#UHCPartnership

Universal Health Coverage Partnership annual report 2022

More than 10 years of experiences to orient health systems towards primary health care

World Health Organization

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Cover photo: A child receives the oral cholera vaccine at a primary health clinic in Isinya, Kenya. © WHO/Billy Miaron

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Acknowledgements

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This report covers the calendar year 2022.
It provides a synthesis of country activities and results achieved with the support of the Universal Health Coverage Partnership in all the participating countries.

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

A nurse observes a newborn at a health centre in Nairobi, Kenya. © WHO/Khadija Farah

List of abbreviations

AAR	after-action review
ACT-A	COVID-19 Tools Accelerator
AEFI	Adverse Event Following Immunization
AFRO	Regional Office for Africa
AMR	antimicrobial resistance
AMRO	Regional Office for the Americas
CADRI	Capacity for Disaster Reduction Initiative
CHW	community health worker
COVAX	vaccines pillar of the Access to COVID-19 Tools Accelerator
COVID-19	coronavirus disease
cPIE	COVID-19 vaccine post-introduction evaluation
CRVS	civil registration and vital statistics
DHIS2	District Health Information System
DRG	Diagnosis-related Group
EDRM	Emergency and Disaster Risk Management
EECA	eastern European and central Asian
EIW	European Immunization Week
EMP MedMon	essential medicines and health products price and availability monitoring mobile (application)
EMRO	Eastern Mediterranean Regional Office
EPHF	essential public health function
EU	European Union
EURO	European Regional Office
EVD	Ebola virus disease
FETP	Field Epidemiology Training Programme
GAVI	Gavi, the Vaccine Alliance
GBT	Global Benchmarking Tool for Evaluation of National Regulatory System of Medical Products (WHO)
GBV	gender-based violence
GP2022	Seventh session of the Global Platform for Disaster Risk Reduction
GPW13	Thirteenth General Programme of Work for 2019–2025
HEARTS	Strategic approach to improving cardiovascular health (WHO)
HFPM	Health Financing Progress Matrix
HHFA	Harmonized Health Facility Assessment
HLMA	Health Labour Market Analysis
HPV	human papillomavirus
HRH	human resources for health
HRHIS	Human Resource for Health Information System
HSC	Health System Connector
HWC	Health and Wellness Centre
iAHO	integrated African Health Observatory
IAR	intra-action review
ICD-11	International Classification of Diseases (11th revision)
IDSRS	Integrated Disease Surveillance and Response Strategy
IHR	International Health Regulations 2005
IHR-PVS	International Health Regulations Performance of Veterinary Services
ILO	International Labour Organization
IPC	infection prevention and control
IPU	Inter-Parliamentary Union
IU	international unit
JEE	Joint External Evaluation
JWT	Joint Working Team on primary health care and universal health coverage (WHO)
MDCC	Multi-Donor Coordination Committee
mhGAP	Mental Health Gap Action Programme
MHPSS	mental health and psychosocial support
MOH	Ministry of Health
MPC	multisectoral preparedness coordination
NAPHS	National Action Plan for Health Security
NBW	National Bridging Workshop
NCD	noncommunicable disease
NHA	National Health Account
NHWA	National Health Workforce Account
oPt	occupied Palestinian territory
PAHO	Pan American Health Organization
PEN	Package of essential noncommunicable disease interventions
PEPFAR	US President's Emergency Plan for AIDS Relief
PFM	public financial management
PHC	primary health care
PHEOC	Public Health Emergency Operations Centre
REMAP	resource mapping
ROM	Results-Oriented Monitoring
SARS-CoV-2	severe acute respiratory syndrome-associated coronavirus 2
SDG	Sustainable Development Goal
SDG3 GAP	SDG3 Global Action Plan for Healthy Lives and Well-being for All
SEARO	South-East Asia Regional Office
SHIF	State Health Insurance Fund
SIDS	small island developing States
SOP	standard operating procedure
SPAR	State Party Self-Assessment Annual Reporting Tool
SPH	Strategic Partnership for Health Security and Emergency Preparedness
SPRP	COVID-19 Strategic Preparedness and Response Plan
SRHR	sexual and reproductive health and rights
STAR	Strategic Tool for Assessing Risks
STEPS	STEPwise approach to surveillance
SUM-Sim	Training, Simulation and Assessment Centre
TWG	Technical Working Group
TZG	Tripartite Zoonosis Guide
UHC	universal health coverage
UHC-P	Universal Health Coverage Partnership
UN	United Nations
UNDP	United Nations Development Programme
UNDRR	United Nations Office for Disaster Risk Reduction
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WGS	whole genome sequencing
WHE	WHO Health Emergencies Programme
WHO	World Health Organization
WISN	Workload Indicators of Staffing Need (WHO)
WPRO	Western Pacific Regional Office

A health worker cleans a window in a lab in Kulob, Tajikistan. © WHO/Lindsay Mackenzie

Executive summary

All World Health Organization (WHO) Member States have a responsibility to build and maintain effective and functioning systems with the capacity to fulfil the right to health and to comply with relevant international treaties or agreements, including the International Health Regulations 2005 (IHR) for public health emergencies. The coronavirus disease (COVID-19) pandemic has underlined the need for a resilient health sector that is capable of producing a surge response to emergencies while ensuring the continuity of health systems. However, in too many countries, health systems are not adequate to maintain essential health services and public health functions.

Following the Seventy-sixth World Health Assembly, held in May 2023, and as the world is not on track to reach the Sustainable Development Goals (SDGs) for health, Member States and WHO are calling for countries to make a radical reorientation of their health systems towards the primary health care (PHC) approach to achieve health for all in the spirit of social justice. The path to universal health coverage (UHC) can be hindered by a lack of evidence to inform policy dialogue and the implementation of policy reforms, and a lack of strong leadership and stewardship, both of which are key to the success of any progress towards UHC. However, as can be seen in this report, in 2022, the UHC Partnership (UHC-P) found a variety of solutions to generating evidence and strengthening national health strategic frameworks to achieve UHC through a PHC approach, even in the context of a pandemic.

A typical intervention that the UHC-P might make, for instance, is the development of a health benefit package. Health benefit packages are increasingly being recognized as important parts of service delivery systems. The UHC-P assisted many countries that are looking to create health care packages that anchor interventions into health systems, from prevention to palliation care and across the life course, articulating those interventions needed for each age cohort. The UHC-P also strengthened access to care through building capacity for health financing and for the workforce, improving health care delivery through integrated service delivery models, including for mental health and noncommunicable disease (NCD) services, and integrating vertical programmes into health benefit packages.

With regards to health security, as the United Nations (UN) agency for public health, WHO is mandated to support countries to strengthen their capacities for health emergencies beyond the COVID-19 pandemic. Through the UHC-P, support is delivered to implement country priority actions through the use of national action plans for health security, while connecting with national health sector strategic plans to ensure linkages between humanitarian and development activities.

Reducing health inequities and ensuring equity of access to health services are both central to UHC.

Reducing health inequities and ensuring equity of access to health services are both central to UHC. As the conditions in which people are born, grow, live, work and age are fundamental to health, promoting healthier populations requires collective action to understand and fight inequities between and within countries. The conditions that people live in are often made worse by discrimination, stereotyping and prejudice, which often affects women and girls, older people, people with disability, or by discrimination, stereotyping and prejudice based on race, ethnicity or sexual identity. Disaggregating data by age, sex, education level and income is essential to identifying inequities in health outcomes and services.

As many of the factors that threaten health and well-being today lie beyond an individual's control, the UHC-P remains committed to supporting Member States to address the determinants of health, to promote multisectoral actions to reduce risk factors, and to prioritize healthy settings and health in all policies.

Fig. 1. UHC-P 2022 timeline

January

- **Regional Office for the Americas:** ENLACE – data portal for indicators relevant to noncommunicable diseases (NCDs), mental health and external causes is launched, improving access to reliable data and information to support decision-making and guide technical cooperation activities.
- **Stories From the Field:** Afghanistan's health system is on the brink of collapse: urgent action is needed.

February

- **Stories From the Field:** Rwanda's primary health care (PHC) strategy improves access to essential and life-saving health services.
- **Stories From the Field:** Strengthening mental health services in the Pacific during COVID-19 and beyond.
- **Live monitoring:** Focus on the African Region.
- **Launch event** for the PHC monitoring framework and indicators.
- **NCD Hard Talk:** Delivering on the Promises.

March

- **Regional Office for Africa:** The National Health Summit in Sierra Leone "Transforming Health Service Delivery Towards Universal Health Coverage" results in an aide-memoire with recommendations to accelerate progress towards universal health coverage (UHC).
- **Regional Office for the Americas:** Virtual briefing session – Health, Recovery and Resilience: Summit of the Americas 2022.
- **NCD Hard Talk:** Beyond the Numbers: The human face of SDG 3.4.

April

- **Regional Office for the Americas:** A comprehensive essential public health functions training strategy to strengthen institutional capacities in the countries of the Region is launched.
- **Regional Office for Europe:** Publication of: Adjusting health financing for people fleeing conflict: policy guidance for countries in Europe.
- **Stories From the Field:** Bahamas: Protecting the population with safe and effective medicines and vaccines.
- **Meeting:** International Strategic Dialogue on NCDs and the Sustainable Development Goals (SDGs).

Global events | Regional events | Accountability mechanisms

Fig. 1. UHC-P 2022 timeline

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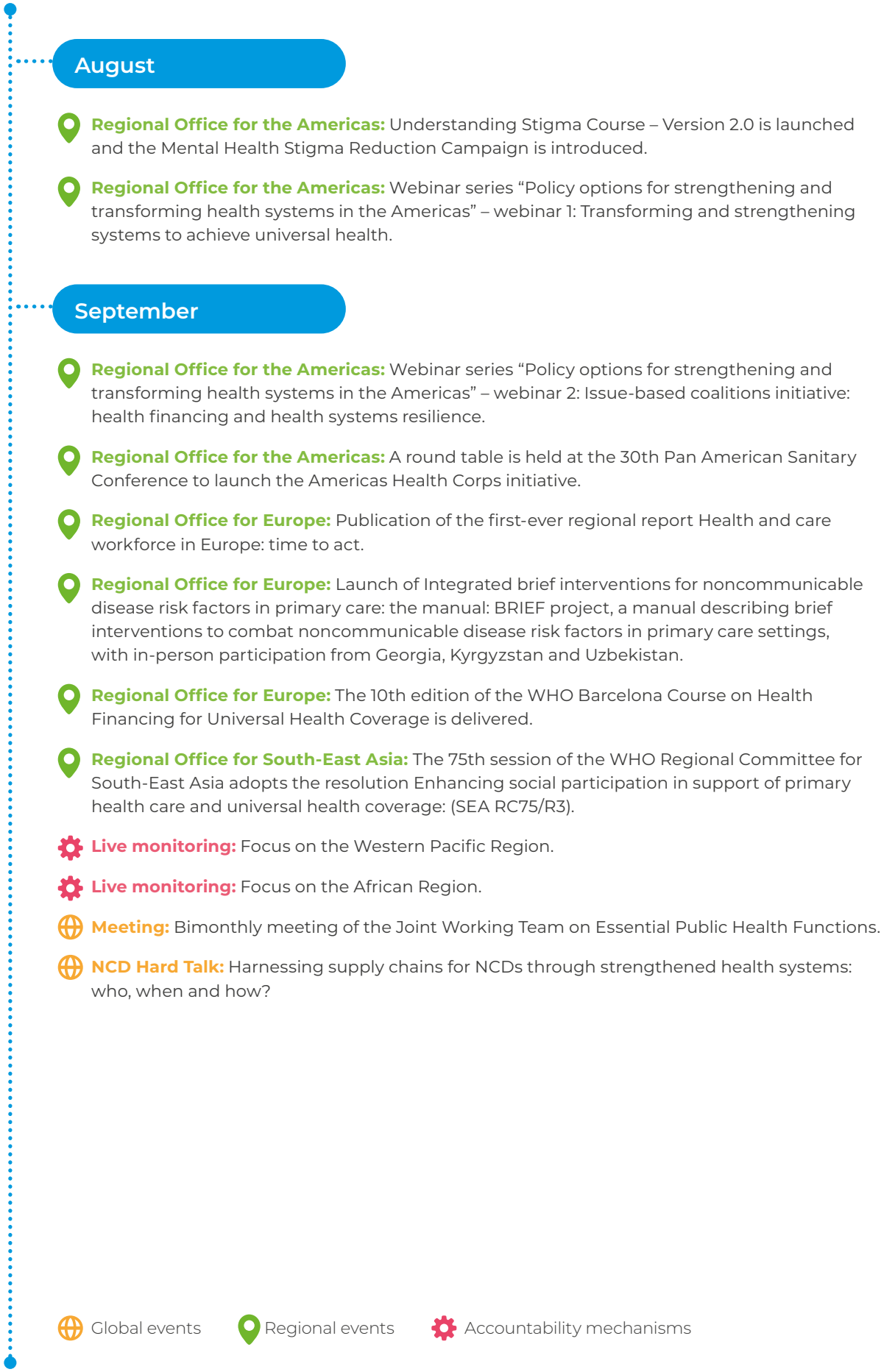


Fig. 1. UHC-P 2022 timeline

October

- **Regional Office for the Americas:** A round table on Older Persons in the Americas: Advances and Challenges takes place in Lima, Peru.
- **Regional Office for the Americas:** A Caribbean Node Meeting – Emerging trends on health professions education in post-pandemic times and the virtual campus of public health – is held in Port of Spain, Trinidad and Tobago.
- **Regional Office for the Americas:** Webinar series "Policy options for strengthening and transforming health systems in the Americas" – webinar 3: How health sector reform impact barriers to access: Are our health systems prepared to move towards resilience and universal access to health?
- **Regional Office for Europe:** An expert workshop on financial protection monitoring for countries in eastern Europe and central Asia is held in Tbilisi, Georgia.
- **Meeting:** 7th Global Symposium on Health Systems Research takes place in Bogota, Colombia.
- **Regional Office for South-East Asia:** A regional meeting on catalysing an integrated approach to quality of care, patient safety and infection prevention and control, to ensure a safe and resilient health care system, takes place in Bangkok, Thailand.
- **Live monitoring:** Focus on the African Region and the Region of the Americas.
- **NCD Hard Talk:** Unlocking behavioural insights for NCDs.

Ministries of health and partners meet to discuss health surveillance for Barbados and the Eastern Caribbean countries. © PAHO

Global events Regional events Accountability mechanisms

Fig. 1. UHC-P 2022 timeline

November

Regional Office for Africa: WHO (Regional Office for Africa working with WHO headquarters) convenes a policy dialogue with ministries of health and finance from 26 countries and critical development, bilateral and multilateral, and international financing partners that leads to a consensus to develop a health workforce investment charter to facilitate dialogue and alignment and stimulate and sustain health workforce investments.

Regional Office for the Americas: Webinar series "Policy options for strengthening and transforming health systems in the Americas" – webinar 4: Social participation: A key element in health systems strengthening and transformation.

Regional Office for South-East Asia: The Regional Forum for primary health care-oriented Health Systems is launched at the Regional Workshop to Strengthen Primary Health Care in the South-East Asia Region, Bangkok, Thailand.

Regional Office for the Western Pacific: The annual UHC technical advisory group meeting with Member States, WHO and partners recognizes the need for a UHC roadmap implementation guide that will support countries, together with WHO, in strengthening health security and reorienting health systems towards a PHC approach.

Live monitoring: Focus on the Western Pacific Region.

Walk the Talk Doha 2022.

December

Regional Office for the Americas: Webinar series "Policy options for strengthening and transforming health systems in the Americas" – webinar 5: Essential public health functions and the health systems transformation.

Regional Office for the Americas: A high-level meeting takes place on Universal Health Coverage Day 2022 with the theme: Build the world we want: a healthy future for all.

Regional Office for the Americas: Four-day meeting on Health Surveillance for Barbados and the Eastern Caribbean Countries brought together the Ministries of Health and partners to identify synergies and encourage common agendas for an integrated approach to surveillance of communicable and noncommunicable diseases, risk factors, and environmental determinants.

Regional Office for the Eastern Mediterranean: A meeting is held to discuss PHC for UHC and health security in the Eastern Mediterranean Region.

Regional Office for South-East Asia: A High-Level Summit, "UHC, We Can", takes place, following an art competition for young people, "UHC, We Want", and a webinar with youth health professionals on "UHC, We Have". The keynote address is given by H.E. Dr Lotay Tshering, Prime Minister of Bhutan.

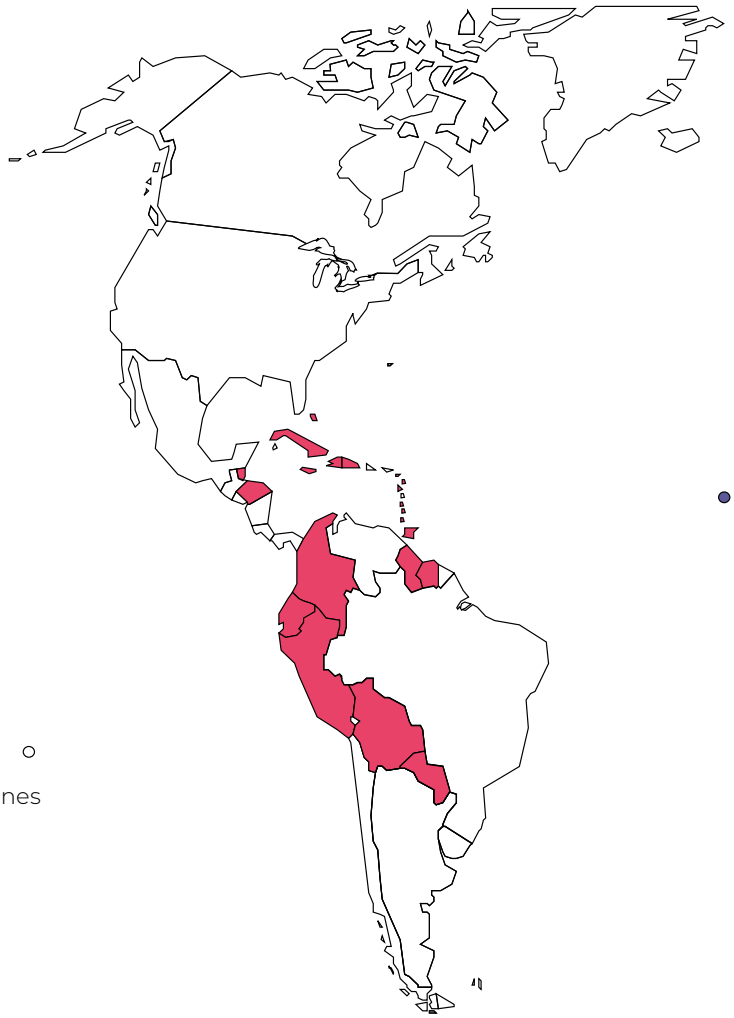
Live monitoring: Focus on the European Region.

Universal Health Coverage Day 2022 at the World Cup Qatar 2022.

Global events Regional events Accountability mechanisms

A lab technician performing a procedure in Tashkent, Uzbekistan. © WHO/Andrey Komissarov

Fig. 2. List of countries and areas supported by the UHC-P in 2022



WHO Region of the Americas

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

WHO African Region

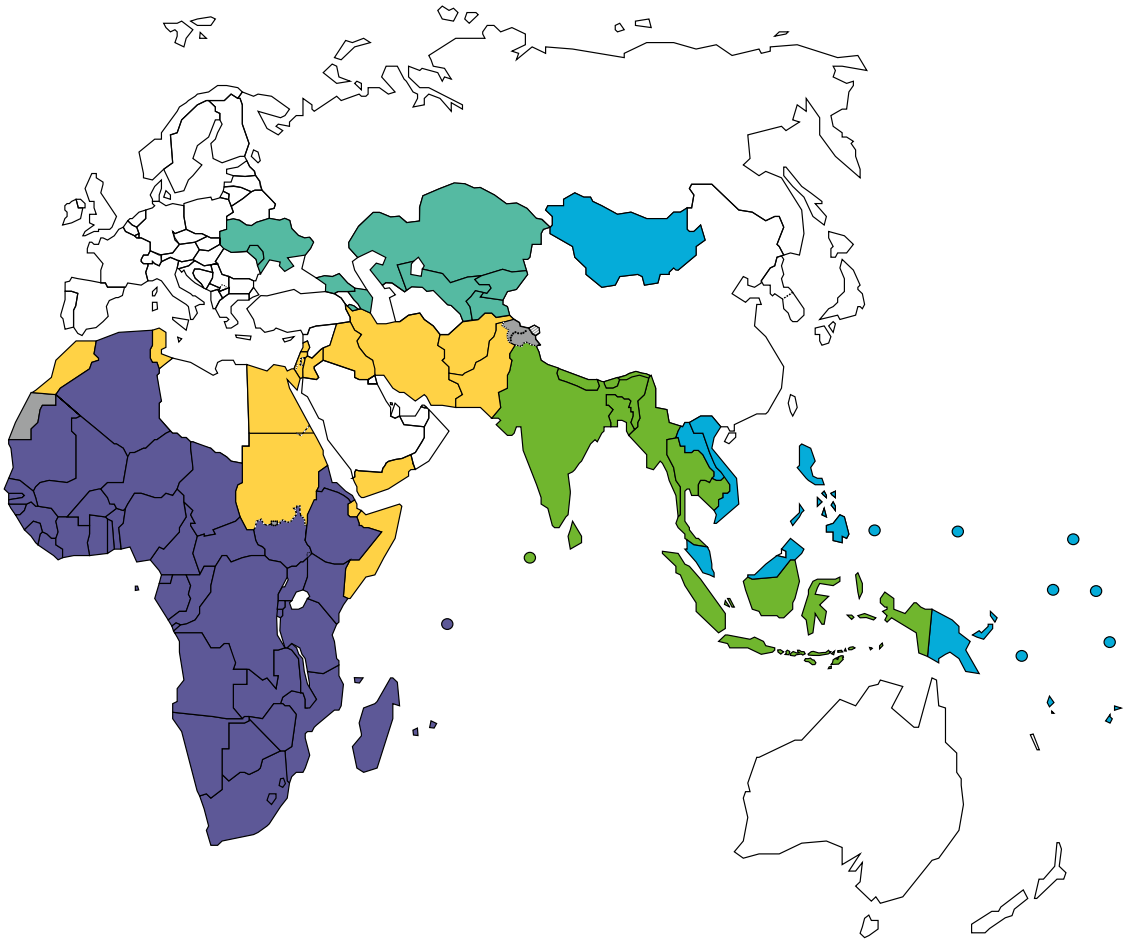
- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cabo Verde
- Cameroon
- Central African Republic
- Chad
- Comoros
- Congo
- Côte d'Ivoire
- Democratic Republic of the Congo
- Equatorial Guinea
- Eritrea
- Eswatini
- Ethiopia
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
-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

WHO Eastern Mediterranean Region

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

WHO European Region

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



WHO South-East Asia Region

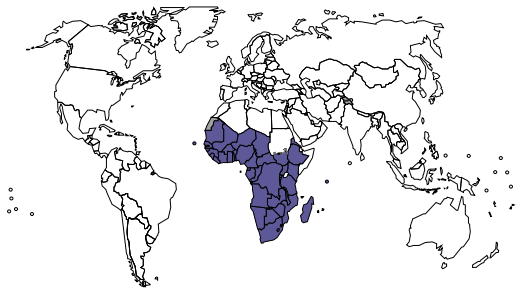
- Bangladesh
- India
- Indonesia
- Myanmar
- Nepal
- Sri Lanka
- Timor-Leste

WHO Western Pacific Region

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

Not Applicable

Regional highlights



WHO African Region

High-Level Meeting on PHC in Nigeria

The International Primary Health Care Summit 2022 was convened in March with the theme: Re-imagining primary health care: evolving a resilient platform for achieving the country's national and global health goals via a peri-COVID era.

Regional workshop on private sector engagement involving 17 countries

A multi-country awareness and consultation workshop was convened on private sector engagement for UHC in November 2022. A pre-meeting rapid assessment survey was conducted in these countries with the publication of findings ongoing. This workshop brought together 17 countries (Angola, Botswana, Burkina Faso, Burundi, Cabo Verde, Comoros, Congo, Côte d'Ivoire, Kenya, Mauritania, Nigeria, Senegal, Sierra Leone, South Sudan, Tchad, Uganda, Zambia) that included this theme as a priority in their 2022/2023 biennial plans.

Multi-cluster missions (Niger, Senegal, South Africa)

Member States requested support from the Regional Office in different areas. This support was provided in a coordinated manner, with thematic working groups being formed, including other relevant clusters and units. Country teams have been encouraged to do the same and work across sectors. Examples of multi-cluster missions in 2022 include support given to **Niger** to develop their national health strategic plan and a coordination framework for its implementation, and support given to **Senegal** to evaluate its national health financing strategy to accelerate progress towards UHC. Thematic working groups were formed across clusters at the regional level with in-country support involving members from different teams.

Health Labour Market Analysis (HLMA)

In collaboration with WHO headquarters and with funding support from the Global Fund to Fight Tuberculosis, HIV and Malaria, the Regional Office for Africa trained a pool of experts from 16 countries to champion sustainable health workforce investments in the context of health system recovery and resilience using HLMA as an important tool. The uptake of HLMA by countries increased substantially following the regional workshop, with **Eswatini**, **Ghana**, **Malawi**, **Mozambique**, **Nigeria**, **Uganda**, **United Republic of Tanzania**, **Zambia** and **Zimbabwe** having started using HLMA or planning to start. Four countries (**Ethiopia**, **Kenya**, **Lesotho**, **Zimbabwe**) were provided with technical and financial assistance to conduct HLMA and health workforce projections to inform health workforce policy.

WHO Region of the Americas

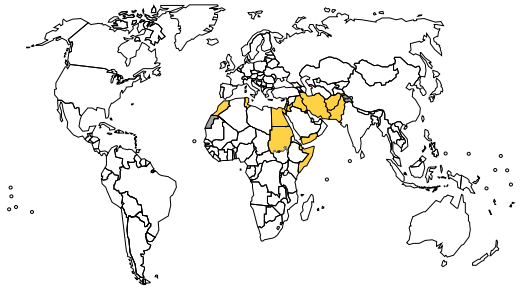
In 2022, the Regional Office for the Americas supported the expansion of health services delivery in the Americas based on PHC, leveraging the UHC-P funding to expand access to comprehensive, integrated health services at the primary care level. This has included advancing integration of noncommunicable diseases (NCDs) into PHC, expanding access to mental health care, improving quality of radiology and mammography care, increasing human papillomavirus testing, and reducing risk factors and improving care for NCDs through WHO's Strategic approach to improving cardiovascular health (HEARTS) initiative.

The Regional Office for the Americas proposed a new Package of Essential Health Services for PHC that included essential interventions to meet the current health needs of the population in **Guyana**, to ensure access to health services for all, covering about 115 different health conditions at the various levels of care. **Jamaica**'s fragmented health system is also currently being transformed and reoriented to provide effective, efficient person-centred care, which is particularly important for tackling NCDs. In **Barbados**, the Regional Office for the Americas coordinated an international mission of health financing experts to advise the government on recommendations for improving and increasing health financing in the context of a local decision to implement a national health insurance scheme in the medium term.

Through advancing the essential public health functions (EPHFs), the Regional Office for the Americas supported the capacity of public health authorities to strengthen health systems and guarantee the right to health for everyone in countries across the Americas. EPHF assessments and strengthening exercises were ongoing in **Bahamas**, **Dominican Republic**, **Jamaica**, **Saint Kitts and Nevis**, **Saint Lucia**, **Suriname** and **Trinidad and Tobago** in 2022.

In 2022, the Regional Office for the Americas also strengthened Member States' capacities to manage public health emergencies by developing profiles for each of the 35 countries in the Region using data from the State Party Self-Assessment Annual Reporting Tool (SPAR) from 2010 to 2021. These profiles were reviewed and discussed, serving as key inputs during the International Health Regulations Regional Meeting, held in December 2022 in **Chile**, focusing on the scope of two specific capacities of the SPAR in the context of lessons learned during the COVID-19 pandemic: coordination, and points of entry and border health.

A patient goes through a routine check at a health centre in Siparia, Trinidad and Tobago. © WHO/Blink Media - Kibwe Brathwaite

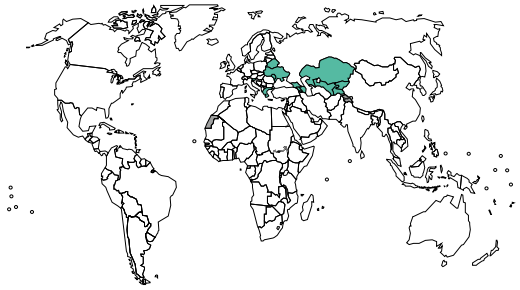


WHO Eastern Mediterranean Region

The diversity of contexts in the Eastern Mediterranean Region makes it a challenge to support countries and areas. Different models of care for family medicine are defined according to various contexts. Following a scoping review, a model has been established at subnational level and is to be replicated throughout the country to advance the agenda of UHC and health security. Based on the Astana framework, these models of care are built on four main levers: governance, financing, resources and information. Several high-level missions (**occupied Palestinian territory (oPt), Pakistan, Sudan**) have been organized for rebuilding health systems. These have shown an appetite for linking high-level strategic commitments with operational solutions, but have seen limited success due to variable levels of understanding of models of care, limited evidence on implementation approaches, limited field visits and limited funds for further work.

In 2022, there was a focus on health financing being linked to governance and access to essential health services, data and innovation, essential health products, and preparedness for health emergencies. The UHC-P also supported work on strengthening the hospital sector to better integrate people-centred health services, with several consultations and mappings identifying that a paradigm shift was required to adopt a PHC approach. This would require moving from disease-based, individual, fragmented and acute care to a needs-based, overall population health, continuum of care and to networks of integrated delivery services. Hospital strategic planning was undertaken in Sudan, Pakistan and the oPt. A hospital framework with indicators was also created at the regional level.

A dialysis patient in south Gaza. © WHO



WHO European Region

In 2022, 50 missions were undertaken in all UHC-P countries of the European Region, focused on PHC strengthening, health financing and improving health workforce and service delivery. The UHC-P launched two WHO PHC Demonstration Platforms, in **Kazakhstan** and in **Sweden**. Four UHC-P countries visited these Platforms: **Georgia**, **Kyrgyzstan**, **Tajikistan** and **Uzbekistan**. WHO's PHC Demonstration Platform is an innovative programme for cross-country experience exchanges on how PHC transformation was implemented, and how strategic visions were realized in practice. Also, a manual for NCD risk factors in PHC was launched in Almaty, Kazakhstan, a hybrid event with in-person participants from Georgia, Kazakhstan and Uzbekistan. Furthermore, six episodes of "Let's Talk PHC" were aired this year, with topics including mental health in PHC; PHC networks; leadership for PHC; digital solutions in PHC; young workforce in PHC; and a motivating work environment for PHC.

The *Health and care workforce in Europe: time to act* report was published in September 2022 and focuses on identifying effective policy and planning responses to these health care workforce challenges across the Region. The report has had more than 7000 downloads and it has been mentioned by more than 500 news outlets and presented at multiple conferences and meetings. The report has also been widely distributed to all the ministries of health in the Region, associations, multilateral partners and academia, including UHC-P countries.

A family nurse at a health centre in Rudaki, Tajikistan. © WHO/Lindsay Mackenzie

WHO South-East Asia Region

In 2022, in **India**, UHC-P support has been accessed through a decentralized model where a range of state-specific support has been provided with a focus on advancing India's vision of Comprehensive Primary Health Care. In **Timor-Leste**, a range of health system support was provided, including co-development of the Essential Service Package for Secondary and Tertiary Care, technical support towards raising pro-health taxes, and work towards developing Timor-Leste's first National Essential Diagnostics List.

In 2022, advancing UHC during the period was especially challenging in **Myanmar** and **Sri Lanka**. In Myanmar, political instability and insecurity since February 2021 and the associated budget cuts, as well as United Nations engagement rules, have significantly impacted UHC-focused country support activities provided by WHO. Thanks to UHC-P's flexibility, activities shifted to purchasing life-saving reproductive, maternal, newborn and child health interventions, and NCD and emergency care services from professional associations and private actors.

Support from UHC-P enabled the use of strategic purchasing models, with associated monitoring and evaluation supported by the health policy adviser and health system team. A phone survey on obstacles to accessing health services identified that half of respondents utilized self-treatment.

In Sri Lanka, the historic economic crisis and structural reform discussions similarly influenced UHC-focused activity by WHO. Nevertheless, the UHC-P enabled WHO to lead a technical analysis of health system efficiency, with a focus on human resources for health (HRH) and service delivery. The technical analysis included national reviews of HRH and service delivery, as well as lessons learned from best practices globally. The technical analysis was a key input to structural reform deliberations in 2022; and to ongoing discussion on options for health financing reform.

A mobile clinic serving remote communities at a Haat Bazaar market in Kalimpong, India. © WHO

WHO Western Pacific Region

In 2022, the Regional Office for the Western Pacific furthered efforts to support countries to accelerate progress towards UHC using PHC as a platform. While many countries opened their economies after COVID-19, it became apparent that time was at a premium to reorient health systems towards PHC. Progress was made in many areas, including creating policy space as a foundational step for future success in PHC reforms, while several Member States advanced health financing policies to protect people against financial hardship and attain efficiency gains. The shift to helping populations to maintain health and well-being was accelerated through initiatives that spanned the entire spectrum of the Triple Billion targets both up and downstream, which can be illustrated by the breadth and depth of activities taking place in the countries of the Region.

The Regional Framework on the Future of Primary Health Care was adopted by Member States at the 73rd session of the Regional Committee for the Western Pacific through resolution WPR/RC73.R2. It highlights five strategic areas of actions: models of service delivery; individual and community empowerment; workforce and provider base; financing; and enabling and supportive environments to enable this transformation. It calls on a need for critical health system transformation to achieve UHC and the SDGs.

In addition, the Regional Office for the Western Pacific, in collaboration with the Regional Office for South-East Asia, World Bank and Asian Development Bank, held the sixth bi-regional health financing workshop in July 2022, with the theme of seeking efficiency gains in the context of pandemic recovery and reorientation towards PHC. Technical discussions and sharing around strengthening social health insurance systems for improved efficiency and financial protection were discussed among participants from ministries of health, ministries of finance, and social health insurance agencies from 20 Member States across the South-East Asia and Western Pacific regions. The workshop has led to increased political consensus on investing in health, strengthened partnerships and identified areas of collaboration in the Region to advance PHC and UHC. Following the meeting, the policy discussions around seeking efficiency gains have translated into country support activities in **Lao People's Democratic Republic** (donor transition and hospital autonomy), **Cambodia** (UHC 2030 roadmap), **Mongolia** (cost containment in public hospitals) and **Malaysia** (the white paper discussion for health financing for the future).

A child doing a reading test for a pair of glasses at a health centre in Krong Kampot, Cambodia. © WHO/Miguel Jeronimo

Fig. 3. UHC-P by the numbers

9 donors

LUXEMBOURG AID & DEVELOPMENT

Belgium partner in development

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

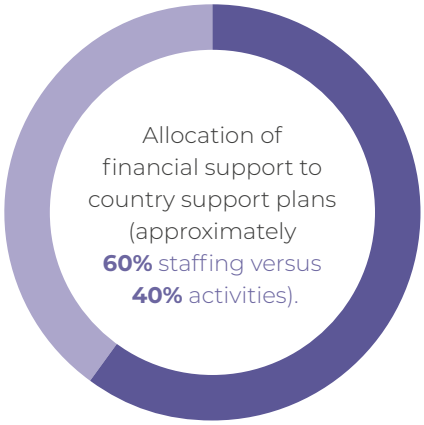
Foreign, Commonwealth & Development Office

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

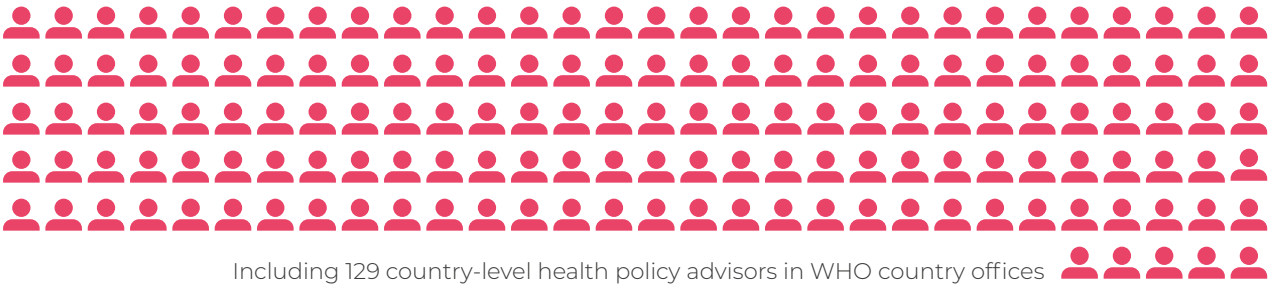
Canada

US$ 527 million

leveraged from partners to assist countries in building resilience and effective health systems, including US$ 69.1 million in 2022.



155 health policy advisors globally

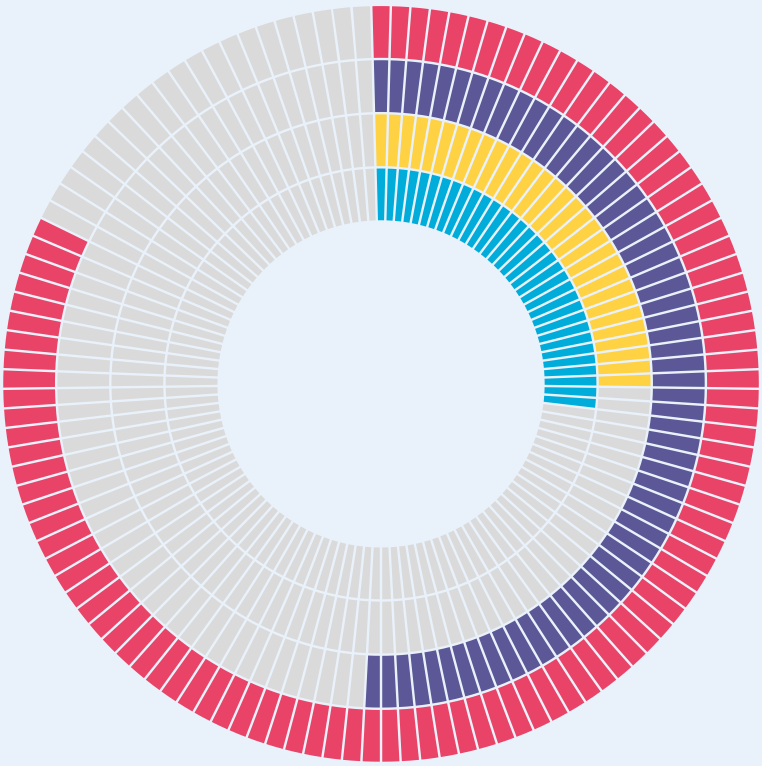


Including 129 country-level health policy advisors in WHO country offices

121 countries in the 6 WHO regions

See the Annex for all UHC-P activities mapped by country

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



1st BILLION:
100 countries

2nd BILLION:
62 countries

3rd BILLION:
31 countries

Better WHO support:
33 countries

Fig. 5. Top 10 outputs supported by the UHC-P in 2022

Output	Top 10 outputs	Number of countries involved
1.1.5	Countries enabled to strengthen their health workforce	69
1.1.1	Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages	67
1.1.4	Countries' health governance capacity strengthened for improved transparency, accountability, responsiveness and empowerment of communities	66
1.2.2	Countries enabled to produce and analyse information on financial protection, equity and health expenditures, and to use this information to track progress and inform decision-making	48
2.1.2	Capacities for emergency preparedness strengthened in all countries	45
1.1.2	Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results	40
1.2.1	Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage	39
1.3.1	Provision of authoritative guidance and standards on quality, safety and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists	36
1.3.3	Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved	31
4.1.1	Countries enabled to strengthen health information and information systems for health, including at the subnational level, and to use this information to inform policy-making	24

A community health volunteer explains the danger signs of acute malnutrition to breastfeeding mothers in Nairobi, Kenya. © WHO/Fanjan Combrink

Introduction

All countries involved in the UHC Partnership (UHC-P) have seen an increase in their UHC index during the last decade, thanks to efforts achieved by national authorities and to the support that global and national health partners have provided to national authorities. In more than 125 countries, the UHC-P demonstrated what can be achieved through health systems strengthening with a primary health care (PHC) approach, including in the context of the coronavirus disease (COVID-19) pandemic and other health emergencies. While much work remains to be done, progress has been achieved in improving the UHC index. This progress needs to be accelerated, building on the experiences and lessons learned from the countries that have been supported by the UHC-P. A decade on from its inception, the Partnership has evolved into one of the largest and most effective platforms for international cooperation on universal health coverage (UHC) and PHC. It is now time to deepen this investment to ensure its sustainability and support countries to achieve health for all.

What is universal health coverage?

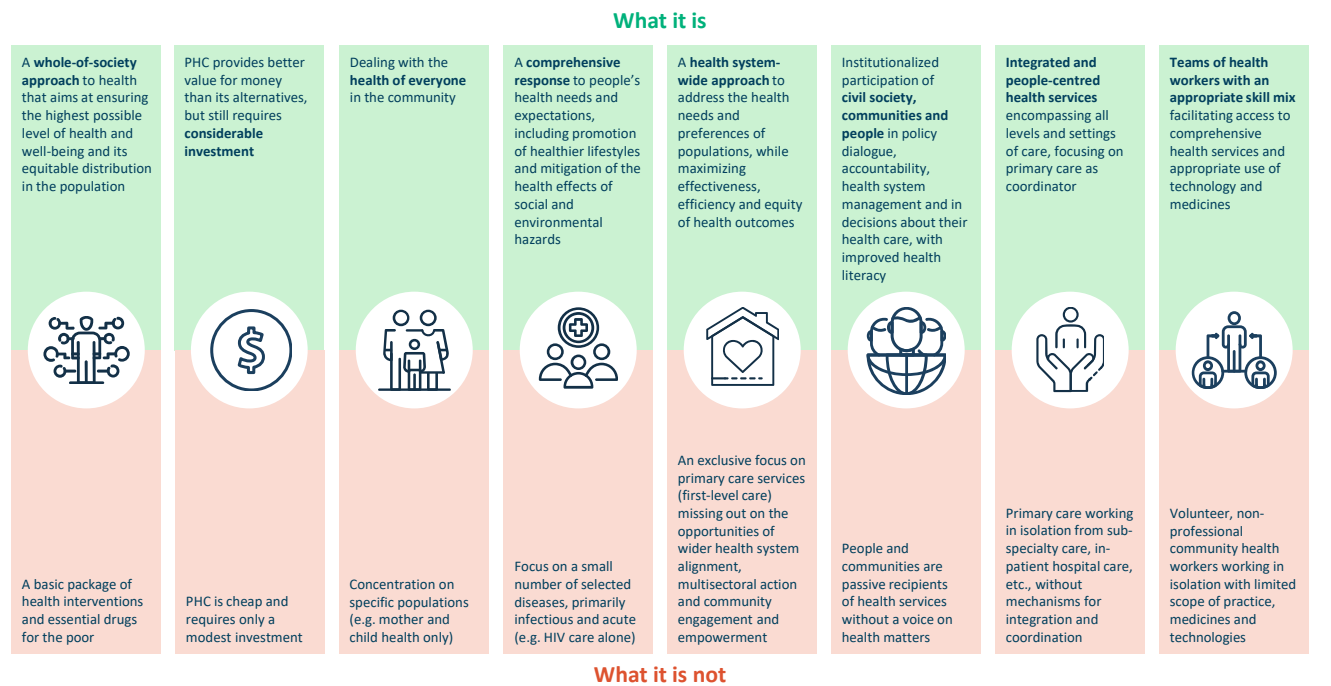
UHC means that all people and communities – with no one left behind – receive the quality services they need, and are protected from health threats, without suffering financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. UHC has been adopted and supported by several World Health Assembly resolutions (WHA58.33, WHA64.8, WHA69.11, WHA71.1 and WHA72.13) and included as one of the three fundamental pillars of the new World Health Organization (WHO) Thirteenth General Programme of Work for 2019–2025 (GPW13).[1,2] UHC is a political choice to be made by every nation.

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

In order to reach UHC, health systems must be oriented towards a PHC approach, which includes three essential components: multisectoral policy and action, empowered people and communities, and PHC and essential public health functions (EPHFs) at the core of integrated health services. In 2022, following the publication of the operational framework for PHC,[3] the monitoring framework and indicators[4] have been published to support countries to assess how decisions, actions and investments address the broader determinants of health while improving service coverage, financial risk protection and, ultimately, the health of individuals and populations. PHC is the main strategic approach of the UHC-P to move towards UHC and health for all. Fig. 6 presents a visual of how experience and recent thinking have shifted the focus and meaning of the PHC movement. This change is intended to widen the scope and perspective of PHC and make it a whole-of-society approach for dealing with health needs, responses and actors' responsibilities.

UHC means that all people and communities – with no one left behind – receive the quality services they need, and are protected from health threats, without suffering financial hardship.

Fig. 6. PHC in practice



Source: Modified from WHO, 2008.[5]

How does the UHC Partnership support countries?

The UHC-P was created in 2011 to promote UHC, aligned with SDG target 3.8, by supporting policy dialogue and providing technical assistance to enable governments to strengthen health systems in governance, workforce, financing, access to health products, information and service delivery, while enabling effective development cooperation (Box 1). Recently, the UHC-P has developed a specific focus on NCDs; health security; and gender, equity and human rights thanks to its flexible and catalytic approach.

In 2022, the UHC-P channelled investments from nine donors (Belgium, Canada, the European Union (EU), France, Germany, Ireland, Japan, Luxembourg, and the United Kingdom of Great Britain and Northern Ireland) to WHO country offices and Member States to ensure continuity between global commitments and country implementations for health systems strengthening (Fig. 7). The activities being funded are supporting WHO's workplan across all three levels of the organization (country, regional and headquarters) based on GPW13, and not as a separate project (Fig. 8). GPW13 has recently been extended until 2025.

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

To ensure consistency, the UHC-P developed a specific tailored and bottom-up approach based on country-selected priority areas and country capacities.

Box 1. UHC-P working principles

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

In-country technical assistance
More than 145 long-term senior policy advisers deployed in countries worldwide to support Member States and ensure approaches and assistance fit for context.

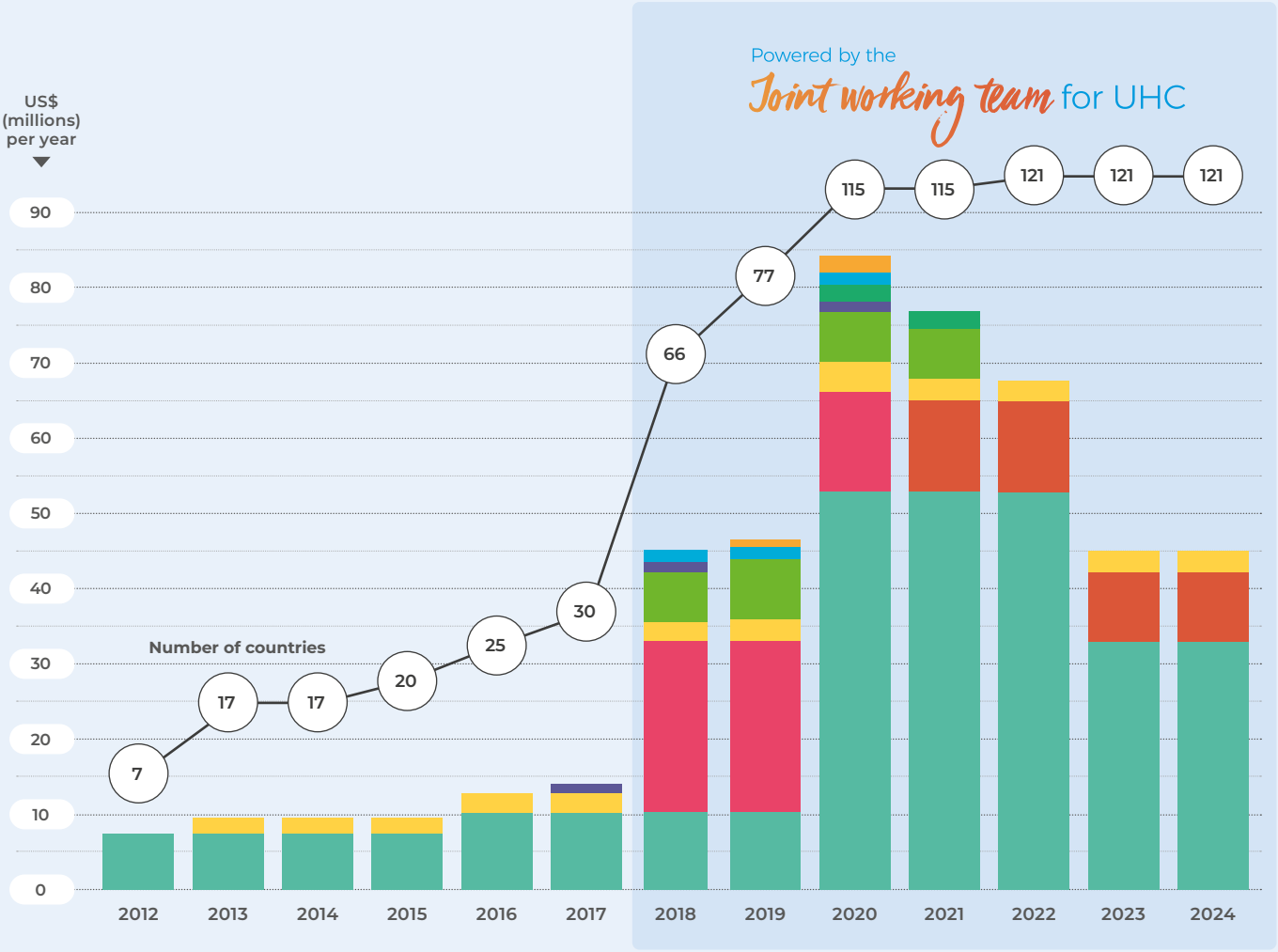
Participatory governance
The UHC-P continues to advocate for policy dialogue and social participation, including in times of crisis, in order to build and maintain trust and ensure policy adherence.

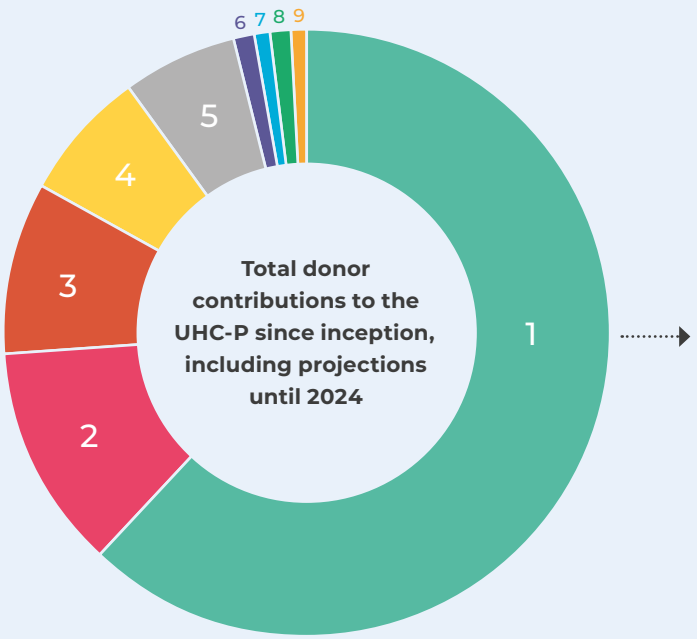
Prepare, respond and maintain essential health services
The UHC-P supports governments to protect communities from the impacts of health emergencies, maintain essential health services and strengthen country capacities to face future health threats.

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

A health worker prepares medicine in Kakinada, India. © WHO/Atul Loke

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





		%	Years	US$
1	European Union	62	2011–2022	295 018 859
2	Japan	12	2018–2021	58 604 545
3	Canada	9	2021–2022	42 593 346
4	Luxembourg	7	2013–2024	32 416 304
5	Foreign, Commonwealth & Development Office	6	2018–2020	26 497 175
6	France	1.1	2011–2021	5 426 198
7	Irish Aid	1.0	2017–2022	4 741 943
8	Belgium	1.0	2020–2022	4 694 836
9	Germany	0.7	2019–2021	3 366 018

The UHC Partnership sets a model for transparency and accountability

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

Multi-Donor Coordination Committee

The Multi-Donor Coordination Committee (MDCC) provides a visible and transparent mechanism to enable discussions and coordination with the donors on successes and challenges related to the implementation of major activities in the framework of the UHC-P. The MDCC met in May 2022. The overall objectives of the MDCC are:

- to improve coordination between WHO and donors, by providing a platform to regularly convene, and streamline programmes, as well as harmonize and align approaches in order to build synergies and prevent duplication of work;
- to share information with a view to aligning donor investments based on aid effectiveness principles – that is, one plan, one monitoring mechanism, one report, in line with the GPW13 and its priorities for countries;
- to identify priorities and gaps in the response with a view to informing the future direction of programme-specific funds, but also other investments, in complementarity with other global initiatives.

The MDCC provides an opportunity to regularly share the challenges and successes of WHO UHC country support plan implementations both with the UHC-P donors and other stakeholders. Serving a catalytic role, the UHC-P allows stakeholders to come together to adapt and find solutions to address challenges and bottlenecks on progress towards UHC at the country level.

UHC-P Steering Committee

In June 2019, under the guidance of the Deputy Director-General of WHO, Dr Zsuzsanna Jakab, a WHO internal High-level Steering Committee was put in place. This Committee comprises the Deputy Director-General, the Executive Director of the UHC Life Course Division, as well as all involved Assistant Directors-General and Executive Directors, as well as the Directors for Programme and Management of the six WHO regional offices. In 2022, one meeting was held in May to exchange information on the UHC-P, resource mobilization and allocation at the three levels of WHO and on the deployment of the three layer approach for intensified PHC support. The main contribution of the Steering Committee to the UHC-P was improving alignment and coherence of WHO in the field and ensuring strong support from senior management for the implementation of managerial processes to ensure fast recruitment procedures and quick availability of funds at the country and regional levels.

Live monitoring mechanism

Live monitoring aims to review progress from WHO's country and regional offices on UHC-P-supported activities, lessons learned and updates on future technical work. It provides a unique opportunity for WHO and partners to actively engage in a regular dialogue on the provision of support to Member States to deliver their UHC goals. Six series of live monitoring sessions were organized – one in February and June and one each month from September to December 2022.

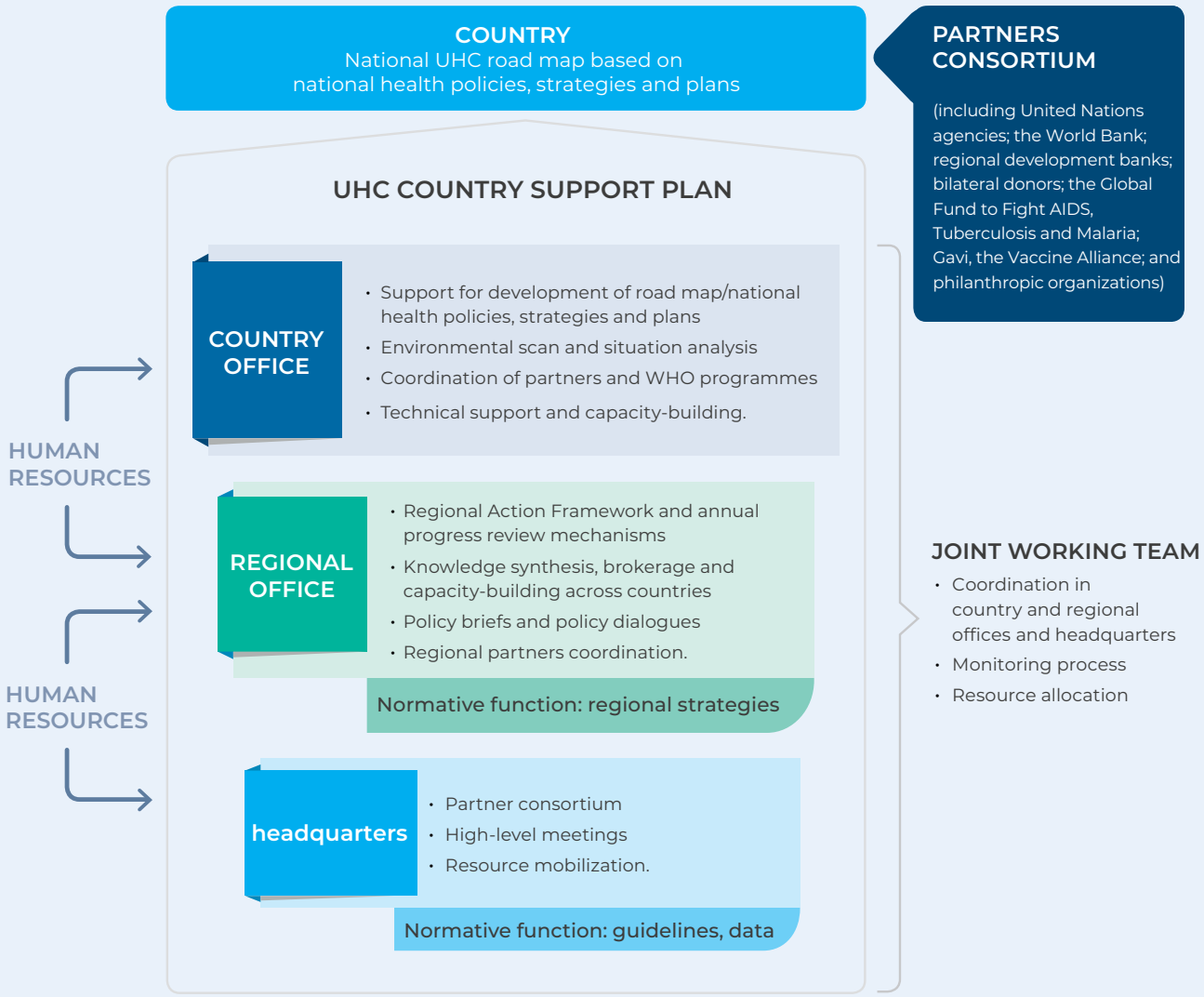
The Joint Working Team for primary health care and universal health coverage and bimonthly meetings

Bimonthly meetings of the Joint Working Team for PHC and UHC (Box 2), co-chaired by WHO headquarters and one of the WHO regions, allow deep discussion and exchange of good practice between the three levels of WHO. The meetings organized in 2022 focused on EPHFs.

Box 2. The Joint Working Team builds and ensures internal coherence and integrated efforts through WHO

The UHC-P benefits from the WHO-wide Joint Working Team (JWT) on PHC and UHC that brings expertise and coherence to all levels of WHO in relation to UHC. The JWT has been established in the GPW13 and represents an operational arm overseeing the day-to-day management of WHO to guarantee harmony, alignment and integration of efforts geared towards UHC implementation at the country level. The JWT continues to ensure the coordination, monitoring and reporting of the UHC country, subregional and regional support plans. Moreover, with the specific focus on NCDs and health security, the JWT welcomed focal points for these specific issues to ensure greater coordination. Some NCD Hard Talks webinars were also organized in 2022 with the support of the UHC-P to discuss and promote solutions for important issues related to NCDs, such as supply chains or international strategic dialogue for NCDs.

Fig. 8. WHO country action framework



UHC: universal health coverage. *Source*: WHO Thirteenth General Programme of Work[6]

The communication strategy

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

Regional and country offices have been actively engaged in the development and co-promotion of stories from the field, which in many cases, also involved cooperation from ministries of health and partners, resulting in unified and amplified messaging. Stories were complemented with newsletters, magazines, feature articles, videos and communication toolkits, which were distributed and promoted across high-traffic pages of the WHO website and other digital and social media platforms at the global, regional and country levels.

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

Operational research

Two studies have already been launched to understand the role of the UHC-P in health governance strengthening. In 2016, the UHC-P concluded a formal evaluation of its actions that focused on lessons learned with regards to its role (convener, broker, technical assistance), strengths (flexibility, bottom-up approach, seed funding, WHO JWT three-levels approach) and weaknesses (roster of technical assistance, difficulties of finding appropriate candidates).[7] Moreover, in the same year, the WHO African Regional Office published a supplement on health policy dialogue in 13 countries in the Region.[8] Lessons learned have informed continued efforts in improving the health dialogue in the 47 Member States within the Region. In 2018, a protocol for a realist evaluation of the role of the UHC-P in strengthening policy dialogue for health planning and financing was published,[9] and results have been collected.[10] This study aimed to analyse policy dialogue processes in their contexts to understand which planning and financing mechanisms were triggered to enable health systems to move towards UHC.

The final results of the realist evaluation were published in 2022.[11] The report theorizes the underlying rationale of the UHC-P, which builds the capacities of ministries of health to lead inclusive, participatory and evidence-informed policy dialogue (Fig. 9). UHC-P support should result in mutual trust to strengthen stakeholders' collaboration, while the evidence and data provided should bring a shared understanding of needs and policy options. The report also reveals the necessary conditions for successful policy dialogue, such as dynamic local stakeholders, promotion of collaboration as a mode of action, involvement and leadership of ministries of health, and synergy of messages and actions from WHO.

The continuous presence of experts in the field is required to allow for close monitoring of policy dialogue, to strengthen trust relationships with ministries of health and advance the strategic thinking and cross-cutting vision of policy dialogue. The report recommends that WHO:

> must strengthen three resources that have demonstrated their added value in the Partnership: 1) policy dialogue international experts who support health ministries and promote inclusivity and multisectoral collaboration; 2) financial support for organizing meetings that support exchanges between stakeholders and the joint drafting of policy documents; and 3) funding for activities that generate knowledge, nurture exchange, enhance stakeholders' competencies and create mutual understanding.[12]

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

The role of health policy advisers is especially highlighted in strengthening the operational arm of WHO and delivering high-quality output to develop, implement and/or strengthen the policies and actions of public institutions for health. The need for long-term partnership and financing support for the health reform process was also acknowledged, and the report recommends a fifth phase of the Partnership to ensure the sustainability of the intervention through the implementation, monitoring and evaluation of the health policies that were built during the first four phases. The report also recommends increasing collaborations with European delegations on the ground – in particular to use all the expertise available to strengthen health systems for UHC.

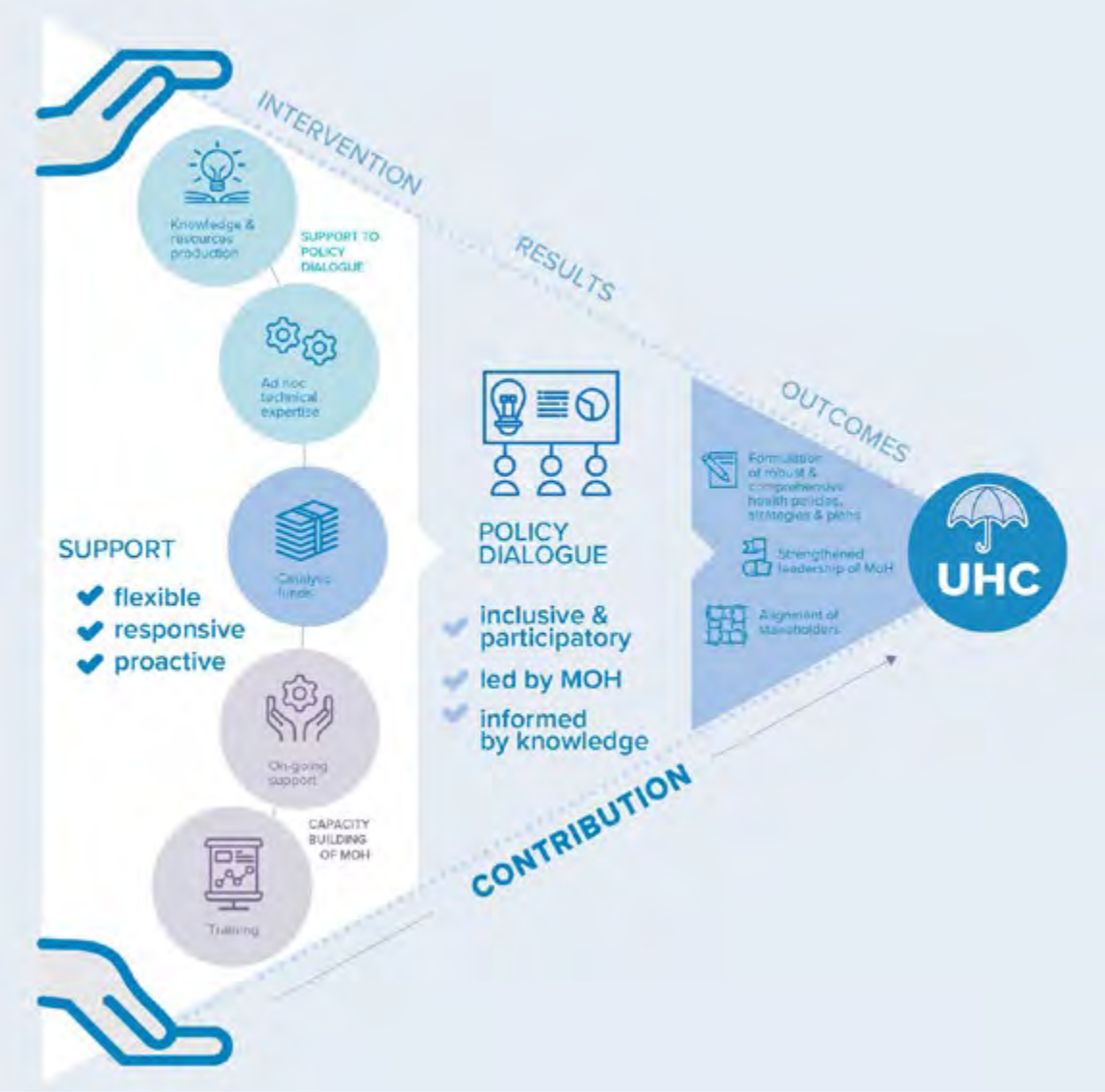
By opening windows of opportunity for policy change based on renewed or innovative commitments, through the UHC Partnership, WHO works on the fundamental contextual factors of the health policy-making process to ensure that global or country-based strategic frameworks are in place to promote health, serve the vulnerable, and keep the world safe.

In 2023, a policy and practice review was published in *Frontiers in Public Health*, as part of the special collection *Health systems recovery in the context of COVID-19 and protracted conflict*.[13] The review included UHC-P experiences from Colombia, Islamic Republic of Iran, Lao People's Democratic Republic, South Sudan, Timor-Leste and Ukraine, and provided operational and countries' perspectives on the strategic and technical leadership provided by WHO to assist Member States in strengthening PHC and EPHFs for resilient health systems. The review demonstrated, and provides lessons and advice on, good practice for other countries that are in the process of strengthening their health systems. This policy and practice review is a first attempt to formulate what has been observed over time through the diverse accountability mechanisms of the UHC-P, within the framework of a larger contribution analysis that should be implemented in the next phase of the UHC-P.

Collaboration with global health initiatives

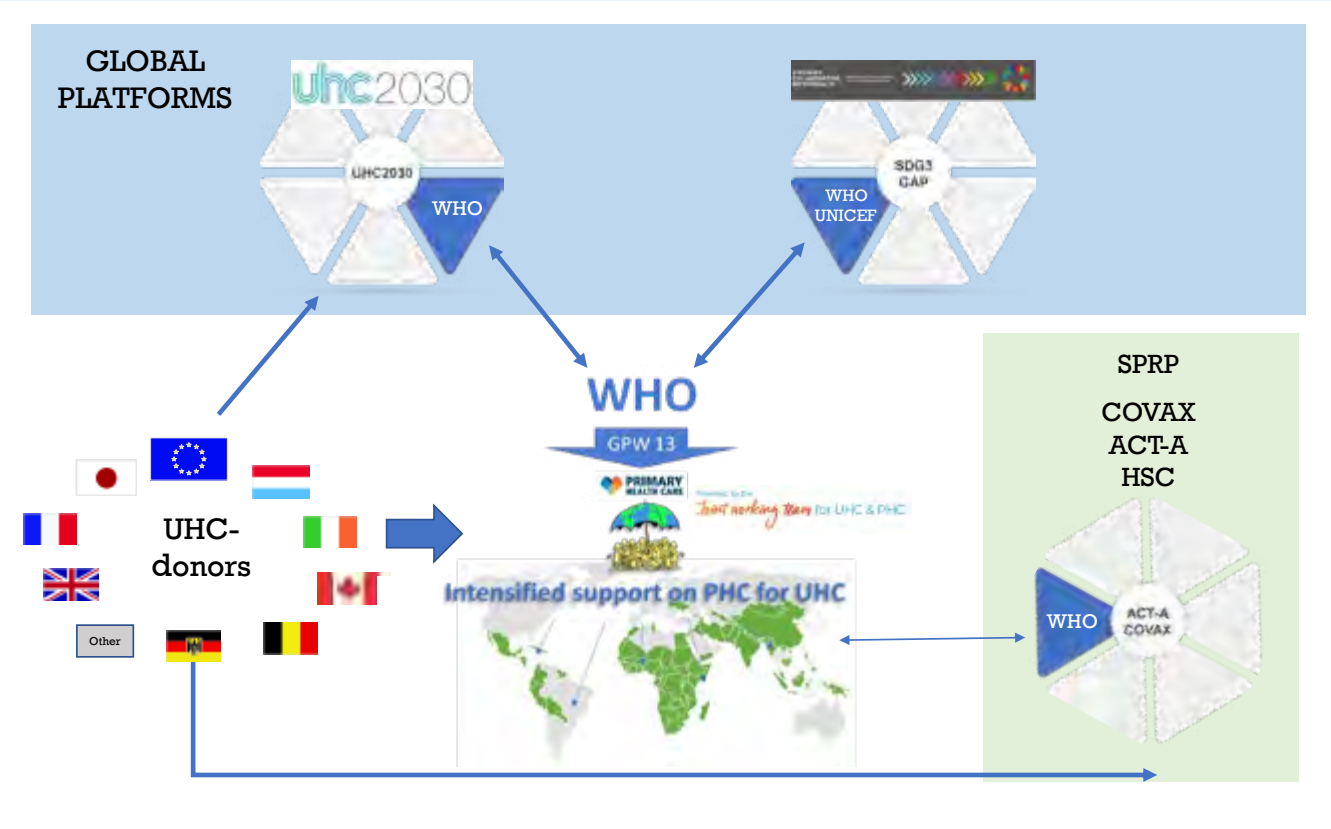
The UHC-P operates under the global multistakeholder platforms of UHC2030 and the SDG3 Global Action Plan for Healthy Lives and Well-being for All (SDG3 GAP) to promote collaborative working globally and in countries through a PHC approach in order to enhance cooperation effectiveness (Fig. 10). In 2016, the International Health Partnership (IHP+) was transformed to UHC2030, whose mission is to create a movement for accelerating equitable and sustainable progress towards UHC. The SDG3 GAP, launched in September 2019 at the UN General Assembly, is a collaboration of 13 leading humanitarian, development and health agencies supporting countries to accelerate progress towards the health-related SDGs. Since the inception of SDG3 GAP, GAP agencies have moved from making commitments to laying the groundwork for a decade of delivery and action on the health-related SDGs through stronger collaboration. Implementation of the GAP is grounded in joint support for countries, builds on existing collaborations, and aims to fill gaps in national mechanisms and processes to achieve its aims. Furthermore, disease-specific work and health systems strengthening can – and should – be mutually reinforcing. However, this cannot be left to chance. If disease-specific work is to prove effective in building systems while achieving disease-specific results, these dual outcomes must be deliberately planned. Through common goals and targets for health, international partners, governments and civil society improve their alignment and shared accountability.

Fig. 9. The Partnership theory highlighted by the realist evaluation



MOH: Ministry of Health; UHC: universal health coverage. *Source*: Robert et al., 2022.[14]

Fig. 10. PHC and the UHC-P in its global environment



ACT-A: Access to COVID-19 Tools Accelerator; COVAX: vaccines pillar of the ACT-A; GPW13: Thirteenth WHO General Programme of Work 2019–2023; HSC: Health System Connector; PHC: primary health care; SDG3 GAP: SDG3 Global Action Plan for Healthy Lives and Well-being for All; SPRP: COVID-19 strategic preparedness and response plans; UHC: universal health coverage; WHO: World Health Organization.

A laboratory technician adjusts her mask at a tuberculosis centre in Kulob, Tajikistan.
© WHO/Lindsay Mackenzie

A member of cleaning staff at a rural hospital in Jetisu, Kazhakstan. © WHO

The WHO Triple Billion strategic priorities

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

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

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

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

1

Ensuring universal health coverage – 1 billion more people benefiting from universal health coverage

Notable results for the first billion in 2022

Health benefit package development and review are increasingly being recognized as the cornerstones of service delivery systems. The UHC-P assisted 12 countries that are moving towards **health care packages** that anchor interventions into health systems, from prevention to palliative care and across the life-course, articulating the interventions needed for each age cohort.

UHC-P strengthened **access to care** through capacity-building for human resources for health (HRH), supporting service provision by improving health care delivery and integrated service delivery models, and integrating mental health and NCD services, as well as vertical programmes into the PHC package.

Eleven countries benefited from UHC-P assistance to carry out activities and capacity-building related to **National Health Workforce Accounts** (NWHA) and Health Labour Market Analyses.

UHC-P supported infection prevention and control (IPC) activities, and processes and activities to mitigate **antimicrobial resistance** (AMR) and improve accreditation and quality of care standards, in 23 countries across four regions.

The UHC-P's work on UHC is fully aligned with SDG target 3.8, which focuses on achieving UHC and includes access to quality essential health care services, financial protection and access to safe, effective, quality and affordable essential medicines and vaccines for all. To reach UHC, health systems must be oriented towards a PHC approach, which includes: multisectoral policy and action, engaged people and communities, PHC and EPHFs at the core of integrated health services, and providing support for ministries of health for evidence-based and inclusive policy-making processes. This will be achieved through the deployment of over 145 health policy advisers in more than 125 WHO country offices and in the six WHO regional offices.

The UHC-P strengthens the operational arm of WHO and supports the development, implementation and strengthening of country health plans and policies. All countries involved with the UHC-P have seen an increase in their UHC index. The UHC-P has contributed to this progress thanks to a flexible (based on country priorities), bottom-up (based on country strategies) and catalytic approach (oriented to create synergies). This has offered a more strategic and innovative way of working to ensure that countries receive assistance tailored to their own contexts, and which responds to their needs and changing priorities. The Partnership also sets a model for accountability based on clear mechanisms to understand what is happening on the ground.

It is estimated that 3.5 billion people lack access to essential health services worldwide. Even when accessible, services are often of poor quality and unsafe, as well as fragmented and inequitably distributed. Services often fail to address vital public health considerations, such as considering the life-course in its entirety, population-specific needs, the growing burden of NCDs, and the ongoing challenges caused by communicable diseases. Implementing robust strategies for PHC is of critical importance to provide UHC to 1 billion more people.

1.1 Access to quality **essential** health services

Primary health care-oriented services for specific diseases and conditions across the life-course

The PHC approach is based on integrated people-centred health services that place people and communities, not diseases, at the centre of health systems, and empower people to take part in inclusive health policy-making processes (Box 3). However, specific diseases and conditions still need to be addressed through the provision of a continuum of health services, and by avoiding the use of vertical approaches that can hinder the ability of health systems to focus on health and well-being for all. For example, in **India**, in the aspirational districts of Uttar Pradesh, the UHC-P improved health services by supporting the establishment of institutional births and caesarean sections at the Shohratgarh PHC centre in Siddharth Nagar, resulting in women having access to emergency obstetric care services in these districts.

UHC-P funding supported the development of quality assurance guidelines for human papillomavirus (HPV) testing in the Caribbean. By 2022, a total of 1500 women had been screened with HPV testing in **Antigua and Barbuda**, achieving the main goal of the pilot project. Currently, the Ministry of Health is completing the laboratory analysis of the screening tests, working on following up women with abnormal results, and is planning for the first procurement, at a reduced cost, of HPV tests through the WHO Regional Office for the Americas Strategic Fund to ensure the adoption and sustainability of the project. In **Philippines**, as a first step in the consideration of whether PhilHealth (the national health insurer) can expand cancer coverage, WHO supported a study to determine the requirement for cancer care services for 14 cancer conditions, and palliative care for people with cancer. In **Sri Lanka**, UHC-P support for the procurement of HPV DNA test kits strengthened the Cervical Cancer Screening Programme by expanding the availability of cervical cancer screening. In **Jamaica**, a situation analysis for NCD surveillance was conducted alongside a more in-depth surveillance of cervical cancer. Building on the results of these analyses, a national plan of action for the elimination of cervical cancer was launched. In selected Caribbean countries, the availability of radiological health services was assessed to provide specific recommendations for improvements (Box 4).

> *"Over the last 10 years, the UHC Partnership has helped to significantly foster the delivery of services along the principles of primary health care in the Americas."*
>
> *Dr James Fitzgerald, Director for Health Systems, Pan American Health Organization*

In **Dominica**, within the context of the Health System Transformation for Achieving Universal Health project, technical support was provided to the Ministry of Health, Wellness and Social Services and the Dominica Hospital Authority to strengthen primary care with a focus on NCDs. This support included reviewing the package of services provided in primary care facilities within the framework of achieving UHC, and strengthening the connectivity between primary and secondary care. Through this collaboration, areas for strengthening primary care were identified with short-, medium- and long-term time frames, providing a vital foundation for the development of a roadmap for strengthening primary care.

In **Ukraine**, to ensure delivery of high-quality, people-centred health services based on PHC strategies and comprehensive essential service packages, the UHC-P supported the implementation of two rounds of the countrywide PHC health facility assessment to support further dialogue with country authorities. In conjunction with the Ukrainian Academy of Family Medicine, dialogue with the professional PHC community was initiated to develop a national framework for clinical audit/supervision as a part of the clinical governance of PHC service delivery; this dialogue is part of the ongoing discussions on the establishment of self-governance mechanisms in the health care sector. To support PHC providers to manage care for neonates, children and adolescents, WHO has facilitated the translation of the recently published *Pocket book of primary health care for children and adolescents*[15] into Ukrainian.

Box 3. European Immunization Week in Azerbaijan

Various awareness-raising activities were carried out in **Azerbaijan** to educate national authorities, educational institutions, local health care workers, medical and nursing students, and the community on the importance of immunization as a primary prevention function of PHC during European Immunization Week (EIW). A three-tiered and 10-day-long EIW 2022 activity was carried out in Shamakhi, a rural region in **Azerbaijan**, including home visits as first-tier activities, vaccination posts in village health points as second-tier activities, and mobile clinics for counselling and treatment of high-risk-bearing people as third-tier activities. A campaign was organized in six villages of Shamakhi to address incomplete COVID-19 vaccinations among adults and incomplete immunization courses for children aged 0–15 years, which also included risk assessment measures. During EIW in Shamakhi: 387 children were vaccinated, of whom 294 (61.7%) had incomplete or uncertain immunization status; of children aged 0–5 years, 46 (20.6%) were stunted and 23 (10.3%) were underweight; of children aged 5–18 years, 38 (15.0%) were overweight or obese and 32 (13.4%) were wasted. In addition, 78 adults received the COVID-19 vaccine; and 1091 residents were screened for disease, of which 53% had a risk of cardiovascular diseases and 64% had a diabetes risk score >7. These activities provided an opportunity to expand the PHC horizons in Shamakhi, and served as an interprofessional education programme. These activities also showed that home visits are a good tool for providing primary prevention without waiting for people to ask for health care.

Box 4. Radiological health services assessment in the WHO Region of the Americas

Assessments of radiological health services were performed in **Antigua and Barbuda**, **Belize**, **Grenada**, **Saint Kitts and Nevis**, **Saint Lucia** and **Saint Vincent and the Grenadines**. These assessments identified any shortcomings and provided specific recommendations for improvement. Each country profile was updated to aid the policy- and decision-makers. The assessments found that the skills and knowledge of radiology services staff have significantly improved, in particular for the staff performing mammography, and for the overall quality and safety of radiology services in general. Nine Caribbean countries (**Antigua and Barbuda**, **Bahamas**, **Grenada**, **Jamaica**, **Saint Kitts and Nevis**, **Saint Lucia**, **Saint Vincent and the Grenadines**, **Suriname** and **Trinidad and Tobago**) completed a Quality Assurance Manual including quality control documentation for more than 80% of the Regional Office for the Americas' recommendations. Twenty-nine radiologists, technologists and medical physicists from these Caribbean countries were also trained with the latest standard screening mammography techniques, protocols, technologies, quality assurance protocols and more during the Improving Mammogram Quality Seminar in November 2022. This project was hosted by the University of Miami Sylvester Comprehensive Cancer Center who provided technical support in collaboration with the Regional Office for the Americas and the MD Anderson Cancer Center, thus strengthening collaboration between these three institutions.

Designing health benefit packages and primary health care models of service delivery

Strengthening PHC is a critical aspect of achieving UHC because PHC can sustain 90% of people's health needs across the life-course. There is no country worldwide which is able to provide every health service to everyone, so choices must be made on the path to UHC. By changing from ad hoc or implicit priority-setting and rationing of services, to systematic, evidence-based and transparent priority-setting, countries can substantially improve access to essential high-quality services, improve health outcomes, and achieve national and global SDG targets. To help achieve these goals, designing health benefit packages is a key activity supported by the UHC-P.

The process of health benefit package development and review is increasingly being recognized as a cornerstone in service delivery systems. Countries are moving towards using health care packages that anchor interventions into public health functions (from prevention to palliative care, and across the life-course), articulating the interventions needed for each age cohort. Health benefit package development has been supported in **Botswana**, **Djibouti**, **Iraq**, **Liberia**, **Sierra Leone**, **Somalia**, **Sudan**, **United Republic of Tanzania** and **Zimbabwe**. A health benefit package review was also undertaken in **Namibia**. In **Timor-Leste**, the UHC-P also co-developed the health benefit package for secondary and tertiary care, to strengthen availability and quality of service, and ensure efficiency.

Guyana pledged to accelerate progress to UHC and has adopted PHC as an operational driver for an equitable health system. To make progress towards this pledge, Guyana's Ministry of Health, in cooperation with the UHC-P, has proposed a new health benefit package for PHC that includes interventions to meet its population's current health needs. The health benefit package was adopted by the Ministry of Health in March 2022 and will facilitate timely delivery of cost-effective, integrated and standardized health services provided close to the communities in which people live. **Eswatini** completed a PHC baseline assessment and developed a roadmap and policy brief, which was further developed into a PHC investment case. Complementing these activities, the UHC-P have supported harmonized health facility assessments (HHFAs) in other countries in the **WHO African Region** (Box 5).

Box 5. Support for health facility assessments in the WHO African Region

The HHFA is a comprehensive health facility survey that assesses the availability of health facility services and the capacities of facilities to provide services at the required standards of quality. This was a top priority in the **WHO African Region** countries this year. **Liberia** and **Zambia** completed an HHFA, and **Burundi**, **Cameroon**, **Central African Republic**, **Côte d'Ivoire** and **Democratic Republic of the Congo** are in the preparatory phases, adapting protocols and questionnaires, building capacity, finalizing methodologies and sampling.

The UHC-P supported health facility assessments in countries, including HHFAs in **Ghana**, **Uganda** and **Zambia**, and a survey of the continuity of health services in 38 of the 47 countries of the Region. This survey highlighted the persisting disruptions to health services, together with a lack of funding and health workforce challenges from the supply side impacting on the health services' sustainability. **Zimbabwe** was supported to routinely monitor health services, and weekly reports were produced and shared with stakeholders.

The assessment of the functionality of subnational (district) health systems was initiated in 2022. This functionality assessment is conducted by the subnational managers, allowing them to analyse their status against the different attributes needed for a functional system at this level. The process was conducted in **Burundi**, **Democratic Republic of the Congo**, **Ghana**, **Guinea**, **Guinea-Bissau**, **Mali**, **Mozambique** and **Namibia** and is ongoing in **Botswana**, **Malawi**, **Uganda**, **United Republic of Tanzania** and **Zimbabwe**. The assessment is scheduled to start in **Burkina Faso**, **Chad**, **Côte d'Ivoire**, **Mauritania**, **Niger**, **Senegal**, **Sierra Leone** and **South Sudan**. The findings have proved crucial in guiding subnational priority actions in countries this far; for instance, the review is now part of the routine annual situation analysis for district planning in **Ghana**, while in **Democratic Republic of the Congo**, a group of five underperforming districts were identified for specific national support.

As part of monitoring and evaluation, district- and facility-level assessment and analysis were observed in a number of countries. **Malawi** conducted zonal review meetings to review progress of the district implementation plans in the context of its health sector strategy and **Ghana** carried out a third round of the health services readiness front-line assessment in health facilities.

Patients' waiting area at a health centre, Lima, Peru. © WHO/NOOR/Sebastian Liste

As a way of improving PHC models of service delivery, the UHC-P supported the implementation of **Peru**'s national plan for integrated health networks through strengthening the management and assignment of resources within the health system. Tools were developed to create civil registries, assign individuals to a multidisciplinary health team, and provide population health management and governance across three different regional health networks. The UHC-P is also supporting **Côte d'Ivoire** in the process of revitalizing the operation of health districts for PHC implementation (Box 6).

The accessibility of high-quality PHC services has been improved in **Azerbaijan**. In September 2021, the three mobile clinics procured with UHC-P support were transitioned to the **Azerbaijani** Management Union of Medical Territorial Units and have been providing PHC services in a remote area of **Azerbaijan**, covering a population of 15 490 in 18 villages. The mobile clinics conduct cardiometabolic risk screening for adults and provide growth monitoring of all children, using WHO growth percentile charts. From September 2021 to December 2022, 1126 adults were screened for their cardiometabolic risk. Of these adults screened, 59% had high blood pressure, 73% were overweight and 73% had at least a mild risk of diabetes. Of the 898 children enrolled in the PHC clinics, 19% of those aged under 5 years were growth stunted and 22% were suffering from wasting.

Uzbekistan benefited from continued UHC-P support in the form of intense technical assistance to the Ministry of Health and the State Health Insurance Fund (SHIF) to implement the stepwise roll-out of health system reforms, starting in Syrdarya in July 2021.

These reforms aim to strengthen **Uzbekistan**'s PHC model and are supported by new health financing arrangements. The reforms have achieved: (i) establishing PHC teams that increase the ratio of nurses to each family doctor in all facilities in Syrdarya within a defined catchment area; (ii) expanding the roles, and the autonomy, of both practising and patronage nurses; (iii) creating stronger links between PHC teams and communities (mahallas) through the role of patronage nurses; and (iv) increasing patient trust in PHC.

The UHC-P supported **Egypt** in strengthening its health care delivery and integrated service delivery model through capacity-building for family medicine, supporting service provision for the family health model, and integrating mental health and NCD services, and vertical programmes, into the PHC package. Similar achievements were made in **Pakistan**, where a PHC-oriented model of care for integrated service delivery was piloted, incorporating an inclusive health approach (health systems, communicable diseases and NCDs) and intersectoral collaboration to address the social determinants of health (including water, sanitation and hygiene, and education).

The UHC-P supported **Iran** to revise its health insurance benefit package, for hypertension management, breast cancer and schizophrenia disorders, using an evidence-informed deliberative process for UHC in alignment with WHO's UHC Compendium.[16] The support included designing a monitoring and evaluation framework, including prerequisites, conditions, indicators, processes, and reporting and documentation of the experiences and lessons learned.

Box 6. Côte d'Ivoire: revitalization of health district services

Background

More than two decades after the choice (in 1994) of the health district as the operational unit of the health system and the appropriate framework for the implementation of PHC in **Côte d'Ivoire**, and despite certain achievements (the production of legislative and regulatory texts, standards documents, health decentralization efforts, and the implementation of specific health programmes), many shortcomings persist: poor appropriation of the health district concept, weak managerial capacity of health district managers, weak health sector governance, weak accountability mechanisms, and poor use of health information for decision-making. According to a 2017 study supported by WHO, the hospital level in Côte d'Ivoire absorbs more than 70% of the budget allocated by the state to the health department, whereas it only receives 24% of the demand for care.

Intervention

The process of revitalizing health district services began in 2017 with the organization of a workshop to reflect on the management of health districts in Côte d'Ivoire, and was reinforced by a situation analysis in the context of the development of the Plan Nation de Développement sanitaire 2021–2025. In view of the problems noted in the functioning of the health district, the Ministry of Health formulated an official request for technical and financial support from WHO and several other partners, with a view to implementing a health district revitalization process.

Key results

- Organization of a workshop to reflect on the management of health districts in Côte d'Ivoire in November 2017.
- Recruitment of five consultants from various partners (WHO, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), World Bank) to develop the regulatory texts defining the organization and operation of health districts.
- In April 2019, in collaboration with the Ministry of Health and the WHO Regional Office for Africa, the WHO Country Office in Côte d'Ivoire organized an Experience Sharing Workshop on Strengthening District Health Systems for the Revitalization of Primary Health Care in Abidjan. This meeting brought together participants from seven countries (**Burkina Faso**, **Congo**, **Côte d'Ivoire**, **Gabon**, **Mali**, **Mauritius** and **Senegal**). Three WHO representatives took part in the workshop.
- In June 2021, a first cohort of 32 District Medical Officers was trained in district management with the support of WHO, UNICEF and World Bank.
- Training of all Regional Health Directors (33 in total) to integrate them into a national pool of trainers.

Benefits

The process of operationalizing the health districts has been recognized as a priority and was included in the Plan Nation de Développement sanitaire 2021–2025 as a strategy required for the implementation of PHC and the march towards UHC. This will enable a smooth implementation of PHC in Côte d'Ivoire.

A health centre in Dakar, Senegal. © WHO/John Wendle

DEEP DIVE

Gender equality, human rights and health equity

Discrimination, human rights violations and abuses, poverty and other determinants of health underlie many health disparities and intersect in ways that limit people's abilities to make decisions about their own health, impede access to quality health care, and worsen physical and mental health outcomes.

Women and girls, gender-diverse people, indigenous peoples, racial and ethnic minorities, persons with disabilities, rural and remote communities and others who experience discrimination, marginalization, and deprivation are often least able to realize their rights to the highest attainable standard of health.

Health systems can reinforce inequities or help to overcome them, but the right action needs to be taken at the necessary scale to achieve impact. PHC is an essential strategy for reorientating health systems and societies to become healthier, equitable, effective and sustainable.

In 2022, the UHC-P supported strengthening PHC by increasing the knowledge and technical capacity to deliver equity-oriented, gender-responsive and human rights-based health services in over 10 countries. (Table 1) Staff from WHO country offices, and their counterparts from ministries of health, received training on the use of tools to assess issues such as gender-related inequities, health inequality monitoring, and barrier assessments to health services. The UHC-P also provided technical assistance to support equity, gender and rights integration in national health policies, strategies and plans, and in health programmes.

WHO is committed to systematically reporting annually on sex-disaggregated data. As of 2023, WHO's mid-term review and end of biennium reports on the implementation of the programme budget will systematically provide information on the collection of sex-disaggregated data, and the analysis of available data. Of the 46 indicators in the GPW13, 31 are suitable for disaggregation and 13 currently have data. The 2022 mid-term review that was made available in May 2023 includes information on sex-disaggregation for the first time.

A nurse prepares a patient in an emergency room, Spanish Town, Jamaica.
© WHO/Jayme Gershen

DEEP DIVE: Gender equality, human rights and health equity

What does WHO do for gender equality, human rights and health equity?

- Documents effective approaches to advancing gender equality, human rights and health equity, and facilitates learning within and between countries on these approaches.
- Develops and implements technical guidelines, norms and tools to advance gender equality, human rights and health equity in health.
- Builds the capacity of the WHO Secretariat to support countries to systematically identify, monitor and address health inequities, implement gender-specific and transformative approaches and fulfil the human right to health and health-related rights; including through online courses and the sharing of best practices.
- Advocates for the prioritization of and investment in gender equality, human rights and health equity within the organization and across partner organizations, including through interagency platforms.
- Provides technical assistance to countries to advance gender equality, human rights and health equity in health policies, programmes, services and beyond.
- Supports engagement of civil society and communities in country-level processes.
- Develops tools to institutionalize and track progress on mainstreaming gender equality, human rights and health equity globally, including through the output score card, the gender marker, the human rights marker, and the monitoring and evaluation framework of the roadmap.

New directions for WHO's work on gender equality, human rights and health equity

The year 2022 has been a pivotal moment for WHO's work on gender equality, human rights and health equity. Following an evaluation that took place in 2021,[17] a number of new initiatives took place in 2022, which are listed below.

- The former Unit for Gender, Equity and Rights was elevated to a full-fledged department: Gender, Rights and Equity – Diversity, Equity and Inclusion.
- The organizational architecture for the Programme for Gender Equality, Human Rights and Health Equity was strengthened by establishing a Gender Equality, Human Rights and Health Equity Leadership group made up of the directors from WHO headquarters and the senior technical leads from each of the six WHO regional offices; in addition, the Global Network of Gender Equality, Human Rights and Health Equity focal points at the three levels of the Organization was revitalized and assigned a performance objective for 20% of their time.
- A roadmap for Gender Equality, Human Rights and Health Equity has been developed to bring clarity and consistency across WHO headquarters, regions and country offices.

Table 1. Country examples on the gender equality, human rights and health equity approach

Ukraine	In the context of integrating gender equality, human rights and health equity into **Ukraine**'s health system, WHO's Country Office in Ukraine reviewed Ukraine's National Health Strategy 2030 with a gender lens and built up the capacity of those involved in developing the strategy through a workshop. WHO also provided input to the draft National Gender Equality Strategy and provided guidance on the review tool for PHC facilities and hospitals. In the first quarter of 2022, WHO facilitated a Gender Audit for the Ministry of Health, organized a capacity-building exercise for the PHC workforce on service delivery to gender-based violence (GBV) survivors and continued to support the WHO Emergency Programme team in **Ukraine** on gender-responsive programming and capacity-building. In addition, the WHO Country Office in Ukraine incorporated gender, equity and human rights programming in the office workplan 2022–2023.
North Macedonia	A WHO assessment on barriers to health in rural, remote and small urban areas in **North Macedonia** has revealed that accessing health services remains a significant challenge for many. The Ministry of Health, alongside the Programme for Gender Equality, Human Rights and Health Equity at WHO and the Delegation of the EU to the Republic of North Macedonia, convened stakeholders from health and other sectors to discuss the initial findings from the assessment and identify strategies to ensure that people have better access to health services, irrespective of the conditions in which they were born, grew up, live, work and age, or their income. The preliminary study findings are organized around the main principles of the Tanahashi Framework, according to which, in order for a person to even obtain coverage, services must be available, accessible and acceptable. The assessment demonstrates that investment in health systems and addressing health determinants needs to be at the heart of the socioeconomic development of the country. This initiative is an excellent example of collaboration across the three levels of WHO. Building on the workshop to discuss the findings, a high-level health forum will take place in May 2023, launching the official report and promoting a more inclusive health care approach in **North Macedonia**'s small urban and rural areas to reduce health inequities.
South Sudan	Gender equality, human rights and health equity issues are major causes of disparities in decision-making power, socioeconomic empowerment, health services coverage and ultimately health outcomes between men and women, boys and girls in most countries globally, including **South Sudan**. There are deeply rooted traditional and societal preferences given to boys over girls, which affects girls' enrolment in education, gives more responsibility to boys than girls, and results in early marriages, with girls being seen as sources of income or dowries and as the only ones to conduct household work. In the long run this results in a perpetual power imbalance that, coupled with the less-than-optimum capacity of health programme managers and care providers to effectively integrate gender, equity and human rights into health sector interventions and programmes, necessitates intervention if there is to be meaningful progress made towards UHC. The WHO Country Office in South Sudan organized two rounds of training for WHO staff and the Ministry of Health on essential steps and approaches for integrating gender equality, human rights and health equity into health programmes. Participants developed significant competencies in the use of WHO gender, equity and human rights integration tools (including gender analysis, and barriers and health equity assessment tools) and were informed on the use of the Innov8 approach for reviewing health programmes to bring all learnings together. Furthermore, the training sessions highlighted other strategic priorities including the need to intensify internal and external advocacy for gender equality, the empowerment of women and health equity.

A health worker conducts a therapy session in Kyiv, Ukraine. © WHO/Christopher Black

Informing, reviewing and adopting health policies

Countries in the **WHO African Region** have developed guidelines, strategic plans and policies to improve access to quality care which puts PHC at its centre. The national health policies set the countries' goals, while national health strategic plans outline the strategies needed to achieve them. In 2022, **Liberia**, **Rwanda**, **Togo** and **Sao Tome and Principe** revised their national health policies, and **Cameroon**, **Liberia**, **Burundi**, **Central African Republic**, **Chad**, **Côte d'Ivoire**, **Eritrea**, **Gambia**, **Sao Tome and Principe** and **Zambia** revised their national health strategic plans, including monitoring and evaluation plans for their implementation, using an inclusive and participative approach.

In **Eritrea**, the completed national health strategic plan was printed and disseminated, and a National Action Plan for Health Security 2022–26 was developed using a multisectoral approach. National health strategic plans were costed in **Cameroon**, **Gambia**, **Côte d'Ivoire** and **Niger** using the One Health tool. An end-of-term evaluation of plans was carried out in **Botswana**, **Cameroon**, **Chad**, **Democratic Republic of the Congo** and **Togo**, with lessons learned informing the development of future plans. In the **Central African Republic**, the government has approved a Universal Health and Preparedness Review roadmap with momentum building for the development of an investment document for health security and health system resilience.

In **Liberia**, the UHC-P supported a rapid assessment, and the mapping and strengthening of health sector coordination. Health sector coordination mechanisms were also strengthened in **South Sudan** and **Zimbabwe**. **Cameroon** ensured the engagement and commitment of partners in the implementation of its national health strategy plan by developing a compact with partners. **Rwanda** developed a community health policy guidance ministerial instruction on community health, and, in **United Republic of Tanzania**, 20 junior staff from Muhimbili University of Health and Allied Sciences were trained in strategic planning. In **Tajikistan**, the UHC-P supported PHC reforms by conducting a Health Labour Market Analysis (HLMA), followed by a policy dialogue to provide inputs for the development of a National Health Workforce Strategy. The UHC-P also set up a joint coordination mechanism between the development partners working on HRH.

To mark the achievement of a broad spectrum of support by collaboration between organizations, with the support of UHC-P, the Government of Tajikistan, WHO and over 18 UN agencies and development partners signed a Joint Statement launching a new era of collaboration on strengthening PHC in the country to achieve UHC (Box 7). In the **occupied Palestinian territory** (oPt), the UHC-P provided technical support to optimize health service planning based on a revised benefit package, with a focus on effective delivery of front-line primary and emergency care services with appropriate referral (Box 8). UHC-P also supported the development and review of national health strategic plans in **Cambodia** and **Kiribati** respectively, and **Fiji** was supported in its development of a national digital health strategy.

The UHC-P provided technical support to **Lao People's Democratic Republic** to strengthen health governance through enhanced coordination with partners to develop its Health Sector Reform Strategy 2021–2030, which is a UHC roadmap to improve equitable access to quality and people-centred health care services with a strong focus on PHC, working towards achieving UHC, and which was endorsed by the Minister of Health in 2022. In close collaboration with UNICEF, WHO supported the development of the PHC law to provide a clear legal framework to implement the PHC policy and relevant strategies to strengthen PHC to achieve UHC. Technical support for **Bahamas** has facilitated the advancement of overall health sector reform by strengthening coordination between relevant stakeholders, including the Public Hospitals Authority, the National Insurance Board and the National Health Insurance Authority (Box 9). Support for **Cambodia**'s health sector reform efforts has created policy space to develop the Primary Health Care Booster Implementation Framework (Box 10).

In 2022, UHC-P assisted in developing or updating national pharmaceutical policies in **Côte d'Ivoire**, **Gambia**, **Namibia** and **South Sudan**, and in updating the national medicines lists in **Benin**, **Burundi**, **Cabo Verde**, **Central African Republic**, **Chad**, **Comoros**, **Eswatini**, **Rwanda** and **Senegal**. In **Cabo Verde**, an agreement was signed and a list of essential medicines established through the small island developing States (SIDS) joint procurement of medicines mechanism.

Box 7. In Tajikistan, a new era of collaboration on strengthening PHC

With the support of the UHC-P, the Government of Tajikistan, WHO and over 18 UN agencies and development partners signed a Joint Statement launching a new era of collaboration on strengthening PHC in the country to achieve UHC. It outlines the way forward to strengthen PHC in the country including: (i) providing stronger governance mechanisms for PHC; (ii) prioritizing financing and resourcing for PHC; (iii) addressing the critical shortage of health workers; (iv) providing investment in infrastructure development and renewal; and (v) expanding the scope of work of PHC to tackle a wider range of conditions. This Joint Statement was signed during the high-level policy dialogue event on PHC organized by WHO and built on the ongoing collaboration and useful conversations between the government and partners on the key challenges to stronger PHC in the country. This action was later followed by a tailored exchange visit to the PHC Demonstration Platform in Almaty, Kazakhstan, to equip mid-level policy-makers and health managers with the knowledge, skills and capacity to advance health care service delivery and health workforce in the country.

The UHC-P also supported strengthened strategic cooperation between **Tajikistan** and **Türkiye** to advance health system reforms in Tajikistan via two high-level government exchange visits to Türkiye to strengthen bilateral cooperation on (i) health financing and (ii) primary health care in line with the National Strategy on Healthcare up to 2030. Intercountry learning allowed both countries to further intensify strategic cooperation on the implementation of a series of ambitious health system reforms in **Tajikistan** with an emphasis on PHC. These visits allowed Tajik representatives to identify best practices for organizing health financing, including benefits packages and provider payments, as part of an efficient health system. Strengthening primary health care, while making it universally accessible and free at the point of use, is central to these reforms.

Box 8. The UHC-P contribution to UHC reforms in the occupied Palestinian territory

With the objective of developing a comprehensive PHC-based health system strategy and an evidence-informed health financing strategy to support progress towards UHC in the **oPt**, the UHC-P provided technical support on optimizing health service planning based on a revised benefit package, with a focus on effective delivery of front-line primary and emergency care services with appropriate referral. This was complemented by a robust monitoring and evaluation system to track progress. Specifically, PHC reform to address health system inefficiencies introduced several pillars of the family practice approach in pilot areas, assessed gaps in service provision and provided data-informed policy recommendations in the context of a COVID-19 surge. In addition, there was a need to reduce the shortage of selected essential medications, equipment and supplies by 20% by August 2022 in the two pilot districts, and implement a digital health information system to support health service delivery (automated stock taking, management) in Bethlehem and Gaza, and strengthen supply chain management.

Looking forward, UHC-P will support a policy dialogue on service planning and health financing, an assessment of the health information system, data quality improvement plan for public hospitals and health accounts (NHAs).

A health worker checking on a patient at a hospital in the occupied Palestinian territory. ©WHO

Box 9. Bahamas: strengthening coordination to advance health sector reform

The Pan American Health Organization's (PAHO's) technical support in **Bahamas** has facilitated the advancement of the overall health sector reforms underway in the country by strengthening coordination among relevant stakeholders, including the Public Hospitals Authority, the National Insurance Board and the National Health Insurance Authority. With the leadership of the Minister of Health and Wellness, the health sector reform is pursuing the creation of a single authority for the provision of health services and the reform of the current governance structure.

The establishment of a Transformation Management Office is underway, which will support the implementation of the health reforms, including the integrated care initiative in partnership with the Inter-American Development Bank. The Transformation Management Office will focus on seven work streams: governance and stewardship, integration of health service delivery, health technology, financing, human resources, medicines, and technologies and infrastructure.

PAHO's ongoing work supporting the EPHF assessment has resulted in the development of the Nursing and Midwifery Strategic Plan as part of the gap identified in EPHF in a joint effort with the Ministry of Health and Wellness and the University of West Indies Collaborating Centre.

Box 10. Primary Health Care Booster Implementation Framework in Cambodia

Policy space was created for developing a Primary Health Care Booster Implementation Framework in **Cambodia** across six action areas: enabling and engaging individuals, families and communities; reorienting the health service delivery model; optimizing and diversifying workforce competencies; leveraging innovation, digital solutions and data; investing in PHC for UHC; and advancing governance and fostering partnerships. Following the acute phase of the COVID-19 pandemic, the WHO Country Office in Cambodia helped create the policy space around PHC to enable more resilience in health security preparedness and response, along with strengthening the foundation to progress towards UHC. The one-team approach between regional and country offices and continuous dialogue enabled relative strengths to be leveraged and support targeted. The staff at the Regional Office contributed by undertaking data analysis, reviews, and field missions to provide support, including targeted assistance on PHC policy and planning, financing and HRH. WHO led the development of the draft Primary Health Care Booster Implementation Framework. Due to the multisectoral nature of PHC, and different decision-makers at the national and subnational levels, a consensus was developed over what the reform process could look like. Owing to the political, administrative and fiscal realities, the scope of the planned reforms is being adjusted and calibrated.

A midwife conducts an antenatal checkup in Beng Village, Cambodia. © WHO/Blink Media Group-Cindy Liu

In a laboratory in Kampong Cham, Cambodia. © WHO/Stephenie Hollyman

DEEP DIVE

Special Programme of Research, Development and Research Training in Human Reproduction

In 2022, thanks to the UHC-P, the Special Programme of Research, Development and Research Training in Human Reproduction worked on the implementation and dissemination of a range of research studies spanning the areas of family planning, health systems strengthening, safe abortion care and violence against women (Table 2). The funds provided by the UHC-P also contributed to in-depth analyses on the impact of the emerging strategies to overcome the sexual and reproductive health and rights (SRHR) implications of COVID-19 through the use of various methodologies, including country situation assessments and systematic reviews. Over the course of this work, direct research and technical assistance was carried out in over 15 countries (**Bolivia**, **Chile**, **Colombia**, **Cuba**, **Ethiopia**, **Ghana**, **India**, **Myanmar**, **Nicaragua**, **Nigeria**, **Pakistan**, **Peru**, **Paraguay**, **South Africa** and **United Republic of Tanzania**).

Table 2. Notable highlights and achievements for the Special Programme of Research, Development and Research Training in Human Reproduction

SRHR integration into health systems/health systems strengthening	The Special Programme of Research, Development and Research Training in Human Reproduction conducted a multipronged approach to identify and analyse health system responses for overcoming disruptions in access to SRHR services, with the aim of generating evidence on improving SRHR service delivery and access in future emergencies. This analysis was carried out using a combination of a systematic review, crowdsourcing methodology and consultations with selected countries to identify emerging service delivery modifications. A peer reviewed manuscript, synthesizing findings from 78 studies and 42 crowdsourced submissions, has been submitted and is in the process of publication.
Contraceptive and fertility care	A multisite research study on the barriers to availability, utilization and readiness of family planning and contraceptive services in COVID-19-affected areas was conducted in three countries – **India** (Indian Council of Medical Research –National Institute of Research in Reproductive and Child Health), **Nigeria** (University of Ilorin Teaching Hospital) and **United Republic of Tanzania** (Ifakara Health Institute). This study analysed the impact of the COVID-19 pandemic on the health system's capacity and any disruptions the pandemic caused in the provision of family planning services in PHC. Data collection has been completed, and data analysis is underway with the aim of publishing results by the third quarter of 2023. Research teams across the countries have presented the study methodology and preliminary findings at various conferences, and a session on disseminating the results of the study is planned at the International Federation of Gynecology and Obstetrics (FIGO) annual conference in October 2023. The protocol for this study has also been published.[18]

DEEP DIVE: Special Programme of Research, Development and Research Training in Human Reproduction

Safe abortion care	A scoping review was conducted to explore the nature and extent of the evidence related to disruptions to procurement of medical abortion medicines during the COVID-19 pandemic. During the planning phase, partners and stakeholders were consulted using a virtual survey, and several virtual meetings were held to engage them in the scoping review and garner their support to make sense of the study findings. The study has been published.[19] This work also supported sentinel sites providing care to women who seek abortion care in Latin America and the Caribbean. Currently, 29 sentinel centres from 13 countries exchange information to improve surveillance of health care indicators of women in an abortion situation, contributing to more than 200 000 cases being registered. Data collected by this network are being used to design, implement and evaluate public policies. Analysis of this data also contributed to a publication.[20] In addition, a symposium was held to increase awareness in the professional ObGyn community about unsafe abortion and a role that this network plays.[21]
Maternal and perinatal health	A living systematic review and meta-analysis on mother-to-child transmission of the severe acute respiratory syndrome-associated coronavirus 2 (SARS-CoV-2) was published.[22] This living review has since been updated to include additional research and has been submitted to *The BMJ* for publication. Analysis on variants of concern is being conducted with data that was extracted up to 31 January 2023 in view of the publication on the effect of Omicron on clinical manifestation, risk factors and maternal and perinatal outcomes. The protocol for this study was updated to reflect these changes and is available to download.[23]
Violence against women/GBV	A scoping review on violence against women and the COVID-19 pandemic is underway with 600 articles being reviewed to identify issues to focus on and gaps in this area. In parallel, a multisite implementation research protocol for scaling up the violence against women health response in PHC is currently undergoing technical and ethical review. This protocol will also be adapted and implemented in **India** using other finance streams.
Sexually transmitted infections and cervical cancer	Research was conducted in **South Africa** to improve the effectiveness of cervical cancer screening and treatment algorithms to accelerate progress towards the elimination of cervical cancer. This study compared two HPV screening and treatment algorithms across 1100 women living with HIV and evaluated the performance of various techniques for primary screening, and as triage for HPV-positive women living with HIV. In addition to conducting the study, funds were used to introduce HPV testing as point-of-care tests followed by ablative treatment in a one-day visit, an awareness campaign on HPV and cervical cancer as a preventable disease, counselling to women and research capacity strengthening. Results from a multi-country study on independent evaluation of point-of-care tests for screening for syphilis and HIV will be disseminated through a supplement in *BioMed Central Infectious Disease*. The publications reflect findings from 14 countries, 27 facilities and 17 000 patients on the use of point-of-care tests to overcome diagnostic constraints in PHC.

Evidence-based strategies for human resources for health

Health systems can only function with health workers. Improving health service coverage and realizing people's rights to the enjoyment of the highest attainable standard of health is dependent on the availability, accessibility, acceptability and quality of the health workforce. The health workforce also has a vital role in building the resilience of communities and health systems to respond to disasters caused by natural or man-made hazards, and related environmental, technological and biological hazards and risks. Key considerations for HRH include the requirement for a skills mix in addition to the skills provided by doctors, nurses and midwives, addressing workforce distribution and the challenges of dual practice, HLMA and the development of National Health Workforce Accounts (NHWA), among other things.

NHWA is used as part of the HLMA framework. NHWA is a system used to improve the availability, quality and use of data on the health workforce to measure HRH performance across different countries using standard indicators. **WHO African Region** countries are at different stages of completing the NHWA process. In 2022, **Benin**, **Central African Republic** and **Sudan** completed the NHWA; **Comoros** completed the 2021 Human Resource for Health Census and **Malawi** conducted the 2022 NHWA data collation, analysis and reports as part of the NHWA roadmap. **Zimbabwe** completed and validated the Comprehensive Health Labour Market Analysis. NHWA processes and activities help to understand the health workforce context, and the demand and supply factors, and these have aided **Zimbabwe** to develop its HRH policies. In **Benin**, NHWA processes and activities have informed an HRH investment plan.

In 2022, in **Ghana**, the UHC-P supported a review of health sector staffing norms/occupational class by finalizing the skills gap analysis tool for the health sector. In **Lesotho**, the Ministry of Health introduced the Workload Indicators of Staffing Need (WISN) tool to establish national staffing standards for the health sector, and to address present and potential staffing gaps. In the same year, data from representative health care facilities were gathered to produce the country's staffing guidelines. The health workforce information system was integrated into the national health information database, the District Health Information System (DHIS2). **Liberia** also completed and validated its WISN report.

In **Ethiopia**, the WISN tool was used to study five major categories of health and care workers, and based on its recommendations and the national HLMA, a consultation meeting was held with the Ethiopian Standards Agency, resulting in the revision of the national staffing standards/norms for comprehensive health posts, health centres, primary and general hospitals.

In **Namibia**, the UHC-P supported the development of the Health Care Workforce Status Report 2022, an innovation by the Ministry of Health & Social Services' Directorate of Human Resource to improve access to health care worker information for evidence-based decision-making.

In 2022, **Cabo Verde**, **Chad**, **Djibouti**, **Egypt**, **Eritrea**, **Gambia**, **Ghana**, **Sudan**, **Tunisia** and **Yemen** were supported by the UHC-P to develop their respective HRH strategic plans. **Mozambique** received support to finalize its 2021 HRH Annual Report. **Ethiopia** revised its existing HRH strategic plan to align with its evolving national and global health-development priorities and goals. **Liberia** completed and validated its community health programme policy and strategy. **Nigeria** finalized, launched and disseminated the National Centre for Disease Control's National Public Health Workforce Strategy to strengthen the HRH involved in emergency preparedness and response.

The UHC-P provided technical assistance to **Sudan** to develop a National Strategic Plan on Human Resources for Health 2030, based on intersectoral and tripartite dialogue and the *Global strategy on human resources for health: Workforce 2030*.[24] To provide information for the upcoming development plan cycles, **Togo** completed an end-term evaluation of its 2016–2020 Human Resources Development Plan and **Zimbabwe** completed an end-term evaluation of its 2016–2021 HRH Strategy. The new HRH Strategy for **Zimbabwe** was developed using findings from the HLMA. **Sudan** was supported in carrying out HRH projections, and establishing a platform for intersectoral and tripartite dialogue as part of the process, with the support of the International Labour Organization (ILO); **Sudan** also carried out an HLMA, and produced a detailed report with recommendations on selected policy options.

The UHC-P supported **Papua New Guinea**'s PHC workforce recruitment efforts using HLMA, which has enabled the health system to fill critical resource gaps and is a stepping stone to further strengthening PHC in the country (Box 11).

In **India**, work has advanced to provide performance-linked payments for health workers. The UHC-P conducted an assessment of team-based performance-linked payments for PHC teams working in health and wellness centres (HWCs) in seven states, resulting in a report with recommendations for the Government of India, and the rolling out of performance-linked payments in 20 districts of Jammu and Kashmir. In addition, the UHC-P developed tools to disburse performance-linked payments for PHC teams in Chhattisgarh, and made these tools available for managing performance-linked payments and the roll-out of the online payment tool across the state.

Box 11. PHC workforce recruitment in Papua New Guinea

The COVID-19 pandemic triggered many discussions in multiple forums about the need for longer-term health systems in **Papua New Guinea**. The UHC-P supported the formulation of an intergovernmental coordination mechanism at the beginning of the pandemic. This coordination mechanism, in turn, opened the door to a more structured and strategic dialogue on HRH standing issues and challenges. **Papua New Guinea** decided to secure sufficient PHC workforce on the ground by expediting the recruitment process and cancelling the existing ceiling on the number of civil servant positions. This change was brought about by newly produced evidence, supported by the UHC-P, on current staffing and vacancies using the NHWA and an HLMA approach. This evidence-based policy-making has enabled the health system to fill a critical resource gap and is a stepping stone in further strengthening PHC in the country.

The UHC-P supported the development of the Health Workforce Development Plan 2022–2030 in **Cambodia**, **Djibouti** and **Lao People's Democratic Republic**. The UHC-P also supported the fourth round of reporting for WHO's global code of practice on the international recruitment of health personnel[25] in **Tuvalu**, complementing the datasets reported through the NHWA platform. In **Pakistan**, the UHC-P helped to develop provincial HRH strategies in line with the national HRH vision; in particular, supporting the Lady Health Workers strategic plan.

Eswatini began using a Human Resource for Health Information System (HRHIS) for regional HRH planning and to monitor natural workforce attrition and making plans for replacements. In **Timor-Leste**, the UHC-P supported the development of an online HRHIS to strengthen HRH planning and management, and link with the health information system. The UHC-P also provided technical assistance to **Timor-Leste** to revitalize the Community Healthcare Worker Programme, which will contribute to strengthening PHC-oriented efforts and enable health service delivery and health promotion closer to communities.

In the **WHO European Region**, even though it is recognized that most countries have made significant progress towards achieving UHC, there are still disparities in access to health care services within and between countries. All countries in the WHO European Region currently face severe challenges related to the health workforce due to the ageing population, which puts a strain on health care systems and increases demand for health services. The Region also faces challenges related to the increasing burden of NCDs, such as cancer, cardiovascular disease and diabetes.

To maximize the provision of technical assistance to UHC-P countries to facilitate policy dialogues for streamlined policy changes, a mixed approach was used by conducting both standalone and joint cross-programmatic missions. An assessment of the HRHIS was discussed in **Ukraine**, and **Kyrgyzstan** was keen to initiate the comprehensive health workforce and rehabilitation assessment and planning to upgrade nursing and midwifery education to professional Bachelor degree programmes.

The UHC-P supported several missions undertaken by **Georgia** to continue the strengthening of HRH governance and health workforce planning for rural PHC, and ran workshops on developing HRH planning capabilities and the underlying governance requirements to outline project plans and timescales.

Quality workforce data and accurate registration of the existing workforce are essential to understanding service gaps and conducting effective HRH analysis and planning to develop a workforce that is responsive to the needs of the population. In 2022, the first health workforce assessment conducted in **Georgia** found that PHC workforce demographics had an ageing profile and a large number of workers were within 10 years of the retirement age (60 years for women and 65 for men) with some people working well into retirement. This assessment was followed by an HRH governance assessment and a policy dialogue with key stakeholders to discuss the assessment findings, identify policy priorities and develop an action plan and timeline for the next steps needed to strengthen HRH planning capacity and capability. During the dialogue, a health workforce roadmap was outlined based on the key needs identified: (i) improved HRH governance; and (ii) a unified HRHIS. In response, WHO supported an assessment of HRH data systems and proposed recommendations for moving to a unified HRHIS. To support capacity-building within the government, WHO has provided ongoing technical assistance through an HRH development course.

The COVID-19 pandemic revealed and accentuated important gaps in the provision of appropriate, community-based, long-term care services for a rapidly growing number of people experiencing a decline in functional ability, across the **WHO European Region**. As countries work to rebuild and strengthen health and long-term care systems, it is essential to support broad dialogue, a common vision for change and focused interventions to bridge existing divides. The *Health and care workforce in Europe: time to act* report[26] focuses on identifying effective policy and planning responses to the health care workforce challenges across the European Region and presents an overview of the health care workforce situation, focusing on medical doctors, nurses, midwives, dentists, pharmacists and physiotherapists in all 53 Member States of the Region, including the UHC-P countries.

Strengthening human resources capacities

In 2022, the UHC-P supported 55 senior officials from the Ministry of Health and agencies in **Ghana** to improve their leadership and management competencies by attending the WHO Pathways to Leadership for Health Transformation training. The UHC-P also developed and implemented tools to assess competency gaps and training needs to evaluate staff at the district, sub-district and community levels in 10 regions, followed by the development and deployment of a system to track these human resource competencies and distribution.

In **Guinea**, 46 regional health inspectors and prefectural directors of health and 75 newly appointed hospital directors were trained as part of HRH strengthening, and 150 health workers were trained on quality management using the HealthWISE approach in the regions of Mamou and Labé, and Conakry. In **Guinea**, **Mali** and **Rwanda**, training of trainers workshops were run, in partnership with the ILO, on occupational health and safety management using the HealthWISE approach.

Capacity-building exercises on NHWA were carried out in **Sierra Leone**, **Uganda** and **United Republic of Tanzania**. In **Uganda**, for example, a national training session was conducted for a multisectoral team of people from the Ministry of Health; health professional regulatory bodies; the ministries of education, finance, national planning, and labour; civil/public services, local government and the Uganda Bureau of Statistics, regional and district health management teams; private health sector health training institutions; and development partners. A key output of the workshop was a consensus on a set of indicators to be tracked nationally.

In **India**, the UHC-P supported the training and mentoring of the PHC workforce to increase the range of service delivery in health wellness centres, in six states and one union territory, to an expanded range of services – oral, ear-nose-throat and mental health – including field-level supportive supervision in the aspirational districts, resulting in a trained health workforce for improved service delivery.

The UHC-P provided technical assistance to strengthen the nursing curriculum in **Belize**, **Turks and Caicos** and **Dominica**, providing simulation labs in these countries. In **Bolivia**, clinic simulations reaching 200 health professionals were conducted, focused on PHC providers addressing chronic disease, mental health and maternal health. The UHC-P extended support to **Jamaica**, funding a hemispheric collaboration between WHO's nursing collaborating centres at the University of Miami and the University of the West Indies that resulted in a new course to develop nurse leaders in **Jamaica**, the 20-week curriculum WHO Regional Office for the Americas Virtual Training on Nursing and Midwifery Leadership.

For years, the traditional midwives of **Bolivia**'s 36 nations and indigenous territories have used traditional medicine practices together with conventional medicine to deliver babies with quality care and warmth, and with respect for interculturality. To facilitate the integration of traditional midwives into the health system, the UHC-P supported integrating traditional midwives into Bolivia's health care system to promote culturally secure births and intercultural dialogue (Box 12).

In **Colombia**, the UHC-P supported efforts to strengthen the first levels of care, through training community health workers (CHWs) in areas that have been affected by armed conflict and where there is wide cultural diversity. A total of 47 CHWs were trained to educate communities, provide basic primary care, and strengthen intercultural care services.

The UHC-P also assisted the development of a Gender Stereotypes and Sexual and Reproductive Rights workshop for health professionals in **Bolivia** working at the first level of care. The workshop included the following topics: the gender lens, positions of power of the doctor and women, gender stereotypes and public health, and the development of gender guidelines for PHC programmes. Technical assistance was provided to ensure gender and women's participation was included in the structures for the local health committees (COLOSAS – Comités Locales de Salud).

Egypt, **Lebanon** and **Sudan** were also supported by the UHC-P to improve health system governance as needed for successful implementation of universal health insurance while insuring an equity, gender and human rights approach. In **Sudan**, for example, a training workshop on the health system response to GBV was held, the results of the PHC facilities readiness assessment to respond to GBV in Khartoum State were disseminated, and an assessment of gender-specific patient needs and barriers to support designing gender-responsive service delivery was completed.

In 2022, in **Azerbaijan**, the UHC-P supported the Shamakhi PHC Fellowship programme, with the participation of 36 national and international fellows, to facilitate sharing knowledge and experiences between local, national and international PHC professionals, with specific training targeted at medical doctors, included supporting the participation of 118 sixth-year medical students in a community-based primary care clerkship programme, and establishing a cohort of 24 doctors to receive two years of comprehensive Emergency Care System (ECS) training, both domestically and abroad, to become champions of transforming the ECS in **Azerbaijan**.

To support efforts to strengthen **Tajikistan**'s HRH capacities for better health system governance and financing, the UHC-P supported comprehensive in-country missions with expert consultation and dialogue with key ministries and agencies to assess current HRH skills and capacities and support comprehensive health workforce strategy development. A technical working group on the implementation of the HLMA in **Tajikistan** was established, comprising key local and international experts who specialize in health data collection, analysis and assessment. The results of this study will inform further policy dialogue on strengthening the health workforce in the country.

The UHC-P supported **Iraq** in 2022 to scale up the implementation of the online family medicine bridging programme for general practitioners, targeting 1000 general practitioners in the first five years (2018–2023); over 100 general practitioners having graduated from the programme, and the number of universities participating in the programme has increased from 10 to 14. The UHC-P also provided technical support to implement the health accreditation programme.

The launching of WHO's Strategic approach to improving cardiovascular health (HEARTS) initiative in **Bahamas** has facilitated an interprofessional approach across the public and private health sectors to comprehensively manage hypertension and diabetes in PHC, and includes a guide for scaling up the HEARTS initiative in PHC to promote interdisciplinary engagement of health professionals, and provide detailed plans for standardizing data collection across facilities. In 2022, HEARTS treatment protocols for hypertension and diabetes were revised and disseminated among public and private primary care physicians in the National Health Insurance Authority scheme. **Suriname** also launched the HEARTS initiative and, in the **Dominican Republic**, the launch of the HEARTS Initiative resulted in training 551 physicians, 347 nurses, 362 CHWs and 143 auxiliary staff. An agreement was signed between the Ministry of Health and the Dominican Republic School of Medicine to include the HEARTS workshop in their curriculum.

Since the inception of the HEARTS programme in 2021 in **Trinidad and Tobago**, over 150 individuals from different organizations and communities have completed the training. The second cohort of 12 leaders were trained in June 2022. Forty health care workers from the regional health authorities also completed the training which included didactic live online sessions, offline course work and practical sessions. A plan for implementing this new approach with a monitoring and evaluation framework, including recommendations, was developed to guide the process post training.

A health worker takes part in PPE training in Baku, Azerbaijan. © WHO/Blink Media - Ehtiram Jabi

Box 12. Integrating traditional midwives into the Plurinational State of Bolivia's health care system to promote culturally secure births and intercultural dialogue

For years, the traditional midwives of **Bolivia**'s 36 nations and indigenous territories have used traditional medicine practices together with conventional medicine to bring life into the world with quality and warmth, and respecting interculturality.

Traditional medicine is an integral part of Bolivia's political constitution and its national health system. The national Family Community Intercultural Health (SAFCI) policy includes concepts of traditional medicine as a way of revaluing and integrating them into the public health agenda as a new way of doing health. This model of care allows health care staff to reach the population with an approach which includes dialogue, respect and recognition of different sets of knowledge. The approach makes connections between bio-medical approaches and traditional medicine, thus constituting a single, universal, intercultural community and inclusive health system that addresses Bolivia's diverse health issues. The Bolivian government's valuing of traditional midwives in indigenous communities contributes to universal access by providing rights-based sexual and reproductive health services that contribute to the reduction of maternal deaths and ultimately improve women's health.

The challenge

Connecting traditional midwifery with health establishments presents a challenge for health systems as there is not yet an effective coordination mechanism for integrating the two visions. While Western medicine regards childbirth as a bio-physiological process, labour represents a cosmic event for many indigenous communities. Childbirth for indigenous women is the confluence of all aspects of life: from social to cultural and emotional. The woman is the protagonist of the event, and the birth must take place in the most natural way possible, in total harmony with her surroundings.

Within the framework of the technical cooperation of the Improving the Health of Women and Adolescents in Vulnerable Situations project, the WHO Country Office in Bolivia developed a plan to integrate traditional midwives into the health system in the areas where the Yuracaré, Mojeño and Yuqui populations live. Thanks to the support of the UHC-P, WHO worked with the Directorate of Traditional Medicine of the Ministry of Health and Sports and partners, such as the nongovernmental organization Plan International, to facilitate the process of linking traditional midwives with health establishments. The midwives and the community both participated in intercultural dialogues. The objectives of this methodology is to exchange learnings, strengthen capacities and create opportunities for the empowerment and leadership of women and adolescents – all of which improves their overall health and well-being.

Results

- Three products were developed to facilitate the integration of traditional midwives into the health system.
- A guide on care during pregnancy, childbirth and the postpartum period using an intercultural approach. The guide seeks to raise the awareness of first- and second-level health care providers on the ancestral knowledge of traditional medicine.
- A guide that compiles the learnings and practices of the traditional midwives from three geographical regions of Bolivia: the highlands, the valley and the lowlands.
- An accreditation process for traditional midwives to be officially integrated in the health system.
- These interventions aimed to increase access to and coverage of sexual health and reproductive health services to offer a broad and comprehensive response. In addition, they sought to recognize the commitment of leadership by women, adolescents and traditional midwives, as well as their respective neighbourhoods and communities.
- The National Directorate of Traditional Medicine officially recognized midwives from the Yuracarés, Mojeños and Yuquis indigenous territories for the preservation of good ancestral practices in childbirth and newborn care after they participated in work sessions with the intercultural dialogue methodology with health personnel and community authorities.

Lessons learned

Despite the advances **Bolivia** has made, the current regulations and implementation experiences are not sufficient to integrate traditional medicine with Western medicine. This is a process that needs to be further consolidated with the sustained commitment of various actors. On the one hand, health personnel must understand the importance of working in coordination with traditional midwives, to integrate their knowledge in the care of women and babies, the use of nutrition based on herbs and native foods, and specific manoeuvres during pregnancy, childbirth and puerperium. On the other hand, traditional midwives must find the space in health services to complement their knowledge and seek help in case of any complications involving the mother or the newborn.

Health financing policies

Health financing is a core function of health systems that can enable progress towards UHC by improving effective service coverage and financial protection. Today, millions of people do not access services due to the cost. Many others receive poor quality of services even when they pay out of pocket. Carefully designed and implemented health financing policies support three core functions: revenue raising, pooling of funds and purchasing of services.

Key issues in health financing include designing incentives for improved quality of care and better health outcomes, and minimizing the impoverishment of the population that can result from unreasonable health costs. The UHC-P supports countries in the development of national health care financing strategies towards UHC, as well as supporting countries' health budget dialogues for UHC, covering issues of fiscal sustainability and public financial management (PFM).

In 2022, the UHC-P supported **Liberia**, **Malawi**, **Pakistan** and **Yemen** to finalize their respective national health financing strategies, and supported **Ghana** to evaluate its national health financing strategy. **South Sudan** and **Angola** completed PFM assessments, and **Gambia** conducted a health expenditure assessment.

The UHC-P assisted **Nigeria** to establish health financing coordination platforms by providing an additional two health financing equity and investment units and establishing a technical working group (TWG) in Enugu and Bayelsa States, as well as approving the National Health Financing Workplan. In addition, parliamentarians were successfully engaged under the Legislative Network for Universal Health Coverage to improve funding for health, and enact mandatory health insurance laws at the federal level as well as for the 36 states and the Federal Capital Territory (Box 13). Policy briefs were developed for scheduled policy dialogues and for the development of a national health funding strategy and strategic plan for **Lesotho**.

In **Rwanda**, the effectiveness of the community-based health insurance health benefit package committee was strengthened by training its members to use the multiple criteria decision approach for evidence-informed deliberative processes when reviewing/designing health benefit packages for UHC; developing standard operating procedures (SOPs) for the health benefit package (including guiding principles, governance structure and roles and responsibilities); and developing guidelines on how to operationalize the decision criteria set in the ministerial instructions to inform data collection and to prioritize health interventions and the methodological protocol outlining the different steps to establish a health benefit package design process.

In **Pakistan** and **Tunisia**, the UHC-P also provided support to develop and implement standards, develop methodological instruments to promote evidence-based adjustments of the benefit package and review legal and regulatory barriers at the institutional and national levels to expand the existing benefit package and its coverage.

In the context of a significant economic crisis in **Sri Lanka**, the UHC-P supported a technical analysis of health system efficiency, with a focus on HRH and service delivery, resulting in identifying opportunities to gain greater efficiencies through action in these two areas, as well as strengthening the linkage of HRH and service delivery in the context of PHC-oriented reforms. This technical analysis informed deliberations on the structural reforms and was also a key input for the discussions in 2023 on health financing options for **Sri Lanka**.

In **India** and **Morocco**, the UHC-P provided technical assistance to national health authorities on the transition to the International Classification of Diseases (ICD-11) and Diagnosis-related Groups (DRGs), building the capacity of personnel and providing resources to support the transition to outcomes-based payments, resulting in an evidence-based scheme resource allocation based on disease pattern intelligence and initiating the transition to an outcomes-based payment system.

The UHC-P supported **Mongolia** by strengthening capacity for strategic purchasing and evidence-based policy-making, and reviewing regulations with a focus on the financing of COVID-19 outpatients and inpatients and home care treatment. Technical assistance was provided to improve the capacity of the Ministry of Health and the Health Insurance General Agency to revise regulations such as performance indicators, hospital selection criteria and the benefit package. The health care financing matrix was revised to assess country progress on health care financing policies and implementation monitoring, and a handbook on methodology to estimate SDG3 indicators and SDG country profile was developed, including service coverage and catastrophic health spending.

In **Georgia**, preparations for implementing DRGs had been initiated before the COVID-19 pandemic resumed in 2022 with in-person and virtual consultations, workshops and recommendations on how best to introduce DRGs. DRGs were officially launched on 1 November 2022, and intensive technical assistance continued, after an introduction, to address the challenges and issues that arose with the launch of the DRGs and propose adjustments as needed.

Box 13. Strategic engagement of parliamentarians significantly improves health insurance coverage for poor and vulnerable populations in Nigeria and supports progress towards UHC

Background

Nigeria, with a population of over 200 million people, of which 40.1% are poor, bears the highest burden of out-of-pocket expenditure in the **WHO African Region** at 70.5% in 2019 and a 10-year average of 74.3%. Anambra State has a population of 5.8 million people who have a health out-of-pocket expenditure of 89.9%, 0.4% insurance coverage and catastrophic health expenditure of 47.7%. The national catastrophic health expenditure is 36.6%, varying from 17.0% to 66.0% in the 36 states and the Federal Capital Territory, means that the poor, 84.1% of whom live in rural areas, do not have access to life-saving PHC services. This in turn results in avoidable complications and even death. When they manage to access care, they are pushed deeper into poverty as they are compelled to sell their assets to pay out-of-pocket expenses.

Intervention

WHO, through the UHC-P, and in line with the GPW13 outcome 1.2, provided technical support to the Government of Nigeria to ensure a reduction in the number of people suffering financial hardship due to illness or as a result of accessing health care. This included the strategic engagement of parliamentarians at the federal level and in states including Anambra, with funding from the EU – under the Legislative Network for Universal Health Coverage – to bring about improved funding for health as well as the enactment of mandatory health insurance laws at the federal level and in the 36 states and the Federal Capital Territory. This has been done by generating health financing evidence that did not exist before and using it for sustained, bespoke capacity-building of parliamentarians, leading to the development and implementation of the Nigeria Legislative Health Agenda.

Key results

- Parliamentarians use of their parliamentary law-making functions (including appropriation of issues), representation, and oversight to bring health high on the political agenda of government.
- Establishment of the Basic Health Care Provision Fund.
- Passage of the National Health Insurance Authority Act 2022.
- Passage of mandatory health insurance laws in Nigeria's 36 states including Anambra State.

Benefits

- The population covered by health insurance has increased by 9 million over the last three years for predominantly poor and vulnerable Nigerians who now have access to a defined package of health services, even in rural areas and even during the COVID-19 lockdown.
- Improved financial risk protection for up to 35% of the population in Anambra State using an innovative adoption mechanism whereby rich philanthropists pay premiums to cover poor and vulnerable community members.
- Improvement in the availability and quality of health care in terms of human resource capacity, medicines, health commodities, equipment, infrastructure and technology.

A nurse counsels a patient before screening in Abuja, Nigeria.
© WHO/Blink Media-Etinosa Yvonne

Viet Nam was supported to align the incentives for referral systems in the ongoing process of revising the national social health insurance law and the governance of social health insurance. This support included experts from WHO and Thailand visiting the country to share international experiences and key messages. The discussions facilitated policy dialogue on health financing functions, and the roles and responsibilities of agencies. The UHC-P has also supported **Mongolia** in its ongoing efforts to move towards strategic purchasing and performance-based financing for PHC. Technical consultations on cost containment and provider payments have led to the revision of the regulations on contracting and PHC performance indicators. The WHO Western Pacific and South-East Asia regions collaborated with the World Bank and the Asian Development Bank, to hold the sixth bi-regional health financing workshop in July 2022, with the theme of seeking efficiency gains in the context of pandemic recovery and reorientation towards PHC (Box 14), with additional support provided to **Lao People's Democratic Republic** in the implementation of its health financing strategy (Box 15).

The UHC-P also provided technical support for equitable health financing strategies and reforms to sustain progress towards UHC in **Belize**, including discussing options to guide the development of a health system transformation framework linked with national health insurance. This support is resulting in a number of recommendations for strengthening the service delivery functions, reshaping health care delivery to integrated health service delivery networks, and reviewing and updating the legal framework that governs the regional health authorities.

Box 14. WHO Western Pacific and South-East Asia regions bi-regional health financing workshops

The WHO Western Pacific Region, in collaboration with the WHO South-East Asia Region, World Bank and the Asian Development Bank, held the sixth bi-regional health financing workshop in July 2022, with the theme of seeking efficiency gains in the context of pandemic recovery and reorientation towards PHC. Technical discussions and knowledge sharing on strengthening social health insurance systems for improved efficiency and financial protection were held with participants from the ministries of health, ministries of finance and social health insurance agencies from 20 Member States across the WHO Western Pacific and South-East Asia regions. The workshop led to increased political consensus on investing in health, strengthened partnerships and identified areas of collaboration in the Western Pacific and South-East Asia regions to advance PHC and UHC. Following the meeting, the policy discussions around seeking efficiency gains have translated into country support activities in **Lao People's Democratic Republic** (donor transition and hospital autonomy), **Cambodia** (UHC2030 Roadmap), **Mongolia** (cost containment in public hospitals) and **Malaysia** (White Paper discussion for health financing for the future).

Box 15. Supporting the implementation of the health financing strategy in Lao People's Democratic Republic

In **Lao People's Democratic Republic**, the UHC-P facilitated dialogue on sustaining public spending and cross-programmatic efficiency to improve the planning and financing of vertical programmes in the context of donor transition, and WHO engaged with the Ministry of Health to support GAVI (the Vaccine Alliance) transition discussions under the backdrop of fiscal stress in the country. The UHC-P also supported the Department of Finance and the Ministry of Health to implement the endorsed Health Financing Strategy 2021–2025, including monitoring the progress of the implementation of the Health Financing Strategy through Health Financing TWG meetings. The Strategy prioritizes PHC and provides a clear direction to improve accountability, efficiency, equity, sustainability and resilience of health systems. Funding from the UHC-P supported the TWG meeting in August 2022 to present the endorsed Strategy and discuss centralized financial management, and supported the finalization of the financial protection analysis, which will be used to inform policy dialogue between the Ministry of Health and Ministry of Finance, and the dialogue with partners. This platform also served to support discussions between the government and development partners on the transition to domestic funding for health for essential public health services. The dissemination meetings on the endorsed Health Financing Strategy 2021–2025 were conducted at the subnational level, and they were followed by a meeting, chaired by the Vice-Minister of Health, to discuss the initial exchange of ideas and the possibility of, and preparation for, reporting to the government on the centralized financial management in the health sector.

Based on several requests from national statistical offices in **eastern European and central Asian (EECA) countries** to strengthen their capacities to calculate catastrophic health spending (SDG indicator 3.8.2), work has been initiated to build trust and capacity among key analysts from EECA countries to monitor financial protection and inform the development of context-specific policy recommendations for reducing out-of-pocket payments and strengthening financial protection in the **WHO European Region**. This assistance culminated in a workshop held in Tbilisi, Georgia, with 50 participants from countries covered by the UHC-P (**Azerbaijan**, **Georgia**, **Kyrgyzstan**, **Republic of Moldova**, **Ukraine**, **Uzbekistan**), as well as **Armenia** and **Kazakhstan**, being trained on monitoring financial protection using a combination of statistical and policy analyses to monitor financial protection and present new evidence on financial protection.

Following on from the establishment of the SHIF in 2020 as a single purchasing agency in **Uzbekistan**, transformations to the health service delivery model have resulted in a refined and more explicitly defined PHC benefit package, which, in 2022, led to a pilot of the new 11 NCD outpatient medicines benefit package in the Syrdarya region, and improved pooling to reduce fragmentation of the health budget at the Syrdarya oblast level and increased flexibility to use budgetary funds at the provider level. The new provider payment methods developed and implemented in Syrdarya (capitation for PHC and outpatient specialist care; a combination of the new case-based payment system and the global budget for hospital care) was also part of **Uzbekistan**'s accelerated progress towards UHC.

The UHC-P provided leadership and engagement at the highest political levels to support **Ukraine** to design and implement strategies to help progress towards UHC. In 2022, during the war, WHO organized and led a two-day in-person meeting on the strategic planning of health financing in **Ukraine** together with the National Health Service of Ukraine to adapt strategic purchasing to changing population needs and to ensure institutional sustainability of the strategic purchaser.

Policy guidance was provided to the government to adopt strategic purchasing of services in response to the war, and the report *Health financing in Ukraine: resilience in the context of war* was published.[27] Numerous analyses to support evidence-based decision-making were carried out, helping to implement budget cuts in the health system while ensuring that access to essential services was maintained. Resilient institutions implementing health financing reform require skilled staff and, since it is not currently possible for the majority of men to travel outside Ukraine, WHO organized in-person training sessions on health financing towards UHC with representatives of the Ministry of Health, Ministry of Finance and National Health Service of Ukraine in Kyiv. This allowed discussions on adapting UHC principles into the local- and war-related contexts of strategic purchasing and enabled participants to share and learn.

In **Tajikistan**, the UHC-P supported an analysis of the current achievements and gaps in delivering and financing health services as part of the State Guaranteed Benefits Programme and persuaded the government to regularly revise and improve the State Guaranteed Benefits Programme. To support strengthening regional cooperation and establishing knowledge translation mechanisms, the capacities and skills of local stakeholders were developed, including technical statisticians and health financing experts from key relevant institutions, on how to calculate and interpret financial protection indicators. **Kyrgyzstan** has been supported in capacity strengthening to reduce out-of-pocket payments and catastrophic health expenditures (Box 16).

In **Republic of Moldova**, the policy paper *Primary health care financing: policy options for the Republic of Moldova* was developed and published.[28] The paper describes the current challenges facing PHC financing in the Republic of Moldova and presents the policy options to improve health outcomes and increase value for money in public spending, reflecting relevant international evidence and experience. The report findings and recommendations were discussed with the National Health Insurance Company and the Ministry of Health.

A doctor measures and examines a child before vaccination in Brovary, Ukraine. © WHO/Christopher Black

Box 16. Kyrgyzstan: strengthening financial protection to achieve UHC

To move towards achieving UHC, **Kyrgyzstan** is focused on reducing out-of-pocket payments and catastrophic health spending. In pursuit of this goal, WHO has worked with **Kyrgyzstan** to build capacity and provide technical support in five key areas.

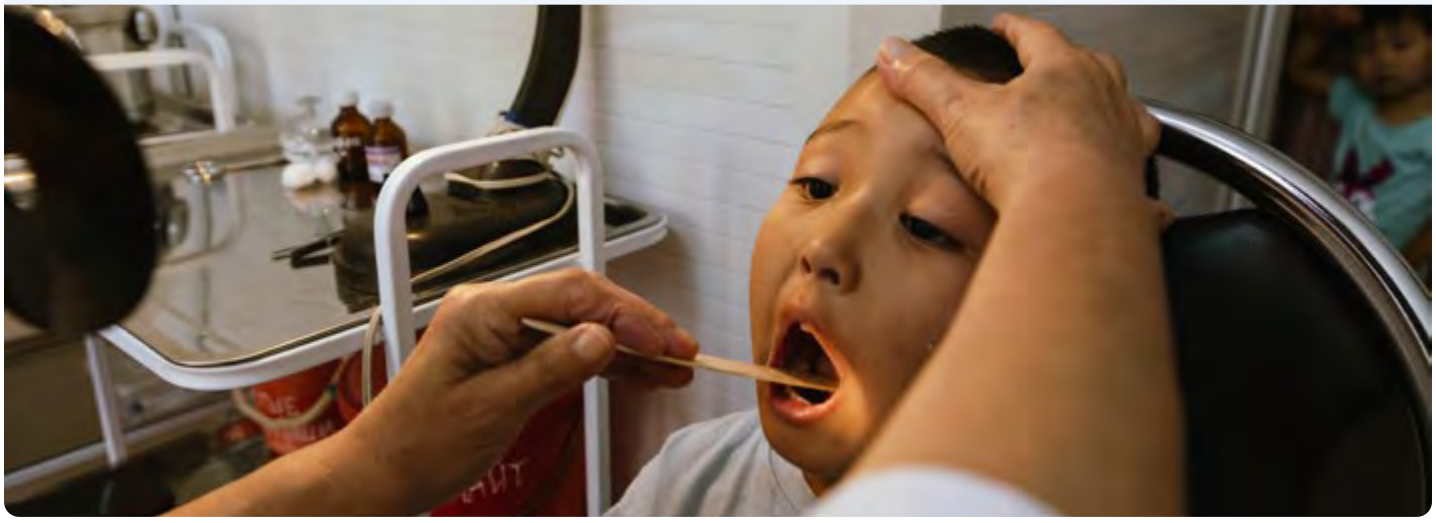
- **Advancing strategic purchasing of essential medicines through the gradual introduction of new DRGs into the case-based payment system** In 2022, WHO supported the development of a roadmap for the gradual introduction of new DRGs into the case-based payment system that will be used as a guide to coordinate and prioritize the next steps taken in 2023.

- **Introducing a price control mechanism for essential medicines** With the support of WHO and other development partners, a temporary price control mechanism for selected medicines was approved in 2022 and is currently being piloted across the country. Preliminary analysis conducted by national authorities found that the prices of the selected medicines have decreased by 3–5%. After the positive results from this pilot, the Minister of Health working group drafted a permanent regulation to introduce a price control mechanism for essential medicines, which is currently undergoing public consultation before being formally submitted for approval by the Cabinet of Ministers. In **Tunisia**, the UHC-P supported the creation of a unified medicines regulatory agency and a more efficient medicines pricing regime.

- **Strengthening monitoring of out-of-pocket payments and reporting on SDG indicator 3.8.2** A Kyrgyz delegation presented data on out-of-pocket payments at a subregional meeting of **EECA countries** held in Georgia in October 2022, which was organized by the WHO Barcelona Office for Health Systems Financing. The figures jumpstarted discussions on the need to revise the State Guaranteed Benefits Package and the need to revise and institutionalize the production of these figures and the routine production of NHAs to support better targeting of the State Guaranteed Benefits Package.

- **Working together across all levels at WHO to improve quality of care and achieve UHC** In June 2022, a coordination meeting brought together representatives and experts from WHO and the **Kyrgyzstan** Ministry of Health, the Mandatory Health Insurance Fund, other national stakeholders and development partners. The coordination meeting reviewed the results of a desk review and other assessment documents on quality of care and put forth a draft strategy, along with a roadmap outlining the next steps. The strategy and roadmap were then presented at a high-level policy dialogue in November 2022, where all parties agreed to them and recommended seeking their formal approval by the government.

- **Creating a vision for strengthening PHC, with a focus on rural areas** To further their thinking on PHC reform, a high-level Kyrgyz delegation undertook a four-day visit to the WHO Primary Health Care Demonstration Platform in Esik, **Kazakhstan**. The visit included participation in a tailored training programme, which provided an opportunity for first-hand learning of how the district is transforming the PHC system in rural areas through expanded multidisciplinary teams. Over the four days, the Kyrgyz delegation focused on how to overcome barriers to implementation and discussed how best practices from the Kazakhstan Primary Health Care Demonstration Platform could be adapted to the realities and needs of **Kyrgyzstan**. Follow-up missions to build on these learnings will take place throughout 2023, including a joint mission on PHC and health financing.



A child is examined for tonsillitis in a medical centre in Karakol, Kyrgystan. © WHO

National Health Accounts and finance tracking

In 2022, most countries in the **WHO African Region** were in various stages of carrying out NHAs. The countries activities ranged from the formation of NHA technical working groups, training of stakeholders on the NHA development process, data collection, analysis and reporting. Countries that conducted activities towards the NHA report include **Botswana**, **Burkina Faso**, **Burundi**, **Cabo Verde**, **Cameroon**, **Chad**, **Côte d'Ivoire**, **Comoros**, **Democratic Republic of the Congo**, **Eswatini**, **Gambia**, **Ghana**, **Guinea**, **Lesotho**, **Liberia**, **Madagascar**, **Mali**, **Malawi**, **Niger**, **Nigeria**, **Senegal**, **Sierra Leone**, **United Republic of Tanzania**, **Togo**, **Uganda** and **Zimbabwe**. **Bolivia**, **Fiji**, **Haiti** and **Timor-Leste** were also supported by the UHC-P to conduct 2018–2019 NHAs (delayed because of the COVID-19 pandemic), resulting in strengthened understandings of health financing to inform discussions with policy-makers and partners on successes, challenges and priorities.

In **India**, the UHC-P supported capacity-building for state-level expenditure estimates in Rajasthan, resulting in institutionalized state health accounts which generate regular expenditure estimates for evidence-based planning.

Bolivia was able to improve its planning and management of medicines and health technology as part of a strategy to improve health coverage and access across its Single Health System (SUS) due to support provided on information management, and coordination across national and subnational actors, with support also given on reducing fragmented purchasing practices through improved demand modelling and predictions.

In **Uzbekistan**, 11 International Nonproprietary Names were prioritized for use for the treatment of the most prevalent NCDs, and methods to forecast demand and set prices were reviewed, including for essential medicines for treating hypertension, ischaemic heart disease, type 2 diabetes, obstructive pulmonary disease and bronchial asthma. This new approach incorporates direct contracts between the SHIF and community pharmacies (the state-owned pharmacy was selected for the pilot first, and several private pharmacies joined the pilot later in 2022) and the use of a newly developed e-prescription module. All patients diagnosed with these conditions now have free access to the covered medicines prescribed by family doctors (as opposed to the approach used previously of providing medicines free of charge only to specific population groups). The programme ensures affordable access to a set of essential medicines and increases the attractiveness of PHC.

In 2022, **Saint Vincent and the Grenadines** and **Suriname** were supported with the implementation of the Health Financing Progress Matrix (HFPM), and **Curacao** was supported to develop a health sector reform agenda, by developing a roadmap for technical cooperation on NHA implementation and assessing payment mechanisms for health and resource allocation.

Technical policy support and in-depth reports in **Jamaica** and **Belize** led to high-level discussions with national authorities on sustainable options for increasing public expenditure in health. In **Barbados**, WHO coordinated an international mission of health financing experts to advise the government on recommendations for improving and increasing health financing in the context of a local decision to implement a national health insurance scheme in the medium term. Findings from a household survey in **Myanmar** on health service availability demonstrated the increasing unaffordability of health care, and highlighted the steep price rises of both medical products (Box 17).

In **Republic of Moldova** and the **oPt**, the UHC-P supported the development of costing methodologies and capacity-building for hospital services, with the view of improving performance in the hospital sector through cost saving and improved efficiencies, resulting in better health outcomes.

Box 17. Myanmar: the high financial burden to access health care

In **Myanmar**, findings from a household survey conducted in 2022 show that, of those accessing private providers, over 90% pay for services, medicines and consumables. Of those who access health care services from public providers, approximately 58% paid for services, medicines and consumables. The financial burden arising from accessing health care services from private health facilities demonstrated that over 12% of people paid for care by borrowing funds and about 10% had to sell assets. Although the share was slightly lower, some of those accessing health care services from public facilities also borrowed funds and sold assets. It may be observed that with the steep depreciation of Myanmar Kyats, combined with supply chain disruption and rising fuel costs due to the scarcity of electricity, health services are reported to be unaffordable, with a steep rise in prices of medicines and supplies.

Health workers at a cholera treatment centre in Balaka, Malawi. © WHO/Moving Minds

DEEP DIVE

Progress implementing the Health Financing Progress Matrix

Systematic monitoring of the development and implementation of health financing policies in support of UHC efforts

Health financing policy plays a central role in accelerating progress towards UHC, both in terms of addressing the problems of the financial hardship people face when they use health services, and influencing the quantity and quality of service coverage. It is therefore a central concern to monitor whether countries are developing and implementing health financing policies which are evidence-based and support the objectives and goals of UHC.

Quantitative measurements are critical to assessing health financing performance for UHC (through financial protection estimates and health expenditure tracking). However, available data always come with a time lag of at least two years, and often significantly more for financial protection data (SDG indicator 3.8.2). Furthermore, while quantitative indicators tell us how a country is performing, whether the trend is improvement or deterioration, they provide no direction in terms of the policy shift requirements to accelerate progress.

In 2018, WHO initiated a process to address this void, namely through the development of the HFPM, which is based on iterative processes of expert consultations and country applications.

Following the expert consultation, HFPM version 1 was released in 2018 – a key milestone in the development process. This version was subsequently field-tested in 19 countries, and further refined based on the lessons learned from the piloting stage, and also through the expansion of the evidence base upon which it was created. The development phase therefore culminated in 2020 with the publication of two key WHO publications: *The Health Financing Progress Matrix 2.0*[29] and *The Health Financing Progress Matrix country assessment guide*.[30] These documents define the 19 "desirable attributes" more clearly, make explicit the relationship between policy interventions and health system performance, and detail guidance for assessors.

What is the Health Financing Progress Matrix?

The HFPM assessment is structured around two major stages, as described below.

Stage 1
Involves mapping the key health coverage schemes and programmes in a country, and describing the key features of each, in terms of their revenue sources, how those revenues are pooled, purchasing arrangements, benefits, the population targeted and any specific arrangements in terms of service delivery. Stage 1 ensures a systemwide perspective for the HFPM, avoiding a narrow focus on a specific scheme or mechanism; for example, social health insurance, or a specific policy, such as results-based financing.

Stage 2
Assesses the country's health financing system in some detail, through the answers to 33 questions; these are the basis of assessing where a country currently is in relation to a set of 19 benchmarks – referred to as "desirable attributes" of health financing systems – across seven major health financing areas. For each question, qualitative analysis, for example of policy statements, or implementation of interventions, is complemented with quantitative data to help the assessor rate the current situation against four progress levels – Emerging, Progressing, Established and Advanced. Detailed guidance is provided for each question, in terms of the criteria to be considered.

Following completion of the HFPM, a third stage involves national authorities discussing the findings and identifying the priority actions that emerged from the assessment. This assessment aims to provide policy-makers with timely information, highlighting strengths but also weaknesses and, hence, priority health financing areas to focus on to establish a conducive health financing environment and accelerate progress towards UHC.

From 2020 to 2022: key steps towards the institutionalization of the HFPM

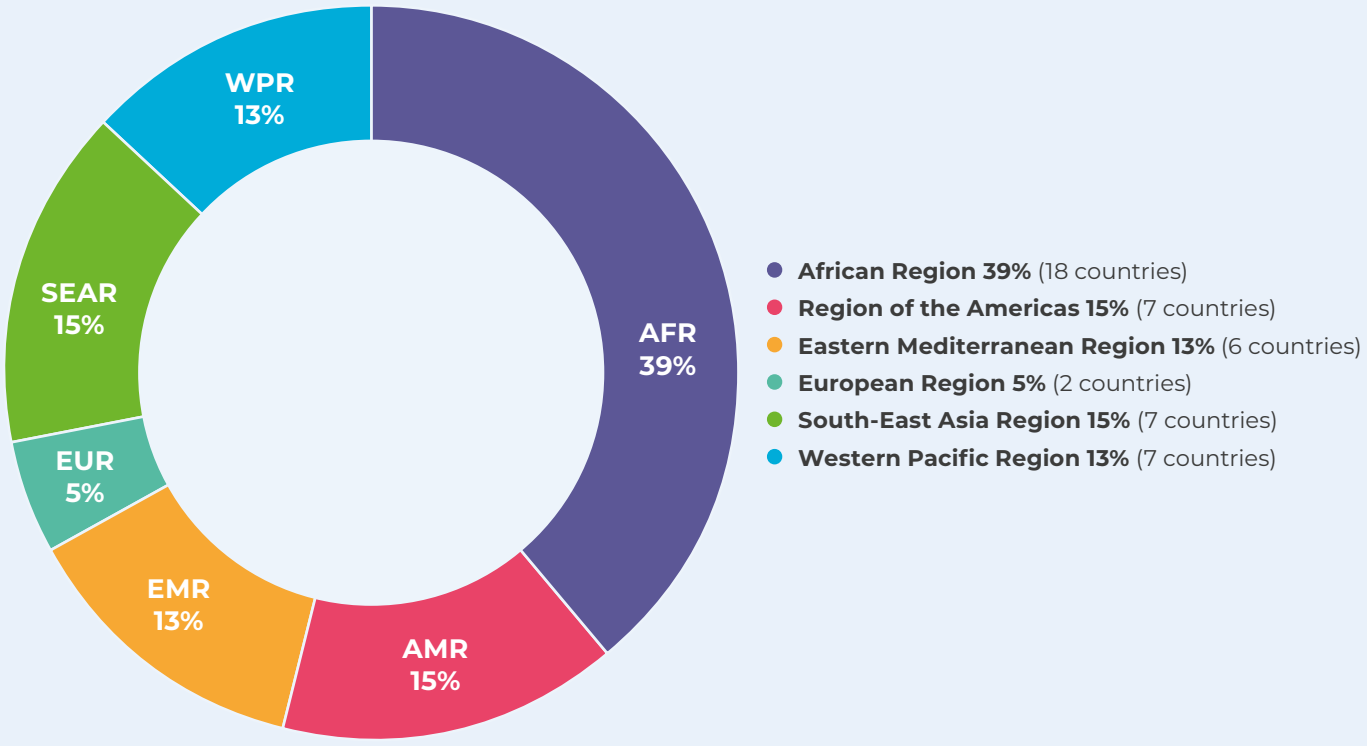
Following the initial development phase, the HFPM entered the second stage of its development: the institutionalization phase. During that phase, it was important for WHO to enhance the visibility of the matrix, position it in the space of the health financing assessment tools and processes, and continue the iterative refinement process.

Demonstrating the relevance of the matrix

The HFPM has a very specific intrinsic value for the health financing assessment: it is the only tool that: (i) promotes a systemwide approach to evaluating a country's health financing system; (ii) is explicit in how specific policies can improve certain elements of health system performance; and (iii) clearly defines what it means, and looks like, to make progress on 33 policy areas, which in turn lends itself to systematically monitoring progress in the development and implementation of policies over time.

Another important aspect of the HFPM is the approach to implementation. If the added value is acknowledged in theory, it is imperative to put the theory into practice and demonstrate the relevance of the HFPM as an assessment tool of health financing systems. Between 2018 and 2022, WHO supported 46 countries to conduct the assessment, and there are now 26 countries in which the assessment is either ongoing or completed, with various approaches being used to undertake and validate findings and scores. Fig. 11 indicates how many processes have been initiated in which WHO Region, and where they were at as of 31 December 2022.

Fig. 11. HFPM implementation in WHO regions as of 31 December 2022



Source: WHO Health Financing team.

Figs. 12 and 13 depict the geographical distribution of HFPM assessments, and the current status of the assessment in the 26 countries where it is being implemented as of 31 December 2022.

Fig. 12. Geographical distribution of HFPM assessments as of 31 December 2022

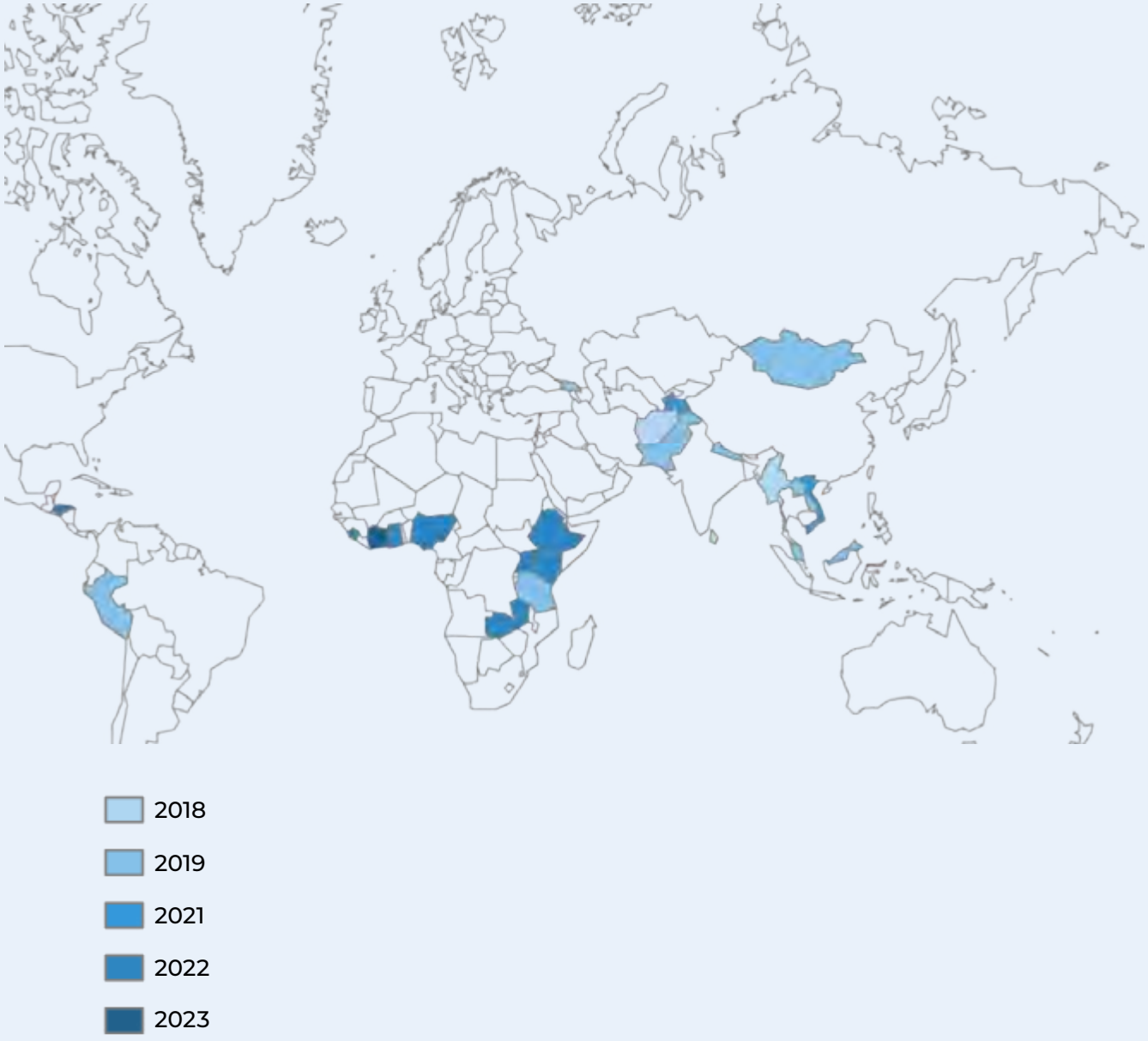
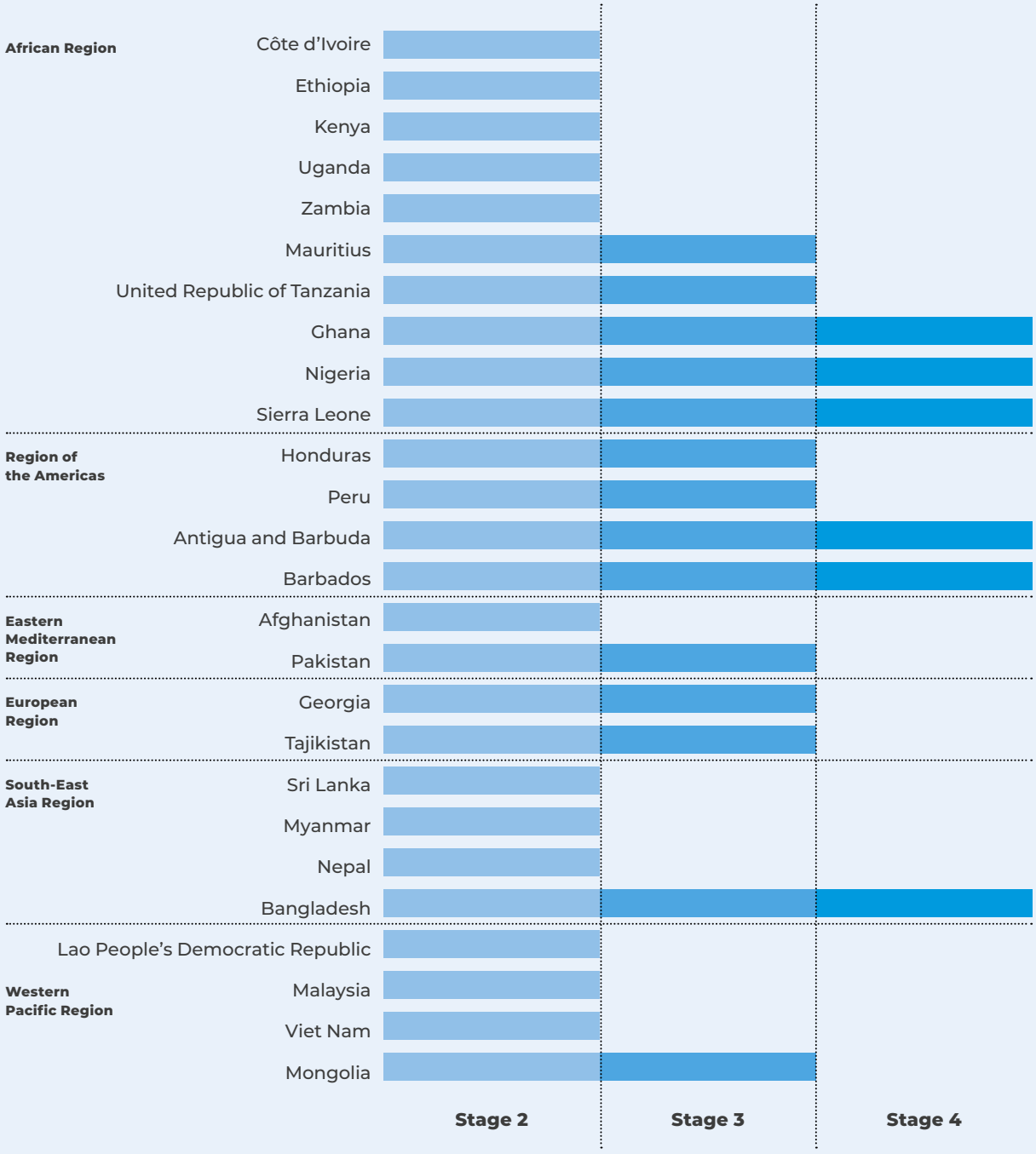


Fig. 13. Current status of the HFPM assessment as of 31 December 2022



Source: WHO Health Financing team.

These assessments have been well received by the national authorities, both in terms of content and process, as the national authorities were engaged both in the interpretation and the validation of the findings. They helped highlight areas of progress but also areas of priority for strengthening and further improvement, and therefore allowed governments to prioritize areas and provide better leadership in health financing.

The following are examples of use cases.

- The fact that some countries have updated the initial assessment, demonstrating its added value to assess progress, is a good indicator of the recognized added value of the HFPM as a policy tool for national authorities.
- In the second phase, an important development has been that, in some countries, the matrix was run as part of a national strategic planning process during the mid- or end-term evaluations. For example, application of the matrix in **Rwanda** or **Uganda** was used as part of the mid-term evaluation process of existing national health financing strategies.

HFPM: application in Pakistan

In **Pakistan**, the HFPM application was initially led by a team from the Aga Khan University, at the request of the Ministry of National Health Services, Regulation and Coordination in 2021. In 2022, the draft report was further updated by the Federal Ministry of Health with WHO support, and then submitted for review to various stakeholders, including World Bank, both to improve the quality of the final assessment, but also to build a consensus around the diagnostic among the various stakeholders.

A number of specific recommendations emerged from the process, in particular on the level of revenues available for the health sector, the need for better coordination in the scaling up of initiatives across provinces – including for the National Health Insurance Programme offering coverage to the poorest segments of the population (Sehat Sehulat) or in the definition and implementation of the Essential Package of Health Services – and the PFM reforms required to support implementation of the major health sector reforms.

A mother and son in Balochistan, Pakistan. © WHO/Panos Pictures/Saiyna Bashir

HFPM: application in Ethiopia

In **Ethiopia**, the matrix was applied by a team from the Ministry of Health (Partnership Cooperation Directorate/ HEFA), under the leadership of Dr Fevan, and with support from WHO, who engaged with the Health Financing TWG (the coordination body for the Ministry of Health and partners on health financing-related issues) that includes representatives of the Ministry of Finance, the Health Insurance Agency and the development partners involved in health financing. The assessment forms a baseline reference to support progress monitoring of the National Health Care Financing Strategy (2015–2035), and annual updates are now planned as part of the routine monitoring activities of the strategy.[31]

Enhance the HFPM visibility in global health

The HFPM as an entry point for capacity-building

The HFPM is essentially a crystallization of what works in health financing for UHC, and those involved in its implementation are first encouraged to complete WHO's existing courses in health financing, including the self-paced e-learning course (in English[32] and French[33]), and the advanced course on health financing for UHC.[34] Subsequently, key individuals from a number of countries preparing for implementation of the assessment have been invited to an in-depth training /briefing event.

HFPM training events

In 2022, two HFPM training events were organized in the **WHO African Region**: the first one was run in English (June 2022 in **Zimbabwe**) and the second in French (November 2022 in **Senegal**).

The primary objective of these training events was to provide an in-depth briefing for ministries of health, and other involved stakeholders, on a range of issues related to the HFPM, as follows:

- **technical content:** concept, evidence base, normative foundations;
- **implementation:** decision points at each of the four phases of implementation;
- **strategic issues**: capacity-building, research agenda, institutionalization and how the HFPM differs from other assessments.

A second objective was to establish and build a network of countries and individuals active in health financing, and who are either currently, or likely in the near future, to be involved in the implementation and use of HFPM assessments.

The first meeting (held in English) attracted over 60 participants from 12 Member States, academia and other partner agencies engaged in health financing, enabling a dynamic exchange of views from a number of perspectives. Official representatives were convened from the following countries: **Botswana**, **Eswatini**, **Kenya**, **Lesotho**, **Malawi**, **Namibia**, **Rwanda**, **South Africa**, **United Republic of Tanzania**, **Uganda**, **Zambia** and **Zimbabwe**. Partner agencies included the Africa Centres for Disease Control and Prevention; African Development Bank; African Health and Policy Association; African Union; East Central and Southern Africa Community; the Global Financing Facility; Ifakara Research Institute; KEMRI Research Welcome Trust; R4D; Southern African Development Community; the Global Fund to Fight Tuberculosis, HIV and Malaria; the Strategic Purchasing Research Center; Thinkwell; and World Bank.

The second meeting attracted over 50 French-speaking participants from 19 Member States, academia and other partner agencies engaged in health financing, enabling a dynamic exchange of views from several perspectives. Official representatives were convened from the following countries: **Burkina Faso**, **Burundi**, **Central African Republic**, **Chad**, **Comoros**, **Congo**, **Côte d'Ivoire**, **Gabon**, **Guinea**, **Madagascar**, **Mali**, **Mauritania**, **Niger**, **Democratic Republic of the Congo**, **Sao Tome and Principe**, **Senegal** and **Togo**. Partner agencies included the European Agency for Development and Health, the Centre of Research in Human Reproduction and Demography, the Global Financing Facility, the Southern African Development Community, the Social Health Protection Network and World Bank.

Collaboration with multilateral agencies

In the **WHO African Region**, the HFPM is closely coordinated with the agenda of the African Union, under which a Health Financing Tracker has been developed, which is essentially an extended version of the Africa Scorecard on Domestic Financing for Health. The HFPM is very different to the Tracker in that it goes deeper into the details of which health financing policies are being developed and implemented in a country, identifies areas of strength and weakness, and identifies priority futures shifts in direction to accelerate progress to UHC.

WHO has also received funding from other donors, such as the Global Fund, to implement the HFPM in four countries, and to co-finance training events.

Digital environment

The key documents for the HFPM are available online, together with reports that have been published.[35] In addition, to support the assessment process, a dashboard of key indicators has been compiled, pulling together information from a range of public databases, including the Global Health Expenditure Database, the International Monetary Fund, Public Expenditure and Financial Accountability, and the ILO.[36]

What are the key lessons from the second phase of the HFPM development?

The publication of the second version of the HFPM, Health Financing Progress Matrix 2.0, and its accompanying guidance document, together with the introduction of quality control mechanisms such as the external review of the process, have helped strengthen the credibility, buy-in, relevance and institutionalization of the HFPM in national dialogues on health financing. Continuous efforts to promote and explain the tool have increasingly positioned it as key to running a health financing assessment in any context.

Conclusions and next steps

Overall, the HFPM provides a common point of reference for policy discussion, prioritization and monitoring over time, based on a systemwide approach to health financing issues, rather than a scheme-centred or a single-policy focus, which is fundamental to the UHC agenda. In some instances, there are indications (that still need confirmation) that HFPM assessments have contributed to progressively shifting the conversation on health financing issues to what really matters in health financing at the country level. In 2023, UHC-P funding will be used to implement the following key activities:

- WHO will develop a version 2.1 of the Country Assessment Guide to include updates based on implementation experiences to date;
- WHO will develop a professional, online dashboard to provide public access to detailed results from completed country assessments;
- WHO will conduct a meta-analysis of 25 countries to identify emerging trends in terms of the development and implementation of health financing policies.

A doctor at a health centre in Addis Ababa, Ethiopia. © WHO/Maheder Haileselassie

1.5 Essential medicines, vaccines, diagnostics and devices for primary health care

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

Strengthening regulatory capacity

Increasing the quality of care was a strong component of UHC-P support to Member States in the **WHO African Region**, to the extent that a roster of trained consultants has been set up to support 28 Member States in the Region to develop and implement national quality and patient safety standards.

In 2022, in the **WHO African Region**, focus was placed on patient safety, IPC, capacity-building of health workers, and accreditation. **Cameroon** developed a draft national quality of care strategy; **Cameroon** and **South Sudan** developed a quality of care roadmap for implementation; **Burundi** conducted quality of care assessments in 36 out of 43 hospitals for maternal and child health; **Guinea** assessed IPC across facilities and developed an operation plan. For health worker capacity-building, **Namibia** held an orientation meeting for health care workers from all 14 regions on the national quality standards and the national quality policy and strategy. **Malawi** ran collaborative learning sessions and held district feedback meetings on quality, and a health systems functionality assessment was conducted and integrated into the national integrated supervision tools. **Eswatini** initiated the accreditation process for the national blood bank, which was assessed against the accreditation standards with recommendations being made for improvements. **Eswatini** also conducted a baseline assessment for radiology, and the recommendations were included into the workplan. Finally, **Ethiopia** was supported to develop a National Patient Safety Training package.

In both the **Dominican Republic** and **Egypt**, the UHC-P supported technical cooperation to build the country's health financing capacity through training and the development of tools. As part of this cooperation, a health technology assessment of pharmaceuticals, equipment, machines, procedures and physical techniques for health prevention and promotion was conducted to inform decision-making based on benefits and efficacy, clinical and technical safety and cost–effectiveness. In **Haiti**, the governance capacities of the national pharmacy, medicine and traditional medicine regulatory authority were strengthened by developing a National Therapeutic Form, which is a normative document guiding the rational use of medicines at service delivery points, intended for daily practice by health care providers (Box 18).

In **India**, quality of care improved at PHC facilities (both rural and urban) through capacity-building activities for PHC facility staff, who then qualified for quality of care certifications. As a result, the Hazipara HWC of Barpeta district (an aspirational district) in Assam was the first HWC in the northeast state to get the national quality certification. Sundernagar HWC was the first HWC to qualify for the national quality certification in Jharkhand. In addition, the UHC-P helped prepare a roadmap for quality upgrades for urban health facilities, including supporting capacity-building initiatives for Quality improvement, National Quality Assurance Standards certification and patient safety for community health officers, medical officers and programme managers in the states of Chhattisgarh, Uttar Pradesh and Assam. Eleven groups were trained and 25 health facilities have applied for National Quality Assurance Standards certification.

Box 18. Strengthening pharmacovigilance and regulatory capacity in Haiti

The UHC-P provided support to strengthen the governance capacities of Haiti's national pharmacy, medicine and traditional medicine regulatory authority by developing a National Therapeutic Form, a normative document guiding the rational use of medicines at service delivery points, intended for daily practice by health care providers. Additional technical cooperation was provided to build the capacity of the national pharmacy, medicine and traditional medicine regulatory authority to ensure the proper implementation and availability of strategic and operational documents to strengthen governance at the national level. As a result of this cooperation a series of pharmacovigilance framework documents have been reviewed and validated to strengthen the quality assurance system of the national pharmacovigilance system. These key tools play a fundamental role in building the Ministry of Health's regulatory and pharmacovigilance system and are also aligned with the strengthening of the regulatory system for all medical products as well as the implementation of the national vaccination plan as part of the COVID-19 response. The development of a mobile application for pharmaceutical information (iOS and Android) aims to make the information on authorized medicines accessible in Haiti.

World patient safety remains a priority for countries with capacity-building held at national and regional levels (**Uganda**); an assessment undertaken in **Botswana**, and strategy development prioritized in **Zambia**. In **Ghana**, a situation analysis of patient safety was conducted, which supported the development of the draft of **Ghana**'s patient safety strategy. In addition, situation analysis is underway to develop the Regional Strategy for Patient Safety in the **WHO African Region**. This support for patient safety was also echoed in **Lao People's Democratic Republic**, where the UHC-P assisted in developing draft patient safety guidelines.

In **Pakistan**, the patient safety friendly hospital framework was scaled up, with two scientific conferences organized to advocate and promote the culture of patient safety, and the patient safety friendly hospital framework was institutionalized at 130 hospitals and PHC facilities. This involved training 54 hospital managers on hospital care management, and providing patient safety equipment to four hospitals to improve quality of care.

In **Kyrgyzstan**, work was undertaken across all levels of WHO and the Ministry of Health, the Mandatory Health Insurance Fund, and other national stakeholders and development partners, in a Quality of Care Coordination Meeting to improve quality of care to achieve UHC. The results of a desk review and other assessment documents on quality of care were reviewed and a draft strategy for improving quality of care was prepared, along with a roadmap outlining the next steps. The quality of care strategy and roadmap were then presented at a high-level policy dialogue in November 2022, where all parties agreed to the strategy and roadmap and recommended that it proceeds for formal approval by the government.

In **Honduras** and **Lebanon**, the UHC-P provided technical support to strengthen various areas of the health system, including essential medicines and diagnostics lists, and the regulations for quality, control and supply of medications. In **Honduras**, the national Essential Medicines List was developed in partnership with the Centro Universitario de Farmacología (CUFAR) and UHC-P assisted with the use of the WHO Global Benchmarking Tool (GBT) for Evaluation of National Regulatory System of Medical Products to update the Institutional Development Plan. Technical cooperation was also provided to update **Bolivia's** essential medicines and health products lists to align with its new health system model.

Benin was supported to revise its essential medical device list and essential in vitro diagnostics list, and to develop and validate guidelines for the conduct of clinical trials in-country. National pharmacovigilance guidelines were developed and completed in **Benin** and **Equatorial Guinea**, and the pharmacovigilance system was evaluated in **Comoros** and **Lesotho**. Standard treatment guidelines were updated in **Eswatini**, **Liberia** and **Rwanda**, while health equipment and infrastructure standards and guidelines were revised in **Chad**, **Comoros** and **Democratic Republic of the Congo** (Box 19).

Burundi also developed its National List of Medical Devices, National List of Essential Diagnostics of Pathogens, Medicines Safety guidelines, and modules for the SOPs for detecting pathogens. In **Chad**, reporting tools were developed and the pharmacovigilance training manual finalized.

In **Ethiopia**, 45 regional blood bank staff from the Blood Safety Information System, from the Hawassa, Arbaminch and Hossaena blood banks, were trained to use the infectious testing auto machine and the blood grouping laboratory auto machine. **Gambia** National Blood Transfusion Services was supported to join an external quality assurance programme and has restarted monitoring visits to 11 blood transfusion centres. In **Philippines**, the UHC-P supported the completion of a rapid country situation analysis of the National Voluntary Blood Services Programme.

In the **WHO Western Pacific Region**, the UCH-P supported the assessment of laboratory systems, including human resources analysis for laboratory systems in **Cook Islands**, **Nauru**, **Samoa** and **Vanuatu**. In **Fiji**, the UHC-P supported the building of the national pharmacovigilance system and raised awareness on safety monitoring activities for medical products as well as providing technical guidance to set up a provisional product registration system linked to import control requirements. Training was organized for border control officers (customs and biosecurity) followed by training in the use of Minilab equipment to detect and identify substandard and falsified medical products, and post-marketing surveillance.

In **Federated States of Micronesia**, technical assistance was provided to draft the National Guidelines for Opioid Prescription for Chronic Pain, which focused on promoting rational drug use and protecting the public from drug misuse and opioid dependency. The revision and updates of the clinical guidelines for COVID-19 in **Fiji**, **Tonga** and **Vanuatu**, including the use of novel COVID-19 therapeutics was completed, accompanied by virtual training sessions in the clinical management and safety monitoring of novel COVID-19 therapeutics for health care professionals in the Pacific island countries.

The UHC-P supported **Egypt** in its efforts to begin restructuring its pharmaceutical sector and strengthening regulations in the medicines and pharmaceutical sectors, to increase dependence on strategic purchasing. Egypt was also supported to develop a national programme for promoting, standardizing and regulating the clinical pharmacy practice, and capacity-building and the institutional development of the Egyptian drug authority. In addition, the UHC-P supported the prequalification of the medicines authority and the establishment and functioning of a health technology governance body, as well as establishing standards and systems for safe medication practices and operating, a drug utilization review programme and medication errors reporting systems.

Box 19. Global Benchmarking Tool results in the WHO African Region

Burundi, **Comoros**, **Madagascar**, **Mali** and **Mauritania** were supported to conduct self-assessments of the regulatory functions of their pharmaceutical regulatory authorities using the GBT. The National Regulatory Authorities in **Nigeria** achieved maturity level 3 in the GBT, and, in **Rwanda**, the benchmarking process for the Food and Drugs Authority's regulatory functions towards maturity level 3 certification was carried out. **Democratic Republic of the Congo** conducted a self-assessment of the regulatory functions of its Pharmaceutical Regulatory Authority, ran training on the implementation of a quality assurance system, and carried out an evaluation of regulatory systems using the GBT, to indicate that the system is well-functioning. **United Republic of Tanzania** developed Good Review Practices Guidelines to improve and standardize internal processes during a medicine's evaluation. The Zambia Regulatory Authority conducted a review of the national guidelines for donation of medicines and allied substances. The Medicines Control Authority of Zimbabwe's Institutional Development Plan was developed based on findings of external assessment using the GBT. Further, the capacity of the Medicines Control Authority of Zimbabwe was strengthened to conduct spot checks at ports of entry for detection of falsified, substandard, and illegal human and/or veterinary medicinal products using handheld devices.

In the **WHO African Region**, 43 (91%) of 47 countries have been assessed using the GBT; 40 (85%) of the national regulatory systems were adjudged to be operating at maturity level 1, one (2%) at maturity level 2 and four (8.5%) (i.e. **Ghana**, **Nigeria**, **South Africa**, **United Republic of Tanzania**) were at maturity level 3. Consequently, 94% of the WHO African Region national regulatory systems are still operating below the maturity level deemed to be that of a well-functioning and stable regulatory system.

Ensuring efficient and transparent procurement and supply systems

In **Sri Lanka**, the UHC-P supported the procurement of equipment for the National Medicines Quality Assurance Laboratory, to enable the inspection of potential contamination in pharmaceutical products, which strengthened the quality of medical products, and guided procurement processes.

These processes were also strengthened in **India**, where the UHC-P supported the implementation of the Drug Vaccine Distribution and Management System in Uttar Pradesh, building the capacity of 10 584 community health officers, resulting in improved medicines availability at HWCs across the state. Two integrated public health labs were operationalized in Chhattisgarh and access to diagnostic services in districts with health outcomes below the national average were improved. In addition, the UHC-P conducted a rapid assessment of the essential drugs supply chain in 20 health facilities and drug warehouses in Jammu and Kashmir, and reported to the state on the gaps, good practices and recommendations for the way forward.

The COVID-19 pandemic response provided lessons on how to achieve equitable access to health products and other technologies to expedite actions on research and development, and local manufacturing of vaccines and other medical products to reduce dependence on imports. The implementation of these lessons learned was seen in a number of countries in the **WHO African Region** in 2022 (Box 20).

Addressing antimicrobial resistance

In response to the COVID-19 pandemic, IPC guidelines were developed across the **WHO African Region** countries, and this work continued in 2022, with both **Comoros** and **Côte d'Ivoire** developing their first national strategic action plans to combat AMR. **United Republic of Tanzania** developed action plans on antimicrobial stewardship programmes in three hospitals and hospital staff were trained on how to set up and manage antimicrobial stewardship programmes in line with WHO guidelines and tools; staff were also trained on data collection using WHO methodology for point prevalence surveys.

Burundi installed the WHONET microbiology laboratory database software and trained sentinel site laboratory technicians on data reporting software; AMR sentinel sites were equipped with diagnostic equipment and technicians were trained in their use. **South Sudan** trained hospital staff on IPC, and the use of the installed waste management incinerator. Capacity was also built in IPC in **Mongolia** (Box 21). In **Lebanon**, the UHC-P expanded its support to the Ministry of Public Health to enable activities to be conducted with the Order of Pharmacists on policy-level interventions related to dispensing antibiotics in pharmacies. In addition, five capacity-building workshops for farmers and veterinarians from different regions were implemented with the Ministry of Agriculture on the rational use of antibiotics. In **Viet Nam**, support was provided to develop the National Strategy for AMR 2023–2030.

Box 20. Supporting countries for improved and more equitable access to health products to ensure efficient and transparent procurement and supply systems in the WHO African Region

Supported by the UHC-P, the Ghana Pharmaceutical Traceability Strategy was operationalized following the formal launch of the National Supply Chain Master Plan 2022–2025. In addition, capacity-building was conducted for 100 selected health workers at the lower levels of care in selected districts across three administrative regions as part of the decentralization of safety monitoring to the lower levels of care. **Côte d'Ivoire** trained 90 pharmacists on logistics management of health products and **Zambia** formed and launched a coordination platform for the Zambia Pharmaceutical Manufacturing initiative.

Furthermore, SIDS countries adopted the requirements for a pooled procurement round in the SIDS initiative. In 2022, SIDS countries of the **WHO African Region**, namely **Cabo Verde**, **Comoros**, **Mauritius**, **Sao Tome and Principe**, **Seychelles** and **Madagascar**, engaged in a pooled procurement mechanism.

In addition, an estimated 15–25% of people in need have access to assistive technology products, following the 2021 endorsement of the framework for improving access to assistive technologies in the **WHO African Region**. Currently, 19% of countries have developed assistive technology strategies and plans, and an assistive technology centre of excellence is being established in **Kenya** to support policy development for the procurement, manufacture, assembling, refurbishing and storage of assistive products and for screening, training and raising awareness.

Box 21. Infection prevention and control in Mongolia

In **Mongolia**, with the support of the UHC-P, capacity was built at national and subnational levels focused primarily on care pathways and clinical/case management, including IPC, supporting the delivery of essential health services. There has been an expansion of telemedicine and mobile services and technologies at the primary health care level, along with delivery of integrated PHC services using mobile technologies and portable devices, including rapid tests as a cost–effectiveness measure. This has been happening alongside improvements in regulation and standards of quality, safety and efficacy of health products and technologies, augmenting access to essential medicines, vaccines, diagnostics and devices through supply chain and procurement strengthening.

A nurse preparing medicine in Hanoi, Vietnam. © WHO/Quinn Mattingly

2

Addressing health emergencies – 1 billion more people better protected from health emergencies

Notable results for the first billion in 2022

In 2022, the **resource mapping (REMAP) tool** was used to support the implementation of national action plans for health security in five countries.

In March 2022, WHO and the Inter-Parliamentary Union (IPU), published *Strengthening health security preparedness: The International Health Regulations (2005)*, **a handbook describing the roles of parliaments in strengthening emergency preparedness and health security**. The handbook was launched during the 144th IPU General Assembly in Bali, Indonesia.

Since 2016, **120 Joint External Evaluation** (JEE) missions have been conducted in 118 countries, with five new missions conducted between 2022 and the first quarter of 2023.

Globally, in 2022, **20 intra-action reviews** (IARs) were conducted for real-time course correction, improvement and strengthening of countries' preparedness and response capacities to the COVID-19 pandemic, with another 25 countries planning reviews across all six WHO regions.

In the WHO African Region, thanks to the UHC-P, 18 countries supported **National Action Plan for Health Security** (NAPHS) implementation to enhance **International Health Regulations 2005** (IHR) capacities.

In the WHO Region of the Americas, following a comprehensive review of the **State Party Self-Assessment Annual Report Tool** (SPAR), using data from 2010 to 2021, the UHC-P supported the development of profiles for each of the 35 countries in the Region, as well as for the Region as a whole and each subregion of the Americas.

The COVID-19 pandemic has highlighted the critical need for whole-of-society and multisectoral approaches to health emergency preparedness and health security. Many countries only embark on multisectoral coordination as a response to an ongoing health emergency. In most cases, this coordination is limited to a specific disease or hazard, does not involve all relevant sectors, and ceases once the emergency has subsided. This ad hoc approach to multisectoral coordination leaves countries vulnerable and ill-prepared for the next disease outbreak and other public health emergencies.

In 2022, the UHC-P supported the countries most at risk, with weak health systems, to improve their preparedness for potential epidemics and pandemics, such as the ongoing COVID-19 pandemic. The pandemic highlighted the importance of strengthening the core capacities of countries under the IHR. Assessments conducted under the IHR Monitoring and Evaluation Framework indicate that many countries lack the capacity to prevent, detect and respond to a health emergency such as the COVID-19 pandemic. Halting transmission and mitigating the impact of an outbreak requires scaling up country preparedness and response operations.

Building resilient health systems, especially in fragile and conflict-affected countries, is critical for paving the way to reaching UHC and achieving the SDGs. A dedicated SDG target for health security (target 3.D) was adopted in 2015 reinforcing the existing IHR, the governing framework for global health security. Health systems strengthening is important in both its role in enhancing health security and as part of the broader agenda of disaster risk reduction and disaster preparedness.

2.1 Countries prepared for health emergencies

Multisectoral engagement for health security

In May 2020, WHO published the multisectoral preparedness coordination (MPC) framework to help countries break out of the cycle of panic followed by neglect.[37] The MPC framework provides countries, ministries and stakeholders outside the health sector with an overview of the key elements needed for multisectoral coordination for health emergency preparedness and health security, informed by best practices, country case studies and technical input from an expert group. The MPC framework represents one of the main pillars of the whole-of-society approach to health emergency preparedness, and the framework is the first publication that is focused on high-level engagement (political engagement and buy-in from both decision-makers and policy-makers) for non-traditional health stakeholders.

In March 2022, WHO with the IPU, published *Strengthening health security preparedness: The International Health Regulations (2005)*[38] and launched it during the 144th IPU General Assembly in Bali, Indonesia. The handbook has gained traction, and various national parliaments have contacted WHO to organize national workshops. In 2022, based on the MPC framework, the UHC-P started the development of various online training tools to further inform stakeholders about the crucial components of the MPC.

The Universal Health and Preparedness Review is an innovative approach to enable a whole-of-government approach to strengthening national capacities for emergency preparedness and the linkages with UHC and healthier populations, while also strengthening the engagement of the highest levels of leadership at the country level to commit to health security strengthening and enable regional and global solidarity and mutual accountability for health security capacity development. **Thailand** piloted the Universal Health and Preparedness Review in April 2022; one of the first countries in the world to do so, and the first in the **WHO South-East Asia Region**. The exercise highlighted some of Thailand's critical assets, such as strong multisectoral coordination, UHC based on robust PHC, a vibrant community of public health leaders and a dedicated workforce.

In the WHO South-East Asia Region, the *Regional strategic roadmap on health security and health system resilience for emergencies 2023–2027*[39] was developed with the support of the UHC-P, following the September 2021 recommendation of the WHO Regional Committee for South-East Asia to use the lessons learned from the COVID-19 response at the regional level. Regional-level consultations with representatives of Member States, development and technical partner agencies, civil society organizations and experts were held in October 2021 to consolidate the lessons and recommendations. In June 2022, a further consultation was held to discuss and provide feedback on the draft Regional Strategic Roadmap. Member States of the Region, supported by WHO and partners, should develop, or revise and implement, their national action plans on health security based on the guidance outlined in this regional roadmap.

Country capacity assessment and planning for health security

The NAPHS is the basis of the new approach to ensure that national capacities in health emergency prevention, preparedness, response and recovery are prioritized, strengthened and sustained in order to achieve health security, while contributing to UHC (Fig. 14). As of March 2023, WHO supported 88 NAPHS workshops in 79 countries. WHO recently published a five-year NAPHS strategy[40] that defines WHO's vision and framework for supporting Member States to accelerate the development, implementation and monitoring of their own NAPHS from 2022 to 2026. To further support countries with their NAPHS, WHO is currently updating the global NAPHS country implementation guidance, and has initiated work on an online platform that countries can use to develop their plan, track implementation, and use for resource mobilization efforts. Finally, to support the implementation of the NAPHS strategy, WHO is establishing a technical advisory group on NAPHS.

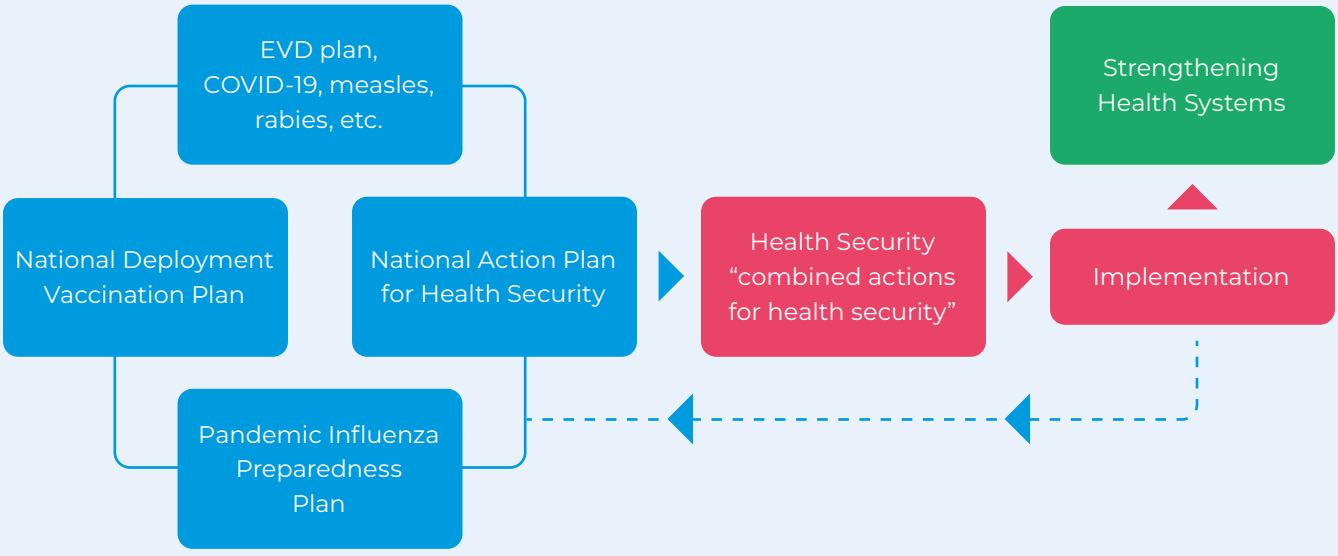
In the **WHO African Region**, thanks to the UHC-P, **Benin**, **Cameroon**, **Cabo Verde**, **Eswatini**, **Ghana**, **Lesotho**, **Liberia**, **Madagascar**, **Mali**, **Mauritania**, **Mozambique**, **Namibia**, **Senegal**, **Seychelles**, **South Africa**, **Uganda**, **Zambia** and **Zimbabwe** supported NAPHS implementation to enhance IHR capacities.

In **Zimbabwe**, WHO engaged a risk communication officer to strengthen risk communication, community engagement and health promotion as part of preparedness for emergencies, and to strengthen the response to COVID-19 outbreaks, and other emergency operations. In **Uganda**, WHO trained a total of 528 health workers and 567 surveillance officers. WHO mobilized stakeholders to monitor detection and response systems within their jurisdictions, reactivated reporting through existing platforms and upgraded the skills of newly recruited staff. In **Seychelles**, WHO helped to establish functional triage stations at all public health facilities and tourism establishments across the country, contributing to improved IPC and case detection. **Gabon** now has the required core preparedness and response capabilities in place, including a quality influenza virus detection capability, and **Ghana** has made progress towards improving coordination of rabies prevention and response by developing a dedicated roadmap (Box 22).

In the **WHO Western Pacific Region**, in **Cambodia**, the UHC-P supported the Influenza Surveillance Review 2022. A joint programmatic assessment of acute respiratory diseases was conducted in late 2022, with the support of international experts from WHO and the US Center for Disease Control. Key recommendations were outlined on strengthening coordination mechanisms and surveillance systems, including systems for early detection of respiratory events. **Papua New Guinea** had a heterogeneous subnational epidemic spread of COVID-19 variants of concern across its 22 provinces, and, in response, preparedness and response plans were developed at the provincial health authorities level (Box 23).

In **Lesotho's** development of its first national food safety policy and strategic plan, 13 priority hazards in the country were identified, and specific multi-hazard preparedness and contingency plans were developed for each of these 13 hazards with the involvement of other sectors, including those working on other issues at points of entry (Box 24).

Fig. 14. Health security combined with health emergency preparedness actions



EVD: Ebola virus disease.

Box 22. Ghana improves coordination of rabies prevention and response

In 2022, **Ghana** made remarkable progress towards improving its coordination of rabies prevention and response by developing a dedicated roadmap. This was the outcome of a gap analysis involving 86 stakeholders from the human, environment and animal health sectors, academia and research institutions at the National Bridging Workshop for Rabies funded through the UHC-P. Ghana is the first country to pilot such an initiative in Africa, which will contribute to the aspiration of eliminating dog-mediated human rabies deaths in the country by 2030.

The Ministry of Health has strengthened its commitment to improve collaboration between the human, environment and animal health sectors involved in the One Health approach. This was demonstrated in the development of a roadmap to address gaps in collaboration among the three sectors, which will be implemented through the One Health TWG as a priority activity for 2023. The 2023 operational plan for NAPHS is also being updated to incorporate the roadmap, an output of an International Health Regulations Performance of Veterinary Services (IHR-PVS) National Bridging Workshop (NBW) attended by 63 participants. The IHR-PVS NBW, supported by the UHC-P, galvanized the commitment of the Ministry of Health to support the finalization of the draft One Health policy, which will institutionalize One Health across the relevant ministries, departments and agencies in Ghana.

With support from the UHC-P, far-reaching awareness on the importance of using a One Health approach in public health emergency preparedness and response was created at a community durbar (reception) to mark the 2022 One Health Day in the western region of Ghana. The reception was attended by 120 participants, ranging from community members to high-level policy-makers. The western region was selected for the event because it was one of the regions affected by the 2022 Marburg Virus Disease outbreak in Ghana, highlighting the importance of multisectoral collaboration across all levels to avert the negative impact of zoonosis-linked outbreaks in Ghana.

Box 23. Papua New Guinea: epidemiology, sampling and interpretation of variants of concern

Introduction

Papua New Guinea has a national sampling strategy developed for SARS-CoV-2 whole genome sequencing (WGS), including all 22 provinces, which are mainly divided into two types of terrain: the highlands, which are connected by one highway; and the islands, which are geographically more difficult to access. From January to March 2022, Omicron BA.1 was found in the highlands region with a reduction in case mortality and morbidity. In addition, there were no Omicron cases in the islands region that had the previously circulating strains. Therefore, Papua New Guinea had a heterogeneous subnational epidemic spread of variants of concern across its 22 provinces. Similar heterogeneous epidemic patterns of spread have been seen previously with other pathogens, which depend on population density, mobility and accessibility of provinces.

Challenges

As the WGS is carried out offshore and there is a time lag for the results, the interpretation of new casts in genotypes and phenotypes is delayed, making planning for the response difficult. There is also a need for a strategy for offshore genome sequencing in some of the Pacific countries, such as Papua New Guinea, where the laboratory system strengthening approach will take a longer time.

Response

Preparedness and response plans have been developed at the level of provincial health authorities, because of the heterogeneity of the micro epidemics, and by training rapid response teams to ensure coverage of last mile deliveries. WHO teams are now able to coordinate an appropriate response to the local surge of cases. To offset the delays in obtaining WGS results, Papua New Guinea has been working to synthesize and analyse epidemiological, clinical and laboratory data, and use data modelling to look at the subnational heterogeneous epidemics and use the data for surge planning at the provincial level so that the country is aware of any early changes in the behaviour of variants of concern.

Box 24. Lesotho first national food safety policy and strategic plan

In **Lesotho**, the UHC-P – with co-funding from the Southern African Development Community – enabled a multisectoral approach to allow Lesotho to develop its first national food safety policy and strategic plan. First, a technical working team conceived the project, engaged an international consultant, coordinated consultations with stakeholders and participated in the validation of the two national documents. Second, with technical support from the **WHO Regional Office for Africa**, a multisectoral team from the One Health ministries (including other priority ministries, institutions of higher learning and representation from the media) conducted a risk assessment exercise using WHO's Strategic Tool for Assessing Risks (STAR). The exercise resulted in the reporting of 13 hazards in the country followed by the development of specific multi-hazard preparedness and contingency plans for each of the 13 priority hazards, which will thereafter be disseminated in the districts. Third, WHO developed and disseminated working tools and guides at points of entry to strengthen preparedness and responses to events that may occur at these locations. These included SOPs for a vector control programme, development of public health emergency plans and generic guidelines for implementing port health services. These exercises also involved other sectors, especially those working on other issues at these points of entry.

A traditional food exhibition symposium in Maseru, Lesotho. © WHO

Resource mapping

Through the UHC-P, WHO has been supporting countries in REMAP, based on multisectorality and inclusivity. The REMAP tool supports Member States, particularly low- and middle-income countries, to implement their health security plans by identifying the financial and technical resources necessary to complete the priority actions for each country. The process promotes dialogue between countries and partners based on data collected on each countries' gaps and needs, and partner activities and priorities; supports monitoring and evaluation of country plans; and promotes partnerships for health security. The UHC-P also supported the development of a web-based version of the Microsoft Excel-based REMAP tool. The web-based version, launched in 2022, allows real-time access and enhanced visualizations.

In 2022, the REMAP tool was used to support the implementation of NAPHS in **Cabo Verde**, **Central African Republic**, **Gambia**, **Madagascar** and **Togo**. The REMAP tool provides details of each health security activity mapped in these countries, including the funding source, timeline, geographical location, nature of the activity, and which technical area (surveillance, laboratory, risk communication) is being supported. This provides countries and partners with details of what is being supported at the country level and by whom, and which key technical and geographical areas are lacking support, enabling needs and gaps to be identified to inform decisions on resource allocation and re-allocation as necessary to implement the country's health security plans.

WHO's Strategic partnership for health security and emergency preparedness portal

A collective global effort is needed to support countries in strengthening health emergency preparedness and building back better from recent health emergencies, such as the COVID-19 pandemic. Collaboration and coordination are essential, including sharing relevant information and ensuring technical and funding contributions are as complementary, synergistic and coordinated as possible. This is the critical role of WHO's Strategic partnership for health security and emergency preparedness (SPH) portal.[41]

In 2022, the UHC-P supported the publication of new, revamped and enhanced versions of various modules on the SPH portal, which allow users to access information at different geographical levels. The functionality of the SPH portal has been expanded to scale up multisector coordination and collaboration for preparedness, and to include improved tracking and monitoring of national preparedness investments towards relevant capacity-building activities, including those contained in NAPHS. The new update includes other improvements such as a robust content management system and faster data upload, as well as the addition of new pages and features. Some of the new modules published in 2022 are: multisectoral coordination for health security preparedness; health emergency preparedness in cities and urban settings; enhanced REMAP; JEE roster of experts; and joint risk assessment. Comprehensive country profiles have also been updated.

The number of investments and activities being tracked through the SPH portal is constantly growing. This visualization of the global partner and donor landscape facilitates the alignment and coordination of stakeholder initiatives to accelerate the implementation of the IHR, and to harmonize efforts with this important initiative. The SPH portal will continue to expand in 2023 with the addition of new pages and features, including pages for Evidence for health security and Resource landscape enhancement, and the development of the digital platform of the Global Strategic Preparedness Network.

Support provided to regional offices for IHR States Parties annual reporting

The IHR State Party SPAR tool[42] is crucial to enabling States Parties to fulfil their obligations under Article 54.1 of the IHR. This tool provides an interpretation of the national capacities required under the IHR for self-assessment and monitoring purposes, and serves as the primary tool for ensuring mutual accountability between States Parties and the WHO Secretariat. The SPAR tool consists of a set of indicators for IHR capacities that are necessary to detect, assess, report and respond to public health risks and public health events of international concern.

WHO has developed learning materials and conducted training sessions on SPAR to further ensure that Member States fulfil their reporting obligations to the World Health Assembly. These training sessions, which include practical exercises using the e-SPAR platform, were conducted in various regions. In the **WHO African Region**, 70 participants from 40 Member States received face-to-face training. In the **WHO Region of the Americas**, 56 participants received online training (in English with simultaneous Spanish translation). In the **WHO European Region**, 64 people participated in online training (in English with simultaneous Russian translation). In the **WHO South-East Asia Region**, online training was carried out with 34 participants from all Member States in the Region.

The number of investments and activities being tracked through the SPH portal is constantly growing.

In **South Africa**, WHO facilitated the National IHR Focal Point, and the relevant multisectoral stakeholders, to complete and submit the 2021 SPAR by March 2022. The IHR capacity average score for the country was 68%; for comparison, the **WHO African Region** regional average was 48% and the global average was 64%. The main gaps were related to the absence of the policy, legal and normative instruments of the IHR; lack of compliance to the requirements for gender equity in emergencies; and the absence of a workforce surge strategy during a public health event. In **Mauritania**, training and advocacy activities undertaken, thanks to the support of the UHC-P, improved coordination and strengthened government leadership to develop strong national health policies, strategies and plans, and monitor implementation, as advised by the IHR.

In the **Region of the Americas**, following a comprehensive review of SPARs using data from 2010 to 2021, the UHC-P supported the development of profiles for each of the 35 Member States in the Region, as well as for the Region as a whole and each subregion of the Americas. These profiles were reviewed and discussed, serving as key inputs during the IHR regional meeting which was held in Chile in December 2022. Delegates from 32 of the 35 Member States, including a large delegation from the Caribbean countries, participated in the meeting. Member States and strategic partners discussed the usefulness of the SPAR in defining national and subregional priorities. Member States agreed that evaluations of IHR implementations should be incorporated into countries' institutional cultures as commitments to national and international security. Constraints to filling out the SPAR and the need to adapt it to the Caribbean, as SIDS, was also defined as a priority.

Integration of biological hazards into national emergency and disaster management policies, strategies and plans

Under the UHC-P, *WHO guidance on preparing for national response to health emergencies and disasters* was published.[43] This guidance outlines possible mechanisms that countries can use to respond to emergencies and disasters by taking a whole-of-society and whole-of-government approaches to ensure multisectoral engagement for health actions. The guidance will help countries to run a participatory process of developing a national health response operations plan that brings together all relevant sectors, public health experts, civil society, and the international community under government leadership, and facilitates ownership, adoption, testing through simulation, and, finally, successful implementation in responding to emergencies and disasters from multiple hazards.

Thanks to the UHC-P, WHO and the United Nations Office for Disaster Risk Reduction (UNDRR) produced a working paper: Inclusion of the impacts of the COVID-19 pandemic on health and health services in reporting for Sendai Framework Monitoring in 2021.[44] WHO and UNDRR ran webinars between 18 and 25 March 2022 to support country reporting for COVID-19 mortality and morbidity data, as well as data on the disruption of the health services. These webinars were attended by over 150 participants, representing all six WHO regions.

Furthermore, WHO developed a health module for the Capacity for Disaster Reduction Initiative (CADRI) assessment. CADRI is a global partnership composed of 20 organizations working towards achieving the SDGs by providing countries with capacity development services to help them reduce climate and disaster risk. To date, there have been 37 country engagements and associated WHO regional deployments, which are useful for understanding the gaps and prioritization of key actions.

A transit health centre set up by WHO and partners to meet emergency health needs in Goma, Democratic Republic of the Congo. © WHO/Guerchom Ndebo

Post COVID-19 recovery towards building back better health systems

WHO organized a COVID-19 lessons learned webinar series to promote and advocate for all-hazards risk management measures used during the COVID-19 pandemic response (implementation of IHR, community risk-informed actions, safety and resilience of hospitals and health facilities, whole-of-society engagement, engaging with multiple interdisciplinary stakeholders, roles of different sectors).

WHO, the UNDRR Global Education and Training Institute (GETI) and the United Nations (UN) Office for South–South Cooperation conducted an online training session to harness south–south cooperation and risk-reduction planning for resilient and healthy cities in the post COVID-19 era. This training session was targeted at local and national government officials (disaster risk reduction and management officers, urban development and planning officers, national associations of municipalities, urban resilience and development practitioners, civil society, the private sector and academia). The training session aimed to increase the understanding and capacity in disaster risk reduction, for effective and equitable public health emergency responses, and south–south cooperation to better prepare stakeholders for reopening cities following the COVID-19 pandemic. The training session has been made accessible to all via an OpenWHO online course.

Thanks to the UHC-P, *WHO guidance on research methods for health emergency and disaster risk management*[45] was published, which aims to harmonize the terms used in health emergency and disaster risk management (Health EDRM) research, identifying mechanisms for ethical review processes, encouraging stronger community participation and stakeholder involvement in the research process, and identifying effective means of translating research into effective policies. A supplementary chapter has been drafted to further guide Health EDRM research within all regions in the context of the COVID-19 pandemic.

To build communities resilient to health emergencies and disasters, WHO, in collaboration with the University of the Philippines Manila, also developed a Community Engagement Learning Package. This is expected to mobilize and strengthen communities to achieve resilience against health emergencies and disasters from all hazards.

In the **WHO Western Pacific Region**, WHO's Health Futures Strategic Dialogue approach has provided tailored support to Member States to initiate and drive long-term agendas for health. The Strategic Dialogue approach aims to support Member States to develop their national policies, strategies and plans to ensure their health systems are better prepared for future health and well-being needs and challenges, including health emergencies.

In 2022, **Mongolia** engaged in a Health Futures Strategic Dialogue and created working groups in three areas: Healthy communities, healthy people; Healthy environments; and Technology and innovation. The UHC-P supported the Minister of Health to organize a series of 18 webinars and workshops between January and July 2022. A coaching and mentoring plan for key staff from the Ministry and the WHO Country Office was also developed throughout this phase to support local ownership of the process and its outcomes. Two Re-imagination sessions were held in September 2022 to help 40 participants re-perceive how the future of Mongolia could look. Through the process, the groups prioritized eight areas of change (environment as resource and life-source, a shifting economy, data systems, distributed and accessible health care, plugged-in cities and sustainable infrastructure, emerging culture, future food systems, reimagined governance).

In addition, the UHC-P initiated discussions with **Cambodia** to embark on a Health Futures Strategic Dialogue. An initial assessment, conducted during a field visit in July 2022, signalled potential opportunities for long-term planning and transformations. To support the initiation of these discussions, WHO designed an introductory workshop on futures-based approaches for senior leaders in the Ministry.

A health centre in Beng Village, Cambodia.
© WHO/Blink Media - Cindy Liu

Hospital preparedness

Through the UHC-P, WHO has been supporting the Safe Hospital Initiative which published the Rapid hospital readiness checklist for COVID-19.[46] This checklist supports countries to determine the current capacities of their hospitals to respond to the COVID-19 pandemic. WHO also conducted various capacity-building initiatives in many regions (workshops on national health emergency response plan development, health facility preparedness and hospital response planning, fire safety in health facilities, and resilient health systems and services in emergency and disaster situations). For **Myanmar**, however, during the pandemic waves, people preferred home visits and telemedicine, and the UHC-P supported the enhancement of home-based care (Box 25).

To advance the high-level strategic dialogue on disaster risk reduction, WHO ran a side event at the seventh session of the Global Platform for Disaster Risk Reduction (GP2022). GP2022 was organized by the UNDRR and was held in Bali, Indonesia, from 23 to 28 May 2022. In the side event, emphasis was placed on identifying and implementing good practices in health facility safety and resilience that contribute to a risk-informed and inclusive COVID-19 response, recovery and rehabilitation in humanitarian and low-resource settings. This platform provided an opportunity to share the innovations and experiences gained during the COVID-19 response to strengthen the safety, functionality and sustainability of health facilities, and to discuss the central role of health facilities in managing the health risks of emergencies and disasters in health systems and the whole of society, among other valuable topics.

The World Reconstruction Conference was held on 23 and 24 May 2022, just preceding the GP2022. Thanks to the UHC-P, WHO was able to facilitate running a parallel session on COVID-19 whole-of-society recovery priorities for health systems strengthening. This session brought together participants from around the world (international organizations, national and local governments, civil society, the private sector and academia) to share experiences on the different dimensions of recovery in the context of multi-dimensional risks.

The three levels of WHO coordinated to assess the functional safety and climate resilience of selected health care facilities in the **Cox's Bazar District of Bangladesh** amid the ongoing COVID-19 pandemic. In collaboration with key partners, in 2022, WHO piloted a new, comprehensive approach to strengthen preparedness and risk management for concurrent emergencies in the protracted, humanitarian setting of Cox's Bazar to protect refugee and host communities from the impacts of disasters, outbreaks and other hazards. Based on a systematic assessment of health facilities safety and resilience for priority hazards, a training session for trainers was organized to conduct systematic assessments of the health facilities in the camps.

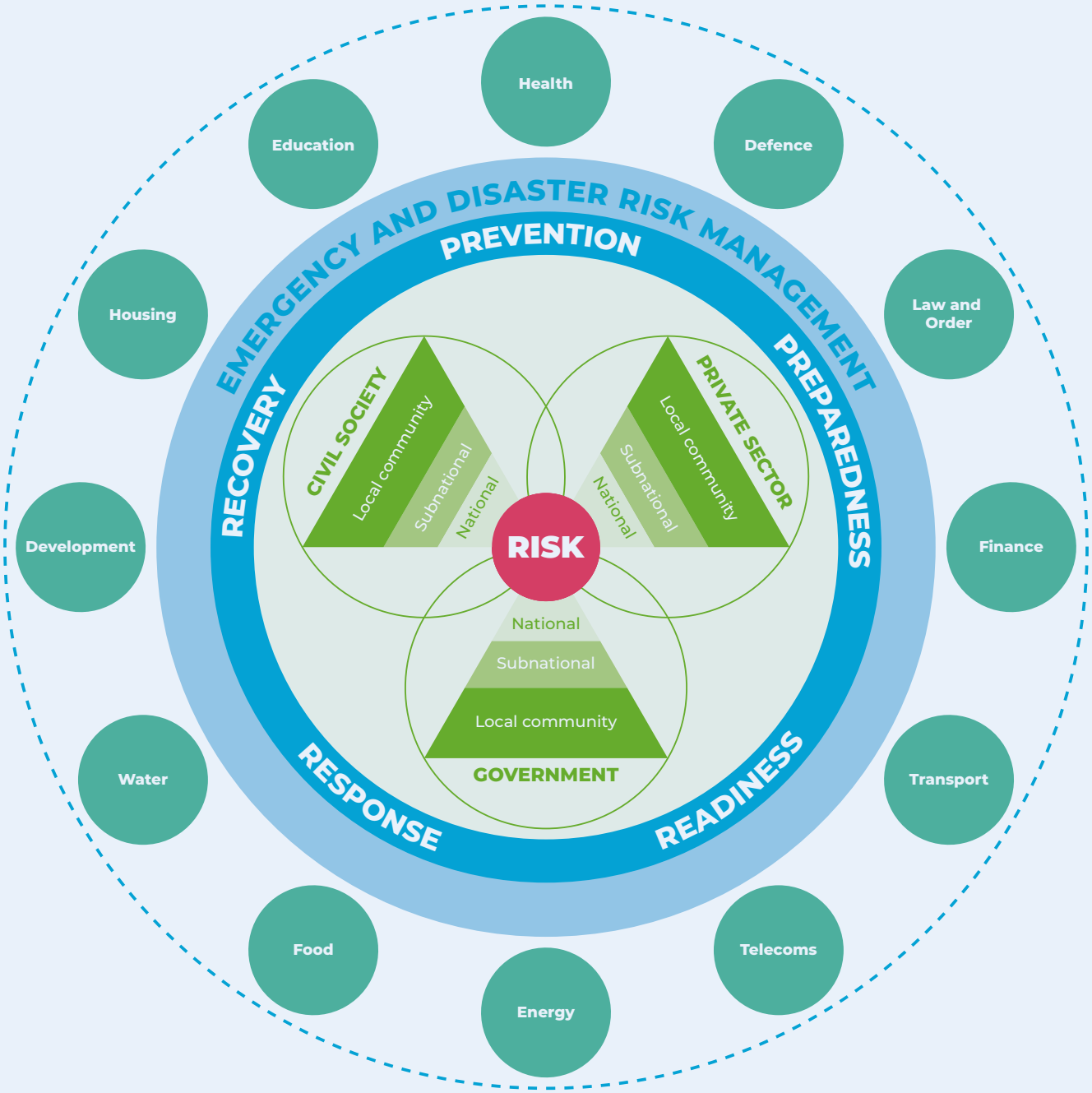
Box 25. In Myanmar, home-based care enhanced the response to the COVID-19 pandemic

In **Myanmar**, in 2022, WHO and World Bank organized a survey on access to health care following the COVID-19 pandemic. Results showed that households sought relatively more care than the previous year for COVID-19, in terms of testing, care and treatment. The survey also suggested that 86% of sampled households received COVID-19 vaccinations, with urban and rich households relatively better vaccinated than rural and poor ones. Some health providers explained that, because of the transmission risk and quarantine requirements, people hardly visited hospitals for inpatient care during the pandemic waves and would rather opt for home visits and telemedicine.

Against this backdrop, the UHC-P supported the training of community volunteers for home-based care and COVID-19 response activity, as well as providing virtual training for hospital staff in the private and non-public sectors. With input from UNFPA, Jhpiego, Local Resource Myanmar, Myanmar Council of Churches and Myanmar Red Cross Society, a curriculum for community volunteers for COVID-19 preparedness and response was developed.

A nurse prepares a vaccine dose in Kutupalong, Myanmar. © WHO

Fig. 15. Whole-of-society approach to health emergency and disaster risk management



Country risk profiles

Thanks to the UHC-P, WHO supported the publication of *Strategic toolkit for assessing risks: a comprehensive toolkit for all-hazards health emergency risk assessment*,[47] in November 2021. The toolkit offers an easy-to-use approach to facilitate national, subnational or local evidence-based assessments of public health risks for planning and prioritization of health emergency preparedness and disaster risk management strengthening (Fig. 15). In 2022, 18 countries, representing four WHO regions, conducted workshops at the national and subnational levels (Box 26).

As countries increasingly seek to define or review their risk profiles in the context of the pandemic, additional WHO surge support was needed to scale up implementation of strategic risk assessments at the national, subnational, city and community levels. To meet these needs and provide a quality-assured process, WHO brought together the regional STAR teams and several WHO country offices in Cairo, Egypt, to review the STAR process steps from the newly published guidance, include best practices from country experiences, and to chart out next steps for the STAR roll-out. In addition, WHO is collaborating with the CADRI, a global partnership, to further integrate the STAR tool and country risk profiles.

Box 26. Emergency care services transformation in Azerbaijan

The WHO Country Office in Azerbaijan organized a ECS Strengthening Week in December 2022, which consisted of a hybrid symposium (about 250 onsite and 150 online participants) to discuss and improve the future vision of ECS in **Azerbaijan**, a high-level workshop to develop short- and mid-term roadmaps for ECS strengthening, training courses for 70 medical and nonmedical professionals, and a community engagement event to raise awareness about the importance of learning cardiopulmonary resuscitation skills.

An ECS capacity group of 24 candidate emergency medicine doctors has been established through a competitive selection process to serve as champions of emergency care service transformation in Azerbaijan. The members of the group will receive comprehensive emergency medicine training for the next two years. In 2022, the group members:

- participated in a programme of 12 half-days of adaptation training, covering basic technical issues in emergency medicine and non-technical skills in teamwork and education/training;
- visited hospital emergency care units in **Türkiye** for three weeks to gain hands-on experience in the organization of emergency care, case management in hospitals, the education process, and emergency unit design;
- joined Türkiye's National Medical Rescue Teams training programmes, including field training in Izmir on 5–9 December 2022, to strengthen their knowledge and skills in medical rescue operations. Planning the response to health emergencies, incident management systems, logistics, human resources management and trauma patient management were among the key topics covered during the training programmes.

WHO also supported the establishment of an Emergency Medical Care Department at **Azerbaijan** Medical University – the first of its kind in the country – for post-graduate medical education. Four faculty members are currently enrolled in a structured training programme designed by WHO as part of the ECS Capacity group. Finally, Sumgait Modular Hospital, which was opened in June 2020 to meet the surge of demand during the COVID-19 pandemic, was reorganized as a Training, Simulation and Assessment Centre (SUM-Sim), using Corpus 3 (the two other corpora will be transferred to SUM-Sim soon). The Centre is envisioned to become a hub for emergency medical training in the country. The first training sessions, on basic life support and endotracheal intubation, were launched at the facility in November 2022 for 48 nurses and 10 emergency medicine doctors. A total of 132 health care professionals were trained in SUM-Sim by the end of 2022 in 13 different courses on emergency medical care.

Implementation of joint external evaluations

In 2014, the IHR Review Committee recommended a move from exclusive self-evaluation for countries to an approach that combines self-evaluation, peer review and voluntary external evaluations involving domestic and independent experts. This recommendation served as the basis for the development of the IHR Monitoring and Evaluation Framework (IHR States Parties SPAR simulation exercises, after-action reviews (AARs) and the JEE). Since then, the JEE tool[48] has undergone several revisions. The latest revision was informed by recommendations from the IHR Review Committee and the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (WHE), and lessons learned from the COVID-19 pandemic. The third edition of the JEE tool was launched in June 2022, and will be translated into six languages. With the launch of the third edition of the JEE tool, WHO developed an online Joint External Evaluation Platform to facilitate external expert participation in certain situations; for example, in cases of travel restrictions.

Since 2016, 120 JEE missions have been carried out in 118 countries, with five new missions taking place between 2022 and the first quarter of 2023. In 2022, JEE missions were conducted in **Algeria** and **Uzbekistan**, using the second edition of the tool, and in **Thailand** and **Nepal** using the third edition of the tool. In the first quarter of 2023, **Sierra Leone** underwent a JEE using the third edition. The JEE mission in **Algeria** was a significant milestone for the **WHO African Region**, as it marked the first round of JEE implementation. With the results of the JEE, countries will be able to draft their NAPHS. Reports from the recent JEE missions are currently being processed and will be published in the Strategic Partnership Portal.

Since 2016, 120 joint external evaluation missions have been carried out in 118 countries, with five new missions taking place between 2022 and the first quarter of 2023.

Intra-action reviews, after-action reviews and simulation exercises

The UHC-P provided technical support to WHO regions and Member States to implement COVID-19 IARs. Global, regional and country training sessions on IAR methodology were conducted to support countries to plan and conduct IARs when necessary. Technical support has been provided virtually and face-to-face, and included IAR planning, facilitation and report writing and reviewing. Globally, in 2022, 20 IARs have been conducted for real-time course correction, improvement and strengthening of countries' preparedness and response capacities to the ongoing COVID-19 pandemic. WHO COVID-19 vaccination IARs have been conducted in 34 countries, with another 25 countries planning reviews across all six WHO regions. In addition, WHO developed and published an addendum to the COVID-19 IAR guidance with additional tools, four additional public health response pillars and more than 600 trigger questions to support countries to conduct periodic reviews of their ongoing national and subnational COVID-19 preparedness and response activities.

In 2022, the UHC-P provided technical support to WHO regions and countries to plan and implement simulation exercises in **Ethiopia**, **Liberia**, **Mauritius** and **Namibia**. In the **WHO European**, **South-East Asia** and **Western Pacific** regions, regional IHR exercises have supported multisector engagement and fostered a comprehensive coordinated approach to emergency management across sectors in health, and across other agencies and ministries. These exercises work with multiple countries during each event and enable countries to share lessons and work towards consistent decision-making. The UHC-P also supported the measles programme of simulation exercises, and the current work by the pandemic influenza programme. Support has included training, reviewing key documentation and contributing to material development and implementation. In addition, AARs have been supported in the **Democratic Republic of the Congo** for the ninth, 10th, 11th and 12th Ebola outbreaks (Box 27). An article highlighting the novel and comprehensive approaches taken in these AARs is currently being developed for publication in a relevant journal.

In addition, training sessions on AARs, IARs and simulation exercises were developed and published on various learning platforms, including OpenWHO, i-learn and the Health Security Learning Platform. Approximately 50 000 learners were enrolled across these different platforms. Two training sessions on simulation exercises were also undertaken in **Albania** and **Congo**. These were designed for both WHO staff and consultants as well as national emergency management counterparts. Representatives from 59 countries were in attendance across both programmes.

Finally, the COVID-19 pandemic has highlighted the importance of accessing, processing and disseminating critical knowledge in a timely manner to guide decision-making processes for the response, especially during uncertain times. The Nuggets of Knowledge Platform proposed by WHO will be designed to capture knowledge gathered from early action reviews, IARs and AARs, as so-called digestible contents (nuggets) within a collaborative and interactive platform, and, most importantly, make the knowledge readily accessible to countries and key responders. This platform will be invaluable for future emergencies by providing a wealth of evidence for decision-making in emergency management. The target is to have 10 000 nuggets of knowledge on one platform on diverse publications on emergency management from the last 10 years.

A health worker prepares blood for storage after blood donation in Brazzaville, Congo.
© WHO/Armel Mboumba

Box 27. Ebola in the Democratic Republic of the Congo: lessons learned and best practices following the AAR

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

The objective of the AAR was to capitalize on best practices, identify areas and actions for improvement, and promote individual and collective learning to ultimately strengthen cross-sectoral preparedness planning and future responses to health emergencies. The AAR conducted in the Democratic Republic of the Congo consisted of a comprehensive mixed-method review that included four phases: a desk and literature review; an online survey; key informant interviews; and focus group discussions.

Some critical actions for improvement were identified, which are listed below.

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

The Democratic Republic of the Congo AAR helped to ensure quality improvement and the strengthening of preparedness and response systems based on learning emerging from actions in responding to three successive EVD outbreaks. The lessons learned were applied during the subsequent EVD outbreak and the COVID-19 epidemic response.

The global analysis of COVID-19 intra-action reviews

Thanks to the UHC-P, WHO conducted a global analysis of COVID-19 IAR implementation that culminated in a report that was published in December 2022.[49] The report summarizes 83 IAR reports from 57 countries and identifies the strategies and solutions that countries used during the pandemic to encourage peer learning and trigger new ideas to advance the pandemic response. It outlines how governments worldwide used existing systems and resources and developed innovative new solutions and strategies during the pandemic. This report also examines countries' views on how the COVID-19 IAR was customized to fit their needs, and the value of the IAR process to their COVID-19 response and beyond. Important topics of interest that are rarely or inadequately reviewed during an IAR, such as provision for vulnerable and marginalized populations, are also considered.

According to the IARs reviewed in this global analysis, several factors proved critical during the COVID-19 emergency preparedness and response process. First, early decisive action from senior leadership enabled countries to prepare before the first COVID-19 case. Second, speed and efficiency were essential for countries to respond to the rapidly evolving COVID-19 context. Third, the agility to evolve with the pandemic ensured that national and subnational response strategies were continually reviewed and updated based on the dynamic situation. Fourth, transparent information exchange between multisectoral stakeholders (at different levels of government and with the private sector, civil society organizations, representatives of vulnerable populations and communities) ensured that all stakeholders were informed and coordinated. All of these actions would not have been possible without the solidarity and joint commitment from all sectors and levels to work together, streamline processes and public communication, and overcome the habit of working independently.

For **Azerbaijan**, the consensus was that an IAR was needed, and this was especially useful for the country to provide an opportunity to share experiences and collectively analyse the ongoing in-country response to COVID-19 by identifying challenges and best practices, documenting and applying lessons learned from the response efforts to date to further strengthen health systems (Box 28).

Box 28. IAR in Azerbaijan: identifying challenges and best practices from the response to COVID-19

During 10–13 May 2022, the WHE and the WHO Country Office in Azerbaijan, together with the Ministry of Health and Management Union of Medical Territorial Units conducted the first IAR for selected pillars of the COVID-19 response in **Azerbaijan**, within the framework of the EU/WHO joint Solidarity for Health Initiative.

This project supported **Azerbaijan**, **Armenia**, **Belarus**, **Georgia**, **Republic of Moldova** and **Ukraine** in their response to COVID-19 and seeks to build more resilient health systems able to better respond to future outbreaks. As the daily case numbers and deaths due to COVID-19 were steadily declining in Azerbaijan in early May, it appeared timely to undertake the review of the response process to date, looking at what worked well, what did not work well, and what should be sustained or needed to be improved or changed altogether. This review was especially needed considering the rather complex health system of Azerbaijan, which consists of several parallel structures and had many state actors involved in the COVID-19 response.

The four-day workshop, facilitated by WHO experts and attended by the national experts from various state entities who have been involved in the COVID-19 response, focused on four pillars of the Strategic Preparedness and Response Plan: country-level coordination, planning and monitoring; surveillance, case investigation and contact tracing; case management and knowledge sharing; and IPC. These pillars were selected by national health counterparts and WHO as critical areas to include in the review. The review process was facilitated and co-facilitated by experts from the WHE Hub for the South Caucasus, the WHO Regional Office for Europe and the WHO Country Office in Azerbaijan. During the review, participants focused on the functional capacities of public health and emergency response systems at the national and subnational levels to identify best practices, gaps and lessons learned and to propose corrective measures and actions for short- and long-term actions, aimed at improving an outbreak response in the future. Responsible agencies have been identified to lead the processes for improvement.

Participants and key officials have reiterated that the IAR was needed, and was especially useful for the country, to provide an opportunity to share experiences and collectively analyse the ongoing in-country response to COVID-19 by identifying challenges and best practices, and then documenting and applying lessons learned from the response efforts to date to further strengthen the health system.

A nurse with a baby who is recovering from bronchiolitis in Yerevan, Armenia. © WHO/Nazik Armenakyan

Human–animal interface

Through the UHC-P, WHO continues to support the roll-out of the IHR-PVS NBW programme to assist countries in developing and implementing their NBW roadmaps, and to access available tools and resources for improved coordination between the public and animal health sectors. In particular, a strong focus was given to **Ethiopia** and **Liberia**, where the UHC-P allowed the recruitment of two NBW catalysts. NBW catalysts are nationally recruited One Health experts whose main mission is to promote and support the implementation of the NBW roadmaps. NBW catalysts and mentors are supported to work together through a community of practice to support One Health systems strengthening in countries.

WHO continues to support the development of operational tools to strengthen country implementation of the principles and best practices taken from the technical chapters of the Tripartite Zoonosis Guide (TZG) – *Taking a multisectoral, One Health approach: a tripartite guide to addressing zoonotic diseases in countries*[50] – which was developed by the Tripartite organizations (Food and Agriculture Organization of the UN, WHO and the World Organisation for Animal Health). Joint risk assessment workshops were held in several countries including **Burkina Faso** and **Senegal**. Multisectoral coordination mechanism workshops were held in **Azerbaijan**, **Gambia**, **Kenya** and **South Sudan**.

Surveillance and information sharing workshops were held in **Sierra Leone** and **Uganda**. A strategic goal for the development of the TZG operational tools is to ensure that implementation at the country level is possible with minimal Tripartite oversight and support. By creating robust facilitation materials, including OpenWHO online training courses and step-by-step guides, operational tools will be readily picked up by countries. Working with the Tripartite, the available operational tools will be included in a final TZG toolkit.

In the **WHO African Region**, **Ghana**, **Guinea**, **Nigeria**, **Senegal**, **South Africa** and **South Sudan** held joint risk assessment workshops to support risk mitigation strategies for zoonotic diseases. The workshops created opportunities for national experts from different levels of the human health, animal health and environmental health sectors to jointly develop a list of priority zoonotic diseases to be addressed.

Cameroon, **Gambia** and **Kenya** conducted an IHR-PVS NBW to streamline collaborative capacities at the animal–human–environment interface. Altogether, over 210 national experts in these three countries gathered to explore various areas of potential collaboration, and jointly developed their multisectoral operational One Health roadmaps to mitigate the risk of the emergence and re-emergence of high-threat pathogens and improve their pandemic preparedness and One Health collaborations.

A camel herder talks to a WHO staff member during a foot and mouth disease campaign in Marsabit, Kenya.
© WHO/Billy Miaron

Strengthening Somalia's health security systems

Public Health Emergency Operations Centres

The establishment of public health emergency operations centres (PHEOCs) is a WHO recommendation to strengthen public health response to emergencies. In its NAPHS, Somalia planned to establish PHEOCs at both the national and state levels. These PHEOCs have so far been used for drought response coordination and planning for integrated immunization campaigns. Technical teams in WHO supported the Ministry of Health with structural designs which could be adapted to construct or establish PHEOCs in Somalia.

WHO procured basic PHEOC information technology equipment, and this equipment has been installed in six PHEOCs. WHO has also supported the development of the PHEOC manual, which was endorsed by the Federal Ministry of Health and Health Services, SOPs and a costed operational plan. These policy documents will guide daily operations at the PHEOCs and longer-term plans. To further build the country's preparedness capacities, WHO supported national and state-level risk assessments to identify priority hazards and the development of risk profiles. These documents will inform the development of the country's all-hazards preparedness and response plan. The policy documents will also guide the country and PHEOCs at national and state level in developing hazard specific contingency plans.

Risk assessment and development of all-hazards plans

Key government officials from the Ministry of Health and other key ministries and agencies participated in the national risk assessment sessions in July 2021. Risk profiling for Somaliland was carried out in November 2021 and a draft report has been developed. Risk assessment for other states (Galmudug, Hirshabelle, Jubaland, Puntland and South West) was conducted in December 2021. The risk assessments will guide development of the all-hazards preparedness and response plans. Discussions to develop an all-hazards preparedness and response plan have already began with the Regional Office for the Eastern Mediterranean and the Federal Ministry of Health and Health Services. There are also plans to update the risk assessments in 2023.

Integrated Disease Surveillance and Response strategy

In 2020, the Somalia Federal Ministry of Health and Health Services and the National Institute of Health made a strategic decision to adapt and implement the Integrated Disease Surveillance and Response strategy (IDSRS). The IDSRS serves as the major framework for strengthening surveillance and response at all levels of the health system in Somalia and is the major vehicle for accelerating the achievement of IHR core capacities.

Subsequently, with support from WHO and other partners, the Federal Ministry of Health and Health Services and the National Institute of Health, together with the ministries of health, convened a one-week multistakeholder workshop in July 2021 to advise key stakeholders on the IDSRS. The workshop outlined the steps needed, and made a start on developing the timelines and a three-year operational plan to implement the IDSRS in Somalia. In 2021 and 2022, the three-year operational plan and technical guidelines (including SOPs and reporting tools) for IDSRS implementation in Somalia were completed, validated and endorsed through several workshops. A reporting tracker for IDSRS has also been developed on DHIS2.

Front-line Field Epidemiology Training Programme (FETP-Front-line)

To address Somalia's limited capacity in its detection and response to health emergencies, the IHR national focal point established the Front-line Field Epidemiology Training Programme (FETP-Front-line) in August 2021 with support from WHO and other partners.

The FETP-Front-line is a three-month on-the-job training course that addresses the critical skills needed to conduct surveillance and response activities effectively at the local level, focusing on improving disease detection, reporting and response. It is based on the principle that improving the epidemiological skills of Ministry of Health staff improves their ability to prevent, detect and respond to public health priority issues, which in turn will improve a country's public health security. It aims to improve the field epidemiology knowledge, skills and competencies of trainees, and blends mentorship with classroom training and practical experience to develop the country's public health workforce.

Three cohorts of the FETP-Front-line have been trained, making a total of 75 participants. The support from the UHC-P mainly benefited the third cohort of the FETP-Front-line which had 28 trainees. Increase in reporting rates for surveillance were observed in the Early Warning Alert and Response Network as a result of FETP-Front-line. At the beginning of 2022, the reporting completeness was 11% which increased to 46% towards the end of 2022.

One Health

The One Health task force in Somalia held coordination meetings on a regular basis. Sensitization meetings for the One Health task force were carried out to strengthen the Multisectoral One Health Coordination Mechanism. Revision of the One Health Strategic Plan for Somalia has begun to ensure that it is in line with the newly established IDSRS. Priority zoonotic diseases have been identified and integrated into IDSRS reporting. The technical guidelines for IDSRS include the detection, reporting and response of priority epidemic-prone zoonotic diseases.

Risk communication

A consultant to strengthen risk communication and community engagement was deployed in the WHO Country Office in Somalia. Draft risk communication guidelines for outbreaks have been developed and are awaiting input from the government for finalization. Training materials for risk communication have been developed and included into the IDSRS training package. Risk communication material for dengue fever, cholera, EVD (which was reported in a neighbouring country) and other priority diseases were developed and shared with health workers. CHWs have been trained on risk communication and are working in 71 districts in **Somalia**. The CHWs conduct door-to-door risk communication, and report using the Open Data Kit platform. The CHWs have been reporting alerts for seven epidemic-prone diseases which are then investigated by the district rapid response teams. The CHWs contributed to detection of 45% of COVID-19 cases.

Points of entry

Draft guidelines for points of entry surveillance for **Somalia** have been developed and are awaiting input from the government for finalization. Assessments of points of entry were conducted at eight entry points in Somaliland. Gaps were identified at these points of entry and an action plan was developed. The action plan for points of entry was aligned with the IDSRS in Somaliland.

Strengthening IHR in Somalia

The national IHR task force members in **Somalia** were nominated and an IHR Secretariat officer was recruited to facilitate communication and implementation of IHR activities. Three sensitization sessions for IHR task force members were conducted and several IHR task force meetings have been held. The draft guidelines for IHR and SOPs for the IHR national focal point, including structure and terms of reference, were reviewed by the IHR national focal point. A training session for IHR task force members was conducted in October 2021 and another capacity-building workshop took place in January 2023 in Mogadishu.

Health system support in Afghanistan

Fundamental and life-saving PHC services in **Afghanistan** are under severe threat, due to a lack of external funding since the change of regime in August 2021. PHC is the foundation of the national health system, providing health services to millions of people across the country. Today, these facilities are struggling to survive, with staff going unpaid for months and severe shortages of medicines, fuel and food, and the country's health system is on the brink of collapse.

The Sehatmandi programme is the backbone of Afghanistan's health system, providing care for millions of people through 2331 health facilities. Since the Taliban gained power, the majority of the funding for the programme has been withdrawn. Without adequate funding, Sehatmandi health facilities are breaking down, affecting the availability of basic and life-saving health care nationwide, humanitarian assistance, polio eradication and COVID-19 vaccination efforts.

The Sehatmandi programme, if fully funded, will continue to provide essential and life-saving care to all Afghans, and the hard-fought gains made in life expectancy, and maternal and child mortality over the past two decades will be kept. WHO is calling on international donors to rapidly finance the Sehatmandi programme, as they have done for almost two decades. Currently, health services are delivered in all 34 provinces under the name of the Health Emergency Response Project supported by World Bank. The three levels of WHO are proactively advocating to convince donors to continue to support the Afghan health system.

A father holding his child at a health centre in Kabul, Afghanistan.
© WHO/Kiana Hayeri

Adapting health financing in Ukraine

WHO provides leadership and engages at the highest political level to support the government to design and implement strategies to help progress towards UHC. Strategic and technical support is provided for increased and better budgeting for health provision and health spending. Key issues in health financing include designing incentives for improved quality of care and better health outcomes and minimizing the impoverishment of the population that can result from unreasonable health costs.

These health financing issues were reflected in 2022 in the context of the war in **Ukraine**. WHO organized and led a two-day in-person meeting on the strategic planning of health financing in Ukraine together with the National Health Service of Ukraine to adopt strategic purchasing to keep up with the changing population needs and to ensure institutional sustainability of the strategic purchaser.

Policy guidance was also provided to the government to adopt strategic purchasing of services in response to the war. In August 2022, the health financing team published the report, *Health financing in Ukraine: resilience in the context of war*.[51] In addition, WHO conducted numerous analyses to support evidence-based decision-making, helping to implement the health system budget cuts that had been outlined in the 2023 public budget, while ensuring that access to essential services was maintained.

Following activities conducted in 2021, three mobile tents were procured and delivered to support clinical management and triage in the third quarter of 2022 and seven more tent kits were installed in Zaprorizhzhia, Mykolaiv, Dnipro, Kharkiv and Volyn oblasts during October to November 2022 to support the Medical Departments of State Emergency Service and the Disaster Medicine Service in their capacity to provide first-line support to those who are in need, and serve in the territories affected by war.

WHO conducted two rounds of the nationwide PHC health facility assessment, and analytical products are being prepared to support further dialogue with country authorities and produce a policy brief. The third wave of the survey that was cancelled in March 2022 is to be completed by the first quarter of 2023 to address PHC capacity to deliver essential health services given the current circumstances of ongoing military attacks and the implications of COVID-19.

Addressing gender-based violence and conflict-related sexual violence

To address GBV as one of the major gender problems and human rights violations occurring in **Ukraine**, and in consideration of the spread of conflict-related sexual violence cases related to the Russian invasion of Ukraine and in accordance with the recently signed Framework for Cooperation between Ukraine and the UN on prevention and response to conflict-related sexual violence and the corresponding Strategy, WHO provided technical support by strengthening the national regulatory framework in managing the first-line response to sexual and GBV survivors aligned with evidence-based practice and WHO technical recommendations on clinical management, psychosocial support, referrals, medico-legal aspects and documentation. Based on WHO's medico-legal care guidelines and toolkit on sexual violence, the WHO Country Office in Ukraine conducted a technical comparative analysis of the national regulations to support further dialogue and alignment of case management with best practice.

To strengthen the capacity of PHC professionals (doctors and nurses) in providing sexual and GBV survivors with high-quality services, WHO developed a two-day training course on prevention and response to GBV based on the WHO curriculum. The training session was conducted in August 2022 and was attended by more than 60 family doctors, nurses and health managers from PHC facilities in three regions (Kyiv, Dnipro, Odesa oblasts). This activity was delivered in partnership with the Ministry of Health, the Ukrainian Foundation for Public Health and PHC experts.

In addition, **Mali** developed training modules on the holistic care of survivor(s) of GBV and initiated training of trainers on holistic care for GBV survivors.

DEEP DIVE

COVID-19 vaccination intra-action reviews: countries share learnings on COVID-19 vaccine roll-outs through a global community platform

Introduction

Under GPW13, WHO has been working towards the Triple Billions targets with one of the key focus points being 1 billion more people better protected from health emergencies by 2023. Currently, as the world faces one of the most challenging protracted emergencies in modern times, the need for rapid and successful deployment of COVID-19 vaccines to reach the global population cannot be emphasized enough. With variants of concern continuing to emerge, creating multiple epidemic waves and an extended global crisis, COVID-19 vaccines are one of the key components in ending the acute phase of this pandemic.

The response in the first year of the COVID-19 pandemic mostly focused on social and public health measures, surveillance and contact tracing, and expanded testing with a comprehensive public health strategy to limit disease transmission. In contrast, the response in the second year of the pandemic focused on the rapid approval and roll-out of multiple COVID-19 vaccines in record time. Considering the multiple vaccine products available, the unique characteristics of COVID-19 vaccines, and the considerations around priority populations for vaccination, COVID-19 vaccine programme implementation planning is complex and differs substantially from prior new vaccine introductions. Review of best practices and lessons learned from the introduction process was crucial for countries. However, the rapid roll-out time frame meant that countries had little bandwidth to conduct the standard WHO new vaccine post-introduction evaluation, which is typically time and resource intensive.

To facilitate country-level COVID-19 vaccination programme reviews, the Health Security Preparedness Department and the Department of Immunization, Vaccines and Biologicals at WHO joined forces to leverage the existing country COVID-19 IAR methodology so countries could conduct a quick but standardized review of specific aspects of their COVID-19 vaccine roll-out as needed. This review methodology has also been coined as a mini version of the COVID-19 vaccine post-introduction evaluation (mini-cPIE) to allow countries to rapidly identify and address gaps and expand good practices. The findings from mini-cPIE can also eventually feed into the comprehensive cPIE in the later phase of vaccine introduction.

Mini-cPIE was developed in line with existing WHO guidance and materials, such as the National Deployment and Vaccination Plan for COVID-19 vaccines, COVID-19 vaccine post-introduction evaluation (cPIE) and the COVID-19 Strategic Preparedness and Response Plan. This not only ensured that WHO guidance given to countries was coherent and streamlined, but it also allowed countries to integrate findings to update their National Deployment and Vaccination Plan following a mini-cPIE. Since the publication of the COVID-19 vaccination IAR trigger questions and accompanying tools in April 2021, as of 31 December 2021, WHO's COVID-19 vaccination IARs or mini-cPIEs have been conducted in 34 countries, with another 25 countries across all six WHO regions planning or expressing an interest in conducting a mini-cPIE.

Participants at a COVID-19 vaccination exercise in Thimphu, Bhutan. © WHO/Rinzi Om Dorji

DEEP DIVE: COVID-19 vaccination intra-action reviews: countries share learnings on COVID-19 vaccine roll-outs through a global community platform

Creating a global platform for the rapid sharing of mini-cPIE findings

To ensure learnings from these reviews would be disseminated rapidly to benefit other countries, from July to December 2021, WHO and partners hosted a virtual community forum for countries to share mini-cPIE experiences and connect. The five sessions held were attended by nearly 1000 participants from more than 125 countries, the UN and other partner agencies. Ten countries from four regions, the **WHO African Region**, the **WHO Region of the Americas**, the **WHO Eastern Mediterranean Region** and the **WHO South-East Asia Region**, were invited to present on a global platform on various emerging themes and pertinent aspects related to the COVID-19 vaccine roll-out. Thematic sessions included lessons from Fragile States/humanitarian contexts, promoting COVID-19 vaccine uptake through unique risk communication and community engagement approaches, and inequities in vaccine uptake and gender considerations.

These clinic sessions were interactive, with peer countries able to directly connect with presenting countries and ask questions. The presenting countries were **Bhutan**, **Bolivia**, **Democratic Republic of the Congo**, **Gambia**, **Ghana**, **Mozambique**, **Senegal**, **South Sudan**, **Somalia** and **Uganda**. Simultaneous interpretation, including translation into French, Spanish, Russian, Arabic and Portuguese, was provided to cater for the different presenters and participants of each clinic session. A Telegram group was also established for participants to continue the discussion following the sessions if they wished to do so.

Highlights from presenting countries

Among the key highlights during the country presentation and the Question and Answer sessions, **Bhutan** illustrated how having the Prime Minister receiving the first and second doses of a heterologous regimen boosted public confidence, resulting in 95% vaccine coverage for the first dose and more than 90% vaccine coverage for the second dose following the national vaccination campaigns. **Gambia** explained how some districts addressed people from rural areas not coming to vaccination centres by using a vaccine caravan to facilitate vaccination and engage communities in remote places. **Ghana** also shared its innovative approach of affixing cost-effective metallic holograms on vaccination cards to authenticate the vaccination status of individuals, as well as using drones to distribute vaccines to hard-to-reach populations. **Senegal** also shared its success in establishing Adverse Event Following Immunization (AEFI) Committees and investigating all severe AEFIs; however, they pointed out a challenge they are addressing related to the unavailability of free medical care for those experiencing serious AEFIs.

Challenges that were overcome by countries were also highlighted during the clinic sessions. **Uganda** shared how it addressed the delay in fund deployment to the operational level by early and transparent communication with health workers to encourage them to continue offering vaccination services while administrative issues were being resolved. **South Sudan** highlighted how it dispelled rumours using survey findings, media engagement, high-level advocacy meetings, radio programmes and talk show jingles, especially when new variants of concern emerged and created a loss of confidence in the current vaccine used. **Somalia** described how it developed forecasting tools and increased the capacity of the contractors for logistics and distribution of vaccines by UNICEF following challenges experienced in the distribution of vaccine doses given the short expiry dates and dosing schedules. **Democratic Republic of the Congo** emphasized how it used interpersonal communication, pre-registration, monitoring of vaccination of pre-registered individuals, and management of refusals to engage and build confidence among the high-risk population. **Mozambique** shared how it used multiple strategies and communication channels to create demand and implemented regular monitoring and management of rumours through a digital platform and a technical group. Finally, **Bolivia** reviewed uptake data disaggregated by geographical area, target population and gender to understand coverage disparities. It highlighted prioritizing the single-dose regimen for hard-to-reach rural and indigenous populations to minimize the risk of drop-out and reduce vaccine inequity.

DEEP DIVE: COVID-19 vaccination intra-action reviews: countries share learnings on COVID-19 vaccine roll-outs through a global community platform

Characteristics of the attendees

To ensure the target audiences were aware of these clinic sessions, extensive advocacy and outreach efforts were made. These efforts included engaging with vaccination and health emergency WHO regional and country focal points and advertising the clinics and registration links on WHO's weekly operational updates, key actions for WHO representatives, social media and other newsletter and networking groups. Based on the registration information, among the attendees of the clinics, 39.5% worked in the immunization sector, 22.7% worked in emergency preparedness and response, and 18.3% worked in programme management. Participants who attended the clinics worked at various levels, with 41.4% working in multinational contexts, 48.6% working in the national context, and 10.0% working in the subnational context. In addition, 40.9% of the participants were COVID-19 national or subnational coordination committee members.

The perceived value of the sessions for attendees

To ensure the sessions were useful, relevant and valuable for participants, a feedback survey was administered to all participants at the end of each clinic to evaluate the sessions. Among participants who responded to the survey, 77.0% considered the sessions extremely or very relevant to their current work, 79.0% reported that they would use what they learned in the sessions in their work, and 79.0% would recommend the sessions to a colleague. When asked about how they might use the information they learned from the sessions, 70.6% would share the information with colleagues, 45.9% would make guidelines, protocols, or other changes to health systems, and 29.4% would change how they work with patients or community members moving forward.

Conclusions

In these clinic sessions, WHO used its convening role to bring together countries, partners and other UN agencies to benefit and learn from each other's experiences during the early phases of their COVID-19 vaccine deployment. Given that the goal of this global platform was to bring added value to countries for their COVID-19 vaccination roll-out, a strong emphasis was placed on listening to feedback from participants to fine-tune the clinics for maximal benefit to the attendees. Therefore, as the clinic sessions progressed, the interactive style and themes also reflected the feedback from participants as well as important issues surrounding COVID-19 vaccine roll-out and uptake. WHO was also cognisant of not requiring too much of the presenters time, as they were often the key person in charge of managing the deployment of the COVID-19 vaccine in their countries. Therefore, short pre-prepared presentation templates were shared in advance to lighten their workload and provide more time for questions and interactive discussion.

With countries around the globe racing to vaccinate susceptible populations, the mini-cPIE clinic series offered a global experience-sharing platform for countries to inspire and learn from one another so they could continue to improve the planning and deployment of COVID-19 vaccines in their individual contexts.

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A health worker loads a syringe at the Soura Alladey COVID-19 vaccination site in Niamey, Niger. © WHO/Sia Kambou

3

Promoting healthier populations – 1 billion more people enjoying better health and well-being

Notable results for the third billion in 2022

Six countries were supported in introducing **pro-health taxes**, such as taxes on sugar and sugar-sweetened beverages or were able to show positive results from these taxes (Dominica, Fiji, Jamaica, Palau, Samoa and Timor-Leste).

The UHC-P supported quality improvements and strengthening activities to plan and deliver **essential NCD clinical services**, following the integration of the Package of Essential Noncommunicable Disease Interventions with HEARTS and cancer control, in 23 countries.

In three countries, which had recognized that their NCD and mental health management required better financing, UHC-P supported **investment case development**. UHC-P also provided technical assistance to develop or update mental health and wellness strategies and policies in six countries.

As the foundation of the GPW13, the Triple Billion targets function both as measurements and policy strategies. They focus on delivering significant improvements in the health of the world's population through evidence-based interventions, strengthened health information systems and providing support for transformational public health policies. The third billion aims to achieve 1 billion more people enjoying better health and well-being through multisectoral action, prevention of NCD risk factors, and promoting healthy settings and health in all policies.

3.1 Multisectoral action for noncommunicable diseases

Whether people are healthy or not is mainly determined by their life conditions. To address health challenges and reduce risk factors, multisectoral engagement beyond the health sector is crucial. PHC is more often than not the first point of care for individuals suffering from NCDs, and is especially effective when an integrated approach is used for prevention and treatment. To lessen the impact of NCDs on individuals and society, a comprehensive approach is needed that requires all sectors, including health, finance, transport, education, agriculture and planning, to collaborate to reduce the risks associated with NCDs, and promote interventions to prevent and control them. The multifactorial nature of NCDs requires a well-coordinated multisectoral response for effective control.

In the **WHO Western Pacific Region**, the UHC-P supported WHO's STEPwise approach to surveillance (STEPS) NCD risk-factor survey in **Cambodia**, and an implementation plan, protocol and questionnaire were finalized in line with the STEPS manual. A detailed draft budget of the STEPS survey was prepared, two data managers were recruited to conduct STEPS in 2023, and a virtual workshop was held for data managers on STEPS data management.

In the **WHO African Region**, in 2022, the Package of essential noncommunicable disease interventions (PEN) assessment was conducted to analyse key bottlenecks and priorities in **Cabo Verde**. This was complemented by training health professionals in the pilot phases of the assessment. **Zimbabwe** undertook assessments of the facilities in the country that were implementing PEN (20 out of the 31), and used the findings to scale up the PEN technical package to include two additional provinces. In **Ukraine**, PHC settings in seven regions (which had benefited from NCD projects in 2015–2018) were assessed on the use of the PEN protocol, followed by revision of clinical protocols and adjustments of existing training materials, to help strengthen PHC capacity in NCD-specific services and the implementation of the integrated management of hypertension and diabetes. **Lao People's Democratic Republic** was also supported by the UHC-P to review and update its Package of Essential Interventions for NCDs.

The UHC-P supported quality improvement and strengthening activities to deliver essential NCD clinical services, following the integration of the PEN with HEARTS and cancer control, in **Cook Islands**, **Fiji**, **Kiribati**, **Marshall Islands**, **Micronesia**, **Nauru**, **Palau**, **Samoa**, **Solomon Islands**, **Sudan**, **Tuvalu** and **Vanuatu**. Furthermore, the essential medicines lists of **Bahamas**, **Barbados**, **British Virgin Islands**, **Guyana**, **Saint Lucia**, **Suriname** and **Trinidad and Tobago** were evaluated to assess their alignment with the requirements of the HEARTS initiative and the recommendations for the treatment of hypertension and diabetes. The evaluations were used to identify gaps and provide recommendations to the countries.

Capacity-building is a central theme in NCD health service delivery. **Nigeria** strengthened 12 PHC facilities in the Federal Capital Territory by building the capacities of medical officers to prevent, promote, diagnose and treat NCDs; and the provision of data tools, medicines and devices to screen and treat hypertension and diabetes using WHO's PEN approach. Technical support was provided to **South Africa** to implement WHO's Global initiative for childhood cancer. Nigeria enhanced the capacity of 50 PHCs in five states (10 per state) to screen and treat cervical cancer. In addition, over 500 health care workers and 75 monitoring and evaluation officers were trained, and data tools, and equipment and supplies were procured and delivered, allowing a total of 16 875 women to benefit from screening.

> *"We are grateful to WHO for supporting us to reach all the provinces in South Africa and for building the capacity of primary health care workers to enable improvements to be made in the screening, early detection and control of noncommunicable diseases."*
>
> *Ms Sandhya Singh, Head of the NCD division, National Department of Health, South Africa*

In the **WHO African Region**, the UHC-P provided support to **Ghana** and **Zimbabwe** as they implemented the WHO Special Initiative for mental health activities. This included the roll-out of Mental Health Gap Action Programme (mhGAP) training in both countries, which ensures that health care workers working in less specialized health care settings are able to recognize and manage common mental health conditions. **Ethiopia** received technical support to roll-out the mhGAP resulting in increased numbers of people reporting mental health conditions weekly, which is indicative of the level of demand in this population. mhGAP training was also conducted and materials provided for community-focused implementation in **Vanuatu**, and, in **Fiji**, mhGAP videos were developed and disseminated for the public domain, and adapted to the local context.

Through the UHC-P, and in collaboration with the United Nations Development Programme (UNDP), a series of NCD and mental health investment cases were undertaken in the Caribbean (Box 29). In **Belize**, technical cooperation from the UHC-P included capacity-building to strengthen mental health services using WHO's mhGAP Intervention Guide in primary care settings. In addition, the revision of the Mental Health Policy was commenced, with the aim of strengthening the integration of mental health into health services. In **Haiti**, support from the UHC-P helped to strengthen the integration of mental health into PHC, using the Mental Health Gap Action Framework, and 34 health care providers were trained.

The UHC-P provided technical assistance to update the mental health and wellness strategy in **Cook Islands** and conducted a review of the Mental Health Policy in **Samoa**. **South Sudan** finalized a costed mental health strategic plan and developed a mental health and psychosocial support (MHPSS) strategic plan.

Bahamas were supported to draft a mental health bill that led to the passing of the Mental Health Act in 2022; momentum has continued with the drafting of a national mental health plan which highlights the protection of human rights and promotion of health equity for all.

An investment case for NCD prevention initiatives and mass media campaigns was completed in **Suriname** in collaboration with the UNDP and the Ministry of Health, and with support from RTI International. The results of this investment case demonstrate a strong evidence base for investing in preventive and control measures that reduce the health and economic burden of NCDs and mental disorders and improve access to care. Building on this work, the WHO Regional Office for the Americas supported Suriname's Ministry of Health with the development of media to support a mass media campaign for NCD awareness and risk factor reductions.

In **Haiti**, the UHC-P supported capacity-building at the primary care level to manage NCDs by training 80 health care providers from three health departments to diagnose and manage diabetes and cardiovascular diseases. Additionally, the **WHO Regional Office for the Americas** reviewed and updated the national NCD strategic plan, revitalized the national NCD task force, and developed a survey on NCD risk factors in school-age children.

Box 29. NCD and mental health investment cases in the WHO Region of the Americas

Through the UHC-P, in collaboration with UNDP, a series of NCD and mental health investment cases were undertaken in the Caribbean, as a tool for ministries of health to engage with the highest level of government and other sectors to advocate investing in NCD prevention and control and ensuring an appropriate level of allocation of domestic resources. For this purpose, NCD and mental health investment cases included an economic analysis using WHO's One Health Tool, led by RTI, and an institutional context analysis led by UNDP. In 2022, results from economic analysis of the **Guyana** NCD investment case were shared with national authorities, and two country case studies (**Jamaica** and **Dominica**) on the earmarking of health taxes on sugar-sweetened beverages, alcohol and tobacco were completed and reviewed by stakeholders.

3.2 Prevention of noncommunicable disease risk factors

Tobacco and alcohol

In **Belize**, surveillance and responses to NCDs were strengthened via a three-day workshop based on STEPS. Building on this work, technical support was provided to draft new bills on tobacco and alcohol controls to help address NCD risk factors. A countrywide communication campaign was launched to reduce the use of alcohol and tobacco, and promote healthy lifestyles.

UHC-P support was able to provide capacity-building in **Cuba** for managing NCDs through a series of workshops for health sector professionals focusing on arterial hypertension and risk factors. These workshops were complemented by the development of a national educational campaign on risk factor reduction for NCDs, including reducing tobacco smoking in teenagers and young people. Enforcement of the tobacco control laws was strengthened in **Fiji** through monitoring and evaluation, and multisectoral enforcement operations at the subnational level.

A patient arrives at a hospital for a regular health check-up in San Juan, Trinidad and Tobago. © WHO/Alasdair Bell

DEEP DIVE

Effective governance and sustainable financing for noncommunicable diseases

NCDs and mental ill health are driven largely by factors and forces beyond the traditional health sector. As examples, 99% of the world now breathes polluted air, contributing to nearly 7 million premature deaths annually,[52] and one of the most cost-effective ways to prevent suicide is by restricting access to highly hazardous pesticides.[53] Without whole-of-government and whole-of-society efforts to address the social, economic and environmental determinants of health, including access to health services, UHC commitments will remain out of reach.

The UHC-P recognizes the importance of whole-of-government and whole-of-society contributions to UHC by supporting the WHO-UNDP Global Joint Programme Catalyzing Multisectoral Action for the Prevention and Control of Noncommunicable Diseases and Mental Health (Table 3). This support has enabled WHO and UNDP to collaborate closely on the ground, supporting country priorities in four crucial multisectoral aspects of UHC: (i) effective fiscal, legislative, and regulatory measures; (ii) policy coherence across government sectors and their partners; (iii) policy and capacity for ensuring equitable access to health care; and (iv) awareness, ownership and engagement of civil society, parliamentarians, local leaders, media and others for population-wide responses.

Support over 2021–2022 has led to a diverse range of impacts on NCD and mental health governance and financing across Africa (**Côte d'Ivoire**, **Nigeria** and **Uganda**), Caribbean (**Guyana**, **Suriname** and **Trinidad and Tobago**) and the Pacific (**Fiji**). Populations in these countries are now better protected from health risks, for example through life-saving new legislation, and enjoy increased access to health services, for example through innovative financing strategies. There is significant momentum for sustaining and growing impact beyond the biennium.

Challenges and lessons learned

Countries also reported shared challenges. An example is inadequate financial resources to meet government requests and adequately engage all key multilateral partners in the fight against NCDs and mental ill health. Countries also reported competing priorities, in particular health emergencies (COVID-19 and Ebola in **Uganda**). Government changeover in some settings slowed momentum for joined-up responses and led to a need to re-galvanize efforts.

Lessons are being learned, and continue to inform the support for countries under this project and beyond, and include those listed below.

- **Multisectoral action and wider partnerships for NCDs and mental health are essential components of UHC and health systems strengthening**. These reduce human and financial pressures on health systems by addressing population level risks, such as tobacco and alcohol use, while advancing people-centred care. **Uganda**'s inclusion of NCD support in its partnership with the US President's Emergency Plan for AIDS Relief (PEPFAR) is a prime example of how engagement outside of the health sector can reinforce action within it while strengthening alignment of donor support with country priorities and needs. This breakthrough was achieved through parliamentarian engagement and convening of multiple stakeholders.

- **Relatively low levels of technical and financial support can catalyse action for NCDs and mental health**. The UHC-P has supported multisectoral policies, plans, laws, investment approaches, stakeholder engagement and other building blocks of effective and inclusive governance. It has strengthened health systems through data and capacity-building. Continuity of catalytic support is needed to sustain progress. There is a particular need to strengthen domestic investments for health through innovative approaches and further explore how tackling NCDs and mental ill health would amplify and sustain the impacts of other development partner support. Health tax revenue analysis and support to integrate NCDs and mental ill health into development plans, strategies and financing frameworks are important in this regard.

- **There is immense value in WHO and UNDP collaborating to spearhead ever stronger UN-wide support**. This has elevated NCDs and mental health as sustainable development issues, broadened stakeholder engagement and opened space for integrated solutions at the health-development nexus. Optimized UN support at the country level encourages the UN to deliver as one. For example, in **Guyana**, WHO and UNDP have integrated respective NCD and mental health activities at the request of the government. Approaches, results, and emerging demand for additional support can inform future directions of the joint programme as well as the UN NCD and mental health multi-partner trust fund, Health4Life.

- **Additional support is needed to demonstrate and act upon the links between NCDs, mental health and global health security**. While some countries used the pandemic as an impetus to strengthen resilience to shocks,[54] others reported COVID-19 as a competing priority. This was the case even though COVID-19, NCDs and mental health are deeply interconnected. Greater attention to NCDs and mental health as part of UHC and global health security is crucial. The COVID-19 pandemic is not over and WHO warns that post COVID-19 condition (long COVID) is affecting hundreds of millions of people worldwide, suggesting an urgent need to prepare health systems. Meanwhile, the climate crisis is also significantly increasing NCDs and mental ill health.

Next steps

The issues of NCDs and mental ill health cannot be solved over a two-year period, but progress is possible through reliable catalytic support. Moving forward, the programme countries will focus on implementing the laws, policies, plans and other measures put in place over the first biennium. This requires technical support on plan costing, the development of implementation guidelines, capacity-building of responsible actors, sustainable financing approaches and support for the coordination platforms, for example.

It remains vital to leverage additional partnerships and funding opportunities at country and regional levels. That includes efforts to further expand support to these countries from the wider UN system and other partners in line with the UN delivering as one and the SDG 3 Global Action Plan. Over the course of 2023, the programme team and supported countries will continue sharing results, challenges, lessons and future directions.

Table 3. Selected results and activities from the WHO-UNDP Global Joint Programme support (2021–2022)

Côte d'Ivoire	• New National Integrated Strategic Plan on NCDs. • New National Multisectoral NCD Committee. • Promotion and advocacy of health taxes with the National Tax Authority. • Cabinet engaged on NCDs and their economic impacts. • Civil society, patient organizations and local authorities actively engaged. • New multistakeholder platform for implementation of the Healthy Cities initiative in six municipalities.
Fiji	• National legal environment and investment framework analyses. • Stakeholder dialogues, broad media coverage, stronger multisectoral commitment and increased political attention. • A new multisectoral NCD strategy and comprehensive national wellness strategic plan advanced. • Profile of NCDs raised as a development issue, with the Government of Fiji announcing a renewed focus on NCDs as a top priority. • Renewed interest in intersectoral partnerships, including with civil society. For example, the Alliance for Healthy Living, a partnership between the Ministry of Health, the Ministry of Trade and Consumers Advocacy groups was relaunched in May 2022.[55]
Guyana	• New Mental Health Bill and Suicide Prevention Act. • Updated National Mental Health Plan of Action 2021–2030 and evaluated National Mental Health Plan and Suicide Action Plan. • New multisectoral working group on MHPSS with representation from 23 organizations, including civil society and academia. • Over 120 000 listeners reached through radio public health campaign "It's Okay Not to Be Okay", aimed at adolescents. • Self-harm surveillance systems implemented in three regions and health personnel trained on data collection. • Over 80 health care providers trained in mhGAP and 30 operators for a COVID-19 hotline. • Investment case for NCDs and mental health advanced together at request of government for integrated support.
Nigeria	• New Mental Health Act (replacing a 1958 act). • Updated National Mental Health Policy. • Drafted National Suicide Prevention Strategic Framework. • New National Mental Health Programme. • First-ever National Alcohol Policy and National NCD Multisectoral Policy. • Stronger National NCD Coordination Mechanism and Tobacco Control Committee. • Ministers engaged in World Suicide Prevention Day and World Mental Health Day.

Suriname	• Updated the national Mental Health Plan of Action and prepared the national Suicide Prevention Plan. • Health workers trained to enhance access to psychosocial support and improve the coordination of MHPSS interventions. • Self-harm surveillance system implemented in three regions and health personnel trained on data collection.
Trinidad and Tobago	• Implementation plan and monitoring and evaluation framework for the Suicide Prevention Strategy developed with Government support for operationalization secured. • Stronger MHPSS TWG (33 members). • Suicide Surveillance System evaluated with training of staff. • Self-harm surveillance system implemented in three regions with health personnel trained on data collection.
Uganda	• Commitment from the Minister of Health and Minster of State for Primary Health Care. • Commitment from Parliament with an advocacy strategy and toolkit developed. • Inclusion of NCDs in the National Health Insurance Bill and the Public Health Act. • Integration of NCD support into HIV Care through the PEPFAR Country Operational Plan 2022 (allocation of US$ 4.5 million). • Stronger National NCD Coordination Mechanism with commitment from members to mainstream NCD action across sectoral plans. • Pledge of mayors and municipal leaders to support action on NCDs through AMICAALL (Alliance of Mayors' Initiative for Community Action on AIDS at the Local Level) and the Healthy Cities initiative. • More than 2 million people reached through advocacy and awareness raising among leaders and the public.

A health worker checks on a child with severe malnutrition in Kepelebyong, Uganda. © WHO/Esther Ruth Mbabazi

DEEP DIVE

Recent global achievements for noncommunicable diseases

NCDs account for 74% of all deaths globally, and 86% of these are premature deaths occurring in low- and middle-income countries.[56] Contributions from the UHC-P and other funding sources have mobilized tangible efforts to strengthen core health system functions with a focus on PHC to address the needs of people living with NCDs. WHO and partners provide strategic support to countries centred around scientific review of norms and standards, facilitation of global mandates, development of technical toolkits, specialized support to strengthen country capacity, and resource mobilization to ensure sustainable programming. Key milestones achieved in 2022 are summarized below.

Updated menu of policy options and cost-effective interventions for the prevention and control of NCDs

The *Global action plan for the prevention and control of noncommunicable diseases 2013–2020*[57] was endorsed by the Sixty-sixth World Health Assembly in 2013 with an Appendix containing a menu of policy options and cost-effective interventions for prevention and control of major NCDs (known as Appendix 3). An updated Appendix 3 has been developed in consultation with Member States and non-states actors, submitted for consideration and endorsed by the 152nd session of the WHO Executive Board. Altogether, 90 interventions and 22 overarching/enabling actions have been identified, representing an expansion from the 2017 list of 88 interventions (including overarching/enabling actions). This guidance will be key in supporting countries prioritizing and scaling up the implementation of evidenced-based and cost-effective intervention, including health care interventions for the early detection, management and rehabilitation of NCDs as part of ongoing efforts to expand national benefit packages at the PHC level.

High-level engagement and global advocacy for NCDs

An International Strategic Dialogue on NCDs and SDGs was convened on 12 April 2022 in Accra, **Ghana**, to raise the priority on NCDs, bring together national and international actors to exchange knowledge and ideas on what it will take to achieve SDG 3.4, and raise the political visibility of heads of state and government to provide strategic leadership for NCDs. The high-level event was co-hosted by the President of Ghana, the Prime Minister of Norway and the Director-General of WHO, who launched the Global NCD Compact 2020–2030 and the Global Group of Heads of State and Government for the Prevention and Control of NCDs. The multi-year aim of the Global Group is to accelerate progress towards achieving SDG targets 3.4 and 3.8 by 2030. The first gathering of the Global Group of Heads of State and Government for the Prevention and Control of NCDs was held on 21 September 2022, on the side-lines of the UN General Assembly in New York, with attendance by five heads of state and governments and other notable representatives.

Launch of the global NCD Invisible Numbers report and NCD data portal

WHO launched the report *Invisible numbers: the true extent of noncommunicable diseases and what to do about them*[58] to guide advocacy on the true scale of NCDs and their risk factors and to highlight concrete actions and investments needed to prevent and control NCDs.

First-ever global coverage targets for diabetes

WHO Member States have supported the creation and endorsed global targets for diabetes, as part of recommendations to strengthen and monitor diabetes responses within national NCD programmes. The targets complement ongoing efforts, and provide a new impetus aimed at addressing the huge treatment gap related to hypertension and diabetes through the implementation of WHO's HEARTS Technical Package, which is now active in over 30 countries.

The five new targets set the standard that, by 2030:

- 80% of people living with diabetes are diagnosed;
- 80% have good control of glycaemia;
- 80% of people with diagnosed diabetes have good control of blood pressure;
- 60% of people with diabetes of 40 years or older receive statins;
- 100% of people with type 1 diabetes have access to affordable insulin and blood glucose self-monitoring.[59]

NCD facility-based monitoring guidance for NCD patients and programmes

WHO launched new guidance on facility-based monitoring to provide a set of relevant, valid and feasible standardized indicators to guide recording and reporting of health services data at the primary care level, unpacking the treatment cascade (percentage of people diagnosed, under treatment and controlled) for NCDs.

Access to NCD medicines: emergent issues during the COVID-19 pandemic and key structural factors

WHO published the *Access to NCD medicines: emergent issues during the COVID-19 pandemic and key structural factors*[60] report which aimed at describing and analysing how the COVID-19 pandemic affected supply chains for NCD health products to identify key vulnerabilities and bottlenecks and to propose key themes and a framework for future policy development. The report assessed the full range of upstream and downstream impacts of the COVID-19 pandemic on access to NCD medicines including manufacturing, shipping, importation and procurement; patient level effects through affordability and availability; and the effects on NCD medicine availability by category of disease.

Measuring price, affordability and availability of NCD medicines with the MedMon App

WHO collects data to measure the price, affordability and availability of NCD medicines through WHO's essential medicines and health products price and availability monitoring mobile application (WHO's EMP MedMon app). This tool enables teams to rapidly collect and analyse data on the price and availability of medicines in health facilities and procurement centres. Based on elements of the WHO/Health Action International method for measuring medicine prices, availability, affordability and price components, WHO's EMP MedMon app allows users to routinely monitor the prices and availability of medicines in a sustainable, cost-effective and timely manner, regardless of user access to the Internet or cellular data. The tool is designed to avoid duplication of efforts and potential manual entry errors that can occur when data are collected on paper and then transferred to an electronic format. Recent progress in the MedMon implementation has involved **Jordan**, **Republic of Moldova**, **Tajikistan** and **Uzbekistan**.

First human insulins prequalified with more flexible storage conditions recommendations

For the first time ever, WHO has prequalified two human insulins: fast-acting human insulin 100 IU/ml and intermediate-acting human insulin 100 IU/ml. The manufacturer of these newly prequalified products has recently addressed the thermostability of the products and updated the storage conditions to provide the option to store the products at temperatures up to 30°C for four weeks before opening. These updated storage conditions will greatly facilitate the use of these essential medicines under challenging temperature conditions, and where there is limited access to refrigeration in some low- and middle-income countries. Insulin prequalification is one of a number of steps WHO has taken as part of WHO's Global Diabetes Compact, to address the diabetes burden and improve access to essential medicines, diagnostics and devices for PHC.

Dialogues with private sector entities, including business associations and the pharmaceutical and health technology industries

WHO convened biannual dialogues with private sector entities, including representatives from international business associations, and the pharmaceutical and health technology industries. The dialogues focused on ensuring commitments and contributions by the private sector entities towards the response on NCDs to achieve SDG targets 3.4, 3.8 and 3.B. The first and second editions took place in 2021 and focused on access to insulin and its associated health technology for diabetes. Many of the manufacturers who participated in the diabetes-themed dialogues came forward with commitments and contributions in response to WHO's requests. In the lead-up to World Diabetes Day on 14 November 2022, WHO hosted a third diabetes-themed dialogue with the private sector entities on 2 November 2022 at WHO headquarters in Geneva. The third dialogue encouraged implementation of and accountability for the commitments and contributions from the private sector entities, including the pharmaceutical and health technology industries to support WHO's activities to strengthen and improve access to medicines and technologies for diabetes, including the manufacturer announcements for 2022. Some of the commitments include participating in WHO's prequalification programme for insulin and for devices (blood glucose meters and point-of-care HbA1c measuring devices) in line with WHO's rules, policies and procedures; participating in pool procurement mechanisms for diabetes medicines and health technology, coordinated by WHO; uninterrupted supply of human insulin for low- and middle-income countries, by completing technology transfers of the active pharmaceutical ingredient to a local manufacturer on the African continent and through contract manufacturing of South-East Asia-based pharmaceutical manufacturing entities; and capacity-building in domestic manufacturing and supply chain management (including cold storage), following international good practice standards.

Landmark global strategy on oral health adopted at the Seventy-fifth World Health Assembly

Oral diseases are among the most common NCDs worldwide. There were estimated to be more than 3.5 billion cases of oral diseases and other oral conditions globally in 2019. While largely preventable, and amenable to early detection and management at PHC level, with simple, evidence-based and cost-effective interventions, oral health is often not comprehensively included in national benefit packages and PHC strengthening efforts.

The global strategy is the first concrete step towards the full implementation of the WHA74.5 resolution on oral health. With actions for WHO Member States, international partners, civil society and the private sector, the strategy sets four overarching goals to guide Member States, to:

- develop ambitious national responses to promote oral health;
- reduce oral diseases, other oral conditions and oral health inequities;
- strengthen efforts to address oral diseases and conditions as part of UHC;
- consider the development of targets and indicators, based on national and subnational contexts, building on WHO guidance, to prioritize efforts and assess the progress made by 2030.

Global report on health equity for persons with disabilities

World Health Assembly resolution 74.8 signalled a demand to ensure the highest attainable standard of health for persons with disabilities, to make health equity for persons with disabilities a global priority, provide Member States with recommendations to advance health equity, and stimulate national-level action. WHO published a global report[61] highlighting key health inequities and indicating that persons with disabilities, at a younger age (up to 20 years younger) than the general population, are at double the risk of developing many health conditions and have more limitations in day-to-day functioning due mainly to unfair and unjust conditions that are avoidable. The report is now the basis for technical guidance being implemented in countries, to support them to advance health equity for persons with disabilities.

The Global Disability Summit held in February 2022 convened heads of state and governments, government ministers, heads of agencies and international organizations, along with private sector and civil society leaders, to accelerate the understanding and recognition that disability inclusion is fundamental to the success of achieving health for all. The key outcomes included the recognition of systemic barriers in the health sector experienced by persons with disabilities; and an increased awareness of the necessity to explicitly include persons with disability in order to achieve global health priorities.

WHO also hosted a thematic pre-summit, Disability inclusion in the health sector, in collaboration with the governments of **Norway** and **Ghana** and the International Disability Alliance, on 12 January 2022. The objective was to galvanize recognition that disability inclusion is fundamental to the success of achieving health and well-being for all.

Countries supported on NCD surveillance

New NCD population-based surveys give countries the evidence needed to guide policy decisions and investments and identify priority population groups at risk. Ultimately this guidance and support will help countries reduce premature mortality from NCDs and reduce important risk factor exposures. In 2022, technical support was provided to countries implementing new national surveys on adult and adolescent NCD risk factors and NCD conditions, including the STEPwise approach to NCD risk factor surveillance (STEPS) and the Global School-Based Student Health Survey.

An occupational therapist helps a child with a disability practice activities of daily living in Hamar, Norway. © WHO/Nazik Armenakyan

Intensified country support to improve NCD service delivery

The Norway NCD Flagship Initiative aims to improve access to NCD services in **Nepal**, **India**, **Myanmar**, **Ethiopia** and **Ghana** through intensified, multi-year support. Countries are actively implementing activities through a PHC approach to strengthen relevant policy levers and at the same time operationally strengthen people-centred NCD services, district by district, for comprehensive coverage of the population at risk.

In 2022, WHO three-level support to coordinate and monitor implementation of activities was carried out with dedicated missions on key technical areas across the spectrum of health system functions, including health facility data and monitoring; capacity-building on WHO PEN, community mobilization, public health leadership and health information management; assessment of access to NCD medicines; and implementation research, as well as supportive supervision and planning.

In the **WHO African Region**, achievements in 2022 have spanned across health system areas through the establishment of integrated PHC pathways for basic NCD services with screening, diagnosis and treatment programmes provided in selected health facilities. Indicators to monitor progress are being defined and development of an e-tracker for patient tracking has progressed. STEPS protocols in **Ethiopia** and **Ghana** have progressed with ethical approval, as has the use of the NCD Navigator tool to gather data on NCD partners. Both countries issued a call for proposals for implementation research projects, with further work expected in 2023. The health service benefit package was finalized and costed in both countries.

The focus of interventions at the country level include integration of NCD services with mental health in **Nepal**, the strategic purchasing model and provision of NCD services in humanitarian emergencies in **Myanmar**, and screening, early diagnosis and referral of complications of hypertension, diabetes and comorbidities on exiting primary care interventions in **India**.

Thought leadership for NCDs

NCD Hard Talks

WHO's NCD department hosts a regular webinar series, NCD Hard Talks, which provides a forum to address critical challenges in addressing the burden of NCDs through PHC by strengthening health systems. In 2022, seven sessions were held on the following topics:

- Health, Money and Power: Influencing the trajectory to 2025 and 2030;
- Beyond the numbers: the human face of SDG 3.4;
- Another meeting, another commitment: What now? International Strategic Dialogue and Outcomes;
- Harnessing the power of facility data to achieve global NCD targets;
- Delivering the promises: Going big on NCDs: Technology, clinical care and the community;
- Harnessing supply chains for NCDs through strengthened health systems;
- Unlocking behavioural insights for NCDS.

Knowledge series on NCDs with World Bank

The NCD department continues a strong collaboration with the World Bank through the WHO–World Bank Knowledge Series on Strengthening the NCD response at the global and country level. The series of joint webinars continued with the second session on 6 September 2022, Global Diabetes Compact – Health Systems Strengthening in Addressing NCDs. The session convened speakers from the Ministry of Health and Ministry of Finance from Ghana, WHO, World Bank, a representative of people living with diabetes, the International Diabetes Federation and the Helmsley Charitable Trust. The webinar also presented global and country-level WHO and World Bank efforts and explored potential areas of synergy.

In addition, the NCD department hosted a dedicated webinar series on hearing loss prevention through safe listening. Key messages included that hearing loss due to noise/loud sounds is preventable; people can avoid hearing loss through adoption of safe listening practices; and governments can facilitate by implementing regulations for safe listening.

A nurse attends to a patient at a primary health centre in Mutanpal village in Bastar district, Chhastisgarh. © WHO/Atul Loke/Panos Pictures

Healthier environment

Philippines was supported to develop strategies for strengthening urban health systems through community engagement, implementing risk-based approaches, enabling the establishment of model barangays, and engaging in multisectoral actions to address the social determinants of health in the populations of urban poor.

Health in all policies

In 2022, the UHC-P provided technical assistance to **Timor-Leste** in its efforts to significantly raise pro-health taxes, which resulted in an increase in taxes on sugar and sugar-sweetened beverages in 2023, and which is expected to improve public health outcomes. Support in this area was also extended in **Cambodia**, and, in addition, TWG meetings were held on the implementation of the National Multisectoral Action Plan for the Prevention and Control of Noncommunicable Diseases 2018–2027. These meetings focused on reviewing the progress made over the past five years on tobacco use, diet and physical activity, achieved through law enforcement and regulations on tobacco, awareness raising in workplaces and schools on healthy diets and physical activity, educational campaigns on reducing consumption of sugar-sweetened beverages, and long-term plans to improve public transport in Phnom Penh. In addition, a start was made on the review of the progress of the National Action Plan for Salt Reduction 2021–2027, and the UHC-P supported a consultation workshop for advocacy of taxation on sugar-sweetened beverages. **Fiji**, **Palau** and **Samoa** were supported in the early stages of discussions on regulating food marketing and health taxes.

Kiribati saw mobilization on plans for food regulation discussions, taking food safety and nutrition into consideration, and the **Marshall Islands** were supported to develop dietary and healthy living guidelines, including the provision of technical support on food marketing restrictions, while **Micronesia** was supported in its development of a national nutrition plan.

In partnership with UNDP, the UHC-P supported the development of a national NCD strategic plan for **Fiji**, including extensive consultations with multisector stakeholders and the development of many foundation documents.

The UHC-P supported **Sudan** to strengthen the existing multisectoral programme on Health in all policies to address the social determinants of health, and supported its roll-out at the subnational level.

A health worker at a health centre in Manila, Philipines. © WHO/Blink Media-Hannah Reyes Morales

A health worker trains midwives on using resuscitation equipment in Bobonaro, Timor-Leste. © WHO/Karen Reidy

4

More effective and efficient

WHO providing better support to countries

Notable results for better support to countries in 2022

The WHO African Region's integrated **African Health Observatory** was expanded with the introduction of three new platforms: the Master Facility List for the African Region; the Africa Health Workforce Observatory; and the Essential Healthcare Package Toolkit.

9 African countries were supported to establish or strengthen their **national health observatories** and 3 to develop their health information system.

5 countries were supported to strengthen their **civil registration and vital statistics systems**.

The UHC-P together with PHC professionals and experts from the information technology industry and business development launched Ukraine's **first Health Hackathon** in September 2022.

Health information and information systems for health

The **WHO African Region's** integrated African Health Observatory (iAHO)[62] – an evidence and information hub – was expanded with the introduction of three new platforms: the Master Facility List for the African Region; the Africa Health Workforce Observatory; and the Essential Healthcare Package Toolkit. These platforms join the COVID-19 Information Hub for Africa and the African Health Observatory Platform on Health Systems and Policies as standalone platforms hosted on the iAHO. During 2021, the iAHO website expanded its reach by more than 500%, and the site architecture has been improved to make it more user friendly.

In 2022, many countries were supported by the UHC-P to establish or strengthen their national health observatories. **Angola**, **Cabo Verde**, **Gambia** and **Malawi** held orientation meetings for their national health observatories with key stakeholders, and **Liberia** and **Uganda** built capacity and updated information on their national health observatories. A regional training of the trainer capacity-building workshop on knowledge product generation was organized in **Côte d'Ivoire** and 37 knowledge products were generated as a result. **Senegal** developed and launched a health care country profile, and **Rwanda** introduced an antenatal care digital toolkit in two districts, aimed to digitalize guidelines.

An automated DHIS2 integration was developed and pilot tested in **Ghana**, and in **Myanmar**, the DHIS2 data management system was revived in 2022. In the **Solomon Islands**, the UHC-P assisted in conducting training for the health information unit on data management and analysis using DHIS2, conducting rapid assessments of the technical capacity of the health information unit to inform restructuring, and supported the Digital Health TWG to develop a national digital health strategy.

The UHC-P also supported **Myanmar**'s revival of the data management system for communicable diseases, including data for HIV/AIDS, tuberculosis and malaria. The UHC-P provided technical assistance to **Timor-Leste** to integrate disease surveillance and data on communicable diseases into the health management information system, improving efficiency and reducing data fragmentation in the health management information system. In **India**, the UHC-P supported the improved monitoring of the performance of Atal Mohalla Clinics in urban settings in Jharkhand, and put in place a functional web-dashboard (Power BI), resulting in near real-time performance monitoring of urban clinics in the State of Jharkhand.

In the **WHO African Region**, **Zambia** drafted a health information system strategy, while **Sudan** sought to strengthen its health information system and **South Sudan** began development of its own health information system policy and strategy.

In **Iraq**, the UHC-P supported the development of the health information system draft national action plan 2020–2024, including key priority areas critical to enhancing the national health information system to monitor progress towards achieving the SDGs. In addition to providing technical guidance and supporting the development and implementation of DHIS2, a proposal for DHIS2 implementation was finalized and submitted to the Ministry of Health; a biweekly multistakeholders meeting was initiated to coordinate efforts, assign roles and responsibilities and set up a timeline for implementation. Advocacy was also undertaken for the development and implementation of a national e-health strategy.

In **Lao People's Democratic Republic** nearly 93% of deaths occur outside health facilities. Despite death notifications being critical for mortality statistics, the lack of a systematic mechanism for collecting death notifications led the UHC-P to support the establishment of a death notification system run by Village Chiefs in all nine districts in Vientiane Capital. Ministry of Home Affairs staff at the central, provincial and district levels, and all Village Chiefs, were trained to use the system developed to capture death notification data and on data entry. The system has been rolled out across all districts in Vientiane Capital and produces vital information on deaths in the community, with online dashboards facilitating easy access to these data. These data allow the Ministry of Health to follow-up with verbal autopsies to provide more accurate cause of death statistics. This system will continue to be rolled out in two additional provinces.

In **Fiji**, the UHC-P supported the digitalization and integration of the national notifiable disease surveillance system. **Egypt** was supported to establish electronic medical records, and to develop master lists and coding for diseases and interventions. To support the prioritization of health reform in **Ukraine** and its commitment to a central role of PHC with integrated digital solutions for health, Ukraine's first Health Hackathon was held in 2022 (Box 30). The importance of digitalization and information infrastructure to health financing reforms was demonstrated in **Uzbekistan**, and this provided an opportunity to support the Ministry of Health to strengthen the health information system (Box 31).

Member States also indicated a continuing need to integrate COVID-19 vaccination and health information into existing systems, for which the UHC-P provided support in **Tonga**. In **Vanuatu**, support was provided to track COVID-19 vaccination records and link them with the civil registration in a collaboration between the Ministry of Health and the Ministry of Internal Affairs. This provided an opportunity to expand the coverage of national identity cardholders using the planned COVID-19 vaccine pre-registration system.

Box 30. First Health Hackathon in the WHO European Region to find digital solutions in health and primary care

The UHC-P together with PHC professionals and experts from the information technology industry and business development launched **Ukraine**'s first Health Hackathon in September 2022. In support of Ukraine's prioritizing health reform and the central role of PHC with integrated digital solutions for health, more than 40 teams worked for over 48 hours on hacking innovative solutions around key health challenges: health promotion, disease prevention, mental health, and health care management to improve the interaction between doctors and patients, and between doctors to support the clinical decision-making process. This hackathon was complementary to WHO's flagship initiative Empowerment through Digital Health.

Box 31. Towards the digitalization of the health system of Uzbekistan to enable PHC and health financing reforms

Several expert missions were undertaken in **Uzbekistan** in 2022 to improve the strategic purchasing of health services, focus on improving the pooling of budgetary funds and implement the blended payment model (case-based and global budget) in the hospital sector, as well as introducing capitation payments in PHC. Additionally, the status of the health financing reform's implementation in Syrdarya oblast was assessed to identify key challenges and propose solutions for the reform's roll-out to other regions.

One of the results of these missions was the discovery that the main technical factor holding back the pace of health financing reforms (towards strategic purchasing of health services) was the lag in developing the information infrastructure. The limited numbers of staff working in ITMed, the responsible agency under Ministry of Health, and competing priorities were the root causes. Since the mission, WHO support has been provided to the Ministry of Health, ITMed and the SHIF in linking business processes to information system needs and defining the roles and responsibilities of ITMed versus SHIF (for which internal capacity will have to be built from the ground up). Throughout 2022, the basis for a Unified Health Information System was strengthened, including an electronic database of the enrolled population and software to collect information about patients treated in hospitals and as outpatients. Modules were created for the SHIF to calculate the budget for hospitals and primary care providers. However, there remain several limitations, not least the capacity of providers to provide quality data, and of both providers and the SHIF to use resulting information to make management and purchasing decisions.

A health worker looks through a microscope at a health centre in Samarkand, Uzbekistan.
© WHO/Anna Usova

Data and innovation

The UHC-P supported the strengthening of the civil registration and vital statistics (CRVS) systems in **Egypt**, **Eswatini**, **Lebanon**, **Peru** and **Philippines**. **Eswatini** launched its CRVS strategy and **Philippines** completed a comprehensive assessment and drafted the CRVS system for the Health Strategic Plan and the National Plan of Action 2023–2028. In **Lebanon**, a refresher training session for the death notification system focal points was held, including expanded training on death certification, expansion of the automated CRVS system at the qada (Noufous) level, and the piloting and expansion of the automated CRVS systems (software adaptation, procurement of information and communications technology, data sharing). Support was also provided to **Egypt** for CRVS system automation, validation and capacity-building, and in **Peru**, integrated PHC was strengthened by developing and providing training for methodologies and tools to support civil registration for three regional integrated health systems (Churcampa, Atalaya and Villa el Salvador).

In **India**, the UHC-P organized a national workshop on strengthening the cause of death information system, in which 40 participants were trained on cause of death information systems to create a pool of master trainers to build the capacity of medical doctors to provide medical certifications of causes of death; combined with the release of the Framework for Audit of Medical Certification of Cause of Death, the UHC-P has supported hospital availability of a tool to review the quality of completed medical certificates of cause of death.

WHO supported **Ghana** in deploying ICD-11 for all facilities reporting on cause of death. Ghana also conducted monitoring and supportive visits to facilities in five regions on ICD-11 recording and cause of death reporting, to better understand any issues and bridge any gaps in the roll-out. **Namibia** held a training of trainers on ICD-11, and the first draft cause of death report was prepared. **Liberia** successfully launched its death registration platform while **United Republic of Tanzania** trained 60 providers on maternal and perinatal death surveillance and response.

In the **WHO Western Pacific Region**, the UHC-P supported the development of the Data Management Competency Framework, which was successfully rolled out in **Papua New Guinea**. This support included an analysis of job roles and responsibilities of the health information workforce, identification and mapping of roles and competencies, and presenting and discussing the findings during a national consultation in August 2022. Cross-sectional collaboration on ICD-11 implementation and all-cause death and excess death monitoring for the pandemic response and actions in the Region were also actively supported, including by facilitating workshops to support the ICD-11 transition and CRVS system strengthening. **Iran** was also supported in the phase I integration of the Application Programme Interface for ICD-11 software into the health information system in selected hospitals and PHC facilities, including for death certificates and cause of death notifications.

In **Republic of Moldova**, as part of standardizing health and financing data collection and processing, a new, unique nomenclature for bed profiles was proposed for use by all institutions in the health system and for integration into all software applications that run in hospitals. After consulting and receiving inputs, the final document, with the coding methodology and recommendations, was presented to the Ministry of Health and proposed for approval and endorsement from 2023. The standardization of the hospital health and expenditure data collection and processing was one of the main pillars for improvement included in the next set of costing exercises and is an urgent issue that needs to be addressed. A hospital mapping exercise started in 2021 to develop a hospital classification based on capacities and competencies and services and roles in the health system, to improve resource allocation in the hospital sector. The results re-emphasized the need for standardization.

Iraq was supported to implement the Astana Declaration through the regional Primary Health Care Measurement and Improvement initiative. Iraq developed its first PHC master indicator list and PHC measurement was being implemented, with further monitoring planned.

In **Pakistan**, the UHC-P supported the delivery and dissemination of the service availability and readiness assessment survey in 12 districts, complemented by a UHC situation analysis and an assessment of the UHC index in 2021, and the development of district and provincial annual plans for an essential public health services implementation and monitoring framework.

“Together we must be steered by shared learning, synergy and action, focused not only on the ‘what’ but the ‘how’. We are all moving in roughly the same direction, but need to start working together to achieve our shared aims. Our objectives are simply too important, our responsibilities too great.”

Dr Poonam Khetrapal Singh,
Director of the WHO Regional Office for South-East Asia,
speaking at the Regional PHC Forum

Conclusion and lessons learned

The world is not on track to reach most of the Triple Billion targets and the health-related SDGs by 2030. Globally, the COVID-19 pandemic has strongly disrupted the coverage of available health services, and financial hardship has worsened in the last few years. The year 2022 saw countries making full-scale adaptations to the pandemic that triggered once-unthinkable lockdowns, upended economies worldwide and killed at least 7 million people worldwide to date.

The COVID-19 pandemic exposed the cracks in health systems worldwide and highlighted the challenges in accessing and providing care, and the negative health outcomes that result from not meeting these challenges. To ensure that no one is left behind in accessing the highest level of health, including in emergency situations, WHO is calling to reorient health systems towards PHC to achieve UHC.

Over the last decade, the PHC approach has been at the heart of the UHC-P, which aims to strengthen health systems through comprehensive and integrated actions. This partnership is supporting national authorities to reform health systems policies to guarantee the availability and accessibility of indispensable primary care and public health functions, and health emergency preparedness and response capacities, while empowering communities through social participation and addressing the determinants of health through multisectoral policies.

While advocating for a PHC approach to reach UHC and health security, the UHC-P, through health policy advisers, makes positive propositions of concrete alternative policies and mobilizes policy-makers to engage in reforms. By opening windows of opportunity for policy change based on renewed or innovative commitments, the UHC-P works on the fundamental contextual factors for the health policy-making process. The reorientation of health systems can be built on experiences and lessons learned from countries supported by the UHC-P.

All countries who are members of the UHC-P have made progress towards achieving UHC during the last decade; however, there are still significant disparities in access to health care services within and between countries. With regards to health financing, indicators for financial hardship have worsened since the COVID-19 pandemic. The pandemic has highlighted the urgent need for health systems to be transformed to achieve the right to health, based on PHC as the foundation to building more resilient health systems and societies. This includes strengthening health systems, integrating vertical programmes, addressing workforce shortages, improving access to medicines and health technology, and ensuring financial protection for all.

Strong leadership and stewardship are key to the success of any progress towards UHC. Coordinating and convening international and key health sector stakeholders has played a huge role in improving country policy dialogue to finally implement health policies and strategies. Social participation is at the heart of the inclusive governance required for countries to stake their individual paths towards UHC while ensuring that no one is left behind.

In addition, UHC can only be achieved by promoting universal social protection that supports poverty alleviation, and by addressing the social determinants of health. There is a need to accelerate and scale up coordinated actions across health and other sectors, including social and economic development sectors, to promote systemic transformations.

Also, achieving UHC can be hindered by a lack of evidence to inform policy dialogue and implementation of policy reforms. Disaggregating data by age, sex, education level and income is essential to identifying inequities in health outcomes and services. Countries must address disparities in the access to health care services to ensure that vulnerable populations have equal access.

However, country political and financial commitments to implementation of health reforms remain an important challenge. There is a growing need to identify adequate strategies that go beyond assuming that by supporting countries to develop evidence-based policies, countries will automatically effectively implement them.

As part of GPW13, one of WHO's strategic shifts is to provide more effective and efficient support to countries, to drive measurable improvement. Looking forward to 2023, this project will continue to support these fundamental changes in the way it works to deliver impact, to ensure that it aligns with the evolving WHO operating model, to remain focused to ensure that all people and communities receive the quality services they need and are protected from health threats, without suffering financial hardship.

References

1 Thirteenth General Programme of Work 2019–2023. In: WHO/About WHO/What we do [website]. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/324775, accessed 28 August 2023).

2 Resolution WHA75.6. Extension of the Thirteenth General Programme of Work, 2019–2023 to 2025. In: Seventy-fifth World Health Assembly, Geneva, 22–28 May 2022. Resolutions and decisions, annexes. Geneva: World Health Organization; 2022 (WHA75/2022/REC/1; https://apps.who.int/gb/or/e/e_wha75r1-Int.html, accessed 21 Feburary 2024).

3 Operational framework for Primary Health Care: transforming vision into action. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF); 2020 (https://www.who.int/publications/i/item/9789240017832, accessed 21 February 2024).

4 Primary health care measurement framework and indicators: monitoring health systems through a Primary Health Care lens. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF); 2022 (https://apps.who.int/iris/bitstream/handle/10665/337641/9789240017832-eng.pdf, accessed 28 August 2023).

5 The world health report 2008: primary health care now more than ever. Geneva: World Health Organization; 2008 (https://iris.who.int/handle/10665/43949, accessed 2 October 2023).

6 Thirteenth General Programme of Work 2019–2023.

7 Formative evaluation of the EU–Luxembourg–WHO Universal Health Coverage Partnership (UHC-P) 2011–2016. Amsterdam: Royal Tropical Institute; 2016 (https://extranet.who.int/uhcpartnership/sites/default/files/reports/FinalReportFormativeEvaluationUHC-w-Annexes-1.pdf, accessed 28 August 2023).

8 Mwisongo A, Nabyonga-Orem J, Yao T, Dovlo D. The role of power in health policy dialogues: lessons from African countries. BMC Health Serv Res. 2016;16 Suppl 4:213. doi: 10.1186/s12913-016-1456-9.C.

9 Robert E, Ridde V, Rajan D, Sam O, Dravé M, Porignon D. Realist evaluation of the role of the Universal Health Coverage Partnership in strengthening policy dialogue for health planning and financing: a protocol. BMJ Open. 2019;9:e022345. doi: 10.1136/bmjopen-2018-022345.

10 Zongo S. Le dialogue sur la stratégie nationale de financement de la santé pour la couverture sanitaire universelle au Burkina Faso. Partenariat pour la CSU; 2018 (in French).

11 Robert E, Zongo S, Rajan D, Ridde V. Contributing to collaborative health governance in Africa: a realist evaluation of the Universal Health Coverage Partnership. BMC Health Serv Res. 2022;22:753. doi: 10.1186/s12913-022-08120-0.

12 Ibid.

13 Saikat S, Selbie D, McDarby G, Mustafa S, Petrova M, Seifeldin R et al. Editorial: Health systems recovery in the context of COVID-19 and protracted conflict. Front Public Health. 2023;11:1205286. doi: 10.3389/fpubh.2023.1205286.

14 Robert E et al. Contributing to collaborative health governance in Africa.

15 Pocket book of primary health care for children and adolescents: guidelines for health promotion, disease prevention and management from the newborn period to adolescence. WHO Regional Office for Europe; 2022 (https://apps.who.int/iris/handle/10665/352485, accessed 29 August 2023).

16 UHC Compendium. In: WHO/Universal health coverage [website]. Geneva: World Health Organization; 2023 (https://www.who.int/universal-health-coverage/compendium#:~:text=The%20UHC%20Compendium%20is%20a,health%20services%20and%20health%20interventions, accessed 29 August 2023).

17 Evaluation of the integration of gender, equity and human rights in the work of the World Health Organization. Geneva: World Health Organization; 2021 (https://cdn.who.int/media/docs/default-source/documents/about-us/evaluation/gehr-report-september-2021.pdf?sfvrsn=fc8a1c04_1&download=true, accessed 7 September 2023).

18 Kabra R, Joshi B, Elisaria E, Akande TM, Allagh KP, Olumide A et al. Determining the impact of the COVID-19 pandemic on availability, use, and readiness of family planning and contraceptive services at selected primary health care facilities in Africa and Asia: protocol for a mixed methods study. JMIR Res Protoc. 2023;12:e43329. doi: 10.2196/43329.

19 Cassinath N, Titulaer P, Läser L, Lavelanet A, Ahsan S, Toedtli FK et al. Disruptions to the procurement of medical abortion medicines during COVID-19: a scoping review. BMJ Open. 2022;12:e064848. doi: 10.1136/bmjopen-2022-064848.

20 Williams CR, Valeria Bahamondes M, Gómez Ponce de León R, da Costa Machado H, Bahamondes L, Caffe S et al. Analysing the context and characteristics of legal abortion and comprehensive post-abortion care among adolescents aged 10–14 in a network of sentinel centres in Latin America: a retrospective cross-sectional study, 2016–2020. Sex Reprod Health Matters. 2023;31:2175442. doi: 10.1080/26410397.2023.2175442.

21 In the framework of the FLASOG Summit, a symposium was held regarding the CLAP MUSA Network and the quality of care for women. In: PAHO/News [website]. Washington, DC: Pan American Health Organization; 2022 (https://www.paho.org/en/news/31-8-2022-framework-flasog-summit-symposium-was-held-regarding-clap-musa-network-and-quality, accessed 1 September 2023).

22 Allotey J, Chatterjee S, Kew T, Gaetano A, Stallings E, Fernández-García S et al. SARS-CoV-2 positivity in offspring and timing of mother-to-child transmission: living systematic review and meta-analysis. BMJ. 2022;376:e067696. doi: 10.1136/bmj-2021-067696.

23 Allotey J, Bonet M, Stallings E, Yap M, Chatterjee S, Kew T. COVID-19 in pregnant women: a living systematic review on prevalence, presentation, prognosis and treatment. PROSPERO 2020; CRD42020178076 (https://www.crd.york.ac.uk/prospero/display_record.

php?RecordID=178076, accessed 1 September 2023).

24 Global strategy on human resources for health: Workforce 2030. Geneva: World Health Organization; 2016 (https://www.who.int/publications/i/item/9789241511131, accessed 29 August 2023).

25 WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva: World Health Organization; 2010 (https://www.who.int/publications/i/item/wha68.32, accessed 29 August 2023).

26 Health and care workforce in Europe: time to act. Copenhagen: WHO Regional Office for Europe; 2022 (www.who.int/europe/publications/i/item/9789289058339, accessed 29 August 2023).

27 Health financing in Ukraine: resilience in the context of war. Copenhagen: WHO Regional Office for Europe; 2022 (http://www.who.int/europe/publications/i/item/WHO-EURO-2022-5882-45647-65535#:~:text=Download%20(5.9%20MB)-,Overview,health%20financing%20reform%20in%20Ukraine, accessed 2 September 2023).

28 Primary health care financing: policy options for the Republic of Moldova. Copenhagen: WHO Regional Office for Europe; 2022 (https://www.who.int/europe/publications/i/item/WHO-EURO-2022-6132-45897-66131#:~:text=To%20strengthen%20PHC%20financing%2C%20the,outpatient%20prescription%20medicines%20more%20affordable, accessed 2 September 2023).

29 Jowett M, Kutzin J, Kwon S, Hsu J, Sallaku J, Solano JG. Assessing country health financing systems: the Health Financing Progress Matrix (Health financing guidance, no. 8). Geneva: World Health Organization; 2020 (https://who.int/publications/i/item/9789240017405; accessed 25 September 2023).

30 The Health Financing Progress Matrix: country assessment guide (Health financing guidance, no. 9). Geneva: World Health Organization; 2020 (https://cdn.who.int/media/docs/default-source/health-financing/country-assessment-guide---public-financial-management.pdf?sfvrsn=b5f7fa36_1&download=true, accessed 2 September 2023).

31 Health Financing Progress Matrix assessment, Ethiopia 2022: summary of findings and recommendations. Geneva: World Health Organization; 2023 (https://www.who.int/publications/i/item/9789240067554, accessed 1 September 2023).

32 e-Learning Course on Health Financing Policy for universal health coverage (UHC). In: WHO/Publications/Overview/e-Learning Course on Health Financing Policy for universal health coverage (UHC) [website]. Geneva: World Health Organization; 2021 (https://www.who.int/publications/m/item/e-learning-course-on-health-financing-policy-for-universal-health-coverage-(uhc), accessed 1 September 2023).

33 Cours en ligne sur la politique de financement de la santé et la couverture santé universelle (CSU). In: WHO/Publications/Vue d'ensemble/Cours en ligne sur la politique de financement de la santé et la couverture santé universelle (CSU) [website]. Geneva: World Health Organization; 2021 (https://www.who.int/fr/publications/m/item/e-learning-course-on-health-financing-policy-for-universal-health-coverage-(uhc), accessed 1 September 2023).

34 Advanced course on health financing for universal coverage (virtual facilitation). In: WHO/Newsroom/Events/Detail/Advanced course on health financing for universal coverage (virtual facilitation) [website]. Geneva: World Health Organization; 2023 (https://www. who.int/news-room/events/detail/2023/02/20/default-calendar/seventh-advanced-course-on-health-financing-for-universal-coverage-for-low--and-middle-income-countries, accessed 1 September 2023).

35 Health Financing Progress Matrix. In: WHO/Health Systems Governance and Financing [website]. Geneva: World Health Organization; 2023 (https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix, accessed 1 September 2023).

36 Health Financing Progress Matrix: Background indicators. In: WHO/Health Systems Governance and Financing [website]. Geneva: World Health Organization; 2023 (https://www.who.int/teams/health-systems-governance-and-financing/health-financing/hfpm-background-indicators, accessed 1 September 2023).

37 Multisectoral preparedness coordination framework: best practices, case studies and key elements of advancing multisectoral coordination for health emergency preparedness and health security. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/332220, accessed 4 September 2023).

38 Strengthening health security preparedness: The International Health Regulations (2005). Geneva: Inter-Parliamentary Union and the World Health Organization; 2022 (https://www.ipu.org/resources/publications/handbooks/2022-03/strengthening-health-security-preparedness-international-health-regulations-2005, accessed 4 September 2023).

39 Regional strategic roadmap on health security and health system resilience for emergencies 2023–2027. New Delhi: WHO Regional Office for South-East Asia (https://apps.who.int/iris/handle/10665/363334, accessed 4 September 2023).

40 World Health Organization strategy (2022–2026) for the National Action Plan for Health Security. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240061545, accessed 4 September 2023).

41 Strategic Partnership for Health Security and Emergency Preparedness (SPH) Portal [website]. Geneva: World Health Organization; 2023 (https://extranet.who.int/sph/, accessed 4 September 2023).

42 IHR State Party Self-Assessment Annual Report. In: Operations/International Health Regulations M&E Framework/States Parties Self-Assessment Annual Reporting [website]. Geneva: World Health Organization; 2023 (https://www.who.int/emergencies/operations/international-health-regulations-monitoring-evaluation-framework/states-parties-self-assessment-annual-reporting, accessed 4 September 2023).

43 WHO guidance on preparing for national response to health emergencies and disasters. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240037182, accessed 4 September 2023).

44 Working Paper: Inclusion of the impacts of the COVID-19 pandemic on health and health services in reporting for Sendai Framework Monitoring in 2021. Geneva: World Health Organization and UN Office for Disaster Risk Reduction; 2021 (https://www.preventionweb.net/sites/default/files/inline-files/Working%20Paper%20-%20Inclusion%20of%20COVID-19%20in%20Sendai%20Framework%20monitoring%202021_0.pdf, accessed 4 September 2023).

45 WHO guidance on research methods for health emergency and disaster risk management. Geneva: World Health Organization;

2021 (https://apps.who.int/iris/handle/10665/345591, accessed 4 September 2023).

46 Rapid hospital readiness checklist for COVID-19 [Excel spreadsheet]. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/332778, accessed 4 September 2023).

47 Strategic toolkit for assessing risks: a comprehensive toolkit for all-hazards health emergency risk assessment. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240036086, accessed 4 September 2023).

48 Joint external evaluation tool: International Health Regulations (2005), third edition. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240051980, accessed 4 September 2023).

49 A global analysis of COVID-19 intra-action reviews: reflecting on, adjusting and improving country emergency preparedness and response during a pandemic. Geneva: World Health Organization; 2022 (https://apps.who.int/iris/handle/10665/365488, accessed 4 September 2023).

50 Taking a multisectoral, One Health approach: a tripartite guide to addressing zoonotic diseases in countries. Geneva, Rome, Paris: World Health Organization, Food and Agriculture Organization of the United Nations, World Organisation for Animal Health; 2019 (http://www.who.int/publications/i/item/9789241514934, accessed 4 September 2023).

51 Health financing in Ukraine: resilience in the context of war.

52 Ambient (outdoor) air pollution. In: WHO/Newsroom/Fact sheets/Detail [website]. Geneva: World Health Organization; 2022 (https://www.who.int/news-room/fact-sheets/detail/ambient-(outdoor)-air-quality-and-health, accessed 27 September 2023).

53 New study highlights cost-effectiveness of bans on pesticides as a suicide prevention strategy. In: WHO/News [website]. Geneva: World Health Organization; 2020 (https://www.who.int/news/item/17-12-2020-new-study-highlights-cost-effectiveness-of-bans-on-pesticides-as-a-suicide-prevention-strategy#:~:text=Bans%20were%20found%20to%20be,suicides%20were%20from%20pesticide%20poisoning, accessed 27 September 2023).

54 Strengthening mental health and psychosocial response to COVID and other crisis in three Caribbean countries: Guyana, Suriname and Trinidad and Tobago. In: PAHO/News [website]. Washington, DC: Pan American Health Organization; 2023 (https://www.paho.org/en/news/22-3-2023-strengthening-mental-health-and-psychosocial-response-covid-and-other-crisis-three, accessed 27 September 2023).

55 National non-communicable diseases' workshop and relaunching of the alliance for healthy living address by permanent secretary for commerce, trade, tourism and transport. In: Ministry of Trade, Co-operatives, Small and Medium Enterprises [website]. Suva: Government of Fiji; 2022 (https://www.mcttt.gov.fj/national-non-communicable-diseases-workshop-and-relaunching-of-the-alliance-for-healthy-living-address-by-permanent-secretary-for-commerce-trade-tourism-and-transport-shaheen-ali/, accessed 27 September 2023).

56 Noncommunicable diseases progress monitor 2022. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240047761, accessed 27 September 2023).

57 Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva: World Health Organization; 2013 (https://iris.who.int/bitstream/handle/10665/94384/9789241506236_eng.pdf?sequence=1, accessed 3 October 2023).

58 Invisible numbers: the true extent of noncommunicable diseases and what to do about them. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240057661, accessed 27 September 2023).

59 Gregg EW, Buckley J, Ali MK, Davies J, Flood D, Mehta R et al. Improving health outcomes of people with diabetes: Target setting for the WHO global diabetes compact. Lancet 2023;401(10384):1302–131. doi: 10.1016/S0140-6736(23)00001-6.

60 Access to NCD medicines: emergent issues during the COVID-19 pandemic and key structural factors. Geneva: World Health Organization; 2023 (https://www.who.int/publications/i/item/9789240069442, accessed 27 September 2023).

61 Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/9789240063600, accessed 27 September 2023).

62 iAHO [website]. Brazzaville: WHO Regional Office for Africa; 2023 (https://aho.afro.who.int/af, accessed 5 September 2023).

Annex

Table of activities by output by country/area

GPW13 OUTCOMES

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

		1 BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													1 BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									1 BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES													
	GPW13 OUTCOMES	**1.1**					**1.2**			**1.3**					**2.1**			**2.2**			**2.3**			**3.1**		**3.2**		**3.3**		**4.1**			**4.2**						**4.3**			
	NUMBER OF COUNTRIES	78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
	GPW13 OUTPUTS	1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO African Region	Algeria	■																																									
	Angola				■	■	■		■			■																															
	Benin	■		■	■	■				■		■				■																											
	Botswana	■				■		■		■																																	
	Burkina Faso	■			■	■	■	■		■									■																								
	Burundi			■	■	■		■	■	■				■																													
	Cabo Verde			■		■		■		■						■																											
	Cameroon	■		■	■	■		■		■						■			■																								
	Central African Republic	■			■	■				■						■																											
	Chad	■			■	■		■		■		■																															
	Comoros			■	■	■		■	■	■																																
	Congo																																										
	Côte d'Ivoire	■			■	■		■		■	■			■																												
	Democratic Republic of the Congo	■			■			■	■	■		■							■																								
	Equatorial Guinea				■		■			■																																	
	Eritrea	■			■	■																																				

		1 BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													1 BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									1 BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES											
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**					**2.1**			**2.2**			**2.3**			**3.1**		**3.2**		**3.3**		**4.1**			**4.2**						**4.3**			
NUMBER OF COUNTRIES		78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO African Region	Eswatini	■			■	■		■		■						■																										
	Ethiopia	■				■			■	■									■																								
	Gabon				■		■																																				
	Gambia				■	■	■	■		■		■				■			■																								
	Ghana				■	■	■	■	■	■	■					■																										
	Guinea				■	■		■																																		
	Guinea-Bissau																																									
	Kenya																		■																								
	Lesotho	■			■	■	■	■		■						■																										
	Liberia				■	■	■	■		■						■			■																								
	Madagascar				■	■		■								■																										
	Malawi				■	■	■	■																																		
	Mali				■	■	■	■								■					■																						
	Mauritania															■																										
	Mauritius																		■																								
	Mozambique	■				■																																				
	Namibia	■			■	■				■						■			■																								
	Niger				■			■																																				
	Nigeria	■	■	■	■	■	■	■	■	■		■																														
	Rwanda	■	■	■	■	■	■		■	■		■																														
	Sao Tome and Principe																																									
	Senegal				■			■		■						■			■																								
	Seychelles															■																										
	Sierra Leone				■	■		■											■																								
	South Africa															■																										
	South Sudan	■	■		■		■			■				■					■		■																						
	Togo	■			■	■		■		■						■																										
	Uganda	■			■	■	■	■								■			■																								
	United Republic of Tanzania	■			■	■		■		■	■	■		■																												
	Zambia	■			■			■	■		■	■				■																										
	Zimbabwe		■		■	■	■	■				■				■																										

		1 BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													1 BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									1 BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES													
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**					**2.1**			**2.2**			**2.3**			**3.1**		**3.2**		**3.3**		**4.1**			**4.2**							**4.3**			
NUMBER OF COUNTRIES		78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO Region of the Americas	Antigua and Barbuda		■		■										■	■					■																					
	Bahamas	■	■		■										■	■										■																
	Barbados		■				■									■	■				■					■				■													
	Belize		■			■						■				■				■																						
	Bolivia (Plurinational State of)	■	■			■	■					■																										■				
	Colombia	■				■																																				
	Cuba		■		■											■										■																
	Dominica	■	■		■			■								■	■				■																					
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	El Salvador	■																																								
	Grenada				■											■	■				■																					
	Guyana	■	■		■	■						■			■																											
	Haiti	■	■	■	■	■	■					■									■									■												
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	Saint Kitts and Nevis		■		■			■								■	■				■					■																
	Saint Lucia		■		■											■	■				■																					
	Saint Vincent and the Grenadines				■											■	■				■																					
	Suriname	■			■											■	■									■																
	Trinidad and Tobago	■	■		■						■				■	■										■																

		1 BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													1 BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									1 BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES AND AREAS												
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**					**2.1**			**2.2**			**2.3**			**3.1**		**3.2**		**3.3**		**4.1**			**4.2**						**4.3**			
NUMBER OF COUNTRIES AND AREA		78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO Eastern Mediterranean Region	Afghanistan	■	■			■		■		■			■	■														■	■	■	■		■	■	■	■		■				
	Egypt						■	■	■																																
	Iraq	■		■	■	■	■	■	■	■				■	■	■			■		■		■			■	■			■	■	■	■		■	■	■	■				
	Iran (Islamic Republic of)					■	■																																			
	Jordan	■	■	■					■		■	■		■	■				■				■		■	■	■			■	■		■				■		■			
	Lebanon	■		■	■			■				■																														
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	occupied Palestinian territory			■				■		■																				■												
	Pakistan	■	■																																							
	Somalia	■	■	■	■	■		■		■		■	■		■	■	■	■	■	■	■	■	■	■		■				■		■	■		■		■	■			■	■
	Sudan	■		■	■	■	■	■		■		■	■	■				■																								
	Tunisia	■			■	■	■	■	■																					■												
	Yemen	■	■	■	■	■	■			■	■			■																												

		1 BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													1 BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									1 BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES												
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**					**2.1**			**2.2**			**2.3**			**3.1**		**3.2**		**3.3**		**4.1**			**4.2**							**4.3**			
NUMBER OF COUNTRIES		78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO European Region	Azerbaijan	■	■		■											■					■																		■		
	Georgia	■		■			■	■			■					■					■																		■		
	Kyrgyzstan	■				■	■				■	■				■					■																				
	Republic of Moldova				■	■	■	■	■				■			■					■									■			■						■		
	Tajikistan	■			■	■	■	■	■		■					■					■													■							
	Ukraine	■	■				■	■								■			■		■	■	■															■		■	
	Uzbekistan	■	■	■	■	■	■		■							■					■																				

		1 BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													1 BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									1 BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES												
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**					**2.1**			**2.2**			**2.3**			**3.1**		**3.2**		**3.3**		**4.1**			**4.2**							**4.3**			
NUMBER OF COUNTRIES		78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO South-East Asia Region	Bangladesh	■																																							
	Bhutan	■																																							
	India	■				■	■	■			■	■																		■												
	Indonesia	■																																							
	Maldives	■																																							
	Myanmar	■				■										■	■					■		■																		
	Nepal	■																																							
	Sri Lanka	■	■			■	■	■				■																													
	Thailand	■																																							
	Timor-Leste	■				■	■	■			■	■																		■		■										

		1 BILLION MORE PEOPLE BENEFITING FROM UNIVERSAL HEALTH COVERAGE													1 BILLION MORE PEOPLE BETTER PROTECTED FROM HEALTH EMERGENCIES									1 BILLION MORE PEOPLE ENJOYING BETTER HEALTH AND WELL-BEING						MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES												
GPW13 OUTCOMES		**1.1**					**1.2**			**1.3**					**2.1**			**2.2**			**2.3**			**3.1**		**3.2**		**3.3**		**4.1**			**4.2**							**4.3**			
NUMBER OF COUNTRIES		78	60	30	68	75	57	46	23	39	28	43	7	25	14	27	11	2	12	7	19	18	17	23	11	29	16	19	4	63	32	25	24	8	13	18	7	15	8	11	8	9
GPW13 OUTPUTS		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.1.2	2.1.3	2.2.1	2.2.2	2.2.3	2.3.1	2.3.2	2.3.3	3.1.1	3.1.2	3.2.1	3.2.2	3.3.1	3.3.2	4.1.1	4.1.2	4.1.3	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.3.1	4.3.2	4.3.3	4.3.4
WHO Western Pacific Region	Cambodia	■			■	■										■										■				■												
	Cook Islands	■	■			■																		■	■	■		■														
	Fiji	■	■		■			■				■														■	■	■		■												
	Kiribati	■	■		■	■																				■		■		■												
	Lao People's Democratic Republic	■			■	■	■	■	■																					■												
	Malaysia						■																																			
	Marshall Islands		■																							■	■															
	Micronesia (Federated States of)		■							■		■														■																
	Mongolia	■	■		■																																					
	Nauru		■			■																			■					■												
	Niue					■																																				
	Palau		■																							■	■															
	Papua New Guinea																													■												
	Philippines		■	■	■	■						■																		■												
	Samoa	■	■			■				■																	■														
	Solomon Islands		■			■						■														■				■												
	Tonga					■						■															■			■												
	Tuvalu		■			■																						■		■												
	Vanuatu	■	■			■																				■				■												
	Viet Nam				■	■	■					■		■										■						■												

A scientist stores malaria vaccines at a lab in Kisumu, western Kenya. © WHO/ Fanjan Combrink

World Health Organization
20 Avenue Appia
CH-1211 Geneva 27
Switzerland
Website: https://www.who.int
Website: https://extranet.who.int/uhcpartnership/reports
Email: jwt@who.int