6th Annual Technical Meeting of the Universal Health Coverage Partnership

11-13 June 2019 - Geneva, Switzerland

Report

Acknowledgement

Some donors have already taken up observer roles such as South Korea, Bill and Melinda Gates Foundation, Italy, Switzerland, Belgium, to name but a few, at the multi-donor coordination committee (MDCC) for UHC Partnership.

More information on the work of the UHC Partnership as well as country-specific documents can be found at www.uhcpartnership.net

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Abbreviations

AMR	Antimicrobial resistance
AU	African Union
BPHS	Basic package of health service for Afghanistan
CHE	Catastrophic health expenditure
CHW	Community health workers
CMR	Crude mortality rate
CS	Civil society
DFID	UK Department for International Development
EDRM	Health Emergency and Disaster Risk Management
EMR	Eastern Mediterranean Region
EPHS	Essential Package of Health Services
ESH	Essential health services
EU	European Union
FCV	Fragile, conflict and vulnerable settings
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility
GPW	General Programme of Work
HDN	Humanitarian to development nexus
HGF	WHO Department of Health systems Governance and Financing
HIS	Health information system
HPV	Human papilloma virus
HRH	Human resources for health
HSEL	Health systems in emergency lab
HSS	Health system strengthening
HWCs	Health and Wellness Centers
IFI	International financing institutions
IMR	Infant Mortality Rate
IPEHS	Integrated Essential Package of Health Services (
JWT	Joint Working Team
MDG	Millennium Development Goal
MoF	Ministry of Finance
MoH	Ministry of Health
NHS	National Health Service
NGO	Non-governmental organization
NCD	Noncommunicable disease
ODA	Official development assistance
OOP	Out of pocket expenditure
PBF	Performance-based financing
PFM	Public financial management
PHC	Primary Health Care
PRP	Performance review and planning
RO	Regional office
SDGs	Sustainable Development Goals
SRH	Sexual and reproductive health
SSB	Sugar-sweetened beverage
TA	Technical assistant
UHC	Universal Health Coverage
UHC-P	UHC Partnership
WCO	WHO country office
WHE	WHO Emergency Programme

Executive Summary

More than 150 participants, including delegates from Ministries of Health from 25 countries, representatives from academia, international agencies, the donor community and WHO officials from the three levels of the Organization, convened in Geneva, Switzerland at the 6th Annual meeting of UHC-Partnership from 11-13 June 2019, to discuss key achievements and challenges on the path towards UHC and health-related SDGs.

The overarching theme of the meeting was Primary Health Care (PHC) as a foundation and key driver for achieving Universal Health Coverage (UHC). Amongst others, discussions focused on strategies to better reach 'the unreached' population in remote or crisis areas through a PHC focused approach and effective coordination.

Key themes emerged from discussions which brought emphasis around specific details:

- **Health systems need a new focus to strengthen PHC in the context of UHC** moving across all SDGs. New approaches must be developed to strengthen health systems and maintain continuity of services during emergency and conflict situations in countries.
- **PHC is an important driver for the UHC agenda** including the necessary link with communicable and non-communicable diseases.
- **PHC must be people-centered.** PHC works towards equity and equality but must account for community preferences when defining health services. The service delivery institutional arrangements should transit from a programme to an integrated people-centered care model. Making primary care attractive is critical in expansion of utilization and coverage of services.
- **Mutual trust** between the community and key players drives effective implementation of PHC. Trusting communities are achieved through the provision of quality services.
- **(Multisectoral) coordination mechanisms and community participation** must be strengthened in countries among health and development partners in stable as well as emergency context. Effective coordination requires joint financing, joint accountability, political drivers and responsibility to communities.
- **Harmonization and alignment** of National Health Plans and Country support plans in countries must be ensured through the refreshing of international health partnership (IHP+) principles.
- Simple and clear messages are key for **effective communication**, particularly at the community level. Countries should develop more effective communication strategies aligned with the country support plans to strengthen mutual accountability.
- The **use of (flexible) external funding must be aligned to achieve UHC.** Countries should build investment cases to leverage more domestic funding and to sustain external resources in protracted crisis.

The meeting was a great success, particularly the policy lab sessions, which enabled participants to understand what actions were taken by local governments to overcome challenges and bottlenecks faced by their health systems. This was highlighted through the presentation of real examples, which helped participants visualize key issues and proposed solutions by the country to help implement PHC.

Introduction and background

Overall context: Universal Health Coverage and Primary Health Care:
Today half of the world's population do not have access to quality essential health services. More than 800 million people incur catastrophic health expenditures, with out of pocket payments exceeding 10% of their household budget. About 100 million people are in poverty because of out of pocket payments. Universal Health Coverage (UHC) is crucial for the achievement of all health targets of the SDG Agenda 2030, and in line with the conclusions of the 2018 Astana conference, Primary Health Care (PHC) is increasingly recognized as a cost-effective, cost-efficient and equitable engine to drive progress towards UHC. In many countries, the majority of people who do not currently have access to essential health services are disadvantaged. PHC is optimally placed to address this, because of its emphasis on tackling the determinants of health and its key role in reducing household expenditures on health. In FCV countries, in cases such as violent conflict or major outbreaks, most of the health burden on affected populations is due to lack of access to essential health services, and disruption in health system.

The WHO 13th General Programme of Work promotes a tailored to needs bottom-up approach to support specific and diverse country priorities for UHC, with the ambitious target of covering one more billion people by 2023. To this end, WHO and its partners will build on the experience of the UHC-Partnership that started its activities in 2011 at country level, and, at global level, ensure global cohesion on UHC with UHC2030 network created in 2017.

Making progress towards achieving UHC at country level through the UHC-Partnership as well as the coordination at global level by UHC2030 is extremely important and will contribute to informing the UN high level meeting on UHC to be held in New-York in September 2019, the Global Action Plan for Healthy Lives and Well-Being for All, and the implementation of the post-Astana PHC agenda.

UHC-Partnership:
WHO, through the creation of the UHC-Partnership in 2011, has established a collaborative agreement with the European Union (EU), Luxembourg and, more recently, France, Ireland, Japan, and the UK to support countries to achieve UHC in an increasing number of countries (from 7 countries in 2011 to 66 by the end of 2018 and will increase in 2019).

The 6th annual technical meeting of the UHC-P, took take place from 11-13 June 2019, in Geneva, Switzerland. This meeting will serve as a continuation of the meetings already held in Geneva (2012), Brazzaville (2013), Hammamet (2014), Barcelona (2016) and Brussels (2017).

The UHC-Partnership aims at strengthening country capacities for the development, implementation, monitoring and evaluation of national health strategies and reforms through promoting Primary Health Care approaches for UHC. The actions and deliverables in each country are different, based on a dialogue between National Authorities, WHO and its partners, tailored to national priorities, and covering a wide range of areas. Following WHO's 13th General Programme of Work (GPW13), agreed actions and deliverables are developed at country level and summarized in WHO UHC country Support Plans, supported by the three levels of the organization in its implementation, and jointly monitored through a live monitoring system. An important characteristic of this approach is flexibility, with the possibility of reviewing country support plans according to the evolution of the situation and the country context and priorities. Moreover, this effort also seeks to strengthen national health planning processes as well as, where appropriate, development cooperation effectiveness in accordance with the principles and behaviors of the International Health Partnership for UHC 2030 (formerly IHP+).

The Country Support Plans help gather country intelligence on UHC progress, details on activities and technical assistance, relevant events and promote knowledge sharing across the organization and with WHO key and implementing partners, on WHO efforts, successes and challenges in supporting UHC. One size does not fit all and each country support plan cover a combination of areas of work along four different dimensions (1) the six health systems building blocks; (2) prevention, health promotion, treatment, emergency care, rehabilitation and palliation; (3) acute and chronic manifestations of communicable and noncommunicable diseases, injuries and mental health conditions, and emerging challenges and goals such as AMR, migrations or addressing polio; and (4) populations across the life course, women's health, new-born, child, adolescent and ageing populations.

For any additional information related to the UHC-P and previous annual technical meetings, please refer to the www.uhcpartnership.net website, which compiles necessary information about the Partnership, including reports from previous meetings.

Objectives of the Annual Technical Meeting
1. Share and discuss amongst peers progress made in the target countries against the UHC goals, including successful support activities, lessons learned and obstacles encountered since the inception of the Partnership; and
2. Further pursue the conceptual reflection around the definition of effective policy dialogue for UHC in countries, based on lessons learnt in Phase III; and
3. Reflect on how the effective development cooperation agenda and IHP+ principles can be reframed to better support health systems strengthening for UHC.

Expected outcomes:
1. Lessons learned, obstacles encountered, and achievements made in countries are discussed; and
2. Recommendations are made to be implemented in the 4th phase of this programme (2019-2022), in line with other sources of funding such as ACP HSS, Japan, France and UK and with the vision developed in the GPW13; and
3. Lessons learned on how to conduct and organize improved policy dialogue and technical support, and work towards UHC, and Sustainable Development Goals (SDGs) are discussed and agreed upon.

1. UHC-P: What has been achieved so far?

The road towards achieving UHC is a constant learning curve for which UHC-P provides technical assistance, catalytic funds and supports country led plans and roadmaps in order to tailor strategies towards countries' needs. *UHC can be seen as a new social contract, working in an atmosphere of solidarity thus contributing to building the foundation for the cohesion of a society*. The UHC-P works towards building strong institutions, making the link between institutions, policies, and results, whilst forging new engagements and fostering cooperation with the regions. During this process, the three levels of WHO come together across the six WHO regional offices (ROs) to collaborate with partners.

The Annual Technical meeting started with an overview regarding the progress and highlights achieved of the UHC-P since its inception. In 2018, the vast majority of activities contained in the 66 developed UHC country support plans were related to PHC, paving the way for UHC-P to become a driver in the implementation of the PHC for UHC agenda in the coming years.

The UHC-P is a truly corporate program utilizing the three levels of WHO, relying on the reporting structure of the GPW13, regional programmes and strong country teams. The UHC-P is results-oriented and country-owned. It aims at leveraging domestic resources and supports institutional and workforce capacity building.
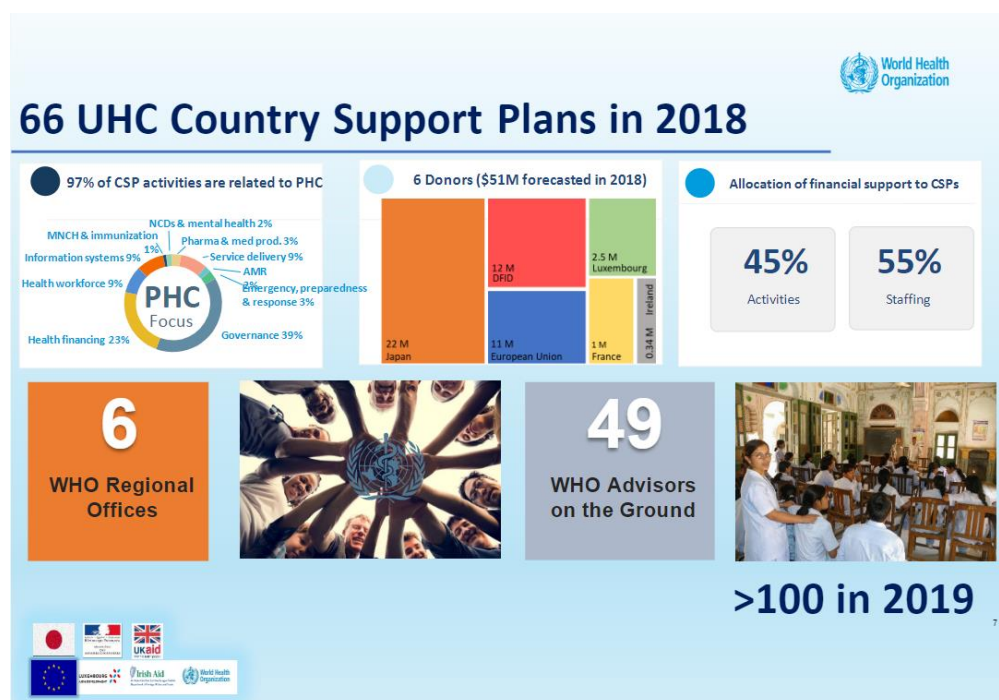
The Joint Working Team (JWT) structure helps harmonize work between different divisions and departments at WHO HQ and across the three levels of the organization. Thanks to new donors, the UHC-P expanded its areas of work, integrating NCDs, PHC, wider scope of health service delivery and health security. The flexible structure of UHC-P enables WHO to provide support to Ministries of Health (MoH) and address country needs, irrespective of the level of maturity of the health system in place. In the future, more emphasis will be put on the monitoring tool and be made accessible to the donors. Additionally, alignment is envisaged with new internal WHO strategic performance review and planning (PRP) process and WHO needs to prepare for the donor-led evaluation process.

1.1. Regional perspective

UHC-P has been helpful for the scale up of UHC activities in **EURO**. *Four themes determined UHC-P phase III: 1) working strongly on governance issues to develop participatory processes and to create transparent institutions by establishing or strengthening purchasing authorities which affect priority setting and resource allocation; 2) the expansion of the fiscal space to strengthen purchasing mechanisms and advanced methods of PHC; 3) a new generation of health workforce reform in region; and 4) working in digital transformation in a number of countries.* Technical assistance is a very important element at country level which has generated many success stories. However, the move towards UHC requires each country to find its own path, dialogue and political cooperation. In EURO, the success of UHC-P was largely due its common principles and its flexibility. The catalytic nature of the funds allowed channeling them around key issues and alignment with the work of partners. Most of the resources support country level activities. Moreover, UHC-P shows WHO at its best across three levels (CO, RO, HQ).

In **AFRO**, the UHC-P enjoys political support from the African Union (AU) and received positive and constructive feedback from AFRO MoHs on how to take UHC action forward in the region. AFRO prioritizes UHC, making UHC-P one of the two AFRO flagship programmes and investing additional resources. AFRO faces the following context specific challenges:

- Learning the lessons applied at the sub-national level: How to translate ideas into actionable field work together with implementing partners, so that achievements made at district and province level match those made at sub-national level?
- Performance: measurement by result and not by processes. Once implemented, how to ensure that different contexts lead to different effective results?
- Identification of innovative ways to solving problems within a feasible manner and according to what is possible at country level and capacities.
- Many of AFRO's countries health systems are under constant stress, struggling with several major outbreaks at the same time, struggling with subthreshold events not big enough to trigger response but still putting stress on health system, so how do you devise PHC approach with so much stress already on health system
- AFRO has a high level of untapped regional capacity which shall be integrated into our work, especially in terms of innovation (we must find a way to leverage this capacity)

In **EMRO** *since the inception of the partnership, the UHC-P has been proven instrumental in terms of garnering political commitment and supporting dialogue.* EMRO is leveraging this commitment in terms of implementation by working with the countries to develop country road maps and translating the global compact into national compact and identifying the roles of different actors, including development partners. This process recognizes the fact that the journey to UHC is a social contract and thus includes other sectors. *The live monitoring system of UHC-P is an excellent modality to better coordinate the funding and finance mechanisms to ensure coherence and complementarity allowing the identification of gaps and recruit new technical assistants*. EMRO is working on establishing a forum for MoHs and Ministry of Finances (MoFs) and the publication of a Health Finance Atlas. Moreover, many EMRO countries face emergencies where implementation is challenging. EMRO put a new structure called 'Health Systems in Emergencies Lab' in the department of Health systems (HSS). This lab bridges the collective outputs required by cross departmental cooperation by providing a post-emergency health system recovery framework and a country guidance on humanitarian and development nexus for health.

In **SEARO**, ¼ of the world's population is located in 11 countries where 800 million people do not enjoy full health coverage. From the financial protection perspective, 65 million people are pushed into poverty every year due to high out of pocket expenditure (OOPs). With an ageing population and an epidemiological transition moving toward NCDs, reforms in health systems are imminent. Two main points of action are required in SEARO: firstly, strengthening access to and quality of frontline primary care services, which are currently underfunded and neglecting NCDs. Secondly, reducing OOPs and increasing primary health care expenditure. *The UHC-P has been a great opportunity in SEARO to support reforms at policy level with flexible funding to address varying needs.*

Since 2018, **WPRO** received UHC-P flexible funding which was used to develop a regional framework for UHC supporting 37 member states. *Participating UHC-P countries observed several common benefits of this flexible funding and were able to identify priorities through conversations with country governments.* WHO Country Offices (WCOs) communicated that their common issue is how to strengthen PHC using different entry points such as national health insurance or health workforce, depending on the country's context. The UHC-P's catalytic funding allowed for the development of the ACP proposal which in turn resulted in further discussions regarding Pacific Island countries-specific reforms. Under new WPRO leadership, a White Paper is currently in development to identify four top priorities for WPRO based demographic and epidemiological changes[1].

Burning Questions:
This session raised several issues to be discussed and resolved during the event:
- How to devise a PHC approach when facing a weak health system
- How to tap into unused resources such as academic institutions providing a high level of regional capacity?
- How to best leverage political commitment in terms of implementation?
- How to translate work UHC-P is doing at country level and even more so at the front line (districts and provinces)?
- How to translate global compact into national compact and identifying the roles of different actors in country, including development partners?

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[1] health security and AMR, ageing and NCD, climate change and environmental health, unfinished agenda including CDs.

2. Future of the UHC-P: PHC on the move

"PHC can no longer be characterized as 'poor health care for poor countries' as all countries are interested in not only improving health outcomes but increasing efficiencies through more evidence-based allocation of existing resources." – Dr Salama, WHO

This session focused on setting the scene and highlighted the necessity of a reinvention of PHC. The UHC-P paves the way in line with the GPW13 principles, providing tailored support to country priorities for PHC, in a flexible manner, and in a bottom-up approach.

PHC provides the adequate framework for a universal development agenda on health which also responds also to emerging epidemiological and demographic trends, changing burden of disease and major gaps uncovered during the MDG period. A more functional approach to healthy living demands continuity of care to address disability and chronic disease. Quality and equity are critical aspects of a revitalized approach to PHC with action beyond national averages.

With regards to fragile states, a new operating model demands intensified country presence, technical guidance, practical support as well as more detailed and robust monitoring and evaluation mechanisms.

WHO now utilizes PHC as a platform to bridge disconnected health system components with service delivery and disease-specific programmes. WHO and its cooperation partners GAVI, GFATM, Global Financing Facility (GFF) and others, will translate lessons learned from developing health system strengthening windows into a coherent PHC approach using practical entry points.[2]

PHC has the potential to alleviate challenged relationships and has the capacity to reinstall lacking trust between health systems and communities, whereby the health community must focus on accountability mechanisms at community level. *Successful PHC demands a bottom-up approach: emerging epidemiological trends are to be analyzed and matched with the service delivery package.* To this end, practical entry points to health reforms regarding commodities and essential medicines packages, budget allocations, financial flows, and human resources needs, should be assessed.

PHC provides a platform for innovation in terms of products. These can be new medicinal formulations or digital tools or programmes such as integration of essential primary health functions into PHC or financing such as taxes on harmful products.

WHO, through its new special programme is committed to working across all key technical departments and the 3 levels of the organization to deliver a new PHC. WHO will shortly be developing an operational framework, finalizing a UHC menu, developing a learning platform, implementing a research agenda and strengthen technical assistance capacity at regional and country level. WHO invites all partners to join this journey.

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[2] such as commodity security and supply chain, human resources support, support for data systems, etc.

2.1. Discussions

The panel discussion on PHC provided an opportunity to understand the global and donor perceptions of the evolving PHC for UHC agenda.

Four take-aways were highlighted in the key note speech "Policy orientation at regional and country levels for PHC" regarding the role of PHC as engine driving UHC: innovative policies should be integrated in an inclusive way; collaboration and coordination must be intensified and harmonized and lastly, PHC must be people-centered. Whilst PHC works towards equity and equality it must account for community preferences when defining health services. *Trust is achieved through the provision of quality services*, therefore adequate providers and knowledgeable work forces are needed in primary care and public health to tackle the complexity of chronic conditions.

WHO pointed out that the Triple Burden of Disease and health care facilities must be better prepared to respond to environmental determinants and climate change induced diseases and ensure access to reliable sources of energy. *PHC is the first entry point into the health system – the highest level of ambition is therefore the minimum level of effort.* Since both the care and prevention agendas are multi-sectoral, they should, in addition to more health promotion options), equity and equality elements, be incorporated from the start of the inception phase to counteract the lack in attractiveness of PHC to citizens and health professionals.

From a donor's perspective, the UK (DFID) regards the PHC for UHC country strategies as a good investment which constitute an important domestic priority for the UK. PHC requires a strong referral system, other interrelated mechanisms to achieve UHC as well as sustainable, equitable financial reforms.

The new Grand-Duchy of Luxembourg development cooperation strategy prioritizes health and supports multi-stakeholder partnerships and people centered programmes such as PHC, HSS and UHC. Luxembourg supports knowledge transfer, country specific information research as well as working with civil society to empower communities to take control of their own health. Luxembourg is fully committed to integrate gender aspects in all its health programmes including UHC.

Countries examples were shared to highlight ongoing PHC work to make progress towards UHC. A number of countries raised issues related to human resources for health (HRH) and the need to increase related support. Similarly, a number of them highlighted the issue of decentralization, financing and allocation of funding between states, harmonization and alignment of plans. The discussion also examined partner's support towards one plan and monitoring as well as issues of community engagement and social participation. It has been noticed that *the new generation of many national health plans demonstrates countries' enhanced understanding and commitment to reinforce PHC to achieve UHC*. As many countries realize that tertiary care is not efficient, they work on reinforcing PHC to turn the care pyramid upside-down.

2.2. Further discussions

UNICEF focused on the principles of the PHC partnership[3]. Six modalities illustrate how to reinvigorate and revitalize PHC at country level:

1. coordination between existing national/sub national mechanisms led by governments,
2. joint situation analysis and prioritization and prompted by the national health planning cycle,
3. a single framework of PHC metrics and measurements,
4. streamlined programmatic policies, operational rules and technical assistance,
5. better aligned resources including increased domestic resources,
6. aligned investment cases and coherent financing plans.

In brief, a*ccelerating PHC progress depends on its operationalization* and global guidance is needed on common HS assessment for PHC as well as on operationalization and a common PHC monitoring framework (currently in progress). At country-level, each agency (WHO, UNICEF, others) needs to assess its strategic approach to PHC strengthening[4] and ensure that the PHC programme is operational.

Regarding PHC in emergencies, the focus is on those left behind. Breach in social contracts and loss of trust by communities hampers delivery of health services. As 85% of humanitarian funding is spent on protracted crises, the humanitarian and development nexus (HDN) is not a small sliver for countries that quickly transit from a humanitarian to a recovery and development phase. *Community ownership and bottom-up approaches are differing in crisis context*. *PHC is and will continue to be delivered in complex and dangerous environments.* WHE and UHC work together to facilitate the creation of a minimum of service delivery which must be upheld even in the most dire country circumstances.

The EU funds health system approaches in countries with fragile PHC and provides assistance to reinforce PHC accountability and better monitoring. *The EU wants other donors to join financing and investment planning via the MDCC and the live monitoring tool. EU Delegations will assist in bringing donors and partners closer together at country level.* Emphasis is placed on strengthening human resource during the next UHC Phase IV[5].

The discussion addressed how to counteract some realities differing at country level from talks held at global level. *The speed of development differs from context to context, requiring essential health services (EHS) and workforce to be adapted to the existing resources and infrastructure on the ground.* Capacity transfer to local actors and adaption in real time at the community level require operational change. Moreover, governance must be built into the system and the specific country context must be assessed before investing. UNICEF expressed its willingness to be an implementing partner in the UHC-P to jointly support the PHC for UHC agenda in countries.

The NGO "Living Goods" presented the delivery of high impact services whilst working with community health workers and digitally empowering them. *Ensuring social participation right*

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[3] Country ownership, bottom-up approach, country needs tailored approach.
[4] Assess whether its program is narrow or broad (vertical or horizontal), assess the level of support in terms of dollars and TA, what guides the planning/M&E.
[5] focus on health security, emergencies and NCDs as health systems building blocks.

from the start is a successful method to move PHC and UHC forward. The NGO develops investment cases that propel governments to invest. This results in strong partnerships such as Uganda's multi-sectoral partnerships for UHC roadmap development where the NGO supported MoH in collecting community data to make informed policies.

Similarly, it was highlighted how in Asia and the Pacific, small and practical steps can change PHC and how simple protocol-based management can lead to effective change. *PHC can act as the gate keeper to high-end* care, critical for NCDs. Other elements are risk reduction and flexibility allowing for quick adjustment to fast developing realities.

The achievement of UHC depends on the leading actors which are the people in communities who must be empowered to take ownership. Currently, Japan experiences an unprecedented ageing population. The country shared its best practices regarding its community-based integrated care system which will allow the elderly to live the rest of their lives in an environment familiar to them, even in need of extended care.

3. Primary health care: new strategies for better 'reaching the unreached' population

This session focused on overcoming implementation challenges in the context of UHC. The shift from MDGs to SDGs was accompanied by disease-specific interventions, structural adjustment programmes and inequities. Health systems are still challenged and need a new focus to strengthen PHC in the context of UHC moving across all SDGs. New approaches must be adopted and five key issues must be emphasized during implementation: *Equity is a difficult but central theme*, along with government stewardship capacity and harmonization of partner activities at national and sub-national level with remodeling and integration of services leading to: 1) improving access in hard to reach areas, 2) package of services (essential, comprehensive, etc.), 3) institutional arrangements for service delivery, 4) quality of care and 5) sustainable financing.

3.1. Country experiences and debate

MoH **Georgia** explained how it improved PHC service quality through its 2013 UHC programme. Georgia followed international guidelines for the detection of NCDs and CDs, aligned with a continuity of care framework. The programme strengthened evidence-based interventions at PHC level, implemented clinical practice guidelines and integrated a screening programme. Donor agencies and multilateral partners supported capacity building activities and the government expanded PHC by integrating more services into the PHC package. Since the implementation of the chronical disease programme in 2017 and community-based interventions, communities benefit from access to quality drugs. Next steps include strengthening HIS at PHC level through modern technology, professional connections in primary care, better qualitative data collection and the introduction of performance-based incentives to promote primary care.

Improving access to primary care in remote settings was demonstrated by **India's** Ayushman Bharat programme as a result from the new NHP 2017. This policy implemented health and wellness centers (HWCs) providing accessible and affordable healthcare to reverse low utilization of PHC services and fragmented delivery. The centers act as gate keepers, watching over outpatient and inpatient referral and cover a continuum of care, utilizing telemedicine. They also focus on critical areas of service provision, patient rights and quality management. *The use of telemedicine and teleconsultations is beneficial for hard to reach communities, reducing inequalities and out of pocket spending.* Expansion plans and an IT application aim to ensure timely disbursement of performance linked payment and data validation.

Expanding primary care services to address NCDs was showcased by **Cabo Verde.** Structural and institutional challenges induced by the horizontal design of PHC services led, in 2007, to *the decentralization of the operational health management which accelerated access to and improved quality of PHC services to populations in remote areas.* Since then, the 'One Health' strategy was implemented, and municipal health commissions became responsible for the operationalization of the health policy. Other good practices include, for example, specialized telemedicine consultations, engagement of community-based NGOs, the integration of public policies addressing NCDs.

Progress towards an equitable national funding for PHC for UHC was illustrated by **Madagascar**. Madagascar aims to put in place an equitable national funding system through

innovative financing and funds dedicated to the poor covered by the state budget. This system is to be achieved through equity funds, tobacco taxes, partnerships with mobile operators, taxes on polluting and sweet products as well as performance-based financing and prepayment mechanisms. Madagascar implemented a national health community policy and promotes public social insurance. These good practices led to an increase of outpatient consultations in pilot zones.

WHO Cambodia shared its lessons learned regarding **expansion of PHC services for NCDs**. To successfully instill the communities' faith in services, WHO Cambodia disseminated adequate information on the new PHC services. India avoided **conflicting interests from different sectors**, through the fact that its public health services and hospitals are governed by states. MoH is responsible for financing and technical assistance, the states therefore need to leverage these interactions to promote MoH's agenda.

WHO Uzbekistan used NCDs as example to explain how *an **investment case** can become an eye-opener for governments to place health higher on their political agenda*. With the change in government 2,5 years ago, many reforms were implemented across sectors. However, Uzbekistan lacks a health financing system, a functioning health information system (HIS), operates an inadequate health service delivery system and has a non-existing HRH strategy. An investment case on NCDs spurred a cooperation between MoH and MoF, resulting in the allocation of 4.7% of GDP to NCDs. Together with the Ministry of Economy (MoE), they developed a health financing strategy.

Discussion also addressed methods of implementation of a tax on sweets in a country where **tax administration** is weak. In the Philippines, sugar-sweetened beverage taxes (SSB tax) have no earmark for health and therefore MoH could not decide how to spend the money. In addition, MoF and MoH could not agree on the technical and allocative capacity provided by MoH despite a possible increase in funds through the SSB tax. Regarding earmarked taxes, WHO HQ remarked that *taxes can play an important role as a PHC instrument but do not serve to increase the health budget. Taxes should be looked at in terms of their health effects* as the effects of earmarking on revenues tends to fade over time. On the financing side, *the effects of earmarking health specific taxes should not be overestimated.*

The issue of **building capacity for equitable domestic funding** was discussed. To transition to the PHC people centered model, WHO Eritrea recommended improving access to PHC in hard to reach areas through effective community engagement (i.e. engagement of CHWs, health committees, women advising women.) In Eritrea, the district health system plays a critical role in the implementation of PHC, ensuring that all health facilities have coordinators and NCD clinics. *With regards to people centered care and coordination mechanisms, coordinating bodies on the ground and at the national level must communicate with each other to become effective beyond the peripheral level thus allowing for integration.*

In conclusion, it was pointed out that countries responding successfully to NCDs at low cost are those increasingly utilizing multi-disciplinary PHC teams. *The common themes emerging from this session include the need for large multidisciplinary integrated PHC teams equipped with early detection mechanisms, linked to community outreach teams.* Other enablers include utilizing public-provider mixes with contracts linked to PHC and quality of care targets. *PHC teams understand their communities and populations very deeply and better*

technologies could be used to risk stratify and target the population most in need of support in a proactive patient-centered manner. It was mentioned that there is a need for a common vision on how to phase the expansion of the PHC service basket.

4. Policy labs – PHC in practice

Policy labs are designed to create a safe space to foster collective problem solving. They enable participants to share and communicate, understand actions undertaken by local governments and incentivise by putting forward best practice examples. The participants separated into six policy lab groups, led by one member state of each WHO region (Ukraine, India, Morocco, Belize, the Philippines, Guinea), to discuss their challenges in health system strengthening. Policy instruments and pragmatic actions were identified concentrating on four themes:

1. transforming the **model of care** and related **health workforce** policy instruments
2. **financing** instruments to expand fiscal space, prioritize, and align incentives
3. policies and instruments of **digital transformation**
4. aligning national and local/community policies in context of **decentralization**

Ukraine's MoH, in cooperation with MoF and venture capital investors, mobilized funding to reform the health system through a "Governmental start-up approach". It was debated how Ukraine can boost PHC providers' performance without financial incentives and how to channel funds into the system without solid attractiveness of PHC.

India's focused on strengthening the wellness component and implementing health promotion/prevention strategies in a curative-focused care response. It also addressed how to enable primary healthcare teams at HWCs to better address other social and environmental determinants and looked for models to influence people's behaviour.

Morocco's policy lab focused on how financing mechanisms would attract health insurers as Morocco's gratuity system did not result in a high increase in PHC service utilisation despite great efforts.

The policy lab led by **Belize** addressed the question which alternative financing mechanisms will support the health system to achieve coverage beyond the vulnerable population.

The Philippines recently passed the UHC Act and currently prepares the guidelines for the implementation for this law. The policy lab concentrated on how to transition from a highly fragmented health system to an integrated health system at the province and city level, while maintaining a devolved set-up.

Guinea explored the use of new technologies to collect and use data from community health systems in other countries, how to sustain the community health model and how to efficiently train and retain community health workers.

The lessons learned from the country examples discussed during the individual policy labs were collated and summarised according to the following four categories. Please see further details regarding each country presentation in the annex.

Models of Care
The current model of care needs change and the health workforce discussions must expand beyond health financing. Moreover, all actors shall facilitate the move towards multi-profile and team-based PHC models. Changes in the health workforce composition are needed and

could be facilitated by HRH roadmaps and transition guides. In conclusion, new instruments for increased quality of care should be developed and promoted, such as online trainings with certification for healthcare workers, adequate guidelines and accreditation.

Financing

Financing as well as the definition of the PHC essential list of service are a priority. The UHC-P community must build upon data and engage different actors and stakeholders to spur the policy process beyond financing. Governments shall tap into unused resources and create a fiscal space for health, looking at specific taxes and other possible instruments to increase efficiency. Moreover, a change in perception can result in making a better case for health as an investment and not as a cost. Another point agreed was to improve utilisation of resources and channelling them to PHC. With regards to rendering PHC more attractive, governments should create the right system of incentives and also incentivize PHC through better funding allocation. The utilisation of PBF and also accreditation mechanisms could be functioning as financing and administrative levers.

Decentralization

PHC operates in decentralized settings where local governments are key actors. Given the number of actors involved in the roll out of PHC for UHC, communication can be simplified through the establishment of simple platforms bringing stakeholders together. The central government should measure/monitor/understand the structure and mandate of the local government, its actions and action gaps, and put in place incentivization using matched grants.

Digitalization

It was recommended to use digitalisation as tool to push the boundaries of health systems to reach the hard to reach and reducing geographical barriers through telemedicine. Integrating digitalisation into new models of care will increase regular contact and service provision to people. Digitalisation can support decision-making, prioritization and governance through targeted use of increased scope and volume of data generated (i.e. essential benefits/services packages). The right mechanisms and instruments must ensure that generated data are comparable and aggregable in order to translate it into decision-making tool on the systems level.

5. Effective coordination for UHC

5.1. What are the changes we want to see?

This session introduced the context and the renewed emphasis on country coordination and whether the proposal to 'reboot' the IHP+ 7 behaviors.

UHC2030 presented the "seven behaviors", which are consensus based governing and coordinating guidelines for all agencies in terms of effective development cooperation in health.

WHO presented coordination issues from the global perspective. Encouraging discussions with more external actors to diversify views and approaches on how to better cooperate to reach the SDGs, could help align interests of countries and donor funds thus closing the information gap. The 2030 Compact induced behavior change through successes and lessons learned and fostered commitments on how to measure countries own successes. Accountability and coordination, (external) funding harmonization and alignment are even more important in the face of the SDGs.

The discussion focused on the global, regional and country perspectives to elaborate on the different coordination needs and related changes.

In Guinea, all donors refer to the **national health plan (NHP**) and are coordinated by the technical committee. Having learned from inefficient coordination and slow implementation in the past, Guinea bundled national health financing mechanisms, thereby creating one single mechanism with the support of MoF and WB. However, the absence of common guidelines caused limited accountability for and transparency in the domestic financing mechanism. WCO Guinea recommended that the 7 behaviors are to be adhered in accordance with the country context accompanied by regular revision. WCO Jordan recommended to increase ownership and to clearly define **roles of donor agencies** in order to achieve transparency and mobilize more funding by donors.

In Kenya, UHC became **politically projectized** as Kenya's political commitment at presidential level led to promises that UHC would be delivered in the second term. Consequently, coordinating structures and engagement with partners became less influential and the health sector coordinator committee developed in the partnership framework did not come to fruition. As a result, direct uncoordinated engagement with MoH caused inappropriate use of funds and withdrawal of donors. The solution would be to bundle funds through the health budget, align the health management- and the health procurement system.

In conclusion, UHC-P can contribute to improve coordination by:
- Revitalize coordination of government at the 3 levels and induce ownership,
- Restore measures of accountability,
- Restructure public health financing mechanisms,
- Finalize the strategic purchasing agent (data should drive the delivery of the health programmes),
- Establish a direct relationship between flexibility of funds and meeting government interests (very important feature of the UHC-P).

5.2. How to bring these changes about?

This session tackled the question how to improve engagement of partners and country actors to contribute to national health and UHC plans in a joined-up way.

Coordination mechanisms for different sectors and partners including Ministries, civil society organizations (CSOs) and service providers are well established in some countries. The **key for successful coordination** is an agreed agenda, aligned with the national strategy, specific objectives for the different participants and tracking of coordination decisions and expenditures. The different interests of the partners need to be understood before any coordination can take place and donors must be willing to be coordinated. *Effective coordination requires joint financing, joint accountability, political drivers and responsibility of communities.* In Cambodia the national structures for coordination for health across all sectors are led by MoH. The P4H Network facilitates the coordination platform for health financing.

RO EMRO sought ways to **prioritize the UHC roadmap** used by the region for implementation of PHC post Astana. Suggestion was made to capitalize on the diverse skill mix and different professions involved in PHC by working with graduated professional to ensure their commitment to UHC. Specific actions regarding strengthening PHC partnerships and workforce in the region were proposed by MoH Georgia, such as specific materials/modules on UHC promotion in undergraduate education and UHC awareness raising in general.

Rhetoric can be overcome to strengthen mutual accountability through more effective communication strategies and a single policy framework, such as a common operational plan. This is the case in Belize, where donors willing to fund activities must be aligned with the Belize National Operational Plan which covers all sectors. Another point raised was that *committed governments are the key of a successful coordination.* Country coordination, driven by MoHs, should also **address global cross cutting issues to contribute to collective goals**. Participants agreed that *mapping coordination platforms can inform about actions already happening on the ground, strategic information sharing and action following decisions will allow for synergies and avoid duplication.* The importance of mutual learning

was emphasized, the need to measure progress on PHC using collective indicators and the need to remind governments of their commitments. It was pointed out that *honesty and trust are the cornerstones for effective coordination to build a good dialogue between partners.* Donors should be more transparent, spur active participation and hold each other accountable.

WHO HQ highlighted the need to support countries further on donor coordination, alignment and harmonization, which is integrated in the UHC-P terms of reference (ToRs). Mutual accountability was understood as a joint accountability from donors and MoH to the beneficiaries and the taxpayers.

6. Health security and health systems strengthening in emergencies

A PHC approach is an essential foundation for health emergency and risk management, and for building community and country resilience within health systems. This session focused on health security and health system strengthening in the context of emergencies. Participants exchanged knowledge and experiences, and discussed the lessons learned regarding emergencies and health security at country level.

6.1. EMRO approach on building health system resilience in emergencies

Countries in the EMRO region are at great risk of natural and man-made emergencies as well as epidemic and pandemic prone diseases. There is a direct association between health system fragility and political fragility/emergency in the region. EMRO established the "Health systems in emergency lab" (HSEL) to improve health system resilience. HSEL brings health system strengthening closer to emergency preparedness, response recovery and transition works at regional and country level. Four cornerstones are necessary for successful integration: 1) willingness of organizations and the people; 2) adequate institutional arrangements; 3) coherent alignment of work and 4) clearly defined collective outputs. *HSEL is a key development in the region to help achieve progress towards UHC in FCV context.*

6.2. Integrating planning for PHC with health emergencies risk management and operations

During emergencies, PHC services are impacted, suffer from decreased capacities to provide services and damaged building blocks. However, a PHC approach develops resilience within health systems and can advance UHC and health security. *Integration of emergency risk management into PHC is a key strategy and community engagement and trust are the building blocks for its success.* The main function of PHC in emergencies is the routine to continue quality health services, provide case management for the emergency related pathologists supporting the response and putting in place continuous preparedness measures. WHO started work in FCV settings and countries dealing with high levels of mortalities, morbidities and outbreaks, which makes resilient PHC services irreplaceable.

Addressing the Humanitarian-Development Nexus (HDN) divide introduces a new approach to working, as the humanitarian partners are new players to WHO in terms of development partners. Due to the increase and difference in modalities applied on the ground, coordination has become an issue.

Action points:
- Humanitarian interventions should apply early recovery approaches in response and seek integration with existing health services and transition governance to local authorities.
- Development oriented work streams should target FCV areas in a more operational manner addressing key bottlenecks.
- Innovative programming in FCV settings should include orientation along SDG3.
- Country specific actions should include: Joint analysis, costed essential packages of health services based on PHC principles, EPHS implementation plan, joint coordination platforms, supply chain management, EWARS and preparedness, monitoring framework, knowledge agenda.

6.3. Health emergency and disaster risk management framework: interlinkage with PHC

WHO launched a Health Emergency and Disaster Risk Management (EDRM) Framework at the 6th Session of the Global Platform for Disaster Risk Reduction in Geneva in May 2019 [6]. The Health EDRM Framework stresses a shift in focus from managing events to managing the risks and consequences of emergencies and will support the attainment of WHO's GPW13 vision, the SDGs, the Sendai Framework for Disaster Risk Reduction, the Paris Agreement and the International Health Regulations (IHR). In a matter of three years, 97 joint external evaluations have been conducted, 59 national plans for health security have been established and 24 One Health national bridging workshops have been held. Despite the unprecedented level of work undertaken in countries to monitor and implement the IHR, substantial needs remain to build country and community capacities to manage risks of all types of emergencies, including emergency prevention and preparedness. Effective collaboration between health systems and health emergency managers at country level will be crucial to effective implementation to strengthen health security, community and country resilience and sustainable development. PHC/community-based clinical care, including the local health workforce, are at the center of EDRM work and future collective action entails the roll out of health EDRM at national level and financing of HSS to strengthen disaster risk management. *Strong focus needs to be placed on multisectoral and health sector coordination mechanisms incorporating all levels of society to optimize the application of country resources for reducing risks and consequences*. Most importantly, the narrative between UHC, health security and Health EDRM must be clear. *Community and national level engagement play an important role in preventing risk and preparedness before emergencies occur and ensure effective response and recovery, including building trust and confidence between actors at all levels. Effective governance as well as strong and resilient communities reduce vulnerability to emergencies and ensure capacities are in place to reduce the risks and consequence of emergencies and disasters.*

From	To
Event-based	Risk-based
Reactive	Proactive
Single-hazard	All-hazard
Hazard-focus	Vulnerability and capacity focus
Single agency	Whole-of-society
Separate responsibility	Shared responsibility of health systems
Response-focus	Risk management
Planning for communities	Planning with communities

Every actor in the health systems should be able to locate themselves in an integrated EDRM framework. Therefore, there is a need to pursue key **shifts in the approach which brings together health systems, PHC and Health EDRM** (see table). The health EDRM framework is based on guiding principles[7] and aims to ensure that Health EDRM is implemented through integration in all health policies and programs that strengthen health systems.

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[6] https://apps.who.int/iris/bitstream/handle/10665/326106/9789241516181-eng.pdf

[7] such as risk-based approach, comprehensive emergency management, all hazards approach, multisectoral and multidisciplinary collaboration, inclusion, people-centered approach.

Future collective actions must entail:
- Roll out the Health EDRM framework with countries,
- Integration of health EDRM and health systems-common narrative, action plan,
- Mainstreaming of health EDRM in all health policies/ programs,
- Financing health systems for health security- IHR implementation,
- Stronger focus on community action and role of local health

6.4. Discussion

WCO Jordan and the Philippines illustrated examples of community and government resilience acting in times of emergency and the role of dialogue between and with all levels.[8] During the discussion, it was debated how subnational health systems play a role in countries' emergency preparedness and what needs to happen within the national emergency response management plans to include the responsibilities of the sub national levels for the emergency response once these levels have plans to act upon accordingly and budgeted for.

A clear example how multi- sectoral efforts paid off was provided by **Morocco.** Its new regulation for migration aims to include access to PHC services for all refugees at no cost. **Japan** highlighted that revitalizing community engagement and action for mutual help is key for a resilient health system. The sense of community cohesion and helping one another has proven to be beneficial with ageing societies and NCDs, especially in the case of emergencies. Different or parallel types of structures should be brought together under the leadership of MoH. **Madagascar's** rapid response and local capacity mobilisation mechanism is led by a national committee for preparedness and response supported by donors. However, this mechanism depends on external aid and needs revision for sustainable financing.

Regarding sustainability of resilience and budgeting for the necessary extra capacity, **EMRO** highlighted that risk management must be integrated into the system. The question of where to place health emergency departments within MoH structures and whether and how health system resilience is measured, causes concern regarding the existing MoH emergency structures. *In the past, misplacement and fragmented structures led to vertical non-dialogue between health emergency departments and health system strengthening department*s. Resilience is measured according to IHR indicators. However, these should be replaced by emergency related indicators in operational structures as part of the formal HS HMIS.

Lebanon aims to mobilise more humanitarian and development aid funds from donors to prevent the collapse of its overstretched health system whilst strengthening the existing system with regards to surveillance and expansion of services. In terms of PHC, MoH developed eight costed packages of health services for the most vulnerable to ensure equity. However, limited available funding threatens the implementation of these packages.

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[8] **Jordan** hosts 2 million Palestinian refugees, of which 90% are placed in hosting communities. The impacts on the health system can be observed by a major setback in health indicators and an increase in health expenditure. With limited funds, Jordan faces the challenge whether to include the refugees into the NHDP. This would require a higher budget to cover higher expenditure, adding more pressure to the already stretched health system. A typhoon hit the **Philippines** in May 2019**.** The government and societal operational initiated rapid first responder action coupled with disaster response and close coordination with actors on ground zero. The recovery process was used to review strains to service delivery and to look at how MoH's response management. Communities have their own disaster-response system and trainings.

Lebanon recognized PHC as entry point for UHC and developed a universal law for UHC to cover the most vulnerable populations, Lebanese and refugees.

The discussions highlighted lessons learned from the **Afghanistan**[9] and **DRC** country cases. In Afghanistan, a substantial improvement in infant mortality rate (IMR) and crude mortality rate (CMR) was achieved with relatively low investments and high equity results in challenging circumstances. This was largely due to the focus on PHC since the start and the recognition that the public health sector can be performant in addition to third party use for annual monitoring. An investment case on Afghanistan aims at ensuring sustainable funding and an increase in domestic funding to alleviate limited investment from both external and domestic resources. Epidemics in DRC were the result of gaps in prevention and surveillance. Under the government's leadership, mechanisms were established for efficient coordination of all development and humanitarian actors. This includes all processes from resources mobilization to operational activities. In order to improve communication with communities before interventions, DRC envisages to strengthen coordination between actors, bringing about institutional change and a culture of permanent engagement between institutions. Moreover, DRC seeks to elaborate the national health security plan, gather the different actors with clear roles and responsibilities to reinforce PHC in health facilities. Similarly, *in order to minimize disruption of the health system following conflicts, the international community needs to continuously adapt its plans regarding delivery and expansion of health services to the changing contexts*. Regarding HDN, immediate access to health care is crucial and health packages and delivery approaches must be adapted to respective environment.

Regarding **HDN for PHC**, *advocacy at ministerial level must include arguments to expand health interventions beyond SDG3 and integrate a peace and security pillar.* WHO's regional coordinators need good arguments to prioritize HDN for PHC and support MoH in finance discussions with MoF. Arguments in favor of prioritization of health and PHC in FCV context include the advantage of the PHC system to being able to reach out to other sectors and respond to needs beyond health. *HDN can contribute largely PHC driven essential package of services, promote coherence among NGOs and mobilize more predictable support for the health sector.* HDN requires an assessment of all tools, results-oriented programming and co-financing according to needs.

Ukraine's acute humanitarian crisis has been ongoing since 2014, with 5.2 million affected people, more than 25% without access to care. WHO supported the transformation of the health system in **Ukraine** during the crisis, allocating 1/3 to emergencies and 2/3 to development. In the future, this ratio will change to 50% development, 40% HDN and 10% humanitarian activity allocation. WHO will tailor responses to context in country, addressing different needs through basic packages. An entry point would be cooperation between WHO HSS and WHE teams on the ground and to integrate mobile health units as well as to build HDN focused capacity for teams in the field.

Local dialogue can be hard in countries with non-government-controlled swaths of land. The UN needs to reiterate its role as a neutral humanitarian partner. Lessons learned include:
- strengthened capacity essential to better position health within cluster systems working in humanitarian settings,

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[9] Please see the annex for the detailed country case

- strong cluster coordinators ensure prioritization of health,
- strengthening existing systems helps to address proliferation of NGOs and duplications of efforts and ensure that development partners respect cluster system,
- better acknowledgement of the role of women in emergency settings.

Adaptation and review of NHPs and coordination mechanisms to the current emergency situation is key. This was illustrated by the lessons learned from **India** which adapted health plans to sub-local level. *Each Indian sub-national state has a distinct disaster management plan including its own monitoring mechanism and natural disaster training module for CHWs*. **Timor Leste** reviewed coordination mechanisms built during emergency periods. Together with all health program implementing actors, resources mobilization, implementation modalities, monitoring progress and challenges were discussed. Improvement in streamlining donor contributions were achieved through a sectorial evaluation.

Some countries, like **Myanmar**, utilize alternative ways to provide health services such as ethnic, often armed, health organizations, trusted by the communities. Health system reforms use the provider/financier split to bring these organizations into health systems through contracting. Several trust issues arise from this approach, for example, adequate use of the public funds provided by the government, or engagement in the publicly owned referral system for higher tiers of care when working at PHC level. Similarly, competition at country level between UN agencies could be diffused through the creation of a unified platform, like the SDG3 Action Plan signed at global level.

In conclusion, *whether in prevention or care, community health workers or health professionals, coherent cooperation is essential to build a cohesive health systems approach.* There is an absolute need to improve communication and collaboration between all actors. *The international community, together with WHO, has strong potential and must find the key to unlock untapped resources to develop sustainable activities linked to the health systems.*

Conclusion

During the three days of the meeting, it became apparent that the people centered PHC approach is part of the solution. *Different actors have different point of views and must work together to build a common health system. A* common evaluation of the PHC system will bring about faster progress towards UHC, in addition to better coordination on the ground and countries' own domestic resource mobilization. *This 6th Technical Annual Meeting taught the participants to aim for the best level possible and that the key levers for change are in place.*

The many insightful country experiences proved that the move from the static PHC systems towards providing comprehensive PHC services through active planning (i.e. India), is the right approach. *Knowledge of the communities benefiting from PHC services, understanding the communities, their needs and their values are crucial in order to tailor the investments that the international health community is making.* Further and better integration of innovations must be addressed, and response must be adapted to the community needs.

Health financing incentives are key to support transformation but are not the solution for every problem. Good health system governance and the creation of reliable health information systems and useable data are important. The discussions highlighted agreement that the health workforce needs to be multidisciplinary and have a skill mix for PHC. At the same time, PHC must be rendered more attractive for citizens, trust being the building stone.

The insightful engagement and open discussions with the participants were the main strength of the meeting. During the policy labs, serving as policy and solution-oriented platform, the rich discussions and country examples provided an important contribution regarding PHC health systems strengthening. More countries are invited to share their experiences during the next meeting's policy labs. The meeting highlighted several key elements to be addressed such as the importance of health systems financing incentives coupled with health service delivery targeted interventions. With regards to digitalization, evidence had been provided on how it has helped some countries to leapfrog (India, Ukraine), maximizing HIS and data collection (Morocco, Belize). It remains important that countries implement health governance policies and EURO welcomed the examples of successful decentralization of resources (Guinea) and the importance of community mobilization (Belize). *Better cooperation in country contexts must be achieved, driven by focus on PHC and health systems and more efficient use of resources. Renewed accountability requires strong support to rethink current ways of operation.* Similarly, better coordination and alignment of the different agendas for UHC are needed in the context of the SDGs. Recommendations were made in favor of local implementation of a universal agenda and to rethink international cooperation whilst focusing on implementation. Moving away from competition should go hand in hand with an efficient use of resources and the development of better monitoring tools to track commitments and achievements.

The interactive voting exercise showed that the main priority is to make PHC more attractive to citizens. It was very useful for WHO to hear the participants' concerns and preferences regarding WHO technical assistance. The discussions have reconfirmed the continuous relevance of harmonization and alignment.

The current discussions, such as WHE, HRH and NCDs, are key in the new UHC-P phase IV programme, which manifests the EU's renewed commitment to UHC-P. *Countries need to promote health and make their health investment case when speaking to the EU delegations.*

No health system is safe from emergencies and health system workers should be sensitized to ensure that every health system block contributes to decrease risks. *Despite different models of collaboration, a common understanding and better communication of these models is needed, supporting health cluster coordination in protracted crisis.* Health system resilience remains still not entirely measurable, a key point which must be addressed. The country examples demonstrated that UHC advancement is possible and health can be improved even in the most desperate situations.

Annexes

I. Key messages, action points and recommendations

Key messages day 1: PHC on the move and reaching the unreached

PHC must be people-centered. PHC works towards equity and equality but must account for community preferences when defining health services. The service delivery institutional arrangements should transit from a programme to an integrated people-centered care model. Making primary care attractive is critical in expansion of utilization and coverage of services.

PHC is the first entry point into the health-system, serving as a gatekeeper to higher, more specialized levels of care. WHO and its cooperation partners as well as GAVI, GFATM, GFF and others, are eager to translate the lessons learned from developing health system strengthening windows over the past years into a coherent PHC approach.

PHC serves as a great **platform**:
- for change, especially during a time of increasing universality and opportunities for innovation,
- for delivering cost-effective interventions, supports families through life course, responds to determinants of health, detects and responds to crises, important link for accountability, ensures no one is left behind,
- bridging disconnected health system components or building blocks with service delivery with disease-specific programmes even in crisis situations.

Mutual trust between the community and key players drives effective implementation of PHC. Trusting communities are achieved through the provision of quality services. Therefore, adequate providers and knowledgeable work forces are needed in primary care and public health to tackle the complexity of chronic conditions. Social participation, right from the start, is crucial in moving forward PHC for UHC.

PHC for UHC at the country level requires **effective coordination mechanisms** between national and subnational levels, as well as between the government and development partners. Governance is vital and must be built into the system.

Transparent and open collaboration among partners ensures maximization of expertise in different areas resulting in effective solutions. However, global guidance is needed regarding common health system assessments for PHC as well as on operationalization and the development of a common PHC monitoring framework.

Action points day 1

Ensure a **skill mix of the health work force** in order to change and adapt policies and practices according to the demand anticipated in the future.

Ensure **alignment of incentives in health financing** by moving away from optimising payment mechanisms sectorally to optimising them across the system.

Improve convenience of PHC and render it more patient-centered by involving the community and providers in the service design.

Key messages day 2: Policy labs – PHC in practice

Simple and clear messages are key for **effective communication**, particularly at the community level. PHC community engagement strategies must include adequate and tailor-made information regarding PHC services and how the community can benefit. This will result in **ownership and trust**, leading to higher usage of PHC services.

Stringent investment cases can propel governments to invest in the health sector and place health higher on their political agenda. This can lead to strong multi-sector partnerships as illustrated by the examples from Uganda and Uzbekistan. An investment case on Afghanistan aims at ensuring sustainable funding and increase domestic funding to alleviate limited investment from both external and domestic resources. Countries also need to keep in mind to promote health and make their health investment case when speaking to the EU delegations.

Digitalization of HS and HRH should be strengthened to improve timely health service delivery, increase hard to reach communities, reduce costs and quality of care.

Action points day 2

Countries should develop more **effective communication strategies** aligned with the country support plans to **strengthen mutual accountability.** Mutual accountability can also be achieved through a single policy framework, such as a **common operational plan,** driven by a committed government

Health systems need a new focus to strengthen PHC in the context of UHC moving across all SDGs. New approaches must be adopted and five key issues must be emphasized during implementation: *Equity is a difficult but central theme*, along with government stewardship capacity and harmonization of partner activities at national and sub-national level with remodeling and integration of services leading to: 1) improving access in hard to reach areas, 2) package of services (essential, comprehensive, etc.), 3) institutional arrangements for service delivery, 4) quality of care and 5) sustainable financing.

Countries should **capitalize on the diverse skill mix and different professions** involved in PHC by working with graduated professionals to ensure their commitment to UHC. UHC promotion in undergraduate education and UHC awareness raising can be achieved through specific educational materials/modules in cooperation with MoH and early engagement of the future workforce in PHC partnerships in the region.

Key messages day 3: effective coordination, HDN and emergencies

A committed government is key for effective coordination. Coordination is a two-way street, whereby governments respond to the needs of external actors and donors respect and align with the IHP+ 7 behaviours and principles.

Honesty, trust and transparent communication are the cornerstones of good coordination to build a dialogue and synergies between partners. Effective coordination requires joint financing, joint accountability, political drivers and responsibility to communities. Alignment

by donors to national common operational plans is essential to avoid duplications and parallel coordination.

The **use of external funding must be aligned to achieve UHC**, paying better attention to the budget cycle will prevent catastrophic expenditure. Improved cooperation between human services, education and health for better partnership leads to better PHC promotion and leverages funding. More stringent coordination is necessary between different levels of government, and South-South collaboration, national health information, accounting and procurement to ensure funding flow regarding the facilities and strategic purchasing.

Coordination can be facilitated by **formalizing the partnership framework** in a formal document and implying donors in the development and implementation of approaches and programmes right from the start. **Consistency and action-oriented coordination** must be applied at all times. At country level, mapping exercises could illustrate the amount of coordination platforms.

PHC brings HDN and countries together. The PHC approach has demonstrated success in improving access and health outcomes across countries despite on-going fragility and conflict. It remains critical to build trust with communities in emergency settings, in order to achieve societal and community resilience.

Countries should build investment cases to leverage more domestic funding and to sustain external resources in protracted crisis. **Capacity and autonomy must be strengthened for disaster respons**e at sub-national levels. More training for HWF is needed to address natural disasters at local level.

Emergencies are a chance to reflect on health system operations as was shown by the examples of India and Timor-Leste. Adaptation and review of NHPs, coordination and monitoring mechanisms to emergency situations is essential to inform response and activities ex ante at local level.

Revitalizing community engagement and emergency training for mutual help is key for a resilient health system as was demonstrated by the examples presented by the Philippines and Japan.

Action points day 3: Integrating planning for PHC with health emergencies risk management and operations and EDRM framework interlinkage with PHC

Humanitarian interventions should **apply early recovery approaches in response** and seek integration with existing health services and transition governance to local authorities. Development oriented work streams should target FCV areas in a more operational manner addressing key bottlenecks.

Country specific health emergencies risk management actions should include: Joint analysis, costed essential packages of health services based on PHC principles, EPHS implementation plan, joint coordination platforms, supply chain management, EWARS and preparedness, monitoring framework, knowledge agenda.

The **Health EDRM framework should be rolled out with countries** ensuring that health EDRM managers are integrated at all levels. Additionally, a common narrative/action plan must be

developed for an integrated Health EDRM within the health systems and governments need to mainstreaming Health EDRM in all health policies and programs. Similarly, all actors should focus more on community action and the role of local health.

Financing health systems for health security and IHR implementation go hand in hand. The mobilization of funds must become more timely through reduced administrative burden. Similarly, financing of health systems for health security (including IHR implementation) must become more sustainable.

WHE integration into PHC/UHC requires careful consideration on where to establish HSS/emergencies structures in MoHs organigrammes to maximize cooperation and coordination.

Recommendations day 3

The **narrative between UHC and WHE** should bridge the disconnect between health systems and health emergency management systems must be addressed.

Increased **knowledge transfer** will positively impact on programmes and capacity building should be supported through better and targeted investment.

Discussions at national level should address the inclu**sion of the responsibilities of the sub-national institutions for the emergency response** in national emergency response management plans.

Resilience and emergency policies and budgets must be in place, followed by **community empowerment through continuous training** on how to deal with natural disasters. All relevant actors must **use one common language** to ensure effective management.

Risk management frameworks should be applicable beyond outbreaks and include measures to prepare and prevent risks. It is therefore imminent to include preparedness and response measures into risk assessments. Management and managerial capacity in emergencies at each level should be increased. **Investment in health system managers** will be fundamental to reduce the risks and emergencies.

Focus needs to be on **multisectoral coordination mechanisms** at local and subnational level in addition to central level to optimize country resources.

Strengthen emergency health teams through better cooperation between **WHO HSS and WHE teams on the ground and integrated mobile health units** as well as HDN focused capacity for teams in the field.

Emergency related indicators must truly capture what happens on the ground. They should therefore be carefully developed an integrated into operational structures as part of the formal HS HMIS.

Innovative programming in FCV settings should include orientation along the SDG3. Additionally, development-oriented work streams should target FCV areas in a more operational manner addressing key bottlenecks.

II.   Informal pre-session on the Live Monitoring

This session provided examples of how the information related to the implementation of the activities of the country support plans can be monitored through the live monitoring tool.

One of the tools developed by the joint working team (JWT) is the new "live monitoring" mechanism, which became operational in 2018. Its aim is to collect and disseminate information on progress made by countries towards UHC. This initiative enables discussion on a quarterly basis with WHO Regional Offices about activities and results achieved at country level: it provides close follow-up of country support plans and is the reporting tool for highlighting activities and products that will be implemented at the national level. It serves as a forum for discussing progress and challenges on a quarterly basis among the three levels of WHO, as well as with relevant WHO technical units, planning units and donors and partners. This working method has encouraged transparency, boosted trust among experts and increased accountability between partners.

The figure below illustrates how live monitoring operates at the country level. The first iteration of the live monitoring mechanism took place in 2018. Based on the information collected, it was concluded that most of the 600 activities implemented with the US$ 40 million allocated in the 66 countries are directly or indirectly related to primary health care.
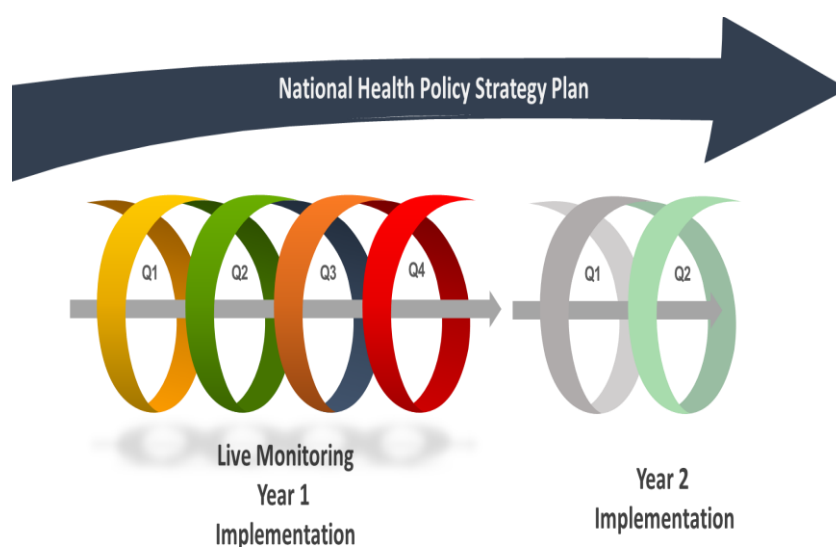
III. Informal session on the Realist Research for UHC

This session provided the first results of the realist research undertaken in 6 West African countries to unpack what and how the support to policy dialogue at country level can lead to results related to UHC in countries. The session consisted of a presentation by Dr Emilie Robert from McGill University and was followed by a discussion in plenary.

It is widely recognized that it is not easy to measure short-term UHC results directly from a WHO technical assistance programme such as UHC-P. Most deliverables are disparate aspects of long-term strategies aiming at covering the population of each target country. There is a need to ensure that the different actions undertaken in each country contribute to UHC. WHO, in close collaboration with its partners, is therefore developing a theory-of-change or chain-of-results approach in order to assess the influence of UHC-P actions on UHC objectives in different countries.

In this context, the realist research approach offers a novel yet crucial way to make sense of programme outcomes, especially in view of the very indirect link between UHC-P actions and the intended overall objective of improved health systems performance and better population health. The multi-country realistic research study launched in 2016 came to a close in 2018, with the final analysis report expected in 2019. The realist approach to qualitative research entails distinguishing the mechanisms (trust, MoH empowerment, shared understanding of governance) which lie behind programme outcomes (alignment of stakeholders, regulatory framework, improved health sector governance, inclusion of actors, etc.) combined with an analysis of the contextual factors that may govern these not necessarily very obvious mechanisms.

This study's target countries were **Togo, Liberia, Democratic Republic of the Congo, Burkina Faso, Niger** and **Cabo Verde**. The study makes it clear that where there is profound insecurity and poor government leadership, UHC-P support is fundamental. It also shows that to produce results, long-term continuity is needed especially in terms of ensuring political, financial and technical support from all partners and stakeholders. Far more detailed study results will be forthcoming in 2019, and several publications are in preparation to deepen our understanding of the intricacies of health policy dialogue.

IV. Policy labs – country presentations

Ukraine

In 2017, Ukraine underwent an important health financing reform. At that time, PHC was underutilized by the communities and WCO explored a start-up approach to make it more attractive. The MoH, in cooperation with MoF and venture capital investors, mobilized funding to reform the health system. The "Governmental start-up approach" was led by MoH leading to the creation of new institutions such as the national health system (NHS) Ukraine and the electronic health governmental enterprise. Key to this reform was the single-payer system based on the new National Health Service and financed by public budget. However, PHC physicians lack capacity cannot solve all the problems alone and funding is limited. It was debated how Ukraine can boost PHC providers' performance without financial incentives and how to channel funds into the system when the clinical part is lagging behind and the attractiveness of PHC has not caught up.

Lessons learned and outcome of the policy lab:
- Policy must be implemented at the central level and capital investments (construction) must be targeting the local level thus responding to each level's comparative advantage in terms of capacity to create synergies
- A mix of financial and non-financial incentives is to be applied
    o Instead of only injecting funds into the system, maintain the level of funding (capitation rate) and play with the incentives within this level to align with priorities to improve the quality of PHC
- PHC becomes more attractive through maximised power of digitalisation and the power of data which could catalyse policy dialogue if the data is credible – digitalisation is to move up on the agenda
- HR management and decentralization are crucial in PHC implementation.
    o Inequalities between regions as consequences of decentralization need to be balanced. Local government action needs to be aligned with central level priorities.
- Decentralization needs to be accompanied by conditional funding grants.

India

India's Ayushman Barat Health and Wellness Centers (HWCs) are designed to ensure an expanded range of comprehensive primary health care service that respond to people's needs in a holistic manner, including the social and mental dimensions of health and well-being. The centers introduced new areas of care and achieved improved mechanisms and outcomes through financial incentives. Continuing care at reduced cost is provided through telemedicine targeting remote communities. IT approaches are being further elaborated as the Pan India Telemedicine network plans to ensure specialist consultations in Health and Wellness Centers in remote areas and existing National Medical College Network facility to create a pan India tele-education, specialist consultation and e-library. The policy lab focused on ways to strengthen the wellness component and implement health promotion/prevention strategies in a curative-focused care response. It also tackled the question on how to enable primary healthcare teams at HWCs to better address other social and environmental determinants and looked for models to influence people's behaviour.

Lessons learned and outcome of the policy lab:

- The health for all approach works but has implementation challenges regarding rolling out comprehensive health care, making it affordable and accessible and providing basic services
- Focus on payment incentives targeting the unit rather than the individual. Provide knowledge-based incentives for health workers to incentivize them and increase efficiency
- Ensure clarity in the programs and interventions on all levels (policy makers and targeted population) as well as task division of community health workers (CHWs)
- Digital health interventions are meant to augment the health system, not be the intervention itself
- Make the difference between telemedicine relating provider to provider or provider to client and therefore telemedicine must be tailored.

Morocco

UHC has been at the forefront in Morocco having achieved a 60% coverage of the population. Challenges remain regarding the implementation of PHC financing mechanisms. The policy lab focused on how financing mechanisms would attract health insurers as Morocco's gratuity system did not result in a high increase in PHC service utilisation despite great efforts.

Lessons learned and outcome of the policy lab:
- Dedicate a PHC un budget programme and a financial incentive system depending on performance indicators
- Autonomy of PHC services must be accompanied by strong competences by the regions thus creating an ownership transfer
- Push for adequate implementation of the currently ongoing digitalisation reform at national level, HIS should include new technologies
- Include civil society (CS) in stakeholder consultations.

Belize

Belize's health sector policy reform in 2000 made good improvements regarding PHC and UHC. It tackled the challenge to cover the population under the national health insurance, which currently only reaches 33% of the most vulnerable segments of the population. The policy lab addressed the question which alternative financing mechanisms will support the health system to achieve coverage beyond the vulnerable population.

Lessons learned and outcome of the policy lab:
- Strive to expand the fiscal space and identify a sustainable health financing mechanism
- Encourage an efficient tax collection process
- Establish better cooperation and dialogue between MOH and MOF to be improved
- Better cooperation between human services, education and health for better partnership leading to better PHC promotion and leverage funding
- Identify instruments to set explicit priorities through a benefits package design
- Increase community involvement, communicate better information regarding the benefits of the essential health care packages
- Collect better data to support dialogue and negotiation, push with evidence for UHC and gradual budget increase over time.

Philippines

Public Health System reforms in 1991 led to a decentralized system in the Philippines with local governance and financing for health at regional, city and municipality levels in a public private system. Health system inefficiencies and inequities remain and out of pocket expenditure accounts for 54% of health expenditures. Furthermore, the integration of health services and financing is challenged, and tension exist between the government and the providers because the private sector does not support their assigned role of being a gatekeeper. The Philippines recently passed the UHC Act and currently prepare the guidelines for the implementation for this law. The policy lab concentrated on the issue how the Philippines can transition from a highly fragmented health system to an integrated health system at the province and city level, while maintaining a devolved set-up.

Lessons learned and outcome of the policy lab:
- Legal framework in place due to the implementation of the UHC law
- Ensure equitable access to quality of health care goods and services and protect against financial risk
- Transition from highly fragmented health system to an integrated health system facilitated through the diffusion of tension with the private providers now called 'navigators' instead of 'gate keepers'; through the establishment of health care provider networks and assigning people to a primary care provider
- Fragmentation and high OOPs could be reduced by rendering PHC more attractive and trusted by the people through reliable social delivery networks and a strengthened the provincial level
- Put in place one PHC pillar but strengthen social health insurance through multi-stakeholders, utilise multi-sectoral coordination, stronger engagement of private sector.

Guinea

Strengthening PHC, PHC HRH and health financing are priority issues in Guinea which has faced several severe health emergencies. Guineas health policy reform is based on the reinforcement of community health for UHC. A UHC financing strategy seeks to counteract bottlenecks in geographical and financial access through increased domestic and global resource mobilisation. The policy lab explored the use of new technologies to collect and use data from community health systems in other countries, how to sustain the community health model and how to efficiently train and retain community health workers.

Lessons learned and outcome of the policy lab:
- Rural communities define the structure of the PHC system
- Political will is key for decentralisation (transfer of funds and competencies)
- Transfer of HRH competences to the communities, harmonize training modules for HRH training, shorten breaks between training and retraining
- Apply one integrated PHC option and streamline services (ESH)

V. Country case: Afghanistan

Afghanistan has known one of the longest protracted complex emergencies due to conflicts, natural disasters and mass populations movements. In 2018, 83 health facilities closed following attacks. MoH's health system reform in 2002 expanded coverage in underserved areas through an essential package of care and cooperated with NGOs service providers. This PHC approach[10] improved access and health outcomes despite on-going fragility and conflict. Nevertheless, the secondary and tertiary health care services are not included in these packages and their services remain suboptimal. To date, coverage of PHC services increased from 9% in 2002 to more than 85%. Major challenges remain. Therefore, an Integrated Essential Package of Health Services (IPEHS) has been adopted to address existing burden of disease and accelerate the move toward UHC. MoH increased focus on PBF and evidence-based prioritization in addition to exploring options to finance IPEHS to address growing burden of NCDs and trauma care. It is crucial that attacks on health facilities stop and multi-partnerships mobilize and share knowledge, expertise, technologies and financial resources to support the realization of the SDGs including UHC.

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[10] basic package of health service for Afghanistan (BPHS) and essential package of health services (EPHS)

VI.   Agenda of the meeting

6th Annual Technical Meeting of the Universal Health Coverage Partnership
11-13 June 2019 - Geneva, Switzerland

AGENDA

Day 1: 11 June 2019		Morning	
8:30-9:00		Registration	
9:15-10:15	Plenary	*Welcome –* - Opening remarks - *Agnes Soucat* - UHC-P: What Has Been Achieved So Far? - *Denis Porignon* Views from the Regions - *Melitta Jakab, Humphrey Karamagi, Gulin Gedik, Tomas Zapata Lopez, Yu Lee Park*	Chair : Agnes Soucat
10:15-10:30	Plenary	Meeting Agenda - Denis Porignon	
10:30-11:00	Coffee break		
11:00-13:15	Panel in plenary	*Future of the UHC-P: PHC on the Move* - Setting the scene: Pete Salama - Key note speeches (10' max each): PHC is an engine for UHC - Discussion with WHO Senior Executives (ADG Healthier populations, EXD Emergency, ADG CD/NCD) and Donor Representatives (EU, Luxembourg, Ireland, Japan, France, United Kingdom) This will be an interactive session with presentations alternating Q&As with panelists and meeting participants. Moderation: Dr. Godelieve van Heteren	**Setting the scene** Pete Salama **Panelists:** ***Donors Repr.:*** European Union France Ireland Japan Luxembourg United Kindgom ***WHO:*** ADG Healthier populations, EXD Emergency, ADG UHC CD&NCD, **Speakers:** Katherine Rouleau, *UToronto and WHO*, David Hipgrave *UNICEF* Diana Nambatya, *Living Goods, Uganda*
13:15-14:30	Restaurant - Lunch		

Day 1: 11 June 2019		Afternoon	

AFRO & SEARO			
14-30-17:30	*Most essential health services for today's health needs – including NCDs and care for the elderly - can be safely delivered by well-functioning primary health care services.* *The session objective is to discuss a common understanding on how to re-align service delivery towards PHC for UHC through experience sharing* *The expected output is to identify good practices to address challenges to making PHC for UHC operational*		
14:30-15:45	Plenary and/or group sessions	*Primary health care: new strategies for better 'reaching the unreached'* Overview of practical implications of PHC for UHC *(20 min)* Best practices presentations *(10 min)* India : quality of care Cabo Verde: expanding primary care services for addressing NCDs Panel discussion (45 min) *Remodeling service delivery institutional arrangements, from programs to person centred services, with a focus on NCDs *Improving quality of care to make services responsive to needs of the people *Building capacity for equitable domestic funding of PHC as part of UHC.	**Speakers** Humphrey Karamagi and Tomas Zapata Lopez India and Cabo Verde country teams **Moderator** Tomas Zapata Lopez Melitta Jakab (EURO) Tamar Gabunia (MoH Georgia) MoH Madagascar
15:45-16:15	Coffee break		
16:15-17:30	Plenary moderated discussion and/or group sessions	*Primary health care: new strategies for better 'reaching the unreached' (continued)* Plenary discussion on challenge issues for making PHC for UHC operational	**Moderators** David Hipgrave (UNICEF) and Humphrey Karamagi
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18:30-21:00	Restaurant	Welcome Cocktail	

Day 2: 12 June 2019	Morning

7:30-8:30: Informal pre-session on the Live Monitoring   **Casey Downey**
*This session will provide examples of how the information related to the
implementation of the activities of the country support plans can be monitored through
the Live Monitoring tool. If you are interested, feel free to come
(room Belle Epoque – ground floor). Seats are limited.*

Chaired by Kevin McCarthy

EURO			Melitta Jakab/Fahdi Dkhimi
8:45-9:00	Plenary	Announcements	Secretariat
9:00-13:00	*In the policy lab, one Member State by WHO region will put forward challenges they are currently trying to address in the area of health system strengthening for Primary Health Care.* *The objective of the session is to engage in discussion and a real time problem solving on a current policy issue.* *The expected output is for each presenting country to gather ideas or solutions for persisting challenges in policy making and collectively to exchange experience on issues faced by countries and discuss concrete solutions to address them.*		
9:00-9:30	Plenary	Introduction (content & objectives – 5 min) Highlight of proposed policy labs (20 min) Logistics of the session (5 min)	**Moderator** Melitta Jakab and Fahdi Dkhimi
9:30-10:45	Group sessions	Policy Labs – 3 parallel sessions	India, Morocco, Ukraine
10:45-11:00		Coffee break	
11:00-12:15	Group sessions	Policy Labs – 3 parallel sessions	Belize, Guinea, Philippines
12:15-13:00	Plenary	Bring it all together	**Moderator** Melitta Jakab and Fahdi Dkhimi + Lab moderators
12.45-14.00	Restaurant	Lunch	

Day 2: 12 June 2019			Afternoon	
			Chaired by Matthias Reinecke (TBD) / Godelieve van Heteren	
UHC2030 *This session will explore the need to "reboot" effective coordination approaches, updating the IHP+ '7 behaviours'. It will focus on experience from countries to unpack specific 'changes we would like to see', then explore actions that countries and partners/programmes can take to help bring these about.*				Richard Gregory
14:00-15:30	Plenary and panel	**Effective coordination for UHC: What are the changes we want to see?** Introduction: context and renewed emphasis on country coordination, proposal to 'reboot' the IHP+ 7 Behaviours (10 min) Panel discussion: global, regional, and different country context perspectives to elaborate on the different coordination needs, and changes needed, in different settings. (40 min) Plenary (30 min) Wrap-up & clarification of discussion questions for following session (10 min)		**Speakers/Moderators** Richard Gregory, UHC2030 Panel discussion, moderated by Godelieve van Heteren: Agnes Soucat EMRO Countries (being finalized): Afghanistan, Guinea, Ukraine. Godelieve van Heteren
15.30-		Coffee break		
15.45-17.00	Plenary and/or group sessions	**Effective coordination for UHC: How to bring these changes about?** *Key discussion question: 'how do we get everyone contributing to national health and UHC plans in a joined-up way'* 'With your neighbor' discussions of questions from end of first half, & highlights from floor (15 min) Panel: country experience of different tools/approaches (20 min) Closing panel: structuring our programmes/support to respond to these needs (20 min)		**Speakers/Moderators** Moderated by Godelieve van Heteren Countries (TBC): Cambodia, Eritrea, Madagascar Panel: PHC partners (David Hipgrave), UHC-P (Gerard Schmets), UHC2030 (Richard Gregory), bilateral donor (Jo Keatinge) TBC)

18:00-19:00 Informal session on the Realist research for UHC   Dheepa Rajan
> *This session will provide the first results of the realist research undertaken in 6 West African countries to unpack what and how the support to policy dialogue at country level can lead to results related to universal health coverage in countries. The session will consist of a presentation by Emilie Robert (Mac Gill University) followed by a discussion in plenary. This session will take place in the main meeting room.*

Day 3: 13 June 2019	Morning 8:45 – 12:30		

			Chaired by Jo Keatinge (UK)
EMRO			Ali Ardalan/ Benjamin Lane
8:45-9:00	Plenary	Announcements	Secretariat
09:00-12:15		*A primary health care approach is an essential foundation for health emergency and risk management, and for building community and country resilience within health systems.* *The session objective is to exchange experience and discuss lessons learned on what works well and less well with regard to emergencies and health security at country level.* *The expected output is key action points and recommendations to countries for strengthening national health security.*	
9:00-10:30	Plenary	*Health security and health systems strengthening in the context of emergencies* EMRO approach on building health system resilience in context of emergencies (*15 min)* Integrating planning for Primary health care with health emergencies risk management and operations (*15 min)* Health emergency and disaster risk management framework (*15 min)* Interactive moderated discussion *35 min*	**Speakers** Ali Ardalan Dirk Horemans Jonathan Abrahams **Moderator** Andre Griekspoor
10:30-10:45		Coffee break	
10:45-12:15	Plenary and panel	*Health security and health systems strengthening in the context of emergencies (continued)* Country case presentation: Afghanistan (15 min) Panel discussion followed by plenary discussion (50 min)	***Speaker*** Shafiqullah Shahim (MoH Afghanistan) **Panelists**: 3 MOH participants from Afghanistan, EURO and AFRO countries + 3 WHO participants
12:00-12:30	Plenary	Wrap up of the meeting and major action points Closing remarks	**Gerard Schmets**
12:30-14:00	Restaurant	Lunch	

VII.   List of Participants