



Building resilient health systems to advance universal health coverage and ensure health security in the Eastern Mediterranean Region

Executive summary

COVID-19 challenged all health systems globally, including those in the Eastern Mediterranean Region. It also highlighted gaps in the design and implementation of health systems.

The Eastern Mediterranean Region is highly diverse and is prone to emergencies from various hazards, including conflicts and humanitarian crises. Prior to COVID-19, several challenges hampered the performance of the Region's health systems, particularly those in fragile, conflict-affected and vulnerable settings. COVID-19 further compromised all health system components, impacting the three universal health coverage goals. It also highlighted gaps in emergency management capacities that are undermining global and national health security.

Advancing universal health coverage and ensuring health security are increasingly recognized as complementary and interrelated health system goals. This technical paper sets out a regional agenda for building resilient health systems towards universal health coverage and health security, based on seven regional priorities:

- strengthening health emergency and disaster risk management in line with the *Plan of action for ending the COVID-19 pandemic and preventing and controlling future health emergencies in the Eastern Mediterranean Region*;
- optimizing ministries of health and building institutions for public health;
- establishing primary health care-oriented models of care;
- enhancing and scaling up a fit-for-purpose, fit-to-practice health workforce;
- promoting equity and enhancing financial protection;
- improving access to medicines, vaccines and health products; and
- fostering an integrated approach in policy, planning and investments for long-term health system resilience.

To progress on these seven priorities, Member States need to invest in various priority actions, adapted to countries' political and socioeconomic environments, with support from WHO and other development partners, by engaging in technical cooperation, sharing experiences, building capacity, tracking progress and mobilizing necessary resources.

Introduction

1. COVID-19 challenged all health systems globally (1,2), including those of the Eastern Mediterranean Region (3). It also highlighted gaps in the design and implementation of health systems. The pandemic – and efforts to control it and mitigate its impact – tested the resilience of health systems and their capacity to maintain essential health services amid emergencies. Lessons are now being distilled on the impact of health systems’ organization on (a) preventing, preparing for, detecting, responding to and recovering from health emergencies, while (b) promoting equitable access to quality health care (4).

2. Besides infecting over half a billion people and claiming more than 6 million lives globally,^{1,2} COVID-19 has entailed immense economic and social costs. The pandemic has already cost the global economy an estimated US\$ 11 trillion and is projected to cost as much as US\$ 28 trillion by 2025 (5).³ This cost could have been largely prevented by investing in health emergency and disaster risk management (HEDRM) (6) and health system strengthening (HSS). A recent systematic review estimated the cost of health emergency preparedness to range between US\$ 1.6 and 43 billion annually, depending on the costing method being used, the range of countries being considered and their income level, and the inclusion or not of global-level initiatives (7). In the Eastern Mediterranean Region, regional gross domestic product (GDP) is projected to decline by 4–5% due to the pandemic (8), and a study by the United Nations Economic and Social Commission for Western Asia suggested that loss to GDP in the Arab world would reach US\$ 42 billion in 2020 (9).

3. Global reviews – 23 to date – of the COVID-19 response⁴ have identified multiple gaps in health system capacity, mainly in low-income countries and fragile, conflict-affected and vulnerable (FCV) settings. They have also identified gaps in health systems’ preparedness for emergencies, including in high-income countries. Of the 131 recommendations made by the various reviews, 58.0% pertain to leadership and governance, 19.1% to systems and tools, 16.8% to financing and 6.1% to equity (10).

4. Advancing universal health coverage (UHC) and ensuring health security are increasingly recognized as complementary and interrelated health system goals, described as “two sides of the same coin” (11). They are also closely linked with two of the regional strategic priorities in WHO’s vision for the Eastern Mediterranean Region, *Vision 2023* (12).

5. Past and ongoing emergencies have highlighted the interconnectedness between HSS for UHC and HEDRM for health security, demonstrating how effective emergency preparedness and response must involve maintaining essential health services – for example, by investing in infection prevention and control. These emergencies have also highlighted how resilient health systems contribute to preventing and mitigating the impact of health emergencies – for example, through investment in building safe hospitals. Nevertheless, actions to build capacities to deliver integrated health and care services and those related to enhancing emergency preparedness and response continue to be carried out in a siloed manner (13).

¹ Based on reported confirmed cases; recent WHO estimates suggest that excess mortality from all causes was closer to 15 million deaths between 1 January 2020 and 31 December 2021. See <https://www.who.int/data/stories/global-excess-deaths-associated-with-covid-19-january-2020-december-2021>.

² In the Eastern Mediterranean Region alone, close to 22 million people had suffered from COVID-19 and close to 350 000 people had lost their lives by mid-2022.

³ The Global Preparedness Monitoring Board 2020 estimated that COVID-19 would cost the world US\$ 21 trillion. See https://apps.who.int/gpmb/assets/annual_report/GPMB_AR_2020_EN.pdf.

⁴ This includes the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme; the Independent Panel for Pandemic Preparedness and Response; the Review Committee on the Functioning of International Health Regulations (2005) during the COVID-19 response; and the Global Preparedness and Monitoring Board.

6. In October 2021, WHO launched its position paper on *Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond* (14). The paper acknowledged the need to modify current thinking on health system design and emphasized the central role of the primary health care (PHC) approach in advancing the dual goals of UHC and health security (see Box 1). Accordingly, one of the five priorities outlined by the WHO Director-General for the next five years is “to support a radical reorientation of health systems towards primary health care” (15).

Box 1. Key recommendations of the WHO position paper *Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond*

- Leverage the current response to strengthen both pandemic preparedness and health systems.
- Invest in essential public health functions including those needed for all-hazards emergency and disaster risk management.
- Strengthen the PHC approach for health security and UHC.
- Invest in institutionalized mechanisms for whole-of-society engagement.
- Promote enabling environments for research, innovation and learning.
- Increase domestic and global investment in health system foundations and all-hazards emergency risk management.
- Address pre-existing inequities and the disproportionate impact of COVID-19 on marginalized and vulnerable populations.

7. The 68th session of the WHO Regional Committee for the Eastern Mediterranean endorsed a plan of action for ending the COVID-19 pandemic and preventing and controlling future health emergencies in the Eastern Mediterranean Region (16). A committee is being assembled to oversee and monitor the implementation of this plan. The present technical paper complements that work by focusing on health system-specific challenges and identifying regional priorities and actions for building resilient health systems for UHC and health security in the Eastern Mediterranean Region.

8. The present paper also aims to adapt the recommendations from the WHO position paper on building health systems resilience (14) – and others – to the Eastern Mediterranean Region’s context and to formulate a regional agenda for national adaptation. The present paper proves timely as several of the Region’s Member States are contemplating their health system recovery with the aim of “building back better” (17). The paper’s release also coincides with the 10th anniversary of the seminal resolution EM/RC59/R.3, adopted by the Regional Committee at its 59th session, on health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action (18). The present paper builds on several previous papers and resolutions related to health systems and health security,¹ in addition to a panel discussion on health systems response to COVID-19 held during the 68th session of the Regional Committee in 2021 (19) and a pre-meeting technical discussion on building health system resilience in the Eastern Mediterranean Region, held prior to the opening of the 65th session of the Regional Committee in 2018 (20).

UHC and health security as dual goals of the health system

9. A health system is defined as “all the activities whose primary purpose is to promote, restore or maintain health” (21). The WHO health system framework identifies three health system goals:

¹ This includes EM/RC68/4, Accelerating health emergency preparedness and response – a plan of action; EM/RC65/4, Advancing universal health coverage; EM/RC62/Tech.Disc.1, Global health security, with special emphasis on MERS-CoV and A(H5N1); EM/RC61/R.2, Global health security – challenges and opportunities with special emphasis on the International Health Regulations (2005); EM/RC60/R.2, Universal health coverage; and EM/RC59/R.3, Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action.

improving health, responding to nonmedical expectations and ensuring financial protection. Since its publication in 2000, the WHO health system framework has been central to reforming many health systems globally.

10. Health systems are dynamic and constantly evolving (22). The last two decades have witnessed two transformative agendas in health system thinking: (a) introducing UHC as a principal health system policy goal, endorsed as a target in the 2030 Agenda for Sustainable Development (Target 3.8) (23), and (b) reinvigorating PHC as an overarching approach for HSS, following the 2018 Declaration of Astana (24). Lately, the Ebola outbreaks in West Africa (2014–2016) and the Democratic Republic of the Congo (2017–2018), and the ongoing COVID-19 pandemic, have revealed the need for a new health system transformation, bringing attention to health security as an additional health system policy goal. A recently published framework on health systems for health security brought together the International Health Regulations (2005) (IHR) core capacities, health system components and elements from related sectors for the purpose of effective management of health emergencies and maintaining essential health services (25).

11. UHC means that “all individuals and communities receive the health services they need without suffering financial hardship” (26). Advancing UHC entails improving access to and the quality of the full spectrum of needed individual and population-focused essential health services: from promotion to prevention, treatment, rehabilitation and palliative care (27). Health security is concerned with “reducing vulnerability to health threats at individual and collective levels” (28). Ensuring health security requires investing in HEDRM, to minimize the hazards and vulnerabilities associated with acute public health events that endanger the collective health of populations (29). PHC is a “whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution” (30). PHC has three components: (a) primary care and essential public health functions, (b) multisectoral policies and actions, and (c) empowered people and communities (31).

12. Advancing the twin goals of health security and UHC requires investing in building resilient national health systems that are also equitable and efficient. Resilience is the “ability of a system, community or society exposed to hazards to resist, absorb, accommodate, adapt to, transform and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions through risk management” (32). Evidence related to building health system resilience is limited (33). The concept of resilience has evolved from an attribute of health systems associated with acute shocks (34) to include chronic and protracted public health challenges that increase pressure on health systems, impinging on their ability to deliver high-quality health services, such as in the context of protracted conflict (e.g. Afghanistan and Somalia) and recurrent emergencies (e.g. Sudan) (35). Accordingly, resilience has become an intermediary objective for health systems, dependent on the performance of all health system components.

13. Evidence suggests that building health system resilience requires investing in essential public health functions (EPHFs) as part of HSS efforts. EPHFs are an indispensable set of actions under the prime responsibility of the state and are fundamental to achieving the goal of public health through collective action.¹ While the IHR provide an overarching legal framework that defines countries’ rights and obligations in handling public health events and emergencies that have the potential to cross borders in a manner to ensure global health security (36), investing in EPHFs contributes to building national health system resilience (37). Accordingly, both IHR core capacities and EPHFs are essential for global and national health security. In 2015, the WHO Regional Office for the Eastern Mediterranean identified a set of four core EPHFs (surveillance, emergency preparedness and response, health protection and

¹ In economic terms, EPHFs are classified as common goods for health, which are population-based functions or interventions that only collective arrangements can finance, regardless of whether they are delivered by public or private sector providers. Examples of common goods for health include policy and coordination, taxes and subsidies, regulations and legislation, information, analysis and communication, and population services. See: Soucat A. Financing common goods for health: fundamental for health, the foundation for UHC. *Health Systems and Reform*. 2019;5(4) (<https://www.tandfonline.com/doi/full/10.1080/23288604.2019.1671125>).

health promotion) and four enabling EPHFs (governance, workforce, communication and research) (38), and developed an assessment tool to help countries identify gaps in their implementation (39). In 2021, WHO proposed a consolidated list of 12 EPHFs and identified key enablers to support their operationalization at country level (40).

14. Moving forward, it is essential to distinguish health system goals from the means of achieving them (28). In this regard, UHC and health security are “what we want” and progressing on one supports the other. HSS and HEDRM are “what we do”, and they need to be done in an integrated manner. PHC is the approach for integrating HSS and HEDRM and advancing the dual goals of UHC and health security.

Health systems in the Eastern Mediterranean Region and the impact of COVID-19

Eastern Mediterranean Region socioeconomic profile and key challenges

15. The Eastern Mediterranean Region is highly diverse, with six high-income, three upper middle-income, eight lower middle-income and five low-income countries/territories (41). The Region is prone to emergencies from various hazards, including disease outbreaks and natural disasters. This is manifested in the increasing number of outbreaks due to emerging infectious diseases – for example, H1N1, MERS-CoV and, lately, COVID-19¹ – and the increasing frequency and severity of extreme weather events, such as droughts and floods. In 2021, five of the 10 largest natural disasters worldwide (as measured by people affected) occurred in the Eastern Mediterranean Region – all of them due to drought.

16. Of particular concern are the multiple conflicts and humanitarian crises affecting almost half of the countries of the Region. As of May 2022, more than 102 million people in the Eastern Mediterranean Region need humanitarian assistance (34% of the global total) – a 95% increase over the past seven years (42). The Eastern Mediterranean Region is also the source of over 60% of the world’s refugees, many of whom remain in the Region (43). Countries impacted by conflict are more prone to and less able to respond to other acute-on-chronic emergencies – for example, in 2021, 26 out of 28 major outbreaks in the Region occurred in FCV settings.

Health systems in the Eastern Mediterranean Region prior to COVID-19

17. Significant disparities and political instabilities in the Region have culminated in different health system designs and levels of performance, with those countries suffering from acute and chronic conflicts having the weakest health systems.

18. Prior to COVID-19, several overarching challenges already hampered health system performance in the Eastern Mediterranean Region, including the need to: secure high-level political commitment; strengthen the capacities of ministries of health and health-related institutions; adopt workable models of care; reduce the share of out-of-pocket payments and enhance financial protection; develop a balanced, skilled and motivated health workforce; reinforce health information systems; and improve access to medicines and essential technologies and strengthen medical supply chains (18).

¹ In 2020–2021, a total of 30 disease outbreaks were reported from 12 Eastern Mediterranean Region countries, including: acute watery diarrhoea in Afghanistan; cholera in Somalia and Yemen; dengue fever in Afghanistan, Pakistan, Sudan and Yemen; diphtheria in Sudan and Yemen; Crimean–Congo haemorrhagic fever in Afghanistan, Iraq and Pakistan; chickenpox (varicella) in Pakistan; extensively drug-resistant typhoid fever in Pakistan; hepatitis E virus in Sudan; measles in the Afghanistan, Somalia and the Syrian Arab Republic; Middle East respiratory syndrome in Qatar (one sporadic case), Saudi Arabia (2 clusters) and the United Arab Emirates (2 sporadic cases); wild poliovirus in Afghanistan and Pakistan; vaccine-derived polioviruses (VDPV) in Afghanistan, Pakistan, Somalia, Sudan and Yemen; and positive environmental samples for cVDPV2 detected in Afghanistan, Egypt, the Islamic Republic of Iran, Pakistan and Somalia. The total number of cases reported from these outbreaks is 707 141, with 1182 associated deaths.

19. FCV settings pose additional challenges to the health system (44) due to insecurity and political instability; fragmented governance arrangements with divided and/or disputed territories; underfunding; lack of trust in government and public health services; disrupted health systems that have limited capacity and are unable to scale up to address increased need; limited local capacities; no social safety nets, in particular for marginalized populations; bureaucratic impediments; lack of technical capacity; insufficient partners with a strong operational presence; and poor coordination among humanitarian and development actors (45).

20. In 2015, all countries of the Region committed to achieving UHC as part of the 2030 Agenda for Sustainable Development; subsequently, in 2018, they signed the UHC2030 Global Compact (46) and endorsed the Salalah Declaration (47), illustrating political commitment with a clear roadmap for transforming national health systems towards UHC. Nevertheless, the UHC Global Monitoring Report 2021 (48) showed that the Region is lagging in achieving the SDG UHC targets.¹ The service coverage index in the Region was estimated at 57 (out of 100) in 2019, below the global average of 68, and the second lowest figure among the six WHO regions. In addition, 12.5% of the population of the Region faced financial hardship in 2017, defined as spending more than 10% of their resources as direct out-of-pocket payments; in 2015, this proportion of the population was 11.8%. It is worth noting that these aggregate indices hide a lot of disparities across population groups.

21. The results from the Region's 2018 joint external evaluations of IHR capacity – which assess country capacities to prevent, detect and rapidly respond to public health risks – range from 31 in Somalia to 90 in the United Arab Emirates, out of a maximum possible score of 100 (49). Between 2016 and 2019, 19 countries/territories (including Palestine) developed national action plans for health security that identified country priorities. However, these plans have barely been implemented for several reasons, such as lack of political commitment, financing and human resources. Progress in implementing these plans is currently being monitored to assess successes and challenges, as well as the impact of COVID-19.

22. Table 1 provides a summary of key health impact, outcome, output, process and input indicators across the four country income groups in the Region.

¹ Service coverage (SDG target 3.8.1) and financial protection (SDG target 3.8.2).

Table 1. Selected health impact, universal health coverage, health security and health system performance indicators across country income groups in the Eastern Mediterranean Region

Core list of indicators	Low-income countries* Afghanistan, Somalia, Sudan, Syrian Arab Republic, Yemen [n=5]	Lower middle-income countries/territories* Djibouti, Egypt, Islamic Republic of Iran, Lebanon, Morocco, Pakistan, Palestine, Tunisia [n=8]	Upper middle-income countries* Iraq, Jordan, Libya [n=3]	High-income countries* Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates [n=6]
I. Health impact				
Life expectancy at birth (years) [2019]	56.5–72.7 (1)	65.6–77.3 (1)(2)	72.4–77.9 (1)	73.9–81.0 (1)
Healthy life expectancy (HALE) at birth (years) [2019]	49.72–62.87 (3)	56.87–66.89 (3)	62.66–67.6 (3)	64.02–70.09 (3)
Maternal mortality ratio (per 100 000 live births) – SDG 3.1.1 [2017]	31–829 (1)	16–248 (1)(4)	46–79 (1)	3–19 (1)
Neonatal mortality rate (per 1000 live births) – SDG 3.2.2 [2020]	11–37 (1)	4–40 (1)(5)	6–14 (1)	3–5 (1)
Under-5 mortality rate (per 1000 live births) – SDG 3.2.1 [2020]	22–115 (1)	17–65 (1)(5)	11–25 (1)	6–11 (1)
Probability of dying from any of CVD, cancer, diabetes, CRD between age 30 and exact age 70 (%) (premature death from NCDs) – SDG 3.4.1 [2019]	22.1–35.3 (1)	14.8–29.4 (1)(2)	15.3–23.5 (1)	10.7–21.5 (1)
Tuberculosis incidence (per 100 000 population) – SDG 3.3.2 [2020]	19–259 (1)	0.4–259 (1)(2)	5–59 (1)	1–34 (1)
II. Health outcomes				
a. Universal health coverage				
UHC single measure – proportion (%) of population receiving essential health services without incurring financial hardship (as per GPW 13) [2019]	21.5–56.9 (6)	45.6–61.2 (6)	53.3–60.7 (6)	58.2–68.3 (6)
UHC: Service coverage index – SDG Indicator 3.8.1 [2019]	27–56 (1)	45–77 (1)(2)	55–60 (1)	69–78 (1)
Population with household expenditures on health > 10% of total household expenditure or income (%) – SDG Indicator 3.8.2 [2012–2020]	0.1–23.8 (1)	1.5–31.1 (1)	3.7 (Iraq) (1)	0.4–4.9 (1)
Population with household expenditures on health > 25% of total household expenditure or income (%) – SDG Indicator 3.8.3 [2012–2020]	0.0–5.6 (1)	0.3–6.4 (1)	0.9 (Iraq) (1)	0.6–1.4 (1)
b. Health security				
Joint External Evaluation of the International Health Regulations (2005) [2016–2018]	31–55 (2)	33–79 (2)	43–56 (2)	68–90 (2)
<i>Detect</i> [2016–2018]	24–53.3 (2)	33–76 (2)	41.3–44 (2)	60–85.3 (2)
<i>Prevent</i> [2016–2018]	38.5–50.8 (2)	42.7–81.5 (2)	52.3–63.1 (2)	66–86.2 (2)
<i>Respond</i> [2016–2018]	37.1–65.7(2)	26–77.1 (2)	34–57.1 (2)	70–98.6 (2)
<i>Points of entry and other IHR related hazards</i> [2016–2018]	20–43.3 (2)	23–86.7 (2)	37–53.3 (2)	60–90 (2)

III. Health outputs				
a. Physical accessibility				
Percentage of facilities offering services according to national defined service package	Not available	Not available	Not available	Not available
Percentage of facilities meeting minimum standards to deliver tracer services	Not available	Not available	Not available	Not available
Percentage of facilities compliant with infection prevention and control measures	Not available	Not available	Not available	Not available
b. Financial accessibility				
Out-of-pocket health expenditure as % of current health expenditure [2011–2019]	54–81 (8)	24–63 (8)	30–50 (8)	7–30 (8)
IV. Processes				
a. Selection and planning of services				
Existence of service packages that cover essential health services and essential public health functions across the full spectrum of care	Data collection in progress	Data collection in progress	Data collection in progress	Data collection in progress
b. Systems for improving quality				
Percentage of facilities with systems to support quality improvement	Not available	Not available	Not available	Not available
c. Resilient health facilities and services				
Percentage of facilities meeting criteria for resilient health facilities and services	Not available	Not available	Not available	Not available
V. Inputs				
a. Governance				
Existence of national health policy oriented to PHC and UHC	Data collection in progress	Data collection in progress	Data collection in progress	Data collection in progress
Existence of health emergency and disaster risk management strategies	Data collection in progress	Data collection in progress	Data collection in progress	Data collection in progress
<ul style="list-style-type: none"> • Existence of national action plan for health security • Existence of influenza plan • Existence of antimicrobial resistance plan • Existence of IHR travel and trade measures • Existence of WHO humanitarian response plan 				
Existence of policy, strategy or plan for improvement of quality and safety	Data collection in progress	Data collection in progress	Data collection in progress	Data collection in progress
Coordination mechanisms with multistakeholder participation and community engagement	Data collection in progress	Data collection in progress	Data collection in progress	Data collection in progress
b. Health financing				
Current health expenditure as % gross domestic product [2011–2019]	4–13 (8)	2–9 (8)	4–8 (8)	3–6 (8)
Current health expenditure per capita in US\$ [2011–2019]	47–73 (8)	62–663 (8)	253–334 (8)	625–1843 (8)
Domestic general government health expenditure as percentage of general government expenditure (%) [2011–2019]	3.9–5.6 (1)	4.3–21.4 (1)(2)	6–12.8 (1)	6.5–11.1 (1)

c. Health workforce				
Density of medical doctors (per 10 000 population) – SDG 3.c.1 [2012–2019]	0.2–12.9 (1)	2.2–22.6 (1)(2)	9.7–26.6 (1)	9.3–27.4 (1)
Density of nursing and midwifery personnel (per 10 000 population) [2012–2019]	1.1–15.4 (1)	4.8–29.6 (1)(2)	23.9–65.3 (1)	24.9–72 (1)
Density of dentists (per 10 000 population) [2012–2019]	0.2–7.2 (1)	0.2–10.2 (1)(2)	3.5–8.8 (1)	1.0–6.7 (1)
Density of pharmacists (per 10 000 population) [2012–2019]	0.3–10.7 (1)	1.5–12.9 (1)(2)	4.1–10.4 (1)	1.6–12.1 (1)
d. Physical infrastructure				
Primary health care facilities per 10 000 population [2015–2019]	0.9–1.5 (2)	0.5–3.5 (2)	2.1–7.1 (2)	0.2–3.8 (2)
e. Medicines and other health products				
Availability of selected essential medicines in public and private health facilities – SDG 3.b.3				
<i>Public</i> # [2012–2019]	48.7 (Sudan) (1)	97 (Palestine) (2)	13 (Libya) – 100 (Jordan) (2)	97–100 (2)
<i>Private</i> # [2012–2019]	59 (Sudan) (1)	11.6 (Tunisia) – 100 (Palestine) (2)	100 (Jordan) (2)	100 (Bahrain, Kuwait, United Arab Emirates) (2)
f. Health information and digital technologies for health				
S-C-O-R-E				
Survey population and health risks [2019–2020]	2–4 (9)	3–4 (9)	3 (9)	3–5 (9)
Count births, deaths and causes of death [2019–2020]	1–2 (9)	1–4 (9)	3 (9)	4 (9)
Optimize health service data [2019–2020]	2–4 (9)	2–4 (9)	2–4 (9)	3–4 (9)
Review progress and performance [2019–2020]	3–5 (9)	3–5 (9)	3–4 (9)	3–5 (9)
Enable data use for policy and action [2019–2020]	3–4 (9)	2–4 (9)	2–3 (9)	2–5 (9)
Percentage of facilities using electronic health records	Not available	Not available	Not available	Not available

* Country income group based on World Bank 2022 classification, see <https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023>.

Data for selected countries/territories are available, and names of the countries/territories have been mentioned in parentheses.

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The impact of COVID-19 on health systems in the Eastern Mediterranean Region

23. The pandemic provided an extraordinary opportunity to implement several health system innovations – for example, strengthening disease surveillance and other essential public health functions; using digital technology in service delivery; building laboratory capacities; promoting multisectoral collaboration; and facilitating private sector engagement. These innovations had long been discussed but opportunities to implement them had not previously been fully seized. However, the pandemic also unveiled how ill prepared the health systems in the Region were to face it (50). This was mainly due to chronic underinvestment in health, IHR capacities and health systems (51). The Region is home to almost 10% of the world’s population but spends less than 2% of the total global expenditure on health, mainly due to limited public financing for health. For example, in 2015 public spending on health in the Region constituted 2.5% and 9% of GDP and general government expenditures, respectively, compared to global estimates of 3.5% and 10%, respectively (52).

24. The emergency situation created by the pandemic and efforts to contain it (e.g. lockdowns and other social public health measures) led to disruption in essential health services (53,54). A series of pulse surveys¹ conducted by WHO throughout the pandemic showed that 94% of participating Member States in the Region had reported disruptions to at least one essential health service in the first round of the survey (55), compared with 94% and 81% in the two following rounds (56,57). Disruption was reported to be the highest in rehabilitative, community and primary care services, and in elective surgeries.

25. Disruption was indicated to be mainly due to community fear and mistrust, travel restrictions (including due to lockdowns) and financial difficulties. Furthermore, services have been hampered by supply-side problems, especially related to staff – who were at higher risk of infection in health facilities as well as in long-term care homes – and supply shortages. Longer-term financial protection is also becoming at risk, especially with the escalating economic impact of the pandemic, increasing poverty levels and contracting public revenues. Disruption of essential health services was more pronounced and long lived in countries that started with health systems that were weaker at the onset of the pandemic. Box 2 provides examples of specific health system challenges highlighted by the pandemic.

Box 2. Health system challenges highlighted by the pandemic

- Suboptimal leadership and uncoordinated efforts, compromising timely decisions and effective responses
- Underutilization of emergency operations centres
- Shortage of health workers and their vulnerability – for example, lack of appropriate skill mix and poor infection prevention and control measures
- Limited capacity for high-end care in secondary and tertiary hospitals and a hospital sector underprepared to respond to various types of emergencies, specifically infectious disease outbreaks
- Inadequate clinical and logistics systems and supply chains that are unable to scale up in an emergency
- Insufficient regional and local production capabilities, in particular for vaccines – with only four countries producing vaccines in the Region prior to COVID-19
- Limited quality, high prices and shortages of medical products and personal protective equipment
- Weak and rigid public financial management systems
- Fragmented health information and surveillance systems
- Inadequate engagement of the public in health system decision-making, which limited the public’s trust in public health messages, allowing for mis- and disinformation to spread rapidly

¹ The WHO national pulse survey on the continuity of essential health services during the COVID-19 pandemic is a global survey that was conducted in three rounds: May–July 2020, January–March 2021 and November–December 2021.

26. At the same time, the pandemic highlighted the longstanding and inadequate situation caused by current health systems' disproportionate concentration on curative care at the expense of public health, investing in prevention, and promoting health and well-being. The pandemic also showed how health systems of the Region are mostly designed with a focus on efficiency at the expense of equity, with less attention paid to multisectoral actions to influence and leverage the various social determinants of health. Finally, the pandemic has also highlighted that national and regional collaboration is suboptimal. Shaping health systems to advance the dual goals of UHC and health security brings back the question of what constitutes a health system and its boundaries, goals and objectives.

27. Additionally, the economic consequences of the pandemic led to a reduction in overall revenues for health at a time when demand for health care increased, with those countries dependent on external funding being particularly affected (58). The pandemic-related restrictions and curbing of civil liberties that were part of many response efforts also resulted in considerable inequities (59,60) and a degradation in public confidence, particularly in contexts where trust was already low (61).

28. As a result, the pandemic negatively affected all three UHC goals: (a) service coverage, due to interruptions in some essential health services and delays in others; (b) financial protection, due to income reductions and increased out-of-pocket payments; and (c) quality, with increased risks of substandard health service delivery, health care-acquired infections, and falsified and substandard treatments. COVID-19 is a call to strengthen IHR core capacities as part of HSS, to address poorly defined emergency management arrangements and weak emergency management capacities, and to enhance investment in One Health.

Key lessons for future health system building

29. The pandemic demonstrated that building resilient health systems is not an option but a necessity for every country's well-being and prosperity, as well as for national and global health security. Below are eight key lessons to consider in building future health systems in the Eastern Mediterranean Region:

- Lesson 1: The pandemic emphasized the need to invest in EPHFs as part of HSS. Reshaping and investing in EPHFs should be the "Step 0"¹ in health system recovery from COVID-19 (62). This entails ensuring proportionate prioritization of public health to meet population health needs, along with enhancing access to individual and population-based interventions and services.
- Lesson 2: COVID-19 uncovered and worsened deep-rooted inequities across and within countries, underlining the importance of mainstreaming equity and participatory approaches in all HSS endeavours. This should start by creating a relevant space for social participation – for example, district health committees or people's health assemblies – to build trust and allow for people's voices to be heard in identifying health needs, formulating policies, and enhancing transparency and accountability in implementation (63). Once a shock strikes, participatory mechanisms can be leveraged for a coordinated whole-of-society response to ensure effective enforcement of control measures.
- Lesson 3: The pandemic highlighted gaps in current service delivery organization, calling for developing country-specific models of care that are fit for context. The recovery from the pandemic provides an opportunity to integrate parallel health programmes – for example, communicable diseases, noncommunicable diseases, mental health, and reproductive, maternal, neonatal, child and adolescent health – in a manner that enhances people-centredness, responsiveness and efficiency. This could be materialized by developing context-specific PHC-oriented models of care, starting by defining integrated comprehensive essential health services packages.
- Lesson 4: The pandemic has shown that health is central to all aspects of life, affecting and being affected by actions far beyond the health sector (e.g. the financial, economic, social development, environment and education sectors), and thereby emphasizing the importance of reshaping health

¹ The term "Step 0" is used to indicate that this is the priority of all priorities, upon which other interventions could be built.

institutions to ensure multisectoral collaboration and coordinated actions by mainstreaming health in all policies. The pandemic is a wake-up call to ensure that ministries of health and related institutions are fit for the needs of the 21st century and the “post-COVID” world.

- Lesson 5: COVID-19 highlighted the vital role of health workers in continuing to provide essential health services while responding to emergencies and other stressors (64). It has also drawn attention to the need to protect and safeguard the health and well-being of the health workforce. In that respect there are obligations upon governments and employers to ensure that health and care workers develop the required skills; are provided with the needed resources; have employment security; and enjoy adequate and regular remuneration and safe, healthy and supportive environments that enable them to deliver respectful and quality care to all (65).
- Lesson 6: COVID-19 underscored that those countries lagging on the UHC service coverage index, with a deficient health system (e.g. low workforce densities, poor infrastructure and equipment, shortage of water and electricity supplies), are unable to deliver essential basic health services and thus have limited capacity to effectively respond to outbreaks and other emergencies. These countries, which are usually low-income countries or in FCV settings, need intensified support from the international community to reach a minimum level of delivery of essential basic health services, to ensure progress on UHC and health security.
- Lesson 7: COVID-19 underscored the need for a “new” world order in which the responsibility for health surpasses national boundaries to become a regional and global good. This calls for considering global health priorities as part of national strategies, by integrating IHR obligations into national health policies, strategies and plans.
- Lesson 8: The pandemic demonstrated the need to establish clear emergency management arrangements and strengthen emergency management capacities, to clarify how the health sector/ministries of health relate with other sectors/ministries and institutions (e.g. a national disaster management authority) and the executive branch of government. This will facilitate coordination among different ministerial departments and improve strategic, operational and tactical management of the response.

Shaping the future of health systems in the Eastern Mediterranean Region: the “what”

Formulating a vision for health systems in the Region post-COVID

30. The scale of the socioeconomic crisis ensuing from COVID-19 is no less great than that which resulted from the Second World War. Several voices are calling for a global “reset” post-pandemic by revisiting our public systems, including those for health, to promote equitable societies and a sustainable and green recovery.

31. National health systems of the future need to acknowledge how interconnected the world has become and give prominence to global health within national policies, strategies and plans. Future health systems need to place individuals and communities at the centre of the system and ensure integration – both horizontally across diseases and vertically across levels of care – rather than continue to be disease-focused and provider-driven. In addition, health systems of the future need to become learning systems, embracing knowledge and innovation.

32. This requires a paradigm shift in health system thinking, from an approach that prioritizes curative care and is primarily concerned with efficiency towards one that is oriented towards health promotion and protection, as well as disease prevention, while embracing quality of life and well-being and mainstreaming equity in all policies and strategies.

33. This could be translated into building resilient health systems towards UHC and health security, where everyone and all communities are protected from emergencies and enjoy the right to access needed health care that is of good quality and with financial protection. Achieving this vision requires

reorienting our health systems towards PHC: towards a system in which multisectorality and community engagement are given as much prominence as primary care and EPHFs. Fig. 1 depicts a theory of change to guide regional and national health systems in realizing the above vision amid the COVID pandemic and, eventually, post-COVID.

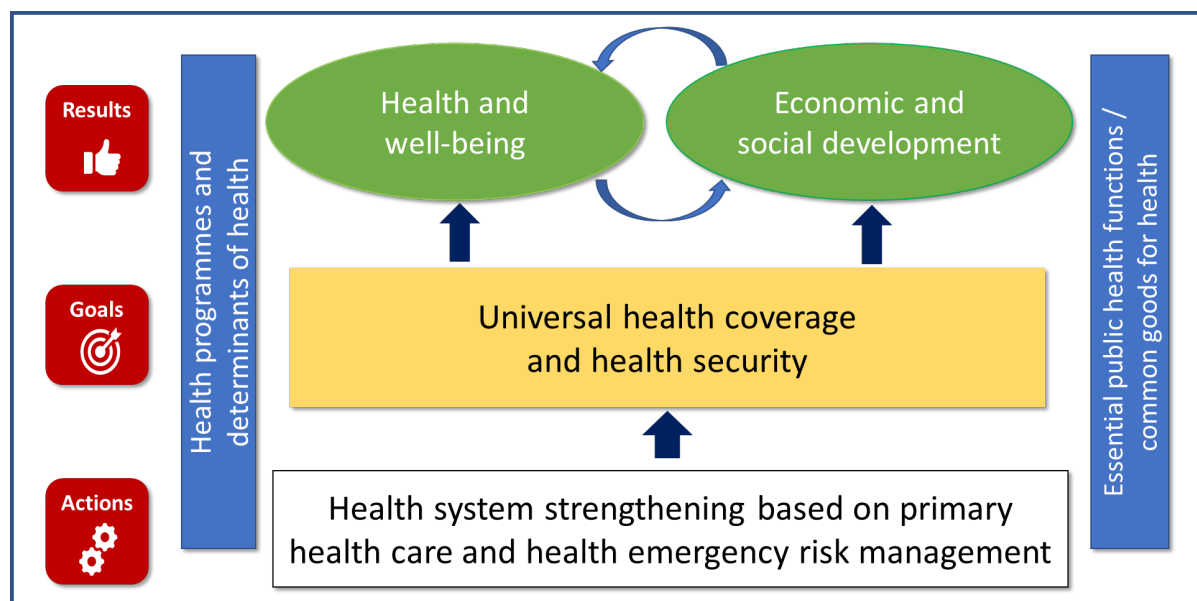


Fig. 1. Building resilient health systems towards UHC and health security in the Eastern Mediterranean Region: a theory of change

Regional priorities for realizing the Region's health system vision post-COVID

34. To realize the above vision, a set of seven complementary regional priorities are proposed (Box 3). Progress on the seven priorities needs to be pursued in tandem by reshaping and investing in health system components and EPHFs, avoiding prevailing fragmentations – hence, regional priority 7. Progress on these priorities will be possible only if health is placed higher in government agendas, including in national budgets, and considered integral to overall national security agendas.

Box 3. Seven regional priorities for building resilient health systems towards UHC and health security

- Regional priority 1: Strengthening HEDRM in line with the *Plan of action for ending the COVID-19 pandemic and preventing and controlling future health emergencies in the Eastern Mediterranean Region*
- Regional priority 2: Optimizing ministries of health and building institutions for public health
- Regional priority 3: Establishing PHC-oriented models of care
- Regional priority 4: Enhancing and scaling up a fit-for-purpose, fit-to-practice health workforce
- Regional priority 5: Promoting equity and enhancing financial protection
- Regional priority 6: Improving access to medicines, vaccines and health products
- Regional priority 7: Fostering an integrated approach in policy, planning and investment for long-term health system resilience

Building resilient health systems towards UHC and health security: the “how”

35. To progress on the seven priorities at regional and national levels, Member States need to invest in various priority actions to be supported by WHO and other development partners. The annex to this paper includes a menu of priority actions, WHO deliverables and country outcomes, to be pursued up to 2030, on the path to building resilient health systems to advance UHC and ensure health security in the Region.

36. The proposed priority actions are directed towards challenges identified before COVID-19, as well as those highlighted by it, and are in line with recommendations made in various WHO guidance documents. They are also based on lessons learned from successful country experiences from within and outside the Region. The proposed priority actions are to be adapted to countries’ political and socioeconomic environments and capacities.

Leveraging a delivery system towards impact at country level

37. Achieving the above vision and the associated priorities requires leveraging the global health governance system and further engaging with national political systems, to position health on the global diplomacy and national socioeconomic development agendas. The pandemic has shown that responsible and decisive leadership is vital (66) in devising the “right” public health strategies and enforcing them, and that individuals’ and communities’ adherence to public health and social measures is also critical. At the national level, effective leadership facilitates agile decision-making during emergencies, while at local levels it ensures that such decisions can be successfully translated and implemented. Developing leadership capacity at all health system levels – national and subnational – and across all stakeholder levels – governments, legislators, IHR national focal points, the private sector, communities, civil society and academia – is paramount to ensure effective implementation of the national vision.

38. It is crucial to remember that each setting is unique. The pandemic did not have the same health impact in all countries, and countries did not have the same ability to implement recommended mitigation interventions. Therefore, measures can only be effective as well as equitable, inclusive and coherent when appropriately adapted to individual contexts. Acknowledging the variation between countries and the differences in baseline capacities, and recognizing the special needs of countries with FCV settings, entails that each country will require its own adapted approach to implementing the seven regional priorities, sometimes with different subnational/regional strategies. Sequencing the reform process will be fundamental to ensuring its success. For this, WHO will develop regional- and country-level delivery stocktake mechanisms, leveraging existing global stocktakes, to assess remaining gaps in reaching global, regional and national targets; identify acceleration opportunities; and bring together data, science and delivery to drive evidence-informed policy processes. Concomitantly, technical assistance shall be provided to build national capacities for effective implementation of related WHO normative guidance and technical packages.

39. By leveraging agile country delivery teams from the three levels of the Organization, WHO shall support Member States in the Region to achieve measurable impact as they progress towards implementing each of the regional priorities. For this, national baselines and targets will be set. WHO will work to track progress on each of the priority actions and assess its contribution to achieving the related country impacts.

Conclusion

40. The lessons from COVID-19 should not go unlearned. The next major outbreak/pandemic is not far away, based on the increasing frequency of outbreaks of emerging and re-emerging infectious diseases in the past 20 years – for example, SARS, H1N1, MERS, Ebola, Zika, COVID-19 and monkeypox. Other emergencies are also increasing in frequency and severity, especially severe weather events due to climate change, and conflict and displacement. Strong and comprehensive health systems are essential for health security and UHC, but systems were largely “in crisis” worldwide and many

were “broken” well prior to COVID-19 (8). The pandemic sounded the alarm that we are only as strong as the weakest health system in the world. Building the resilience of health systems is impossible without political leadership, adequate and sustained financing, a competent workforce and functioning systems (e.g. supply chains and hospital management information systems).

41. Evidence is clear that investment in preparedness offers significant returns. For more effective impact and sustainable results, HSS for UHC and HEDRM for health security need to be integrated (67). Building resilient health systems based on the PHC approach is the most effective, efficient and sustainable approach to advance the dual goals of UHC and health security. Current global and domestic fiscal realities dictate that integrating the two goals within one national health system is a fiscal imperative too. Reorganizing and investing in health systems offer additional economic, social and political benefits (68).

42. For a country to align and integrate its national action plan for health security and its national health policy, strategy and plan – while acknowledging the respective boundaries of each – would constitute a cost-effective strategy for building resilient health systems towards UHC and health security. The recently launched Universal Health and Preparedness Review process (69) provides a new opportunity for investing in emergency preparedness and response using a health system approach.

43. Finally, it should be acknowledged that Member States and development partners made impressive efforts to strengthen health systems in the Region following the adoption of Regional Committee resolution EM/RC59/R.3 in 2012 (70). It is hoped that this year’s paper and the related discussion will generate similar momentum for building resilient health systems to advance UHC and ensure health security, as the Region recovers from the COVID-19 pandemic. We also hope that this paper will help to guide regional efforts in preparation for the Second High-level Meeting on UHC at the United Nations General Assembly in September 2023.

Recommended actions for Member States and for the Secretariat

Recommended actions for Member States

44. While there is a need to work on all of the priority actions, the 10 most urgent recommended actions for Member States are as follows:

- Set up a high-level multisectoral mechanism to oversee health system resilience building, with clear roles and responsibilities for its stakeholders.
- Align/integrate the national action plan for health security with/into the national health policy, strategy and plan, and mobilize necessary domestic resources for their effective implementation.
- Optimize ministry of health structures by mainstreaming/separating commonly combined functions – for example, regulation, financing and provision – to enhance performance and ensure accountability.
- Clarify and reinforce national emergency management arrangements, including functional linkages between ministries of health and national disaster management authorities.
- Adapt context-relevant model(s) of care for the effective delivery of quality pre-defined essential health services packages – including at hospital level – leveraging the PHC approach.
- Strengthen national health information systems, leveraging digital health, to support access and monitor progress towards UHC and health security.
- Convene relevant ministries and other stakeholders to conduct a health labour market analysis and develop health workforce strategic plans.
- Convene policy and societal dialogues between ministries of finance, health, social development and others to advocate for more, and more flexible, public money for health, financial protection and investment in IHR core capacities as a national responsibility.
- Strengthen national regulatory authorities to ensure the quality, safety and efficacy of health products.
- In FCV countries and settings, leverage humanitarian coordination and response mechanisms to expand coverage of essential health services packages while supporting key elements of the health system to build back better institutions, employing a humanitarian–development–peace nexus approach.

Recommended actions for the Secretariat

45. WHO support should be country-focused and integrated, in line with the differentiated approach stipulated in the Thirteenth General Programme of Work (GPW 13) and *Vision 2023 (12)* and it should:

- a) In all Member States: deliver integrated support to mainstream the seven regional priorities in national health strategies and other health system reforms towards improved resilience.
- b) In low-income countries and FCV settings: deliver intensified support as recommended in the Programme Budget 2022–2023 budget increase document (WHA 75/6) (71).

46. To support the implementation of the various priority actions, WHO, along with development partners, should do the following:

- engage in technical cooperation with Member States to adapt the regional priority actions to the national context and ensure their effective implementation;
- leverage the Regional Health Alliance, the SDG3 Global Action Plan and its associated accelerators and UN country teams to ensure implementation of nationally-identified priority actions.
- share experiences of what does and does not work in relation to pursuing the various priority actions;
- build the capacity of regional and national expertise in HSS and HEDRM to build resilient health systems, moving towards UHC and health security;
- support Member States in the Region in tracking progress on each of the seven regional priorities and the associated priority actions; and
- facilitate resource mobilization in support of national efforts to ensure the effective implementation of priority actions and progress towards achieving the dual goals of UHC and health security.

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Annex

Regional priorities, WHO deliverables and country outcomes towards building resilient health systems to advance universal health coverage and ensure health security in the Eastern Mediterranean Region

Regional priority	Priority actions	Key WHO deliverables up to 2030	Country outcomes up to 2030
Regional priority 1: Strengthening health emergency and disaster risk management (HEDRM) in line with the <i>Plan of action for ending the COVID-19 pandemic and preventing and controlling future health emergencies in the Eastern Mediterranean Region.</i>	1.1 Set up a high-level multisectoral mechanism to oversee health system (re-)building/recovery from COVID-19.	<ul style="list-style-type: none"> Regional guidance on multisectoral engagement in building health system resilience by investing in and leveraging all health system components and HEDRM functions. 	<ul style="list-style-type: none"> Cabinet-level structure/mechanism for the oversight of health system transformation established, with clear roles and responsibilities for each line ministry and other stakeholders. Multisectoral engagement in building health system resilience improved by investing in and leveraging all HEDRM functions.
	1.2 Establish a functional public health emergency operations centre (PHEOC) and strengthen HEDRM capacities within the ministry of health (MOH).	<ul style="list-style-type: none"> Technical cooperation to establish PHEOCs. Technical assistance to strengthen HEDRM capacities within MOHs. 	<ul style="list-style-type: none"> A functional PHEOC established. HEDRM capacities within MOHs strengthened.
	1.3 Align/integrate national action plans for health security (and other HEDRM plans) with/into national health policies, strategies and plans (NHPSPs) – including at subnational level – while maintaining relevant outreach.	<ul style="list-style-type: none"> Guidance note on integration of HEDRM into NHPSPs, with clear operational linkages between MOH and responsible national disaster and emergency management agencies. Technical assistance to regularly update and implement NAPHS and other HEDRM plans. Operational guidance on a stepwise approach to strengthen hospital resilience with an all-hazards approach. 	<ul style="list-style-type: none"> NAPHS aligned with/integrated into NHPSPs. NAPHS up to date and fully implemented. Hospitals have resilience plans for emergencies in line with NHPSP.
	1.4 Enhance the capacity of all health system components towards ensuring health security by addressing the gaps identified by various reviews – e.g. universal health and preparedness review (UHPR) and International Health Regulations (IHR) (2005) monitoring and evaluation framework.	<ul style="list-style-type: none"> Regional roadmap to strengthen countries' health systems for health security, informed by IHR (2005) monitoring and evaluation framework. Technical assistance to conduct UHPRs. 	<ul style="list-style-type: none"> UHPR review conducted and recommendations implemented. Health systems for health security strengthened, informed by the IHR (2005) monitoring and evaluation framework, including a self-assessment annual report, joint external evaluation, after-action review and simulation exercise.
	1.5 Ensure predictable and flexible funding to strengthen emergency preparedness and response capacities as part of NHPSPs.	<ul style="list-style-type: none"> Guidance note on ensuring predictable and flexible funding to strengthen emergency preparedness and response capacities. 	<ul style="list-style-type: none"> Predictable and flexible funding established to strengthen emergency preparedness and response capacities, and a budget line defined in the MOH/government budget.
	1.6 Strengthen community preparedness and engagement to prevent, detect and respond to threats and health events.	<ul style="list-style-type: none"> Design and implement capacity-building programmes to empower communities and civil society organizations towards building a resilient health system. Establish and build the capacity of formal and informal front-line workers, including community health and social workers, in HSS towards UHC and health security. 	<ul style="list-style-type: none"> Communities engaged in assessments and decision-making on suitable interventions for UHC and health security and their implementation. Well-trained front-line community health and social workers engaged in preparedness and response.
	1.7 Operationalize the humanitarian–development–peace nexus (HDPNx) approach in FCV countries and settings.	<ul style="list-style-type: none"> Technical assistance to operationalize the HDPNx approach for strengthening and streamlining humanitarian response with build back better recovery and development efforts. Technical cooperation to develop and implement plans for health system recovery from COVID-19. 	<ul style="list-style-type: none"> Humanitarian response and development efforts streamlined, leveraging an HDPNx approach in protracted emergency settings.

Regional priority	Priority actions	Key WHO deliverables up to 2030	Country outcomes up to 2030
Regional priority 2: Optimizing ministries of health and building institutions for public health	2.1 Reorganize the MOH to mainstream/separate the commonly combined functions of regulation, financing and provision, to enhance performance and accountability.	<ul style="list-style-type: none"> Guidance note on reorganizing/reshaping MOHs, to enhance performance and accountability. Technical assistance to map and assess implementation of essential public health functions (EPHFs). Technical cooperation to strengthen EPHFs to enhance health system resilience. 	<ul style="list-style-type: none"> MOH institutions reformed/transformed to fit the needs of the 21st century. EPHF capacities strengthened, forming a basis for health system recovery.
	2.2 Establish a multisectoral platform for collaborative governance, to bring together all stakeholders involved in the health sector and related sectors.	<ul style="list-style-type: none"> Guidance note on establishing multisectoral platforms for collaborative governance. Analytical report on existing multisectoral platforms for collaborative governance in the Region – e.g. High Health Authority, National/High Health Council, Supreme Council for Health. Build regional/national capacities in leadership and governance, including across relevant stakeholders. 	<ul style="list-style-type: none"> Roles and responsibilities of various stakeholders in the health sector and related sectors – including those of government entities (e.g. finance, economy, social development, environment), civil society organizations, parliamentarians, etc. – well defined. A multisectoral platform – e.g. High Health Authority, National/High Health Council, Supreme Council for Health – established. National/subnational institutions – e.g. purchasing authorities or national health insurance agencies, provider organizations, regional health agencies, national medicines agency – functioning.
	2.3 Clarify and reinforce national emergency management arrangements, ensuring functional linkages between the MOH and government institutions responsible for emergency preparedness and response – e.g. national disaster management authorities.	<ul style="list-style-type: none"> Technical cooperation to develop/revise roles and responsibilities – i.e. terms of reference (ToRs) of health working groups/MOH under national emergency management structure. 	<ul style="list-style-type: none"> The ToRs of health working groups/MOH under the national emergency management structure revised/developed and endorsed.
	2.4 Set up relevant mechanisms for institutionalizing a culture of participation and transparency in decision-making.	<ul style="list-style-type: none"> Develop country guidance and list of indicators to institutionalize and monitor progress of “participatory governance” in health decision-making. 	<ul style="list-style-type: none"> Participatory governance mechanisms and structures – e.g. <i>dialogue sociétal</i>, people’s health assembly, <i>états généraux</i> – established/institutionalized.
	2.5 Build institutional and individual capacities in operational and implementation research, to cultivate a “learning health system” towards UHC and health security.	<ul style="list-style-type: none"> Develop regional research agenda on health systems towards UHC and health security. Support establishment of WHO collaborating centres for UHC and health security. 	<ul style="list-style-type: none"> National research agenda on building health systems for UHC and health security developed. Research centres/programmes on UHC and health security established. A critical mass of researchers built, in support of the national research agenda on health systems for UHC and health security.
	2.6 In FCV countries/settings, leverage humanitarian coordination and response mechanisms (e.g. Health Cluster, Humanitarian Country Team) to progressively expand coverage of an essential health service, support and sustain key elements of the health system (e.g. health workforce, supply chain, health information system, district health teams) and build back better institutions.	<ul style="list-style-type: none"> Regional guide and operational plan for strengthening/streamlining humanitarian response towards build back better recovery. Country support plan on development and implementation of health system recovery. 	<ul style="list-style-type: none"> Humanitarian response streamlined and includes a build back better recovery and an HDPNx approach in protracted emergency settings.

Regional priority	Priority actions	Key WHO deliverables up to 2030	Country outcomes up to 2030
Regional priority 3: Establishing PHC-oriented models of care	3.1 Define a context-specific UHC priority benefit package (UHC-PBP)/essential health services package (EHSP).	<ul style="list-style-type: none"> Regional guidance note on UHC-PBP/EHSP development, costing and implementation. 	<ul style="list-style-type: none"> A context-specific UHC-PBP/EHSP developed and implemented.
	3.2 Adapt the service delivery model to ensure effective delivery of UHC-PBP/EHSP.	<ul style="list-style-type: none"> Strategic paper on defining PHC-oriented models of care in the Region. 	<ul style="list-style-type: none"> National/subnational PHC-oriented model of care revamped.
	3.3 Strengthen hospitals within the primary health care (PHC) approach, to ensure integrated, people-centred health services; enhance hospital emergency preparedness for tackling future emergencies and other public health challenges.	<ul style="list-style-type: none"> Guidance note on developing and implementing national hospital sector strategy towards building resilient hospitals and hospital sector in line with the regional framework for action. Technical cooperation to develop and implement national hospital strategic plan in line with regional framework for action for hospital sector. Capacity-building of hospital managers using WHO capacity-building programmes. 	<ul style="list-style-type: none"> National hospital sector strategic plan developed and implemented. Hospital managers' capacity built. Hospitals safe in emergencies and able to deliver health services to meet the surge in demand in emergency situations
	3.4 Invest in continuous quality improvement.	<ul style="list-style-type: none"> Regional roadmap on continuous quality improvement to promote adoption of evidence-informed policies and programmes towards institutionalizing quality and patient safety (QPS) measures and infection prevention and control practices. 	<ul style="list-style-type: none"> QPS integrated within PHC-oriented models of care, with a vision towards continuing quality improvement.
	3.5 Strengthen national health information systems (HIS) to monitor progress towards UHC and health security.	<ul style="list-style-type: none"> Technical cooperation to strengthen HIS, including eHealth. 	<ul style="list-style-type: none"> National HIS strengthened, including at facility level.
	3.6 Integrate health programmes – e.g. communicable diseases, noncommunicable diseases, mental health, and reproductive, maternal, neonatal, child and adolescent health – into PHC.	<ul style="list-style-type: none"> Technical cooperation to integrate health programmes into PHC, leveraging UHC-PBP definition and PHC-oriented model of care development. 	<ul style="list-style-type: none"> Health programmes integrated into PHC.
	3.7 Establish strong linkages between community health and facility-based services, with strong systems for supervision and oversight, and referral.	<ul style="list-style-type: none"> Guidance note on strengthening linkages between community health and facility-based services. Technical cooperation to strengthen linkages between community health and facility-based services. 	<ul style="list-style-type: none"> Health programmes integrated into PHC.
Regional priority 4: Enhancing and scaling up fit-for-purpose, fit-to-practice health workforce	4.1 Convene relevant ministries and other stakeholders to conduct a health labour market analysis and engage an inclusive policy dialogue to develop health workforce strategic plans.	<ul style="list-style-type: none"> Facilitate evidence-based multisectoral and multistakeholder policy dialogues on health workforce policies and strategies. Technical cooperation to identify appropriate strategies to address health workforce challenges and develop health workforce strategic plans. Building capacities in health workforce governance, health labour market analysis and planning. 	<ul style="list-style-type: none"> Strategic plans developed to provide a strategic vision for the health workforce.

Regional priority	Priority actions	Key WHO deliverables up to 2030	Country outcomes up to 2030
	<p>4.2 Secure adequate funding to invest in production and employment capacity of health and care workers; and strengthen health workforce governance and regulation of competency-based education and practice.</p> <p>4.3 Provide enabling working environment, with adequate working conditions and suitable remuneration, incentives, supportive systems and context-based retention strategies to ensure delivery of services and improve performance of health workers.</p> <p>4.4 Protect and safeguard the health and well-being of health and care workforce and ensure that all employers are informed of their legal and policy responsibilities regarding health and safety hazards in their working environments.</p> <p>4.5 Generate improved data and evidence on health workforce, including by establishing/strengthening national health workforce observatory and national health workforce accounts.</p> <p>4.6 Benchmark the functions, sub-functions and tasks in the delivery of EPHFs, map all personnel engaged and conduct competency-gap assessments to inform the development and strengthening of workforce, with a focus on public health capacity and emergency preparedness and response competencies.</p>	<ul style="list-style-type: none"> • Technical cooperation in identifying investment needs and developing investment cases. • Technical cooperation in strengthening health workforce regulation. • Technical cooperation in identifying and implementing adequate employment and retention strategies. • Advocate and promote the assurance of adequate measures to protect and safeguard the health and well-being of health and care workforce. • Capacity-building for health workers on their legal and policy responsibilities. • Develop related communication materials. • Generate regional information and evidence to inform health workforce strategies. • Establish mechanisms to enhance the monitoring of health workforce in the Region. • Identify the competencies required to deliver EPHFs. • Build regional surge capacities to respond to emergencies and develop policies and plans for rapid mobilization of surge capacities during emergencies. • Guidance on integration of HERDM in curricula of health professional education institutions. • Faculty capacity-building on introducing HERDM in curricula. 	<ul style="list-style-type: none"> • Education and employment capacities are adequate and balanced. • Employment opportunities for health workers increased. • Balance in distribution of health workers improved. • Occupational risks and morbidity and mortality reduced. • Health workforce observatory established. • The number/quality of health workforce indicators reported on is progressively increased. • Health workforce enhanced and has competencies to deliver EPHFs. • Reliable surge of qualified staff in response to emergencies. • HEDRM integrated into undergraduate and postgraduate curricula for all cadres of health professionals.
Regional priority 5: Promoting equity and enhancing financial protection	<p>5.1 Convene policy and societal dialogues between ministries of finance, health, social development and relevant government and nongovernment entities – including parliament and media – to advocate for more, and more flexible, public money for health, including for investing in IHR core capacities and EPHFs as a national responsibility.</p>	<ul style="list-style-type: none"> • Regional platform of MOHs and ministries of finance/economy/planning/social development established, to deliberate financing for health in the Eastern Mediterranean Region", in partnership with World Bank, Islamic/African/Asian Development Banks, linked with the Regional Health Alliance. • Five national policy dialogues on financing for health organized with MOHs, finance and other relevant ministries and stakeholders (e.g. parliament, media). 	<ul style="list-style-type: none"> • Number of people suffering from financial hardship in the Region reduced by 10%. • Allocation to the health sector from government budgets increased in five Member States. • Dedicated budget and flexible spending for HEDRM increased in 10 Member States. • Financial hardship as measured by SDG 3.8.2 reduced in five Member States.

Regional priority	Priority actions	Key WHO deliverables up to 2030	Country outcomes up to 2030
	5.2 Make an economic and business case for investing in EPHFs and NAPHS as part of NHPSP to the ministries of finance.	<ul style="list-style-type: none"> • Technical cooperation with five Member States to develop economic and business cases for investing in NHPSP, including NAPHS, EPHFs or other specific public health priorities (e.g. noncommunicable diseases, tobacco), while avoiding duplication. • Promotion of relevant fiscal instruments to improve macroeconomic impact on health (such as health taxes, health investment in fiscal stimulus packages, and inclusion of health in debt relief packages). • Regional economic case for investing in health, health systems, EPHFs and other common goods for health. 	<ul style="list-style-type: none"> • Economic case for investing in health, at large or as related to a specific public health priority, developed and used in national policy dialogue with the Parliament. • Sufficient budget for EPHFs/common goods for health distributed, executed and coordinated in a timely manner across all relevant ministries and levels of government. • National capacity in health economic analysis built in three Member States.
	5.3 Develop and implement equitable health financing policies and strategies towards increasing public money for health, prepayment and pooling and enhancing efficiency.	<ul style="list-style-type: none"> • Mapping of health financing systems in the Region on a continuous basis, as part of the Eastern Mediterranean Region Health Financing Atlas. • Technical assistance to develop health financing policies/strategies, guided by UHC and health security goals. • Technical cooperation to implement health financing reforms in five Member States. 	<ul style="list-style-type: none"> • New health financing policies or strategies developed and endorsed in five Member States. • Purchasing organizations (e.g. social health insurance agencies) established/strengthened in five Member States. • Shift from passive to strategic purchasing in five Member States.
	5.4 Properly sequence expanding coverage and make the case for focusing on the poorest and vulnerable first, pursuing the implementation of the Salalah Declaration on the Road to UHC in the Eastern Mediterranean Region.	<ul style="list-style-type: none"> • Technical cooperation to develop UHC roadmaps in line with the Salalah Declaration and the regional guidance documents. • Technical assistance for defining benefits/entitlements for the entire population with provisions for poorest/vulnerable groups. 	<ul style="list-style-type: none"> • UHC roadmaps developed in five Member States. • Benefit packages defined in five Member States using the regional UHC-PBP, UHC compendium and other evidence.
	5.5 Develop policies for reducing financial barriers during large-scale health emergencies, including frontloading of health facilities to address increased expenditures to scale up epidemic treatment capacity, and waiving direct charges.	<ul style="list-style-type: none"> • Technical guidance for health financing arrangements during acute and chronic emergencies. 	<ul style="list-style-type: none"> • Systems put in place to leverage sufficient financing for health from public sources during an emergency, including leveraging prevailing public financial management rules.
	5.6 Produce and routinely analyse information on health expenditures (using the System of Health Accounts 2011), financial protection and equity, and health financing policy implementation (e.g. using the health financing progress matrices); use this information to track progress towards UHC and health security and improve institutional capacity for transparent decision-making in priority-setting and resource allocation.	<ul style="list-style-type: none"> • Technical cooperation to institutionalize health accounting in five Member States. • Capacity-building in resource tracking including disease- and programme-specific tracking. • Technical assistance for measuring financial protection in the context of UHC and health security. • Guidance documents on specific health expenditure tracking and financial protection analysis, including for health security, PHC and health promotion. 	<ul style="list-style-type: none"> • Health accounting for regular production of health spending data institutionalized in five Member States. • Policy dialogue on financial protection reforms organized in five Member States and used to transform prevailing pooling arrangements. • Priority-setting institutions/arrangements for the health sector established – e.g. by establishing subregional/national health technology assessment agencies.

Regional priority	Priority actions	Key WHO deliverables up to 2030	Country outcomes up to 2030
Regional priority 6: Improving access to medicines, vaccines and health products	6.1 Strengthen national regulatory authorities (NRAs) to ensure the quality, safety and efficacy of health products, including medicines, vaccines, blood products, medical devices and diagnostics.	<ul style="list-style-type: none"> Capacity-building and technical assistance to strengthen regulatory capacities for the regulation of medicines, vaccines, blood products and medical devices. Support NRAs for the benchmarking of regulatory systems to ensure appropriate oversight of the safety, quality and efficacy of medicines and other health technologies. Facilitate regional collaboration and regulatory convergence and harmonization. 	<ul style="list-style-type: none"> National regulatory systems for regulating medicines, vaccines, blood products, medical devices and diagnostics strengthened. NRA self-benchmarking conducted in 13 Member States. Regional network established to foster collaboration and work-sharing, exchange information on regulatory activities and harmonize regulatory activities. Six NRAs have achieved maturity level 3 for medicines and vaccines, and two medicine national control laboratories have become prequalified.
	6.2 Promote technology transfer (including through the COVID-19 Technology Access Pool) and local production; strengthen research and development of quality medicines and vaccines and other health products that meet public health needs.	<ul style="list-style-type: none"> Support Member States to improve their capacity in research, development and production of quality medicines and vaccines of high priority for the Region. Support Member States in promoting technology transfer under voluntary and mutually agreed terms. Facilitate collaboration and the exchange of information and experiences among Member States in the area of local production. 	<ul style="list-style-type: none"> Capacity in research and development of medicines and health products enhanced to improve access to these products. Transfer of technology and production of medicines, vaccines and health technologies promoted. mRNA technology successfully implemented in two Member States. Two manufacturing medicine quality control laboratories and one vaccine are prequalified.
	6.3 Revamp current supply chain systems at regional and country levels through developing comprehensive mechanisms to ensure timely availability of assured quality medicines, vaccines and other health products, with integrated emergency stocks linked with hazard-specific contingency plans that allow targeted rapid scaling up of supplies when needed.	<ul style="list-style-type: none"> Conduct in-depth assessments of the national medical supply chain management systems. Support Member States for capacity-building in the supply chain management and procurement of medicines, vaccines and health products. Support countries in implementing health technology assessment process. Support Member States to implement regional pooled procurement of selected medicines and vaccines. 	<ul style="list-style-type: none"> Supply management systems assessed. National policies and strategies on the procurement system and guidelines on good procurement, distribution and storage practices are developed and implemented to ensure the flow of quality essential medicines and health products on a regular basis. Health technology assessment process implemented in four Member States. Regional pooled procurement process of selected medicines and vaccines implemented.

Regional priority	Priority actions	Key WHO deliverables up to 2030	Country outcomes up to 2030
Regional priority 7: Fostering an integrated approach in policy, planning and investment for long-term health systems resilience	<p>7.1 Convene policy dialogues between key stakeholders for UHC and health security to advocate and generate consensus on ensuring harmonization between the health sector and health security, and disease/hazard/population-specific planning towards more effective and efficient use of available resources for sustained health system resilience.</p> <p>7.2 Conduct joint mapping of health sector resources and capacities, including those that depend on multisectoral collaborations, to identify the current baseline and inform integrated planning and actions that address the identified gaps in meeting population health needs and national priorities.</p> <p>7.3 Identify and mandate key stakeholders within and across health and allied sectors to actively participate in joint planning, including budgeting and monitoring and evaluation aspects, as well as implementation of joint actions with shared accountability towards the interdependent goals of UHC and health security.</p>	<ul style="list-style-type: none"> • Facilitate policy dialogues between MOHs and other line ministers and key stakeholders in Member States for UHC and health security to advocate and generate consensus on ensuring harmonization between health sector and health security. • Regional Health Alliance is leveraged to facilitate policy dialogue among governments and health partners on ensuring harmonization between the health sector and health security, and disease/hazard/ population-specific planning towards more effective and efficient use of available resources for sustained health system resilience. • Guidance note on joint mapping of health sector resources and capacities, including those that depend on multisectoral collaborations. • Undertake a joint multisectoral assessment of zoonotic risks, zoonotic control capacities and gaps. • Country support plans that identify and mandate key stakeholders within and across health and allied sectors to actively participate in joint planning, including budgeting and monitoring and evaluation aspects. • Contribute to the development and piloting of new tools, guidance documents and training materials. 	<ul style="list-style-type: none"> • Regular and dynamic policy dialogue established between MOHs and other line ministries and key stakeholders for UHC and health security to advocate and generate consensus on ensuring harmonization between the health sector and health security. • National multisectoral One Health committee/hub/team, comprising governmental and nongovernmental members, established and has clear ToRs. • Regular joint mapping conducted of health sector resources and capacities, including those that depend on multisectoral collaborations, and a clear indicator integrated into the national health information system. • Priority zoonotic risks identified and systems' capacities documented to inform planning. • Regular analysis conducted to identify and mandate key stakeholders within and across health and allied sectors to actively participate in joint planning, including budgeting and monitoring and evaluation aspects.