Ensure Health for All

Facts, Solutions, Case Studies, and Calls to Action

OVERVIEW

Healthy girls and women are the cornerstone of healthy societies. Provide girls and women access to health throughout their lives and they deliver a healthier and wealthier world. While many countries continue to face daunting obstacles to realizing health for all, there are demonstrated strategies that can help break down these barriers. This brief discusses some of the approaches that can help communities improve the access that girls and women have to a comprehensive range of services for their enjoyment of physical and mental health and rights. Included among these approaches are: implementing women-centered care; integrating service delivery; optimizing the health workforce; realizing health for all through Universal Health Coverage (UHC); and boosting the prevention of non-communicable diseases. Importantly, girls and women should be involved in the design, implementation, evaluation, and accountability of policies, programs, and services.

SECTION 1: FRAMING THE ISSUE

Healthcare is a human right, not a privilege. Yet each year, more than 3 billion people do not receive the health services they need, 800 million people face financial challenges while accessing healthcare, and nearly 100 million are impoverished by the costs of healthcare.[1,2,3]

While treatment is becoming more accessible for certain diseases, it remains unaffordable and inaccessible for many people worldwide. Adequate healthcare is often out of reach when it comes to treating non-communicable diseases (NCDs) that develop slowly over time, such as cardiovascular disease, diabetes, and cancer.[4,5] A 2018 study on mortality in low-quality health systems, showed that of 8.6 million preventable deaths in 137 low- and middle-income countries (LMICs), 5 million were caused by poor-quality care and 3·6 million, were caused by non-utilization of health care.[6]

New HIV infections among young women (aged 15-24 years) are approximately 44% higher than they are among young men.[7] Additionally, each year approximately 204 million women in the developing world have one of the four major, curable STIs (chlamydia, gonorrhea, syphilis and trichomoniasis),[8] however 82% do not receive the health services they need.[9] Access to mental health care remains equally challenging, despite 10% of pregnant women experiencing a mental disorder globally and self-harm being one of the leading causes of death for adolescent girls aged 15-19-years.[10,11] Sexual and reproductive health issues such as unwanted pregnancy, gender-based violence, and discrimination based on sexual orientation or gender identity, are among factors that contribute to poor mental health.[12] The reverse effect is true as well. Despite limited research on the topic, mental health issues such as depressive disorders have been shown to hold an important role in the development and outcomes of chronic disease.[13]

In order to respond to the needs of all girls and women throughout their life cycle, health systems must provide services across a women-centered continuum of care. In 2015, the World Health Organization (WHO) released a global strategy that called for a shift in the design of health systems toward a more integrated, people-centered approach.[14] For example, in 2016, a WHO report described a detailed framework, strategies, and policy options for integrated, people-centered health services.[15] The framework sets forth a world in which "all people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient, and acceptable."[16]

To attain health for all, in 2018, WHO launched its thirteenth general programme of work (GPW 13) emphasizing this shift toward a people-centered framework by focusing on the key priorities of achieving Universal Health Coverage (UHC), addressing health emergencies, and promoting healthier populations.[17] Building off this strategy, women-centered care should focus on the context and health needs of girls and women; it should be all encompassing across maternal, sexual, and reproductive health needs; and it should be inclusive of all women, from infancy to old age. It should emphasize patient empowerment, strong relationships with healthcare providers, and focus on strengthening healthcare systems that account for the heterogeneity and vulnerability of the population.[18]

SECTION 2: SOLUTIONS AND INTERVENTIONS

While communities and countries face unique obstacles to achieving access to health services for all girls and women, there are demonstrated strategies that can help realize this goal:

- Ensure health for all through Universal Health Coverage
- Implement people-centered care, with a focus on all girls and women
- Increase investments in integrated healthcare services, particularly at the primary care level
- Optimize health workforce resources to enhance both the continuum and continuity of care

Ensuring access to comprehensive healthcare for girls and women is linked to the achievement of multiple SDGs and targets, including:

SDG 1: End poverty in all its forms everywhere

- **1.3** Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable

SDG 3: Ensure healthy lives and promote wellbeing for all at all ages

- **3.1** Reduce the global maternal mortality ratio to less than 70 per 100,000 live births

- **3.2** End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births

- **3.3** End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases

- **3.4** Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

- **3.7** Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

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- Maintain health information with life-long individual medical records, ideally patient-held

- Ensure medical products and technologies are safe and accessible

- Ensure prevention, screening, and treatment options for non-communicable diseases and mental health

Ensure Health for All through Universal Health Coverage

Universal Health Coverage (UHC) is rooted in the human rights framework, with equitable access to resilient, people-centered health systems at its core. While initially conceived within the parameters of healthcare financing, UHC has evolved into a commitment to healthcare equity, quality and accessibility.[19] Adhering to the principle of Leaving No One Behind, the 2017 Tokyo Declaration on UHC also stressed the importance of prioritizing the most marginalized members of the population, including those affected by emergencies, migrants, stigmatized groups, and girls and women.[20]

Increasingly, countries are building momentum toward improving access to UHC to provide quality health services that are equitable and affordable for all. A growing body of evidence calls for a combination of clinical interventions and outreach that builds awareness of healthy lifestyles and encourages their adoption.[21,22]

More than 100 low- and middle-income countries (LMICs), home to three-quarters of the world's population, have taken steps to pursue UHC as it relates to financing. However in addition to financing, countries need to strengthen their health systems to provide access to quality healthcare services for all. Any progress toward UHC needs to be cost effective, equitable, and in line with countries' national priorities and context.[23,24]

All countries can make progress toward UHC, even those with low levels of public spending on health (less than $40 per capita).[25] However, as the amount of public spending increases, there is generally more systematic improvements in health system performance.[26] While no unifying blueprint exists, core guiding principles based on country experiences include:

- Increasing funds: Governments have successfully combined funds from different sources, with compulsory contributions (often sourced from consumption taxes) as a key mechanism to increase the amount of pooled capital.[27,28,29,30]

- Pooling resources across the population: This allows the redistribution of resources from the wealthy to the poor and from the healthy to the sick.[31,32,33] Pooling schemes should be integrated and draw across diverse income and social groups, including women, migrants, people with disabilities, and marginalized populations. Schemes that are fragmented may leave the most vulnerable behind. For example, social health insurance that covers the formal workforce may exclude women, who are more highly engaged in the informal economy.[34]

- Strategically designing benefits packages: Although the benefits packages may vary, they should respond to the needs of women, low-income groups, and marginalized populations.

- Improving medicines-related efficiency: Buy at the lowest cost through transparent, competitive bidding; test and ensure quality throughout the distribution chain; modify regulations to encourage the use of generics; and encourage rational use of all medicines.[35]

- Task shifting: Allow health workers at lower levels to take on more responsibility as appropriate.[36]

- Assessing status quo and plans for reform: Determine primary causes of current system inefficiencies and which are feasible to change in the short, medium, and long term.[37] Develop a set of efficiency indicators specific to the country and invest in methods to collect indicator data and to evaluate progress.[38]

- Using intersectoral planning for health equity: Incorporate the social determinants of health into planning by engaging other sectors of the government from the beginning, consulting the community and civil society, and examining existing inequities.[39]

Reviews suggest that comprehensive UHC schemes in LMICs, inclusive of the full range of sexual and reproductive health services, have a positive effect on access and use of health services and on financial protection (as measured by out-of-pocket expenditures), especially when targeting low-income populations.[40,41,42] For example, eliminating fees for maternal health services has often led to increases in skilled deliveries and caesarean sections at public health facilities.[43,44] However, appropriate measures need to be taken to offset the loss of revenue and respond to the increased demand for services.

Additionally, to make progress toward realizing UHC, health systems need to acknowledge barriers beyond economic ones. These barriers can be geographic (where services are not within reach), epidemiological (where services do not meet varying health needs of heterogeneous populations), or cultural (where the workforce does not possess context-specific sensitivity for effective service delivery).[45] Driving universal health for all requires differentiated approaches based on capacity, cultural context, and population vulnerability.

Quality healthcare that is accessible and available for all, particularly the most vulnerable, strengthens the resilience of communities and countries and provides a natural overlap between emergencies, UHC, and healthier populations.[46] Universal healthcare can then form the foundation for serving populations in fragile or conflict-affected settings by integrating inclusive health systems with health emergency risk management.[47] In order to leave no one behind, health systems need to adopt a pro-equity approach

- **3.8** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all

- **3.b** Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

- **3.c** Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

- **3.d** Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

SDG 5: Achieve gender equality and empower all women and girls

- **5.1** End all forms of discrimination against all women and girls everywhere

- **5.2** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual, and other types of exploitation

that focuses on the needs and accessibility of those from the poorest wealth quintiles, alongside people with disabilities, indigenous populations, and those in fragile settings.[48]

Case Study: Indonesia Makes Strides Toward UHC

Over the past 20 years, Indonesia has undergone a number of improvements in key health indicators and has made progress toward UHC.[49] By the end of 2016, nearly 172 million individuals — more than 60% of the population — were covered by the Jaminan Kesehatan Nasional (JKN) program, one of the largest single-payer social health insurance schemes.[50] National targets aim to reach the remaining population and to have universal coverage by 2019.[51] Meanwhile, Indonesians have become healthier in terms of a number of key health indicators.[52] For example, they have seen declines in the under-five mortality rate, from 222 per 1,000 live births in 1960 to 27 per 1,000 in 2015.[53] Life expectancy has increased to 69 years in 2014, up from 63 in 1990.[54] However, as a larger share of the burden of disease shifts to NCDs, Indonesia will need to adapt to higher utilization of its health system and shift toward more preventative rather than curative care.[55]

Implement People-Centered Care, with a Focus on All Girls and Women[1]

Universal health and accessibility must be prioritized across all levels of the health system, and girls and women must be involved in this process to ensure that their perspectives and priorities are included. The table below shows the key characteristics of conventional vs. women-centered care.

	CONVENTIONAL CARE	WOMEN-CENTERED CARE
FOCUS	Illness and cure	Health needs, including prevention, episodic care, and chronic care
RELATIONSHIP BETWEEN WOMEN AND PROVIDERS/ SYSTEM	Limited to the consultation	Enduring throughout the life cycle
NATURE OF CARE	Episodic, curative care	Comprehensive, continuous, and client-centered
RESPONSIBILITY OF PROVIDER/SYSTEM	Effective and safe advice during consultation	The health of women in the community throughout their life; consideration of the social determinants of health
ROLE OF WOMEN	Consumers of care	Partners in managing their own health and the health of those in the community

[Table adapted from report of WHO meeting on People-Centered Care in Low- and Middle-Income Countries held 5 May 2010.[56]]

Increase Investments in Integrated Healthcare Services, Particularly at the Primary Care Level

There are many strategies to integrating health service delivery, and a WHO framework containing five key strategies has been developed.[57] These include 1) engaging and empowering people and communities; 2) strengthening governance and accountability; 3) reorienting the model of care by training providers to offer various services and placing multiple services at the same facility; 4) coordinating services within and across sectors by providing referrals as needed among service providers; and 5) creating an enabling environment.[58] Integration is not about offering all possible services in a single package. Rather, it should consider the local epidemiological context. For example, as the onset of diabetes during pregnancy is associated with a range of risks to maternal and newborn health, integration of service delivery and care coordination is crucial, particularly in countries with a high burden of diabetes.[59,60]

Integration also makes sense from the patient perspective. The ability to receive multiple services from a single provider, or at the same site, reduces travel time and increases the likelihood that girls and women will seek out these services.[61] And where treatment of stigmatized diseases such as HIV is integrated with other services, concerns about disclosure are reduced.[62,63] Integrated care provision has also been shown to normalize HIV testing.[64]

While government investment in primary care and intervention is essential to achieving UHC, building partnerships between the public and private sector is also important in some settings.[65] Health systems in many low- and middle-income countries (LMICs) are heavily dependent upon private providers, with little accountability to protect patients and health systems. In such settings, the private sector needs to be complementary and integrated with the local health system and should be equitably accessible for all. An integrated system with regulated public-private partnerships can align private practice with public needs, fill gaps in underdeveloped public systems, and bring forward new and innovative healthcare approaches while ensuring maximum impact.[66,67] However, integrated

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1 For the duration of this brief, *people-centered care, with a focus on girls and women* will be referred to as *women-centered care*.

- **5.6** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

- **9.1** Develop quality, reliable, sustainable and resilient infrastructure, including regional and transborder infrastructure, to support economic development and human well-being, with a focus on affordable and equitable access for all

SDG 11: Make cities and human settlements inclusive, safe, resilient, and sustainable

- **11.2** By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities, and older persons

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public-private partnerships must be subject to a framework of accountability to effectively sustain impact. Managing accountability in public-private partnerships can include balancing different public demands, cost-effectiveness, risk sharing, innovation, reliability, transparency, and security. Although potentially challenging to regulate and hold accountable, public-private partnerships are important because they can improve government services. Similarly, leveraging private capacity can be valuable in fragile and conflict-ridden settings, where public infrastructure cannot serve healthcare needs alone.

Case Study: DREAMS project aims for an AIDS-free generation

The DREAMS project aims for an AIDS-free generation. Across sub-Saharan Africa, girls and young women make up 74% of new HIV infections among the adolescent population.[68] Launched in 2014, the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) partnership aims to reduce the high incidence of HIV infections among girls and young women in ten countries (Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe) through integrated efforts.[69] DREAMS' holistic approach includes a core package inclusive of health and issues outside of the health sector and addresses the structural drivers that impact HIV risk in girls, such as poverty, gender inequality, sexual violence, and education. The following six areas serve as a focus for the project: strengthening capacity for service delivery; keeping girls in secondary school; linking men to services; supporting pre-exposure prophylaxis (PrEP); providing a bridge to employment; and applying data to increase impact.[70] In 2017, data from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) showed significant declines in new HIV diagnoses among adolescent girls and women. In the 10 countries implementing the DREAMS partnership, most of the highest HIV-burden communities saw around a 25% to 40% decline in new HIV diagnoses among young women. Additionally, new diagnoses decreased in nearly all DREAMS intervention districts.[71]

Case Study: Primary Healthcare in Costa Rica

Primary care stands as a solid base for Costa Rica's healthcare system, which is recognized for its structural and functional cohesiveness. Managed by the Caja Costarisience de Seguridad Social (CCSS), the primary care services are continuing to develop with the establishment of Centros de Atención Integral en Salud (CAIS).[72] These centers represent an extended model of primary care and provide a variety of services ranging from maternity care and rehabilitation to minor surgery. CAIS integrates upward to secondary care providers, and this clear vertical integration ensures care is provided at the appropriate level. Evidence suggests that 80% of the primary care presentations are solved at that level, without referral to secondary care.[73]

Optimize Health Workforce Resources to Enhance Both the Continuum and Continuity of Care

To ensure that women, youth, and adolescents receive comprehensive and timely care, the continuum and continuity of care should be based upon a system of referrals and coordination among community-based providers, primary care clinics, first-level hospitals, and referral hospitals. To realize this goal, the lack of skilled medical professionals must be addressed at every level of the system. To maximize operational efficiency, task shifting and task sharing — whereby less-credentialed providers are trained to manage specific tasks — can help to close the human resources gap. Such strategies are endorsed by the WHO and implemented in a number of low- and middle-income countries (LMICs) to deliver HIV-related services and essential interventions for maternal and newborn health.[74,75] Task shifting and sharing can involve a range of mid-level and lay health workers, including non-physician clinicians, nurses, midwives, and community health workers. In a systematic review of 53 studies, the quality of care for maternal and child communicable and non-communicable diseases (NCDs) provided by mid-level health professionals was similar to the quality of care provided by higher-level health professionals.[76]

Specific models take into consideration the local health workforce, disease burden, and existing gaps in service delivery. Such innovative responses to the shortage of human resources have substantial potential to improve women's access to health services. In the case of NCDs, non-physician health workers have been shown to successfully detect and manage these and other chronic conditions.[77] A review of studies utilizing community health workers for prevention and detection of NCDs in LMICs found that community health worker involvement resulted in improvements in tobacco cessation, lowering blood pressure, and diabetes management.[78] However, due to the small number of studies and low-quality evidence currently available, research must be expanded.[79,80,81]

Additionally, it is important to emphasize that the availability of health workers does not ensure quality of care in itself. To provide effective services, health workers need to be equipped with appropriate knowledge and skills, as well as an environment that supports access to quality care.[82] This includes the physical, financial, legal, and political conditions that integrate quality improvement into pre-service and in-service training in order to build a competent workface that is capable of providing high-quality care — especially to those most in need.[83]

To reach those most in need, equitable distribution of the health workforce is necessary. This equitable distribution across social, economic, and geographic lines requires strategic investment that can translate into employment opportunities, especially for women and young people. The global demand for health workers is expected to double by 2030, with a need for an estimated 40 million new jobs.[84] Investment in the health workforce for the future should account for inequities of access, demographic shifts, technological changes, and socioeconomic transitions. The workforce should be geared toward addressing the social determinants of health as well as the physical ones.[85] To respond to these demands and potential opportunities, there is greater need for multi-sectoral engagement across the interconnected areas of employment, education, health, finance, and gender.[86]

Relevant International Agreements:

- Declaration of Alma-Ata, International Conference on Primary Health Care (1978)

- The 1979 Convention on the Elimination of All Forms of Discrimination against Women (Articles 11 (1) (f), 12 and 14 (2) (b))

- The 1989 Convention on the Rights of the Child (Article 24)

- The Committee on Economic, Social and Cultural Rights, general comment N° 14 on the right to the highest attainable standard of health (2000)

- The UN General Assembly of September 2011 released Political Declaration on NCDs

- The UN Resolution on Universal Health Coverage (2012)

- The WHO launched the Global action plan for the prevention and control of NCDs (2013-2020)

- WHO Mental health action plan (2013-2020)

- Sustainable Development Goals (SDGs) (2015-2030)

- Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents (2017)

- Tokyo Declaration on Universal Health Coverage (2017)

- WHO's 13th General Programme of Work (2019-2023)

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Gender inequalities in health and in the health workforce must also be addressed, particularly with respect to women's formal representation in the health sector and girls' and women's contribution to informal, unpaid care work.[87] Strengthening and using gender- and age-disaggregated data can help identify these structural gaps, while increased female representation in decision-making bodies can result in gender-transformative policy development that overcomes gaps and gender biases in the health labor market.[88] Reformed policies can maximize women's formal participation in the health workforce, improve opportunities for formal education, and address issues related to women's security, work conditions, and mobility.[89]

When disasters and emergencies take place, the health consequences can be devastating — resulting in loss of life, disability, and mental trauma. The aftermath and period of recovery is usually burdened with many challenges, including limited access to maternal, sexual and reproductive health.[90,91] Although women are the main providers of care in crisis settings, gender biases, harassment, and physical and sexual violence remain persistent challenges for health workers.[92] During humanitarian emergencies, violence against health infrastructure, workers, and transport systems impairs access to safe and reliable health services, particularly for girls and women. Health workers and facilities have increasingly become deliberate targets in conflict situations, with 701 reported attacks on healthcare workers in 23 conflict-affected countries in 2017 alone.[93] Health service delivery becomes more complicated in these emergency settings, but maintaining the health workforce is especially important for building resilience, reducing health vulnerability, and recovering from the emergency itself.[94] In emergency settings, greater focus and investment in the health workforce is needed, especially in terms of staff safety and mobility, surge capacity, training, and preparedness.[95,96]

Case Study: *Task Shifting the Management of Non-Communicable Diseases to Nurses in Kibera, Kenya*
Kenya has a disproportionately high burden of NCDs, which account for more than 50% of all hospital admissions and deaths. The situation is worse in informal settings and overwhelming for the health systems.[97] The tertiary health facilities manage the NCDs, placing a workload strain on their staff. To address this issue, the Ministry of Health (MOH) and Médecins Sans Frontières introduced a model that involved task shifting the care of stable NCD patients in Kibera clinics to nurses in primary health facilities. Results from early impact evaluations indicate that nurses, working in resource-constrained primary settings, can effectively manage NCD patients.[98]

Case Study: *HIV and UHC Investments in Rwanda*
Rwanda has made significant progress in health coverage by adopting coordinated programs between HIV and UHC.[99] The Ministry of Health prioritized integrated, community-based platforms by aligning HIV-specific interventions with efforts to strengthen primary care to ensure access and comprehensiveness of health services. For example, supply chains and information tracking systems developed for HIV were leveraged for other programs.[100] In addition, the Ministry also adopted an inclusive governance approach — seats for civil society organizations (CSOs) were reserved on the board of the former National AIDS Control Commission (2001–2010) and the ongoing Global Fund Country Coordinating Mechanism. These efforts contributed to an 80% decline in AIDS-related mortality and a 90% increase in national health insurance plan coverage

Maintain Health Information with Life-Long Individual Medical Records, Ideally Patient-Held

Individual medical records are the backbone of comprehensive care for girls and women. They are important tools for planning and managing care coordination, documenting history, and monitoring progress so as to understand the health needs of girls and women throughout their lives. The confidential aggregation of data from individual records also provides information that can be used to guide forecasting, supply planning, resource allocation, and evaluation.[101] Individual records are needed to permit continuity of information across encounters with the health system over services, time, and distance; they are also necessary for accurate reporting.[102]

Another innovative strategy, originally driven by HIV and TB programs, is the use of electronic medical record systems.[103] The World Health Organization (WHO) has published a reference manual outlining considerations needed to introduce such systems, including educating staff, computer literacy, funding for infrastructure, data security, and quality assurance.[104] One purported advantage of electronic medical records is that they are generally more efficient or accurate than paper-based systems when large numbers of patients are involved.[105,106] Some studies have shown that they also can support the chronic clinical management of HIV and TB patients.[107]

Ensure Medical Products and Technologies Are Safe and Accessible

Equitable access to comprehensive health services requires the availability of essential medicines, vaccines, and technologies. In reality, some medicines are chronically unavailable in LMICs as a result of countries failing to include medicines on the essential drug list,[108] inefficiencies in procurement and distribution systems, and unnecessarily high prices.[109]

Countries should implement the framework recommended by the WHO to ensure equitable access to high-quality, safe, and cost-effective medicines.[110] It includes the following components:

- Rational selection of medicines: Countries must develop active purchasing based on the costs and benefits of alternatives.[111]

- Affordable pricing: Governments should ensure transparency in purchasing and tenders by monitoring and publicizing medicine prices.[112] Policies that support the purchase of generic drugs — the norm for HIV/AIDS — should be extended to NCDs.[113]

- Remove taxes and duties: Countries should use their negotiating power to control mark-up, addressing excessive taxes and duties on medicines.[114]

- Universal Health Coverage (UHC) and sustainable financing: Governments should seek private-sector partners willing to embrace a social business model, whereby firms seek to maximize social profit while making financial profit to cover their costs and provide returns to their owners.[115]

- Reliable health and supply systems: Governments need to team with commercial partners and apply modern business techniques to optimize the efficiency and reliability of drug distribution systems. This includes a greater application of supply-chain optimization analysis, a technique commonly applied in the private sector to manage distribution.[116]

In the case of emergency situations, medicines and medical devices must be available and standardized to allow for their efficient, effective, and safe usage when the need arises.[117,118] Effective supply chain management is a vital component of successful service delivery, starting with needs forecasting and procurement, followed by transportation and distribution of essential medicines and supplies. In emergency settings, supply chains need to be strong, sustainable, and flexible from the onset of crisis through periods of recovery. Without access to relevant medicines, supplies and equipment, health workers cannot provide essential services.[119]

Supply chains should also be able to meet the diverse needs of all affected populations, including girls and women. Emergency response mechanisms should be integrated with national health systems in order to provide and sustain effective, gender-sensitive services at the onset of crisis and through periods of recovery.[120] This includes the initial provision of high-quality, integrated sexual and reproductive health services through the Minimum Initial Service Package (MISP).[121] In addition to being a source of essential equipment and supplies, the MISP forms a set of corresponding, priority activities that are carried out by trained staff to manage and respond to gender-sensitive health issues. Implementation of the MISP serves as a starting point to prevent maternal and newborn deaths, unwanted pregnancies, unsafe abortions, sexual violence, and the possible spread of sexually transmitted infections in crisis settings.[122]

Case Study: Social Business Initiatives to Improve Access to Essential Drugs in Kenya

Governments are increasing their partnerships with drug manufacturers for mutual gain. These alliances, known as social business interventions, pair commercial partners with governments or non-profit organizations. In 2012, the government of Kenya teamed with a pharmaceutical industry partner, Novartis, to launch the Familia Nawiri program to increase access to essential drugs for otherwise under-treated conditions — including hypertension and diabetes — in the poorest communities.[123] Community health educators, often women, played a pivotal role in community engagement and linking community members with healthcare providers for care and access to medicines.[124]

Case Study: The Elimination of HIV Transmission from Mother to Child in Cuba

In 1997, Cuba introduced a program for preventing mother-to-child HIV transmission in a healthcare system that is universal and free of charge.[125] The Cuban Ministry of Public Health provided antiretroviral treatment for all HIV-positive pregnant women, along with breast milk substitutes.[126] While initial treatments were largely maintained through donations of antiretrovirals, in 2001 the government facilitated local production of generic antiretroviral drugs. With the introduction of locally produced drugs, the proportion of patients with access to antiretrovirals increased significantly.[127] By 2014, Cuba reported fewer than 100 HIV-positive pregnant women. In 2015, Cuba was formally recognized by the WHO for eliminating mother-to-child transmission of HIV.[128]

Ensure Prevention, Screening, and Treatment Options for Non-Communicable Diseases

Improving mechanisms for prevention, screening, and treatment of NCDs is critical to achieving better health outcomes.[129] For example, addressing gestational diabetes through prevention, universal early screening, post-partum screening, treatment, and management will not only improve maternal and newborn health, but also help to prevent the onset of type 2 diabetes and other associated NCDs in women, their babies, and subsequent generations.[130] Mental health is also an important risk factor for premature mortality around the world. Mental health disorders like depression can be linked with chronic illnesses and can also lead to behaviors that increase risk of other NCDs, such as substance abuse, harmful alcohol use, poor diet, and reduced physical activity.[131] Individuals dealing with mental health conditions are also less likely to seek help for NCD symptoms, which may affect prognosis and treatment.[132] Primary care-based interventions with screening, treatment, and education, can help mitigate the impact of mental health illnesses and consequently, NCDs.

On the prevention side, achieving reductions in the four primary risk factors that are common to the top NCDs — tobacco use, physical inactivity, alcohol abuse, and unhealthy diet — is a cornerstone of the Global NCD action plan.[133] Malnutrition also is a concern. Children born to malnourished women or to women at risk of or diagnosed with diabetes in pregnancy are more likely to develop chronic illnesses such as diabetes or heart disease as they grow older.[134]

Increased access to point-of-care (POC) diagnostic testing, bringing services closer to women, children, and families, has been shown to improve patient care, especially in settings with limited laboratory infrastructure and where the bulk of the population lives in rural settings.[135] For example, POC CD4 diagnostic testing to monitor immune function in patients with HIV has been shown to improve linkages to HIV care and timeliness of antiretroviral initiation.[136]

When disasters and emergencies take place, health service delivery becomes more complicated. Following a coup in Mali in 2012, the health system was severely impacted.[137] Non-governmental organization (NGO) Santé Diabète developed a humanitarian response for patients with diabetes that included evacuating children, providing medicines and tools for management of diabetes, and supporting people who became internally displaced.[138] People with NCDs should be viewed as particularly vulnerable in emergency settings, as they have specific needs.[139] Emergency responses should be tailored to the patient's particular context, such as whether they are internally displaced or if they remain in conflict areas.[140]

Governments play an important role in promoting healthy behaviors through policies and tools — within and outside of the traditional health sector.[141,142] Toward this end, the WHO and The Lancet Commission on Investing in Health recommend high-priority, cost-effective, and achievable interventions such as taxation, regulation, and legislation.[143,144] For example, many studies show that taxing tobacco reduces its use and can prevent deaths, while also raising revenue.[145,146] Taxation on alcohol and sugar-sweetened beverages can provide similar benefits.[147,148,149] Yet the implementation of these measures remains uneven. Of the 194 countries that completed the 2015 NCD country capacity assessment survey, 87% reported taxes on tobacco and 80% on alcohol, whereas only 18% had fiscal policies on non-alcoholic beverages with a high sugar content.[150]

Involving girls and women as partners in the management of their health and as agents of change within their communities is essential not only to prevention, screening, and treatment efforts, but a fundamental aspect of women-centered care. As women often make decisions that directly affect diet in their households, they are also uniquely positioned to help tackle the NCD crisis in their families and communities.[151] Girls and women need to be equipped with better information about NCD risk factors and the health consequences of their lifestyle choices.

Case Study: ASHA — Women as Community Health Workers in India

India's National Rural Health Mission was launched in 2005, aiming is to provide every village in the country with a trained female community Accredited Social Health Activist (ASHA).[152] ASHAs serve as a link between their own community and the public health system. As community health activists, ASHAs provide education on a range of health issues, including reproductive and sexual health, and healthy lifestyles and nutrition to contribute to the prevention of diabetes and other NCDs.[153]

SECTION 3: THE BENEFITS OF INVESTMENT

There are multiple benefits to building health systems that provide a continuum of care for all girls and women. First and foremost, it saves lives and, subsequently, money. The returns on investment in health are 9 to 1, and an estimated quarter of the economic growth between 2000 and 2011 in LMICs resulted from improvements to health.[154] Scaling up the full package of clinical and outreach interventions for NCDs to 80% coverage across 42 LMICs — which account for 90% of the global NCD burden — would cost $11.4 billion annually from 2011 to 2025. This equals an annual cost of $1 per person in low-income countries, $1.50 in low- and middle-income countries, and $3 in upper-middle-income countries.[155] In order to make significant progress on SDG 3 in LMICs by 2030, an additional $371 billion in health spending would be needed each year, with 75% of that cost going toward health systems strengthening.[156] As a result, 97 million lives would be saved and life expectancy would increase by 3-8 years.[157]

Integrating prevention and control of NCDs within other programmatic areas, such as HIV, maternal, newborn, and child health, and sexual and reproductive health, may enhance synergies and linkages, and improve efficiencies in the delivery of services to women and families in LMICs.[158] Taking action to expand and improve the health workforce also brings about benefits in terms of job creation, economic growth, social welfare, and gender empowerment, in addition to health system strengthening.[159]

Investing in prevention and screening helps reduce health risks and costs. Evidence shows that vaccinating girls against the human papilloma virus (HPV) over the next 10 years — a cost of only $10 to $25 per person — would avert more than 3 million deaths from cervical cancer across 72 LMICs.[160] Additionally, screening vaccinated women for cervical cancer just three times in their lifetime would reduce mortality by another 20-25%.[161]

While significant progress has been made on curbing the HIV epidemic, marginalized groups, including girls and women, are still vulnerable in many communities, and pace of progress is not matching global ambitions.[162] While funding for the AIDS response increased in 2017, it still remained 20% short of targets set by the UN General Assembly.[163]

Furthermore, the moral and economic costs of failing to invest in integrated health systems are staggering. In the absence of new interventions, the cumulative economic loss to LMICs from the four main NCDs — cardiovascular disease, cancers, respiratory diseases, and diabetes — is estimated to be more than $7 trillion between 2011 and 2025. On average, the economic burden of these NCDs amounts to an annual loss per person of $25 in low-income countries, $50 in low- and middle-income countries, and $139 in upper-middle-income countries.[164]

Undetected or untreated, NCDs, including mental illnesses, cause severe complications, disability, and premature death. They can affect productivity, increase financial hardship, burden health systems, and hinder economic growth. For example, reducing the mortality from ischemic heart disease and strokes by 10% has the potential to reduce economic losses in LMICs by $25 billion each year.[165] The international community needs to act now to curb the NCD crisis, especially for girls and women who suffer inequities in accessing the health services they need.

SECTION 4: CALLS TO ACTION

Governments bear the greatest responsibility to ensure that girls and women have access to comprehensive healthcare, but everyone has a role to play to reduce barriers to integrated services that promote the health and wellbeing of all.

In order to power progress for all, many different constituents must work together — governments, civil society, academia, media, affected populations, the United Nations, and the private sector — to take the following actions for girls and women:

- Prioritize health for all through Universal Health Coverage. (Most relevant for: governments and the private sector)

- Eliminate legal, financial, social, and institutional barriers that prevent access to comprehensive health services for all girls and women, including age of consent for accessing services. (Most relevant for: governments)

- Set and meet national targets across girls' and women's health and wellbeing needs — including sexual and reproductive health, as well as communicable and non-communicable diseases. (Most relevant for: governments)

- Maintain accessible health information with life-long individual medical records. (Most relevant for: governments and the private sector)

- Promote all girls' and women's involvement in sport as a critical way to foster wellbeing and healthy behaviors. (Most relevant for: governments, civil society, the United Nations, and the private sector)

- Focus efforts toward more integrated, women-centered care to address the needs of all girls and women along the life cycle. (Most relevant for: governments, civil society, the United Nations, and the private sector)

- Build the capacity of health workers and address health worker shortages and general well being, particularly in rural and underserved areas and in emergency and conflict settings. (Most relevant for: governments, civil society, the United Nations, and the private sector)

- Build and disseminate evidence of the impact of women-centered care. (Most relevant for: governments, civil society, academia, media, affected populations, the United Nations, and the private sector)

- Tailor responses in emergency settings to ensure the specific health needs of the population, especially vulnerable groups and girls and women, are factored into the plan. (Most relevant for: governments, civil society, and the United Nations)

Disclaimer: The views and opinions expressed in this technical paper are those of the authors and do not necessarily reflect the official policy or position of all partnering organizations.

These briefs are intended to be used by policymakers, decision-makers, advocates, and activists to advance issues affecting girls and women in global development. These materials are designed to be open-source and available for your use.

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ENDNOTES

1 "Tracking Universal Health Coverage: 2017 Global Monitoring Report." World Health Organization and the International Bank for Reconstruction and Development / the World Bank, 2017. Web. <http://documents.worldbank. org/curated/en/640121513095868125/pdf/122029-WP-REVISED-PUBLIC. pdf>.

2 Ibid.

3 "World health statistics 2018: monitoring health for the SDGs, sustainable development goals." World Health Organization, 2018. Web. <http://apps.who. int/iris/bitstream/handle/10665/272596/9789241565585-eng.pdf?ua=1>.

4 Knaul, Felicia Marie, et al. "Achieving Effective Universal Health Coverage and Diagonal Approaches to Care for Chronic Illnesses." *Health Affairs* 34.9 (2015): 1514-1522. Web. <http://content.healthaffairs.org/content/34/9/1514.abstract>.

5 "NONCOMMUNICABLE DISEASES: A PRIORITY FOR WOMEN'S HEALTH AND DEVELOPMENT." 2011. Web. <http://www.who.int/pmnch/topics/maternal/2011_women_ncd_report.pdf.pdf>.

6 E Kruk, Margaret , Anna D Gage, Naima T Joseph, Goodarz Danae, Sebastián García-Saisó and Joshua A Salomon. "Mortality due to low-quality health systems in the universal health coverage era: a systematic analysis of amenable deaths in 137 countries." The Lancet, Sep 2018. Web. <https://www. thelancet.com/action/showPdf?pii=S0140-6736%2818%2931668-4>.

7 "UNAIDS DATA 2017." UNAIDS 2017, 2017. Web. <http://www.unaids.org/ sites/default/files/media_asset/20170720_Data_book_2017_en.pdf>.

8 Singh, S, JE Darroch, and LS Ashford. "Adding It Up: The Costs and Benefits of Investing in Sexual and Reproductive Health 2014." New York: Guttmacher Institute, 2014. Web. <http://www.guttmacher.org/pubs/AddingItUp2014.pdf>.

9 Ibid.

10 "Global Accelerated Action for the Health of Adolescents (AA-HA!): guidance to support country implementation." World Health Organization, 2017. Web. <http://apps.who.int/iris/bitstream/handle /10665/255415/9789241512343-eng.pdf?sequence=1>.

11 "Maternal and child mental health." *Mental health.* World Health Organization , Web. <http://www.who.int/mental_health/maternal-child/en/>.

12 "Defining Sexual Health Report of a technical consultation on sexual health 28–31 January 2002." Geneva: World Health Organization, 2002. Web. <http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf>

13 Chapman, Daniel P., Geraldine S. Perry, and Tara W. Strine. "The Vital Link Between Chronic Disease and Depressive Disorders." *Prev Chronic Dis* 2.1 (2005). *Centers for Disease Control and Prevention*. Web. <https://www.cdc. gov/pcd/issues/2005/jan/04_0066.htm>.

14 "WHO global strategy on people-centred and integrated health services." Interim Report. Geneva: World Health Organization, 2015. Web.

15 *Framework on integrated, people-centred health services*. World Health Organization, Apr. 2016. Web. <http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf?ua=1>.

16 Ibid.

17 "Draft thirteenth general programme of work, 2019–2023." World Health Organization , 5 Apr 2018. Web. <http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf>.

18 Ibid.

19 Ibid.

20 "Universal Health Coverage Forum 2017 "Tokyo Declaration on Universal Health Coverage: All Together to Accelerate Progress towards UHC"." The World Bank, 2017. Web. <http://www.worldbank.org/en/news/statement/2017/12/14/uhc-forum-tokyo-declaration>.

21 Jamison, Dean T., et al. "Global health 2035: a world converging within a generation." *The Lancet* 382.9908 (2013): 1898–1955. Web. <http://www. thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext>.

22 "Scaling up action against noncommunicable diseases: how much will it cost?" Geneva: World Health Organization, 2011. Web. <http://apps.who. int/iris/bitstream/10665/44706/1/9789241502313_eng.pdf>.

23 "Tracking universal health coverage: first global monitoring report." Geneva: World Health Organization, 2015. Web. <http://apps.who.int/iris/bitstre am/10665/174536/1/9789241564977_eng.pdf?ua=1>.

24 "Draft thirteenth general programme of work, 2019–2023." World Health Organization , 5 Apr 2018. Web. <http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf>.

25 Jowett, Matthew, et al. *Spending targets for health: no magic number*. Working paper. World Health Organization, 2016. Web. <http://apps.who.int/iris/bitstream/10665/250048/1/WHO-HIS-HGF-HFWorkingPaper-16.1-eng. pdf?ua=1>.

26 Ibid.

27 Giedion, U., E. A. Alfonso, and Y. Díaz. "The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence." UNICO Studies Series No. 25. Washington: The World Bank, 2013. Web. <http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/14/000333037_20130214125444/Rendered/PDF/753260NWP0Box30ewofExistingEvidence.pdf>.

28 Kutzin, Joseph. "Anything goes on the path to universal health coverage? No." *Bulletin of the World Health Organization* 90.11 (2012): 867-868. Web. <http://www.who.int/bulletin/volumes/90/11/12-113654/en/>.

29 Lagomarsino, Gina. "Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia." *The Lancet* 380.9845 (2012): 933–943. Web. <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61147-7/fulltext>.

30 Evans, David B, Riku Elovainio, and Gary Humphreys. "Health systems financing: the path to universal coverage." The World Health Report. Geneva: World Health Organization, 2010. Web. <http://apps.who.int/iris/bitstre am/10665/44371/1/9789241564021_eng.pdf>.

31 Kutzin, Joseph. "Anything goes on the path to universal health coverage? No." *Bulletin of the World Health Organization* 90.11 (2012): 867-868. Web. <http://www.who.int/bulletin/volumes/90/11/12-113654/en/>.

32 Brearley, Lara, Robert Marten, and Thomas O'Connell. "Universal Health Coverage: A Commitment to Close the Gap." London: Rockefeller Foundation, Save the Children, UNICEF, and the World Health Organization, 2013. Web. <http://www.savethechildren.org.uk/sites/default/files/images/Universal_health_coverage.pdf>.

33 Evans, David B, Riku Elovainio, and Gary Humphreys. "Health systems financing: the path to universal coverage." The World Health Report. Geneva: World Health Organization, 2010. Web. <http://apps.who.int/iris/bitstre am/10665/44371/1/9789241564021_eng.pdf>.

34 Ravindran, TK Sundari. "Universal access: making health systems work for women." *BMC Public Health* 12 Suppl 1.S4 (2012). Web. <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-S1-S4>.

35 *Second Annual UHC Financing Forum Greater Efficiency for Better Health and Financial Protection: Background Paper (Forum Edition)*. World Bank, 20 Apr. 2017. Web. <http://pubdocs.worldbank.org/en/616561494511379987/UHC-Efficiency-Background-Paper-V10-170419-1100.pdf>.

36 Ibid.

37 Ibid.

38 Ibid.

39 Blas, Erik, et al. "Intersectoral planning for health and health equity." *Strategizing national health in the 21st century: a handbook*. By Gerard Schmets, et al. Geneva: World Health Organization, 2016. Web. <http://apps.who.int/iris/bitstream/10665/250221/3/9789241549745-chapter12-eng.pdf?ua=1>.

40 Giedion, U., E. A. Alfonso, and Y. Díaz. "The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence." UNICO Studies Series No. 25. Washington: The World Bank, 2013. Web. <http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/14/000333037_20130214125444/Rendered/PDF/753260NWP0Box30ewofExistingEvidence.pdf>.

41 Moreno-Serra, R. and P. C. Smith. "Does progress toward universal health coverage improve population health?" *The Lancet* 380.9845 (2012): 917-923. Web. <https://www.ucdmc.ucdavis.edu/iphi/Committees/MPAC/resources/UniversalHealthcareCoverageandPopulationHealth_Lancet_2012.pdf>.

42 "IPPF Calls for G7 leaders to prioritize the full range of sexual and reproductive health services in Universal Health Coverage." 2016. Web. <http://www.ippf.org/news/IPPF-calls-G7-leaders-prioritize-full-range-sexual-and-reproductive-health-care-services-Univer>.

43 McPake, B., et al. "Removing user fees: learning from international experience to support the process." *Health Policy Plan.* 26 Suppl 2 (2011): ii104-117. Web. <http://heapol.oxfordjournals.org/content/26/suppl_2/ii104.full>.

44 Witter, Sophie, et al. "The national free delivery and caesarean policy in Senegal: evaluating process and outcomes." *Health Policy Plan.* 25.5 (2010): 384-392. Web. <http://heapol.oxfordjournals.org/content/25/5/384.long>.

45 "Draft thirteenth general programme of work, 2019–2023." World Health Organization , 5 Apr 2018. Web. <http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf>.

46 Ibid.

47 Ibid.

48 Ibid.

49 *INDONESIA HEALTH FINANCING SYSTEM ASSESSMENT: SPEND MORE, RIGHT & BETTER*. Policy brief. World Bank, 28 Oct. 2016. Web. <http://pubdocs.worldbank.org/en/633911492102648134/112931-WP-Policy-Note-HFSA-Indonesia-Published.pdf>.

50 Ibid.

51 Ibid.

52 Ibid.

53 Ibid.

54 Ibid.

55 Ibid.

56 "People-centred care in low- and middle-income countries." Geneva: World Health Organization, 2010. Web. <http://www.personcenteredmedicine.org/doc/genevathree/geneva2011i.pdf>.

57 "Service delivery and safety." *World Health Organization*. n.d. Web. 21 Aug. 2017. <http://www.who.int/servicedeliverysafety/areas/people-centred-care/strategies/en/>.

58 "WHO Global Strategy on People-Centered and Integrated Health Services: Interim Report." World Health Organization. 2015. Web. <http://apps.who.int/iris/bitstream/10665/155002/1/WHO_HIS_SDS_2015.6_eng.pdf?ua=1&ua=1>.

59 Gounder, C. R. and R. E. Chaisson. "A diagonal approach to building primary healthcare systems in resource-limited settings: women-centred integration of HIV/AIDS, tuberculosis, malaria, MCH and NCD initiatives." *Tropical Medicine & International Health* 17.12 (2012): 1426–1431. Web. <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-3156.2012.03100.x/full>.

60 Azenha, Gustavo S, et al. "Recommendations towards an integrated, life-course approach to women's health in the post-2015 agenda." *Bull World Health Organ* 91 (2013): 704–706. Web. 22 Mar. 2016. <http://www.who.int/bulletin/volumes/91/9/BLT.13.117622.pdf>.

61 Winestone, Lena E., et al. "Acceptability and feasibility of integration of HIV care services into antenatal clinics in rural Kenya: A qualitative provider interview study." *Glob Public Health* 7.2 (2012): 149-163. Web. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3493571/>.

62 Ibid.

63 van den Akker, T., et al. "HIV care need not hamper maternity care: a descriptive analysis of integration of services in rural Malawi." *BJOG: An International Journal of Obstetrics & Gynaecology* 119.4 (2012): 431–438. Web. <http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2011.03229.x/full>.

64 Otiso, L, et al. "Decentralising and integrating HIV services in community-based health systems: a qualitative study of perceptions at macro, meso and micro levels of the health system." *BMJ Global Health* 2 (2017): e000107. Web. <http://gh.bmj.com/content/bmjgh/2/1/e000107.full.pdf>.

65 Wadge ,Hester et al. "How to harness the private sector for universal health coverage" *The Lancet*, 2017. Web. <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31718-X/fulltext>.

66 Ibid.

67 Wadge, Hester et al. "EVALUATING THE IMPACT OF PRIVATE PROVIDERS ON HEALTH AND HEALTH SYSTEMS." Imperial College London, 2017. Web. <https://www.imperial.ac.uk/media/imperial-college/institute-of-global-health-innovation/centre-for-health-policy/public/IMPJ5551-Health-Report-Update-Final-Web.pdf>.

68 "DREAMS IS COMMITTED TO REDUCING HIV AMONG ADOLESCENT GIRLS AND YOUNG WOMEN." *DREAMS Partnership*, DREAMS, Web. <www.dreamspartnership.org/aboutdreams/#what-we-do>.

69 Ibid.

70 "DREAMS innovation challenge: Innovating for an AIDS-free future for girls and women." 2016. Web. <http://www.pepfar.gov/documents/organization/247602.pdf>.

71 "DREAMS: Partnership to Reduce HIV/AIDS in Adolescent Girls and Young Women." *U.S. Agency for International Development*, USAID, 2018, <www.usaid.gov/what-we-do/global-health/hiv-and-aids/technical-areas/dreams>.

72 ECD. Costa Rica 2017. 2017, https://read.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-systems-costa-rica-2017_9789264281653-en#page3. Accessed 6 Aug 2018.

73 Ibid.

74 "Addis Ababa Declaration." Paper presented at the International Conference on Task Shifting. Geneva: World Health Organization, 2008. Web. <http://www.who.int/healthsystems/task_shifting/Addis_Declaration_EN.pdf?ua=1>.

75 "WHO recommendations: optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting." Geneva: World Health Organization, 2012. Web. <http://apps.who.int/iris/bitstream/10665/77764/1/9789241504843_eng.pdf>.

76 Lassi, Zohra, et al. "Quality of care provided by mid-level health workers: a systematic review and meta-analysis." *Bull World Health Organ* 91 (2013): 824–833I.

77 Joshi, R., et al. "Task Shifting for Non-Communicable Disease Management in Low and Middle Income Countries – A Systematic Review." *PLoS One* 9.8 (2014). Web. <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0103754>.

78 Jeet, Gursimer, et al. "Community health workers for non-communicable diseases prevention and control in developing countries: Evidence and implications." *PLOS One* (2017). Web. <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0180640>.

79 Jafar, Tazeen H., et al. "Community based lifestyle intervention for blood pressure reduction in children and young adults in developing country: cluster randomised controlled trial." *BMJ* 340 (2010). Web. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881949/>.

80 Neupane, D., et al. "Community health workers for non-communicable diseases." *The Lancet Global Health* 2.10 (2014). Web. <http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(14)70303-1/fulltext?rss=yes>.

81 Jeet, Gursimer, et al. "Community health workers for non-communicable diseases prevention and control in developing countries: Evidence and implications." *PLOS One* (2017). Web. <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0180640>.

82 "Delivering quality health services A global imperative for universal health coverage." World Health Organization, Organisation for Economic Co-operation and Development, and The World Bank, 2018. Web. <http://documents.worldbank.org/curated/en/482771530290792652/pdf/127816-REVISED-quality-joint-publication-July2018-Complete-vignettes-ebook-L.pdf>.

83 Ibid.

84 "FIVE-YEAR ACTION PLAN FOR HEALTH EMPLOYMENT AND INCLUSIVE ECONOMIC GROWTH (2017–2021)." World Health Organization , 2018. Web. <http://apps.who.int/iris/bitstream/handle/10665/272941/9789241514149-eng.pdf?ua=1>.

85 Ibid.

86 "Delivering quality health services A global imperative for universal health coverage." World Health Organization, Organisation for Economic Co-operation and Development, and The World Bank, 2018. Web. <http://documents.worldbank.org/curated/en/482771530290792652/pdf/127816-REVISED-quality-joint-publication-July2018-Complete-vignettes-ebook-L.pdf>.

87 "Human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth." Report by the Secretariat. World Health Organization , 15 May 1991. Web. <http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_18-en.pdf?ua=1>.

88 "FIVE-YEAR ACTION PLAN FOR HEALTH EMPLOYMENT AND INCLUSIVE ECONOMIC GROWTH (2017–2021)." World Health Organization , 2018. Web. <http://apps.who.int/iris/bitstream/handle/10665/272941/9789241514149-eng.pdf?ua=1>.

89 Ibid.

90 *Global strategy on human resources for health: Workforce 2030*. World Health

Organization, 2016. Web. <http://www.who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf>.

91 Roome, Edward, Joanna Raven, and Tim Martineau. "Human resource management in post-conflict health systems: review of research and knowledge gaps." *Confl Health* 8.18 (2014). 2 Oct. 2014. Web. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4187016/>.

92 "Human resources for health and implementation of the outcomes of the United Nations' High-Level Commission on Health Employment and Economic Growth." *I. High-Level Commission on Health Employment and Economic Growth.* World Health Organization , 2016. Web. <http://apps.who.int/iris/bitstream/handle/10665/250047/9789241511308-eng.pdf?sequence=1>.

93 "VIOLENCE ON THE FRONT LINE: Attacks on Health Care in 2017." SAFEGUARDING HEALTH IN CONFLICT. May 2018. Web. <https://reliefweb.int/sites/reliefweb.int/files/resources/SHCC2018final.pdf>.

94 *Global strategy on human resources for health: Workforce 2030*. World Health Organization, 2016. Web. <http://www.who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf>.

95 Ibid.

96 Roome, Edward, Joanna Raven, and Tim Martineau. "Human resource management in post-conflict health systems: review of research and knowledge gaps." *Confl Health* 8.18 (2014). 2 Oct. 2014. Web. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4187016/>.

97 Some D, Edwards JK, Reid T, Van den Bergh R, Kosgei RJ, Wilkinson E, et al. (2016) Task Shifting the Management of Non-Communicable Diseases to Nurses in Kibera, Kenya: Does It Work? PLoS ONE 11(1): e0145634. doi:10.1371/journal. pone.0145634

98 Ibid.

99 Jay, Jonathan et al. "Building from the HIV Response toward Universal Health Coverage". PLOS Medicine, vol 13, no. 8, 2016, p. e1002083. Public Library of Science (PLoS), doi:10.1371/journal.pmed.1002083.

100 Ibid.

101 Mate, Kedar S., et al. "Challenges for routine health system data management in a large public programme to prevent mother-to-child HIV transmission in South Africa." *PLoS One* 4.5 (2009). Web. <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0005483>.

102 Ibid.

103 Fraser, H. S. F. and J. Blaya. "Implementing medical information systems in developing countries, what works and what doesn't." *AMIA Annu Symp Proc.* (2010): 232–236. Web. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3041413/>.

104 *Electronic Health Records: Manual for Developing Countries*. Geneva: World Health Organization, 2006. Web. <http://www.wpro.who.int/publications/docs/EHRmanual.pdf>.

105 Lewis, Trevor, et al. "E-health in low- and middle-income countries: findings from the Center for Health Market Innovations." *Bulletin of the World Health Organization* 90 (2012): 332-340. Web. 23 Feb. 2016. <http://www.who.int/bulletin/volumes/90/5/11-099820/en/>.

106 Fraser, H. S. F. and J. Blaya. "Implementing medical information systems in developing countries, what works and what doesn't." *AMIA Annu Symp Proc.* (2010): 232–236. Web. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3041413/>.

107 Ibid.

108 "Essential medicines and basic health technologies for noncommunicable diseases: towards a set of actions to improve equitable access in Member States." WHO Discussion Paper. Geneva: World Health Organization, 2015. Web. <http://www.who.int/nmh/ncd-tools/targets/Final_medicines_and_technologies_02_07_2015.pdf>.

109 Evans, David B, Riku Elovainio, and Gary Humphreys. "Health systems financing: the path to universal coverage." The World Health Report. Geneva: World Health Organization, 2010. Web. <http://apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf>.

110 Ibid.

111 Ibid.

112 Ibid.

113 Jarvis, Jordan. "JORDAN JARVIS, THE LANCET YOUTH COMMISSION ON ESSENTIAL MEDICINES POLICIES." 29 Feb. 2016. Web. 22 Mar. 2016. <http://www.unsgaccessmeds.org/inbox/2016/2/29/0c87t0dtsq8u5k-6crci4ttc8d2sw7q>.

114 Evans, David B, Riku Elovainio, and Gary Humphreys. "Health systems financing: the path to universal coverage." The World Health Report. Geneva: World Health Organization, 2010. Web. <http://apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf>.

115 Wagner, A. K., J. P. Thompson, and D. Ross-Degnan. "Social Business Interventions to Improve Access to Medicines." Maryam Bigdeli, David Peters, and Anita Wagner. *AHPSR Flagship Report 2014 - Medicines in Health Systems: Advancing access, affordability and appropriate use*. Geneva: World Health Organization, 2014. Web. <http://www.who.int/alliance-hpsr/resources/FR_Ch5_Annex4.pdf>.

116 Ibid.

117 *The Interagency Emergency Health Kit 2011: Medicines and medical devices for 10 000 people for approximately three months*. World Health Organization, Dec. 2015. Web. <http://www.who.int/medicines/publications/emergencyhealthkit2011/en/>.

118 *The Interagency Emergency Health Kit 2011: Medicines and medical devices for 10 000 people for approximately three months*. World Health Organization, Dec. 2015. Web. <http://www.who.int/medicines/publications/emergencyhealthkit2011/en/>.

119 Foster, Angel M.et al. "THE 2018 INTER-AGENCY FIELD MANUAL ON REPRODUCTIVE HEALTH IN HUMANITARIAN SETTINGS: REVISING THE GLOBAL STANDARDS." Reproductive Health Matters2017; Vol. 25(51): 18-24, 2017. Web. <http://www.msh.org/sites/msh.org/files/foster_the_2018_inter_agency_field_manual_on_reproductive_health_in_humanitarian_settings.pdf>.

120 Ibid.

121 Ibid.

122 "What is the Minimum Initial Service Package?." UNFPA, Apr 2015. Web. <https://www.unfpa.org/resources/what-minimum-initial-service-package>.

123 Anita K, Wagner et al.. "Social Business Interventions to Improve Access to Medicines." *Medicines in Health Systems: Advancing access, affordability and appropriate use.* Department of Population Medicine, Harvard Medical School and Harvard Pilgrim Health Care Institute, Mar 2014. Web. <http://www.who.int/alliance-hpsr/resources/FR_Ch5_Annex4.pdf>.

124 Ibid.

125 "PREVENT HIV, TEST AND TREAT ALL: WHO SUPPORT FOR COUNTRY IMPACT." *PROGRESS REPORT 2016.* World Health Organization, 2016. Web. <http://apps.who.int/iris/bitstream/handle/10665/251713/WHO-HIV-2016.24-eng.pdf?sequence=1>.

126 Pérez, Jorge, et al.. "Approaches to the management of HIV/AIDS in Cuba : case study." World Health Organization, 2004. Web. <http://www.who.int/hiv/pub/prev_care/en/cuba.pdf>.

127 Ibid.

128 "PREVENT HIV, TEST AND TREAT ALL: WHO SUPPORT FOR COUNTRY IMPACT." *PROGRESS REPORT 2016.* World Health Organization, 2016. Web. <http://apps.who.int/iris/bitstream/handle/10665/251713/WHO-HIV-2016.24-eng.pdf?sequence=1>.

129 "GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013-2020." Geneva: World Health Organization, 2013. Web. <http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf>.

130 Hod, M et al. "The International Federation of Gynecology and Obstetrics (FIGO) Initiative on Gestational Diabetes Mellitus: A Pragmatic Guide for Diagnosis, Management, and Care." International Journal of Gynecology and Obstetrics. 131(3) 2015. Web. <http://www.ijgo.org/pb/assets/raw/Health%20Advance/journals/ijg/FIGO_Initiative_on_GDM.pdf>

131 Pryor, Laura , Marine Azevedo Da Silva and Maria Melchior. "Mental health and global strategies to reduce NCDs and premature mortality." *The Lancet Public Health*. Elsevier Ltd, 2017. Web. <https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30140-8.pdf>.

132 Ibid.

133 "GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013-2020." Geneva: World Health Organization, 2013. Web. <http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf>.

134 Fall, CH. "Fetal malnutrition and long-term outcomes." *Nestle Nutr Inst Workshop Ser.* 74 (2013): 11-25. Web. 22 Mar. 2016. <http://www.ncbi.nlm.nih.gov.ezproxy.cul.columbia.edu/pubmed/23887100>.

135 Fonjungo, Peter N., et al. "Access and Quality of HIV-Related Point-of-Care Diagnostic Testing in Global Health Programs." *Clin Infect Dis* 62.3 (2016): 369-374. Web. <https://www.ncbi.nlm.nih.gov/pubmed/26423384>.

136 Vojnov, L, et al. "POC CD4 Testing Improves Linkage to HIV Care and Timeliness of ART Initiation in a Public Health Approach: A Systematic Review and Meta-Analysis." *PLoS ONE* 11.5 (2016): e0155256.

137 Besançon, Stéphane, et al. "Diabetes in an emergency context: the Malian case study." *Conflict and Health* 9.15 (2015). *BioMed Central*. Web. <https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-015-0042-9>.

138 Ibid.

139 Ibid.

140 Ibid.

141 Jamison, Dean T., et al. "Global health 2035: a world converging within a generation." *The Lancet* 382.9908 (2013): 1898–1955. Web. <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext>.

142 "Global status report on noncommunicable diseases 2014." Geneva: World Health Organization, 2014. Web. <http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1>.

143 Jamison, Dean T., et al. "Global health 2035: a world converging within a generation." *The Lancet* 382.9908 (2013): 1898–1955. Web. <http://www.

thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext>.

144 "Scaling up action against noncommunicable diseases: how much will it cost?" Geneva: World Health Organization, 2011. Web. <http://apps.who.int/iris/bitstream/10665/44706/1/9789241502313_eng.pdf>.

145 Chaloupka, F., A. Yurekli, and G. Fong. "Tobacco taxes as a tobacco control strategy." *Tob Control* 21 (2012): 172-180. Web. <http://tobaccocontrol.bmj.com/content/21/2/172.full>.

146 "Scaling up action against noncommunicable diseases: how much will it cost?" Geneva: World Health Organization, 2011. Web. <http://apps.who.int/iris/bitstream/10665/44706/1/9789241502313_eng.pdf>.

147 Chaloupka, F., A. Yurekli, and G. Fong. "Tobacco taxes as a tobacco control strategy." *Tob Control* 21 (2012): 172-180. Web. <http://tobaccocontrol.bmj.com/content/21/2/172.full>.

148 "Scaling up action against noncommunicable diseases: how much will it cost?" Geneva: World Health Organization, 2011. Web. <http://apps.who.int/iris/bitstream/10665/44706/1/9789241502313_eng.pdf>.

149 Escobar, Maria A Cabrera, et al. "Evidence that a tax on sugar sweetened beverages reduces the obesity rate: a meta-analysis." *BMC Public Health* 13 (2013). Web. <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1072>.

150 "Assessing national capacity for the prevention and control of noncommunicable diseases." Report of the 2015 Global Survey. Geneva: World Health Organization, 2014. Web. <http://apps.who.int/iris/bitstream/handle/10665/246223/9789241565363-eng.pdf?sequence=1 >.

151 "Women's Activities in the Food Chain; Influence on Family Nutrition. United Nations. Web. <http://www.unsystem.org/scn/archives/npp04/ch10.htm>

152 "About Accredited Social Health Activist (ASHA)." 2 Sep. 2014. Web. <http://nrhm.gov.in/communitisation/asha/about-asha.html>.

153 Ibid.

154 "UN Commission: New investments in global health workforce will create jobs and drive economic growth." *World Health Organization*. 20 Sep. 2016. Web. <http://www.who.int/mediacentre/news/releases/2016/global-health-workforce/en/>.

155 "From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries." Geneva: World Health Organization and World Economic Forum, 2011. Web. <http://apps.who.int/medicinedocs/documents/s18804en/s18804en.pdf>.

156 Stenberg, Karin, et al. "Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries." *The Lancet Global Health* 5.9 (2017): E875-887. 17 Jul. 2017. Web. <http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30263-2/fulltext>.

157 Ibid.

158 Lamptey, P., et al. *Discussion paper on how to promote the inclusion of the prevention and control of noncommunicable diseases within other programmatic areas*. WHO GCM/NCD Working Group 3.1. 2016.

159 *Global strategy on human resources for health: Workforce 2030*. World Health Organization, 2016. Web. <http://www.who.int/hrh/resources/global_strategy_workforce2030_14_print.pdf>.

160 Goldie, Sue J. and Steven Sweet. "Global Cervical Cancer Prevention: Health and Economic Benefits of HPV Vaccination and Screening." Summary of Prior Work. Boston: Harvard School of Public Health, 2013. Web. <http://globalhealth2035.org/sites/default/files/working-papers/summary-1-cervical-cancer-prevention-cih.pdf>.

161 Ibid.

162 *Understanding Fast-Track: Accelerating Action to End the AIDS Epidemic by 2030*. UNAIDS, Jun. 2015. Web. <http://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf>.

163 "MILES TO GO CLOSING GAPS BREAKING BARRIERS RIGHTING INJUSTICES." UNAIDS, 2018. Web. <http://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf>.

164 "From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries." Geneva: World Health Organization and World Economic Forum, 2011. Web. <http://apps.who.int/medicinedocs/documents/s18804en/s18804en.pdf>.

165 Ibid.