Translating political commitments into actions to enhance Universal Health Coverage in the Eastern Mediterranean Region

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Abstract

Background: Many countries in the Eastern Mediterranean Region (EMR) have developed packages of services for achieving Universal Health Coverage (UHC), however, policymakers, especially in resource-constrained countries, still face challenges in delivering equitable, efficient and sustainable health services.

Aims: To provide guidance for EMR countries and develop packages of services for UHC.

Methods: We used information gathered from narrative reviews, national experiences and expert consultations to develop step-by-step guidance for the development of national packages of services for the achievement of UHC by countries in the EMR.

Results: The processes used to develop packages of services varied between EMR countries and these processes may not have involved all relevant stakeholders. We highlight in this paper the iterative processes, including several phases and steps, to be used by EMR countries for developing packages of services for UHC. These processes also make provision for continuous monitoring and revision to make necessary improvements as morbidity patterns evolve.

Conclusion: Developing a package of services for the achievement of UHC is a significant milestone for EMR countries and it is central to shaping the healthcare system for effective delivery of services.

Keywords: UHC, PHC, health systems, service delivery, EMR

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Introduction

Universal Health Coverage (UHC) means that all individuals and communities receive the health services they need, with good quality and without suffering financial hardship (*1*). The health services should include promotion, prevention, treatment, rehabilitation, and palliative care (*2*). However, limited resources, evolving health needs, increasing expectations of individuals, and rapid technological developments all challenge the realization of UHC in most countries (*3,4*). To address the equity and efficiency dilemma associated with the trade-offs between the 3 UHC dimensions of whom to cover, what to cover, and to what extent to cover, the Lancet Commission on Investing in Health proposed in 2013 the progressive universalism approach (*4*). This approach hinges on defining a high-priority package of interventions for the entire population, while ensuring financial protection for all and introducing additional interventions as resources are made available.

In 2018, Member States of the WHO Eastern Mediterranean Region (EMR) endorsed the Salalah Declaration on UHC as a regional roadmap to achieve UHC by 2030 (*5*). This declaration is anchored on defining what to cover under a national health agenda as a basis for advancing UHC through progressive universalism. The programmes, services, and interventions to be considered are labelled packages of priority services for UHC (*6,7*). Designing and implementing such a package allows governments to focus their financial, technical, and managerial support on prioritized programmes, services, and interventions with maximum impact on the health and well-being of the population (*8*).

Defining a package of services for UHC

The EMR defines a package of services for UHC as a set of health interventions to which a population is guaranteed access through a range of government assurance mechanisms. These mechanisms may include direct financing or direct service provision for some groups, mandatory contribution and prepayment schemes, and regulatory structures that indicate what public and private entities must pay for or deliver. Packages are usually designed to: include interventions that are essential to meet people's needs throughout their lifespan; include services for many diseases and population-specific programmes; and span the full spectrum of promotive, preventive, resuscitative, curative, rehabilitative, and palliative care (*9,10*). Identifying what to include in a package of services for

UHC should be based on several principles, such as: (1) high quality and patient-centred care; (2) support of progressive universalism; (3) context specificity and explicit criteria; (4) coverage through relevant financial arrangements; (5) democracy and inclusiveness; (6) support for health system planning and implementation; (7) strengthening of health security; (8) use of evidence-informed and deliberative processes; and (9) openness and transparency in all steps of the process (*11*). Deciding upon what should be in and what should be out of a package of services for UHC requires a systematic and institutionalized process with clearly defined criteria. To support countries in designing their packages, the WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) has outlined a set of key considerations for Member States (*12*,*13*).

Regional status and challenges

Natural and human-made emergencies in the EMR contribute to many challenges that undermine performance of the health system and limit health outcomes. Currently, 8 of 22 countries in the EMR face complex humanitarian emergencies (*14*). More than 30 million people in the EMR are displaced, and 108 million need humanitarian assistance (*15*). At the same time, changes in lifestyle and the environment are affecting the morbidity and mortality patterns in all countries, including in countries affected by fragility, conflict, and violence (*16*). Those factors, in addition to weak performing health systems in some countries that have inefficient governance structures and processes, inadequate financial protection arrangements, unregulated private sector delivery, shortage in the health workforce, and limited access to essential drugs and vaccines, have slowed progress towards achieving UHC (*17*). In the EMR, the Service Coverage Index ranged between 25.0% and 77.0% in 2020, and in the same year, 6.1 million people experienced catastrophic health expenditure (*18*, *19*). The situation became more challenging following the COVID-19 pandemic as essential health services in almost all countries were interrupted (*20*).

In most EMR countries, it is unclear which health services have been chosen based on defined criteria, such as the burden of disease or health needs, and whether those services were updated following any change in the epidemiological situation and population characteristics. Provision of relevant health services across the various levels of the health system, and defining clear patient pathways and referral systems, can improve the quality, equity, and efficiency of the health system. It is our conviction that all EMR countries could benefit from instituting evidence-informed decisions to expand their service coverage (*21*).

Many countries in the EMR have developed packages of services for UHC. However, some still maintain implicit entitlements, leaving room for inequity, ambiguity, and health system inefficiencies. Despite ample support of donors for development of packages of services for UHC in countries affected by fragility, conflict, and violence, the packages developed are not always adequately implemented, further compromising service coverage and financial protection (*22*). We argue that an evidence-informed approach to developing explicit packages of services for UHC can promote efficient use of resources, and enhance health equity, service quality, and governance structures and mechanisms.

Status of packages of UHC services in selected EMR countries

Several countries have explicit packages of UHC services under various names. The processes for developing those packages vary between countries, and it is unclear whether all relevant stakeholders were engaged in the process in many countries. The packages agreed upon may or may not be provided, and the quality standards of the services are unclear. Table 1 describes the process and stage of development of the packages in some EMR countries.

Designing a national package of UHC services

We propose a set of steps to be followed by countries as they define their packages of UHC services. Some of these steps could be implemented simultaneously.

Phase 1: Preparation

Advocacy and awareness: initially, an advocacy campaign should be planned to mobilize policy-makers and stakeholders, including academia, civil society, and parliamentarians, at the national and subnational levels.

Establishment of an organizational structure and mechanism: with Ministry of Health leadership, a committee responsible for the planning and development of the package should be established. This committee should be composed of: policy-makers; health service managers; representatives of the national health insurance agency; representatives of the Ministry of Finance; epidemiologists; health economists; health system experts; patient associations; and representatives of nongovernmental organizations, WHO, and other development partners.

Stakeholder engagement: the stakeholder analysis should identify relevant groups and institutions and examines their perceptions, attitudes, and influence, and accordingly develop an engagement plan, taking stock of stakeholder power dynamics, and should make use of available resources within the country (*23*). Potential stakeholders who should be considered when mapping are: patients, the public and carers (the community), opinion leaders, healthcare providers and health professionals, purchasers, payers, policy-makers, product makers (manufacturers and technology producers), and academia (*24*).

Phase 2: Development

Situation analysis: this should describe the current package, health system functions and architecture,

Table 1 Status of development and implementation of universal health coverage priority benefits packages in the Eastern Mediterranean Region

Afghanistan	In 2003, Afghanistan introduced a basic package of health services delivered through primary care, and an essential package of hospital services. Because of changing epidemiological and health needs, those packages were reviewed, and a new integrated package of essential health services was developed in 2021 (*38*).
Islamic Republic of Iran	In a recent effort supported by WHO, 2 high-burden and high-cost conditions, multiple sclerosis and diabetes, were selected. A benefits package was developed through an evidence-informed deliberative process. This experience is considered a pilot for other conditions and is planned to be scaled up for all health services funded by the government (*24*).
Lebanon	The Lebanese essential health service package was developed in 2016 through a consultative process with health policy-makers, health economists, professional associations, national and international donor agencies, and the community. UN Children's Fund, UN High Commisioner for Refugees, and European Union supported its development, and the World Bank and local NGOs implemented the package in primary healthcare centres. The package has been under revision since 2021 (*39*).
Morocco	Morocco has prepared a draft of the primary health care benefit package but it has not yet been endorsed. Currently, WHO supports Morocco in reviewing and developing a new package based on consultative predefined criteria (*29*).
Pakistan	A national essential package of health services was developed in 2020 through an evidence-informed deliberative process that involved a wide range of stakeholders, including WHO, London School of Hygiene and Tropical Medicine, Aga Khan University, Radboud University, local NGOs, and the private sector. The package was led by the Ministry of National Health Services Regulation and Coordination, and Health Planning, System Strengthening and Information Analysis Unit. Taking guidance from the national package, all provincial health departments have now developed their own packages.
Somalia	An essential package of health services was developed in 2021 through consultation with the Ministry of Finance, health policy-makers, NGOs, health economists, the private sector, medical associations, and development partners. The Ministry of Health, World Bank, and WHO all played a key role in initiating the formulation of the health package. However, development of the implementation plan was constrained by the shortage of financial resources and poor coordination (*40*).

NGO = nongovernmental organization.

governance, and administrative arrangements, and the human and financial resources and capacities.

Data and evidence: priority health problems should be identified from available data sources, such as the Global Burden of Diseases Study, electronic medical records, national official statistics, and peer-reviewed and grey literature. The mapping should also include the geographic and socioeconomic factors of illness.

Dialogue and selection criteria: the responsible focal point should coordinate the choice of a reference list of interventions as a benchmark. For this, the WHO Service Package Delivery & Implementation Tool is a valuable resource that incorporates several packages such as the EMRO reference package, EMRO reference package for emergency situations, and national service packages. While choosing their respective packages, countries should consider the benefits and drawbacks of the available resources and choose from the ones most consistent with the local context (*13,25–27*). The package of UHC services focal point and working groups should determine the criteria that guide the selection of interventions through a consultative process. Some of the criteria used are (*28*): availability of resources; feasibility of implementation; cost-effectiveness of the proposed interventions; socioeconomic distribution of the health concern; availability and sustainability of funding; budget impact; political and community acceptance; and political interest and commitment. After the national team (the focal point and relevant working group) has decided on the criteria, the package of services should be chosen quantitatively using multiple-criteria decision analysis. Alternatively, the package focal point should use qualitative methods, such as policy dialogues and nominal group techniques, to choose relevant interventions (*29–31*).

Decision: at this stage, legal instruments should be issued to adopt the package of services nationally. The laws and regulations should be issued in compliance with the country's legal and administrative environment.

Phase 3: Implementation

Communication: the package of UHC services should be disseminated to relevant stakeholders, such as policy-makers, funders, service providers, and the community, using appropriate communication strategies and channels.

Institutionalization: implementation bodies should be aware of the package and their role in implementing it. Each body should be responsible for establishing the necessary institutional arrangements for implementation. Operational capacities and resource gaps could surface at this stage, and a mechanism should be established to identify those gaps and coordinate relevant solutions.

Monitoring and evaluation: A monitoring body should develop indicators for measuring the status of implementation of the package, identifying implementation gaps, and evaluating the impact of the package. Also, a separate entity should monitor the

epidemiological situation and highlight any population health risks.

It is crucial to establish a systematic review process through which interventions could be added, removed, or modified according to the changing morbidity and mortality pattern in the country. The frequency of the review is country-specific, and depends on the evolving epidemiological situation and anticipated modifications or health system reforms. For example, where the disease pattern is consistent, and no human-made or natural crises are anticipated, the package of services could be revised every 5 years. In more volatile situations, or in the event of a crisis, or a drastic change in the population or epidemiological structure, such as when migrant numbers suddenly increase, health authorities may wish to revise the package more frequently, every 2 years, or even immediately after a crisis.

Conclusion

Despite the COVID-19 pandemic, health policy-makers worldwide must sustain progress towards achieving UHC. Lack of access to services during the pandemic precipitated a broader healthcare access gap and drove more people into financial hardship (*32*). Undoubtedly, UHC indicators have worsened, and the disruption of essential health services has created a global rise in mortality and morbidity (*33*). The pandemic has revealed gaps in the current service delivery, and the need to develop country-specific, fit-for-context models of care. Recovery from the pandemic provides an opportunity for integrating vertical health programmes, for example: communicable and noncommunicable diseases; mental health; and reproductive, maternal, neonatal, child, and adolescent health, to enhance people-centeredness, responsiveness, and efficiency, and define integrated, comprehensive, essential health service packages (*34*).

Competing priorities and financial pressures often influence the choice of health services to be maintained during emergencies. In such conditions, the need for rapid solutions makes evidence-informed policy decisions unlikely. However, having a package of UHC services can help countries in defining a priority list of essential health services, thus fostering efficient and fair solutions in times of crisis (*35*).

A well-developed package of UHC services can be the centrepiece of a healthcare system and help shape all other elements in the health system (*6*). Designing a package is the first step in ensuring that health services reach those who need them. All health system components must be reorganized to deliver those entitlements. Well-defined, coherent processes, an adequately trained health workforce, accountable institutions, rationally selected drugs and technologies, equitable and sustainable financing arrangements, and high-performing health information systems are all prerequisites for effective implementation of the UHC package (*36*). Eliciting and managing people's expectations and educating them about their entitlements are essential to advance the UHC goals of equity in access, quality, and financial protection (*7*). During implementation, countries could prioritize certain disadvantaged groups, such as poor people, and strengthen the referral systems between various delivery platforms to ensure timely and uninterrupted health services, and consequently, successful implementation of the package.

Health entitlements supported by the legislative tools can help mitigate the impact of protracted fragility and increased healthcare needs in countries affected by violence, natural disaster, or war. Intense efforts are needed to build the capacity of Member States in priority setting, evidence generation and utilization, fiscal space analysis, intersectoral and community engagement, and the rule of law (*37*).

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Traduire les engagements politiques en actions visant à renforcer la couverture sanitaire universelle dans la Région de la Méditerranée orientale

Résumé

Contexte : De nombreux pays de la Région de la Méditerranée orientale ont mis au point des ensembles de services pour assurer la couverture sanitaire universelle (CSU), mais les responsables de l'élaboration des politiques, en particulier dans les pays aux ressources limitées, sont encore confrontés à des difficultés pour fournir des services de santé équitables, efficaces et durables.

Objectif : Fournir aux pays de la Région de la Méditerranée orientale des orientations et mettre en place des ensembles de services visant à renforcer la couverture sanitaire universelle.

Méthodes : Nous avons utilisé les informations recueillies à partir d'examens narratifs, d'expériences menées au niveau national et de consultations avec des experts pour élaborer des orientations détaillées. Ces dernières ont pour objectif de mener à la création d'ensembles de services nationaux visant à garantir la couverture sanitaire universelle dans les pays de la Région.

Résultats : Les procédures utilisées pour mettre au point ces ensembles de services variaient d'un pays à l'autre et n'ont pas nécessairement impliqué toutes les parties prenantes concernées. Dans le présent article, nous mettons en évidence les processus itératifs, comprenant plusieurs phases et étapes, que ces pays doivent suivre pour mettre en

place les ensembles de services permettant de garantir la CSU. Ces processus prévoient également un suivi et une révision continus afin d'apporter les améliorations nécessaires en fonction de l'évolution des tendances en matière de morbidité.

Conclusion : La mise au point d'un ensemble de services permettant de réaliser la CSU constitue une étape majeure pour les pays de la Région de la Méditerranée orientale et joue un rôle central dans la conception d'un système de santé capable de fournir des services efficaces.

تحويل الالتزامات السياسية إلى إجراءات من أجل تعزيز التغطية الصحية الشاملة في إقليم شرق المتوسط

عوض مطرية، رضا مجدزادة، دينا العصفور، حسن صلاح، ظفر ميرزا

الخلاصة

الخلفية: أعد العديد من البلدان في إقليم شرق المتوسط حُزم خدمات من أجل تحقيق التغطية الصحية الشاملة، ولكن لا يزال راسمو السياسات، لا سيَّما في البلدان ذات الموارد المحدودة، يواجهون تحديات في تقديم خدمات صحية مُنصِفة وفعَّالة ومستدامة.

الأهداف: هدفت هذه الدراسة الى تقديم الإرشادات لبلدان إقليم شرق المتوسط وإعداد حزم الخدمات من أجل تحقيق التغطية الصحية الشاملة.

طرق البحث: استخدمنا المعلومات المجمعة من الاستعراضات السردية والخبرات الوطنية ومشاورات الخبراء لإعداد إرشادات مُفصَّلة لإعداد حزم وطنية من الخدمات من أجل تحقيق التغطية الصحية الشاملة في بلدان إقليم شرق المتوسط.

النتائج: تباينت العمليات المستخدمة في إعداد حزم الخدمات بين بلدان إقليم شرق المتوسط، وقد لا تشمل هذه العمليات جميع أصحاب المصلحة المعنيين. ونسلط الضوء في هذه البحث على العمليات المتكررة، التي تتضمن عدة مراحل وخطوات، لتستخدمها بلدان إقليم شرق المتوسط في إعداد حزم الخدمات من أجل تحقيق التغطية الصحية الشاملة. وتنص هذه العمليات كذلك على الرصد والتنقيح المستمريْن لإدخال التحسينات اللازمة مع تطور أنماط المراضة.

الاستنتاجات: يُعَد إعداد حزمة من الخدمات لتحقيق التغطية الصحية الشاملة مرحلة رئيسية مهمة لبلدان إقليم شرق المتوسط، ولها دور محوري في تشكيل نظام الرعاية الصحية من أجل تقديم الخدمات بفاعلية.

References

1. Tracking universal health coverage: 2021 global monitoring report. World Health Organization, International Bank for Reconstruction and Development; 2021 (https://www.who.int/publications/i/item/9789240040618, accessed 22 June 2023).
2. Universal health coverage (UHC). Geneva: World Health Organization; 2021 (https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc), accessed 22 June, 2023).
3. Horton R, Das P. Universal health coverage: not why, what, or when--but how? Lancet. 2015 Mar 28;385:1156–7. https://doi.org/10.1016/S0140-6736(14)61742-6 PMID:25458724
4. Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A et al. Global health 2035: a world converging within a generation. Lancet. 2013 Dec 7;382:1898–955. https://doi.org/10.1016/S0140-6736(13)62105-4 PMID:24309475
5. Salalah Declaration signals countries' firm commitment to Universal Health Coverage [website]. Cairo: WHO Regional Office for the Eastern Mediterranean; 2022 (http://www.emro.who.int/media/news/salalah-declaration-signals-countries-firm-commitment-to-universal-health-coverage.html, accessed 22 June 2023).
6. Mirza Z, Mataria A, Salah H, Gedik G, Ismail A. 'Health Benefits Package': a centerpiece of Universal Health Coverage. East Mediterr Health J. 2018;24(4):405–6. https://doi.org/10.26719/2018.24.4.405
7. Making fair choices on the path to Universal Health Coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage. Geneva: World Health Organization; 2014 (https://www.who.int/publications/i/item/9789241507158, accessed 22 June 2023).
8. Chalkidou K, Glassman A, Marten R, Vega J, Teerawattananon Y, Tritasavit N et al. Priority-setting for achieving Universal Health coverage. Bull World Health Org. 2016;94:462–7. http://dx.doi.org/10.2471/BLT.15.155721
9. Health in All Policies (HiAP) framework for country action. Health Promot Int. 2014 Jun;29 Suppl 1:i19–28. https://doi.org/10.1093/heapro/dau035
10. Jamison DT, Alwan A, Mock CN, Nugent R, Watkins D, Adeyi O et al. Universal Health Coverage and intersectoral action for health: key messages from Disease Control Priorities. Lancet. 2018;391(10125):1108–20. https://doi.org/10.1016/S0140-6736(17)32906-9
11. Principles of health benefits packages. Geneva: World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240020689, accessed 22 June 2023).

12. Development of universal health coverage priority benefits packages – key considerations (draft). Cairo: WHO Regional Office for the Eastern Mediterranean; 2019.

13. WHO UHC Service Package Delivery & Implementation (SPDI) Tool. Build and implement UHC packages with SPDI [website]. WHO (https://uhcc.who.int/uhcpackages/, accessed 10 July 2023).

14. Humanitarian response. United Nations Office for the Coordination of Humanitarian Affairs; 2022 (https://www.humanitarianresponse.info/en, accessed 20 July 2022).

15. Global humanitarian overview [website]. United Nations; 2022 (https://2022.gho.unocha.org, accessed 22 June 2023).

16. Wise PH, Shiel A, Southard N, Bendavid E, Welsh J, Stedman S et al. The political and security dimensions of the humanitarian health response to violent conflict. Lancet. 2021 Feb 6;397:511–21. https://doi.org/10.1016/S0140-6736(21)00130-6 PMID:33503458

17. Mataria A, Brennan R, Rashidian A, Hutin Y, Hammerich A, El-Adawy M et al. 'Health for All by All' during a pandemic: 'Protect Everyone' and 'Keep the Promise' of Universal Health Coverage in the Eastern Mediterranean Region. East Mediterr Health J. 2020 Dec 9;26(12):1436–9. https://doi.org/10.26719/2020.26.12.1436 PMID:33355380

18. UHC service coverage index [website]. Cairo: Eastern Meditteranean Health Observatory; 2022 (https://wem-rho1.emro.who.int/Indicator/TermID/82, accessed 22 June 2023).

19. Global health observatory data repository. Catastrophic out-of-pocket health spending [website]. Geneva: World Health Organization; 2022 (https://apps.who.int/gho/data/view.main.FINANCIALPROTECTIONWHOREG01v?lang=en, accessed 22 June 2023).

20. Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic. Interim report: November–December 2021. Geneva: World Health Organization; 2022 (https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2022.1, accessed 22 June 2023).

21. AlYafei N, Jaleel B. Preparing to meet the oral health needs of the elderly in Qatar - a model for domiciliary oral health care services. World J Adv Res Rev. 2020;8(3):184–91. http://dx.doi.org/10.30574/wjarr.2020.8.3.0459

22. Garry S, Checchi F, Cislaghi B. What influenced provision of non-communicable disease healthcare in the Syrian conflict, from policy to implementation? A qualitative study. Confl Health. 2018 Nov 12;12:45. https://doi.org/10.1186/s13031-018-0178-5 PMID:30459826

23. Silberberg M, Martinez-Bianchi V. Community and stakeholder engagement. Prim Care. 2019 Dec;46(4):587–94. https://doi.org/10.1016/j.pop.2019.07.014.

24. Nouhi M, Baltussen R, Razavi SS, Bijlmakers L, Sahraian MA, Goudarzi Z et al. The use of evidence-informed deliberative processes for health insurance benefit package revision in Iran. Int J Health Policy Manage. 2022 Mar 2;11(11):2719–26. https://doi.org/10.34172/ijhpm.2022.6485 PMID:35247943

25. Chang AY, Horton S, Jamison DT. Benefit-cost analysis in disease control priorities. In: Jamison DT, Gelband H, Horton S, Jha P, Laxminarayan R, Mock CN et al., editors. Disease control priorities: improving health and reducing poverty. Washington: The International Bank for Reconstruction and Development/The World Bank; 2017.

26. UHC Compendium. Health interventions for Universal Health Coverage [website]. Geneva: World Health Organization; 2020 (https://www.who.int/universal-health-coverage/compendium, accessed 22 June 2023).

27. UHC Compendium Service Package Delivery & Implementation (SPDI) Tool [website]. Geneva: World Health Organization; 2022 (https://uhcc.who.int/uhcpackages/, accessed 22 June 2023).

28. Verguet S, Hailu A, Eregata GT, Memirie ST, Johansson KA, Norheim OF. Toward Universal Health coverage in the post-COVID-19 era. Nat Med. 2021 Mar 15;27:380–7. https://doi.org/10.1038/s41591-021-01268-y.

29. Akhnif EH, Hachri H, Belmadani A, Mataria A, Bigdeli M. Policy dialogue and participation: a new way of crafting a national health financing strategy in Morocco. Health Res Policy Syst. 2020;18:114. https://doi.org/10.1186/s12961-020-00629-2.

30. Rankin NM, McGregor D, Butow PN, White K, Phillips JL, Young JM et al. Adapting the nominal group technique for priority setting of evidence-practice gaps in implementation science. BMC Med Res Methodol. 2016;16(1):110. https://doi.org/10.1186/s12874-016-0210-7 PMID:27566679

31. Kea B, Sun BC-A. Consensus development for healthcare professionals. Intern Emerg Med. 2015 Apr;10(3):373–83. https://doi.org/10.1007/s11739-014-1156-6 PMID:25430678

32. Al-Mandhari AS, Brennan RJ, Abubakar A, Hajjeh R. Tackling COVID-19 in the Eastern Mediterranean Region. Lancet. 2020 Dec 5;396(10265):1786–8. https://doi.org/10.1016/S0140-6736(20)32349-7 PMID:33220856

33. Wang H, Paulson KR, Pease SA, Watson S, Comfort H, Zheng P et al. Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020–21. Lancet. 2022 Apr 16;399(10334):1513–36. https://doi.org/10.1016/S0140-6736(21)02796-3 PMID:35279232

34. Building resilient health systems to advance UHC and ensure health security in the Eastern Mediterranean Region (draft). Cairo:World Health Organization Regional Office for the Eastern Mediterranean; 2022.

35. Blanchet K, Alwan A, Antoine C, Cros MJ, Feroz F, Amsalu Guracha T et al. Protecting essential health services in low-income and middle-income countries and humanitarian settings while responding to the COVID-19 pandemic. BMJ Glob Health. 2020 Oct;5(10):e003675. https://doi.org/10.1136/bmjgh-2020-003675 PMID:33028701

36. Glassman A, Giedion U, Smith PC. What's in, what's out: designing benefits for universal health coverage. Brookings Institution Press; 2017.

37. Darawsheh B, Germeni E. Implementing health technology assessment in Kuwait: a qualitative study of perceived barriers and facilitators. Int J Technol Assess Health Care. 2019;35(6):422–6. https://doi.org/10.1017/S0266462319000710 PMID:31771676

38. The essential package of hospital services for Afghanistan. Islamic Republic of Afghanistan Ministry of Public Health; 2005 (https://platform.who.int/docs/default-source/mca-documents/policy-documents/guideline/afg-cc-46-01-guideline-2005-eng-essential-hospital-services.pdf).

39. Hemadeh R, Hammoud R, Kdouh O. Lebanon's essential health care benefit package: a gateway for universal health coverage. Int J Health Plann Manage. 2019 Oct;34(4):e1921–36. https://doi.org/10.1002/hpm.2850 PMID:31271234

40. Essential package of health services (EPHS). Somalia, 2020. Federal Republic of Somalia Ministry of Health and Human Services; 2020 (https://reliefweb.int/report/somalia/essential-package-health-services-ephs-somalia-2020).