Stories from the Field

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WHO MAGAZINE ON UNIVERSAL HEALTH COVERAGE (UHC)

World Health Organization

Powered by the Joint working team for PHC & UHC

#UHCPartnership

PRIMARY HEALTH CARE

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About the UHC Partnership

The Universal Health Coverage (UHC) Partnership is one of WHO's largest initiatives on international cooperation for Primary Health Care (PHC) and UHC. It promotes UHC through strengthening health systems by improving governance, access to health products, workforce, financing, information and service delivery, and enabling effective development cooperation in countries.

Since 2019, the UHC Partnership has expanded its technical support to include a special focus on non-communicable diseases and health security, while maintaining efforts in favour of health systems strengthening for UHC through a primary health care approach.

The UHC Partnership's aim is to build country capacity and reinforce the leadership of ministries of health to build resilient, effective and sustainable health systems in order to make progress towards UHC. It aims to bridge the gap between global commitments and country implementation and is part of the UHC2030 global movement to build stronger health systems for UHC.

The UHC Partnership is in its tenth year of operation. Since it started in 2011, it has evolved into a significant and influential global partnership working in 115 countries and areas in all 6 WHO regions, with the support of 9 significant donors. There are over 100 health policy advisors operating on the ground with support from WHO advisors in headquarters and regional offices and over 3 billion people benefiting from interventions that increasingly relate to community level, people-centred, integrated primary health care.

UHC Partnership and COVID-19

As soon as COVID-19 was declared a Public Health Emergency of International Concern in January 2020, the UHC Partnership, through the cooperation and agreement of all its donors, reprogrammed its funding and technical expertise to support countries in preparing for and responding to the pandemic. With countries at different stages of their response and each with distinct needs, flexibility in terms of funding and adapting to local contexts and changing priorities allowed WHO to deliver assistance in a timely manner, where it is needed.

The UHC Partnership is funded by

- The European Union
- The Grand Duchy of Luxembourg
- Irish Aid
- The Government of Japan
- The French Ministry for Europe and Foreign Affairs
- United Kingdom – Foreign, Commonwealth & Development Office
- Belgium
- Canada
- Germany

Welcome

to another special issue of WHO's stories from the field on universal health coverage (UHC)

These stories document how countries are reshaping their health systems amid one of the most devastating pandemics in history.

COVID-19 continues to highlight inequities within and across countries. The world's commitment to health as a human right will largely determine the sustainability of economies and societies as we build and rebuild, during the pandemic and far into the future.

Accelerating progress towards universal health coverage relies on greater investments in primary health care (PHC) to bring services closer to people. PHC best serves communities and empowers them to choose healthier lifestyles, prevent diseases or access early detection, treatment and recovery.

On World Health Day, 7 April 2021, WHO called on countries to invest in PHC, recommending a target of spending an additional 1% of GDP.

Cover Image Bagfeldshers of Tsagaannuur soum health centre travelled to reindeer herders to deliver health services, including MCH care, vaccination and elderly care. ©WHO/Mongolia

People-centred PHC, with equity in service delivery, ultimately paves the way for a fairer, healthier world for all. PHC is essential to an equitable recovery from the COVID-19 pandemic and to ensure that countries are better prepared to prevent and respond to future health emergencies. It is also the best way for countries to achieve UHC and the health-related Sustainable Development Goals.

The UHC Partnership, one of WHO's largest initiatives for international cooperation for UHC, is providing vital and timely support to enable countries to take advantage of the opportunity to emerge stronger from the pandemic. It is working to ensure that the investments made throughout the COVID-19 response will result in health system reforms that improve both health security and progress towards UHC.

The stories in this publication demonstrate the depth and breadth of work that WHO, through the UHC Partnership, is undertaking to achieve health for all. They document the results of collaboration with governments, communities and our partners.

Frontline health workers in Bijapur testing for Malaria by door-to-door house visits during the third phase of the Malaria Mukt Bastar Campaign. ©WHO/Dr Varun Kakde

Evidence reveals that PHC-oriented health systems have consistently produced better health outcomes, enhanced equity, and improved efficiency. Scaling up PHC interventions across low- and middle-income countries could save 60 million lives and increase average life expectancy by 3.7 years by 2030.

Contents

In all of these country stories, WHO country offices, with support from the UHC Partnership, has provided technical assistance and advice to each government's response to COVID-19 and has collaborated with other public and private sector partners to contribute to a coordinated response and enhance development cooperation.

Mongolia - 24

WHO Western Pacific Region

With its vast land area, Mongolia faces many challenges in delivering health services to disadvantaged and remote communities such as nomadic populations, migrants and unregistered people. Using mobile health technologies through a primary health care approach is proving to be a low-cost effective way to address inequities and ensure that everyone, everywhere can access the health services they need.

Sudan - 32

WHO Eastern Mediterranean Region

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

Uzbekistan - 40

WHO European Region

Even as it battles with COVID-19, Uzbekistan is maintaining strong momentum to reform its health system and provide quality, affordable health services to the entire population. The country is implementing an important transformation that will bring more robust people-centred primary health care and service delivery that protects the most vulnerable.

Zimbabwe - 48

WHO Africa Region

The COVID-19 pandemic has left many people in Zimbabwe unable to visit health clinics due to prevention and containment measures, and associated fears of contracting the virus. More than 80% of facilities reported a decline in uptake of essential health services, prompting the Government to take action to ensure people could get the services they need, and to step up action to maintain the safety of all frontline health workers and patients.

Caribbean

Boosting the capacities of nurses in critical care during COVID-19

Countries can only deliver universal health coverage if they have a strong, equitably distributed and well performing health workforce. With increasing numbers of patients needing intensive care treatment after COVID-19 struck, ministries of health in the Caribbean region needed to invest in boosting the capacities of nurses in critical care. With PAHO/WHO support, over 80 nurses in 7 countries received training that has improved the availably and quality of care for critical care patients.

Brittany Baptise is a nurse at the Scarborough General Hospital in Trinidad and Tobago, in the Caribbean. Today is her day off and she smiles as she describes how nervous she was when she learned that she would be working in an intensive care unit (ICU) to treat COVID-19 patients.

"I was a bit fearful because, coming from the medical ward, we didn't really know the rules and function of an ICU. I had no formal training, I had little knowledge about how the ventilator works, the settings and these things."

By the end of September 2020, Brittany was trained and working in the ICU with new skills and competencies to offer as part of an integrated team of health professionals. She was one of a cadre of 82 nurses across 7 Caribbean countries to take part in a 4-week training course to learn new skills and competencies to work in ICUs. These nurses are now making significant contributions to hospitals across the Caribbean providing critical care to COVID-19 patients.

The arrival of COVID-19 has severely challenged progress in this area

This is crucial to the achievement of universal health coverage (UHC), which is dependent on a sufficient, equitably distributed and well-performing health workforce. The arrival of COVID-19 has severely challenged progress in this area.

Urgent need for critical care nurses during the COVID-19 pandemic

In March 2020, the Caribbean Region recorded its first imported case of COVID-19. By mid-March 2021, there had been more than 100,000 confirmed cases, and some 2,000 deaths across 20 countries in the Caribbean. The pandemic exposed a range of weaknesses in country health systems and the health workforce; a key problem being a shortage of critical care nurses.

Registered nurses play an important role in the delivery of quality care to patients

Registered nurses play an important role in the delivery of quality care to patients especially in the critical care environment. With the rising numbers of new COVID-19 infections and associated complications, nurses had to be prepared to function at a higher level within the critical care clinical environment.

However, Ministries of Health in the Caribbean were challenged with a shortage of properly trained critical care nurses. It was clear that the numbers, skills and capacities of these nurses required boosting.

Recognizing the urgent need, the University of West Indies School of Nursing, a PAHO/WHO Collaborating Centre for Nursing and Midwifery, developed a course to equip nurses with the right skills and competencies to provide critical nursing care in ICUs.

Image 1 PAHO prepares Barbados for COVID-19 testing. ©PAHO/WHO Brenda Lashley

"The genesis of the course, the introduction to critical care nursing, was interesting. With COVID-19 as a pandemic, there was a need for scaling up of nursing personnel to respond to the pathophysiology of the disease. We were asked by the Ministry of Health in Trinidad and Tobago, to develop this programme, but when we recognized that this is an issue that was not just affecting Trinidad and Tobago, we decided to reach out to PAHO/WHO and ask for support," said Dr Oscar Noel Ocho, Director of the University of the West Indies School of Nursing.

"When we were approached about scaling up the training, we knew it was a great idea to take this on at the subregional level. Taking the training to scale allows all Caribbean countries to benefit from the shared knowledge and standardized approach to the training – it's a public good available to the entire Caribbean,"

Jessie Schutt-Aine, Subregional Programme Coordinator for the Caribbean

The PAHO/WHO Trinidad and Tobago Country Office supported the training of 2 cohorts of a total of 50 nurses from the Ministry of Health of Trinidad and Tobago. The PAHO Subregional Programme for the Caribbean, through the UHC Partnership, supported an additional cohort of 32 nurses from 6 other countries of the Caribbean: Antigua and Barbuda, Belize, Barbados, Dominica, Guyana and Suriname.

The UHC Partnership works in 115 countries and areas to help governments accelerate progress towards UHC with a primary health care approach, through funding provided by the European Union (EU), the Grand Duchy of Luxembourg, Irish Aid, the Government of Japan, the French Ministry for Europe and Foreign Affairs, and the United Kingdom – Foreign, Commonwealth & Development Office and Belgium. In 2021, Canada and Germany also joined the Partnership. In 2021, Canada and Germany also joined the Partnership.

Related work on health security

During the COVID-19 pandemic, PAHO and the UHC Partnership with additional funds from the EU, have supported health security and emergency preparedness activities in the Caribbean including strategic risk assessment, strengthening regulation and surveillance of medicines and vaccines safety and quality, and capacity building on the International Health Regulations (IHR 2005). Support has also been provided in the review of legislation to support implementation of public health measures, training to establish national emergency operations centres, and the development of epidemiological analysis capacity at the national and sub-national level.

Image 2 PAHO/WHO and Dr Oscar Noel Ocho, Director of the University of the West Indies School of Nursing, working together to support the Caribbean. ©PAHO/WHO
Image 3 Registered nurse, Rehemia Reyes, Head of Adult ICU at the Eric Williams Medial Sciences Complex. Preceptor for the ICU nursing course.©PAHO/WHO
Image 4 A patients with Lymphatic Filariasis at the Georgetown Public Hospital, Guyana. ©PAHO/WHO - Sonia Mey-Schmidt

2

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Critical care training in theory and practice

"The best part is that it is developed by the University of the West Indies for nurses in the Caribbean. That is really critical because it means that when nurses come out of this initial course, anyone anywhere in the Caribbean who is practicing can benefit, especially as it relates to COVID-19," said Dr Erica Wheeler, PAHO/WHO Representative.

The 4-week training was a combination of virtual sessions with face-to-face training in a clinical setting

The 4-week training was a combination of virtual sessions with face-to-face training in a clinical setting. The nurses took part in daily theoretical online sessions, and for one day a week they had face-to-face training in a critical care setting. The course covered clinical care for COVID-19 patients; foundations of critical care; management of respiratory conditions; renal dysfunction and replacement theory; epidemiology and infection control; management of neurological conditions; and the Critical Care Practicum.

In each hospital, the Ministry of Health identified a member of staff who acted as preceptor and provided mentoring and clinical supervision to the student nurses.

Nurses were totally unfamiliar with the ICU environment

One of the preceptors was Rehemia Reyes, Head Nurse of Adult ICU at the Eric Williams Medical Sciences Complex. "One of the challenges that we faced during this intensive care introduction is that nurses were totally unfamiliar with the ICU environment. For most of them, it was their first time to step into the ICU, which is very intimidating because of all the unfamiliar equipment," she said.

Already, changes are taking place with nurses actively working in ICUs in hospitals across the region. Nurses who have been trained are able to think critically about their work in the ICU, are no longer intimidated by the ward environment and equipment, are able to better assess patients and communicate more effectively with patients and colleagues. From a health systems perspective, the nurses have gained new skills, which they can transfer to general wards, and their additional capacities can facilitate task sharing and task shifting as an alternative to shortages of health care workers during the pandemic.

Michelle Edwards-Benjamin, Secondary Care Nurse Manager at Scarborough General Hospital, Tobago said, "This course has had a tremendous impact on the services that we offer here in Trinidad and Tobago. Firstly, it has increased the capacity of the staff to work in the ICU.

Image 5 Registered nurse, Rehemia Reyes, Head of Adult ICU at the Eric Williams Medial Sciences Complex. ©PAHO/WHO
Image 6 Nurses training. ©PAHO/WHO

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This course gave untrained staff a foundation

The course came at a time where we were moving from a 2-bedded ICU to a 5-bedded facility, and obviously with the increase in beds there was a great demand for staff. So this course gave our untrained staff a foundation, which they could use to build upon and enable them to work in the ICU. It really improved our competence, our capacities in our staffing and it also allowed us to provide a higher quality of care for our patients needing ICU care."

The impact will not only be in our ICU but it will also be to the wider nursing staff, because with these nurses gaining confident skills, knowledge and competence, it will also impact the care they give on the general wards, which means that our patients will benefit from improved outcomes. So it is fantastic."

Sherma Alexander Campbell, General Manager of Nursing of North West Regional Heath Authority, Port of Spain, General Hospital

WHO has declared 2021 as the International Year of Health and Care Workers in recognition of their dedication to providing care during the COVID-19 pandemic that has challenged health systems worldwide. Health workers, including critical care nurses are vital to health emergency responses and for health system preparedness and resilience.

This critical care training will also have an impact beyond the ICUs

Having greater numbers of skilled nurses means that more people can access the care they need and fewer will die. This critical care training will also have an impact beyond the ICUs and contribute to a stronger health system overall throughout the Caribbean.

60 SEC SUMMARY

Caribbean

Fact

A cadre of 82 nurses across 7 Caribbean countries - Antigua and Barbuda, Belize, Barbados, Dominica, Guyana, Suriname and Trinidad and Tobago – have received training to support critical care in intensive care units for COVID-19 patients.

Why it matters

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

Expected results

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

In practice

PAHO/WHO in collaboration with the UHC Partnership supported 82 nurses to attend a 4-week training course, and scaled up the capacity of the health workforce in the Caribbean during the COVID-19 pandemic and beyond.

World Health Organization

India - Chhattisgarh

Ensuring essential health services during COVID-19

India's ambitious programme to bring health services closer to communities by expanding comprehensive primary health care is gradually reaching the most remote and fragile areas of the country. In Chhattisgarh State, local communities are now able to access health and wellness centres near their homes. When COVID-19 struck, this network of primary health care centres served as a foundation for providing uninterrupted essential health services.

In the Mangalnar village in Bijapur district, Rajeshwari and her husband Gopi conceived a child after ten years of waiting. In early April, during a strict lockdown to combat COVID-19, Rajeshwari went into premature labour. She was just 24 weeks pregnant.

Thanks to the referral network in the district, she was promptly moved to the nearest community health centre where she delivered her baby safely. However, with a birth weight of a meagre 510 grams, the tiny baby's fight for survival had just begun. After close to three months of care in a sick newborn care unit at a district hospital and tele-mentoring from the experts at the Apex health care institute of the All India Institute of Medical Sciences in Raipur, she became the youngest preterm baby to survive in the region.

Rajeshwari

"Because of our bitter past we had almost given up hope, but thanks to the tireless efforts of the doctors and nurses, our daughter has miraculously survived."

The experience of successfully caring for this baby during a crisis such as COVID-19 has boosted the morale of health workers in Bijapur. After discharge, the family came back to the district hospital once for follow-up before moving to a relative's home in Bhilai, where the baby is doing well.


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Image 1 Chief Medical and Health Officer, Bijapur (centre) with District Health Coordinator, WHO (extreme right) visiting a Health Wellness Center @Office of Chief Medical and Health Officer, Bijapur, WHO
Image 2 From 510 grams on the fourth day of admission to 1.41 kg on the eightieth day of discharge. @District Hospital, Bijapur, Office of Chief Medical and Health Officer, Bijapur
Image 3 SHC Hiroli, Dantewada on the day of its re-opening, after being nonfunctional for nearly two decades. @Office of Chief Medical and Health Officer, Dantewada

Maintaining essential services during COVID-19

Bastar region, located in the southern part of Chhattisgarh in central India, is one of the most difficult to reach areas in the country. Six decades of violent insurgency has led to a lack of overall development. This, combined with dense forests, has made many of the areas unserviceable by health care workers. As a result, the region has some of the poorest health indicators in India, lagging behind national averages. But in recent years, the launch of the Transformation of Aspirational District Programme has helped the region make huge leaps in overall development, but the journey has just begun.

WHO is providing expertise to support and reinforce the Health and Wellness Centre programme

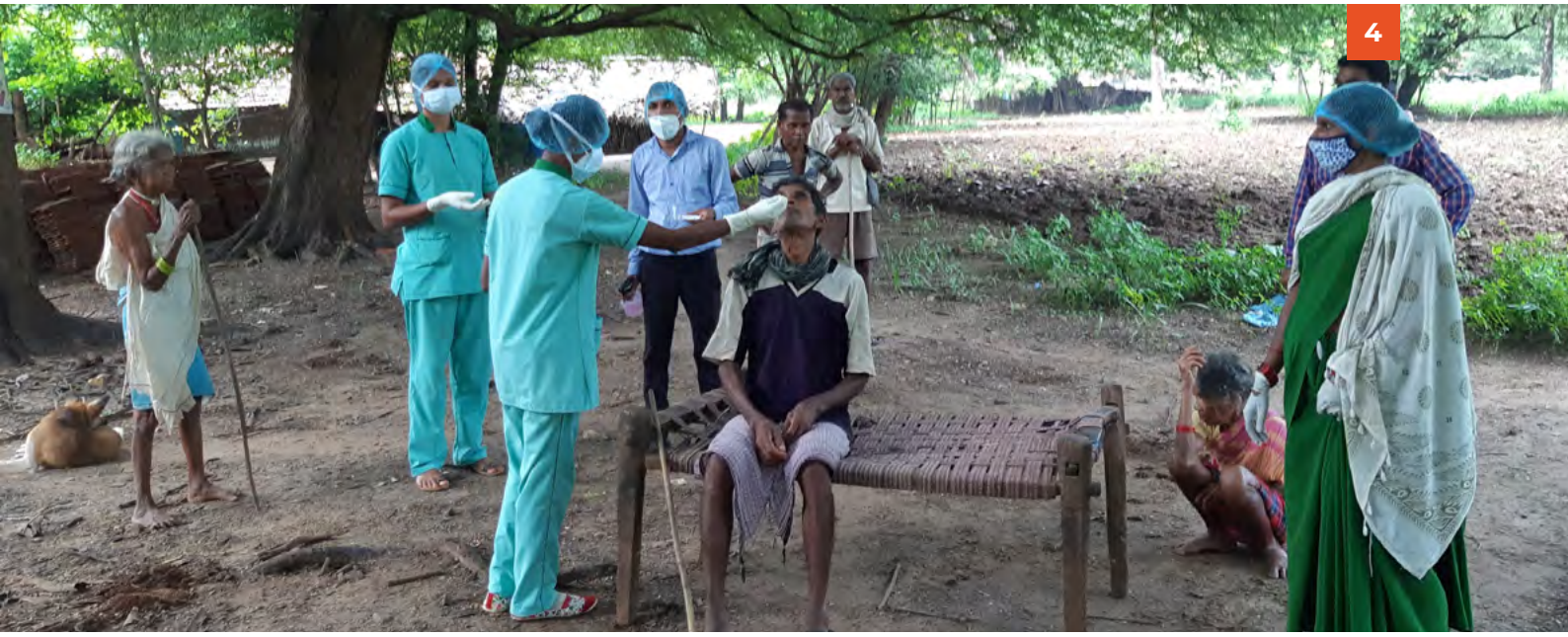
As part of its support to the state government of Chhattisgarh, WHO is providing technical expertise to the districts of Bijapur, Dantewada and Sukma in the Bastar region to support and reinforce the Health and Wellness Centre programme. This is part of WHO's assistance, through the UHC Partnership, to support equitable access to essential health services at sub-national levels, through major reforms to strengthen local health systems including primary health care, with a focus on marginalized groups.

"The proactive partnership between WHO and the state government of Chhattisgarh has been invaluable in progressing towards Universal Health Coverage. Successful continuation of essential health services in some of the most resource-constrained districts during the peak of the COVID-19 pandemic is a testimony of this collaborative approach. With continued technical assistance from WHO and other partners, Chhattisgarh is committed to improving the quality of care while expanding Comprehensive Primary Health Care in the state," said Dr Priyanka Shukla, Mission Director - National Health Mission, Government of Chhattisgarh.

"WHO India is proud to partner with the Chhattisgarh Government in providing technical mentoring, as a result, policy inputs are working well on the ground. Under the guidance of state government, collaborations between local administrations, WHO and the UHC Partnership are helping expand comprehensive primary health care in Aspirational Districts. Reorganization of essential services during the pandemic is one example of how such partnerships can help health systems in states adapt so that achieving UHC continues even in the most challenging situations," said Dr Roderico H Ofrin, WHO Representative to India.

The UHC Partnership works in 115 countries and areas to help governments accelerate progress towards UHC through funding provided by the European Union (EU), the Grand Duchy of Luxembourg, Irish Aid, the Government of Japan, the French Ministry for Europe and Foreign Affairs, the United Kingdom – Foreign, Commonwealth & Development Office and Belgium. In 2021, Canada and Germany also joined the Partnership.

In Bijapur, Dantewada and Sukma, up to 70% of women age 15-49 and children under five are anemic. The burden of



noncommunicable diseases (NCDs) is steadily rising with up to 8% of men and 7% of women age 15-49 years showing early symptoms of hypertension and diabetes.

Health and Wellness Centres at the PHC level provide a good platform for expansion

Health and Wellness Centres at the PHC level provide a good platform for the expansion of services to prevent and manage these conditions. Since early 2019, with technical support from WHO India, about 50% of existing sub health centres in all three districts have been upgraded to Health and Wellness Centres. This network of recently strengthened facilities are proven to be pivotal in providing uninterrupted essential health services during the COVID-19 pandemic.

The District Administration, with support from WHO, was keen to revitalize health infrastructure in villages affected by decades of violent conflict. Along with meticulous planning, this process demanded wide-scale collaboration between district administration, local community, village leaders and frontline health workers.

Collaborative efforts, coupled with the urgency created by the COVID-19 pandemic, helped make primary health care available in the most far-flung areas. Service delivery at sub health centres in Bedre in Bijapur, Hiroli in Dantewada, and Gachanpalli, Kolaiguda and Minpa in Sukma were revived and strengthened after remaining non-functional for nearly two decades. Each of these centres caters to a population of over 3,000, bringing primary health care closer to these vulnerable local communities.

Image 4 Health workers from Sukma district conducting COVID-19 community screening in Gorkha village.
©WHO/Dr Janmejaya Samal

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Capacity building

India has regularly demonstrated its commitment to strengthening its national health care system as well as its pandemic preparedness in order to detect and respond to public health risks, such as COVID-19. Over the past few years, the country has completed different exercises and reports, such as the State Party Self-Assessment Annual Reporting, designed to detect, assess, notify and respond to public health risks.

The impact of lockdown on essential health services was acute

In the initial weeks of COVID-19, along with fear and confusion in the community, the impact of a nationwide lockdown on essential health services was acute.

The facility-based care was brought almost to a standstill. However, this quiet period provided an opportunity to build the capacity of various cadres of health care workers in infection prevention and control protocols for COVID-19. WHO provided training support in Bijapur and Sukma, both districts facing widespread and severe health worker shortages, and the district administration also trained school teachers in active surveillance of COVID-19. This freed frontline health workers to be able to resume essential health services.

"The contributions of WHO during the COVID-19 pandemic have been immense. From technical support to capacity building, WHO's support has been indispensable. Collaboration with WHO facilitated strengthening of district health systems for delivering essential health services during the pandemic in addition to the operationalization of quarantine centres, fever clinics, and a dedicated COVID-19 hospital," said Dr Chandra Bhan Prasad Bansod, Chief Medical and Health Officer and Civil Surgeon, Sukma.

Reorganization of services in response to COVID-19

The recent expansion of services in the form of Health and Wellness Centres and mentoring support from WHO has enabled a much-needed reorganization of health services. Whether it was providing support to the maternal health programme through antenatal care, child immunization or supplying monthly dosages of medicines to patients with NCDs or diabetes, frontline health workers efficiently reorganized services for home-based care.

Armed with training on active surveillance and infection prevention and control protocols from WHO, auxiliary nurse midwives with help from community health volunteers known as 'mitanins' increased the frequency of home visits for surveillance of COVID-19 and other health needs.

Image 5 Fever clinic at a health facility in Sukma. Fever clinics were established outside health facilities, keeping in mind physical distancing protocols and to keep suspected cases of COVID-19 separate from the regular flow of patients. ©WHO/Dr Janmejaya Samal

Image 6 Rural Health Officer in Bijapur testing for Malaria by door-to-door house visits during the third phase of the Malaria Mukt Bastar Campaign. ©WHO/Dr Varun Kakde

Image 7 Health workers collecting blood samples from the community for COVID-19 a sero-surveillance study in Bijpaur. ©WHO/Dr Varun Kakde

A health call centre was established

With support from WHO a health call centre was established in Dantewada to ensure essential health services, and separate fever clinics were established at all secondary and tertiary levels of health facilities in three districts. This helped safeguard health workers from exposure to COVID-19. As a result of efforts to minimize the impact of the pandemic on essential health services, the number of antenatal care registrations in Bijapur, Dantewada and Sukma substantially increased from 1,496 in March 2020 to 2,238 in May 2020.

"Every village we provide services to has quite a few number of migrant workers put in home quarantine, we have to go visit them every day for COVID-19 surveillance. We use this opportunity to visit pregnant women registered with us and inform them that Health and Wellness Centres are fully functioning even in lockdowns so as not to miss date of their antenatal care visits."

Rashmi Kaware, Community Health Officer, Health and Wellness Centre, Health and Wellness Center Mingachal, Bijapur.

Essential health services at quarantine centres

Another pressing challenge was to screen, detect and to address the health needs of huge numbers of returning interstate migrants. Over a three-month period, the three districts together experienced an influx of approximately 50,000 interstate migrant workers who were accommodated in various quarantine centres. Duty rosters of school health teams, practitioners of Indian traditional medicines known as AYUSH providers, were reorganized to provide COVID-19 screening and essential health services at quarantine centres. WHO provided planning and mentoring support for the reorganization. These crucial actions allowed auxiliary nurse midwives, rural medical assistants and community health officers to use their time for providing essential health services.

Reaching the most marginalized with essential health services

While COVID-19 has inevitably presented new challenges to the people and the health system of Chhattisgarh State, it has galvanized solid local action to reinstate and strengthen primary health care services, building the foundation for UHC. The Government, with technical support and training from WHO, has worked hard to ensure that the whole population, even those in the hardest to reach places, are not left behind.

"Revitalization of the Sub Health Center Hiroli has bought primary health care near the community and now they don't need to travel 8km for their basic health needs. It will also build the community's trust in the public health system and motivate health care workers," said Rajesh Bhera, Rural Health Officer - Sub Health Center Hiroli, Dantewada.

60 SEC SUMMARY

India

Fact

In Chhattisgarh State, strengthening a network of health and wellness centres under the Ayushman Bharat programme, is pivotal in providing uninterrupted essential health services particularly during the COVID-19 pandemic.

Why it matters

In this region which has suffered decades of violent conflict, many primary health care services needed improvement. The population is largely vulnerable and there is high prevalence of anemia and noncommunicable diseases. Primary health care is the best way to ensure that they receive the support they need.

Expected results

In three districts of Bijapur, Dantewada and Sukma, the implementation of India's ambitious Health and Wellness Centre programme is being strengthened to provide primary health care services to all communities and help advance progress towards universal health coverage.

In practice

In association with the District Administration, WHO has provided training support and capacity building to reform primary health care systems to deliver essential health services to vulnerable communities during the time of COVID-19 and beyond.

World Health Organization

Mongolia

Mobile health clinics bring primary health care to vulnerable communities

With its vast land area, Mongolia faces many challenges in delivering health services to disadvantaged and remote communities such as nomadic populations, migrants and unregistered people. Using mobile health technologies through a primary health care approach is proving to be a low-cost effective way to address inequities and ensure that everyone, everywhere can access the health services they need.

Norov Bayarjargal, a local herder in the Gobi Desert, stands in front of a makeshift mobile health clinic in Dersene-Us, his native village in the southern tip of Mongolia. Beside him are two yurts and occasional herds grazing the land, but in the distance there is nothing but desert and sky for miles. Norov has just had a consultation with a mobile health team from the sub-provincial health centre, which visits herder communities in their own homes.

The mobile health team screens herders and their families for diseases

The mobile health team screens herders and their families for communicable and non-communicable diseases, signs of cholesterol and sugar in their blood and they offer ultrasounds for women. One month ago, through this service, Norov was diagnosed with gallbladder and kidney problems and was referred to the nearest local (sub-province or soum) health centre, where a specialist gave him the medicines he needed.

"Because of the mobile health screening, I was diagnosed early and received timely treatment. The health professionals advised me to cut down my salt and animal fat intake. I know that health is wealth and that I need to make healthy living choices now, irrespective of financial challenges," said Norov.

With a vast land area, Mongolia faces many challenges in delivering health services to its citizens especially those living in disadvantaged and remote rural areas, including vulnerable and nomadic populations, migrants and unregistered people.

From 2016-2020, the government operated an initiative called: 'Expanding use of mobile health technology in primary health care towards universal health coverage in Mongolia' or M-Health. It was supported by WHO, through the UHC Partnership and the Korea Foundation for International Health Care and Community Chest of Korea.

Primary health care providers are also noticing the difference that the M-Health initiative is making to the lives of remote populations.

"Thanks to the M-Health initiative, the quality and access to preventive health examinations among local people has improved in the last two years. In 2019, coverage of preventive health examinations reached 90% of the population. Most remote herders live 130 kilometres away from the soum [sub-province] health centre and health workers mainly reached them through the mobile health service delivery," said Dr Chuluuntsetsetseg Erdenechuluun, Head of the Mandakh Soum Health Center, Dornogobi Province.

Most remote herders live 130 kilometres away from the health centre

Mongolia is among the 115 countries and areas to which the UHC Partnership helps deliver WHO support and technical expertise in advancing UHC. The Partnership is funded by the European Union (EU), the Grand Duchy of Luxembourg, Irish Aid, the Government of Japan, the French Ministry for Europe and Foreign Affairs, the United Kingdom – Foreign, Commonwealth & Development Office and Belgium. In 2021, Canada and Germany also joined the Partnership.

Laying the foundations for equity

All the lowest administrative units in Mongolia have primary health care (PHC) facilities, making health services geographically, financially and administratively accessible. But there are challenges. Although Mongolia has 7,500 PHC providers who are working at 536 facilities, use of these local services is not optimal as communities tend to bypass them to access secondary or tertiary level care. The ongoing problem threatened to become more acute when COVID-19 arrived.

Recent investments in PHC for UHC, such as increasing the budget, introducing Social Health Insurance (SHI) financing for extending the PHC service package served as a critical foundation for the health system, allowing it to adapt to the pandemic scenario.

'Leave no one behind', was the driver to deliver PHC services

The principle of equity, or the ambition to 'leave no one behind', was the driver to deliver PHC services to the most disadvantaged, hard-to-reach populations in Mongolia. In times of COVID-19, reaching remote populations with the same level of engagement and communication as the rest of the country is vital.

WHO, through the UHC Partnership, has been working closely with the government since 2018 to strengthen PHC strategic financing and improve quality of care. This previous work has also been fundamental in laying the foundations for a stronger national response to COVID-19.

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Reaching remote groups through mobile health

Herders, due to their remote settings and lifestyles, are often unable to visit a soum or sub-province health centre. They are grateful that early diagnoses of diseases and subsequent consultations are available locally and that they have further examinations once a year, when needed.

"I was very appreciative that herders like me got screened for diseases at home, and I did not have to travel a long distance to get medical services," said a herder from Adaatsag Soum, Dornogobi Province.

> **"I was wondering why medical people came to my home, and then they explained it was for us to undergo for preventive ultrasound and ECG examinations. I was surprised that medical equipment had become such a small size."**
>
> Herder from Shiveegobi Soum, Gobisumber Province

The Mongolian State Policy on Health (2017-2026) identifies the "need to expand the use of mobile service and technologies at the primary health care level to better reach out to target groups such as people in remote areas and the poor and vulnerable populations".

The M-Health initiative is now being implemented in 21 provinces across Mongolia and 9 districts in Ulaanbaatar City. Bringing the initiative to urban areas is helping migrants from rural to urban areas who have lost their herds and livelihoods, and are particularly vulnerable.

People of all ages, including older people, children and adolescents are able to access M-Health services, especially those living in remote rural and urban areas.

As part of the initiative, PHC providers conduct integrated health services through three types of service delivery: home visits, mobile health services combined with home visits and health centre services. All these include health examinations, screening and health promotion activities related to maternal and child health, communicable diseases and non-communicable diseases. Mobile health services, in combination with home visits, are mostly used to reach disadvantaged communities, including herders, migrants, and low-income groups.

At the request of the Ministry of Health and local health organizations, WHO also supporting capacity building for integrated PHC service delivery so that patients get the quality people-centred care throughout their life-course, including prevention, treatment, rehabilitation and palliative care.

The Government of Mongolia, along with local governments, recognized the value and cost-effectiveness of reaching remote and disadvantaged populations. As a result, since 2016, this initiative has been expanded to another 121 local areas supported mostly by local governments and a few of them supported by development partners and private companies. In 2021, in order to maintain essential health services during the COVID-19 pandemic and beyond, WHO has been continuously providing support in other 63 remote areas.

Image 1 Mobile Health Team of Mandakh Soum Health Centre reached herders' homes. Mandakh soum, Dornogobi Province. July 2019. ©Mandakh Soum Health Centre, Dornogobi Province
Image 2 Khalkhgol soum health centre organized mobile health services at the soum centre. ©Khalkgol soum health centre, Dornod province

Dr Sergey Dioroditsa, WHO Representative to Mongolia

"Expanding use of mobile health technology at PHC has resulted in the M-Health initiative being a key component for outreach services during COVID-19 ensuring that services reach the unreached at national and subnational levels of the health system."

The M-Health initiative also contributes to stronger coordination, collaboration and integration of the various work programmes within WHO Mongolia and with various partners including the Ministry of Health, development partners, donors and other key stakeholders.

"The Government of Mongolia has committed to making PHC more responsive and equitable to the needs of the population. I would like to note that measures, taken by Ministry of Health with support of World Health Organization bring significant progress in the health sector towards achieving UHC," said Dr Sereejav Enkhbold, Minister of Health, Mongolia.

Responding to COVID-19

On 11 November 2020, the first local case of COVID-19 was confirmed in Mongolia and numbers reached 4,073 within four months. Compared to other countries around the region, Mongolia has had relatively low number of cases, with four reported deaths as of 18 March 2021. In order to prevent the virus from spreading, the government focused on risk communication and community engagement. COVID-19 has been a litmus test to the readiness of Mongolia's emergency response built over the last decade.

Based on lessons learned from SARS and H1N1, a multi-sectoral coordination and communication system was established for all types of emergencies. The foundation of Mongolia's strategy for COVID-19 has been solidarity, early preventative measures, strong coordination and partnership and a culture of continuous improvement.

Mongolia has been integrated into national and local general disaster management

Over the past years, Mongolia has demonstrated its commitment to strengthening and improving its pandemic preparedness efforts. Pandemic preparedness planning in Mongolia has been integrated into national and local general disaster management planning, processes and structures. Plans and processes have involved multiple sectors, civil society, NGOs, private sector and health cluster partners. In 2017, the country volunteered for a Joint External Evaluation (JEE) of its capacities to prevent, detect and respond to health emergencies. A formal

Image 3 Norov Bayarjargal, a herder of Nomgon soum, Umnugobi Province, received health services from the mHealth initiative. ©WHO/Mongolia
Image 4 Dr Ren Minghui, WHO Assistant Director-General, participated in a home visit organized by the Family Health Centre. "Undrakh Ireedui" Family Health Centre, Subdistrict #19, Chingeltei district, Ulaanbaatar. ©WHO/Mongolia centre, Dornod province
Image 5 Mobile health team of Gurvansaikhan soum health centre with herders. The Province Department of Health and WHO Mongolia team joined the local team in Gurvansaikhan soum, Umnugobi Province. ©WHO/Mongolia

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coordination system for preparedness and response to all types of public health events and emergencies was established in 2017. Since 2016 Mongolia has completed six Simulation Exercises (SimEx) to further develop, assess and test the functional capabilities of its emergency systems, procedures and mechanisms to be able to respond to outbreaks or public health emergencies, such as COVID-19.

"Thanks to WHO's continued support to prepare, strengthen multi-sectoral information sharing, management of resources, and workforce development, we didn't have any local transmission of COVID-19 until 11 November 2020," said Sayanaa Lkhagvasuren, Advisor on COVID-19 prevention to Mongolia's Deputy Prime Minister.

Primary health care and universal health coverage

Many health issues, as well as COVID-19, have the gravest impact on people who are socially, economically or geographically disadvantaged. Addressing equity and reaching those most in need of health services requires a strong focus on PHC for UHC, as a response to current and future health challenges. The UHC Partnership will continue to support the government with the expansion of telemedicine, mobile services and mobile and portable technologies at the PHC level, including rapid COVID-19 tests as a cost-effective measure. The Partnership will also support the strengthening of multisectoral collaboration to address health for all policies.

5

Mongolia

Fact

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

Why it matters

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

Expected results

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

In practice

WHO, through the UHC Partnership, has supported the strengthening of primary health care and the health system backed by adequate funding, strong health plans and evidence-based policies.

World Health Organization

Sudan

Community dialogues empower disadvantaged populations to decide on their health priorities

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

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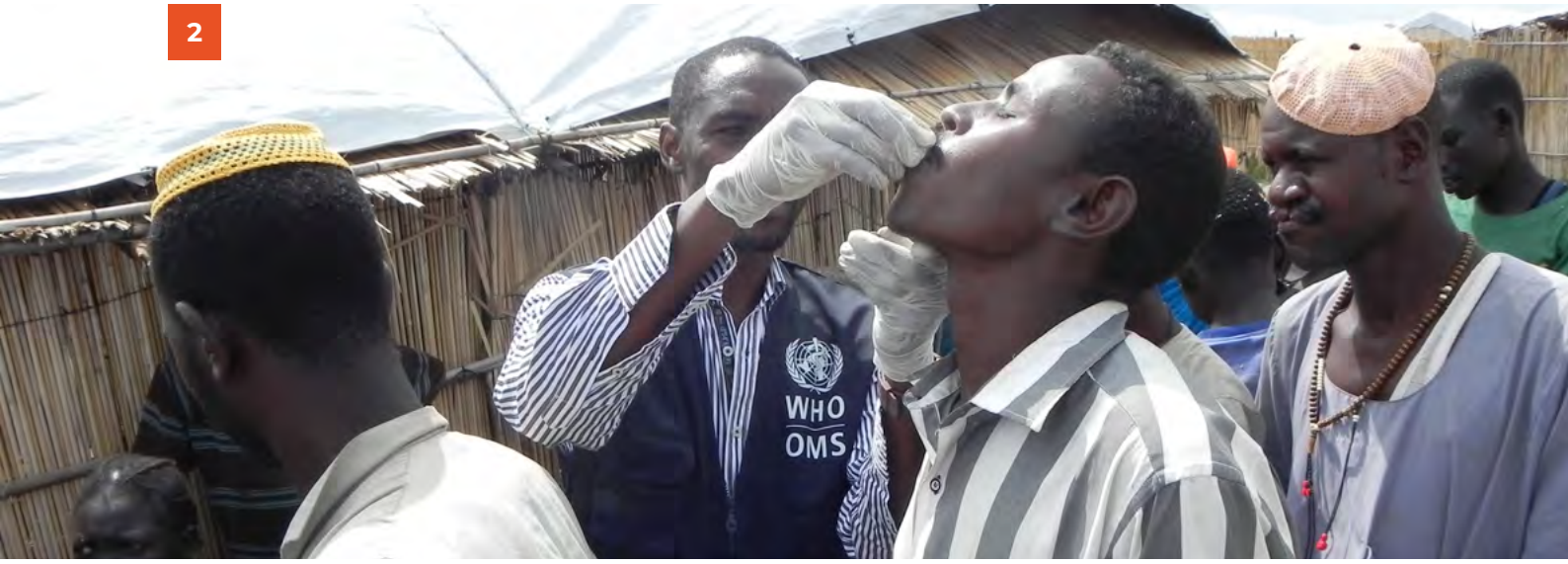

When violence erupted in Darfur in 2004, Bahja Ahmed and her five young children were forced to leave their village. They had spent 12 years living in a camp for internally displaced people (IDPs) in North Darfur State and returned to their home village in 2018 following the signing of the Doha Peace Agreement.

Our health centre was destroyed during the war

"We returned to our homeland with hope to regain what we lost during the conflict and displacement, but unfortunately we lack basic services. Our health centre was also destroyed during the war," said Bahja.

To obtain health care, she had to travel long distances by lorry or donkey to the nearest city and pay for services. She often could not afford it. "The only option for me was to use traditional and herbal medicines," she said.

WHO, through the UHC Partnership, underscores that supporting vulnerable communities in a post-conflict environment requires a meaningful and community-driven approach to find pragmatic and workable solutions. Working in close collaboration with the Ministry of Health and local health authorities, WHO has established a process to actively involve communities in improving local health services. Through regular participatory meetings between communities and local health authorities, people like Bahja and their families are now able to identify their health needs and priorities and support concrete steps to rebuild and improve services.

"This is the first time for somebody to visit us to discuss our health issues since our return. The dialogue with local officials provided a platform for us to discuss our health issues and activate the village health committee which had not meet for long time," said El Omda Adam, a community leader in Bahja's village, Darfur.

Image 1 Community health dialogue session. ©WHO/North Darfur Sub-office
Image 2 WHO team supporting Oral Cholera Vaccine. ©WHO/Khaled Sarour

Health equity means leaving no one behind

Community engagement is an important and integral process for any health system development effort, especially to improve health equity and achieve universal health coverage (UHC). Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those who are at the highest risk of poor health, because of their low socioeconomic conditions.

Sudan's Darfur region has faced many difficulties over the past decades

Sudan's Darfur region has faced many difficulties over the past decades, with its population suffering from the devastating impact of the war leading to death, disease and displacement for millions. Now, many people who previously fled to IDP camps are returning to their home villages. They arrive back to find little infrastructure remaining, and extremely limited health services available.

"The bottom-up approach is important to strengthen community engagement and to enable our societies to be part of the decision-making process. The community's role is a cornerstone towards attaining universal health coverage in Sudan," said Dr Arwa Gaddal, Director of states support and local health system strengthening Department, Federal Ministry of Health.

Poor social, economic and environmental conditions of these vulnerable and disadvantaged populations demand an urgent and effective response. WHO, through the UHC Partnership, has since late 2018, worked closely with the Ministry of Health, local health authorities and other partners and communities to bring people to build a healthier life for everyone in Sudan.

Community health dialogues bring together communities

Community health dialogues bring together communities, local authorities, local health partners such as non-government organizations and community-based organizations to discuss health priorities and concerns, and envisage a way to prioritize and plan for better health outcomes.

"Local communities know their priorities, therefore, it is important to engage them in the planning of health interventions to ensure ownership and full participation," said Dr Ni'ma Saeed Abid, WHO Representative in Sudan.

Sudan is among the 115 countries and areas to which the UHC Partnership helps deliver WHO support and technical expertise in advancing UHC with a primary health care approach. The Partnership is funded by the European Union (EU), the Grand Duchy of Luxembourg, Irish Aid, the Government of Japan, the French Ministry for Europe and Foreign Affairs, the United Kingdom – Foreign, Commonwealth & Development Office and Belgium. In 2021, Canada and Germany also joined the Partnership.

Image 3 Assessment of nutritional status of a child in an IDP camp in Darfur. ©WHO/South Darfur Sub-office

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Community engagement helps improve health outcomes

In West Darfur, a team from WHO, the Ministry of Health, the local health authority and the United Nations African Union Hybrid Operation in Darfur (UNAMID) visited four communities living in Kreinik, Mornie, Serba and ElGeneina in November 2020. The team held several in-depth discussions with each community and was guided by a questionnaire to identify gaps in the health services including promotive, preventive, curative, rehabilitative and palliative health care.

The community engagement approach has proven to be sustainable. It has been institutionalized through the local health authorities which now have greater capacities to regularly engage with local communities in setting the health agenda and monitoring implementation.

"Enhancing community engagement is a crucial element for building resilient local health and community systems to respond to the needs of the population, particularly underserved and disadvantaged groups such as IDPs, returnees and rural communities. Our experience in institutionalizing the community health dialogues proved that local communities could contribute to addressing health system bottlenecks. For example, the inequitable distribution of frontline health workforce is being addressed by providing retention packages."

Dr Imadeldin Ismail, Coordinator UHC/Health Systems Strengthening Unit, WHO Country Office in Sudan.

In all communities, the team and the community members discussed health challenges, epidemics and crises in the area, as well as the response and performance of the health team and coordination mechanisms. The communities made suggestions to improve the performance of the health team. In turn, the health team proposed what the community could do to contribute to better health outcomes in the locality.

The meetings concluded with a summary of community recommendations

The meetings concluded with a summary of community recommendations to be implemented and monitored, some of which were instigated and supported by the communities themselves. For example, one of the main barriers to accessing health services is the lack of health workers in rural areas, often due to poor retention. Some communities, as a result of community dialogues, created incentives for health workers to stay and work locally, such as giving them housing, water and agricultural land.

"Community health dialogues are a very powerful tool towards community stabilization and empowerment to address root causes of violence and instability in Darfur and other parts of the country. This approach is very much in line with the mandate of the African Union United Nations Hybrid Operation in Darfur (UNAMID)," said Ezzedin Adam, Community Stabilization Officer, UNAMID.

Health empowerment in the Durti community

The Durti community in El Geneina is a strong example of health empowerment. The community identified several key issues: medicine shortages, environmental problems due to the manufacturing of bricks in residential areas, stagnant water everywhere, which contributes to the spread of tropical diseases such as malaria, open defecation, lack of drinking water, maternal and childhood health issues, and kidney problems among others. There are no public health or nutrition health workers in the area. While the community participated in cleaning campaigns and sensitization visits to houses, they had never been engaged in identifying their own health priorities or taken part in planning. Although the health committee existed, it had never been active.

The team supported the Durti community to activate the health committee to act as a community representative body and an early warning mechanism. The committee could work closely with the health team to set the community's health agenda, prioritize, plan and raise awareness. The team also discussed the importance of the community volunteering to solve some of the more urgent health issues relating to the environment such as removing stagnant water and fumigation.

The newly functioning health committee also followed up with the locality executive director to get support with fumigation and also to move the brick manufacturing operation to outside the residential area. The community also organized and paid for a donkey-drawn cart to take away rubbish from a central area, located near the health clinic. This will contribute to better health conditions particularly reduction of morbidity and mortality related to diarrhoeal and other water- and vector-born diseases.

With future funding and support, this community engagement process will be replicated

With future funding and support, this community engagement process will be replicated in ten other states in Sudan. The dialogues and subsequent action will further promote health equity, and support Sudan in accelerating the achievement of UHC as it rebuilds and simultaneously tackles COVID-19—its current major health challenge.


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Responding to COVID-19

The COVID-19 crisis has exacerbated existing vulnerabilities in the population and further compromises Sudan's efforts to build its democracy, economy and other systems including the health system. Health services are already overstretched and risk collapse.

The COVID-19 crisis has exacerbated existing vulnerabilities in the population

Water and sanitation coverage is poor, and approximately three million children remain out of school. Sudan has simultaneously battled outbreaks of diphtheria, malaria, chikungunya and polio from January to October 2020. The pandemic adds to the challenges of internal conflicts, political instability, economic crisis, climate change, natural disasters, disease outbreaks and gaps in basic service provision.

Sudan had its first community-acquired case of COVID-19 in March 2020, and the government announced a national health emergency. WHO worked to enhance coordination mechanisms with health partners, bringing in development partners and the humanitarian cluster to draw and mobilize resources to support the national COVID-19 response plan. The European Commission was a strong supporter of the humanitarian-development nexus, to strengthen the health system to respond to the pandemic, and the UHC Partnership has played a key role to engage partners and ensure a strong national response to COVID-19.

Sudan has faced several concurrent health emergencies and outbreaks in the past few years including dengue fever, chikungunya, rift valley fever, diphtheria, measles and circulating vaccine-derived polioviruses. Sudan organized the Joint External Evaluation (JEE) in 2016, and gaps identified by the JEE were translated in to the Sudan National Action Plan for health security (NAPHS). As part of the monitoring framework of International Health Regulations (2005), Sudan successfully conducted reviews for several declared public health events including Rift Valley fever, cholera and COVID-19. Several international actors (Italian Corporation, EU, Germany and Norway) are supporting Sudan to improve core capacities required by the IHR (2005) but still the NAPHS is highly underfunded.

Health equity is fundamental for UHC

The experience of community engagement in Sudan shows how empowering communities helps them to identify and prioritize their health needs and the issues that make it harder for people to live healthy lives and obtain the health care they need. Community dialogues provide the space and opportunity for communities to speak up, take responsibility for their health, to hold local health authorities and teams accountable, and to act as an early warning system in times of crisis.

Image 4 Community health dialogue in Abu Gao village, North Darfur State with active participation of women and youth. ©WHO/North Darfur Sub-office

Image 5 WHO team checking water quality in a village in Darfur. ©WHO/El Monshawe

Sudan

Fact

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

Why it matters

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

Expected results

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

In practice

WHO, through the UHC Partnership, is working hand in hand with the Ministry of Health, local health authorities and other partners to institutionalize community engagement in the primary health care based health system, crucial in moving towards universal health coverage and peace.

World Health Organization

Uzbekistan

Strengthening its health system in the midst of COVID-19 crisis

Even as it battles with COVID-19, Uzbekistan is maintaining strong momentum to reform its health system and provide quality, affordable health services to the entire population. The country is implementing an important transformation that will bring more robust people-centred primary health care and service delivery that protects the most vulnerable.

Dilshod Soliev, 40, has a kidney problem that has required him to undergo hemodialysis on a regular basis for the past few years at the Syrdarya regional hospital in Uzbekistan.

"It was difficult to receive the care I needed. I waited in long queues, and single-use devices and filters were not available. I had to wait a week to receive test results," Dilshod said.

The government is promoting a renewed emphasis on population health management

Now, hope for more effective health care closer to the community is on the way for Dilshod and many others with chronic conditions. The government is promoting a renewed emphasis on population health management where family physicians with a teams of nurses will play a central role in prevention of chronic diseases, early detection and long-term care.

Strengthened primary health care (PHC) teams with rationalized hospital care and the optimal joint use of resources will lead to successful health system reform. A Syrdarya Oblast multiprofile centre is part of a pilot project to strengthen health service delivery. More importantly, the lessons learned from the project will inform the rollout of effective services at community-based levels across the whole country.

Dr Azam Kholmatov works in the Syrdarya Oblast multiprofile centre and said, "I am proud that my region was selected as pilot site for the health systems reform. With the implementation of state health insurance and planned changes, more people in Uzbekistan will be able to receive better quality services under this benefit package."

Reforming the health system to achieve UHC

Uzbekistan's health system required reforms in three areas: quality of services, equity in health financing and efficiency in health spending. From 2019-2025 the government is embarking on a far-reaching and ambitious reform agenda with an overall objective for Uzbekistan to improve the health of the whole population through universal health coverage (UHC).

WHO, through the UHC Partnership, has provided technical support to the government throughout the process, to lay the foundation for a strong and sustainable health system. Uzbekistan is among the 115 countries and areas to which the UHC Partnership helps deliver WHO support and technical expertise in advancing UHC with a PHC approach. The Partnership is funded by the European Union (EU), the Grand Duchy of Luxembourg, Irish Aid, the Government of Japan, the French Ministry for Europe and Foreign Affairs, the United Kingdom – Foreign, Commonwealth & Development Office and Belgium. In 2021, Canada and Germany also joined the Partnership.

The government's intention is to scale up these reforms

WHO supported the development of a legal foundation for the health system transformation, including a Presidential Resolution establishing mandatory health insurance and a strategy for piloting service delivery reforms in Sydarya Oblast.

The government's intention is to scale up these reforms to the entire country by 2025. This includes:

- Strengthening service delivery in PHC to ensure that patients are treated more efficiently, without always having to go to a hospital, closer to their communities.
- Establishing a State Health Insurance Fund to finance a guaranteed package of PHC services and reduce out-of-pocket expenses, and
- Restructuring service delivery systems in public hospitals to address high expenditure associated with tertiary level facilities.

It is expected that these reforms will contribute to effectiveness and responsiveness, equity and efficiency, and, in turn accelerate progress towards UHC.

Syrdarya Oblast at the forefront of reform

Primary health care reforms are central to addressing issues of health inequity in Uzbekistan. The country has a large and fragmented network of single-disease hospitals and specialist clinics that complicated efforts to use health resources efficiently. There was a heavy dependence on hospitals for health care services, partly due to under-resourced PHC centres and low uptake of outpatient services. The system needed to enhance quality of care, good management and strategic governance. The limited capacity to deliver services at community level and to ensure access for vulnerable populations contributed to serious health and financial inequities.

The new service delivery reforms promote the provision of PHC services

The new service delivery reforms promote the provision of PHC services that are evidence-based. They also expand the role and functions of family physicians, nurses and other health care professionals in early detection and health services for disease prevention.

Syrdarya Oblast is at the forefront of these latest reforms and will operate a pilot project from June 2021 to the end of 2022. It comprises five components of a new model including health service delivery, health governance and management, health financing, digitalization and project management. The first results of the pilot will be gradually replicated in other regions of the country in 2023-2025.

"Within the framework of this pilot project, a state-guaranteed package of free medical services and medicines will be approved, multi-professional teams of medical specialists will be formed, and a unified e-platform for monitoring the population's health will be established," said Azizov Abdulla Abdusalamovich, Deputy Minister of Health of the Republic of Uzbekistan.

The key goal is to improve the coverage and quality of services, while reducing the financial hardship of patients. Every person in the region needs to be aware of her or his health rights, with access to a state- guaranteed package of services. Already, previous efforts to reform PHC has had a number of positive impacts in the country, with good geographical access to PHC services achieved, even in rural areas. But there is still much more to be done to eliminate inequities and improve access to quality, affordable services at the community level.

Image 1 An Uzbek mother holds her small child. The Government of Uzbekistan aims to improve the health of the whole population through achieving universal health coverage. © WHO/Malin Bring
Image 2 Dilshod Soliev has visited the Syrdarya regional hospital in Uzbekistan on a regular basis for the past few years. ©WHO/Elena Tsoyi
Image 3 A nurse holds a baby in a primary health care clinic in Uzbekistan, where routine immunizations for children are taking place. ©WHO/Anna Usova
Image 4 A mother and her two children visit a health professional in a primary health care centre. ©WHO

"In 2019, as the leader of the Syrdarya regional health department, I was invited to a Ministry of Health policy dialogue of health system reform. At this meeting, recommendations for comprehensive reforms were presented, and my region was asked to pilot those reforms. When I first heard about creating multi-profile teams at the primary care level, limiting access to narrow specialists and restructuring the hospital sector, I was opposed. I simply could not see how such ambitious reforms could be implemented,"

recounted Dr Rustam Yuldashev, Head of the Regional Health Department in Syrdarya. He has been an active participant in the transformation of ambition and practice.

"Now, after one and a half years of joint work, of the Ministry of Health with the Ministry of Finance, and other ministries, and with the support of WHO, I am convinced. Together, we have developed, step-by-step, a new model for delivering services, supported by a new model of financing them. I am fully committed to leading the pilot project in Syrdarya region."

Dr Rustam Yuldashev, Head of the Regional Health Department in Syrdarya

A Syrdarya team of health specialists is heavily engaged in the pilot project design. With high-level government and WHO support through the UHC Partnership, the team has helped build local capacity through training of trainers and mentoring visits.

"The health workers of Syrdarya are very proud to be at the frontline of this reform. It is a huge responsibility – the responsibility to show health workers across Uzbekistan, and all the people we serve, what the path towards universal health coverage can look like," added Dr Yuldashev.

In the future, PHC centres will be equipped with medical brigades comprising a family physician as well as nurses and midwives. At the later stage of the reform, centres will also be equipped with multi-disciplinary teams to better prevent and tackle noncommunicable or chronic diseases and to ensure the integration of social care and public health services at PHC level.

PHC networks or "unions" will also share health resources and work between outpatient centres and primary hospitals to ensure integration, optimal and efficient usage of resources and avoid duplication of service delivery. These reforms in service delivery are supported by a shift in the way services are purchased, moving away from payments for inputs among individual providers to payment for outputs among networked providers. Instead of facilities receiving line-item budgets for staff and supplies, a union of PHC providers will receive a flexible payment for each person registered in the district it serves, and for each admission.

Image 5 A group of nurses and midwives learn maternal care skills with a mannequin. Through service-based practical training, nurses and midwives play an important mentorship and leadership role in consolidating the knowledge, skills and judgment of new staff. © WHO/Maggie Langins
Image 6 A person in a WHO vest talks to a health professional at the entrance of the National Perinatal Centre in Tashkent, Uzbekistan. An ambulance is parked behind them. © ???
Image 7 xxxx

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Health sector reform in the midst of COVID-19

Reforms were underway when the COVID-19 health crisis emerged. Uzbekistan had its first confirmed case on 15 March 2020 and by the start of 2021, had recorded over 77,000 cases with 614 deaths.

WHO worked with the government to develop a strategic preparedness and response plan for COVID-19. WHO and its partners also provide support to the government in the areas of risk communication and community engagement, country operations, logistics and procurement, emergency public health measures, clinical and health interventions, surveillance and laboratory support.

To maintain the momentum of the important transformation of the health system, WHO, in part through the UHC Partnership, participated in high-level meetings, facilitated technical working groups, shared guidelines and good practices, and continued to review and revise draft legislation. To allay government concerns about implementing service delivery and health financing reforms in the midst of a pandemic, WHO provided additional evidence and facilitated several rounds of discussion.

Dr Lianne Kuppens, Representative of the WHO Country Office for Uzbekistan said, "In the spirit of collaboration embodied by the UHC Partnership, intersectoral action led by the President's Administration has been key to the adoption of such comprehensive reform in delivery and financing, and now, its implementation. WHO has worked closely with the whole of the Government of Uzbekistan, almost daily, from instant messaging to formal dialogue and training, and virtually, when that was the only option available."

The process of rebuilding consensus within the Government of Uzbekistan provided an opportunity to further engage other health development partners in the Syrdarya pilot. WHO convened regular meetings with all health development partners, as well as ad hoc meetings with key partners in health financing such as the World Bank, Asian Development Bank and German Development Bank. These partners joined WHO in expressing support for the reforms and commitment to collaborate in their implementation.

In addition, the National Action Plan for implementing the International Health Regulations (IHR 2005) was approved by the Ministry of Health in January 2020 and the country is moving forward with practical steps. Uzbekistan requested a Joint External Evaluation (JEE) of IHR, which provides a great opportunity for the country to identify possible gaps in all areas of emergency health system preparedness, including developing joint national action plans, strengthening multi-sectoral coordination mechanisms, establishing Emergency Operation Centres and other important emergency preparedness components.

This emergency preparedness, along with the broader health system reforms taking place, will better protect Uzbekistan from epidemics and other health emergencies in the future. Deploying health resources at the PHC level will alleviate the burden on hospitals and support the management of risk factors that may complicate the prevention and treatment of outbreak diseases.

Moving towards people-oriented PHC, with equity in service delivery, supports health security and a resilient health system, and ultimately paves the way for a fairer, healthier society.

60 SEC SUMMARY

Uzbekistan

Fact

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

Why it matters

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

Expected results

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

In practice

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

World Health Organization

Zimbabwe

Data-driven decisions maintain essential health services during the COVID-19 response

The COVID-19 pandemic has left many people in Zimbabwe unable to visit health clinics due to prevention and containment measures, the national lockdown and associated fears of contracting the virus. This means they have missed out on services such as immunization, reproductive and maternal health, prevention and treatment of chronic diseases. More than 80% of facilities reported a decline in uptake of essential health services, prompting the Government of Zimbabwe to take action to ensure people could get the services they need, and to step up action to maintain the safety of all frontline health workers and patients.

Lilosa Muti's 6-week old baby, Joshua, was due to have his rotavirus and Penta vaccine, which protects against diphtheria, tetanus, whooping cough, polio and other serious diseases. But Lilosa had no intention of taking him to his appointment at the health clinic at Bikita Rural Hospital in Masvingo Province, Zimbabwe.

"I was scared my son might be infected with COVID-19 if he visited the hospital. We have had 3 reported COVID-19 cases in Bikita and rumour has it one of the cases had visited the hospital before," explained Lilosa.

She was surprised to learn that all services were available

Thankfully, a village health worker spoke with Lilosa and allayed her fears. Two days later, she visited the hospital where she was surprised to learn that all services were available. On arriving, Lilosa and baby Joshua underwent the COVID-19 pre-screening process before the appointment and then Joshua received all his vaccines.

Claretta Majova, a specialist in integrated management of childhood illness, was the nurse on duty. She followed the standard operating procedures during COVID-19, including Infection Prevention and Control (IPC), as prescribed by the Ministry of Health and Child Care (MoHCC). She also took the opportunity to disseminate messages to encourage behaviours that reduce the transmission of COVID-19. She expressed concern about the general lack of attendance.

We have experienced a huge decrease of clients coming to the hospital for essential services

"We have experienced a huge decrease of clients coming to the hospital for essential services such as vaccines. This has been due to the national lockdown, which restricted movements in March, 2020. In addition, the communication gap in Bikita was filled with misinformation, which led residents like Lilosa to not visit the hospital to vaccinate her baby," said Claretta.

This situation is replicated right across Zimbabwe, with a decline in people accessing essential services in health facilities in all 10 provinces. Yet these are crucial for their health and wellbeing.

WHO, with support from the Universal Health Coverage Partnership, has worked closely with the MoHCC and provided technical assistance to strengthen the delivery of essential health services at rural, district and provincial health facilities prior to and during the COVID-19 pandemic. The MoHCC, with technical guidance from WHO, developed a tool to monitor disruptions of the delivery of essential health services caused by industrial action. The MoHCC conducted a field test and trained health workers to use the tool before it was adopted and implemented.

Image 1 Lilosa Muti holding her six week old baby, Joshua, as she waits to get attended to at Bikita Rural Hospital, Zimbabwe. ©WHO/TatendaChimbwanda
Image 2 Claretta Majova, a specialist in Integrated Management of Childhood Illness Nurse at Bikita Rural Hospital, Zimbabwe. ©WHO/TatendaChimbwanda

As a result of the routine monitoring tool, the MoHCC was able to receive data that enabled them to identify and address the challenges affecting delivery of essential health services. For example, they embarked on integrated outreach and ensured health care workers had access to much-needed personal protective equipment (PPE) according to the findings of the IPC assessment. The routine monitoring of health services report was used to inform the prioritization of fieldwork on the Rapid Assessment of continuity of essential services and to triangulate the results of the assessment.

"We envisioned having a system that gives us real-time data; a robust weekly routine monitoring system that rides on an existing system, in this instance the District Health Information System, forming part of the weekly disease surveillance report."

Dr Rugare Kangwende, Director of Monitoring and Evaluation, MoHCC

Outreach efforts are communicating with communities to reassure them

Village health workers and primary health care (PHC) outreach efforts are communicating with communities to reassure them about the safety and need to access essential services.

Zimbabwe is among the 115 countries and areas to which the UHC Partnership helps deliver WHO support and technical expertise in advancing UHC with a primary health care approach. The Partnership is funded by the European Union (EU), the Grand Duchy of Luxembourg, Irish Aid, the Government of Japan, the French Ministry for Europe and Foreign Affairs, the United Kingdom – Foreign, Commonwealth & Development Office and Belgium. In 2021, Canada and Germany also joined the Partnership.

Protecting people and health workers

Providing essential health services during a crisis like the COVID-19 is a challenge, even in well-developed health systems. All countries deeply affected by the pandemic have struggled. For Zimbabwe, as elsewhere in Africa, the need to continue non-COVID-19 services such as immunization, access to medicines, sexual and reproductive health including treatment of HIV, and diagnosis and treatment of non-communicable diseases (NCDs) is vital.

"Equity is a key concern. COVID-19 has the greatest impact on communities that are already vulnerable and marginalized, especially those with high levels of diseases and which have less access to essential health services. The principles of UHC still hold in a pandemic. We must always meet the health needs of the most vulnerable at all times," said Dr Alex Gasasira, WHO Representative in Zimbabwe.

Frontline health workers and patients also need to be protected

Frontline health workers and patients also need to be protected in times of crisis but this is not an easy task. Providing safe health services during a pandemic requires PPE for health workers, proper entrance screening for COVID-19 and triage systems for patients. However, according to a survey WHO conducted in Zimbabwe, 22% of all health facilities did not have this screening point in place and 25% of facilities lacked an isolation room. Where facilities did have screening points, some were devoid of health workers or had inadequate supplies of PPE.

Even before COVID-19, the Zimbabwean health system already faced serious challenges

Even before COVID-19, the Zimbabwean health system already faced serious challenges with health workforce shortages, low staff morale and infrastructure in need of upgrading. The impact of COVID-19 was further compounded by protracted industrial action leading to the disruptions of primary health centre provision in Harare and some other provinces.

Preparation and response to COVID-19

Zimbabwe reported its first case of COVID-19 on 20 March 2020. Within one year, the country has recorded 36,717 cases and 1,516 deaths as of 23 March, 2021.

For a country like Zimbabwe, which had a weakened health system, the public health response was a challenge. The COVID-19 pandemic exposed gaps in even the most advanced economies, demonstrating even more how the resilience of all countries to cope with emergencies depends heavily on the strength of their health systems. WHO supports countries to strengthen health emergency preparedness capacities before a crisis even occurs.

Image 3 WHO Country Representative Dr Alex Gasasira (right) handing over clinical equipment to support the COVID-19 response from the African Development Bank to MoHCC Deputy Minister (left) Dr John Chamunorwa Mangwiro. ©WHO/Kudzai Tinago

Zimbabwe, under the International Health Regulations (IHR) 2005, had reported on its capacities to develop and maintain core public health capacities by completing the State Party Self-Assessment Annual Report in both 2018 and 2019. In 2018, the government also conducted a simulation exercise to help develop, assess and test its capabilities to respond to outbreaks or public health emergencies and conducted a multi-sectoral Joint External Evaluation to identify critical gaps in the health system.

When COVID-19 arrived in Zimbabwe, the government developed an emergency response and preparedness plan comprising 8 pillars, one of which was case management and continuity of essential health services. It aimed to ensure that essential service delivery did not grind to a halt as a result of the pandemic.

To support Zimbabwe on this front, WHO, through the UHC Partnership, collaborated with a range of Global Health Initiative partners including UNICEF, UNFPA, UN Women and Africa Centres for Disease Control and Prevention.

"To mitigate the impact of COVID-19, the MoHCC with support from UNICEF, WHO and other partners have developed and rolled out service continuity guidelines which include integrated outreach services across all 10 provinces to compliment community-based services offered by village health workers. The integrated outreach activities use the primary health care approach to bring services closer to people. It is anticipated that owing to the scale up of integrated outreach services (commencing September 2020 as a COVID-19 response measure) the essential services indicator coverage will continue to improve to pre-COVID-19 levels," said Dr Paul Ngwakum, UNICEF Zimbabwe Chief of Health and Nutrition.

In October 2020, with support from the UHC Partnership and other partners, the MoHCC conducted a national rapid assessment of the continuity of essential health services in all 10 provinces of Zimbabwe.

The assessment sought to identify the state of service delivery in communities and any bottlenecks to effective service provision for both COVID-19 cases and other essential services. It also reached out to provincial and district implementers with technical support to solve the related problems they were experiencing.

The assessment found a decline in access to essential health services in all 10 provinces as a result of COVID-19. Overall, 6% of all health facilities were completely closed, and 86% reported a decline in attendance. Reasons for the decline of service use included the general situation of the national lockdown and the spread of misinformation, along with fears of catching COVID-19 at health facilities circulating among community members. Health workers were also afraid of contracting COVID-19, exacerbated by a lack of PPE and information. Inadequate capacity and a failure to provide outreach services to the population also heightened the problem.

Image 4 Children washing thier hands during MDA. @WHO/Tatenda Chimbwanda
Image 5 A woman getting her family planning pills at Mpilo Hospital in Bulawayo. ©WHO/Tatenda Chimbwanda
Inage6 Baby Joshua getting vaccinated. ©WHO/Tatenda Chimbwanda
Image 7 Health care workers administering medication for worms in Mt Darwin.©WHO/Tatenda Chimbwanda


4
Children


5
zbc
NOTICE


6


7
Do you think you have TB?
Together we can reduce the risk of COVID-19

Information-driven systems help improve access to essential health services

In August 2019, prior to the pandemic, WHO, through the UHC Partnership, worked with the MoHCC to develop a tool for the weekly routine monitoring of health services. This was a means to track the continuity of essential health services. WHO trained MoHCC staff at central, provincial and district hospitals and at primary care facilities on how to use the weekly routine monitoring tool.

The tool collects information from all primary and secondary health facilities nationwide

When the COVID-19 outbreak began, the MoHCC, with support from WHO, updated and adapted the tool to the new context. This followed requests from several partners for rapid assessments. However, the MoHCC needed a robust and sustainable system, building on the existing system. The tool collects information from all primary and secondary health facilities nationwide including data on work attendance by health personnel, patients visits to outpatient and casualty emergency departments, patient admissions to hospitals, major operations, renal dialysis sessions, family planning services, postnatal care, institutional and complicated deliveries and antenatal care attendance. It further collects data on institutional and community deaths, immunization and vitamin A supplements, tracer medicines status and tuberculosis diagnosis. It also finds information on HIV testing and viral load, COVID-19 testing and availability of PPE.

Ideally, the weekly routine monitoring of health services report forms part of the weekly disease surveillance report and meetings that are conducted to help identify disruption in service provision and appropriate interventions that can then be instituted with examples of good practice shared across health facilities. On a quarterly basis, in-depth explanatory and exploratory analysis is done.

Life-saving decisions rely on robust and timely data

COVID-19 is a strong reminder that the continuity of essential health services needs to be part of a pandemic response and ensuring health security. Protecting the most vulnerable in times of calm or crisis is one of the core principles of UHC, and relies on equitable and resilient health systems. People having the right information at the right time makes all the difference in saving lives, providing treatment and preventing disease. Monitoring and analysis of health systems functions followed by practical support is crucial to the decision-making process across the health system.

Protecting the most vulnerable in times of calm or crisis is one of the core principles of UHC

60 SEC SUMMARY

Zimbabwe

Fact

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

Why it matters

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

Expected results

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

In practice

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

World Health Organization

“We cannot build a safer world from the top down; we must build from the ground up [...] It starts with strong primary health care and public health systems, skilled health workers, and communities empowered and enabled to take charge of their own health. That must be the focus of our attention, and our investment.”

Dr Tedros Adhanom Ghebreyesus, WHO Director-General

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