

Stories

From
The Field

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World Health
Organization

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Joint working team for UHC



#UHC Partnership



About the Universal Health Coverage Partnership

The Universal Health Coverage Partnership (UHC-P) promotes universal health coverage (UHC) by fostering policy dialogue on strategic planning and health systems governance, developing health financing strategies and supporting their implementation, and enabling effective development cooperation in countries.

The UHC Partnership's aim is to build country capacity and reinforce the leadership of the Ministry of Health to build resilient, effective and sustainable health systems in order to make progress towards UHC. We aim to bridge the gap between global commitments and country implementation and serve as a country-level resource for UHC2030, the global movement to build stronger health systems for UHC.

The UHC Partnership is in its ninth year of operation. Since it started in 2011, it has evolved into a significant and influential global partnership working in 115 countries in all 6 WHO regions, with the support of 7 significant donors. There are 34 health policy advisors operating on the ground with support from WHO advisors in Head Quarters and Regional Offices and over 900 million people benefiting from interventions that increasingly relate to community-level, people-centred, integrated primary health care.

The UHC Partnership is supported by the European Union, the Grand Duchy of Luxembourg, Japan, Ireland, France and United Kingdom.

Welcome to 'Stories From The Field'

The WHO magazine about how countries all around the world are working to achieve universal health coverage (UHC).



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The Joint Working Team for UHC at WHO has collaborated with colleagues in Regional and Country Offices to bring you these inspiring stories of change.

The stories demonstrate how health systems are getting stronger and providing better quality services, how care at the primary level is expanding and becoming more effective and accessible, and how communities and citizens are engaging with governments in meaningful ways to influence health policy and practice.

All this contributes greatly to make progress towards UHC; the goal that we are all striving for to ensure that everyone around the world has access to the health care they need, without being driven into poverty because of the cost.

Of course, the impact that we are seeing is not achieved by WHO alone. We work in close association with governments and other national health stakeholders in their endeavours to achieve better health outcomes for the population. We hope these articles give a flavour of how we work and what we can all achieve when we work strategically together.

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If you don't have time to read every word, you might like our 60-second summary at the end of each article!

The project has achieved numerous successes at federal levels and in Bauchi and Cross River states.

Dr. Wondimagegnehu Alemu,
WHO representative in Nigeria (2016 – 2018)



Nigeria Producing well-trained, skilled and qualified health workers to achieve UHC

A project in Nigeria is transforming the health workforce in Cross River and Bauchi States. Many health training schools have regained accreditation and are now training and producing highly qualified and skilled health workers.

In 2014, a project began called 'Enhancing the Ability of Frontline Health Workers to Improve Health in Nigeria', funded by the Government of Canada through the Global Affairs Canada (GAC). The project has the overall aim of improving the health of infants, children, women, and men in Bauchi and Cross River States by strengthening the capacities of frontline health workers to deliver maternal, neonatal and child health care services at the primary health care level.

The project is being implemented by WHO, the Global Health Workforce Alliance (GHWA) and the Population Council (PC) through partnerships formed with the Federal Ministry of Health, the Bauchi State Ministry of Health and its Departments, Agencies and Parastatals and the Cross River State Ministry of Health and its Departments, Agencies and Parastatals.



Health training institutions

One of the project's key activities is training and producing skilled health workers which has achieved many positive outcomes so far. Health training institutions in both States are much stronger and better able to produce sufficient number of qualified frontline health workers with appropriate skill-sets. Combined with increased government investment in the health workforce from the government, health services are heading in the right direction to achieve universal health coverage.

When the 'Enhancing the Ability of Frontline Health Workers to Improve Health in Nigeria' project started in 2014, only 3 out of 11 health training institutions in Bauchi and Cross River States had official accreditation from the regulatory bodies to train and confer degrees to health workers. The other institutions had their accredited status withdrawn for a range of reasons: they did not have adequate

tutor-pupil ratios, their equipment was obsolete and not well maintained, or they did not have a conducive teaching, learning and housing environment to train health workers.

“The truth of the matter is that if you don't have trainings going on, as the years go by and more people retire from service, they phase out and everywhere becomes empty and shutdown and of course we can't offer services,” said Dr Betta Edu, Director General, Cross River State Primary Healthcare Development Agency.

WHO conducted a needs assessment in these 11 institutions and clearly identified what they needed to improve in order to regain accreditation. With the government's lead, WHO improved the teaching and learning conditions, providing technical assistance in reviewing and mentoring, while the government worked on improving the institutions' physical infrastructure and refurbishment.

Now there is much cause for celebration. The health institutions regained their accreditation status and all 11 institutions are now training health workers with conducive teaching environments and state of the art equipment.

Without the support of Global Affairs Canada and WHO, the dream of establishing the College of Nursing and Midwifery would not have materialised.

Hajiya Rakiya Saleh, Provost, College of Nursing and Midwifery, Bauchi State

Cross River State

Health workforce training institutions in Cross River State have received a revitalizing boost since the 'Enhancing the Ability of Frontline Health Workers to Improve Health in Nigeria' project started in 2014. To date, all five of its nursing and midwifery schools are accredited and able to admit and train health workers. This means that the State can now recruit highly trained and professional front line health workers and place them where they are most needed.

The project supported the professional training for nursing school educators, provided contemporary teaching and learning equipment in demonstration rooms and laboratories, and provided technology support in the form of computers, printers and Internet connection. Libraries were replenished with contemporary text-books and learning tools, and technical support was provided to develop training curricula, manuals and methods. Offices, classrooms and dormitories were revamped with new furniture and most schools also received a 32-seater bus so that students could easily travel between learning sites.

As of 2019, there are now over 400 nurses, midwives, community health extension workers (CHEWS) and junior community health extension workers (JCHEWS) in various health training institutions in Cross River State. They are now receiving training with modern demonstration equipment in an improved learning environment that is equipped with standard ICT facilities, updated curricula, and relevant books. This next generation of the health workforce also benefits from well-trained, qualified and motivated teaching staff.

Exposing these trainees to modern practical and demonstration equipment, and contemporary techniques and methods results in well-trained and high-quality professional frontline health workers. Now Cross River State has a rich reservoir of incoming health workers - some of whom started graduating in September 2018 - and quality schools. The health care delivery system will be stronger as a result, and the population will have access to better quality services.

Bauchi State

The Bauchi State College of Nursing and Midwifery has developed with support from the 'Enhancing the Ability of Frontline Health Workers to Improve Health in Nigeria' project. Established in 2011, but unable to obtain accreditation due to a lack of resources, the College is now a thriving hub for training health workers from all over the State. It now has teaching and learning equipment for demonstration rooms, libraries, dormitories and science laboratories and an additional 20 tutors.

The College of Health Technology Ningi has also grown its capacity to deliver world-class health training. The library is restocked with new books, and is now benefitting from new technology and equipment, instructional materials and student handbooks and curriculum. These interventions resulted in the Community Health Practitioners Board of Nigeria granting the school accreditation.



School of Midwifery, Ogoja, Cross River State
Photo: WHO



Bauchi State College of Nursing and Midwifery. Photo: WHO



The College of Health Technology Ningi library. Photo: WHO



NIGERIA

FACT

A project in Nigeria is transforming the health workforce in Cross River State and Bauchi State. Many health training schools are much stronger and are now training and producing highly qualified and skilled health workers.

WHY IT MATTERS

Having the right numbers of qualified and skilled health workers to deliver frontline maternal, neonatal and child health care services at the primary health care level is crucial for UHC.

EXPECTED IMPACT

A rich reservoir of incoming health workers, quality training schools and a strategy for placing health workers where they are most needed are good steps towards UHC. The health care delivery system will be stronger as a result and the population will have access to better quality services.

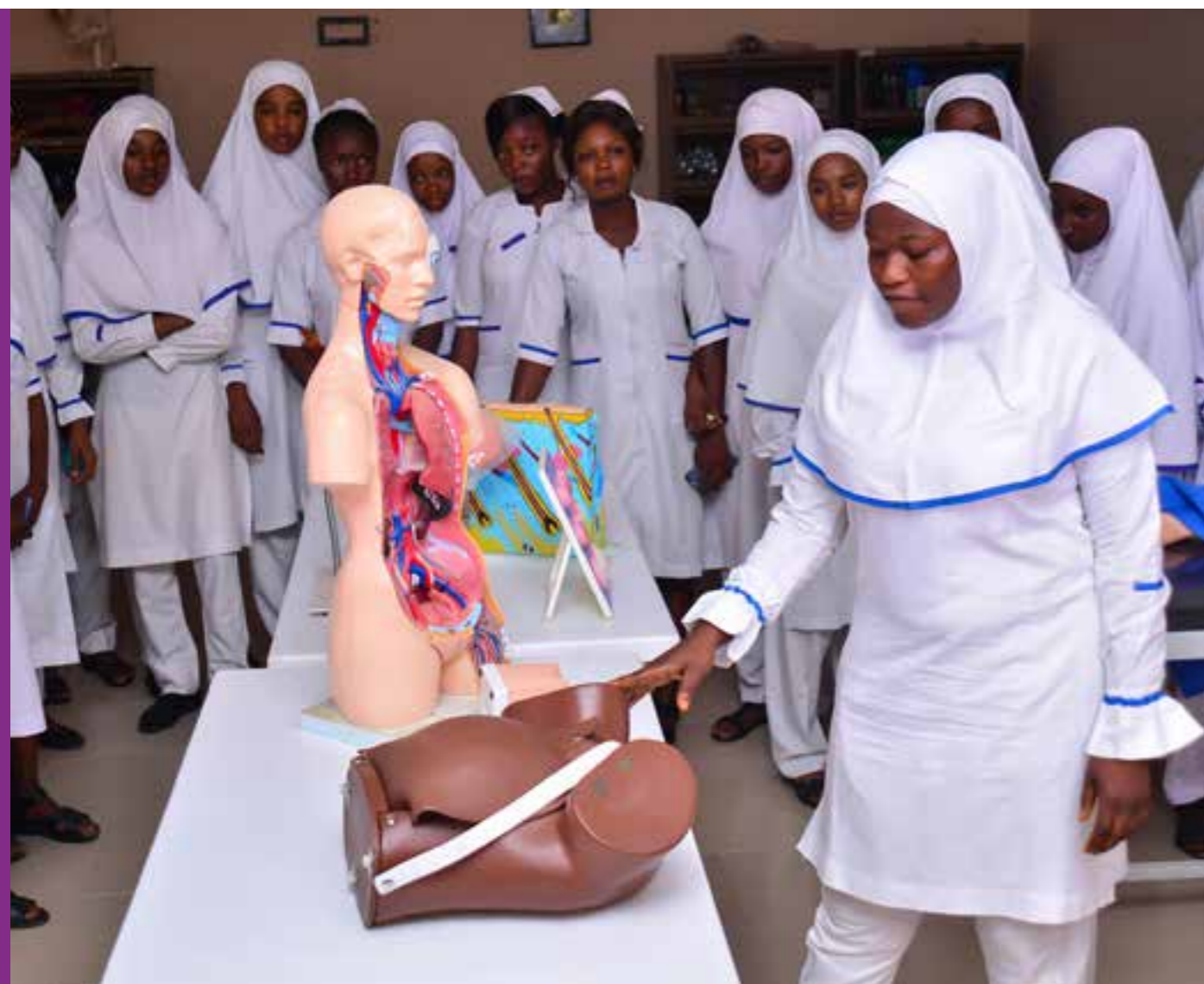
IN PRACTICE

The project is being implemented by WHO, Global Health Workforce Alliance and the Population Council, in partnership with the Federal Ministry of Health, the Bauchi State Ministry of Health and the Cross River State Ministry of Health.

This project is consistent with Nigeria's drive towards achieving universal health coverage through Primary Health Care revitalization as outlined in the National Strategic Health Development Plan II.

This requires adequate numbers of competent, highly skilled, motivated and productive frontline health workers that are equitably distributed.

Dr Peter Clement Lasuba, Officer-in-Charge, WHO Nigeria.



Gender matters

As part of the project, WHO supported Bauchi and Cross-River States in establishing gender desks and appointing gender desk officers. WHO worked with the University of Calabar's Department of Public Health of the University of Calabar to develop a gender training manual. During a five-day training, the newly-appointed gender desk officers learned how to conduct gender analysis and mainstream gender into health planning to make activities and policies more gender sensitive. In Bauchi State in the north, where gender issues are keenly felt, there have been some advances. For example, a State gender policy has been developed and is being implemented. Generally, midwifery is seen as a female cadre. As a result, most of the training schools previously only admitted females, but now male students are also in midwifery schools. As simple as it sounds, this is progress.

WHO also supported the Nursing and Midwifery Council of Nigeria (NMCN) to review the curriculum training for midwives to include gender-based violence education and other gender-specific maternal and child health topics and themes. The curriculum has become far more gender transformative than before, and graduates are now able to apply a gender lens in whatever they are doing.

Task-shifting training

WHO was also part of a consortium of partners supporting the government to develop a national task-shifting and task-sharing policy. WHO then supported the Cross River and Bauchi States to adapt the national policy to their own particular contexts and the Population Council supported the States in the policy's implementation with guidance from WHO.

First there was a need to train the cadre of health workers whose tasks would be shifted or shared. As a part of the project, the Population Council provided training around core maternal and child health interventions and emergency obstetric care at the primary care level. The Population Council also provided supportive supervision visits conducted by a joint team led by the Bauchi and Cross River States' State Primary Health Care Development Agency (SPHCDA) of Bauchi and Cross River States

Summary

In combination, these interventions in Cross River and Bauchi States have boosted the quality and professionalism of the health workforce. There is now a pool of well-trained

and skilled frontline health workers to enter into service upon graduation. The project has also enabled more strategic approaches for ensuring better distribution of the right number of workers with the right skills across all health centres. In the future, this will have a powerful impact on the health services delivered and the wellbeing of the population, allowing for clear progress on the road towards UHC.



Egypt Laying the foundations: making UHC a reality

On Easter Monday in 1859, the foundation was laid for the new city of Port Said, on Egypt's northern coast. It was the beginning one of Egypt's most ambitious projects of modern times - the construction of the Suez Canal. One hundred sixty years later, Port Said is laying the foundation for another ambitious project: universal health coverage for all Egyptians.

The right to health is explicitly enshrined in Egypt's new constitution, which also defined the principle of social health insurance. Since the law was passed in 2014, the Egyptian government has been working hard, with the support of the WHO Country

Office in Egypt, to operationalize this principle and make UHC a reality. Port Said will be the first to implement Egypt's new universal health insurance programme as part of making coverage available to all.



Building a foundation

There are three aspects to UHC: accessibility, availability, and affordability. While Egypt's health sector reforms address all three aspects of the health care system, for many people the biggest barrier to accessing health care is affordability.

So one of the top priorities of the reforms is to ensure that everyone can afford care by creating and implementing a new universal health insurance programme.

Putting a new national health insurance programme in place required overhauling Egypt's health sector, which included changing governance structures and revamping health organizations. WHO worked closely with the Egyptian government on the development of the new law and is collaborating closely with various ministerial and UHI committees on the transformation process.

The new law, which was voted in December 2017, mandates the separation of financing from the provision of health services.

It also establishes three new health structures: a Universal Health Insurance Organization to manage the insurance programme; the Health Care Organization, which oversees the provision of services; and the Accreditation and Oversight Organization, which is responsible for setting quality standards, monitoring quality, and granting accreditation.

Using as a basis the six building blocks of health systems as developed by WHO, the work included carrying out costing and actuarial studies to inform UHI financing as well as technical discussions and professional dialogues.

WHO also provided capacity-building workshops for government officials to enable them to regularly update the national health accounts and financial risk protection indicators.

As part of the process, WHO carried out an extensive assessment of the country's strategic purchasing system and its governance structure, and provided a number of recommendations for implementation of reforms to the system.

As part of the process, WHO carried out an extensive assessment of the country's strategic purchasing system and its governance structure, and provided recommendations for implementation of reforms to the system.

The result of all this work is a law which makes universal health insurance compulsory for all, while also securing credible funding, introducing new, diversified funding mechanisms, reforming pooling and purchasing arrangements, and redefining cost-sharing structures.

The process of developing the law engaged a number of different stakeholders, including civil society.

From law to reality

Work on improving access to health services, meanwhile, is moving ahead steadily in Port Said. With the assistance of the government, health facilities are being renovated, equipment is being secured for hospitals and other facilities, and registration of programme participants has begun.

To assist with this last workstream, WHO is supporting the development of the health information system, which includes indicator lists, civil registration and vital statistics, and electronic medical records.

WHO is also contributing at the local level by conducting capacity-building workshops for general practitioners, dentists and nurses in Port Said. It has also introduced Patient Safety Friendly Hospital initiatives in a number of hospitals and primary health care facilities in the governorate. Community engagement is also a key element in the implementation of the new insurance law.

WHO is working with the governorate to design a public awareness campaign along with avenues for community participation. In particular, the government is seeking to address the needs of the most vulnerable segments of Port Said's population.



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Primary health care model

Egypt is addressing the other two aspects of UHC, accessibility and availability, by building their health system around a primary care model, with a goal of addressing the majority of people's health needs through community-based care.

Much of the work to build a primary care-based model has already taken place over the last two decades. Historically, Egypt had placed a disproportionate emphasis on specialized care, but beginning in 1997, a series of reforms led to the creation of the family health model, with the family classified as the basic unit of care.

This was characterized by a responsive and comprehensive package of services that included maternal and child health services, family planning, immunization and management of childhood illnesses.

This improved the quality of PHC service delivery, and resulted in sharp declines in both maternal and under-5 mortality rates. However, even with these reforms, a substantial proportion of the population remained unable to afford health care. The previous health care system provided insurance for only approximately 58% of the population; hence, the need for a new law which provides insurance for everyone.

The new universal health insurance law reinforces the primary health care model. It stipulates that primary health care facilities are to serve as the first level of contact, and that primary care physicians should receive specialized training in family medicine.

Conclusion

By making health insurance available to everyone, and reinforcing a community-based approach, Egypt will be poised to meet the changing needs of its growing population. Port Said was once known around the world for having a vibrant and diverse population; perhaps now it will be known for having a population that is as healthy as it is vibrant.



EGYPT

FACT

The right to health is explicitly enshrined in Egypt's new constitution. Port Said will be the first to implement Egypt's new universal health insurance programme to make health services available to all.

WHY IT MATTERS

The previous health system only provided insurance for about 58% of the population, and many people could not afford to access health services.

EXPECTED IMPACT

Health insurance for everyone means that the whole population can access the health services they need, with an emphasis on primary care.

IN PRACTICE

The Egyptian government worked closely with WHO on the development of the new law on health insurance. Now WHO is collaborating with ministries and universal health insurance committees on the transformation process.



Dominica Strengthening primary care with a new cadre of community health workers

In Dominica, an island in the West Indies with a population of just over 70,000, change is underway to transform the health system into one that focuses increasingly on primary health care, is people- and community-centred and is better placed to achieve universal health coverage and access (or Universal Health, as it is known in the Region of the Americas).



The Pan American Health Organization, the regional office of the World Health Organization (PAHO/WHO) has been working with the Dominica Ministry of Health and Social Services to undertake a thorough assessment of the health system, and specific recommendations are now being

implemented. One example of this is the cadre of 27 new community health workers (CHW) who graduated from a training programme in September 2018, and are now starting work in communities to support health services at the primary level.



Building a stronger health system

In 1978, at the time of the Alma Ata declaration, the Dominica health system was a model for primary health care, but over the past several years the primary health care system grew weaker faced with resource constraints and a greater national focus on hospital care. Unfortunately, the population's health situation in Dominica worsened following Hurricane Maria, which devastated the island in September 2017. This has had a significant impact on human resources for health and the operation of community health centres, several of which were destroyed or made non-functional.

A systematic approach to strengthening the health system and primary health care services was required. Japanese grant funding through the UHC-Partnership supported a comprehensive assessment of the Dominica health system after Hurricane Maria. The PAHO/WHO technical team was comprised of seven persons focusing on various strategic aspects of universal health coverage and access. The team conducted the assessment in association with the Dominica Ministry of Health and Social Services and the National Health Commission during 2018 and early 2019.

It culminated in a comprehensive report which argued strongly that UHC in Dominica will only be achieved through strengthening primary health care and simultaneously addressing weaknesses within the health system relating to governance, health financing, resource allocation and management, and ensuring an integrated approach to health services delivery with inter-sectoral and community participation. The report made several high-level recommendations to implement action during 2019-2020.

The training of the CHWs was just one of the more urgent recommendations for health system strengthening. The skills-based training of CHW in Dominica intends to address the shortage of health personnel and increase the capacity to deliver people-centered care within community settings and multidisciplinary teams. All this greatly strengthens primary health care.

“It was a pleasure working with the PAHO/WHO team of experts, the management team in the Ministry of Health and Social Services and members of the Dominica National Health Commission to conduct the comprehensive assessment and facilitate the training of the CHWs. Even though there were many challenges, as would be expected following a major hurricane, the teams worked collaboratively to overcome them and bring to fruition the project deliverables. We are looking forward to implementing the major recommendations of the assessment report during the course of the next two years, to enable the transformation of the Dominica Health System to one that is PHC-based, resilient, sustainable and capable of attaining universal health coverage and access and the UN SDGs,” Dr. Rufus Ewing, Advisor for Health Systems and Services for Barbados and the Eastern Caribbean Countries and the Project Manager.

The course was a great opportunity to achieve clarity on health, the community and what makes a community, how it functions and what can affect its functionality. Health is broad and has many areas which taught us that we have to adapt to different personalities and to different environments. The course has produced 27 qualified foot soldiers for their respective communities and by extension the primary health care service in Dominica.

Ms Bertisha Bertrand, graduate CHW.



Training community health workers

The Ministry of Health and Social Services in collaboration with PAHO and with the support of Japanese funding through the UHC Partnership, has trained a cadre of 27 CHWs. The CHW training was conducted by skilled and experienced Dominica-based nurses in collaboration with the Ministry of Health and Social Services and WHO PAHO. The curriculum was developed by the course instructors and vetted and approved by PAHO.

The six-month programme took place at the University of the West Indies Open Campus in Dominica, and comprised 13 subject areas and Basic Clinical Skills. All participants passed the Basic Life Support exam and received certificates at an official graduation ceremony on 15th April 2019. Family and friends of the graduating class, the Permanent Secretary in the Ministry of Health and Social Services, Mrs Letitia Lestrade-Wyke, Master of Ceremony, Mrs Terrillia Ravailiere the Chief Nursing officer, and other staff from the Ministry of Health and University of the West Indies open campus attended the ceremony.

The Minister of Health and Social Services, Hon Dr Kenneth Darroux congratulated the graduates on the successful completion of the programme. He said that the training was conceptualized in-order to respond to the need for increased human resource capacity in the health sector.

“Taking into consideration the constantly increasing demand on our health services both quantum and quality and juxtaposing this against available resources human and otherwise, you can appreciate that today’s ceremony is a step in the right direction towards narrowing this ever-widening gap.”

Minister Darroux thanked PAHO for the technical support provided to the program, and commended the PAHO Country Program Specialist, Ms Anneke Wilson on the great work done since being assigned to Dominica.

Ms Wilson spoke to the graduates, saying,

“Always remember when you chose to become a Community Health Aid [Worker], you made one of the most important decisions of your life, you have chosen to dedicate yourselves to the care of others.”

Ms Jean Jacob, Program Coordinator for the Community Health Aide programme, provided a comprehensive report on the course including theoretical and practical components of the programme as well as the collaboration with a number of organizations within the communities.

Ms Bertisha Bertrand spoke on behalf of the graduating class. She said that on starting the course she had very little knowledge about the role of a Community Health Aide. She is pleased to also now have a more in-depth awareness of the meaning of health.

Reflections from the graduates

“I was introduced to the health industry by my mother who is a Community Health Nurse. Just to see her whole effort toward caring for people and taking care of the elderly, children, young or old, I felt that I wanted to play a part.”
Mr Vigilant, graduate CHW

“One of the things that motivated me was caring for persons who are unable to care for themselves, because we all know that living a healthy lifestyle is key to any society.”
Ms Winston, graduate CHW

“The six months was intensive. Coming into the programme I honestly had no idea what I was getting myself into but I must say it has really given me a deeper appreciation for the health services and the ability to be able to reach out to the community and to assist everyone especially the elderly.”
Ms Peter, graduate CHW

Summary

The training of CHWs in Dominica is just one of many initiatives geared towards transforming Dominica’s health system to become a strong and sustainable people- and community-centred health system, based on primary health care in order to achieve universal health coverage and access and the Sustainable Development Goals. There is much more work to be done over the next

two to three years to implement the major recommendations actions needed for the transformation of the health system. But already, communities are beginning to enjoy the impact of being able to access primary health services where skilled, qualified and motivated CHWs are hard at work.



Community health workers receiving certificates. Photo: WHO



DOMINICA

FACT

Dominica’s health system is transforming into one that focuses increasingly on PHC and is better placed to achieve UHC and access (or Universal Health, as it is known in the Region of the Americas).

WHY IT MATTERS

Dominica’s PHC system was growing weaker due to resource constraints and a greater national focus on hospital care. Hurricane Maria devastated the island in 2017, which had a significant impact on human resources for health and the operation of community health centres.

EXPECTED IMPACT

Training a cadre of new community health workers to support PHC means that communities can enjoy access to primary health services where skilled, qualified and motivated health workers are hard at work. In the long term, the whole health system will be stronger, making progress towards UHC.

IN PRACTICE

PAHO/WHO has been working with the Dominica Ministry of Health and Social Services to undertake a thorough assessment of the health system and specific recommendations are now being implemented.



Syrian Arab Republic

Tackling NCDs in emergencies through primary health care

Patients in north-western Syrian Arab Republic are receiving treatment and care for noncommunicable diseases (NCDs) in primary health care settings, despite living through a conflict.

“ I visited the primary healthcare center because I started to feel my heart flutter, my chest began to tighten, I felt pain and a shortness of breath. I could hardly walk. At the center, I got an appointment with the internal medicine doctor, and they did laboratory tests and an electrocardiogram for me, then, they gave me the needed medications and diet instructions. I've followed the instructions and, thank God, I got better and feel well now. I pay regular visits to the doctor and have less symptoms than before.” These are the words of Hana Haj Omar, a woman from Mardebseh in Idlib governorate in the Syrian Arab Republic. She was fortunate enough to be able to visit a centre like this, which could give her the health services she needed.

Providing primary health care services in a country like the Syrian Arab Republic, which is facing one of the world's most complex humanitarian emergencies, presents many challenges for addressing non-communicable diseases (NCDs). With a severely weakened health system, challenges include short supplies of medicines and ensuring access and continuity in health services.

In the country, an estimated 45% of all deaths are related to NCDs, which include cardiovascular disease, diabetes, cancer and chronic respiratory disease among others. Cardiovascular disease alone accounts for 25% of all deaths. NCDs are also increasing in younger people and tend to be chronic. Risk factors include tobacco use, physical inactivity, harmful use of alcohol, and unhealthy diets.

“ In north-western Syria priorities such as trauma care remain but this does not mean that the impact of chronic illnesses related to NCDs should be underestimated. The problem is not visible enough due to the ongoing conflict,” says Annette Heinzlmann, World Health Organization (WHO) Emergency Lead for the response in north-western Syrian Arab Republic.

To lessen the impact of NCDs on individuals and society, WHO integrated NCD care into primary health care (PHC) for the first time in 2018, with financial support of USAID. Delivering NCD interventions through primary health care strengthens early detection and timely treatment, especially in a setting with limited resources. It is an important way to reduce the risk factors associated

with these diseases and implement low-cost solutions for treatment.

Nine health facilities in northwestern Syrian Arab Republic piloted the integrated approach to treating NCDs, which encompassed improving diagnosis and treatment at the primary care level. WHO and its partners had to find innovative solutions to fit the care setting, which, due to the emergency situation, can frequently change.

“ Oftentimes, patients don't realize the severity of their symptoms and don't seek care. But also, with a diagnosis, there is often no continuity of care for various reasons including displacement, shortages in medicines and of medical staff. However, despite immense challenges and limited resources, WHO is investing in NCD care,” said Heinzlmann.

Leave no one behind

Universal health coverage means no one must be left behind, including people living in emergency settings. In the difficult context of a complex humanitarian emergency, it is all the more important for WHO and partners to work together to ensure that the people of the Syrian Arab Republic receive the health care services they need.



NCD patients waiting to receive care at PHC centre of Maerdaba Idlib northwestern Syria. Photo: WHO.



NCD patient receives care at Zerdana PHC in Idlib northwestern Syria. Photo: WHO.

Improving health worker capacity

Controlling NCDs involves more than medicines or medical supplies. It requires skilled health workers who work according to standard protocols and put patients at the heart of care.

In order to ensure that local health workers were able to diagnose and treat patients with NCDs, WHO trained over 240 people from the nine pilot facilities in the PEN (Package of Essential Non-Communicable disease) protocols for diagnosis and treatment of NCDs in resource-limited settings. Due to security limitations, trainings for participants from north-west Syrian Arab Republic were held in Gaziantep, Republic of Turkey.

Returning as master trainers, they cascaded trainings for all staff working in the selected health facilities. This created standardized treatment through a structured drug protocol, improved patient-centric services, consistent monitoring and follow-up, and increased screening. These are all vital components in the road to recovery for NCD patients.

WHO and its partner Primary Care International (PCI) provided remote mentoring and support to the health facilities and implementing partners through the duration of the programme to ensure adherence to protocols for diagnosis and treatment of major NCDs for several months. The trainings sought to develop 'NCD champions': health workers with clinical NCD skills, and understanding of the systems and leadership required to deliver good NCD care.

“ I am confident that the remote mentoring has resulted in direct positive outcomes for NCD patients in north-western Syrian Arab Republic, in terms of diagnosis, treatment, and more evidence-based use of limited resources. The doctors and nurses I worked with here have been extraordinarily enthusiastic, and keen to cascade the training to their colleagues.” Dr Adam Sandell, PCI clinical team.

This patient today (Hana), was not aware that she has hypertension which led to which led to an oedema in her leg and accelerated heart rate. These are complications as a result of her heart failure, caused by the hypertension. When we saw those symptoms; an electrocardiogram and laboratory tests were done, she was given the needed medications - diuretic pills and antihypertensive drugs - and has made noticeable progress. This is one of the success stories of this centre.

Dr Jamal Alwan, Internal Medicine doctor at Mardebseh primary healthcare center.



SYRIA

FACT

Patients in north-western Syrian Arab Republic are receiving treatment and care for NCDs in primary health care settings, despite living through an ongoing conflict.

WHY IT MATTERS

The country is facing a complex humanitarian emergency. Its health system is severely weakened, with short supplies of medicines and medical staff and difficulties to ensure access and continuity in health services. NCDs are responsible for 45% of all deaths.

EXPECTED IMPACT

People are able to access health PHC services for NCD care, despite the huge challenges facing the health system. There is a marked increase in the number of patients being diagnosed with and treated for NCDs.

IN PRACTICE

WHO has collaborated with partners such as USAID and Primary Care International to integrate NCD care into PHC in health facilities in the north west of the country. The project trained over 240 local health workers to diagnose and treat patients with NCDs, delivered remote mentoring and provided NCD emergency kits.

Increasing treatment capacity

Part of the remote mentoring included WHO providing NCD emergency kits comprising medical equipment and 22 essential medicines for chronic diseases such as hypertension, cardiac diseases, diabetes, chronic respiratory disease, and selected mental health and neurological conditions. They also included 'field guides' illustrating NCD treatment protocols based on WHO standards.

These kits were reviewed and updated in 2016, and again in 2018, to fit the context in the Syrian Arab Republic. Used for the first time in north-western Syrian Arab Republic, by the end of the programme, 27 NCD emergency kits had been distributed, which provided a three-month supply of medicine for 90000 people.

During the course of the programme, Syria Relief and Development, an NGO partner, reported marked increases in the number of patients being diagnosed with and treated for NCDs.

Interlinking access to medicines and medical supplies with capacity building activities ensures continuity of care for patients.



Doctor checks patient test results in PHC in Idlib Northwestern Syria. Photo: WHO.



Tajikistan Strengthening rehabilitation in UHC to leave no one behind

Tajikistan's focus on 'health for all' is taking on significant meaning for thousands of adults and children suffering from a range of health conditions, impairments and disabilities. Rehabilitation services are an important part of primary health care and achieving universal health coverage. By taking a primary health care approach, the government is transforming access to services and reaching parts of the population often left behind.



A confident Robia. When asked what she wants to be when she grows up, without hesitation she replies, "A therapist... the kind that helps children." She does not see any reason why this would not be possible.
Photo: WHO / Satish Mishra.

The National Programme is a big step forward and we are confident that it will improve the health of people with disabilities, as well as support their education, employment and self-esteem for full inclusion in society,

Mr Asadullo Zikrihudoev, Chairman of the National Association of Persons with Disabilities in Tajikistan.

Robia was only six months old when she fell ill in 2009 and was unable to move her legs. After a month, doctors diagnosed her with polio and she was sent to a rehabilitation centre but for several years there was no progress. In 2013, however, things changed. Robia started to have physiotherapy and received training in everyday life skills that could make her independent. She received a support brace from the National Orthopaedic Centre, which is adjusted as she grows. She is now thriving at school, getting good grades, and continues to visit the rehabilitation centre twice a week. Her mother knows how important the services have been. "As a result my child began to feel better, more active, more cheerful. Now she walks independently using a brace and stick. She has friends and helps me around the house."

Robia is just one of many children and adults who have benefited from the government of Tajikistan's work to establish a national rehabilitation programme, which started in 2013. It has transformed the lives of many people, and crucially, services are free of charge to those who need them. This is a key step towards universal health coverage (UHC). WHO has provided support to the government, promoting rehabilitation as a key element of a strong health system and by providing policy and implementation advice for the programme.

What is rehabilitation and who is it for?

Rehabilitation involves a set of interventions that helps people to function in society better. It may be needed by anyone who experiences difficulties in mobility, vision, hearing, speech, swallowing or cognition, for example. While rehabilitation is often associated with disability, it is also important for people who are ageing, those who have experienced injuries, who have mental health conditions or who live with non-communicable diseases (NCDs) such as a stroke or diabetes. Rehabilitation can improve people's ability to participate more fully in everyday life and can improve their ability to return to work or school. It can also reduce the costs of ongoing health care and support.

Awareness of the need for rehabilitation dates back to the Alma Ata Declaration of 1978 which states that to address the main health needs of people in the community, health care must include promotive, preventive, curative, rehabilitative and palliative services. Today, rehabilitation is even more significant than in previous decades because of ageing populations and the huge increase in NCDs.

In Tajikistan, NCDs have increased by 18% in the last decade and are the leading cause of death and disability, accounting for 59% of all deaths in 2014. Currently, there are over 180,000 registered children and adults with disabilities in Tajikistan. People with disabilities, older people and people with NCDs make up the largest groups in need of rehabilitation services.

As countries strive to meet Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages), rehabilitation must inevitably be part of the fundamental approach to strengthening the health system. But in the midst of other priorities it can sometimes get overlooked. Often it takes a particular 'event' for a government to realise the significant positive impact that rehabilitation can have on a population's health and productivity. This is what happened in Tajikistan.

Strong government leadership

In 2010, a large polio outbreak affected several hundred adults and children who had irreversible impairments and urgently needed rehabilitation services. However, Tajikistan's traditional approach to rehabilitation, based on an outdated model, was not working. The government approached WHO in 2012 for support in improving these crucial services. It was a perfect opportunity for WHO to promote rehabilitation as a key aspect of a strong health system.

The Government's strong leadership and political support for rehabilitation drove significant reforms across the health system. This was triggered partially by the polio outbreak but it had an impact which reached far beyond polio. At the government's request, WHO worked with the Ministry of Health and Social Protection (MOHSP) in 2013 to undertake a situational analysis of existing rehabilitation policy and governance and the impact of service provision on people with health conditions, impairments and disabilities.

The analysis found a scarcity of trained rehabilitation professionals (physiotherapists, occupational therapists, speech and language therapists, orthotic and prosthetic technicians, psychologists and physical and rehabilitation medicine doctors). Also, most rehabilitation services were located in urban areas, rather than rural areas where the majority of the population lives. Coordination for referrals was weak, and there was little funding for rehabilitation services. This situation, however, quickly changed.

Developing a National Programme

Between 2013 and 2016 the MOHSP developed a national policy, systems and services for rehabilitation. Beginning in 2016, the MOHSP further strengthened and expanded rehabilitation services from tertiary to primary levels, and this work is ongoing.

WHO supported this thorough policy development process with advocacy and technical advice and collaborating with development partners like United States Agency for International Development (USAID) and United Nations Partnership to Promote the Rights of Persons with Disabilities (UNPRPD) to mobilize funds for Tajikistan.

The Government developed a multi-sectoral National Programme on Rehabilitation of Persons with Disabilities (2017-2020) through a consultative process involving ministry representatives, disabled people's organisations, national and

international non-governmental organisations, and donors. Following the launch of the programme, rehabilitation and assistive products were included in the state-guaranteed health service (the basic benefit package). The package ensures guaranteed and free services for certain segments of the population, especially the poor. To date, over 180 000 men, women and children have benefitted.

This National Programme focuses on all people with long-term physical, sensorial and intellectual impairments, those with mental health conditions and those with functional difficulties caused by NCDs, surgery, infectious diseases, neurological disorders, injuries or ageing. The Programme aims to provide all these people with high-quality services to ensure their full and equal enjoyment of human rights and to respect their dignity.

The National Programme on Rehabilitation (2017-2020) aims to create an enabling environment with equal opportunities for all. WHO's support in involving diverse disability and development stakeholders has made a significant contribution to shaping the National Programme to better meet the needs of its users

Dr Saïda Umarzoda, First Minister of Health and Social Protection.



Representatives of organization for people with speech and hearing impairment providing their inputs in drafting of the National Programme on Rehabilitation – Leaving no one behind. Photo: WHO/ Satish Mishra



Wheelchairs are on the national priority assistive product list. Photo: WHO/ Satish Mishra

Nine-year-old Robia Rahimova (right) plays with her friend Mariam Narzuloeva. Thanks to the rehabilitation interventions, Robia has learned to walk using a support brace and forearm crutch, regaining functionality as well as her confidence and cheerfulness. Photo: WHO/ Satish Mishra.



Services in the community

Before 2013, most rehabilitation services were centralized and in major urban centres; but this was a barrier to the 73.6% of the population living in remote rural areas who needed to access health and rehabilitation services in their own communities. The Tajikistan government promoted Community-delivered Rehabilitation as way to bring services to the community and ensure better access. From 2016, community rehabilitation programmes have been established in 35 of Tajikistan's 66 districts, benefitting nearly 10 000 people in rural areas.

Assistive products

Assistive products are a key aspect of rehabilitation. A national priority assistive products list was developed to guide future activities such as product development and production, service delivery, market shaping, procurement and reimbursement. For example, Tajikistan imports about 800 wheelchairs a year; however, the annual need is greater than 11 700.

MOHSP, with the support of WHO, produced a report in 2019 showing that Tajikistan's current levels of quality wheelchairs are insufficient, and maintenance repair centres are not provided for or are underfunded. To reach universal coverage of wheelchairs, the government needs 10 000 wheelchairs annually over the next 3-5 years. This is important as the strength of the assistive product provision system influences the way a person accesses health services and integrates into society, including education and employment. People need to access assistive products that are appropriate for them and of good quality, without suffering financial hardship as a result.

Health workforce for rehabilitation

A strong multidisciplinary rehabilitation workforce, and rehabilitation concepts promoted in all health workforce education, is crucial in order to provide comprehensive rehabilitation services.

The MOHSP have trained and improved the capacity of rehabilitation centre staff (including physiotherapists and occupational therapists), who attended national capacity-building workshops. This led to the establishment of rehabilitation units within the hospitals and strengthening of existing rehabilitation centers. The MOHSP is supporting six local health workers - physiotherapists, occupational therapist and therapy assistants - to attend formal long-term training programmes outside Tajikistan, with the obligation to return to the country to support the MPHSP in providing rehabilitation services nationwide.

WHO is collaborating with the World Confederation for Physical Therapy and the World Federation of Occupational Therapists (WFOT) to further strengthen rehabilitation in Tajikistan. In 2018, WHO welcomed representatives of the WCPT and WFOT to Dushanbe to facilitate collaboration with the MOHSP to improve capacity building and education for rehabilitation professionals. This has led to initiation of programme to strengthen rehabilitation education in Tajikistan.

Data matters

Collecting accurate and up-to-date information about health and rehabilitation is one of the most important elements for the Government of Tajikistan in order to make evidence-informed decisions and progress towards UHC. WHO provided technical support to the Agency for Statistics on how to gather reliable data on areas such as health service use, unmet needs and the financial burden on households of paying for health. Now the Household Budget Survey contains a health and disability module, and those who conducted the interviews for the survey received in-depth training on using interview technology and processing the data. The impact of this goes further, as now information on health and disability will also be included in the national census (due to take place in 2020).

“The revised health module allow us to collect data on household expenditure on health for informed policy-making and better targeting of public funds as a key strategy to mitigate the impact of out-of-pocket payments on household welfare,” said the First Deputy Director of the Agency of Statistics, Tajikistan.

Summary

With high-level political engagement and leadership, the government of Tajikistan has established a modern rehabilitation system within a relatively short period of time and has strengthened vital services to parts of the population often left behind.

Rehabilitation is an essential part of the continuum of care, along with prevention, promotion, treatment and palliative care, and should therefore be considered an essential component of integrated health services. Rehabilitation is relevant to people with many different health conditions and those experiencing disability across the lifespan and across all levels of healthcare. Through including rehabilitation as an essential element of the health system, Tajikistan is making strong progress towards UHC and health for all.

Prevention of impairments and access to quality services for different health conditions also requires a strong health system which is still an ongoing work in Tajikistan, especially for conditions amenable to primary health care such as vaccination, good hypertension and diabetes detection and management.



TAJIKISTAN

FACT

As part of primary health care and making progress towards UHC, Tajikistan has established a National Rehabilitation Programme for adults and children suffering from a range of health conditions, impairments and disabilities.

WHY IT MATTERS

Awareness of the need for rehabilitation dates back to the Alma Ata Declaration of 1978. Today, rehabilitation is more important than ever because of ageing populations and the huge increase in non-communicable diseases.

EXPECTED IMPACT

Rehabilitative and assistive products have been included in Tajikistan's state-guaranteed health service. The package ensures free services for certain segments of the population, especially the poorest, and over 180,000 people have benefited.

IN PRACTICE

Tajikistan's Ministry of Health and Social Protection has led the way to establish the National Rehabilitation Programme; WHO has promoted rehabilitation as a key element of a strong health system and provided policy and implementation advice.

Health and disability questionnaires are new to us, we never collected such data. It is good that WHO organized the training for us, we have learned a lot.

said Zarrina Mazutova, and interviewer from Kushonion District, Khatlon Region.



Liberia Task-sharing for UHC: training nurses and midwives in obstetrics, neonatal care and anesthetics

In Liberia, a transformative project is training nurses and midwives to become qualified obstetric and neonatal clinicians. It reduces the delays commonly experienced in recognizing and treating emergencies, saves lives and ensures that mothers and babies receive the health care they need.

A trainee midwife clinician in Liberia is very clear that her newly acquired skills are saving lives.

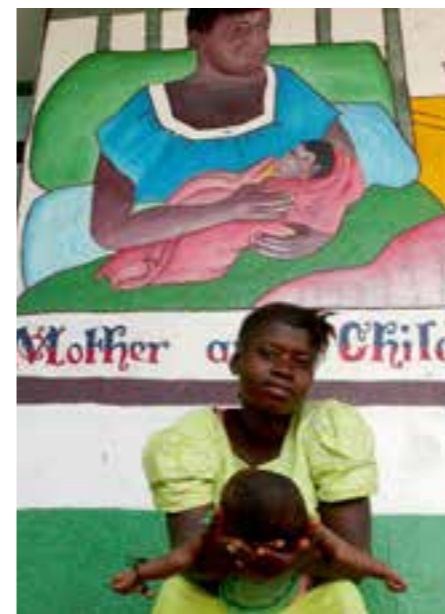
“A mother with obstructed labor referred to our rural hospital when my senior doctor had just left to find food to eat. I had to do a cesarean section along with the intern doctor. During the surgery, the patient had a deep posterior tear in the uterus, which was repaired without the senior doctor's help. It was difficult, but it was done. I monitored the patient and her baby, the whole night worrying about bleeding, but she did not bleed. We had to keep the urinary catheter in for seven days to prevent a fistula forming due to the first obstructed labor, and she was discharged eight days later along with her baby.”

In Liberia, a transformative project is training nurses and midwives to become qualified obstetric and neonatal clinicians. It reduces the delays commonly experienced in recognizing and treating emergencies, saves lives and ensures that mothers and babies receive the health care they need. Through improving the first level referral hospital-based maternal and neonatal care and coordinating with community-based care throughout Liberia, the country is taking firm steps towards universal health coverage (UHC).

The nurses and midwives are being trained to far higher levels than usual in obstetric and neonatal care in what is known as ‘task-sharing’ with other medical professionals. Why is this so important? Maternal and newborn deaths in Liberia are tragically all too frequent. Every day, an event claims the lives of four to five mothers and eight to ten newborns and most deaths occur around the perinatal period, immediately before and after birth. Many deaths are due to delays in recognizing a life-threatening emergency at the community level. Other causes are delays reaching a hospital with the right facilities and staff to treat the patient, and delays at hospitals to identify and respond to the emergency. Added to this is the problem of the lack of doctors in Liberia, with only 298 doctors and 16 obstetricians available in a population of about 4.8 million. Nurses, midwives and community birth attendants have the potential to carry out critical medical tasks.



A new born baby in Monrovia, Liberia © 2015 K O'Chel/Mi, Courtesy of Photoshare.



A mother waits with her baby at a private clinic in Kolahun, Liberia. © 2005 Kevin McNulty, Courtesy of Photoshare.

Reducing deaths in women and children

For some years the Government of Liberia has prioritized reproductive, maternal, newborn, child and adolescent health to save lives and accelerate progress towards Sustainable Development Goal 3 (SDG3) targets for reducing maternal and neonatal mortality and achieving UHC. According to the latest Liberian Demographic and Health survey, the general coverage of the majority of interventions for reproductive, maternal, newborn, and child health increased substantially during 2007-2013. But there are variations in coverage across the regions with the North-Western and South-Eastern B region experiencing a 25% higher maternal and newborn mortality than the national average.

Liberia is aiming for a 50% reduction in national maternal and newborn deaths and stillbirths by 2023, to be on track to meet SDG3 by 2030. For this to be achieved, increased numbers of pregnant women and newborns must have equitable access to high-quality services in hospitals and selected health centers. Importantly, efforts need to focus on hard-to-reach communities and vulnerable women and adolescent girls and babies in 11 rural counties.

Neonatal care for babies with life-threatening breathing difficulties has significantly improved. From August 2017 to November 2017, 65 babies with respiratory failure were successfully treated with nasal continuous positive airway pressure and discharged home.

The training programme

The Liberian Ministry of Health, WHO Liberia, United Nations Population Fund Liberia, and the non-governmental organization Maternal and Child Health Advocacy International (MCAI) have collaborated since 2013 and later created a formal partnership. They started work together on an innovative task-sharing project in advanced obstetric care and, then, a similar task-sharing project in advanced neonatal care. The Liberian Medical and Dental Council and the Liberian Board for Nursing and Midwifery provide regulation and licensing for the project. The project has been implemented for six years and is now being scaled up and rolled out to a large proportion of rural Liberia. WHO hosts the Partnership and its day-to-day functions at the country level and provides office space, training facilities, logistical support, and funding for training of the midlevel obstetric and neonatal advanced training and apprenticeship. It has also facilitated and conducted a baseline needs assessment, and independent evaluation of the work with funding support from Irish Aid.

The training follows a curriculum developed by MCAI with technical input from WHO and approved by the Partnership. It combines ongoing academic classroom-based teaching, practical apprenticeship-based training, and rigorous continuous assessment. Liberian and international experts work together for class-based teaching and ongoing evaluations. However, sustainability is essential, and Liberian doctors mainly conduct obstetrics apprenticeship component with minimal reliance on international experts.

Representatives of the Partnership carefully selected experienced midwives, nurses, and community birth attendants to undertake extensive training and undergo rigorous continuous assessment, to become qualified obstetric clinicians after three years and qualified neonatal clinicians after two years. At the end of their training, each skilled clinician is capable of safely and independently performing advanced obstetric care, including abdominal surgery and advanced neonatal care. It means they can

work more effectively in partnership with doctors to treat patients and to avoid dangerous delays in managing life-threatening emergencies. The approach has transformed patient care coordination and integration.

From the start of the advanced obstetric training in October 2013 to November 2017, the first 11 trainee obstetric clinicians undertook a total of 1,654 Caesarean sections. Neonatal care for babies with life-threatening breathing difficulties has significantly improved. From August 2017 to November 2017, 65 babies with respiratory failure were successfully treated with nasal continuous positive airway pressure and discharged home. This treatment would not be available without the neonatal programme and most of these 65 babies would have died without this treatment

The landmark task-sharing project in advanced obstetrics has led to 11 qualified obstetric clinicians, currently supports nine interns who have completed 2 of the three years of training, and from 1 February 2018 took on ten new trainee obstetric clinicians. The success of this project has recently led to the roll-out of the training to include advanced courses in neonatology and anesthesia.

Integrating obstetric, neonatal and anesthetic care is, therefore, vital for improving Liberia's response to emergencies and reducing the deaths or disability of mothers and babies. Highly-trained health professionals including nurses, midwives and community birth assistants, working together in teams in rural hospitals and health centers, is critical for providing adequate health services. As referral systems between the community and primary referral hospitals grow stronger, community health workers play a vital role. They offer an active community outreach component, connecting communities and families with the health system, which is growing ever more compelling. Quality health care that is well coordinated, integrated and linked at the primary health care level is part of the all-important steps towards UHC.



LIBERIA

FACT

In Liberia, a transformative project is training nurses and midwives to become qualified obstetric and neonatal clinicians.

WHY IT MATTERS

Maternal and newborn deaths in Liberia are tragically too frequent. Every day, an event claims the lives of 4-5 mothers and 8-10 newborns. Most deaths occur around the perinatal period, immediately before and after birth.

EXPECTED IMPACT

Liberia is aiming for a 50% reduction in national maternal and newborn deaths and stillbirths by 2023, to be on track to meet SDG3 by 2030.

IN PRACTICE

WHO has collaborated with the government through a formal partnership with other health stakeholders, and provides the partnership with office space, training facilities, logistical support, and funding for training.





Kyrgyzstan Improving access to quality essential medicines

In June 2017, Kyrgyzstan introduced three new laws focused on medicines and medical devices. National health authorities worked for several years on developing these strategic laws, and WHO actively contributed to the process and promoted their adoption.



The new laws on medicines allow the state to regulate the prices of essential medicines, making them more affordable to patients. Improving access to quality essential medicines for the population is a significant measure for strengthening a country's health system. It is also an integral step forward on the path to universal health coverage, which Kyrgyzstan set out to achieve when it adopted the Sustainable Development Goals.

Kyrgyzstan's path to accessing essential medicines

In Kyrgyzstan, almost all citizens pay for medicines out of pocket and the state only pays for 10% of the cost. Medicines are the second-largest expenditure for most families after food. Recent studies have shown that essential medicines in Kyrgyzstan are among the most expensive in the world. The mark-ups on the cost of medicines by pharmaceutical companies can reach as much as 130%.

Historically, during the early years of Kyrgyzstan's independence, the government did not interfere with prices in the pharmaceutical market. Meanwhile, price controls were actively established and revised in many countries of the European Union. The Commonwealth of Independent States including Azerbaijan, Kazakhstan, Republic of Moldova, Russian Federation, Ukraine and Uzbekistan have adopted laws on pricing regulation.

In August 2017, three new strategic laws on regulating medicines and health technologies came into effect in Kyrgyzstan. The laws were a major turning point for strengthening the Kyrgyz health-care sector overall.

The Kyrgyz Government from now on can regulate the prices of medicines and medical devices to make them more affordable. This is an important step towards establishing equitable access to quality essential medicines for the Kyrgyz citizens.

Dr Kosmosbek Cholponbaev,
Minister of Health of the Kyrgyz Republic.

Promoting new laws and strengthening collaboration

In 2018, national authorities with WHO's support made bold steps towards the development of the bylaws in different areas of medicines and medical devices regulation in order to implement and fully enforce these new legal provisions.

To ensure correct interpretation, additional bylaws were also introduced to support medicines pricing regulation enhancing overall regulation in this sector. In this context, WHO continues to provide specific technical assistance to Kyrgyzstan to achieve internationally recognized quality standards on:

- the regulation of quality and circulation of medicines and medical devices;
- post-marketing control and monitoring of medicine and medical devices; and
- the transparency, predictability and accountability of the pharmaceutical sector.

The state can now monitor the effectiveness and side effects of drugs that have already been allowed onto the market through post-marketing control measures. High-quality medical products will now enter the market more easily, because medicines that have already been tested by strong regulatory authorities – such as, the United States Food and Drug Administration, or the European Medicines Agency – or pre-qualified by WHO, will be given preference.

Technically and financially the World Health Organization helped a lot. Moreover, we have studied all the rules and practices that exist around the world and have developed our own drug pricing policy.

Dr Kosmosbek Cholponbaev,
Minister of Health of the Kyrgyz Republic.

Strengthening capacity of the National Regulatory Agency

In order to implement the new laws effectively, the country must increase the capacity of governmental institutions and authorities responsible for the regulation of the pharmaceutical sector. WHO is assisting this process by supporting the Kyrgyz National Drug Regulatory Agency to conduct a self-assessment and produce an institutional development plan. The agency plays a key role, serving as a gatekeeper for medicines entering the national market.

Kyrgyzstan's National Regulatory Agency is currently assessing the maturity of its regulatory function using a harmonized approach: the WHO Global Benchmarking Tool. WHO technical assistance will enable the identification of strengths and areas for improvement, as well as the elaboration of an institutional development plan. This plan will identify the technical and financial support needed for its implementation with continued monitoring of progress and impact.

To further promote health equity, Kyrgyzstan recently updated its national list of essential medicines. This document provides guidance on which medicines are considered most effective and safe, meet the most important needs in the country's health system, and should therefore be accessible and affordable for the population. The updated national list contains 85% of the medicines on the WHO Essential Medicine List, which recommends medicines with proven clinical efficacy and safety as well as comparative cost-effectiveness. The WHO's Essential Medicine List is revised every two years, and is a guide for countries on the core medicines that a national health system needs.

Going forward, WHO will continue to work closely with the Ministry of Health in ensuring access to essential medicines. Effective regulatory systems are an essential component of health systems and contribute to better public health outcomes. WHO plays a pivotal role in supporting countries in strengthening their regulatory systems to ensure that all medicines brought into the market are safe and effective.



A pharmacy in Kyrgyzstan. Photo: WHO/Mihail Grigorev.



KYRGYZSTAN

FACT

Kyrgyzstan has established three new laws on medicines and health technologies which allow the state to regulate the prices of essential medicines, making them more affordable to patients.

WHY IT MATTERS

In Kyrgyzstan, almost all citizens pay for medicines out-of-pocket and the state only pays for 10% of the cost. Medicines are the second-largest expenditure for most families after food.

EXPECTED IMPACT

The population will have greater access to quality essential medicines without suffering financial hardship. The health system will be stronger, an important step on the path to universal health coverage.

IN PRACTICE

National health authorities worked for several years to develop these laws; WHO contributed to the process, promoted their adoption and continues to provide specific technical assistance to achieve international standards.

Lebanon new Policy Support Observatory and National Health Forum : a milestone for UHC

In Lebanon, a new Policy Support Observatory (PSO) is strengthening the governance of the health sector with renewed vigour.

The PSO works by encouraging reliance on scientific evidence and knowledge and facilitates the work of the "National Health Forum" (NHF), a platform for systematic open and transparent collaboration among national health stakeholder networks. The NHF engages various networks of national and international partners, academia, non-governmental and governmental entities. The PSO informs new or existing health policies and projects to strengthen the health system.

The PSO and the NHF demonstrate the Ministry of Public Health's (MoPH) commitment to improve the health system in meaningful ways. The Lebanese Health Strategic Plan 2016- 2020 highlights health sector governance as one of the four strategic goals to make progress towards universal health coverage (UHC). WHO is proud to play a role to support this vital work through supporting the PSO's conceptualisation and technical implementation of projects.

Why the PSO?

Fifteen years of civil war, which ended in 1990, left Lebanon with a weakened health system, destroyed public health facilities and a dispersed health workforce. The provision of health services was mainly managed by private health facilities and a flourishing NGO sector. Adding to the frailty of the health system were poorly regulated private health services and the pressing need for the MoPH to use public funds to purchase health services from private and NGO sectors.

In 1998 the MoPH decided to take action. It made the transition from its role as the direct service provider to modernizing its governance and regulatory capacity. It did so using the power of information, surveys and studies. Working through a set of networks with a large variety of stakeholders provided information on the geography of interests and positioning of professionals, organisations, consumers and political actors; this has been essential to develop rational policies and strategies.

As a result, the MoPH developed a home-grown collaborative governance style that moved it from being a passive bystander to the main steward of the health care system. Initially, those arrangements were occurring on an ad hoc basis, risking long-term sustainability.

The PSO contributed to institutionalizing the MoPH's reliance on evidence for policy making. It also facilitates the MoPH led collaborative governance by expanding it in two dimensions. First, a 'technical' one that takes full advantage of strategic intelligence sources: scientific evidence, operational knowledge and mapping of stakeholder's interests. Second, a 'political' one of building social consensus through systematic, open and transparent collaboration with stakeholder networks. This not only enhances the resilience of the health system but also provides structured analytical and decision-making support capacity that will help spread innovation and facilitate sharing and adoption of best practices.

WHO is committed to working with the Ministry of Public Health to make this initiative a success. Achieving universal health coverage requires countries to build a consensus not only on the scope of services to be covered, but also how they are financed, managed, and delivered. Lebanon's Policy Support Observatory will help the Ministry of Health do all of that.

Dr. Tedros Adhanom, Director General,
WHO (at the PSO launch event)





LEBANON

FACT

A new Policy Support Observatory (PSO) is strengthening the governance of the health sector in collaborative ways. The PSO encourages reliance on scientific evidence and knowledge to inform health policy and engages networks of partners.

WHY IT MATTERS

Fifteen years of civil war left Lebanon with a weakened health system, destroyed public health facilities and a dispersed health workforce. The government needed to modernise its health systems governance in order to achieve UHC.

EXPECTED IMPACT

The health system will become stronger through institutionalised sources of intelligence and evidence, collaborative decision-making and political consensus sought among stakeholder networks.

IN PRACTICE

The PSO was launched by the Ministry of Health in April 2018, in partnership with WHO and the American University of Beirut Faculty of Health Sciences. WHO is now supporting the implementation of several PSO projects.

Cooperation in practice

A landmark in PSO's existence was formulating its work programme of projects based on their alignment with the MoPH agenda and opportunities to move forward. The projects were identified based on several consultations with MoPH departments, partners, experts and discussions during two first guiding committee meetings.

In 2018, Lebanon joined the Universal Health Coverage Partnership (UHC Partnership), which is co-funded by the European Union, the Grand Duchy of Luxembourg, Irish Aid, Japan and France. Under the UHC Partnership and EU Madad funds, WHO is supporting the implementation of several PSO projects including interventions to explore the feasibility and development of a deployment strategy for use of state-of-the-art Electronic Health Records; a plan for a national Health Information Management System; and establishing care coordination, referral pathways and reprofiling of Primary Health Care teams for people-centred care.

In parallel, WHO also supports knowledge production for assessing the targeting of public resources to vulnerable populations; surveys on providers' practice profiles for in-depth insights on re-organizing service delivery in a cost-effective way and possible options for task shifting among providers; and assessing service user expectations, preferences and health seeking behaviours. It also supports other work for reinforcing the pharmaceutical sector through expanding the Bar Code system and supporting the automation of the Early Warning, Alert and Response System (EWARS), as part of efforts to advance health security.

“The voices are calling for bridging the gap between scientific research and the process of policy-making and decision-making, especially the gap between the academic sector and the government,” said Dr. Fadlo Khuri, President of the AUB

In conclusion, the PSO is modernising a traditional administrative approach by allowing the MoPH to reinforce its authority and institutionalize strategic intelligence and collaborative decision-making. The PSO will assist the NHF to serve as an important platform to foster policy dialogue to develop more reliable and shared policy objectives in order to make genuine progress towards UHC.

The health sector today is characterized by interdependence, networking and multisectoral cooperation, and this initiative will contribute to promoting effective and flexible collaborative approaches to health sector governance in Lebanon.

Dr. Jawad Al-Mahjour, former Acting Director, WHO-EMRO



Launching the PSO

In April 2018 the MoPH, in partnership with the WHO and the American University of Beirut (AUB) Faculty of Health Sciences, launched the PSO through the tripartite collaboration agreement. The PSO is physically hosted at the premises of MoPH for proximity with its departments yet is intended as an instrument for integrated, but not incorporated, support to the MoPH. The PSO received the utmost endorsement at its launching event where the highest leadership of all three institutions participated from national, regional and international levels including: former Minister of Health and current Deputy Prime Minister of Lebanon Ghassan Hasbani, Director General Dr. Walid Ammar; WHO Director General Dr. Tedros Adhanom Ghebreyesus, former WHO acting regional and country directors Dr. Jawad al Mahjour and Dr. Gabriele Riedner; AUB president Dr. Fadlo Khuri and Dean of FHS, Dr. Iman Nuwayhid as well as representatives from various ministries, public institutions, and professional associations, in addition to experts and researchers from all over Lebanon.

“The project we are launching today is not a new one aiming at fulfilling wishes and possible future goals, the Policy Support Observatory is to consolidate existing practices and sustain previous achievements,” said Dr. Walid Ammar, Director General of the MoPH, Lebanon

“This Observatory will facilitate communications with all parties and partners, especially citizens, to ensure the sustainability of cooperation, effectiveness and scientific policy, away from political influence or any other subjective effects,” said Ghassan Hasbani, former Minister of Health, current Deputy Prime Minister, Lebanon

During May 2018, the PSO's guiding committee was formed with members from the partner organizations and independent experts including WHO. By the following May 2019 the guiding committee held its third meeting to discuss progress on the implementation of the work programme, and welcomed a new member from the Saint Joseph University joined; a testament to the high interest the PSO was gaining among academic circles. The MoPH also enjoys strong collaboration with the AUB. Currently, the AUB through its Faculty of Health Sciences is a member of the PSO guiding committee and in collaboration with WHO oversees work-packages to operationalize the PSO.



Estonia making medicines affordable and accessible for all

The Estonian government has introduced a new people-centred approach that makes paying for prescriptions simple and affordable for the patient; a progressive step towards UHC.

In the past getting the additional reimbursement depended on the patient's awareness and ability to apply for it. The current system is much fairer. The benefit is calculated automatically and the person does not have to pay significant amounts of money out-of-pocket to get the medicines he or she needs.

Riina Sikkut, former Minister of Health and Labour in Estonia.

Tiiu, who lives in Southern Estonia, takes care of her husband Wiktor who needs different medications to treat his cardiovascular disease, diabetes and psoriasis. He takes six tablets in the morning and two in the evening, plus ointments and creams for the skin. Both Tiiu and Wiktor are pensioners and had previously considered the out-of-pocket costs for their medicines to be significant, despite a subsidy from the government and being eligible for additional reimbursement owing to Wiktor's high prescription costs. Tiiu and Wiktor had never applied for additional reimbursement because they did not know it existed. They may have been entitled to that benefit for years.

“Last year it was such a pleasant surprise when I went to collect the repeat prescriptions at the pharmacy and the pharmacist informed me that because the cumulative amount of co-payments I had paid so far this year exceeded 100 euros I now had to pay much less than I thought. The new mechanism makes it very comfortable and simple,” said Tiiu.

All patients in Estonia expect to make a co-payment towards their prescriptions at pharmacies. However, before 2018, the system left some of the poorest and oldest people in the population having to pay significant amounts to obtain the medicines they needed. Most patients had to pay a substantial percentage of their prescription costs and only received additional reimbursement if their co-payments exceeded 300 euros a year; also, an overly bureaucratic and complex process meant that although they were entitled to claim back some of the money they had paid for medicines, many patients often did not.

This all changed in 2018, when the government introduced a more people-centred approach that makes paying for prescriptions simpler and cheaper for the patient. Affordability – ensuring people can access health services without suffering financial hardship – is a crucial aspect of universal health coverage (UHC). Today in Estonia, all patients can benefit from a seamless and more protective payment system for prescribed medicines. When their spending on prescriptions in one year

exceeds 100 euros, the government immediately covers half of any further costs until patients have paid 300 euros in total, after which the government pays almost all (90%) of any further costs. Patients do not have to apply for this benefit and wait to be reimbursed, as in the past; it now happens automatically and on the spot, through the pharmacy's information technology system.

Out of pocket payments for prescription medicines have significantly declined thanks to the improved system. The figures speak for themselves. In 2017 only 3,000 people benefited from additional reimbursement, but that rose to 134,000 people in 2018. The number of people spending more than €250 annually on outpatient prescriptions fell dramatically from 24,000 in 2017 (2.8% of the population) to 1,000 in 2018 (0.1%).





Pharmacy Euroapteek, Tallinn, Estonia Photo: WHO/Gerli Sirk

Making medicines affordable

The new process has transformed how people in Estonia access prescribed medicines, and is a good example of how progressive steps really do help a country to move towards UHC. Medical practitioners easily recognise the difference it can make to people's health and wellbeing.

“It is a really positive step. On one hand, there's a direct impact by reducing spending on medicines for patients, which leads to better adherence and reduces the risk of adverse events. On the other hand the automatic nature of the benefit is positive, especially considering the age of the main target group. It is very good that patients or their caregivers do not have to apply for the benefit or fill in separate forms; this saves time and transport costs,” said Diana Ingerainen, General Practitioner from Järveotsa Perearstikeskus, Estonia

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Diana Ingerainen, General Practitioner from Järveotsa Perearstikeskus, Estonia

Step change for UHC

Although Estonia's intention was to ensure affordable access to medicines, the previous complicated co-payment system was actually failing those who needed it most. WHO has worked with the Government of Estonia over a number of years to help influence and ensure a smooth transformation process.

In 2010, the Health Insurance Fund and the Estonian Ministry of Health and Labour asked WHO to do an analysis of the financial sustainability of the Estonian health system. WHO interviewed 28 different health stakeholders to see how they understood the system's sustainability and values and what stakeholders thought was most important to protect in the health system. Findings showed that financial protection for households was not very strong and needed to improve.

A more recent WHO analysis found that the extent of financial hardship in Estonia was quite high compared to many other EU countries. This was mainly driven by people having to pay out of pocket for outpatient medicines and experienced by people in poorer households. Over a period of years, WHO has gently advocated a fairer co-payment system that puts the patient's perspective at the centre of the transformation and encouraged

step-by-step progress towards UHC. The government understood that something needed to change and in 2018 took the lead to establish an improved co-payment system, which provides better protection for people facing relatively high out-of-pocket payments for medicines.

The improvements are in line with the 'Tallinn Charter: Health Systems for Health and Wealth'; a powerful statement signed in 2008 by all European member states, WHO and other development partners. It promotes equity, solidarity, financial protection and health through health system performance monitoring, assessment and improvement. In 2018, to celebrate the Charter's ten year anniversary, member states reaffirmed their commitment to its values and WHO presented the work on Estonia's financial protection transformation, with Estonia's Minister of Health and Labour present.

The experience of Estonia and other countries – documented in a new WHO study – demonstrates that although co-payments cause financial hardship, especially for poor people, it is possible to make medicines more accessible and affordable for everyone. Countries can take progressive steps towards UHC by putting people at the centre of health reforms, and designing systems to meet patients' needs.



Pharmacy Marja Apteek, Tallinn, Estonia WHO/Gerli Sirk



ESTONIA

FACT

The Estonian government has introduced a new people-centred approach that makes paying for prescriptions simpler and affordable for the patient; a progressive step towards UHC.

WHY IT MATTERS

Affordability is a crucial aspect of UHC. Before 2018, Estonia's system left some of the poorest and most elderly people in the population having to pay significant costs to receive the medicines they needed.

EXPECTED IMPACT

Out-of-pocket payments for prescription medicines have significantly declined in Estonia. In 2017 only 3 000 people benefited from the co-payment system, but that rose to 134 000 people in 2018.

IN PRACTICE

WHO has worked with the Government of Estonia over a number of years to advocate a fairer co-payment system and help influence a smooth transformation process.

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If you have comments or feedback please contact jwt@who.int



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There's no single path to UHC. All countries must find their own way in the context of their own social, political and economic circumstances. But the foundation everywhere must be a strong health system, based on primary care with an emphasis on disease prevention and health promotion.

Dr Tedros, Director-General, WHO

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