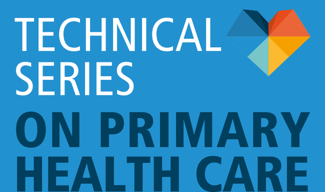
Operational Framework for Primary Health Care

Transforming Vision Into Action



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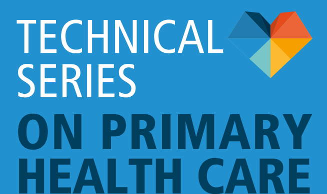

Operational framework for primary health care: transforming vision into action

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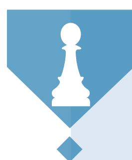

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Preface

The World Health Assembly in resolution WHA72.2 (2019) requests the Director-General inter alia "to develop, in consultation with, and with the involvement of more expertise from, Member States, and in time for consideration by the Seventy-third World Health Assembly, an operational framework for primary health care, to be taken fully into account in the WHO general programmes of work and programme budgets in order to strengthen health systems and support countries in scaling-up national implementation efforts on primary health care". This operational framework builds on an initial draft that was prepared as part of a technical series to support the Global Conference on Primary Health Care (Astana, 25 and 26 October 2018). It was then revised following expert review, public consultation, civil society consultation, key informant interviews and consultations with Member States.

This operational framework, the related Vision for primary health care in the 21st Century, and associated technical documents are informed by reviews of the literature, regional reports prepared in 2018 on primary health care, country case studies on primary health care, a synthesis of lessons learned over the past 40 years, input from the International Advisory Group on Primary Health Care, and thematic reports on key issues relevant to primary health care. It builds on WHO's work on primary health care over the past 40 years, notably the Global strategy for health for all by the year 2000, Primary Health Care 21: "Everybody's business", the Commission on Social Determinants of Health, the WHO Framework for Action for Strengthening Health Systems to Improve Health Outcomes, the World health report 2008: primary health care (now more than ever), and WHO's framework on integrated, people-centred health services.

Acronyms

AIDS	acquired immune deficiency syndrome
HIV	human immunodeficiency virus
PHC	primary health care
SDG	Sustainable Development Goal
SDG3 GAP	Global action plan for healthy lives and well-being for all
UHC	universal health coverage
UHC2030	International Health Partnership for Universal Health Coverage 2030
UNICEF	United Nations Children's Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization

Glossary

Access (to health services) The ability, or perceived ability, to reach health services or health facilities in terms of location, timeliness and ease of approach.

Accountability The obligation to report or give account of one's actions, for example, to a governing authority through scrutiny, contract, management and regulation or to an electorate.

Active participation mechanisms Mechanisms that are designed to achieve accountability and representation of community interests at the local, subnational and national levels.

Ambulatory care sensitive conditions Chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active primary care, for example, asthma, diabetes and hypertension.

Amenable morbidity The incidence of illness considered avoidable by health care interventions.

Amenable mortality Deaths considered avoidable by health care interventions.

Care coordination A proactive approach that brings care professionals and providers together around the needs of service users to ensure that people receive integrated and person-focused care across various settings.

Care pathway (or clinical pathway)**.** A structured multidisciplinary management plan (in addition to clinical guideline) that maps the route of care through the health system for individuals with specific clinical problems.

Carers (or caregivers, informal carers)**.** Individuals who provide care for a member or members of their family, friends or community. They may provide regular, occasional or routine care or be involved in organizing care delivered by others. Carers are in contrast with providers associated with a formal service delivery system, whether paid or on a volunteer basis (formal caregiver).

Case management A targeted, community-based and proactive approach to care that involves case-finding, assessment, care planning and care coordination to integrate services around the needs of people with a high level of risk requiring complex care (often from multiple providers or locations), people who are vulnerable, or people who have complex social and health needs. The case manager coordinates patient care throughout the entire continuum of care.

Catchment area A geographical area defined and served by a health programme, facility or institution, which is delineated based on population distribution, national geographical boundaries and transportation accessibility.

Change management An approach to transitioning individuals, teams, organizations and systems to a desired future state.

Chronic care Health care that addresses the needs of people with long-term health conditions.

Clinical governance The processes through which actors are held accountable for continually improving the quality of their health services and safeguarding high standards of care.

Clinical guidelines Systematically developed, evidence-based recommendations that support health professionals and patients to make decisions about care in specific clinical circumstances.

Clinical integration The coordination of patient care across the system's different functions, activities and operating units. The degree of coordination of care depends primarily on the patient's condition and the decisions made by his or her health team. Clinical integration includes horizontal and vertical integration.

Coherence (of a national health policy, strategy or plan) (a) The extent to which proposed strategies are aligned with the priorities identified in the situation analysis; (b) the extent to which programme plans are aligned with the national health strategy and plan; (c) the extent to which the different programmatic strategies in the national health policy, strategy or plan are coherent with each other; or (d) the extent to which the budget, monitoring and evaluation framework and action plan introduce the proposed strategies.

Collaborative care Care that brings together professionals or organizations to work in partnership with people to achieve a common purpose.

Community A unit of population, defined by a shared characteristic (for example, geography, interest, belief, or social characteristic), that is the locus of basic political and social responsibility and in which every day social interactions involving all or most of the spectrum of life activities of the people within it takes place.

Community health worker Person who provides health and medical care to members of their local community, often in partnership with health professionals; alternatively known as village health worker, community health aide or promoter, health educator, lay health adviser, expert patient, community volunteer or some other term.

Comprehensiveness of care The extent to which the spectrum of care and range of available resources responds to the full range of health needs of a given community. Comprehensive care encompasses health promotion and prevention interventions, as well as diagnosis and treatment or referral and palliation. It includes chronic or long-term home care and, in some models, social services.

Continuity of care The degree to which a series of discrete health care events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences.

Continuum of care The spectrum of personal and population health care needed throughout all stages of a condition, injury, or event throughout a lifetime, including health promotion, disease prevention, diagnosis, treatment, rehabilitation, and palliative care.

Co-production of health care Health services that are delivered in an equal and reciprocal relationship between professionals, people using care services, their families and the communities to which they belong. Co-production implies a long-term relationship between people, providers and health systems whereby information, decision-making and service delivery become shared.

Course of life approach An approach suggesting that the health outcomes of individuals and the community depend on the interaction of multiple protective and risk factors throughout people's lives. This approach provides a comprehensive vision of health and its determinants, which calls for the development of health services centred on the needs of its users at each stage of their lives.

Disease management A system of coordinated, proactive health care interventions of proven benefit and communications to populations and individuals with established health conditions, including methods to improve people's self-care efforts.

District health system (a) A network of primary care health facilities that deliver a comprehensive range of promotive, preventive and curative health care services to a defined population with active participation of the community and under the supervision of a district hospital and district health management team. (b) A network of organizations that provides, or makes arrangements to provide, equitable, comprehensive and integrated health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and for the health status of the population that it serves. *See also*: integrated health services delivery network

Empanelment (or rostering)**.** The identification and assignment of populations to specific health care facilities, teams, or providers who are responsible for the health needs and delivery of coordinated care in that population.

Effectiveness The extent to which a specific intervention, procedure, regimen or service does what it is intended to do for a specified population when deployed in everyday circumstances.

eHealth Information and communication technologies that support the remote management of people and communities with a range of health care needs through supporting self-care and enabling electronic communications among health workers and between health workers and patients.

Empowerment The process of supporting people and communities to take control of their own health needs resulting, for example, in the uptake of healthier behaviours or an increase in the ability to self-manage illnesses.

Engagement The process of involving people and communities in the design, planning and delivery of health services, thereby enabling them to make choices about care and treatment options or to participate in strategic decision-making on how health resources should be spent.

Equity in health The absence of systematic or potentially remediable differences in health status, access to health care and health-enhancing environments, and treatment in one or more aspects of health across populations or population groups defined socially, economically, demographically or geographically within and across countries.

Essential medicines Medicines that satisfy the priority health care needs of the population and are selected based on public health relevance, evidence on efficacy and safety, and comparative cost– effectiveness.

Essential public health functions The spectrum of competences and actions that are required to reach the central objective of public health — improving the health of populations. This document focuses on the core or vertical functions: health protection, health promotion, disease prevention, surveillance and response, and emergency preparedness.

Evaluation A process that systematically and objectively assesses the relevance, effectiveness and impact of activities in the light of their objectives and the resources deployed. Several varieties of evaluation can be distinguished, such as evaluation of structure, process and outcome.

Family practice (or general practice)**.** The discipline for the provision of comprehensive and continuing health care to individuals in the context of their family and community. Its scope encompasses all ages and both sexes. Providers often include generalist practitioners or family medicine doctors, physician's assistants, family nurses, and other health professionals.

First level of care The entry point into the health care system at the interface between services and community; when the first level of care satisfies several quality criteria, it is called primary care. *See*: primary care.

Fragmentation (of health services) (a) Coexistence of units, facilities or programmes that are not integrated into the health network; (b) the lack of service coverage of the entire range of promotion, prevention, diagnosis, treatment, rehabilitation and palliative care services; (c) the lack of coordination among services in different platforms of care; or (d) the lack of continuity of services over time.

Functional integration The extent to which key support functions and activities such as financing, human resources, strategic planning, information management, marketing and quality assurance and improvement are coordinated across all units in a system.

Gatekeeping The processes by which primary care authorizes access to specialty care, hospital care, and diagnostic tests, for example through required referral.

Goal-oriented care Care that is planned and delivered based on goals and targets as explicitly elicited from each individual for the achievement of the highest possible level of health, as defined by that individual.

Harmonization The coordination of donor contributions and activities, the transparent sharing of information and the attempt to be collectively effective and avoid duplication in alignment with national health policies, strategies and plans.

Health State of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

Health benefits package The type and scope of health services that a purchaser buys from providers on behalf of its beneficiaries.

Health governance The wide range of steering and rule-making related functions carried out by governments and decision-makers as they seek to achieve national health policy objectives. Governance is a political process that balances competing influences and demands. It includes: maintaining the strategic direction of policy development and implementation; detecting and correcting undesirable trends and distortions; articulating the case for health in national development; regulating the behaviour of a wide range of actors, from health care financiers to health care providers; and establishing transparent and effective accountability mechanisms.

Health in All Policies approach An approach to public policies across sectors that systematically takes into account the implications for health and health systems of decisions, seeks collaborations, and avoids harmful health impacts in order to improve population health and health equity. A Health in All Policies approach is founded on health-related rights and obligations. It emphasizes the effect of public policies on health determinants and aims to improve the accountability of policy-makers for the effects on health of all levels of policy-making.

Health literacy The achievement of a certain level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions.

Health managers The authorities responsible for overseeing the operations and day-to-day delivery of services, including processes of planning and budgeting, aligning resources, managing implementation and monitoring results.

Health product. Health technologies and devices used for prevention, diagnostics, treatment, rehabilitation or palliation. It includes medicines, vaccines, medical devices, in vitro diagnostics, protective equipment, assistive devices, and vector control tools.

Health service Any service (not limited to medical or clinical services) aimed at contributing to improved health or to the diagnosis, treatment and rehabilitation of individuals and populations.

Health service delivery processes The unique processes that contribute to the performance of health service delivery, including: selecting services, designing care, organising providers, managing services and improving performance.

Health system performance The degree to which a health system carries out its functions of governing, financing, resourcing and delivering services, to achieve its goals.

Holistic care Care that considers the whole person, including psychological, social and environmental factors, rather than just the symptoms of disease or ill health.

Horizontal integration Coordination of the functions, activities or operating units that are at the same stage of the service production process; examples of this type of integration are consolidations, mergers and shared services within a single delivery platform.

Indicator Explicitly defined and measurable metric that helps in the assessment of the structure, process or outcomes of an action or a set of actions.

Integrated health services The management and delivery of health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services through the different functions, activities and sites of care within the health system.

Integrated health services delivery network A network of organizations that provides or makes arrangements to provide, equitable, comprehensive and integrated health services to a defined population and is willing to be held accountable for its clinical and economic outcomes and for the health status of the population that it serves.

Medical device An article, instrument, apparatus or machine that is used in the prevention, diagnosis or treatment of illness or disease, or for detecting, measuring, restoring, correcting or modifying the structure or function of the body for some health purpose. Typically, the purpose of a medical device is not achieved by pharmacological, immunological or metabolic means.

Medical equipment A medical device requiring calibration, maintenance, repair, user training, and decommissioning – activities usually managed by clinical engineers. Medical equipment is used for the specific purposes of diagnosis and treatment of disease or rehabilitation following disease or injury; it can be used either alone or in combination with any accessory, consumable, or other piece of medical equipment. Medical equipment excludes implantable, disposable or single-use medical devices.

Mental health A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his/her community.

Model of care A conceptualization of how services should be delivered, including the processes of care, organization of providers and management of services. The model of care evolves to meet the health aims and priorities of the population and to improve the performance of the health system.

Multidisciplinary teams various health care professionals working together to provide a broad range of services in a coordinated approach. The composition of multidisciplinary teams in primary care will vary by setting but may include generalist medical practitioners (including family doctors and general practitioners), physicians assistants, nurses, specialist nurses, community health workers, pharmacists, social workers, dieticians, mental health counsellors, physiotherapists, patient educators, managers, support staff, and other primary care specialists.

Multisectoral action on health Policy design, policy implementation and other actions related to health and other sectors (for example, social protection, housing, education, agriculture, finance and industry) carried out collaboratively or alone, which address social, economic and environmental determinants of health and associated commercial factors or improve health and well-being.

Mutual (shared) accountability The process by which two (or multiple) partners agree to be held responsible for the commitments that they have made to each other.

Out-of-hours primary care The organization and provision of primary care services outside the regular office hours of primary care facilities on weekdays and all day on weekends and holidays for urgent/acute conditions that can be safely managed in primary care.

Participation The extent to which a person participates in decision-making – in this document regarding his or her own health care and health system. Social participation is the right and the capacity of the population to participate effectively and responsibly in health decisions and implementation of such decisions. Social participation in health is an aspect of civic participation, a condition inherent to the exercise of freedom, democracy, social control over public action, and equity.

Person-centred care Care approaches and practices in which the person is seen as a whole, with many levels of needs and goals, the needs being derived from their personal social determinants of health.

People-centred care An approach to care that consciously adopts the perspectives of individuals, carers, families and communities as participants in and beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways. People-centred care also requires that people have the education and support they need to make decisions and participate in their own care.

Personal health services Health services targeted at the individual, including health promotion, timely disease prevention, diagnosis and treatment, rehabilitation, palliative care, acute care and long-term care services.

Population-based approach An approach to health services that uses information about the population to make decisions about health planning, management, and geographical location. Such an approach seeks to improve the effectiveness and equity of interventions, and to achieve improved health and distribution of health in the population. This is achieved in the context of the culture, health status, and health needs of the geographical, demographic, or cultural groups represented by a population.

Population health An approach to health care that seeks to improve the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

Population health services Health services targeted at the population as a whole with the aim to improve health and well-being on a large scale.

Primary care A key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.

Primary health care A whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services; (b) multisectoral policy and action; and (c) empowered people and communities.

Primary health care-oriented health system Health system organized and operated to guarantee the right to the highest attainable level of health as the main goal, while maximizing equity and solidarity. A primary health care-oriented health system is composed of a core set of structural and functional elements that support achieving universal coverage and access to services that are acceptable to the population and equity enhancing.

Quality care Care that is safe, effective, people-centred, timely, efficient, equitable and integrated.

Referral The direction of an individual to the appropriate facility or specialist in a health system or network of service providers to address the relevant health needs. Counter-referral may occur when an individual is referred back to primary care for follow up care following a procedure in secondary or tertiary care.

Referral form A standardized form throughout the network of service providers that ensures that the same essential information is provided whenever a referral is initiated. It is designed to facilitate communication in both directions – the initiating facility completes the outward referral, referral letter, and at the end of care, the receiving facility completes the counter-referral to the original facility, reply letter.

Referral guidelines A mapping of the linkages across the different platforms of the health system to ensure that health needs are addressed irrespective of the platform at which care was first sought. It facilitates management of cases across different delivery platforms.

Regulation The imposition of constraints upon the behaviour of an individual or an organization to force a change from preferred or spontaneous behaviour.

Resilience The ability of a system, community or society exposed to hazards to resist, absorb, accommodate to 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.

Self-care Individuals, families and communities are supported and empowered to appropriately manage their health and well-being when not in direct contact with health services.

Self-management The knowledge, skills and confidence to manage one's own health, to care for a specific condition, to know when to seek professional care, or to recover from an episode of ill-health.

Service delivery platforms Modes or channels of health service delivery. Examples include public and private health facilities (for example, health posts, clinics, health centres, mobile clinics, emergency care units, district hospitals, and pharmacies), other entities (for example, home-based care, schools, community centres, long-term care facilities) and outreach services, campaigns or digital platforms. These can be classified in a variety of ways. Examples are family-oriented community-based services; population-oriented schedulable services; and individual-oriented clinical services at different levels (primary level, first referral level and second referral level).

Service package A list of prioritized interventions and services across the continuum of care that should be made available to all individuals in a defined population. It may be endorsed by the government at national or subnational levels or agreed by actors where care is by a non-State actor.

Settings/sites of care The varied types of arrangements for service delivery, organised further into different facilities, institutions and organizations that provide care. Settings include ambulatory, community, home, in-patient and residential services, whereas facilities refer to infrastructure, such as clinics, health centres, district hospitals, dispensaries, or other entities, for examples, mobile clinics and pharmacies.

Shared decision-making An interactive process in which patients, their families and carers, in collaboration with their health provider(s), choose the next action(s) in their care path following an informed analysis of possible options, their values and preferences.

Social care services Services to improve the social welfare of those who need them.

Stakeholder An individual, group or organization that has an interest in one or multiple aspects of the health system.

Stewardship A responsibility for the effective planning and management of health resources to safeguard equity, population health and well-being.

Universal health coverage Ensured access for all people to needed promotive, preventive, resuscitative, curative, rehabilitative, and palliative health services, of sufficient quality to be effective, while also ensuring that the use of these services does not expose any users to financial hardship.

Urgent/acute conditions Those conditions that are sudden in onset and require immediate attention.

Vertical integration The coordination of the functions, activities or operational units that are in different phases of the service production process. This type of integration includes the links between platforms of health service delivery, for example between primary and referral care, hospitals and medical groups or outpatient surgery centres and home-based care agencies.

Vertical programmes Health programmes focused on people and populations with specific (single) health conditions.

Well-being A multidimensional construct aiming at capturing a positive life experience, frequently equated to quality of life and life satisfaction. Measures of well-being typically focus on patient-reported outcomes covering a wide range of domains, such as happiness, positive emotions, engagement, meaning, purpose, vitality and calmness.

Definitions in this glossary are adapted from the following sources:

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Executive summary

Background

Pursuant to resolution WHA72.2 (2019), the Director-General has developed a draft operational framework for primary health care, to be taken fully into account in the WHO general programmes of work and programme budgets in order to strengthen health systems and support countries in scaling up national implementation efforts on primary health care. Its primary audience is national, and where appropriate, subnational government leaders. The operational framework is also aimed at informing the actions of other country- and global-level actors, such as non-State actors, including funders and civil society. Following consultation with, and input from, Member States, the draft operational framework is submitted for consideration by the Seventy-third World Health Assembly in 2020.

Primary health care, as outlined in the 1978 Declaration of Alma-Ata and again 40 years later in the 2018 WHO/UNICEF document A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals, is a whole-of-government and whole-of-society approach to health that combines the following three components: multisectoral policy and action; empowered people and communities; and primary care and essential public health functions as the core of integrated health services.*(1)* Primary health care-oriented health systems are health systems organized and operated so as to make the right to the highest attainable level of health the main goal, while maximizing equity and solidarity. They are composed of a core set of structural and functional elements that support achieving universal coverage and access to services that are acceptable to the population and that are equity enhancing. The term "primary care" refers to a key process in the health system that supports first-contact, accessible, continued, comprehensive and coordinated patient-focused care.

Building on the principles of the Declaration of Alma-Ata, the Declaration of Astana was adopted at the Global Conference on Primary Health Care on 25 and 26 October 2018 in Astana. In the Declaration of Astana, Member States reaffirmed their commitment to primary health care as a cornerstone of sustainable health systems for the achievement of universal health coverage and the health-related Sustainable Development Goals.

The Declaration of Astana commitments – to make bold political choices for health across all sectors, build sustainable primary health care, empower individuals and communities, and align stakeholder support to national policies, strategies and plans – was built on previous resolutions aimed at strengthening the vision of primary health care in the Declaration of Alma-Ata: WHA69.24 (2016) on strengthening integrated, people-centered health services, WHA65.8 (2012) on the outcome of the World Conference on Social Determinants of Health and WHA62.12 (2009) on primary health care, including health system strengthening. In resolution WHA62.12, the Sixty-second World Health Assembly requested the Director-General to prepare implementation plans for four broad policy directions, including putting people at the centre of service delivery. These four policy directions for reducing health inequalities and improving health for all were identified in The world health report 2008: primary health care now more than ever, published on the thirtieth anniversary of the international conference of Alma-Ata.*(2)*

The Seventy-second World Health Assembly in 2019 welcomed the Declaration of Astana in resolution WHA72.2 and urged Member States to take measures to share and implement the vision and commitments of the Declaration of Astana according to national contexts.

The WHO regional committees have also called for strengthening of primary health care, notably in regional reports on primary health care prepared for the 2018 Global Conference on Primary Health Care in Astana *(3)*

Importance of primary health care

Despite remarkable improvements in the health outcomes of the global population during the era of the Millennium Development Goals, important gaps persist in people's ability to attain the highest possible level of health. About half of the world's population lack access to the services they need, and poor health disproportionally affects those faced with adverse social and other determinants of health, driving health inequity both within and between countries.*(4)*

Health is central to the 2030 Agenda for Sustainable Development as it relates to many of the Sustainable Development Goals and is the specific focus of Goal 3 (Ensure healthy lives and promote well-being for all at all ages). Commitment to equity and leaving no one behind is captured in target 3.8 on achieving universal health coverage. Universal health coverage means that all individuals and communities receive the health services they need – including promotive, protective, preventive, curative, rehabilitative and palliative – of sufficient quality, without experiencing financial hardship.

The demonstrated links of primary health care to better health outcomes, improved equity, increased health security and better cost-efficiency make primary health care the cornerstone of health systems strengthening. Health systems built on the foundation of primary health care are essential to achieve universal health coverage.

Primary health care-oriented health systems are required to effectively tackle WHO's current priorities including: WHO's Thirteenth General Programme of Work, 2019–2023, with its triple focus on promoting health, keeping the world safe and serving the vulnerable; the global action plan for healthy lives and well-being for all, including the primary health care "accelerator" to enhance collaboration between partners in order to accelerate progress at the country level on the health-related targets of the Sustainable Development Goals; WHO's framework on integrated people-centred health services; and WHO's framework for action for strengthening health systems to improve health outcomes, with its six building blocks, in which the principles and strategies for action are aligned with the overall approach of primary health care and the "levers" outlined in the operational framework.

Primary health care levers of the operational framework

The operational framework proposes 14 levers (see Table 1) needed to translate the global commitments made in the Declaration of Astana into actions and interventions. Such actions and interventions can be used to accelerate progress in strengthening primary health care-oriented systems and ultimately lead to a demonstrable improvement in health for all without distinction of any kind.

Actions and interventions related to each lever are not intended to be carried out independently: they are intimately interrelated, and impact and enable each other. They need to be an integral part of the national health strategy, prioritized, optimized and sequenced in a way that guarantees overall results along the three dimensions of universal health coverage.

For each lever in the operational framework, there is a narrative description. A non-exhaustive list of proposed actions and interventions to be considered at the policy, operational and implementation levels, as well as actions and interventions to be carried

out by engaged people and communities, is also included in the operational framework. It also includes a list of tools and resources to facilitate the actions in each lever. A country case study compendium that illustrates how one or, more commonly, several levers can be implemented to advance primary health care is forthcoming.

The four core strategic levers comprise political commitment and leadership, governance and policy frameworks, funding and allocation of resources, and the engagement of communities and other stakeholders. Without these core strategic levers, actions and interventions carried out through use of the operational levers are unlikely to lead to effective primary health care. Actions and interventions related to all levers, in particular those related to governance and finance, need to be developed using an inclusive and ongoing policy dialogue that engages the community as an actor. The use of the core strategic levers paves the way for the use of other levers. The implementation of all levers needs to take into consideration the contexts, strengths and weaknesses of the health system, and the national, subnational and local priorities for universal health coverage.

In order to implement policy changes that strategically direct resources to the areas of greatest need and document progress made in strengthening primary health care over time, decision-makers need high-quality data on all three components of primary health care. To that end, a framework for monitoring and evaluation of primary health care – with indicators aligned with the levers of the operational framework, existing efforts in monitoring universal health coverage and other routine planning, monitoring and evaluation processes – will be prepared as a separate technical document as a supplementary tool.

It is expected that countries will select the levers and indicators that are most pertinent to their settings, based on an assessment of their needs, the capacity of their systems and their health governance models. It is also assumed that the specific actions, interventions and strategies used to bring about a visible improvement in primary health care will vary between settings and over time and will have an impact on, as required, health promotion, prevention of disease, and curative, rehabilitative and palliative care. As economies, institutions and resources evolve, both the levers used and the ways in which they are operationalized should also evolve.

Enablers of success

The levers in the operational framework are based on evidence and experience gained over years of implementing health system reforms. They align with the well-known building blocks and functions of effective health systems. The added value of this framework is that it provides guidance to countries throughout the national planning cycle on how commitment to primary health care can be translated into health for all through intersectoral actions, empowered people and communities, and integrated health services centred on people.

The experience of the past four decades, including the era before the Millennium Development Goals, provides important insight into the factors and conditions that have either enabled or hindered strengthening of primary health care. The levers of the operational framework should be considered in the development of a contextualized strategy to strengthen health systems, to strengthen the national planning cycle and integrate implementation across sectors. The operational framework should therefore be used throughout the different steps of the operational planning process, understanding that in the 21st century, the role of health ministries is to create enabling conditions and an environment conducive to improving health. Health ministries should also empower actors

and hold them accountable for their actions. They should steer the health sector as a whole in an inclusive manner, involving public, private and civil society actors as outlined in the handbook on national health policies, strategies and plans.*(5)*

For many countries, the integration of primary health care across a wide range of policies, strategies, activities and services is likely to require substantial transformation of the ways in which health-related policies and action are prioritized, funded and implemented. This reorientation of the health system requires clear political commitment and strong leadership at all levels to effectively implement all levers and achieve the desired results.

The engagement of people, as individuals, and communities, and of stakeholders from all sectors to work together to define health needs, identify solutions and prioritize action is central to primary health care. Special effort should be made to reach and meaningfully engage vulnerable and disadvantaged populations who disproportionally experience poor health, while often lacking the resources to participate in traditional engagement mechanisms. Promotion of social accountability will strengthen community engagement. Optimally, engagement of communities and other stakeholders should be integrated across sectors and inform actions and interventions related to all levers.

Incremental change in health systems as a result of actions and interventions related to any of the levers included in this operational framework will not be sufficient to implement the 2030 Agenda. That will require bold action based on political leadership with an explicit, strong and well-defined vision, engagement of people, communities and other stakeholders, guided by evidence and a monitoring and evaluation framework that is relevant to primary health care.

Many countries will still require external technical and/or financial support to bring about an improvement of primary health care for universal health coverage. In each of these countries, strong leadership and advocacy for harmonization and alignment of global donors and technical partners involved in strengthening primary health care are needed more than ever, under the leadership and at the direction of each country. The international community, through platforms such as the International Health Partnership for UHC 2030, should support such harmonization and alignment at the country level.

Introduction

In the Declaration of Astana (2018), countries and international partners committed themselves to orienting health systems towards primary health care (PHC) for accelerated progress on universal health coverage and the health-related Sustainable Development Goals (SDGs). The bold vision and commitments codified in the Declaration of Astana must be transformed into meaningful action in order to move towards health for all, without distinction of any kind (Box 1).

Box 1. The Declaration of Astana: vision and commitments

We envision:

Governments and societies that prioritize, promote and protect people's health and well-being, at both population and individual levels, through strong health systems;

Primary health care and health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed;

Enabling and health-conducive environments in which individuals and communities are empowered and engaged in maintaining and enhancing their health and well-being;

Partners and stakeholders aligned in providing effective support to national health policies, strategies and plans.

We commit to:

- make bold political choices for health across all sectors,
- build sustainable primary health care,
- empower individuals and communities, and
- align stakeholder support to national policies, strategies and plans

The Declaration of Astana is supported by A vision for primary health care in the 21st century,*(1)* which defines the modern concept of PHC, describes the components of a comprehensive PHC approach (Box 2) and outlines how they promote health, equity, and efficiency. The document also explains how PHC aligns with and contributes to universal health coverage (UHC) and the Sustainable Development Goals (SDGs). The document further highlights some of the lessons learned over the past 40 years regarding successful implementation of PHC and describes the challenges faced. Finally, it outlines a vision of PHC for this century and proposes key levers to achieve the vision (Table 1)[1].

[1] Note: Some levers have been revised during consultation and do not appear verbatim as in A vision for primary health care in the 21st century. The overall content remains the same.

Box 2. Primary health care components

1. **Integrated health services with an emphasis on primary care and public health functions:** meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population, with essential public health functions as the central elements of integrated health services;
2. **Multisectoral policy and action:** systematically addressing the broader determinants of health (including social, economic and environmental factors, as well as individual characteristics and behaviour) through evidence-informed policies and actions across all sectors;
3. **Empowered people and communities:** empowering individuals, families and communities to optimize their health, as advocates of policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and caregivers.

These levers expand on the health system building blocks to identify key elements of the health system that can be used to accelerate progress on PHC. The levers are interdependent, inter-related, and mutually reinforcing. The levers are separated into core strategic and operational levels. Core strategic levers can pave the way for actions around other levers; any sustainable improvement in the operational levers is unlikely without a strong grounding in the strategic levers. Actions and interventions for each lever are thus not intended to be carried out independently, and they should be mutually and comprehensively considered throughout national health planning processes.

Figure 1: Primary health care components

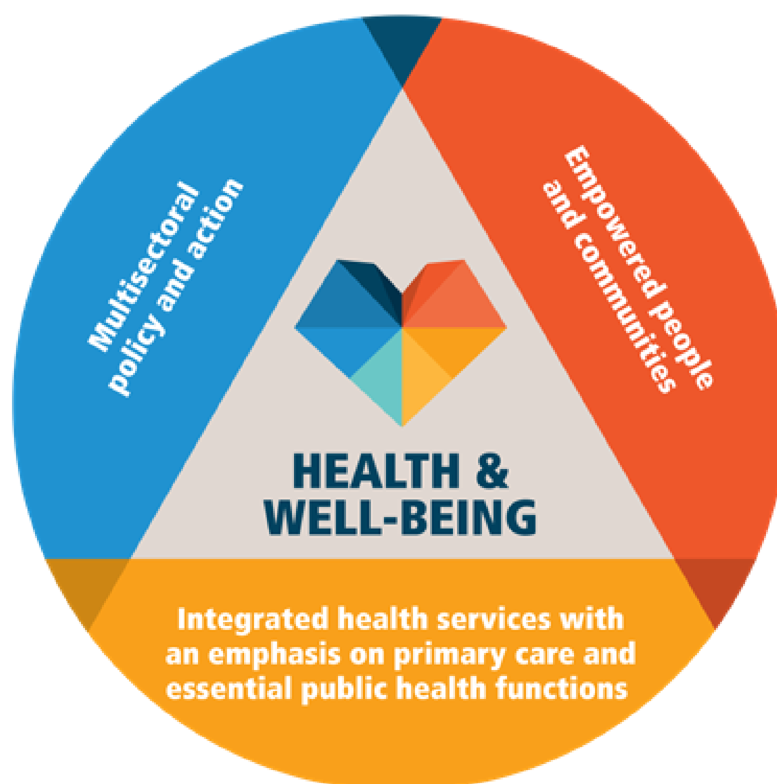


Table 1. Overview of primary health care levers

Title	Full description
Core strategic levers	
Political commitment and leadership	Political commitment and leadership that place PHC at the heart of efforts to achieve universal health coverage and recognize the broad contribution of PHC to the SDGs
Governance and policy frameworks	Governance structures, policy frameworks and regulations in support of PHC that build partnerships within and across sectors, and promote community leadership and mutual accountability
Funding and allocation of resources	Adequate funding for PHC that is mobilized and allocated to promote equity in access, to provide a platform and incentive environment to enable high-quality care and services and to minimize financial hardship.
Engagement of community and other stakeholders	Engagement of communities and other stakeholders from all sectors to define problems and solutions and prioritize actions through policy dialogue

Title	Full description
Operational levers	
Models of care	Models of care that promote high-quality, people-centred primary care and essential public health functions as the core of integrated health services throughout the course of life
Primary health care workforce	Adequate quantity, competency levels and distribution of a committed multidisciplinary primary health care workforce that includes facility-, outreach- and community-based health workers supported through effective management supervision and appropriate compensation
Physical infrastructure	Secure and accessible health facilities to provide effective services with reliable water, sanitation and waste disposal/recycling, telecommunications connectivity and a power supply, as well as transport systems that can connect patients to other care providers
Medicines and other health products	Availability and affordability of appropriate, safe, effective, high-quality medicines and other health products through transparent processes to improve health
Engagement with private sector providers	Sound partnership between public and private sectors for the delivery of integrated health services
Purchasing and payment systems	Purchasing and payment systems that foster a reorientation in models of care for the delivery of integrated health services with primary care and public health at the core
Digital technologies for health	Use of digital technologies for health in ways that facilitate access to care and service delivery, improve effectiveness and efficiency, and promote accountability
Systems for improving the quality of care	Systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health services
Primary health care-oriented research	Research and knowledge management, including dissemination of lessons learned, as well as the use of knowledge to accelerate the scale-up of successful strategies to strengthen PHC-oriented systems
Monitoring and evaluation	Monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors

This operational framework for primary health care provides more in-depth information for each lever and proposes actions and interventions to guide countries' efforts to strengthen PHC-oriented health systems. It draws extensively on the published literature, existing guidance documents, and, in some areas, agreements that have already been made by WHO's Member States in the context of the World Health Assembly.

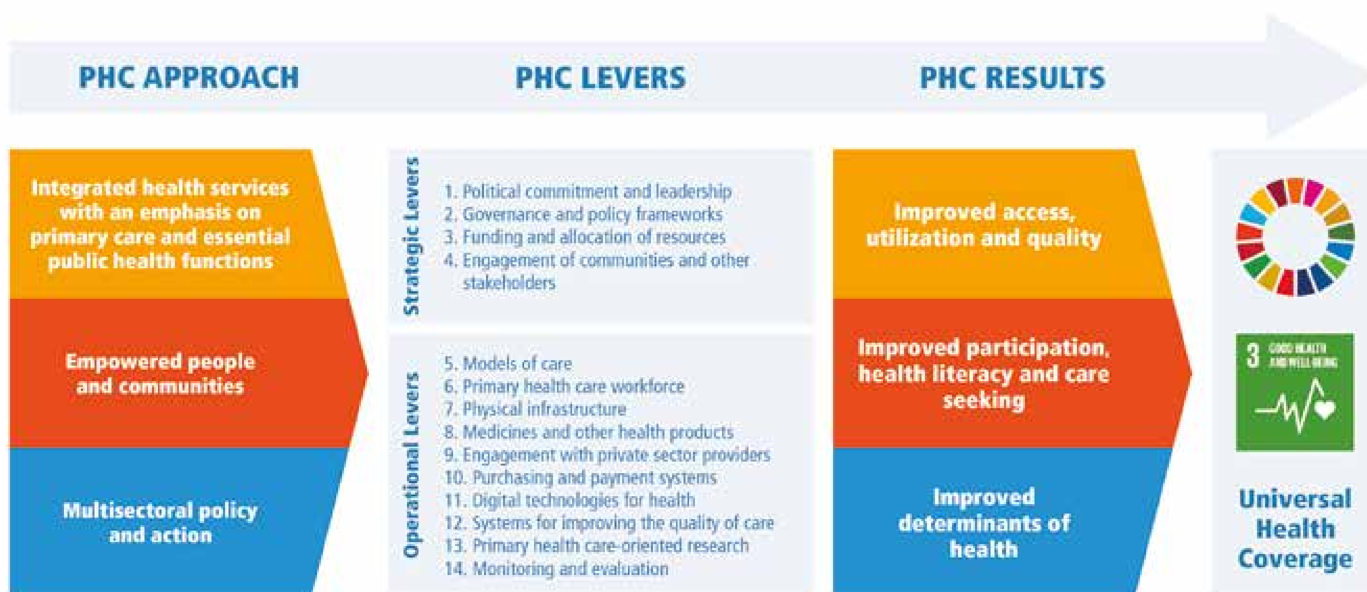
For each lever, a consistent structure is used:

- narrative description
- actions and interventions that can be applied at policy, operational and implementation levels
- tables showing tools and resources that facilitate actions and interventions for each lever (the complete list is in Annex 1).

The document concludes with a section on how international partners can better support countries to operationalize the Declaration of Astana.

The operational framework is further supported by two companion documents which are currently under development: *(1)* performance measurement and monitoring guidance and *(2)* a compendium of case studies demonstrating the implementation of levers and related outcomes.

Figure 2: Primary health care theory of change



Who should use this document?

The document is primarily intended to assist countries in fulfilling their commitments to improving PHC. Governments and policy-makers, both national and subnational, are a key audience. In addition, many of the actions are relevant for other stakeholders at the country level, such as nongovernmental organizations, the private sector and development partners. Those in academic institutions may find this document useful for identifying areas requiring further research. Given the central role of people and communities in PHC, each table of actions has a dedicated column focused on these roles.

The document also highlights the role of international partners in supporting the efforts of countries to improve PHC. This can be facilitated by WHO's Global action plan for healthy lives and well-being for all, an initiative through which international partners are improving collaboration to accelerate progress towards the health-related SDGs through PHC.

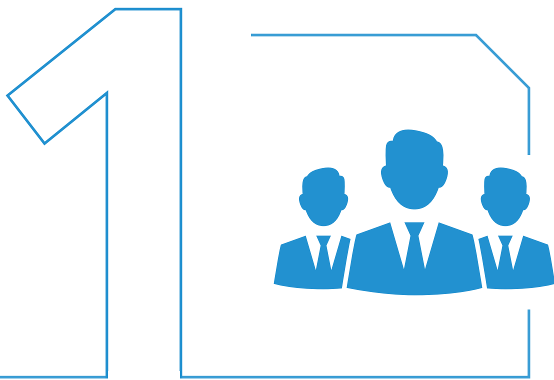
How this document should be used?

The operational framework's levers should be used to guide and inform national planning processes and decision-making for the implementation of PHC. Actions are proposed for each lever. However, the levers and their related actions are not intended to provide a one-size-fits-all approach. The levers and actions will have different significance in countries with different levels of social or economic development, degrees of PHC orientation and health status. This document is intended to be applicable to a wide range of countries and thus includes a range of actions, not all of which will be appropriate to or should be prioritized in every country. The tables of actions provide a menu of practical, evidence-based suggestions that countries can contextualize to accelerate efforts around PHC.

The levers should be considered throughout the different steps of the national planning processes for health and development. Countries will need to assess, prioritize, optimize and sequence the levers and their respective actions, while considering specifically how the core strategic levers can facilitate planned actions in the operational levers. This process should occur in the context of an inclusive planning process with community participation that includes the most vulnerable, disadvantaged and marginalized people. The selection and implementation of specific actions should be informed by a robust evidence base, both local (for example, the social, economic, and environmental situation and trends in the country, the disease burden, and the strengths and weaknesses of the health system) and global (for example, what has been shown to work or not work in improving PHC), as well as by the values and preferences of a diverse range of stakeholders. In addition, actions should be refined according to progress and as further evidence and experience are generated to advance PHC.

Recognizing that appropriate implementation of actions and interventions across the levers requires high-quality data to inform policy decisions and prioritization, supplementary guidance for monitoring PHC performance is being developed. It will include indicators for all three components and 14 levers to monitor progress across the three PHC components and 14 levers of the operational framework that are aligned with those being used in ongoing universal health coverage and SDG monitoring efforts. The guidance will also highlight where and how countries can invest in data sources to ensure regular, reliable and accurate information. Finally, it will focus on methods and best practices to analyse and use data to drive performance improvement, providing examples of cascade analysis, benchmarking and use of data to inform policy dialogues, PHC reform processes and broader health sector performance reviews. Best practice dashboards and profiles within these processes for investment and advocacy will be highlighted.

Core strategic levers



Political commitment and leadership

Political commitment and leadership that place PHC at the heart of efforts to achieve universal health coverage and recognize the broad contribution of PHC to the SDGs

The history of global health is in many ways a history of political commitment and leadership: areas that have seen sustained commitment and leadership have witnessed impressive changes, whereas those that have not have often languished. Commitment and leadership within the health sector are important, but truly transformational change requires commitment and leadership beyond the health sector: the involvement of Heads of State and Government, other political leaders (for example, parliamentarians), civil society and influential community, religious and business figures is important for mobilizing large-scale improvements in PHC.

These leaders must ensure that PHC is treated as a priority by formalizing commitments to it (for example, through declarations), by highlighting it in key documents (such as national development plans and/or plans to achieve universal health coverage and the SDGs), by regularly communicating its importance, by providing adequate financing and, ultimately, by focusing on the implementation of efforts to improve PHC. Commitment and leadership are particularly important because of the ambitious vision of PHC, in particular, the complexities associated with its three inter-related components: integrated health services, multisectoral policy and action, and empowered people and communities.

Effectively delivering integrated health services requires political commitment and leadership as health systems are too often skewed away from public health and primary care. In particular, tertiary care is often privileged at the expense of primary care, and public health functions frequently suffer from underinvestment. Embracing the vision of PHC means taking difficult decisions to reprioritize resources and reorient systems.

Addressing social, economic, environmental and commercial determinants of health through multisectoral policy and action cannot be done without political commitment and leadership because of the considerable challenges associated with multisectoral responses. In particular, multisectoral policy and action requires tackling the silo approach that leads to the separation of sectors, as well as the different incentives that different sectors may operate under (for example, non-health ministries will have their own priorities that may or may not result in a focus on the areas that are most important for improving health outcomes). Multisectoral policies and action often require the development of partnerships that cut across sectors and involve public and private actors. In many countries, health ministries do not have enough power and influence to tackle this challenge on their own and need support from the top levels of government. Additionally, the status quo — including social, economic, environmental and commercial factors that harm health — is often supported by entrenched and powerful interests that are not keen to accommodate change. Overcoming this resistance and supporting multisectoral responses to health requires concerted political commitment and leadership.

> *“Embracing the vision of PHC means taking difficult decisions to reprioritize resources and reorient systems.”*

Similarly, empowering people and communities entails making difficult decisions that require commitment and leadership. Many of the populations that have the worst health statuses face systemic discrimination based on race, ethnicity, gender, sexual orientation, socioeconomic status, location (for example, rural), religion, educational status and disability. In this context, empowerment requires a redistribution of power to fully engage all people and communities. Within these communities — even marginalized ones — there are also opportunities for individuals to demonstrate leadership and support the empowerment of others.

Understanding that in the 21st century the role of health ministries is to create enabling conditions and an environment conducive to improving health, those authorities have an important stewardship role in orienting national health sector policies, strategies and plans around PHC, including throughout their development and implementation processes. Health ministries should also empower actors – both within and outside of the health sector – and hold them accountable for their actions. They should steer the health sector in an inclusive manner that involves public, private and civil society actors as outlined in WHO's handbook on national health policies, strategies and plans.*(5)*

The history of efforts to implement PHC highlights an important pitfall to avoid. Although a comprehensive approach to PHC should be positioned as foundational to achieving universal health coverage and health for all, this has not always happened as it is often easier to favour selective approaches that have ready-made constituencies and clearly delineated interventions. This course has resulted in improved outcomes for individual diseases or life-course needs at the expense of improving comprehensive PHC-oriented health systems, which are better positioned to address the variety of health needs of individuals and communities in an integrated and people-centred manner. Achieving the vision of comprehensive PHC, therefore, requires stronger political commitment and leadership than that which has characterized the past 40 years since the Declaration of Alma-Ata.

Table 2. Political commitment and leadership: actions and interventions

At national level
• Cultivate champions for PHC across influential sectors of society (government, community, religious, business), either through formal structures (for example, high-level groups) or individually (for example, ambassadors). • Develop a comprehensive vision of PHC and formalize commitment to PHC as a priority for the whole of government (through formal declarations, policies or laws; by integrating it as a core component of national strategies, including both broader development strategies, such as national development plans and plans to achieve the SDGs; and health sector-specific policies, strategies and plans) and by ensuring that there are adequate cross-governmental structures in place to oversee PHC. • Communicate extensively about the commitment to improve PHC. • Ensure that the rhetoric on commitment is matched by the provision of adequate financing for PHC (see also Section 2.3). • Hold accountable those responsible for the implementation of PHC (including not only health ministry officials but also other government leaders, such as parliamentarians, and officials of other ministries required to address other determinants of health). • Create an enabling environment for participation of communities, including marginalized and vulnerable people across all age groups, by proactively identifying barriers and opportunities for empowering people and communities, by building community capacities for meaningful dialogue, and by providing and regularly evaluating policy dialogue mechanisms. • Follow through on commitments to adopt human rights-based approaches.

At subnational level

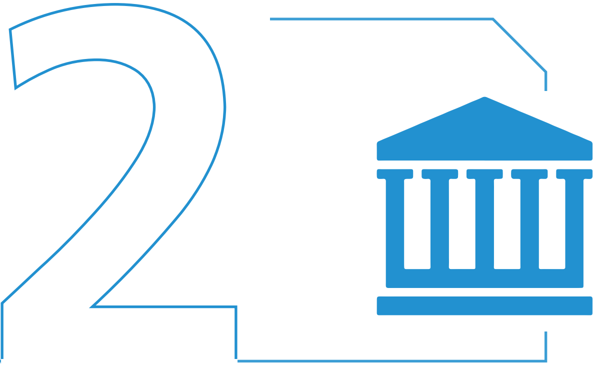
- Collaborate with higher administrative levels to ensure that community needs and views are given appropriate attention in decision-making.
- If appropriate given the level of decentralization, carry out the same efforts at the subnational level as at the national level:
    - cultivate local champions
    - formalize commitments to PHC (including by integrating PHC as a core component of local development and health strategies)
    - communicate the commitment to PHC
    - provide adequate financing.

By people and communities

- Hold political leaders accountable for improving PHC.
- Develop networks at community level to ensure that community voices are heard.
- Participate in efforts to establish inclusive processes.
- Demonstrate leadership as a champion for the comprehensive vision of PHC.
- Share information about good practices around accountability among peers (both within and between countries).

Table 3. Political commitment and leadership: tools and resources

Health system tools and resources
Conceptual framework on the contribution of law to UHC
Country planning cycle database
Legal access rights to health care
Strategizing national health in the 21st century: a handbook



Governance and policy frameworks

Political Governance structures, policy frameworks and regulations in support of PHC that build partnerships within and across sectors, and promote community leadership and mutual accountability

Governance refers to "ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability".(6) Historically, in most low- and middle-income countries, governments have focused on delivering public sector services themselves rather than embracing a broader vision of governance that integrates the public and private sectors in a mixed health system. This arrangement is becoming increasingly outmoded, given both the growing range of actors involved in the health sector and the recognition that the health ministry cannot act as a service provider for all health services. For example, the private sector (either for-profit or not-for-profit) is a crucial player in health in many settings and a recent WHO survey of 65 Member States showed that over 40% of health care in the surveyed countries is provided by the private sector (including services provided to the poorest people). The importance of involving actors from other sectors is increasingly recognized.

This broader vision of governance requires governments to oversee and guide the whole health system, not just the public system, to protect the public interest.*(6,7)* The transformation from the traditional role of health ministries as providers of services to stewards for health that engage a full range of actors (including from non-health sectors and private sector health actors) has not been an easy one in many low- and middle-income countries, but this transformative change in the governance of health is critical for a comprehensive approach to PHC.

In many countries, embracing the role of steward will require changes and capacity-building for health ministries. The shift from focusing primarily on providing services directly to guiding a health system that mixes public and private provision requires the development of skills in partnership, monitoring, oversight and regulation.

Another important dimension in improving governance is increasing the role of communities. The result can be to make PHC-oriented health systems more responsive, not only because the greater role allows rapid recognition of local concerns, but also because communities can more effectively advocate to have their emerging needs recognized. One outcome can be a prompt response, in contrast to distant subnational and national governments, which may not be able to react with similar agility or flexibility. Leveraging this role needs effective governance structures and processes at national, subnational and local levels that allow for better community participation, enhanced legitimacy and improved accountability, resulting in sustainable, equitable and high-quality care. Examples of such a governance structure include participation of community-elected representatives as full members of facility or district management structures or establishing a community advisory board that has a formal role in providing an oversight of health services.

In the absence of formal roles of communities in local health governance, health care providers and managers may remain resistant to community accountability and respond only to internal government or organizational accountability mechanisms. Legitimizing the roles of community networks can ensure that district health systems effectively allow participation, fulfil user needs, and are accountable to the individuals and communities they serve. Such local health governance must be embedded in supportive national and subnational health systems to ensure transparency and equity so that local power structures and existing inequities are not reflected in decentralized health systems. Such multilevel governance also

makes health systems more resilient, as one level can compensate for governance gaps at another level.

Another important shift that should be embraced is a whole-of-government approach, particularly given the need for multisectoral policy and action. An important tool for doing this is the Health in All Policies approach, which was officially recognized by the Health Assembly in resolution WHA62.12 as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity". *(8,9)* In the Health in All Policies approach, the health sector is seen as the champion for health, keeping health firmly on the political agenda, but aware of the need for joined-up work that seeks overall societal gains.*(5)*

There is no single model for implementing the Health in All Policies approach, but experience from across the world has led to the identification of a set of characteristics that are central to successful implementation: "good governance; development of strong and sound partnerships based on co-design, co-delivery, and co-benefits; dedicated capacity and resources; and the use of evidence and evaluation".*(10)* WHO has developed a series of materials that can help countries to initiate, implement and sustain Health in All Policies, including a training manual and a series of case studies.*(11–13)*

Monitoring and evaluation are covered below (see Section 3.10), but it is important to highlight the critical role that transparency and access to data have in ensuring good governance. These are required for governments to fulfil their stewardship roles, for civil society to be able to press for accountability, and for multisectoral actors to understand the linkages between their work and health outcomes. The media and individuals have an increasingly important role to play in ensuring that accurate health information is publicized and made widely available, as social media and other technology-driven shifts increasingly enable user-generated content to spread widely.

> *This broader vision of governance requires governments to oversee and guide the whole health system, not just the public system, to protect the public interest.*

These shifts in governance should be supported by policy frameworks that reflect the broad definition of PHC. In particular, the concept of PHC as having three inter-related components – integrated health services, multisectoral policy and action, and empowered people and communities – should be embedded in key policy frameworks that govern the health sector. As PHC is an orientation and not simply a programme, it does not necessarily mean that each country should have a dedicated PHC policy. Instead, it is more important that the comprehensive vision of PHC is included in the set of policy frameworks that are most relevant for each country, including a national health policy/strategy, a strategy for universal health coverage, subsector policies, or for areas such as the health workforce or medicines, and even programme strategies addressing issues such as reproductive, maternal, newborn, child and adolescent health and nutrition, or HIV/AIDS.

The process of developing and then implementing these frameworks should also embrace a PHC orientation. This process includes using a participatory approach that empowers people and communities to play an active role in shaping the policies that influence their lives. Such an approach would require moving beyond solely technocratic processes that rely only on experts in capital cities to using methodologies that engage people and communities where they live, including an acknowledgement of the complexity of the power dynamics that shape the ability of people and communities to participate meaningfully.

Table 4. Governance and policy frameworks: actions and interventions

At national level
• Strengthen the health ministry's stewardship role and technical capacities to facilitate multisectoral arrangements with other ministries and institutions and to enable engagement of or partnerships with the private sector and other actors (such as professional associations and trade unions) when and where useful and appropriate. • Legitimize local health governance by strengthening (or developing where necessary) institutional mechanisms relevant to the organization of different levels of government and competencies assigned for health and social affairs. • Establish legislative mandates and a clear governance and accountability framework for a Health in All Policies approach following the WHO country guidance and dedicate resources to support and sustain multisectoral work. • Legitimize the role of communities in local health governance and processes that allow for greater community and civil society involvement in a non-discriminatory manner (for example, community-elected representatives in governance structures or community advisory boards). • Provide funding and oversight to collaborative community governance of PHC to ensure the availability of adequate resources and their equitable use. • Ensure accountability for PHC in the health ministry in a manner that works across the traditional departmental boundaries and is linked to the team(s) responsible for universal health coverage, the broader determinants of health and the health-related SDGs. • Use evidence to document the linkages between health and other government policy priorities (including by using methodologies more commonly used in other sectors, such as economic modelling and qualitative research). • Support the use of audit tools, such as health impact assessments and policy audits, to enable transparency in the examination of health and equity outcomes of policies. • Support efforts to publicize the data on the performance of health services, even if the findings are not positive, and support cross-sectoral monitoring of the impacts of policies in other sectors on health. • Reflect a PHC orientation across all relevant policy and strategy frameworks.

At subnational level

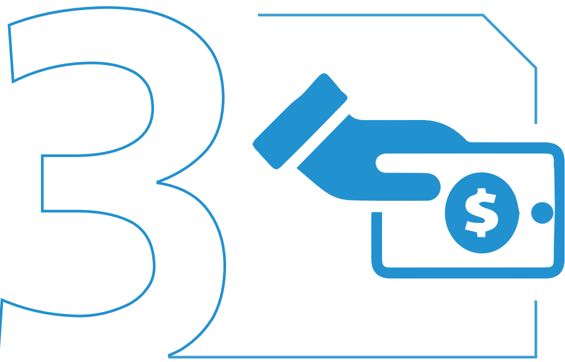
- Reform and align the integrated PHC-oriented governance mechanism and planning processes at the subnational level to respond to its three components
- Create community-based multi-stakeholder forums for collective accountability and action on health and health-related issues.
- Create an organizational culture that supports monitoring and evaluation through knowledge sharing, open feedback and a demand for data in decision-making processes.
- Strengthen PHC-oriented management protocols that encourage provider report cards, patient satisfaction surveys, patient-reported outcomes and balanced scorecards.
- Support public, private and community actors to develop competencies for engaging across the PHC components.

By people and communities

- Advocate community-steered institutional arrangements to which government officials responsible for PHC are accountable.
- Participate in efforts to establish inclusive processes (for example, by engaging in planning forums) and hold leaders in the public and provide sectors accountable.
- Disseminate widely data on health service performance.

Table 5. Governance and policy frameworks: tools and resources

Health system tools and resources
Health in All Policies as part of the primary health care agenda on multisectoral action
Health in all policies training manual
Health in all policies: Helsinki statement. Framework for country action
Key learning on Health in All Policies implementation from around the world: information brochure
Primary health care and health emergencies: brief
Primary health care and health emergencies (long document)
Progressing the Sustainable Development Goals through Health in All Policies - Case studies from around the world
Road Map for the Plan of Action on Health in All Policies
Strategizing national health in the 21st century: a handbook



Funding and allocation of resources

Adequate funding for PHC that is mobilized and allocated to promote equity in access to provide a platform and incentive environment to enable high-quality care and services and to minimize financial hardship.

Resources come from three sources: domestic public revenue, private households and firms (particularly, voluntary pre-paid contributions and out-of-pocket expenditure), and external sources, mainly development assistance for health. The composition of these sources varies significantly among countries, both within and across income levels. In general, however, and largely owing to differences in fiscal capacity, low- and lower-middle-income countries rely more heavily on out-of-pocket payments (which simultaneously are a cause of inequitable access and, for those who do pay, of financial hardship), whereas in upper-middle- and high-income countries, domestic public funding generally predominates. External funding is a small share in most middle-income countries but in low-income countries accounts for about 30% of total health spending on average.*(14)*

The share of domestic resources spent on PHC is largely a function of three factors:*(15)*

- the share of a country's gross domestic product that goes to general government expenditure (which in turn is a function of fiscal capacity);
- the share of general government expenditure that goes to health; and
- the share of government health expenditure that goes to PHC.

There is significant variability across countries in all three factors and it has historically been difficult to quantify expenditure on PHC. The methodology for accounting for health expenditure (the System of Health Accounts 2011) does not include a direct measure of expenditure on PHC, but WHO published the first preliminary data estimating PHC expenditure for the Global Conference on Primary Health Care,(16) although due to technical constraints, the current estimated PHC expenditure definition does not include expenditure for several public health functions, empowering people and communities or the multisectoral nature of PHC. PHC is the most efficient route to universal health coverage, yet the overall funding for PHC is insufficient. Of the 16 low-income countries for which data are available, in 2016 none spent more than US$50 per capita on PHC and only five spent more than US$30 per capita on PHC.*(17)*

> *Within the scope of PHC, funds should be rationally allocated among primary care, public health interventions, and initiatives that promote community engagement and multisectoral coordination. At the broader health system level, a major challenge in many countries is that tertiary care facilities receive disproportionately large shares of health budgets.*

The most effective approach to increasing domestic financing for PHC will vary considerably depending on both a country's starting point (for example, the solution in a country that raises very little revenue as a share of its gross domestic product is likely to be different from one that mobilizes sufficient revenue overall, but allocates only a small share to health) and local political economic considerations.

In general, efforts to raise resources for PHC and use them most effectively should be embedded in a broader health financing strategy that encompasses the entire health sector. Developing or updating a health financing strategy should be undertaken in collaboration with a range of stakeholders, both within the health sector and outside it (such as, finance ministries). For example, in some countries, collaboration with other sectors has resulted in the establishment of health-promoting taxes on harmful products, such as tobacco and alcohol. These not only promote healthier environments and reduce overall health burden, but also help to raise resources for health.

Such a strategy should also address key issues related to the allocation of resources within the health sector. Within the scope of PHC, funds should be rationally allocated among primary care, public health interventions, and initiatives that promote community engagement and multisectoral coordination. At the broader health system level, a major challenge in many countries is that tertiary care facilities receive disproportionately large shares of health budgets. This imbalance both reduces the financing available for PHC and increases costs to the entire health system, with an over-reliance on using hospitals to deliver primary care services being a significant driver of inefficiency in many countries. Addressing inefficiencies in other parts of the health system matters because such actions can provide the basis for pro-PHC reallocations.

The question of how to use resources that have been mobilized to pay for health services is covered below in Section 3.6.

Table 6. Funding and allocation of resources: actions and interventions

At national level

- Ensure that PHC is explicitly addressed within health financing strategies.
- Monitor the level of spending on PHC through national health accounts analysis, as well as “deeper dives”, including public expenditure reviews.
- Strengthen public financial management systems to enable more effective, efficient and equitable budgeting and budget execution in the health sector, including for PHC.
- Establish key performance indicators for PHC to monitor allocation of funds.

At subnational level

- Monitor the distribution of public funds across various service delivery platforms within sub-national units as well as differences in per capita health allocations across subnational levels.
- Develop capacity at the subnational level to monitor expenditures and analyse and address barriers to use health services.

By people and communities
• Advocate increased transparency regarding public spending on health and improved efficiency in spending existing allocations, including for PHC. • Build capacity to monitor budget and expenditure review processes. • Form alliances with civil society groups that conduct broad-based (that is, non-health sector-specific) reviews of budgets and expenditures.

Table 7. Funding and allocation of resources: tools and resources

Health system tools and resources
A system-wide approach to analysing efficiency across health programmes
Building the economic case for primary health care: a scoping review
Community health planning & costing tool
Global Health Expenditure Database - estimations of primary health care expenditure
Integrated Community Case Management Gap Analysis Tool (Forthcoming, UNICEF)
OneHealth Tool
Primary health care on the road to universal health coverage: 2019 monitoring report
Strengthening Primary Health Care through Community Health Workers - Investment Case and Financing Recommendations
UHC intervention compendium (Forthcoming, WHO)
WHO CHOICE

Engagement of communities and other stakeholders

Political Engagement of communities and other stakeholders from all sectors to define problems and solutions and prioritize actions through policy dialogue.

Building collaborative relationships that enable stakeholders to jointly define health needs, identify solutions and prioritize actions through contextually appropriate and effective mechanisms is central to PHC. Anchoring the pursuit of health in engaged and empowered people and communities brings to life the commitment of PHC to refocus on the whole-person and entire communities rather than diseases. Engaging communities should be part of a comprehensive strategy to reorient health systems to meet the expectations and needs of populations, while taking into account changing societal contexts.

Communities comprise a diversity of actors, including individual users of health services and their families, lay public members, and private sector constituencies (both for-profit and not-for-profit), including civil society organizations (for example, consumer groups, community-based, faith-based and nongovernmental organizations, and affiliate groups). People and communities, and their capacity, desire and mechanisms to engage are constantly evolving, in part owing to changing social dimensions which have a profound impact on the process of engagement as well as on overall health and well-being. For example, factors such as globalization, population movement, humanitarian emergencies and conflict result in fundamental changes to community structures and behaviours – such as the breakdown of extended families and the increased isolation of carers. Considering these human and social dimensions is critical to a people-centred approach and for effective community engagement.

The agriculture and development sectors have a long history of community engagement in projects (for example, community-driven development and participatory learning and action). More recent efforts have focused on delivering aid through co-development and local ownership (for example, "doing development differently"). The health sector has also developed numerous models and frameworks related to community participation and empowerment since the Declaration of Alma-Ata in 1978.(18-20)

> *Anchoring the pursuit of health in engaged and empowered people and communities brings to life the commitment of PHC to refocus on the whole person and entire communities rather than diseases.*

Community and population engagement in health can be considered at three interlinked levels: in the governance of health systems, in planning and priority setting, and in the implementation and delivery of health services. In each of these, community engagement seeks to identify the interests and priorities of stakeholders and align shared goals and actions. As such, people are both co-owners and co-producers of health, with a central role in improving service delivery and coverage and influencing national health planning and priority setting. Governance approaches must support these roles accordingly by creating enabling environments that foster mutual respect and trust necessary for meaningful dialogue, partnership and joint action. Moreover, they must ensure the responsiveness of health systems to the voices of people and communities, including through the allocation of resources for identified needs and priorities.

Communities and stakeholders also have an important two-pronged role in accountability, including: holding health systems accountable to their populations' needs; and contributing to accountability in the governance, planning, delivery and evaluation of health care. Creating enabling conditions for accountability will require governments to invest in building the capacities of communities (for example, health literacy improvement programmes) as well as governments.

Engagement is not a single, discrete intervention or strategy, but an ongoing and system-wide way of working. As noted above, communities are neither homogenous nor static and have their own histories and dynamics, which are continuously evolving. Accommodating the changing, divergent and, at times conflicting, views of multiple constituencies in a community (for example, between younger and older age groups) will require a range of strategies and processes at multiple levels.

Developing these strategies or processes may include mobilization through health-specific structures (for example, health committees, patient advocacy groups, participatory research programmes and community health workers) as well as broader structures (for example, village committees, women's groups and rural development associations). Different engagement methods can be used at national, subnational and local levels. They may span from simple measures to solicit feedback (for example, suggestion boxes), to the active provision of input (for example, through community advisory boards), to more extensive involvement in steering the direction and/or co-management of health services (for example, through participation in governance bodies and/or in decision-making about the allocation of resources). The selection of approaches should be relevant and context-specific and should adapt and evolve according to the changing needs and experiences of communities.

The needs, rights and inclusion of vulnerable, marginalized and disadvantaged groups must also be prioritized throughout all levels of engagement. These groups often have specific needs, but frequently lack the resources and opportunities to participate in traditional engagement mechanisms. Their inclusion requires flexible and adaptable processes as well as the establishment of safe and trusting environments developed progressively through deliberate and sustained efforts.

Engagement of private sector constituencies should explicitly consider their interests and objectives, which may not always be aligned to the public good. Potential challenges include unresolved conflicts of interest, regulatory capture (in which regulatory agencies serve the interest of the industries they are meant to be monitoring and regulating) and the abuse of market power. Even when objectives are more closely aligned, such as with not-for-profit groups, governments may struggle to effectively harness these disparate efforts to help to meet the health objectives of governments and populations. For instance, governments may have incomplete information about the not-for-profit providers or lack the governance mechanisms to align the activities with national health systems and priorities. Finally, as part of the engagement process, it is important to be aware of the possibility that consumer groups may be captured by commercial interests.(21)

Table 8. Engagement of communities and other stakeholders: actions and interventions

At national level
• Engage in dialogue with policy makers and leaders to foster the creation of environments and cultures that support collaborative action and facilitate interprofessional ways of working. • Conduct community and stakeholder mapping. Routinely, assess the strengths of community and stakeholder relationships and embed processes for understanding their needs and preferences. Use this information to optimize engagement and facilitate empowerment. • Partner with national, subnational and local stakeholders and groups to identify and strengthen mechanisms to engage communities in the processes of governance, planning and priority-setting (including resource allocation), and service delivery. • Make special efforts to support the participation of people and communities in accountability mechanisms, including the engagement of sections of a community that might otherwise not be involved in activities, such as the vulnerable and disadvantaged or young and older people. • Promote health literacy and related approaches that support community members and groups to effectively participate in health. • Engage in capacity-building efforts to ensure that communities are aware of their roles and rights and have the tools and resources to participate fully and enter into meaningful partnerships. • Support efforts of civil society organizations to engage more actively in improving health system performance. • Develop training programmes for health professionals on community engagement and integrate the programmes into national curricula for medical education. • Conduct stakeholder mapping and analysis to ensure optimal engagement and empowerment of relevant communities and stakeholders.

At subnational level
• Support the development of structures (for example, health committees) at district, town and village levels and support participation of all social groups in these structures. • Support efforts to foster dialogue between different elements of the community (for example, between community-based organizations, local authorities, private sector and academic institutions). • Promote the development of locally-tailored community action plans that address collectively-identified needs and goals. • Assess and strengthen the capacities of local authorities to use participatory planning and implementation methods and tools. • Develop community monitoring mechanisms for monitoring outbreaks, epidemics, and diseases of high priority (for example, between community-based organizations and academic institutions). • Appoint focal points for community engagement in various sections of the health ministry (for example, those responsible for planning, budgeting and monitoring) and in subnational (for example, district) health committees.

By people and communities

- Ensure individuals and communities know their rights and what they can expect from their health care providers.
- Ensure opportunities and mechanisms exist for individuals and communities to provide feedback on their care/service experience and responsiveness.
- Partner with community-based organizations to build local health literacy, develop community-based accountability mechanisms and local advocacy initiatives to that address participation in health governance, planning and priority setting and implementation.
- Support the formation of associations or networks to enable a more representative engagement in governance, planning and priority setting, and implementation.
- Provide opportunities for individuals and communities to participate in mechanisms that build on local strengths and assets, identify problems, formulate solutions and prioritize actions that improve health service implementation, monitoring and evaluation.

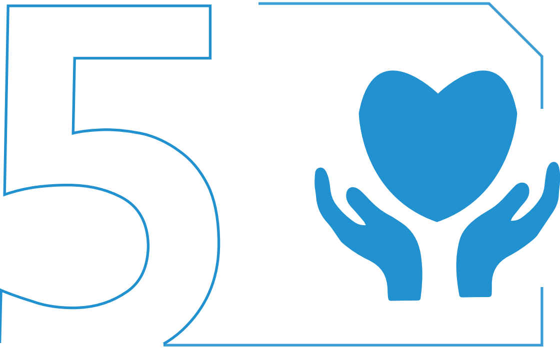
Table 9. Engagement of communities and other stakeholders: tools and resources

Health system tools and resources
Community health planning & costing tool
Community planning toolkit
Community Tool Box
Compassion resilience toolkit
Minimum Quality Standards for Community Engagement
Realising the value: Ten key actions to put people and communities at the heart of health and wellbeing
WHO community engagement framework for quality, people-centred and resilient health services
WHO Handbook on Social Participation for Universal Health Coverage (Forthcoming, WHO) UHC2030 civils society consultation
Working Together: A toolkit for health professionals on how to involve the public

Programme-specific tools and resources

An evidence map of social, behavioural and community engagement interventions for reproductive, maternal, newborn and child health
WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health
Working with individuals, families and communities to improve maternal and newborn health (with toolkit for implementation)

Operational levers



Models of care

Models of care that promote high-quality, people-centred primary care and essential public health functions as the core of integrated health services throughout the course of life

A model of care is a conceptualization of how services should be delivered, including the processes of care, organization of providers and management of services, supported by the identification of roles and responsibilities of different platforms and providers along the pathways of care. The model of care evolves in response to the changing health aims and priorities of the population and to improve the performance of the health system. The model of care should be adapted to optimize effectiveness, equity and efficiency. In turn, the model of care has implications for the arrangement of structural elements (governance, financing, workforce, physical environment, information systems and other health technologies), which should be used to facilitate the desired model of care. Different models of care can co-exist in one health system and be used for delivering the various required functions in a health system. Successful models of care evolve in response to continuous performance monitoring changing populations, health needs and contexts with the aim of ensuring that all people receive the right care, at the right time, by the right team, and in the right place.

> *Successful models of care evolve in response to continuous performance monitoring, changing populations, health needs and contexts with the aim of ensuring that all people receive the right care, at the right time, by the right team, and in the right place.*

Models of care must be tailored to local contexts as what is required and feasible will inevitably differ between what works best in a fragile, conflict-affected setting and a stable upper-middle income country or between an urban and rural community. However, there are some principles that are common across all settings. First, models of care should promote integrated health services, strategically prioritizing primary care and public health functions and ensuring adequate coordination between them. A review prepared for the Global Conference on Primary Health Care identified six models for integrating public health and primary care functions:(22)

- public health professionals integrated into primary care
- public health services and primary care providers working together
- comprehensive and proactive benefit packages that include public health
- primary care services within public health settings
- building public health incentives in primary care
- multidisciplinary training of primary care staff in public health.

Secondly, at the level of individual health care services, health systems need to be reoriented to facilitate access to services closer to where people live (for example, home-based and community-based care, primary care in long-term care facilities, step-down units for rehabilitation in local hospitals, dedicated emergency care units at comprehensive health centres and first level hospitals), taking into consideration context (for example, living conditions, public transport, availability of emergency transportation and pre-hospital care), people's preferences and cost-effectiveness. They also need to ensure that primary care is

both the first and regular point of contact at the core of the health system with established linkages to all other delivery platforms through functioning referral and counter-referral systems.

In this reorientation, model of care may define structures or functions to guide patients to the most appropriate place to receive care for a given situation. A gate-keeping function may be designated to primary care providers to ensure their role at the first point of contact for most conditions, responsible for the delivery of primary care services as well as the coordination and referral of care to other sites and platforms. Additionally, out-of-hours primary care might be established for urgent or acute time-sensitive conditions that can be either safely managed in primary care or referred to other service delivery platforms, which requires that dedicated emergency units be established in comprehensive health centres and/or first level hospitals to ensure timely response for emergent health needs. The role of hospitals must also be considered. A substantial proportion of a country's health workforce, technology and financial resources is concentrated in hospitals; they are responsible for training many health service professionals and have the political, economic and social power to facilitate or hinder transformation of the system. To facilitate PHC-orientation, hospitals must move away from their traditional definition as physical buildings (bounded by walls and beds) and instead see themselves as flexible organizations that pull together scarce resources and function as a public good. Hospitals should leave behind their isolating status as institutions uniquely responsible for individual patients requiring highly specialized acute care, and instead embrace joint responsibility with other care providers for population health. Hospitals must also broaden their focus from immediate, acute episodes to a wider and ultimately more effective focus on integrated care pathways.

Thirdly, models of care should promote continuous, comprehensive, coordinated and person- and people-centred care, rather than focus on specific diseases (particularly considering the growing recognition of the importance of addressing multimorbidity). Finally, models of care should recognize the crucial role of PHC in addressing both existing and emerging health problems (including the shifting disease burdens that many countries face as communicable diseases are better controlled but noncommunicable ones become more prevalent).

An important strategy for ensuring that models of care adopt a PHC orientation is with multidisciplinary teams (also discussed in Section 3.2). There is not a single model for these teams, but they typically combine a range of skills and professions, such as community health workers, nurses, family doctors, pharmacists, dieticians, social workers, traditional medicine practitioners and management/administrative staff, in order to be able to address the full needs of the individuals they serve. Connecting community health workers with facility-based staff is a particularly important aspect, both to improve the quality of care offered by the former and because they can play a vital role in linking communities to facilities and delivering population-based services.

Another common strategy is to entrust the health of defined communities to specific teams through the process of empanelment. Also referred to as rostering, this entails the assignment of individual patients or populations to individual primary care providers, teams or facilities. Provider assignments might be compulsory or voluntary and can be based upon geographical catchment area or individual choice. Empanelment encourages providers/teams to take responsibility for a holistic approach to the health of the people under their care, which facilitates the delivery of both public health and primary care functions.

PHC-oriented models of care require a bridging of the three components of PHC. On the production end, people and communities should feature throughout the design and organization of models of care, and models of care should mutually reinforce and empower community participation. On the user end, models of care should also promote patient engagement and self-management support through educational and supportive interventions that enable individuals' capacities to manager their own health. Similarly, PHC-oriented models of care should also create opportunities for national, subnational and community level multisectoral action to address the broader determinants of health.(23) The integration of health services and social care services for example is of growing importance to address population needs.

Governance, accountability, financing for results, health and social workforce arrangements, the development and use of evidence-based tools and guidelines (such as care pathways, clinical guidelines, and facility standards and protocols), facility organization and management processes (such as supportive supervision, efficient resource management and community engagement), and functioning information systems are critical enablers for successful models of care.(23–29) When designing new models of care that promote integrated health services, it is also important to examine the possibilities opened up by new technologies. Innovations in models of care delivery, such as those facilitated by digital technologies for health (see Section 3.7), can facilitate continuous improvement in the responsiveness and efficiency of the system. For example, if both community health workers and facility-based staff have access to a patient's electronic health records, updates about the patient can be shared in real-time, thus facilitating holistic models of care to ensure that all health personnel are providing complementary, reinforcing information and improving the quality of care.

Table 10. Models of care: actions and interventions

At policy level
• Develop models of care that are suited to the country and local contexts and advance the principles of promoting comprehensive integrated health services (including combining public health and primary care), placing primary care as the first and regular point of contact, ensuring that care is continuous, comprehensive, coordinated and person- and people-centred, and addressing both existing and emerging issues. • Ensure that policy frameworks are updated to reflect the evidence about successful models of care, such as the importance of connecting community health workers with facility-based staff. • Consider adopting new and appropriate health technologies that can facilitate holistic models of care. • Support the development of new models of care through targeted training programmes for health professionals and policy-makers. • Develop and strengthen information systems for the monitoring and facilitating of the evaluation of models of care and benchmarking.

At operational level

- Support the development of local leadership and empowerment of people and communities within models of care suited to local needs and that are age relevant and gender sensitive.
- Formalize collaborative relationships within multidisciplinary teams.
- Establish two-way referral systems that ensure that primary care facilities (as the first point of contact for most people) can refer seamlessly to other service delivery platforms.
- Establish integrated health services delivery networks.

By people and communities

- Advocate for models of care that embody key PHC principles.
- Participate in designing new models of care and reviewing their performance.

Table 11. Models of care: tools and resources

Health system tools and resources
Continuity and coordination of care: a practice brief to support implementation of WHO's framework on integrated, people-centred health services
Critical pathways towards integrated people-centred health services (Forthcoming, WHO)
Integrating health services: brief
Local Engagement Assessment and Planning (LEAP): A toolkit for enhancing integrated and people-centred health services (Forthcoming, WHO)
Primary health care and health emergencies: brief
Primary health care and health emergencies (long document)
Primary health care: closing the gap between public health and primary care through integration
The transformative role of hospitals in the future of primary health care
UHC intervention compendium (Forthcoming, WHO)
Access to rehabilitation in primary health care: an ongoing challenge

Programme-specific tools and resources

Age-friendly Primary Health Care Centres Toolkit

Child Friendly Communities in ESAR: An Integrated Approach to Community Platforms

Implementing malaria in pregnancy programmes in the context of World Health Organization recommendations on antenatal care for a positive pregnancy experience

Integrated care for older people (ICOPE) implementation framework: guidance for systems and services

Integrated care for older people: realigning primary health care to respond to population ageing

Mental health in primary care: illusion or inclusion?

Nutrition - WASH Toolkit. Guide for Practical Joint Actions

Planning and implementing palliative care services: a guide for programme managers

Primary health care as an enabler for "ending the epidemics" of high-impact communicable diseases: brief

Sexual, reproductive, maternal, newborn, child and adolescent health in the context of primary health care

Tackling NCDs - 'Best buys' and other interventions for the prevention and control of NCDs

The AIDS response and primary health care: linkages and opportunities

Tools for implementing WHO PEN (Package of essential noncommunicable disease interventions)

Traditional and complementary medicine in primary health care

Why palliative care is an essential function of primary health care

Primary health care workforce

Adequate quantity, competency levels and distribution of a committed multidisciplinary primary health care workforce that includes facility-, outreach- and community-based health workers supported through effective management supervision and appropriate compensation

The PHC workforce includes all occupations engaged in the continuum of promotion, prevention, treatment, rehabilitation and palliative care, including the public health workforce and those engaged in addressing the social determinants of health. It also includes caregivers, most of whom are women, complementing the actions of salaried workers.(30) Beyond service provision, health workers also include management/ administrative staff who are crucial for the functioning of the health system across different care settings, for example, information officers and planners. Health workers are a critical pathway to attaining the targets in SDG3 (Ensure healthy lives and promote well-being for all at all ages) and other health-related SDGs. An adequate, well-distributed, motivated, enabled and supported health workforce is required for strengthening PHC and progressing towards universal health coverage.

According to 2013 data, estimates show a projected global shortfall of 18 million health workers to achieve and sustain universal health coverage by 2030, primarily in low- and lower-middle-income countries, including 2.6 million doctors, 9 million nurses and midwives, and 5.9 million representing other health worker categories.(31)

Improving the availability and distribution of PHC workers where there are shortages is essential, but it is also important to improve the productivity and performance of the existing workforce. Adopting a diverse, sustainable skills mix geared to PHC, including proper links through all service delivery platforms to the social services workforce, ensures a more effective and efficient use of resources while better aligning to community needs. In some contexts, optimizing the skills mix of the PHC workforce includes harnessing the potential of community health workers operating in inter-professional primary care teams.

WHO's Global strategy on human resources for health: Workforce 2030 (32) and the recommendations of the United Nations High Level Commission on Health Employment and Economic Growth provide the strategic orientation and policy options for strengthening the health and social workforce for PHC, universal health coverage and the health-related SDGs.

The four objectives of the Global strategy on human resources for health have a direct bearing on the PHC workforce:

- optimize performance, quality and impact of the health workforce through evidence-informed policies on human resources for health
- align investment in human resources for health with the current and future needs of the population and health systems, taking account of labour market dynamics and education policies
- build the capacity of institutions at subnational, national, regional and global levels for effective public policy stewardship, leadership and governance of actions on human resources for health
- strengthen data on human resources for health for the monitoring and accountability of national and regional strategies, including the Global strategy.

Meeting these objectives will require concerted efforts and accountability to overcome multiple challenges, including ensuring sufficient availability and distribution of health workers, improving productivity and performance for a better quality of care, and enhancing the management and utilization of human resources.

The need to address each of these factors differs across countries. The starting point for effective health workforce planning is to understand the health labour market dynamics on the basis of a robust evidence base to ensure adequate skilled health workers, which in turn requires an understanding of the current and future profile of the health and social workforce (quantity, distribution, skill mix, education, regulation, inflow/outflow, working conditions and remuneration). Responding to these challenges also requires a multisectoral effort, including engaging with the education, labour and finance sectors.

When assessing the availability and distribution of the health workforce, it is important to take a holistic view and recognize that a multidisciplinary team (also discussed in Section 3.1) is often the best way to deliver care. Delivering primary care through well-functioning, multidisciplinary teams requires optimizing health workers' skill mix. There is no ideal model for these teams as each country organizes its health and social workforce on the basis of its own context, resource availability and investment capacity. The ideal composition of a multidisciplinary teams should enable the delivery of continuous, comprehensive, coordinated and people-centred care.

In some countries, PHC strategies are based on physician-led models, whether it be a general physician or a family doctor, as they have a comprehensive generalist skill set that is essential for tackling the range of issues that arise in primary care. Other countries may opt to have a more diverse composition of primary care teams that could include paramedical staff, nurse practitioners and community health workers, in addition to doctors. In some instances, where available resources and skills are overstretched, optimizing the skill mix could be achieved by reorganizing scopes of practice (often referred to in the literature as "task-shifting", "task-sharing", "delegation" or "substitution"), by which non-statutory tasks performed by a specific occupation may be extended to other occupations through additional training and are regulated to ensure safe practice.

Given the multisectoral nature of PHC, it is also important to consider how to involve professions in other sectors, such as water and sanitation, education and the environment, as well as those with expertise in engaging people and communities, such as community development specialists or anthropologists.

> *"Improving the availability and distribution of workers is essential, but it is also important to improve processes and accountability to maximize the utilization, productivity and performance of the existing workforce."*

It is important to recognize that the issues associated with recruiting, training, deploying and retaining each of the types of health workers may differ and so require different solutions. One particularly common challenge is the recruitment and retention of community health workers. Some countries have improved this by formalizing their role, for instance by paying and integrating them into PHC systems (for example, by connecting them to health facilities), but this is not yet the norm for all community health worker programmes. The WHO guideline on health policy and system support to optimize community-based health worker programmes provides additional evidence on integrating community health workers in health systems.(33)

Improving the availability and distribution of workers is essential, but it is also important to improve processes and accountability to maximize the utilization, productivity and performance of the existing workforce. Apart from inappropriate skill mix and unclear roles and expectations, performance constraints also include competency gaps, insufficient

motivation, inadequate compensation and unsuitable incentives, weak supervision and work processes, unclear guidelines, and difficult work environments. Thus, even where there are no critical workforce shortages, health workers may still fail to provide quality care.(34) Section 3.8 addresses several aspects of improving quality of care, but it is also the case that simple improvements in the management of human resources for health can frequently pay big dividends. Steps such as defining roles and responsibilities within a multidisciplinary team, improving communications, ending discriminatory practices and behaviour, balancing workloads and providing supervision and feedback are basic functions of good human resources management that are too often not done systematically. Investing in building management capacity among health workers and administrative staff can be an important way to improve performance.

In most countries, well-chosen interventions can help to achieve quick wins and remove critical bottlenecks. However, developing a fit-for-purpose PHC workforce, especially in countries facing critical shortages, requires a medium- to long-term strategic response, although some short-term interventions can also help to achieve quick wins. A concerted response at the national, subnational and community levels with the support of global and regional development partners can help to accelerate progress towards an adequate, competent, well distributed and multidisciplinary PHC workforce.

Table 12. Primary health care workforce: actions and interventions

At policy level

- Develop evidence-based health workforce policies, strategies and plans that prioritize investments in the PHC workforce to meet community and population needs.
- Establish appropriate forums or intersectoral coordination mechanisms that engage ministries of education, labour, finance and planning to ensure the alignment of different constituencies and stakeholders around issues of health workforce education, skills, employment and remuneration (including supporting these ministries to incorporate the needs of health workers into their own sectoral plans).
- Mobilize adequate funding from domestic and donor sources to sustain the supply, recruitment, deployment and retention of PHC workforce and minimize premature exit.
- Improve the distribution of the workforce through appropriate strategies (for example, regulations, financial and non-financial incentives, education) to deploy PHC workers in underserved communities and facilities.
- Align health worker education and skills to community and population needs and strengthen education and training institutions to scale-up and sustain the production of PHC workers in appropriate quantity, quality, and relevance to respond to current and future health priorities.
- Reorganize scopes of practice, if needed, to expand access to critical services and optimize primary care delivery.
- Strengthen governance capability of national regulatory authorities to appropriately regulate health professional education and practice, including public and private sector actors.
- Support the development of professional bodies that can engage actively in policy dialogue and provide oversight.

At operational level

- Ensure that PHC health workers have the core competencies required to deliver the defined package of health services.
- Institutionalize interprofessional continuing education and training for PHC teams to ensure that they are enabled and equipped with broad-based, and up-to-date skills.
- Establish management processes and accountability for optimizing motivation, satisfaction, retention and performance.
- Promote decent work that ensures gender-sensitive employment free of violence, discrimination and harassment, manageable workloads, adequate remuneration and incentives, and occupational health and safety.
- Develop and apply job descriptions for all PHC workforce occupations with appropriate competencies, expectations and key tasks, linked with merit-based recruitment, deployment, performance and progression.
- Provide career development opportunities through job security, supportive supervision, and career development pathways (including for community health workers).
- Strengthen health workforce information systems and/or implementing national health workforce accounts in order to inform policy and planning and strengthen monitoring of performance.
- Consider alternative workforce configurations based on the setting and resource availability to respond to evolving health needs and populations.
- Provide unpaid carers with adequate support (financial or in kind).

By people and communities

- Enhance accountability of PHC staff at community-, outreach- and facility levels through regular monitoring and feedback on performance.
- Ensure representation of PHC staff on professional bodies.
- Participate in the selection and deployment of staff at community-, outreach- and facility levels.

Table 13. Primary health care workforce: tools and resources

Health system tools and resources
Building the Primary Health Care Workforce of the 21st Century
CHW Guideline: Health systems supports for CHWs
Community Health Worker Assessment and Improvement Matrix (CHW AIM): Updated Program Functionality Matrix for Optimizing Community Health programmes
Global Competency Framework for Universal Health Coverage (Forthcoming, WHO)

Global Strategy on Human Resources for Health: Workforce 2030

National Health Workforce Accounts Handbook and Implementation Guide

WHO guideline on health policy and system support to optimize community health worker programmes

Working for Health & Growth: Investing in the health workforce

Workload Indicators of Staffing Need (WISN)
User's manual

Programme-specific tools and resources

Building an adolescent-competent workforce

Cancer workforce strategy for comprehensive prevention and control (Forthcoming, WHO)

Core competencies in adolescent health and development for primary care providers

Midwifery education modules - Education material for teachers of midwifery

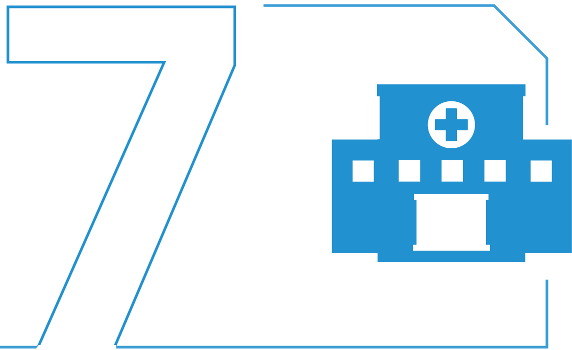
Strengthening midwifery toolkit

Strengthening quality midwifery education for universal health coverage 2030: Framework for action

Strengthening the capacity of community health workers to deliver care for sexual, reproductive, maternal, newborn, child and adolescent health

Using auxiliary nurse midwives to improve access to key maternal and newborn health interventions in sexual and reproductive health

WHO Competency Framework for Health Workers' Education and Training on Antimicrobial Resistance



Physical infrastructure

Secure and accessible health facilities to provide effective services with reliable water, sanitation and waste disposal/recycling, telecommunications connectivity and a power supply, as well as transport systems that can connect patients to other care providers

The physical infrastructure of health facilities has important impact on both the ability of health care providers to do their jobs and patient satisfaction, which in turn tends to affect the use of health services. Infrastructure needs and maintenance are often overlooked or neglected, however, particularly in primary care settings such as clinics and health centres. (35) Key elements of physical facility infrastructure include having reliable water supply, sanitation and waste disposal/recycling, telecommunications connectivity and power supply.

Effective infection prevention and control measures and water, sanitation and hygiene (WASH) services in health care facilities are at the foundation of quality care. Facilities should have water and sanitation services available for all users, including patients' family members. They should meet national standards and be regularly maintained with enough skilled staff to keep them functioning and clean. These measures ensure that all services are provided in a clean and safe environment, which is essential to maintain the health of the health workforce as well as the broader population. Without such standards, patients are placed at higher risk of acquiring infections while seeking care, thus resulting in infections that are more difficult and expensive to treat and, in some cases, can contribute to antimicrobial resistance. Furthermore, safe treatment and disposal of infectious waste and sewage is important for preventing the spread of the spread of illness in communities. In addition, the cleanliness of facilities and the availability and functionality of specific services, such as toilets and drinking water, have an impact on those seeking care and patient satisfaction.

> *The physical infrastructure of health facilities has important impact on both the ability of health care providers to do their jobs and patient satisfaction, which in turn tends to affect the use of health services.*

Telecommunications connectivity is becoming an increasingly indispensable aspect of the physical infrastructure for health care. Many countries rely on electronic systems for data collection. Thus, workers at facilities without connectivity may not be able to report regularly or may have to rely on their own personal technology. Additionally, as discussed in Section 3.7, advances in digital technology hold considerable promise for improving health services, but these potential benefits will be significantly undermined if facilities are unable to offer reliable connectivity to support initiatives and tools, such as telemedicine, e-learning, electronic health records or SMS text messaging for patient-specific and population-wide communications (for example, for patient appointment reminders or health promotion campaigns).

Reliable power supply is indispensable to the operations of health facilities. It is needed not only for telecommunications connectivity, but also for a wide range of other purposes including ensuring adequate lighting for diagnostic and medical procedures and ensuring functioning medical and non-medical equipment (for example, refrigerators necessary to maintain cold chains). Reliability has become considerably more feasible in recent years as

an off-grid power supply, particularly through solar panels, has become more affordable and easier to install. Otherwise, unstable power can cause equipment failures which are difficult to repair and affect facility capacity to deliver care, particularly in remote settings.

In 2019 a consultation by the Regional Office for South-East Asia on strengthening frontline services for universal health coverage proposed the following areas to work "differently" to ensure cleaner and safer facilities that draw on many of the core strategic and operational levers:(36)

- ensure the essentials: for example, ensuring adequate WASH systems and power supply through multisectoral collaboration; promoting community engagement in demanding the essentials; advocating with parliamentarians and decision-makers; and supplying protective equipment to facility cleaning staff
- implement standards: for example, defining clear standards for facilities using tools such as Service Availability and Readiness Assessments; disseminating standards to all stakeholders; and using legislative support to enforce standards
- strengthen management, monitoring and supervision: for example, training facility managers; introducing accreditation systems based on standards; and systematically reporting adverse events
- improve health facility resilience: for example, sterilizing medical equipment to prevent infections; ensuring essential water and power supplies to respond to emergencies; and implementing health infrastructure standards The final aspect of the physical infrastructure is transport, A lack of transport can act as a significant barrier to care and can exacerbate inequalities and is therefore a critical aspect of overall infrastructure. There are several possible ways that local officials can approach this, including direct ownership of vehicles (for example, ambulances), partnerships with private transport providers or via vouchers that subsidize the cost of transport. The ability to move patients who require more advanced or more emergent care than can be delivered at primary care facilities to secondary or tertiary facilities is particularly important to ensuring access. Additionally, appropriate and adaptable transportation systems may be necessary for other aspects of care, such as the provision of services in difficult access areas or for outreach campaigns.

The physical infrastructure of health care facilities also plays an important role in enhancing trust between people and communities and the health system. This entails that health facilities be responsive to both the medical as well as the non-medical needs of the people and communities they serve, including physical, cultural and religious needs. This may entail creating comfortable waiting spaces, physical structures that ensure the privacy of visits (particularly for sensitive or intimate matters), taking measures for more child-friendly environments (such as placing steps tools for small children by lavatories for handwashing) or creating separate designated areas for males and females. Attention should also be paid to ensuring that people with a wide range of abilities can access and use all health facilities. Features that should be considered include elevators, escalators, ramps, wide doorways and passages, safe stairs with railings, rest areas with comfortable seating, adequate signage,

and accessible public toilets.

Table 14. Physical infrastructure: actions and interventions

At policy level

- Establish national standards for infection prevention and control.
- Develop implementation plans to ensure that all health facilities have WASH systems, transportation, telecommunications connectivity and a reliable power supply.
- Develop policies that promote universal physical access (within a reasonable commuting time) to health facilities for people of all ages and abilities.

At operational level

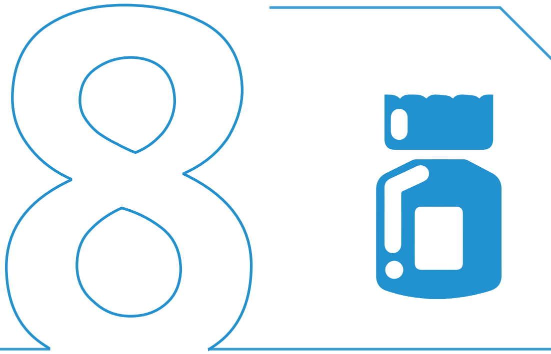
- Ensure that all newly-constructed health facilities have reliable WASH systems, telecommunications connectivity and a reliable power supply.
- Ensure proper management and maintenance of health facilities, prioritizing reliable infection prevention and control and WASH systems, telecommunications connectivity, and a reliable power supply.
- Establish protocols to ensure gender-sensitive facilities that are free of violence, discrimination and harassment.
- Develop an approach that ensures that transport is not a barrier to accessing or delivering services.

By people and communities

- Use established mechanisms to facilitate reporting on health facility standards and functions (for example, citizens’ scorecards).

Table 15. Physical infrastructure: tools and resources

Health system tools and resources
AccessMod
Access to Modern Energy Services for Health Facilities in Resource-Constrained Settings: a review of status, significance, challenges and measurement
Core questions and indicators for monitoring WASH in health care facilities in the Sustainable Development Goals
Essential environmental health standards in health care
Overview of technologies for the treatment of infectious and sharp waste from health care facilities
Safe management of wastes from health-care activities: a summary
Training modules in health-care waste management
WASH in health care facilities - Practical steps to achieve universal access to quality care
Water and sanitation for health facility improvement tool (WASH FIT) - A practical guide for improving quality of care through water, sanitation and hygiene in health care facilities
WHO/UNICEF guidance on health facility indicators



Medicines and other health products

Availability and affordability of appropriate, safe, effective, high-quality medicines and other health products through transparent processes

PHC relies on access to health products including medicines, vaccines, medical devices, in vitro diagnostics, protective equipment and vector-control tools, and assistive devices. These must be of assured safety, efficacy/performance and quality. In addition, they must be appropriate, available and affordable.

Ensuring that appropriate health products are available and affordable depends upon several policy decisions and integrated processes related to the assessment, selection, pricing, procurement, supply chain management, maintenance (in the case of medical devices), prescribing and dispensing (in the case of medicines) and safe and appropriate use of all health products.

Availability of health products should be guided by evidence-based selection processes, such as a health technology assessment, a systematic assessment of the properties, effects and impacts of a health technology.(38) It is a multidisciplinary process that evaluates the social, economic, organizational and ethical issues related to health technology, informing decisions on when, where and how it can be used. Global guidelines, such as lists of essential medicines, vaccines, medical devices and assistive products, are useful in determining which health technology is appropriate for local assessment to support health services according to the model of care (for example, the WHOs Model List of Essential Medicines (39) and other lists included in Table 17). As it is essential to ensure appropriate health products are available for primary care services to respond to population needs, WHO is currently developing a specific list of health products for primary care services.

"Ensuring that appropriate health products are available and affordable depends upon several policy decisions and integrated processes related to the assessment, selection, pricing, procurement, supply chain management, maintenance (in the case of medical devices), prescribing and dispensing (in the case of medicines) and safe and appropriate use of all health"

National regulatory authorities are responsible for ensuring safety, efficacy/performance and quality of health products across the health system. Registration or marketing authorization of health products is a key regulatory step to allow health products into a country. National regulatory authorities are responsible for ensuring that health products are stored, distributed and dispensed appropriately. These activities entail the licencing of establishments, such as storage facilities or pharmacies. As substandard medicines are estimated to be responsible for hundreds of thousands of deaths each year,(37) post-market surveillance at all levels is essential to ensure the safety and performance of health products. If medicines cause a serious adverse event or a medical device does not perform as expected, it is important to report back to the national regulatory authorities so that the benefits and risks of the issue can be assessed, and action can be taken if needed.

Good procurement practice and policies that favour the purchase of generic medicines play a key role in ensuring quality products at affordable prices. Such polices support the effective use of government resources and contribute to the reduction of out-of-pocket expenditure for patients.

Good supply chain management ensures that quality products are available across the health system. Supply chain management competencies that are particularly required in health facilities include stock management and maintenance (of medical devices as well as refrigerators for the cold chain). A key aspect of supply chain management entails ensuring the availability of health products during an outbreak, a natural disaster, or other emergency. This is becoming increasingly critical as extreme events become more common as a result of climate change and it is important to build the resilience of supply chains.(40) Reliable tracking of products is a key dimension of good supply chain management and some countries have deployed logistics management information systems to ensure the ready availability of information about health products. Good supply chain management, emphasizing primary care, should encompass not only facilities but also health products used by community health workers.

The procurement of medical equipment (including extended warranties and accessories) that can appropriately work with unstable energy, high humidity or extreme temperatures is important to ensure functional operation in facilities, avoid long waiting times and minimize the need to send patients to other facilities owing to equipment breakdown or lack of consumables, especially in remote settings.

Maintenance of health products is another critical issue, particularly for medical equipment. This often requires specialized skills that may not be readily available at health facilities and thus, the availability of adequate budget for maintenance, spare parts or consumables and eventual replacement of equipment is also significant. It is important to ensure that health workers have the necessary competencies for the implementation of clinical practice guidelines, appropriate prescribing and dispensing of medicines, and appropriate and safe use, decontamination and/or disposal of medical devices to avoid cross infections. This is especially essential as the indiscriminate use of antibiotics when a diagnostic is not available can contribute to the spread of antimicrobial resistance, an increasing threat to individual and population health. .

Finally, although this section has focused primarily on health products in health facilities, PHC also draws on several products from outside the health sector. Food-related technologies are particularly important, including those for the preparation of food, such as cooking stoves that do not contribute to air pollution, accidental burns or intoxication, as well as products to ensure safe drinking water to avoid the spread of infectious diseases.

Table 16. Medicines and other health products to improve health: actions and interventions

At policy level

- Ensure the development of health technology policies that include all health products and consider processes of: innovation, assessment, selection, regulation, pricing, procurement, supply, use, maintenance and decommissioning.
- Strengthen national regulatory bodies to ensure safety, effectiveness/performance and quality, including by using the WHO Global Benchmarking Tool for the formulation of institutional development plans.
- Engage in collaborative approaches for the registration of health products and follow up in case of adverse events.
- Use evidence-based selection methods, including health technology assessments and use of WHO's essential and priority lists, to guide procurement and reimbursement decisions.
- Establish pricing policies to make full use of generics and other procurement strategies that maximize resources and reduce out-of-pocket payments.
- Strengthen supply chain management to ensure availability of health products (including maintenance of medical devices) at the point of use.
- Establish national lists of essential medicines and health products for primary care.
- Ensure adequate domestic resources to provide access to health products in primary care.
- Ensure national capacity to prepare for and respond to the needs for health products in emergency situations, including diagnostics, personal protective equipment, medicines and medical devices.

At operational level

- Implement technical guidelines, norms and standards for quality assurance and the safety of health products.
- Strengthen governance and oversight, including on the efficiency and integrity of the supply chain, including through support of information technology.
- Ensure capacities for the appropriate prescribing, dispensing and use of medicines, as well as the correct management and maintenance of medical devices, especially before new products are introduced.
- Undertake periodic random surveys of storage, availability and quality of health products.
- Ensure the maintenance of health products (particularly medical equipment).
- Ensure training of health workforce on the appropriate and safe use of health products.
- Establish the local capacity to mobilize health technology during health emergencies, including personal protective equipment needed.

By people and communities

- Participate in decision-making around the adoption of new health technologies.
- Participate in the monitoring of price, availability, safety and quality of health products.

Table 17. Medicines and other health products: tools and resources

Health system tools and resources
Antimicrobial resistance and primary health care: brief Long document (forthcoming, WHO)
2019 WHO AWaRe Classification Database of Antibiotics
Good governance for medicines: model framework, updated version 2014
Guide to integrated community case management procurement and supply and management Planning for Global Fund Grants
Interagency package: essential health products for primary health care (Forthcoming, WHO)
Roadmap for access to medicines, vaccines and health product 2019-2023: comprehensive support for access to medicines, vaccines and other health products
Selection of essential medicines at country level – Using the WHO model list of essential medicines to update a national essential medicines list
TOWARDS ACCESS 2030 - WHO Medicines and Health Products Programme Strategic Framework 2016 - 2030
WHO Antimicrobial Stewardship Programmes in health-care facilities in LMICs - A WHO Practical Tool Kit
WHO Global Model Regulatory Framework for Medical Devices including in vitro diagnostic medical devices
WHO Global Surveillance and Monitoring System for substandard and falsified medical products
WHO guideline on country pharmaceutical pricing policies
WHO lists of priority and medical devices
WHO medicines quality assurance guidelines

WHO model list of essential in vitro diagnostics
WHO priority assistive products list
World Health Organization model list of essential medicines: 21st list 2019

Programme-specific tools and resources
Appropriate storage and management of oxytocin – a key commodity for maternal health WHO/UNICEF/UNFPA Joint Statement
Interagency list of medical devices for essential interventions for reproductive, maternal, newborn and child health

Engagement with private sector providers

Sound partnership between public and private sector providers for the delivery of integrated health services

In the health area, the private sector refers to all non-State actors involved in health: for-profit and not-for-profit, formal and informal, and domestic and international entities. Almost all countries have mixed health systems with goods and services provided by the public and private sector and health consumers requesting these services from both sectors. The private sector's involvement in health systems is significant in scale and scope and includes the provision of health-related services, medicines and other health products, health insurance, supply chain management, training for the health workforce, information technology, as well as infrastructure and support services.

The term private sector covers a wide array of actors and services across the health system, including as a source of financing, a developer of new technologies and products, a manager of supply chains, an advocate, and a service provider.(41) Thus, engagement with the private sector is included in many of the core strategic and operational levers. However, this lever does not attempt to aggregate the private sector's role across all the levers, but rather focuses specifically on the important role of private sector providers in service delivery.

This area is critical because virtually every country has a mixed health system that includes both public and private provision of care. The share varies by the service in question,(41–44) and, as noted in section 2.2 (paragraph 21), a recent WHO survey found that in most of the 65 surveyed countries the private sector provides over 40% of care with some countries exceeding 70%. In many countries, a significant proportion of primary care services is delivered by the private sector, ranging from individual doctors, traditional medicine practitioners, social workers, pharmacists, dieticians or others running informal medicines shops to non-profit providers such as faith-based or nongovernmental organizations. Additionally, several companies provide occupational health services to their employees. These programmes are typically aimed at health and safety at work, but they often also provide primary care to workers (and their families).

It is important to emphasize that in most countries the public and private sectors are not sealed off from each other. Individual health professionals may practise in both sectors and a significant share of patients seek services from both (sometimes for the same condition). Moreover, actions that are aimed at one sector (for example, improving the quality of care in public facilities) often end up influencing the other sector (for example, by shifting the demand from lower-quality private providers to the public sector.(41,45)

Both public and private sector share responsibility for provision of services, but governments must oversee and guide the whole health system in order to protect the public interest. To do this the role of health ministries as stewards for health must be reinforced. Several approaches and tools can be used to ensure successful stewardship. At the level of policy

development, the private sector should be treated as a constituency that can bring relevant expertise and it is often valuable to invite private sector representatives to participate in designing relevant strategies and policies. The Joint Learning Network for Universal Health Coverage has identified five key steps to strengthening dialogue with the private sector, including finding common ground (“win-wins”) and establishing a regular consultative process.(46)

WHO’s work in this area focuses on supporting countries to work on six governance behaviours: building understanding, delivering strategy, enabling stakeholders, fostering relations, aligning structures and nurturing trust.

Of note, there is a potential for conflicts of interest (for example, by pushing a national policy shift that ends up benefitting a commercial interest) and it is important for national authorities to be alert to this possibility and to take steps to minimize it: for example, by working with trade associations or networks that may be less likely to have conflicts and by ensuring complete transparency in all engagements with the private sector.

Regarding the private sector in the delivery of care, one framework (47) highlights four possible government approaches for engagement:

- prohibition: the banning of some or all forms of private practice, such as the prohibition of unlicensed providers; in practice, bans are uncommon because they are often difficult to enforce
- constraint: although outright bans are rare, most countries place some constraints on private providers, typically in the form of regulations such as statutory controls, accreditation or self-regulation by professional bodies; these cover areas such as human resources, medicines, facilities and equipment
- encouragement and incentivization: many countries seek to incentivize the private sector to improve access to services and/or their quality; a range of mechanisms are used for this purpose, including public-private partnerships, social franchising, social marketing, tax benefits, and the provision of training and/or other support to improve the quality of care
- purchasing: many governments contract private providers for some elements of service delivery (for example, laboratory and/or medical equipment services, and supply chain management for medicines); most national health insurance schemes contract private providers for both outpatient and inpatient care; some also use voucher programmes to target subsidies at particular populations (for example, to reduce financial barriers to disadvantaged populations accessing maternal and child health services).

> *Both public and private sector share responsibility for provision of services, but governments must oversee and guide the whole health system in order to protect the public interest. To do this the role of health ministries as stewards for health must be reinforced.*

In any given country, it is typically the case that multiple approaches will be taken at the same time to address different aspects of engagement with the private sector. To assist with this, WHO has developed a decision-making model and a set of tools designed to support evidence-based decision-making, including:

- understanding a country's health markets, types of private actors, and the nature and scale of private activity
- identifying potential areas of risk and opportunity posed by the private sector to a country's health goals
- assessing governance and regulatory capacity, matching this capacity to its envisaged role for the private sector, and helping with the design of reforms to fill capacity gaps
- identifying different modes of control or engagement of the private sector.

The framework of government approaches to private sector engagement and WHO'S decision-making model aim to help countries to formulate policy on the private sector and choose and deploy legal and financial policy tools to implement it.

To further support this work, WHO is currently developing the following:

- a new road map on engaging the private health service delivery sector through governance in mixed health systems, which describes the six behaviours noted above in more detail. It is intended to facilitate a new way of governing mixed health systems by building consensus around the means and strategies of engaging the private health sector in health care service delivery. It provides guidance towards achieving a well-governed health system in which public and private actors collectively deliver on equity, access, quality and financial protection.(48)
- recommendations for understanding the private sector's contribution to health by building the best available picture using existing data, while simultaneously investing in multi-sectoral improvements to standard data availability
- recommendations on principles for engaging the private sector
- guidelines for designing policies related to the private sector in health
- new guidance that is intended to address the accountability challenges posed by the private sector.

To address the fact that many countries do not have an accurate sense of the extent of private sector provision, the Joint Learning Network for Universal Health Coverage has also produced a step-by-step guide to mapping private sector providers, which is critical to ensuring an adequate information base for decision-making.(46) A somewhat broader approach to conducting private sector assessments has been developed by the SHOPS and SHOPS Plus projects, which have conducted assessments in more than two dozen countries and prepared a guide to carrying out assessments based on this experience.(49)

Finally, it is also important to ensure the participation of private providers in national monitoring and evaluation efforts, ideally including through health management information systems. This involvement has proven challenging in several countries,(50) but new technologies are creating opportunities for stronger collaboration on monitoring systems, and private sector actors and networks should hold themselves accountable for participating in national systems.

Table 18. Engagement with private sector providers: actions and interventions

At policy level

- Develop an approach to engaging with the private sector around policy development (for example, through a regular consultative engagement process or platform), including how to manage conflicts of interest.
- Identify challenges (for example, elements of service delivery that are lagging) and assess whether greater private sector engagement could improve performance.
- Develop the approach (for example, constraint, encouragement, purchasing) for engaging with the private sector that is best suited to addressing the challenge identified.
- Assess legal and regulatory frameworks to ensure that they adequately address the private sector, including about issues of accountability.
- Conduct provider mapping or a private sector assessment to ensure accurate information about the scope of private sector service delivery.
- Proactively reach out to private providers to ensure inclusion in national monitoring and evaluation systems.

At operational level

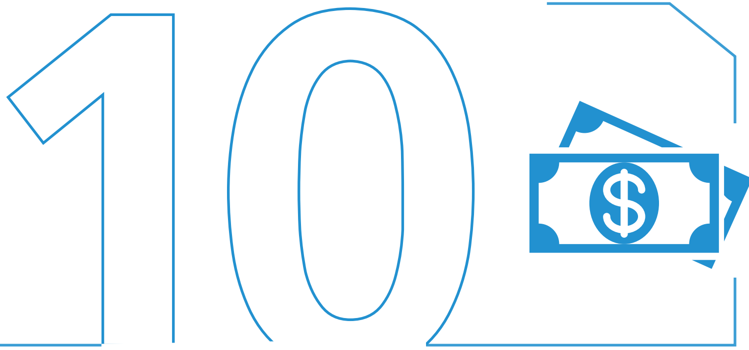
- Strengthen capacity to conduct oversight/control of the private sector according to laws and regulations.
- If appropriate and given the extent of decentralization to subnational levels, develop an approach to engaging with the private sector around policy development (for example, through a regular consultative engagement process or platform), including how to manage conflicts of interest.

By people and communities

- Organize alliances or networks that can improve the representation of the private sector in policy dialogue with the government.
- Engage actively in existing policy-making bodies.
- Contribute data to health information systems.

Table 19. Engagement with private sector providers: tools and resources

Health system tools and resources
Engaging the private sector for service delivery
Engaging the Private Sector in Primary Health Care to Achieve universal health coverage: Advice from Implementers, to Implementers
Draft road map for engaging the private health sector for universal health coverage Final document (forthcoming, WHO)
Regulation of private primary health care
The private sector, universal health coverage and primary health care



Purchasing and payment systems

Delivery of integrated health services with primary care and public health at the core

Purchasing and payment systems that foster a reorientation in models of care for the PHC-oriented purchasing and payment systems aim at fostering the implementation of PHC-oriented models of care (see Section 3.1). When supported by adequate resource flows in support of PHC and driven by PHC-oriented models of care, purchasing and payment systems increase the accessibility of priority interventions to the entire population and the integration of services with primary care and public health at their core. Strategic purchasing – including benefits design, provider payment methods and contracting arrangements – can strengthen the PHC orientation of models of care and promote the integration of health services while advancing other health system objectives.

Benefits design should always involve the participation of people and communities, including providers and purchasers, and should aim to promote equity and leave no one behind. Health service packages, often the basis for benefit entitlements, should take into account the model of care and reflect a comprehensive spectrum of population-wide and individual-based services and interventions throughout the course of life. Through inclusion of promotive, protective, preventive, resuscitative, curative, rehabilitative and palliative care services, across service delivery platforms, service packages can guide delineation of roles and improve coordination across service delivery platforms, thus informing the effective and efficient allocation of resources and improving integration. Additionally, changes to access conditions in a benefits package, such as reductions in cost-sharing mechanisms (lowering of user fees or policies for user fee removal), can incentivize the use of primary care services. Many countries have started to move away from charging user fees as it has become clearer that they have significant negative effects on poorer populations and worsen inequality.

The way in which providers are paid has a profound impact on the volume and quality of health services delivered. Designing and implementing appropriate provider payment methods can provide the right incentives to promote integrated health services centred around primary care and public health. The use of primary care services, for example, might be incentivized through relatively higher remuneration rates. Introducing newer approaches to provider payment is assuming a greater importance as PHC-oriented systems are increasingly being led by family physicians in low- and middle-income countries. The most commonly used provider payment methods include a line item budget (staff salary being the line item), global budget, fee for service, capitation (per capita payment), per diem, and case-based payment (for example, diagnosis-related groups). The first four are more relevant for the payment of primary care providers and are explained in Table 20.

Table 20. Assessment of provider payment methods

Payment method	Characteristics	Incentives for providers	When the method may be useful
Line item budget	• Providers receive a fixed amount for a specified period to cover specific input expenses (for example, for personnel, medicines, and utilities), but shifting funds from one line item to another is usually not possible.	• Increase referrals, increase input, spend all remaining funds by the end of the budget year • No incentive or mechanism to improve efficiency	• Management capacity of the purchaser and providers is low; cost control is a top priority
Global budget	• Providers receive a fixed amount for a specified period to cover aggregate expenditures to provide an agreed-upon set of services • Budget is fixed but can be used more flexibly and is not tied to line items.	• Global budgets are formed based on input: underprovide services, increase referrals, increase input • Global budgets formed based on volume: increase the number of services, increase referrals, decrease input (possible efficiency)	• Management capacity of the purchaser and provider is at least moderate; competition among providers is not possible or not an objective; cost control is a top priority
Fee for service	• Providers are paid for each individual service • Fees are fixed in advance for each service or group of services	• Increase the number of services, including above the necessary level; reduce input per service, which may improve the efficiency of the input mix	• Increased productivity, service supply and access are top priorities; there is a need to retain or attract more providers; cost control is a low priority
Capitation (per capita)	• Providers are paid a fixed amount in advance to provide a defined set of services for each enrolled individual for a fixed period of time	• Improve efficiency of the input mix, attract enrolees, decrease input, underprovide services, increase referrals, improve output mix (focus on less expensive health promotion and prevention), attempt to select healthier (less costly) enrolees	• Management capacity of the purchaser is moderate to advanced; strengthening primary care and equity are objectives; cost control is a priority; choice and competition are possible

Source: Adapted from reference *(51)*.

Although there is no ideal payment method for all contexts and each method has its strengths and weaknesses, many countries are moving towards blended payment systems that include for example capitation and fee-for-service payment. The reason is both because they are the most consistent with the philosophy of PHC (encouraging population-based management and productivity) and because the alternatives have demonstrated shortcomings in supporting a PHC-oriented health system. Capitation is structured around paying for a defined set of services for a defined catchment area population (or for the people affiliated to that facility) and period of time, rather than tying payment to specific diagnostic and curative services when those services are delivered, and so it is often linked to empanelment (see Section 3.1, paragraph 52).

A growing number of new provider payment mixes is emerging, which explicitly seek to align payment incentives with health system objectives related to care coordination, quality, health improvement and efficiency by rewarding the achievement of targeted performance measures. These have become collectively known as "pay for performance". For instance, a pay for performance system may aim to support the integration and coordination of care across the health system by incentivizing primary care providers to deliver more promotive, protective or preventive services or by incentivizing other care providers to support the delivery of services in care settings closer to the community (for example, by providing second opinions through teleconsultation to primary care providers or through local hospital-based hospital to patient referral or transfer). The data on the impact of pay for performance mechanisms on health outcomes are mixed. Their most important contributions may be their reinforcing effects on broader performance improvement initiatives and their spill-over effects to other health system strengthening that occurs as a by-product of the incentive programmes.(52)

Contracting is another useful purchasing mechanism to drive PHC-oriented models of care by generating provider accountability to PHC-related goals and objectives. Contracting terms, for example, might be designed to link payments to the successful achievement of national and/or local health outcomes or to support the creation, expansion and management of integrated provider networks based on community needs.

Adequate data are critical to well-functioning purchasing and payment systems, so strengthening monitoring capacity should be included in any strategic purchasing reform.(53)

"Although there is no ideal payment method for all contexts and each method has its strengths and weaknesses, many countries are moving towards blended payment systems."

Table 21. Purchasing and payment systems: actions and interventions

At policy level

- Develop an inclusive participatory approach to provider payment and contracting in all care settings as part of the wider health-financing and strategic-purchasing strategy, with the view to reorienting models of care toward primary care and support coordination and integration.
- Define a comprehensive benefit package that includes promotive, protective, preventive, resuscitative, curative, rehabilitative and palliative care services before selecting payment methods.
- Use a combination of costing and other information to ensure adequate resources to deliver the comprehensive benefit package.
- Set national health policies that remove user fees for primary care services.
- Set health benefits package access conditions that reduce user fees for primary care services.
- Establish contracting mechanisms that generate provider accountability to PHC-oriented goals and objectives.
- Strengthen monitoring systems to ensure that purchasing and payment mechanisms are based on robust data.

At operational level

- Ensure appropriate delineation of roles across service delivery platforms and providers based on agreed models of care and available resources.
- Support continuous improvement of purchasing and payment systems through regular monitoring of the incentives and possibly adjustment/s to the payment method.
- Promote transparency by releasing data on budgets and expenditures to the maximum extent.

By people and communities

- Participate in the design and development of national strategic purchasing strategies, benefits package design, and contracting – for example in policy dialogues, on technical advisory committees, on health insurance oversight boards.
- Monitor facility or provider performance to ensure desired quality of care that minimizes under- or over-provision
- Familiarize individuals and community with cost-sharing rules and mechanisms.

Table 22. Purchasing and payment systems: tools and resources

Health system tools and resources
Analytical guide to assess a mixed provider payment system
Governance for strategic purchasing: An analytical framework to guide a country assessment
Purchasing health services for universal health coverage: how to make it more strategic?
Strategic purchasing for universal health coverage: key policy issues and questions - A summary from expert and practitioners' discussions

11 Digital technologies for health

Use of digital technologies for health in ways that facilitate access to care and service delivery, improve effectiveness and efficiency, and promote accountability

Digital technologies — from information and communications technologies, such as the internet and mobile telephony, to the more recent development of advanced computing leading to use of big data, artificial intelligence and genomics — are improving effectiveness and efficiency of integrated health services and delivery of care. Although access is not yet universal, more than eight in 10 people in developing countries own a mobile phone and nearly half the global population uses the Internet. These technologies are more equitably distributed across the planet than income, in that even the region with the lowest mobile penetration — sub-Saharan Africa — has 78 mobile cell subscriptions per 100 people.(54,55)

The revolution in information and communications technologies has brought about important shifts in how individuals and communities manage their own health and access information about health conditions, treatment options and the availability (and sometimes quality) of service providers. These shifts can play an important role in advancing the core PHC tenet of empowering people and communities by putting new power in the hands of people and shifting the nature of the relationship between medical provider and patient by reducing the asymmetry of information. However, too much of the information currently available is only in English or other languages that are typically not the first language of people in low- and middle-income countries. In addition, low digital health literacy limits the potential impact of these information and communications technologies in these settings. Digital technologies are creating new ways that people can hold service providers to account, as well as enabling more effective and larger-scale advocacy and health promotion efforts.

Digital technologies are also having profound effects on the provision of health services, particularly through the rapid expansion of digital health interventions, particularly mHealth (mobile health) and eHealth (electronic health) initiatives. Governments have rapidly responded to this changing landscape by developing national strategies Today more than 120 countries have developed national policies or strategies for eHealth, telemedicine or digital health.(56,57)

Digital health interventions may target four primary uses:(58)

- for clients (for example, targeted client communication, such as reminders, peer communications, personal health tracking and citizen reporting)
- for health workers (for example, client identification and registration, health records, decision-support tools, telemedicine, referral coordination, training, prescription and/or diagnostics management)
- for health systems' managers (for example, human resources management, supply chain management, civil registration and vital statistics)
- for data services (for example, data collection, management and use, location mapping and data exchange).

WHO has recently completed an extensive review of the evidence for a few selected digital health interventions.(59) The evidence for the effectiveness of many interventions is still limited, but 10 recommendations were made, most of which highlighted the fact that currently the interventions could only be recommended in certain situations, such as when standard operating procedures and data privacy standards were in place.

Despite the limited evidence base, digital health interventions have been expanding rapidly as they are perceived to offer ways to address major health system challenges, some of which are highly relevant for PHC. For example, an increasing number of countries are attempting to redress human resources' constraints across the health system, through e-learning or telemedicine, particularly in relation to primary care. The former aims to build capacity among health workers through electronic courses or other forms of pre and in-service training. These can reduce the cost of training, improve access to expertise, and enable access to training in settings that have limited educational facilities.

Telemedicine can provide access to specialist expertise at a distance by transmitting medical images and clinical data or descriptions to off-site facilities that support diagnosis and can propose treatment options. Areas of focus so far include radiology, dermatology, pathology and psychiatry, but improvements in mobile technology are expanding the range of devices and services that can be offered, including in new areas such as cardiology and ophthalmology. The COVID-19 response in many countries has demonstrated the feasibility of this approach as part of maintaining essential health services. These technologies can help to redirect interventions from secondary and tertiary care facilities, such as hospital settings, to people's home. This change is transforming primary care and moving health systems towards a more people-centred and integrated model of health service delivery. However, it is also important to note that any digital health intervention such as telemedicine requires an enabling environment including infrastructure, trained workforce, privacy and safety protocols, proper legislations, policy and compliance.

Other innovative technologies, such as artificial intelligence and genomics, are gaining momentum owing to advanced computing power and availability of vast amounts of data. Use of artificial intelligence in medicine and public health, although still in its early stages and further away from widespread use in low- and middle-income countries, is likely to have a major impact in the coming years. For example, artificial intelligence is already starting to be used to improve diagnoses (for example, computer-aided diagnostics when specialists are unavailable) and personalized genomics has the potential to enable tailored treatment approaches.

> *"The revolution in information and communications technologies has brought about important shifts in how individuals and communities manage their own health and access information about health conditions, treatment options and the availability (and sometimes quality) of service providers."*

Advances in information and communications technologies have already shaken up health information systems and the traditional paper-based systems have been partially or fully replaced by electronic systems for collecting, coding and aggregating data in many countries, resulting in significant improvements in the timeliness and accuracy of information systems, for example through District Health Information System 2.(60) Electronic health records are less widespread, but WHO reported a nearly 50% increase in the use of these systems between 2010-2015.(56) Ensuring legislation to protect confidentiality is an important component of electronic health records, but has lagged behind in a number of countries.

Two other emerging applications of information and communications technologies that are particularly relevant to PHC are the ability to use "big data" approaches to analyse patterns and trends and to improve the targeting of public health efforts (sometimes called "precision public health"). New technologies have already made an impact in supply chain management (for example, through electronic information systems for logistics management) and there are efforts underway to use cutting-edge approaches, such as blockchain technology to improve the reliability of supply chains.

Digital technologies are also increasingly driving the development of medical and assistive devices that can accelerate diagnosis, support decision-making and facilitate delivery of care.

Across all these areas, it is essential to ensure that ethical concerns are properly addressed. Data protection in particular is critical to maintaining the privacy of sensitive health information.

In response to a request from Member States, the Secretariat is preparing a global strategy on digital health2 to address existing gaps in research, innovation, development, collaboration and adoption of appropriate digital health solutions in support of PHC, universal health coverage and the health-related SDGs. The global strategy has the following four strategic objectives: (1) promote global collaboration and advance the transfer of knowledge on digital health; (2) advance the implementation of national digital health strategies; (3) strengthen governance for digital health at global, regional and national levels; and (4) advocate people-centred health systems that are enabled by digital health.(61) The strategy further proposes a series of actions to be taken by Member States, partners and the Secretariat in order to attain its objectives. The global strategy is being submitted to the Seventy-third World Health Assembly for consideration.

Table 23. Digital technologies for health: actions and interventions

At policy level

- Develop, as appropriate, national eHealth strategies, architecture, frameworks, and plans and legislation as well as data protection policies around issues such as data access, sharing, consent, cybersecurity, privacy, interoperability and inclusivity, unique personal health identifiers, consistent with international human rights obligations.
- Examine whether the conditions are appropriate for introducing digital health interventions.
- Establish mechanisms to learn about new developments in information and communications technologies globally and identify gaps in existing efforts that could be filled through new technologies.

At operational level

- When evidence demonstrates effectiveness, scale up digital health interventions from pilot schemes, including the integration of digital technologies into existing health systems' infrastructures and regulation.
- As appropriate, conduct health technology assessments.
- Accelerate efforts to implement digital health information systems, including eHealth records.

[2] Document A73/4.

By people and communities

- Use digital technologies to become informed consumers of health information.
- Use new avenues enabled by technology to provide feedback on health services.

Table 24. Digital technologies for health: tools and resources

Health system tools and resources
Community Information Integration (CII) and the Central Patient Attached Registry (CPAT), a tool to integrate community Electronic Medical Records (EMRs)
Data and innovation: draft global strategy on digital health Final document (forthcoming, WHO)
Designing Digital Health Interventions for Impact
Digital education for building health workforce capacity
Digital Health Atlas
Digital Health for RSSH for Global Fund guideline
Digital technologies: shaping the future of primary health care
Framework for the implementation of a telemedicine service
National eHealth strategy toolkit
UNICEF Digital Health approach
WHO guideline: recommendations on digital interventions for health system strengthening

Systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health services

Systems for improving the quality of care

Systems at the local, subnational and national levels to continuously assess and improve the quality of integrated health services

The Lancet Global Health Commission on High Quality Health Systems in the SDG Era highlighted that more deaths in low- and middle-income countries are now occurring as a result of poor-quality care than owing to a lack of access to care.(62)

Quality care is effective, safe and people-centred. It needs to be timely, efficient, equitable and integrated. It is essential for improving performance, maintaining trust, ensuring the sustainability of the health system and guaranteeing that all efforts and resources invested in facilitating access to and delivering care are translated into improving people's health. Quality care requires careful planning that involves and engages key stakeholders, including users of care. Quality control through internal monitoring and continuous measurement, alongside quality assurance, ensures that processes are adhering to a set standard and are continuously improved through quality improvement interventions to enhance performance. Systems at the local, subnational and national levels should be equipped to continuously assess, assure, evaluate and improve the quality of primary care, as well as other health services, through tailored interventions selected from a wide range of evidence-based quality improvement interventions to best suit their needs.

A range of approaches can be used, but the emphasis should be on developing a multimodal suite of interventions tailored to the local context, while simultaneously working to improve the broader health systems' environment and culture that support the delivery of quality care. The joint publication of WHO, the Organisation for Economic Co-operation and Development and the World Bank in 2018 on delivering quality health services highlights the importance of developing a national quality strategy and/or policy and proposes that governments select a set of evidence-based quality improvement interventions in relation to four categories: the health system environment; reducing harm; improvement in clinical care; and patient, family and community engagement and empowerment.(63)

Health system environment

Improving the quality of integrated health services, including primary care services, will depend not only on interventions focused on care processes and service delivery, but also on efforts to create the supportive conditions, governance processes, legislative environment and culture necessary to enable providers and professionals to meet the desired levels of care. This action will include a strong focus on the capacity of the health workforce to deliver quality care, as well as accountability mechanisms linked to assessment against defined, evidence-based quality standards.

Reducing harm

These interventions focus on the main activities aimed at upholding the foundational principle of causing no avoidable harm to people. Achieving this requires multimodal and

multidisciplinary action to implement a range of practical tools – such as safety protocols and checklists – while systematically managing risk and addressing the training needs and behavioural and cultural changes required to build a sustainably safe environment.

Improvement in clinical care

This category of interventions focuses on processes and tools aimed at increasing the effectiveness of clinical care. It incorporates critical tools to support health workers in planning effective clinical management – such as context-appropriate standards, pathways, protocols, , checklists, standardized clinical forms and clinical decision support tools – as well as improvement processes that can identify improvement needs, for example clinical audit and morbidity and mortality reviews.

Patient, family and community engagement and empowerment

People and communities often know best the challenges they face in receiving quality care — whether due to uncoordinated services, poor clinical skills or the insufficient provision of information — so engaging them as partners in efforts to improve quality is critical. There is a need to ensure engagement of patients, families and communities in planning, delivering and evaluating quality health services. PHC provides a natural bridge between communities and services. Interventions that may be considered in efforts to improve quality of care include formalized community engagement and empowerment, improving health literacy, employing shared decision making, and ensuring measurement and use of data on patients' experience of care. In addition to the categories on quality improvement intervention listed above, countries may look to promote collective action to address challenges to quality through the application of continuous quality improvement programmes and methods. There are many frameworks for quality improvement, but they generally share a commitment to using data to inform learning mechanisms that feature cycles of planning, action, assessment and improvement. Quality improvement mechanisms should not be considered as a final step in service delivery or health system development, but instead as a starting point on which health planners can base service delivery objectives and planning, regardless of health system maturity or context.

> *“A range of approaches can be used, but the emphasis should be on developing a multimodal suite of interventions tailored to the local context, while simultaneously working to improve the broader health systems' environment and culture that support the ”*

The pivotal role of establishing national directions on quality is further expanded upon in WHO's Handbook for national quality policy and strategy.(64) Other key resources include Quality in primary health care and WHO's Technical Series on safer primary care.(65,66)

In any approach to improving quality, it is important to recognize that a change management process is typically required. This necessitates setting a vision (and targets), building support for the changes, communicating clearly about them and tracking progress. A range of multisectoral stakeholders may be involved in these efforts, including people and communities, service providers (public and private), professional bodies, nongovernmental and faith-based organizations, academic institutions and health professional education and training institutions, external evaluation or licensing agencies, health technology assessment agencies, health ministries and subnational, facility and community quality teams.

Table 25. Systems for improving the quality of care: actions and interventions

At policy level
• Develop a national quality policy and/or strategy involving stakeholders in alignment with national health policy and planning processes. • Routinely measure and publicly report on the quality of health services, including measures of patients' experience. • Ensure that quality improvement efforts are adequately financed, sustained and that successful pilot projects are scaled up. • Include principles of quality in the pre- and in-service training of health professionals, as well as in continuous professional development.

At operational level
• Develop a costed operational plan to support the execution of the national quality policy/strategy. • Institute mechanisms to enable individuals, families and communities to provide feedback on quality health services (for example, patient complaint forms) and then incorporate the feedback in improvement efforts. • Develop and sustain governance, accountability and leadership for quality and safety at the local level, for example, district and primary care quality teams and focal points. • Develop systems to monitor adherence to standards of care. • Put in place an infrastructure for generating knowledge and sharing learning on quality health services.

By people and communities
• Contribute to the development of national directions on quality, as well as their operationalization at the subnational level. • Collaborate and engage with health professionals and providers, for example through feedback and formal community engagement mechanisms, to discuss clinical performance and contribute to the design of improvement activities.

Table 26. Systems for improving the quality of care: tools and resources

Health system tools and resources
A compendium of tools and resources for improving the quality of health services
Core components for Infection, prevention and control - Implementation tools and resources
Handbook for national quality policy and strategy - A practical approach for developing policy and strategy to improve quality of care

Improving the quality of health services: tools and resources

WHO Integrated health services toolkit (including modules for primary care, emergency and critical care)

WHO emergency care toolkit:
Emergency Care Systems Assessment Tool
International Registry for Trauma and Emergency Care
WHO-ICRC Basic Emergency Care course: approach to the acutely ill and injured
Medical Emergency Checklist
Trauma Checklist

Primary care toolkit and critical care components (forthcoming)

Minimum Requirements for infection prevention and control (IPC) programmes

National Quality Policy and Strategy Tools and Resources Compendium

Quality in primary health care

Quality of care: what are effective policy options for governments in low- and middle-income countries to improve and regulate the quality of ambulatory care?

Taking Action: Steps 4 & 5 in Twinning Partnerships for Improvement

Programme-specific tools and resources

Care for Child Development Package

Caring for the sick child in the community, adaptation for high HIV or TB settings

Companion of choice during labour and childbirth for improved quality of care

Counselling for maternal and newborn health care - a handbook for building skills

Emergency Triage Assessment and Treatment (ETAT) course

Enhanced capacity building training for frontline staff on building trust and communication facilitator's guide

Every Newborn: an action plan to end preventable deaths

Global standards for quality health care services for adolescents

Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level

HEARTS technical package

Integrated management of adolescent and adult illness (IMAI) modules

Implementation guide for the Global standards for quality health care services for adolescents

Integrated care for older people (ICOPE):guidance for person-centred assessment and pathways in primary care

Integrated care for older people (ICOPE): Handbook App

Integrated management of childhood illness (IMCI) Chart Booklet

Integrated management of childhood illness (IMCI) set of distance learning modules

Management of the sick young infant aged up to 2 months

Management of the sick young infant aged up to 2 months: IMNCI training course

Managing complications in pregnancy and childbirth: a guide for midwives and doctors – 2nd ed.

Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential

Pocket book of hospital care for children: Second edition

Quality of care for maternal and newborn health: a monitoring framework for network countries

Quality, equity, dignity: the network to improve quality of care for maternal, newborn and child health – strategic objectives

Service delivery framework and tools for infants, children and adolescents living with HIV

Standards for improving quality of maternal and newborn care in health facilities

Standards for improving the quality of care for children and young adolescents in health facilities

Surgical Care at the District Hospital - The WHO Manual Revision (forthcoming, WHO)

Survive and thrive: transforming care for every small and sick newborn

Tools for implementing WHO PEN (Package of essential noncommunicable disease interventions)

Cardiovascular risk prediction charts

WHO recommendations on interventions to improve preterm birth outcomes

WHO recommendations on newborn health

Primary health care-oriented research

Research and knowledge management, including dissemination of lessons learned, as well as the use of the knowledge to accelerate scale-up of successful strategies to strengthen PHC-oriented systems

Health systems, policies, strategies and operational plans should be informed by the best available evidence of what works and how. Health systems research and implementation research on interventions that support all three components of PHC is key to providing this information. This operational lever links directly with all other levers in the operational framework as health systems and implementation research should comprehensively foster the creation, management, dissemination and use of knowledge around all levers to advance progress in PHC.

Implementation research related to PHC is grappling with several key challenges, including:

- devising strategies to address population needs and policy priorities and for adopting efficient approaches to priority setting
- determining optimal ways to engage with people, communities and other multisectoral stakeholders in improving health outcomes
- reinvigorating a focus on equity, such as effectively addressing the urban–rural divide or gender dimensions of health
- ensuring the delivery of essential services during emergency situations
- identifying the best approaches for adequately responding (in terms of both management and prevention) to the challenges posed by multimorbidity and inappropriate polypharmacy, across service delivery platforms
- understanding the quality of health services (including effectiveness, people-centeredness, timeliness, integration, efficiency and safety) and operational research to evaluate the impact of interventions to improve these dimensions of quality
- assessing the impact of and the most effective modalities for both private- and public-sector service delivery, including assessing the implications for equity
- developing and supporting models of knowledge transfer to bridge the knowledge gap and promote knowledge uptake in implementation and PHC systems' research.

Given that PHC-oriented research should focus on all three components of PHC, it should similarly bring together a broad range of stakeholders from the health sector as well as other sectors responsible for areas that influence people's health, such as education, labour or transport. Relevant stakeholders that need to be involved include research funders (public and charities), academic institutions and research centres, health technology assessment institutions, scientific societies, ministries responsible for science and research, and other government decision-makers and health care professionals. To the maximum extent

possible, external researchers should partner with local institutions and build capacity in these institutions so that they can lead research processes. Additionally, it is important to engage people and communities in the research process to the maximum extent feasible so as to ensure an understanding of which problems require implementation research and an appropriate design of studies, followed by cooperation with them in the dissemination of findings and, finally, translating these into policy change.(67–70) Participatory action research acknowledges the important contributions that people and communities bring to prioritizing questions, knowledge creation and evidence-based action in health, such as:(71)

- answering questions that are important to communities and help to understand the social determinants of health
- understanding the ways social roles and relationship affect the performance of health systems
- strengthening communication and mutual respect among stakeholders in health – including those most vulnerable and disadvantaged
- bridging gaps between knowledge and practice
- enhancing the credibility of research findings
- strengthening social accountability mechanisms.

It is not enough to simply conduct this research. It is crucial to ensure its dissemination to inform policy- and decision-making. Means of dissemination are being rapidly transformed as new options are enabled by modern information and communications technologies, such as wikis and learning models that operate virtually. Sharing successful approaches and models is important, but sharing examples of failures is also important so that others can learn from these.

Political commitment to and leadership of PHC (see Section 2.1) are enabling factors to ensure that newly generated knowledge and learning around PHC is not only disseminated, but reflected in governance, policies, strategies and plans. The implication is that funding for PHC overall (see Section 2.3) must ensure adequate and sustainable allocation of funds for PHC-oriented research to inform and accelerate decision-making and action around the PHC levers. Both political commitment and allocation of funding demonstrate how PHC-oriented research is mutually enabling to and enabled by the other levers.

Table 27. Primary health care-oriented research: actions and interventions

At policy level

- Increase targeted funding for PHC-oriented research capacity (such as within national research institutes or schools) and dedicated financing, including for complex systems' research through standard and specific calls for proposals.
- Adopt efficient models of knowledge transfer, potentially as part of the specific remit of PHC research institutes.
- Apply an equity lens to health systems policy research and evaluation.
- Develop and implement approaches to the co-production of PHC-oriented research (including research questions, design, dissemination and use of results) with people and communities, as well as establishing the involvement of people and communities as a requisite for access to publicly-funded projects.

At operational level

- Support the development of PHC-oriented research networks.
- Support implementation research to inform the scale-up of effective interventions and models.
- Involve communities in developing a shared research agenda for public health.

By people and communities

- Advocate for the involvement of people and communities in research questions, study design and conduct and dissemination.
- Participate when public and patient involvement is introduced (for example, through community advisory boards).

Table 28. Primary health care-oriented research: tools and resources

Health system tools and resources
A health policy analysis reader: The politics of policy change in low- and middle-income countries
A Health Policy and Systems Research Reader on Human Resources for Health
Evidence synthesis for health policy and systems: a methods guide
Health Policy and Systems Research - A Methodology Reader
Implementation Research in Health: A Practical Guide
Implementation research toolkit
Participatory Action Research in health systems - A Methods Reader
Primary Health Care Systems (PRIMASYS) Case Studies
Rapid reviews to strengthen health policy and systems: a practical guide

Monitoring and evaluation

Monitoring and evaluation through well-functioning health information systems that generate reliable data and support the use of information for improved decision-making and learning by local, national and global actors

Monitoring, evaluation and review of health progress and performance are essential to ensure that priority actions and decisions are implemented as planned against agreed objectives and targets. Within the context of PHC, this means that countries will need to be able to assess gaps, determine priorities, establish baselines and targets, and track progress and performance across all the operational framework's strategic and operational levers in their efforts to strengthen the three components of PHC.

As the ultimate goal of strengthening PHC is health for all without distinction of any kind, as embodied in universal health coverage and the health-related SDGs, countries will need to be able to track how their decisions, actions and investments in PHC are addressing and improving service coverage, financial risk protection, determinants of health and ultimately the health status of individuals and populations.

This endeavour requires that countries establish a comprehensive, coherent and integrated approach to monitoring and evaluation based on a logical, results-based framework that encompasses equity dimensions and multisectoral components across its entirety. The framework should: include indicators that align with the operational framework levers and other related monitoring efforts (for example, in health systems performance, UHC and the SDGs); rely on accurate and up-to-date data from a range of well-functioning country data systems; and enable a stepwise or "cascade" analysis that links inputs to results and facilitates decision-making and performance improvement. Indicators must provide enough depth and specificity to allow countries to assess, plan, manage and prioritize areas for PHC performance at national, subnational, facility and community levels in order to take corrective action, allocate resources appropriately and inform policy dialogue. To avoid duplication and fragmentation, PHC performance monitoring should be aligned with and embedded within country processes for monitoring and review of national health sector plans, strategies and accountability mechanisms.

Indicators

Considerable progress has been made in recent years in reaching agreement on standard indicators that can be used to track progress in PHC.(28,72–75) Still, gaps remain, particularly in areas beyond service delivery with less consensus on the most appropriate methods, such as "empowered people and communities" and "multisectoral policy and action". However, the need to measure effective service coverage and the integrated nature of the SDGs have prompted attention in these areas and resulted in evolving methods, innovations and learning.(62,76,77)

Data sources

Effective assessment and monitoring of PHC performance will need countries to rely on, and invest in, a broad range of data sources.

Health facility information systems, including routine clinical reporting systems and facility assessments, are the cornerstone of PHC monitoring. Routine facility reporting systems, sometimes known as health management information systems, provide real-time information about service utilisation and coverage, individual client care and health outcomes. These data are essential for improving service delivery.

Countries will also need to establish a regular system of facility assessments to provide objective measures for evaluating the availability, readiness, quality and safety of health services, including measures to evaluate preparedness and response capacities ("resilience") in the event of an emergency or outbreak. Individual-level surveys should be incorporated to assess patients' experiences and outcomes and better understand community knowledge and needs. All countries should have electronic logistics information systems and comprehensive databases on health facilities (a master facility list) that encompass both public and private sector provision. All countries should have systems of national health accounts and national health workforce accounts maintained according to international standards.

Public health surveillance systems that draw from both routine facility data as well as event-based channels that tap into a wider range of sources will also be required. These should include community-based sources, given the critical role of primary care facilities and their community linkages in detection and early warning.

The use of population-based surveys will also be important to better understand and meet broader population needs, such as barriers in access to care, for the improvement of effective coverage.

Regular qualitive assessments will be necessary to monitor progress across many levers, such as advancing the implementation of legislation, governance mechanisms, policy reforms, regulatory systems, PHC design and models of care, among others.

> *"Countries will need to be able to track how their decisions, actions and investments in PHC are addressing and improving service coverage, financial risk protection, determinants of health and ultimately the health status of individuals and populations."*

As multisectoral policy and action are crucial to PHC, data should also be drawn from other sectors, such as water and sanitation, education, environment and agriculture. In addition, health data should be incorporated into other sectors' performance evaluations. Examination of multisectoral data that impacts health should also be considered within existing multisectoral coordination mechanisms. The specific data will vary by country depending on the most relevant determinants of health, and data collection will typically require collaboration with relevant non-health ministries.

As highlighted in Section 3.7, information and communications technologies are opening new possibilities, with mobile phones and tablets facilitating the rapid collection and sharing of data. Their applications can also help to address the extent to which all providers — including community health workers, private sector providers and providers in remote areas — are covered by data collection systems. Such technologies can also support the

important role of people and communities in generating information about their own health and experiences of interacting with health systems. For example, in high-income countries, information and communications technologies have enabled people to track their own health status and key determinants of health (such as caloric intake or exercise levels) and report on the quality of care that they receive much more accurately than in previous generations.(78)

Robust privacy and data protection systems should be in place across all sources of data.

Measurement to drive performance improvement

Having reliable data sources is necessary for improving performance, but it is not enough: the data must be used to identifying bottlenecks and implement course corrections. Health ministry officials, district and facility managers, health professional associations, individual providers (public and private), legislative bodies, communities, patients and the media all demand accessible, high-quality health information for multiple purposes.

There are technical dimensions to this challenge, such as the need for interoperable systems and the need for data to be made available in a timely manner and in easy-to-digest formats. This is a major element to building a culture of regular review and use of data to inform decision-making. However, completing the process from data collection, analysis and use requires behavioural change —through for instance training and incentives — in addition to technical solutions. One way to institutionalize data use is to create a regularly occurring process by which key stakeholders come together to examine data and make course corrections based on it. Many countries hold annual reviews of progress, occasionally in the form of a widely consultative national health assembly.(79) Midterm reviews of national strategies are another important moment to synthesize and analyse data and reflect on performance. Such reviews should be informed by a comprehensive analytical report that provides an in-depth synthesis and analysis of all relevant data. At health facility and subnational levels, scorecards or dashboards including a limited set of key indicators with targets and "traffic lights" have significant potential for supporting regular reviews of primary care performance and improving data quality.

Guidance

To support countries in their efforts to track and monitor PHC performance, the Secretariat is developing an accompanying guidance for monitoring PHC performance to provide a coherent results-based framework for monitoring the strengthening of PHC-oriented health systems towards the achievement of universal health coverage and the health-related SDGs. It will provide countries with a menu of indicators to monitor progress across the three PHC components and 14 levers of the operational framework that align with ongoing universal health coverage and SDG monitoring efforts. It will also highlight where and how countries can invest in data sources to ensure regular, reliable and accurate information. Finally, it will describe methods and best practices to analyse and use data to drive performance improvement, providing examples of cascade analysis, benchmarking and use of data to inform policy dialogues, PHC reform processes and broader health sector performance reviews. The guidance will also cover best practice dashboards and profiles within these processes for investment and advocacy.

Table 29. Monitoring and evaluation: actions and interventions

At policy level
• Establish effective governance and country led mechanisms for PHC monitoring and evaluation within the context of national health strategy monitoring and review of health strategies. • Ensure multisectoral and multistakeholder engagement and participation (for example communities, private sector, civil society groups and patient groups) in development and implementation of PHC performance monitoring and evaluation. • Ensure that activities for monitoring and evaluation and for health information systems strengthening are costed and funded with full stakeholder alignment and support. • As an integral part of national health planning around PHC, design and implement a comprehensive framework that guides the monitoring, prospective evaluation and review of PHC, and aligns with monitoring efforts to attain UHC and other national priorities, including the SDGs. • Build a culture of reviewing progress and performance, including systematic analyses of qualitative and quantitative information and using the findings to make decisions, through conducting regular and transparent multi-stakeholder reviews. • Ensure that results from reviews are used to drive resource allocation to most vulnerable populations and priorities.

At operational level
• Agree on key, nationally appropriate indicators to track progress on PHC strengthening across all three components of the PHC operational framework. • Strengthen systems to generate data on selected indicators, including routine facility reporting systems, health facility assessments, health finance and workforce accounts, logistic management information systems, qualitative assessments, patient and community surveys and monitoring systems, household surveys, and other research studies and evaluations. • Apply information and communications technologies to extend the reach of health management information systems and patient monitoring systems, for instance to communities, private sector and remote areas. • Develop incentives (financial and non-financial) to promote improvements in data quality and supervise the system of data collection, using techniques such as a system of random assessments or lot quality assurance approaches. • Use information from routine systems as a starting point for improving supportive supervision of frontline workers. • Build capacity to collect, analyse and use data at all levels for local decision-making, from community, facility, subnational and national levels. • Ensure that results of reviews and related PHC information, including from other sectors, are published and made widely available to all stakeholders.

By people and communities

- Engage in the use of information and communications technologies to improve personal tracking of health and in community monitoring systems
- Engage in efforts to improve the quality of health services by using reporting mechanisms to identify good and bad practices.

Table 30. Monitoring and evaluation: tools and resources

Health system tools and resources
Analysis and use of health facility data toolkit
Data Quality Review (DQR) toolkit
Global Reference List of 100 Core Health Indicators (plus health-related SDGs), 2018
Harmonized approach to health facility assessments (HFA)
Health Data Collaborative
Health facility and community data toolkit
Health system performance assessment: working towards a common understanding
Indicators and Measurement Registry (IMR)
Measuring the performance of primary health care
Monitoring, evaluation and review of national health strategies: a country-led platform for information and accountability
Primary health for universal health coverage and the Sustainable Development Goals – performance measurement and monitoring (Forthcoming, WHO)
Service Availability and Readiness Assessment (SARA)

Programme-specific tools and resources
Analysis and use of health facility data - Guidance for RMNCAH programme managers
Birth defects surveillance: atlas of selected congenital anomalies

Making Every Baby Count: audit and review of stillbirths and neonatal deaths
Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death
The WHO application of ICD-10 to deaths during the perinatal period: ICD-PM
Tripartite Monitoring and Evaluation (M&E) framework for the Global Action Plan on Antimicrobial Resistance
WHO recommendations on home-based records for maternal, newborn and child health

Contributions by international partners

1. As recognized in the commitments in the Declaration of Astana, the alignment of stakeholders' support to national policies, strategies and plans under country leadership is essential to make sustainable progress on PHC towards universal health coverage. International partners — including organizations in the United Nations system, bilateral and multilateral donors, philanthropies and partnerships — support PHC in countries in a wide variety of ways at national, regional and global levels. This support includes provision of normative guidance, technical assistance, capacity-building, financing, support for cross-border learning, development of tools, and knowledge generation and management. These efforts must be stepped up in order to accelerate progress.

2. In addition to continuing to support PHC in these ways, international partners have increasingly recognized that they can become more efficient and effective in the provision of their support by better coordinating their efforts under the guidance and direction of countries. Global partners must deliver PHC support through an integrated approach that capitalizes to the maximum the diverse strengths and capacities of different stakeholders, while responding to country-identified priorities and needs. The alignment of donor and technical support to national health sector policies, strategies and plans, especially in countries that depend heavily on external funding to make PHC a reality, is especially important to make the vision of PHC a reality.

3. Over the past two decades, countries and the global development community have committed themselves to principles of development effectiveness, including the "seven behaviours" for health development effectiveness and the principles that guide the UHC2030 Global Compact for progress towards universal health coverage (see Table 31). In addition, during the Fourth High-Level Forum on Aid Effectiveness in 2011, the following principles were agreed upon by more than 160 countries and 50 organizations in the Busan Partnership agreement, building on prior agreements on Aid Effectiveness in Rome (2003), Paris (2005) and Accra (2008): (1) inclusive development partnerships; (2) ownership of development priorities by developing countries; (3) focus on results; and (4) transparency and accountability to each other.

Table 31. Principles of development effectiveness

Seven behaviours for health development effectiveness	Guiding principles of UHC2030 Global Compact
• Provide well-coordinated technical assistance • Support a single national health strategy • Record all funds for health in the national budget • Harmonize and align with national financial management systems • Harmonize and align with national procurement and supply systems • Use one information and accountability platform • Support South-to-South and triangular cooperation	• Leaving no one behind: a commitment to equity, non-discrimination and a rights-based approach • Transparency and accountability for results • Evidence-based national health strategies and leadership, with government stewardship to ensure availability, accessibility, acceptability and quality of service delivery • Making health systems everybody's business – with engagement of citizens, communities, civil society and the private sector • International cooperation based on mutual learning across countries, regardless of development status and progress in achieving and sustaining universal health coverage and development effectiveness principles

The International Health Partnership for Universal Health Coverage 2030 (UHC2030)

1. UHC2030 is the multi-stakeholder movement to accelerate progress towards UHC. Its diverse membership and constituencies include countries, international organizations and global health initiatives, philanthropic foundations, civil society and the private sector.

2. UHC2030 seeks to contribute to stronger, more resilient health systems and the expansion of both coverage and financial protection. Its objectives and approach include enhancing commitment (political and financial) and accountability for UHC and promoting more coherent joint working by countries and all relevant health partners in response to countries' health systems and UHC needs.

Global action plan for healthy lives and well-being for all

1. WHO, in partnership with 11 other organizations in the United Nations system, is facilitating an initiative to improve the collaboration of global actors to leverage the reach, experience and expertise of the collective global health community to accelerate progress towards the health-related targets of the 2030 Agenda for Sustainable Development. The SDG Global Action Plan for healthy lives and well-being for all (SDG3 GAP) brings together the commitment of the 12 organizations in the United Nations system under a common approach founded upon four strategic commitments:(80,81)
   - engage: a commitment to work together with countries to identify priorities and plan and implement together
   - accelerate: a commitment to act together to support countries under specific accelerator themes, including gender equality and global public goods
   - align: a commitment to harmonize operational and financial strategies, policies and approaches
   - account: a commitment to review progress and learn together to enhance shared accountability.

2. Within SDG3 GAP, PHC has been identified as the first of seven cross-cutting accelerator themes in which partner collaboration and joint action offer substantial opportunities to step up progress towards Goal 3 and the other health-related SDGs.(81) The remaining six accelerator themes – sustainable financing for health; community and civil society engagement; determinants of health; innovative programming in fragile and vulnerable settings for disease outbreak responses, research and development; innovation and access; and data and digital health – link closely to the core strategic and operational levers under the umbrella of PHC and offer further opportunities for partners to join together in a collective PHC approach in countries.

3. In addition to these 12 United Nations entities, global partners working on PHC were previously convened in an "Implementing Partners for PHC" group that also examined issues of coordination. In 2019, the group joined together with SDG3 GAP partners in an agreement to better coordinate and collaborate on PHC implementation under the PHC accelerator. This broader group is considering the development of a partner collaborative under the umbrella of UHC2030.

4. SDG3+ GAP partners have agreed on several joint actions on primary health care (Table 32).

Table 32. Global action plan for healthy lives and wellbeing: agreed joint actions on primary health care

Country-level actions	Global/regional-level actions
Support countries through aligned, collective action in the following areas: • support assessment of PHC, aligning existing agency-level approaches and using a common approach to health systems assessment; • provide tailored and coordinated country support to strengthen health systems for PHC by generating evidence, country prioritization, planning and budgeting, mobilization of financing, and health workforce development to improve coverage and equity, including in fragile and vulnerable settings; • provide assistance to identify who is being left behind and why, and prioritize integration with other sectors to influence determinants of health and health outcomes.	Ensure more coherent, effective support to countries by aligning approaches and tools and promoting action on public goods in the following areas: • collaborate on the three components of PHC using existing mechanisms, including reframing financial support, where appropriate • use existing global mechanisms to agree on a framework for the monitoring of PHC with improved metrics to be made available for adaptation and use by countries, including on financing • refine and strengthen the capacity of partners to effectively engage, accelerate, align and account in order to advance PHC through their work at country level using common tools, instruments and approaches • develop, finalize and scale-up "leave no one behind" tools and approaches to promote common United Nations Country Team Guidance.

5. UNICEF and WHO, co-leaders of the PHC accelerator, will support the coordination function at country and global level. This coordination mechanism does not supersede or replace any ongoing health sector coordination arrangements that already exist in a given country.

6. Incremental change in PHC as a result of isolated actions and interventions along the levers included in this draft operational framework will not be sufficient to achieve UHC and the health-related SDGs. The two latter objectives will require bold action based on political leadership with an explicit, strong and well-defined vision and the engagement of people, communities and other stakeholders, guided by evidence and a monitoring and evaluation framework relevant to PHC. Lessons from prior efforts to coordinate partners around national health policies, strategies and plans must be applied to these ongoing mechanisms if global partners are to be part of a successful PHC transformation in countries. In each country, strong governmental leadership and ongoing advocacy for the harmonization and alignment of global donors and technical partners involved in strengthening PHC are needed if we are to deliver on the vision of PHC and the commitments made in the Declaration of Astana.

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Annex

Tools and resources to support the implementation of primary health care levers

Tool/resource	Location	Lever(s) [3]
2019 WHO AWaRe Classification Database of Antibiotics	https://adoptaware.org/Medicines and other health products	
A compendium of tools and resources for improving the quality of health services	https://www.who.int/servicedeliverysafety/compendium-tools-resources/en/	Systems for improving the quality of care
A health policy analysis reader: The politics of policy change in low- and middle-income countries	https://www.who.int/alliance-hpsr/resources/publications/hpa-reader/en/	PHC-oriented research
A Health Policy and Systems Research Reader on Human Resources for Health	https://www.who.int/alliance-hpsr/resources/publications/9789241513357/en/	PHC-oriented research
A system-wide approach to analysing efficiency across health programmes	https://apps.who.int/iris/handle/10665/254644	Funding and allocation of resources
Access to rehabilitation in primary health care: an ongoing challenge	https://apps.who.int/iris/handle/10665/325522	Models of care
AccessMod	https://www.who.int/choice/geoaccess/en/	Models of care Physical infrastructure
Access to modern energy services for health facilities in resource-constrained settings: a review of status, significance, challenges and measurement	https://apps.who.int/iris/handle/10665/156847	Physical infrastructure

Tool/resource	Location	Lever(s) [3]
Age-friendly Primary Health Care Centres Toolkit	https://apps.who.int/iris/handle/10665/43860	Models of care
An evidence map of social, behavioural and community engagement interventions for reproductive, maternal, newborn and child health	https://www.who.int/maternal_child_adolescent/documents/social-behavioural-community-engagement-interventions-evidence/en/	Engagement of communities and other stakeholders
Analysis and use of health facility data toolkit	https://www.who.int/healthinfo/tools_data_analysis_routine_facility/en/	Monitoring and evaluation
Analysis and use of health facility data - Guidance for RMNCAH programme managers	https://www.who.int/healthinfo/FacilityAnalysisGuidance_RMNCAH.pdf?ua=1	Monitoring and evaluation
Analytical guide to assess a mixed provider payment system	https://www.who.int/publications-detail/analytical-guide-to-assess-a-mixed-provider-payment-system	Purchasing and payment systems
Antimicrobial resistance and primary health care: brief	https://apps.who.int/iris/bitstream/handle/10665/326454/WHO-HIS-SDS-2018.56-eng.pdf	Governance and policy frameworks Medicines and other health products Systems for improving the quality of care
Appropriate storage and management of oxytocin – a key commodity for maternal health WHO/UNICEF/UNFPA Joint Statement	https://www.who.int/reproductivehealth/publications/appropriate-storage-management-oxytocin/en/	Medicines and other health products
Birth defects surveillance: atlas of selected congenital anomalies	https://www.who.int/publications-detail/9789241564762	Monitoring and evaluation

Tool/resource	Location	Lever(s) [3]
Building an adolescent-competent workforce	http://apps.who.int/iris/bitstream/10665/183151/1/WHO_FWC_MCA_15.05_eng.pdf?ua=1	Primary health care workforce
Building the economic case for primary health care: a scoping review	https://apps.who.int/iris/handle/10665/326293	Funding and allocation of resources
Building the Primary Health Care Workforce of the 21st Century	https://apps.who.int/iris/handle/10665/328072	Primary health care workforce
Cancer workforce strategy for comprehensive prevention and control	Forthcoming, WHO	Primary health care workforce
Care for Child Development Package	https://www.unicef.org/earlychildhood/index_68195.html	Systems for improving the quality of care
Care for child development: improving the care for young children	https://www.who.int/maternal_child_adolescent/documents/care_child_development/en/	Engagement of communities and other stakeholders
Caring for newborns and children in the community - Package of resources	https://www.who.int/maternal_child_adolescent/documents/community-care-newborns-children/en/	Engagement of communities and other stakeholders
Caring for the child's healthy growth and development: Caring for newborns and children in the community	https://www.who.int/maternal_child_adolescent/documents/child-healthy-growth-development/en/	Engagement of communities and other stakeholders
Caring for the sick child in the community, adaptation for high HIV or TB settings	https://www.who.int/maternal_child_adolescent/documents/newborn-child-community-care/en/	Systems for improving the quality of care
Child Friendly Communities in ESAR: An Integrated Approach to Community Platforms	https://unicef.sharepoint.com/teams/ESAR-Health/Child%20Health/UNICEF%20ESAR%20Child%20Friendly%20Communities%20Ref%20Guide%20FINAL%2028May2018.pdf	Models of care

Tool/resource	Location	Lever(s) [3]
CHW Guideline: Health systems supports for CHWs	https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1	Primary health care workforce
Community health planning & costing tool	https://www.msh.org/resources/community-health-planning-and-costing-tool	Funding and allocation of resources Engagement of communities and other stakeholders
Community Health Worker Assessment and Improvement Matrix (CHW AIM): Updated Program Functionality Matrix for Optimizing Community Health Programmes	https://www.unicef.org/media/58176/file	Engagement of communities and other stakeholders Primary health care workforce
Community Information Integration (CII) and the Central Patient Attached Registry (CPAT), a tool to integrate community Electronic Medical Records (EMRs).	https://actt.albertadoctors.org/PMH/panel-continuity/CII-CPAR/Pages/CII-Tools-and-Resources.aspx	Engagement of communities and other stakeholders Digital technologies for health
Community planning toolkit	https://www.communityplanningtoolkit.org/community-engagement	Engagement of communities and other stakeholders
Community Tool Box	https://ctb.ku.edu/en	Engagement of communities and other stakeholders
Companion of choice during labour and childbirth for improved quality of care	https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/companion-during-labour-childbirth/en/	Systems for improving the quality of care
Compassion resilience toolkit	https://compassionresiliencetoolkit.org/healthcare/a-toolkit-for-healthcare/	Engagement of communities and other stakeholders

Tool/resource	Location	Lever(s) [3]
Conceptual framework on the contribution of law to UHC	https://www.who.int/publications-detail/uhc-law-infographic	Political commitment and leadership Governance and policy frameworks
Continuity and coordination of care: a practice brief to support implementation of WHO's framework on integrated, people-centred health services	https://apps.who.int/iris/handle/10665/274628	Models of care
Core competencies in adolescent health and development for primary care providers	http://apps.who.int/iris/bitstream/10665/148354/1/9789241508315_eng.pdf?ua=1&ua=1	PHC workforce
Core components for Infection, prevention and control - Implementation tools and resources	https://www.who.int/infection-prevention/tools/core-components/en/	Systems for improving the quality of care
Core questions and indicators for monitoring WASH in health care facilities in the Sustainable Development Goals	https://www.who.int/water_sanitation_health/publications/core-questions-and-indicators-for-monitoring-wash/en/	Physical infrastructure
Counselling for maternal and newborn health care - a handbook for building skills	https://www.who.int/maternal_child_adolescent/documents/9789241547628/en/	Systems for improving the quality of care
Country planning cycle database	https://extranet.who.int/countryplanningcycles/	Political commitment and leadership Governance and policy frameworks Funding and allocation of resources Engagement of communities and other stakeholders Monitoring and evaluation

Tool/resource	Location	Lever(s) [3]
Critical pathways towards integrated people-centred health services	Forthcoming, WHO	Models of care
Data and innovation: draft global strategy on digital health	https://apps.who.int/gb/ebwha/pdf_files/EB146/B146_26-en.pdf Final document (forthcoming, WHO)	Digital technologies for health
Data Quality Review (DQR) toolkit	https://www.who.int/healthinfo/tools_data_analysis/en/	Monitoring and evaluation
Designing Digital Health Interventions for Impact	https://www.unicef.org/innovation/reports/designing-digital-interventions-lasting-impact	Digital technologies for health
Digital education for building health workforce capacity	https://apps.who.int/iris/handle/10665/331524	Digital technologies for health
Digital Health Atlas	https://digitalhealthatlas.org/en/-/	Digital technologies for health
Digital Health for RSSH for Global Fund guideline	https://www.theglobalfund.org/media/4759/core_resilientsustainablesystemsforhealth_infonote_en.pdf	Digital technologies for health
Digital technologies: shaping the future of primary health care	https://apps.who.int/iris/handle/10665/326573	Digital technologies for health
Draft road map for engaging the private health sector for universal health coverage	https://www.who.int/news-room/articles-detail/public-consultation-on-the-draft-who-roadmap-engaging-the-private-health-sector-through-integrated-service-delivery-governance-in-mixed-health-systems Final document (forthcoming, WHO)	Engagement with private sector providers
Emergency Triage Assessment and Treatment (ETAT) course	https://www.who.int/maternal_child_adolescent/documents/9241546875/en/	Systems for improving the quality of care
Engaging the private sector for service delivery	https://www.who.int/news-room/articles-detail/public-consultation-on-the-draft-who-roadmap-engaging-the-private-health-sector-through-integrated-service-delivery-governance-in-mixed-health-systems	Engagement with private sector providers

Tool/resource	Location	Lever(s) [3]
Engaging the Private Sector in Primary Health Care to Achieve universal health coverage: Advice from Implementers, to Implementers	https://www.jointlearningnetwork.org/resources/primary-health-care-indicator-inventory/	Engagement with private sector providers
Enhanced capacity building training for frontline staff on building trust and communication facilitator's guide	https://www.who.int/servicedeliverysafety/areas/qhc/trust-communication_training-guide.pdf?ua=1	Systems for improving the quality of care
Essential environmental health standards in health care	https://www.who.int/water_sanitation_health/publications/ehs_hc/en/	Physical infrastructure
Every Newborn: an action plan to end preventable deaths	https://www.who.int/publications-detail/every-newborn-an-action-plan-to-end-preventable-deaths	Systems for improving the quality of care
Evidence synthesis for health policy and systems: a methods guide	https://www.who.int/alliance-hpsr/resources/publications/hsr-synthesis/en/	Primary health care -oriented research
Framework for the implementation of a telemedicine service	https://iris.paho.org/handle/10665.2/28414	Digital technologies for health
Global Competency Framework for Universal Health Coverage	Forthcoming, WHO	Primary health care workforce
Global Health Expenditure Database - estimations of primary health care expenditure	https://apps.who.int/nha/database/DocumentationCentre/Index/en	Funding and allocation of resources
Global Reference List of 100 Core Health Indicators (plus health-related SDGs), 2018	https://www.who.int/healthinfo/indicators/2018/en/	Monitoring and evaluation
Global standards for quality health care services for adolescents	https://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/	Systems for improving the quality of care

Tool/resource	Location	Lever(s) [3]
Global Strategy on Human Resources for Health: Workforce 2030	https://apps.who.int/iris/bitstream/handle/10665/250368/9789241511131-eng.pdf?sequence=1	Primary health care workforce
Good governance for medicines: model framework, updated version 2014	https://apps.who.int/iris/handle/10665/129495	Medicines and other health products
Governance for strategic purchasing: An analytical framework to guide a country assessment	https://www.who.int/publications-detail/governance-for-strategic-purchasing-an-analytical-framework-to-guide-a-country-assessment	Purchasing and payment systems
Guide to integrated community case management procurement and supply and management Planning for Global Fund Grants	https://www.childhealthtaskforce.org/sites/default/files/2018-12/Guide%20to%20iCCM%20PSM%20Planning%20for%20Global%20Fund%20Grants%20%28English%29_Nairobi%20iCCM%20Meeting%202016.pdf	Engagement of communities and other stakeholders Medicines and other health products
Guidelines on core components of infection prevention and control programmes at the national and acute health care facility level	https://www.who.int/gpsc/ipc-components-guidelines/en/	Systems for improving the quality of care
Handbook for national quality policy and strategy - A practical approach for developing policy and strategy to improve quality of care	https://apps.who.int/iris/handle/10665/272357	Systems for improving the quality of care
Harmonized approach to health facility assessments (HFA)	https://www.who.int/healthinfo/systems/Standardized-HFA-Flier-Dec2019.pdf?ua=1	Monitoring and evaluation
Health Data Collaborative	https://www.healthdatacollaborative.org/	Monitoring and evaluation
Health facility and community data toolkit	https://www.who.int/healthinfo/facility_information_systems/Facility_Community_Data_Toolkit_final.pdf?ua=1	Monitoring and evaluation

Tool/resource	Location	Lever(s) [3]
Health in All Policies as part of the primary health care agenda on multisectoral action	https://extranet.who.int/iris/restricted/handle/10665/326463	Governance and policy frameworks
Health in all policies training manual	https://apps.who.int/iris/handle/10665/151788	Governance and policy frameworks Engagement of communities and other stakeholders
Health in all policies: Helsinki statement. Framework for country action	https://apps.who.int/iris/handle/10665/112636	Governance and policy frameworks Engagement of communities and other stakeholders
Health Policy and Systems Research - A Methodology Reader	https://www.who.int/alliance-hpsr/resources/publications/9789241503136/en/	Primary health care -oriented research
Health system performance assessment: working towards a common understanding	https://www.uhc2030.org/what-we-do/coordination-of-health-system-strengthening/uhc2030-technical-working-groups/health-systems-assessment-technical-working-group/	Political commitment and leadership Governance and policy frameworks Monitoring and evaluation
HEARTS technical package	https://www.who.int/cardiovascular_diseases/hearts/en/	Systems for improving the quality of care
Implementation guide for the Global standards for quality health care services for adolescents	https://apps.who.int/iris/bitstream/handle/10665/183935/9789241549332_vol2_eng.pdf?sequence=4	Systems for improving the quality of care
Implementation Research in Health: A Practical Guide	https://www.who.int/alliance-hpsr/resources/implementationresearchguide/en/	Primary health care -oriented research
Implementation research toolkit	https://www.who.int/tdr/publications/topics/ir-toolkit/en/	Primary health care -oriented research

Tool/resource	Location	Lever(s) [3]
Implementing malaria in pregnancy programmes in the context of World Health Organization recommendations on antenatal care for a positive pregnancy experience	https://www.who.int/reproductivehealth/publications/implementing-malaria-pregnancy-programmes-brief/en/	Models of care
Improving the quality of health services: tools and resources	https://apps.who.int/iris/handle/10665/310944?locale-attribute=pt&	Systems for improving the quality of care
Indicators and Measurement Registry (IMR)	https://apps.who.int/gho/data/node.wrapper.imr?x-id=1	Monitoring and evaluation
Integrated care for older people (ZICOPE) implementation framework: guidance for systems and services	https://www.who.int/ageing/publications/icope-framework/en/	Models of care
Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care	https://www.who.int/ageing/publications/icope-handbook/en/	Systems for improving the quality of care
Integrated care for older people (ICOPE): Handbook App	https://www.who.int/ageing/health-systems/icope/en/	Systems for improving the quality of care
Integrated care for older people: realigning primary health care to respond to population ageing	https://apps.who.int/iris/handle/10665/326295	Models of care
Integrated Community Case Management Gap Analysis Tool	Forthcoming, UNICEF	Funding and allocation of resources Engagement of communities and other stakeholders

Tool/resource	Location	Lever(s) [3]
WHO Integrated health services toolkit (including modules for primary care, emergency and critical care)	WHO emergency care toolkit: Emergency Care Systems Assessment Tool: https://www.who.int/emergencycare/activities/en/ International Registry for Trauma and Emergency Care: https://www.who.int/emergencycare/irtec/en Basic Emergency Care course: approach to the acutely ill and injured: https://www.who.int/publications-detail/basic-emergency-care-approach-to-the-acutely-ill-and-injured Medical Emergency Checklist: https://www.who.int/publications-detail/who-medical-emergency-checklist Trauma Checklist: https://www.who.int/emergencycare/trauma-care-checklist-launch/en/ Primary care toolkit and critical care components (forthcoming)	Systems for improving the quality of care
Integrated management of adolescent and adult illness (IMAI) modules	https://www.who.int/3by5/publications/documents/imai/en/	Systems for improving the quality of care
Integrated management of childhood illness (IMCI) Chart Booklet	https://www.who.int/maternal_child_adolescent/documents/IMCI_chartbooklet/en/	Systems for improving the quality of care
Integrated management of childhood illness (IMCI) set of distance learning modules	https://www.who.int/maternal_child_adolescent/documents/9789241506823/en	Systems for improving the quality of care
Integrating health services: brief	https://apps.who.int/iris/handle/10665/326459	Models of care
Interagency list of medical devices for essential interventions for reproductive, maternal, newborn and child health	https://apps.who.int/iris/handle/10665/205490	Medicines and other health products

Tool/resource	Location	Lever(s) [3]
Interagency package: essential health products for primary health care	Forthcoming, WHO	Medicines and other health products
Key learning on Health in All Policies implementation from around the world: information brochure	https://apps.who.int/iris/handle/10665/272711	Governance and policy frameworks Engagement of communities and other stakeholders
Legal access rights to health care	https://www.who.int/publications-detail/uhc-law-in-practice-legal-access-rights-to-health-care-introduction	Political commitment and leadership Governance and policy frameworks
Local Engagement Assessment and Planning (LEAP): A toolkit for enhancing integrated and people-centred health services	Forthcoming, WHO	Models of care
Overview of technologies for the treatment of infectious and sharp waste from health care facilities	https://www.who.int/water_sanitation_health/publications/technologies-for-the-treatment-of-infectious-and-sharp-waste/en/	Physical infrastructure
Making Every Baby Count: audit and review of stillbirths and neonatal deaths	https://apps.who.int/iris/handle/10665/249523	Monitoring and evaluation
Management of the sick young infant aged up to 2 months	https://www.who.int/maternal_child_adolescent/documents/management-sick-young-infant-0-2-months/en/	Systems for improving the quality of care
Management of the sick young infant aged up to 2 months: IMNCI training course	https://www.who.int/maternal_child_adolescent/documents/management-sick-young-infant-0-2-months-training/en/	Systems for improving the quality of care

Tool/resource	Location	Lever(s) [3]
Managing complications in pregnancy and childbirth: a guide for midwives and doctors – 2nd ed.	https://www.who.int/maternal_child_adolescent/documents/managing-complications-pregnancy-childbirth/en/	Systems for improving the quality of care
Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death	https://apps.who.int/iris/handle/10665/87340	Monitoring and evaluation
Measuring the performance of primary health care	https://www.jointlearningnetwork.org/resources/primary-health-care-indicator-inventory/	Systems for improving the quality of care
Mental health in primary care: illusion or inclusion?	https://apps.who.int/iris/handle/10665/326298	Models of care
Midwifery education modules - Education material for teachers of midwifery	https://www.who.int/maternal_child_adolescent/documents/9241546662/en/	Primary health care workforce
Minimum Quality Standards for Community Engagement	https://www.unicef.org/mena/reports/community-engagement-standards	Engagement of communities and other stakeholders
Minimum Requirements for infection prevention and control (IPC) programmes	https://www.who.int/infection-prevention/publications/min-req-IPC-manual/en/	Systems for improving the quality of care
Monitoring, evaluation and review of national health strategies: a country-led platform for information and accountability	https://apps.who.int/iris/handle/10665/85877	Monitoring and evaluation
National eHealth strategy toolkit	https://apps.who.int/iris/handle/10665/75211	Digital technologies for health

Tool/resource	Location	Lever(s) [3]
National Health Workforce Accounts Handbook and Implementation Guide	https://www.who.int/hrh/statistics/nhwa/en/	Primary health care workforce
National Quality Policy and Strategy Tools and Resources Compendium	https://apps.who.int/iris/handle/10665/329961	Systems for improving the quality of care
Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential	https://apps.who.int/iris/bitstream/handle/10665/272603/9789241514064-eng.pdf	Systems for improving the quality of care
Nutrition - WASH Toolkit. Guide for Practical Joint Actions	https://www.unicef.org/eap/reports/nutrition-wash-toolkit-guide-practical-joint-actions	Models of care
OneHealth Tool	https://www.who.int/choice/onehealthtool/en/	Funding and allocation of resources
Participatory Action Research in health systems- A Methods Reader	https://equinetafrica.org/sites/default/files/uploads/documents/PAR_Methods_Reader2014_for_web.pdf	Primary health care -oriented research
Planning and implementing palliative care services: a guide for programme managers	https://www.who.int/ncds/management/palliative-care/palliative_care_services/en/	Models of care
Pocket book of hospital care for children: Second edition	https://www.who.int/maternal_child_adolescent/documents/child_hospital_care	Systems for improving the quality of care
Primary health care and health emergencies: brief	https://extranet.who.int/iris/restricted/handle/10665/326451	Governance and policy frameworks Engagement of communities and other stakeholders Models of care

Tool/resource	Location	Lever(s) [3]
Primary health care and health emergencies (long document)	https://apps.who.int/iris/rest/bitstreams/1251548/retrieve	Governance and policy frameworks Engagement of communities and other stakeholders Models of care
Primary health care as an enabler for "ending the epidemics" of high-impact communicable diseases: brief	https://apps.who.int/iris/handle/10665/326294	Models of care
Primary health care on the road to universal health coverage: 2019 monitoring report	https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1	Funding and allocation of resources Engagement of communities and other stakeholders Models of care
Primary Health Care Systems (PRIMASYS) Case Studies	https://www.who.int/alliance-hpsr/projects/primasys/en/	Primary health care -oriented research
Primary health care: closing the gap between public health and primary care through integration	https://apps.who.int/iris/handle/10665/326458	Models of care
Primary health for universal health coverage and the Sustainable Development Goals – performance measurement and monitoring	Forthcoming, WHO	Monitoring and evaluation
Progressing the Sustainable Development Goals through Health in All Policies - Case studies from around the world	https://www.who.int/social_determinants/publications/Hiap-case-studies-2017/en/	Governance and policy frameworks

Tool/resource	Location	Lever(s) [3]
Purchasing health services for universal health coverage: how to make it more strategic?	https://www.who.int/publications-detail/purchasing-health-services-for-universal-health-coverage-how-to-make-it-more-strategic	Purchasing and payment systems
Quality in primary health care	https://apps.who.int/iris/handle/10665/326461	Systems for improving the quality of care
Quality of care for maternal and newborn health: a monitoring framework for network countries	https://www.who.int/docs/default-source/mca-documents/advisory-groups/quality-of-care/quality-of-care-for-maternal-and-newborn-health-a-monitoring-framework-for-network-countries.pdf?sfvrsn=b4a1a346_2	Systems for improving the quality of care Monitoring and evaluation
Quality of care: what are effective policy options for governments in low- and middle-income countries to improve and regulate the quality of ambulatory care?	https://apps.who.int/iris/bitstream/handle/10665/208217/9789290616955_eng.pdf?sequence=1&isAllowed=y	Systems for improving the quality of care
Quality, equity, dignity: the network to improve quality of care for maternal, newborn and child health – strategic objectives	https://www.who.int/maternal_child_adolescent/documents/quality-care-network-objectives/en/	Systems for improving the quality of care
Rapid reviews to strengthen health policy and systems: a practical guide	https://www.who.int/alliance-hpsr/resources/publications/rapid-review-guide/en/	Primary health care -oriented research
Realising the value: Ten key actions to put people and communities at the heart of health and wellbeing	https://www.health.org.uk/publications/realising-the-value	Engagement of communities and other stakeholders Systems for improving the quality of care

Tool/resource	Location	Lever(s) [3]
Regulation of private primary health care	https://www.jointlearningnetwork.org/resources/primary-health-care-indicator-inventory/	Engagement with private sector providers Systems for improving the quality of care
Road Map for the Plan of Action on Health in All Policies	https://iris.paho.org/handle/10665.2/31313	Governance and policy frameworks Engagement of communities and other stakeholders
Roadmap for access to medicines, vaccines and health product 2019-2023: comprehensive support for access to medicines, vaccines and other health products	https://apps.who.int/iris/handle/10665/330145	Medicines and other health products
Safe management of wastes from health-care activities: a summary	https://www.who.int/water_sanitation_health/publications/safe-management-of-waste-summary/en/	Physical infrastructure
Selection of essential medicines at country level – Using the WHO model list of essential medicines to update a national essential medicines list	https://www.who.int/publications-detail/selection-of-essential-medicines-at-country-level	Medicines and other health products
Service Availability and Readiness Assessment (SARA)	https://www.who.int/healthinfo/systems/sara_introduction/en/	Monitoring and evaluation
Service delivery framework and tools for infants, children and adolescents living with HIV	http://www.childrenandaids.org/Paediatric-Service-Delivery-Framework	Systems for improving the quality of care Models of care
Sexual, reproductive, maternal, newborn, child and adolescent health in the context of primary health care	https://apps.who.int/iris/handle/10665/326297	Models of care

Tool/resource	Location	Lever(s) [3]
Standards for improving quality of maternal and newborn care in health facilities	https://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/	Systems for improving the quality of care
Standards for improving the quality of care for children and young adolescents in health facilities	https://www.who.int/maternal_child_adolescent/documents/quality-standards-child-adolescent/en/	Systems for improving the quality of care
Strategic purchasing for universal health coverage: key policy issues and questions - A summary from expert and practitioners' discussions	https://www.who.int/health_financing/documents/strategic-purchasing-discussion-summary/en/	Purchasing and payment systems
Strategizing national health in the 21st century: a handbook	https://apps.who.int/iris/handle/10665/250221	Political commitment and leadership Governance and policy frameworks Funding and allocation of resources Engagement of communities and other stakeholders Monitoring and evaluation
Strengthening midwifery toolkit	https://www.who.int/maternal_child_adolescent/documents/strenthening_midwifery_toolkit/en/	Primary health care workforce
Strengthening Primary Health Care through Community Health Workers - Investment Case and Financing Recommendations	https://www.who.int/hrh/news/2015/CHW-Financing-FINAL-July-15-2015.pdf	Funding and allocation of resources Engagement of communities and other stakeholders

Tool/resource	Location	Lever(s) [3]
Strengthening quality midwifery education for universal health coverage 2030: Framework for action	https://www.who.int/maternal_child_adolescent/documents/strengthening-quality-midwifery-education-framework/en/	Primary health care workforce
Strengthening the capacity of community health workers to deliver care for sexual, reproductive, maternal, newborn, child and adolescent health	https://www.who.int/maternal_child_adolescent/documents/community-capacity-h4plus/en/	Primary health care workforce
Surgical Care at the District Hospital - The WHO Manual	https://www.who.int/surgery/publications/scdh_manual/en/ Revision (forthcoming, WHO)	Systems for improving the quality of care
Survive and thrive: transforming care for every small and sick newborn	https://www.who.int/publications-detail/survive-and-thrive-transforming-care-for-every-small-and-sick-newborn	Systems for improving the quality of care
Tackling NCDs - 'Best buys' and other interventions for the prevention and control of NCDs	https://www.who.int/ncds/management/best-buys/en/	Models of care
Taking Action: Steps 4 & 5 in Twinning Partnerships for Improvement	https://www.who.int/servicedeliverysafety/twinning-partnerships/steps4-5/en/	Systems for improving the quality of care
The AIDS response and primary health care: linkages and opportunities	https://extranet.who.int/iris/restricted/handle/10665/328102	Models of care
The private sector, universal health coverage and primary health care	https://extranet.who.int/iris/restricted/handle/10665/312248	Engagement with private sector providers
The transformative role of hospitals in the future of primary health care	https://apps.who.int/iris/handle/10665/326296	Models of care

Tool/resource	Location	Lever(s) [3]
The WHO application of ICD-10 to deaths during the perinatal period: ICD-PM	https://apps.who.int/iris/bitstream/handle/10665/249515/9789241549752-eng.pdf?sequence=1	Monitoring and evaluation
Tools for implementing WHO PEN (Package of essential noncommunicable disease interventions)	https://www.who.int/ncds/management/pen_tools/en/	Models of care Systems for improving the quality of care
TOWARDS ACCESS 2030 - WHO Medicines and Health Products Programme Strategic Framework 2016 - 2030	https://www.who.int/medicines/publications/towards_access2030/en/	Medicines and other health products
Traditional and complementary medicine in primary health care	https://apps.who.int/iris/bitstream/handle/10665/326299/WHO-HIS-SDS-2018.37-eng.pdf	Models of care
Tripartite Monitoring and Evaluation (M&E) framework for the Global Action Plan on Antimicrobial Resistance	https://www.who.int/antimicrobial-resistance/global-action-plan/monitoring-evaluation/tripartite-framework/en/	Monitoring and evaluation
UHC intervention compendium	Forthcoming, WHO	Funding and allocation of resources Models of care
UNICEF Digital Health approach	https://www.unicef.org/innovation/reports/unicefs-approach-digital-health%E2%80%8B%E2%80%8B	Digital technologies for health
Using auxiliary nurse midwives to improve access to key maternal and newborn health interventions in sexual and reproductive health	https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/rhr1422/en/	Primary health care workforce
WASH in health care facilities - Practical steps to achieve universal access to quality care	https://www.who.int/water_sanitation_health/publications/wash-in-health-care-facilities/en/	Physical infrastructure

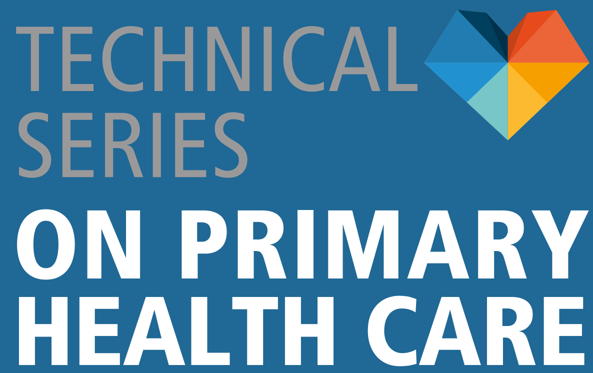
Tool/resource	Location	Lever(s) [3]
Water and sanitation for health facility improvement tool (WASH FIT) - A practical guide for improving quality of care through water, sanitation and hygiene in health care facilities	https://www.who.int/water_sanitation_health/publications/water-and-sanitation-for-health-facility-improvement-tool/en/	Physical infrastructure
WHO Antimicrobial Stewardship Programmes in health-care facilities in LMICs - A WHO Practical Tool Kit	https://apps.who.int/iris/bitstream/handle/10665/329404/9789241515481-eng.pdf	Medicines and other health products
WHO Cardiovascular risk prediction charts	https://www.who.int/news-room/detail/02-09-2019-who-updates-cardiovascular-risk-charts	Systems for improving the quality of care
WHO CHOICE	https://www.avenirhealth.org/software-onehealth.php	Funding and allocation of resources
WHO community engagement framework for quality, people-centred and resilient health services	https://apps.who.int/iris/bitstream/handle/10665/259280/WHO-HIS-SDS-2017.15-eng.pdf	Engagement of communities and other stakeholders
WHO Competency Framework for Health Workers' Education and Training on Antimicrobial Resistance	https://www.who.int/hrh/resources/WHO-HIS-HWF-AMR-2018.1/en/	Primary health care workforce
WHO Global Model Regulatory Framework for Medical Devices including in vitro diagnostic medical devices	https://www.who.int/medical_devices/publications/global_model_regulatory_framework_meddev/en/	Medicines and other health products

Tool/resource	Location	Lever(s) [3]
WHO Global Surveillance and Monitoring System for substandard and falsified medical products	https://www.who.int/medicines/regulation/ssffc/publications/gsms-report-sf/en/	Medicines and other health products
WHO guideline on country pharmaceutical pricing policies	https://apps.who.int/iris/handle/10665/153920	Medicines and other health products
WHO guideline on health policy and system support to optimize community health worker programmes	https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1	Primary health care workforce
WHO guideline: recommendations on digital interventions for health system strengthening	https://apps.who.int/iris/handle/10665/311941	Digital technologies for health
WHO Handbook on Social Participation for Universal Health Coverage	https://www.who.int/activities/promoting-participatory-governance-social-participation-and-accountability https://www.uhc2030.org/what-we-do/accountability/civil-society-consultation-on-handbook-on-social-participation-for-uhc/	Engagement of communities and other stakeholders
WHO Lists of priority and medical devices	https://www.who.int/medical_devices/priority/en/	Medicines and other health products
WHO medicines quality assurance guidelines	https://www.who.int/medicines/areas/quality_safety/quality_assurance/guidelines/en/	Medicines and other health products
WHO model list of essential in vitro diagnostics	https://apps.who.int/iris/handle/10665/329527	Medicines and other health products

Tool/resource	Location	Lever(s) [3]
WHO recommendation on community mobilization through facilitated participatory learning and action cycles with women's groups for maternal and newborn health	https://www.who.int/maternal_child_adolescent/documents/community-mobilization-maternal-newborn/en/	Engagement of communities and other stakeholders
WHO recommendations on home-based records for maternal, newborn and child health	https://www.who.int/maternal_child_adolescent/documents/home-based-records-guidelines/en/	Monitoring and evaluation
WHO recommendations on interventions to improve preterm birth outcomes	https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/preterm-birth-guideline/en/	Systems for improving the quality of care
WHO recommendations on newborn health	https://www.who.int/maternal_child_adolescent/documents/newborn-health-recommendations/en/	Systems for improving the quality of care
WHO/UNICEF guidance on health facility indicators	https://www.who.int/healthinfo/tools_data_analysis_routine_facility/en/	Physical infrastructure
Why palliative care is an essential function of primary health care	https://apps.who.int/iris/handle/10665/328101	Models of care
Working for Health & Growth: Investing in the health workforce	https://apps.who.int/iris/bitstream/handle/10665/250047/9789241511308-eng.pdf?sequence=1	Primary health care workforce
Working Together: A toolkit for health professionals on how to involve the public	https://www.weahsn.net/our-work/involving-our-patients-and-the-public/working-together/	Engagement of communities and other stakeholders Systems for improving the quality of care
Working with individuals, families and communities to improve maternal and newborn health	https://www.who.int/maternal_child_adolescent/documents/who_fch_rhr_0311	Engagement of communities and other stakeholders

Tool/resource	Location	Lever(s) [3]
Working with individuals, families and communities to improve maternal and newborn health: a toolkit for implementation	https://www.who.int/maternal_child_adolescent/documents/community-engagement-mnh-toolkit/en/	Engagement of communities and other stakeholders
Workload Indicators of Staffing Need (WISN) User's manual	https://www.who.int/hrh/resources/wisn_user_manual/en/	Primary health care workforce
World Health Organization model list of essential medicines: 21st list 2019	https://apps.who.int/iris/handle/10665/325771	Medicines and other health products

[3] Cross-cutting tools/resources may map to additional levers than how they are represented in the tables of tools and resources throughout the document.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