GLOBAL STRATEGY FOR INTEGRATED EMERGENCY, CRITICAL AND OPERATIVE CARE, 2026–2035

DRAFT 2: For Member State review

BACKGROUND

1. Emergency, critical and operative care (ECO) represents a continuum of interrelated health services at the foundation of a health system's ability to meet people's needs across the life course and to respond effectively to public health emergencies. While these services are overlapping and interdependent, their planning and management is fragmented in many contexts, resulting in costly inefficiency, delayed care and avoidable loss of life. Recognizing this, in 2023 the World Health Assembly adopted resolution WHA76.2 on *Integrated emergency, critical and operative care for universal health coverage and protection from health emergencies*. In 2024 through decision WHA 77(8), the Assembly requested the WHO Secretariat to develop a global strategy for integrated ECO to support the implementation of resolution WHA76.2 for the period 2026–2035, and to translate the global strategy into a global action plan with targets to be achieved by 2035.

2. Integrated ECO is a strategic approach to planning and coordinating the continuum of ECO services – including associated rehabilitative and palliative interventions – to meet people's needs across the life course. Effective ECO implementation requires integration across levels of the health system, across disease- or population-specific programmes and across sectors.

3. ECO services address key high-burden conditions, including: complications of pregnancy and birth; injuries, such as those caused by road traffic crashes and disasters; non-communicable diseases, such as asthma, heart attack and stroke; and infectious conditions, such as sepsis, malaria, diarrhoeal diseases and pneumonia from both common and high-risk respiratory pathogens. However, because ECO is not disease- or population-specific, its actual and potential contribution to the health system and global and national health agendas is often unrecognized.

4. Integrated people-centred service delivery requires ECO services that are linked to communities through primary care and by communication, transportation, referral and counter-referral mechanisms. Only integrated planning that places primary care relationships at the centre of the ECO-system[1] will ensure timely and appropriate access to needed ECO. This integration contributes to efficiency and effectiveness, enables economies of scope and scale across disease- and population-specific programmes, and is essential to a comprehensive PHC approach.

[1] The term "ECO-system" here refers to emergency, critical and operative care services and the mechanisms that ensure they are accessible to the people who need them, e.g. communication, transportation, referral and counter-referral mechanisms.

OVERVIEW OF THE GLOBAL SITUATION

Burden of conditions addressable by emergency, critical and operative care

5. The conditions addressable by ECO span all major health areas, encompass the top global causes of death and disability, and are responsible for an estimated 38 million deaths and 1.3 billion disability adjusted life years annually.[2]

6. Effective, integrated ECO services are essential to mitigate the impact of increasing public health risks, including outbreaks, conflicts, disasters and climate-related events.

7. Factors contributing to worse ECO outcomes in low- and middle-income countries (LMICs) include inadequate health worker numbers and skills, limited equipment, and gaps in service design and delivery that cause delayed recognition and disrupted continuity of care.

Access and coverage of emergency, critical and operative care

8. Access to ECO is most limited in low- and lower-middle-income countries, with particularly high unmet need for ECO services in many African and Asian countries. There also are wide variations in ECO access within countries, particularly between rural and urban areas.

9. In many countries, geospatial distribution of hospitals is not aligned with need, and ECO services are concentrated in political or urban centres. This has severe consequences in countries with large, distributed populations, a high proportion of rural poor and fragmented transport networks.

Socio-economic considerations, including cost-effectiveness and impact of gaps in emergency, critical and operative care

10. ECO services can be highly cost-effective, and a lack of investment in ECO compromises outcomes and reduces impact of other interventions, increasing overall system costs. Essential ECO built on early recognition and timely appropriate intervention often decreases the need to use scarce advanced care resources. The effectiveness of many proven interventions - including medications and procedures - decreases with delays to care, so timely access to ECO amplifies impact and returns on investment across the health system.

11. The consequences of inadequate access to ECO include physical suffering, functional limitations and detrimental impacts on psychological and economic well-being. Lack of adequate ECO can lead to acute, life-threatening complications as well as chronic disabilities that hinder employment, compounding the burden on individuals, families and society.

12. Annually, tens of millions of people - most of them in LMICs - face catastrophic health expenditure attributable to ECO on the basis of out-of-pocket payments alone. Tens of millions more

[2] Wimmer S, Sarabu S, Hynes EC, Plummer ML, Bognini MS, Kebede MA et al. Global burden of emergency and operative conditions: an analysis of Global Burden of Disease data, 2011-2019. Bulletin of the World Health Organization. 2025;103:194–203. doi: http://dx.doi.org/10.2471/BLT.24.292412

face catastrophic expenditure attributable to nonmedical costs of accessing ECO, such transport and food costs.

Health system determinants of emergency, critical and operative care

13. ECO cuts across traditional global health initiatives and across disease- and population-specific funding streams and is vulnerable to insufficient or inconsistent funding.

14. Globally, inadequate health workforce numbers, capacities and planning hinder ECO provision, particularly in low-resource settings and in the African, Southeast Asian and Western Pacific regions. ECO quality is frequently compromised by lack of dedicated personnel and insufficient supervision of junior or rotating health workers.

15. ECO health workers are disproportionately exposed to infectious and other hazards, including violence, because ECO services often address high acuity conditions, involve invasive procedures and must be directly accessible to the public day and night. ECO health workers may also be particularly psychologically and physically vulnerable during public health emergencies due to exposure risks, increased patient volume, crowded or unfamiliar working environments and attacks on personnel and facilities.

16. Training of lay people (such as bystanders, community first aid responders and other community health workers) and of non-specialist primary care staff to deliver ECO has been shown to save lives but is under-implemented. Many first-contact health workers practice without the support of dedicated ECO training.

17. Lack of infrastructure, equipment, medicines and consumables are challenges for health systems overall, but ECO services can be particularly vulnerable. ECO delivery is frequently constrained by limited availability and maintenance of diagnostic laboratory and radiology equipment and essential equipment for monitoring patients.

18. Digital health technologies – such as mHealth, computer-aided dispatch systems, electronic health record systems, telemedicine and clinical decision support applications – have been widely shown to improve access to and quality of ECO. However, challenges include gaps in regulatory structures needed to maintain data security and privacy and limited interoperability across digital systems.

19. There is a dearth of evidence to guide ECO policy and implementation, particularly in settings where resources are limited and prioritization is critical. Even when data are collected, they are rarely aggregated or analysed to inform integrated planning.

Emergency, critical and operative care integration within models of care

20. In recent years, countries have increasingly focused on explicitly defining packages of services intended for universal health coverage (UHC), but in many cases, these packages focus on traditional global health interventions, such as vaccinations and pre-natal care, and include few ECO services.

21. Well-designed UHC packages explicitly map priority services to defined delivery settings, including communities, clinics, ambulances and hospitals. Increasingly, countries also define "alternate" platforms that expand access to services or support strategic shifts to ensure safe continuity of essential health services during crises (e.g. home-based self-care, mobile health teams, telemedicine). Integrated ECO planning improves effectiveness and efficiency, but many countries plan community- and facility-based care separately, or design primary care and hospital strategies in isolation, limiting the coherence of care pathways and disrupting continuity of care.

22. Within a primary-health-care-oriented model of care, people-centred pathways optimize movement across the health system with strong communication and referral linkages among communities, ambulances, clinics and hospitals. However, mechanisms to link communities to ECO services (e.g. empanelment systems and universal access numbers) and to link levels of care to each other (e.g. referral and counter-referral systems) are often under-developed and fragmented.

23. Simple, affordable prehospital care and transport systems can decrease mortality from many conditions, but their availability and scope in LMICs are extremely limited. Early and accurate recognition and referral in community and facility-based primary care dramatically improves outcomes, increasing overall efficiency and effectiveness by rationalizing the use and maximizing the impact of scarce ECO resources at hospital level. Having core ECO services available at first-level hospitals is strategic and cost-effective for many conditions, but first-level hospitals in many countries lack dedicated emergency units or 24-hour staffing for intensive care units and operating theatres.

24. Empowering communities as both users and providers of ECO may involve: ensuring community representation in planning and facility management committees, providing first aid training for bystanders and community health workers and supporting advocacy by community organizations. Such advocacy has successfully led to expanded ECO service coverage and training, and to laws and policies addressing access, quality and protections for bystanders who assist the acutely ill or injured.

Emergency, critical and operative care service delivery processes

25. Gaps in key ECO processes are widely documented at all levels. Optimizing service delivery through standardized protocols or checklists has been widely shown to reduce mortality and to be feasible and well-accepted in all settings, but there remain implementation gaps. Further, most ECO practice guidance has been developed for and based on evidence from high-resource settings and may not be feasible or appropriate in all contexts.

Special considerations for emergency, critical and operative care during public health emergencies and humanitarian crises

26. The same health system must deliver for everyday population health needs and maintain and surge services during public health emergencies. Strategic shifts in service planning and delivery are essential for effective response to hazards and for safe, continued delivery of essential health services.

27. Service delivery challenges during crises may include overwhelming patient volumes, understaffing, clinical practice beyond usual scope or in unfamiliar settings, lack of equipment and supplies, and delayed or unavailable transfer to higher levels of care. Because health care encounters themselves may become a source of transmission during outbreaks, services may be suspended for

safety reasons, often with long-term consequences. Attacks on healthcare may impact health worker and patient safety, service continuity, and access to care. Gaps in real-time data sharing and patient tracking may limit evidence-based decision-making and resource allocation.

28. Where relevant, the community-based health workforce, humanitarian partners and emergency medical teams can be central to effective management of public health emergencies, including for detection, risk evaluation, response and recovery.

VISION AND GOAL

Vision

29. By 2035, all people have timely access to the high-quality emergency, critical and operative care they need without financial hardship, and health systems have the capacity for rapid scale up of emergency, critical and operative care during public health emergencies and in humanitarian settings.

Goal

30. Strengthen emergency, critical and operative care for UHC by: (a) incorporating ECO into national policies for sustainable funding and effective governance; (b) ensuring integrated planning of ECO informed by systematic collection and strategic analysis of data; (c) explicitly including ECO services into UHC packages, service delivery platform design and optimized care pathways; (d) empowering communities in the planning and provision of ECO; (e) supporting, training and protecting the health workforce who deliver ECO; (f) optimizing service delivery processes to maximize ECO quality; and (g) ensuring surge capacity for and coordination of ECO services during public health emergencies.

STRATEGIC OBJECTIVES

Strategic objective 1: Emergency, critical and operative care governance and financing – Ensure essential ECO policy, regulation and legislation; integrate ECO services into national planning and financing mechanisms; and coordinate ECO readiness and surge capacity for public health emergencies

31. Strategic objective 1 aims to strengthen ECO governance, financing and coordination at the national level as part of UHC and health security agendas. National policies, regulations and standards should facilitate universal access to high-quality, needs-based ECO services for all. Key mechanisms include integrated planning for UHC, innovative and sustainable financing, coordination across public and private sectors, and core legislation, such as laws on the right to access acute care without payment prior and on protections for bystanders who assist the ill or injured.

32. ECO must be fully integrated into relevant national assessment, planning and reform processes, including national health strategic plans and strategies for UHC, PHC and hospitals; and into mechanisms for the coordination and management of disasters, outbreaks and other public health emergencies. Effective ECO delivery and related prevention and risk-reduction efforts require linkage

across relevant sectors, including transport and education. National health financing strategies should incorporate ECO services protected by government assurance mechanisms, such as publicly funded service delivery, health and social insurance schemes, or policies that regulate what private entities must deliver or pay for. Sustainable partnerships within and outside of the health sector, as well as engagement with communities, civil society and the private sector, are essential to mobilize resources.

33. A designated lead agency should have the authority, responsibility and resources to coordinate integrated ECO planning and implementation. The lead agency may be an existing agency but should be specifically empowered to coordinate across the ECO continuum and to set and enforce standards, including through certification and accreditation of health workers and facilities.

Strategic objective 2: Emergency, critical and operative care within models of care – Include priority ECO services within UHC packages and map them to defined service delivery platforms; ensure integrated, people-centred ECO pathways; optimize management and teams to deliver ECO; and empower communities as users and providers of ECO

34. Strategic objective 2 focuses on models of care, including incorporating ECO services within a UHC package; mapping ECO services to well-defined delivery platforms and settings; and designing people-centred care pathways, including referral and counter-referral.

35. Key first-contact functions include public system activation, dispatch of emergency care health workers and early recognition in primary care. Community first aid responder programs have been shown to be effective and cost-effective. Optimal primary care provides (a) health promotion and disease and injury prevention; (b) early recognition, timely management and transfer for acute conditions when appropriate; and (c) coordination of care encounters across different levels of care and across the life course. Optimizing first-contact care reduces complication rates, improves outcomes and limits overuse of scarce hospital resources.

36. Key functions of hospitals include delivering ECO at all hours, providing advanced interventions, and supporting decision-making at primary care level. Well-defined models of care specify minimal functional criteria for emergency units, critical care units and operating theatres. In particular, strengthening ECO capacity at first-level hospitals enables first-contact access out-of-hours and life-saving care at all times. First-level hospitals should have dedicated emergency units, basic critical care capacity and operating theatres that are able to deliver essential surgical and anaesthesia services 24 hours per day, ensuring access to needed care close to home and across the life course.

37. To optimize people's movement across the health system, care pathways should be defined for key conditions, such as sepsis, injury, complications of pregnancy and birth, noncommunicable diseases and mental health conditions. A robust system for patient referral, counter-referral and emergency transfer should guide decision-making with explicit protocols and should promote linkages and coordination of care across public and private health care settings. Digital tools and systems that promote seamless information sharing, such as integrated electronic health records that enable efficient referral and counter-referral across the ECO continuum, can improve patient safety, reduce duplication of services and enhance continuity of care.

38. Professionalization of leaders and managers at national, sub-national and facility levels is fundamental to the effectiveness and efficiency of ECO. Governments should ensure adequate numbers of and well-defined competencies for managers and foster an enabling environment for continuous ECO quality improvement.

39. Community engagement in ECO service planning and provision should include structured mechanisms for incorporating community perspectives in strategic planning and monitoring; and education on early recognition, care seeking, self-care and first aid.

Strategic objective 3: Emergency, critical and operative care workforce planning and capacity building – Plan for adequate numbers and appropriate distribution of health workers who deliver ECO; build and maintain capacity to deliver high-quality ECO; and protect the ECO workforce from workplace hazards

40. Strategic objective 3 aims to ensure an optimal health workforce to deliver ECO services to meet population needs. Integration of ECO into health workforce planning is key to establishing appropriate capacities across service delivery platforms. Policies should optimize health worker roles and include recommended staffing ratios for emergency units, critical care units, and operating theatres that account for case volume, acuity, and complexity and ensure 24-hour coverage. Explicit policies should ensure that health workers receive proper training, supervision and technical support, and health worker perspectives should routinely be incorporated into ECO service planning.

41. A system for dedicated pre- and in-service ECO training of all relevant health workers is critical for a resilient, high-quality health system. Community-based ECO can be strengthened by training of the public and, where relevant, formally designating and training community first-aid responders who can be activated and dispatched within their communities. Foundational acute care training, such as the WHO/ICRC Basic Emergency Care course, are essential for all clinicians and should be incorporated into undergraduate curricula for health workers. Other important foundational ECO training includes the WHO Basic Critical Care course, the WHO Operative Care at the First Level Hospital learning programme, and instruction in mass casualty management and response to chemical, biological, radiological, and nuclear agents or threats. Training and certification pathways should be established and regulated for prehospital and facility-based health workers. ECO specialist training pathways should be developed for nurses, mid-level health workers, doctors and other relevant groups.

42. Supportive supervision of health workers is important to performance management and staff retention and promotes compliance with standards of practice, high-quality ECO delivery and health worker satisfaction.

43. Measures to protect health workers from infectious and other hazardous exposures, injuries, violence and burnout are crucial and include reliable provision of protective equipment and security for prehospital settings, clinics and hospitals.

Strategic objective 4: Emergency, critical and operative care service delivery and quality – Provide high-quality, multidisciplinary ECO services; and ensure essential ECO infrastructure, equipment and supplies

44. Strategic objective 4 focuses on evidence-informed ECO service planning, including development of national guidelines and context-specific clinical protocols and pathways. ECO delivery processes should be supported by standardised approaches, and quality should be monitored and improved through the use of case-based registries and audits, with analyses at facility, subnational and national level. A team-based culture of quality improvement is vital, as are validated tools, such as clinical decision support algorithms and checklists.

45. Strategic objective 4 prioritizes multidisciplinary, team-based delivery of ECO to optimise care continuity and comprehensiveness, enhance the efficiency of service delivery and improve patient outcomes and satisfaction. For example, multi-disciplinary interprofessional care by doctors, nurses, and rehabilitation professionals is associated with better outcomes, particularly in high-risk or complex cases.

46. Explicit standards should specify essential equipment, supplies and medications linked to priority services and aligned with the functional roles of service delivery platforms as defined within the local model of care. Mechanisms for dynamic supply chain management, including inventory tracking and redistribution mechanisms, should be designed to ensure the availability and distribution of essential health products for ECO service delivery.

Strategic objective 5: Emergency, critical and operative care data for decision-making and quality improvement – Evaluate health system capacity to deliver ECO and document need for and utilization of ECO services; identify ECO evidence gaps; and set research priorities to inform policy and planning

47. Strategic objective 5 seeks to enhance data collection and analysis at system, facility and case levels to provide timely and relevant feedback on ECO to health workers and planners.

48. Decision-making on resource allocation, capacity building, quality improvement and public health emergency management should be informed by regular assessment of the geospatial and temporal trends of conditions that can be addressed by ECO, system capacity to deliver ECO, ECO utilization and access barriers, particularly for vulnerable populations such as people with disabilities. At regular intervals, national ECO assessments should be conducted to identify system-level gaps and clarify country-specific action priorities to inform policy and planning.

49. Routine health information systems should be strengthened to incorporate ECO data and ensure standardized clinical documentation for ECO delivery at community, prehospital, outpatient, emergency unit and inpatient levels. Standardized data from clinical registries can be used to monitor and track treatment outcomes, support research, facilitate corrective actions as part of quality improvement initiatives, and inform national, subnational and local planning and management.

50. Context-relevant research on clinical and public health aspects of ECO is critical to guide planning, particularly in settings where limited resources require prioritisation and difficult trade-offs. Explicit identification of research priorities at national, regional and global levels can accelerate inquiries that inform policy choices.

Strategic objective 6: Emergency, critical and operative care in public health emergencies and humanitarian crises – Strengthen health systems to provide ECO continuity, from readiness to response and recovery

51. Strategic objective 6 aims to optimize ECO services in settings affected by disasters, outbreaks, and conflict. Strong and well-resourced ECO is vital to effective health system response to hazards, to maintaining the continuity of essential health services during crises, and to creating more resilient and fit-for-purpose health systems during recovery. As part of preparedness, UHC packages

should incorporate the full continuum of ECO and explicitly identify priority services for high-risk hazards and core services that need to be maintained during crises.

52. Countries should undertake national risk assessments to inform the design of context-relevant ECO surge capacity and resource allocation. ECO should be fully integrated in national emergency coordination mechanisms and in planning and regular drills for all-hazard responses. ECO funding needs to be flexible and contingency funding available to manage surge in demand for ECO services and supplies. Provisions for ECO delivery should be integrated into risk management strategies at regional, district and community levels, and the roles and functions of ECO in all phases of the management of public health emergencies should be explicitly defined with adequate operational detail to support rapid scaling. In fragile and conflict-affected settings, flexible models, adaptive strategies and inter-agency coordination can be especially important.

53. To ensure continuous provision of ECO services during crises, alternative delivery platforms, including those able to support surgical procedures, should be designated. This may include contingency planning for expanded clinical space and building modular or mobile clinical units.

54. The health workers who deliver ECO should be engaged in crisis risk assessment, planning and response coordination, including regular multisectoral simulation exercises. Special consideration should be given to physical protection of ECO workers in insecure settings, their retention during protracted emergencies, and training and deployment to ensure needed capacities.

55. Strategic procurement of medicines and other health products based on assessed needs, support for local procurement, and strengthening of national pharmaceutical systems are key to optimizing ECO services in crises. This may require adaptive and context-specific solutions to transport medicines to hard-to-reach areas and protect temperature-sensitive medicines. Well-defined, rapid regulatory and approval pathways for emerging therapeutics are also important during public health emergencies.

56. Humanitarian partners and national and regional emergency medical teams can backstop local health workers, bolster provision of supplies and extend ECO services to reach vulnerable populations, such as people with disabilities. Coordination among international and local stakeholders and context-adapted approaches are essential to effective engagement.

ROLES OF WHO, MEMBER STATES AND PARTNERS

WHO

57. WHO will fulfil a leadership and coordination role in promoting and monitoring global action on ECO for UHC and protection from public health emergencies. WHO will set the general direction and priorities for global ECO advocacy, partnerships and networking; articulate evidence-based policy options; and provide Member States with technical and strategic support.

58. WHO will translate this strategy into a global action plan for integrated ECO, including a monitoring framework with indicators for tracking progress and measurable targets to be achieved by 2035, in accordance with decision WHA77(8).

59. WHO will enhance its capacity at global, regional and country levels to provide necessary coordination, technical guidance and support for the efforts of Member States and other relevant actors to strengthen ECO.

60. WHO will continue working with partners – including convening the Acute Care Action Network and the Global Alliance for Care of the Injured - to facilitate implementation of the strategy through joint advocacy, dissemination and coordinated implementation of WHO tools and resources, and linkages for multidisciplinary ECO research. WHO will foster multi-country exchange to share information, skills and technology to strengthen ECO services.

61. WHO will collaborate with Member States to ensure there is uptake, support and accountability for the strategy at the national level. WHO will assist Member States to identify high-priority ECO services and to integrate these services into UHC planning processes. WHO will continue to design and update technical guidance, standards and curricula for capacity building, and clinical tools to support quality, timely ECO with currently available resources in LMICs.

62. WHO will continue to assist Member States to conduct ECO-system assessments and use data for decision-making and quality improvement. WHO will work with countries and experts to develop indicators and targets for ECO outcomes and cost-effectiveness analyses and will maintain and expand ECO modules on the WHO clinical registry platform.

Member States

63. Member States should allocate sufficient resources for ECO strengthening to ensure ECO services meet minimum standards.

64. Member States should establish a lead national agency with sufficient capacity and resources to provide strong ECO leadership, coordination and accountability for the national ECO-system across public, private and other non-governmental providers, including prehospital care.

65. Member States have the responsibility to integrate ECO into national and subnational health policies and strategies, addressing standards for: a skilled ECO workforce; adequate equipment, infrastructure and supplies for ECO delivery; and documentation, monitoring and evaluation of access to and quality of ECO services. Member States should identify explicit national ECO action priorities based on population-needs and system-capacity assessments.

66. Member States should incorporate ECO into models of care by including ECO services in UHC packages and in the strategic design of platforms and pathways to meet population health needs, drawing on WHO resources and tools, such as the WHO UHC Service Package Delivery and Implementation platform. National, subnational and facility-level governance mechanisms should coordinate prehospital and facility-based ECO services, including transfer and referral, and linkages with public health emergency management.

67. Member States have the responsibility to establish regulatory mechanisms for institutions, providers and personnel who deliver ECO services. Dedicated pre- and in-service skill-based training in ECO should be provided to all relevant health workers, taking advantage of accessible training curricula (e.g. the WHO/ICRC Basic Emergency Care course) and digital platforms (e.g. the WHO Academy). Planning at district, sub-district and facility levels should optimise health worker roles and, where appropriate, incorporate task-sharing approaches.

68. Member States should ensure that ECO health workers are protected from injuries, violence, and infectious and other hazardous exposures.

69. Member States can adapt and operationalize WHO guidance and standards on ECO infrastructure, personnel, material resources and processes, including implementing WHO guidelines, checklists, protocols, and digital tools for clinical decision support.

70. Member States can support key ECO processes by developing regulatory structures for and optimizing digital technologies to support system activation and dispatch, referral and care planning, telemedicine, clinical decision support and health workforce and resource management.

71. Member States should establish structured mechanisms to incorporate community perspectives in strategic planning, monitoring and delivery of ECO. Community members should be educated on early recognition, care seeking, and first aid.

72. Member States have the responsibility to assess the structure, capacity and functioning of the national ECO-system, care pathways and delivery at the facility level, using systematic approaches such as the WHO national ECO-system assessments, the Core Clinical Care Readiness Planning Tool, and the WHO ECO facility-level assessment. Member States should operationalize explicit targets and indicators, building on the anticipated global action plan and monitoring framework for integrated ECO.

73. Member States should have dedicated strategies to safeguard essential ECO in disasters, fragile settings and conflict-affected areas, including convergent approaches across humanitarian programming and national UHC planning, such as through the WHO-Global Health Cluster H3 (high-priority health services for humanitarian response) process.

Partners, civil society and private sector

74. United Nations agencies and international partners, including professional organizations, have important roles to play in ECO advocacy and implementation, including through resource mobilization; scale-up of WHO tools and other evidence-based interventions; exchange of experiences; provision of technical support, capacity-building and material resources; and research and surveillance.

75. Civil society is key to ECO service delivery and to encouraging governments to develop robust national and subnational ECO policies and plans and contributing to implementation. Civil society can support communities and lead grass-roots mobilization and advocacy.

76. The private sector has a vital role in supporting Member States, including in ECO service planning, delivery, and quality improvement; health worker capacity-building; and production and provision of material resources to ensure high quality ECO.