

Universal Health Coverage Partnership



Supporting policy dialogue on national health policies, strategies and plans and universal health coverage

Year 6 Report

2017



World Health Organization

Cover photos: © World Health Organization

Universal Health Coverage Partnership



Supporting policy dialogue on national health policies, strategies and plans and universal health coverage

Year 6 Report

2017

WHO/UHC/HGF/HGS/2018.2

© World Health Organization 2018

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>).

Under the terms of this licence, you may copy, redistribute and adapt the work for non-commercial purposes, provided the work is appropriately cited, as indicated below. In any use of this work, there should be no suggestion that WHO endorses any specific organization, products or services. The use of the WHO logo is not permitted. If you adapt the work, then you must license your work under the same or equivalent Creative Commons licence. If you create a translation of this work, you should add the following disclaimer along with the suggested citation: "This translation was not created by the World Health Organization (WHO). WHO is not responsible for the content or accuracy of this translation. The original English edition shall be the binding and authentic edition".

Any mediation relating to disputes arising under the licence shall be conducted in accordance with the mediation rules of the World Intellectual Property Organization.

Suggested citation. Universal Health Coverage Partnership: Supporting policy dialogue on national health policies, strategies and plans and universal health coverage. Year 6 report. Geneva: World Health Organization; 2018 (WHO/UHC/HGF/HGS/2018.2). Licence: [CC BY-NC-SA 3.0 IGO](https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

Cataloguing-in-Publication (CIP) data. CIP data are available at <http://apps.who.int/iris>.

Sales, rights and licensing. To purchase WHO publications, see <http://apps.who.int/bookorders>. To submit requests for commercial use and queries on rights and licensing, see <http://www.who.int/about/licensing>.

Third-party materials. If you wish to reuse material from this work that is attributed to a third party, such as tables, figures or images, it is your responsibility to determine whether permission is needed for that reuse and to obtain permission from the copyright holder. The risk of claims resulting from infringement of any third-party-owned component in the work rests solely with the user.

General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.

This report was prepared by the **WHO Department for Health Systems Governance and Financing**.
Page layout design by **Community Systems Foundation**.

Printed in Switzerland.

Contents

Acknowledgement	v
Abbreviations	vii
Background and Introduction	1
UHC Partnership Results and Impact	9
Specific Objectives and Expected Results	17
Expected Result 1	18
Expected Result 2	22
Expected Result 3	25
Expected Result 4	28
Expected Result 5	30
Expected Result 6	33
Lessons Learned	37
Principal Challenges	43
Conclusion and Way Forward	47
Abbreviations	48

Acknowledgement

The Universal Health Coverage Partnership is co-funded by the **European Union**, the **Grand Duchy of Luxembourg**, and **Irish Aid**, as well as the World Health Organization.

This document has been produced with the financial assistance of the European Union, the Grand Duchy of Luxembourg and Irish Aid. The views expressed herein can in no way be taken to reflect the official opinion of the European Union, the Grand Duchy of Luxembourg or Irish Aid.

More information on the UHC Partnership can be found at www.uhcpartnership.net.



LUXEMBOURG
AID & DEVELOPMENT



Irish Aid

An Roinn Gnóthaí Eachtracha agus Trádála
Department of Foreign Affairs and Trade

Abbreviations

AOP	Annual Operational Plan
BHI	Boma Health Initiative
CSEM	Civil Society Engagement Mechanisms
DFID	UK's Department for International Development
DHIS2	District Health Information Systems 2
ER	Expected Results
EU	European Union
GPW	General Programme of Work
HF	Health Financing
HiAP	Health in All Policies
HPG	Health Partnership Group
HRH	Human Resources for Health
HSDP	Health Sector Development Plan
HSR	Health Sector Reform
IHR	International Health Regulations
JA(H)R	Joint Annual (Health) Review
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MoH	Ministry of Health
NCDs	Non-communicable Diseases
NHA	National Health Accounts
NHI	National Health Insurance
NHIF	National Health Insurance Fund
NHP	National Health Policy
NHPSP	National Health Policies, Strategies and Plans
SARA	Service Availability and Readiness Assessment
SDGs	Sustainable Development Goals
SO	Specific Objectives
SSB	Sugar Sweetened Beverages
UHC	Universal Health Coverage
WHO	World Health Organization



A man gets vaccinated against yellow fever in Kara, northern Togo. WHO / Olivier Asselin.

BACKGROUND AND INTRODUCTION

“Universal Health Coverage (UHC) is ultimately a political choice. It is the responsibility of every country and national government to pursue it.”

Dr Tedros Adhanom Ghebreyesus, Director-General of WHO

In the era of the Sustainable Development Goals (SDGs), treading the path towards UHC, health security and health outcomes requires robust policies, political will and strong capacity of governments to steer the health sector. Policy dialogue can be an important 'steering wheel' for governments to drive evidence-informed decision-making. In practice, this means brokering consensus amongst all relevant stakeholders on health priorities to move jointly towards set targets. Those priorities must then be detailed in national health plans, in essence charting the country's road map towards UHC, while at the same time ensuring that resources are mobilized & capacities built for successful implementation.

Recognizing this, in late 2011 the World Health Organization (WHO) entered into a collaborative agreement with the European Union (EU), joined shortly thereafter by the Grand Duchy of Luxembourg and since 2017 by Irish Aid. The aim of this agreement was to support policy dialogue on the development and implementation of national health policies, strategies and plans, with a view of promoting universal health coverage, people-centred care, and health in all policies in a number of target countries.

Today, the UHC Partnership (the UHC-P or the partnership) supports 36 target countries in the WHO regions of Africa, Eastern Mediterranean, Europe, South-East Asia, and Western Pacific. The support is anchored in three thematic pillars: fostering policy dialogue on strategic planning and health systems governance, developing health financing strategies and supporting their implementation, and enabling effective development cooperation in

countries. Through UHC-P-funded health systems advisors placed in countries, WHO has been able to strengthen its presence on the ground. WHO's work includes responding to ad-hoc requests of the Ministry of Health (MoH), while at the same time building trust, capacities, and technical expertise for medium and long term UHC objectives. Country-based health systems advisors are backstopped by WHO regional offices as well as headquarters, and are in close contact with local offices of UHC-P partners. In essence, a broad range of experts bundle efforts and create synergies to move forward along the path towards UHC.

Currently in its third phase, the partnership has established itself as a cornerstone for in-country support for health systems strengthening endeavours on the road towards UHC. Over the course of six years of implementation, the UHC-P has grown from 7 countries in phase I to 36 countries in phase III, a remarkable success story of sustained support to health systems strengthening. Afghanistan, Georgia, Jordan, Lebanon, Ethiopia, the Islamic Republic of Iran, and Mauritius are the newly joined members in 2018 so far. United Republic of Tanzania will join in 2019 and more countries have expressed their interest!

This report will cover the calendar year 2017 which represents: Year 6 of the partnership for phase I EU-funded countries, Year 5 of the partnership for phase II EU-funded countries and Luxembourg-funded countries (Burkina Faso, Cabo Verde, Mali, Niger & Senegal) except Laos PDR (Year 3), and Year 2 for phase III EU-funded countries (Burundi, Morocco, Tajikistan, Ukraine, Guinea-Bissau, Kyrgyzstan, South Africa and Zambia).

The UHC Partnership in a nutshell

36 UHC-P Countries

5 WHO Regions

20 Policy Advisors on the ground

~900 million people benefitting

3 Key Pillars:

I. Strategic Planning and Health Systems Governance

II. Health Financing

III. Effective Development Cooperation

14 Key Areas of Work:



Strategic National Planning



Capacity Building



Decentralization



Human Resources for Health



Service Delivery



Access to Medicines



M&E / Health Information



Visibility



Harmonization & Alignment



National Compact



Public Financial Management



Health Accounts



HF System Support



HF Strategy

7 Years In Operation:

Phase I
2011-12



Phase II
2013-15



Phase III
2016-18



Liberia, Moldova, Sierra Leone, Sudan, Togo, Tunisia, Vietnam

Burkina Faso, Cabo Verde, Chad, Democratic Republic of Congo (DRC), Lao PDR, Guinea, Mali, Mozambique, Niger, Senegal, South Sudan, Timor-Leste, Yemen

Burundi, Guinea-Bissau, Kyrgyzstan, Morocco, South Africa, Tajikistan, Ukraine, Zambia, Afghanistan, Georgia, Jordan, Lebanon, Ethiopia, the Islamic Republic of Iran, Mauritius, United Republic of Tanzania (2019)

We are pleased to welcome IrishAid as our new partner

The year 2017 was important for the partnership as we have added on a new partner: the UHC Partnership is pleased to welcome Irish Aid. One of the key factors for attracting new donors is the UHC Partnership's results-oriented approach that is tailored to country needs, embedded in a flexible funding structure enabling a prompt reaction to evolving new priorities of the government in a given target country.

In the vein of 'One World, One Future', [Ireland's Policy for International Development](#) sets out the vision of 'a sustained and just world, where people are empowered to overcome poverty and hunger and fully realise their rights and potential.' Today, Irish Aid is supporting long term development and providing humanitarian assistance in over 80 countries to help build better futures for some

of the world's poorest communities. A particular focus is placed on communities in sub-Saharan Africa.

Irish Aid committed its engagement from 2017 to 2020, by investing 3.1 million euro for three countries: Mozambique began in 2017, Ethiopia will start in 2018, and United Republic of Tanzania will join in 2019. The UHC Partnership is looking forward to a fruitful collaboration with Irish Aid. Welcome!



Irish Aid

An Roinn Gnóthaí Eachtracha agus Trádála
Department of Foreign Affairs and Trade

Outlook to 2018 and newly joined UHC Partnership member countries!

Afghanistan is a landlocked, Central Asian country with a population of 35 million people. Decades of war waged a heavy toll on the country's healthcare system while substantially increasing the need for medical care. The Ministry of Public Health's National Health Strategy 2016-2020 sets a framework for the health sector to achieve economic and human resources self-reliance, in anticipation of a steep decline in development assistance received by Afghanistan over the coming years. **The UHC Partnership inception mission to develop a country roadmap jointly with the MoH is planned this year.**



Georgia is a country in the Caucasus region between Eastern Europe and Western Asia. The Georgian Healthcare System State Concept 2014-2020 serves as a national health plan, promoting health in all policies. A top priority has been to increase access to and improve the quality of health services for the 3.7 million Georgians. The 2013 launched 'State Universal Health Care Programme' enables all citizens with no state or private insurance to benefit from a minimum service package. However, out-of-pocket expenditure remains high. **The UHC Partnership supports the review and operationalization of the primary care strategy 2016-2023, and builds capacity around strategic purchasing with a view to enhancing efficiency in the organization and delivery of publicly financed health services.**



Jordan, located in the Middle East with borders along the Dead Sea and at the northern tip of the Red Sea, has a population of 10 million people. Jordan's economic development and political stability have helped it build a solid health system. However, challenges persist such as an aging population, the growing burden of chronic disease, as well as significant stress on public services placed by the influx of refugees from neighbouring countries. Jordan's National Strategy of the Health Sector 2016-2020 places access to UHC as a long-standing strategic goal. **The UHC Partnership has supported a review of the governance arrangements in the health sector and assessed the capacities of the Ministry of Health; this role has been taken into account in the formulation of the Ministry of Health Strategic Plan 2018-2022.**



Lebanon is a middle-eastern country on the eastern edge of the Mediterranean Sea, with a population of 6 million people. Thanks to a series of health reforms, the health system has been remarkably resilient given dwindling human and financial resources and other challenges evolving from the huge influx of refugees. The Health Strategic Plan 2016-2020 foresees to modernize and strengthen sector governance, to improve collective public health and promotion, to continue to progress towards UHC and to develop and maintain emergency preparedness and health security. **The UHC Partnership inception mission to develop a country roadmap jointly with the MoH is planned this year.**



Ethiopia is a landlocked country in the Horn of Africa and the continent's second-most populous, with 102 million people. The 4th Health Sector Transformation Plan 2015/16-2019/20 fits within Ethiopia's broader Second Growth and Transformation Plan, and is also the first phase of the 20-year health sector strategy called 'Envisioning Ethiopia's Path to Universal Health Care through strengthening of Primary Health Care'. Out of pocket spending remains high, and the government has committed to enlarge the share of the population being enrolled in health insurance. **The UHC Partnership inception mission to develop a country roadmap jointly with the MoH is planned this year.**



United Republic of Tanzania is a country in Eastern Africa within the Great Lakes region, with a population of 56 million people. Today, the government runs four health insurance schemes alongside multiple private options, but the vast majority of the population remains uninsured, leading to significant inequities in access to care. United Republic of Tanzania's 4th Health Sector Strategic Plan (2015-2020) provides for a new health financing strategy aimed at helping the country achieve UHC, by addressing this complex and fractured health insurance market. **WHO has been providing technical and policy advisory support over the past years, the UHC Partnership will be complementary to achieving this goal.**



The Islamic Republic of Iran is a country in the Middle East with a population of 81 million people. Most of the population benefits from health insurance, principally from public insurers, yet out-of-pocket spending as a share of current health expenditure remain high. The 6th five year National Plan of Economic, Social and Cultural Development of the Islamic Republic of Iran 2017-2021 sets the following strategic directions for the health sector: improving stewardship of the health system, expanding health service coverage of the population and increasing financial protection mechanisms. **In line with those priorities, the UHC Partnership is supporting an in-depth health systems governance and financing assessment, which includes an evaluation of citizen's voice mechanisms, private sector engagement, and financial protection.**



Mauritius is an island nation located 2,000 kilometres off the South-East coast of Africa in the Indian Ocean with a population of 1.3 million people. The Mauritian government approaches healthcare as a human right, and provides free public health services for primary care. Due to a shift towards non-communicable diseases (NCDs), and a demographic transition to an aging population, the government is placing a heavy focus on people-centred and integrated care, with an emphasis on human resource planning and on building monitoring and accountability initiatives. **The UHC Partnership will support the on-going assessment of NCDs through a health systems strengthening lens, with information feeding into the elaboration of a new health sector strategic plan.**



UHC Partnership is fully in line with WHO's future vision of work

The UHC-P has been pioneering an approach to supporting countries in a flexible and demand-driven manner. This is now also emphasized in WHO's 13th General Programme of Work (GPW) 2019-2023. WHO has set its future vision of providing support to countries to strengthen health systems for UHC, address emergencies, and promote healthy populations. As shown in figure 1, WHO's overall mission is three-fold: (i) to promote health, (ii) to keep the world safe and (iii) to serve the vulnerable. The goals linked to these are identified as the "triple billion":

- ▶ 1 billion more people benefitting from universal health coverage.

- ▶ 1 billion more people protected from health emergencies, and
- ▶ 1 billion more people enjoying better health and well-being.

The "strategic shifts" show how WHO will work – the actions the Organization will take to pursue the 'triple billion' goal. These actions comprise health systems strengthening interventions to drive public health impact in every country. Furthermore, WHO has developed a tailored approach, to be "fit-for-purpose" and "fit for context", by defining four modalities based on a country's capacity and vulnerability. In brief, the four modalities are implemented in different settings ranging from a mature health system to a fragile context:



Figure 1: WHO's draft thirteenth general programme of work 2019-2023

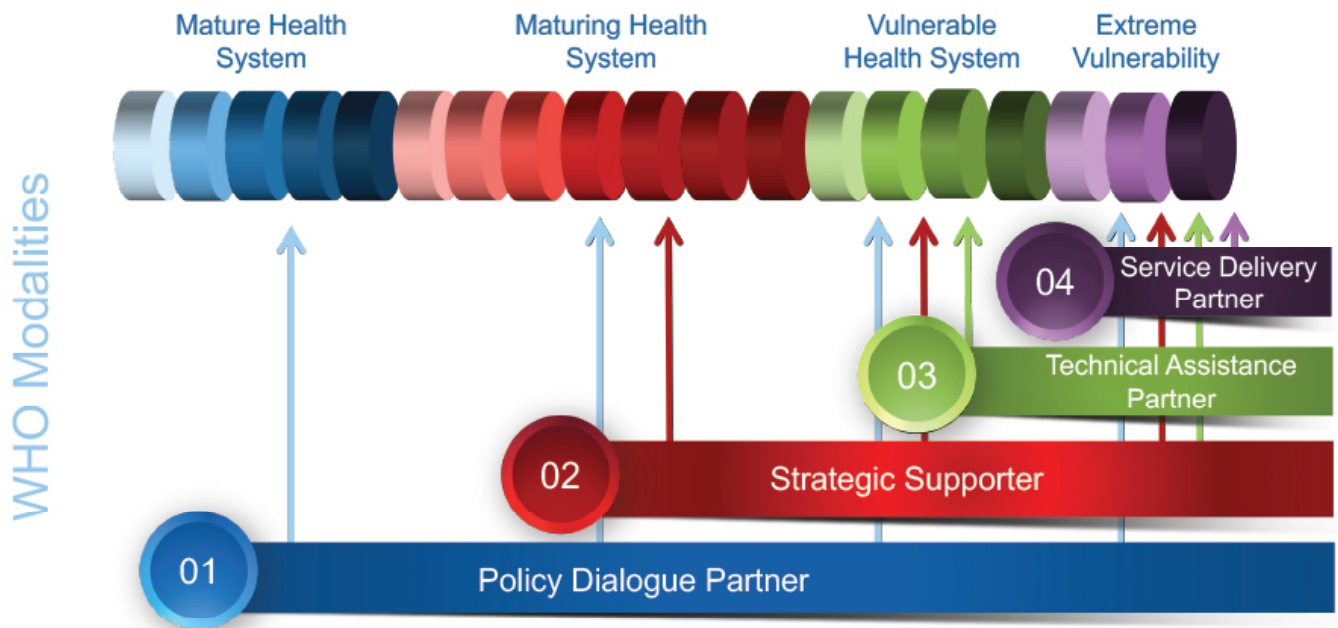


Figure 2: Continuum of support to be provided by WHO under the four modalities

1. Policy dialogue to foster transformation and develop systems of the future in all countries, including high income countries
2. Strategic Supporter to strengthen country institutions for better-performing systems including in emerging and middle-income countries
3. Technical assistance to build the foundations for health systems in countries with severe gaps in resources, mostly low-income countries
4. Service Delivery (substitution) to fill critical gaps in emergencies

Certainly, each country is unique, and the modalities shall reflect a non-mutually exclusive continuum. This means that some countries may benefit from technical assistance, strategic support, and facilitation of policy dialogue. Most importantly, each country receives support to ensure a bottom-up diagnostic and planning process, as emphasized and implemented by the UHC-P since 2011. This process is led by the MoH in order to develop a roadmap, jointly with WHO assistance, which identifies a country-specific set of coordinated and prioritized actions towards progress on health systems strengthening for UHC. Since its inception, the partnership has provided support to all four modalities depending on countries' needs. It has also heavily emphasized the importance of engaging a broad range of stakeholders into a policy dialogue. Experiences in countries have shown that policy dialogue can be an

important means to convene stakeholders, build trust, and gain a mutual understanding of the UHC concept, and hence to create a more favourable environment for partners in a country to work collectively towards UHC and health-related SDGs.

In addition, the GPW emphasizes that delivering results for countries also requires two additional complementary sets of actions, beyond direct country support: (1) stepping up leadership at the national, regional and global levels on core issues such as equity and human rights, gender, and health diplomacy; and (2) delivery and dissemination of high-quality global public goods that yield positive impacts at country level, including WHO's normative guidance, international health agreements and conventions, and data, research and innovation.

These three categories of WHO actions under the GPW are mutually supportive and translate into stronger impact at the country level. This governance architecture is also closely in line with the current structure of the UHC-P, with health systems advisors being placed in countries and a back-stopping option to gain support from the three levels of the organization. In this regard, funding flows are mostly directed to country offices, and a smaller fraction to regional offices and headquarters. A certain flexibility to adjust funding flows has allowed for quick responses to evolving priorities in countries.



Washing hands in a health clinic in Conakry, Guinea. UN Photo / Martine Perret. Guinea.

UHC PARTNERSHIP RESULTS AND IMPACT

In the following pages, several examples of result chains are presented that outline the results of roadmap activities and their linkages to overall achievements in health outcomes. Activities are related to one another according to Specific Objectives and Expected Results (see table 1), and they contribute to health systems strengthening as a whole. WHO-led UHC Partnership activities have brought decisive and tangible results. A plausible path from achieved results to potential future impact can be ascertained, and is sketched below.

Nonetheless, before looking into some country examples, it is advisable to take a step back and reflect on whether or not improved health outcomes can 'always' be traced back easily to a certain set of activities. Taking the example of an immunization program, the process seems straightforward:

children who receive vaccination will be protected from one of most severe diseases; a common indicator to measure impact is to look at an increase in immunization coverage. However, what changes when the health system is considered, and more system-wide bottlenecks are tackled? For example, what impact is triggered from a policy dialogue that aims to change the governance architecture of a health system? Given increased pressure from development partners to show results (improved health outcomes of a population) with each dollar spent, it is worth reflecting upon such processes in more detail. Indisputably, this is not a question about the importance of measuring results; a routine monitoring and evaluation mechanism is deemed necessary to adjust strategies if activities have not yielded expected results.

Mali



UHC Partnership-led activities have supported much-needed health workforce planning and management.

Evaluation of the human resources for health plan 2009-2015

Technical assistance provided for a directory of human resources and a new health workforce plan, in cooperation with WHO Country Office and various partners, in particular USAID

Due to flexible funding modalities of the UHC Partnership, an additional activity was added to support the investment case for human resources for health. The objective was to analyse the current situation and gain a better understanding of persisting deficits, highlighting the need for more health professionals till 2030. One of the recommendations was to invest more money into the recruitment process.

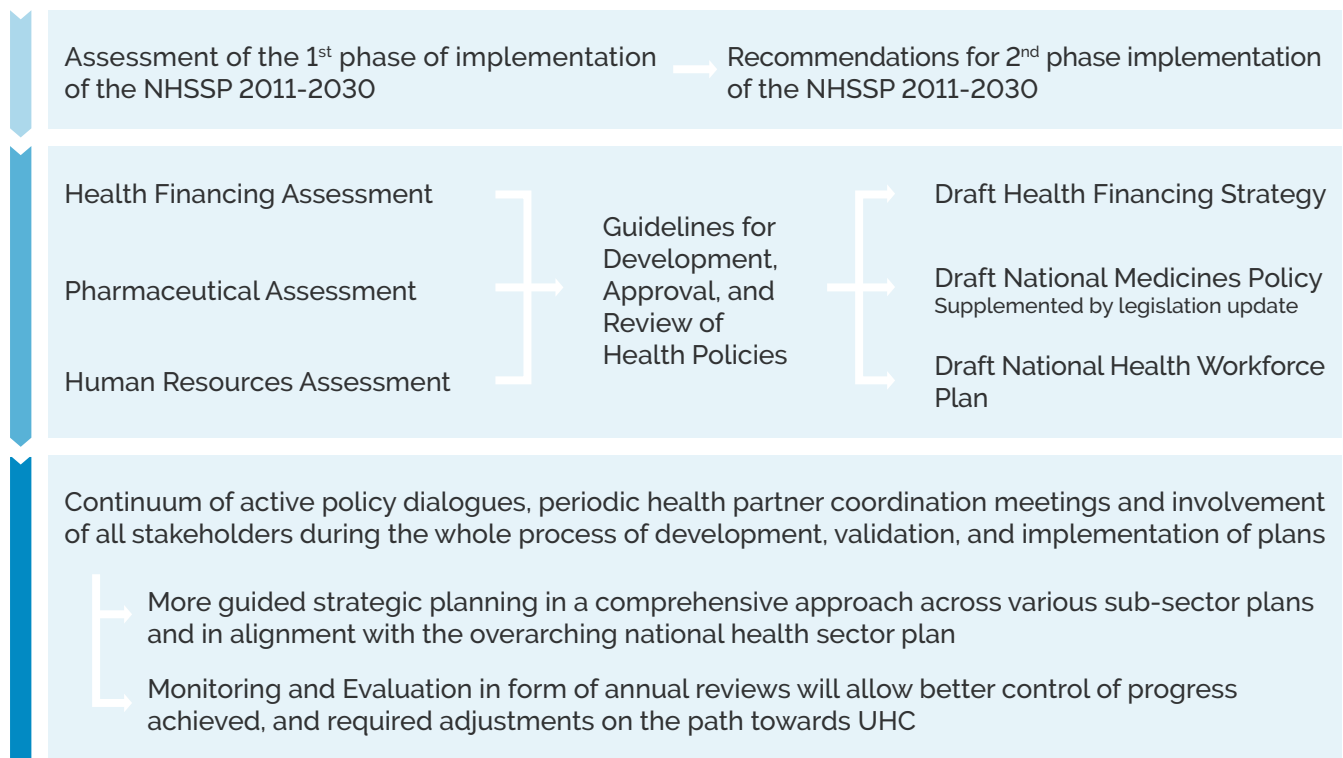
As a result, following significant advocacy efforts, more resources were dedicated to the recruitment process. The number of professionals being recruited increased from 386 in 2016 to 1,227 in 2017.

- ▶ Flexible funding structures allowed the UHC Partnership to add an additional activity to the UHC-P roadmap, and therefore respond to a new request of the MoH in a timely manner.
- ▶ Investment case provided evidence to take immediate action to fill gaps in human resources for health to improve access to health services. It remains to be seen how well new health professional are embedded into the systems, and if capacity building and trainings are necessary to ensure quality health service provision.

Timor Leste



UHC Partnership-led activities have supported strategic planning processes to improve the development and implementation of evidence-based health (sub-sector) policies, strategies and plans



- ▶ The health sector is better guided on how to move forward in the next five years, adequately addressing the more pressing issues and revising and/or strengthening some strategies based on the UHC-P supported “Assessment of the first phase of implementation of the NHSSP 2011-2030” and the “Recommendations for second phase implementation of the NHSSP 2011-2030”.
- ▶ The Guidelines for Development, Approval and Review of Health Policy in Timor-Leste, that were approved, launched, disseminated and began implementation during 2017, will facilitate quality, alignment and procedure of new policies in the sector. It remains to be seen if these technical outputs, through policy dialogue, will enable a policy translation and successful implementation with positive effects on the health outcomes of the population.



Tunisia

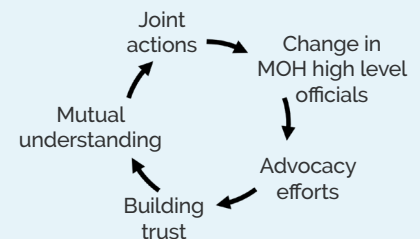
UHC Partnership-led activities have supported the launch of the second phase of the societal dialogue

Dialogue Sociétal Phase I (2012-2014)

Development of a 'livre blanc' after broad consultation, including regional consultations and citizen jury.

Interim period marked with renewed efforts to convene, advocate, build trust and create a mutual understanding towards UHC

Government changes and instability, combined with overall tense political environment, led to a break in the Dialogue Sociétal work. Nevertheless, this period was not idle: civil society continued to advocate for participatory approaches, media sensitization sessions were held, and several technical analyses were prepared.



Launch of Phase II of the Dialogue Sociétal (July 2017)

The process of the dialogue sociétal is back on track after a long and challenging interim period. Initially, phase II was supposed to focus more on operational documents based on the 'livre blanc.' Due to the shifts in the MoH, it was seen as crucial to realign Phase II goals to new needs and dedicate this phase to the drafting of a national health strategy towards UHC by 2030. Working groups are in place, this time with involvement of the citizen jury, along with numerous regional meetings scheduled. Tunisia exchanges on its experience of citizens participation with a network of countries sharing the same aspirations.

The Dialogue Sociétal is slowly becoming institutionalized as a means for health policy-making in Tunisia, thereby transforming the population into active stakeholders and ultimately changing health governance in the country completely.

- ▶ Key milestone achieved to anchor participatory governance structures in decision-making: the same participatory approach as phase I has been preserved and even improved.
- ▶ Clear timeline on the way forward: the *Dialogue Sociétal* steering committee agreed on a roadmap which would aim at developing the national health strategy in the course of 2018 and having it approved in 2019, as a guiding document for the sectoral component of the 2020-2024 and 2025-2029 5-years national development plans. The UHC-P will continue its technical support to established working groups as well as facilitating meetings and harmonizing responses from partners.

'This second phase particularly aims at implementing recommendations identified in the 'livre blanc' which resulted from the first phase of the dialogue, with support of the World Health Organization and the European Union.'

Mrs. Samira Merai, former Minister of Public Health, Tunisia

Ukraine



UHC Partnership-led activities have supported health reform planning and implementation

Overarching reform concept (2015)

Covers all aspects of health systems reform including health financing, service delivery, pharmaceutical sector and public health. Health financing reform was selected as the key enabler to kick-start the necessary changes in health systems governance, organization and incentive systems.

Targeted Health Financing Concept Note (2016)

Adopted and endorsed by the Prime Minister and a coalition of all key international donors active in the country.

Law on State Financial Guarantees for Provision of Medical Services (2017)

Adopted by the Parliament and enacted by Presidential Decree on 27 December 2017

Principles and values set in the Health Financing Concept Note have been successfully translated into the framework legislation on health financing of health care in Ukraine (provider autonomy, provider-purchased split, a new purchasing agency, and a targeted service delivery focus at primary care level).

Bylaws for implementation of the new health financing system (forthcoming in 2018)

The bylaws have been drafted to fill the framework legislation with more details. Additionally, the development of governance and organisational structure for the new health financing system are detailed. This in turn is further supported with provision of know-how, technical assistance and capacity building for translating the legislation into organizational setup, procedures, mechanisms and capacities to launch the health system transformation for the people of Ukraine.

Current reforms in health financing have opened the possibility to significantly improve:

- access to health care services and equity in service use,
- financial protection of the population, and
- efficiency of health care service provision

- ▶ The health system transformation toward UHC has started with support of the UHC-P (technical assistance and policy advisory): changes in health system governance, organization and incentive system have been enabled and anchored in law.
- ▶ Changes will enable a significant increase in efficiency of service provision, reduce financial burden of people and catastrophic health expenditures, and hence improve service access and equity in service use.

UHC Partnership contributions - and how to put achieved results into a 'realist context'?

Since 2016, the UHC-P has been collaborating with the University of Montreal and McGill University to conduct a realist research intervention study in selected UHC Partnership countries. The objective of the study is to better understand the role of the UHC Partnership, by making more explicit the linkages and key elements of how the partnership contributes to the results in health systems strengthening on the path towards UHC in a given country context. Context matters a lot; there is no blueprint for a single strategy to drive progress in all countries. In fact, the road to yield results is often bumpy, with lots of ups and downs, rather than a straight one – hence, an exclusively linear iteration of activities will not help understand the impact of those activities.

The realist research approach, a qualitative method, is an innovative way of looking at an intervention (e.g. the UHC Partnership) in a given context. More information on key elements linked to context, mechanisms and outcomes is provided in the box below; a more detailed overview is provided in the research protocol (publication forthcoming).

In simplified terms, the intervention theory which has been developed by the study team tries to capture key elements of how the partnership

is working in countries, and how this may have contributed to achieved results in strengthening health systems and ultimately to UHC targets. In this regard, key elements of the UHC-P have been identified, as follows:

Flexibility: the ability to adapt to the changing priorities of the MoH

Catalytic funding: the availability of seed funding

Responsiveness: the ability to position and respond to requests from the MoH

Pro-activeness: the ability to anticipate steps for implementation, expectations or needs of the MoH

As shown in figure 3, the contribution of the UHC-P (the tapering bar at the bottom of the figure) gets quantitatively smaller as we move along the process chain towards UHC. The process going from left to right can be split into two parts. In the first part, through funded activities, the UHC-P aims to create a successful policy dialogue by strengthening the capacities of the MoH for improved leadership; by providing technical assistance for a better evidence base for policy decisions; and by facilitating a dialogue which is inclusive and participatory of all

REALIST RESEARCH: what is this all about? Context – Mechanisms – Outcomes

Realist research is an innovative way to look at complex interventions in the real world, with the objective of finding out how a complex social intervention works (for example, a programme to support health systems strengthening in a given country), in what context (taking country diversity with its various players into account), and how it contributes with its activities to expected and unexpected outcomes. This theory-based evaluation approach tries to unfold complex chains of processes. It aims to shed more light onto why a program faces certain challenges and why it is successful in other areas, by understanding better the contextual factors and by uncovering hidden key elements: for instance, whether values, agendas, and needs are mutually understood by stakeholders; whether trust in a structured and transparent process is ensured; and whether Ministries of Health hold ownership over processes to move national plans forward (mechanisms).

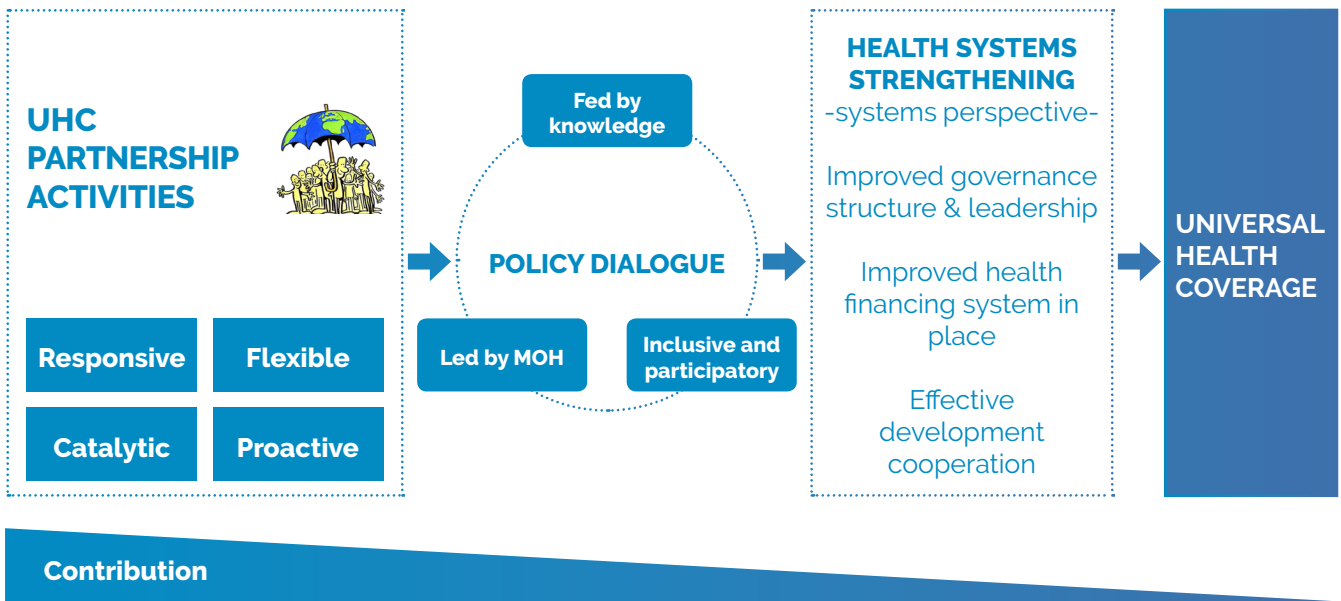


Figure 3: A simplified theory of how the UHC Partnership contributes towards UHC targets

relevant stakeholders, including the population. The policy dialogue thus enabled (second part) certain results, both desired and undesired; this depends on which stakeholders are involved and on the specific way forward for strengthening the country's health systems, which then may yield increased protection from financial hardship or improved access to quality health services (UHC tracer indicators).

This process, which entails various in-between steps, needs to be adequately taken into

consideration when analysing the effectiveness of the partnership and how its activities have yielded results. In summary, we repeatedly highlight that it is difficult to make a direct link from one activity to one specific output, given various actors involved, given increased harmonization and alignment efforts, given complex structures and interlinkages, etc. However, it is clear that joint efforts by partners in a country to strengthen the health system architecture can lead to improved health outcomes of the population.



A nurse at the Rafik Hariri University Hospital,
near Beirut's southern suburbs.
WHO /Christopher Black.

SPECIFIC OBJECTIVES AND EXPECTED RESULTS

Once a country joins the UHC Partnership, an inception mission is organized by WHO staff. During this phase, the Ministry of Health with WHO support convenes key health stakeholders to align on a **country roadmap**, with activities which support the current needs of the country in areas linked to policy dialogue on strategic planning and health systems governance, health financing and/or effective development cooperation (or any other health systems strengthening area). Each year, or as needed (such as when a disease outbreak occurs, or the political situation of the country changes drastically), activities are revised and updated according to

countries' needs and progress achieved. These activities are linked to three specific objectives and six related expected results, outlined in Table 1. In the following pages, we describe example country achievements according to these specific objectives and expected results. This is meant to be a brief description of just a sample of country examples. The list is not exhaustive, and more details can be found in the annual country reports.

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

Table 1: Specific Objectives and Expected Results

Specific Objectives (SO)		Expected Results (ER)	
SO I	To support the development and implementation of robust national health policies, strategies and plans to increase coverage with essential health services, financial risk protection and health equity.	ER 1	Countries will have prepared/developed/updated/adapted their NHPSP through an inclusive policy dialogue process leading to better coverage with essential health services, financial risk protection and health equity.
		ER 2	Countries will have put in place expertise, monitoring and evaluation systems and annual health sector reviews.
SO II	To improve technical and institutional capacities, knowledge and information for health systems and services adaptation and related policy dialogue.	ER 3	Countries requesting health financing (HF) support will have modified their financing strategies and systems to move more rapidly towards universal health coverage (UHC), with a particular focus on the poor and vulnerable.
		ER 4	Countries receiving HF support will have implemented financing reforms to facilitate UHC.
		ER 5	Accurate, up-to-date evidence on what works and what does not work regarding health financing reforms for universal coverage is available and shared across countries.
SO III	To ensure international and national stakeholders are increasingly aligned around NHPSP and adhere to other aid effectiveness principles.	ER 6	At country level, alignment and harmonization of health aid according to national health plans is consolidated and accelerated.

Expected Result 1

Countries will have prepared/developed/updated/adapted their NHPSP through an inclusive policy dialogue process leading to better coverage with essential health services, financial risk protection and health equity.

Activities under ER 1 are within the work stream of providing support to strategic planning and health systems governance. In particular, this means to foster an inclusive and participatory policy dialogue to develop and implement national health policies, strategies and plans (NHPSP), to strengthen subnational capacity for regional and district planning, and also to gain a better alignment across other disease-specific sub-sector plans.

With the shift from the Millennium Development Goals (MDGs) to the SDGs, the MoH is increasingly expected to steer the health sector and all its stakeholders to drive progress towards the health-specific goal of UHC. In this regard, the **governance architecture of a health system** is pivotal for the MoH to fulfil its role. The UHC-P is providing increased technical support on strengthening governance structures, functions and processes of health systems, as shown in [Lao PDR](#).



LAO PDR: Improved governance architecture to enable successful implementation of the health sector reform

At the request of the MoH Cabinet, the UHC-P supported the review of the governance structure, functions, and processes of the health sector reform (HSR). The reason for this review is linked to the 2017 annual UHC-P meeting in Brussels, in which the need to improve the governance architecture across health systems was highlighted and recognized by MoH officials from Lao PDR. The review recommended several strategies for strengthening governance and accelerating the reform process, especially related to policy advice and capacity building mainly at the local level. It also increased awareness of the need for alignment of existing plans and strategies.

As a result, a Ministerial Decree was released to establish a HSR Committee, assigning the Cabinet of the MOH to oversee the implementation, and ensure the re-alignment of the 5 key pillars of the HSR with the 8th five year health sector development plan (HSDP). This has led to the merge of 3 Secretariats (HSR, Sector Wide Group and 3 Builds Committee) into one Secretariat and to the re-structuring of 8 technical working groups of the HSDP into 5 technical working groups to reflect the 5 key pillars of the HSR. Such restructuring and realignment will streamline reporting requirements to the National Commission for HSR within the Prime Minister's office, to the National Assembly and to the Government's annual round table meeting. This governmental shift has also rationalized structures within the MoH to better address health priorities and reporting of Global Health Initiatives, improve public financial management, and streamline information management and reporting.

“My ministry has made good progress towards achieving UHC [...]. There is a more systematic process for data collection which supports us in evidence-based decision making, stronger governance and accountability.”

**H.E the Minister for Health Associate Professor Dr Bounkong Syhavong,
UHC Forum in Tokyo, December 2017**



GUINEA-BISSAU: National Health Policy (NHP 2017) finally validated after a 25 year-long process

Improved strategic planning in Guinea-Bissau will now help to guide national priorities in health. One key milestone was the UHC-P-supported development and validation of the NHP after an inclusive and broad consultative process. Notably, the first version of the NHP was developed in 1993! The steering committee finally validated the NHP in April 2017. The new NHP 2017 is waiting for approval by the Council of Ministers in order to be enacted by the Parliament.

In alignment with the NHP 2017, the development of the National Health Development Plan 2018-2022 is under way. The UHC-P will continue its support towards the plan's finalization in 2018 along with efforts for a successful implementation. In this regard, a key challenge remains the lack of human resources in the General Directorate of Health Systems Administration; a rapid placement of technical staff is necessary to build further capacities to progress on UHC.

In addition, the UHC-P provides continued support to **strategic planning in health** – one of its core support areas in countries. Strategic planning aims at identifying, sequencing and timing medium-term interventions for the health sector in a comprehensive way. The national health policy, strategy or plan (NHPSP) guides the activities and investments that are necessary for achieving medium-term outcomes and impact. The partnership supported the development and

implementation of a multitude of NHPSPs (see countries listed in table 2), as well as, in the case of [Chad](#) and [Cabo Verde](#), the development of regional plans that are aligned with or feed into national health planning processes. In the [Democratic Republic of Congo](#), [Mali](#), [Liberia](#), and [Togo](#), support was provided for annual operational plans (AOP). The table below provides a summary overview of the UHC-P support in 2017.

Table 2: Example list of UHC-P support to the development of NHPSP, regional and operational plans

Country	NHPSP / Regional Plans / AOP	Comment
Timor-Leste	Recommendations for the 2nd phase of implementation of the National Health Sector Strategic Plan (NHSSP) 2011-2030	Assessment of the 1st phase of implementation of the NHSSP 2011-2030 was conducted which provided information to the development of recommendation for the second phase of the plan.
Sudan	National Health Policy 2017 – 2030	Formulation and endorsement of the NHP 2017-2030; in addition review of the National Health Sector Strategic Plan (NHSSP) 2016 – 2021.
Chad	National health development plan, French abbreviation PNDS III 2018 – 2021, and regional health development plans	Apart from national and regional plans, a monitoring and evaluation (M&E) plan was developed.
Togo	PNDS 2017-2022 ; Health Systems strengthening plan, French abbreviation PNRSS 2018-2022; AOP 2017-19	M&E and a communication plan were endorsed, too. A framework for analysing the AOPs for alignment with the strategic plan was developed; WHO used this framework to analyse 21 out of 54 available AOPs.
Sierra Leone	NHSSP 2017 - 2021	Process brought together key health development partners.
Guinea Bissau	National Health Policy (NHP) 2017	NHP 2017 developed and validated; currently awaiting approval by the Council of Ministers to be enacted by the Parliament. In addition, the development of the PNDS III 2018 – 2022 is in process.
South Sudan	National Health Policy 2016-2026	Adopted and launched by the vice president in 2017. The policy was used to draft the National Health Sector Strategic Plan 2017-2022 and guide the operational plans and budgets for 2017/18 fiscal year.
Zambia	National Health Strategic Plan 2017-2021	Inclusive and participatory process enabled.
Cabo Verde	Regional health plans	Developed by all 8 regions (all but two were fully validated). Feed into the national health plan in 2018. M&E plan for each region were developed, too.
DRC	AOP for the health zones	Development of AOP 2018 for the health zones, and the various departments in the MoH at the central level.
Mali	AOP in seven regions	Workshops were carried out which were inclusive of all stakeholders for the development of AOPs in the seven health regions.
Liberia	AOP in all 15 counties	Planning guides updated, and mapping of partner activity & resources carried out; used for all 15 county AOPs and the MoH AOP at the national level. This included planning for implementation of IHR, too.



BURUNDI: The country's first operational guide (in French: '*Guide Opérationnel Gestion des Districts Sanitaires au Burundi*') will improve district health management

In Burundi, the MoH mobilized partners around the development of an operational guide for the management of health districts, with the support of the UHC-P. This guide was validated by a wide range of actors in the health sector, and highlighted the importance of strengthening district health management in the country. Before 2017, there was no such guide available. WHO first assisted in an analysis of health district performance, which revealed that health district management needed common management tools to standardize management and increase its effectiveness. The guide will be the basis for restructuring and training the district health teams in 2018.

In several countries, **guidance documents on policy and planning** were prepared in order to increase alignment of various plans between national, regional and district levels, as well as between plans focusing on specific health systems building blocks and the overarching national health plan. This was linked to capacity building initiatives in the form of training modules and courses for health policy makers, as in the case of [Timor-Leste](#), [Burkina Faso](#), and [Burundi](#).

Beyond the national health strategic plans, support was also provided for the **development and implementation of other sub-sector plans** – for example human resources for health in [Burkina Faso](#), [Mali](#), [Timor-Leste](#) and [Lao PDR](#), for medicines and health technologies in [Timor-Leste](#) and [Liberia](#), or information systems in [Senegal](#), [Sierra Leone](#) and [Timor-Leste](#). In this regard, the UHC-P is increasingly providing support to **law and regulation** in the forms of legal frameworks, for example in [Cabo Verde](#), [Lao PDR](#), [South Africa](#) and [Ukraine](#).



MOROCCO: Strong evidence base built for human resource for health management

With the support of the UHC-P, the MoH in Morocco has invested heavily in building up a strong evidence base for the management of human resources for health (HRH). A series of studies and an ongoing health sector satisfaction survey of health professionals have been undertaken.

Key challenges are linked to a demographic change of the population (ageing) and a shift towards non-communicable diseases. Young medical doctors tend to train in specialized care, settle in urban areas, and practice in the private sector - leading to a major deficit in trained health professionals in rural areas and in the public system. Capacity building and more generalist training is seen as crucial, while incentives need to be provided to attract physicians to the public sector. The various health workforce analyses will feed into the development of a new HRH plan in Morocco which is planned for 2018, and will allow for more evidence-based policy decisions anchored in a more thorough understanding of the current situation. In relation to this, a planned model for an Observatory for Human Resources for Health shall document and analyse the HRH situation in a rigorous, systematic and continuous way, and support the strategic management of HRH through the analysis and formulation of policy options and strategies.

Expected Result 2

Countries will have put in place expertise, monitoring and evaluation systems and annual health sector reviews.

Activities under ER 2 aim to strengthen expertise in countries related to monitoring and evaluation (M&E) processes. M&E is a crucial mechanism by which health stakeholders can better understand how NHPSP activities are being implemented, how budgets are being spent, and what impact these activities are achieving. In addition, strong M&E systems allow for programme modifications adapted to the context as necessary. There are several assessment tools (developed by WHO among others) to help countries assess their current situation, monitor, and evaluate.

The process of **Joint Annual (Health) Reviews (JA(H)R)** is institutionalized in most countries. The UHC-P

provided support to a multitude of annual reviews, along with technical assistance and or training for the **Service Availability and Readiness Assessment (SARA)**, and the **District Health Information Systems 2 (DHIS2)** (see countries in table 3 below).

Several countries developed or updated **tools and plans for M&E** for their national health plans. In **Niger**, a guide was developed for M&E for the National Health Plan 2016-2020. **Togo** also finalized and validated an M&E plan for the NHSP 2017-2022. In **Cabo Verde**, an M&E plan for each regional health plan was developed. Similarly, in **Chad**, an M&E plan was developed in addition to regional plans and a national plan (see tables 2 and 3).



SOUTH SUDAN: Key milestones in M&E have been achieved to build a resilient health system

South Sudan's MoH convened the Health Summit in March 2017 to launch the new National Health Policy. The summit also included a modified joint annual review to review the HSDP 2012-2016 achievements and challenges including lessons learnt and best practices. It also formed part of the situational analysis for the Health Sector Strategic Plan 2017-2022. In addition, WHO through the UHC-P facilitated dialogue and supported the MoH to mobilize additional funds (\$557,000) to make \$957,000 to support the service availability and readiness assessment (SARA) for the first time under the GAVI Health Systems Strengthening program in 2018.

Moreover, WHO with support of the UHC-P continued on the Boma Health Initiative (BHI) through the development of implementation guidelines, service packages, job aids, training manuals and reporting tools; and a training of trainers. The BHI is a community health extension worker strategy to strengthen community systems. WHO supported resource mobilization for the BHI through the development of a Gavi Alliance grant proposal for piloting the above-mentioned tools in Jubek state in 2018-2019. Final agreements are currently made; around \$800,000 is allocated to this initiative.

Note: Besides South Sudan's UHC-P country report, more information can be found [here \(BHI\)](#) or [here \(Health Summit\)](#).

“We believe the Boma Health Initiative will be a cornerstone of the new National Health Policy, and if this Initiative is implemented with strong support from partners and donors, then more people in South Sudan will have a chance to lead healthier lives like never before.”

Dr Abdulmumini Usman, WHO Representative for South Sudan

Table 3: Example list of UHC Partnership support to M&E exercises in countries (light blue indicates an ongoing process or draft report)

Countries	JA(H)R	SARA	DHIS2	Comments
Burkina Faso	■			Jahr completed and report developed.
Chad	■			Jahr completed and report developed.
DRC	■			Jahr provided the opportunity to review the latest National Health Strategic Plan 2016-2020, and improved weaknesses in monitoring.
Liberia	■			The review was extended to the subnational levels (regions/counties).
Mozambique	■			Jahr completed and report developed.
Sierra Leone	■			In addition, health information strategic plan and the investment framework developed. MoH officials were trained in DHIS 2 and data demand and use.
South Sudan	■	■		Jahr used for the end-evaluation of the Health Sector Development Plan 2012-2016. Process to conduct a SARA was initiated, too.
Togo	■			An annual review of the health systems performance was conducted.
Niger	■			The review was extended to the subnational levels (regions/counties).
Viet Nam	■			Jahr of the 5-year health sector plan has further increased development partners' confidence in the results and its usage as a trusted source.
Sudan	■		■	JAR 2016-17 and accountability & legal review were conducted for the first time.
Zambia	■			First JAR since 2013; the process was initiated and will be finalized in 2018.
Burundi		■		In addition, the human resource for health mapping in the private sector (in addition to the public sector), and a baseline assessment of UHC was supported.
Guinea	■			Guides at national, regional and district levels were developed along with the pre-report that will inform the national joint health sector review meeting. Draft SARA report developed; DHIS2 operationalized in 8 regions and 38 health districts; and SITREP for accountability of the triennial plan for health system recovery and resilience developed for 2016.
Timor-Leste	■			There was not a Jahr per se; however, a five year health sector review meeting as part of the NHSSP first phase's evaluation was held.
Mali			■	Health database using DHIS 2 further established, along with trainings for district and regional personnel. This was used to produce the annual health statistics and the weekly epidemiological surveillance reports.



DEMOCRATIC REPUBLIC OF CONGO: Addressing accountability for results

The end term evaluation of the PNDS 2011-2015 noted that there was a lack of ownership of the plan by national authorities as well as inadequate monitoring of implementation. With the development of the PNDS 2016-2020, the UHC-P took steps to address this shortfall. Support was provided for the annual health sector review in 2017. The support was instrumental in raising awareness of the importance of the sector review. Health system actors got a clear picture of the first year of implementation of the PNDS. It made it possible to identify the various bottlenecks causing poor performance that undermined the implementation of the PNDS and to formulate recommendations to address these.

In addition, WHO supported the validation of the M&E plan, which was developed alongside the PNDS 2016-2020. This provided an opportunity to build consensus on the platform for monitoring the current plan and increase accountability for results in the sector. The next step will be to ensure an effective implementation of the review's recommendations with the involvement of all relevant stakeholders at various levels of the health system, as well as sustaining high-quality annual reviews for the entire duration of the current plan.

For some countries, there was an emphasis on **capacity building and support for health services management and community health systems**. Through a tripartite cooperation between WHO, Cabo Verde and Brazil, a capacity building

programme was put in place for Municipal Health Commissions. Through local workshops, about 100 members of the municipal health commissions have been trained.



GUINEA: Capacity building at regional and district level improves management of health services

In Guinea, the capacity of three regional health teams (Kankan, Kindia, Nzérékoré) and 18 district health teams was built in health service management at the subnational level, in cooperation with WHO and the Government of Japan. In addition, WHO facilitated the development of a national programme of integrated multisectoral community development through the "Rural Pipeline" approach to promote UHC at the local level. This rural pipeline programme aims to retain human resources for health with a view to maintaining progress in community health. Consequently, the district health system is strengthened with the involvement of all stakeholders.

Expected Result 3

Countries requesting health financing (HF) support will have modified their financing strategies and systems to move more rapidly towards universal health coverage, with a particular focus on the poor and vulnerable populations.

Activities under ER 3 focus on the development of health financing strategies and reform options, with a focus on expanding coverage to the poor and vulnerable groups.

The UHC-P provided continued support for the **development and implementation of health financing strategies**. In [Mali](#), [Senegal](#), [Guinea](#), [Burkina Faso](#), and the [Democratic Republic of Congo](#), health financing strategies were finalized, while in other countries the finalization of the draft

and /or a final approval by governmental bodies is still pending (see countries in table 4 below).

Moreover, the UHC-P supported a series of countries in developing legal provisions on health financing and UHC. For example, in [South Africa](#) the National Health Insurance (NHI) White Paper was finalized and approved by the Cabinet in June 2017. Major achievements were also recorded in [Ukraine](#) and [Zambia](#), as outlined in the boxes below.

Table 4: Example list of UHC-P support to the development of health financing strategies.

Country	HF Strategy	Comment
Mali	HF Strategy	The finalization of the national HF strategy facilitated the drafting of a Bill on universal health insurance scheme.
Senegal	HF Strategy	Development and validation of the national HF strategy towards UHC. This strategy is accompanied by a sectoral investment plan and an implementation plan.
Burkina Faso	HF strategy	HF strategy validated in October 2017.
Burundi	HF Strategy	The MoH led the development of the national HF strategy. This was followed by a road map for the implementation of the strategy.
DRC	HF strategy	HF strategy finalized and validated, which will form the basis for sustainable resource mobilization for the financing of health services.
Togo	Draft HF Strategy	The national HF strategy for UHC is in the process of being finalized. An analysis examining different scenarios in resource mobilization will be undertaken in 2018.
Mozambique	Draft HF strategy	Strategy developed and policy options currently under discussion at the highest level of the MoH.
Timor-Leste	Draft HF Strategy	HF policy options in late 2016 were redefined and further explored in a HF country diagnosis, which led to a draft HF strategy. Final agreements and approval of MoH is still pending.



BURKINA FASO: Health Financing strategy validated – a key milestones for an improved health financing system

In October 2017, the steering committee validated the national health financing strategy. The Committee was chaired by the Secretary General of the Ministry of Health, and included the different directorates of the Ministry of Health and the Ministries of Territorial Development, Social Protection, Economy and Finance, representatives of trade unions, the private sector and civil society organizations. Some minor adjustments remain to be made to the current strategy before it will be presented to the Council of Ministers. This has been a remarkable step for Burkina Faso. The elaboration of the health financing strategy was a lengthy process including various rounds of policy dialogue, with the first workshop dating back to February 2015. A roadmap for the operationalisation of the strategy was also developed.

At the regional level of WHO AFRO, the partnership supported a regional workshop that served to finalise the **financial protection analyses** in eight countries in the Region including the [Democratic Republic of Congo](#) and [Burkina Faso](#). For many

countries, this is the first time evidence is being produced of the status of financial protection. These reports will be published in a journal supplement to further knowledge sharing within the region.



UKRAINE: law on State Financial Guarantees for Provision of Medical Services has been enacted

As part of the Ukraine's health system transformation process, the UHC-P supported the creation of the framework laws for the new health financing system. In 2017, completely changing the key assumptions of the health care system: the principle of provider autonomy was introduced, along with a provider-purchaser split, fund pooling into a newly created purchasing agency to reduce fragmentation, and a targeted service delivery focus at primary health care. The UHC-P is currently focused on providing technical support to the creation of all the bylaws to fill the framework legislation with further details. This in turn is further supported by the provision of know-how, technical assistance and capacity building for translating the legal provisions into organizational setups, procedures, mechanisms and capacities to launch the health system transformation in a palpable way for the whole population of Ukraine.

The key success factors of the UHC-P have been its catalytic use of funds and flexibility. For example, the initial roadmap for Ukraine only envisioned the creation of the health financing reform concept, while the process in Ukraine has progressed much faster. Due to its flexible funding modality, activities focused on implementation were added along the way. The placement of a senior staff person in the WHO country office further increased responsiveness to the changing needs of MoH, as well as the long-term sustainability of the technical assistance. This has also enabled better pro-activeness in collaboration with the WHO Regional Office for Europe by providing the capacity to anticipate reform needs and consecutive steps so that the technical assistance and capacity building activities were at hand by the time reform progress required these.

Finally, UHC-P funds have been utilized in combination of other funding sources – like that from the Swiss Development Cooperation which covered large parts of the policy dialogue and capacity building needs of all the reform areas, including health financing. This is also envisioned with new allocation of Japanese funds which will be blended with existing funds to catalyze developments of the health service purchasing mechanisms for example.



ZAMBIA: National Health Insurance Bill

The UHC-P support was provided to the Ministry of Health and the Ministry of Justice for the finalization of the [National Health Insurance Bill](#), which is currently going through parliamentary reading. The partnership advised on best practices in quality assurance systems and the modalities for establishing a national insurance fund, including its governance structure. Once enacted, the bill aims to provide for sound financing for quality health care services universally accessible to the population. This also includes the establishment of the National Health Insurance Fund. To this effect, WHO, with the support of the UHC-P and in collaboration with the International Labour Organization and USAID, provided input to finalize the systems development roadmap for the national health insurance.

WHO, through the partnership, also provided assistance on **resource mobilization for country development, including health**. In [Niger](#), the WHO country office prepared and participated in a round table with donors held in Paris. This led to the mobilization of \$23 billion dollars over the next five years for the National Economic and Social Development Plan of Niger, more than the expected \$17 billion. In [Togo](#), a consultative round table was facilitated with representatives of the Togolese private sector to explore options for private sector contributions to financing health.

The resources mobilized will be used to trigger progress towards UHC, focusing predominately on the implementation of recommendations and priorities set in national plans.

Expected Result 4

Countries receiving HF support will have implemented financing reforms to facilitate UHC.

Activities under ER 4 relate to policy advisory and technical support for implementing health financing reforms to accelerate progress towards UHC. In particular this means to strengthen capacity building, generate new evidence and provide policy advisory and technical guidance for reform initiatives. Activities include, among others, the institutionalisation and regular production of national health accounts, costing exercises, as well

as technical work on public financial management, fiscal space, purchasing arrangements including payment systems and benefit package design.

The UHC Partnership has supported national health account (NHA) exercises as well as their institutionalization in several countries, which is a key source of information to track health expenditure over time ([see countries in list below](#)).

Table 5: Example list of UHC-P support to the regular production of national health accounts

Country	NHA	Comment
Burkina Faso		Estimation of the 2016 NHA supported, which was validated by stakeholders.
DRC		The 2015 NHA was completed and validated. This indicated that 40% of health expenditure emanates from households and of this proportion, 90% were directly out of pocket.
Liberia		The 2015/16 NHA was completed alongside a public expenditure review and a comprehensive resource mapping.
Mali		The 2016 NHA was completed and validated.
Togo		The 2013-14 NHA was completed and validated.
Mozambique		MoH capacity was built on NHA methodology as part of efforts towards institutionalization, while the 2015 NHA was completed.
Guinea		The 2014, 2015 and 2016 NHA are in the process of being finalized.
Sierra Leone		The 2014 NHA was validated, and feedback obtained to address some of the data gaps identified. Data collection for NHA 2015/2016 is on-going.
Guinea Bissau		Support was provided to institutionalize the process of producing NHA. A draft report was developed.
Timor-Leste		Global health data base updated and 2002 – 2015 data revised; in addition awareness of MoH and Ministry of Finance on NHA was created.
Tunisia		The 2014 NHA was further refined, especially through the classification by diseases of more than 75% of expenditures. NHA are produced on a frequent basis, and the process is fully institutionalized.



TUNISIA: Health Examination Survey 2016 – UHC tailored surveys

The Tunisian Health Examination Survey was produced by the National Institute of Public Health in 2016 with the financial support of WHO EMRO. UHC-P funds were later used to boost the dissemination and further analysis of results. The survey, based on a representative sample of the Tunisian population, provides an up-to-date picture of the health situation of the country (health condition, behaviour, physical access to care, financial protection etc.). It especially sheds light on the growing burden of NCDs and health-related risk behaviours, and hints at deficiencies in the existing service delivery model.

It helped pick out a number of challenges to be addressed by the forthcoming national health strategy. It has also been globally acknowledged as a state-of-the-art national initiative to monitor progress towards UHC, and was highlighted on page 19 in the WHO/World Bank Global UHC monitoring report 2017. Further exploitation of data will enhance the evidence base, especially an in-depth financial protection analysis, and help move the country further towards developing evidence-based policy decisions to enhance its health financing system and ultimately to progress towards UHC.

The UHC-P has continued to support **various studies to generate an evidence base** around specific aspects of health financing systems in order to inform policy dialogue. In [Chad](#), technical assistance was provided to the UHC unit, with financial support from the UK's Department for International Development (DFID), for fiscal space analysis and identification of options for innovative financing. In [Niger](#), the WHO country office provided technical support in collaboration with the French Development Agency to conduct a study on innovative financing for UHC. [Liberia](#) has developed a roadmap for health financing reform based on the fiscal space analysis conducted in the previous year. This highlighted the immediate

need to improve efficiency of resource use through strengthened public financial management and strategic purchasing, and streamlining of the performance-based financing implementation in the health sector. In [Mozambique](#), the partnership strengthened public financial management with support for the development of the Medium Term Expenditure Framework 2018-2020 and related costing capacity building at subnational levels. Support was also provided for costing the reproductive, maternal, neonatal, child and adolescent health and nutrition investment case, which resulted in the mobilization of resources from DFID and the Global Financing Facility.



SOUTH AFRICA: Sugar sweetened beverages (SSB) tax

During the inception phase in 2016 of the UHC-P, the WHO country office in South Africa had submitted its recommendations for the Davis Tax Committee on Sources of revenue for the National Health Insurance in South Africa including the proposal for taxing the sugar sweetened beverages. Technical assistance and policy advisory by the UHC-P has been provided since to facilitate the process.

In December 2017, the President of South Africa passed the bill on Health Promotion Levy which will result in the taxing of sugar sweetened beverages, or SSB tax (Act No. 14, 2017: Rates and Monetary Amounts and Amendment of Revenue Laws Act, 2017). The SSB tax will be implemented from April 2018 and is likely not only to discourage and reduce the consumption of unhealthy foods/drinks and the related preventable disease burden, but will also generate additional Government revenue that can be utilized to finance public health services. South Africa is one of a handful of countries globally to have passed such a law.

Expected Result 5

Accurate, up-to-date evidence on what works and what does not work regarding health financing reforms for universal coverage is available and shared across countries.

This work serves to help countries inform and develop their health financing strategy and reform plans with the aim of accelerating progress towards UHC. By sharing country experiences, countries can learn from each other what works well and what works less well.

The UHC-P created several opportunities for capacity building and sharing experiences across countries. Each year, the **annual inter-country technical meeting of the UHC Partnership**, which took place in Brussels in March 2017, convened around 180 participants to celebrate achievements, collectively share experiences on challenges and ruminate on innovative solutions at the country level, with the aim of jointly enhancing health systems governance and financing systems in countries (a [video](#) capturing five years of UHC-P experiences was produced). Bringing together various actors from different countries has proven to be pivotal to cross-fertilize knowledge, and has led to collaborations between countries that go beyond regional borders.

In 2017, [Tunisia](#) attended the National Health Assembly in Thailand to learn more about institutionalizing participatory governance mechanisms, in view of making progress on its own Societal Dialogue work. In [Sudan](#), joint efforts were carried out by the National Health Insurance Fund (NHIF) and the Public Health Institute to design a new NHIF governance architecture, an EU-funded project. To this end, a study mission was organized to learn from the Rwandan experience.

For capacity building in health financing, the WHO organized various learning courses. The capacity of national officials in French-speaking countries was reinforced through the **global course on health financing for universal health coverage for francophone countries** in Rabat organized

by WHO in collaboration with the World Bank. 20 countries joined, with more than 120 participants. All francophone countries from the UHC-P (Burkina Faso, Burundi, DRC, Guinea, Mali, Morocco, Niger, Senegal, Chad, Togo, and Tunisia) were part of this capacity strengthening workshop that focused on strategic purchasing and fiscal space / budgeting processes. Another opportunity was provided through the annual **WHO course on health financing in low and middle income countries** held in Barcelona in June 2017. In addition, WHO Office in Europe organized the first course on **health financing for universal health coverage in Russian**; all the four UHC-P countries from the European region participated, and a [video](#) was produced summarizing key messages. These meetings offered the opportunity for knowledge exchange on country experiences – for example, to reflect on [Kyrgyzstan's](#) hospital safety assessment.

The agenda on strategic purchasing was further promoted and developed throughout the year. The global meeting on 'strategic purchasing for UHC: Unlocking the potential' in April 2017 gave the opportunity to contribute to conceptual clarification and consensus-building on strategic purchasing issues in order to refine policy questions and set a global and country level policy agenda. Moreover, the health financing working paper on key policy issues and questions around strategic purchasing for UHC was provided and also translated into [French](#) to allow for a broader community to learn from findings based on experts' and practitioners' discussions. In addition, the global collectivity project on strategic purchasing, which WHO co-initiated and co-facilitates, together with ITM and the Communities of Practices on Financial Access to Health Care and on Performance Based Financing, has made it possible to reach out to more policy makers and practitioners in countries; their experiences have been of immense importance



KYRGYZSTAN: Improving the quality of hospital care

The UHC-P continued to provide technical assistance to the national expert team to organize and conduct a hospital safety assessment in the north of the country (4 oblasts – Chui, Issyk-kul, Naryn and Talas) and the capital Bishkek, covering 36 hospitals from all levels of services provision (tertiary, secondary and rayon territorial level). The safety levels of the hospitals were analysed through hospital safety indexes, which contributed to a comprehensive action plan to strengthen the resilience of the hospitals.

A round table policy dialogue was conducted with the MoH authorities, experts and developmental partners, including UN Agencies, in August 2017. The aim was to discuss study findings which include the analysis of all 70 hospitals assessed during the two rounds: 44.3% of hospitals were classified under safety group “B” indicating an average acceptable level of safety while the remaining 39 hospitals or 55.7% were classified under safety group “C” indicating a low level of safety. The results from the hospital safety assessment will feed into policy discussions on the development of a country health service delivery master plan and for the development of individual hospital master plans – ultimately aiming to improve the quality of hospital care in Kyrgyzstan.

to developing and further fine-tuning policy recommendations and policy analysis guidance tools. In this regard, a Rapid Assessment Guide on purchasing was developed. A [blog on performance based financing](#) and verification were also created to foster knowledge exchange. In addition, an analytical framework on mixed provider payment system analytical framework was developed, and applied in [Morocco](#), [Burkina Faso](#) and [Lao PDR](#). Key overarching findings are presented in the box below. The framework will be applied in more countries in 2018; one of the UHC-P countries will be [Tunisia](#).

Finally, a work stream was also initiated on information systems for strategic purchasing.

To date, most health systems have fragmented health information systems composed of multiple, disconnected, often overlapping information sub-systems. Although there is a wealth of collected data that is relevant for decision-making in purchasing, its use is often suboptimal. Integration of a health financing data system should allow combining data from multiple sources in order to orient decisions on the mixed provider payment system and monitor its efficiency and equity. As a preliminary step, an expert was contracted to develop the first draft of a “roadmap towards integrated data system for strategic purchasing”. This will be completed in the coming year, notably with country work.

COUNTRY CASE STUDIES ON ISSUES AROUND STRATEGIC PURCHASING: learnings from Morocco, Burkina Faso and Lao PDR

Three country case studies have been undertaken in Burkina Faso, Morocco and Laos. The country studies assessed the purchasing arrangements with a particular focus on mixed provider payment systems, including patient cost sharing. The country studies also explored the related governance arrangements and how these are conducive for strategic purchasing or how they actually impede purchasing from being strategic.

The country studies were guided by the analytical framework that was developed as a guidance document for such country assessments. Some of the key findings were:

- 1) System fragmentation in purchasing leads to highly mixed (“messy”) provider payment systems, with non-aligned payment methods that result in an incoherent set of incentives that providers are faced with.
 - 2) When there are gaps in governance (e.g., weak oversight, weak regulation and enforcement, fragmented information systems), providers are more likely to respond to incentives set by more financially attractive provider payment and thus engage in patient cream-skimming and resource shifting.
-

Expected Result 6

At country level, alignment and harmonization of health aid according to national health plans is consolidated and accelerated.

ER 6 relates to effective development cooperation, and hence summarizes all activities that aim at improving harmonization and alignment of health stakeholder activities with the overarching national health policy, strategy, or plan and the health in all policies approach. This means increased endeavours to convene policy dialogue particularly with development partners, to jointly assess and evaluate the health sector, as well as to commit to a national compact, for example. UHC Partnership activities strongly contribute to UHC 2030 commitments.

The UHC Partnership continued to play its role as convener and broker to foster policy dialogue between various actors in order to enhance effective development cooperation in countries. This included the facilitation of several partner forums, such as in [Sudan](#).

A **mapping of development partner interventions** in health was also carried out in some countries.

In [Chad](#) and [Togo](#), through further advocacy, the funding proposals for the Global Fund and Gavi have been aligned to the National Strategic Health Plan. In [Viet Nam](#), the UHC-P supported the update of the [online database](#) that maps the support of development partners and international non-governmental organisations to the health sector, to reflect support in and beyond 2017. Activities that ended prior to 2017 have been archived for trend analysis. The UHC-P also supported briefing and advocacy materials, including a brochure to promote the use of the database by relevant partners.

The [Democratic Republic of the Congo](#) worked on strengthening **coordination mechanisms** in the health sector and across sectors. The meetings of the national health sector coordinating committee and its sub-committees were facilitated by the UHC-P. This contributed to the process of the joint annual review. In addition, the MOH and other relevant ministries identified national focal points for the International Health Regulations



SUDAN: Health Sector Partners Forum

Through the UHC-P, the WHO Country Office of Sudan supported the Health Sector Partners Forum, an inclusive platform with the active participation of all stakeholders to make joint progress towards UHC. Country leadership, with the proactive involvement of Sudan's Minister of Health, has also made a difference, particularly observed in the case of the Health in All Policies approach.

Various harmonization and alignment measures have been established to channel donor support and domestic resources to the country's UHC priorities. In this regard, removing silos within the WHO Country Office also served to emphasize a joint willingness to look inward and engage in transformation. Moreover, under the four sub-committees (technical, oversight, humanitarian, and development partners), coordination and consensus was generated around key themes, such as the Humanitarian, Development and Peace Nexus, Universal Health Coverage, Joint Annual Reviews, and Health in all Policies. Besides the country office, technical experts from WHO EMRO and HQ provided valuable inputs in the forum's deliberations. The Oversight Committee established a joint monitoring and evaluation plan for the sector.



GUINEA: Strengthening health sector coordination

Following the Ebola outbreak, the health sector coordination mechanisms in Guinea had fragmented, leaving a vacuum. The response to the outbreak had been led by a different ministry than the MOH. WHO, through the UHC-P, has provided targeted technical assistance to revive the health sector coordination platforms in the country. At the end of 2017, decentralized Health Sector Coordinating Committees at the level of 8 regions and 38 health districts have been launched. Terms of reference for the various coordinating committees were updated and harmonized. These committees meet regularly as planned and the quality of discussions has greatly improved.

Moreover, the quality of the facilitation of regular monthly coordination meetings of technical and financial partners has also been transformed, with increased engagement of participants. This has significantly improved WHO's visibility and strengthened its leadership in its current role as leader of health partners. All this has resulted in better coordination between the national authorities and the technical and financial partners within the sector, as well as improved harmonization among the development partners in their interventions in the health sector.

(IHR) and analysed the level of coordination of IHR implementation. A mapping of development partners and their interventions at provincial level was undertaken. In [Burundi](#), the UHC-P led the process of reviewing the development partners'

framework, at the request of the MOH. This was aimed at fostering greater alignment of partners to the national health priorities and processes and strengthening the leadership of the MOH and its coordinating role in the health sector.



LIBERIA: Signature of the country compact

In April 2017, a key milestone to enhance effective development cooperation in Liberia was achieved with the signature of the [national compact](#) – a result after a series of policy dialogue activities between the government and development partners. Health governance for effective development cooperation was recognized as an increasingly important strategic focus to ensure moving towards UHC. The national compact aims to establish a joint health governance mechanism for better coordination in the health sector. A series of policy meetings at subnational and national levels have already followed. In addition, support was provided to the partner coordination unit at the central ministry of health to strengthen the platform for regular policy dialogue and health sector coordination meetings, to further facilitate a successful implementation of the national compact agreements.

At the occasion of the signing ceremony, Dr. Bernice Dahn, Minister of Health, expressed her gratitude to all development partners for their unwavering support and commitment and to the UHC partnership in Liberia for its pivotal role in making this process a reality.



**A child and his mother at the Sino-Kinois Hospital
in Kinshasa, DRC. WHO / Eduardo Soteras Jalil.**

LESSONS LEARNED

As mentioned in previous reports, the UHC Partnership has been instrumental in **strengthening WHO's key role**, with the MoH, in convening and brokering not only in-country stakeholders around critical policy dialogue issues but also development partners, via health sector coordination mechanisms rendered more functional and effective. A stronger WHO country presence, with more focused backstopping and support from WHO's 3 organizational levels, has been the driving force for this. Other major lessons learned which have been mentioned in previous reports, and are mentioned here as a reminder of what defines the UHC-P, are the **absolute imperative of flexibility** of UHC-P funding which has enabled countries to react to evolving situations and priorities in real time. Being timely is also closely linked to the ability to act as a **catalyst** for other funding sources

and in-kind contributions by allowing decisions to be made at the right place and right time.

WHO's added value is its technical expertise, especially on UHC, a notion that can so easily be understood superficially and confused. WHO's decisive role in ensuring that UHC is viewed broadly, with a distinct emphasis on complementing well-reflected financing mechanisms with robust and participatory governance arrangements and a focus on health service quality, is heavily reinforced through the partnership.

We refrain from repeating further lessons learned which have been repeated elsewhere – clearly, this is not to diminish its importance in any way but rather to focus the reader on 4 relevant issues which emerged specifically over the course of 2017.

#1 MINISTRY OF HEALTH BOOST IN LEADERSHIP AND ENGAGEMENT WITH THE PRIVATE SECTOR

Two growing areas of technical support for partnership countries are: strengthening the stewardship role of governments for engaging the private sector in service of UHC, and leveraging legal frameworks to boost UHC implementation. The private sector is a major player, and in some settings it is the dominant player in health service delivery and the provision of health system inputs – it goes without saying, then, that UHC can only be achieved if the private sector is an active partner, convinced of the need to steer towards UHC goals. However, health policy-makers require better tools to engage with the private sector as they may not have been natural partners in the past, depending on the country context.

The UHC-P is thus focusing much attention on building the capacity of governments to develop

effective and tailored strategies to collaborate meaningfully with the private sector. For example, in [Cabo Verde](#), following the 2016 rapid assessment of health system governance and regulation, the partnership continued its support to (i) the development of a decree creating an independent entity for the regulation of health services, (ii) the revision of the bill for health service regulation to include private sector providers, and (iii) the legislative framework for public-private partnerships. Final approval from the MoH is expected in 2018. The process has aided the MoH to build its own capacities in this area, gaining a more strategic and comprehensive perspective on how the private sector can be embedded in the 'one health' approach with its ambition of allowing citizens to better claim their health rights.

Work in Cabo Verde and other UHC-P countries has been the catalyst for the creation of a new WHO decision-making model to strengthen the stewardship role of governments for engaging the private sector in health.¹ The decision-making model walks governments through a transformational process to positively interact with the private sector, thereby strengthening the MoH's stewardship role. The model provides a flexible framework that is adaptable to different country contexts and priorities, useful for analysing the current situation of the private sector and for shaping potential future engagements.

In addition, the role of legal frameworks in implementing UHC has long been overlooked.² Laws can enable and facilitate UHC reform, at the same time acting as a barrier when they are not in place to adequately and explicitly support UHC. Laws are especially central to improving access to services, addressing issues of quality and supporting the implementation of health financing reforms or health worker regulations. New normative guides and technical briefs are currently under development to support country efforts in this matter.

#2 TAKING POLITICAL ECONOMY INTO ACCOUNT IN DESIGNING AND IMPLEMENTING HEALTH REFORMS

Political and economic forces in health reforms have been increasingly recognized by countries. In order to be effective, strategies aimed at designing and implementing health financing reforms, for example, need to consider both technical and political factors. In this regard, WHO has started a new work plan to develop a framework of applied political economy strategies that policymakers and practitioners can employ to increase the likelihood that technically sound health financing reform will be implemented and achieve its objectives. This is accompanied by a guidance document. Certainly, a blueprint does not exist, and country context matters. However, the normative work – through a rigorous analysis of country experiences, existing literature and a strong analytical framework – aims to bring light into how countries can more proactively incorporate political economy considerations in designing and implementing health financing reforms.

At the country level, WHO supported [South Africa's](#) National Department of Health (NDOH) in assessing the perceptions of various stakeholders regarding the establishment of the national health insurance.

To achieve this, WHO hired a professional media company to facilitate monitoring of the media reports, which was critical in early identification and response to adverse media reports regarding NHI. It was also useful for better understanding the positions and perceptions of various stakeholders regarding the NHI. WHO also commissioned a study by the Institute of Social and Economic Research, Rhodes University. This used focus group discussions with key stakeholders, including public and private providers, the beneficiaries of medical schemes and others. Even though respondents across all social groups endorsed the values and principles of the NHI, there were still significant anxieties about its implementation and the consequences of the envisaged changes to the health care system. Based on these findings, the NDOH, with the support of WHO, has initiated the development of a communication strategy. This will focus on spreading fundamental messages on NHI using billboards, radio and pamphlets. Such communication strategy is vital to garnering public and stakeholder confidence in the health systems and financing reforms planned under NHI.

¹ WHO (2018): Decision Making Model: Strengthening the Stewardship Role of Governments to Engage the Private Sector for Universal Health Coverage.

² Clarke, Rajan and Schmets (2016): Creating a supportive legal environment for universal health coverage, Bulletin of the World Health Organization 2016; 94: 482.

#3 INTER-SECTORALITY: LOOKING AT THE HEALTH SECTOR AND BEYOND

None of the SDGs can be achieved without simultaneously addressing all of the SDGs together – this is both the opportunity and the challenge of the SDGs. The lesson for the health sector is that there is no way around working closely with other sectors, in service of both health-related as well as all other goals. The importance of Health in All Policies (HiAP) is emphasized.^{3 4} Cognizant of this, the UHC-P is increasingly engaging in targeted events with other sectoral actors, as well as capacity building for more intersectoral coordination and action. This engagement helps MoHs to explore 'unchartered' territories, i.e. new topics and potential new priorities that allow for frontier work in health, going beyond the traditional boundaries of health care as set in the MDG era.

For example, in [Guinea-Bissau](#), the UHC Partnership contributed to the development of a [Right to Health in Guinea Bissau](#) report. The report examines the right of all individuals to the highest attainable standard of physical and mental health in Guinea-Bissau. It has been jointly prepared by the Human Rights Section of the United Nations Integrated Peacebuilding Office in Guinea-Bissau, and by the Office of the United Nations Health Commissioner for Human Rights. In [Burundi](#), with the support of the UHC-P, the MoH initiated a review of health policies in non-health sectors aimed at addressing social determinants of health and reducing the

risk of NCDs. [Mauritius](#) is currently finalizing a large-scale study to address the burden of NCDs through a health systems strengthening approach, including intersectoral action. In [Senegal](#), a mission was organised to the Kaolack region to convene national actors to discuss evolving challenges around the social determinants of health, since their impact on health has become a concern in other sectors as well. This aided in building a fruitful policy dialogue with actors in health and beyond. In [Timor-Leste](#), the UHC-P provided support through capacity building to the MoH by participating at the intersectoral forum for nutrition, convened by the National Council for Food Security and Nutrition which is led by the Ministry of Agriculture and Fisheries). In [Viet Nam](#), WHO through the UHC-P continued its support to the Health Partnership Group (HPG) by facilitating meetings, convening various partners, as well as providing technical materials and coordination of partners' responses and inputs into the policy dialogue. In 2017, a provincial multi-sectoral meeting was held by the HPG involving different ministries and development partners to discuss new issues related to climate change and its impact on health. This followed another technical meeting that focused on air pollution and health, resulting in a commitment to forming a multisectoral sub-group of the technical working group on environmental health.

#4 FOSTERING PARTNERSHIPS AT THE GLOBAL LEVEL IS PIVOTAL TO HARMONIZING DEVELOPMENT AID FOR BETTER ALIGNED AND EFFECTIVE IN-COUNTRY SUPPORT, DRIVEN BY THE NEEDS OF THE POPULATION

The UHC Partnership's aim is to build country capacities and hence reinforce the leadership of the MoH to build resilient and effective health systems in a sustainable manner. By holding close ties to global-level debates, the UHC-P can be seen as

a bridge that helps close the gap between global commitments and country realities. Even though harmonization of international aid has been in the global spotlight over the years, the gap remains substantial in some countries. The partnership

³ World Health Organization and the Government of South Australia (2017): Progressing the Sustainable Development Goals through Health in All Policies: Case studies from around the world.

⁴ Blas et al. (2017): Intersectoral planning for health and health equity. In: Schmets, Rajan, Kadandale. Strategizing national health in the 21st century: a handbook; pp. 599-639.

attempts to help translate global commitments into practical implementation options for health systems strengthening at the country level.

The UHC-P thus works hand in hand with the [International Health Partnership for UHC2030](#), the global movement to promote stronger health systems for UHC. UHC2030 provides a multi-stakeholder platform to improve collaboration on health systems strengthening. This has also led to the active participation of the UHC-P at the high-level forum on universal health coverage from 12 to 15 December 2017 in Tokyo, Japan. The Government of Japan, the World Bank, the World Health Organization, UNICEF, and UHC2030 convened this forum. At the closing, the co-organizers adopted the Tokyo Declaration on Universal Health Coverage. The UHC Partnership is highlighted as an exemplary initiative strengthening country systems and platforms for UHC. This

emphasizes once more that the UHC Partnership is one of the country-level resources to draw on in the push towards UHC targets by 2030.

In the conviction that results can only be achieved collectively, the UHC-P also appreciates close collaborations with other related UHC2030 alliances, partnership and programmes, such as the two newly established initiatives, the [Health Systems Governance Collaborative](#), and the [Civil Society Engagement Mechanism \(CSEM\)](#), as well as [P4H, the social health protection network](#), in fostering engagements towards UHC. As rightly put in the Tokyo Declaration, global coordination and advocacy must go hand-in-hand with in-country work. "We support the increased alignment of efforts among all development partners through country-led, multi-stakeholder coordination platforms in line with the UHC2030 Global Compact Principles."

#5 USING CONVENTIONAL COMMUNICATION CHANNELS AND SOCIAL MEDIA

The UHC-P has invested more in communications, using both conventional channels and social media, acknowledging that the tasks of the partnership is core to the work of WHO and is not yet well known.

The [handbook: strategizing national health in the 21st century](#) was launched during the World Health Assembly in May 2017, a practical strategic health planning guide for policy-makers, much of the material for which was drawn from UHC Partnership country experiences. As part of its information dissemination campaign, the UHC Partnership organized four webinars by providing insights to selected chapters of the handbook: [priority setting for national health policies, strategies and plans](#); [strategic planning: turning priorities into health plans](#); [budgeting for health](#), and [monitoring, evaluation and review of national health policies, strategies and plans](#).

In fall 2017, WHO through the UHC-P also participated in the Devex-led [Healthy Horizons](#) Universal Health Coverage Campaign. Over

10 weeks, Devex asked key players in global health, development, and the private sector how they perceive the road to UHC and the health-related SDGs. The campaign stimulated a global conversation by official partners, such as Devex, the International Federation of Pharmaceutical Manufacturers & Associations, the International Federation of the Red Cross, Philips, and UNICEF. WHO took part as an independent contributor and provided information to the series in the form of sponsored articles, interviews, and short videos: [Q&A: why UHC makes for a good investment](#); [Putting people front and centre: Participatory health in the 21st century](#); [Prioritizing the public purse for universal health coverage](#); a [Facebook live chat with Dr. Gérard Schmets](#), and a twitter chat with Dr. Agnès Soucat and others on 2 November 2017. The microsite, [Healthy Horizons](#), recorded around 22,000 page views. Article posts on the Devex homepage accounted for 33,000 page views, with WHO-sponsored pieces ranked in the top list. New media channels such as the Facebook live chat have reached around 12,000 views so far.

As previously mentioned, the UHC-P gathered in Tokyo for the 2017 UHC Forum, and engaged with various stakeholders and country representatives to foster collaboration. In conjunction with the Health Systems Governance Collaborative, a side event was organized for participants to explore new ways of governing and partnering for UHC. [The ten-point Mini-Manifesto](#) was produced at the end. A social media campaign was undertaken during the event. The UHC-P umbrellas were a true fun fact and welcomed by participants to take home – around the world!

In addition, the [UHC Partnership website](#) has been revamped. This was due to an analysis revealing potentials to improve the structure and accessibility of the website content, as well as visual features. The new layout and structure of information allows a more user-friendly experience, with current

events and recent news more easily accessible. The website has been updated, and information is available in both English and French. New methods of engagements are currently being explored to transform the platform from a publicly available communication tool to a more collaborative platform for stakeholders. This shall help to engage more countries to exchange information and lessons learnt across partnership countries. As for social media, the UHC-P has had a twitter account @UHCPartnership since mid-2017, and has already reached more than 500 followers. The purpose here is also to inform interested global health advocates about UHC-Partnership activities and results, global-level commitments, updates of newly released research papers and much more. Finally, communication and media presence on UHC Partnership supported events have been amplified at the country level, partly in local languages.

“We commit to jointly mobilizing political leadership around the world so that countries develop their own roadmaps towards UHC, with clearly indicated targets, indicators and specific plans. We support the increased alignment of efforts among all development partners through country-led, multi-stakeholder coordination platforms in line with the UHC2030 Global Compact principles. We also promote country-level engagement with diverse stakeholders from non-governmental and private sector partners to enhance shared ownership and accountability. We welcome the contribution of international initiatives such as the Tokyo Joint UHC Initiative, the UHC Partnership, Providing for Health Partnership, and the Global Financing Facility (GFF), which aim to strengthen country systems and platforms for UHC and preparedness in a collaborative manner.”

Extract from the Tokyo Declaration on Universal Health Coverage



The National Paediatric Hospital in Hanoi,
Viet Nam. WHO / Emmanuel Eraly.

PRINCIPAL CHALLENGES

The work of the UHC Partnership is at the heart of systems reform and the changing role of ministries of health in the 21st century. This clearly comes with inherent challenges; in addition to those which

are highlighted in past reports, 3 salient challenges in 2017 concerning resources and efforts are elaborated upon below.

#1 UNIVERSAL HEALTH COVERAGE IS A POLITICAL CHOICE MADE BY EVERY COUNTRY

The political economy of any issue involves all stakeholders, including the population. Some illustrative examples are provided below to highlight the various challenges derived from vested interests.

▶ **Lack of understanding contributing to palpable anxiety and apprehensions:** In South Africa, the implementation of the NHI represents a substantial shift which necessitates a massive re-organization of the current two-tiered public and private health system. The lack of lucid understanding and interests of different stakeholders are contributing to palpable anxiety and apprehensions. Investments in having all key stakeholders on board, and in achieving greater consensus and agreement, are pivotal to enabling a well-coordinated and harmonized approach.

▶ **Political instability** with frequent changes in Ministry of Health leadership and a lack of qualified human resources in the ministry

continued to pose challenges to implementation in countries like Guinea-Bissau and Togo.

▶ **Election years** in countries may risk bringing health agendas to a pause or provoking delays in approvals, until a new government is formed. The example of Timor-Leste has shown once more that policy dialogue is closely linked and influenced by actors and context, and it cannot be separated from the governance environment and politics. Stability of government and having a solid counterpart is essential for moving towards UHC. This has affected the results of many policy-related activities, due to difficulties in undertaking fruitful policy dialogue and/or engaging relevant stakeholders, or because approval of policy/strategic documents has been delayed, affecting planned progress.

▶ **Extensive restructuring processes in the MOH,** and the resultant turnover, may lead to delays as officials integrate themselves into their new roles, as was the case in Zambia.

#2 POLICY DIALOGUE AND GOVERNANCE ARE COMPLEX, SLOW, AND ACHIEVEMENTS ARE NOT ATTRIBUTABLE TO THE PARTNERSHIP ONLY

Continued effort will be made to better link **UHC partnership-led activities to overall results and health outcomes.** Nevertheless, work on health

policy and on capacity building is complex and does not immediately bear fruits, especially not in the lifespan of a development project, as pauses

and even setbacks are to be expected. Moreover, these fruits are often the result of several parallel initiatives led by different actors, each intervening at a different stage of the result chain. In this context, it is difficult to expect or display immediate and full attribution of achieved results to a single initiative. More important is to examine the process and the crucial elements to have achieved certain results,

in order to learn from country experiences. In this regard, the aforementioned realist research study in some UHC Partnership African countries is a step in the right direction. Study results will better reveal the role of the UHC Partnership in countries, and the critical elements for its success and potential to further improve its efficiency.

#3 MANAGING AND COORDINATING THE UNIVERSAL HEALTH COVERAGE PARTNERSHIP

From a management point of view, **coordination of the UHC Partnership** due to an increased number of countries and partners requires a new and more structured approach to guarantee alignment in programme implementation and vision. This is the reason why a new coordination committee will be established in 2018, which will allow more coherent messaging and more systematic sharing of knowledge and information. The committee consists of members from the WHO regional offices and headquarters as well as the European Union, Grand Duchy of Luxembourg, and Irish Aid. This will provide the platform to address various issues related to the management and coordination of and the technical support to the partnership. As

an example, with a constantly increasing number of countries, especially in the African Region, more resources and staff time are needed to provide adequate supervision and technical backup support. The same applies to resources needed at headquarter-level to enable effective management and coordination of the partnership.

In addition, the committee also invites representatives from other donor agencies investing in the UHC agenda, such as the Government of Japan, DFID, France and Germany to participate. Discussions will allow fine-tuning the programmes to each other to achieve the optimal synergies and avoid duplication of work.



Hiwot and her seven month old baby Elizabeth, or Elsa, in Debre Zeit, Ethiopia. WHO /Petterik Wiggers.

CONCLUSION AND WAY FORWARD

Looking back at 6 years of programme implementation, the UHC Partnership experience in currently 36 countries has brought solid, sustained achievements to strengthen health systems to make progress towards universal health coverage and health-related SDGs.

We acknowledge both the achievements and the arduous path ahead; it will be crucial to continue the work by providing the financial support and technical expertise to countries' specific needs on the road towards UHC. Applying a systems perspective and understanding the key elements that drive change is a process which requires time, but the UHC Partnership has shown that it is possible. It involves capacity building of professionals working in both government departments and non-state institutions, to enable a shift in thinking that moves away from disease-specific programme targets towards a broader health systems perspective.

The more holistic and ambitious SDGs encourage health stakeholders to step out of their 'comfort zone' – both in terms of areas of work and of people to engage with. Working more collectively with other sectors beyond health is becoming increasingly important. This only adds a layer of complexity to the Ministry of Health's role in the 21st century: not only must it reach out smartly and collaborate with the broad range of health sector stakeholders but it needs also to understand perspectives from outside its sector.

This poses immense challenges, and requires the UHC Partnership's sustained and very flexible approach to systems strengthening support, according to the needs of the country. The UHC Partnership model has helped create a mutual and enhanced understanding of the UHC concept, and most importantly a genuine interest to strive jointly for UHC at the pace of each target country, by leaving no one behind.



#UHC Partnership

A country-level resource for [uhc2030](#)

www.uhcpartnership.net



World Health
Organization

