VOLUME 1

DISEASE CONTROL PRIORITIES • FOURTH EDITION

Country-Led Priority Setting for Health

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DISEASE CONTROL PRIORITIES • FOURTH EDITION

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Disease Control Priorities

This fourth edition of *Disease Control Priorities (DCP4)* builds on the first three editions, all published by the World Bank. Using experiences from collaboration and capacity strengthening in a select number of low- and middle-income countries, *DCP4* summarizes, produces, and helps translate economic evidence into better priority setting for universal health coverage, public health functions, pandemic preparedness and response, and intersectoral and international action for health. *DCP4* aims to be relevant for countries committed to increasing public financing of universal health coverage and other health-improving policies, recognizing the need to set priorities on their path toward achieving the Sustainable Development Goals and beyond. The project is a collaboration between the World Bank and the University of Bergen, Norway, to develop and co-publish *DCP4* in four volumes with broad inputs from individuals and institutions around the world. These plans will likely evolve in the course of the work.

More people live longer and have better lives today compared to any other time in history. The world's population is aging at dramatic speed. Improved living standards and new technologies are driving this change. However, we live in times of increased risks. No country can afford all technologies that are effective at improving health and well-being—and progress is unequal. The COVID-19 (coronavirus) pandemic has emphasized the vulnerability of countries when a threatening new infection affects life, the health system, work, and the economy. Climate change is another major challenge. Those already worse off are especially affected, both by direct and indirect effects on the health system, the economy, and the environment. During times of crisis, health care providers and policy makers must decide whom to prioritize and which programs to protect, expand, contract, or terminate.

These challenges are not unique to pandemics and climate change. Resource allocation decisions under scarcity are always being made, creating winners and losers when compared to the status quo. Such decisions may exacerbate or ameliorate existing inequities, which are often substantial. These risks are not the only reminders of the importance and urgency of priority setting in global health;

in many low-income countries, the unfinished agenda with respect to infections and maternal and child mortality competes with increasing needs to prevent and treat chronic conditions such as cardiovascular diseases, cancer, and mental health. How should countries prioritize among infectious diseases, maternal and child health programs, and prevention of noncommunicable diseases? How should a health ministry define essential health benefit packages to be financed under universal health coverage reforms? Priority setting is key, and we now have the experience and the tools needed to improve and implement decision-making support for more efficient and fair resource allocation on the path toward better health and well-being for all.

Disease Control Priorities provides a periodic review of the most up-to-date evidence on cost-effective and equitable interventions to address the burden of disease in low-resource settings. *DCP3* included nine volumes laying out a total of 21 essential intervention packages that contained 218 unique health sector interventions and 71 intersectoral policies. Each essential package addressed the concerns of a major professional community and contained a mix of intersectoral policies and health sector interventions. Since then, several countries have used this evidence and translated it into revised health system priorities. In many countries, experts from the World Health Organization and the World Bank have been substantially involved. Key results have been published in a series of high-impact journal articles. *DCP3* relied primarily on cost-effectiveness analysis to evaluate interventions, using benefit-cost analysis in some cases to address the overall impacts on social welfare. It also introduced a new and extended cost-effectiveness analysis method to account for the equity and financial protection impacts of extending coverage of proven effective interventions. *DCP4* builds on these methods but differs substantially from its predecessors by adopting a country-led approach to priority setting.

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Foreword by Justice Nonvignon

Growing up in a rural area near Accra, I often heard stories of neighbors dying of malaria, leading me to believe that there was little we could do to lessen the impact of poverty-related diseases like malaria, except for praying. During that period, many families strived to secure basic health services, which were not readily accessible, so that their children could thrive, live longer, and be happy. They did everything to save their children, often sacrificing their meager household resources and other basic needs. Even at such a young age, I understood that resources were limited or not available in the quantities we would expect. The daily reminder came when we would make many demands of our parents, and they would often remind us that they did not have the resources to meet all our demands, despite their best efforts to address our most pressing needs. They tried to inform us and, if possible, convince us of the challenges.

Just as children rely on their parents to allocate limited resources among their limitless wants and needs, the public expects decision-makers to distribute resources in an equitable, fair, and transparent manner. But, in practice, how do decision-makers—at national and subnational levels—decide for which needs to channel the limited resources first, and how, at any given time? Most of the time, the decision is based on individuals' or small groups' opinions and recommendations and happens implicitly for various understandable reasons, such as a large disparity between needs and available resources; a fear of accountability; limited system capacity; and a lack of contextualized framework, evidence, and tools to guide priority-setting decisions.

Low- and middle-income countries face ever-increasing health needs without much increment in the pot of funding. For instance, the growing burden of noncommunicable diseases further strains the already stretched health system. The priority-setting challenges also affect existing prioritized programs. For example, the growing number of vaccines available to countries (with malaria and HPV vaccines

lately joining the introduction train in many African countries) raises the hope of delivering better health to the population, but it also means decision-makers face the dilemma of deciding where to cut off to introduce these newer and more expensive vaccines. Such vaccine introductions have a high risk of crowding out other equally important health services or investments. These considerations are a day-to-day dilemma for decision-makers, especially in low- and middle-income country settings.

There is growing interest and effort in many countries to introduce and strengthen priority-setting systems to systematically address such dilemmas and improve efficiency, fairness, and transparency. One of the cross-cutting challenges reported by the majority of African Union Member States is capacity issues, such as a lack of contextualized frameworks, data and evidence, analytic tools, and trained human resources—and many countries frequently request technical support.

Recognizing this issue as a major challenge to the scale-up of priority setting in Africa, the Africa Centres for Disease Control and Prevention began an effort in 2022 to develop a harmonized continental framework for evidence-informed priority setting, as well as options to support African Union Member States in its implementation. In addition, a guidance document on how to contextualize priority setting for public health emergency preparedness and response was developed. These two efforts led to interactions with experts and policy makers from ministries of health and finance and quasi-health sectors in 44 of 55 countries over a period of 18 months. The interactions (in the form of interviews, in-person workshops, and consultative sessions) led to the development, validation, and launch of a continental framework for priority setting for Africa, as well as two guidance documents on institutionalizing evidence-informed priority setting more broadly and in the context of epidemic preparedness and responses. Thus, Africa has taken steps to develop contextually relevant evidence-informed priority setting, which will guide implementation across countries, and harmonize partner support for countries. Such implementation, guided by country experiences in the region, is crucial to ensuring that priority setting does not, indeed, become only an academic exercise.

The development of the continental framework has benefited from earlier work by the International Decision Support Initiative, the Disease Control Priorities Project, the World Health Organization's WHO-CHOICE, and others. This volume, *Country-Led Priority Setting for Health*—which covers the overall lessons in defining and implementing universal health coverage benefits packages and country-specific lessons synthesized from the experiences of many countries—could greatly contribute to facilitating learning across countries. Such experiences remind us that a one-size-fits-all approach to priority setting does not solve problems; it rather compounds them. Although it is helpful to use lessons from one context for another,

it is more important to not simply pluck and plant but to ensure that country context plays a key role in designing or redesigning solutions.

Whether it relates to developing or revising health benefits packages or informing introduction or scaling-up decisions, priority setting should focus not only on the decision-making process but also on the postdecision implementation period and eventually the health outcomes affected by the decision. Thus, countries should ensure that their prioritized essential lists of health services can be implemented and should commit to addressing the health system constraints and regularly monitor progress and adjust along the way.

In the current discourse of global health, it is common to limit the role of priority setting to country decision-making. However, priority setting is essential also for regional and global decision-making, including decision-making by development partners within and across countries. Priority setting should not be limited to government decision-making alone. For example, in global health financing, how do we apply the concept of priority setting to determine what, when, and how global health institutions (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria; Gavi, The Vaccine Alliance; and the Pandemic Fund) decide on allocating scarce resources to critical health interventions? Are these decisions informed by a systematic, transparent priority-setting process? Assessing the processes for priority setting is critical, as is assessing the impact of priority setting on health outcomes.

The collaborations and learning with researchers and policy makers among countries demonstrated by the various chapters presented in this volume are commendable, and I believe this will enhance the relevance and impact of the lessons learned.

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Foreword by Juan Pablo Uribe

The world is facing an era marked by complex and overlapping challenges. At the country level, health systems face new threats—shrinking fiscal space for health, changes in disease burdens, and climate change and fragility and demographic shifts—that significantly impact access to quality, affordable health services for all. However, such complexities also bring unique opportunities to rethink, innovate, and chart a course that leads us closer to achieving universal health coverage (UHC). This pursuit, grounded not in naive optimism but in an unwavering commitment to evidence and pragmatism, is what shapes the spirit of the fourth edition of the *Disease Control Priorities Project (DCP4)*.

The journey that began over three decades ago with the 1993 World Bank report *Investing in Health*—a pivotal work that effectively became the first edition of *DCP*—laid the groundwork for using economic evaluation to inform health priority setting and the creation of cost-effective health benefits packages. This first edition provided the impetus for reimagining health investments as a vehicle for economic growth and equity, particularly in low- and middle-income countries. Since then, subsequent editions of *DCP* have progressively expanded both the scope and depth of evidence, widening our understanding of prioritizing diseases, interventions, and health system strategies.

As we launch Volume 1 of *DCP4,* which is dedicated to country- and economy-led priority setting, we recognize the profound advancements that have emerged over the past 30 years. *DCP4* is uniquely positioned to serve as a critical reference for implementing country- and economy-driven, locally tailored strategies to improve health outcomes. The emphasis in this volume uniquely lies in real-world case studies where countries have successfully adopted priority-setting practices.

The fourth edition is timely, as it responds to growing questions about the so-called "know-do gap." There is a recognized need for faster dissemination of knowledge and more streamlined paths to implementation. By focusing on concrete country and economy experiences, this volume highlights actionable strategies for integrating priority setting into national health agendas. This is in line with the World Bank country-led model and its approach to knowledge, along with the strong focus on country leadership and ownership of the Global Financing Facility for Women, Children and Adolescents (GFF).

The work presented in *DCP4* also underscores the value of a systemwide approach. As countries and economies seek to achieve UHC, they are increasingly learning from the successes and limitations of single-disease, vertical programs that were initially funded through off-budget grant financing. The integration of these vertical programs into broader primary health care systems offers lessons in building sustainable systems that deliver essential high-quality services that are accessible to all. These efforts, when aligned with deliberate design of health benefit packages, remain a promising pathway to UHC.

In sum: this volume is more than an academic compendium. It is a guide for policy makers, health professionals, and advocates dedicated to creating sustainable and impactful change. With strong political and technical leadership at the country level, and by leveraging critical knowledge, we can work together to create a world where every health need is met.

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Foreword by Dr. Bruce Aylward

Fundamental to the Sustainable Development Goal agenda is the achievement of universal health coverage (UHC), part of Sustainable Development Goal 3, by 2030. That goal requires ensuring that all people, everywhere, can receive quality health services, when and where needed, without incurring financial hardship. Since 2000, many low-income countries and lower-middle-income countries have made substantial improvements in their coverage of essential services, although out-of-pocket expenditure has risen at the same time (WHO and World Bank 2023).

With just over five years remaining to 2030, the world remains off track to achieve UHC. The proportion of the global population not covered by essential health services has stagnated, and impoverishment due to ill health is increasing (WHO and World Bank 2023). Ensuring adequate health financing is critical to reverse this trend and to protect populations from high levels of out-of-pocket expenditure and from having to make the difficult choice between poverty and health. Unfortunately, providing an essential package of high-quality health services remains unaffordable for many countries within current levels of health expenditure (Hailu et al. 2021; Stenberg et al. 2019). Globally, the challenges of increasing health needs, together with new technological development and aging populations, are placing considerable financial pressure on the health sector.

Financing UHC is increasingly challenging. Many countries are grappling with a lack of access to concessional financing to invest in health service expansion, managing aid volatility, and navigating competing needs to adapt to the changing climate and prepare for future pandemics, while maintaining essential health services. Ensuring that any financing available is spent well is a critical health policy challenge globally. Against this backdrop, there are early signs of reductions in public spending on health: since 2021, health spending has reduced in several countries where data are available (WHO 2023).

Disease Control Priorities (DCP) has a long track record as a global public good informing decision-makers as they define essential packages of health services. This fourth edition of DCP *(DCP4)* includes a welcome and timely shift to supporting country-level processes using DCP and other evidence, and the implementation of packages. *DCP4*'s Volume 1 presents an impressive compendium of country-led actions over recent years to ensure health sector resources are spent well. This is no easy task—it requires locally relevant evidence on what works, an understanding of value for money, and institutionalizing structures for stakeholders and social participation. At the World Health Organization, we are pleased to have contributed to this effort, working with countries, organizing our clinical guidance to align with priority setting, producing global evidence on costs and cost-effectiveness, and providing guidance on effective ways to institutionalize priority setting.

DCP4 demonstrates that, even in the most resource-constrained settings, countries have been able to successfully define their pathway to UHC. Achieving UHC will require implementation of these priorities—as well as links with health financing and delivery systems—to ensure impact on the ground. We look forward to our continued partnership with DCP, working together to accelerate progress toward UHC.

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Main Messages from Volume 1

This volume presents and critically discusses how selected low- and middle-income countries have translated available evidence into priority setting and the processes they have followed in designing and implementing essential health service packages within the framework of universal health coverage (UHC). Many countries are implementing reforms to move them closer to UHC, with an essential package of health services (EPHS) serving as one of the key policy tools for achieving this goal. EPHSs define which services are covered in the context of limited resources, the proportion of health care costs financed through various schemes, and who is eligible to receive these services. Drawing cross-cutting lessons from the country experiences detailed in this volume and from an in-depth evaluation of selected programmatic areas (modules), such as school health and nutrition, essential surgery, and essential noncommunicable diseases, we highlight 12 main conclusions.

1. Substantial improvement has been observed in laying foundational work for EPHS design.

Significant improvement has been observed compared to earlier efforts in terms of laying the foundational work for evidence-informed priority setting, such as stakeholder engagement; evidence synthesis; EPHS design processes and institutional capacity building, particularly in evidence generation and synthesis; economic analysis; and decision-making.

However, experience in various countries has also identified significant weaknesses in the design and implementation of UHC packages, including issues related to feasibility, affordability, alignment with service delivery, financing, and health system readiness. These weaknesses can impede meaningful progress.

2. High-level leadership is essential for ensuring the success of an EPHS revision and its implementation.

A fundamental lesson learned is that the design and revision of an EPHS must be led and owned by the respective country's high-level leadership. Packages developed without sufficient involvement from national authorities are less likely to lead to successful implementation. Achieving success requires sustained high-level political commitment, active involvement of key stakeholders, health system preparedness, affordability, secured funding, and strong leadership for implementation. Government leadership is therefore essential, and early engagement of the planning and finance actors (and subnational authorities in decentralized systems) is crucial for success.

3. Open and inclusive decision-making processes are needed.

Our review of decision-making processes finds that countries generally follow a stepwise process for EPHS revision, though the implementation of specific steps varies. Fair process is promoted through stakeholder involvement but does not always include patient and community representatives. Key recommendations for countries include ensuring meaningful early key stakeholder engagement and enhancing transparency in the decision-making process, both of which are crucial for fairness. Additionally, countries should continue to take steps toward institutionalizing their EPHS revision process to support regular revision and sustainability.

4. Despite improved evidence and thorough policy processes, there is lack of implementation.

EPHSs have an impact only when they are implemented, yet a significant implementation gap remains in many countries. The failure to incorporate delivery considerations already at the prioritization and design stage can result in packages that undermine the goals countries have for service delivery. Furthermore, developing a health service package without considering health system constraints, such as well-trained human resources, infrastructure, and financing, undermines its potential value.

Critical translational work is needed to move from criteria-driven formulations to packages designed to support implementation. Package design elements that can strengthen implementation include the use of a common taxonomy of interventions, entries expressed as services rather than diseases, specification of local delivery platforms with assignment of services to platforms, and visualizing the link to burden of disease.

To ensure sustainability, countries need to develop affordable and feasible EPHSs, along with implementation plans that address health system constraints.

5. There is a weak link between priority setting, financing, and budgets.

The link between EPHS design and health financing mechanisms is weak. Our review of country experiences found that using EPHSs to directly leverage funds for health has rarely been effective. Furthermore, empirical evidence is limited regarding the role of EPHSs in mobilizing resources. This inability to mobilize resources may be due to a lack of strategic and solid high-level government leadership and poor alignment to financing mechanisms throughout the design process. Improved dialogue between health policy makers, public finance authorities, and higher-level political leaders, such as the president's or prime minister's office, can help link additional public spending to progress on UHC indicators.

EPHS development has been more successful in facilitating resource pooling across different financing schemes. It aids in assessing the performance of coverage schemes, which can lead to a harmonization of UHC interventions and identification of gaps between financing and service delivery. Developing and revising EPHSs is also crucial for strategic purchasing as countries build health technology assessment capacity.

High-level political leaders' and public finance authorities' commitment is critical to link EPHSs to raising new revenue. Furthermore, the design of EPHSs should be based on realistic projections of fiscal space for health and must be aligned with purchasing arrangements and public financing management systems.

6. Countries may benefit from using standardized methods and tools while localizing economic evidence.

For the analytical methods and tools used for UHC health benefit package design, we find that countries have used cost-effectiveness evidence as a core criterion for EPHS design. Yet most countries rely on published cost-effectiveness studies from other settings, despite the known limitations of this approach. Additionally, EPHS costing exercises have usually been done by international consultants rather than by local health economists, and the costing has not been linked to budgeting or financing arrangements, hindering its implementation. We identify two needs relating to EPHS analysis. First, the methods have varied widely across country projects, so analysts would benefit from international guidance, including on how to do an EPHS costing exercise, and how to extrapolate cost-effectiveness evidence from the literature when local data are lacking. Improvements in tools like the Integrated Health Tool and DCP FairChoices Analytics Tool could also help bridge these gaps. Second, development partners need to invest more in local analytical capacity, including both formal training programs to increase the number of local health economists and short courses for practitioners already working in government. Addressing these needs is essential to ensuring that the EPHS is locally owned and led.

7. The role of the private sector has been ignored.

The role of the private sector in delivering EPHSs has largely been ignored. The private sector—although a major provider of health services in many low- and middle-income countries—frequently operates on self-guided and market-oriented objectives and does not align with public sector goals, including UHC. In health systems where the private health sector provides a major part of essential health services, implementing EPHSs without involving the private sector is unrealistic. Despite growing guidance on developing UHC packages of health services, the role of the private sector in implementing these packages is generally missing. Addressing this gap is critical for the transition from package design to effective implementation. Governments need to address key barriers related to governance, regulation, accountability, and quality of services, guided by existing evidence and international experience.

8. A comprehensive monitoring and evaluation plan should be an integral part of EPHS design and implementation.

Monitoring and evaluation plans for EPHS implementation should be integrated into the UHC policy process from the very beginning. The EPHS monitoring and evaluation process, although focused narrowly on the implementation of EPHSs themselves, should align with the global monitoring framework for UHC and the Sustainable Development Goals indicators on service coverage and catastrophic expenditures. Evaluation activities should focus on changes in service coverage and financing of high-priority health services that can serve as "tracer measures."

9. Although a remarkable neglect of research on school-age children ages 5–14 years persists, a transformation has started.

Global interest in school-based health and nutrition interventions to promote cognitive skills and education outcomes has grown since the World Bank's *World Development Report 1993: Investing in Health* and throughout the *Disease Control Priorities* (*DCP*) series. Countries have increasingly recognized this area as an investment in human capital, with momentum accelerated by two major social shocks: the 2008 food, fuel, and financial crisis that initiated a global recession and the 2020 COVID-19 pandemic.

Health and education and well-being and learning all benefit if they work together. Substantial evidence now shows that investment in the whole 8,000-day period of development is a necessary contribution to the creation of human capital. Investment after the first 1,000 days (the next 7,000 days of life) offers returns not only to health and education but also to many other important sectors. Evidence increasingly supports the relevance and effectiveness of the school health package proposed in *DCP3* and encourages the inclusion of additional components. Coverage of programs worldwide has seen sustained increases, with even greater momentum spurred by the COVID-19 pandemic.

10. Access to essential surgery remains low in low- and middle-income countries.

Regarding essential surgery, DCP finds that country commitment to increasing availability of essential surgery remains low in developing countries despite the compelling investment case presented in earlier DCP publications and the Lancet Commission on Global Surgery. Experts involved in programs to advance surgical care in low- and middle-income countries point to the need to use language that policy makers can better understand and to partner with in-country organizations and champions in disseminating findings. Greater dissemination of the information in *DCP3 Essential Surgery* to several audiences (for example, policy makers, academics, and professional communities) also is needed.

11. Expanding noncommunicable disease interventions in low- and middle-income countries is a major challenge.

To respond to demographic and epidemiological changes, countries need to expand programs and services to include more noncommunicable disease (NCD) interventions. Previous editions of DCP have been influential in the international NCD discourse and in specific country projects. However, much more needs to be done on NCDs, and these DCP country collaborations have given us crucial insights into the gaps in the existing evidence. For example, DCP has been effective at identifying and promoting a handful of "best buys," but these have covered a relatively small number of specific NCD conditions, and countries also benefit from guidance on the "worst buys." Digital tools to support priority setting for NCDs have shown promise, and we can learn from these experiences as we continue to develop the DCP FairChoices Analytics Tool. Because many of the specific actions on NCDs take place outside the health sector, it will also be important to consider intersectoral interventions (for example, tobacco taxes) and to engage other stakeholders within government (for example, finance ministries). It is also important to engage nongovernment stakeholders, including civil society organizations, persons with lived experience, and local researchers. Fostering durable multisector coalitions can help ensure that political commitment to NCDs translates into financial commitment, implementation, and impact.

12. New tools and platforms are becoming available for sharing evidence.

The scientific and technical community is clearly moving more into the digital and online space with each passing year. Printed books and Excel spreadsheets have extremely limited use in the setting of rapid growth in research and evidence in low- and middle-income countries. The DCP4 team will use alternative ways to disseminate findings by producing continuously updated online content and open-access online analytical tools that can incorporate local data.

Abbreviations

AB-HWC	Ayushman Bharat Health and Wellness Center (India)
ACEi	angiotensin-converting enzyme inhibitors
ASHA	Accredited Social Health Activist (India)
BCEPS	Bergen Center for Ethics and Priority Setting
BHCPF	Basic Health Care Provision Fund (Nigeria)
BMPHS	Basic Minimum Package of Health Services (Nigeria)
BPHS	Basic Package of Health Services (Afghanistan)
BRICS	Brazil, Russian Federation, India, China, and South Africa
CABCT	Comisión Asesora de Beneficios, Costos y Tarifas (Colombia)
CAUSES	Catálogo Universal de Intervenciones Esenciales en Salud (Mexico)
CEA	cost-effectiveness analysis
CHE	current health expenditure
CHSI	Costing of Health Services in India
CI	confidence interval
CNSSS	National Social Security Council in Health (Colombia)
CPHC	comprehensive primary health care
CR	contributory regime
CRES	Health Regulation Commission, or Comisión de Regulación en Salud (Colombia)
CSO	civil society organization
DALY	disability-adjusted life year
DCP	*Disease Control Priorities*
DCP1	*Disease Control Priorities,* first edition
DCP2	*Disease Control Priorities*, second edition
DCP3	*Disease Control Priorities*, third edition
DCP4	*Disease Control Priorities,* fourth edition
DHIS2	District Health Information System 2
DRBCTAS	Dirección de Regulación de Beneficios, Costos y Tarifas del Aseguramiento en Salud (Colombia)
DTP	diphtheria, tetanus, pertussis

ECD	early childhood development
EHCP	essential health care package (Zanzibar)
EHP	Essential Health Package (Malawi)
EHP-TWG	EHP Technical Working Group (Malawi)
EMRO	Eastern Mediterranean Regional Office (of World Health Organization)
EPHS	essential package of health services
EUHC	essential universal health coverage
FAO	Food and Agriculture Organization of the United Nations
FMoH	Federal Ministry of Health (Nigeria, Sudan)
FPGC	Catastrophic Spending Protection Fund, or Fondo de Protección para Gastos Catastróficos (Colombia)
FPP	Family Physician Program (Islamic Republic of Iran)
FRP	financial risk protection
FSSHIP	Formal Sector Social Insurance Programme (Nigeria)
GBD	Global Burden of Disease
GCEA	generalized cost-effectiveness analysis
GDP	gross domestic product
GFF	Global Financing Facility for Women, Children and Adolescents
GGHE	general government health expenditure
GHPs	General Health Policies (Islamic Republic of Iran)
GP	general practitioner
GPE	Global Partnership for Education
HBP	Health Benefits Package (Nigeria)
HCI	Human Capital Index
HIPtool	Health Interventions Prioritization tool
HMIS	health management information system
HPV	human papillomavirus
HRC	Healthcare Reform Committee (Nigeria)
HSSP	Health Sector Strategic Plan (Malawi)
HTA	Health Technology Assessment (Islamic Republic of Iran)
HTP	Health Transformation Plan (Colombia, Islamic Republic of Iran)
IETS	Instituto de Evaluación Tecnológica en Salud (Colombia)
IMSS	Mexican Institute of Social Security, or Instituto Mexicano del Seguro Social
INSABI	National Institute of Health for Well-Being, or Instituto de Salud para el Bienestar (Colombia)
INVIMO	Instituto Nacional de Vigilancia de Medicamentos y Alimentos (Colombia)
IPEHS	Integrated Package of Essential Health Services (Afghanistan)
kg	kilogram
km	kilometer
LAYS	learning-adjusted years of schooling
LiST	Lives Saved Tool
LMICs	low- and middle-income countries
LNC	Lancet Nigeria Commission

M&E	monitoring and evaluation
MIPRES	Mi Prescripción
MoF	Ministry of Finance
MoH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare (India)
MoHME	Ministry of Health and Medical Education (Islamic Republic of Iran)
MoHSP	Ministry of Health and Social Protection (Colombia)
MoNHSR&C	Ministry of National Health Services, Regulations & Coordination (Pakistan)
MoPH	Ministry of Public Health (Afghanistan)
NCD	noncommunicable disease
NCDI	noncommunicable diseases and injuries
NGO	nongovernmental organization
NHA	National Health Authority (India)
NHIA	National Health Insurance Authority (Nigeria)
NHIF	National Health Insurance Fund (Sudan)
NHIS	National Health Insurance Scheme (Nigeria)
NHM	National Health Mission (India)
NHP	National Health Policy (India)
NHV	Natonal Health Vision (Pakistan)
NITI Aayog	National Institution for Transforming India
NPHCDA	National Primary Healthcare Development Agency (Nigeria)
NSHDP	National Strategic Health Development Plan (Nigeria)
NSOAP	national surgical, obstetric, and anesthesia plans
NTD	neglected tropical disease
OHT	OneHealth Tool
OOP	out of pocket
ORS	oral rehydration solution
PAC	Program for Extension of Coverage, or Programa de Ampliación de Cobertura (Mexico)
PHC	primary health care
PHS	private health sector
PM-JAY	Pradhan Mantri Jan Arogya Yojana (India)
POS	Mandatory Health Plan, or Plan Obligatorio de Salud (Colombia)
POS-S	Mandatory Health Plan–Subsidized, or Plan Obligatorio de Salud–Subsidiado (Colombia)
PPP	public-private partnership
RAF	Resource Allocation Formula (Malawi)
RE-AIM	Reach, Effectiveness, Adoption, Implementation, and Maintenance (framework)
REDCap	Research Electronic Data Capture
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
RMNCH	reproductive, maternal, newborn, and child health
SABER	Systems Approach for Better Education Result

SaLTS	Saving Lives through Safe Surgery
SCHI	Supreme Council of Health Insurance (Islamic Republic of Iran)
SCI	service coverage index
SDG	Sustainable Development Goal
SHA	state health agency (India)
SHI	social health insurance
SORMAS	Surveillance Outbreak Response Management and Analysis System
SP	Seguro Popular (Mexico)
SPDI	Service Planning, Delivery, and Implementation
SR	subsidized regime
SSA	Sub-Saharan Africa
STI	sexually transmitted infection
TaRL	Teaching at the Right Level
TB	tuberculosis
TD	tetanus-diphtheria
THE	total health expenditure
TWG	Technical Working Group
UHC	universal health coverage
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UPC	Unidad de Pago por Capitación (Colombia)
USAID	United States Agency for International Development
VIA	visual inspection with acetic acid
WFP	World Food Programme
WHO	World Health Organization
WHO-CHOICE	World Health Organization Choosing Interventions That Are Cost-Effective
ZEHCP	Zanzibar essential health care package