboration with governments and partners – will facilitate countries in development of context-specific PHC-oriented models of care at the subnational level. The first phase of the initiative includes three countries and areas, with each of them selecting two subnational sites for implementation (**Pakistan – Islamabad Capital Territory and Charsadda district**; **occupied Palestinian territory – Bethlehem District and Gaza**; **Sudan – Gazera and Darfour**). Afghanistan and Oman have expressed interest in joining the initiative and will likely be included in the second phase, starting from October 2022.

Finally, considering the need for conceptualizing and operationalizing PHC comprehensively through its three components, partners for the GAP PHC accelerator have prioritized implementation of PHC-oriented models of care in the two-year workplan on PHC.

Scene at a pharmacy in Lahore, Pakistan. © WHO / Blink media – Saiyna Bashir

WHO European Region

During 2021, the WHO Regional Office for Europe focused on maintaining the political momentum for UHC amid waves of the COVID-19 pandemic and as countries began their recovery strategies. This work involved identifying, documenting and analysing the lessons learned from the transformation of PHC across the Region during the pandemic, and encouraging cross-country learning. This resulted in a series of 16 country vignettes describing policy instruments for strengthening the role of PHC during the pandemic response, as well as maintaining essential health services. Furthermore, five talk shows from the series "Let´s Talk PHC" were delivered, engaging more than **1000 participants from over 40 countries**. The talk shows connected practitioners, policy-makers and researchers from across the Region. The Regional Office also held three virtual consultations with 35 Member States. All these activities informed the resolution on "Realizing the Potential of Primary Health Care: Lessons learned from the COVID-19 pandemic and implications for future directions in the WHO European Region", approved by Member States in the 71st session of the Regional Committee for Europe.

The Regional Office also launched the first edition of the tailored training and mentorship programme on strengthening PHC performance measurement and management by the WHO European Centre for PHC. The course was delivered virtually and included the participation of **Georgia**, **Ukraine** and **Uzbekistan**. In-person health system country support was progressively re-started and several country missions on PHC and health financing were organized in UHC-P-supported countries (**Georgia**, **Tajikistan**, **Ukraine** and **Uzbekistan**).

The WHO Barcelona Office for Health Systems Financing published the first ever regional report on health expenditure tracking for the WHO European Region titled *Spending on health in Europe: entering a new era*, summarizing health spending patterns and trends in the Region and informing health financing reforms to progress towards UHC during the recovery from the COVID-19 pandemic. In addition, in 2021, a new country-specific analysis on financial protection for **Georgia** about the impact of out-of-pocket payments for medicines on individuals and families was launched, accompanied by a complementary web story and video. The fifth edition of the WHO Barcelona course on health systems strengthening for improved tuberculosis prevention and care took place virtually in November with more than **100 participants** from all UHC-P countries.

An online COVID-19 clinic in Georgia. © WHO / Vladimir Valishvili

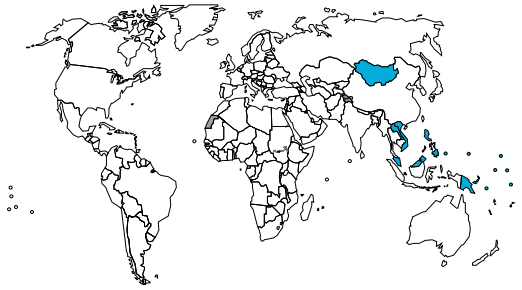
WHO South-East Asia Region

The WHO South-East Asia Region is home to a quarter of the world's population. Successive waves of the COVID-19 pandemic have had an unprecedented impact on health and economy in the Region, threatening decades of progress in service delivery and poverty alleviation. Notably, with respect to the latter, the World Bank estimated in March 2022 that two thirds of the people who fell into or remained in extreme poverty globally due to the pandemic reside in South Asia. The UHC-P resources have been critical to the Regional Office's health systems–focused efforts in the Region. Despite significant COVID-19-related challenges, the period saw delivery of focused health systems support to sustain and accelerate progress towards UHC across the Region.

At country level, UHC-P support has been central to the development of national health sector policies, standards and guidelines; to assess the utilization of essential health services; to operationalize and support the delivery of health service packages and, in the case of **Myanmar** (where engagement with government authorities is limited), to provide direct service delivery support in life-threatening situations. The period has been particularly notable in terms of the expansion of technical support through UHC-P support at subnational level (i.e. presence of health system advisors at state and district level in **India**; decentralized support in **Indonesia**).

Notably, at the 74th session of the WHO South-East Asia Regional Committee, reflecting on lessons learned from COVID-19, ministers of health in the Region committed to reorient health systems towards PHC, including through increased public investment, as the primary approach to simultaneously ensure health system resilience and the achievement of UHC and the health-related SDGs (SEA/RC74/R1). Moreover, through the Declaration of Health Ministers, South-East Asia Region ministers of health emphasized a "once-in-a-century opportunity" to enable such transformation, including calling for a regional PHC Strategy to guide, support and monitor PHC orientation of health systems. In addition, building on lessons from COVID-19, the South-East Asia Regional Strategy for Primary Health Care: 2022–2030 was launched on UHC Day in December 2021, with the participation of ministers of health from across the Region. The PHC Strategy elaborates a set of seven values and 12 interdependent strategic actions.

A team of community health workers in Haryana State, India. © WHO / Christine McNabv



WHO Western Pacific Region

In 2021, WHO country offices and the Regional Office sustained efforts to support countries to accelerate progress towards UHC despite the challenges posed by the ongoing pandemic. The Regional Office brought PHC to the front of the health agenda with work on the regional framework on PHC. Experts from across the Region convened in a three-day consultation to brainstorm on the future of PHC in the Region and to provide inputs on the key elements to be reflected in a regional framework.

While many countries experienced recurrent COVID-19 surges, progress was made in many areas, including in strengthening essential service delivery with a focus on PHC, health financing evidence generation to guide policy and strengthened capacity to regulate and manage health commodities, which supported the access to COVID-19 vaccines in countries. In addition, in the Pacific, significant progress was made in the capacity and delivery of services for mental health and NCDs as a consequence of these needs highlighted by the COVID-19 pandemic.

Lao People's Democratic Republic has introduced a system of licensing and registration to strengthen the health workforce. © WHO / Ben Duncan

Fig. 3. UHC-P by the numbers

9 donors

LUXEMBOURG AID & DEVELOPMENT

Belgium partner in development

Irish Aid An Roinn Gnóthaí Eachtracha agus Trádála Department of Foreign Affairs and Trade

MINISTÈRE DE L'EUROPE ET DES AFFAIRES ÉTRANGÈRES Liberté Égalité Fraternité

Foreign, Commonwealth & Development Office

Canada

US$ 382 million

leveraged from partners to assist countries in building resilience and effective health systems, including US$ 76.7 million in 2021.

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

3 levels of allocations: **70%** for country office, **15%** for regional office and **15%** for headquarters.

131 health policy advisors globally

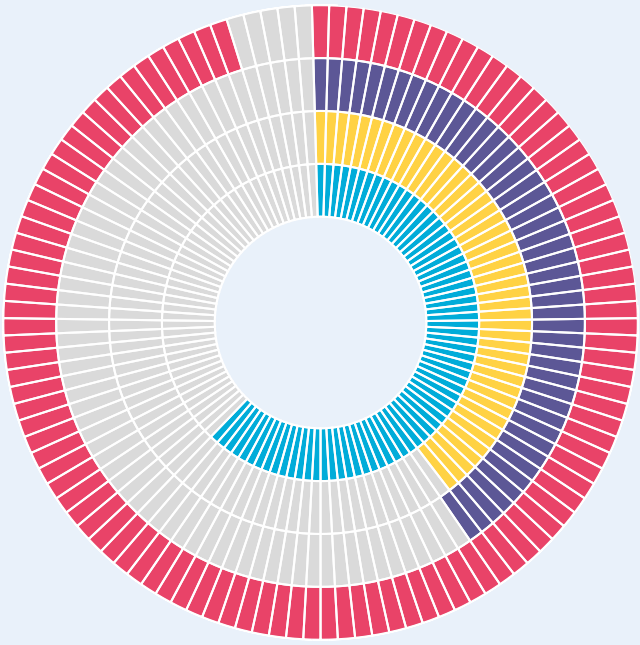
112 country-level health policy advisors in WHO country offices, with **16** under recruitment.

19 regional health policy advisors.

115 countries in the **6** WHO regions

See Annex 2 for all UHC-P activities mapped by country.

Fig. 4. UHC-P key thematic areas (number of countries involved)



1st BILLION: 110 countries

2nd BILLION: 47 countries

3rd BILLION: 46 countries

Data and innovation: 72 countries

Fig. 5. Top 10 outputs targeted through the UHC-P

Number of countries that have implemented top 10 outputs from the WHO 13th General Programme of Work		
1.1.1	Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages.	**78**
1.1.5	Countries enabled to strengthen their health workforce.	**75**
1.1.4	Countries' health governance capacity strengthened for improved transparency, accountability, responsiveness and empowerment of communities.	**68**
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**
1.1.2	Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results.	**60**
1.2.1	Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage.	**57**
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.	**46**
1.3.3	Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved.	**43**
1.3.1	Provision of authoritative guidance and standards on quality, safety and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists.	**39**
4.1.2	WHO Impact Framework and Triple Billion targets, global and regional health trends, Sustainable Development Goal indicators, health inequalities and disaggregated data monitored.	**32**

A mother sits with her child under a mosquito net at a nutrition stabilization centre in Abu Shouk internally displaced people camp in North Darfur, Sudan. © WHO / Lindsay Mackenzie

Introduction

The year 2021 was a rough year for health. The coronavirus disease 2019 (COVID-19) pandemic shocked essential public health functions and service delivery, with 94% of countries experiencing disruption in their essential health services.[1] If the universal health coverage (UHC) target for 2030 had been off track before the pandemic, it is even further off track now. In addition, social and economic measures have disrupted national economies, shrinking available resources for health and other sectors for human development. The pandemic has demonstrated the importance of public health and primary health care (PHC) as the first line of defense against emergencies and the foundation of UHC and healthier people. PHC – through multisectoral action, integrated health services, community empowerment and strengthening overall health systems functions – is a key approach towards realizing UHC.

Despite the challenges, all countries involved in the UHC Partnership (UHC-P) have seen an increase in their UHC index during the last decade, thanks to all global and national health partners in support of national authorities. In 115 countries, the UHC-P demonstrated what can be achieved through health systems strengthening with an integrated PHC approach, including more recently in the context of a pandemic and health emergencies. While much work remains to be done, much progress has been achieved in improving the UHC index. This progress needs to be accelerated and to build on the experiences and lessons learned from countries supported by the UHC-P. A decade on, the Partnership has evolved into one of the largest and most effective platforms for international cooperation on UHC and PHC. It is now time to deepen this investment to ensure its sustainability and to support countries to achieve health for all.

Blood pressure check at a primary health centre in Lebanon. © WHO / Natalie Naccache

What is 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).[2] 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 road map towards UHC.

In order to reach UHC, health systems must be oriented towards a PHC approach, which includes three essential components: multisectoral policy and action, empowered people and communities, and PHC and essential public health functions (EPHFs) at the core of integrated health services. In 2021, following the publication of the operational framework for PHC,[3] a monitoring and evaluation framework[4] was developed to support countries to assess how decisions, actions and investments are addressing the broader determinants of health while improving service coverage, financial risk protection, and ultimately, the health of individuals and populations. PHC is the main strategic approach of the UHC-P to move towards UHC and health for all. Fig. 6 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.

How does the UHC-P support countries?

The UHC-P was created as a joint undertaking by the European Commission and WHO 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, workforce, financing, access to health products, information and service delivery, while enabling effective development cooperation (see Box 1). It was, from the beginning, designed as a multi-donor partnership and one of the instruments with which the European Commission was underpinning its new role in global health as communicated in 2010.[5,6] Recently, the UHC-P has developed a specific focus on noncommunicable diseases (NCDs), to respond to the ever-increasing burden of NCDs on population health. The UHC-P is also working on health security, thanks to its flexible and catalytic approach, to build medium-term sustainable health emergency preparedness and response capacities. In the context of the COVID-19 pandemic, activities support the response to the pandemic, including vaccination and the continuity of essential services.

As of October 2022, through the UHC-P, the World Health Organization (WHO) has scaled up support on UHC to 115 target countries across all six WHO regions. In terms of results, in 2021 as it was 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 but will see increased commitments in the next phase of the Partnership. 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 the instrumental approach of the Organization in assisting Member States to achieve UHC.

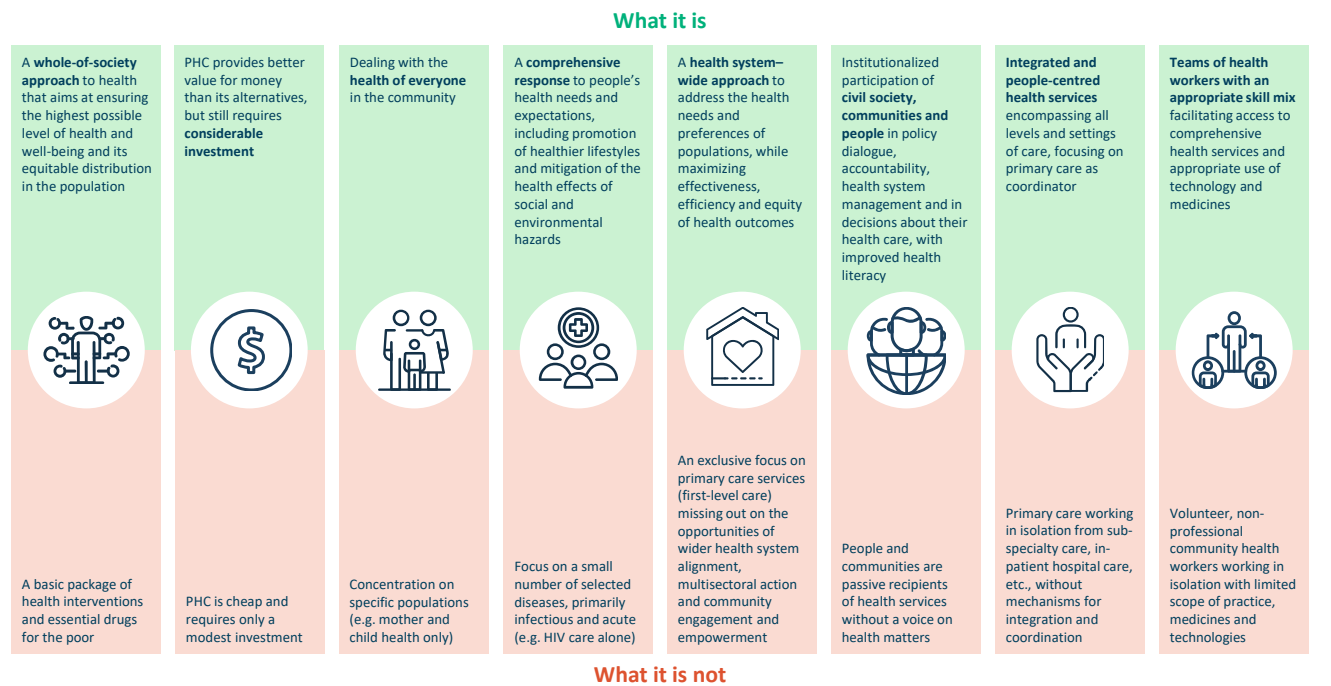
Additionally, the UHC-P supports the development of "WHO public health goods" – an internal concept to the WHO's planning process referring to WHO's technical products on norms/standards, data and research.[7] These products encompass rigorous science- and evidence-based recommendations on matters that affect peoples' health; provide general information and facts pertaining to a public health topic; include health information and evidence ranging from global statistics to monitoring data; or introduce innovations, horizon scanning results and research. (See Annex I for a list of WHO global public goods supported by the UHC-P.)

In 2021, the UHC-P channelled investments from nine donors (Belgium, Canada, the European Union [EU], France, Germany, Ireland, Japan, Luxembourg, and the United Kingdom of Great Britain and Northern Ireland) to ensure continuity between global commitments and country implementation for health systems strengthening. In the context of the COVID-19 pandemic, intensified integrated support to 10 countries started in 2021 thanks to Canada. These countries benefited from specific support to: guarantee the continuity of essential health services; elaborate on a review of innovations and service delivery modifications in response to COVID-19; produce trainings and guidance on gender, equity and human rights for WHO officers; as well as conduct a technical review of the Regional PHC Strategy in the WHO South-East Asia Region. In addition, discussions are continuing with investment banks to fund investment plans in priority countries. Funded activities are supporting the WHO workplan across all three levels of the Organization (country, regional and headquarters) based on the GPW13, and not as a separate project.

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 workplan for each funding, as well as the utilization and distribution at all levels (see Fig. 7).

Community interaction in the Plurinational State of Bolivia. © WHO / PAHO

Fig. 6. PHC in practice



Source: Modified from *The world health report 2008*.[8]

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

More than 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.

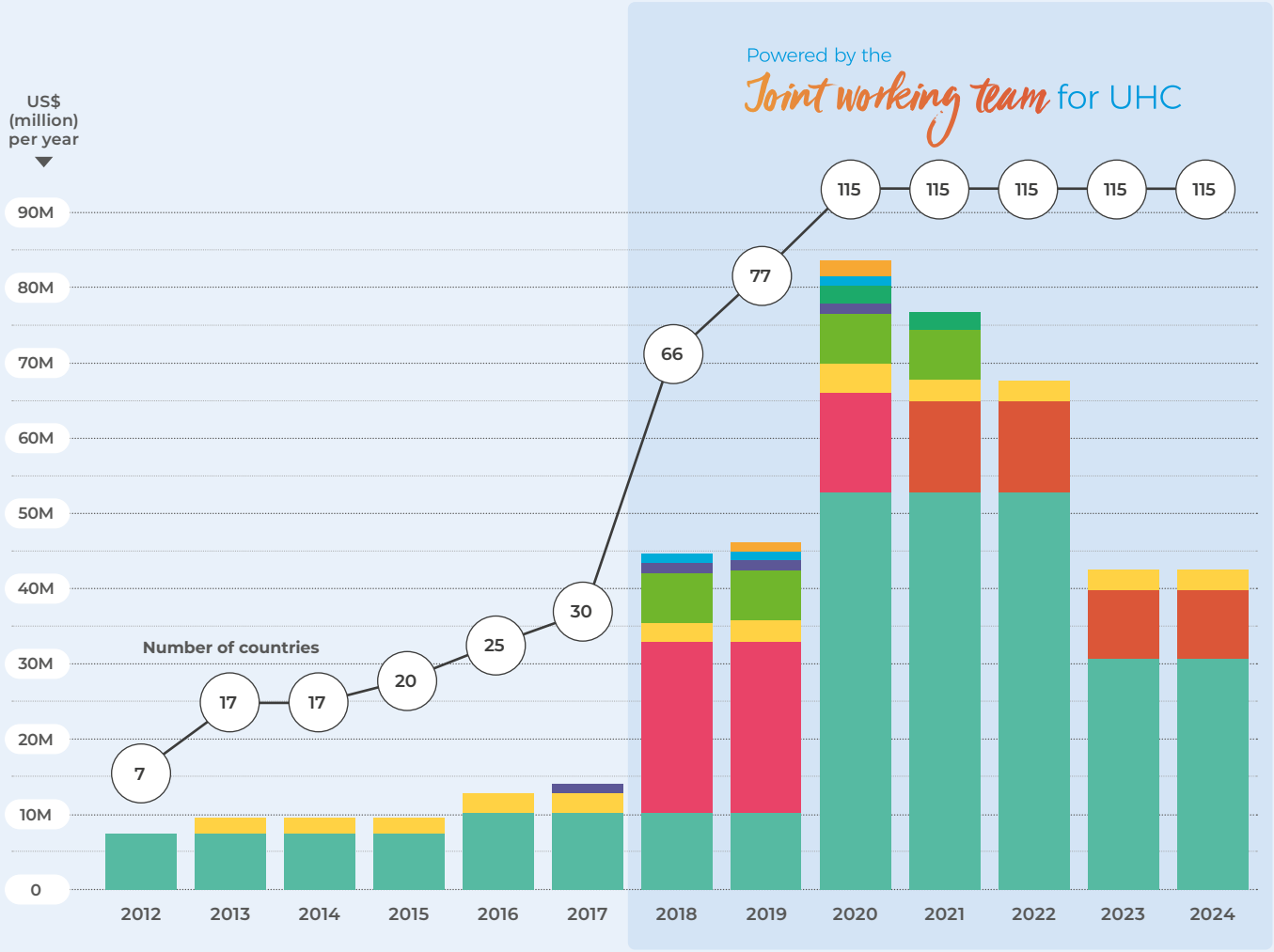
Prepare, respond to and maintain essential health services

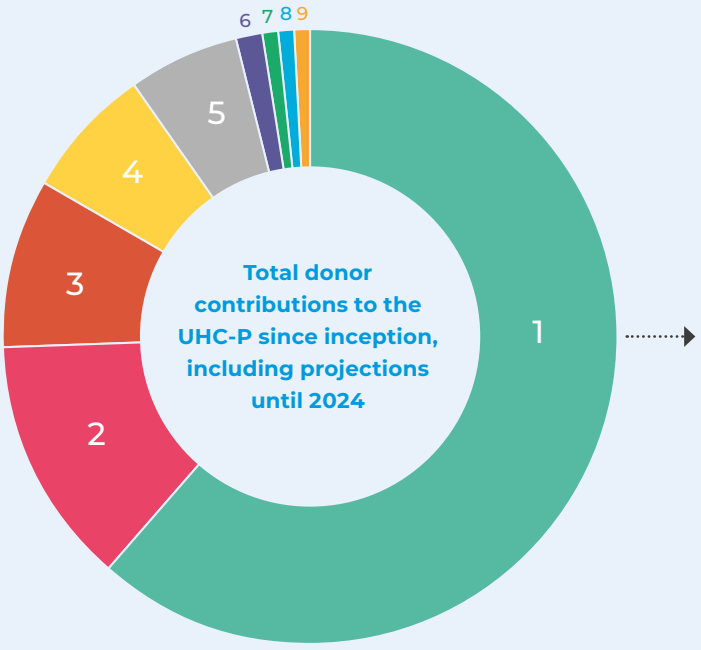
The UHC-P supports governments to protect communities from the impacts of COVID-19, maintain essential health services and strengthen country capacities to face future health threats.

PHC as the foundation of strong health systems

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

Fig. 7. Evolution of financial support provided by an increasing number of donors





		%	Years	US$ Millions
1	European Union	62	2011–2024	290,633,741
2	Japan	13	2018–2021	58,604,545
3	Canada	9	2021–2024	42,284,810
4	Luxembourg	7	2013–2024	32,416,304
5	Foreign, Commonwealth & Development Office	6	2018–2021	26,497,175
6	France	1.2	2017–2021	5,426,198
7	Belgium	1.0	2020–2022	4,694,836
8	Irish Aid	0.76	2018–2021	3,531,289
9	Germany	0.7	2019–2021	3,366,018

The UHC-P sets a model for transparency and accountability

To improve transparency and mutual accountability, and ensure systematic monitoring of implementation, as well as continuity and stability of the efforts at national level, the UHC-P is organized around a strong and high-level internal governance structure supported by the political commitment of world leaders. The governance structure of the UHC-P is based on several pillars: the Multi-Donor Coordination Committee, the high-level EU–WHO Steering Committee (Senior Officials Meeting), the UHC-P Steering Committee, the live-monitoring mechanism, the Joint Working Team for UHC and bimonthly meetings, the communication strategy, operational research, and collaboration with global health initiatives.

Multi-Donor Coordination Committee

The Multi-Donor Coordination Committee (MDCC) provides a visible and transparent mechanism to enable discussions and coordination with donors on successes and challenges related to the implementation of major activities in the frame of the UHC-P. The MDCC met in April and November of 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 with 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 the response with a view to informing future direction of programme-specific funds but also other investments in complementarity with other global initiatives.

The MDCC provides an opportunity to regularly share challenges and successes in 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 on progress towards achieving UHC at country level.

High-level EU–WHO Steering Committee

Once a year, a high-level EU–WHO Steering Committee is organized with Senior Officials. This meeting is an opportunity to discuss the wider collaboration between both organizations, mutual priorities, and the coordination of activities in order to achieve their complementarity based on the specific mandate of each organization. The next Senior Officials Meeting will take place in early 2023.

UHC-P Steering Committee

In June 2019, under the guidance of the 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, as well as all involved Assistant Directors-General and Executive Directors, as well as the Director for Programme and Management of the six WHO regional offices. In 2021, two meetings were held in February and October 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 the alignment and coherence of WHO in the field and ensuring strong support from 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 – one in May/June and one in December.

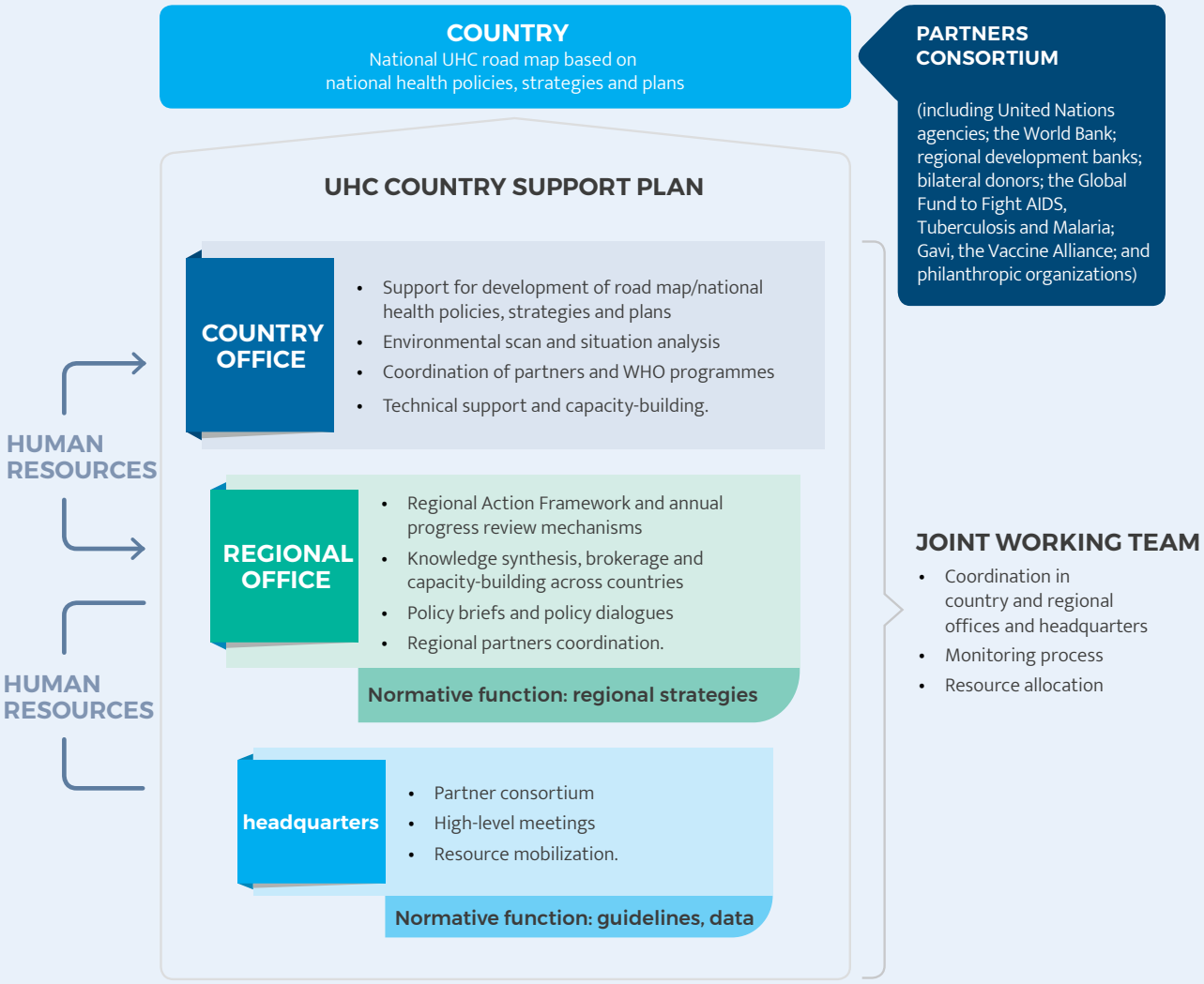
Joint Working Team for UHC and bimonthly meetings

Bimonthly meetings of the Joint Working Team for PHC and UHC (see Box 2) – co-chaired each time by WHO headquarters and one WHO region – allow deep discussions and exchange of good practice between the three levels of WHO. The meetings organized in 2021 focused on migrations and health, and on PHC on the road to UHC.

Box 2. Joint Working Team to build and ensure internal coherence and integrated efforts through WHO

The UHC-P benefits from the WHO-wide Joint Working Team (JWT) on PHC and UHC 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 focal points for these specific issues to ensure greater coordination. Some “NCD Hard Talks” were also organized in 2021 with the support of the UHC-P to discuss and promote solutions for important issues related to NCDs, such as policy will or pooled procurement for NCD. WHO’s country action framework is presented in Fig. 8.

Fig. 8. WHO country action framework



Source: WHO Thirteenth General Programme of Work[9]

Communication strategy

A communication strategy has been elaborated to cover the fourth phase of implementation (2019–2023) to contribute to the overarching goal of stronger commitment, action and solidarity by Member States to achieve UHC and build more resilient health systems. The implementation of the strategy, which began in mid-2020, focused on generating greater awareness and support, promotion of country experiences and evidence-based approaches, and demonstration of the value of international solidarity and strong political will to achieve health for all.

Regional and country offices have been actively engaged in the development and co-promotion of stories from the field which, in many cases, also involved cooperation from ministries of health and partners, resulting in unified and amplified messaging. Stories were complemented with newsletters, magazines, feature articles, videos and 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.

UHC-P communications became more agile and responsive throughout the year, covering topics related to evolving country priorities in the midst of the COVID-19 pandemic and other developments. This has led to greater visibility and relevance of the UHC-P at key opportunities, such as the World Health Assembly, WHO's Executive Board sessions, UHC Day, World Health Day, among others. The UHC-P website has also seen a significant increase in visits, reaching over 2 million in the past year. A new, more robust website has also been built to enable the UHC-P to enhance its presence online and bring more timely and accessible information and resources to its audiences and stakeholders.

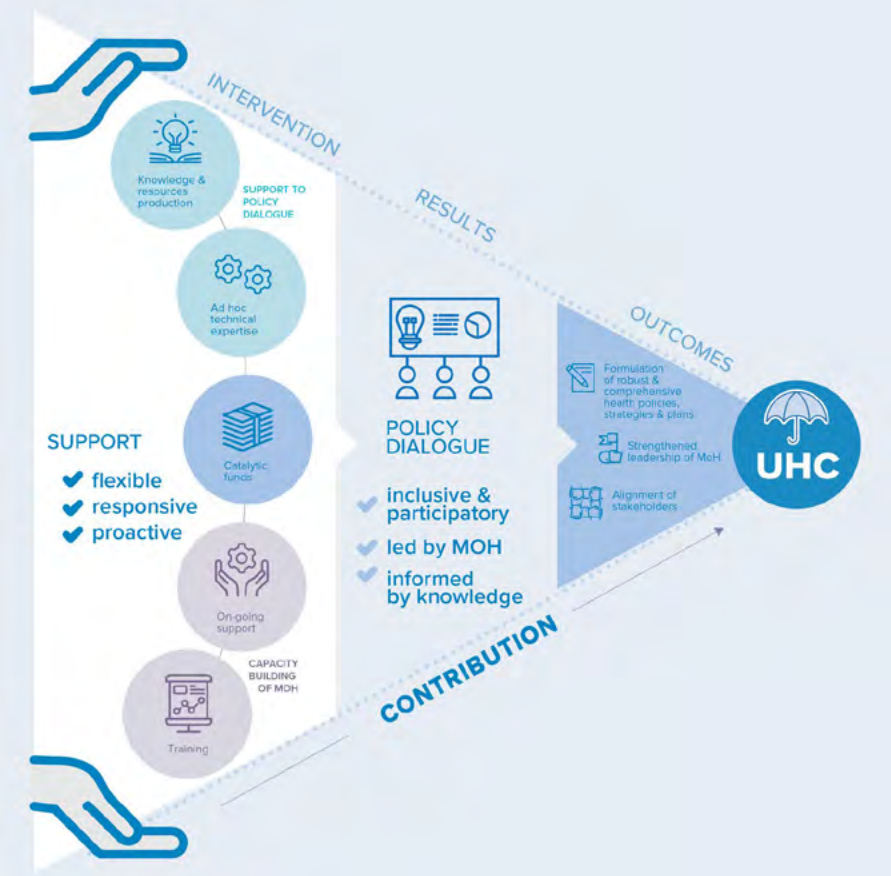
Operational research

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 regard to its role (convener, broker, technical assistance), strengths (flexibility, bottom-up approach, seed funding, WHO JWT three-levels approach), and weaknesses (roster of technical assistance, difficulties finding appropriate candidates).[10] Moreover, in the same year, the WHO African Regional Office published a supplement on health policy dialogue in 13 countries in the Region.[11] Lessons learned have informed continued efforts in improving health dialogue in the 47 Member States within the African 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 results have been collected. 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.

Final results of the realist evaluation have been published in 2022.[13] The report theorizes the underlying rationale of the UHC-P, which builds capacities of ministries of health to lead inclusive, participatory and evidence-informed policy dialogue (see Fig. 9). 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 also reveals the necessary conditions for successful policy dialogue, which include: dynamic local stakeholders, promotion of collaboration as a mode of action, involvement and leadership of the ministry of health, and synergy with WHO messages and actions.

The continuous presence of experts in the field is recognized to allow for close monitoring of the policy dialogue, strengthening trust relationships with ministries of health and advancing strategic thinking and the cross-cutting vision of policy dialogue. The report recommends the strengthening of three resources that contribute to real added value in the Partnership: (1) international experts on policy dialogue who support health ministries and promote inclusivity and multisectoral collaboration; (2) financial support for meetings that support exchanges between stakeholders and the joint drafting of policy documents; and (3) funding for activities that generate knowledge, nurture exchange, enhance stakeholders' competencies and create mutual understanding.

Fig. 9. The Partnership theory



MOH: Ministry of Health
Source: Robert et al. (2022).[14]

In 2021, the UHC-P was also the object of the external monitoring system of the former Directorate-General for International Cooperation and Development of the European Commission (now the new Directorate-General for International Partnerships), known under the name of Results-Oriented Monitoring (ROM). The report highlights the high relevancy of the intervention because of its flexible and bottom-up approach based on a menu of activities, which ensures a well-framed response to current needs of ministries of health. The intervention logic is recognized as clear and comprehensive, and the implementation structure as complex but functioning well.

The role of health policy advisors is especially distinguished to strengthen the operational arm of WHO and deliver high-quality outputs in developing, implementing and/or strengthening policies and actions of public institutions for health. The need for long-term partnerships and financing support for the health reform process is also acknowledged and the report recommends a phase V of the Partnership to ensure the sustainability of the intervention through the implementation, monitoring and evaluation of health policies built during the first phases. The report also recommends increasing the collaboration with European delegations on the ground – especially to use all expertise available to strengthen health systems for UHC.

Collaboration with global health initiatives

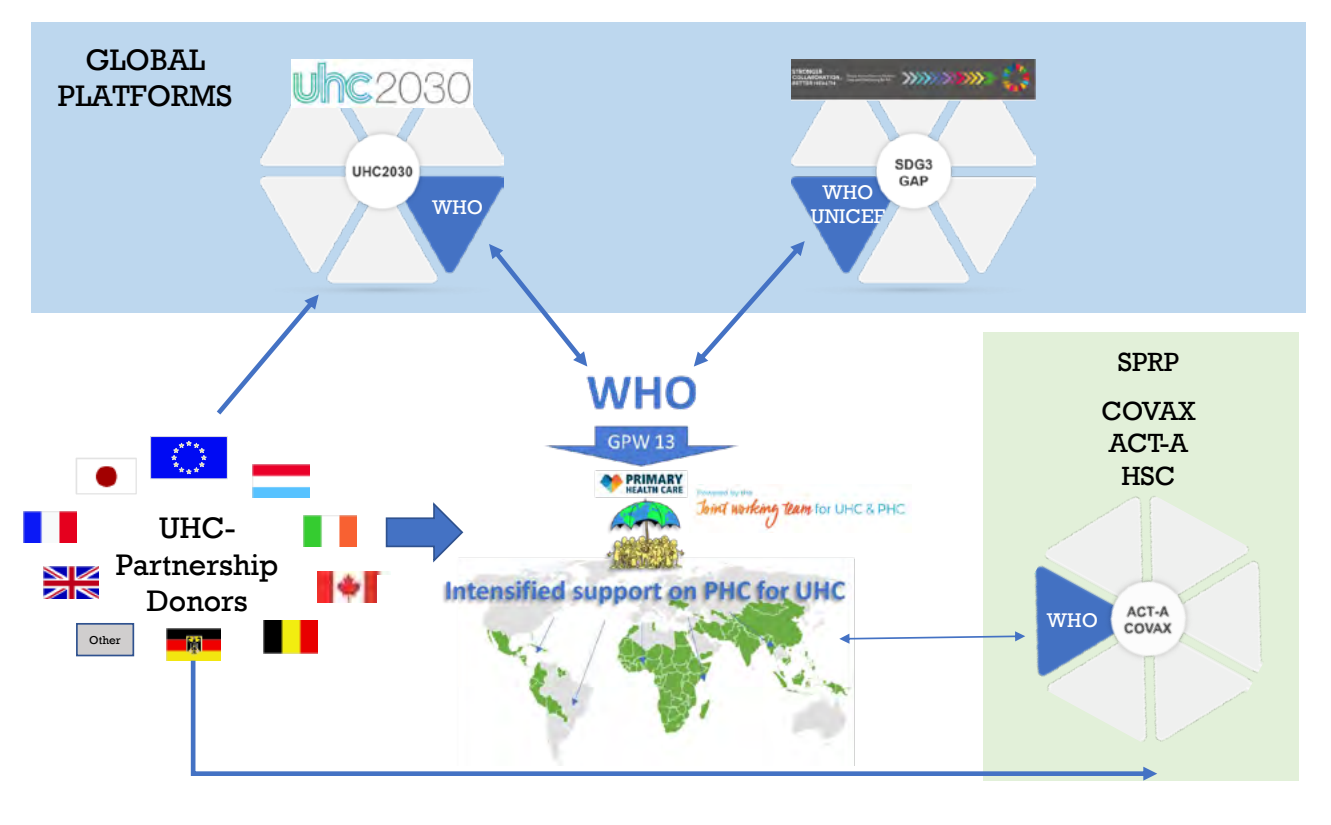
The UHC-P operates under the global multi-stakeholder platforms of UHC2030 and of the SDG3 Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) to promote collaborative working globally and in countries through a PHC approach in order to enhance cooperation effectiveness (see Fig. 10). Until 2016, UHC2030 had been known as the International Health Partnership (IHP+). Its mission is to create a movement for accelerating equitable and sustainable progress towards UHC. Collaborations between the UHC-P and the UHC2030 platform focused especially on the establishment of National Compacts, the elaboration of the handbook on social participation, and the implementation of multi-stakeholder policy dialogue and coordination mechanisms for health systems strengthening efforts in countries. Together, they also supported the set of key asks developed with all actors of the UHC movement for the United Nations High-level Meeting on UHC in 2019.

The SDG3 GAP,[15] 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. Furthermore, 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.

In addition, in 2022, the UHC-P welcomed the revision of the EU global health strategy. Following a public consultation, the European Commission is preparing an informed EU external health action strategy on the EU's role in global health. The new strategy should be presented in November 2022.

> *"As part of the Global Gateway, we want to lead global action rooted in universal values of human rights, equality, solidarity and cooperation. Our new Global Health Strategy will contribute to reaching the Sustainable Development Goals and be better prepared through reinforced partnerships. Health professionals, researchers, private sector, civil society and youth all have an important role to play in shaping and implementing this Strategy to make sure we reach our objective."*
>
> Jutta Urpilainen, European Commissioner for International Partnerships[16]

Fig. 10. 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; SDG3 GAP: SDG3 Global Action Plan for Healthy Lives and Well-being for All; SPRP: COVID-19 strategic preparedness and response plans; UHC: universal health coverage; WHO: World Health Organization

A doctor examines a child in a primary care centre in Azerbaijan. © WHO

The 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), this work is increasingly 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 the GPW13 along the Triple Billion targets (three strategic priorities: sections 1–3) and the 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. 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, see Annex II.

1. Universal health coverage

1 billion more people benefiting from UHC

Notable results for the first billion in 2021

Fifty-two countries benefited from technical assistance from the UHC-P in the development of their **national health policies** to be aligned with the goal of achieving UHC. This included support to two high-level WHO missions to Pakistan and Sudan focused on integrating UHC and health security.

The UHC-P supported progress in the development, implementation, or **review of essential public health packages and services in over 21 countries**.

Twenty-six countries were supported by the UHC-P to carry out activities to establish **National Health Workforce Accounts** and 30 countries were supported in the development and establishment of national health accounts (NHAs) for systematically tracking health spending.

The UHC-P supported the continued implementation of a programme to promote the adoption of global best practices in the **prevention and control of cardiovascular disease** (the HEARTS technical package for cardiovascular disease management) in Cuba, Dominican Republic, Saint Lucia and Trinidad and Tobago, and the programme's expansion to include Bahamas, Dominica and Guyana.

Infection prevention and control technical support – including to address **antimicrobial resistance** – resulted in guidelines, surveys, or training activities taking place in 12 countries.

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 PHC and EPHFs 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 was an important focus.

In 2021, the UHC-P supported a number of approaches and outputs that contributed to normative development for UHC. For example, the UHC Compendium[17] was developed, which is a database of health services and intersectoral interventions designed to assist countries in making progress towards UHC. The publication *Voice, agency, empowerment – handbook on social participation for UHC*[18] was designed to provide practical guidance on strengthening meaningful government engagement with populations, communities and civil society for national health policy-making and institutionalizing new or existing participatory health governance mechanisms. The UHC-P also provided support for the WHO position paper "Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond", recognizing that UHC and health security are complementary goals and providing recommendations on their integration (see Box 3).[19]

1.1 Access to quality essential health services

Throughout 2021, the UHC-P maintained its focus on high-quality, people-centred health services, based on the stated needs of partner countries. To achieve this objective, strengthening PHC as a foundation for UHC and designing essential services and essential benefit packages are key activities of the UHC-P.

Designing essential benefit packages and PHC models of service delivery

All countries in the **African Region** put measures in place to ensure continuity of essential health services even in the face of the COVID-19 pandemic. Countries updated policies and guidelines for prevention and management of various conditions and also developed guidelines for continuity of essential health services. Infection prevention and control (IPC) measures for health workers were prioritized across all countries to lower risk of COVID-19 infection. This was also seen in **Azerbaijan** in the context of the COVID-19 pandemic, where the UHC-P supported the PROACT-Care project, which aims to prevent excess deaths by increasing access to essential health-care services through PHC strengthening, health workforce strengthening and community engagement. During the initial stages of the pandemic, **Zimbabwe** experienced declines in the use of essential health services, and WHO worked with the Ministry of Health and Child Care to develop a tool to monitor and support the continuation of essential health services during the pandemic (see Box 4).

The pandemic also provided opportunities for countries to review service delivery mechanisms to be aligned to the achievement of UHC. **Lesotho** revised, updated and costed its essential health service package in accordance with UHC and health security objectives, while **Cameroon** assessed health district functionality to enable updating activity packages for PHC. **Seychelles** developed, adapted and printed various tools to support health system strengthening, including guidelines for continuity of essential health services, while **Burkina Faso** developed and validated the person-centred integrated essential health services packages by level of care to achieve UHC. With UHC-P support, ministries of health developed or revised and costed essential health services packages in **Ethiopia**, **Niger**, **Sao Tome and Principe** and **South Africa**. **Liberia** reviewed the 2011–2021 essential package of health services and developed its 2021–2025 essential package of health services. In **Timor-Leste**, the UHC-P supported completion of the essential service package for PHC and developed the associated implementation road map.

Hospitals are part of the PHC approach, included in essential packages of services. They have to be included when considering the comprehensiveness of health needs.

Box 3. WHO position paper: Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond

The COVID-19 pandemic has had far-reaching consequences for all parts of society, causing unprecedented disruption of health services as national authorities struggle to cope. Stringent public health and social measures as a response to the current pandemic have drastically affected lives and livelihoods, plunging the world economy into recession, not to mention resulting in record unemployment rates.

Progress made in many countries towards SDG 3 has not only stalled, but even threatens to regress, as health stewards are simultaneously confronted with the pandemic response, health system recovery and long-term development challenges. Even countries scoring well on traditional health security and UHC measures have struggled with responding to and managing the risks of this pandemic. The burden of this struggle has been borne disproportionately by the most vulnerable communities in all countries.

This paper provides leaders and policy-makers at national and local levels with the following recommendations for the medium and long term, positioning health within the wider discussions on socioeconomic recovery and transformation:

- Leverage the current response to strengthen both pandemic preparedness and health systems.
- Invest in EPHFs, including those needed for all-hazards emergency risk management.
- Build strong PHC foundations.
- Invest in institutionalized mechanisms for whole-of-society engagement.
- Create and promote enabling environments for research, innovation and learning.

Box 4. Data-driven decisions maintain availability and access to essential health services in Zimbabwe during the COVID-19 response

Fact: Delivery of essential health services needs to be regularly monitored and maintained during the COVID-19 pandemic response. Ensuring equity in access to services means meeting the health needs of all people, including vulnerable and marginalized communities.

Why it matters: During the COVID-19 pandemic, Zimbabwe experienced a nationwide decline in the use of essential health services due to strict national lockdown measures, fear of contracting the virus, and misinformation circulating in communities.

Expected results: People – especially those who are vulnerable such as children, pregnant women, older people, or those living with chronic illnesses – will have the knowledge and confidence to safely access essential health services during the pandemic.

In practice: WHO worked with the Ministry of Health and Child Care to develop and adapt a tool to monitor and support the continuation of essential health services during the pandemic.

A woman getting her family planning pills at Mpilo Hospital in Bulawayo, Zimbabwe. © WHO / Tatenda Chimbwanda

In **Congo**, health workers in 93 health centres from the 12 health districts were trained on the minimum package of PHC and services, with new modules focused on skills. Health teams in 48 health areas benefited from eight supervision missions, and health facilities that were selected to provide care for the universal health insurance scheme were accredited.

There were also several **Eastern Mediterranean** countries and areas that were supported in developing essential packages of health services in 2021, including **Afghanistan**, **Djibouti**, **Pakistan**, **Somalia** and **Tunisia**. In **Djibouti** and **Somalia** this package was costed, and in **Pakistan** and **Tunisia** technical assistance was provided in re-designing PHC and defining the PHC benefit package. In **Jordan**, technical support was provided for mapping the existing interventions/services delivered and financed through public funding; the final report defined all interventions delivered at different levels and compared these with the regional priority benefit package. In the **occupied Palestinian territory (oPt)**, a hospital profile was finalized to inform a hospital strategy and bed capacity analysis; the oPt was also supported to reform its hospital sector to make progress towards UHC (see Box 5).

Work on the regional framework on PHC in the **Western Pacific Region** brought PHC to the forefront of the health agenda in 2021. Experts from across the Region convened at a three-day consultation to brainstorm on the future of PHC in the Region and to provide inputs on the key elements to reflect in a regional framework. In **Viet Nam**, technical assistance was provided to the Ministry of Health in developing national action plans and guidelines to strengthen PHC, which included developing the basic health service packages, design and establishment of the Viet Nam Centers for Disease Control and Prevention system and strengthening the grassroots health system.

In **Indonesia**, the UHC-P's support focused mainly on PHC, including the development of an integrated service delivery model at the PHC level, a countrywide assessment of PHC-level service readiness across the country, assessment of minimum service standards at the PHC level, and strengthening the health information system for PHC-related health infrastructure, facility and equipment. In **Mongolia**, WHO also contributed to strengthened capacity for essential health services at the PHC level through revision of PHC regulations, provision of mobile health technology and essential medical equipment and devices, and training of staff (see Box 6).

In the **European Region**, in **Georgia**, a team from the Ministry of Health participated in the first edition of the tailored training and mentorship programme on strengthening PHC performance measurement and management, organized by the WHO European Centre for Primary Health Care and the WHO collaborating centre for quality and equity in PHC systems in Amsterdam. The team from Georgia worked on development of a package of indicators to assess integration of priority NCDs into PHC under the new PHC reforms.

PHC and UHC are complex; they need to be guided by flexible and agile principles for planning to really support transformation in countries.

With PHC at its heart, UHC-P support provided technical inputs to further refine the PHC strategy in **Ukraine** and to ensure gradual improvement of the model of care, including conducting an analysis of the results of contracting PHC providers in 2019–2021, and initiating its costing in 2021. This analysis also identified gaps and challenges in the eHealth information system and suggested systematic improvements in data collection from contracted providers to improve oversight, measure their productivity, evaluate the impact of the purchasing arrangements and inform further steps in the health reform.

Box 5. oPt reforms its hospital sector to make progress towards UHC

Fact: The Palestinian health system is working to transform the hospital sector to deliver people-centred care through strengthening its secondary care and reaffirming its contribution towards achieving UHC.

Why it matters: The hospital sector is struggling to meet the needs of all patients. Achieving health for all requires an integrated and people-centred approach to provision of care in hospitals.

Expected results: At least 53 hospitals in the West Bank with around 520 000 annual patient admissions, in addition to 34 hospitals in Gaza with an estimated 210 000 patient admissions yearly, will benefit from improved services once the new hospital sector policy is implemented.

In practice: WHO supported the Ministry of Health to reform its hospital sector and helped develop a profile for the oPt. The Ministry is also preparing to adopt the WHO strategic framework of action on the hospital sector.

Box 6. Mongolia's mobile health clinics bring PHC to vulnerable communities

Fact: Mongolia is reaching remote populations and ensuring they can all receive good-quality and affordable services by introducing a mobile people-centred integrated PHC approach.

Why it matters: Mongolia has a vast land area, so "leaving no one behind" means adapting mobile health services and technologies to get to those who are otherwise hard to reach.

Expected results: Nomadic populations can access integrated health services, receive health promotion interventions, early diagnosis and treatment of diseases in time for these to have a positive impact.

In practice: WHO, through the UHC-P, has supported the strengthening of PHC and the health system, backed by adequate funding, strong health plans and evidence-based policies.

Box 7. Uzbekistan strengthens its health system in the midst of COVID-19 crisis

Fact: Uzbekistan is embarking on a far-reaching and ambitious reform agenda to improve the health of its whole population through UHC. A pilot project in Syrdarya Oblast will provide lessons for the whole country.

Why it matters: Uzbekistan's health system previously relied on hospitals and specialist clinics for health services, while there was limited PHC capacity. Vulnerable community populations suffered health and financial inequities as a result.

Expected results: The people of Uzbekistan will access health care without suffering financial hardship; PHC, financial and service delivery reforms will ensure patients receive quality, affordable care close to their community.

In practice: WHO, through the UHC-P, provided technical support to the Government to lay the foundations for a robust and sustainable health system, and to maintain reform processes, alongside strong health security measures, during COVID-19.

In 2021 in **Uzbekistan**, with UHC-P support, new multidisciplinary PHC teams were established in Syrdarya Oblast, composed of one family doctor, one practising nurse, two patronage nurses and one midwife, all shared among three teams. A referral system was also introduced, contributing to rationalizing patient flow to narrow specialists, and has reinforced the role of family doctors in the system and for patients. The system has started optimizing patient flow and cases of self-referral have dropped, driven by the fact that referral is needed for services to be provided free of charge. This has contributed to increasing patients' perceptions of the importance of PHC (see Box 7).

In the **Americas Region**, support from the UHC-P facilitated implementation of the initial phases of the EPHFs approach in **Bahamas**, **Dominican Republic** and **Suriname**. This involved situation analyses of the health systems, including their progress towards UHC and institutional mapping, as well as measuring of institutional capacities for implementation of public health actions. The results will be the main input for developing action plans for strengthening institutional capacities, and technical cooperation plans. In addition, the Pan American Health Organization (PAHO) worked on developing a set of tools for training health authorities and implementing teams on the renewed EPHFs assessment, with a virtual course to be launched in 2022 along with a virtual platform to facilitate EPHFs assessments.

In **Peru**, the Ministry of Health approved the National Plan for the Implementation of Integrated Health Service Network Model, to contribute to improving the population's access to health services in the framework of the National Plan 2030 – "Peru, Healthy Country". Focused on implementing the model at the national level in a progressive, planned, systematic and sustainable manner, this approach is expected to transform the current organization of services to improve the response of the National Health System, and establishes the regulatory framework and guidelines that will allow the integration process of the public, private and mixed health services provider institution.

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 provision of 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.

In **Azerbaijan**, the UHC-P supported the procurement of three mobile family health centres in three remote villages without any working facilities. PHC service coverage included: all three levels of prevention (i.e. screening, diagnosis and treatment) of NCDs; reproductive health; common childhood, child growth and development issues; immunization; and acute symptoms. These mobile clinics currently serve 24 (out of 62) villages, with a total population of 19 103. In addition, the UHC-P supported the establishment of four Village Doctor Points with adequate facilities, serving a total of 33 893 people from 38 rural villages and two towns, as well as supplying an additional two family health centres, 13 Village Doctor Points and village medical points in Shamakhi with basic medical devices such as electrocardiograms, glucometers, sphygmomanometers, medical consumables and medical bags for PHC workers.

In **Islamic Republic of Iran**, technical support was provided for reviewing selected diseases (multiple sclerosis and diabetes mellitus) in the UHC Benefit Package by using multiple criteria decision analysis and evidence-informed deliberative processes.

HEARTS is 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 an 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). In 2021, the UCH-P supported seven countries in the **Region of the Americas** to implement the HEARTS initiative (see Box 8).

The UHC-P also supported various countries in the **African Region** in developing disease-specific guidelines related to sexual and reproductive health. The **Central African Republic**, for example, developed national guidelines on self-care, delegation of tasks, safe abortions and post-abortion care; maternal and perinatal death monitoring and response; and a national maternal death audit guide. Health workers were trained on various guidelines, such as maternal and perinatal death surveillance and response, IPC measures, hormonal contraception and HIV, diagnosis and treatment of cervical cancer, delegation of tasks and self-care.

Mauritius developed a joint HIV testing services national policy, and **Seychelles** finalized its adolescent and sexual health reports, including capacity-building of health workers on strategic assessment, based on the WHO-sponsored strategic approach to strengthening reproductive health policies and programmes. **Cabo Verde** adopted the new WHO partograph, developed and validated the policy and standards for sexual and reproductive health services, and implemented a plan for the improvement of maternal, neonatal and infant care. **Benin** developed national guidelines for the creation of a network of neo-obstetrical emergency care maternity units and also updated and disseminated sexual and reproductive health and rights guidelines, protocols, algorithms and training materials, including comprehensive safe abortion care. The updated guidelines were integrated into the curricula in health worker training schools.

Box 8. HEARTS initiative for cardiovascular diseases in the Region of the Americas

The UHC-P supports the implementation of HEARTS in the **Americas Region**, which is taking place in **Cuba**, **Dominican Republic**, **Saint Lucia** and **Trinidad and Tobago**, and in 2021 was expanded to include **Bahamas**, **Dominica** and **Guyana**. **Bahamas** and **Guyana** drafted their respective implementation plans and completed planning for the remote monitoring pilot, with blood pressure monitors and glucometers procured to facilitate remote monitoring; treatment guidelines for hypertension and diabetes were incorporated into PHC services. The roles of the members of the implementation care team were defined for the HEARTS initiative, and the PHC providers have been trained in the HEARTS methodology, with capacity-building conducted for health-care staff who will support in-country implementation, to ensure the availability of skilled human resources. **Bahamas** also conducted a pharmaceutical review to confirm access to essential medicines and consideration for procurement using the PAHO Strategic Fund, and incorporated both the private sector and the National Health Insurance providers to implement the initiative. In **Dominica**, the HEARTS Technical Package was implemented with an emphasis placed on monitoring and evaluating of its implementation. Baseline data were collected, and baseline data gathered on blood pressure control and coverage, which will assist in determining the success of the initiatives employed, to standardize and maximize quality control at health facilities. It is expected that this initiative will significantly increase the quality of care being provided to persons with chronic disease in all countries.

The roll-out of the HEARTS initiative has contributed to the strengthening and improved availability of quality services for community-level management of CVDs. Standardized treatment algorithms have allowed for standardization and consistency of treatment and have reduced high out-of-pocket costs for medications.

Ageing

In the **Western Pacific Region**, a regional webinar was organized to foster knowledge exchange on age-friendly environments during which countries (**Australia**, **China**, **Japan**, **Philippines**, **Viet Nam**) shared their experiences of creating age-friendly environments. Technical support was also provided for policy and legislation in **Malaysia** for capacity-building around baseline assessments and plan of action development for the age-friendly cities and communities initiative.

Further, the healthy ageing team collaborated with academia to generate evidence for an investment case for healthy ageing. Some of the collaborations included: working with Hong Kong Polytechnic University (**China**, **Hong Kong SAR**) to generate an investment case for improving NCD prevention and control and collaborating with Pinetree Care Group (China) to develop a nutritional intervention for older persons using information and communications technologies, which can help address the prevalent nutritional deficiency in older adults.

In **Barbados**, a national consultation was held in 2021 to begin discussions about the policy for the elderly population. This built on past UHC-P support to the updated national policy on ageing and the development of a national strategic plan with a monitoring and evaluation framework for elderly health-care services. As a result, the development of "a comprehensive report on a situational assessment exercise of the elderly population in **Barbados**" was developed and shared with the Ministry of People Empowerment and Elder Affairs. Plans to develop the policy are expected to be completed in 2022 with the support of the UHC-P.

A herder family receives services at a mobile health clinic in Umnugobi Province, Mongolia. © WHO

Informing, reviewing and adopting national health policies

Strategic frameworks for achieving UHC are an important contributor to leadership and governance (see Box 9). For example, in the **European Region**, the UHC-P continued to support the development of a new National Health System Development Strategy 2030 in **Republic of Moldova** through a participatory and consultative process with key national stakeholders, ensuring that the indicators established in the health system strategy were based on SDG indicators. A three-year rolling strategy was developed in **Ukraine** to improve governance and performance of the National Health Service, with an ultimate goal to transform it into a mature purchasing agency playing a key role in achieving UHC. PHC performance indicators and passports were developed to inform evidence-based policy-making to inform a review of the network of contracted PHC providers, and update the Program of Medical Guarantees in Ukraine.

Legislation drafting was also supported by the UHC-P in **Kyrgyzstan**. The UHC-P supported the creation of and provided technical assistance to the Kyrgyzstan PHC Task Force, which focused on developing areas deemed essential to PHC reform, resulting in drafting regulations on the referral systems from PHC to secondary and tertiary care, as well as revision of the regulatory base for PHC working hours.

A number of countries in the **African Region** were supported by the UHC-P to review and update their national health policies and strategic plans in 2021, including **Congo**, **Eritrea**, **Ethiopia**, **Gambia**, **Liberia**, **Mali**, **Rwanda**, **Sierra Leone**, **Seychelles** and **Zambia**. In **South Africa**, WHO provided technical support to the Office of the President for implementation of the Presidential Health Compact committing to strengthening nine pillars for a stronger health system capable of providing access to quality health services for all South Africans.

Evidence, consultation and participation: the basics for policy dialogue!

In 2021, with respect to UHC-specific policies and dialogue, the **Kenya** UHC Policy was finalized, edited and launched by the President, while in **Namibia**, the national policy dialogue on UHC was initiated and a road map to finalize the UHC policy framework was developed. Furthermore, **Kenya** reviewed several policies, including the policy on regulation of food, drugs, devices and chemical substances, alongside finalization of the Kenya Food and Drug Administration Bill, with consensus-building ongoing to address resistance from stakeholders in other key sectors. The **Kenya** National Policy on Integrated Donation Management of Human Blood, Tissue and other Medicinal Products of Human Origin was updated, reviewed and endorsed by counties, and is awaiting endorsement by the Minister of Health. The harmonized blood transfusion, tissue and transplant bill was endorsed by Parliament and was awaiting senate approval.

Box 9. Health strategic frameworks for UHC

Since the beginning of the 21st century, based on the Alma Ata Declaration of Health for All and the principles of PHC, WHO has strongly advocated for health systems strengthening. The *2000 World health report* was probably the first milestone in this long journey. The report brought global attention to the performance of health systems and found that some countries did not issue any national health policy, and in many others they were perceived as unrealistic and never operationalized.

Leadership and governance involve ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design, and accountability. Functional health systems that deliver high-quality services to the population are the main priority for governments. Achieving this requires permanent, well-structured and dynamic processes, with a true consensus between the demand and supply of services, as well as between governments, service providers and the population.

Since its creation, the UHC-P supports policy dialogue as an efficient way to create trust between these stakeholders and deliver national health policies for UHC. This well-documented approach can ensure convergence between these actors and allow the development of evidence-based and inclusive policy. In 2021, the UHC-P provided technical support for the development of national health policies in 52 countries.

The UHC-P contributed to two handbooks on strategizing national health in the 21st century[20] and on social participation for UHC[21] to help inform leadership, governance and policy dialogue.

Rwanda and **South Sudan** each conducted their respective Annual Joint Health Sector Reviews, and identified future policy directions. **Congo** disseminated legislation reinforcing the re-organization and functioning of the district health management teams, hospital and health centre management in accordance with the law on the transfer of the management of PHC to the local authorities. A follow-up rapid evaluation was also conducted of the takeover of PHC management by populations and local authorities.

With respect to community health workers, **Mozambique** finalized its National Health Community Strategy, developed the community health workers training manual, and conducted training-of-trainers sessions for 35 community health workers on the community health package. **Benin**, **Liberia** and **Uganda** also completed their respective Community Health Workers Policy and Strategy, and developed training materials for community health workers' curriculum and implementation. With support from WHO, **Benin** was able to carry out supervisory visits to PHC facilities, covering over 50 remote health facilities and linking community health workers.

In the **Western Pacific Region**, the UHC-P supported health systems governance through the development of national health policies, strategies and plans which place PHC at the heart of efforts towards UHC, as well as updating of health legislation. In **Mongolia**, the UHC-P supported development of a COVID-19 law to prevent, combat and mitigate the socioeconomic impact of COVID-19. Furthermore, major policy and legal reforms have been enacted with comprehensive laws on health, health insurance, medical services and drug regulation being ratified. The amendment and development of these laws have become priorities during the pandemic, with emphasis given now to ensure their alignment to the SDGs and its focus on vulnerable populations. In **Viet Nam**, the UHC-P also supported technical briefs and multisector policy dialogue on major health laws, including the Law on Examination and Treatment and Social Health Insurance Law Revisions.

In **Lao People's Democratic Republic**, WHO supported the Ministry of Health in its finalization of the Health Sector Reform Strategy 2021–2030 through consultation meetings. The Health Sector Reform Strategy provides direction and priorities for health sector reform across five pillars – service delivery, human resources for health, financing, health information system and governance – to guide the strategic intervention and approach towards reform of the health sector till 2030. In addition, WHO facilitated a process of identifying future PHC health needs and strengthening PHC systems to future-proof the national health system and meet the needs of an older population with a higher burden of NCDs through development of the Health Sector Reform Strategy 2021–2030. WHO also played a key role in coordinating with partners in routine health programmes and COVID-19 response. As a member of the Sector Working Group Secretariat and co-chair of the Sector Working Group, WHO provided continued support for donor coordination and to the Lao Ministry of Health to monitor implementation of the COVID-19 operational plan and to share with partners to facilitate alignment in support.

In **Eastern Mediterranean countries**, technical support was also provided for the development of national health policies in **Afghanistan** (2021–2030) and **Tunisia**, as well as for the establishment of a national health observatory in **Morocco** that will support policy and health strategy development and implementation. In **Djibouti**, technical support was provided for undertaking overall health sector institutional reform and conducting the related national societal dialogue (Etats Généraux de la Santé). The UHC-P also supported **Djibouti** in conducting a mid-term review of its National Health Development Plan (2020–2024). In addition, two high-level WHO health system missions for governance took place in **Jordan** and **Sudan** in 2021, focused on UHC and health security (see Box 10).

Box 10. High-level WHO health system missions for governance

In **Jordan** the mission explored options for transforming the current governance arrangement in the health sector and advised on new priorities for the next strategic planning cycle, shared global experiences, and proposed a vision and strategy for transforming the health sector around UHC and health security. In **Sudan**, the mission assessed health system challenges, took stock of recent developments, and identified a collaborative agenda for health systems strengthening around UHC and health security. The mission also explored the functions and structure of the Ministry of Health – at federal and state levels – and its relevance to meet the goals in the National Health Support Plan. In order to address some of the more immediate health needs, the mission proposed selected "quick wins" which could relieve some of the acute health pressures affecting **Sudan**, including prioritizing the control of the COVID-19 pandemic. In order to realize the above vision, the mission proposed four strategic shifts in the health system in Sudan: (a) focusing resources on priority services, infrastructure and human resources; (b) building a resilient health system at all levels – federal, state and local; (c) transforming the Federal Ministry of Health; and (d) instituting participatory governance and practice, leveraging multisectoral approaches to address social and environmental determinants of health using a Health in All Policies and whole-of-government approach.

A mother in Ghana brings her baby back to the hospital for a postnatal visit.
© WHO / Blink Media – Nana Kofi Acquah

Mobilizing policy-makers and strengthening policy dialogue for UHC

In the **African Region**, capacity-building for UHC at the policy-maker and leadership levels took place in a number of countries in 2021. In **Lesotho**, a total of 24 senior management members of the Ministry of Health were recruited for training on leadership and management competencies to drive its health sector reform goals (UHC, SDGs) and effectively address the rapidly changing pandemic context, strengthening efforts of the Government, civil society and private sector capacity to deliver quality HIV and tuberculosis prevention, treatment, care and support services. **Angola** conducted capacity-building on the SDG model for national counterparts (United Nations Collaborative initiative) and **Malawi** built capacity of its District Health Management Teams through training them in leadership, governance and integration of quality of health care in 13 of 14 districts.

South Sudan conducted a leadership and governance conference that oriented senior national and state-level Ministry of Health leadership on key governance structures, principles and skills. In **Ghana**, senior Ministry of Health leaders participated in the "Pathways to Leadership for the Transformation of Health in Africa" programme to build their leadership and governance skills. **Benin** strengthened the functionality of its National Council for Primary Health Care, the National Council for Hospital Medicine and the Health Sector Regulatory Authority through strengthening their strategic and operational planning, conducting annual performance reviews, and developing performance indicators, guidelines and tools. In order to strengthen community health governance systems, the Ministry of Health of **Gambia** assessed 165 village health development committees to evaluate their functionality and identify existing challenges.

Moreover, **Mozambique** celebrated 2021 UHC Day by convening a national conference with the participation of the Permanent Secretary of the Ministry of Health. **Madagascar** participated in working meetings on UHC Advocacy for revitalization of the National Committee for Strengthening the Health System and developed a national strategy for health financing towards UHC. **Gambia** organized a South–South learning led by the Minister of Health to support UHC policy dialogues, and held policy dialogue and technical meetings to revitalize delivery of primary health services, with advocacy for phasing out user-fee-driven revenue retention at PHC facilities.

In the **Eastern Mediterranean Region**, through a series of meetings with departments involved in health sector situation analysis, UHC-P support has gone towards providing technical guidance and advice to professionals in the Ministry of Public Health and Population in **Yemen** on how to develop strategic long-term priorities and a strategic plan that can contribute to progress towards UHC and reduce the effect of the ongoing war. Mobilizing policy-makers and strengthening policy dialogue can also happen from the bottom up – in **Sudan**, the UHC-P supported community dialogues to empower disadvantaged populations to decide on their own health priorities (see Box 11).

Collaboration amongst international agencies is an important factor for achieving UHC and mobilizing policy-makers and strengthening policy dialogue. The joint GAP "PHC for UHC Mission to **Pakistan**" took place in March 2021 and was co-hosted by the Government of Pakistan and the WHO Country Office with support from the WHO Regional Office for the Eastern Mediterranean. The key objectives of the mission were to review progress in PHC and health financing reforms towards UHC (see Box 12).

Box 11. UHC-P support for community dialogues in Sudan

In the war-torn Darfur region of Sudan, communities are taking an active role in rebuilding their health services and advancing UHC. 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-invigorating health committees and supporting local health workers.

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, which is crucial in the move towards UHC and peace.

Community dialogue in North Darfur, Sudan. © WHO / Lindsay Mackenzie

Box 12. Joint GAP "PHC for UHC Mission" in Pakistan

The joint GAP "PHC for UHC Mission to Pakistan" took place during the first week of March 2021 and was co-hosted by the Government of Pakistan and the WHO Country Office with support from the WHO Regional Office for the Eastern Mediterranean. Participants included the federal and provincial governments; Gavi, the Vaccine Alliance (Gavi); Global Financing Facility (GFF); Global Fund to Fight Tuberculosis, AIDS and Malaria (the Global Fund); Joint United Nations Programme on HIV/AIDS; United Nations Population Fund; United Nations Children's Fund (UNICEF); the World Bank; other local and international development partners and civil society organizations. The key objectives of the mission were to review progress in PHC and health financing reforms towards UHC, and to agree on a medium-term, multi-partner support agenda, including opportunities to leverage existing external financing. Following a series of meetings with political leaders and policy-makers in health and finance, planning and development sectors at federal and provincial level, as well as thematic discussions and field visits, the GAP agencies issued a joint statement in which they renewed their commitment to a more aligned approach towards PHC for UHC, and to developing an action plan to deliver on these commitments and work with the Government towards a national "PHC for UHC Compact" in connection with the UHC2030 Global Compact. A second GAP coordination committee meeting was held during August 2021. WHO provided assistance for UHC situation analysis and estimation of UHC index at federal, national and district levels for monitoring and evaluation of UHC progress.

Health systems can only function with health workers; improving health service coverage and realizing the right to the enjoyment of the highest attainable standard of health is dependent on the availability, accessibility, acceptability and quality of health workers. The health workforce also has a vital role to play 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.

Evidence-based strategies for human resources for health

Evidence-based strategies for human resources for health use a variety of approaches to capture labour roles in health systems service delivery and management (see Box 13). For example, National Health Workforce Accounts (NHWAs) are used as part of the Health Labour Market Analysis (HLMA) framework. This is a system to improve the availability, quality and use of data of the health workforce to inform measurement of human resources for health (HRH) performance across different countries using standard indicators. WHO's Workload Indicator of Staffing Need (WISN) methodology is used for evidence-based planning, for recruitment and redeployment of existing staff to health facilities, and to generate evidence for presenting a viable case for HRH investment

Countries were also supported to strengthen management of the workforce through HRH-specific strategies. With UHC-P support, national plans for HRH were developed, reviewed, updated or evaluated in **Burkina Faso**, **Cabo Verde**, **Gambia**, **Ghana**, **Ethiopia**, **India**, **Lao People's Democratic Republic**, **Lesotho**, **Mauritania**, **Mozambique**, **Niger**, **Senegal**, **Timor-Leste**, **Togo**, **Uganda** and **United Republic of Tanzania**.

In addition, **Mali** developed a plan for the recruitment, training and career motivation of HRH, the 2020 statistical directory of human resources in the health sector and the mapping of health personnel in the public and private sectors and in communities. **South Africa** developed a costed HRH Strategic Plan for 2020/21 to 2024/25, the National Strategic Direction for Nursing and Midwifery Education and Practice, and disseminated the Roadmap for Strengthening Nursing and Midwifery 2020/21–2025/25. **Zimbabwe** revived its Human Resource for Health Task Force and its sub-committees.

In the **Western Pacific Region**, capacity was built through training on NHWAs and global HRH reporting processes for eight countries and areas (**Kiribati**, **Marshall Islands**, **Federated States of Micronesia, Palau**, **Samoa**, **Tokelau**, **Tonga**, **Tuvalu** and **Vanuatu**). Technical support on NHWA was provided by the UHC-P also in **Islamic Republic of Iran**, as well as in 17 countries in the **African Region**. **Ethiopia**, **Islamic Republic of Iran** and **Tonga** were supported in using WHO's WISN methodology and **Guinea**, **Kenya** and **Mauritania** trained stakeholders on WISN methodology and tools, while **Liberia** conducted trainings of trainers and expert working groups, as well as training for data collectors, for WISN. The **Zimbabwe** Health Services Board developed a specialists need-based plan based on gaps analysis and training needs to inform development of national training needs. **Eritrea** also completed the health worker job analysis assessment where job descriptions for health workers were revised.

Box 13. Generating evidence for human workforce for health in the African Region

The 17 countries in the **African Region** carried out activities to establish NHWAs. **Eritrea** conducted advocacy meetings for its NHWA, and in **Cameroon**, **Central African Republic**, **Lesotho**, **Mozambique**, **Senegal**, **Uganda** and **United Republic of Tanzania**, officials were trained to lead the development and institutionalization of their NHWAs. **Ethiopia** and **Senegal** established NHWA Thematic Working Groups to oversee NHWA implementation. **Burundi** identified HRH data sources and validated the data collection tools for its NHWA.

Kenya developed its NHWA and reported on 12 indicators; **Zambia** elaborated on its NHWA 2017–2019 and used the findings to inform development of its National Health Sector Strategic Plan 2022–2024. **Burkina Faso**, **Cameroon**, **Malawi** and **Mauritania** finalized their NHWAs. **Ethiopia** established an Integrated Human Resources Information System (IHRIS) Thematic Working Group, developed and tested the IHRIS requirements, and conducted IHRIS training of trainers. **Eswatini** is piloting the use of IHRIS to quantify nursing cadres. **Nigeria** established the National Health Workforce Observatory, which hosts the National Health Workforce Registry, and made plans to collect data to update this Registry.

Countries in the **African Region** were at different stages of implementing HLMA to understand the health workforce context and demand and supply factors to inform HRH policy. **Mali** organized working meetings for the preparation of the HLMA study. **Ethiopia** conducted regional-level HLMA in nine regions and two city administrations. **Lesotho** finalized HLMA and used the findings to develop recruitment and deployment guidelines. **Zimbabwe** carried out an HLMA study, focusing on specialist doctors, nurses, pharmacists and laboratory scientists to guide projection of specialists' needs for training.

Strengthening human resource capacities

The ongoing COVID-19 pandemic continues to impact countries and health systems worldwide. Seventeen countries in the **African Region** (**Angola**, **Benin**, **Burkina Faso**, **Chad**, **Côte d'Ivoire**, **Eswatini**, **Ghana**, **Guinea**, **Guinea-Bissau**, **Kenya**, **Mali**, **Mauritania**, **Liberia**, **Niger**, **Nigeria**, **Senegal** and **Togo**) conducted surveys on the impact of COVID-19 on HRH. **Kenya** estimated HRH needs for COVID-19 response and maintenance of essential services. **Zambia** recruited COVID-19 surge capacity human resources (48 medical doctors, 135 nurses and 14 biomedical technologists), while **Seychelles** increased surge capacity to support data management by recruitment of one additional data manager. **Congo** strengthened the country's capacity in public health skills through recruitment, supervision and redeployment of 24 public health juniors in 12 departmental directions and 12 health districts.

At the community health worker level, in **Mali**, 442 community health workers were trained in community-based surveillance and 319 members in community mobilization strategies. A total of 332 health providers were trained on protocol for the prevention and management of NCDs (diabetes and hypertension) at the peripheral level. An interactive virtual training facility was established at the national level in **Sudan** (College of Physicians and Surgeons at Juba Teaching Hospital) for continuous training of health workers; and in **South Africa**, training of master trainers was undertaken to build capacity of community health workers on priority NCDs and their interaction with COVID-19.

In collaboration with the University of Pretoria, an NCD prevention curriculum was developed for medical students and was piloted in universities in **Benin**, **Namibia**, **South Sudan** and **Zambia**. Lessons from piloting of modules have been documented and will be used to inform scaling up to other countries that have expressed interest such as **Cabo Verde**, **Mozambique** and **United Republic of Tanzania**. In **United Republic of Tanzania**, 500 health workers were mentored and supervised on screening and triage, essential emergency and critical care and IPC measures.

In the **Region of the Americas**, the COVID-19 pandemic exposed current limitations in strategic planning on HRH, which impacted service delivery. In **Belize**, the UHC-P supported the training of a group of community health workers on the early detection of diabetes and its complications. In **Jamaica**, 30 nurses benefited from nursing leadership training, which included improving data quality on nursing and midwifery, which will advance the strategic directions for nursing and midwifery for the next five years. Building on these significant efforts, the Jamaican Ministry of Health and Welfare started adopting a more strategic and broader approach to include all HRH, including nurses and midwives. Nine nurses from **Suriname** participated in the critical care nursing virtual course led by the University of the West Indies in **Trinidad** and were provided with the knowledge and skills needed to function effectively in a hospital intensive care unit setting. Caribbean countries also put in place training to scale up critical care nursing during the pandemic (see Box 14).

Box 14. Caribbean countries boost the capacities of nurses in critical care during COVID-19

Fact: A cadre of 82 nurses across seven Caribbean countries – Antigua and Barbuda, Belize, Barbados, Dominica, Guyana, Suriname and Trinidad and Tobago – have received training to support critical care in intensive care units for COVID-19 patients.

Why it matters: Ministries of health in the Caribbean were faced with a shortage of critical care nurses, who were urgently needed to care for the increasing number of COVID-19 patients in intensive care units.

Expected results: Caribbean countries are making progress to develop a health workforce that is appropriate to the context and qualified to meet the health needs of their people, including in times of crisis.

In practice: PAHO/WHO, in collaboration with the UHC-P, supported 82 nurses to attend a four-week training course, and scaled up the capacity of the health workforce in the Caribbean during the COVID-19 pandemic and beyond.

Critical care nurses in training in the Carribean. © PAHO/WHO

At the broader human workforce planning and strategic decision-making level, a human resources audit of the health sector was implemented in **Guyana**, allowing for a clear description of the different positions and profiles at the Ministry of Health, and providing policy options for future reorganization of the health sector in the country. Similarly in **Suriname**, a situation analysis on health workforce was developed, related to population needs and priorities which would inform the development of a National Strategy for Nursing, incorporating lessons learned from the COVID-19 pandemic as well as the changing needs of the country.

In many regions, health workers benefited from various training sessions. In **Azerbaijan**, the UHC-P supported two training-of-trainers programmes and 18 modules (including COVID-19 case management and immunization; risk assessment diagnosis and management of cardiometabolic diseases; diabetes; diagnosis and treatment of common mental health problems and geriatric symptoms in PHC settings; childhood immunization; and symptom management in PHC) reaching 580 local PHC workers. Furthermore, with the funding of SDG3 GAP, under the UHC-P umbrella, the Shamakhi Fellowship Program was started, which is a "learn and teach fellowship programme" aiming to help PHC workers gain knowledge and skills on screening for cardiometabolic risks in adults, practise real patient encounters in rural and remote areas, and get acquainted with the main attributes of PHC.

In the **African Region**, **Mauritius** trained 32 training-of-trainers laboratory professionals on WHO's Laboratory Quality Management System and developed a cascade training plan targeting training of 400 laboratory personnel across the country. Additionally, 58 trainers received training on IPC, and cascade training reaching 1845 health workers followed. An additional 21 Ministry of Health officers were trained on haemovigilance to support establishment of a national haemovigilance system. **Ghana** trained 55 senior members in the health sector on leadership and management.

In the **Western Pacific Region**, support was provided to **Mongolia** to strengthen the capacity for prevention, early detection and response to violence against children at school settings and private health-care facilities. This involved training more than 5500 social workers, school physicians, teachers of 53 public schools in Bayanzurkh and Songinokhairkhan districts, and 900 physicians and health workers in private health facilities and family health centres in all nine districts of Ulaanbaatar City. This training was conducted by the team of specialists of the one-stop service centre based at the National Traumatology and Orthopedics Research Center, in collaboration with the Family, Child and Youth Authority and Health Department of the capital city. In **Viet Nam**, a series of workshops was used to introduce the concept of an integrated and coordinated care model to provincial and local health administrators, using health-care needs to address NCDs and the health needs of elderly patients. In **Malaysia**, WHO conducted a series of training workshops for the methods and case studies to develop a master plan for health-care facilities and workforce, and continued to support the Malaysian Minister of Health in updating the health facility master plan in 2022.

In **Lao People's Democratic Republic**, WHO also supported the Ministry of Health in conducting trainings on mental health and psychosocial support to core trainers from different departments in the Ministry, central hospitals, mass organizations and the Ministry of Labour and Social Welfare. The aim was to enhance the capacity of health workers and staff in the hygiene and health promotion units and mass organizations to help with case-finding in the community and provide services in their respective health-care facilities to improve mental health and well-being in the country.

In the **Eastern Mediterranean Region**, more than 100 000 physicians registered for an online training course organized by the WHO Regional Office for the Eastern Mediterranean on "Primary health care practice in the context of the COVID-19 pandemic". The course aimed to support personnel in maintaining essential health services while also helping to control the pandemic, to overcome the severe shortage of family physicians in the Region, and to reach the target of three physicians per 10 000 population. The Regional Office recently launched a Regional Professional Diploma in Family Medicine. This landmark new training programme was developed in collaboration with several other United Nations agencies and the Arab Board of Health Specializations under the auspices of the SDG3 GAP. It is designed to give existing general physicians a solid foundation in family medicine through two years of part-time training which can be undertaken alongside work, and should provide the needed qualified family practitioners in the Region.

In **Afghanistan**, hospital managers were trained to improve hospital management. The National Medical Council also benefited from support to improve the registration of physicians and dentists and to develop guidelines for continuous medical education. In **Morocco**, certified trainings at the master's degree level built capacity for quality of care and provision of sexual and reproductive health services.

Health workers are at the centre of NCD service delivery, yet often remain the weakest link in the health system. Countries are faced with critical decisions on how to "shape" their health workforce to be fit-for-purpose, ensuring that future and current health workers have the required competencies, supervision, resources and motivation to deliver care to quality standards. However, there are few analyses of what specific changes within the health workforce and governing policies are needed to address the increasing burden of NCDs (see Box 15).

Box 15. Building an NCD-ready workforce – technical meeting held in July 2021

WHO has committed to improving HRH for addressing NCDs. The *Global status report on noncommunicable diseases 2014* calls for the "incorporation of public health aspects of NCD prevention and control in teaching curricula for medical, nursing and allied health personnel, and provision of in-service training. Policies and legal frameworks will be required to promote the retention of health workers in rural areas, particularly in primary care".[22] The WHO Global Conference on Noncommunicable Diseases (Montevideo, 18–20 October 2017) highlights a commitment to invest in health workers as an essential part of strengthening health systems and social protection and to work to ensure a highly skilled, well-trained and well-resourced health workforce to lead and implement actions to promote health and prevent and control NCDs.

The WHO *Global strategy on human resources for health: workforce 2030* report recognizes four objectives: to optimize workforce performance, quality and impact; to align investment in HRH with population needs; to build institutional capacity for effective stewardship and leadership on HRH; and to strengthen HRH data for monitoring.

The growing burden of NCDs and population ageing is estimated to generate demand for 40 million health workers by 2030. A paradigm shift is needed to optimize the current and future health workforce to be "NCD ready", with high-level commitment at policy level and practical guidance for implementation on the ground. In this light, a strategic round table on "Building an NCD-ready workforce" was held on 3–4 June 2021 with objectives to:

- Provide an overview of key concepts, latest evidence, country experiences and current global work on the optimization of the health workforce to deliver NCD services.
- Discuss key policy levers and strategies needed to ensure appropriate prioritization of NCDs in workforce planning, competency-based capacity-building, and meaningful engagement of the community as providers and consumers of NCD services.
- Discuss a road map to support countries in building an NCD ready workforce across different levels of care and workforce cadres.

A nurse conducts screening for noncommunicable diseases at a local clinic in Kiribati. © WHO / Yoshi Shimizu

1.4 Health financing

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 services that are of poor quality 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 2021 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. To assist countries in achieving this outcome, the UHC-P has supported the development of the Resources Portal on Public Financial Management for Public Health to raise understanding and awareness of the role of public financial management (PFM) rules and processes for effective COVID-19 vaccine delivery, and more broadly for health spending. The repository contains various types of materials (working papers, policy briefs, audio files, video podcasts) produced by a range of partners and experts, and includes resources on general PFM issues, PFM and health spending, PFM and COVID-19, and PFM and vaccination.[23,24]

Health financing policies

Through the support of the UHC-P, **PAHO** was able to provide technical assistance in the development and implementation of the National Health Insurance legislation in order to strengthen financial protection in health in **Saint Kitts and Nevis**. Similarly in **Guyana**, a package of health services for PHC was prepared and, with the support of the UHC-P, a review of international and local costing data was completed, including finance scenarios estimating funding requirements. This costing package became the basis for the preparation of a Health Finance Strategy. The completed package of essential health services was costed and presented to the Minister of Health. In 2021, the UHC-P supported the design of the package of health services in **El Salvador**, with the costing of this package contributing to the National Health Plan.

In the **Eastern Mediterranean Region**, UHC-P support to **Afghanistan** and **Egypt** enabled technical support for the institutionalization of a costing and pricing framework within the universal health insurance system and beyond, while in **Morocco**, the national health insurance agency was supported in developing their health insurance financing plan. Moreover, UHC-P support also went to commissioning studies to strategically support the UHC agenda in the country. For example, these included a large study of costing for hospitals to support UHC generalization (40 hospitals are included), a costing analysis for PHC (16 primary health centres) in collaboration with the World Bank, and costing and cost-benefit analysis of the family planning programme. Moreover, a health financing strategy was adopted through a collaborative partnership with the Government and key partners, including WHO, the World Bank and the EU. Similarly, the UHC-P, through the WHO Country Office in **Pakistan**, provided technical assistance to the Ministry of National Health Services Regulation in Pakistan for assessing the health financing situation in the country through Health Financing Progress Matrices assessment, which will be followed by support for development of the health financing strategy.

In **Sudan**, provider payment mechanisms were developed for implementation of the UHC essential benefit package with full involvement by the Federal Ministry of Health and the national health insurance fund. In **Islamic Republic of Iran**, technical support was provided for revising the health insurance benefit package related to hypertension management, breast cancer and schizophrenia disorders, along with designing a monitoring and evaluation framework for the health insurance benefit package. In **oPt**, a country report and seven policy briefs were developed to advance financial protection in health, and in **Afghanistan**, the UHC-P supported a health insurance feasibility study, a policy paper on health financing options, and a comprehensive in-depth situation analysis of the health financing system using progress matrices.

> *Financial protection is more than an objective – it is a fundamental value to improve human dignity. Dignity is key for the UHC Partnership.*

In 2021, the WHO **Western Pacific Regional Office** held a health financing workshop for UHC in collaboration with the WHO **South-East Asia Regional Office**, the World Bank and the Asian Development Bank (ADB), with participants from 20 Member States' ministries of health, finance, as well as social health insurance agencies across the two regions. The workshop helped identify and assess ongoing policy options in terms of strengthening domestic resource mobilization and public financial management for UHC for pandemic response and building back better and fairer.

In **Malaysia**, WHO conducted a series of capacity-building workshops to strengthen strategic purchasing, with a focus on NCD management in PHC and to support the expansion of a programme that purchases NCD-related health services from private providers through public financing for those who cannot afford to seek care from private providers. In **India**, the UHC-P supported the institutional review of strategic purchasing for UHC in Kerala and Chhattisgarh states, leading to revised human resources structure, operational guidelines, monitoring templates and training needs assessment and plan.

At country level, tailored technical support was provided for developing and implementing national health financing strategies on a wide range of topics. For example, in **Lao People's Democratic Republic**, WHO supported the Department of Planning and Finance of the Ministry of Health in finalizing the draft Health Financing Strategy 2021–2025 (see Box 16). In **Viet Nam**, WHO provided high-level advocacy to the Ministry of Health and National Assembly regarding the importance of public financing and equitable access to essential health services, such as COVID-19 vaccines, diagnosis and treatment, as well as non-COVID-19 essential health services. This resulted in the National Assembly approving Resolution Number 12, which provided a policy framework to use public financing for COVID-19 services for both public and private sectors, in line with WHO guidance. In **Timor-Leste**, the UHC-P supported studies on health financing diagnostics and public financial management bottlenecks and supported pro-health taxes analyses and advocacy.

In the **European Region**, the Strategic Dialogue on Health Financing for **Ukraine**, supported by the UHC-P, brought together the Minister of Health and his management team, representatives from the Prime Minister's and President's offices, the Ministry of Finance and other stakeholders to discuss and develop strategic direction for health financing reform in the coming years. In **Georgia**, the UHC-P also supported the development of a road map for phased implementation of the revised PHC Basic Benefit Package, which included the integration of early child development and priority NCDs (diabetes, hypertension/CVD, chronic obstructive pulmonary disease and asthma). The proposed payment system mixes capitated payment, rent allowance and add-on payments for priority services. A working group was established within the Ministry of Health to review the tool and work on adoption of the PHC payment model, for which WHO continued to provide support.

With support provided by the UHC-P, a new output-based provider payment model in a pilot region (Syrdarya) in **Uzbekistan** was introduced. The newly established State Health Insurance Fund offers a benefit package of health services and medicines to be guaranteed by the Government. Contracts for the purchasing of health services included in the package were signed with all health-care facilities in the region. The benefit package includes health services delivered at health facilities at all tiers of the health-care system, but with a focus on PHC and NCDs. For the first time, free services at higher levels became conditional on referral from a family physician. A capitation payment model for outpatient care was successfully designed to facilitate a shift in orientation from narrow specialists to PHC teams, and a case-based payment model for inpatient care was developed in accordance with good international practices.

Box 16. Improving sustainable health financing to achieve UHC in Lao People's Democratic Republic

In **Lao People's Democratic Republic**, the Government aims to graduate from least developed country status by 2026 and prepare for smooth donor transition in the coming years. However, due to high government debt burden and limited fiscal space which have been exacerbated during the pandemic, there are many challenges in health financing. In this context, the UHC-P supported the Lao Ministry of Health in the following areas:

- WHO provided technical support for developing strategic direction and defining a clear set of priorities to improve sustainable health financing through development of the Health Financing Strategy, endorsed in 2021, and its implementation. In line with the Health Financing Strategy, WHO also supported the Ministry in identifying priorities and actions to prepare for smooth donor transition across programmes and coordinating with partners.
- The Government has introduced the national health insurance scheme nationwide since 2016. To support the Government in tackling implementation challenges and sustainability issues, WHO supported the Ministry of Health in updating the national health insurance strategy, which will provide a basis for revision of the National Health Insurance Law. In the immediate term, based on the costing data of health-care services, WHO also worked with partners to support the Ministry in developing data-informed policy decisions to improve sustainability through revision of provider payment and co-payment, while ensuring poor and vulnerable populations are well protected.
- WHO has supported the Ministry of Health in producing the National Health Account Report annually since 2011. In 2021, WHO provided technical support to publish the report for year 2019. In addition, the Organization provided support for joint work by the Ministry of Health and the Lao Statistics Bureau under the Ministry of Planning and Investment to conduct financial protection analysis of the Lao Expenditure and Consumption Survey 4, 5 and 6 household survey data. The analysis highlighted equity issues in access to health services and financial protection. The NHA report and the financial protection analysis aim to provide data and evidence to inform the Government's policy decisions to improve overall health financing and financial protection, specifically for vulnerable populations, in order to achieve UHC.

UHC-P support in pilot introduction of health financing reform in Sughd Oblast of **Tajikistan** was key to accelerating government efforts around health financing reform (see Box 17). A new health financing mechanism unit has been established and equipped with staff; it required an information technology infrastructure to further improve efficiency of funds allocation and strategic purchasing in Sughd Oblast, guide implementation of health financing reform in the region and support attainments geared towards UHC.

In the **African Region**, **Kenya** conducted policy dialogue on effective public finance management to improve strategic purchasing at the subnational level. Strengthened capacities for developing/review of health financing strategic plans geared to UHC were developed in **Ethiopia**, **Kenya**, **Liberia**, **Madagascar**, **Nigeria**, **Sierra Leone** and **South Sudan**. **Democratic Republic of the Congo** developed UHC road maps for provincial and national levels, while **Ethiopia**, **Kenya**, **Mauritius**, **Nigeria** and **Zambia** reviewed their respective health financing systems using the Health Financing Progress Matrix. The **Mozambique** National Health Strategic Plan was costed using the One Health Costing Tool, and **Malawi** costed its health financing strategy. **Burundi** conducted a situation analysis to inform development of its national health financing strategy, and **Zambia** developed the national medium-term expenditure framework of the health sector plan (2022–2024). In **United Republic of Tanzania**, 20 officials of the Ministry of Health and the Ministry of Finance were oriented on public finance management. **Senegal** developed the monitoring and evaluation plan for the national finance strategy road map, which was validated by the technical committee. UHC-P support also helped build capacity in health financing for UHC in health insurance agencies, ministries of health, ministries of finance, and at subnational levels in **Angola**, **Ethiopia** and **Namibia**. The UHC-P also supported strategies for awareness raising on the importance and implication of achieving health for all, and on the importance of generation of financial protection data for monitoring UHC in **Cameroon**. In addition, **Ethiopia** began using the Health Financing Progress Matrix to assess its national financing policies, with technical support provided on costing the Health Sector Transformation Plan II, including a cost-effectiveness analysis and fiscal space analysis.

Health insurance reforms and other prepayment mechanisms mainly targeting vulnerable populations were implemented in **Chad**, **Comoros**, **Ethiopia**, **Gabon**, **Gambia**, **Kenya**, **Madagascar**, **Mali**, **Niger**, **Nigeria**, **Rwanda**, **Sao Tome and Principe**, **Senegal**, **South Africa**, **Togo**, **Uganda** and **Zambia**. The **South Africa** National Health Insurance Work Streams worked on reforming strategic purchasing mechanisms, and **Gambia's** National Health Insurance Bill passed into law. The **Rwanda** Community Based Health Insurance Implementation and Sustainability Plan 2021–2030 was developed and validated. **Nigeria** conducted costing for the health benefit package for Imo State and began implementation of a mobile technology health insurance programme. The **Ethiopian** Health Insurance Agency also made progress with revision of the health insurance benefit package design.

Box 17. Comprehensive support in Tajikistan for better public health governance, health financing and strengthened PHC

Through UHC-P-supported interventions in 2021, there was a significant increase in the orientation of Tajikistan's health system orientation towards PHC and EPHFs. UHC-P support in a pilot introduction of health financing reform in Sughd Oblast was of paramount importance to accelerate government efforts for implementation of health financing reform in the country. The UHC-P's contribution in coordinating and convening key health sector stakeholders played a significant role in strengthening policy dialogue to support progress on the strategic priorities as set out by the National Health Strategy and coordination between and among the ministries and development partners. This has also positively impacted the multisectoral side of health-related interventions, allowing partners to align and coordinate their technical and financial support with the Government's agenda. More specifically, the ongoing collaboration between key health development partners (the Islamic Development Bank, World Bank, GFF, EU, ADB, Global Fund and Gavi) resulted in endorsement of a joint statement in support of strategic health financing transition in the country and commitment to support the implementation of essential health financing reforms in the coming years to sustain progress towards UHC.

A comprehensive analysis of the PHC situation in Tajikistan – in partnership with the National Republican Training & Clinical Family Medicine Center and the Deutsche Gesellschaft für Internationale Zusammenarbeit within the frame of the EU-funded health development programme – confirmed the need for further prioritization of family medicine principles in the country's health system. This includes: (i) the development of a model for integrating vertical programmes and ambulance service into PHC facilities at the district level; (ii) stronger governance arrangements; (iii) infrastructure modernization; (iv) introduction of e-health and distance learning; (v) strengthening prevention and treatment of NCDs, with the aim of decreasing patients' financial hardship and increasing effectiveness of PHC services. A cost estimate and budget impact assessment of the most common essential medicines for hypertension, asthma and type 2 diabetes showed that these medicines could be covered by 1.1% of the total government health expenditure. Introduction of these medicines in the first five reform districts of Sughd Oblast can cost as little as 0.5% of the oblast health budget and provide immediate benefits for low- and middle-income groups.

NHAs and finance tracking

In the **European Region**, technical assistance was provided to six countries (**Georgia**, **Kyrgyzstan**, **Republic of Moldova**, **Tajikistan**, **Ukraine** and **Uzbekistan**) to produce full health accounts studies and to institutionalize reporting in the routine statistical health information system (see Box 18). Tracking the sources and uses of financial resources in Member States is fundamental for producing health expenditure data according to international standards. Data collected and mapped by countries are published on the Global Health Expenditure Database.

UHC-P support in **Republic of Moldova** strengthened strategic purchasing functions in the National Health Insurance Company to improve resource allocation in hospitals and adjust the payment policy, by developing and adjusting the tariffs and relative values for the Diagnosis-related Group (DRG) system.

In cooperation with the WHO Barcelona Office for Health System Financing, the UHC-P supported development of the report, "Can people afford to pay for health care? New evidence on financial protection in **Georgia**" along with the accompanying communication efforts (video, press release and interviews) and local media attention, raising the issue of financial protection and the high incidence of catastrophic health spending among Georgian households to the highest level of the Government. Following release of the report, the Prime Minister stated that the high price of pharmaceuticals is a major concern, and instructed government officials to address this concern. Similarly, in the **Region of the Americas,** the UHC-P supported evidence generation for health financing reform (see Box 19).

Box 18. First-ever system of cataloguing and costing services at all levels of health care in Kyrgyzstan

For the first time the system of cataloguing and costing services at all levels of health care has been set up in **Kyrgyzstan**, with UHC-P support. The consistent and coherent support provided by the UHC-P towards strengthening the single-payer strategic purchasing function in Kyrgyzstan facilitates the shift of the Mandatory Health Insurance Fund from its current role as a passive financier to the active selective purchaser of health services – a crucial condition for improving the quality and quantity of NCD preventative and curative services. The new set of DRGs prompts a more reliable systemic recording of health services at the inpatient level. The new system has 657 diagnostic groups with four criteria of complexity for each group, which allows for a more nuanced and accurate identification of the amount to be paid to hospitals for delivering these services. For example, the number of DRGs on NCDs increased from 23 to 120 groups. Through the UHC-P, WHO supported the establishment of cost calculation systems in 28 reference hospitals for treatment of 35 000 diseases. The main purpose is to establish a sustainable system of health service cost calculation in public hospitals and increase the capacity of the single-payer system as a strategic purchaser of health services. This will equip the system with costing data for analysis and planning, for revision of the State Guaranteed Benefit Package, as well as for systematic updates of the DRG system. This leads to better use of limited resources allocated by the Government to the health sector and contributes directly to improve state benefit coverage and the accessibility of health services.

Box 19. Producing health financing evidence in the Region of the Americas

In the Region of the Americas, the UHC-P supported the generation of evidence for health financing reform through Health Financing Progress Matrices, Financial Protection Indicators, and the System of Health Accounts 2011. Under the first area, studies on burden of disease and fiscal space and a health financing system profile were developed in **Barbados**, and a Costing and Efficiency Study of Selected Facilities in **Saint Kitts and Nevis**. The Health Financing Progress Matrices assessment was successfully completed in **Antigua and Barbuda** and **Barbados**, followed by validation workshops with senior officials from key stakeholder organizations to identify baseline data on strengths and weaknesses in current health financing arrangements. The expectation is that similar assessments will be performed for other Caribbean countries. An Introduction to Financial Protection Indicators in Health Workshop was held and financial protection indicators in health were estimated for **Grenada** and **Saint Kitts and Nevis** using the Household Budgetary Survey databases for 2006/2007 and 2007/2008, and then presented to national authorities. On the System of Health Accounts, two workshops offering an overview and an introduction to the Health Accounts Production Tool were part of the capacity-building activities provided to **Barbados** and **Saint Vincent and the Grenadines**, equipping participants with knowledge on the classifications; the production process – including identification of stakeholders; and the discussion on policy uses according to context in their countries. The corresponding reports were produced, as well as a participants' manual. In addition, a 10-week online course was delivered to over 70 participants from nine Caribbean countries.

In the **African Region**, most countries were in various stages of carrying out NHAs. The countries' activities ranged from formation of NHA technical working groups, training of stakeholders on the NHA development process, data collection, analysis and reporting. Countries that conducted activities towards the NHA report include **Botswana**, **Burundi**, **Cameroon**, **Central African Republic**, **Comoros**, **Democratic Republic of the Congo**, **Ethiopia**, **Gabon**, **Guinea**, **Kenya**, **Lesotho**, **Madagascar**, **Malawi**, **Mali**, **Mauritius**, **Mozambique, Niger**, **Nigeria**, **Sierra Leone**, **Togo**, **Uganda** and **Zambia**. More specifically, **Botswana**, **Burundi**, **Central African Republic**, **Comoros**, **Kenya** and **Uganda** had final NHA reports in place in 2021. With WHO support, countries' capacities were built and NHAs were produced in **Burkina Faso**, **Cabo Verde**, **Cameroon** (draft), **Central African Republic**, **Chad**, **Comoros**, **Congo**, **Côte d'Ivoire**, **Democratic Republic of the Congo**, **Ethiopia**, **Gabon**, **Gambia**, **Ghana**, **Guinea**, **Guinea-Bissau**, **Kenya**, **Lesotho**, **Liberia**, **Madagascar**, **Malawi**, **Mauritius**, **Namibia**, **Niger**, **Nigeria**, **Sierra Leone**, **South Africa**, **Togo**, **Uganda**, **United Republic of Tanzania**, **Zambia** (draft) and **Zimbabwe**. Road maps for NHA institutionalization were produced in **Malawi** and **Uganda**, and capacity-building and high-level advocacy on NHA has been continuously supported in **Eritrea**.

With respect to finance and expenditures tracking related to COVID-19, **Gambia** and **Kenya** generated evidence for the health financing system to enable COVID-19 response and preparedness to future epidemics, and **Burkina Faso**, **Ghana** and **Senegal** conducted COVID-19 expenditure tracking.

In the **Eastern Mediterranean Region**, **Afghanistan** and **Iraq** were also supported in the development and finalization of NHAs, with 27 members of the Iraqi NHA team representing national and subnational levels trained on the System of Health Accounts 2011 and Health Accounts Production Tool. In addition, support was provided for estimation of public health expenditure on COVID-19 preparedness and response in Iraq for 2020.

National accounts are the most visible and easiest way to demonstrate where health finances come from and move out.

UHC-P support in the **Western Pacific Region** targeted producing and validating health expenditure data for the annual update of the Global Health Expenditure Database in 2021. The 16th WHO-OECD Asia Pacific Health Accounts Experts meeting was held in 2021 as part of ongoing efforts to provide leadership in health accounts methodology improvement, promote cross-country learning, and support capacity-building and health accounts institutionalization in the Region.

Technical discussions were held with national counterparts from **Malaysia** and **Viet Nam** on the methodologies in estimating PHC and COVID-19 health expenditure tracking to inform policy-making. In addition, training on the use of the new Health Accounts Production Tool was provided to national focal points from **Cambodia**, **China**, **Lao People's Democratic Republic**, **Mongolia** and **Viet Nam**, and to improve health expenditure data collection and mapping.

Ongoing progress was made to update SDG indicator 3.8.2 which monitors financial protections and progress towards UHC for the joint WHO–World Bank global update. Tailored support was provided to countries by request (e.g. **Lao People's Democratic Republic**, **Malaysia**, **Mongolia**, **Viet Nam**) to produce country-specific financial protection reports and build strong working relationships between health and national statistics agencies.

Dr Luo Dapeng, WHO Representative in Afghanistan. © WHO

DEEP DIVE

PHC financing: a central component of the WHO health financing portfolio

Introduction

Increasingly, PHC financing is being prioritized in many countries where governments are engaging in PHC revitalization strategies. This has shifted the focus from hospital-centric reforms to broader health systems and health financing reforms.

Being provided with UHC-P flexible resources is critical for WHO health financing/health system advisors to tailor support to promote key policy agendas (often through evidence generation and policy dialogue). The UHC-P has been instrumental for WHO to be able to contribute effectively to the policy dialogue on PHC financing.

In 2021, WHO used resources from the UHC-P to carry out a wide range of activities to improve PHC financing in Member States. The range of activities can be grouped into seven main activities:

1. WHO provides support to **better track spending on PHC** through the NHA work and the introduction/development of a PHC module. Such information has proved critical for advocating for more resources for PHC and tracking the share of financing flows that are dedicated to PHC, **estimating imbalances in the distribution of health financing in the sector**.

2. WHO supports the monitoring of **financial protection** and, wherever possible, the running of component analyses to isolate the **effects of payments on PHC services at the level of out-of-pocket payments (OOPs) paid by households at the point of care** and its consequences in terms of financial hardship. At times, the analyses can focus on a specific range of health services, such as tracking the financial burden of disease-specific interventions on households (for example, NCDs).

3. WHO supports the design of policy interventions aimed at **mobilizing more resources for PHC**, which implies more resources for health but earmarked for PHC (for example, introduction of an excise tax on tobacco or sugary beverages whose revenues are earmarked – at least in part – to preventive services and health promotion).

4. WHO supports the **definition of benefit packages to be provided to the population at a partially or fully subsidized rate**. This type of work entails both generating evidence to assess the efficacy of some interventions and also conducting economic analyses to measure their effectiveness and the potential budgetary impact if they are included in the benefit package.

5. WHO provides technical assistance to support the formulation and implementation of strategies aimed at reverting the **skewed distribution of health financing away from PHC in the health sector** (for example, WHO attempting to move resources from tertiary levels to front-line PHC services).

6. WHO colleagues have supported the formulation of interventions aimed to **improve spending on PHC**, and achieve better value for the money that is allocated for PHC. The Organization regularly supports modifications to purchasing arrangements for PHC services, especially in terms of changes in payment methods (shift to capitation, introduction of pay for performance), but also in terms of new provider selection and contracting modalities.

7. WHO provides **technical assistance on the overall governance architecture and the information management arrangements that are conducive to improved PHC financing**. The Organization facilitates dialogue to enhance coordination across different national institutions that need to work together to improve PHC financing (for example, the ministry of health with the national health insurance scheme). This also includes work on performance monitoring frameworks for PHC service provision (including for quality). Other important work is related to coordination and alignment of the donor community to support PHC revitalization reforms.

The three following deep dives into WHO health financing work illustrate what types of activities WHO concretely undertook in 2021 with the support of the UHC-P, and shows how they influenced the policy dialogue on PHC financing. These provide both country-specific and transversal lessons that can feed into the global dialogue on PHC financing.

Evaluation of the P4P experience for PHC services in Kyrgyzstan

WHO long-term health financing–related engagement in Kyrgyzstan*

One of WHO's core missions is to support its Member States in all areas of health systems financing: raising revenue, pooling funds, (re)designing coverage policy and purchasing services. Following its independence, Kyrgyzstan initiated a fundamental transformation of its health financing system with WHO – the country's main technical partner – supporting the process closely. One key strategic decision was to promote a clear separation of some key health system functions – namely, stewardship, purchasing and service provision – through the establishment of a single-payer system – the Mandatory Health Insurance Fund (MHIF).

Following this decision, WHO supported not just the redefinition of Ministry of Health roles and responsibilities, but also the reengineering of existing purchasing arrangements in the country. One major reform consisted of adopting an output-based payment model – more specifically, a case-mix payment – for treated cases. As a convener of development partners in the health sector, WHO conducted several high-level policy discussions to promote the reform of the payment system and enable a paradigm shift from passive budget allocations to efficient management of resources and service delivery.

After years of implementation and positive changes, some concerns still persist regarding PHC financing – an unfinished agenda hampering progress towards UHC in the country. Two main issues remain persistent:

- First, there is an imbalance in the health financing flows that are still skewed towards hospitals. The single purchaser's budget – the MHIF – allocated to PHC has not increased sufficiently to enable an increasing role of PHC in prevention, diagnosis and treatment. Due to their excessive, inefficient and fragmented hospital infrastructure, hospitals are still funded irrespective of their performance, generating concerns about efficiency in health-care service provision.

- Second, there are design issues with the payment method used to pay for PHC services – capitation. Capitation rates vary by PHC provider types because different adjustment coefficients apply in different geographic locations and depend on the entitlement of the served population. The expansion of the role of PHC has also been hampered by characteristics of the payment arrangement for PHC providers, including the capitation formula itself, low rates of payment and poor performance monitoring. From 2012, the country tested different pay-for-performance (P4P) modalities to address some of these concerns, which were generalized in 2018. Following three years of implementation of the P4P, the performance add-on was discontinued in spring 2021.

Upon recommendations from the WHO Regional Director for Europe, the Ministry of Health established a PHC Task Force in May 2021 whose mission was to investigate the different barriers hampering progress towards PHC in the country. The task force identified the P4P experience, and the current role of the provider payment mix in terms of the slow progress in PHC development as key areas of interest. It therefore established a working group to assess the effectiveness of the payment system and develop recommendations for future improvements. With UHC-P support, WHO – in collaboration with local consultants – contributed to this effort by providing analytical work and evaluating the effect of the P4P on the overall PHC payment design, budgeting and contracting system.

Scope and methodology of the P4P evaluation

In 2021, data were collected to assess the effectiveness of the P4P payments in improving key health indicators, including quality of care. Focus group discussions, surveys and interviews with providers and patients were conducted to assess stakeholders' satisfaction with the programme and with the overall PHC financing system. Bigger cities were initially excluded from the analysis due to the difference in service delivery model, being more specialist care centred and therefore requiring a different methodological approach. Based on the results of the analytical work, WHO conducted consultations with MHIF and the Working Group to develop relevant policy recommendations for improvements of the PHC financing system.

Following data collection and collation, a technical report was developed in 2021 and completed in early 2022.

* Information for this section was obtained from: Kaija Kasekamp and Triin Habicht (consultants to the WHO Barcelona Office for Health Systems Financing), and Joana Madureira Lima and Aigul Sydykova (from the WHO Country Office Kyrgyzstan).

** Quantitative data analysis was based on e-Health Center, MHIF and provider-level data. E-Health Center and MHIF provided nationwide data. Provider-level data included six selected providers from three different regions. Individual interviews were conducted with family doctors based on special questionnaires, and two focus group discussions were held with family doctors.

Key findings and lessons learned

Assessing the impact of the P4P system to service delivery was challenged by the short implementation period (three years) and frequent changes in indicators measured, which made it difficult to periodically monitor progress.

However, despite the relatively short period of implementation, positive impacts were identified:

- The number of family doctors increased in urban areas. Many specialists in urban areas were retrained on family medicine concept basis as only providers practising family medicine were entitled to bonuses.
- The P4P system significantly increased the work motivation of family doctors – 76% surveyed in the study felt that their work motivation has increased. The P4P used to be beneficial especially for young professionals because it rewarded good performance, and not solely on seniority; however, despite the positive effect on motivation in young professionals, the P4P was replaced by a base salary increase based on seniority for all staff working in a PHC facility.
- Providers made efforts to improve data submission, enhancing accountability and transparency in service provision.
- Moreover, 69% of family doctors noted that performance payment had a strong impact on improving the performance and quality of their work. Improvements were seen in several clinical areas such as monitoring and timely registration of pregnant women, home visits to newborns, and identification and registration of patients with type 2 diabetes and hypertension.

Nevertheless, the analysis also indicated many deficiencies of the P4P system, including insufficient training of providers, deficient data systems, limited incentives for nurses, and frequent changes in indicators. One major challenge described by all stakeholders was the burdensome monitoring process which was initially meant to be automated. The surveys and focus group discussions also indicated reduced attention to non-P4P-related conditions – more than half of the surveyed doctors (61%) noted that priorities had shifted more towards P4P-tracked diseases.

The analytical work clearly indicated that the goal set by the Kyrgyz Government to improve the attractiveness of PHC, enhance the quality and performance of PHC workers and increase the motivation of providers was achieved. During the presentation of the findings to the Working Group, participants agreed that the P4P intervention should be gradually reintroduced, while improving the design of the system to provide more attention and time to training, improving data collection and monitoring mechanisms.

Nevertheless, the P4P system should still align with and be a supportive component of the overall PHC financing arrangements. There is still an urgent need to revise the PHC benefit package to better meet population health needs and align the PHC funding with those needs. In addition, PHC providers' remuneration should be increased to help them meet the costs of living. Such an increase would enhance the attractiveness of family medicine as a practice. The living wage should be paid to PHC providers through capitation payments, with a possibility to increase basic living wage through bonuses. Last, but not least, there is a need for a rethink and a comprehensive redesign of the overall PHC provider payment system – aiming for better blending of payment methods and adequate resourcing. Improved public financial management, budgeting and contracting mechanisms are also key to supporting successful implementation of such a redesign.

Proposed next steps with the support of the UHC-P

To support the broader objective of improving the PHC payment system and enhancing the strategic purchasing function to strengthen PHC, WHO will develop a country-specific policy brief on PHC financing summarizing the strengths and weaknesses of the existing system and providing policy recommendations. The policy brief will be published later in 2022.

The policy recommendations serve as a basis for a detailed road map defining priorities and next steps for improving PHC financing. Some of these priority areas are:

- As MHIF is currently in the process of refining the benefit package, donor support could be used to conduct costing for the revised package to define the gap between the package versus the actual level of funding, indicating need for future investments and enabling explicit priority-setting if the budget envelope is limited.
- Kyrgyzstan could also benefit from donor support to increase the uptake of digital information systems and improve the quality of data, which is a precondition to reintroducing the P4P and improving the current payment design.

- Furthermore, since there is no universal and equitable system developed at national level, the uneven availability of investment in infrastructure and equipment is particularly concerning. Donors could support the Ministry of Health to update the PHC infrastructure to meet international standards while at the same adapting it to the Kyrgyz context.

- The Working Group was mandated to extend the analysis of the P4P-related payments to urban settings in order to better understand regional differences. Therefore, donor support is needed to extend the study on the effectiveness of P4P to Bishkek and/or Osh regions to assess the payment system incentives in urban settings.

Midwife Bahja and her children are beneficiaries of a new health-care centre in Abu Gaw, Sudan. The village's original health centre was destroyed during the armed conflict in 2004 which also drove residents, including Bahja, to flee. Since 2018, about 8000 people have returned to the village from displacement camps. The community identified rebuilding the health centre as a priority through a series of community health dialogues with health authorities, which was facilitated by WHO with support from the UHC Partnership. © WHO / Lindsay Mackenzie

WHO support for the design and implementation of the PHC-blended capitation system in Egypt

Background

Egypt is currently undergoing a major change in its health-care system. In 2018, the country issued a Universal Health Insurance (UHI) Law which sets the potential for progress towards UHC over 10 years of a geographically phased implementation plan. The law implies major institutional transformation to health financing functions and stipulates important changes such as purchaser–provider split, stricter referral rules, regulated cost sharing, and reorientation of PHC as the gatekeeper for the insurance system.

Drivers for change

Prior to implementation of the UHI Law, purchaser–provider integration was the dominant arrangement in the public sector. Public funds flow through a rigid line-item budget which is based, in most cases, on historical trends, where facility managers have no to minimal autonomy on their internal financial resources. On the other hand, unregulated fee-for-service (FFS) is the prevailing payment method by purchasers in the private sector. Most of the health services providers receive multiple funding streams, with different payment methods, contractual modalities, and a loosely defined non-uniform benefit package. These features, among others, contribute to the inconsistency and variation in health-care costs and quality across providers.

Given the increased importance of PHC under the UHI system, and under the overall institutional transformation in the financing system, a new model of blended capitation was introduced by a multi-stakeholder committee. The committee included representatives from the Ministry of Health and Population, Ministry of Finance, UHI authorities and the WHO Country Office.

The new form of prospective payment was generally accepted by stakeholders since it ensures financial sustainability to the purchaser (UHI Authority) as well as provides an appropriate level of funding, predictability and flexibility to health-care providers (the Public Health Care Authority and private sector when contracted). It also minimizes the risk of supplier-induced demand and overprovision of services that are commonly experienced in FFS payment models.

To counteract negative incentives associated with the capitation model – namely, underprovision of services and/or increased referrals to higher levels of care – the committee recommended to: (a) pay a set of priority services and minor interventions on a FFS basis, and (b) withhold a proportion of the capitation payment (around 15%) to be paid retrospectively if certain key performance indicators (KPIs) are achieved. For the first stage, the focus is only on process-related KPIs (e.g. patient utilization, referral rates) that are readily available and could be easily reported through a health management information system without the need for extensive data collection or high verification cost. As the system matures and more data become available, the committee suggested introducing adjustment coefficients for capitation payments and further refining the pay-for-performance component.

Achievements

Blended capitation has become the dominant payment arrangement under the UHI system for PHC services. Based on the UHI roll-out plan, it has now been implemented in two governorates that have total capacities of more than 90 PHC units and centres, covering a population of around 1.5 million. WHO undertook a comprehensive assessment and produced a guiding policy document[25] and a journal article[26] to guide the design of the new payment system. Moreover, WHO contributed to the designated committees to further advise on design and implementation sequencing.

Remaining and emerging challenges

Moving away from rigid line-item budgeting and towards blended capitation payment for PHC can be considered good progress towards more strategic purchasing for UHC. Nevertheless, several challenges remain, or have emerged during the implementation stage:

- **Lack of financial management capacities at the PHC level, as well as limited financial autonomy**, did not create an enabling environment to convey incentives to front-line providers. While allocation of funds is based on base-per-capita rate multiplied by the number of enrollees for each PHC facility, the real transfer of funds occurred between the UHI Authority (payer) and the public authority for health care (the umbrella organization for public providers) and not to PHC facilities directly. Received funds are then reallocated from the central level to PHC facilities, not necessarily following the same allocation criteria. This additional layer – while temporarily necessary due to lack of capacities – may turn capitation payment into disguised global budget payments and nullify the intended incentives supposed to be created by capitation payment. Intensive capacity-building at the facility levels, in addition to gradual increase in autonomy and consideration of direct facility financing, can be considered as policy options to overcome this challenge.

- **Payment mix is not aligned**. Capitation payment under the UHI system covers only curative services, while preventive services are covered by another purchaser (Ministry of Health and Population) according to the UHI Law. This new health system architecture may lead to an explicit separation of curative services versus preventive and promotive services, which may not help promote a focus on integrated people-centred health services geared towards care coordination and continuity. Moreover, different – and sometimes conflicting – payment methods by different financing agents (e.g. input-oriented line-item-based budget by the Ministry of Health and Population for preventive services versus output- or population-based payments by the UHI Authority for curative services) would create a non-aligned mixed payment system that can lead to undesirable provider behaviour – namely, resource shifting to curative care provision, thus possibly resulting in resource shortages for preventive and promotive health care. Therefore, in order to avoid distortions in provider behaviour, it is recommended that the funding streams and provider payment methods for preventive and promotive care be aligned with those for curative care.

- **Competition between providers in different sectors is yet to be activated at the PHC level despite stipulated by the Law**. The capacity for open enrollment is restricted during certain enrolment windows, thus suspending an important feature for promoting quality of care and beneficiaries' responsiveness through competition of providers on enrollees. A wider strategy for private sector engagement while ensuring proper regulation and incentives are in place is needed to address this issue.

Next steps

In 2022, WHO is planning to further assess the implementation of the UHI programme and develop a series of policy briefs to disseminate the findings. One policy brief will be focusing on the reforms in the field of provider payment methods. The evaluation will adapt the Health Financing Progress Matrix to assess how implementation of the UHI Law has contributed to improving the overall health financing structure and performance in Egypt.

WHO Pakistan Country Office's multi-pronged strategy to improve PHC and sustainable health financing

A clearly defined UHC package of essential services that needed to be further operationalized

By signing the UHC2030 global compact in 2018, the Government of Pakistan committed to work with renewed urgency to accelerate progress towards UHC, through building and expanding equitable, resilient and sustainable health systems. The Government has set a target to increase Pakistan's service coverage index from 45 out of 100 in 2017 to 65 out of 100 by 2030. Pakistan was lately prioritized by the GAP for SDG3+ for intensified support under accelerators 1 and 2, related to PHC and sustainable financing for health.

WHO, along with partners, supported the Government of Pakistan in developing a UHC benefit package/essential package of health services (EPHS) guided by the Disease Control Priorities 3 (DCP3) evidence. The package was endorsed by the inter-ministerial Health and Population Council in October 2020. This was a landmark achievement towards UHC advancement as Pakistan was one of the first countries to develop a UHC benefit package based on the DCP3. UHC-P funds played a catalytic role in advocacy for UHC reforms and developing the package.

The Government has prioritized 88 interventions for district EPHS, of which 56 relate to community and PHC and the remaining 32 relate to first-level hospitals. The baseline cost for implementation of the prioritized district-level interventions is US$ 12.98 per person per year. When fully implemented, they are expected to avert up to 40.36 million disability-adjusted life years.

In 2021, WHO used UHC-P resources to support the implementation process, and contributed to addressing three key challenges:

Challenge 1: Raising revenues to implement the UHC benefit package

As Pakistan is moving towards implementation of the UHC benefit package, the most important challenge is the resource gap between available resources and the estimated cost for EPHS implementation. The Government is exploring internal and external resources to mobilize resources for UHC benefit package implementation.

To continue the momentum on UHC, WHO organized a high-level "PHC for UHC" mission of eight SDG3+ GAP partners in March 2021 to review the status of PHC and

sustainable health financing, and to advise on a model of care to ensure effective implementation of the UHC benefit package. The objective was to coordinate and align technical support to implement major national strategies to improve PHC, align support to monitor PHC improvement, and consolidate key external aid flows to support the development and the implement of a UHC investment case, and finalize a PHC for UHC compact.

As signatories of a joint statement signed during this high-level mission, the partners are committed to align their approach towards "PHC for UHC" and work together to build a sustainable PHC model for integrated service delivery. Since then, SDG3 GAP partners are engaged to develop and implement the joint commitment and action plans. An SDG3 GAP Coordination Committee – led by the WHO Head of Mission – is constituted at country level to align the support for PHC strengthening and sustainable health financing. A technical working group for PHC strengthening and health financing of partners is also established under the GAP Coordination Committee.

SDG GAP partners are collaborating to develop a national and provincial-level health financing framework and health financing strategy for UHC to move the effort forward. WHO is providing technical assistance (in collaboration with P4H) for developing a health financing strategy for resource mobilization for health to advance UHC, and enhancing health security. The World Bank supports the strategy by conducting a health system financing assessment and a fiscal space analysis.

WHO is also conducting cross-programmatic efficiency analyses of selected vertical programmes (tuberculosis [TB], malaria, HIV/AIDS, Expanded Programme for Immunization) to identify inefficiencies across the selected health programmes and their implications on the overall health system.

In addition, the GFF supports the World Bank in conducting resource mapping and expenditure tracking, as well as detailed analysis of PFM at the district level. The Resource Mapping and Expenditure Tracking and PFM analyses will close existing data gaps in primary health-care financing at the district level.

The emerging opportunities being discussed for financing PHC-based EPHS include the upcoming National Health Support Project (NHSP) supported by the World Bank, GFF, Gavi and other partners, building on the success of the National Immunization Support Project co-funded by the Bill & Melinda Gates Foundation, Gavi, United States Agency for International Development (USAID) and the World Bank. High-impact financing instruments for the World Bank's NHSP include disbursement-linked indicator mechanisms to promote integrated programming with existing programmes and promote equitable access in remote, marginalized areas. WHO is engaged with the World Bank to support refining of the disbursement-linked indicator and preparing an implementation guidance note for the NHSP. WHO advocated with the World Bank for use of NHSP funding for UHC financing.

Challenge 2: Developing a model of care to deliver the UHC benefit package

The first step to developing a model of care consisted of further adjusting/adapting the UHC benefit package to the context of implementation. As health is devolved to the provinces, the next big challenge was to move towards development of localized UHC benefit packages/EHSP for each province/federal area based on the local disease epidemiology, burden of disease, priorities, etc. WHO and UNICEF, along with the Ministry of National Health Services, Regulations and Coordination, supported provinces in developing the localized packages based on DCP3 in 2021 and early 2022. All provincial governments have endorsed the localized packages.

The WHO Pakistan Country Office provided support to the Government for piloting a PHC-oriented model of care for UHC benefit package implementation. The pilot is being implemented in Islamabad Capital Territory and Charsadda districts (1 April 2021 – 30 September 2022). WHO engaged all stakeholders – including the Government (both federal and provincial) – and SDG3+ GAP partners during planning and implementation of the model of care initiative to solicit their feedback and exchange information for future cooperation. The model of care is supporting access to prioritized interventions of the UHC benefit package related to NCDs; communicable diseases, including TB, hepatitis, HIV/AIDs; reproductive, maternal, newborn, child and adolescent health; nutrition; and immunization; as well as an open gymnasium and mental health services. It is also addressing the intersectoral and social determinants of health through establishing and training community health committees, community engagement, health education in schools and communities and improving water, sanitation and hygiene services in the model schools.

The successful implementation of this pilot initiative will present a good model for further replication in other districts, when other funding opportunities are emerging for improvement in health service delivery – for example, NHSP by the World Bank and partners.

Challenge 3: Improving access to PHC services for the economically vulnerable groups

The affordability of health care is a key dimension for achieving UHC. In low- and middle-income countries, a large number of people lack sufficient financial means to access health-care services.

Financial risks are measured by the following two indicators:

- Population with household expenditures on health > 10% of total household expenditure or income (%): The value for Pakistan was 4.5 in 2015 compared to 1.03 in 2010.
- Population with household expenditures on health > 25% of total household expenditure or income (%): The value for Pakistan was 0.5 in 2015 compared to 0.02 in 2010.

The two values indicate that Pakistan was already experiencing a rising trend in household expenditure on health from 2010 to 2015, while the population was already negatively affected by high levels of poverty. The current COVID-19 pandemic, very high inflation rates and worsening economic situation in the country are expected to have serious financial risks on the population and to increase household expenditures on health.

In 2015, the Government launched the Sehat Sahulat Program, a major public health insurance programme for the provision of indoor services free of charge to families living below the national poverty line (< US$ 2 per day), with the primary objective to enhance financial protection for the eligible population. The programme covers a wide range of services, including most of the secondary and tertiary hospital-level prioritized services defined under the UHC benefit package. However, the Sehat Sahulat benefit package excludes outpatient treatments, which are increasingly posing a threat to poor households in terms of financial protection.

In 2021, WHO started to support a pilot experiment that consists of the inclusion of PHC-level services in the Sehat Sehulat benefit package in Islamabad Capital Territory. Through the OPD Pilot project (launched in August 2021), outpatient services at the primary health-care level are being provided free of charge through general practitioners (private sector) using the EPHS. These services include sexual and reproductive health and rights and family planning services. The pilot is for one year and includes a final evaluation for assessment and to draw on lessons that may help in advocating for generalization of the outpatient benefits in other provinces, helping the programme to provide better financial protection to the targeted population

An EPI worker, Majra bibi prepares pentavalent vaccine in a province in Pakistan.
© WHO / Asad Zaidi

Access to essential medicines, vaccines, diagnostics and devices for PHC has substantial impacts on health. Quality-assured, safe and effective medicines, vaccines and medical devices are fundamental to a functioning health system. Working to increase access to essential pharmaceuticals is a key thematic of UHC-P activities.

Strengthening regulatory capacity

WHO supported countries in strengthening regulatory systems for pharmaceuticals and other health commodities. For example, using its global benchmarking tool, WHO supported assessment of the Medicines Regulatory Agency in **Fiji**. At the regional level, the regulatory functions for medical products in the Pacific were strengthened through the initial stages of the subregional regulatory platform: the operational plan and budget for the initial five years were developed, and work is in progress to create a website for information sharing. To support the accreditation process for national laboratories, and ensure laboratory procedures were documented in **Grenada**, a laboratory biosafety manual was developed by WHO, which included procedures followed in the laboratory to ensure safety of staff. The draft manual was prepared and shared with stakeholders for comments and is currently being finalized. **Guinea** developed a law on biosafety and produced tools for monitoring of adverse effects following immunization. In **United Republic of Tanzania**, 50 medicines and medical devices authority drug inspectors acquired new skills on prevention, detection and timely response to incidents of substandard and falsified medicines. The **Dominican Republic** was able to resume work on strengthening capacities for regulatory procedures for medicines for NCDs, specifically capacity-strengthening of service plan pharmacists in PHC. And in **Georgia**, the UHC-P provided input on the Law of Georgia on Medicinal Products and Pharmaceutical Activities to inform the reorganization of the national drug agency and its merging with the national regulatory agency (see Box 20).

Regulations of pharmaceutical products is a key ask for the pharmaceutical sector.

In the **Region of the Americas**, through the UHC-P, PAHO provided technical guidance for the development of a draft report on equitable access to essential medicines for NCDs in the Caribbean. This report was developed by the Healthy Caribbean Coalition (a civil society–based alliance that comprises more than 40 Caribbean-based health nongovernmental organizations [NGOs]) and focused on access to essential NCD medicines in 13 Caribbean countries. Furthermore, the Caribbean Regulatory System issued 76 product recommendations to Member States, inclusive of nine COVID-19 vaccines. Ninety-four product dossiers were screened by the Caribbean regulatory system, of which 85 were direct applications from sponsors and nine were COVID-19 vaccine dossiers reviewed voluntarily for Member States of the Caribbean Public Health Agency. The Caribbean Regulatory System continues to support Member States by keeping its recommendations updated according to the latest WHO emergency use listing procedure.

The Essential Medicines List: 45 years on, still at the centre of efficiency for pharmaceutical strategies in countries.

In 2021, the UHC-P supported the development or revision of national medicine policies and strategies and essential medicines lists in **Afghanistan**, **Botswana**, **Cabo Verde**, **Cameroon**, **Chad**, **Comoros**, **Congo**, **Djibouti**, **Eswatini**, **Gambia**, **Kenya**, **Lesotho**, **Madagascar**, **Mauritania**, **Mauritius**, **Mozambique**, **Nigeria**, **Rwanda**, **Sierra Leone**, **Timor-Leste**, **Tunisia**, **United Republic of Tanzania**, **Viet Nam** and **Zambia**. In **Islamic Republic of Iran**, a situation analysis was conducted for implementing e-prescriptions in the main health insurance organizations and the Ministry of Health and Medical Education. **Eritrea** formulated its institutional development plan for the National Medicines and Food Administration, updated the standard operating procedures and tools of working documents, and completed a review and provided recommendations for the accreditation process of the National Drug Quality Control Laboratory. Moreover, **Ghana** finalized its national medicine pricing strategy, the national supply chain master plan was reviewed and disseminated, and the national health technology assessment strategy was launched.

In **India**, the UHC-P – in partnership with the Ministry of Health and Family Welfare and other partners – supported capacity-building for current good manufacturing practices, with 323 pharmaceutical enterprises participating in six online workshops (12 days each). The UHC-P also supported a mentorship programme on prequalification standards for pharmaceutical companies in the country.

Furthermore, to improve access to COVID-19 vaccines, the UHC-P supported the NGO Medical Mission Primary Healthcare Suriname in the development and airing of COVID-19 vaccine promotional material targeting those living in the **Suriname** hinterlands. The Ministry of Health received additional support for the development of vaccination promotion material in different languages. Similarly, **Bahamas** developed a multimedia campaign for adherence to COVID-19 protocols, COVID-19 vaccination, and return to PHC facilities for care. Patient safety is an important aspect of ensuring trust in the health system and assuring improved access to essential medicines, vaccines, diagnostics and devices for PHC. In **Pakistan**, for example, WHO has been providing technical support for the implementation of the Global Patient Safety Collaborative (see Box 21).

Box 20. Better access to medicines in Georgia

The UHC-P provided input on the Law of Georgia on Medicinal Products and Pharmaceutical Activities, which informed the reorganization of the national drug agency as it was merged with the national regulatory agency. This catalysed interest in national authorities to collaborate with WHO in the areas of pharmaceuticals and resulted in a request for additional assistance for improving access to and quality of pharmaceutical products. The initiated and sustained work in the areas of pharmaceuticals has contributed to inclusion of the country in the WHO certification scheme on the quality of pharmaceutical products moving in international commerce. A mission on access to medicines in Georgia was also organized in 2021 to evaluate national pricing reimbursement frameworks, facilitate dialogue, and develop a road map for strengthening the pricing and reimbursement system and the positive reimbursement list. The mission findings will inform recommendations to the Ministry of Labor, Health and Social Affairs to implement activities to support gradual reduction of OOP expenditures for medicines. Furthermore, the Prime Minister has discussed the Draft Law on Medicines introduced in Parliament and expressed an intention to regulate the market. The Ministry is committed to advancing reforms in these key areas and has asked WHO for continued support in these directions.

Box 21. Support for patient safety in Pakistan

WHO has been providing technical support for implementation of the Global Patient Safety Collaborative in Pakistan. Some of the key activities supported under this initiative over the last year include:

- WHO Pakistan Country Office led two missions with national patient safety experts to conduct a baseline survey of three hospitals on critical criteria for patient safety standards. Based on the evaluation, the WHO team provided technical guidance to the hospital teams to achieve the level for patient safety standards.
- A one-day capacity-building workshop was organized on patient safety research. The main objective of the workshop was to produce new knowledge that improves the capability of health-care systems – including health-care organizations and practitioners – to reduce the harms associated with health care.
- WHO provided support to the Ministry of National Health Services Regulations and Coordination and provincial health departments to integrate health-care commission standards and WHO patient safety standards for effective implementation.
- Various activities were organized for the commemoration of World Patient Safety Day across the country.
- A study was commissioned on the assessment of patient safety and adverse events at six tertiary care hospitals in Pakistan; data collection has been completed, and data cleaning, analysis and report writing is in progress.

On the patient safety PHC initiative, WHO conducted a training-of-trainers workshop on the PHC-oriented model of care initiative to build the capacity of PHC providers (in Islamabad Capital Territory and Charsadda districts) on patient safety.

A doctor checks on a boy who was displaced by the floods in Pakistan.
© WHO / Mobeen Ansari

A pharmacy in Kyrgyzstan. © WHO / Mihail Grigorev

Ensuring efficient and transparent procurement and supply systems

In **Honduras**, the UHC-P supported two studies related to the management of medicines and health technologies: a study on the availability of medicines in health establishments (regional study) and a study on the chain of medicines and supplies to address the COVID-19 pandemic in the country. In addition, PAHO supported **Honduras** with the development of a draft national plan for pharmaceutical services based on PHX in Honduras and disseminated the plan to relevant stakeholders.

A WHO country mission in **Seychelles** assessed the implementation of the Small Island Developing States pooled procurement agreement. The agreement aims to leverage the pooled procurement programme to reduce costs and improve access to quality medicine.

With UHC-P support, for the first time in **Kyrgyzstan**, prices of medicines, including a large number for the treatment of NCDs, are being regulated via a government decree on the introduction of price controls for a number of medicines prescribed at PHC level for NCD management. Increasing the affordability of these medicines is critical to addressing the burden of NCD in the country. WHO promoted policy dialogues with manufacturers and distributors to find a consensus around how to improve price data sharing, which subsequently informed the amendments to the regulation for the next round of approval. The revised draft legislation was approved in July 2021 and it formed the basis for further facilitation of implementation of the price control mechanism.

Over the last few years in **Libya**, there have been extensive shortages of medicines and medical supplies, low stocks of vaccines and a lack of trusted information about the health situation and the supply chain. Medical supply chain management and the health information system were almost nonexistent until strengthening of the health information system and supply chain management project started building institutional and individual capacities to reform supply chain management and integrate these reforms within the Ministry of Health (see Box 22).

Addressing antimicrobial resistance (AMR)

IPC guidelines were developed across **African Region** countries in response to the COVID-19 pandemic. These were targeted at health workers in order to reduce COVID-19 and other disease transmission while attending to patients. **Botswana** developed several IPC guidelines, including National IPC Guidelines and a monitoring and evaluation framework on the management of COVID-19 among health community workers, with follow-up training for them and support supervision for IPC using the WHO scorecard. About 36 trainers received training using WHO-adapted curriculum, and in turn conducted training of about 8000 district health workers. **South Africa** developed a national IPC strategic plan and practical manual with follow-up training of over 550 IPC focal points across all nine provinces, and **Eswatini** and **Mauritius** finalized their respective IPC guidelines. **South Sudan** procured and distributed basic IPC materials to health facilities for practical illustration of IPC practices for health workers.

Zambia conducted an antimicrobial point prevalence survey, received support for the development of a national antimicrobial resistance (AMR) monitoring guide, and supported seven sentinel laboratories by providing reagents for culture and antibiotic susceptibility testing. **Burundi** began the development of an AMR surveillance system which included development of the national microbiological diagnostic protocol, the manual of medical bacteriology technique, and a list of priority pathogens to be monitored in the AMR surveillance system. **Guinea** developed guidelines for the proper use of antibiotics. **Mali** launched an external quality assurance programme to ensure the quality of AMR, consumption and use data. In **Sierra Leone**, 76 hospital staff from 12 hospitals had their capacities built around antimicrobial stewardship and pharmacovigilance. In **South Africa**, the AMR consumption survey report was developed as part of the AMR national action plan report. **United Republic of Tanzania** also developed antimicrobial stewardship guidelines for health facilities, reported AMR surveillance data to the global antimicrobial surveillance system, and submitted information on antimicrobial use in facilities in 15 regions to the global antimicrobial surveillance system for antimicrobial use.

In 2021, **Afghanistan** implemented a national action plan for antimicrobial resistance, adapted guidelines for the implementation of the safe hospital initiative, and developed IPC guidelines for health facilities.

Box 22. Pioneering project in Libya to improve medicines supply chain management and health information system

Fact: A meaningful shift in relationships and a new vision for progress is driving Libya's health information system and medical supply chain management. A pioneering project is building capacity throughout the system.

Why it matters: Libya was left with the legacy of a deeply under-developed health system. Extensive shortages of medicines and medical supplies, low stocks of vaccines and a lack of trusted information about the supply chain have been commonplace.

Expected results: The population has better access to safe and essential medicines, and the health system is strengthened.

In practice: Thanks to close collaboration with national authorities and financial support from the EU, WHO experts have been able to strongly advocate for improved supply systems and have supported people at all levels – from medicines warehouses to ministries – to improve management practices.

A member of a WHO-supported emergency medical team examines a patient's x-ray in the emergency room of a medical centre in Libya. © WHO / Blink Media – Nada Harib

A health worker meets with her patient at Tulagi Clinic, Solomon Islands. © WHO / Blink Media – Neil Nuia

2. Addressing health emergencies

1 billion more people better protected from health emergencies

Notable results for the second billion in 2021

In every country in the African Region, a **Public Health Emergency Operations Centre** (PHEOC) was activated to coordinate the development of a costed national COVID-19 response plan and the implementation of day-to-day COVID-19 response activities. Most of the PHEOCs were enacted before the first COVID-19 case was reported and put in place mechanisms for COVID-19 screening at points of entry, quarantine and surveillance.

Twenty-one countries were supported to develop or implement a **national action plan for health security** (NAPHS) through staffing, procurement, infrastructure establishment, strategic risk assessment, reporting and capacity-building through trainings and workshops.

Nine countries have been supported in resource **mapping for health security**. The WHO REMAP tool supports Member States in implementing their health security plans through the identification of financial and technical resources necessary to complete country priority actions.

The new regional **Asia Pacific Strategy for Emerging Diseases** has been adopted, which includes a five-year regional strategic plan for health emergency preparedness and response to strengthen regional health security capacities.

In the Region of the Americas, after-action reviews (AAR) were carried out to assess specific responses related to COVID-19, specifically, after hurricanes Eta and Iota during the first quarter of 2021; the **emergency medical team** response in Costa Rica for COVID-19; and three AARs in Brazil (for arenavirus, arboviruses and flooding).

For more than 10 years, the UHC-P has been dedicated to work with countries to prepare for health emergencies and take actions to ensure that those affected by health emergencies – especially the most disadvantaged – have access to essential life-saving health services and public health interventions. As recent years have shown, the increasing frequency and severity of climate-related hazards, combined with the added challenge of vector-borne diseases (Ebola, Zika, dengue, Chikungunya, COVID-19), imposes heavy human and economic tolls, and places a heavy burden on health-care systems.

The latest experiences have demonstrated that all countries – regardless of their stage of economic development – remain vulnerable to public health emergencies, including severe infectious disease outbreaks. Health security threats are not new, but the nature and range of threats are increasingly complex. Health systems can quickly become overwhelmed during the response to unprecedented outbreaks and other health emergencies.

In the case of the COVID-19 pandemic, assessments conducted under the International Health Regulations 2005 (IHR) monitoring and evaluation framework indicate that many countries lack the capacities to prevent, detect and respond to effectively handle COVID-19. Halting transmission and mitigating the impact of the outbreak requires scaling up country preparedness and response operations, including enhancing existing respiratory disease-surveillance systems, indicator-based surveillance, community event-based surveillance, and sentinel surveillance, establishing active case-finding at points of entry, and raising awareness in the population through risk communication and community engagement.

Building resilient health systems to improve health security, especially in fragile and conflict-affected countries, is critical for paving the way to reaching UHC and achieving the SDGs. To address these challenges, WHO continues to support countries to strengthen health emergency preparedness, prevention and response capacities using a one-health multisectoral approach, through the implementation of the IHR, with NAPHS linked to national health strategic plans or integrated disease surveillance and response (IDSR), for instance.

2.1 Countries prepared for health emergencies

Under the UHC-P, countries have been supported to increase preparedness for health emergencies through strategic risk assessment, the development of health response plans and the implementation of IHR. Using results of the assessments, countries were able to apply evidence to inform country planning, prioritize key actions for rapid scale-up of capabilities for high risks, and rationalize and make effective use of limited resources for strengthening health emergency and disaster risk management capacities (see Box 23).

Implementing the IHR through NAPHS

IHR Monitoring and Evaluation Framework assessment results have informed the development of all-hazards NAPHS for strengthening key areas vital for health emergencies preparedness and response, including those related to surveillance, zoonotic diseases, points of entry, workforce development, laboratory, and risk communications.

While many countries have developed and published NAPHS in recent years, implementation of activities and priorities have remained a major challenge during the reporting period. The main reason for the lack of implementation of NAPHS activities is due to the COVID-19 pandemic, as many countries have been overwhelmed with emergency response operations and competing priorities. In addition, implementation challenges were exacerbated due to domestic financial and technical gaps, lack of monitoring and follow-up systems, and having to move from a high-level static plan towards a more operational, living plan that is regularly reviewed and updated. In an effort to respond to the COVID-19 pandemic, national authorities advanced the assessment of EPHFs with the completion of a situational analysis and an institutional mapping in Bahamas (see Box 24) and strengthening of emergency response in Cambodia (see Box 25).

In the **African Region**, all 47 countries have been supported to assess their IHR capacities using the State Party Self-Assessment Annual Reporting Tool, while 46 countries have been supported to conduct Joint External Evaluation (JEE) assessments since 2016, and 36 countries conducted risk assessment. Member States have also been supported to assess the functionality of their IHR capacities through AARs and simulation exercises to enhance readiness for health emergencies.

In 2021, there was notable progress in the development and finalization of NAPHS. NAPHS aim to enhance health system resilience and to strengthen the capacity for prevention, detection and response to public health emergencies. Five countries (**Botswana**, **Cabo Verde**, **Central African Republic**, **Mali**, **Seychelles**) were especially supported to develop their NAPHS. For example, the UHC-P enabled **Central African Republic** to finalize its first-ever NAPHS, with the final version

presented to the Prime Minister and other members of Government; **Seychelles** to advance a draft that is currently awaiting validation; and **Cabo Verde** to appoint focal points and hold various workshops for NAPHS.

In addition, 16 countries (**Benin**, **Cabo Verde**, **Cameroon**, **Eswatini**, **Ghana**, **Lesotho**, **Liberia**, **Madagascar**, **Mali**, **Mozambique**, **Namibia**, **Senegal**, **Seychelles, Uganda**, **Zambia** and **Zimbabwe**) have been supported to engage NAPHS implementation through staffing, procurement, infrastructure establishment, State Parties Self-Assessment and Annual Reporting and capacity-building through trainings and workshops. For instance, in **Benin**, the UHC-P supported Abomey-Calavi district to procure medical supplies and equipment in treatment centres and build capacity of health workers in case management. In **Uganda**, more than a thousand health workers and surveillance officers were trained on the detection and response systems within their jurisdiction and the reporting system. In **Seychelles**, WHO helped to establish functional triage stations at all public health facilities and tourism establishments across the country, contributing to improved IPC and case detection.

Integrated health systems are critical for resilient global health security.

In the WHO **South-East Asia Region**, the new regional Asia-Pacific Strategy for Emerging Diseases was adopted in 2021 and includes a five-year Regional Strategic Plan for Health Emergency Preparedness and Response to strengthen regional health security capacities. The work of the UHC-P in the Region is guided by this strategy, which has served as a framework for action to advance the implementation of the IHR for health security over the past 15 years. With the support of the UHC-P, a review process was conducted to analyse specific country achievements and progress in strengthening IHR capacities under the relevant overarching frameworks; consolidate common challenges, best practices and recommendations to prepare and inform high-level policy briefings in the upcoming regional governing meetings; and formulate a regional strategic road map for strengthening preparedness and response to emergency.

A hygienist prepares a nurse to enter an Ebola treatment centre in Uganda. © WHO / Jimmy Adriko

Box 23. New WHO Strategic Partnership for Health Security and Emergency Preparedness Portal

A collective global effort is needed to support countries in strengthening health emergency preparedness and building back better from the pandemic. Collaboration and coordination are essential, including sharing relevant information and ensuring technical and funding contributions are as complementary, synergistic and coordinated as possible. This is the critical role of the WHO Strategic Partnership for Health Security and Emergency Preparedness (SPH) Portal.

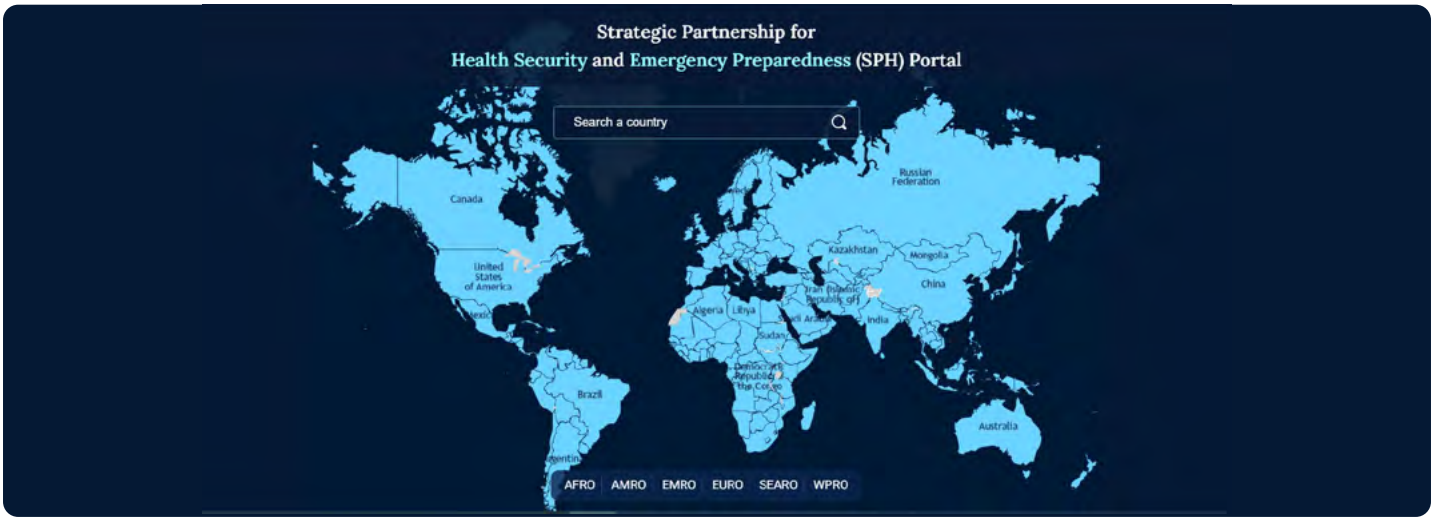
In 2021, WHO published the new, revamped and enhanced version of the SPH Portal with views at all three levels – global, regional and national. The functionality of the SPH Portal was expanded to scale up multisectoral coordination and collaboration for preparedness, and to better include tracking and monitoring of national preparedness investments towards relevant capacity-building activities, including those contained in NAPHS. The new update includes the implementation of information technology (IT) improvements, with a robust content management system and faster data load, as well as the addition of new pages and features. The new version of the SPH Portal went live at the beginning of 2021 with a wide range of new features, including the creation of comprehensive country profiles, and has been further expanding since. These profiles provide SPH Portal users with data and analysis for each country, covering risks and hazards, country capacity, national plans, as well as the donor and partner resource landscape in the country.

The SPH Portal provides data and analysis on national, regional and global IHR monitoring and evaluation frameworks for health security capacities, actions and activities, as well as on the different needs and gaps in 19 distinct technical areas. The SPH Portal facilitates the sharing and exchanging of information on health security investments and activities, and on the IHR monitoring and evaluation framework on a national, regional and global scale, while also enhancing COVID-19 preparedness.

The number of investments and activities tracked through the SPH Portal is constantly growing. This visualization of the global partner and donor landscape facilitates the alignment and harmonization of stakeholder initiatives to accelerate implementation of the IHR. Globally, the resource landscape tracks and displays, as of 31 December 2021, 3452 different activities from 62 donors and partners for a total amount of disclosed contributions of over US$ 7.89 billion. The resource landscape also covers the Public Health Emergencies section which tracks and displays, as of 31 December 2021, 1004 different activities from 19 donors and partners globally.

The SPH Portal has multiple automatic direct connections with other WHO-approved portals/platforms and data sources, such as the WHO Global Health Observatory, State Party Self-Assessment Annual Reporting Tool, the WHO Health Emergency Dashboard and Partners Platform, etc. Data synchronization is performed daily through the application programming interface. Some WHO-approved applications extract data directly from the SPH Portal, such as the JEE toolkit and the IHR benchmarks. WHO is working on expanding the automations to display more information in the future.

Expansion of the SPH Portal continues in 2022, including the addition of new pages and features such as evidence for health security; IHR national focal point knowledge base; links to the WHO Health Emergency Dashboard and the Global Health Observatory; UHC; and the development of a global strategic preparedness network page in the Portal.



Box 24. Assessment of EPHFs in Bahamas

In an effort to respond to the COVID-19 pandemic, the national authorities in Bahamas advanced the assessment of EPHFs in the country with the completion of a situational analysis and an institutional mapping. The activities that took place included the following:

- A coordinating team was created composed of members of the Ministry of Health and Wellness, the Public Hospital Authority and the National Health Authority.
- A steering committee was also established and a kickoff meeting conducted presenting the highlights of the EPHF framework and methodology. An initial workplan with a timetable of all the phases was also presented.
- Two consultants and an administrative assistant were hired to advance in phase one.
- The coordinating team facilitated the technical work of the different activities and validated the information collected in this initial phase.
- A draft report of the situational analysis was presented to the coordinating team and several recommendations were given for clarification and completion of specific data.
- For the institutional mapping, great efforts were made to have ample participation of the key stakeholders who have direct or indirect interaction in the execution of each of the 11 functions.
- Focus groups were conducted for each of the functions with the participation of the experts in the various institutions. All focus group meetings were recorded and a rapporteur annotated the main discussion points.
- Additional interviews with some sectors/experts were needed to complement additional information for the situation analysis.
- An initial draft report for the institutional mapping was presented to the coordinating team, which provided recommendations for completion of the report.

Multi-Hazard Response Framework

In the **Region of the Americas**, in order to support countries to improve their preparedness capacity, the WHO Regional Office worked on the development of an online training course on the Multi-Hazard Response Framework. It aims to provide a reference framework for organization of the health sector at national and subnational levels, for the elaboration or updating of national emergency and disaster response plans, in the face of all hazards that may constitute a public health emergency, regardless of their origin, magnitude, intensity, or type of evolution. This instrument was developed through a collaborative process since the end of 2017 with experts from the Region of the Americas, through the bibliographic review of national response plans of the countries of the Region, and is aligned with the WHO Global Strategic Framework for Emergency Preparedness of 2017, as well as PAHO's Action Plan for Disaster Risk Reduction 2016–2021.

A key step in implementation of the Multi-Hazard Response Framework is the Strategic Tool for Assessing Risks (STAR), which is a comprehensive toolkit which enables countries and regions to conduct a strategic, rapid and evidence-based assessment of public health risks for planning and prioritization of health emergency and disaster risk management activities. The STAR outcomes and results can be used for planning and prioritization of key actions relating to the risks described through the assessment. The prioritization of hazards will allow rational and effective utilization of limited resources for strengthening health emergency and disaster risk management capacity, in the context of competing priorities (see Box 26).

In June 2021, a three-day remote training course on STAR was carried out for the **Caribbean subregion** with the participation of health disaster coordinators, PAHO health emergencies focal points, and country programme specialists, for a total of 40 participants from 18 countries and territories. This tool had already been implemented in 2019 and 2020 in **Chile**, **Dominican Republic**, **Guatemala**, **Nicaragua**, **Paraguay** and **Peru**.

Additionally, a training package for the Multi-Hazard Response Framework, risk assessment, and the Preparedness Index for Health Emergencies and Disasters was published, as well as a self-training course on the Framework. An in-person workshop was carried out on STAR and the Preparedness Index for Health Emergencies and Disasters methodologies in **Turks and Caicos**, as well as the development of country health sector risk assessment. A STAR training was also executed in Central America, and support to assess health risks in the health sector were provided for **Chile** and **Honduras**.

AARs and intra-action review

In the context of the COVID-19 pandemic, many countries were supported in several exercises as part of the IHR monitoring framework. For instance, in the **African Region**, to gauge performance across various response pillars, countries held intra-action review meetings to assess implementation of the COVID-19 response plan, including the identification of successes and challenges in implementation in order to develop more effective pandemic control mechanisms (see Box 27).

In **Bhutan**, the Minister of Health, with the collaborative support of WHO, conducted an intra-action review in February 2021. This review was not an evaluation of the country's response to the pandemic, but instead an opportunity for responders to review the work done and find areas of improvement and build a resilient health system for health security. A wide range of participants were ensured based on their involvement in the response to the COVID-19 pandemic. Similarly, the facilitators were selected based on their experience and depth of knowledge. The intra-action review helped the Ministry of Health to understand their challenges, identify gaps and come up with ways to move forward in strengthening COVID-19 response in the country. Key recommendations were made from the intra-action review to further reinforce emergency preparedness and response activities.

In the **Region of the Americas**, AARs were carried out to assess specific responses to COVID-19 or incidents that included COVID-19. These included the aftermath of hurricanes Eta and Iota during the first quarter of 2021; the emergency medical team response in **Costa Rica** for COVID-19; and three AARs in **Brazil** (for arenavirus, arboviruses and flooding). Additionally, the UHC-P provided guidance to implement COVID-19 intra-action reviews and to conduct periodic reviews of their national and subnational COVID-19 response. This new methodology has been developed to review the actions during a response, while the actions are ongoing, so as to be able to take timely corrective measures. Moreover, in **Belize**, it was agreed that there needs to be better collaboration when it comes to human, animal and environmental health. The UHC-P supported the creation of the One Health Committee through the development of contacts involving ministries and other potential members.

Box 25. Cambodia's Master Plan for COVID-19

Support has been delivered to strengthen three priority areas in Cambodia's Master Plan for COVID-19. This plan aims to: (i) strengthen local public health emergency preparedness and response capacity by improving public health, health care and community engagement systems; (ii) increase connectivity and coordination at all levels, and (iii) invest in ongoing performance improvement. Its vision is for all provinces to have a resilient and sustainable health security system for early detection and to be ready to respond to COVID-19 and other public health emergencies through collective responsibility. There are four objectives to achieve:

- To establish functioning Incident Management Teams and Emergency Operations Centres in each of the selected provinces, manage the provincial response to the emergency, and coordinate with non-health sectors, partners and the national Incident Management Support Team and the Emergency Operations Centre.
- To establish multi-source surveillance for assessing risk and informing decision-making on non-pharmaceutical interventions, response strategies and health-care resource mobilization in each of the selected provinces.
- To strengthen the capacity of rapid response teams in the selected provinces through field work.
- To learn from the experiences of the selected provinces and improve overall provincial detection, management, coordination and response to COVID-19 in Cambodia.

In the first phase of this effort, seven provinces (Kratie, Prey Veng, Svay Rieng, Kampot, Takeo, Kandal and Tbong Khmum) were prioritized because of their vulnerability – that is, their public health and clinical capacity, and their risk of transmission given known high-risk settings.

The funds supported the joint visit of the Minister of Health and WHO to the seven provinces, which facilitated dialogue with the provincial health directors, deputy directors and Rapid Response Team Chiefs to map out the existing health security system. These visits also identified challenges within the system in responding to the current COVID-19 outbreak, discussed the applicability and feasibility of international standards for health security systems in the provinces, and identified practical steps to addressing the challenges. The information obtained during these visits was used to organize workshops and webinars on Incident Management Systems and multi-source surveillance, and were conducted with focal points from each province. The joint visit provided on-the-ground coaching for these activities and additionally trained local administrators and security forces in case investigation and contact tracing to better integrate the non-health sector into the health security system.

Provincial health security systems were strengthened through the following core components: incident management; multi-source surveillance; rapid response; and integration of the non-health sector. Moreover, support was given to approaches that are expected to build sustainable health emergency capacities, targeted at provincial gaps and needs, which will result in long-term preparedness beyond COVID-19. The focus on incident management and on integrating the non-health sector contributes to governance, as it improves coordination and leadership to develop policies, strategies and plans, and their implementation monitoring. The third objective relates to the health workforce as they strengthen provincial workforce capacity to implement IHR core capacities and requirements – specifically, surveillance, national health emergency framework and points of entry. The focus on surveillance and rapid response teams contributes to health information, as it strengthens the collection, analysis, reporting and use of data available to monitor health security and UHC progress.

Box 26. Bangladesh conducts first strategic risk assessment workshop virtually in 2021

Thanks to the UHC-P, WHO developed the STAR toolkit, which was published in November 2021. STAR offers an easy-to-use approach to facilitate national, subnational, or local evidence-based assessments of public health risks for planning and prioritization of health emergency preparedness and disaster risk management strengthening. The STAR tool, which builds upon 75 in-country workshops conducted since 2016, supports countries to meet one of the core requirements under the IHR for risk assessment. The toolkit also facilitates progress towards national disaster risk reduction in line with the Sendai Framework for Disaster Risk Reduction. It has been conceptually designed so it can be adapted to national contexts as needed, and so that it can be used to focus on a subset of hazards based on country priorities. Accordingly, at the request of the Government, the STAR methodology was adapted to concentrate on strategically assessing the infectious hazards within the country.

In Bangladesh a first STAR workshop was organized in 2021 and resulted in the development of a country risk profile and the prioritization of key actions to enhance prevention and mitigation of identified risks. Held virtually across five days in May 2021 – with support from WHO and Bangladesh's Institute of Epidemiology, Disease Control and Research and National Influenza Centre – the workshop brought together epidemiologists and government representatives from the animal health sector, points of entry, aviation, animal husbandry, disaster management, climate change, communications, socioeconomics, academia, military, as well as partners from the World Bank to map infectious hazards with pandemic potential.

The results of the STAR workshop are expected to support national risk-based health emergency planning and continued prioritization of risk-informed actions to better prevent, mitigate, detect early, prepare for, be ready for, respond to and recover from a health emergency. Bangladesh is the first country within the South-East Asia Region to conduct the STAR exercise.

In 2021, WHO streamlined the STAR and its resulting country risk profile to be incorporated into existing emergency preparedness tools, including IHR-related tools. The usage of the country risk profile for an all-hazards risk-informed health emergency plan is now integrated into thve *States party self-assessment annual report*, second edition, under "C7.1 Planning for health emergencies".

In addition, WHO is collaborating with the global partnership, Capacity for Disaster Reduction Initiative, to further integrate the STAR tool and country risk profile.

Box 27. Ebola virus disease outbreak in Democratic Republic of the Congo: lessons learned and best practices

From May 2018 to December 2021, Democratic Republic of the Congo experienced four consecutive outbreaks of Ebola virus disease (EVD). Among these, the response to the EVD outbreak in North Kivu was particularly challenging due to it spreading in an active conflict zone, which ultimately resulted in 3470 cases and nearly 2300 deaths.

In order to capitalize on best practices, identify areas and actions for improvement, and promote individual and collective learning, an AAR was organized to ultimately strengthen cross-sectoral preparedness planning and future responses to health emergencies. The AAR conducted in the country used a comprehensive mixed method that included four phases: a desk and literature review, an online survey, key informant interviews, and focus group discussions. Below are some critical actions for improvement that were identified:

- Decentralize the coordination of emergency response operations at provincial levels; leverage and scale up existing subnational structures and resources.
- Adapt and harmonize the clinical trial procedures used in different provinces and build the local capacity of staff from the Ministry of Health to conduct trials.
- Develop guidelines for the mandatory inclusion of traditional healers in community-based monitoring of diseases.
- Reinforce cross-border disease surveillance with neighbouring countries.
- Strengthen the capabilities of provincial laboratories to rapidly deploy mobile laboratories into the field with genome sequencing.

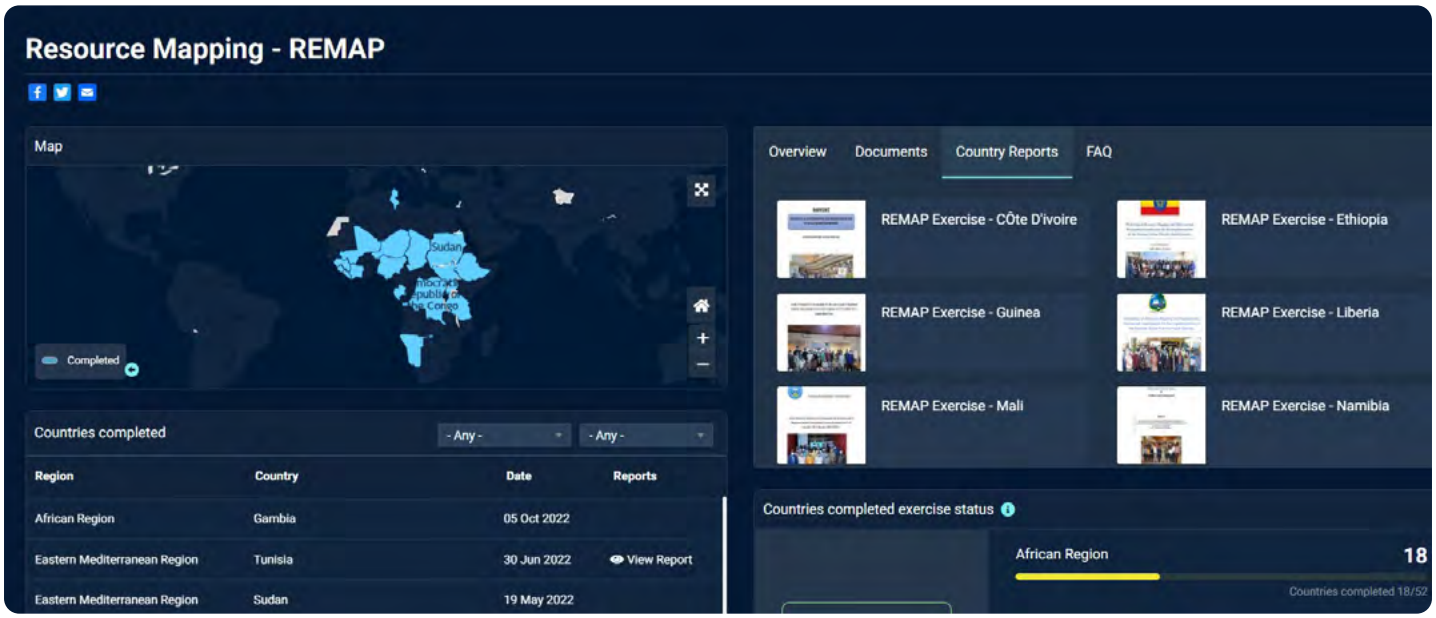
The AAR for Democratic Republic of the Congo helped to ensure quality improvement and the strengthening of preparedness and response systems based on learning that emerged from actions when responding to the three successive EVD outbreaks (9th–12th). The lessons learned were applied during the subsequent 13th EVD outbreak and the COVID-19 epidemic response.

Resource mapping

The WHO REMAP tool supports Member States, particularly low- and middle-income countries, in implementing their health security plans through the identification of financial and technical resources necessary to complete country priority actions. The process promotes dialogue between countries and partners based on data collected on country gaps and needs and partner activities and priorities, supports monitoring and evaluation of country plans, and promotes partnerships for health security. REMAP provided details of each health security activity mapped in countries, including the funding source, timeline, geographical location, nature of the activity, and which technical area (i.e. surveillance, laboratory, risk communications) is being supported.

This allowed the countries and partners to know what is being supported in the country and by whom, and what key technical and geographical areas are lacking support, identifying needs and gaps to inform decisions on resource allocation and re-allocation necessary to implement the country's health security plans. The development of a web-based version of the REMAP tool, which is currently in Excel, has also been supported through the UHC-P. The web-based version, planned for 2022 launch, will allow real-time access and enhanced visualizations.

Through the UHC-P, countries in the **African Region** (**Chad**, **Democratic Republic of the Congo**, **Gabon**, **Guinea**, **Liberia**, **Mali**, **Nigeria** and **South Sudan**) have been supported in resource mapping (using REMAP), which is based on multisectorality and inclusivity, for NAPHS implementation in 2021. The REMAP exercise in **Nigeria** in September 2021, for example, resulted in the mapping of more than US$ 384 million in health security investments from 46 partners and government organizations, with participation from 14 different ministries and government agencies in the mapping. REMAP in Nigeria revealed major investment gaps in areas such as immunization, laboratory, workforce development and reporting. In the **South-East Asia Region**, the UHC-P further supported an ongoing resource mapping exercise in 34 provinces in **Indonesia**. More than US$ 730 million was mapped in 2021 from over 80 partners.



To prevent high-threat health hazards, the UHC-P supports the research agenda for epidemiological surveillance, scale-up of prevention strategies and reinforcement of IPC measures. The COVID-19 pandemic has highlighted the critical need for whole-of-society and multisectoral approaches to health emergency preparedness and health security.

Many countries only embark on multisectoral coordination as a response to an ongoing health emergency. In most cases, this coordination is limited to a specific disease or hazard, does not involve all relevant sectors, and ceases once the emergency has subsided. This ad hoc approach to multisectoral coordination leaves countries vulnerable and ill-prepared for the next disease outbreak and other public health emergencies.

To break this panic-neglect cycle, WHO published the multisectoral preparedness coordination framework in 2020. It 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 by an expert group.

Implementation of prevention strategy

In the **Region of the Americas**, **Barbados** assessed three main points of entry (the Grantley Adams International Airport, the Bridgetown and Port Saint Charles Seaports) benefiting from technical assistance from the UHC-P. The assessment included a review of protocols and guidelines, and practices utilized by the environmental health department, including inspections, surveillance, communication and sanitation. A contingency plan was also developed with focus on the core capacity risks, gaps, development of compliance and verification of compliance.

In **Saint Vincent and the Grenadines**, the UHC-P supported preparation for the pandemic with proven prevention strategies. A webinar on stress management and psychological first aid was organized with front-line workers. This webinar was designed to equip non-specialists with the tools to appropriately provide the initial response to individuals experiencing psychological distress to crisis situations. The stress management webinars also assist front-line workers to address their own mental well-being whilst looking after others.

In the **African Region**, the UHC-P provided technical assistance to countries for implementing prevention strategies (see Box 28). For instance, all countries closed their airports to international travel in 2020 when the pandemic began, and closed land and sea borders, along with other lockdown measures such as limiting public transportation and banning mass gatherings for different durations. In 2021, measures to gradually open borders were implemented with requirements for COVID-19 testing. All countries also implemented screening measures and quarantine of incoming travelers based on country guidelines at the points of entry. Surveillance was intensified with screening of all passengers arriving from high-risk countries, before the first cases were reported in Africa. For most countries, once the first case was reported, call centres were established for reporting of suspected cases and to provide information on where to seek testing and/or treatment services. In addition, all countries closed schools to limit transmission of COVID-19 – most closed for a duration ranging from 19 days (Mauritius) to 610 days (Uganda) between 2020 and 2021. IPC measures were put in place before schools reopened.

The COVID-19 pandemic has highlighted the critical need for whole-of-society and multisectoral approaches to health security.

In the **Western Pacific Region**, the UHC-P provided guidance and support for preparedness to the COVID-19 pandemic. For instance, in **Mongolia**, technical support was provided to review the training materials developed in 2020 to align with WHO interim guide updates. WHO's updated guidelines on COVID-19 IPC have been translated into Mongolian and used to review training materials and national guidelines. In **Lao People's Democratic Republic**, WHO conducted training of trainers at the provincial level on safe delivery of essential health services according to IPC measures and COVID-19 clinical management for district hospitals. In addition, technical support was provided to the Centre for Communication and Education on Health through procurement of equipment for the knowledge, attitudes and perception surveys and social listening. This equipment also served for contact tracing and vaccination registration during outreach activities. In addition, the workforce of the Centre for Communication and Education on Health was also trained on data collection and analysis to improve risk communication, and to provide timely and accurate information on COVID-19 to the public and strengthen social listening by the Ministry of Health at central and subnational levels. In **Viet Nam**, risk communication capacities have been strengthened through the development of the Master Plan for Health Risk Communication, 2020–2025. This also included introduction and utilization of social listening for risk communication, and facilitation of coordinated routine communication activities.

In the **Eastern Mediterranean Region**, technical assistance was provided in **Egypt** to maintain essential health services during the pandemic and build capacities for preventive measures. Trainings were organized for PHC centres to manage manage patient flow; track continuity of maternal and child health services, sexual and reproductive health services, and NCD diagnosis and prevention; or to improve IPC measures in health facilities.

Box 28. Detecting and reporting diseases, conditions and events in Uganda

In 2000, Uganda adopted an integrated approach to detecting and reporting of priority diseases, conditions and events, including epidemic-prone diseases, using the IDSR strategy as recommended by WHO's Regional Office for the African Region. The IDSR is a strategy of choice that acts as an early warning system for detecting and reporting of priority diseases, conditions and events, as well as for responding to public health emergencies. In this strategy, health personnel at district, health subdistrict and health facility levels, together with the local communities, are mandated to identify, report and monitor the burden of priority diseases, conditions and events.

During the last decade, the scope of public health threats has expanded greatly with the emergence of new diseases like COVID-19, severe acute respiratory syndrome, pandemic influenza, EVD, nodding disease and others. Additionally, NCDs such as diabetes, hypertension and cancers have also increased considerably. Other public health hazards like floods, landslides, chemical and radio nuclear hazards have also increased in recent years. The IDSR strategy presents a cost-effective overall government strategy to prevent and respond to the numerous public health threats using local resources. The IDSR is also the implementation strategy that supports the country to achieve core capacity requirements as stipulated under IHR instruments.

Since its inception, the IDSR programme in Uganda has made landmark achievements in containing highly infectious disease outbreaks like Ebola and Marburg, as indicated by the 2004 and 2016 IDSR evaluations and the 2017 JEE assessment. The case fatality rates for diseases like cholera have been reduced from 6.8% in 2001 and 2.0% in 2009 to less than 1% in 2016. Over the same period, the completion for weekly disease surveillance reports increased from 49% to 85%. The proportion of outbreaks investigated within 48 hours of notification increased from below 10% in 2001 and 69% in 2009 to 82% in 2016. This successful performance attests to an efficient system for epidemic prevention and management.

Building on the gains made so far in the implementation of IDSR, Uganda adapted in 2021 the third edition of the IDSR guidelines to upgrade the existing standards of the national disease surveillance system. It seeks to sustain the gains and progress made towards achieving an efficient surveillance system. The revised guidelines strengthen disease detection, reporting and provision of real-time surveillance data using new technologies and platforms such as event-based disease surveillance, community-based surveillance, the One Health approach, cross-border surveillance and electronic IDSR, so as to improve disease surveillance in Uganda at all levels.

The country – through technical support from the UHC-P – developed a national roll-out phased plan to ensure countrywide dissemination of the IDSR. This plan builds on partner mobilization to ensure success. The national roll-out incorporates the national agenda for establishing the core capacity requirements for the IHR and Uganda's contribution to the global health security agenda, especially in containing the different public health events.

In addition, trainings were organized to contribute to the country's implementation of the third edition of the IDSR strategy in Uganda. Gathering 1095 health workers from 18 districts, they aimed at building the capacity of participants on prevention, early detection and prompt response to public health emergencies in the country.

IDSR training of trainers conducted in December 2021, Uganda. © WHO

Human-animal interface

Through the UHC-P, WHO continues to support the roll-out of the National Bridging Workshop (NBW) programme to assist countries in developing and implementing their NBW road maps and to accessing available tripartite tools and resources for improved coordination and One Health capacity in-country. Specifically, NBW catalysts have been hired in **Belize**, **Côte d'Ivoire**, **Ethiopia**, **Gambia**, **Liberia** and **Togo**. NBW catalysts and mentors are supported to work together through a community of practice to support One Health systems strengthening in countries. With this additional networking and training, NBW catalysts are aware of available tripartite tools and resources and can work with national partners to ensure strategic advancement of the NBW road maps.

WHO continues to support the development of operational tools to strengthen country implementation of principles and best practices associated with the Tripartite Zoonoses Guide. The UHC-P has supported the final development and implementation of the joint risk assessment operational tool and the multisectoral coordination mechanism operational tool. The joint risk assessment operational tool was published in December 2020 in all the United Nations languages and is readily available to countries with a host of supportive facilitation resources. The multisectoral coordination mechanism operational tool has been fully developed for piloting and includes important facilitation materials that are being modified after each iterative and developmental pilot. The most recent developmental pilot occurred in **Kenya**; forthcoming pilots are planned in **Gambia** and **Somalia**. Multisectoral support has also benefited **Lesotho** (see Box 29).

A strategic goal for the development of Tripartite Zoonoses Guide operational tools is to ensure that implementation at country level is possible with minimal tripartite oversight and support. By creating robust facilitation materials, including online training and step-by-step guides, operational tools will be readily picked up by countries. Working with the tripartite, the available operational tools will be included in a final Tripartite Zoonoses Guide Toolkit. Further training of NBW mentors and catalysts – as well as regional and national tripartite counterparts – on the resources available in the toolkit will ensure that countries can access operational tools that support implementation of the NBW road maps.

One Health is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystems.

Over the last two years, WHO has developed the response preparedness programme to support countries in developing their own intersectoral operational framework for the joint management of zoonotic disease outbreaks. The programme now includes three primary components: (1) an online learning package available on the Open WHO training platform; (2) a 3.5-day interactive national training workshop, and; (3) continued education through follow-up learning assignments.

The workshop primarily targets human and animal health sectors at national and subnational levels but may also include other actors involved in zoonotic outbreak response, such as the environment sector, financial sector or relevant NGOs, among others. Together, the participants define the roles of responsibility of each of the actors during the various phases of the development of a zoonotic disease outbreak, organize their approach to coordinate for optimal response, and identify critical gaps in their existing operational capacities. Using other resources than the UHC-P, part of the response preparedness programme was piloted in **Serbia** in December 2021, and there are multiple pilots planned in the second quarater of 2022.

Box 29. Technical assistance for health security in Lesotho

Lesotho greatly benefited from support from the UHC-P in several technical areas. First, using a multisectoral approach, the country was able to develop the first National Food Safety Policy and Country Strategic Development Plan with co-funding from the South African Development Community. A technical working team conceived the project, engaged an international consultant, coordinated consultations with stakeholders and participated in the validation of the two national documents. Second, with technical support from the WHO Regional Office for Africa, a multisectoral team from the One Health Ministries – including other priority ministries, institutions of higher learning and representation from media – conducted a risk assessment exercise using the WHO STAR. The exercise resulted in the reporting of 13 hazards in the country followed by the development of specific multi-hazard preparedness and contingency plans for each of these, which will thereafter be disseminated in the districts. Third, WHO developed and disseminated working tools and guides in the points of entry to strengthen preparedness and response to events that may occur at these locations. These included standard operating procedures for vector control programmes, development of public health emergency plans and generic guidelines for implementing port health services. These exercises also involved other sectors, especially those working on other issues at these points of entry.

Innovations for prevention

In the **African Region**, following the increasing legislation of mask wearing and sanitation as a measure to prevent infections coupled with low global availability of masks to meet the demand, African countries began local production of cloth and surgical masks and sanitizers to boost their availability and affordability. **Central African Republic**, **Eswatini**, **Gambia**, **Ghana**, **Kenya**, **Nigeria**, **Rwanda** and **Uganda** are some of the countries that continued local manufacture of reusable cloth masks in 2021 and also moved to producing disposable masks. **Rwanda** started to manufacture its own ventilation machines. In addition, countries such as **Comoros**, **Gabon**, **Ghana**, **Kenya**, **Liberia**, **Madagascar** and **Nigeria** expanded their laboratory capacity for COVID-19 testing by scaling up GeneXpert[27] testing and introduction of rapid antigen tests in 2021.

In order to reduce transmission and reduce severity of COVID-19 illness, vaccines were introduced in **Africa** between January and April 2021, with mass vaccination campaigns being carried out in most countries. With the support of the Partnership, countries have developed and updated their vaccine deployment plans to address challenges of distribution, improve access and mitigate vaccine hesitancy, which was widely experienced in many of the African countries.

In the **South-East Asia Region**, with the unprecedented surge of COVID-19 cases in the Region, some Member States requested technical assistance to develop country-specific models to guide the development of response strategies and plans, through generating forecasts of the key epidemiological and operational indicators under different scenarios and policy choices (e.g. introduction of variants of concern, public health measures and vaccination). Thanks to the UHC-P, the Regional Office has worked with two institutions (Monash University and James Cook University) to develop a model on forecasting of COVID-19 cases and to provide technical advice/capacity-building for **model development** in **Indonesia**, **Nepal** and **Sri Lanka**.

In **Sri Lanka**, the COVID-19 pandemic and subsequent economic challenges placed great strain on the country's health system capacity, especially at primary level. As such, during the reporting period the country benefited from support for close monitoring of the disruption of essential services and maintenance of curative services. Support included establishment and upgrading of designated COVID-19 units at tertiary/secondary/PHC-level hospitals throughout the country during the reporting period. The UHC-P also enabled the operationalization of the PHC/shared cluster approach, including through review of evidence in the context of significant economic crises.

In the **Western Pacific Region**, the UHC-P provided technical and financial support to set up a hotline to provide medical consultations and support timely referral to those under home isolation. Since it was set up the hotline has become a key platform to provide medical advice/consultation to COVID-19 patients for home-based cases. WHO provided technical support in improving environment cleaning and disinfection for non-health isolation facilities and quarantine facilities, and training at national and subnational levels.

COVID-19 vaccination of front-line workers in Sri Lanka. © WHO

2.3 Health emergencies rapidly detected and responded to

Following the COVID-19 pandemic, each WHO regional and country office has continued to prioritize health security preparedness, readiness and response by engaging and working in partnership with multisectoral partners to accelerate country readiness capacity. The COVID-19 pandemic brought about an unprecedented global health emergency. It has raised the awareness of Member States on investing in preparedness and readiness, and to have access to updated information and guidance on how to deal with the virus.

Joint incident management teams were set up to provide timely and tailored support to Member States, and to coordinate with partners' resources and assistance to contain and suppress the COVID-19 virus. This coordination included training and technical guidance on critical preparedness, readiness and response actions for COVID-19, working with government and community sectors to ensure that a whole-of-government, whole-of-society response is planned and implemented. Furthermore, the joint incident management teams engaged with countries to procure critical laboratory and medical supplies, communicate with the public and engage with communities on how to protect themselves and others, especially the vulnerable and those at highest risk.

Health emergency response centres

In the **African Region**, COVID-19 was first reported in **Nigeria** on 28 February 2020 and was in all African countries by 12 May. All countries put into place coordination mechanisms to implement the COVID-19 prevention and response plan. The WHO country offices coordinated partners to establish national and regional incident management teams in countries to support governments in effective COVID-19 response. The mechanisms in place not only served for COVID-19 response but have also enabled institutionalization of emergency response centres which are better equipped for response to any future emergencies/pandemics. Most countries activated a joint national COVID-19 task force comprising high-level multi-agency/ministerial officials to guide a coordinated response. This was the case in **Botswana**, **Eritrea**, **Ghana**, **Guinea-Bissau**, **Kenya**, **Liberia**, **Malawi**, **Mauritius**, **Namibia**, **Rwanda**, **Seychelles**, **Sierra Leone**, **South Sudan**, **Uganda**, **United Republic of Tanzania**, **Zambia** and **Zimbabwe**.

A PHEOC was activated in every country in **Africa** to coordinate the development of a costed national COVID-19 response plan and implementation of pandemic response activities on a day-to-day basis. Most of these PHEOCs had been established before the first reported COVID-19 case. The PHEOCs set up mechanisms to screen for COVID-19 at points of entry, and during quarantine and surveillance. PHEOCs were initially established at the national level but later decentralized with increasing cases at subnational levels.

The PHEOCs worked across all pillars to ensure a multi-pronged approach to COVID-19 pandemic prevention and response. Moreover, all countries instituted measures to ensure the continuity of essential health services, including: close monitoring of service utilization and coverage; developing guidelines to ensure continuity of essential health services; and supporting surge capacity staff to be able to manage COVID-19 cases while still being able to provide other essential services.

In the **South-East Asia Region**, human resources supported by the UHC-P carried out some background work to strengthen the regional Health Emergency Operations Centre (HEOC) and develop a training module for HEOCs and operational readiness. A simulation exercise involving the HEOC and operational readiness for relevant participants was also organized. In addition, discussions are progressing on revising the readiness checklist to adopt a more risk-based approach. It is planned for this checklist to be used to conduct country readiness assessments in priority countries once finalized. Efforts are being made to support HEOCs in Member States. In **Myanmar**, where United Nations policy restricts engagement with Myanmar governmental authorities, the ongoing and humanitarian challenge and policies for engagement made the planned UHC-P health system support challenging to deliver (see Box 30).

In the **Eastern Mediterranean Region**, in **Djibouti**, the UHC-P collaborated with UK-Med to deploy an emergency team on the request of the Ministry of Health from June to September 2021 to support the ongoing COVID-19 pandemic response. Specifically, the team provided trainings and capacity-building for case management, IPC, intensive care nursing and medical staff interventions, and biomedical support. A total of 162 doctors and nurses have been trained on case management, oxygen therapy, non-invasive ventilation, mechanical ventilation, cardiopulmonary resuscitation, basic life support, advanced cardiac life support and COVID-19 vaccines administration. Furthermore, **Morocco** was supported to build emergency capacity for 26 health managers through a training conducted by Montreal University, and in **Papua New Guinea**, a training was conducted for the first formal rapid response team (RRT) in the country (see Box 31).

COVID-19 front-line health workers in Papua New Guinea. © WHO / Ren Taukarai

Box 30. Delivering essential health services in Myanmar

The humanitarian situation in Myanmar is concerning. Since the beginning of 2021, at least 1900 people have been reported as murdered by the army, 1 million people are internally displaced and 14 million people urgently need humanitarian assistance. Moreover, hundreds of thousands of Rohingyas were forced to flee to Bangladesh in 2017. As the United Nations is restricting engagement with Myanmar governmental authorities, delivering support to strengthen the health system is very challenging. However, the UHC-P managed to deliver life-saving essential services to over 4000 beneficiaries through engagement of the private sector and professional associations. Medical supplies and operational costs for delivery of life-saving interventions have been supported to reach over 300 000 people. In addition, the UHC-P was able to support a campaign in Myanmar for improvement of community and provider knowledge on patient safety and quality of care during the COVID-19 pandemic, despite the ongoing humanitarian challenge.

Box 31. Rapid response team in Papua New Guinea

The first formal RRT training in Papua New Guinea was conducted for the National Capital District and the national RRT in November 2019, and was a five-day, in-person multidisciplinary training. The plan had been to expand and build the rapid response capacity to address public health events at subnational levels across the country, but this plan was disrupted in 2020 due to the onset of the COVID-19 pandemic. The pandemic itself highlighted the urgent need for this capacity. To navigate between the demands of establishing RRT training and providing technical support during the ongoing pandemic, the team – with support from partners – developed an interactive virtual training package and a modified two-day on-site training package to build RRT capacity for immediate and longer-term impact in the country.

The first virtual RRT training was rolled out in the country to Oro Province and was well received by the Oro provincial RRT; a follow-up on-site visit was also organized. The two-day, modified on-site trainings were piloted and rolled out to five provinces: Autonomous Region of Bougainville, Gulf, Manus, Western Highlands, and West New Britain provinces. The training was well received and found to be extremely useful and appropriate for the health workers and the provincial incident management team. Training was conducted for six provincial RRTs, supported under this funding to build capacities of the health workforce to prepare, prevent, detect and respond to health emergencies.

As of November 2021, the country has at least 80 skilled workforce and eight provincial RRTs for COVID-19 and future emergency response. The RRTs are supporting COVID-19 interaction reviews to share experiences and strengthen the ongoing response. Planning is already underway to conduct follow-up on-site visits to the six pilot provinces, followed by rolling out of the two-day modified on-site RRT training to five additional provinces by June 2022.

Rapid response team (RRT) training at Manus Province, Papua New Guinea.
© WHO

Public health and social measures

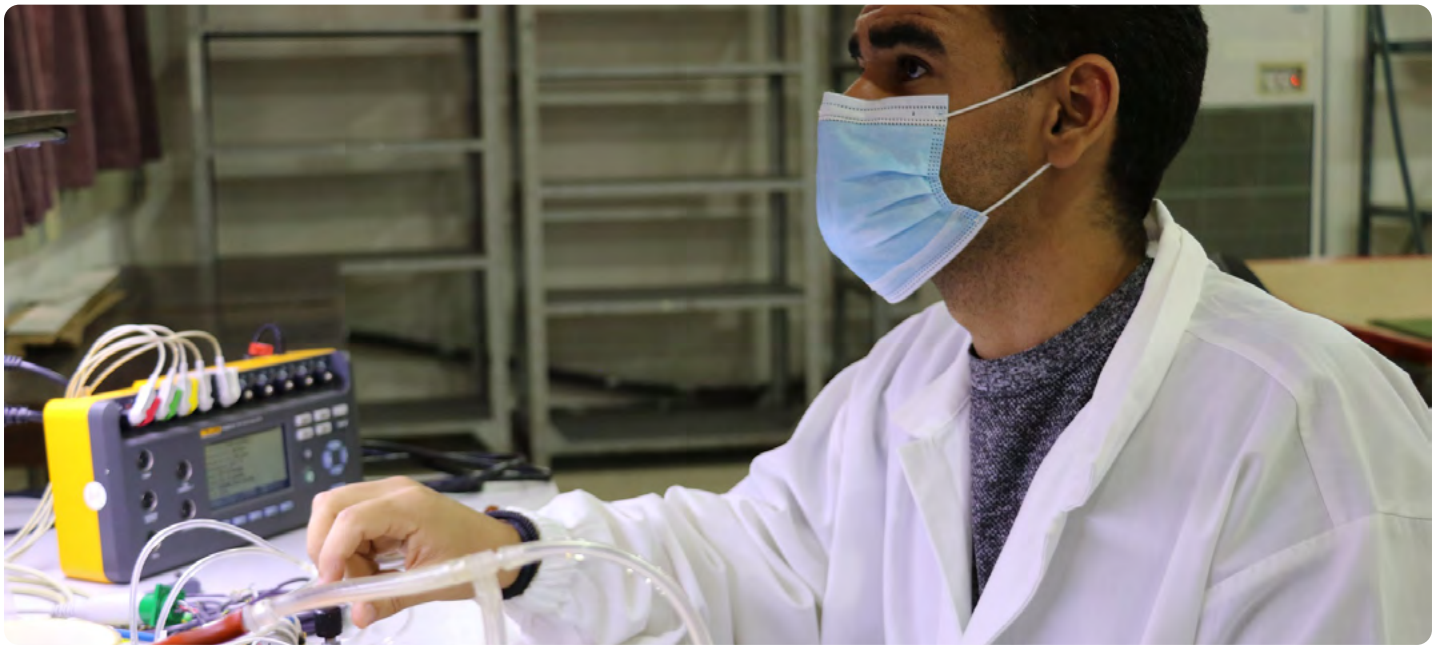
The evolving COVID-19 pandemic situation demanded that control of COVID-19 transmission through public health and social measures (PHSM) be balanced with their associated socioeconomic costs. To inform this issue, in-depth analysis of PHSM implementation is considered highly useful for understanding the enablers and barriers to compliance, the potential extent of effectiveness and lessons learned.

In the **South-East Asia Region**, the Regional Office worked with the Tata Institute of Fundamental Research to analyse the potential impact of PHSM on transmission and mortality in **Mumbai (Maharashtra, India)** and synthesize lessons learned to inform future policy decisions. Several rounds of technical discussions were conducted on the potential role of variants in the surge of cases in Mumbai and/or whether the relaxation of PHSM could explain the severe upsurge of cases; the discussions included some projections on case incidence, effective reproduction number, re-infections, etc. The project has helped to inform policy measures to reduce transmission of the virus and formulate appropriate recommendations, particularly in terms of adjusting PHSM. In addition, a consultant was recruited to work on the PHSM regional dashboard and conduct regional epidemiological analysis of the COVID-19 pandemic.

In the **Region of the Americas**, the UHC-P has continuously supported countries to ensure that COVID-19 risk mitigation measures are in place, including advice for travelers on the self-monitoring of signs and symptoms; surveillance and case management at points of entry and across borders; capacities and procedures for international contact tracing; and environmental controls and public health and social measures at points of entry and onboard conveyances.

In the **Region of the Americas**, the Regional Office activated its technical teams with the support of the Partnership before the pandemic hit the Region in early 2020. The Regional Office continued to strengthen its information systems, such as the SISMED911 – a medical emergency information system to respond to inter-hospital and pre-hospital medical emergencies. In **Cuba**, technical support was provided to the reorganization and expansion of hospital services in response to COVID-19, and to strengthen the first level of care in the management of the pandemic. In **Barbados**, a two-day multi-stakeholder workshop was held to discuss and plan the most efficient and effective use of resources for an optimal response to the pandemic. Several areas involved in the response (surveillance at points of entry, contact tracing, quarantine measures, mobile testing in communities, availability of personal protective equipment, workforce, vaccination programme and risk communication) were examined, and deficiencies and solutions discussed.

In **Suriname**, technical assistance was provided to the Minister of Health with a special focus on mental health and psychosocial support (MHPSS) during the COVID-19 pandemic. This reflected a pivot away from the development of a surveillance system for mental health indicators to a more pressing need in response to the critical mental health needs of health workers on the front lines of the pandemic. A workplan was developed with the Minister of Health consisting of activities supporting the improvement of the mental health and psychosocial well-being of people affected by the global COVID-19 pandemic. Technical assistance was provided to the Mental Health Department during execution of the MHPSS plan, which included the development of folders for health workers on ways to manage stress, and a series of four live television programmes discussing how people can cope with changes due to the pandemic. Furthermore, technical assistance was given to the Minister of Health in adapting, promoting and organizing an online training on psychosocial support during COVID-19; 189 persons participated, of whom 91 took the final exam and 90 passed.



A health worker in Cuba during the COVID-19 pandemic. WHO / PAHO. © WHO

3. Promoting healthier populations

1 billion more people enjoying better health and well-being

Notable results for the third billion in 2021

Multisectoral action to **address the burden of NCDs** was supported in eight countries, with an additional five countries specifically addressing cervical cancer.

The UHC-P supported **capacity-building** on prevention and management of NCDs in 29 countries.

Eleven countries also focused on **strengthening prevention and management of NCDs** through developing policies, strategies and guidelines.

The UHC-P supported nine countries in the elaboration and **adoption of bills, legislation and tax modelling** related to tobacco, alcohol and sugar-sweetened beverages (SSBs).

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 an individual's control, the UHC-P is committed to supporting Member States to address determinants of health, promote multisectoral actions to reduce risk factors, and prioritize health in all policies and healthy settings.

Indeed, promoting healthier populations requires collective action to understand and fight the health inequities that exist 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 fundamentally linked to their states of health, actions are entailed outside the health sector through inter-ministerial and intergovernmental collaboration and coordination. Following the Alma Ata and Astana Declarations, the UHC-P supports the PHC approach to achieve health for all in the spirit of social justice, emphasizes health as a human right, and advocates for community decision-making in the provision of care.

Whether people are healthy or not is determined by their life conditions. 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 that requires 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, requiring a well-coordinated multisectoral response for their effective control.

For example, in 2021, the UHC-P supported the Ministry of Health of **Cuba** to develop and print infographics on risk management, people with disability and tobacco control. In addition, it also included documents on the management of NCDs aimed at family doctor and nurse offices, with an emphasis on care of people with diabetes during the COVID-19 pandemic, and in isolation centres specifically in Matanzas Province. Similarly in **Saint Kitts and Nevis**, with the onset of the COVID-19 pandemic and the subsequent decrease in access to NCD services, the country explored innovative ways to support control of blood pressure and sugar levels in patients with chronic diseases. A needs assessment was conducted to inform the development of the mobile hypertension campaign messages to mitigate against the modifiable risk factors for patients with chronic diseases. And in **Fiji**, WHO worked in partnership with the United Nations Development Programme to support multisectoral action on NCDs. This included an NCD legal and policy analysis as well as a budget analysis to support the development of the new NCD Strategic Plan (2022–2030).

In **Barbados**, a national multisectoral school nutrition policy was developed after multiple consultations with the technical experts group. The policy focuses on healthy eating and adequate physical activity, and was accompanied by a mass media campaign for World No Tobacco Day implemented nationwide. Similarly, in the **Western Pacific Region**, the Health Promoting Schools initiative was strengthened and scaled in **Fiji** and **Tonga** to include more schools and more students; in **Tonga**, early childhood education centres were added to the Health Promoting Schools initiative to have a positive impact on children at even younger ages.

Beyond fighting diseases, the UHC-P works to ensure healthy lives and promote well-being for all at all ages, leaving no one behind.

In **Guyana**, the UHC-P supported the development of a national cancer control programme with participation of key stakeholders. This process has allowed for stakeholder involvement and ownership for cancer prevention and control, recognizing that the development of an effective prevention and control programme require linkages and partnerships with sectors other than health. In **Suriname**, the UHC-P via PAHO provided technical assistance to the drafting and completion of the National Cancer Plan. During a process of evaluating the previous cervical cancer plan, the analysis and review of background documents, reference material, previous programme plans, lessons learned, as well as the most recent data and trends and consultations with stakeholders led to development of a cervical cancer plan which was drafted, reviewed and approved for implementation. **Nigeria** was supported to strengthen

primary health centres to screen and treat NCDs, including cervical cancer, using the WHO Package of Essential NCD Interventions (PEN), and also to provide integrated care of older persons. **Nigeria** also strengthened primary health centres to deliver services for NCDs and mental health; over 5000 women in 20 primary health centres were screened and treated in two states (Kebbi and Niger). The country also phased in implementation of the PEN, focusing on hypertension in 12 primary health centres in the Federal Capital Territory, and another 24 centres in Kana and Ogun States.

In the **Western Pacific Region**, the cervical cancer elimination initiative showed progress in 2021 through UHC-P-supported technical assistance in developing cancer control policies for **Kiribati**, implementing standards of practice in **Federated States of Micronesia**, and supporting cancer screening in **Tuvalu**. A UHC-P-supported situation analysis for cancer control was completed in **Fiji** and **Solomon Islands**, while the national plan for cancer control was finalized in **Cook Islands**. In addition, the UHC-P is supporting implementation of the mental health package in **Pacific island countries and territories** (see Box 32).

The **Eastern Mediterranean Region** countries that were especially active in tackling the prevention and control of NCDs were **Iraq, Islamic Republic of Iran** and **Sudan** (see Box 33). In **Iraq**, NCD care has been introduced as an integral part of PHC services and the PEN includes screening and essential care for hypertension and diabetes, cardiovascular risk prediction, and detection of chronic respiratory diseases. WHO supported building capacity of 72 physicians from all over **Iraq** on the updated national guidelines for the management of hypertension, diabetes, asthma and chronic obstructive pulmonary disease based on international evidence and WHO guidelines and protocols, including PEN and HEARTS. Strengthening and expansion of essential NCD care packages will eventually enable the country to reduce premature mortality attributed to these diseases.

Box 32. SIDS Summit for Health: For a healthy and resilient future in Small Island Developing States

In June 2021, WHO hosted the SIDS Summit for Health: For a healthy and resilient future in Small Island Developing States. The Summit was organized because Small Island Developing States (SIDS) face unprecedented health challenges, including the impacts of climate change such as natural disasters; the ongoing COVID-19 pandemic and its severe economic and social repercussion; and the high prevalence of NCDs with economic and social determinants.

The UHC-P is a strong supporter of **SIDS**. For instance, Member States that are **Pacific island countries and territories** have taken the opportunity of the COVID-19 pandemic to strengthen mental health provisions in PHC. The WHO Mental Health Gap Action Programme (mhGAP) helped to strengthen the diagnosis and management of mental illness in **Cook Islands**, **Kiribati**, **Marshall Islands** and **Nauru**, and a mental health assessment has been incorporated into NCD assessment tools in **Solomon Islands**. To strengthen the identification, basic management and referral of people with mental illness, WHO also supported the adaptation of the Basic Psychosocial Skills Guide for COVID-19 Responders across Pacific island countries and territories.

Further, in **Fiji**, **Kiribati** and **Marshall Islands** communication materials on stress management strategies and referral routes have been disseminated to strengthen community identification and basic self-management of mental health. In **Mauritius**, several activities have been supported by the UHC-P to ensure an evidence-based and inclusive policy-making process in the country, especially in terms of NCDs and health financing. These include the revision of the National Health Strategy, the establishment of NHAs to monitor health system performances, the sharing of good practices and lessons learned on monitoring and detecting NCDs, and the creation of a National Health Assembly to institute an inclusive and participatory societal dialogue.

Box 33. The “Be Healthy Be Mobile” programme in Sudan

In **Sudan**, the “Be Healthy Be Mobile” programme, comprising a virtual consultation initiative, was initiated to ensure continuity of NCD services during the COVID-19 pandemic. The programme also aimed to strengthen the role, effectiveness and reach of PHC as a gatekeeper to the health system. People living with NCDs can call from all states, and family doctors could respond even from their homes in different states. A business application on WhatsApp complemented the hotline to facilitate the exchange of prescriptions and laboratory investigations. This initiative is expected to change the face of health service delivery in **Sudan**, particularly during the ongoing COVID-19 emergency. The application also includes an automated interactive voice recorder to identify the patient’s geographical location and their chronic diseases, contributing to data collection of the NCD situation.

In the **African Region**, several countries also focused on strengthening prevention and management of NCDs at the policy and service delivery levels. The **South Africa** National NCD Prevention and Control Strategic Plan embraced a comprehensive approach, putting into context human rights, equity, UHC, integration, engagement with and empowerment of people and communities and the life-course approach, in line with WHO guidance. Guidelines were developed for the treatment of hypertension and diabetes at the PHC level, which are being used to improve access to screening, treatment and follow-up, as well as improving outcomes of treatment of hypertension. Moreover, guidelines for cancer prevention and management were developed and used, including for palliative care, and addressing all gaps, ranging from lack of diagnosis, misdiagnosis or delayed diagnosis, to obstacles to accessing care, abandonment of treatment, death from toxicity, and higher rates of relapse. **Mali** developed NCD prevention and management protocols at the community level, training 332 community health providers in seven health districts. **South Sudan** completed the review, update and validation of the new PEN guidelines and developed tools for primary and secondary care. Additionally, the review, update and validation of the COVID-19 case management guidelines were completed, and 25 participants took part in a training-of-trainers workshop on the revised guidelines. **Cabo Verde** finalized the pilot structures and supervision instruments for implementation of the PEN at the PHC level, and **Seychelles** introduced the Seychelles PEN in two health facilities, as well as the Diabetes Passport. In addition, WHO supported **Rwanda** to finalize the WHO approach to NCD risk factor surveillance, including survey protocol, tools and budget, as well as data quality monitoring, data analysis and reporting; 75 data collectors, supervisors and data managers were trained in this approach.

In **Mongolia**, capacity on prevention and management of NCDs (CVDs and diabetes) of health-care providers from 132 primary health centres of six provinces and one district was strengthened. This has had a positive impact, with the increased commitment of local province governors and their management teams to support local health-care providers through allocation of increased funds for the necessary infrastructure, logistics and medical supplies, thereby promoting the health and well-being of local citizens. WHO also provided capacity-building across various aspects of mental health and early detection and management of NCDs. These included capacity-building on the mhGAP and/or Basic Psychosocial Skills training in **Cook Islands**, **Kiribati**, **Marshall Islands**, **Nauru**, **Samoa**, **Solomon Islands** and **Tonga** (see Box 34). The training was also adapted for the Pacific islands, self-directed and online, resulting in over 500 COVID-19 responders being trained.

Technical assistance on implementation was also provided to various countries in the Pacific. These included support for the decentralization of NCD services in 280 health facilities across **Cook Islands**, **Fiji**, **Marshall Islands**, **Federated States of Micronesia** and **Tuvalu**, which helped to avoid disruption of NCD services during the pandemic and increase access to NCD services for patients in more remote geographic areas. Establishing telemedicine/teleconsultation access at the diabetes hub in Suva (**Fiji**) and in health centres in **Federated States of Micronesia** increased access to the PEN and oral health services.

In the **Western Pacific Region**, WHO provided technical assistance on mental health and NCDs across various countries, including strengthening mental health planning and policies in **Cook Islands**, **Fiji**, **Kiribati**, **Nauru**, **Tonga** and **Vanuatu**; and through planning workshops, policy reviews and/or drafting of plans, policies, or legislation. This resulted in an endorsed Mental Health Policy in **Vanuatu** (see Box 35). Interestingly, **Nigeria** also developed and adapted guidelines, policies, acts and regulations, and finalized the Mental Health Bill which was adopted by the Parliament in February 2021. In **South Africa**, capacity-building of medical officers and professional nurses in an integrated approach for the management of mental disorders in general health services was undertaken, as well as reducing the high volume of inappropriate referrals to specialized psychiatric hospitals. This was done in selected general health-care facilities designated to provide 72-hour assessments as stipulated in the Mental Health Care Act of 2002, as well as mental health units attached to general hospitals, by using the WHO mhGAP tool. This results in improved access to mental health care, a reduction in treatment gaps, as well as improved quality of mental health services.

Box 34. Support for mental health interventions and coordination in Caribbean countries

In a continued effort to provide support to countries within the subregion of the Caribbean in establishing a response to humanitarian emergencies such as socio-environmental disasters, and for MHPSS interventions and coordination, supervision training was successfully provided to 445 participants, including mental health professionals, social workers, educator-teachers, humanitarian workers and emergency experts from 14 countries in the Caribbean: **Bahamas**, **Barbados**, **Belize**, **Cuba**, **Dominica**, **Grenada**, **Guyana**, **Haiti**, **Jamaica**, **Saint Lucia**, **Saint Kitts and Nevis**, **Saint Vincent and the Grenadines**, **Suriname** and **Trinidad and Tobago**. This course – delivered from December 2020 to May 2021 – was followed by supervision support for the rest of the year. The supervisory sessions guided participants on how to establish, organize and facilitate MHPSS coordination and strengthen current adjunct applicable skills for use in complex humanitarian emergencies and relief operations, such as needs assessments, monitoring and evaluation, understanding the humanitarian context, and self-care.

Box 35. Strengthening mental health services in the Pacific during COVID-19 and beyond

Fact: Pacific island countries and territories are seizing the opportunity presented by the COVID-19 pandemic response to strengthen mental health coordination, governance, service provision and community mental health interventions.

Why it matters: The COVID-19 pandemic has generated mental health challenges among people across Pacific island countries and territories, and at the same time has caused disruption to mental health services, especially at community level.

Expected results: Through increased awareness and social capital, communities will have a better understanding of mental health, increased access to the mental health support and care they need, and improved health and well-being.

In practice: WHO has coordinated with a range of partners to support ministries of health across 21 Pacific island countries and territories in strengthening mental health services within PHC and the community.

mhGAP training in Kiribati. © WHO

In the **Region of the Americas**, the UHC-P supported the analysis to estimate the population at risk for severe COVID-19 due to underlying health conditions in 12 Caribbean countries. This analysis presents the distribution of the population with one underlying health condition and with multimorbidity (two or more conditions), by age and sex. The results were used for shielding strategies, vaccination planning and for the planning of NCD programmes, as persons living with NCDs were especially impacted by the pandemic. These data contributed to protecting the gains, preventing setbacks and fostering the progress reached in areas related to NCDs and their risk factors.

The UHC-P provided support for the extensive efforts to improve the quality of stroke care in **Kyrgyzstan**, resulting in implementation of the international register for quality of stroke care in hospitals, with other international scales which will be introduced to medical workers. For example, recommendations on reporting control of hypertension in PHC were included in checklists of the mandatory health insurance fund which are used for improved planning and purchasing of services. Also, streamlined standard operating procedures for nurses were developed and approved by the Ministry of Health, and more responsibilities were given to nurses to improve quality of care in the control of hypertension. A clinical audit on heart attack and stroke was conducted in all regions in the country.

At global level, the elaboration of WHO Public Health Goods for NCDs was also an important achievement (see Box 36).

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.[28] 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.[29] 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.[30]

Across the **Western Pacific Region**, efforts to address risk factors through health taxes and other legislative tools were supported by WHO. In **Papua New Guinea**, a Tobacco Control Regulation Bill was enacted by Parliament, which promotes healthy settings for a smoke-free environment. Alcohol tax modelling was completed in **Kiribati**, **Nauru**, **Palau** and **Tonga** to inform fiscal policy prioritization and advocacy for NCD prevention. In the same way, food tax modelling was also completed in **Kiribati**, **Nauru** and **Palau**. These tax modelling projects are driving policy development and will be used in discussions in an upcoming fiscal policy workshop demonstrating the value of proposed global tracking of taxes for alcohol and SSBs. Alcohol legislation was passed in **Vanuatu** to set blood alcohol limits for drunk driving; other alcohol control legislation to restrict marketing is drafted but still pending.

In accelerating the implementation of the WHO Framework Convention on Tobacco Control, **Botswana** enacted a comprehensive tobacco control law while **Côte d'Ivoire** adopted decrees on large graphic health warnings on tobacco packages, and both **Côte d'Ivoire** and **Togo** adopted track-and-trace systems for tobacco products. **Ethiopia** adopted a directive for the implementation of smoke-free environments; bans on tobacco advertising, promotion and sponsorship; tobacco packaging and labelling; tobacco product regulation; protection against tobacco industry interference; and tobacco-related licensing and sales. **Ghana** ratified the Protocol to Eliminate Illicit Trade in Tobacco Products, bringing the number of African Parties to the Protocol to 21. **Mauritania** implemented graphic health warnings covering 70% of the principal display areas.

Demonstrating how taxes are a disincentive while contributing to government revenue, **Cabo Verde** is allocating tobacco tax revenue to national health programmes, and **Madagascar** used the resources from earmarked tobacco tax revenues to build a national centre for tobacco cessation and treatment of tobacco dependence. With the built capacity of technical experts from **Benin**, **Cabo Verde**, **Cameroon**, **Ethiopia**, **Gambia** and **Togo**, tobacco tax policy and reform resulted in increases in government revenues. **Gabon**, **Guinea** and **Uganda** were supported by the UHC-P to implement tax and price measures on tobacco products while **Benin**, **Côte d'Ivoire** and **Gabon** were supported to introduce innovative and sustainable health financing mechanisms through the allocation of tobacco tax revenue for health.

The UHC-P supported **Dominica** in developing a mass media campaign to promote tobacco control legislation. The campaign was also developed and implemented to support the development, passage and implementation of the tobacco legislation currently being drafted. Once the legislation has been drafted and the supportive regulations are finalized, it is expected that its implementation will result in the creation of healthy public spaces. In **Grenada**, PAHO provided technical assistance in the development of a mass media campaign to support the implementation of smoke-free legislation and child nutrition policies. In **Antigua and Barbuda**, a smoke-free campaign targeting young and older adults was implemented on World No Tobacco Day. The smoke-free campaign specifically targeted key youth and adult populations in the community who are more at risk of tobacco use. The campaign was designed to support the development, passage and implementation of tobacco regulations. In **Bahamas**, public service announcements about tobacco pollution and smoking cessation began to be developed and are expected to be disseminated in 2022.

With the support of the UHC-P, in 2021, **Suriname** began a process of designing and implementing a tobacco cessation programme. Upon completion of the tobacco cessation strategy in the first half of 2021, the Ministry of Health began working with the tobacco cessation framework to expand their tobacco cessation programme. **Liberia** discussed implementation of the WHO Framework Convention on Tobacco Control and incorporated this into its draft policy and strategy on tobacco control.

During the height of the COVID-19 pandemic, changes in policies and regulations on alcohol occurred in some countries, which are currently being assessed. **Liberia**, **Rwanda** and **Sao Tome and Principe** were supported to develop policies to reduce the harmful use of alcohol in line with the SAFER technical package. The technical package for SAFER focuses on five key alcohol policy interventions that are based on accumulated evidence of their impact on population health and their cost-effectiveness. **Uganda** was also supported towards the development of a multi-agency and multisectoral road map for implementation of prioritized SAFER interventions, including availability, screening, brief intervention and treatment intervention areas.

Double burden of malnutrition

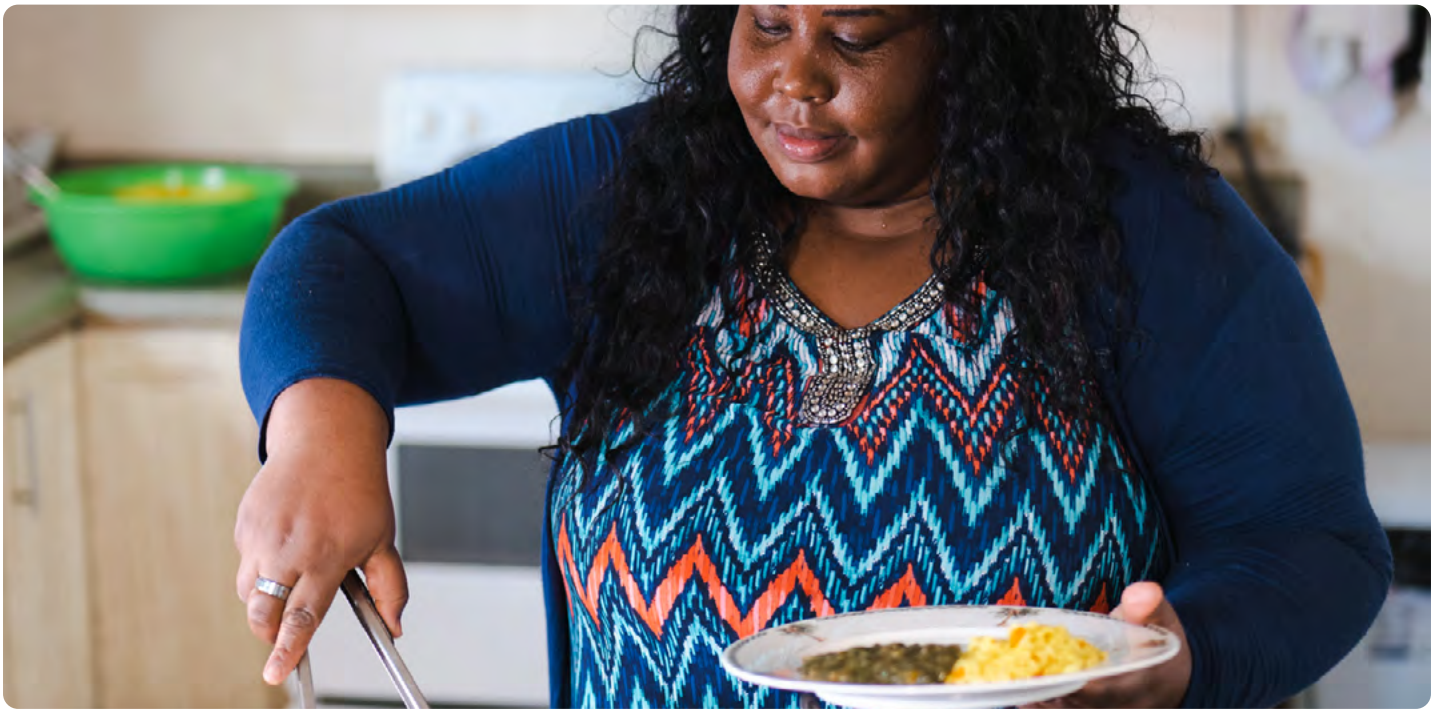
Obesity and undernutrition are two sides of the double burden of malnutrition, and today more people are obese than underweight in every region except sub-Saharan Africa and Asia.[31] Once considered a problem only in high-income countries, overweight and obesity are now dramatically on the rise in low- and middle-income countries, particularly in urban settings. Worldwide, obesity has nearly tripled since 1975, affecting 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.

Antigua and Barbuda ran a SSB campaign using multiple platforms to target parents and children with the objective of increasing public awareness of the harms associated with excessive consumption of SSBs. This included building public support and encouraging policy-makers to implement a ban on SSBs in schools and restriction of marketing to children, as well as implementation of a tax on sugary drinks. The campaign was developed to support the development and implementation of the SSB taxation policy. Similarly, **Madagascar** is supported to develop and implement a fiscal policy for SSBs as a best-buy measure for NCD risk factor reduction.

Kenya, **Uganda** and **United Republic of Tanzania** are supported to adopt and implement food labelling standards and nutrient profile models to promote healthy diets in the East African community through the global regulatory and fiscal policy adoption project. **United Republic of Tanzania** was supported to design and implement a survey on assessing the behaviour of schoolchildren towards reading food labels and the influence of food marketing on purchasing power.

Côte d'Ivoire and **South Sudan** were supported to raise awareness on the harmful effects of unhealthy diets and the benefits of consuming healthy diets among youth and schoolchildren, respectively. **South Sudan** is working towards building the capacity of women operating roadside restaurants on healthy diet consumption. In **Malaysia**, WHO supported a nationwide survey on salt content in street foods, which is the first phase of a salt reduction project funded by Resolve to Save Lives.

At global level, the WHO Department of Noncommunicable Diseases – in collaboration with the WHO Division of Access to Medicines and Health Products – has convened a series of biannual dialogues with the private sector (see Box 37).



Stevvalyn is making healthier food choices after taking a chronic disease self-management course, implemented by PAHO/WHO with the support of the UHC Partnership. © WHO / Alasdair Bell

Box 36. WHO public health goods for NCDs

WHO's guidance on the integration of NCDs

WHO's guidance on the integration of NCDs responds to the United Nations General Assembly Resolution 2018 and WHA69.24 resolution, on WHO's commitment to integrate NCD prevention and control into other programmes such as HIV and broader maternal and child health programmes, especially in PHC through a people-centred approach. The guidance outlines strategic actions and practical solutions in response to the challenges of integration of NCD services. The objective is to maximize the impact of health services and extend access to NCD care. The development of the guidance continued through 2021, and key concepts and recommendations have been presented through global and regional webinars and events. The guidance is expected to be launched in December 2022 with further work to apply the recommendations in countries and support for implementation research projects.

UHC benefit package

No country can afford to deliver the whole list of health services to the entire population. Priority-setting is inevitable, and shifting from an ad hoc implicit rationing of services to a systematic, evidence-based and transparent priority-setting can substantially improve health outcomes and increase access to high-quality critical services for NCDs and accelerate progress towards achieving SDG target 3.4. In response to demand by WHO Member States, a Strategic Dialogue on Strengthening NCD Services through UHC Benefit Package was held from 14 to 15 July 2020, at which there was a consensus that countries needed further guidance on how to ensure NCD services are prioritized in the national UHC benefit package.

A guidance document was prepared through multiple meetings of a Technical Working Group comprising experts on NCD, health systems, economics, policy specialists and clinical doctors across all levels of the Organization. The document provides step-by-step guidance on priority-setting and health benefit package design focusing on NCDs. Countries can use this as a reference when preparing a road map to revise their health benefit package, and it is vital for NCD programme managers in low- and middle-income countries. In addition, this document is an essential guide for technical officers, advisors and policy-makers at the health ministries working on health benefit packages or essential health service package preparation.

Box 37. Private sector dialogues at global level

Dialogues with the private sector were held in the context of supporting the commitments made in the United Nations Political Declarations on the Prevention and Control of NCDs in 2011, 2014 and 2018, as well as the implementation of World Health Assembly Resolution 74.4 (WHA74.4), adopted in May 2021. The Resolution marked a historic milestone in the world's collective efforts to address the global diabetes epidemic and urged Member States to raise the priority given to prevention, diagnosis and control of diabetes, as well as the prevention and management of risk factors such as obesity.

Two WHO dialogues with the private sector were held in February and September 2021 and focused on access to insulin and its associated health technologies for diabetes. Planned follow-up dialogues with the private sector will also occur in other NCD disease areas, including hypertension, cancer, respiratory diseases, oral health, rehabilitation, sensory impairments and disability.

The dialogues aim to define meaningful and effective contributions by the pharmaceutical and health technology industries to the implementation of national responses for the prevention, management and control of NCDs and the attainment of related SDGs and UHC.

The WHO Secretariat plans to continue private sector engagement towards strengthening the collaboration between stakeholders, including non-State actors as appropriate and in accordance with WHO policies. This is particularly the case for the development of contributions and commitments by relevant private sector entities to WHO appeals for improving access to medicines and associated health technologies for people living with NCDs.

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. Underlying these is the importance of good governance and multisectoral, multi-stakeholder engagement.

Cameroon, for example, is being supported to implement the Good Urban Governance for Health and Well-being initiative in Douala, in collaboration with the Swiss Development Cooperation and WHO headquarters. The aim of the initiative is to enhance good governance, health and well-being through multisectoral and multi-stakeholder engagement. The project has resulted in the following key achievements:

- Six local municipalities in Douala have developed institutional and policy frameworks on good urban governance for health and well-being.
- Stakeholder mapping was conducted on promotion of urban governance and city profiling was supported through the engagement of local academic institutions to guide implementation.
- Approximately 300 stakeholders – including local leaders and communities – have been sensitized on addressing health and well-being challenges and a follow-up will be done to support implementation and documentation of lessons learned.

Health in All policies

UHC-P-supported countries were enabled to adopt, review and revise laws, regulations and policies to create an enabling environment for healthy cities and villages, housing, schools and workplaces.

In the **African Region**, WHO in collaboration with the University of Pretoria supported development of Health in All policies curriculum for public health and health economics students. The modules have been implemented in partnering universities in **Benin**, **Namibia**, **Sudan** and **Zambia**. Evaluation on progress made and lessons learned is being conducted.

Zambia was supported to strengthen the use of a multisectoral approach and Health in All policies during COVID-19 response. Using a multisectoral approach, other sectors and partners mobilized financial and human resources to support implementation. The country successfully applied a healthy settings approach during the pandemic in schools, prisons, markets, refugee camps, hospitals, villages and cities to engage and forge partnerships across different sectors. Under the leadership of WHO, the multisectoral committee on Health in All policies advocated for implementation of a multisectoral approach.

Ethiopia, **Ghana**, **Kenya** and **United Republic of Tanzania** received technical support to finalize and revise their national Health in All policies framework to address social determinants of health at national and subnational levels.

Walk The Talk: the Health For All Challenge event in Geneva.
© WHO / Peter Willet

A child is weighed as part of a screening for malnutrition in North Darfur, Sudan. © WHO / Lindsay Mackenzie

4. More effective and efficient WHO providing better support to countries

Notable results in data, innovation and health information systems support in 2021

Civil registration and vital statistics (CRVS) systems were supported by the UHC-P in 10 countries.

Fifteen countries were supported to set up or strengthen use of their **National Health Observatories** and also validate and update data to feed into the **Integrated African Health Observatory** (iAHO).

More than 18 countries were supported in strengthening their use of **digital health information platforms**, including at the district level.

WHO supported the **Healthy Island Monitoring Framework** final report to map the data availabilities and sources for each of 48 indicators among 22 Pacific island countries and territories, and provided concrete recommendations to support the long-term goal of improving essential monitoring whilst reducing the countries' reporting burden.

Country information profiles were developed by compiling data from different data sources for tracking changes in SDG and UHC situations in countries and conducting country-focused SDG/UHC analyses in over 27 countries.

UHC-P support has demonstrated that factors contributing to success in 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 high research capacity in some 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 receiving the services they need and where resources are being allocated. 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

In the **Region of the Americas**, **Bahamas** was supported in increasing tele-health and health information management capacities at the PHC level (see Box 38) and **Suriname** implemented a web-based patient management information system in 30 clinics that cover the rural hinterlands. Through the UHC-P, support was provided to the medical mission – a faith-based NGO providing health services to persons in hard-to-reach areas in the country – to train health workers in the use of a new web-based patient management information system. Training health workers to directly input patient data into the web-based system and utilize this data for decision-making on cases has had significant impact on the way patients are managed in the hinterlands. Additionally, case files can be retrieved at the headquarters in the capital, Paramaribo, for specialist consultation and to facilitate remote consultations where necessary.

In the **Eastern Mediterranean Region**, a number of countries have undergone comprehensive reviews, development and strengthening of their health information systems and digital health architecture, including **Afghanistan**, **Egypt**, **Iraq**, **Sudan** and **Tunisia** (see Box 39). For example, **Egypt** made strides in supporting health information system development and functional medical records, as well as establishment of electronic medical records. In **Sudan**, the UHC-P supported technical assistance in organizing the annual health information system meeting that focused on identifying specific bottlenecks and challenges using the outcomes of the national health information system assessment at the state level. With direct collaboration of the Central Bureau of Statistics, WHO supported Sudan's Multiple Indicator Cluster Surveys oversight and technical committees, which included UNICEF and the National Statistical Bureau.

Box 38. Health information system for PHC in Bahamas

Bahamas focused on improving its health information system by increasing its tele-health and health information management capacities at the PHC level for service delivery, monitoring of treatment compliance to achieve NCD disease control, disease surveillance, and monitoring of health service users and usage. The main activities in 2021 included:

- The Information Systems for Health (IS4H) road map was approved by the National Steering Committee and implementation was ongoing during 2021.
- A minimum data set was established and an initial report completed; preliminary indicators were identified and the indicator compendium includes a chapter on NCDs.
- The mortality backlog classification was completed with the support of contracted mortality coders.
- An IS4H maturity model assessment with recommendations has been finalized and presented to IS4H committees for comments. PAHO supported the assessment by providing technical advice for the implementation plan with a local information and communications technology lead consultant. The IS4H framework continues its implementation with the development of the medium-term IS4H Strategic Plan for the Bahamas.

Box 39. Comprehensive support to Iraq's health information system and data improvement

In **Iraq**, key steps have been taken to strengthen the national health information system at various levels, including generating required high-quality annual analytical reports on health sector progress and performance, and disaggregation of health-related SDG data. The use of IT in data collection, data storage and data analysis has increased and many professionals working in public hospitals were trained on the WHO International Classification of Diseases, 10th Revision (ICD-10), and were supported in conducting SCORE (Survey Count Optimize Review Enable) assessment and production of a SCORE report for Iraq. The SCORE guides countries to invest in areas that will have the greatest impact on data quality. It comes at a particularly important time as COVID-19 has created unprecedented demand for high-quality data and highlighted the need to address longstanding data gaps. WHO also supported capacity-building for 75 participants from the Federal Ministry of Health and the Erbil, Dahuk and Sulaymaniyah governorates on generation of quality data for informed decision-making and monitoring and evaluation. Participants were trained on the quantum geographic information system and standardization of national statistical forms for availability, reliability and quality of data. Iraq's PHC measurement and improvement (PHCMI) profile was completed; a list of 125 key indicators for PHC was updated and endorsed by the Ministry of Health to monitor progress and improvement in PHC services in the country in line with regional and global demand for reporting. A national committee was established to implement, monitor and follow up on the PHCMI project in line with the National Health Policy 2014–2023, the National Health Strategy 2018–2022, the GPW13 and SDGs. Furthermore, PHCMI Progression Model Assessment was completed; data collected and analysed from six governorates for 33 measures, followed by internal and external scoring. The next step is to support Iraq in developing a PHC improvement plan. The Ministry of Health is also regularly given technical support to produce a detailed and comprehensive annual statistical report of the health sector.

A mobile health clinic in Iraq. © WHO / Sebastian Meyer

In **Azerbaijan**, the UHC-P supported the introduction of an electronic PHC database and the electronic PHC record system using a specific web-based application.

In the **African Region**, health information systems strengthening activities were focused on routine District Health Information System (DHIS2) improvement and institutionalizing digital health platforms. There was focus on improving routine monitoring and reporting, strengthening disease surveillance and CRVS systems. Furthermore, health information strategies and plans were revised or developed to respond to emerging needs and priorities. For example, technical and financial support was provided for optimization of DHIS2 platforms in **Botswana** and **Cabo Verde**. **Lesotho** updated key elements of its national web-based data systems for the health sector, and both **Chad** and **Lesotho** strengthened staff capacity to use the DHIS2. Seven countries (**Burkina Faso**, **Burundi**, **Ethiopia**, **Guinea-Bissau**, **Rwanda**, **Seychelles** and **Uganda**) were supported to develop rehabilitation strategic plans and to integrate rehabilitation data into the DHIS2. **Burkina Faso** and **Ethiopia** have also integrated rehabilitation data into the DHIS2. **Madagascar** carried out supervision of health professionals on the IDSR and DHIS2 use, and validated the procedure manual for management of the DHIS2 data. **Ethiopia** conducted integrated supportive supervision for DHIS2 data reporting. **Malawi** conducted health facility–based annual data quality reviews in 135 out of 140 health facilities, with a focus on the data quality aspects of completeness, timeliness and validity, and addressing computation errors with transfer of data from paper to the electronic DHIS2 system. The UHC-P support to **Mauritius** enabled technical support for the data collection, analysis and reporting of aggregated data for the IDSR, the Expanded Programme of Immunization (EPI) and HIV/AIDS, hepatitis and TB in the DHIS2. This is a key milestone achieved for real-time surveillance from community level to central level. Staff working in EPI, HIV/AIDS, hepatitis and TB received training in data collection so they could become trainers and cascade this knowledge to their peers.

Several countries took steps towards strengthening use of digital health information platforms. The E-Health Strategy in **Namibia** was finalized and launched; the WHO Digital Health Platform was adopted, and the billing and dependent modules were piloted. **Guinea**, **Malawi**, **Nigeria** and **Uganda** developed health information and digital health strategies specific to their country's needs. In **Liberia**, NCD indicators were developed for inclusion in the DHIS2 platform, and 63 data officers from 15 counties were trained in DHIS2 use and data analysis. In **Timor-Leste**, the UHC-P supported technical assistance for comprehensive DHIS2 strengthening and supported the development of the Digital Health Strategy.

The UHC-P supports the development of strong integrated health information systems for evidence-based policy development.

All countries in the **African Region** were introduced to the harmonized tool and approach for facility assessment. With technical and financial support from WHO, **Burkina Faso**, **Burundi**, **Democratic Republic of the Congo**, **Liberia**, **Rwanda**, **Uganda** and **Zambia** used the tools to assess the service availability and capacity in their health-care facilities. In the **Eastern Mediterranean Region**, **Pakistan** undertook a service availability and readiness assessment survey of its health facilities in four UHC demonstration districts (Kasur, Larkana, Kech, Charsadda) as well as in Azad Jammu Kashmir and Gilgit Baltistan. In the **Western Pacific Region**, the UHC-P supported **Lao People's Democratic Republic** in the development of its health facility master list alongside the standard operating procedures for its maintenance. Support was also provided to host this information online linked to the Ministry of Health website. Further, WHO also supported the compilation of an integrated village master list comprising the various existing village lists in the country, and supported the multi-agency dialogue to standardize the list.

In the **Western Pacific Region**, support was provided to strengthen national capacity in health information systems management. In **Papua New Guinea**, for example, WHO supported the development of the draft monitoring and evaluation framework and strategic plan for the National Health Plan 2021–2030, aligned with global and reporting commitments and SDG and UHC monitoring. WHO also supported capacity-building in health information management (see Box 40).

Support was also provided to countries in piloting and scaling digital health approaches and innovations, with the Western Pacific Regional Office providing three training workshops on digital health covering leadership, governance, legal frameworks, different tools and key technical areas to build country capacity in **Malaysia**, **Philippines** and **Pacific island countries and territories**. In addition, a digital maturity assessment was conducted through close engagement with governments and technical experts in the latter countries and territories. In **Viet Nam**, technical groups from the Ministry of Health and a national university convened to develop guidelines on telemedicine for PHC in the context of the COVID-19 pandemic, to ensure continued provision of essential services during the COVID-19 pandemic and beyond.

Box 40. Building capacity in health information management in Papua New Guinea

In **Papua New Guinea**, the UHC-P provided capacity-building support for a workshop, with participation of provincial health information officers (PHIOs) from all 22 provinces, programme managers at the National Department of Health (NDoH), and development partners to train and provide updates on issues related to recording, reporting and analysing data from national health information systems. For the first time, PHIOs were introduced to the concept of data quality review and undertook practical exercises in data visualization, data analysis and use of geographic information system methods. Discussions from the workshop helped to identify PHIOs' capacity-building needs and inform development of the Monitoring and Evaluation Strategy.

A key finding from the PHIO workshop was the need for an increased emphasis on data quality and training PHIOs on data quality verification methods. As a result, WHO assisted the NDoH to include data quality reviews during National Health Information System supervisory visits conducted at 40 health facilities in 10 provinces from October 2021 to February 2022. For the first time, NDoH staff used standard WHO tools and methods to review the data quality of five selected indicators routinely reported in the National Health Information System. The review found significant variation in data quality, with only one indicator reported accurately in over half of the 10 provinces visited. As a result of the systematic approach adopted, NDoH staff were able to identify clear actions for improving data quality and to initiate discussions with programmes – enhancing collaboration between programmes and health information staff on data-related issues.

4.2 Data and innovation

On the data front, the CRVS system in **Egypt** benefited from improved automation, validation and capacity-building, with technical and financial support from the UHC-P, and **Burkina Faso**, **Eritrea**, **Eswatini**, **Ethiopia** and **Mali** developed strategic plans for CRVS systems. **Kenya** reviewed the CRVS Business Process Mapping and identified areas for improvement. This has informed the development of a national CRVS electronic system. Rapid mortality surveillance was implemented in six counties to assess all-cause mortality patterns during the COVID-19 pandemic, quantify excess mortality due to COVID-19 and inform decision-makers about the full magnitude of the health consequences of COVID-19. Support covered design of the reporting system, data quality review, monitoring visits and national CRVS stakeholder forum, where the findings were disseminated. **Rwanda** scaled up use of its CRVS system. In **Viet Nam**, UHC-P support for a workshop to strengthen the CRVS systems will inform a pilot of WHO's verbal autopsy tool. In **India**, the UHC-P provided support for the development of an online tool for improving death audit and selection of cause of death.

In **Sudan**, the UHC-P supported the development and update of health indicators for the national census. The process will be continued until 2023 with direct support from the WHO Regional Office for Africa and WHO headquarters. The aim is to efficiently use the census to reflect agreed health indicators, assuring health is considered in the planning process as a priority, and using the results to develop the health system and improve quality of health while taking into account financial and demographic dynamics.

All countries in the **African Region** received training on medical certification and classification of cause of death; they developed road maps for implementation and roll-out of the tools and processes for medical certification of cause of death. An electronic tool for medical certification of cause of death developed by WHO was adopted by **Botswana**, **Burundi**, **Kenya**, **Mauritania** and **Uganda**. The tool is based on the 11th revision of the WHO International Classification of Diseases (ICD-11) and implemented within the DHIS2 framework. In addition, **Ghana** transitioned from ICD-10 to ICD-11 and aimed to scale up countrywide by early 2022.

In **Malaysia**, a series of training workshops to monitor health equity by using the WHO Health Equity Assessment Toolkit were held to help the Ministry of Health generate evidence to plan for targeted programming for the vulnerable. As a result, the Institute for Health Systems Research was able to report on health-related SDGs and UHC tracer indicators in a disaggregated manner to identify population subgroups in Malaysia experiencing more of a health burden. WHO supported the Healthy Island Monitoring Framework final report to map the data availabilities and sources for each of 48 indicators among 22 **Pacific island countries and territories**, and provided concrete recommendations to support the long-term goal of improving essential monitoring whilst reducing the reporting burden to the countries. To inform the regional SDG and UHC report, country-focused analyses were conducted in **China**, **Lao People's Democratic Republic**, **Philippines**, **Viet Nam** and **Pacific island countries and territories** to develop country information profiles through compiled data from different data sources for tracking changes in SDG and UHC situations in countries. Both the 2020 national health profile as well as the health equity profiles for five states were developed in **India** in 2021, along with the national SDG dashboard enhanced with district data.

Through UHC-P support, significant advancements were made in the establishment and strengthening of national health observatories in the **African Region**

(see Box 41). Based on their respective capacities and functions, these observatories can undertake public health surveillance, monitor health systems, and conduct specialized analyses of health policy–related matters, health-related warnings, policy-oriented advice, and health information and knowledge production and management.[32] Ultimately, they serve to capture and share information already existing among the varied specific information, surveillance and monitoring systems. Forty-one countries worked to complete an annual data verification and validation exercise, reviewing data and other published evidence (analytical and knowledge resources) on their national health observatories, contributing to enhanced transparency and reliability.

Box 41. National health observatories for more transparency and reliability

Several **African Region** countries were supported to set up or strengthen use of their national health observatories and also validate and update data to feed into the iAHO. **Burundi**, **Cabo Verde**, **Cameroon**, **Côte d'Ivoire**, **Guinea**, **Liberia**, **Mali**, **Namibia**, **Nigeria**, **Rwanda** and **South Africa** received technical and/or financial support to establish their national health observatories. This included training of staff on use of national health observatories in **Côte d'Ivoire**, **Namibia**, **Nigeria** and **Rwanda**; **Burundi** updated its national observatory database and organized a national advocacy workshop for the official establishment of the observatory and developed regulations on its operation. **Côte d'Ivoire** and **Mali** developed a national road map for the establishment of their respective national health observatories, while **Ghana** re-established its national health observatory. **Mozambique** trained 14 professionals from its national health observatory on the use of iAHO, with the WHO Regional Office for Africa providing technical assistance with three staff. Forty-one countries worked with the Regional Office to complete an annual data verification and validation exercise, reviewing data and other published evidence (analytical and knowledge resources) on their national health observatories, as embedded within the iAHO. The purpose was to strengthen the quality of the data and identify areas for improvement. The remaining six countries' national health observatory data were reviewed by the Regional Office team.

A WHO expert speaks to nurses and medical student interns about how to interpret and use data to monitor performance in a hospital in Kenya. © WHO / Billy Miaron

5. Conclusion and looking forward to 2022 and 2023

By the end of 2021, the UHC-P was reaching its 10th year of existence. It was created to promote UHC by supporting policy dialogue and providing technical assistance to enable governments to strengthen integrated health systems. Pursing the objectives of the Alma Ata Declaration, the UHC-P has adopted since its beginning a PHC approach as the programmatic engine of a sustainable health system for UHC, health-related SDGs and health security.

The UHC-P provides technical support and catalytic funding to strengthen governance structures, essential functions and processes of health systems. It allows for the rationalization of structures within ministries of health to better address health priorities, improve public financial management, and streamline information management and reporting. National health sector coordination is also strengthened through agreements on and rules and regulations for the private sector and public–private partnerships. The UHC-P supports countries with flexible funds and agile programming, adapting quickly to evolving contexts and priorities. The evaluation of the programme led by the EU in 2021 highlighted the high relevancy of the intervention because of its flexible and bottom-up approach based on a menu of activities, which ensures a well-framed response to the current needs of ministries of health.†

In addition to the first WHO GPW13 pillar[33] (achieving UHC), the UHC-P has been increasingly committed to addressing the two other pillars of the GPW13, namely addressing health emergencies and promoting healthier populations. With an increasing commitment to address NCDs in phase IV (2019–2022) of the programme, the UHC-P will develop greater focus in phase V on multisectoral, environmental and climate change–related issues for healthier populations. Recent experiences have demonstrated that all countries, regardless of their stage of economic development, remain vulnerable to public health emergencies, including severe infectious disease outbreaks. Relying on lessons learned during the 2014–2016 Ebola outbreak in West Africa and in fragile, conflict-affected and violent settings, health policy advisors played a critical role during the COVID-19 pandemic to support early recovery of health systems, maintain essential health services and strengthen health emergency preparedness, prevention and response capacities using a One Health multisectoral approach. In order to prevent, prepare and respond to shock events and build resilient health systems, the UHC-P supports the integration and alignment of policies and planning between health systems strengthening, health security and other health programmes.

COVID-19 laid bare the inadequacies of our global preparedness to health emergencies, and exacerbated the inequities within and between countries. We learned that preparedness requires:

- **Solidarity:** We need to ensure universal rights and equity – if anyone is left behind, we are all left behind.
- **Sustainability:** We need to innovate and build back better for people, the planet, prosperity and peace.
- **Systems:** We need systems that are resilient to provide services for health and well-being at all times.

In response to an important lesson learned from the COVID-19 pandemic, the UHC2030 strategic narrative to guide advocacy and action on health systems for UHC and health security goals makes it clear that strengthening health systems, with a focus on PHC, provides the foundations for both UHC and health security.[34] The United Nations General Assembly decided in August 2021 to organize a one-day High-level Meeting on UHC in New York in September 2023.[35] The Secretary-General will issue a progress report in early 2023 and the interactive multi-stakeholder hearing will be scheduled before the end of June 2023. This High-level Meeting is intended to contribute to continued momentum to achieving UHC and ensuring that we continue to work towards global preparedness to health emergencies.

† See Annex III for the Executive Summary of the Results-Oriented Monitoring Review 2021.

A doctor and patient at the Centre for Diabetes Assistance and Endocrinology in Brazil. © WHO / Panos / Eduardo Martino

Endnotes

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Annexes

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Annex 1

List of WHO global public goods supported by the UHC-P

DIVISION	UNIT	GLOBAL GOOD (GG)	DELIVERABLE	ACTIVITIES	EXPECTED ACHIEVEMENT
Universal Health Coverage / Life Course	Maternal, Newborn, Child and Adolescent Health and Ageing (MCA)	**2** – Guidelines on comprehensive assessment of older people	· 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.		2022
		4 – UHC service package for long-term care	· 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.		2022
	Health Workforce (HWF)	**329** – National health workforce accounts (NHWA) data platform	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.	· Data mining, triangulation, validation and release. · Generation of data analytics and visuals. · System maintenance and update.	2021
		322 – Health Labour Market Analysis (HLMA) Guidebook	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.	· 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.	2021
		327 – WHO guideline on HWF development, attraction, recruitment and retention in rural and remote areas	An update of the 2010 policy recommendations/ guidelines on "Increasing access to health workers in remote and rural areas through improved retention".	· 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.	2021
		1363 – The Global Competency and Outcomes Framework	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.	· Literature review. · Development of draft competency framework. · Consultations: Global Health Workforce Network education hub, meeting and virtual review. · Editing, publication and dissemination.	2021
		330 – State of the World's Nursing report (data/ investment case/ regional and country dialogue)	Nursing report.	· Development of the report. · Consultations. · Editing, design and printing. · Report launch.	2020

DIVISION	UNIT	GLOBAL GOOD (GG)	DELIVERABLE	ACTIVITIES	EXPECTED ACHIEVEMENT
Universal Health Coverage / Life Course	Health Workforce (HWF)	Strategic Directions for Strengthening Nursing and Midwifery 2021–2025	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.	· 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.	2021
		326 – International best practices on health personnel regulation and institutional accreditation	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.	· Scoping review of health practitioner regulation across countries. · Technical Expert Group on Health Practitioner Regulation convened to guide the development for the GG. · Systematic review on health practitioner regulation commissioned to inform the recommendations of the GG.	2022
		325 – Bilateral agreements to optimize mutual benefits of health worker migration – a "how-to" guide	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.	· 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.	2022
	Integrated Health Services (IHS)	**924** – Resilience Toolkit	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.	· 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.	2022
		888 – Guidance to countries and partners on service planning and role delineation, including methods and tools for community health needs	Guidance on operationalization of health service packages.		2022
			Capacity-building (flagship courses and mentoring) on health service organization, planning and management aimed at decision-makers at the subnational level (e.g. district health authorities and health facility managers).		2022
			Technical package of standards and tools to improve performance assessment and monitoring of health service delivery and quality.		2022
		870 – Quality Toolkit: A co-developed package of technical resources supporting planning, implementation and evaluation of national efforts on quality	Evidence on implementation and impact of key facility-based interventions to improve patient safety and quality.		2022

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Universal Health Coverage / Life Course	Integrated Health Services (IHS)	**859** – Competency Framework for Leadership for Patient Safety	Competency Framework for Leadership for Patient Safety.		2022
		332 – Guidance for strengthening monitoring and evaluation (M&E) of national health sector strategies	Guidance for strengthening M&E of national health sector strategies, with focus on primary health care (PHC) and UHC (revised edition).		2022
		868 – Practical guidance for health-care providers and policy-makers on palliative care	Guidance for strengthening palliative care.		2022
	Health Systems Governance and Financing (HGF)	**258** – Guidance on procedural aspects of using data to support health benefit package selection	A "how-to" guide to developing health benefit packages for UHC.	Stakeholder meeting and ad hoc Technical Advisory Group (TAG) meetings to develop and review guidance document.	2022
			Report on Member States survey on how benefit package decisions are made, and what is in benefit packages.	Survey development, translation, analysis and dissemination.	2022
		259 – One Health Tool, WHO-CHOICE and Epic: tools to develop economic evidence in support of UHC	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.	Development of draft modules on Excel and programming costs (external), and expert group meetings.	2022
			Visualization module for WHO-CHOICE tool.	Development of draft visualizations and programming.	2022
		1416 – The UHC Menu: An expanded repository of recommended interventions	UHC Menu database.	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.	2022
		1416 – The UHC Menu: An expanded repository of recommended interventions	UHC Menu database web platform.	Further develop the UHC Menu web platform to incorporate the full database of interventions and all associated fields, and a data visualization function.	2022
		590 – How to enhance domestic and development financing for scaling up action on the NCD-related SDGs	WHO flagship book on taxes on alcohol, tobacco and sugary drinks.	Authors' review meetings to finalize text, editing and layout, and printing.	2022
			Country reports on the case for more or higher health taxes, developed through coordinated technical assistance (TA), including estimations on health impact.	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.	2022
		257 – UHC global monitoring reports: Monitoring of financial protection coverage	2021 UHC financial protection report.	Capacity-building workshops, analysis of publicly available household expenditure surveys in collaboration with World Bank; establishment of microdata repository; country consultation.	2022

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Universal Health Coverage / Life Course	Health Systems Governance and Financing (HGF)	**1310** – Guidance for the design, implementation and monitoring of health financing for UHC: the Health Financing Progress Matrix (HFPM)	HFPM Country Assessments.	· 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.	2022
		1311 – Guidance to strengthen engagement between national health and finance authorities on the revenue-raising and efficiency dimensions of sustainable health financing	Guidance for better public financial management of health resources and services.	· 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 (n English and French). · Guidance document on implications of integrated service delivery for health budget reforms.	2022
		251 – Strengthening strategic purchasing	· 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.	· 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.	2022

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Universal Health Coverage / Life Course	Health Systems Governance and Financing (HGF)	**1362** – Tools and guidance to support the strengthening of health institutions for more effective governance for UHC	UHC Law in Practice survey tool for assessing service access rights and three country case studies.	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.	2021
			Establishment of the Coalition on Anti-corruption Transparency in Health (formerly ACTA; now called CATCH).	· 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 set-up 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.	2021
			Advice to Member States on public policy to the private sector in health.	Literature reviews, deliberations by our expert group on the private sector, consultation, editing, publication, dissemination.	2022
Deputy Director-General's Office (DDGO)	Health and Migration (PHM)	**1328** – Global Report on Health and Migration	National action plans on refugee and migrant health developed in priority countries.	· 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.	2022
		1328 – Global Report on Health and Migration	· 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.	· 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 curricula 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.	2022
UHC / Communicable and Noncommunicable Diseases	Mental Health and Substance Use (MSD)	**521** – Guidance and best practices for policy-makers and planners to achieve UHC and promote human rights	Practical guidance on good practice community-based mental health services promoting human rights and recovery.	· 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.	2021
		523 – Progress with attainment of SDG health target 3.5 with alcohol and treatment coverage for substance use disorders component	Global report.	· 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. · Commission chapters. · Develop the report. · Technical review and editing. · Layout and production. · Launch and dissemination.	2021

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UHC / Communicable and Noncommunicable Diseases	Mental Health and Substance Use (MSD)	**525** – Integrated technical packages for substance use disorders	Integrated technical package on identification and management of disorders due to substance use.	· 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.	2021
		535 – The Minimum Services Package for Mental Health and Psychosocial Support (MHPSS) in Humanitarian Settings	Inter-agency minimum service package for emergencies.	· 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).	2022
		541 – Measuring the progress of implementation of the Comprehensive Mental Health Action Plan 2013–2020, including coverage of severe mental health conditions	Mental Health Atlas report.	· 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 advisors. · 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.	2021
	Noncommunicable Diseases (NCD / ISD)	**566** – Guidance on how to integrate NCDs into national HIV/AIDS, TB, and sexual and reproductive health programmes	Strategic guidance document.	Systematic review, drafting, technical and expert meetings.	2021
			Toolkit.	Region and country field testing, finalization, editing, design, dissemination.	2021
		1430 – Guidance on an approach to prioritize NCDs in national UHC benefit package	Guidance on UHC Benefit Package.	Systematic review, drafting, technical and expert meetings, region and country field testing, finalization, editing, design, dissemination.	2021
		Proposed new GG: Guidance on screening	Guidance on NCD screening.	Systematic review, drafting, technical and expert meetings, region and country field testing, finalization, editing, design, dissemination.	2021
		Proposed new GG: Guidance on integrated chronic care	· 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.	· 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.	2021
			NCD Prevention Training (Oxford University).	Updating of curriculum and programme for NCD Package of Essential NCD (PEN) disease interventions; travel support for staff to facilitate training.	2021
			Community mobilization for NCD prevention and control services training.	Finalization of training package for community mobilization for NCD prevention and control services.	2021
				Travel support for staff to facilitate training.	

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UHC / Communicable and Noncommunicable Diseases	Noncommunicable Diseases (NCD / ISD)	GG on recommendations for task sharing	Supply chain management of NCD medicines and technology.	Technical country work for assessment and support of supply chain management of NCD medicines/technology.	2022
		Proposed GG product: Guidance for integrating NCD and communicable disease medicines and health products when transitioning countries			
		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			2022
		686 – Global action plan for the implementation of the WHO Special Initiative on Climate Change and Health in Small Island Developing States (SIDS)	South-to-South collaboration – Caribbean and Pacific on trade and NCD, access to medicines, climate change and NCD, and COVID-19 and NCD.	· Technical papers on trade and NCD. · Convene Pacific and Caribbean experts for consensus. · Dissemination of outcome.	2021
DDGO	Global NCD Platform / UNIATF	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	A full-time P5 technical officer to lead advocacy and resource mobilization for the NCD and Mental Health Catalytic Fund.	· 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.	2022

DIVISION	UNIT	GLOBAL GOOD (GG)	DELIVERABLE	ACTIVITIES	EXPECTED ACHIEVEMENT
UHC / Healthier Population	Health Promotion 1 – Public Health Law and Policies (LAW)	**249** – Supporting governments to make effective law and regulation necessary to implement UHC	Database of litigation tracking legal challenges to Member States implementation of health measures to address COVID-19.	· 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
	Health Promotion 2 – No Tobacco (TFI)	**779** – WHO Report on the Global Tobacco Epidemic	Integrating brief tobacco interventions into NCD prevention and control in primary care in six priority African, Caribbean and Pacific (ACP) countries.	· 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.	2022
			Reducing infant mortality through tobacco control and stakeholder engagement.	· Headquarters and national consultants. · Translation of guidance package. · Evaluation of questionnaires.	2022
			Awareness raising/importance of compliance with tobacco control legislation.	· Data analyst hired. · National consultant hired. · Translation of surveys.	2022
	Nutrition and Food Safety (CC – Healthy Diets)	**556** – Guidelines on food environment	WHO guidelines on policy actions to improve food environment to promote healthy diets and improve health and nutrition throughout the life course.		2021
	Health Promotion – Environmental Climate Change and Health (ECH / PHE)	**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	Improved awareness, basic environmental infrastructure, and HWF capacities to provide essential environmental health standards in health-care facilities.	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.	2022
		1317 – Intervention guide for community health and environmental workers on evidence-based action on environmental health	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.	· 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.	2022

DIVISION	UNIT	GLOBAL GOOD (GG)	DELIVERABLE	ACTIVITIES	EXPECTED ACHIEVEMENT
UHC / Healthier Population	Health Promotion – Environmental Climate Change and Health (ECH / PHE)	**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	Strengthening countries' capacities to provide safe and decent working conditions in health care.	· 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.	2022
		682 – Guidance, tools and information products to support implementation of the Bonn Call for Action to improve radiation protection in health care	Quality and safety in paediatric fluoroscopy-guided interventions in Latin American and Caribbean countries ("OPRIPALC" is the acronym of its title in Spanish).	· 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.	2022

DIVISION	UNIT	GLOBAL GOOD (GG)	DELIVERABLE	ACTIVITIES	EXPECTED ACHIEVEMENT
UHC / Healthier Population	Health Promotion 3 – More Physical Activity (RUN)	**759** – Global guidelines on physical activity and sedentary behaviour	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.	· 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, people living with chronic disease and people living with 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
	Social Determinants of Health (SDH)	**733** – Guidance to support implementation of the draft country framework for action across sectors (HiAP): intervention packages addressing Social Determinants of Health	Implementation Guidance for Action Across Sectors to Improve Health, Equity and Well-Being.	· 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.	2022
		Work for GG #733 will align with GG #584 and #590.	(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.	· Coordinate the establishment of the interdepartmental working group with engagement process for cross-organizational focal points and advisors (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.	

DIVISION	UNIT	GLOBAL GOOD (GG)	DELIVERABLE	ACTIVITIES	EXPECTED ACHIEVEMENT
Access to Medicines and Health Products	Health Product Policy and Standards (EMP)	**120** – 117 WHO Model List of Essential Medicines and In Vitro Diagnostics	National Essential Medicines Lists updated and methodology reviewed.	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.	2022
		118 – List of priority medical devices for NCD; list of Medicines for PHC; Interagency Emergency Health Kits	National Medical Devices Lists for NCD/PHC updated. Interagency Emergency Health Kits revised.	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.	2022
		132 – WHO Secretariat to promote best practices in countries and regional institutions to improve procurement and supply chain efficiency, including for pooled procurement	Pooled procurement mechanisms and networking of procurement agencies in place.	· 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.	2022
		134 – Interagency guidelines for safe disposal and operational principles for good pharmaceutical procurement	Normative guidelines revised and disseminated.	Support strengthening of in-country supply chain management to ensure timely access to appropriate medicines and technologies health products.	2022
		157 – Shortages database	Set-up of global repository for tracking and responding to global shortages of medicines and vaccines.	Support the introduction and implementation of routine digital real-time stock level monitoring.	2022
		142 – Monitoring the availability and predictors of access to medicines, vaccines	M&E integrated into national health plans and systems: country profiles, national surveys and assessments.	Strengthen capacity for regular monitoring of availability, pricing and expenditure of medicines and health products at country and regional level.	2022
		146 – Drug alert and global medical products alerts	Interoperability between national, regional and global alert mechanisms improved.	Support use of Global Surveillance and Monitoring Systems for better prevention, detection and response to substandard and falsified medical products.	2022

DIVISION	UNIT	GLOBAL GOOD (GG)	DELIVERABLE	ACTIVITIES	EXPECTED ACHIEVEMENT
Antimicrobial Resistance (AMR)	Surveillance, Prevention and Control (SPC)	**21** – Global AMR Surveillance (GLASS)	AMR module developed for DHIS2.	· 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.	2022
			Pilot implementation of the DHIS2 AMR module.	· 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.	2022

DIVISION	UNIT	GLOBAL GOOD (GG)	DELIVERABLE	ACTIVITIES	EXPECTED ACHIEVEMENT
Emergency Preparedness (WPE)	Country Capacity for IHR / Human Animal Interface for IHR	Operational tools to build capacities at the International Health Regulations (IHR) human–animal–ecosystem interface	Improved collaboration between human health and animal health actors.	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.	2022
		Global guidance on point-of-entry screening measures	Strengthened IHR implementation at points of entry.	· 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.).	2022
	Multisectoral Engagement for Health Security	Guide for multisectoral preparedness coordination for IHR and health security	Enhanced multisectoral preparedness coordination in ACP countries.	Support countries in multisectoral preparedness coordination for enhanced health security.	2022
Polio Transition	Polio Transition Team	Costing, planning and budgeting tool for surveillance of vaccine-preventable diseases (VPDs) in priority countries for polio transition	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.	· 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.	2021

Annex 2

Table of activities by output by country/area

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

		1 BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													1 BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									1 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**			
NUMBER OF COUNTRIES		78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
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	■	■	■	■						■		■		■												■	■	■		■		■		■		■						
	Côte d'Ivoire	■	■	■	■	■	■	■				■		■		■	■		■	■	■	■		■	■	■				■			■	■	■	■	■	■	■	■	■	■	■
	Democratic Republic of the Congo	■	■	■	■	■	■	■		■	■	■	■	■	■	■			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
	Equatorial Guinea	■																																									

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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**				
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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		■		■	■				■												■																					
	Togo	■	■		■	■	■	■		■	■				■								■							■												
	Uganda	■			■	■	■	■	■		■	■		■		■				■										■	■		■	■	■	■						
	United Republic of Tanzania	■		■	■	■	■		■	■		■		■									■	■						■	■	■	■			■						
	Zambia	■	■			■		■	■	■		■	■	■					■			■	■	■						■	■	■	■		■							
	Zimbabwe	■			■	■		■	■	■						■	■			■	■	■								■	■	■	■		■					■	■	■

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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**			
NUMBER OF MEMBERS		78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
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	■				■						■																										■				
	Bolivia (Plurinational State of)	■														■																										
	Colombia		■																																							
	Cuba		■		■	■																				■																
	Dominica	■	■		■	■	■			■		■														■																
	Dominican Republic		■		■	■																				■				■												
	Grenada				■	■	■					■																															
	Guyana	■	■	■	■			■				■																					■									
	Haiti										■	■																														
	Honduras	■	■		■																																					
	Jamaica	■			■	■	■				■																															
	Paraguay	■			■	■	■	■	■																																	
	Peru	■	■		■			■																		■																
	Saint Kitts and Nevis	■	■		■	■																																				
	Saint Lucia		■				■																							■												
	Saint Vincent and the Grenadines		■		■	■	■					■														■	■			■												
	Suriname		■	■	■	■				■	■															■		■														
	Trinidad and Tobago																																									

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WHO Eastern Mediterranean Region	Afghanistan	■			■	■	■																								■											
	Djibouti	■				■																																				
	Egypt	■			■		■			■	■																			■												
	Iraq	■			■	■	■																								■											
	Islamic Republic of Iran	■				■	■																							■		■										
	Jordan	■																																								
	Lebanon						■	■		■				■			■													■													
	Morocco	■			■	■	■																							■		■										
	occupied Palestinian territory				■		■																																				
	Pakistan	■				■	■																																			
	Somalia	■				■																																				
	Sudan	■	■		■	■	■																	■							■											
	Tunisia				■				■		■																					■										
	Yemen				■																																						

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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**			
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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	■	■	■	■	■	■		■							■																										

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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**			
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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	■	■	■	■	■	■	■	■	■	■	■																		■	■	■						■			

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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**			
NUMBER OF COUNTRIES		78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
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 3

Results-Oriented Monitoring Review 2021 – Executive Summary

In a global context facing a double burden of noncommunicable and communicable diseases, including a pandemic caused by a novel virus and growing health security risks related to climate change, more than a third of the world's population has no access to a basic health facility. This action reflects the EU's recognition of WHO as coordinator of the global public health response, materialized in an allocation of €146,700,000 to support global progress towards universal health coverage (UHC) through health system strengthening (HSS) activities at regional and country level.

This highly relevant intervention responds to the current needs and rights of the target groups/ beneficiaries because it is demand driven, very flexible and well-integrated within country plans and regional frameworks. It has shown a high degree of adaptation, not only in the way of working during the COVID-19 pandemic, but also finding opportunities out of the pandemic. Many governments are rethinking how to use a HSS approach to adjust their systems to the new reality, which has played in favour to support the work towards UHC. Still, in fragile contexts, health and humanitarian emergencies as well as COVID-19, may take full attention and capacity from longer-term plans and priorities.

The intervention logic is sound and clear. There is a comprehensive global Logical Framework (Logframe) with a coherent vertical logic. Impact, Outcomes, Outputs are SMART, and indicators are RACER. The global level Logframe includes clear baselines, targets and verification sources. An indicative menu of activities is included to allow for flexibility. Developing country level Logframes with target indicators at activity level could generate quantitative evidence to pull the case for HSS.

Managerial, planning, resource coordination and reporting are aligned with WHO's corporate planning, resource coordination and monitoring processes. The implementation structure is complex but functioning well. An extensive recruitment of highly qualified health system policy advisors permanently located in selected countries has strengthened the WHO operational model. The quality of outputs is generally very good.

Health sector country coordinating mechanisms operate reasonably well but the European Union Delegations (EUDs) are rarely involved. There are some key areas where the EU has extensive expertise that have not yet been fully exploited (e.g. gender, human rights, participation).

There are promising indications of adequate progress, with targets already reached for some indicators (SO4, SO6, SO10) and others on good track (SO7, SO9). The intervention influences the development, implementation and/or strengthening of policies and actions of the ministries of health and other public institutions. By strengthening different HSS components, it contributes to the overall objective of advancing towards UHC. However, attributing impact is complex. No country can ever fully achieve UHC, and there are very diverse understandings of what "universal health coverage" means.

Despite advancement in terms of building capacities, the consolidation and implementation of policy change processes – which is essential to reap the benefits of many of the investments already made – still depends on continued availability of EU funds. Health reform processes require strong financing and partnerships to take place over a sustained period, and then require additional support to be implemented, monitored and evaluated.

A new Phase (Phase V) is needed to ensure the sustainability of the intervention. It should incorporate a "planetary health" approach with specific attention to environmental issues, as well as gender and disability. It should enhance health security, the implementation of the humanitarian–development–peace nexus (HDPNx), examine participatory processes, and catalyse co-development of exit strategies in selected countries. Specific guidelines should institutionalize greater cooperation between EUDs and WHO.

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