Programme budget 2014-2015 Performance Assessment
Programme area: 4.2 Integrated People-Centred Health Services

OUTCOME 4.2. POLICIES, FINANCING AND HUMAN RESOURCES ARE IN PLACE TO INCREASE ACCESS TO INTEGRATED PEOPLE-CENTRED HEALTH SERVICES

I. OVERVIEW OF MAJOR ACHIEVEMENTS AND CHALLENGES

The Secretariat finished the drafting of the Framework on Integrated, People-centred Health Services (IPCHS) in late 2015. The Framework calls for reforms to reorient health services, putting individuals, families, carers and communities at their centre, supported by responsive services that better meet their needs and respect social preferences, and that are coordinated both within and beyond the health sector, irrespective of country setting or development status. Making progress towards the United Nations’ Sustainable Development Goal 3, including target 3.8 on universal health coverage, requires countries to move towards ensuring that all people and communities have access to health services that are high quality, safe and acceptable. Cost-efficient, effective approaches to service delivery must be maximized for this to be attainable and sustainable. An integrated, people-centred approach is crucial to the development of health systems that can respond to emerging and varied health challenges, including urbanization, the global tendency towards unhealthy lifestyles, ageing populations, the dual disease burden of communicable and noncommunicable diseases, multimorbidities, rising health care costs, disease outbreaks and other health-care crises.

The IPCHS Framework sets forth a compelling vision in which “all people have equal access to quality health services that are co-produced in a way that meets their life-course needs and respects social preferences, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient and acceptable; and all carers are motivated, skilled and operate in a supportive environment”. Given that health systems are highly context-specific, the framework does not propose a single model of people-centred and integrated health services. Instead, it proposes five interdependent strategies that need to be adopted, including: (1) empowering and engaging people; (2) strengthening governance and accountability; (3) reorienting the model of care; (4) coordinating services within and across sectors; and (5) creating an enabling environment. Strategic approaches, potential policy options and interventions for each of the above strategies were also identified. The appropriate mix of policies and interventions to be used at the country level will need to be designed and developed according to the local context, values and preferences. The IPCHS Framework is the result of the inputs gathered through peer reviews and technical consultations from more than 140 experts representing research organizations, ministries of health and academia, among others. In addition, the framework benefited from input from an extensive public consultation as well as consideration and discussion at WHO Regional Committees.

The draft Global Strategy on Human Resources for Health: Health workforce 2030 (GSHRH) has been developed in response to resolution WHA67.24 (2014), on Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage. A consultation process was initiated in mid-2014 using the Global Health Workforce Alliance platform and in collaboration with key stakeholders to inform the development of the strategy. Eight thematic working groups took the lead in gathering evidence on specific themes based on a comprehensive health labour market framework for UHC. An extensive consultation process of the draft GSHRH was organized covering regional technical and public consultations. The GSHRH was also discussed in a number of regional committees and will be presented to the 69th World Health Assembly (WHA) in 2016.

Both the ‘Framework on Integrated, People-centred Health Services’ and the ‘Global Strategy on Human Resources for Health: Health workforce 2030’ are critical components of the WHO strategic vision towards universal health coverage.
II. OUTPUT MEASUREMENT

Output 4.2.1. Policy options, tools and technical support to countries for equitable people-centred integrated service delivery and strengthening of public health approaches

<table>
<thead>
<tr>
<th>Output indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>Achieved Value:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries routinely assessing the costs and impact of different service delivery options and the related expenditures</td>
<td>45</td>
<td>80</td>
<td>78</td>
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</table>

Overview of achievements and challenges

Although there was partial achievement in meeting the specific target for output indicator 4.2.1, there was considerable progress in strengthening both people-centred integrated service delivery and public health approaches across all levels of the Organization. A total of 64 countries (beyond the target for output indicator 4.2.1) have been reached across all WHO regions with support on the following lines of work: i) service delivery assessments (Côte D’Ivoire, Democratic Republic of the Congo, United Republic of Tanzania, Honduras and Guatemala; 22 Eastern Mediterranean Region countries; Belarus, Estonia, Croatia, Tajikistan, Macedonia, Malta, Poland, Serbia, Slovakia; Slovenia & Ukraine); ii) broad service delivery reforms (Cape Verde, Swaziland and Côte D’Ivoire, Costa Rica, Haiti, Honduras, Panama and Nicaragua; Afghanistan, Egypt, Iraq, Iran (Islamic Republic of), Libya, Morocco, Pakistan, Palestine, Somalia and Yemen; Cyprus, Kosovo and Lithuania; Cambodia, Lao People’s Democratic Republic, Philippines, China, Marshall Islands, Mongolia, Palau and Solomon Islands); primary health care (PHC) revitalization (Gambia, Mali, Malawi, Rwanda, South Africa and Zimbabwe; 22 Eastern Mediterranean Region countries; Solomon Islands, Tonga and Samoa); iii) hospital reform (Libya, Pakistan, Palestinian occupied territory, United Arab Emirates); iv) services management (El Salvador, Guatemala and Honduras; 22 Eastern Mediterranean Region countries; Liberia); v) role of private sector in service provision (22 Eastern Mediterranean Region countries); and vi) Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and Gavi Alliance (GAVI) health systems strengthening (HSS) proposals and services integration (Cambodia, Lao People’s Democratic Republic, Papua New Guinea, Solomon Islands and Viet Nam).

In terms of deliverables, at the country level there’s been significant progress in identifying capacity strengthening needs, and supporting the adoption and implementation of the global framework on integrated people-centred health services, as well as on promoting national and local level approaches based on public health principles in order to reduce inequalities, prevent disease, protect health and increase well-being. At the regional and global levels, there has been a significant gain in compiling lessons learnt and best practices from countries around the world, and in developing strategies, tools and capacity-building activities for supporting the implementation of integrated, people-centred health services and financing for universal health coverage.

Achievements and challenges in countries

Main challenges identified in the biennium include: lack of capacity to respond to public health emergencies; difficulties in continuity of policy-dialogue over time; deficiencies in resource mobilization; lack of availability of experts in the field; existence of old silo habits and resources available across WHO programmes; and continued weak collaboration across the different WHO regions.

Achievements and challenges at regional and global levels

The Secretariat finished the drafting of the Framework on Integrated, People-centred Health Services (IPCHS) during 2015, which had undergone a broad consultation process with Member States and other key stakeholders. A decision was made to bring the IPCHS Framework to the Board (EB) and WHA in 2016, to allow for better coordination with the Global Health Workforce Strategy, but to release the strategy in draft form in March 2015. In addition, the Secretariat started testing its recommendations with the goal of expanding the evidence for people-centred integrated care in selected countries, such as Mali, Rwanda and South Africa.
Several WHO regional offices have also developed strategies in support of UHC with IPCHS, namely the PAHO/Region of the Americas Strategy for Universal Access to Health and Universal Health Coverage, through Integrated Health Service Delivery Networks; the Framework for Action on Coordinated/Integrated Services Delivery and the Public Health European Action Plan of the Regional Office for Europe; the Framework for action on advancing universal health coverage in the Eastern Mediterranean Region and the Road Map for Strengthening Service Provision Through Family Practice Approach of the Regional Office for the Eastern Mediterranean; the Regional Strategy for Universal Health Coverage and the South-East Asia Primary Health Care Innovation Network of the Regional Office for South-East Asia; and the resolution on Universal Health Coverage Moving Towards Better Health and a study on hospital service delivery and support to disease-specific programmes funded by GFATM and GAVI in order to help them integrate better with the health system in the Eastern Mediterranean Region.

Risks and assumptions

The risks (lack of political commitment and financial resources; high turnover of policy makers and management; and emergency situations such as outbreaks of Ebola and ZiKa) and assumptions (active participation and collaboration with Member States and other partners; availability of practices and supporting tools; WHO technical capacity; and WHO internal collaboration across programmes) hold for the completion of this report. In the African Region, the Ebola outbreak diverted time and resources from completing originally planned activities. In addition, a lack of dedicated resources, particularly financial and human resources have hampered implementation efforts in some countries. Competing leadership on UHC and quality health services claimed by other international organizations, coupled with a lack of coordination, knowledge sharing and collaboration on cross cluster issues on health services strengthening should be highlighted. To manage this, it was mandated that the main HIS strategies being released during this period were linked explicitly in timing and content and that a specific cross cluster timeline on major reports be produced and monitored.

Gender, equity and human rights and social determinants of health

Both Gender and equity are a focus area of the new IPCHS Framework with action areas exploring innovative health service models for gender or SES based groups. Key strategies, policy options and programmatic interventions promoted by this Framework include: empowering and engaging people and communities; reaching the underserved and marginalized; bolstering participatory governance; promoting health rights and entitlements; gender, cultural and age-sensitive services; health in all policies; and intersectoral partnerships, among others.

Output 4.2.2. Countries enabled to plan and implement strategies that are in line with WHO’s global strategy on human resources for health and the WHO Global Code of Practice on the International Recruitment of Health Personnel

<table>
<thead>
<tr>
<th>Output indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>Achieved Value:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries that have an investment plan for scaling up and/or improving training and education of health workers in accordance with national health needs</td>
<td>30</td>
<td>35</td>
<td>16</td>
</tr>
</tbody>
</table>

Overview of achievements and challenges

Every health system faces challenges with its workforce which affect its performance or ability to adequately address the needs and expectations of populations. Governments are constantly exploring different policy options to respond to a range of constraints such as health worker shortages, misdistribution and retention in rural and underserved areas; imbalances in skill-mix, and low productivity and performance. As governments formulate policies and strategies to ensure that their populations have access to people-centred and integrated health services and to social care, it is equally necessary to explore realistic and feasible health workforce reforms to support the service delivery model towards UHC and to address key human resources for health (HRH) challenges in order to progress. WHO has developed various normative products, facilitated experience and knowledge sharing, provided the necessary technical support and reinforced national efforts to develop, implement, monitor and evaluate health workforce strategies.

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**Achievements and challenges in countries**

Overall, countries have shown various levels of progress in implementing different areas of health workforce development, of which examples are presented below:

Forty-five countries have developed/reviewed their national human resources for health policies, strategies and plans (Afghanistan, Bangladesh, Bolivia, Brazil, Cameroon, Cape Verde, Chad Comoros, Côte D'Ivoire, Cook Islands, Curacao, Egypt, Eritrea, Fiji, Gabon, Gambia, Ghana, Granada, Guinea, Honduras, Iraq, Kiribati, Liberia, Maldives, Malaysia, Mauritania, Moldova, Mongolia, Namibia, Nigeria, Peru, St Lucia, Saint Martin, St Kitts and Nevis, Sierra Leone, Somalia, Sudan, Suriname, Swaziland, United Republic of Tanzania, Timor-Leste, Togo, Tonga, Trinidad and Tobago and Yemen). Sudan established principles and processes for development of health workforce strategy at State level. Botswana, Fiji, Namibia, Niger and Zimbabwe have completed an exercise to determine the staffing needs at facility level using the Workload Indicators for Staffing Need (WISN) tool.

A number of countries have focused on strengthening their HRH information systems (Afghanistan, Democratic Republic of Congo, Jordan, Mozambique, Malawi, Republic of Moldova, Sudan), developing or strengthening HRH observatories (Benin, Democratic Republic of Congo, Hungary, Kazakhstan, Palestine, Togo) and publishing country profiles (Cambodia, Democratic Republic of Congo, Kiribati, Lao People’s Democratic Republic, Madagascar, Marshall Islands, Mongolia, Mozambique, Malaysia, Papua New Guinea, Solomon Islands, Tokelau, Tonga, Vanuatu). In Afghanistan, the decentralized human resource management information system has improved coordination among HRH stakeholders. Strengthening areas related to health professional education and training, including regulation was targeted in Afghanistan, Cambodia, Cameroon, Chad, Equatorial Guinea, Eritrea, Fiji, Guinea, Iran (Islamic Republic of), Iraq, Lao People’s Democratic Republic, Mongolia, Nigeria, Oman, Sudan, Togo, Viet Nam and Yemen.

Efforts to further health professional development in several Pacific Member States (Fiji, Kiribati, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu) continued through the Pacific Open Learning Health Network (POHLN) as well as through efforts to integrate foreign trained medical graduates. All countries of the South-East Asia Region, particularly those facing critical shortages of HRH, paid special attention to increasing the production of the health workforce and improving the quality and relevance of health personnel education.

Bhutan, Indonesia, Sri Lanka and Thailand developed country action plans for retention and education of health workforce which are now being implemented. The Philippines implemented mechanisms to increase the health workforce at the subnational level; the local government units that are covered by the WHO subnational initiative were able to hire additional doctors using their own funds. Papua New Guinea developed a health sector human resources policy and implementation of the enhancement plan 2013-2016 is ongoing. In Viet Nam, an assessment of gaps in different cadres of health professionals was undertaken through collaboration between the Ministries of Education and Training and Health. The European Union (EU) funded project “Better managing health professionals mobility has been successfully implemented in the Republic of Moldova. The project resulted in strengthened technical capacity to assess, monitor and plan human resources for health.

Besides the development of a national strategy on HRH, the project resulted in the establishment of a legal framework for international recruitment of health personnel in line with the principles of the WHO Global Code of practice for the International Recruitment of Health Personnel (The Code). Roundtable discussions were organized on health professional regulation and licensing in Tajikistan and Moldova; and on nursing and midwifery education and practice in Albania, Kazakhstan, Russia, Serbia and Uzbekistan. The implementation of commitments made at the Recife Third Global Forum on HRH has led Egypt to produce evidence on the HRH public-private mix.

As part of the Muskoka grant, Burkina Faso, Benin, Chad, Guinea, Mali, Mauritania, Niger and Senegal have carried out an institutional capacity training of their midwifery schools and developed actions plans to improve the availability of midwifery competencies. In addition, these countries have mapped implementation of the recruitment, deployment and retention strategies during the last 10 years to inform their new national health plans. Progress on nursing and midwifery strategies has also been made in Bhutan, Iraq and Tunis.

Challenges hindering progress included limited funding and institutional capacities, and restrictive budget ceilings. In addition, conflict and security issues have affected progress on activities in a number of countries. The Ebola outbreak response diverted human and financial resources from other planned activities. In some countries, the HRH agenda has not received adequate attention in the overall health agenda.
Achievements and challenges at regional and global levels

WHO has provided support to countries, including for HRH policy development and planning, enhancing education capacities and quality through faculty development, strengthening capacities in leadership, management and governance, and reinforcing frontline health workers.

In the Region of the Americas, an analysis of the level of achievement of the Regional Goals for HRH 2007-2015 has been prepared by Member States to guide future priorities and define a new post 2015 HRH agenda aligned to the Global Strategy on HRH: health workforce 2030. The Virtual Campus remains an important capacity building instrument for countries on health issues that are specific to the regional mandate and priority public health programmes. The Virtual Campus has achieved financial sustainability. It provides technical support as a regional learning platform and supports the growth and development of country nodes. In the African Region, a regional consultation was convened in Brazzaville in July 2014 to review the quality and relevance of medical education and training. It resulted in a number of action points to enhance research, education quality and quality systems, and the investment case for medical education and partnership arrangements. The Eastern Mediterranean Medical Education Study (EMMES) and expert consultation were completed. The study guided the development of a regional framework for action to ensure the quality of medical education in the Eastern Mediterranean Region. A road map to guide the transformation of nursing and midwifery in the Region was also developed. The Arab Administrative Development Organization (ARADO) of the League of Arab States, with technical inputs from WHO, held a conference on migration of health workers in the Arab region and advocated for the implementation of the Code. In the European Region, the strategic directions on nursing and midwifery and compendium of good practice based on 55 case studies from 18 countries have been developed and were launched in a technical briefing during the 65th Regional Committee for Europe. The EU Joint Action on Health Workforce Planning and Forecasting has contributed to capacity building beyond Europe.

In the South-East Asia Region, the regional strategy on strengthening health workforce education and training was produced in alignment with the WHO guidelines on transforming and scaling up health professionals’ education and training, and a related resolution was adopted by the 67th Regional Committee. The education guidelines, as well as those on increasing access to health workers in remote and rural areas through improved retention, have created momentum in countries of the Region for strengthening health professional education, addressing geographical imbalances and improving retention. Commitments were made to developing national action plans to form the basis for health workforce development over the coming decade. An intercountry workshop was organized in Bangkok to support the monitoring of implementation of the Code. The information and knowledge on HRH in the Western Pacific region has been improved through HRH country profiles and regional reviews on critical issues, including health workforce regulation, health workforce mobility, and recruitment and retention strategies to increase access to health workers in rural areas. A continuous regional dialogue and efforts are ongoing to address these issues. Improving quality and capacities in health professional education has received attention including faculty development in education institutions, development of internship programmes and continuous professional development (CPD). The Regional Office worked closely with countries undergoing health reforms, for example, a policy roundtable was organized on Chinese health reform, which provided insight into the challenges of HRH and developing strategies to strengthen the requirements for, and retention of, PHC workers. The Pacific Health Workforce Mobility Project has been commissioned to provide insight into the dynamics and implications of HRH migration in the Pacific island countries.

At global level, the draft Global Strategy on Human Resources for Health: Health workforce 2030 (GSHRH) has been developed in response to resolution WHA67.24 (2014) on Follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards universal health coverage. The GSHRH puts forward the adoption of national health workforce accounts (NHWA) as a harmonized, integrated approach for annual and timely collection of health workforce information. In 2015, the Health Workforce Department established a Technical Advisory Group (TAG) to support and inform the development of NHWA. An initial structure of NHWA comprising 10 modules aligned to the health labour market framework was developed supported by a process to map existing health workforce indicators.

In response to a request from the WHO EB at its 136th session in January 2015, an Expert Advisory Group (EAG) was established to advise the Director-General on preliminary evidence on the relevance and effectiveness of the Code, and to provide recommendations to guide its future implementation. The work of the EAG resulted in a report by the Director-General (document A68/32.1) in which she concludes that the Code is highly relevant especially in the context of growing regional and inter-regional labour mobility; and that evidence of
its effectiveness is emerging. The EAG called for the correction of the limited response to the first round of reporting. In accordance with resolution WHA63.16, Member States were requested to report on implementation progress via the second round of national reporting. In collaboration with the OECD and EUROSTAT, a migration data module was introduced in the OECD/EUROSTAT/WHO EURO Joint data collection questionnaire (2014-2015) for 62 countries to monitor the international migration of health personnel. By end 2015, 117 countries had established a DNA representing a 37% increase from the first national round of reporting and with major improvements in certain regions; and 65/117 have submitted a report to the Secretariat. The vast majority of countries submitting reports are known to be source and destination countries for international migration of health personnel.

The Global Evaluation Tool developed in response to resolution WHA 66.23 on the evaluation of health workforce education and training was produced. The Midwifery Educator Competencies and related tools were produced and published in English and French in line with the strategic direction for nursing and midwifery 2011-2015. As part of the Muskoka grant, seven case studies on human resources for health strategy implementation in relation to education, recruitment, deployment and retention were conducted (Burkina Faso, Côte d’Ivoire, Chad, Mali, Mauritania, Niger and Senegal) to inform the evidence around the framework for rural pipeline strategies (train, recruit, deploy and retain in rural areas). In addition, labour market analysis and job preferences analysis were conducted in Burkina Faso, Togo, Niger and Côte d’Ivoire in support of health workforce planning. Quality assessments of midwifery training schools in Burkina Faso, Côte d’Ivoire, Mali, Mauritania, Senegal and Guinea supported nursing and midwifery policy development in these countries.

As part of the support for Ebola-affected countries, WHO contributed to the development of the health workforce component of the health system recovery plans, including analysis of investment plans in order to advocate for more resources for HRH. In addition support was provided to other countries in humanitarian emergencies (Central African Republic and South Sudan).

Challenges hindering progress included very limited funding for planned activities, which affected implementation and engagement with countries. In some regions, there is limited availability of HRH experts to provide technical support to countries. In addition, political instability and limited capacities in some ministries of health affected the pace of implementation.

**Risks and assumptions**

Government commitment and engagement with development partners are important assumptions. Political changes, institutional and individual capacities, resource constraints, high turnover in national counterparts and emerging emergencies constitute the main risks. With the renewed interest in HRH, a major risk is fragmentation in the approach with other United Nations (UN) agencies, the World Bank and other major donors or influencers.

Measures to mitigate:

1. Insufficient funding to support programme implementation: resource mobilization effort to generate commitments from donors around the GSHRH and other products supporting its implementation, e.g. NHWA.
2. Insufficient staffing – support through secondments, interns and short term contracts as well as through collaborating centres.
3. Fragmentation - enhanced collaboration with partners and other actors using the GSHRH and other deliverables to build consensus on concepts and approaches to implementation.

**Gender, equity and human rights and social determinants of health**

1. The GSHRH emphasizes and integrates principles in relation to the right to health, rights of health workers, gender, ethical recruitment practices, global solidarity and equity.
2. The development of an e-book on integrating a social determinants approach in health workforce training and education.
3. Processes of development of health workforce strategies and country profiles include disaggregated data.
Output 4.2.3. Guidelines, tools and technical support to countries for improved patient safety and quality of services, and for patient empowerment

<table>
<thead>
<tr>
<th>Output indicator</th>
<th>Baseline</th>
<th>Target</th>
<th>Achieved Value:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of countries with official engagement in new patient safety initiatives</td>
<td>20</td>
<td>40</td>
<td>42</td>
</tr>
</tbody>
</table>

Overview of achievements and challenges

There was full achievement of the specific target for output indicator 4.2.3, through progress made in improving safety and quality of health care. A total of 42 countries (beyond the target for output indicator 4.2.3) have received support across all WHO regions. WHO worked at global, regional and national levels to support the Ebola Response through infection prevention and control, safe services strengthening and health systems recovery efforts in the three Ebola affected countries, as well as health systems preparedness in the surrounding countries. With the work carried out during the previous biennium in this area, momentum has been created and all Member States are very concerned about the quality and safety of the healthcare services that are provided to people of their respective countries. Now they are looking for WHO Technical and Expertise assistance in order to develop programmes to ensure quality and safety. The Regional Office for Africa provided guidance for developing a national patient safety policy and plans for countries to adapt and implement. Kenya organized a nationwide assessment of patient safety levels based on documented processes and levels of risk, which is meant to serve as a baseline against which future interventions can be measured.

Two recent resolutions adopted by the Regional Committee for South-East Asia, SEA/RC68/R4 on Patient safety contributing to sustainable Universal Health Coverage (UHC) in September 2015 and by the Regional Committee for the Western Pacific, WPR/RC/66.R2 on Universal Health Coverage - Moving towards better health” in October 2015, have again emphasized the importance of and need for safer health systems for moving towards UHC. In the Eastern Mediterranean Region, the Member States were supported to move towards institutionalizing Patient Safety and improving quality of care. A Patient Safety assessment tool, Patient Safety toolkit and curriculum have been developed/updated. Country visits and meetings were organized to build national capacities. A network of experts and WHO collaborating centres (CCs) has effectively provided support in the European Region.

Quality and safety is in high demand in the South-East Asia Region especially since the Region is a popular destination for medical tourism. The Regional Office has planned and implemented many activities to support Member States achieve higher standards in Patient Safety and improve health Care Quality as a part of the overall contribution to achieving UHC Goals. During the next biennium (2016-2017), Patient Safety activities will be expanded to include many other areas under four main pillars, namely, expansion of service delivery infrastructure, especially to achieve hard to reach populations with safe and quality care; human resource development for ensuring safe care; information and evidence generation for policy development; sharing interventions and experience; and networking to bring together other stakeholders involved in delivering safe, good quality, people centered integrated health care. The Regional Office for the Western Pacific supported Member States to increase the quality and safety of health services, developed innovative tools and supported development policies, guidelines and the establishment of a mechanism for collecting and sharing best practices and models on patient safety.

At the regional and global levels, there has been a significant gain in compiling lessons learned and best practices from countries around the world, and in developing strategies, tools and capacity-building activities for supporting the implementation of strategies for patient safety and quality of care.
Achievements and challenges in countries

Achievements:

Establishment of a Centre for Patient Safety and Quality/Health Care Quality Secretariat (Oman, Sri Lanka); development of policy options, governance mechanisms, a strategic plan, a roadmap and guidelines on patient safety and quality services (Botswana, Iran (Islamic Republic of), Latvia, Moldova, Morocco, Togo, Zimbabwe); a patient safety curriculum (Thailand and France); raising awareness on Patient safety (Lebanon); technical support to review health care associated infections guidelines and practices, and surveillance guidelines (Kuwait); country assessment, field visits and workshops (Jordan, Papua New Guinea); institutionalizing accreditation system (India, Indonesia, Iraq, Sri Lanka, Thailand, Tunisia); injection safety programmes (Egypt, India); medication safety assessment (Morocco, Sudan); implementation of patient safety standards (East Jerusalem); development of a training manual on delivery of quality healthcare services (Sudan); Patients for patient safety (Malaysia, Qatar); Safety and quality indicators (Iran (Islamic Republic of), Jordan, Malaysia, Oman, Tunisia, Morocco, Viet Nam); trainings on patient safety and quality of health services (Eritrea, Poland, Swaziland, Zambia, typhoon affected areas -Philippines); provision of emergency and surgical care (Mongolia); development of Surgical Safety Checklist (Swaziland); development of infection prevention and control plans; development of post Ebola recovery plans for health system resilience that include patient safety and IPC (Ebola affected countries); implementation of EU-funded project on blood safety in Montenegro. The Ministry of Health and Family Welfare in India organized and conducted the first national convention on Quality Assurance in Public Health, which represents a big step towards ensuring the safety and quality of health care services provided in India.

Challenges:

- High adverse event rates (14% of inpatient admissions) affect overall relatively low quality of care at public and private hospitals.
- Lack of financial resources and trained managers and health care providers at the country level.
- Lack of public private partnership at the country level for patient safety.
- This is a relatively new area of interest in countries which has received low priority and is now gaining momentum.
- Funding and technical capacity.
- Ebola outbreak response diverted human and financial resources from other planned activities.
- Restrictive country budget ceilings.
- Limited staff capacity.

Achievements and challenges at regional and global levels

Achievements:

Major progress was realized in the area of 4.2.3 in the past biennium, including the following regional and global deliverables and achievements:

- Adoption of Resolution WHA68.15 at WHA68 on strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage; and development of WHO Global Surgical Workforce Database.
- Adoption of a decision at EB136 on blood and other medical products of human origin.
- Launch of the WHO Traditional Medicine Strategy.
- 2014 and 2015 World Blood Donor Days delivered successfully in collaboration with hosts Sri Lanka and China, respectively.
- 2014 and 2015 World Hand Hygiene Days delivered successfully in collaboration with WHO Collaborating Centres (University Hospitals Geneva) with a focus on reducing Antimicrobial Resistance.
- Final draft completed of the WHO Framework on Integrated People Centred Services.
• Implementation and evaluation of a pan Europe-Africa partnership-based approach to improve service delivery safety.

• Launch of the new WHO guideline on the use of safety-engineered syringes for intramuscular, intradermal and subcutaneous injections in health-care settings; production and implementation of infection prevention and control guidelines and technical documents for Ebola Virus Disease in six Ebola affected countries and 14 Ebola preparedness countries.

• Implementation of the Surgical Unit-based Safety Programme in five African countries resulting in a reduction in surgical site infections.

• Alcohol-based hand rubs included in the list of essential medicines as supported by WHO Guidelines for Hand Hygiene.

• Launch of the Safe Childbirth Checklist and Implementation Guide.

• A WHO Thematic Framework was prepared on Patient Safety and Quality, with a Global Framework for Action 2016-2019 involving headquarters (WHO HQ) and all regional offices, which includes five themes: 1) Leadership and governance; 2) Health work force; 3) Information availability and use; 4) Patients’ role; and 5) Safety and quality culture, systems and infrastructure, including specific areas.

• Finalization of a EU-WHO Collaborative project on the Minimal Information Model for Patient Safety Incident Reporting and Learning.

• Establishment of WHO Global Patient Safety and Quality Network, connecting key stakeholders including national and international patient safety and quality agencies and institutions; Ministry of Health focal points across all six WHO regions; WHO country, regional and global office focal points for patient safety and quality of care.

• The Regional Office for the Eastern Mediterranean developed and disseminated Patient safety toolkit and assessment tools.

• A Health Care Quality Improvement Network has been established in the Asia Pacific Region.

• The South-East Asia Regional Strategy for Patient Safety was adopted in a resolution at the 68th Session of the Regional Committee.

Challenges:

The main challenges for this output have arisen from the extra commitment required to provide support to the Ebola response to which staff in infection prevention, blood safety, health services organization and primary care have all contributed. In addition, it is clear that such emergency issues have had an effect at regional level, necessitating reorganization of the regional health systems team. Conflict and emergency situations hinder easy access to hospital care services, particularly in certain countries in the region.

Risks and assumptions

Eliciting a positive response from Governments and partners on improving service provision and safety through allocation of sufficient funds and reviewing and updating relevant policies and strategies is still the main assumption for moving towards UHC. Strong and sustained intersectoral collaboration; effective public private partnership in HWF training and service provision at all levels of care; ensuring universal access to at least PHC services and the availability of essential services, including public health services, at all levels of care; and improving the quality, safety and comprehensiveness of care also remain as key assumption to achieve outputs and deliverables related to this programme area.
The risks are as follows:

- Challenges associated with delays in hiring relevant staff in WHO, and more importantly, at the ministry of health (MOH) level.
- Recruitment of highly qualified short term experts and consultants.
- Increased motivation of WHO staff at all levels to work efficiently.
- Quality and safety of care within the private sector is a major area of concern, but with no central focus from WHO or other partners.
- Staff training and capacity development within WHO – overburdened staff are regularly finding it difficult to execute staff development plans meaning that leadership and management skills risk stagnating.
- Insufficient resources, delayed availability and inadequate efforts to mobilize resources.
- Weak communication and negotiation skills and at different levels of the Organization, particularly in the areas of health systems in emergencies and health security.
- Strategies are under way to prevent risks and overcome the consequences of existing risks that will damage health systems in general and service provision in particular.
- Establishing a network/roster of international health system experts.
- Assisting Member States to improve resource planning for timely recruitment, with priority given to remote and disadvantaged areas.
- Beginning exploratory work on regulating public private partnerships.
- Examining ways to institutionalize on job training.
- Capacity development and more intensive efforts to develop proposals to mobilize resources at the regional and country level in particular.
- Creating a cross cluster mechanism on health systems, security and International Heath Regulations (2005) (IHR) to look at better planning, distribution and transparency in decisions related to Human resources and financial issues.
- Updating list of stakeholders with their mandates and areas of interest.

**Gender, equity and human rights and social determinants of health**

Health equity is one of the principles of service provision and WHO promotes integration of Gender, Equity and Human Rights Based approaches in health systems development and moving towards UHC.

The new WHO Framework on Integrated, People Centred Health Services lays out a set of strategic directions and policy options for countries to address equity and gender issues, particularly in the following areas:

1. Area 1.1. Empowering and engaging individuals and families
2. Area 1.2. Empowering and engaging communities
3. Areas 1.3 Reaching the underserved and marginalized
4. Area 2.1. Bolstering participatory governance
5. Area 4.3 Coordinating across sectors

Adequate steps were taken during the planning of training programmes/workshops to encourage female participation; gender, human rights and ethics were considered in all the activities where applicable.
III. SUMMARY OF FINANCIAL IMPLEMENTATION FOR THE PROGRAMME AREA

<table>
<thead>
<tr>
<th>2014-2015 (US$ 000)</th>
<th>AFRO</th>
<th>AMRO</th>
<th>SEARO</th>
<th>EURO</th>
<th>EMRO</th>
<th>WPRO</th>
<th>HQ</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHA approved budget</td>
<td>30,000</td>
<td>6,000</td>
<td>22,300</td>
<td>11,700</td>
<td>15,400</td>
<td>23,900</td>
<td>42,200</td>
<td>151,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funds Available (as at 31 Dec 2015)</th>
<th>AFRO</th>
<th>AMRO</th>
<th>SEARO</th>
<th>EURO</th>
<th>EMRO</th>
<th>WPRO</th>
<th>HQ</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible Funds</td>
<td>13,193</td>
<td>7,066</td>
<td>11,710</td>
<td>6,655</td>
<td>9,376</td>
<td>8,401</td>
<td>12,571</td>
<td>68,972</td>
</tr>
<tr>
<td>Voluntary Contributions Specified</td>
<td>12,058</td>
<td>561</td>
<td>7,187</td>
<td>7,205</td>
<td>3,244</td>
<td>5,411</td>
<td>16,049</td>
<td>51,715</td>
</tr>
<tr>
<td>Total</td>
<td>25,251</td>
<td>7,627</td>
<td>18,897</td>
<td>13,860</td>
<td>13,860</td>
<td>13,812</td>
<td>28,620</td>
<td>120,687</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funds available as a % of budget</th>
<th>AFRO</th>
<th>AMRO</th>
<th>SEARO</th>
<th>EURO</th>
<th>EMRO</th>
<th>WPRO</th>
<th>HQ</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff costs</td>
<td>15,245</td>
<td>5,800</td>
<td>5,417</td>
<td>4,252</td>
<td>5,390</td>
<td>5,219</td>
<td>19,606</td>
<td>60,929</td>
</tr>
<tr>
<td>Activity costs</td>
<td>11,100</td>
<td>2,058</td>
<td>13,705</td>
<td>8,408</td>
<td>6,784</td>
<td>7,955</td>
<td>8,429</td>
<td>58,439</td>
</tr>
<tr>
<td>Total expenditure</td>
<td>26,345</td>
<td>7,858</td>
<td>19,122</td>
<td>12,660</td>
<td>12,174</td>
<td>13,174</td>
<td>28,035</td>
<td>119,368</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditure as a % of approved budget</th>
<th>AFRO</th>
<th>AMRO</th>
<th>SEARO</th>
<th>EURO</th>
<th>EMRO</th>
<th>WPRO</th>
<th>HQ</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure as a % of funds available</td>
<td>104%</td>
<td>103%</td>
<td>101%</td>
<td>91%</td>
<td>96%</td>
<td>95%</td>
<td>98%</td>
<td>99%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff expenditure by Major Office</th>
<th>AFRO</th>
<th>AMRO</th>
<th>SEARO</th>
<th>EURO</th>
<th>EMRO</th>
<th>WPRO</th>
<th>HQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>25%</td>
<td>10%</td>
<td>9%</td>
<td>7%</td>
<td>9%</td>
<td>9%</td>
<td>32%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Major financial implementation issues which affected programme delivery

Output 4.2.2 - The major initial implementation issue is linked to availability of financial resources which do not allow for the additional staff needed to successfully achieve the programme objectives. Funds will thus be required to cover the existing funding gap in the next biennium.

Output 4.2.2 - Measures taken to reduce costs by encouraging synergies and collaborative work.

IV. LESSONS LEARNT AND OUTLOOK FOR 2016-2017

Lessons learnt in 2014-2015

Fundraising will be needed to successfully implement the strategy to be adopted by WHA69. Ensure allocation of more flexible funding to programmes that do not have specified funds. Improve collaboration across programmes and different levels of the Organization. Operational improvements in areas of procurement and travel were implemented to maximize value for money and save on operational costs.

Impediments due to any outbreak and emergency response including the response to the Ebola crisis

None.

Outlook for 2016-2017: Planning for Sustainable Development Goals (SDGS)

WHO invested in enhancing communications and advocacy for UHC with governments and civil society. Output 4.2.2 - Intensified work on HRH to establish the baselines and work plans for SDG 3c implementation.