Table 1. Examples of governance and financing approaches.

Domain	Examples of factors influencing the approaches of national responses					
	Countries with the least deaths per 100,0000, with a population of over 20 million		Countries with the most deaths per 100,0000, with a population of over 20 million		Countries in the middle category in terms of deaths per 100,000 population	
Governance approach	China: Established top-down governance structures to reach across all levels within the government and created a whole-of-government approach. The State Council established a Joint Prevention and Control Mechanism. It is a platform for communication, collaboration, and mobilizing resources between 32 different ministry and departments. It consists of workgroups responsible for COVID-19 control, medical treatment, research, education, logistics, frontline works, etc. At local levels, emergency response leading groups, headed by local government leaders, were established in provinces, cities, and counties across the country. The local emergency response leading groups are responsible for implementing the central government's policies and control strategies, thus forming a top-down system.	Mozambique: Opted for a multi-sectoral, whole-of-government approach. The Ministry of Health established an Emergency Commission to ensure effective coordination of COVID-19 prevention and response through the efforts of nine Technical Working Groups co-led by Ministry of Health staff and development partners. The Government's disaster agency (INGC) and the Ministry of Economy and Finance are currently working with line ministries to identify the needs and priority measures to be taken. Aligned with this, the Humanitarian Country Team, led by the Resident Coordinator and composed of UN agencies, NGOs, Red Cross and donor representatives, is developing a Response Plan to COVID-19, focusing on sector-specific impacts of COVID-19.	Peru: The central government engages infrequently with regional health authorities. In the early stages (end of March), the president convened via teleconference between regional health governors together with the Minister of the Interior, the Minister of Health, and the Minister of Agriculture. They each presented the plans of their sectors and the measures that are adopted to guarantee security and food supply.	Mexico: The Ministry of Health initiated a national meeting of state governors and health authorities to coordinate efforts to respond to COVID-19. During the meeting, state authorities agreed to participate in working groups to learn first-hand the national situation, updates, and the decisions made to address each step of the pandemic. It was also agreed that local and municipal governments will be involved and will collaborate on communicating cases, incidents, and necessary actions.	Germany: A whole-of-government approach was adopted. At the national level, the central government convenes weekly as the "Small Corona Cabinet". It consists of the Chancellor and various ministries. Additionally, the government convenes on a weekly basis in the "Large Corona Cabinet". Besides the members of the small cabinet, ministers from specific ministries depending on issues discussed are invited to join. The Ministry of Health and the Ministry of Home Affairs and Sports established a crisis committee, which helps with the operationalization and implementation of decisions made by the Corona Cabinets. The Ministry of Health also hosts a working group, which consists of experts from the Ministry of Finance and the Ministry for Foreign Affairs, as well as contact persons from the private sector.	Japan: Set up the Coronavirus task force which consists of diverse medical experts (virologists, infectious disease, molecular genetics, genomic medicine, and computational science) and includes 36 high-ranking bureaucrats from several ministries. The headquarters acts as the site of the prime minister's decision-making process on the country's virus countermeasures.
Prior epidemic experiences	Thailand: Past experience with the 2003 SARS outbreak, as well as H1N1 in 2009 led to significant investments in surveillance and early warning systems.	Niger: Past experience with cholera prepared Niger for a rapid response including co-ordination or treatment facilities, risk communication, and community education.	Argentina: Surveillance programme has been in place since 2002, with screening and surveillance measures implemented during the Ebola and H1N1 outbreaks. However, no specific experience with domestic novel epidemics has occurred.	Mexico: Experience from the 2009 H1N1 outbreak led to the establishment of surveillance activities that have used a sentinel model, although Mexico did not implement a responses plan for COVID-19.	South Korea: Previous experience from MERS in 2015 meant the country had a response plan prepared for outbreaks of respiratory illnesses and stockpiles of PPE, among other things.	Singapore: Previous experience from the 2003 SARS outbreak helped to shape the national pandemic response plan.
Leadership and co-ordination	Mozambique: Whole-of-government approach with multiple inter-ministerial working groups.	China: Centralised leadership supplemented with whole-of-government approach. Central government policies and measures are implemented by subnational actors.	United States: Inconsistent messaging from central government leadership, often publicly at-odds with scientific leadership. Subnational leadership and governance often responsible for implementing measures.	Argentina: Response co-ordinated by the national level ministry of health, although implementation of measures and policies occurred at the subnational level.	Uruguay: Emergency response at the national and subnational levels, with the president acting as a central figure in the response and good co-ordination between different levels of government.	Pakistan: Co-ordination across national and subnational governments facilitated by a national co-ordination centre chaired by the prime minister with all provincial chief ministers and several federal ministers. Provincial governments have implemented varying levels of interventions, while the

						federal government implements national measures.
Scientific advice	Uganda: Multisectoral committee of economists, anthropologists, public health experts, and other experts assembled to address the multifactorial nature of an effective scientific response.	Sri Lanka: Backed by an existing robust public health workforce, early and effective public health interventions by the government to test, trace, and quarantine, with social distancing measures were introduced prior to the first case being detected.	Mexico: Lack of clear direction from central political leadership; messages were conflicting with scientific recommendations and the role of the scientific community was minimised.	Peru: A multi-sectoral scientific working group was established to provide advice on issues related to care and management of COVID-19. Yet, many experts resigned over the course of its activities due to a lack of decision-making on pandemic related measures.	Singapore: Establishment of a COVID-19 Research Working Group early in the pandemic with guidance from the chief scientist at the Ministry of Health, which maintains close contact with government decision-makers.	New Zealand: Technical Advisory Group established as part of the Ministry of Health's response, which held regular meetings to develop the country's COVID-19 response.
Community engagement	Niger: Training sessions for the traditional chiefs of 95 urban sectors of Niamey on COVID-19 prevention and containment, including their roles as community surveillance leaders.	Uganda: Ministry of Health facilitated community engagement and risk communication in both physical and virtual communities, such as villages, places of worship, and virtual communities. Stakeholders work with existing community structures to build voluntary action networks.	United Kingdom: Lack of clarity in communication and engagement channels with the community, as well as relief measures that often did not meet the needs of vulnerable populations, in spite of support measures introduced for racialised communities.	United States: No clear national-level attempts at community engagement, although subnational implementation of targeted interventions show local efforts to engage communities in the response.	Sweden: WhatsApp groups in 15 languages on COVID-19 were established for migrants, as well as hotlines and other digital platforms for sharing information among migrants.	South Korea: Effective public-government partnership in promoting and adhering to personal hygiene measures, with government measures accounting for public input.
Financing	Sri Lanka: The government established a COVID-19 security fund with financing available for measures aimed at reducing COVID-19 transmission.	Thailand: Funds earmarked for the procurement of medicines and essential equipment to manage COVID-19 patients.	Peru: 26 million USD (100 million soles) were transferred from the central government to the Ministry of Health earmarked for pandemic prevention and control, and health systems capacity strengthening in response to COVID-19.	United Kingdom: 7 billion USD (5 billion GBP) COVID-19 response fund for the NHS and other public services facing pressures due to COVID-19.	Fiji: A total sum of approximately 37 million USD provided for the national COVID-19 response, with an additional 17 million USD domestically funded to procure medical equipment.	Germany: The federal government announced 3.4 billion USD (2.8 billion EUR) in funding for hospitals to adapt to increased ICU demands.

Table 2. Examples of inner context factors influencing COVID19 national responses

Domain	Factor	Examples of factors influencing the inner context of national responses		
		Countries with the least deaths per 100,0000, with a population of over 20 million	Countries with the most deaths per 100,0000, with a population of over 20 million	Countries in the middle category in terms of deaths per 100,000 population

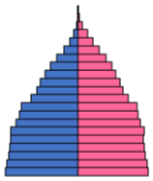
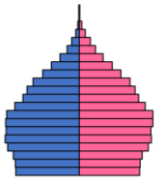
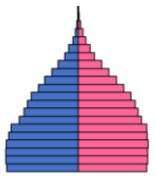
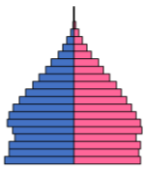
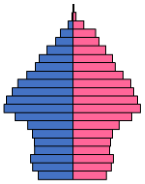
Virus and disease characteristics	Waves & variants of concern	China: First wave of the epidemic in Hubei province, with lockdowns introduced in parts of the province starting 23 January and lasting until March-April 2020.	Vietnam: Resort city of Da Nang evauated 27 July after outbreak of COVID-19, requiring the movement of some 80,000 people.	Brazil: P.1 variant believed to have emerged in November 2020, estimated to be around 2.5 times as infectious as original strain, and caused widespread infection in Manaus.	United Kingdom: Spike in cases in the southeast in December caused by the B.1.1.7 variant believed to have emerged in September 2020, which is estimated to be 40-80% more infectious than the original strain.	South Korea: Outbreak in the city of Daegu in February 2020 linked to a service at the Shincheonji Church of Jesus.	Sweden: Surge in COVID-19 cases and deaths between October and December.
Heightened economic vulnerabilities	Impact on economy	Thailand: The number of people living under $5.5 USD/day (in purchasing power terms) is expected to double in 2020. This has been attributed to Thailand's dependence on tourism and exports.	Sri Lanka: Sri Lanka's economy was impacted by drops in tourism, declines in apparel exports, and a slowdown in imports and raw materials from China which has dampened the supply chain. The government prioritised a continuation of agriculature for rural communities during lockdowns.	United Kingdom: Despite large-scale financial assistance during COVID-19 lockdowns and business closures, an estimated 3 million persons in the UK did not receive financial support in May to June 2020. The self-employed were particualry excluded.	Argentina: Argentina's already weak economy contracted further in 2020, exacerbating economic vulenrabilties. A decline in domestic demand drove increases in unemployment, declines in wages, and spikes in the poverty level in 2020.	Nigeria: Nigeria is facing one of the worst economic contractions in forty years, with up to seven million additional Nigerians falling into poverty. The severe contractionis driven by falling oil prices, reduced private investment, and lowered remittances from abroad.	Pakistan: In 2020, Pakistan's GDP contacted by 1.5%, with 50% of the population seeing income or job impacts from the pandemic. The impacts are concentrated among informal and low-skilled workers, and poverty has increased from 4.4 to 5.4% in 2020.
Inequities within countries	Gender	Mozambique: The government of Mozambique received aid from the Government of Norway to ensure the health, protection, and safety of 500,000 women and girls in Cyclone Idai and Kenneth affected areas.	Vietnam: The Ministry of Health issued guidelines for COVID-19 prevention and treatment for vulnerable groups including pregnant women and infants.	Peru: In April 2020, the government briefly announced a gendered lockdown. The policy was rescinded within a week as essential services were overcrowded on women's days and as it raised concerns of stigma and human rights violations for transgender or gender non-conforming people.	Argentina: Studies found a 32% increase in calls to an intimate partner violence hotline as of April 2020 following the introduction of mobility restrictions; the government took intersectoral action to support those seeking help.	India: The Indian government enacted specific policies to support and protect widows during the pandemic.	New Zealand: Funds were provided for groups that might need extra mental health and well-being support at this time, including pregnant women and new parents and rainbow communities amongst others.
	Children	Niger: Child Protection is working to adapt programmes and advocate for the involvement of child protection actors in the response for vulnerable children, children living in the streets, children deprived of liberty, and internally displaced children.	Mozambique: Child Help line and Radio Mozambique held a two-hour live call raising visibility on violence against children and providing essential advice to parents and children.	United States: The government collaborated with private organisations to provide ~1,000,000 meals to students in certain schools in rural areas that closed as a result of COVID-19.	Argentina: As part of strict stay-at-home orders in April 2020, children were not allowed to travel between the homes of separated parents.	Fiji: Following reports in April 2020 of children who were found out in towns and cities, the Government advised parents to keep their children home during school closure.	Russia: 234,000 schoolchildren, mainly from low-income and large families, were provided with computer technology to help them cope with study-at-home measures.
	Older adults	China: In January 2020, community elderly care	Thailand: Those who are over 70 years old were urged to	Peru: In May 2020,	United Kingdom: In March 2020, people over 70 were told to	Uruguay: People over the age of 65 urged to stay home and	Sweden: Elderly people above the age of 70 years old were advised to

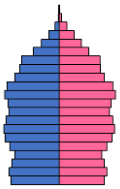
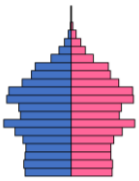
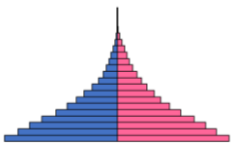
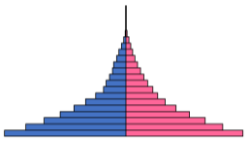
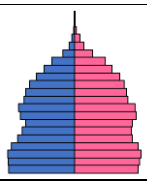
		services, which require mass gatherings, were suspended. If elderly care services were needed, community workers provided door-to-door services.	stay home at all times unless they have to seek medical treatment or essential errands.	"Operation Tayta" was launched. This is a multisectoral strategy to prevent and control COVID-19, through care for the elderly in their homes.	abide by distancing rules and those classed as extremely vulnerable because of an underlying health condition were asked to stay at home until the end of June.	support and offered financial support measures through employers.	stay home as much as possible and avoid close contact with other people.
	Persons with disabilities	Niger: Organisations such as the Nigerian Association of the Locomotive Disabled (ANHL) have made nearly 33,000 masks since the start of the pandemic until October 2020.	Sri Lanka: Financial support of 25.69 USD (5,000 Rs.) were distributed among persons with disabilities, amongst others, affected due curfew to promote the Government's 'Stay at Home' initiative.	Spain: Contingency fund allocated in March 2020 to the Ministry for Social Rights aims at providing essential care, support, safety and food to persons with disabilities, amongst others, affected by the closure of social centres.	Argentina: The Health Ministry published guidance for the assistance and support of people with disabilities on 20 May 2020; REDI (Network for the Rights of Persons with Disabilities) has been working towards implementation of the guidelines.	India: To enable economic security of persons with disabilities, three months increased pension was given in advance.	Russia: Six-month extension was automatically granted for citizens whose next disability re-certification expires from 1 March to 1 October 2020.
	Racialised, Indigenous & marginalised communities	Uganda: Vulnerability mapping to define populations that are "vulnerable" based on age groups, hospital coverage, poverty, access to water, sanitation and hygiene, as well as connectivity and power.	Nigeria: On 30 March 2020, the Nigerian president directed that two-month conditional cash transfers be paid immediately to the most vulnerable in the population. These individuals will also receive two months of food rations.	Brazil: Operations supported by the armed forces provided health services to Indigenous peoples in the Amazon in order to avoid displacement to cities for treatment.	United States: A report from August 2020 found that 42.9% of deaths were in Hispanic or Black individuals; In Boston, the city provided grants to support communities of colour in responding to pandemic.	New Zealand: The National Action Plan 3 included Māori Partnership which recognises Māori as priority group in the national response to COVID-19.	Fiji: Fiji government agencies partnered with UN-Habitat and RISE (a Wellcome Trust funded programme with support from the Asian Development Bank) to provide rapid response support to informal settlements in Fiji. Measures included raising awareness for safe hygiene, providing trusted and useful information about the pandemic, and supporting community leaders to share information with residents.
	Migrants, refugees, and internally displaced persons	Mozambique: Nearly 6,500 residents were resettled at designated sites following Cyclone Kenneth. Site assessments indicate that COVID-19 prevention actions have been conducted. However, none of the sites have easy access to a health centre or isolation space.	Thailand: Non-Thais holding all visa types were allowed to stay in Thailand until 31 July 2020. Migrants from Cambodia, Laos, and Myanmar were also allowed to work temporarily.	Spain: In April 2020, the government issued measures to enhance temporary hiring of land workers, a policy which supported migrant workers whose working permit was about to expire after lockdown.	United States: Some states allocated funds to support immigrants who have no access to federal funding and experienced job and income loss and food and housing related stresses as a result of the pandemic.	India: Estimated 40 million internal migrant workers; Kerala has been on the forefront of providing welfare to stranded migrant workers by setting up over 15,541 relief camps and shelters, accounting for 65% of total camps in the country.	South Korea: The government relaxed measures on prosecuting those who overstayed their visas and foreign nationals being tested for COVID-19 at public medical facilities are exempted from mandatory reporting to the authorities.
Congregate settings	Shelters for people experiencing homelessness	Mozambique: Some resettlement sites established following Cyclone Kenneth in June have established facilities for prevention of COVID-19	Thailand: Ministry of Social Development implemented a program to house and feed people without accommodation.	United States: The CDC recommended that shelters encourage residents to shelter in place, test staff and residents, and promptly	Spain: 357.5 million USD (300 million EUR) transferred to the Autonomous Communities to reinforce the protection of vulnerable people,	Uruguay: Elderly homeless people were transferred to permanent shelters, there were protocols to prevent the spread of the virus in shelters, and additional	India: Food and shelter were provided by state governments to migrants left stranded by implementation of lockdown orders in 2020.

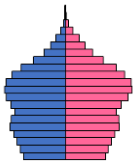
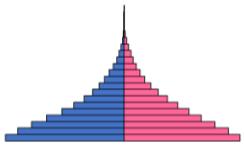
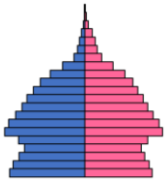
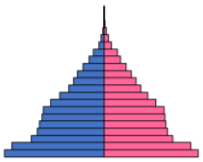
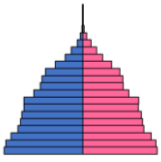
		transmission and information sharing.		isolate those with symptoms.	particularly to ensure basic services to persons experiencing homelessness.	budget was given to create new shelters and extend stay hours.	
	Student or workers dormitories	Thailand: In December 2020, an outbreak was reported in Samut Sakhon, which is home to many migrant workers. To contain the outbreak, which started at a market and its dormitories, mass testing was conducted and strict public health measures were enforced.	Vietnam: In December 2020, over 100,000 students in Ho Chi Minh City were told to stay at home, and a dormitory was closed, after a teacher contracted COVID-19 from an imported case.	United Kingdom: In September 2020 multiple outbreaks were reported in universities across the UK. Students were asked to self-isolate in dorms and refrain from socialising.	Spain: In October 2020, students in a dormitory in Valencia were found to have a 20% test positivity rate, which prompted a switch to online learning.	Singapore: In May 2020, 86% of the country's 17,548 COVID-19 cases were reported from foreign worker dormitory residents; multiple response measures were enacted in reaction to contain the outbreak and prevent future cases.	South Korea: In December 2020 an outbreak occurred at a student dormitory at Ajou Motor College in Boryeong. Municipal health authorities conducted testing and contact tracing.
	Prisons	Thailand: The Thai government took several measures to curb the spread of COVID-19 within prisons. Including: - 14-day quarantine for new prisoners, - suspension of vocational training programmes outside of prisons and familial visits, - frequent temperature screening, - compensation for inmates that died from COVID-19, - early or temporary release using electronic monitoring bracelets.	Sri Lanka: In October 2020 riots occurred in a prison in Colombo over rising COVID-19 infections in prisons. Inmates staged protests demanding an increase in testing and new isolation facilities for infected prisoners.	Peru: In April 2020, riots occurred in a prison in Lima after 600 inmates were found to have COVID-19. Subsequently, 1500 incarcerated individuals who had been charged with minor offences were released to ease crowding.	United States: In May 2020 the Marion Correctional Institution in Ohio reported that of 2500 detainees, more than 2000 had tested positive for COVID-19.	India: After March 2020, Over 42,000 people under trial and 18,000 individuals were released from prisons to ease crowding.	Japan: In April 2020, a defendant at Tokyo Detention House, eight officers at Osaka Detention House, and one officer in Hokkaido were confirmed to have COVID-19. In June 2020, a prison in Kyoto ran an outbreak response drill with officers separating an infected individual and disinfecting the facility.
	Long-term care sector	China: In January 2020, specific rules were enacted for people who are allowed to enter nursing homes including 14 days quarantine before entering nursing homes/elderly care intuitions.	Thailand: On 12 May 2020, guidance for care homes was released by the Department of Health Service Support, Ministry of Public Health, and Department of Older Person, Ministry of Social Development and Human Security.	United Kingdom: In 2020 a policy banning visits was challenged on human rights grounds, with calls for close relatives to be considered key workers and receive testing in order to safely enter facilities to provide care for family members.	Mexico: In May 2020, COVID-19 outbreak investigations in Monterrey, Mexico identified 40 unregistered long term care facilities highlighting the fragmented, largely privatised, and disconnected long term care sector.	South Korea: Enacted preventive measures including active monitoring of residents for symptoms, proactive testing of staff and residents, linkages to national surveillance systems and local governments to secure resources, and investigations to ensure compliance.	New Zealand: Family advocacy groups were key in advocating for a human rights-based approach including greater co-ordination, supplies, testing, and overall long-term care system strengthening.

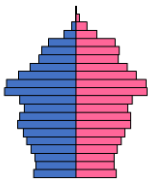
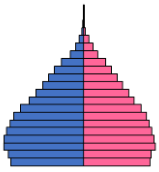
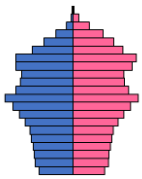
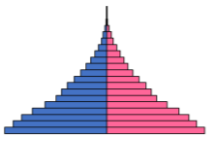
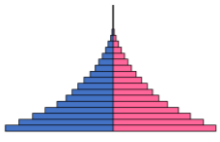
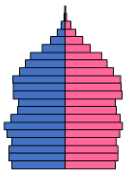
Media and public discourse	Infodemic, social media, and risk communication campaigns	Thailand: The government used an evidence-based risk communication approach and conducted surveys to assess the communication capacity and understand perceptions of protective measures.	Sri Lanka: The government collaborated with the media to amplify correct information, de-stigmatisation, and 'myth-busting' efforts.	United States: The US CDC provided a social media tool kit and library for public use to communicate COVID-19 information.	Brazil: The Brazilian ministry of health was responsible for providing updated information and press conferences on the virus. In June 2020, there was a brief decision to stop publishing daily cases and deaths due to disputes regarding the figures; however, the Brazilian Supreme Court ordered a continuation of the publications.	New Zealand: The All Blacks rugby players, television personalities, and actors spread awareness to their social media followers.	Singapore: Government agencies regularly fact check pandemic information and send notificatiosn through WhatsApp, social media, and the government's COIVD-19 website.

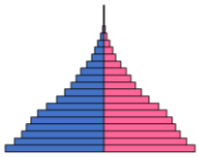
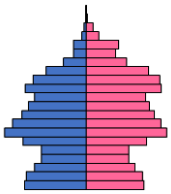
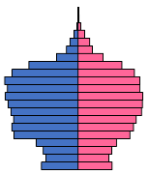
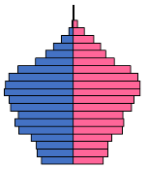
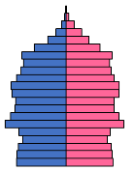
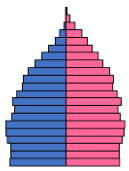
Table 3. Outer contextual factors influencing COVID-19 National responses

Country Cases[1] Deaths[1] Global Health Security[2] Universal Health Coverage[3] Indices	Population pyramid (2019, sex disaggregated)[4]	Population density[5]	Income status[6]	2019 GDP (US$ million)[7]	Health system organisation
Countries with the most deaths per 100,0000, attributed to COVID-19 with a population of over 20 million as of 06 Novembe					
Argentina **63 299.81** Cumulative confirmed cases per million **1 363.93** Cumulative confirmed deaths per million **25 | 42** GHS | UHC Indices Ranking		16/km²	Upper middle income	444,458	A highly decentralised health system comp of private and public sectors and a social sec sector that is managed by a federal struc Individual provinces determine the delivery organisation of public health services whic free to citizens and funded by taxation.
Brazil **67 467.20** Cumulative confirmed cases per million **1 838.53** Cumulative confirmed deaths per million **22 | 27** GHS | UHC Indices Ranking		25/km²	Upper middle income	1,877,114	The Unified Health System (SUS) pro universal and free healthcare for every Municipal governments are tasked with provision of health services and the Nat Epidemiology Center (CENEPI) oversees h surveillance during outbreaks.
Mexico **18 058.96** Cumulative confirmed cases per million **1 667.13** Cumulative confirmed deaths per million **28 | 42** GHS | UHC Indices Ranking		66/km²	Upper middle income	1,268,868	The health system in Mexico comprises main components operating in paralle employment based social insurance scheme public assistance services for the unins supported by a financial protection scheme 3) a private sector.
Peru **53 426.64** Cumulative confirmed cases per million **1 811.36** Cumulative confirmed deaths per million **49 | 36** GHS | UHC Indices Ranking		26/km²	Upper middle income	230,746	Peru has a decentralised health care sy administered by five entities: the Minist Health (MINSA); *EsSalud*; and the Armed F (FFAA), National Police (PNP), and the pr sector. The government is proact redistributing healthcare workers to geographically inaccessible regions and population is covered by mandatory h insurance.
Spain **74 187.43** Cumulative confirmed cases per million **1 659.53** Cumulative confirmed deaths per million **15 | 13** GHS | UHC		92/km²	High income	1,393,644	Decentralised system comprising of organisational levels: 1) Central, Ministr Health, 2) Autonomous Communities an Local, Areas de Salud. The Inter-territorial E of the National Health System (CISNS responsible for co-ordinating and liaising ar central and autonomous region administrat Healthcare is free for citizens.

Indices Ranking					
United Kingdom **65 115.68** Cumulative confirmed cases per million **1 880.82** Cumulative confirmed deaths per million **2 | 2** GHS | UHC Indices Ranking		281/km²	High income	2,833,301	Residents are entitled to free public health ca through the National Health Service (NHS), wh funded primarily through taxation, while NHS England, oversees and allocates funds to Clinic Commissioning Groups, which govern and pay care delivery at the local level. Residents regis with a local GP of their choice who act as gatekeeper to higher levels of care.
United States **96 909.13** Cumulative confirmed cases per million **1 728.69** Cumulative confirmed deaths per million **1 | 10** GHS | UHC Indices Ranking		36/km²	High income	21,433,225	Mix of public and private, for-profit and non- insurers and healthcare providers that op around federal and state regulations. The fe government provides funding for na programmes for subpopulations such as the el children and veterans. Private insurance is dominant form of coverage that is primarily of through employers.
Countries with the least deaths per 100,0000, attributed to COVID-19 with a population of over 20 million as of 06 Novembe					
China **71.13** Cumulative confirmed cases per million **3.37** Cumulative confirmed deaths per million **51 | 27** GHS | UHC Indices Ranking		149/km²	Upper middle income	14,340,600	Multiple insurance schemes maximise popu coverage through the provision of publicly fu basic medical insurance while the urban emp are required to enrol in an employment-l program. Other residents can voluntarily en Urban-Rural Resident Basic Medical Insur financed primarily by central and governments. The basic medical insurance cover all levels of care, anchored by a s primary care sector.
Mozambique **2 228.89** Cumulative confirmed cases per million **25.82** Cumulative confirmed deaths per million **153 | 150** GHS | UHC Indices Ranking		40/km²	Low income	15,195	The health system is anchored by its primary providers, acting as reference points for h levels of care. Health sector expenditures fo implementation of National Health Se activities are financed either by the state bu or multilateral donors and most health ser remain concentrated in urban areas.
Niger **214.45** Cumulative confirmed cases per million **7.89** Cumulative confirmed deaths per million **132 | 176** GHS | UHC Indices Ranking		20/km²	Low income	12,912	Health services are provided largely by charit religious, and non-governmental organisat as well as government hospitals in urban are medican centers in smaller towns. Access to is limited and health service users have to substantial charges.
Sri Lanka **4 734.41** Cumulative confirmed cases per million **29.98**		328/km²	Lower middle income	83,978	Universa, free, and state-funded public h care system. Adopted a pro-poor approach covers all Sri Lankans. Strong health surveil system enables monitoring of outbreaks thr a network of providers that offer diagn testing for common diseases.

Cumulative confirmed deaths per million **120 | 100** GHS | UHC Indices Ranking					
Thailand **794.56** Cumulative confirmed cases per million **2.01** Cumulative confirmed deaths per million **6 | 25** GHS | UHC Indices Ranking		136/km²	Upper middle income	544,152	Provides essential services for citizens at a stages through Universal Health Cove Extension of coverage to high-cost treatn improved financial protection for even the vulnerable. A robust primary care system a large of community health workers en equitable access to health services.
Uganda **910.67** Cumulative confirmed cases per million **7.46** Cumulative confirmed deaths per million **63 | 151** GHS | UHC Indices Ranking		195/km²	Low income	37,788	Decentralised health system with village, pa and other health centres, general hospitals regional and national referral hospitals. High of-pocket health expenditures with plans National Health Insurance Scheme. Repor inequities in access and care particularly amo the poor.
Vietnam **29.21** Cumulative confirmed cases per million **0.36** Cumulative confirmed deaths per million **50 | 53** GHS | UHC Indices Ranking		296/km²	Lower middle income	329,537	Embraces public-private partnerships wi focus on building a reliable primary health sector through the fortification of numer commune health centres that deliver pri care and preventive services. Fragme schemes were consolidated under a un national health insurance and free enrol was offered to the poor.
Countries in the middle category for deaths per 100,0000, attributed to COVID-19 as of 06 November 2020					
Egypt **2 174.47** Cumulative confirmed cases per million **127.51** Cumulative confirmed deaths per million **87 | 93** GHS | UHC Indices Ranking		104/km²	Lower middle income	302,335	Pluralistic health system with public and pr health services. Public healthcare covera provided by the Ministry of Health at no co citizens. However, public services are repor underfunded and have low staffing levels.
Fiji **101.51** Cumulative confirmed cases per million **2.23** Cumulative confirmed deaths per million **168 | 107** GHS | UHC Indices Ranking		49/km²	Upper middle income	5,497	Health services are provided through a net of nursing stations, health centres and hosp The public sector is supported by the govern through general taxation and distribution is poor.

Germany **39 466.89** Cumulative confirmed cases per million **974.78** Cumulative confirmed deaths per million **14 | 13** GHS | UHC Indices Ranking		235/km²	High income	3,861,550	Health insurance is mandatory and fina through general wage contributions ar dedicated, supplementary contribution, shared by employers and workers. Governmer a minimal role in direct delivery of healthcar monitors quality of services through an ove committee.
India **12 545.73** Cumulative confirmed cases per million **141.39** Cumulative confirmed deaths per million **57 | 128** GHS | UHC Indices Ranking		424/km²	Lower middle income	2,870,504	Decentralised health system whereby states a primarily responsible for organising health services and citizens receive free care at publ facilities. Many households seek care from pr providers and pay out-of-pocket due to poor resource allocation and inequitable access.
Japan **4 495.86** Cumulative confirmed cases per million **78.58** Cumulative confirmed deaths per million **21 | 13** GHS | UHC Indices Ranking		334/km²	High income	5,148,781	Employs a statutory health insurance sy comprising of employment-based and reside based plans (managed and organised prefectures). Uptake of private health insura high and used primarily as a supplement t insurance for financial buffering reasons.
Liberia **414.62** Cumulative confirmed cases per million **16.81** Cumulative confirmed deaths per million **111 | 170** GHS | UHC Indices Ranking		47/km²	Low income	3,064	In recent years has made efforts towards h system strengthening after both conflict Ebola greatly impacted health services. government, donors, and other partners National Community Health Assistant Pro now reaches over 70% of the previously unse population. There is still limited acces specialist care.
Nigeria **799.07** Cumulative confirmed cases per million **10.00** Cumulative confirmed deaths per million **96 | 159** GHS | UHC Indices Ranking		229/km²	Lower middle income	448,120	Three-tier structure with federal, state, and health service delivery responsibilities. O low expenditure on health, as such citizens high out-of-pocket expenses due to poor h insurance coverage.
New Zealand **539.38** Cumulative confirmed cases per million **5.39** Cumulative confirmed deaths per million **35 | 2** GHS | UHC Indices Ranking		18/km²	High income	210,224	Achieved universal health coverage throu mostly publicly funded, regionally adminis delivery system. District health boards are ch with planning, purchasing, and providing h services at the local level. Approximately one of the population has private insurance.

Pakistan **3 623.72** Cumulative confirmed cases per million **77.81** Cumulative confirmed deaths per million **105 | 151** GHS | UHC Indices Ranking		255/km²	Lower middle income	276,114	Mixture of public and private sectors. Hea primarily the responsibility of the prov government and is provided through a t tiered delivery system starting with Basic H Units. In early 2021, the province of Kh Pakhtunkhwa became the first to provide a care (up to 6497 USD/1 million Rs), however of the population of the population in Pak pays large amounts out-of-pocket for care.
Russia **32 265.44** Cumulative confirmed cases per million **729.33** Cumulative confirmed deaths per million **63 | 58** GHS | UHC Indices Ranking		9/km²	Upper middle income	1,689,302	All citizens are entitled to state-funded through Obligatory Medical Insurance (O There are a mix of public and private health facilities. However, physical accessibility rer a challenge to non-urban dwellers and a minority possess private health insurance.
Singapore **10 427.77** Cumulative confirmed cases per million **5.13** Cumulative confirmed deaths per million **24 | 6** GHS | UHC Indices Ranking		8,305/km²	High income	374,390	Government-run publicly subsidised univ healthcare system, delivered through va financial protection schemes, with a signif private healthcare sector.
South Korea **2 328.63** Cumulative confirmed cases per million **35.44** Cumulative confirmed deaths per million **9 | 6** GHS | UHC Indices Ranking		512/km²	High income	1,646,739	Universal health coverage with most cit covered by the National Health Insurance Se (NHIS). Citizens pay premiums based on inc levels or property valuations. Those who unable to pay will receive Medical Aid (MA) all costs covered. A small out-of-pocket pay is still needed to access health services.
Sweden **92 911.96** Cumulative confirmed cases per million **1 378.61** Cumulative confirmed deaths per million **7 | 6** GHS | UHC Indices Ranking		23/km²	High income	531,283	Decentralised system where the bulk of h and medical costs are paid for by regiona municipal taxes. In 2018, 13.5 per cen healthcare was financed by regional council carried out by private care providers oper under the same regulations and charge similar to municipal care facilities.
Uruguay **53 218.06** Cumulative confirmed cases per million **669.60** Cumulative confirmed deaths per million **81 | 25** GHS | UHC Indices Ranking		19/km²	High income	62,212	The National Healthcare Fund (FONASA) i financial entity responsible for collecting allocating resources to the health system. T are two main schemes, one for direct p healthcare for lower income groups and other is the National Health Insurance Sy that subsidises private health services fo employees and their families, pensioners, retirees.

Sources:

1. Cases and deaths reported due to COVID-19 as of 06 November 2020
2. Global Health Security Index 2019: https://www.ghsindex.org/wp-content/uploads/2019/10/2019-Global-Health-Security-Index.pdf
3. Universl Health Coverage Index 2017: https://data.worldbank.org/indicator/SH.UHC.SRVS.CV.XD?most_recent_value_desc=false
4. Population pyramids: https://www.populationpyramid.net
5. Population density: https://worldpopulationreview.com/country-rankings/countries-by-density
6. World Bank Country Group: https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups
7. Gross Domestic Product (GDP) as of 2019 https://www.imf.org/external/datamapper/NGDPD@WEO/ARG/CHN/ESP/LKA/GBR/USA/VNM/URY/SGP/PAK/DEU/SWE/BRA/EGY/FJI/IND/JPN/LBR/MOZ/NZL/NER/NGA/PER/RUS/KOR/THA/UGA/MEX/MLI?year=2021
8. Percentage GDP spent on health as of 2018: https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS

Hospital beds per 1,000 population as of most recent year data collected: https://data.worldbank.org/indicator/SH.MED.BEDS.ZS