

ADVANCING ACCESS

A practical advocacy toolkit for improving access to NCD medicines, diagnostics and medical devices

The Advancing Access advocacy toolkit is part of a collection of resources developed by the NCD Alliance and the University of Geneva NCD Policy Lab, designed to support advocates who want to improve access to NCD medicines, diagnostics and medical devices, previous working title Global NCD Access Advocacy Platform (GNAAP).

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Introduction

Noncommunicable diseases, including mental health and neurological conditions (hereafter ‘NCDs’), cause 43 million deaths each year — three quarters of all deaths globally — yet millions of these deaths could be prevented or delayed through timely access to affordable and quality-assured medicines, diagnostics and medical devices (hereafter: medicines and medical devices). In low- and middle-income countries (LMICs), essential medicines for conditions such as diabetes, cardiovascular diseases, chronic respiratory diseases, cancer, and mental health and neurological conditions are often unavailable or unaffordable, while basic diagnostic tools and other medical devices remain out of reach for many health systems and communities.

A **2025 NCD Alliance commissioned report** identified access to medicines as one of the largest bottlenecks to expanding access to NCD services and a key determinant of financial risk from NCDs, with out-of-pocket expenses for NCDs being twice as high per facility visit as for infectious diseases. Despite a **global target** that was set to achieve 80% availability and affordability of essential medicines and basic technologies for NCDs by 2025, many LMICs are far from achieving it. This target was renewed in **the Political Declaration** emerging from the 4th UN High-Level Meeting on NCDs and Mental Health (HLM4), where all Member States committed to a global target that **‘at least 80% of primary health care facilities in all countries have availability of World Health Organization-recommended essential medicines and basic technologies for noncommunicable diseases and mental health conditions, at affordable prices, by 2030.’**

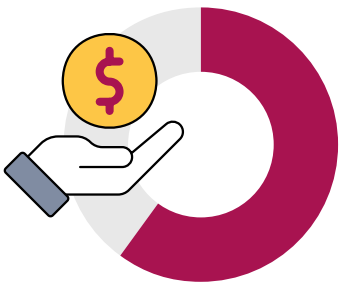
This commitment was strengthened with an additional target that **‘60% of countries must implement financial protection policies covering or limiting out-of-pocket costs for essential NCD and mental health services.’**

Importantly, the Declaration shifts toward actionable solutions: pricing policies, transparency, stronger regulatory systems, pooled procurement, resilient supply chains, local production, and technology transfer, highlighting the fact that **many access barriers are political and systemic – they are not technical inevitabilities.**

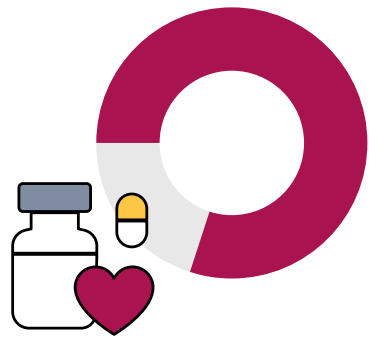
Access barriers are shaped by policy decisions, governance arrangements, financing choices, and market dynamics. Improved access depends on a series of interconnected steps in the access pathway, including selection, regulation, forecasting, procurement and pricing. Weaknesses at any stage can limit availability, affordability, or quality of medical products. Understanding how these systems operate enables advocates to identify where change is needed and who has the power to make it happen.

All UN Member States have committed to achieving key access-related **TARGETS BY 2030:**

60% OF COUNTRIES have financial protection policies in place for NCD and mental health services



80% OF PRIMARY CARE FACILITIES in all countries have availability of WHO-recommended essential medicines and basic technologies at affordable prices



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What is the Advancing Access advocacy toolkit?

The Advancing Access advocacy toolkit aims to **bridge the gap between NCD advocacy and the operational and technical levers to improve access to NCD medicines and medical devices**. Its purpose is to help advocates gain a deeper and more comprehensive understanding of why people in their country are unable to access essential NCD medicines and medical devices, and to strengthen technical advocacy asks towards ministries of health, ministries of finance, and other relevant bodies.

Many people using this toolkit are likely to have lived experience of accessing NCD medicines and medical devices – and of the challenges commonly faced. This is a valuable form of expertise, and it should be used together with the technical guidance in this toolkit.*

* We are grateful to the following members of the NCDA Our Views, Our Voices Global Advisory Committee for their support and guidance in the development of the toolkit: Mohammed Seyam, Evans Majau, Ikram Eseghir and Mark Barone.

Who is the Advancing Access advocacy toolkit intended for?

The toolkit is primarily intended for people who are active as NCD advocates, but is not limited to this group. We consider anyone with the capacity and willingness to be part of the change driving improved access to NCD medicines and medical devices to be an advocate, and encourage them to use this toolkit. Some users will already have previous technical expertise with access to medicines and medical devices, but this is not required – if advocates are just getting familiar with access processes, that is not a problem.

- **National NCD advocates:** The toolkit can support discussions with ministries of health and other national stakeholders, help identify barriers to access, and inform the development of national policy recommendations and interventions.
- **Regional NCD advocates:** The toolkit can help connect regional advocacy and policy-making with national priorities and challenges. It can also support the identification of common barriers across countries and inform regional approaches.
- **International advocates:** The toolkit can inform briefings for UN missions and multilateral agencies, support engagement in global policy processes, and help identify gaps in existing tools, financing and technical support.
- **Other advocates and allies:** Health professionals, people with lived experience of NCDs, WHO country-offices and health ministers are just a few examples of those ‘access allies’ who may want to save and improve lives by addressing access barriers.



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How to use the Advancing Access advocacy toolkit?

The sections of this toolkit guide users to gather information that is relevant for **assessing the different steps of the access pathway**, before developing a **context-specific set of evidence-based advocacy actions**. The toolkit provides guidance for driving system-level change, and it also allows users to analyse barriers linked to specific products if they choose this more granular approach.

ADVANCING ACCESS:

Advocacy through five key steps of the pharmaceutical value chain

SNAPSHOTS

A high-level view of each step: What it is, why it matters, related problems and barriers, and who is responsible.

KNOWLEDGE CHECKLISTS

Deepen the understanding of each step by gathering important information about access in a local context.

ADVOCACY STRATEGIES

A selection of advocacy actions and tips to consider and adapt for use in developing a locally tailored advocacy strategy.

Follow-the-Product barrier analysis

An analysis of a specific chosen NCD medicine or medical device which is linked to access problems in a given context. Helps identify barriers and advocacy actions to address them.

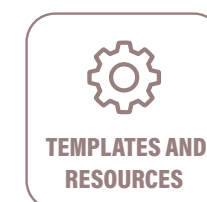
Tools and initiatives

Existing resources which will support advocates in gathering information and/or carrying out advocacy actions.



Templates and resources

Customisable templates and other resources designed especially for access advocacy.



Advancing Access product list

A compiled list of WHO-recommended NCD medicines and medical devices, to be used in primary healthcare systems with strong referral systems to secondary and tertiary care.



The toolkit focuses on supporting advocacy to improve access to NCD medicines and medical devices by addressing **five system-level problems** that are commonly observed in health systems. Some or all of these problems may be observed in a given country. These problems are the entry point for the Follow-the-Product barrier analysis.

Five commonly observed access problems:

1.	Medicines/devices are not prescribed or used in the country	
2.	Medicines/devices are used but are not available or continuously available in public facilities or pharmacies	
3.	Medicines/devices are available but are not of adequate quality	
4.	Medicines/devices are available but unaffordable	
5.	Medicines/devices are not being reimbursed and people must pay out of pocket (both public and private sector)	



This toolkit recognises its own limitations. Most of its suggested advocacy actions are directed towards governments and other public sector actors, but many important access barriers are influenced by stakeholders beyond government, including (but not limited to) pharmaceutical companies (both the research-based and the generics and biosimilar industry), wholesalers, health insurers and other private sector actors as well as donors. Broader health system challenges, such as health workforce strengthening, prescribing, and patient medication adherence and use, may also influence access but are not addressed in detail here.

ADVANCING ACCESS

Advocacy through five key steps of the pharmaceutical value chain

Access problems rarely have a single cause, so to understand why a problem occurs, it is necessary to comprehensively examine the systems involved in the access pathway.

Advocates working to improve access should understand the operational and technical processes that are involved – how products are selected, approved, regulated, quantified, priced, procured, and made available to the people who need them.

This toolkit focuses on five key steps within the pharmaceutical value chain:

Step 1: Selection

Step 2: Regulation

Step 3: Forecasting

Step 4: Pricing

Step 5: Procurement

For the purpose of this toolkit, these can be considered five areas where governments and other public sector actors can act to improve access to medicines and medical devices. While they are presented in order, in reality these steps do not always take place in a linear way.

The following sections provide a **Snapshot** of each step, briefly explaining what it is and why it matters for access, linked problems and common barriers that drive them; a **Knowledge Checklist** to help gather relevant information; and a basic **Advocacy Strategy** for the step. It may be helpful to use this strategy as a starting point for developing a more detailed and context-specific strategy for implementation.

ADVANCING ACCESS

Advocacy through five key steps of the pharmaceutical value chain

Some points within the **Knowledge Checklists** will also support completion of the **Follow-the-Product barrier analysis**. This toolkit aims to serve advocates with varying levels of experience in access to medicines and medical devices, so you may already have some, all or none of the information to gather in the **Knowledge Checklists**.

The availability of information relating to the access pathway varies widely between countries. If some of the information is unavailable, WHO country offices, health professionals and associations, or other relevant civil society or technical organisations such as academic institutions can be contacted. These collaborations can be extremely valuable in access-related advocacy, and it is highly recommended to collaborate with other advocates and allies working on the same or similar issues.

See Stakeholder Mapping resource.

Overall, interacting with governments with technical, specific questions about access, and formally requesting data is a powerful advocacy act in itself, even before any policy change is achieved. It signals that civil society is informed, no longer willing to be kept in the dark on access issues, and actively demanding transparency and accountability, putting pressure on governments to explain concretely how they will meet global targets including those from the [2025 Political Declaration on NCDs and Mental Health](#).

STEP 1

SELECTION

Selection Snapshot

What is it

‘Selection’ is the national process by which medicines and medical devices are assessed, prioritised, and included on a country’s Essential Medicines List (EML), Essential Diagnostics List (EDL), standard treatment guidelines (STGs), and/or reimbursement list and national formularies.

Why it matters

Selection can be considered the gateway to public access, and is inextricable from reimbursement. Medicines and medical devices that are not included in national lists or guidelines are far less likely to be procured, publicly funded or routinely used within the health system. Decisions made during selection can also trigger downstream discussions on issues such as pricing and population coverage.

Problems and barriers

Access barriers within the Selection step can contribute to four of the five **health system problems** highlighted in this toolkit:

- Medicines/devices are not prescribed or used in the country
- Medicines/devices are used but are not available or continuously available in public facilities or pharmacies
- Medicines/devices are available but unaffordable
- Medicines/devices are not being reimbursed and patients must pay out of pocket

These are some of the most common **selection-related barriers** driving the problems above:

- Medicines/devices are not included in national EML / EDL and/ or reimbursement, formulary, or procurement lists
- National lists are outdated (not updated in last three to five years)
- Lists and treatment guidelines, NCD policies and/ or prescribing are misaligned

TOOLS AND INITIATIVES

Selection-related tools and initiatives

which can support your advocacy work:

- WHO Model List of Essential Medicines (EML) and the WHO Model List of Essential Medicines for Children (EMLc)
- WHO Model List of Essential In Vitro Diagnostics
- WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list
- WHO Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care
- WHO PEN-Plus

Additional disease-specific technical packages and tools

- WHO How to develop and implement a national drug policy 2nd edition
- UHC Compendium and the Service Package Delivery and Implementation (SPDI) Platform
- WHO report Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, 2nd ed

Knowledge Checklist

1. Country’s Essential Medicines List, reimbursement list, procurement list, and/or national formulary(ies)

What this is

These lists define which medicines and medical devices are officially prioritised for procurement, public financing, reimbursement and use within the national health system. They will often be the starting point for access-related advocacy work and will inform the selection-related questions which are included in the Product Analysis for problems 1, 2, 4 and 5.

Where to find it

- Ministry of Health website
- National Medicines Regulatory Authority website
- [WHO country office](#) (may hold copies of the most recent national EML or be able to advise where it can be obtained, particularly if WHO provided technical support during the last update)
- [WHO Repository of national EMLs](#) (for country-submitted EMLs) or [list of electronic essential medicines lists](#)

Key points to check

- Existence of the list/s
- Whether the list/s influence procurement decisions
- Date of last update (ideally within the last three to five years)
- Alignment of the list/s with treatment or clinical guidelines
- Inclusion (or omission) of core NCD medicines and medical devices ([See Advancing Access product list](#))

2. Knowledge of the national selection committees and selection processes

What this is

Understanding who decides which medicines and medical devices are included (e.g. national medicines/therapeutics committee), how often they meet, and what criteria they use for deciding which medicines and medical devices to prioritise for procurement and public funding.

This information will be useful for selection-related advocacy work, ensuring communications reach the most relevant bodies and individuals. It will also inform the [Stakeholder Mapping](#).

Where to find it

- Ministry of Health website or UHC policy documents
- National drug or pharmaceutical policy documents
- Terms of Reference (ToR) for EML or Health Technology Assessment (HTA) committees (if published)
- Direct engagement with:
 - Ministry of Health pharmaceutical services departments
 - WHO country offices
 - Health professionals
 - Public hospitals and health facilities

Key points to check

- Who/ which institution makes selection decisions?
- What criteria or guiding documents are used to decide which products are prioritised for procurement and public funding?

3. Knowledge of existing guidelines and policies on NCDs and/or specific treatments

What this is

Clinical guidelines and policies (e.g. NCD strategies, STGs) that indicate what type of NCD care and treatment is officially recommended for specific diseases. These should align with the national EML and other selection documents, as listed in Knowledge Checklist item 1.

This information will also be needed for addressing a key selection barrier: misalignment between lists and treatment guidelines or NCD policies or prescribing. This can lead to major gaps in care and access to treatment.

Where to find it

- Ministry of Health websites
- National NCD plans or UHC policy documents
- Professional medical associations websites
- WHO country office or WHO IRIS repository (for nationally adopted WHO guidelines)
- Regional health bodies (where guidelines are harmonised): eg PAHO

Key points to check

- Existence of STGs and consistency with national NCD strategies, EML / EDL / reimbursement lists / formularies
- WHO guidance on recommended products to select, including treatment guidelines and packages, the Package of Essential NCD Interventions (PEN), EML, EDL, etc. Refer to the [Advancing Access product list](#) and familiarise yourself with what has been selected in your country (in your national EML, for example).



Advocacy Strategy: Selection

Advocacy aim: All national selection lists are updated, harmonised with treatment guidelines and NCD policies, and used for guiding reimbursement.

Action 1

Update national selection lists and treatment guidelines, ensuring key NCD medicines and medical devices are included.

How to do this

- Start by mapping what already exists – obtain the country’s nEML, nEDL and STGs for the relevant disease area, and identify gaps against the WHO lists (EML, EDL, PEN and disease-specific packages) (note that adaptation of the WHO lists to national contexts is to be expected). For a collated list, the *Advancing Access list of NCD medicines and medical devices* can be used.
- Where a key NCD medicine or medical device is missing, prepare a short evidence brief (with burden of disease data, WHO recommendation status) to support an addition request to the national EML committee. This approach is most effective if collaboration with relevant professional medical associations or key health professionals is possible.
- If no review has happened in several years, request the review cycle directly from the Ministry of Health and/or selection committee.

Mitigating obstacles

- If review cycles are infrequent or absent, propose a fixed review schedule (e.g. aligned to WHO’s biennial EML update) as a concrete policy ask.
- If the committee has limited technical capacity, offer to connect them with civil society, professional medical associations or academic technical networks that can support evidence review.
- If a meeting is difficult to secure, make the request through a patient organisation or professional medical association with existing government relationships.

Stakeholders

- Ministry of Health, national EML committee, medical professionals and patient organisations.

Tips for advocates

- In 2027 the WHO will celebrate 50 years of the EML – leverage this as an advocacy/campaign opportunity to request the government to update the national EML.
- If the country’s lists are not publicly available, document this lack of transparency as a barrier to accountability.
- Reach out to clinicians and academics who may be working on similar issues and can provide technical insight and influence on lists.

Action 2

Align lists, guidelines, and NCD policies

How to do this

- This is a continuation of Action 1. Choose one priority NCD medicine or medical device and trace it across every relevant document – is it on the nEML, and the STGs? Is there a corresponding diagnostic on the EDL? Are both products mentioned in the national NCD strategy and the reimbursement list?
- Where it appears in one but not the other, document the disconnect and use it as a concrete case study to bring to the relevant committee.

Mitigating obstacles

- If policy processes are siloed between government departments, identify a single product-level inconsistency to use as an example of why cross-departmental coordination is needed.
- Propose a formal mechanism linking documents (if there is none) – for example, a requirement that any new nEML addition be cross-checked against STGs and reimbursement lists before finalising.

Stakeholders

- Ministry of Health, national EML committee, medical professionals and patient organisations.

Tip for advocates

- Start small and specific: a single well-documented example is often more persuasive than a general statement on lack of alignment.

Action 3

Ensure lists and guidelines inform procurement, reimbursement and financing decisions for key NCD medicines and medical devices

How to do this

- To reach people, NCD medicines and medical devices must not only be listed but also procured and reimbursed by the public health system. Advocacy at this stage needs to make the human and financial case for reimbursement.
- Build the case using (where available) demand data showing how many patients need the medicine or medical device and the current treatment gap, out-of-pocket cost data, and lived experience testimony from patients describing the human consequences of non-reimbursement (delayed treatment, financial hardship), as well as cost-effectiveness and return on investment data.

Mitigating obstacles

- If procurement or reimbursement decisions are driven by cost alone, try to find long-term cost-effectiveness data to make the economic case, and look for examples of regional precedent in comparable countries within the same region.
- If there are weak institutional links between the nEML committee and finance or procurement bodies, flag this disconnect and bring the same evidence to both sides. Advocate for the lists to be formally included in procurement regulations or insurance reimbursement frameworks.

Stakeholders

- Ministry of Health and Finance, procurement agencies, health insurance and reimbursement bodies, donors and health professionals.

Tip for advocates

- The EML committee has already done its job by listing the medicine or medical device. The audience here is typically the body that manages the national health insurance (Ministry of Health), Ministry of Finance, and/or a benefits package review committee and or Health Technology Assessment board.

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50 years of Essential Medicines Lists, it's time to update yours

2027 will mark the 50th anniversary since the first issue of the WHO Essential Medicines List (EML) in 1977.

The Lancet Commission on Essential Medicines, a global commission of experts mandated to develop priority recommendations to accelerate universal access to essential medicines, will issue its new report to coincide with this date.

The WHO advocates that the anniversary is a timely opportunity to review/update national EMLs, which may not contain the most up-to-date recommendations or contain products which are no longer recommended. At the country-level, it has been proposed that the review could include introduction of additional information such as the availability of generics and biosimilars, local production as a factor in recommending drugs, and renewed discussions on the role of medicine pricing to inform the WHO EML selection processes. This will be key for ensuring that the WHO EML and its translation to national lists translates to improved access. Aligning national lists with WHO's list will also be an area of greater focus.

2027 is therefore a key advocacy opportunity to engage your ministry of health on access to medicines and medical devices. Leverage this opportunity to request key nEML updates, and other policies mentioned in this toolkit to improve availability, accessibility and affordability of key NCD medicines and medical devices.



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Acknowledgements

CASE STUDY

Selection and reimbursement of insulin analogues in Brazil

This case study was provided by Mark Barone.

Key message

Combining listing with pricing policies allowed Brazil to expand access to insulin analogues for both type 1 and type 2 diabetes while protecting the long-term sustainability of public healthcare budgets.

In 2017, [rapid-acting insulin analogues were incorporated into Brazil's Unified Health System \(SUS\) for people with type 1 diabetes](#) following assessment by the National Commission for the Incorporation of Technologies (CONITEC). While the clinical benefits of rapid-acting analogues were recognised, affordability and budget impact presented challenges. These were overcome through subsequent price negotiations and large-scale public procurement, which helped reduce costs and support their availability through the public health system at no cost to patients.

A similar approach was adopted for long-acting insulin analogues. **In 2019, Brazil incorporated long-acting insulin analogues for type 1 diabetes, but explicitly conditioned incorporation on achieving a treatment cost equal to or lower than that of human NPH insulin.** Over the following years, [technical assessments were conducted to establish therapeutic equivalence and acceptable price ceilings based on the cost of NPH insulin](#). These analyses informed national procurement processes, [culminating in federal purchases of long-acting analogues in 2024](#).

The Brazilian experience illustrates how health technology assessment, price negotiation, and centralised procurement can be combined to improve access to insulin analogues while protecting the sustainability of public healthcare budgets. Listing was a key step in the process, enabling it to be prioritised for public financing or procurement and subsequently reimbursed in the public health system.

More recently, [Brazil expanded access to both rapid-acting and long-acting insulin analogues for people with type 2 diabetes](#) as part of a broader strategy to strengthen the sustainability and resilience of insulin supply within the public health system. This policy shift was driven not only by clinical considerations but also by increasing global constraints in the supply of human insulins (NPH and regular), prompting the Ministry of Health to diversify treatment options, increase the availability of analogue insulins in Brazil's public universal healthcare system, and invest in domestic production capacity for insulin. **It is important to note that Brazil was able to ensure that the prices of human and analogue insulin were the same, which in many countries is not the case with analogue insulins being substantially more costly than human insulin for health systems and individuals, and with these higher prices not considered justified by existing scientific evidence.**

CASE STUDY

Global to national advocacy: How a WHO EML listing improved national treatment access

This case study was provided by the MS International Foundation.

Key message

Listing on the WHO EML strengthens advocacy, particularly when combined with local evidence-gathering and relationship-building.

In 2023, the MS International Foundation (MSIF) achieved a landmark result: multiple sclerosis (MS) treatments were listed on the WHO EML for the first time. The listing has become a powerful tool for national advocacy, helping MS organisations around the world make the case for national listing, aligned with treatment guidelines, and covered by health benefit packages or national insurance schemes. The same global decision has translated into different national outcomes depending on each country's health system and advocacy route: government subsidies for the products following advocacy linked to the WHO EML listing ([Nepal](#)), updated guidelines ([UAE](#)), formal registration of a treatment following WHO EML listing ([Iran](#)), national EML listing and changing prescribing practice (Malaysia), and insurance coverage of treatments (Ghana, Chile, [Albania](#)).

Across these seven countries, the WHO EML listing was used alongside locally gathered evidence (MS registries, patient testimonies, etc), relationship-building with health authorities, regulators and the public, and sustained advocacy engagement. What the listing consistently provided was the legitimacy of a globally recognised, independent recommendation that advocates could point to when making the case for inclusion as an essential medicine, guideline development, registration, or reimbursement, even where in many cases it was never formally cited in a national policy document.

STEP 2

REGULATION

Regulation Snapshot

What is it

Before a medicine or medical device can be sold in a country, the National Regulatory Authority must check that it is safe, effective, and of high quality. Through this process of regulation, all products are evaluated before they enter the market to ensure they meet these standards. Based on the outcome of the evaluations, the product is either authorised for sale and marketing or denied.

Why it matters

Decisions about the regulation of medicines and medical devices have a direct impact on access, determining whether products can enter a market, how quickly people will be able to access them, and the conditions in which they can be used. Regulation processes also ensure quality, safety and effectiveness. Effective regulatory systems can accelerate access to medical products, while bottlenecks can create significant barriers.

Problems and barriers

Access barriers within the Regulation step can contribute to four of the five **health system problems** highlighted in this toolkit:

- Medicines/medical devices are not prescribed or used in the country
- Medicines/medical devices are used but are not available or continuously available in public facilities or pharmacies
- Medicines/medical devices are available but are not of adequate quality
- Medicines/medical devices are not being reimbursed and patients must pay out of pocket

These are some of the most common **Regulation-related barriers** driving the problems above:

- Weak quality regulation compromises assurance of medicine/device safety, efficacy and consistency
- Lack of regulatory capacity and complexity of regulatory processes increase costs, cause problems with timely medicine/device approval and registration, and/or lack of market entry for products (only **26%** of regulatory agencies worldwide have reached WHO Maturity Level 3 or 4)
- Lack of effective collaboration and coordination among key stakeholders, policymakers, and health workers in regulatory processes.

Who is responsible

The main responsible body within a country is the National Regulatory Authority (NRA), which can be an independent entity or part of the Ministry of Health. However, there are numerous stakeholders involved in the regulation of medicines and medical devices beyond government. For instance, for a product to be considered for regulatory approval in a country, manufacturers must voluntarily submit a detailed product dossier to the NRA. Another example: for manufacturers to use the Collaborative Registration Procedure, products must first be prequalified by WHO or a WHO-Listed Authority (WLA). Get a more in-depth view with the **Stakeholder mapping**.



Regulation-related tools and initiatives which can support your advocacy work:

- WHO Collaborative Registration Procedure for Medical Products
- WHO Prequalification Programme
- WHO tools for strengthening regulatory systems

Knowledge Checklist

1. Country's regulatory approval status for key NCD medicines and medical devices

What this is

The regulatory approval status of a medicine or medical device confirms whether it has been formally assessed and authorised for use by the NRA or regional/global equivalent. A medicine or medical device (produced by a specific manufacturer under a brand name) must typically be registered before it can be legally procured, prescribed, or reimbursed within the health system.

Where to find it

- Ministry of Health website
- Regional regulatory databases (e.g. [FDA's public register](#), [EMA's public register](#), [Western Pacific Regional Alliance of NRAs for Medical Products](#), [South-East Asia Regulatory Network](#), [Pan-American Network for Drug Regulatory Harmonization](#), where applicable)
- National Regulatory Authority (NRA) website: publicly searchable product registers where available (e.g. <https://web.pharmacyboardkenya.org/regulatory-functions/>)

Key points to check

- Existence of a publicly accessible register of approved NCD medicines and medical devices
- Registration status of core NCD medicines and medical devices.
(See Advancing Access product list)
- Whether the country participates in the WHO Collaborative Registration Procedure (CRP) and/or has a formal reliance policy that recognises SRA/WLA or WHO Prequalification decisions (and whether this pathway is actually used in practice)
- Any medical products that are procured or used in practice but not formally registered (a common gap in LMICs)

Note: To find the information for this checklist item, the NCD medicine or medical device to focus on can be selected from the *Advancing Access product list*, which collates relevant WHO guidance.

Regulatory waivers in the procurement of medicines and medical devices

Many global health initiatives (such as Global Fund or PEPFAR, for example) benefit from special import licenses enabling unregistered medicines to be authorised and imported, usually in an emergency situation. While this enables faster access to essential medical products, this mechanism weakens the incentives to build national regulatory capacity.*

[Learn more.](#)

NCDs have not historically benefited from these special import licenses that were used for HIV, TB and malaria, for example, and traces back to the vertical funding architecture that prioritised infectious diseases and built the regulatory work-arounds for these conditions.

[Learn more.](#)

* The literature, however, is not unanimous – one experience from Brazil shows how regulatory reliance enabled the national regulatory agency to 'bolster its internal capacity' [See https://doi.org/10.1016/j.socscimed.2024.117563](https://doi.org/10.1016/j.socscimed.2024.117563)

2. Knowledge of the national regulatory approval process and timeline

What this is

Understanding how medicines and medical devices move through the national regulatory review process – who conducts the assessment, how long it typically takes, and which reliance or collaboration mechanisms exist. This will provide insight into the capacity and efficiency of the country’s NRA and is essential for identifying bottlenecks between regulatory approval and patient access.

Where to find it

- NRA website: regulatory guidelines, submission requirements, and standard operating procedures (where published)
- National drug or pharmaceutical policy documents
- [WHO Global Benchmarking Tool \(GBT\) reports](#); provides a maturity rating for the NRA and identifies systemic gaps
- Direct engagement with WHO country office: can advise on the regulatory maturity of the NRA and any ongoing capacity-building support

Key points to check

- Existence of a published registration pathway and timeline
- Whether reliance mechanisms are in place (e.g. recognition of WHO Prequalification, WLA/SRA decisions, or regional harmonisation through AMRH or a similar body)
- Average time from submission to approval for priority categories of NCD medicines/devices
- Existence of expedited or fast-track pathways for essential or priority NCD medicines/devices

3. Knowledge of the regional regulatory authority relevant to the country of interest

What this is

Many countries participate in regional harmonisation or reliance initiatives that can accelerate access to medicines and medical devices. Understanding whether the country participates in these mechanisms may help identify opportunities to strengthen national regulatory processes.

Where to find it

- WHO [Prequalification Programme](#)
- WHO [Collaborative Registration Procedure](#)
- [African Medicines Agency \(AMA\)](#) & [The African Medicines Regulatory Harmonization \(AMRH\)](#)
- [European Medicines Agency \(EMA\)](#)
- [The Pan American Network for Drug Regulatory Harmonization \(PANDRH\)](#)
- [Western Pacific Regional Alliance of NRAs for Medical Products](#)
- [South-East Asia Regulatory Network \(SEARN\)](#)
- [SwissMedic](#)
- [EU-M4All](#)

Key points to check

- Is your country a member?
- Has your country adopted reliance pathways?
- Are NCD medicines and medical devices being assessed through these channels?

Advocacy strategy: Regulatory

Advocacy aim: Key NCD medicines and medical devices are registered, appropriately regulated (high-quality), and approved in a timely manner.

Action 1 Encourage governments to strengthen the capacity and resources of national regulatory authorities (NRAs).

How to do this

- Start by benchmarking the NRA's current maturity level using WHO's Global Benchmarking Tool results, if publicly available, or by requesting this information directly from the NRA or Ministry of Health.
- Use any documented capacity gaps (e.g. low maturity level, long registration timelines or backlogs) as the evidence base for a capacity-strengthening request to the Ministry of Finance, framed around the cost of delayed access to NCD care.

Mitigating obstacles

- If other budget priorities compete with regulatory strengthening, try to find data on the cost of delayed registration (this could mean reliance on more expensive imported alternatives).
- If donor funding for regulatory strengthening is only available short-term, advocate for transition planning to be built into this programme from the outset, so that gains are not lost when donor funding ends. Donor support for regulatory capacity is often tied to time-limited project cycles and can be withdrawn or redirected as donor priorities shift, so an explicit **exit strategy** is key to ensuring improvement made during the funded period will be sustained once the external funding stops.

Stakeholders

- Ministry of Health, Ministry of Finance, NRA staff, WHO Country Office, WHO Regional Offices

Tips for advocates

- The absence of a publicly accessible register, or significant gaps between medicines and medical devices in use and those formally registered, can indicate a problem in regulatory capacity and should be documented as part of the analysis.
- Where registration timelines are long, undefined, or inconsistently applied, this may point to NRA capacity constraints rather than product-specific issues.
- It may also indicate that reliance pathways or regional harmonisation mechanisms are underused (**see action 2**).

Action 2

Advocate for the use of regulatory reliance mechanisms to accelerate registration of NCD medicines and medical devices (where appropriate)

How to do this

- Assess first whether reliance mechanisms would support the regulatory process by reviewing your country's NRA current maturity level (if a WHO Global Benchmarking Tool assessment has been conducted) and comparing the country's average product registration timelines against the 90-day Collaborative Registration Procedure (CRP) benchmark.
- Then check whether your country already participates in any regional reliance mechanism or harmonisation initiative.
- After this, the priority NCD medicines and medical devices that are not registered can be identified, and you can check whether they have been approved by a Stringent Regulatory Authority (SRA) or WHO-Listed Authority (WLA).
- This status determines whether reliance mechanisms like the CRP are available. If a medicine or medical device qualifies but the country's NRA has not joined CRP, advocate directly to the Ministry of Health for NRA participation, using the 90-day fast-track timeline as a concrete benefit to cite.
- If the product of interest is not part of WHO prequalification or CRP, advocating for their inclusion to relevant stakeholders, explaining the market and patient need this would address, can be considered.

Mitigating obstacles

- Since products need prior SRA/WLA or Prequalification approval to use reliance mechanisms, focus advocacy on medicines and medical devices already in that pipeline, while considering separately advocating for expanded lists as a longer-term goal.
- If manufacturers are not prioritising CRP or prequalification submission due to limited market incentives, pair this advocacy with Action 2 under Procurement (e.g. strategic purchasing approaches like pooled procurement) to demonstrate that aggregated demand can make submission more attractive to manufacturers.

Stakeholders

- Stringent Regulatory Authorities (SRAs) and WHO-Listed Authorities (WLAs), Regional reliance mechanisms, WHO Regional Offices, Prequalification and Collaborative Registration Procedure department, Ministries of Health, pharmaceutical companies and manufacturers.

Tips for advocates

- Link regulatory reliance and efficiency mechanisms to procurement advocacy: strategic purchasing approaches can make it more appealing for manufacturers to submit their NCD medicines and medical devices for regulatory approval, because governments will be able to ensure adequate demand.
- These mechanisms can be key for accelerating access to medicines and medical devices and securing lower prices.

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CASE STUDY

WHO Prequalification of insulin

Key message

Even when a WHO prequalification pathway exists, manufacturers will not necessarily use it without clear demand.

In 2019, WHO launched its first prequalification programme for insulin, nearly two decades after the broader prequalification programme was launched. Manufacturers did not submit any products to this first call. WHO issued a second call for expression of interest in 2022, and in September of that year prequalified four human insulin biotherapeutic products, all submitted by an originator company. Another originator company prequalified a long-acting analogue insulin.

The main barriers identified for lack of uptake of prequalification for insulin similar biotherapeutic products are the lack of guaranteed return on investment and the perceived complexity of prequalification requirements for biosimilars. WHO recommends that procurement agencies linked to the Prequalification Programme set up a platform for advance purchase agreements with manufacturers (as a way of guaranteeing demand) to boost participation for insulins. Multiple prequalified insulins would enable competitive tendering, drive down prices and strengthen supply security by reducing dependence on any single manufacturer.

[Learn more.](#)

CASE STUDY

Unregistered essential medicines in Uganda

Key message

Lack of registration creates risk of low-quality medicines and medical devices, waste of public procurement resources and shifts costs onto patients.

A 2012 study finds that almost half of all essential medicines had no registered product with the Ugandan regulatory authority, while unregistered essential medicines were found in private pharmacies. This has implications for drug quality. Moreover, over 70% of products on the Ugandan National Drug Register were non-essential, which has the effect of diverting public resources away from the medicines most needed in the public health system and potentially limits the affordable options for patients.

[Learn more.](#)



STEP 3

FORECASTING

Forecasting Snapshot

What is it

Pharmaceutical forecasting is the process of predicting demand for a medicine or medical device. Accurate forecasting is essential for determining what to buy and in what quantity, and it aligns global production with national needs. This information should form the basis of national procurement lists, ensuring they align with national disease burdens and needs.

Forecasting and procurement go hand-in-hand, and it may be helpful to consider these two steps of the toolkit together. Forecasting (estimating need) and supply planning (translating need into an order or procurement plan) are the two processes that form part of quantification.

Why it matters

Forecasting should ensure an adequate supply of medicines and medical devices for population needs while avoiding wastage due to overstocking. This helps secure a reliable supply of medicines and medical devices for people who require them while making efficient use of health budgets.

Problems and barriers

Access barriers within the Forecasting step can contribute to two of the five **health system problems** highlighted in this toolkit:

- Medicines/devices are not prescribed or used in the country
- Medicines/devices are used but are not available or continuously available in public facilities or pharmacies*

These are some of the most common **Forecasting-related barriers** driving the problems above:

- Lack of alignment of health system with incidence and prevalence
- Lack of diagnosis (leading to underestimated need), variable management (leading to inconsistent prescribing practices), poor treatment adherence (consumption data may underestimate need)
- Inaccurate or inexistent data collection due to inadequate Health Management Information Systems
- Poor data on real needs to inform forecasting and funding/planning

* When products are not available in the public health system, individuals may either purchase at a retail outlet, go without, or ration their supply.

Who is responsible

- Ministries of Health, hospitals, and facilities use a combination of epidemiological data (disease prevalence and patient numbers) and historical consumption records to estimate how much of a given product will be needed and when.
- Health Technology Assessment Agencies (HTA) evaluate the clinical and economic value of new technologies to inform decisions on pricing negotiations and whether they should be adopted into health systems, which in turn shapes future demand projections.
- Pharmacists and clinicians play a key role in feeding data into the forecasting process; for instance, through consumption and stockout reports, and updates to national treatment guideline that change which products are prescribed and in which quantities. Get a more in-depth view with the **Stakeholder Mapping**.

Forecasting-related tools and initiatives which can support your advocacy work:

- WHO Global Health Observatory
- Global Burden of Disease (IHME) Study
- WHO STEPS and National Health Surveys
- UNICEF Forecasting & Supply Planning for All Tool (FSP4All tool)



TOOLS AND INITIATIVES



Knowledge Checklist

1. Knowledge of your country's NCD forecasting and procurement processes

What this is

Forecasting of medicines and medical devices typically is based on one of two quantification methods: consumption (if the products being procured have records of past consumption and predictable needs; this method relies on past use and is adjusted for stockouts, expiration of over-stocked items and projected changes in use), or morbidity (for new products with no use data or with an expected change in consumption). The UN Development Programme (UNDP) has a [helpful webpage](#) summarising these two methods.

For NCDs in particular, it is recommended that countries use a third method of forecasting alongside consumption and morbidity: enrolment-based (patient/cohort) forecasting. Instead of simply predicting the total number of NCD cases in a broad general population, enrolment-based forecasting models follow a registered group of individuals over years, tracking demographic, clinical, and lifestyle data as well as disease onset, retention in care, and treatment outcomes. Machine learning and artificial intelligence tools can be used to support analysis of data gathered. This method is well suited to contexts where diagnosis rates are low and data gaps are common.

It is often difficult to find out whether forecasting is being done effectively or at all, so work in this step is likely to focus on demonstrating the gap between need and forecasted need to demonstrate demand for specific NCD medicines and medical devices.

Each country has its own specific process for estimating, budgeting and procuring medicines and medical devices. Understanding how forecasting feeds into procurement cycles, including who makes decisions and how often forecasts are updated, is key for establishing where the entry points are for influencing the process.

Where to find it

- National NCD plans and strategies
- National budgets
- Central Medical Stores procurement schedules
- WHO country offices
- Hospitals and health facilities

Key points to check

- Who is responsible for forecasting in your country?
- What data informs the forecasting?





2. Awareness of data gaps

What this is

Reliable data is essential for effective forecasting, ensuring that demand for specific NCD medicines and medical devices is accurately quantified. Countries typically rely on consumption-based forecasting, which uses recorded dispensing or procurement data, rather than morbidity-based approaches, because disease burden figures do not translate directly into procurement need. Consumption data, however, is frequently distorted due to unrecorded stock-outs and expired or overstocked items, for example; and morbidity data is lacking in many contexts. Moreover, consumption-based forecasting works when demand is stable, but for NCDs, demand will often grow as diagnosis and enrolment improve.

There are various reasons for distortion of consumption data; e.g., not all people with a condition are diagnosed, not all diagnosed patients seek care, not all who seek care are prescribed treatment, and not all who are prescribed treatment adhere to it consistently. Prescribing practices and guidelines may also vary across facilities and regions. This is why it is recommended that countries incorporate enrolment-based forecasting, as mentioned above in **Knowledge Checklist item 1**. Ideally, forecasting should be based on a mix of consumption (past volumes used / procured), morbidity data, and enrolment (patient/ cohort) data.

Where to find it

- WHO Global Health Observatory STEPS Survey (WHO)
- National HMIS data
- IHME Global Burden of Disease estimates
- NCD Country Capacity Survey
- National procurement agency (information on stock-outs, expired or overstocked items which skew consumption data)

Key points to check

- Are there peer-reviewed publications or reports analysing whether national epidemiological data align with estimated need forecasts and procurement lists?
- Are there peer-reviewed publications or reports that find clear gaps in data (i.e. diseases which do not have data available) or data which is of poor quality?





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Advocacy strategy: Forecasting

Advocacy aim: National procurement lists are aligned with estimated need forecasts and the country's disease burden.*

*Note: List names may vary by country and may contain volumes and/or lists of medicines and medical devices for procurement prioritisation.

Action 1

Investigate what data are informing your country's forecasting and identify gaps across different stakeholders

How to do this

- Engage relevant stakeholders to understand what forecasting methods are currently used and where the key gaps and misalignments lie.
- Advocates should focus on promoting dialogue across these groups and understanding what is recorded at each level (medical stores, health facilities and patients) and where data can be distorted.

Mitigating obstacles

- If procurement list data is not publicly available, submit a formal information request to the Ministry of Health or procurement agency.
- Bear in mind that some Ministries do forecasting at (a) facility level, feeding into a national forecast, or (b) programmatically / vertically (e.g. HIV programme forecast, etc).

Stakeholders

- Health facilities and professionals, medical stores, procurement agencies, patients, Ministry of Health (Department of Pharmacy or Pharmaceutical Services), Ministry of Finance.

Tips for advocates

- The most valuable starting point could be to simply talk to everyone affected by the procurement process to understand where and why forecasts fall short.
- Include an explicit ask in your advocacy that forecasts are not only accurately produced but also funded and committed in the procurement budget.



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Action 2

Advocate for strengthened NCD forecasting tools and pilots that are adaptable to different contexts, as well as data collection methods.

How to do this

- Engage with health professionals as a key stakeholder to understand current capacity gaps, as they often have first-hand knowledge of where forecasts fail in practice.
- Engage with the agency or unit responsible for pharmaceutical forecasting and quantification in your country. This could be a dedicated forecasting unit, procurement agency function, or a process run by the Ministry of Health.
- Where capacity already exists for other disease areas (eg immunisation, TB), propose extending or adapting that same institutional capacity to cover NCD products, since the underlying skills (consumption analysis, supplier engagement) may transfer across.

Mitigating obstacles

- If forecasting staff or institutions lack familiarity with NCDs, pair capacity-strengthening efforts with technical input from implementing organisations (CHAI, PATH), or a WHO country office.

Stakeholders

- Health facilities and professionals, medical stores, procurement agencies, patients, implementing organisations (e.g. PATH, CHAI)

Tips for advocates

- A documented capacity improvement can show funders and ministries that investment in forecasting capacity pays off in measurable terms (*see case study below*).
- In countries where there is a lack of formalised forecasting and/or information, it may be helpful to start with simple requests such as: a public call to WHO for forecasting support or guidance, or a request to the Minister of Health to establish a seat for civil society organisation representation on the forecasting committee.
- You may find it useful to conduct a segmented analysis of NCD medicines and medical products by product characteristics. Cold-chain, biologic products with a short shelf-life and concentrated supplier base (like insulin) forecast very differently from ie, stable oral antihypertensives.

Note: For NCDs a high proportion of medical need is ‘invisible’ due to lack of awareness and screening. Evolving need into demand requires broader health system efforts such as awareness-raising, improved screening and diagnosis.

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CASE STUDY

CHAI's capacity-building activities on NCD forecasting

This case study was provided by the Clinton Health Access Initiative (CHAI).

Key message

Building NCD forecasting capacity translates into better reflection of need and more accurate procurement volumes

Since 2022, CHAI has supported Ministries of Health to build capacity to improve accuracy of NCD medicine and medical device demand forecasting, supporting facility- and national-level public sector procurement to better align with population needs. Capacity-building activities across countries include training national, regional and/or health facility staff on NCD forecasting and prioritisation of NCD medicines and medical devices for procurement, and enabling working groups at multiple levels to coordinate more effectively on NCD product priorities. Support focuses on strengthening implementation of existing forecasting methods, validating consumption data with additional sources such as epidemiological data to improve accuracy of forecasts in reflecting needs, and improving application of product prioritisation frameworks such as VEN (vital, essential, non-essential) to classify NCD medicines and medical devices for procurement.

In Cambodia and Uganda, after receiving CHAI's support, NCD medicine and medical device forecasts now better reflect need. At the national level in one country, forecasted quantities for first-line pharmacological treatments for diabetes and hypertension doubled or more; in another, planned procurement volumes increased across all key diabetes and hypertension products.

CASE STUDY

Learnings from HIV forecasting

This case study was provided by Kaushik Ramaiya.

Key message

Supply confidence is key to forecasting.

Early antiretroviral programmes defaulted to oversupply and initially drove significant waste, but this supply confidence drove clinic attendance, as crowded facilities with long wait times and/or unreliable supply can deter patients from coming to the clinic. This forecasting, based on calculations by oversupply, generated real consumption data by drawing people into care and ensured that future forecasts were accurate.

Learn more [here](#) and [here](#).



CASE STUDY

A community centred approach to strengthening forecasting

This case study was provided by Kate Armstrong.

Key message

Collective action to involve people with lived experience and address NCD community priorities directly contributes to accurate demand data and health system strengthening.

Clarifying the demographic profile of a community is an essential early step to accurate forecasting – especially where uninterrupted supply of essential medicines is key to survival. Accurate prevalence and incidence data are key to documenting increases in community size, which in turn drives demand.

Since 2004, the Australia-based non-government organisation **CLAN (Caring & Living As Neighbours)** has used a rights-based, community development approach to redress inequities for children and adolescents living with NCDs in lower-income countries. Having identified all children living with the same NCD in a country as members of a united, non-geographically based “community”, CLAN facilitates collaborative, multisectoral efforts across five community priorities for optimising quality of life and well-being: affordable access to essential medicines and equipment; education, research and advocacy; optimal medical management; encouragement of family support group meetings; and **reducing financial burdens on families**.

The organisation **@MATES4Kids (Maximising Access To Essential Supplies for Children)** connects childhood NCD communities internationally through a community of practice network, and supports engagement in regional and global advocacy, forecasting and action.

Meaningful engagement of people with lived experience requires upfront investment in NCD communities, and this contributes to sustainable health system strengthening and accurate forecasting in the long-term.

STEP 4

PRICING

Pricing Snapshot

What is it

Pricing is the step which determines how much governments pay for NCD medicines and medical devices, and influences the prices at consumer-level. In the field of pharmaceuticals, pricing is a complex process shaped by many factors, including manufacturing and regulatory costs, government pricing policies, market demand and dynamics, pharmaceutical companies’ price-setting, and other factors such as mark-ups and taxes.

Why it matters

Pricing affects access to NCD medicines and medical devices in two ways. First, high manufacturer prices may mean that governments cannot afford to reimburse products (this may also lead to the products not being listed entirely). Second, where individuals must pay for medicines and medical devices either fully or partially out of pocket, the actual price they must pay determines whether the treatment is affordable. In many LMICs, out-of-pocket spending remains the primary means by which people access medicines and medical devices.

WHO defines a ‘fair’ price as ‘one that is affordable for health systems and patients and that at the same time provides sufficient market incentive for industry to invest in innovation and the production of medicines.’

Problems and barriers

Access barriers within the Pricing step can contribute to two of the five **health system problems** highlighted in this toolkit:

- Medicines/devices are not prescribed or used in the country
- Medicines/devices are available but unaffordable

These are some of the most common **pricing-related barriers** driving the problems above:

Medicines/devices are not prescribed or used in the country:

- Limited product entry:** Where regulatory and market conditions do not incentivise the entry of generics or biosimilars (follow-on products) into the market (e.g. due to complex or lengthy approval procedures, lack of competitors, small market size and/or low forecasted demand), prices remain high and health systems may opt not to list or reimburse a medicine/device.
- Lack of national pricing** policy to regulate pricing of medicines/devices.

Medicines/devices are available but unaffordable:

- Pricing mechanisms:** Pricing mechanisms such as internal and external reference pricing, and tools such as cost-effectiveness or Health Technology Assessments can help governments determine a reasonable price and strengthen their negotiating position; however, many LMICs lack the capacity to apply these tools effectively.
- Procurement systems:** Governments’ ability to secure fair prices depends on their ability to bring competitive approaches and pool national or regional demand. Fragmented purchasing across facilities or regions weakens negotiating power.
- Mark-ups along the supply chain:** Distributor and wholesaler mark-ups applied between manufacturer and dispensing can inflate the price ultimately paid by health systems or patients.
- Taxes and tariffs:** import duties and VAT applied to medicines/devices add to the final price and disproportionately affect LMICs, who rely on imported products.

Who is responsible

The Ministry of Health typically sets the national pricing policy and leads in negotiations, working alongside finance and trade ministries on reimbursement decisions and industrial policy for generics and biosimilars.

Some countries have Health Technology Assessment (HTA) bodies, which conduct an evaluation to determine the value of a medicine or medical device for patients and the broader health system. Ministries of Health can then use these assessments in price negotiations. Many LMICs have insufficient capacity to conduct HTAs - this is more commonly used in HICs - which is why LMICs often use price reliance, deciding on an appropriate price based on comparable prices within the same region. For this, cross-country price transparency is needed.

Wholesalers and distributors, who transport medicines and medical devices from manufacturers to pharmacies and health facilities, may cause prices to increase with additional charges and costs, known as mark-ups, applied throughout the supply chain to cover overhead, distribution and dispensing fees, and profit. [Learn more.](#)

While list prices are often publicly available, negotiated prices are often kept under non-disclosure agreements and therefore rarely published.



Pricing-related tools and initiatives which can support your advocacy work:

- WHO Guideline on Country Pharmaceutical Pricing Policies
- WHO Academy Course on Pharmaceutical Pricing Policies
- WHO/HAI Survey on Pricing and Availability of Medicines
- Pharmaceutical Pricing and Reimbursement Information network (PPRI)
- TRIPS Flexibilities Database
- Voluntary Licensing via the Medicines Patent Pool

Knowledge Checklist

1. Knowledge of regulatory frameworks that govern pharmaceutical pricing in your country

What this is

Regulatory frameworks are sometimes regulated by national competition law acts, or consumer law. There may also be a dedicated medicines pricing act. These are often difficult to find, so uncovering whether there is a pricing policy is an important advocacy finding in itself.

Where to find it

Try to find the national competition or procurement act or pharmaceutical pricing policy. These regulatory frameworks will vary country by country and may be covered under different names.

Kenya's regulatory frameworks governing pricing of medicines and medical devices, for example, include the **Public Procurement and Disposal Act (2005) and the Competition Act No. 12 (2010)**.

Key points to check

- Which pricing policies are mentioned in the act or policy? (see below for a list of different pricing policies)
- Are prices and mark-ups of medicines and medical devices regulated via the policy or otherwise?

2. How many manufacturers supply a given medicine or medical device in your country

What this is

The number of manufacturers present for a given medicine or medical device determines the degree of competition and directly influences price. Check whether a generic or biosimilar is available alongside any originator product, which also influences price by making the product more affordable. The **Advancing Access product list** provides a prioritised reference of WHO-recommended NCD medicines and medical devices.

Where to find it

NRA product registers, WHO or UNICEF supply catalogues.

3. What method your government uses to determine an appropriate price

What this is

Governments use different approaches to set, assess or lower prices, including internal reference pricing, external reference pricing, value-based pricing, mark-up regulation, promoting price transparency, tendering and negotiation, promoting the use of quality-assured generics and biosimilars, pooled procurement, cost-plus pricing, and tax exemptions or reductions. Understanding which method your country uses reveals how prices are justified and where there may be room to challenge them. Learn more about the different policies [here](#).

Where to find it

Ministry of Health pricing policy document, or HTA body publications where they exist.

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4. What procurement methods your country uses, and whether these affect pricing

What this is

Competitive tendering, pooled procurement, and framework agreements can drive prices down by leveraging volume or competition. Understanding your country's procurement approach helps identify whether pricing is being actively assessed and managed.

Where to find it

National procurement agency documentation, Ministry of Health procurement guidelines.

5. What mark-ups are added by distributors, wholesalers and pharmacies

What this is

Mark-ups applied along the supply chain by manufacturers, wholesalers, distributors, and others to cover overhead, distribution and dispensing fees, and to make a profit, can inflate the final price. These mark-ups are often not formally published.

Where to find it

This information can be difficult to find through official sources. Speaking directly with pharmacists or other supply chain actors can help.

6. Whether taxes and tariffs are applied

What this is:

Import duties and VAT add cost that is ultimately passed on to patients or health systems. Some countries exempt essential medicines from these.

Where to find it

Finance or customs ministry documentation.



Advocacy strategy: Pricing

Advocacy aim: Medicines and medical devices are affordable to health systems and patients.

Action 1 Map information gaps in pricing data.

How to do this:

- Compile what pricing information is currently available in your country across list prices, reimbursement prices, and procurement prices, and identify which of these are missing, outdated, or inconsistent. In practice, formal pricing data will often be difficult to access.
- A useful complementary approach is to check actual prices in pharmacies and compare these against independent third-party repositories such as the WHO/HAI pricing and availability data and PPRI country profiles, since official documents may be difficult to locate. Try to cross-reference these sources to obtain a reasonable picture of whether prices appear excessive.

Mitigating obstacles:

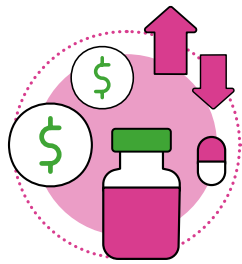
- If very little pricing data is public in practice, document this gap explicitly as a finding in itself.
- Where list prices exist, do not treat them as definitive: list and negotiated prices can differ substantially.

Stakeholders:

- Ministry of Health, procurement agencies, payers/insurers.

Tips for advocates:

- If only list prices are accessible or no pricing data is available at all, flag this clearly in advocacy materials.



Action 2

Advocate for the adoption or strengthening of pricing policies across the following areas, using Knowledge Checklist findings to prioritise where the gaps are.

How to do this

- Medicines entry: Advocate for policies that incentivise the entry of generics and biosimilars.
- Pricing frameworks:
 - Use the WHO Guidelines (2020) to assess which pricing mechanisms are feasible and appropriate for your country’s context.
 - If no pricing policy exists in your country, documenting that gap and pointing to the WHO guideline is itself a concrete advocacy ask.
 - If government technical capacity is limited, identify whether the WHO Country Office or a technical partner could provide implementation support.
- Procurement: Advocate for competitive tendering processes and where feasible and appropriate, pooled procurement to leverage volume for lower prices.
- Mark-ups and taxes: Advocate for the removal or reduction of import duties and VAT on essential medicines, and for formal regulation of distributor and wholesaler mark-ups.

Mitigating obstacles

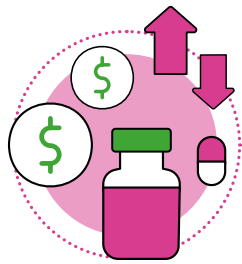
- If government technical capacity is limited, identify whether the WHO Country Office or a technical partner could provide implementation support.

Stakeholders

- Ministry of health, WHO country office, payers/ insurers, HTA bodies.

Tips for advocates

- Each pricing policy comes with benefits and limitations, and not all are appropriate in every context.
- Before advocating for a specific policy, use the WHO Guidelines (2020) to assess whether it is feasible and likely to be effective for the medicine or medical device and setting you are focusing on.
- If no pricing policy exists in your country, documenting that gap and pointing to the WHO Guidelines is a concrete advocacy ask.
- Engaging governments with technical, specific questions about pricing sends a strong advocacy message in itself: it signals that civil society is informed, expects transparency, and is holding governments accountable.
- Refer back to your Knowledge Checklist findings to identify which of the areas listed above represents the most significant gap in your country and prioritise accordingly.



CASE STUDY

Unregulated medicine prices in Sudan

Key message

Without pricing regulation, prices of imported medicines can far exceed international reference levels.

One study found that the prices of imported medicines in Sudan were ten times higher than global reference prices, and that prices charged by the central medical stores were nearly twice what the procuring agency had originally set. The lack of pricing regulation, or lack of enforcement of existing policy, is widespread across African countries and is one of the factors affecting timely and affordable access to quality-assured medicines and devices.

[Learn more.](#)

REPORT

Delivering on health and financial protection for all

A 2025 NCD Alliance report on access to medicines shows that variation in pricing across and within countries is having a significant effect on the value gained from health budget spending on medicines. The report includes a four-country case study that identified minimum prices for selected essential NCD medicines, and highlights that medicine prices are often higher in lower-income settings. If all LMICs were able to obtain these medicines at the minimum prices observed in the case study, estimated spending would be 20% to 50% lower.

The report emphasises the need for LMICs to shift to a ‘high volume, low margin’ pricing model, and identifies three policies that can work together to facilitate this shift: (I) increased global and regional production of generic medicines, (II) greater use of pooled procurement, and (III) engagement of private sector suppliers and dispensaries.

[Read the full report here.](#)





STEP 5

PROCUREMENT

Procurement Snapshot

What is it

Procurement is the process through which medicines and medical devices are purchased. Procurement generally occurs after a medicine or medical device has been selected for use within the health system (through inclusion in a national formulary, essential medicines or diagnostics list, reimbursement list, or other approved benefits package) and registered.

Why it matters

If procurement processes are effective, they result in effective, quality-assured medicines and medical devices being purchased in the correct volume, at the right time, at an affordable price, and in alignment with health needs in a given context. Poor procurement can drive stockouts, inflate prices, and allow entry of substandard medicines and medical devices into the supply chain. For this reason, it is important to consider total value, not just unit price as a principle in NCD medicines and medical devices procurement. Supplier reliability, quality, and supply security matter enormously when a patient needs the same medicine every month for life; a low-cost contract that stocks out or delivers short-dated products costs more than it saves.

Problems and barriers

Access barriers within the Procurement step can contribute to four of the five **health system problems** highlighted in this toolkit:

- Medicines/devices are not prescribed or used in the country
- Medicines/devices are used but are not available or continuously available in public facilities or pharmacies
- Medicines/devices are available but unaffordable
- Medicines/devices are not being reimbursed and patients must pay out of pocket

These are some of the most common **Procurement-related barriers** driving the problems above:

- Weakness in procurement systems: inefficient and lengthy planning and purchasing/distribution; procurement processes are fragmented (public/private streams); lack of accountability and fragmentation of responsibilities across the supply chain
- Variations and lack of consolidating in medicine/device procurement practices within countries
- Procurement processes are not guided by nEML/EDL/reimbursement, formulary or procurement lists, treatment guidelines or NCD policies and prescribing, or forecasting
- Quality-assurance gaps in tenders, risking substandard products
- Mark-ups in the supply chain

Who is responsible

National public procurement is generally managed by the Ministry of Health through centralised pharmaceutical procurement agencies, commonly called Central Medical Stores (CMS), which manage the national medical stock. Private pharmacies and hospitals manage their own procurement. In LMICs, much procurement is also driven by international organisations and donors, according to organisational priorities and not necessarily according to national disease burden. Get a more in-depth view with the *Stakeholder Mapping*.



Procurement-related tools and initiatives which can support your advocacy work:

- 1999 WHO Operational principles for good pharmaceutical procurement
- WHO Model Quality Assurance System for Procurement Agencies (MQAS): Assessment Tool



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Knowledge Checklist

1. Knowledge of how the procurement cycle works and the procurement structure in-country

What this is

Pharmaceutical procurement is the sourcing of medicines and medical devices and involves a sequence of events: selection of products and needs assessment and quantification, tendering or negotiation, contract award and delivery, quality check and monitoring. The actors involved generally include a Ministry of Health, a procurement agency or Central Medical Store (CMS), a tendering committee, suppliers/manufacturers, and a regulatory authority. Price is determined by the procurement method (tender, negotiation, direct purchase), the volume purchased, the number of competing suppliers, availability of generics and biosimilars, and other factors. Procurement can be public (using government funds) or private (pharmacies, private hospitals, patients).

The choice of procurement method can affect the final price.

The main methods are:

- Open tender:** Suppliers submit offers and the contract is awarded to the most advantageous bid. Open tendering often results in the lowest prices when multiple suppliers compete.
- Restricted tender or direct negotiation:** Suppliers are approved in advance through a formal process considering good manufacturing practices, financial viability, and past performance, among other factors. Restricted tenders trade the price competition of open tendering for greater quality assurance and supply reliability and are therefore preferred when the pool of qualified suppliers is small.
- Competitive negotiation:** The buyer approaches a limited number of pre-identified suppliers (typically at least three) and may negotiate directly to obtain a specific price. This method is most common in the private sector, as in public sector procurement through direct bargaining with suppliers is prohibited.
- International or local shopping:** As above, the buyer contacts a small number of suppliers (typically three) and requests price quotations. Unlike competitive negotiation, bargaining or negotiation is generally not permitted.
- Direct procurement:** The simplest method where the buyer purchases directly from a single supplier, at either the supplier’s quoted list price or a standard pre-negotiated discount off that price, without competitive bidding. This method is recommended for very small or emergency purchases as the absence of competition makes it the least likely to produce optimal pricing. It is also used when a medicine or medical device has a single manufacturer.



Key points to check

- Does the country use a centralised procurement system (with a CMS or other national procurement agency), or a decentralised system, with private hospitals and pharmacies managing their own procurement? In practice, many countries have a mixed system: public facilities are served by centralised procurement while the private sector operates independently.
- Is there a published national formulary or procurement list that governs what the CMS buys (and does it include NCD products)?
See the Selection module.
- Is the procurement agency compliant with the WHO Model Quality Assurance System for Procurement Agencies (MQAS)?
- Does the country participate in any regional pooled procurement mechanism?

Where to find it

For an overview of procurement processes:

- [The Open Contracting for Medicines Guide](#) gives a good overview of the procurement process.
- The WHO Guideline on Country Pharmaceutical Policies assesses 10 policy instruments for managing medicine and medical device prices, including: External and internal reference pricing, value-based pricing, mark-up regulation across the pharmaceutical supply and distribution chain, promoting price transparency, tendering and negotiation, promoting the use of quality-assured generic and biosimilar medicines, pooled procurement, cost-plus pricing for setting the price of medicines and devices, and tax exemptions or tax reductions for medicines and devices.
See Pricing module.

For country-specific data:

- Central Medical Stores:** For available medicines and medical devices and procurement methods.
- Ministry of Health website:** Look for the national medicines policy, essential medicines list, annual procurement reports and tender notices.
- HAI database:** If a WHO/HAI [survey](#) has been conducted in the country, it contains information on price components including procurement.
- WHO Pharmaceutical Sector Country Profiles:** Helps countries assess their pharmaceutical sector to identify where the gaps are.

Donations of medicines and medical devices

Donations of medicines and medical devices are common and may come from pharmaceutical companies or governments in the form of aid. WHO has developed [Guidelines for medicines donations](#) to ensure best practices in the donation of these products. Donations can (unintentionally) create additional financial and administrative burden when not done appropriately.





Advocacy strategy: Procurement

Advocacy aim: High-quality medicines and medical devices are reliably available to those who need them, without wastage or inconsistencies in quality or pricing.

Action 1

Push for national procurement agencies to be benchmarked against and comply with the WHO Model Quality Assurance System for Procurement Agencies (MQAS).

How to do this:

- Check whether the national procurement agency has been assessed against MQAS; if not, advocate directly to the Ministry of Health for compliance with the system, citing the Global Fund’s and other major donors’ requirements for MQAS compliance as established precedent.
- Push for MQAS compliance to be a formal requirement for any agency procuring NCD medicines or medical devices with public funds.

Mitigating obstacles:

- If procurement agencies lack awareness of the MQAS, set up a briefing session with WHO country or regional office to introduce the framework and its benefits.
- If MQAS assessments require technical or budgetary resources that are lacking, identify whether donor partners can co-fund or offer technical support to the process, and frame this as a capacity-building opportunity.

Stakeholders:

- Ministry of Health; National procurement agencies; WHO country and regional offices

Tips for advocates:

- The Global Fund and other major donors already require MQAS as part of their quality assurance policy, which gives advocates a concrete external precedent to cite.



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Action 2

Identify and advocate for improvements within existing procurement systems

How to do this

- Start by mapping the bottlenecks within your country's procurement system.
- Engage procurement agencies, Central Medical Stores and health facility staff to understand where delays, inefficiencies or price distortions occur in practice.
- Use this mapping to identify feasible improvements within the existing system, such as better aggregation of demand across facilities or regions, or more competitive tendering processes.
- Where a regional pooled procurement mechanism already exists (such as the *PAHO Strategic Fund*), check whether priority NCD-relevant medicines and medical devices are included in its scope.
- Refer back to your work from the *Forecasting module*, as forecasting data accuracy, visibility and transparency are essential for effective procurement.

Mitigating obstacles

- Focus first on what can be improved within the existing system before advocating for larger structural reforms.
- If information on the national procurement system and processes is difficult to find, an official information request can be written to ask the Ministry of Health for their procurement data, which is often legally a matter of public record.

Stakeholders

- National procurement agencies, Central Medical Stores, health professionals, and where relevant, regional mechanisms such as the PAHO Strategic Fund.

Tips for advocates

- The most useful starting point is often a conversation with those operating the procurement system, as they will know where the practical bottlenecks are.
- Last-mile issues such as stock-outs may not necessarily be a procurement failure – they can also stem from problems in distribution, inventory-management, or logistics failures. Ask about the existence of these problems in your conversations with individuals operating the procurement system (see point above).
- Requesting procurement data itself sends an advocacy message, signalling that civil society expects transparency and accountability in how medicines and medical devices are purchased.
- Along with price, prioritise supply security and resilience as a procurement consideration to reduce the risk of stock outs or other supply issues. Diversifying qualified suppliers, framework agreements with call-offs, and buffer strategies reduce the risk of single-source dependence.
- Advocate for funding of forecasted need in the procurement budget: Accurate forecasts need not only be produced but funded and committed in the procurement budget. Engage the Ministry of Finance in discussions on the gap between forecasted need and funded quantity of NCD medicines and medical devices.

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CASE STUDY

PAHO Strategic Fund pooled procurement of antihypertensive medicines (2020)

Key message

Pooling demand across countries can secure substantially lower prices than any one country can achieve alone.

In 2020, PAHO consolidated regional demand for 18 antihypertensive medicines with the participation of six countries, resulting in an international tender. The tender generated long-term supply agreements for generic antihypertensive medicines approved by PAHO and WHO reference regulatory authorities, securing regionally accessible prices that individual country procurement had failed to achieve. A benchmarking [study](#) comparing Strategic Fund prices against public procurement databases for five antihypertensive medicines found that countries buying outside the fund were paying anywhere from 20% to 99% more.

[Learn more.](#)

REPORT

Delivering on health and financial protection for all

A 2025 NCD Alliance report on access to medicines shows that the budget for NCD medicines is currently insufficient in many LMICs because of low demand for NCD services due to low awareness, diagnosis and treatment adherence. To reach the 80% coverage target, the quantity of NCD medicines manufactured and procured worldwide would actually need to increase by several-fold; for hypertension for example, it would be a factor of about four. This highlights that procurement can only be as effective as the forecasting and quantification that informs it.

[Read the full report here.](#)



Follow-the-Product barrier analysis

Identifying and addressing product-specific access barriers

This section uses a step-by-step approach to identify and analyse access barriers as they present for specific NCD medicines and medical devices.

To complete the Follow-the-Product barrier analysis, first you will need to establish which product will be analysed. The *Advancing Access product list* can be consulted, which compiles WHO recommendations for medicines and devices to be used in primary healthcare systems with strong referral systems to secondary and tertiary care.

Then select the main access issue to investigate from a list of **five problems that are commonly observed in LMIC health systems** (previously introduced). More than one of these problems often exist within a country – and sometimes, all of them. In this case, the analysis can be repeated for each problem observed.

1. Medicine/device is not prescribed or used in the country
2. Medicine/device is used but is not available or not continuously available in public facilities or pharmacies
3. Medicine/device is available but is not of adequate quality
4. Medicine/device is available but unaffordable
5. Medicine/device is not being reimbursed and patients must pay out of pocket

After selecting the problem to be addressed, you will be directed to the corresponding barrier analysis questionnaire. The questionnaire is designed to identify barriers that may contribute to the problem, determine where within the access pathway these barriers arise, and highlight policy decisions that governments can make to support health systems in addressing them.

This toolkit focuses specifically on five key steps within the access pathway where government policies or decisions can influence health systems – **Selection, Regulation, Forecasting, Pricing and Procurement**. Therefore, for each access problem, the Follow-the-Product barrier analysis includes questions related to one or more of the five steps. Because access barriers are often interconnected and can arise at multiple points within the system, it is likely that more than one barrier will be identified – this reflects that barriers exist at multiple steps of the access pathway.

For every barrier identified, the toolkit provides suggested advocacy actions as well as supporting tools and resources.

To begin the barrier analysis for specific products, start here:

Choose the product: You can refer to the *Advancing Access product list*

Choose the problem you will focus on (this step can be repeated in case of multiple problems):

- Problem 1**
Medicine/device is not prescribed or used in the country
- Problem 2**
Medicine/device is used but is not available or not continuously available in public facilities or pharmacies
- Problem 3**
Medicine/device is available but are not of adequate quality
- Problem 4**
Medicine/device is available but unaffordable
- Problem 5**
Medicine/device is not being reimbursed and patients must pay out of pocket

PROBLEM 1

Medicine/devices not being prescribed (by healthcare professionals) or used in-country

Question			
Is the medicine/device included in treatment guidelines and the national EML / EDL, formulary, procurement or reimbursement list?			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Continue to next question		
No	If the medicine/device is not included in treatment guidelines and the national EML / EDL, formulary, procurement or reimbursement lists, this reduces the likelihood of it being continuously available through the public system and being reimbursed. Inclusion on the national EML is typically a prerequisite for inclusion in reimbursement or health benefit packages, and signals political prioritisation of the medicine/device. Price can be a reason why a medicine/device is not selected for inclusion.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs	Inclusion of the medicine/device on all relevant lists so it can be prescribed, used and reimbursed. Note: WHO EML/EDL should be used to guide selection.
Included in some but not all	If the medicine/device is not included in all relevant lists, if lists are outdated (not revised in the last 3–5 years), or if they are misaligned with one another, this can create gaps in availability. Moreover, in many settings, prescribing is also influenced by what healthcare workers expect to find available: guidelines that are not actively implemented or disseminated may have limited impact on prescribing behaviour. Note: Not all countries will have all list types. What matters is that the lists which do exist are aligned and actively used.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs	Aligning and/or updating relevant lists to include this medicine/device.

Question			
Is the medicine/device registered with the National Regulatory Authority?			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Continue to next question		
No	If the medicine/device is not registered, it cannot be procured through conventional public procurement channels and will either not enter the country at all, enter illegally, or require a special authorisation process, making procurement lengthy and costly and/or circumventing national processes. Registration also affects price competition: where no or very few suppliers are registered, the Ministry of Health has almost no leverage on price. A key reason why the manufacturer (or marketing authorisation holder) may not seek registration in a given country is the absence of a credible demand signal or a commercially viable market, which reduces their incentive to engage with regulatory processes. Additional factors include limited regulatory capacity in-country and/or complex, costly regulatory processes that present barriers to timely medicine/device approval.	WHO Prequalification programme, WHO Collaborative Registration Procedure, WHO tools for strengthening regulatory systems	Encourage governments to strengthen the capacity and resources of National Regulatory Authorities and/or use reliance pathways where appropriate to accelerate registration.

Question

Is the medicine/device available in the public sector? (This is to establish whether demand for the medicine/device is being accurately quantified. For example, check whether pharmacies usually have enough stock for all patients, without frequent stock-outs or large amounts expiring.)

Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Continue to next question		
No	When demand is not accurately quantified, procurement may not be suited to actual population needs, resulting in availability gaps (stockouts and/or shortages) or waste (expired medicines/devices). Even where demand is being quantified, procurement decisions may not be guided by forecasting data (possibly due to insufficient budget) creating a disconnect that also contributes to availability gaps.	UNICEF Supply Forecasting Tool (as a model) and forthcoming WHO NCD Forecasting tool; WHO Global Health Observatory (for disease burden data); IHME Data Portal, STEPS Data portal; 1999 WHO Operational principles for good pharmaceutical procurement (currently under review with an updated version expected end of 2026)	Advocate for strengthened NCD forecasting tools and pilots that are adaptable to different contexts, as well as data collection methods, to better align procurement lists with estimated need forecasts and the country’s disease burden.

Question

Is the medicine/device affordable?

Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Continue to next question		
No	Price can lead to the medicine/device not being selected, prescribed or used; the national budget for procurement may be exhausted, leading to inconsistent availability in pharmacies; or the medicine/device may be too expensive for the patient.	WHO Guideline on Country Pharmaceutical Pricing Policies; WHO Academy Course on Pharmaceutical Pricing Policies	Raise awareness of pharmaceutical pricing policies and associated mechanisms to ensure medicines and devices are affordable to health systems and patients.

Question			
Is the medicine/device being procured in sufficient quantities in the public sector? (eg. Do pharmacies receive what they requested?)			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Where the medicine/device is being procured but not reaching patients, the issue may lie in how it is being procured, not just whether it is. Health information systems may be too weak to appropriately communicate demand. Procurement may be occurring but not of appropriate formulations, for example. Other weaknesses may include inefficient or lengthy planning and purchasing cycles, fragmented procurement (across public and private streams), and lack of accountability across the supply chain. Gaps in healthcare worker training may also be a factor but are beyond the scope of this toolkit.	1999 WHO Operational principles for good pharmaceutical procurement (currently under review with an updated version expected end of 2026)	Monitoring the supply chain to find gaps.
No	If the medicine/device is registered and listed but not being procured, this may indicate poor forecasting and quantification processes that do not inform procurement, or lack of budget.	1999 WHO Operational principles for good pharmaceutical procurement (currently under review with an updated version expected end of 2026)	Advocate for strengthened NCD forecasting tools and pilots that are adaptable to different contexts, as well as data collection methods, to better align procurement lists with estimated need forecasts and the country’s disease burden.

PROBLEM 2

Medicine/device is used but not available or not continuously available in public facilities or pharmacies

Question			
Is the medicine/device included in treatment guidelines and the national EML / EDL, formulary, or procurement list?			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Continue to next question		
No	If the medicine/device is not included in treatment guidelines and the national EML / EDL, formulary, procurement or reimbursement lists, this reduces the likelihood of it being continuously available through the public system and being reimbursed. Inclusion on the national EML is typically a prerequisite for inclusion in reimbursement or health benefit packages, and signals political prioritisation of the medicine/device. Price can be a reason why a medicine/device is not selected for inclusion.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs	Inclusion of the medicine/device on all relevant lists so it can be prescribed, used and reimbursed. Note: WHO EML/EDL should be used to guide selection.
Included in some but not all	If the medicine/device is not included in all relevant lists, if lists are outdated (not revised in the last 3–5 years), or if they are misaligned with one another, this can create gaps in availability. Moreover, in many settings, prescribing is also influenced by what healthcare workers expect to find available: guidelines that are not actively implemented or disseminated may have limited impact on prescribing behaviour. Note: Not all countries will have all list types. What matters is that the lists which do exist are aligned and actively used.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs	Aligning and/or updating relevant lists to include this medicine/device.

Question			
Is the medicine/device registered by the National Regulatory Authority?			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Continue to next question		
No	If the medicine/device is not registered, it is unlikely to be continuously available in public pharmacies as it cannot be procured through standard channels and would require special authorisation. Any medicine/device found in facilities without registration may also be falsified or substandard. A key reason why manufacturers may not seek registration in a given country is the absence of a credible demand signal or a commercially viable market, which reduces their incentive to engage with regulatory processes. Additional factors include limited regulatory capacity in-country and/or complex, costly regulatory processes that present barriers to timely medicine/device approval.	WHO Prequalification programme, WHO Collaborative Registration Procedure, WHO tools for strengthening regulatory systems	Encourage governments to strengthen the capacity and resources of National Regulatory Authorities and/or use reliance pathways where appropriate to accelerate registration.

Question			
Are stockouts/expiries isolated/occasional? (This is to establish whether demand for the medicine/device is being accurately quantified)			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Continue to next question		
No	If shortages/stock-outs/expiries recur predictably, this could point to a forecasting/quantification problem. When demand is not accurately quantified, procurement may not be suited to actual population needs, resulting in availability gaps (stockouts and/or shortages) or waste (expired medicine/ devices). Even where demand is being quantified, procurement decisions may not be guided by forecasting data (possibly due to insufficient budget) creating a disconnect that also contributes to availability gaps.	UNICEF Supply Forecasting Tool (as a model) and forthcoming WHO NCD Forecasting tool; WHO Global Health Observatory (for disease burden data); IHME Data Portal, STEPS Data portal	Advocate for strengthened NCD forecasting tools and pilots that are adaptable to different contexts, as well as data collection methods, to better align procurement lists with estimated need forecasts and the country’s disease burden, as well as mobilisation of the budget.
Question			
Is the medicine/device being procured in sufficient quantities in the public sector? (e.g. Do pharmacies receive what they requested?)			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	The problem may lie beyond the scope of this toolkit.		
No	If demand is being reasonably estimated at facility level but supply still falls short, there may be a disconnect between that data and actual procurement decisions, which can explain availability gaps.	1999 WHO Operational principles for good pharmaceutical procurement (currently under review with an updated version expected end of 2026)	Monitoring the supply chain to find gaps.

PROBLEM 3

Medicine/device is available but not of adequate quality

(Signs of poor quality: quality test failures, medicine/device recalls, reports of substandard or falsified medicines, regulatory warnings.)

Question			
Is the medicine/device registered by the National Regulatory Authority?			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	If the medicine/device is registered but not of good quality, this may be due to limited regulatory capacity which does not ensure medicine/device quality, safety and efficacy. In practice, medicine/device quality issues often come to light not through formal regulatory channels but through signals such as increased adverse event reports, clinician observations of unexpected treatment failure (for example, patients failing to achieve blood pressure control despite adherence), or case reports and qualitative data from healthcare providers.	WHO Model Quality Assurance System for Procurement Agencies (MQAS): Assessment Tool; WHO tools for strengthening regulatory systems; WHO Prequalification Programme; WHO Collaborative Registration Procedure; Quality assurance of pharmaceuticals: a compendium of guidelines and related materials, tenth edition. Volume 2. Good manufacturing practices and inspection.	Encourage governments to strengthen the capacity and resources of National Regulatory Authorities (NRA) and/or use reliance pathways where appropriate to accelerate registration. Here the responsibility is not only on the NRA but also on procurers who need to define quality assurance requirements and apply them. Refer to the WHO MQAS for procurement agencies under review.
No	Limited regulatory capacity increases the risk of falsified or substandard medicine/devices entering the market.	WHO Model Quality Assurance System for Procurement Agencies (MQAS): Assessment Tool; WHO tools for strengthening regulatory systems; WHO Prequalification Programme; WHO Collaborative Registration Procedure; Quality assurance of pharmaceuticals: a compendium of guidelines and related materials, tenth edition. Volume 2. Good manufacturing practices and inspection.	Encourage governments to strengthen the capacity and resources of National Regulatory Authorities and/or use reliance pathways where appropriate to accelerate registration.

Question			
Does the procurement process include clear quality requirements?			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	If quality requirements are included in procurement, the barrier may lie in how those requirements are applied or enforced.		
No	The absence of quality-assurance requirements in tender documents increases the risk of having substandard or falsified medicines/devices entering the market.	WHO Model Quality Assurance System for Procurement Agencies (MQAS): Assessment Tool; Quality assurance of pharmaceuticals: a compendium of guidelines and related materials, tenth edition. Volume 2. Good manufacturing practices and inspection.	Encourage governments to strengthen the capacity and resources of National Regulatory Authorities (NRAs) and/or use reliance pathways where appropriate to accelerate registration. Here the responsibility is not only on the NRA but also on procurers who need to define quality assurance requirements and apply them. Refer to the WHO MQAS for procurement agencies under review.

PROBLEM 4

Medicine/device is available but unaffordable

Question			
Is the medicine/device included in treatment guidelines and the national EML / EDL, formulary, or procurement list?			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	If the medicine/device is listed and available but unaffordable, the barrier may lie in the design of the reimbursement or health benefit package which does not cover the product in question or, only partially, with high co-payments leaving significant costs to the patient. Inclusion on the national EML is typically (though not universally) a prerequisite for inclusion in a reimbursement scheme, but does not guarantee it.	WHO UHC Compendium and the SPDI Tool; WHO ‘How to develop and implement a national drug policy’ 2nd edition	Inclusion of the medicine/device in the benefit package of a reimbursement scheme or UHC policies.
No	The medicine/device may be unaffordable because it is not included in relevant lists, which may prevent it from being prioritised for public financing or price regulation. Price may also be the reason it was not listed in the first place, or there may be conflicts of interest in the national selection process.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs; WHO Managing conflicts of interest, a how-to guide for public pharmaceutical-sector committees in low- and middle-income countries.	Inclusion of the medicine/device on all relevant lists so it is more likely to be prioritised for public financing. Note: WHO EML/EDL should be used to guide selection.
Included in some but not all	The medicine/device may be unaffordable because lists are incomplete, outdated, or misaligned with one another, which may prevent it from being prioritised for public financing or price regulation. Not all countries will have all list types, what matters is that the lists that exist are aligned and actively used.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs	Aligning and/or updating relevant lists to include this medicine/device.

Question

Is the medicine/device free at the point-of-care, included in the benefit package of a reimbursement scheme, health insurance coverage or is there a UHC policy around the medicine/device?

Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	If the medicine/device is included in a reimbursement scheme or benefit package in theory, but patients still pay out-of-pocket in practice, this may indicate that the scheme is not well-designed (for example, co-payments are too high), or that high manufacturer prices and/or supply chain mark-ups are undermining it.	WHO UHC Compendium and the SPDI Tool; WHO 'How to develop and implement a national drug policy' 2nd edition	Inclusion of the medicine/device in the benefit package of a reimbursement scheme or UHC policies.
No	If the medicine/device is listed but not reimbursed, then patients may be paying the full retail price out-of-pocket.	WHO UHC Compendium and the SPDI Tool; WHO 'How to develop and implement a national drug policy' 2nd edition	Inclusion of the medicine/device in the benefit package of a reimbursement scheme or UHC policies.

Question

Is the medicine/device procured through a competitive tender or negotiated pricing mechanism?

Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	Competitive procurement is in place but the medicine/device remains unaffordable: high manufacturer price and/or supply chain mark-ups may be limiting the impact of procurement negotiations.	WHO Guideline on Country Pharmaceutical Policies	Identifying and advocating for improvements within existing procurement systems, so that high-quality medicines and devices are reliably available to those who need them, without wastage or inconsistencies in quality or pricing.
No	Absence of competitive procurement or price negotiation mechanisms may be contributing to high medicine/device prices.	1999 WHO Operational principles for good pharmaceutical procurement (currently under review with an updated version expected end of 2026)	Identifying and advocating for improvements within existing procurement systems, so that high-quality medicines and devices are reliably available to those who need them, without wastage or inconsistencies in quality or pricing.

PROBLEM 5

Medicine/device is not reimbursed, patients are paying out-of-pocket (public and private sector)

Question			
Is the medicine/device included in treatment guidelines and the national EML / EDL, formulary, or procurement list?			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	If the medicine/device is not reimbursed but is listed in all relevant lists, it may be due to budget constraints.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs	Inclusion of the medicine/device on all relevant lists so it is more likely to be reimbursed. Note: WHO EML/EDL should be used to guide selection
No	If the medicine/device is not included in relevant lists or treatment guidelines, it is unlikely to be reimbursed. Price may also be a reason it was not listed.	EML, EDL, WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list; PEN; national STGs	Inclusion of the medicine/device on all relevant lists so it is more likely to be reimbursed. Note: WHO EML/EDL should be used to guide selection

Question			
Is the medicine/device free at the point-of-care, included in the benefit package of a reimbursement scheme, health insurance coverage or is there a UHC policy around the medicine/device?			
Answer	Likely barrier(s) identified	Relevant tools	Advocacy focus
Yes	If the medicine/device is included in a reimbursement scheme or benefit package in theory, but patients still pay out-of-pocket in practice, this may indicate that the scheme is not well-designed (for example, co-payments are too high), or that high manufacturer prices and/or supply chain mark-ups are undermining it.	WHO UHC Compendium and the SPDI Tool; WHO 'How to develop and implement a national drug policy' 2nd edition	Inclusion of the medicine/device in the benefit package of a reimbursement scheme or UHC policies.
No	If the medicine/device is listed but not free at the point-of-care, included in the benefit package of a reimbursement scheme or health insurance coverage, then patients will pay the full retail price out-of-pocket.	WHO UHC Compendium and the SPDI Tool; WHO 'How to develop and implement a national drug policy' 2nd edition; WHO Guideline on Country Pharmaceutical Pricing Policies	Inclusion of the medicine/device in the benefit package of a reimbursement scheme or UHC policies.

Highlighted tools and initiatives

Selection: Priority tools

WHO Model List of Essential Medicines (EML) and the WHO Model List of Essential Medicines for Children (EMLc)

The WHO Essential Medicines List contains the medications considered to be most effective and safe to meet the most important needs in a health system. Medicine selection for the EML is based on public health relevance, efficacy, safety, availability, feasibility, and acceptability. Applications to update the EML are assessed every two years by a WHO Expert Committee. The 2025 list contains 523 medicines, with newly added medicines for cancer, diabetes, cystic fibrosis, tobacco cessation and sickle cell disease. The WHO EMLc is a separate list for children up to and including 12 years of age.

The WHO EML is a model list used to guide governments, procurement agencies, and health systems in developing their own national essential medicines lists and selecting the priority medicines for their national context. National EMLs often inform which medicines should be available at the point of care, procured, and prioritised when resources are constrained, and which medicines will be included in health benefit packages. The exact use varies between countries, so make sure to check what the situation is in your national setting. This is especially critical for NCDs, where various treatment options may exist and rational selection is essential for low-resource settings to maximise health impact.

On the global and regional level, the WHO EML is used to prioritise medicines by various initiatives, such as global health initiatives (e.g. Gavi, Unitaid, Global Fund, UNICEF), for strategic purchasing and procurement systems (e.g. PAHO Strategic Fund), and other access initiatives like the Medicines Patent Pool, which only considers medicines listed or soon to be listed on the WHO EML. Applications to delete, edit or add medicines onto the list can be submitted to WHO by any stakeholder.

Related tools and resources

- To support the development of national EML please see [Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list](#).
- To check your county’s current list, please see the [WHO Repository](#) of national EMLs and Global Essential Medicines dashboard, a [database](#) of essential medicines lists for 137 countries.

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WHO Model List of Essential In Vitro Diagnostics

The WHO Model List of Essential In Vitro Diagnostics (EDL), like the Essential Medicines List, serves as a model list for governments, procurement agencies, and health systems to develop their own national lists, ensuring the most vital tests are available, accessible, and affordable across different healthcare settings. Unlike the WHO EML, which was established in 1977, the EDL has only been in existence since 2018.

The first edition of the EDL focused heavily on infectious diseases like HIV, tuberculosis and malaria, but subsequent updates have seen the inclusion of a growing number of NCD diagnostics, including for cancer, diabetes, cardiovascular disease, COPD, and chronic kidney disease, making it a key tool for NCD advocates working at national, regional and global levels. While countries are beginning to use the list to guide the prioritisation of diagnostics, many countries do not use national diagnostics lists, and uptake is still developing. Early diagnosis is a pillar of an effective NCD response, yet approximately half the global population has little to no access to even basic diagnostic testing, signaling an urgent need for advocacy and action.

The WHO EDL influences global and regional policy to prioritise diagnostics by various global and regional initiatives, such as for strategic purchasing and procurement. Anyone can submit an application to add, edit, or delist an in vitro diagnostic category via expression of interest to the EDL Secretariat.

WHO Selection of essential medicines at country level: Using the WHO model list of essential medicines to update a national essential medicines list

This WHO resource provides step-by-step guidance at country level on the selection of essential medicines, using the WHO Model List of Essential Medicines as a guide for updating national essential medicines lists (nEMLs). It summarises key aspects of the evidence-based approach to medicines selection and describes strategies and processes to ensure successful implementation of nEMLs.

Main focus areas include the establishment of a national committee for evidence-based medicines selection, WHO's guiding principles for evaluating and selecting medicines, linkage of medicine selection to national treatment guidelines, transparency in decision making, comparative costs and cost-effectiveness, addressing potential conflicts of interest, and tracking of medicine use. In essence, this resource accompanies countries in building robust national medicine policies by adapting a globally recognised standard and processes to meet their specific health challenges.

The target audience specified by WHO for this document are ministries of health responsible for nEMLs and reimbursement lists, and policy or decision makers considering establishing systems for selecting medicines or updating medicines lists as part of efforts to ensure access to medicines and UHC. However, advocates may also find it highly useful to inform and guide conversations with these key stakeholders.

Related resources

To support the development of a national EDL please see the [WHO technical brochure](#) on how to develop and implement a national essential diagnostics list.

Related resources

[WHO Priority Medical device information system MeDevIS - an open access WHO electronic database of Medical Devices](#), including in vitro diagnostics, some assistive products and other health products.

WHO Package of Essential Noncommunicable (PEN) Disease Interventions for Primary Health Care

WHO PEN defines a minimum set of interventions for the detection, diagnosis, treatment and care of diabetes, cardiovascular diseases and chronic respiratory diseases, as well as the early diagnosis of cancer in primary care, suitable for use in low-resource settings. The package includes ready-to-use clinical resources, designed for primary health care physicians and health workers, and a list of health products that should be available in all health care facilities, making it a useful, NCD-specific complement to the WHO EML, with a set of necessary interventions for countries to draw on and utilise.

The WHO PEN document provides a step-by-step implementation guide for integrating NCDs into PHC. It supports stakeholder engagement, assessment of current NCD service provision, development of an NCD service delivery model at PHC level, capacity building for healthcare workers, monitoring and evaluation, and review and scale-up.

In terms of access to medicines, diagnostics and other medical devices, WHO PEN complements the WHO EML and EDL, with a focus on implementation that makes WHO PEN ideal for advocates working towards more comprehensive health system strengthening for NCDs. PEN can also be used alongside the [WHO UHC Compendium](#) and SPDI platform to cost and plan delivery of these interventions as part of a national benefit package.

WHO PEN-Plus

WHO PEN-Plus is a strategy for the African Region (WHO AFRO) to tackle severe, complex NCDs like type 1 diabetes, rheumatic heart disease, and sickle cell disease, bringing essential care for these diseases to underserved populations by decentralising services from urban hospitals to clinics and district care centres, closer to where people live. It expands on WHO PEN to cover these regional health priorities that often fall through the cracks.

Additional disease-specific technical packages and tools

- [WHO HEARTS](#) technical package for cardiovascular disease management in primary health care
- [WHO HEARTS-D](#) for diagnosis and management of type 2 diabetes
- [WHO Intersectoral Global Action Plan on Epilepsy and Other Neurological Disorders \(IGAP\) 2022–2031](#)
- [WHO Mental Health Gap Action Programme \(mhGAP\)](#)
- [WHO List of Priority Medical Devices for the Management of Cardiovascular Diseases and Diabetes](#)
- [Global Diabetes Compact](#)
- [WHO Guideline for the Pharmacological Treatment of Hypertension in Adults](#)
- [WHO List of Priority Medical Devices for Cancer Management](#)
- WHO report [Improving Access to Medicines for Neurological Disorders](#)
- [Global Initiative for Asthma \(GINA\)](#)

Selection: Additional tools

[WHO How to develop and implement a national drug policy 2nd edition](#)

This WHO resource provides detailed guidelines for countries to develop national medicines strategies that are accessible, affordable, effective and safe. It covers all of the essential areas involved – drug selection, procurement, regulation, quality assurance, rational use, finance, and monitoring – making it a vital tool for national governments and health ministries, health professionals and policymakers as well as organisations and advocates working towards improved access to medicines. Note that this resource is from 2001, and pending an update from WHO.

The primary use of this resource is to provide a step-by-step guide for governments and ministries, particularly in LMICs, to plan, develop, implement and monitor formal drug policies that align with their specific health needs and context. It is also a useful framework for policymakers and for advocates working to improve access to medicines, with a focus on the selection of essential medicines.

[UHC Compendium and the Service Package Delivery and Implementation \(SPDI\) Platform](#)

The UHC Compendium and SPDI platform are WHO tools designed to support countries to select services for Universal Health Coverage. The compendium is a global repository of health interventions spanning promotive, preventive, diagnostic, resuscitative, curative, rehabilitative and palliative services as well as intersectoral interventions. The WHO SPDI platform is a digital planning tool to implement these services. SPDI helps translate the Compendium data into concrete health service packages with clear implementation roadmaps, linking services to required human resources, equipment, medicines, and diagnostic tools. It includes the OneHealth Tool (OHT), designed to support strategic health planning in LMICs. Costs, budget impact, and systems requirements can be outputted; and in some cases, cost-effectiveness analyses as well. A series of videos provide an overview of how the SPDI platform enables countries to create context-relevant UHC packages, along with guidance on using the platforms and tools.

[WHO report Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, 2nd ed](#)

This document outlines a collection of high-priority and recommended strategies for tackling NCDs, providing a cost-effectiveness rationale to support advocacy for NCD interventions. It covers prevention and the following NCD care areas:

- Pharmacological interventions for tobacco users
- Care for alcohol use disorders
- Pharmacological interventions to manage diabetes, cardiovascular diseases, chronic respiratory diseases, and cancer

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Regulation: Priority tools

WHO Collaborative Registration Procedure for Medical Products

The WHO Collaborative Registration Procedure (CRP) is a reliance and collaboration mechanism to accelerate registration of medicines and medical devices. National regulatory authorities (NRAs) participating in CRP can rely on the product evaluations already conducted by Stringent Regulatory Authorities (SRAs) or WHO Prequalification (PQ), allowing them to fast-track their national registration procedure. NRAs must sign a participation agreement with WHO confirming their commitment to the procedure requirements before they can adopt and implement the CRP.

It is important to note that a product only becomes available through CRP if the manufacturer actively opts in to the procedure and consents to the sharing of their product dossiers with participating NRAs; CRP participation is not automatic upon prequalification or SRA approval.

The CRP’s aim is for NRAs to be able to issue a regulatory decision on a submitted product within 90 days, thereby avoiding delays in registering products in a country. The 69 countries that take part in the WHO CRP are [listed here](#). The list of SRA CRP registered products is [available here](#) and covers mainly HIV/ AIDS, TB, malaria, reproductive health, and vaccines (for more details of the process [see this source](#)). For NCDs, the list includes mounjaro (for T2D), oncology biologics and some products for neurological disorders. The list of PQ CRP registered products is [available here](#) and to the best of our knowledge does not include any NCD products. CRP can also be used for prequalified in vitro diagnostics (IVDs).

WHO Prequalification Programme

The WHO Prequalification Programme (PQP) is an international quality assurance mechanism established in 1987. Products that meet WHO prequalification requirements are listed as prequalified and become eligible for procurement by UN agencies, governments and other partners, and are subject to ongoing monitoring. For LMICs with limited regulatory capacity, WHO PQP enables the purchase of large volumes of quality-assured products from manufacturers which have been vetted by the programme. The programme also significantly reduces the time and resources required for a product to achieve regulatory approval and is a trusted pathway to safe and effective products. The key difference with CRP is that in PQP, WHO acts as the assessor, directly evaluating product dossiers; whereas in CRP, WHO enables NRAs to rely on assessments carried out by other NRAs.

For a product to be considered for prequalification, WHO must issue an invitation to manufacturers for a specific product. If interested, the manufacturer must then submit a comprehensive dossier for the relevant products or ingredients. If the application is successful, the product is added to the WHO List of Prequalified Products.

The programme is widely acknowledged as having been successful in establishing quality assurance for HIV, TB and malaria medicines. For NCDs, long-acting insulin analogues have been prequalified, as well as biosimilars for cancer. WHO has issued expressions of interest for tobacco cessation products, IVDs for diabetes and GLP-1s.

WHO tools for strengthening regulatory systems

WHO offers several frameworks to strengthen regulatory systems and accelerate approvals of health products.

- [The WHO Global Benchmarking Tool \(GBT\)](#) evaluates NRAs across 268 indicators, assigning maturity levels (ML1-4). NRAs reaching ML3 or ML4 are designated [WHO-Listed Authorities \(WLAs\)](#), which means that other NRAs can ‘rely’ on their regulatory decisions, allowing them to speed up their own national drug approvals based on the assessments performed by these trusted authorities.
- [WHO Good Reliance Practices](#) (2021) and [WHO Good Regulatory Practices](#) (2021) provide guidance on how NRAs should implement reliance in practice.
- [Quality assurance of pharmaceuticals: a compendium of guidelines and related materials: volume 2: Good manufacturing practices and inspection, 10th ed.](#) This compendium summarises recommendations and guidelines related to Good Manufacturing Practices (GMP) to facilitate countries' establishment of robust regulatory systems and upholding of international standards in pharmaceutical quality assurance.

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Forecasting

Priority tools

WHO Global Health Observatory

The WHO Global Health Observatory is a comprehensive online repository providing data on over 1,000 health indicators for 194 member states. It acts as a central portal for tracking global health priorities, including mortality, disease prevalence, health system resources, and progress toward the Sustainable Development Goals.

For NCD forecasting, it is particularly useful for providing standardised data on disease burden (prevalence, incidence, mortality), risk factor data, health service capacity, and medicine availability, which can be used in the creation of evidence-based projections for medicine needs, supporting a shift from reactive procurement to proactive, data-driven forecasting.

Global Burden of Disease (IHME) Study

The IHME Global Burden of Disease, Injuries and Risk Factors study quantifies levels and trends in health and enables comparison between diseases, risk factors, countries, regions, age groups, etc. Country profiles can be used to model the size of the patient population requiring treatment.

WHO STEPS and National Health Surveys

WHO STEPS Surveys and National Health Surveys provide country-level data on risk factors and diseases (eg hypertension prevalence, diabetes rates, smoking) and, in some cases, diagnosis and treatment rates.

Forecasting tools in development

Several NCD forecasting tools are in development, including by WHO, the Coalition on Access to NCD Medicines led by PATH, and the NCDI Poverty Network & Clinton Health Access Initiative. Details to be added on publication.

Additional tools

UNICEF Forecasting & Supply Planning for All Tool (FSP4All tool)

The UNICEF Forecasting & Supply Planning for All tool (FSP4II) is a set of digital, spreadsheet and guidance resources used to estimate future demand for health products. These tools help countries prevent stockouts, align procurement with budgets, and ensure forecasting is accurate enough to meet needs.

FSP4II and its associated frameworks can be used for NCD medicines and diagnostics. Although the tool was designed for vaccines and immunisation supplies, the principles and methods are adaptable to NCD products. [There is an accompanying manual available here.](#)

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Pricing: Priority tools

WHO Guideline on Country Pharmaceutical Pricing Policies

The WHO Guideline on Country Pharmaceutical Pricing Policies (2020) is designed to support countries in their development of pricing policies for pharmaceutical products. It presents ten policies, evidence-based recommendations on their implementation, and various considerations when operationalising the policies and recommendations. The ten policies include: external reference pricing, internal reference pricing, value-based pricing, mark-up regulation across the supply and distribution chain, price transparency, tendering and negotiation, promoting the use of quality-assured generic and biosimilar medicines, pooled procurement, cost-plus pricing, and tax exemptions or reductions.

WHO Academy Course on Pharmaceutical Pricing Policies

The WHO Academy has developed an online course to equip policymakers and health professionals with knowledge on pharmaceutical pricing policies. The course is self-paced, in English and takes roughly 4.5 hours to complete.

WHO/HAI Survey on Pricing and Availability of Medicines

The WHO/HAI Survey on Pricing and Availability of Medicines is a standardised survey methodology used to measure price, availability, and affordability and price components, such as taxes and mark-ups. The methodology analyses data on prices of medicines (government procurement prices and out-of-pocket costs for patients) and compares them against international reference prices. Each survey covers up to 50 medicines (14 global core medicines that allow for global and regional comparisons; and 36 supplementary medicines).

The key metric is the Median Price Ratio (MPR) which is calculated by dividing the median local unit price of a medicine by an IRP. An MPR of ‘2’ means the local price is twice the IRP; an MPR below 1 means it is cheaper. This allows for comparisons between countries. Affordability is measured by calculating how many days’ wages of the lowest paid unskilled government workers are needed to purchase a standard treatment course.

Pharmaceutical Pricing and Reimbursement Information network (PPRI)

The Pharmaceutical Pricing and Reimbursement Information (PPRI) network, hosted by the Austrian National Public Health Institute (GÖG) as a WHO Collaborating Centre, produces country-level profiles covering pharmaceutical systems with a focus on pricing, procurement, and reimbursement across both outpatient and inpatient settings. Profiles are available in longer and shorter versions, alongside the more concise PPRI Pharma Briefs series (introduced in 2019), which offer up-to-date country snapshots.

Pricing: Additional tools

TRIPS Flexibilities Database

Medicines Law & Policy (ML&P) is an independent non-profit organisation based in the Netherlands which provides research and resources on intellectual property and health. They host the TRIPS Flexibilities Database, which documents instances when authorities have invoked, planned to invoke, or have been asked to invoke a TRIPS flexibility for public health reasons, particularly to ensure access to medicines.

The TRIPS (Trade-Related Aspects of Intellectual Property Rights) Agreement of the World Trade Organization (WTO) provides the international legal standard of intellectual property protection for WTO members. There are certain ‘flexibilities’ to the agreement which enable ‘developing’ and ‘least-developed countries’ easier access to health technologies.

The flexibilities included in the database are compulsory licensing, including public non-commercial use (TRIPS art. 31), patent exceptions (TRIPS art. 30), the Least Developed Country transition provisions (Paragraph 7 of the **Doha Declaration on TRIPS and Public Health**) and parallel import (Paragraph 5(d) Doha Declaration). ML&P also provides a decision-making **flowchart** to identify which flexibility is best suited to your needs, as well as model licences, case studies and guides for invoking TRIPS flexibilities.



Voluntary Licensing via the **Medicines Patent Pool**

The Medicines Patent Pool (MPP) is a UN-backed public health organisation that works to increase access to affordable, patented medicines in LMICs through voluntary licensing. MPP partners with patent-holders to sublicense manufacturing rights to generic companies, thereby fostering competition, reducing prices, and facilitating local production. Originally focused on HIV, Hepatitis C, and tuberculosis, MPP has expanded to include NCDs due to their rising burden in LMICs – namely cancer, diabetes, and cardiovascular diseases.. **MPP research** shows voluntary licensing can enhance patient reach by up to four times for NCD medications, with added benefits for suppliers as well. In 2022, MPP signed its first license for an NCD treatment, **the cancer drug nilotinib**.

Through these efforts, MPP supports the production and distribution of affordable, high-quality generic versions of patented NCD treatments, improving access for patients in resource-constrained settings. Advocates can use the **database of patents and licenses** provided by MPP to check the patent status of a drug and, if relevant, contact the MPP regarding voluntary licensing.

Procurement: Priority tools

1999 WHO Operational principles for good pharmaceutical procurement

This document is the main reference from WHO on good pharmaceutical procurement. It primarily targets procurement for public sector health systems and details 12 operational principles that member states should use as minimum standards for a cost-effective and reliable procurement system.

The 12 operational principles relate to: efficient and transparent management; drug selection and quantification; financing and competition to maximise the use of financial resources; supplier selection and quality assurance, specifying that prospective suppliers should be pre-qualified and quality-assured.

While the guide is over 20 years old, it is still a useful resource as the 12 core principles are applicable to modern procurement systems. The Global Fund, for example, requires that procurement offices adhere to these principles as a minimum standard. WHO is planning an update of this report.

WHO Model Quality Assurance System for Procurement Agencies (MQAS): Assessment Tool

The MQAS, adopted by the WHO Expert Committee on Specifications for Pharmaceutical Preparations in 2005 and revised in 2014, provides a standardised framework for assessing the quality assurance systems of procurement agencies across five modules: general requirements (physical resources, policies and standards); prequalification; purchasing; receipt and storage; and distribution.

Its accompanying assessment tool ([TRS 986 Annex 4](#)), developed collaboratively by UNICEF, USAID, MSF, ICRC, the Global Drug Facility and others, allows any organisation to evaluate a procurement agency's level of compliance with the MQAS in a consistent and comparable way. The Global Fund and other major donors have endorsed the MQAS as part of their quality assurance policy for pharmaceutical procurement.

For advocates, the MQAS is useful as a benchmark for what good procurement practice looks like, and as a basis for holding procurement agencies accountable — whether by supporting assessments, referencing MQAS compliance in policy dialogue, or advocating for its adoption by national procurement systems that do not yet apply it.

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Cross-cutting tools and initiatives

Access to Oncology Medicines (ATOM) Coalition

The ATOM Coalition is a global initiative led by the Union for International Cancer Control, launched in May 2022 to address inequity in access to cancer medicines in LLMICs. The coalition brings together over 40 partners, including pharmaceutical and diagnostic companies, civil society organisations, and medical societies, to improve the affordability, availability, and proper use of essential cancer medicines.

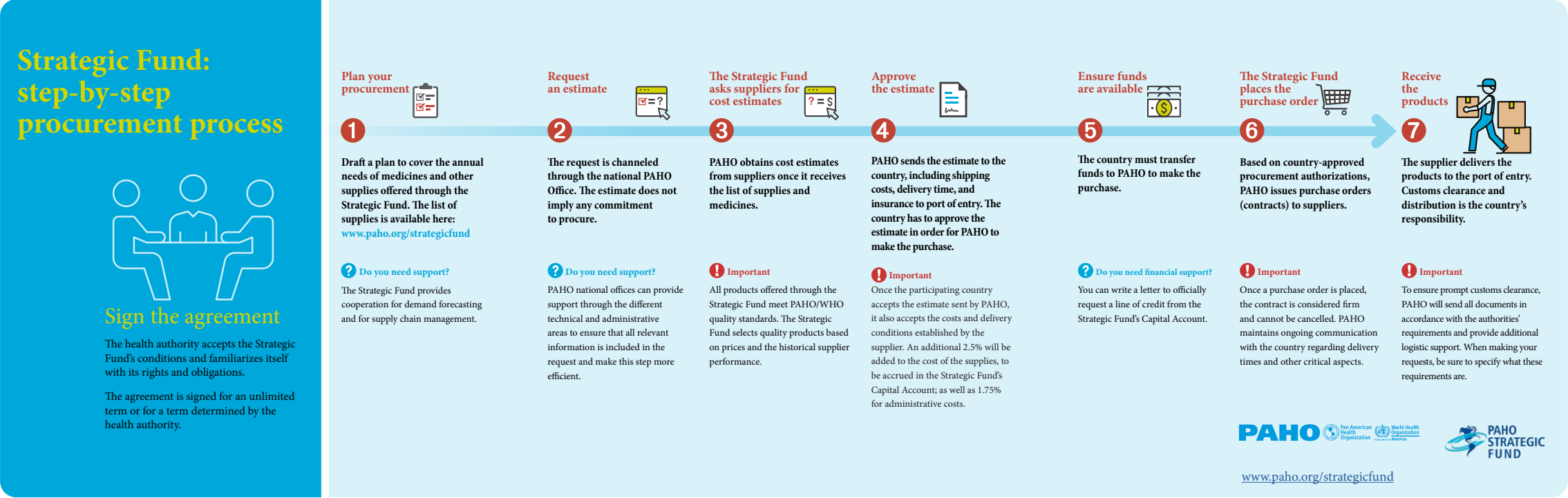
The ATOM Coalition focuses on country capacity-building for stronger supply chains, increasing use and availability of biosimilars and generics, and increasing the number of new medicines coming through the pipeline from suppliers. Using methods such as pooled purchasing, voluntary licensing, tiered pricing and partner commitments, the ATOM Coalition seeks to support long-term sustainable, affordable access to essential cancer treatments.

Regional pooled procurement via the PAHO Strategic Fund

The PAHO Strategic Fund (officially named the PAHO Revolving Fund for Essential Medicines and Strategic Public Health Supplies) is a regional technical cooperation mechanism for pooled procurement of essential medicines and other health supplies for the Americas. The Fund operates by aggregating demand across member countries. Rather than each country negotiating individually with suppliers, PAHO pools orders across 34 countries and territories and conducts a single international tender.

The mechanism is part of a broader plan to facilitate UHC in the region. The Strategic Fund includes an initiative specifically to expand access to NCD medicines and technologies within PHC, and offers technical support in areas including data-based planning, quality assurance, and capacity building for improved access to medicines and medical products. It also works with member states to strengthen supply chain management and systems.

All countries that are members of PAHO can purchase medicines and supplies through the Strategic Fund. For detailed instructions, see this [step-by-step guide](#). The list of essential NCD medicines available through the [PAHO Strategic Fund is available here](#).



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Advocacy templates and resources

Template letter to Ministry of Health

You can download an editable version of this template letter in [Word here](#).



<Address of Recipient>

<Address of Sender>

<Date>

Strengthening national selection processes to improve access to essential health products for noncommunicable diseases

Your Excellency <Name>

It is my privilege to contact you on behalf of [organisation/coalition name], a [national/regional/international] organisation working to support equitable access to essential health services and medicines, particularly for people living with noncommunicable diseases (NCDs).

Noncommunicable diseases including cardiovascular diseases, diabetes, chronic respiratory diseases, cancer, and mental health and neurological conditions represent a growing proportion of morbidity and mortality in [Country]. Ensuring equitable and sustainable access to essential medicines and diagnostics for NCDs is critical to achieving Universal Health Coverage and realising the right to health for all.

Our recent review of the national medicines selection system indicates that while

[Country] [indicate barrier: eg has a national Essential Medicines List, there are important opportunities to strengthen its alignment with global evidence-based standards, particularly the WHO Model Essential Medicines List and WHO Essential Diagnostics List.]

Specifically, we note:

▪ [note specific gaps identified in the barrier analysis here]

These gaps may contribute to late diagnosis or interrupted treatment, inefficiencies within the health system, and avoidable out-of-pocket expenditure for patients living with NCDs,

In light of this, we respectfully recommend the following actions:

[note key asks here]

We would welcome the opportunity to engage constructively with the Ministry of Health and relevant technical departments to support these efforts, including through evidence sharing, regional peer learning, or technical assistance.

We commend the Ministry's leadership in advancing equitable access to healthcare and remain committed to supporting national efforts to strengthen access to essential medicines for all.

Yours sincerely,

[Name] [Title] [Organisation] [Contact details]



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Stakeholder mapping

The stakeholder mapping below identifies key stakeholders that are likely to be relevant in most countries. It includes stakeholders that you may wish to direct your advocacy towards, as well as stakeholders that may support and strengthen your advocacy. The list is not exhaustive, and you are encouraged to add other local, national or regional stakeholders.

For more support on identifying and engaging stakeholders, please refer to NCD Alliance’s [Practical Guide to Strategic Advocacy Planning](#) (Step 3 Political Mapping and Step 4 Build Support among Constituencies).

You can **download this Stakeholder Mapping** in an editable [Excel format here](#).

	Stakeholder Name	Category	Level	Value chain stage	Role / Mandate	Power (1-5)	Interest (in access) (1-5)	Priority Tier	Engagement Strategy
1	WHO	Multilateral	Global	All stages	Sets global norms, updates Model EML and EDL, coordinates global regulatory reliance mechanisms (CRP, PQ)	4	5	HIGH	Submit letters of support for EML applications; request support for updating nEML; engage at WHA; request to issue broader EOLs for WHO PQ
2	PAHO/EMRO/AFRO/ SEARO/EURO/WPRO	Multilateral	Regional	All stages	Implements WHO norms regionally; may run access-specific programmes (eg PAHO Strategic Fund)	4	5	HIGH	Align national advocacy with regional office strategies
3	Innovative pharmaceutical industry	Industry	Global	All stages	Represents originator pharmaceutical industry; sets prices for patented medicines	5	3	HIGH	Engage on voluntary licensing, tiered pricing, supporting PQP and CRP
4	Donors (UNITAID, GAVI)	Donor	Global	Procurement; Pricing	Innovative financing; fund market interventions to improve access to HIV, TB, tools, vaccines.	5	3	MEDIUM	Advocate for inclusion of NCDs
5	NGOs/CSOs (Medicines Patent Pool, MSF, CHAI, etc)	Civil society	Global	All stages	Global access advocacy, may support governments on specific aspects eg forecasting, supply planning, pricing, intellectual property.	3	5	HIGH	Build coalition relationships for coordinated advocacy
6	NCD Alliance Global	Civil society	Global	All stages	Global advocacy network for NCDs; coordinates national NCD alliances; official relations with WHO	3	4	HIGH	Build coalition relationships for coordinated advocacy; contact to learn about national alliances
7	National NCD Alliances	Civil society	National	All stages	See ncdalliance.org for list of national alliances	3	4	HIGH	Primary coalition partner for shared access agenda
8	Regional NCD Alliances	Civil society	Regional	All stages	See ncdalliance.org for list of regional alliances	3	4	HIGH	Use to amplify national work, share country learnings and amplify messaging

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	Stakeholder Name	Category	Level	Value chain stage	Role / Mandate	Power (1-5)	Interest (in access) (1-5)	Priority Tier	Engagement Strategy
9	Ministry of Health	Government	National	All stages	Sets national medicines policy, EML, formulary, reimbursement, procurement decisions.	5	4	HIGH	Make the case for inclusion in nEML; identify key stakeholders (healthcare professionals, parliamentarians) and ask for their sign-on
10	National regulatory authority (if applicable)	Government	National	Regulatory	Approves medicines for market; can fast-track generics via reliance pathways.	4	3	MEDIUM	Advocate for adoption of reliance pathways and to invest in reaching ML3
11	National procurement agency / Central medical stores (if applicable)	Government	National	Procurement	Purchases and distributes medicines; determines which products are stocked.	4	3	MEDIUM	Engage on tender criteria, to ensure quality-assurance and generic competition
12	Parliamentarians	Government	National	All stages	Can raise access issues on the political agenda	4	3	HIGH	Brief with data on access issues and key asks to bring political attention to the issue
13	WHO Country Office	Multilateral	National	All stages	Technical and operational in-country support on access topics	4	3	HIGH	Use as a technical ally to support government engagement
14	Journalists/Media	Media	National	All stages	Can raise public awareness of access issues, raising them on the political agenda	4	3	MEDIUM	Useful to engage if planning a specific campaign; need 'newsworthy' statistics or facts
15	HTA Body/Reimbursement committee	Government	National	Selection/ Reimbursement	Assesses cost-effectiveness; recommends medicines for public funding. Mostly HIC-based.	4	3	MEDIUM	Advocate for publicly accessible HTA criteria, challenge exclusion decisions through formal review processes
16	Patient associations	Civil society, lived experience	National / Regional /Global	Selection/ Reimbursement, Pricing	Represent people living with NCDs; lived-experience evidence; public pressure.	3	5	MEDIUM	Build capacity to self-advocate, leverage for lived experience evidence
17	Generic medicines, diagnostics and technologies industry	Industry	National / Regional	All stages	Manufactures and/or imports generic medicines.	3	4	MEDIUM	Engage on registration of products in LMICs; expand portfolios into NCD generics; file for PQ;
18	WHO-Listed Authorities	Government	National	Regulatory	National regulatory authority compliant with WHO indicators; can speed up registration process and participate in WHO CRP	4	3	MEDIUM	Encourage to engage in CRP and share assessment reports via the reliance pathway
19	Healthcare professionals	Public sector	National	Selection/ Reimbursement, Pricing	First-hand experience of access issues when prescribing or dispensing, can be useful advocacy ally	3	4	HIGH	Engage this group for insight on access issues at the prescribing/dispensing level, and for advocacy support
20	Ministry of Finance	Government	National	All stages	Decides on budget allocation	4	3	MEDIUM	Advocate for financial prioritisation of NCD access

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The eight steps of Strategic Advocacy Planning*

These eight steps help provide building blocks for civil society to plan and conduct advocacy efforts. As advocacy is rarely a linear process and there is need to adapt to rapidly changing environments, organisations can use these steps sequentially or refer to specific ones to guide them during their advocacy campaign at specific stages or when revising existing plans.

Step 1: Advocacy situation analysis

Gather data and assess the current status of NCD prevention and control, access to NCD medicines and medical devices, the policy and legal environment relating to access, and stakeholders, potential partners, and other factors in your setting to plan your overall advocacy strategy.

Step 2: Select priority issues, goals, objectives

Based on what you learn in your advocacy situation analysis, select your access advocacy issue, and determine your goals and objectives for your advocacy campaign.

Step 3: Political mapping

Map out those who have direct decision-making capacity or influence over your selected advocacy issue.

Step 4: Advocacy tactics and messages

Successful NCD advocacy involves forming partnerships for a common purpose, both within and beyond the NCDs and health sectors, to achieve your advocacy goals and objectives.

Step 5: Build support among constituencies

Select your advocacy tactics and create your advocacy messages to tell those who have the power to make a change why you want the change and how it will help increase access to NCD medicines and medical devices and improve the lives of people living with NCDs, etc.

Step 6: Create a workplan and budget

Develop a detailed workplan and budget to take concrete steps towards making your NCD advocacy campaign a reality.

Step 7: Roll out the advocacy plan

Assess when the time is right to launch your access advocacy campaign (a window of opportunity).

Step 8: Monitor and evaluate

Keep track of your access advocacy campaign activities and assess your progress through monitoring, make adjustments when needed, and measure your overall achievements and lessons learned through evaluation. Do not forget to celebrate progress and advocacy wins, thanking champions and allies, and ensuring continued motivation of partners.

*Adapted from the NCD Alliance [Practical Guide to Strategic Advocacy Planning](#)

ANNEXES

Annex 1

Advancing Access advocacy toolkit development process

Collaboration between the NCD Alliance (NCDA) and the University of Geneva’s NCD Policy Lab (UNIGE) emerged from a shared recognition that access to medicines, diagnostics and technologies for noncommunicable diseases (NCDs) remains one of the biggest global implementation gaps for reaching Sustainable Development Goal 3.4 (SDG3.4) to reduce premature mortality from NCDs by one-third by 2030. Despite multiple political commitments, progress towards universal access to NCD medicines, diagnostics and medical devices remains slow and uneven.

In 2024, NCDA and UNIGE developed an [advocacy brief](#) to support civil society in pushing for stronger access policies in the lead-up to the fourth UN High-Level Meeting on NCDs and Mental Health (HLM4), supported by 19 organisations working in access. This work highlighted inconsistencies between political commitments to address access issues and actual implementation. Across key NCDs, including diabetes, cancer, cardiovascular diseases, mental health and neurological conditions, and chronic respiratory diseases, the bottom line is clear: many commitments have been made by Member States and the World Health Organisation (WHO), but implementation is insufficient and off-track to meet global targets.

In 2025, three key processes converged to create the Advancing Access advocacy toolkit:

1. The technical foundation:

WHO is developing the Operational Framework on Access to Medicines and Medical Devices for NCDs in Primary Care, which will provide a set of actions to address both cross-cutting and disease-specific challenges related to access to medicines and medical devices, along with a selection of indicators to monitor implementation. This framework provides the technical backbone for the toolkit. NCDA and UNIGE have continuously engaged with the WHO NCDs and Mental Health Department during the parallel development of the Framework and the toolkit to ensure alignment and complementarity.

2. The Geneva Hackathon:

In June 2025 NCDA and UNIGE brought together experts from diverse organisations and backgrounds to collaboratively map existing technical tools and initiatives, understand why some of these resources are underused or poorly implemented, and identify key barriers to implementation. Over two days, participants worked to develop practical recommendations for scaling up the use of effective tools, engaging relevant stakeholders, and designing innovative approaches for disseminating these solutions. The insights and outcomes from this [Hackathon](#) laid the groundwork for our idea for a coordinated, cross-cutting advocacy initiative, setting the stage for the creation of the **Advancing Access advocacy toolkit**.

3. A workshop on cross-cutting advocacy priorities for access to NCD medicines, diagnostics and medical devices:

This workshop, held in Geneva in November 2025, convened key stakeholders in access and NCDs. Participants established key advocacy areas and opportunities as well as the responsibilities of different actors in the access ecosystem.

What are the Advancing Access resources?

The resources produced through the Advancing Access collaboration at the time of publishing this toolkit are the following:

- Advancing Access: A practical advocacy toolkit for improving access to NCD medicines, diagnostics and medical devices
- **Advancing Access:** Global priorities to improve access to NCD medicines, diagnostics and medical devices
- **Access to essential medicines, diagnostics and medical devices for NCDs:** Priorities for the 4th UN High-Level Meeting on NCDs
- **Advancing Access: A collated list of WHO-recommended essential NCD medicines, diagnostics and medical devices for primary healthcare settings**

Process for the toolkit development:

The toolkit is based on five key steps of the pharmaceutical value chain: **selection, regulatory, forecasting, procurement, pricing.**

The **barriers** in each step are aligned with the WHO's forthcoming Operational Framework..

The barriers were then associated with the five problems:

1. Certain medicines/devices are not prescribed or used in the country.
2. Medicines/devices are used but not available or not continuously available in public pharmacies.
3. Medicines/devices are available but not of adequate quality.
4. Medicines/devices are available but unaffordable.
5. Medicines/devices are not being reimbursed, patients are paying out of pocket.

A prototype was developed for one module of the toolkit and tested on eight **global organisations** on technical content and expertise, and **17 national and regional alliances** and lived experience advocates for feasibility and technical input.

Annex 2

Advancing Access: A collated list of WHO-recommended essential NCD medicines, diagnostics and medical devices for primary healthcare settings

You can download an Excel version of the list [here](#)

Please **see Annex 3** to read about the methods used to develop this list.

INN (medicine)/diagnostic/device	Strength/ formulation	EML/EDL	PEN	Operational framework	Additional source/ protocol	Disease area	Notes/remarks
Goserelin		✓	X	X		cancer	therapeutic alternative to Leuporelin
Leuporelin	Injection: 75 mg; 22.5 mg in pre-filled syringe.	✓	X	X		cancer	
Triptorelin		✓	X	X		cancer	therapeutic alternative to Leuporelin
Cyclophosphamide	Powder for injection: 500 mg; 1 g; 2 g in vial. Solid oral dosage form: 25 mg; 50 mg.	✓	X	X		cancer	
Methotrexate	Concentrated injection: 1000 mg/10 mL. Injection: 50 mg/2 mL. Powder for injection: 50 mg (as sodium) in vial. Tablet: 2.5 mg (as sodium).	✓	X	X		cancer	
Anastrozole	Tablet: 1 mg.	✓	X	X		cancer	
Tamoxifen	Tablet: 10 mg; 20 mg (as citrate).	✓	X	X		cancer	
Capecitabine	Tablet: 150 mg; 500 mg.	✓	X	X		cancer	
Carboplatin	Injection: 50 mg/5 mL; 150 mg/15 mL; 450 mg/45 mL; 600 mg/60 mL.	✓	X	X		cancer	
Vinorelbine	Capsule: 20 mg; 30 mg; 80 mg. Injection: 10 mg/mL in 1 mL, 5 mL vial.	✓	X	X		cancer	
Human papillomavirus vaccine	Injection: 10 mg/mL in 1 mL, 5 mL vial.	✓	X	X		cancer	
Papanicolaou smear test		X	X	X		cancer	
HPV nucleic acid test		X	X	X		cancer	
VIA screening tools: speculum, light source, acetic acid		X	X	X		cancer	
HPV self-sampling or point-of-care testing		X	X	X		cancer	

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Clinical breast exam: exam table, gloves, breast awareness education		X	X	X		cancer	
Cryotherapy/thermal ablation (where feasible and trained staff available)		X	X	X		cancer	
thiazide or thiazide-like diuretic		X	✓	✓	HEARTS	cardiovascular diseases	
calcium channel blocker (CCB) (long acting) (amlodipine)	Tablet: 5 mg (as maleate, mesylate or besylate).	✓	✓	✓	HEARTS	cardiovascular diseases	
angiotensin converting enzyme inhibitor (ACE-I) (long acting) (enalapril)	"Oral liquid: 1 mg/mL (as hydrogen maleate) [c]. Tablet: 2.5 mg; 5 mg; 10 mg (as hydrogen maleate)."	✓	✓	✓	HEARTS	cardiovascular diseases	
angiotensin receptor blocker (ARB) (losartan)	Tablet: 25 mg; 50 mg; 100 mg.	✓	✓	X		cardiovascular diseases	
Statin (simvastatin)	Tablet: 5 mg; 10 mg; 20 mg; 40 mg.	✓	✓	✓	HEARTS	dyslipidaemia	
Beta-blocker (bisoprolol)	Tablet: 1.25 mg; 5 mg.	✓	✓	✓	HEARTS	cardiovascular diseases	
Acetylsalicylic Acid (aspirin)	Tablet: 100 mg.	✓	✓	✓	HEARTS	cardiovascular diseases	
Isosorbide dinitrate	Tablet (sublingual): 5 mg.	✓	✓	X		cardiovascular diseases	
Furosemide	Injection: 10 mg/mL in 2 mL, 5 mL ampoule. Oral liquid: 20 mg/5 mL; 50 mg/5 mL [c]. Tablet: 20 mg; 40 mg.	✓	✓	X		cardiovascular diseases	
Heparin sodium	Injection: 1000 IU/mL; 5000 IU/mL; 20 000 IU/mL in 1 mL ampoule or vial.	✓	✓	X		cardiovascular diseases	
Glyceryl trinitrate	Tablet (sublingual): 500 micrograms.	✓	✓	X		cardiovascular diseases	
"Total cholesterol: Point-of-care tests"						cardiovascular diseases (dyslipidemia)	
peak flow meter, mouth pieces & nozzles		X	✓	✓		chronic respiratory diseases (asthma & COPD)	
spacers for inhalers		X	✓	✓		chronic respiratory diseases (asthma & COPD)	

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INN (medicine)/diagnostic/device	Strength/ formulation	EML/EDL	PEN	Operational framework	Additional source/ protocol	Disease area	Notes/remarks
Beclometasone	"Powder for inhalation: 100 micrograms per actuation; 200 micrograms per actuation in dry powder inhaler. Suspension for inhalation: 100 micrograms per actuation; 200 micrograms per actuation in pressurized metered-dose inhaler."	✓	✓	✓		chronic respiratory diseases (asthma & COPD)	therapeutic alternative to budesonide
(oral) Prednisone	"Oral liquid: 5 mg/mL [c]. Tablet: 5 mg; 25 mg."	✓	✓	✓		chronic respiratory diseases (asthma & COPD)	
Salbutamol (inhaled)	"Injection: 500 micrograms/mL (as sulfate) in 1 mL, 5 mL ampoule. Solution for inhalation: 100 micrograms (as sulfate) per actuation in pressurized metered-dose inhaler; 2.5 mg/2.5 mL; 5 mg/2.5 mL (as sulfate) in 2.5 mL single-dose ampoules for use in nebulizers; 5 mg/mL (as sulfate) in multi-dose bottle for use in nebulizers."	✓	✓	✓		chronic respiratory diseases (asthma & COPD)	
Tiotropium bromide (inhaled)	"Powder for inhalaton: 18 micrograms in capsule. Solution for inhalation: 1.25 micrograms; 2.5 micrograms per actuation in soft mist inhaler."	✓	X	✓		chronic respiratory diseases (COPD)	
Budesonide + formoterol (inhaled)	Powder for inhalation: 100 micrograms + 6 micrograms per actuation; 200 micrograms + 6 micrograms per actuation in dry powder inhaler.	✓	X	✓		chronic respiratory diseases (asthma)	
Oxygen	Inhalation (medical gas).	✓	✓	✓		chronic respiratory diseases (asthma & COPD)	
Ipratropium (inhaled)	Solution for inhalation: 20 micrograms per actuation in pressurized metered-dose inhaler.	✓	✓	✓		chronic respiratory diseases	
Oxygen devices; Oxygen masks and tubes		X	X	✓	Medical Devices for CVD and Diabetes	chronic respiratory diseases	

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Dry-powder inhalers		✓	X	X		chronic respiratory diseases (asthma and COPD)	
(Metered dose) inhaler		✓	X	✓		chronic respiratory diseases (asthma)	
Nebulizer						chronic respiratory diseases (asthma and COPD)	
Nebulized ipratropium						chronic respiratory diseases (asthma)	
Empagliflozin	Tablet: 10 mg; 25 mg.	✓	X	✓		diabetes	
Semaglutide (therapeutic alternatives: Dulaglutide, Liraglutide, Tirzepatide)	Injection solution: 0.68 mg/mL; 1.34 mg/mL; 2.68 mg/mL.	✓	X	✓		diabetes	On EML only for adults with type 2 diabetes with established CVD or CKD and obesity (BMI ≥30)
Blood glucose meter and strips		✓	✓	✓	Medical Devices for CVD and Diabetes	diabetes	
Urine collection kit, urine test strips		✓	✓	X	Medical Devices for CVD and Diabetes	diabetes	
Urine protein dipstick or strips		✓	✓	X		Medical Devices for CVD and Diabetes	diabetes
Glucose (dextrose) infusion		X	✓	X		diabetes	
Insulins (human or analogue) (pens, syringe, needle, vials (of insulin), swabs, lancet, strips, refrigerator)	Refer to EML	✓	✓	✓	HEARTS	diabetes, cardiovascular diseases	
Gliclazide	Solid oral dosage form: (controlled-release tablets) 30 mg; 60 mg; 80 mg. *glibenclamide not suitable above 60 years.	✓	✓	✓	HEARTS	diabetes, cardiovascular diseases	
Metformin	Tablet: 500 mg (hydrochloride).	✓	✓	✓	HEARTS	diabetes, cardiovascular diseases	

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INN (medicine)/diagnostic/device	Strength/ formulation	EML/EDL	PEN	Operational framework	Additional source/ protocol	Disease area	Notes/remarks
Reflex hammer		X	X	X	Medical Devices for CVD and Diabetes	diabetes; mental health and neurological conditions	
128 Hz Tuning fork		X	✓	X	Medical Devices for CVD and Diabetes	diabetes; mental health and neurological conditions	
Blood pressure measurement device		X	✓	X	Medical Devices for CVD and Diabetes	diabetes; mental health and neurological conditions	
Examination light		X	X	X	Medical Devices for CVD and Diabetes	diabetes; mental health and neurological conditions	
Levodopa + Benserazide	Tablet: 100 mg + 10 mg; 100 mg + 25 mg; 250 mg + 25 mg.	✓	X	X		mental health and neurological conditions	
Diazepam	Tablet (scored): 2 mg; 5 mg.	✓	✓	X		mental health and neurological conditions	
Ibuprofen	"Oral > Liquid: 200 mg per 5 mL; 100 mg per 5 mL Oral > Solid > tablet: 200 mg; 400 mg; 600 mg"	✓	✓	X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	mental health and neurological conditions; palliative care	
Magnesium sulfate	Injection: 0.5 g/mL in 2 mL ampoule (equivalent to 1 g in 2 mL; 50% weight/volume); 0.5 g/mL in 10 mL ampoule (equivalent to 5 g in 10 mL; 50% weight/volume).	✓	✓	X		mental health and neurological conditions	
Lamotrigine	"Tablet: 25 mg; 50 mg; 100 mg; 200 mg. Tablet (chewable, dispersible): 2 mg; 5 mg; 25 mg; 50 mg; 100 mg; 200 mg."	✓		X		mental health and neurological conditions	
Thiamine (Vitamin B1)	"Injection: 50 mg/mL (hydrochloride) in ampoule or vial [c]. Tablet: 50 mg (hydrochloride)."	✓	X	X		mental health and neurological conditions	
Baclofen	Intrathecal injection: 500 micrograms/mL in ampoule. Oral liquid: 10 mg/5 mL. Tablet: 10 mg.	✓	X	X		mental health and neurological conditions	

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Levodopa + Carbidopa	Tablet: 100 mg + 10 mg; 100 mg + 25 mg; 250 mg + 25 mg.	✓	X	X		mental health and neurological conditions	
Carbamazepine	Tablet (scored): 100 mg; 200 mg; 400 mg.	✓	X	X		mental health and neurological conditions	
Sumatriptan	Tablet: 50 mg.	✓	X	X		mental health and neurological conditions	
Valproic acid	Tablet (enteric-coated): 200 mg; 500 mg.	✓	X	X		mental health and neurological conditions	
Phenobarbital	Injection: 30 mg/mL or 60 mg/mL [c], 200 mg/mL (sodium). Oral liquid: 15 mg/5 mL. Tablet: 15 mg; 30 mg; 60 mg; 100 mg.	✓	X	X		mental health and neurological conditions	
Phenytoin	"Injection: 50 mg/mL (phenytoin sodium). Oral liquid: 30 mg/5 mL (phenytoin). Solid oral dosage form: 25 mg; 50 mg; 100 mg (phenytoin sodium). Tablet (chewable): 50 mg (phenytoin)."	✓	X	X		mental health and neurological conditions	
Levetiracetam	Concentrate solution for infusion: 100 mg/mL in 5 mL ampoule or vial. Solution for infusion: 5 mg/mL; 10 mg/mL; 15 mg/mL in 100 mL bag.	✓	X	X		mental health and neurological conditions	
Amitriptyline	Tablet: 25 mg; 75 mg (hydrochloride).	✓	X	X		mental health and neurological conditions	
Fluoxetine	Solid oral dosage form: 20 mg (as hydrochloride).	✓	X	X		mental health and neurological conditions	
Haloperidol	Tablet: 2 mg; 5 mg.	✓	X	X		mental health and neurological conditions	
Risperidone	Solid oral dosage form: 0.25 mg to 6.0 mg.	✓	X	X		mental health and neurological conditions	
Chlorpromazine		✓	X	X		mental health and neurological conditions	therapeutic alternative to haloperidol
Fluphenazine	Injection: 25 mg (decanoate or enantate) in 1 mL ampoule.	✓	X	X		mental health and neurological conditions	

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INN (medicine)/diagnostic/device	Strength/ formulation	EML/EDL	PEN	Operational framework	Additional source/ protocol	Disease area	Notes/remarks
Biperiden	Injection: 5 mg (lactate) in 1 mL ampoule. Tablet: 2 mg (hydrochloride).	✓	X	X		mental health and neurological conditions	
Trihexyphenidyl		✓	X	X		mental health and neurological conditions	therapeutic alternative to biperiden
Lithium carbonate	Solid oral dosage form: 300 mg.	✓	X	X		mental health and neurological conditions	
Buprenorphine		✓	X	X		mental health and neurological conditions	therapeutic alternative to methadone
Acamprosate calcium	Tablet: 333 mg.	✓	X	X		mental health and neurological conditions	
Naloxone	Injection: 400 micrograms (hydrochloride) in 1 mL ampoule.	✓	X	X		mental health and neurological conditions	
Methadone	"Concentrate for oral liquid: 5 mg/mL; 10 mg/mL (hydrochloride). Oral liquid: 5 mg/5 mL; 10 mg/5 mL (hydrochloride)."	✓	✓	X		mental health and neurological conditions; cancer pain	
Midazolam	Injection: 1 mg/mL in 5 mL vial; 5 mg/mL in 1 mL or 3 mL vial. Oral liquid: 2 mg/mL [c]. Solid oral dosage form: 7.5 mg; 15 mg.	✓	X	X		mental health and neurological conditions	
Lorazepam	Injection: 2 mg/mL in 1 mL ampoule; 4 mg/mL in 1 mL ampoule.	✓	X	X		mental health and neurological conditions	
Naltrexone	Injection suspension (extended-release): 380 mg in vial.	✓	X	X		mental health and neurological conditions	
Pulse oximeter		X	✓	X		asthma and COPD	
thermometer		X	✓	X		N/A	
stethoscope		X	✓	X		N/A	
measurement tape		X	✓	X		N/A	
weighing machine		X	✓	X		N/A	
Codeine	Tablet: 30 mg (phosphate).	✓	✓	✓		N/A	Pain management

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INN (medicine)/diagnostic/device	Strength/ formulation	EML/EDL	PEN	Operational framework	Additional source/ protocol	Disease area	Notes/remarks
Amoxicillin	"Powder for injection: 250 mg; 500 mg; 1 g (as sodium) in vial. Powder for oral liquid: 125 mg/5 mL; 250 mg/5 mL (as trihydrate) [c]. Solid oral dosage form: 250 mg; 500 mg (as trihydrate). Tablet (dispersible, scored): 250 mg; 500 mg (as trihydrate) [c]."	✓	✓	X		N/A	Antibiotic
Erythromycin	Ointment: 0.5% [c]	✓	✓	X		N/A	Antibiotic
Sodium chloride	Injectable solution: 0.9% isotonic (equivalent to Na+ 154 mmol/L, Cl− 154 mmol/L).	✓	✓	X		N/A	Dehydration
Spironolactone	Tablet: 25 mg.	✓	✓	X		N/A	diuretic, sometimes used in heart failure
Epinephrine (adrenaline)	Injection: 1 mg/mL (as hydrochloride or hydrogen tartrate) in 1 mL ampoule.	✓	✓	X		N/A	anaphylaxis
Hydrocortisone	Cream or ointment: 1% (acetate).	✓	✓	X		N/A	
Refrigerator		X	X	✓	Medical Devices for CVD and Diabetes	N/A	
Paracetamol (acetaminophen)	Oral liquid: 120 mg/5 mL or 125 mg/5 mL*; 250 mg/5 mL [c]. *The presence of both 120 mg/5 mL and 125 mg/5 mL strengths on the same market would cause confusion in prescribing and dispensing and should be avoided. Suppository: 250 mg [c]. Tablet: 250 mg; 325 mg; 500 mg. Tablet (dispersible): 100 mg, 250 mg [c].	✓	✓	X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	
Ranitidine	"Oral > Liquid: 75 mg per 5 mL (as hydrochloride) Oral > Solid: 150 mg (as hydrochloride) Parenteral > General injections > unspecified: 25 mg per mL in 2 mL ampoule (as hydrochloride)"	✓		X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	for GERD

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INN (medicine)/diagnostic/device	Strength/ formulation	EML/EDL	PEN	Operational framework	Additional source/ protocol	Disease area	Notes/remarks
Cyclizine	Oral > Solid > tablet: 50 mg (hydrochloride)	✓		X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	therapeutic alternative to metoclopramide and promethazine
Metronidazole (for topical application - crush tablet)	Oral > Solid > tablet: 200 mg; 250 mg; 400 mg; 500 mg	✓		X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	for foul smelling wounds
Lactulose	Oral > Liquid: 3.3 to 3.4 g per 5 mL oral liquid	✓		X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	therapeutic alternative to senna
Senna	Oral > Liquid: 7.5 mg per 5 mL oral liquid	✓	✓	X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	for constipation
Bisacodyl	not specified in EML	✓		X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	therapeutic alternative to senna
Metoclopramide	"Oral > Liquid: 5 mg per 5 mL Oral > Solid: 10 mg (hydrochloride) Parenteral > General injections > unspecified: 5 mg per mL in 2 mL ampoule (hydrochloride)"	✓		X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	for nausea
Fluconazole	Oral > Solid > capsule: 50 mg , Oral > Liquid: 50 mg per 5 mL; 50 mg per 5 mL powder for oral liquid	✓		X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	for oral thrush

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INN (medicine)/diagnostic/device	Strength/ formulation	EML/EDL	PEN	Operational framework	Additional source/ protocol	Disease area	Notes/remarks
Morphine	"Granules (slow release; to mix with water): 20 mg; 30 mg; 60 mg; 100 mg; 200 mg (morphine sulfate). Injection: 1 mg/mL [c]; 2 mg/mL[c]; 10 mg/mL (morphine hydrochloride or morphine sulfate) in 1 mL ampoule. Oral liquid: 5 mg/5mL [c]; 10 mg/5 mL (morphine hydrochloride or morphine sulfate). Solid oral dosage form (slow release): 5 mg [c]; 10 mg; 30 mg; 60 mg; 100 mg; 200 mg (morphine hydrochloride or morphine sulfate). Tablet (immediate release): 10 mg (morphine sulfate)."	✓	✓	X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care; cancer pain	
Haloperidol	"Oral > Liquid: 2 mg per mL Oral > Solid: 0.5 mg; 2 mg; 5 mg"	✓		X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)	palliative care	therapeutic alternative to metoclopramide
Diazepam	Tablet (scored): 2 mg; 5 mg.	✓	✓	X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)		
Furosemide	Injection: 10 mg/mL in 2 mL, 5 mL ampoule. Oral liquid: 20 mg/5 mL; 50 mg/5 mL [c]. Tablet: 20 mg; 40 mg.	✓	✓	X	SPDI Palliative Care Reference Filter (part of Primary Care Reference Filter)		

Annex 3

Methodology for Advancing Access product list

Purpose and scope

This document collates essential NCD medicines, diagnostics and devices for the following noncommunicable diseases (NCDs) from official WHO guidance prioritised for primary healthcare-centred settings.

- Diabetes
- Cardiovascular diseases (hypertension, dyslipidaemia, cardiovascular diseases).
- Chronic respiratory diseases (asthma, chronic obstructive pulmonary disease).
- Mental health (depression, psychosis and bipolar disorder, alcohol and drug use disorders / opioid dependence: see methodology below).
- Neurological conditions (epilepsy and parkinson's disease, with migraine and muscle spasticity also represented; see methodology below).
- Cancer (breast and cervical cancer; see methodology below)
- Palliative care (see methodology below)

Countries normally use the WHO Essential Medicines List (EML) and WHO Essential Diagnostics List (EDL) to guide product selection, but as these lists go beyond primary care, we wanted to anchor the selection in NCD-relevant WHO guidance across disease areas. For the table below we used the 2025 EML and the 2023 WHO EDL followed by the WHO Package of Essential NCD Interventions (PEN) to anchor and prioritise interventions, with further cross-referencing against disease-specific packages (listed below).

Intended use

This list is intended as a practical and prioritised reference (up to June 2026) of WHO recommended medicines, technologies and tools for NCD advocates to assess which interventions are available in health systems and incorporated into health benefit packages, procurement lists and others across NCD areas in their given country or context. It is designed to support accountability for the targets set out in the 2025 Political Declaration on NCDs and Mental Health, including the commitment that 80% of primary health care facilities should have essential NCD medicines and basic technologies available at affordable prices.

This document is not intended to provide clinical or policy guidance, its purpose is to collate existing WHO guidance in an accessible, easy-to-use format. The selected list has been developed in collaboration with the WHO NCD and Mental Health department. Please always refer to appropriate WHO documents for decision-making as these are updated on a regular basis. This document is up to date as of June 2026.

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Process for diabetes, cardiovascular diseases and chronic respiratory conditions:

1. Review the 2025 EML and 2023 EDL.
2. PEN core list of medicines and essential technologies and tools were used to narrow down and remove any products not appropriate for primary healthcare settings.
3. Cross-checked against disease-specific WHO technical packages:
 - Diabetes: HEARTS D: diagnosis and management of type 2 diabetes (2020), WHO list of priority medical devices for management of cardiovascular diseases and diabetes (2021), Global Diabetes Compact (2021).
 - Cardiovascular disease: HEARTS: Technical package for cardiovascular disease management in primary health care: Risk-based CVD management (2020); WHO list of priority medical devices for management of cardiovascular diseases and diabetes (2021), Guideline for the pharmacological treatment of hypertension in adults (2021).
4. For medicines and diagnostics, only products appropriate for PHC that were included either in PEN and/or EML /EDL were included.
5. For devices, the following devices and equipment were included: Peak flow meter and nozzles, spacers for inhalers, oxygen devices, masks and tubes, dry-powder inhalers, metered dose inhaler, nebulizer, clinical chemistry analyser, reflex hammer, tuning fork, blood pressure measurement device, examination light, pulse oximeter, thermometer, stethoscope,

measurement tape, weighing machine, refrigerator. As PEN coverage of devices is limited, device selection was cross-referenced against disease-specific WHO technical packages (listed above) and validated by WHO technical teams to ensure alignment with PHC settings.

6. A lead/ expert and WHO teams reviewed the list, adding or removing products as needed to ensure clinical relevance and appropriateness.

For the EML, EDL and PEN columns, a ✓ indicates the product is included and a X indicates it is not. Additional columns indicate whether the product is included in the WHO's Operational framework on access to essential medicines and related health technologies for non-communicable diseases at the primary care level and/or any additional source or protocol. The notes column is used for additional explanation where needed.

Process for cancer:

Cancer was treated differently from the other disease areas because PEN does not cover cancer and the EML/EDL include a much broader range of oncology products than would be appropriate to list in full for a primary-care focused toolkit. The process for cancer was therefore as follows:

1. Breast and cervical cancer were selected as tracer conditions in consultation with WHO and other experts, on the basis that together they represent a breadth of treatment classes: chemotherapy, hormonal therapy, immunotherapy, and vaccination; and many of the included medicines have broader oncology applications beyond these two cancers. WHO has a dedicated global focus on both cancers, reflected in the Global Strategy to Accelerate the Elimination of Cervical Cancer Initiative and the Global Breast Cancer Initiative (GBCI).
2. Starting from the 2025 EML and the 2023 EDL, products relevant to the diagnosis and treatment of breast and cervical cancer were identified.
3. Since PEN does not include a cancer component, the list was also checked against cancer-specific WHO technical packages which contain product indications: the WHO List of Priority Medical Devices for Cancer Management (2017) and the Global Breast Cancer Initiative.
4. A lead/ expert in oncology and WHO teams reviewed the list, adding or removing products as needed to ensure clinical relevance and appropriateness.

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Process for mental health and neurological conditions:

Mental health and neurological conditions were treated differently from the other disease areas because they are not covered in PEN and the EML/EDL include a much broader range of products that would be appropriate to list in full for a primary-care focused toolkit. The process was therefore as follows:

1. In line with the mhGAP and the WHO report on access to medicines for neurological disorders, depression, psychosis and bipolar disorder, alcohol and drug use disorders / opioid dependence were selected as priority conditions for which pharmacological treatment is included in primary healthcare, and epilepsy and Parkinson's disease as tracer conditions for neurological conditions in primary healthcare.
2. Starting from the 2025 EML and the 2023 EDL, products relevant to the diagnosis and treatment of the selected conditions were identified.
3. The list was checked against the mhGAP intervention guide and formulary.
5. A lead/ expert in mental health and neurology and WHO teams reviewed the list, adding or removing products as needed to ensure clinical relevance and appropriateness.

Process for palliative care:

For Palliative Care, the [WHO Palliative Care Reference Filter](#) was used. This list was developed in 2025 through a structured, evidence-informed methodology involving WHO technical review and validation by the Technical Advisory Group for Integrated Clinical Care (TAG-IC2). For palliative care, this list includes a robust validated set of palliative care medicines for primary care. For this reason, the Reference Filter — rather than PEN's limited palliative care section — was used to cross-check and validate the palliative care product list.

The UHC Service Planning, Delivery and Implementation (SPDI) platform – Palliative Care Reference Filter

The Palliative Care Reference Filter defines a set of core health services for palliative care. These services are designed for delivery across a wide variety of care settings, including community, outpatient, and hospital levels. The services are intended to be applicable for all life stages and resource levels, including low-resource settings.

The filter supports countries in the development of palliative care service packages, and the SPDI Platform helps in aligning the services with national priorities and adapting to local context and population needs.

This filter was developed through a structured, evidence-informed process that included identifying core services, mapping them to appropriate delivery platforms, defining assumptions for low-resource settings, and conducting expert and technical reviews.

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List of abbreviations

UN	United Nations
WHO	World Health Organisation
EML	Essential Medicines List
EDL	Essential Diagnostics List
UHC	Universal Health Coverage
PAHO	Pan American Health Organisation
CONITEC	(Brazil) National Commission for the Incorporation of Technologies
NRA	National Regulatory Authority
WLA	WHO-Listed Authority
PEPFAR	President's Emergency Plan for AIDS Relief
HIV	Human Immunodeficiency Virus
TB	Tuberculosis
CRP	Collaborative Registration Procedure

SRA	Stringent Regulatory Authority
GBT	Global Benchmarking Tool
AMRH Programme	African Medicines Regulatory Harmonisation programme
AMA	African Medicines Agency
EMA	European Medicines Agency
PANDRH	Pan American Network for Drug Regulatory Harmonization
SEARN	South-East Asia Regulatory Network
UNDP	United Nations Development Programme
STEPS	WHO STEPwise approach to NCD risk factor surveillance
HMIS	Health Management Information Systems
HTA	Health Technology Assessment
MQAS	Model Quality Assurance System for Procurement Agencies
CMS	Central Medical Stores

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- Access to Medicines Foundation
- FIND
- World Stroke Organisation
- Global Initiative for Chronic Obstructive Lung Disease
- Federation of International Respiratory Societies
- International Union against Tuberculosis and Lung Disease
- The George Institute
- Medecins Sans Frontieres
- London School of Hygiene & Tropical Medicine Centre for Global Chronic Conditions
- World Sleep Society
- Blue Circle Diabetes Foundation
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- Ghana NCDA
- Kenya Mended Hearts Patient Association
- Eminence associates for social development
- Malawi NCDA
- Cambodia NCDA
- Ethiopia NCDA
- Indonesia NCDA
- NABD-BC2
- East Africa Diabetes Study Group
- East Africa NCD alliance
- Africa NCD Network
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