EU-LUXEMBOURG-WHO
Universal Health Coverage Partnership

4th Annual Technical Meeting
Report | Barcelona, Spain

1-3 March 2016

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Acknowledgements

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The Meeting in Numbers

3 days of workshop	45 participants from WHO country offices
130 participants	26 senior MoH officials
30 countries represented	4 representatives of donor agencies

Executive Summary

The fourth Annual Technical Meeting of the European Union, Luxembourg and WHO Universal Health Coverage Partnership (UHC-P) in Barcelona was an opportunity to discuss not only the achievements and lessons learnt from Phases 1 and 2 of the UHC-P, but also to look to the future by discussing the UHC-P's direction under its third phase, in the context of the new global development framework.

Within just four years, considerable and visible progress has been made with regard to the programme's expected results in all three focus areas: policies, financing and development effectiveness. In some partner countries, the programme contributed to making health an exemplary model for inclusive and effective policy dialogue, including around health financing, that has improved policy dialogue in other sectors. The programme's flexible approach to country-level planning and success in strengthening WHO's role as convener, facilitator and coordinator of policy dialogue have been recognised as a major added value.

Recommendations that emerged from the discussions centred on the need to strengthen coordination beyond the health sector to integrate UHC and health in all policies; to push for International Health Partnership (IHP+) compliance by donor agencies at global level and for alignment of global health initiative (GHI) HSS windows at country level, to reinforce the nexus between health security and systems strengthening; and to provide country offices with clear guidance on how to implement and monitor the health Sustainable Development Goals (SDGs).

Within just four years, considerable and visible progress has been made with regards to the programme's expected results in all three focus areas: policies, financing, and development effectiveness.

Next steps include, among others, updating Country Roadmaps for Phase 3; researching and evaluating results in order to establish evidence for UHC-P's added value; improving visibility and communication of achievements; and developing guidance and capacity-building on SDG and International Health Regulations (IHR) implementation.

Introduction

Since its inception in 2011, the European Union, Luxembourg and WHO Universal Health Coverage Partnership (UHC-P) has successfully supported policy dialogue on national health policies, strategies and plans (NHPSP) within all of its partner countries[1] . Over just four years, the UHC-P significantly expanded both its geographic scope (from seven to 27 partner countries) and its thematic scope, with additional emphasis on health financing and aid effectiveness through the International Health Partnership (IHP+) since 2013.

Based on three major pillars (health financing, IHP+ and NHPSP Policy Dialogue), the UHC-P builds WHO and Ministries of Health country capacities for the development, negotiation, implementation, monitoring and evaluation of robust and comprehensive NHPSP, with the aim of promoting UHC, people-centred primary care, health in all policies and the implementation of the Aid/ Development Effectiveness agenda.

The programme remains an important European Union (EU) and the Grand Duchy of Luxembourg development policy priority[2] . Under Phase 3 of the UHC-P, which started in January 2016, the EU and Luxembourg therefore continued their support to the programme, thereby enabling seven new countries to join the UHC-P, in addition to Laos, which joined in August 2015.


Burundi


Guinea-Bissau


Morocco


South


Tajikistan


Ukraine


Zambia

Potential new donor countries, such as Germany and Japan, as well as possible new partner countries, including the Kyrgyz Republic, Lesotho and Republic of Congo, are currently exploring the possibility of either supporting or joining the programme, and were therefore invited as observers to this meeting.

The 2016 meeting placed greater emphasis than ever before on the UHC-P's future – notably on how to use lessons learnt in Phases 1 and 2 for the implementation and orientation of Phase 3 in the context of the new global health and development framework.

The objectives of the meeting were as follows:

• Four years into the UHC-P and following the recent launch of Phase 3 of the programme, to set the scene in terms of what is successful, what is more difficult to achieve, and what is the overall context for implementation of activities in the coming three years.

• To understand divergences and similarities in UHC-P activities implemented by its partner countries, and discuss how to show results.

[1] See documents at www.uhcpartnership.net

[2] For Luxembourg, see: http://www.gouvernement.lu/4556247/sante-2014.pdf; For the EU: see communication (2010) on The EU role for Global Health.

In order to reach these objectives, the agenda of the meeting was articulated around the following topics:

- UHC-P Phases 1 and 2: global results and lessons learnt
- Management, visibility and evaluation
- International Health Regulations
- Sustainable Development Goals
- Global health initiatives and IHP+
- Integrated services and local health systems
- Health financing for UHC
- The role of institutions in advancing the UHC agenda
- "Realist research" to generate evidence and document results
- Workforce 2020: the global strategy on human resources for health
- Access to quality-assured essential medicines and health products
- SDG monitoring: a common agenda to strengthen health information systems
- Phase 3 Country Roadmaps

The meeting was highly participatory, with the number of formal presentations limited to the necessary minimum in order to leave ample time for working group discussions. The level of participation and the quality of the debates was very high, as perceived by the participants[3] . The agenda focused on allowing represented countries to draw on the lessons learnt during UHC-P Phases 1 and 2 in order to jointly assess how to best shape the UHC-P's future role and activities in the context of a new development and global health landscape.

The meeting also provided an opportunity to review the template for country roadmaps that will be updated for each country.

[3] 71 participants completed meeting evaluations. The overall rating note was 4.2/5. The most highly-rated sessions were: IHR and SDGs; Health Financing for UHC; GHIs and IHP+; and Integrated services and local health systems. Technical materials presented were useful, but should always be available also in French. There was some criticism of time management, and a too tightly-packed agenda, with not enough time allowed for substantive group discussions and feedback. Logistics and venue were very well appreciated.

Meeting proceedings

1. The UHC Partnership's added value: present and future

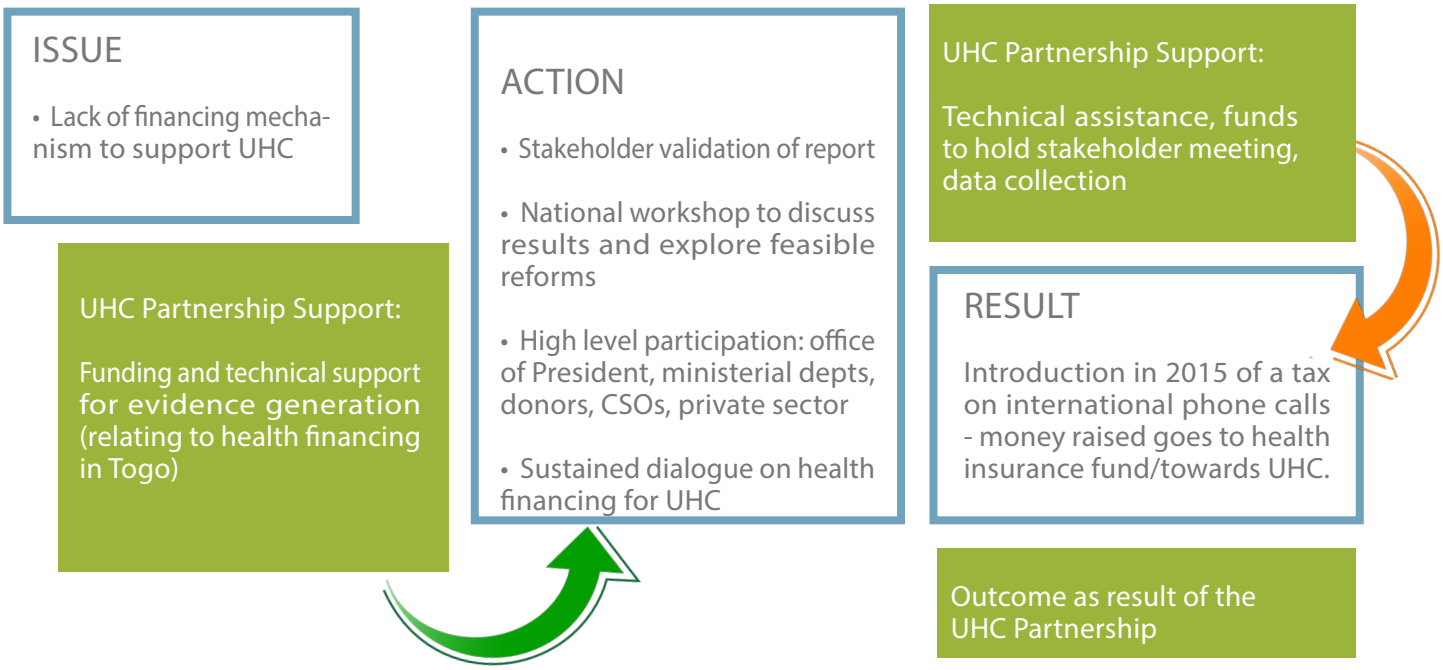
"The EU-Luxembourg-WHO partnership is a cutting-edge programme, which, despite its complexity and challenges, has already achieved a lot – and with relatively little money".

Dr Matthias Reinicke, health sector advisor at the Directorate General International Cooperation and Development - EuropeAid, European Commission, at the opening plenary.

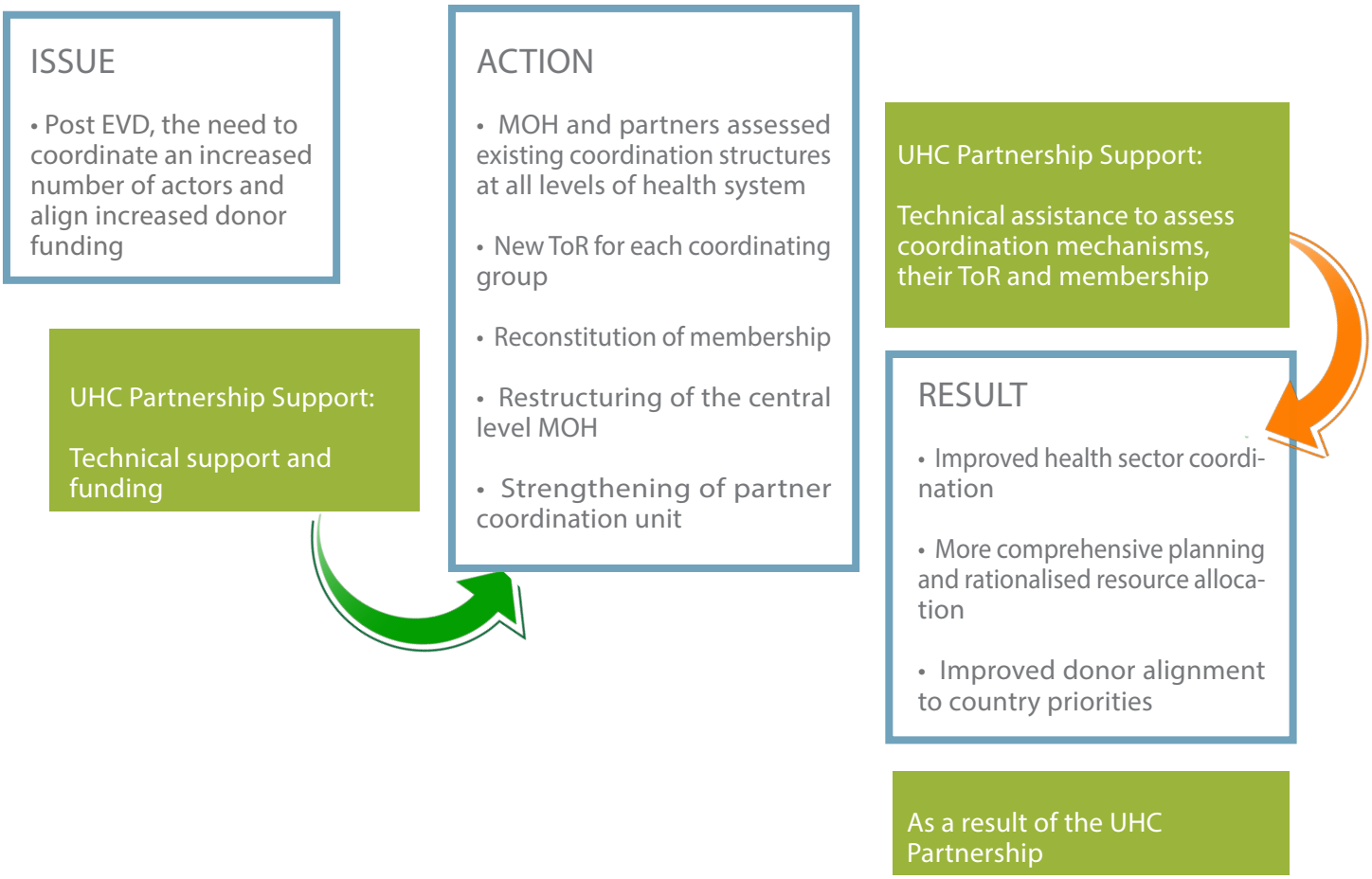
Indeed, a lot has been achieved within just four years of the UHC-P. As demonstrated by WHO during the opening session of the 4th Annual Technical Meeting, most of the 19 Phase 1 and 2 partner countries have been able to showcase significant progress against the programme's expected results over the past years – with more than half of the countries showing major achievements in the areas of "Inclusive and participatory policy and strategic plan development" as well as "Strengthening participatory review mechanisms".

Some of the countries where UHC-P activities have had a particularly direct and positive impact are demonstrated in the "results chains" figures below, which illustrate the programme's added value in Liberia and Togo. The Togo example, for instance, shows how the Partnership supported the MoH to mobilize additional resources to fund national health insurance – a major contributor to achieving UHC in the country.

Country Example 1: TOGO



Country Example 2: LIBERIA



Participants attributed the following main areas of added value to the programme:

• The UHC-P's flexibility and adaptability to changing country contexts (e.g., Ebola in West Africa partner countries), which also allows for addressing gaps (e.g., working with the Parliament to monitor the follow-up of health policy recommendations in Moldova)

• WHO's strengthened role as a convener, coordinator and facilitator of policy dialogue.

• The programme's demand-tailored technical assistance and policy dialogue support.

Country example

In Tunisia, results achieved through the UHC-P were used to promote an inclusive, multi-stakeholder dialogue in sectors others than health (see 2014 Annual Report).

In Timor-Leste, the MoH was the first of the line ministries to develop an M&E framework with the support from the UHC-P. The experience has been showcased by the government for replication in other sectors.

All these results are described in detail in the annual reports available on the UHC-P website (www.uhcpartnership.net).

Action points

• Country reporting is essential for the visibility of the UHC-P. Partnership actors should maintain the necessary commitment to ensure good quality reporting in Phase 3.

The UHC-P's future role could involve:

• Coordinating and facilitating health policy dialogue across all sectors to integrate UHC and health in all policies.

• Engaging partners from the sub-national levels in policy dialogue around UHC (e.g., by funding sub-national workshops).

2. Demonstrating results and best practice: visibility, research and evaluation

As WHO HQ and regional and country offices plan for Phase 3, translating programme resources into continued gains requires an evaluation of the factors that underpin results achieved to date and WHO's capacity to support Ministries of Health in developing and implementing robust NHPSP. Ensuring tried-and-tested HSS interventions and approaches are refined and adapted to suit diverse country contexts – an overarching theme of the meeting – is the focus of new operational research to solidify the evidence base and inform country strategies in Phase 3 of the programme.

In two distinct work streams with unique methodologies and rationales, an ambitious evaluation and research agenda will be executed in 2016.

	EXTERNAL EVALUATION Royal Tropical Institute (KIT) | Netherlands	OPERATIONAL RESEARCH McGill & Montreal Universities | Canada
FOCUS	External evaluation of UHC-P results and achievements and UHC-P contribution to strengthening WHO capacity to support Ministries of Health	"Realist research" of UCH-P as a complex social intervention to understand how it contributes to strengthening health policy dialogue and planning towards UHC
RATIONALE	To understand how the UHC-P: • Supported development and implementation of robust NHPSP to improve UHC, particularly among the poor and vulnerable • Increased technical and institutional capacity, e.g., to develop policy using up-to-date, accurate evidence • Aligned international partners and national stakeholders around NHPSP • Strengthened the relevance, efficiency and visibility of WHO support	To understand the challenges and successes of the UHC-P and enable theoretical and methodological advancements by: • Identifying the contexts in which WHO is/ is not able to (i) act as convener/broker to trigger synergy among stakeholders, (ii) play its role as technical expert, and (iii) foster MoH leadership and stewardship role • Identifying mechanisms triggered in these contexts, unfolding the chains of processes, and highlighting feedback loops
METHODS	• Quantitative, qualitative and financial study • Data collection through country visits by KIT team & local partners + telephone interviews • Quantitative, qualitative and financial analysis and webinar on key findings	• Qualitative study with focus on country team involvement and sustained presence in field • Data collection through semi-directed key informant interviews, group discussion and observations • Stakeholder and transversal analyses; realist content analysis of cases

WHO, MoH and donor stakeholders with direct links to the programme will benefit most from the outcomes of this evaluation and research, but results and lessons learnt must also be shared with the wider community of stakeholders interested in the programme's impact.

The UHC-P's communications partner, Community Systems Foundation, provided an overview of the mechanisms in place to convey UHC-P learning and results, and discussed country-level stakeholders' role in "telling the story" of the UHC-P to communicate often complex policy issues and achievements to diverse audiences. Discussion focused on the UHC-P website (http://www.uhcpartnership.net) as the principle showcase for sharing "success story" articles, country profiles and Country Roadmap progress, and participants shared a number of helpful suggestions for how to refine website content in Phase 3 of the programme. These included: (i) enhancing dialogue and experience sharing among target countries by refining and marketing the website's discussion forum function, (ii) developing new functionality for sharing scientific research and policy content, (iii) exploring the use of social media platforms and methods for reaching communities that lack reliable internet access, and (iv) cooperating to improve visibility and content sharing between the UHC-P and WHO websites. Individual interviews for future success story articles were also conducted with representatives from Ministries of Health, WHO Country Offices, the European Union and Luxembourg.

Action points

External Evaluation

• In-country interviews/document collection by core evaluation team in Sudan, Tunisia, South Sudan, Liberia, Sierra Leone, Mozambique Democratic Republic of Congo *(Apr-May 2016, schedule and countries TBC).*

• In-country interviews/document collection by local consultants in Guinea, Mali, Burkina Faso, Senegal, Vietnam and Lao PDR *(Apr-May 2016, schedule and countries TBC).*

• Video conference/telephone interviews by KIT in Moldova, Chad, Niger, Cape Verde, Yemen, Timor-Leste, and Togo *(Apr-May 2016, schedule and countries TBC).*

Operational research

• After the pilot in Togo, the first phase of research will be implemented in five or six countries.

Visibility and communications

• Development of Phase 3 website and visibility enhancement strategy *(Q2 2016)*, including a focus on the website's forum function (to actively facilitate dialogue and information sharing among partner countries) and a UHC-P newsletter.

• Website Country Roadmaps to be updated following review and approval of Phase 3 Roadmaps *(Q2 2016).*

• Development of success story articles following meeting interviews; design and implementation of new systems to support HQ-Country Office 'story telling' engagement *(Mar-Apr 2016).*

3. The new global development framework

One of the programme's strengths is that it seeks, from the beginning, to be embedded in existing country processes. On the other hand, it is important that countries, at least to some extent, adapt their activities to incorporate supranational commitments.

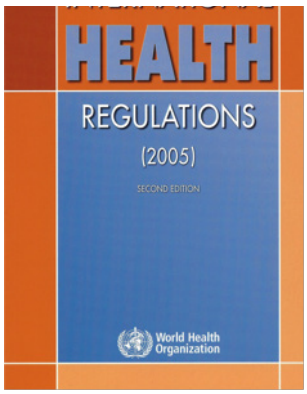
With the event clearly focused on the future, participants were challenged to think about the UHC-P's continued role in light of the new major global trends and developments, including:

- The new SDG framework
- The progressive transition of the IHP+ initiative towards becoming the "UHC 2030 Alliance"
- The increased importance of health security for the global health agenda (e.g., IHR)
- The tendency of the global health initiatives (GHIs) to increasingly focus on health systems strengthening through new, dedicated windows

Goal no. 3 of the 2030 agenda for sustainable development is to "ensure healthy lives and promote well-being for all at all ages" – and universal health coverage is an explicit target of the agenda:

Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all (SDG 3.8).

The presentation on SDGs allowed participants to recognize that overall, even if the SDGs are broad and complex, health is in a relatively good position, despite some issues that are missing and/or insufficiently explicit (e.g., immunization, ART, AMR, and pneumonia). Indeed, where the MDGs were criticized for stimulating programmatic fragmentation within the health sector, the SDGs were conceived as "integrated and indivisible", and frame health as both a major contributor to and beneficiary of sustainable development. The SDGs provide new opportunities to put health system governance at centre stage and to consider health in a more integral manner alongside economic, social and environmental goals. Moving from theory to practical action will be a challenge, however. Meeting discussion centred on the need for deeper debate and cooperation among stakeholders – both around health system architecture and strategy and also investment in country-led platforms for monitoring and evaluation and health information systems.



The recent Ebola and Zika outbreaks also reminded the international community about the importance of strengthening health systems in partner countries.

It is against this backdrop that the International Health Regulations (IHR) have, in recent years, gained in importance both at international and national level. Adopted in 2005, the IHR are the only global, legally binding instrument of international law against international spread of disease. They oblige its signatory states, among others, to establish and operate National IHR Focal Points which would notify, within 24 hours, public health events of international concern

(PHEIC) to WHO. The IHR also oblige member states to develop eight core capacities at points of entry, across all sectors, related to legislation and policy, coordination, surveillance, response, preparedness, risk communications, human resources and laboratory tests.
IHR implementation was raised at the UHC-P meeting in order to discuss the linkages between the IHR core capacities and the building blocks of the health system. In this context, a key concern raised by participants was the need to avoid reverting to a vertical approach by building on the many interlinkages between developing IHR core capacities and strengthening health systems. One example mentioned was the need to support, through the UHC-P, the integration of emergency response skills training into overall training modules for health workers at community level. Another suggestion was to ensure that IHR concerns become part of the sector policy dialogue – also within sectors other than health.

Action points

• WHO to support countries in increasing IHR focal point centres' status, resources and epidemiological surveillance capacities.

• WHO to facilitate the integration of IHR into national legal frameworks, country-level sector policy dialogue and HRH training modules.

• Countries to focus on MDG-SDG transition in Phase 3 Country Roadmaps, with specific attention to (i) UHC-P role in strengthening information and monitoring systems, (ii) alignment of health sector actors on common principles, e.g. via Paris Declaration and IHP+, and (iii) outreach to stakeholders beyond the health sector.

4. Overcoming fragmentation

Overcoming fragmentation in external and domestic health funding, policies and structures continues to be a major challenge – as reflected by the many comments received from the meeting participants about this topic.

Fortunately, promoting health aid effectiveness through the IHP+ is one of the three core pillars of the UHC-P. In essence, the IHP+ is an initiative aimed at bringing together development partners around one (national) health strategy, one budget and one M&E framework, by encouraging signatories to adopt "seven behaviours" in line with effective global development cooperation principles.

Unfortunately, as noted by many participants, many IHP+ signatory donor agencies have been inconsistent with regard to their adherence to these principles. A key problem perceived by some participants is the vertical approach taken by the GHIs, such as Gavi and the Global Fund (both signatories to the IHP+), which have often created parallel systems that hinder HSS – leading to duplication, higher transaction costs, and challenges to national capacities.

Key to the table next page:
Tier 1 & Tier 2 Focus countries for Gavi's Partnership Engagement Framework: T1 = 10 countries with most under-immunized children. T2 = the next 10 countries facing challenges in coverage (due to equity, conflict, etc); Initial Self-Financing: Linear vaccine co-financing amount of $0.20 per dose; Preparatory transition: Co-financed share of vaccines increases by 15% a year; Accelerated transition from Gavi support: Co-financing of vaccines increases gradually; Fully self-financing from Gavi support: Country finances 100% of vaccines; Wave 1 & 2: phasing of GFF operations.

Selected GHIs in EU-Luxembourg-WHO-UHC countries

Country	IHP+	GAVI		Global Fund	World Bank
	IHP+ Signatory	PEF Focus Country	Transition Status	Focus Country	GFF
Burkina Faso	✓		Initial self-financing	✓	
Burundi	✓		Initial self-financing		
Cape Verde	✓				
Chad	✓	T1	Initial self-financing	✓	
Democratic Republic of the Congo	✓	T1	Initial self-financing	✓	Wave 1
Guinea	✓		Initial self-financing	✓	
Guinea-Bissau	✓		Initial self-financing		
Lao Peoples Democratric Republic			Preparatory Transition		
Liberia	✓		Initial self-financing		Wave 2
Mali	✓		Initial self-financing	✓	
Moldova			Accelerated Transition		
Morocco					
Mozambique	✓		Initial self-financing	✓	Wave 2
Niger	✓	T2	Initial self-financing	✓	
Senegal	✓	T2	Preparatory Transition		Wave 2
Sierra Leone	✓		Initial self-financing		
South Africa				✓	
South Sudan			Initial self-financing	✓	
Sudan	✓	T2	Preparatory Transition		
Tajikistan			Preparatory Transition		
Timor-Leste			Accelerated Transition		
Togo	✓		Initial self-financing		
Tunisia					
Ukraine			Fully Self-Financing		
Viet Nam	✓		Accelerated Transition		
Yemen		T2	Preparatory Transition		
Zambia	✓		Preparatory Transition		

A few new developments around IHP+ and the GHIs were also discussed, which may provide opportunities for overcoming these challenges by drawing on the role of the UHC-P. IHP+ is in the process of broadening its mandate towards becoming a "UHC 2030 alliance", possibly proving political momentum to convey a shared global vision of UHC and catalyse better coordination and alignment of HSS. Moreover, some of the GHIs – such as the Global Fund and Gavi – have created new HSS windows, which have led to a better coordination of efforts in some UHC-P partner countries.

Country examples

• In Sudan, Gavi and Global Fund programming is being brought together under one coordination body.

• In Morocco, a concept note has been prepared for the Global Fund on disease bottlenecks that are anchored in HSS. This identifies solutions beyond HIV and TB (the country has a low prevalence of the two diseases).

• In Sierra Leone, an 'HSS Hub' has been instituted within the health ministry, which brings all the HSS components together to reduce fragmentation.

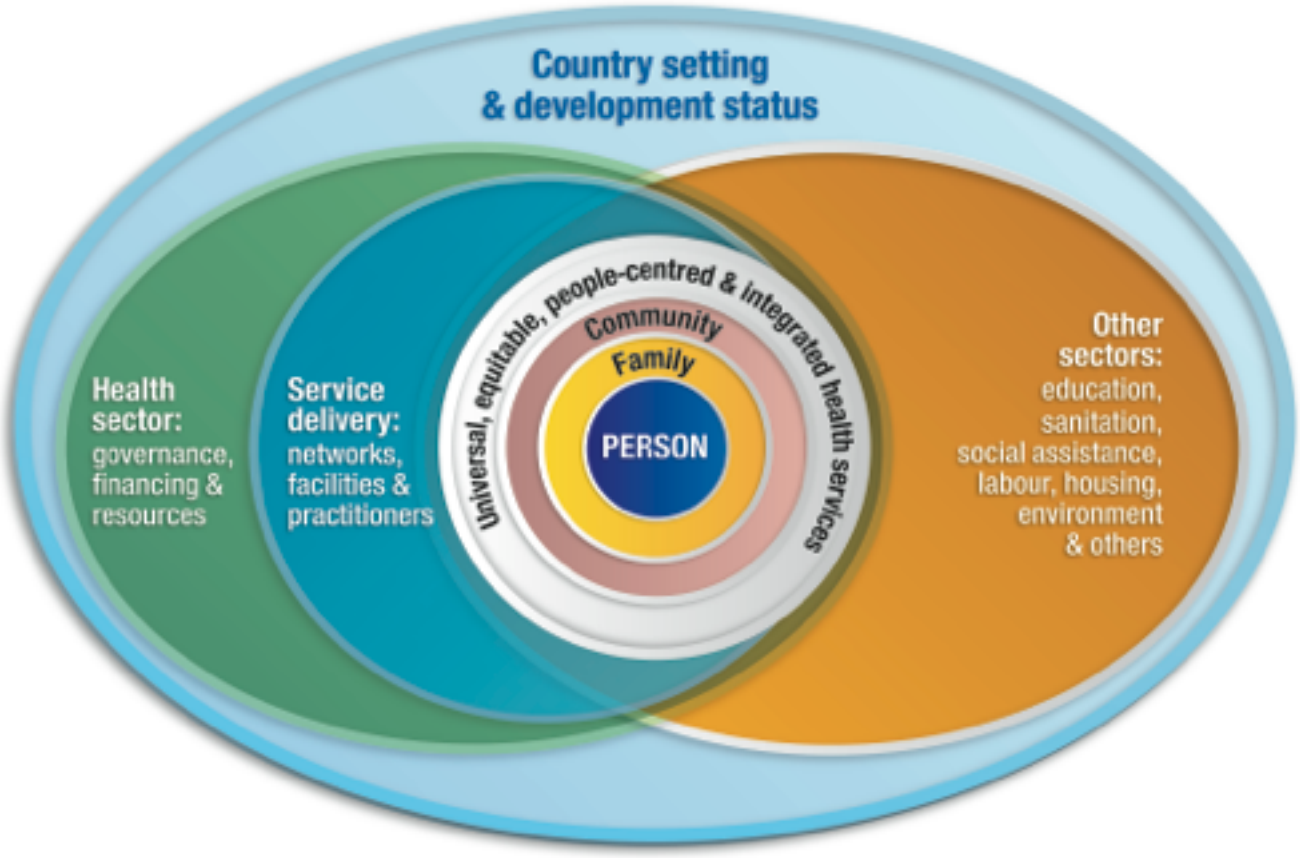
• In Chad, when preparing the Global Fund and Gavi proposals, an assessment of health system constraints was drawn up on the basis of the NHPSP and disease national plans. In the three proposals, the different HS constraints were spread across different partners to work in a holistic way.

Participants recognized that, within the framework of the UHC-P, HSS often focuses heavily on health financing and insurance without paying enough attention to service delivery reforms, patient needs, and the quality of services themselves. This issue was also discussed during the meeting. It was noted that under the WHO Framework on People-centred and Integrated Health Services, UHC-P HSS activities must concentrate on:

• Consciously adopting individuals', carers', families' and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people rather than individual diseases, and respect social preferences;

• Ensuring patients have the education and support they need to make decisions and participate in their own care; and

• Ensuring people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative services according to their needs throughout the life course.



The above figure represents the relationship of the person with her/his environment and the various levels of the health system – including the multisectoral factors that influence health and health services.

Weaknesses at the local and district level – whether in health management structures and processes, facility capacity, community structures, or the availability of locally managed resources – can limit access to routine care and services, and can also have devastating effects when communities are faced with public health emergencies like the Ebola outbreak in West Africa. Meeting discussion centered on the additional steps the UHC-P can take to ensure programme assistance is focused on supporting and strengthening capacity at the district level, including advocating for the utilization of new funding mechanisms for HSS (e.g. from Gavi and the Global Fund) where they are available and have yet to be operationalized.

Action points

• Advocate for IHP+ seven behaviours compliance as well as harmonisation at the level of donor countries' headquarters.

• Ensure that the GHIs' new HSS windows are aligned with countries' NHPSPs in the framework of UHC, including alignment with efforts to strengthen capacity at the district and local levels.

• There is a will to integrate services, but the means are dependent on central and local levels as well as GHIs – the UHC Partnership could offer a way to bring them together.

• In GHI transition countries, a transition plan needs to be established and accompanied by relevant capacity-building for implementation (including health diplomacy).

5. Improving health system governance: innovative tools for assessing and strengthening institutions at the local and national levels

For WHO, health system leadership and governance "involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, attention to system design and accountability".

Common challenges

Even where suitable legal frameworks are in place, weak coordination, institutional capacity and accountability remain a challenge in UHC-P target countries. Many meeting participants described difficulties in information sharing and accountability between local, regional and national authorities that limit efforts to monitor and respond to public health threats of national concern. Likewise, countries whose health systems rely increasingly on the private sector have difficulty negotiating the incentives and solutions needed to improve health outcomes and access to services.

Persistent health governance challenges have slowed progress toward UHC. Rather than a narrow focus on specific UHC law or individual laws, modern approaches to health systems governance must therefore consider the complex, systems-level "jigsaw puzzle" of enabling and inhibiting factors that determine supportive legal environments for UHC.

Domain	Focus	Enabling factors for UHC
Quality	Implementation of QI methods and strategies; assurance of safe services and safe inputs	Regulation of health workforce, medicines and infrastructure; protection of patient rights
Institutional Arrangements	Health system architecture designed to match population needs; incentives for appropriate provision and use; managerial efficiency and effectiveness	Assignment of powers, rights and responsibilities; private sector regulation
Equity	Non-discrimination; access based on need	Legal protection; financial protection; coherence with international laws and norms
Financing	Revenue collection; pooling; purchasing	Public financial management and procurement regulation; transparency and reporting
Health Security	Public health preparedness	Implementation of International Health Regulations

In order to identify opportunities to build health governance improvements into UHC-P Phase 3 Country Roadmaps, the 4th Annual Technical Meeting took stock of existing target country strategies, as well as the WHO tools and support available to guide countries in designing tailored interventions in governance, law and regulation that meet their unique needs.

Governance is a critical function of the health system and yet one that has received less attention in health systems strengthening approaches in the past. In many instances, governance has been approached through a broader lens of formulation of policies and plans with less attention paid to implementation and system design. The WHO Action Plan on "Health Systems Governance for Universal Coverage" identifies the need for normative work on governance as well as development of best practices based on country assessments and experiences. To fill critical gaps in the work on health system governance, it is necessary to assess how this function is exercised, for example through a *WHO Toolkit for Assessing Health Systems Governance*. Such an assessment instrument will explore six dimensions of governance: system design, accountability, transparency, intelligence and information, participation and responsiveness. During the meeting, participants were asked to think about major bottlenecks in governance and institutional arrangements in their country context, including at local level, and how they could formulate or amend their roadmap to include work on governance and institutional reforms.

The *Health System Legal Assessment (HSLA) i*s another WHO tool that supports the systematic assessment of the use of law in health systems to understand how laws either enable or block UHC. The HSLA works to:

- Understand how laws are made and implemented;
- Check on strengths and weaknesses of a country's legal system;
- Determine the extent to which a country's laws are consistent with its health policy objectives;
- Make recommendations about law reform as part of work on HSS efforts; and
- Ensure that work on health law reform is well integrated into a country's broader UHC reform process.

Action points

- WHO HQ to finalize and pilot the Toolkit for Assessing Health Systems Governance and the tool for Health System Legal Assessment

- To continue TA and support for HSLA; finalize new publication on health law and regulation and the national health planning process; develop policy briefs and 'how to' guides on UHC law topics and develop clearing house for information about UHC law reform

- Partnership countries to consider conducting HSLA with WHO HQ support and to formulate or amend Country Roadmaps to include institutional reform activities

6. Health financing for UHC: strengthening revenue raising, pooling and strategic purchasing

Equitable access to quality health services and financial protection – the principle tenets of universal health care – are inextricably linked to how countries mobilize revenues and allocate resources for health.

In setting the stage, two cross-cutting notes of caution emerged from HF panel discussions: (i) universal health insurance is not the same as universal health coverage, and (ii) service delivery and health financing are two sides of the same coin. No country can "spend its way to UHC", and mobilizing additional revenue alone will not allow for progress towards UHC if purchasing arrangements do not lead to efficiency and quality of care within the service delivery system.

Country example

Vietnam has achieved dramatic growth in coverage following the introduction of SHI in 1994 – reaching 60% of the population by 2010 and 75% by 2015. However, continuing this momentum is increasingly a challenge, particularly in terms of enrolling informal sector workers with no transactional relationship to the government and poor/near-poor populations with historically low rates of health system utilization.

One key theme that emerged from the meeting is that, while there is no "one-size-fits-all" approach to HF reform, several established principles should be considered as stakeholders adapt strategies to the unique political and economic contexts of their countries.

Another theme of the health financing session focused on "new revenue-raising mechanisms" and a summary presentation on four country studies (Togo, Benin, Mali and Mozambique) was provided. These analyses sought to project the potential revenue mobilisation through various new revenue-raising mechanisms (for instance, taxes/levies on air tickets, fixed and mobile telephony, alcohol, tourism, and extractive industries) as well as their (political) feasibility, sustainability, stability, progressivity (i.e., equity in financing), administrative efficiency, and possible positive and negative side effects. The studies revealed that this type of work can provide an opportunity to exchange with the MoF and other stakeholders, more so as the study process can intensify a dialogue and interest with stakeholders outside health to think about health financing. For the MoH, it implies thinking beyond revenue generation and HF and beyond the health sector. When doing this type of work, it is most important not to lose sight of the broader picture and be clear on broader health financing strategy for UHC.

Several key lessons learnt emerged from the working group discussions on new revenue-raising mechanisms, namely:

• Removal of inefficient subsidies on fuel and electricity can be considered as new revenues from which the health sector can benefit.

• Countries have designed very context-specific solutions – e.g., the Sudan Zakat Fund

• New financing mechanisms can be used as an entry point for reforming health financing structures and for bringing the dialogue beyond the level of the health ministry. Through its innovative financing assessment, the UHC-P can play a key role in providing the evidence base for this dialogue.

• Country feedback suggested that in countries where there is an overall and clear political commitment from government to increase the share of the budget going to health, a discussion or push for earmarking for health may not be helpful.

Action points

• Additional effort needed in Phase 3 to improve communication and national policy dialogue on HF with broad range of stakeholders (e.g., Ministries of Finance and Social Protection, civil society, private sector).

• Strategies needed to facilitate access to services for poor/vulnerable populations.

• Include TA and policy dialogue to emphasise the need for public funding, pooling for increased redistributive capacity, and strategic purchasing

7. Continuing to support key health system pillars through the UHC-P: medicines, information systems and health workforce

Workforce 2030

The ILO estimates that 41.1 skilled health workers per 10,000 population are necessary to provide health services to all in need[4], but Africa and Asia face a deficit of 2.8 million and 7.1 million skilled health workers, respectively, relative to estimated need. WHO's draft Global Strategy on Human Resources for Health calls on member states to:

1. Optimize the existing health workforce in pursuit of SDGs and UHC;
2. Anticipate future workforce requirements by 2030 and plan for necessary changes;
3. Strengthen individual and institutional capacity to manage HRH policy, planning and implementation; and
4. Strengthen the data, evidence, and knowledge for cost-effective policy decisions.

Workforce 2030 meeting discussions focused on examining the draft milestones associated with these four strategic objectives, particularly with regard to improving MoH and civil servant capacity to implement key actions with support from the UHC-P.

Access to medicines

Access to essential, quality-assured, affordable medical products is not only one of six WHO leadership priorities – it is also an essential pre-condition for achieving UHC. As illustrated by Dr Gilles Forte, WHO's EMP/PAU Coordinator, during the meeting, between 20% and 60% of health expenditures in LMIC go to medicines and up to 80% to 90% of medicines are purchased out-of-pocket, thus leading to sometimes catastrophic health expenditures at the household level.

In order to improve the availability, affordability and use of safe, effective and quality-assured medicines in 15 African countries, the EU/ACP/WHO Renewed Partnership (RP) for pharmaceutical policies was launched in 2012, with a €10.85 million in support from the EU. Eight UHC-P countries (Mali, Senegal, Mozambique, Guinea, DRC, Burundi, Zambia, and Togo) have participated in the initiative to date and, according to Forte, the idea for the programme's next Phase (from September 2016) is possibly to integrate the programme into the UHC-P. One of the programme's key lessons learnt, according to Forte, is that inter-country collaboration can play a major role in increasing access, as EAC harmonization for regulations for medicines has facilitated and accelerated access to new medicines.

Country examples

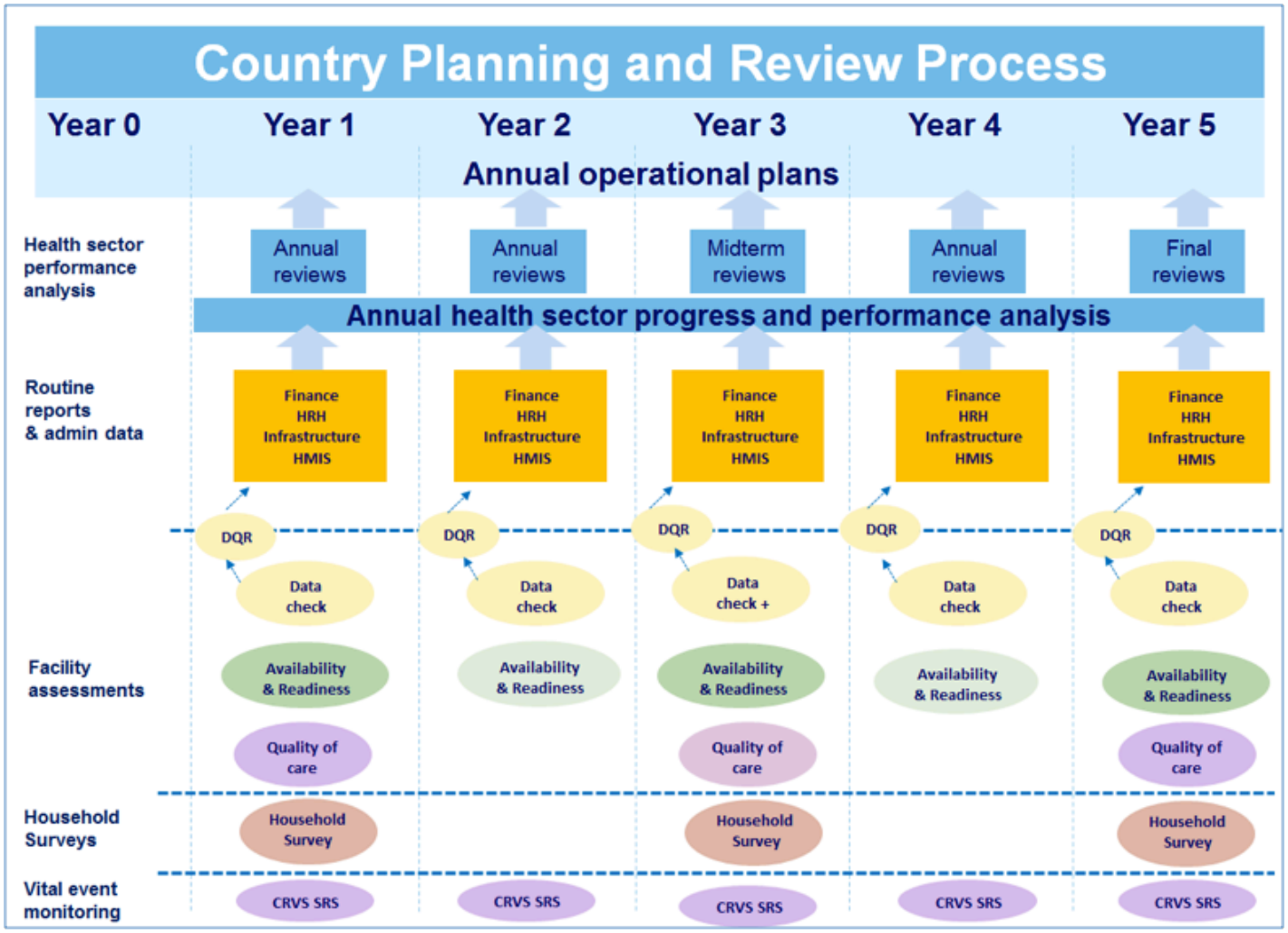
- Improved national supply systems (national procurement plans, mapping of supply systems, training on drug management) in 12 countries, including Burundi, Guinea, DR Congo and Togo.
- Improved quality of medicines and reduced occurrence of substandard medicines in all eight UHC-P countries participating in the programme.

[4] http://www.ilo.org/global/about-the-ilo/multimedia/maps-and-charts/WCMS_244649/lang--en/index.htm

Health Information Systems

In order to ensure adequate SDG monitoring in future, meeting participants discussed the key attributes and possible priority actions for each of the currently preferred sources of health data and information at country level, namely: civil registration and vital statistical (CRVS) systems; household surveys and censuses; facility and community information systems; and administrative data sources.

An indicative timeline for when best to use each of these data collection methods was also provided:



Country example

In Timor-Leste, all partners came together to support the MoH's HIS reform – with WHO's technical support and training under the UHC-P.

Action points

• Assess possibility of integrating pharmaceutical component (EU/ACP/WHO programme) into UHC-P country roadmaps, where applicable (from Sep 2016).

• Set up a joint plan of action to support and strengthen HIS in monitoring the SDGs.

• Consider opportunities to support HRH global plan and key actions following World Health Assembly approval, particularly support for intersectional dialogue (e.g., with Ministries of Education and Finance).

Action points and next steps

I. Action Points

HQ/ROs

• Advocate for IHP+ seven behaviours compliance as well as harmonization at the level of donor/GHI agencies' headquarters.

• Support countries in integrating IHR into country-level policy dialogue on national security, development and HSS policies and programmes, as well as national legal frameworks and HRH training modules.

• Support countries in increasing IHR focal point centres' status, resources and epidemiological surveillance capacities.

• Provide country offices with clear guidance on how to implement health SDGs.

• Continue TA and support to countries for HSLA and other normative guidance and tools.

• Coordinate multi-country operational research to better demonstrate results.

• Support external evaluation and ensure coherent dissemination of evaluation results at country and regional level.

• Ensure smooth financial and administrative management of the UHC-P, with a particular focus on new partner countries and deployment of policy advisors.

WCOs

• Coordinate and facilitate health policy dialogue across all sectors to integrate UHC and health in all policies. Improve communication and national policy dialogue on HF and HRH global plan, with broad range of stakeholders (e.g., Ministries of Education, Finance, and Social Protection; civil society; private sector).

• Bring together GHIs and central- and local-level actors in order to promote an integrated, people-centered approach to service delivery. Engage partners from the sub-national levels in the policy dialogue around UHC (e.g., by funding sub-national workshops).

• Ensure that the GHIs' new HSS windows are aligned with countries' NHPSPs in the framework of UHC, including alignment with efforts to strengthen capacity at the district and local levels.

• In GHI transition countries, establish a transition plan, accompanied by relevant capacity-building for implementation (including health diplomacy).

• Elaborate targeted strategies to facilitate outreach to poor/vulnerable populations who are eligible for no-cost/subsidized services.

II. NEXT STEPS

HQ/ROs

• Provide country offices with clear guidance on how to implement health SDGs and IHR.

• Finalize new publication on health law and regulation and the national health planning process.

• Develop policy briefs and 'how to' guides on UHC law topics and develop clearinghouse for information about UHC law reform.

• Provide countries with support for visibility actions and guide countries on how to better use the UHC-P online forum (continuous).

• Provide normative guidance on strategic planning (NHPSP Handbook).

WCOs

Complete Phase 3 Country Roadmaps and their funding allocations (Q2 2016). Each country to review and adapt its Roadmap, taking stock of the discussions during the meeting. The revised template will be circulated by mid March; Roadmaps will be collected by the end of March.

• Countries to focus on MDG-SDG transition in Phase 3 Country Roadmaps, with specific attention to (i) Joint action plan for strengthening information and monitoring systems, (ii) alignment of health sector actors on common principles, e.g. via Paris Declaration and IHP+, and (iii) outreach to stakeholders beyond the health sector.

• Integrate IHR concerns into the policy dialogue and TA in Phase 3 Country Roadmaps.

• Partnership countries to consider conducting HSLA with WHO HQ support and to formulate or amend Country Roadmaps to include institutional reform activities.

• Include TA and policy dialogue on exploring new revenue raising options in Phase 3 Country Roadmaps.

• Assess possibility of integrating pharmaceutical component (EU/ACP/WHO programme) into Country Roadmaps, where applicable (from Sep 2016).

Improve visibility and communication (continuous):

• On a more regular basis, flag events and stories which may be worth sharing on the UHC website to WHO HQ and CSF; exchange lessons learnt and best practices by engaging in the online UHC-P forum (through the UHC-P admin site).

• Country reporting is essential for the visibility of the UHC-P. Partnership actors should maintain the necessary commitment to ensure good quality reporting in Phase 3.

External Evaluation (Q2 2016):

• In-country interviews/document collection by core evaluation team in Sudan, Tunisia, South Sudan, Liberia, Sierra Leone, Mozambique Democratic Republic of Congo (Apr-May 2016, schedule and countries TBC).

• In-country interviews/document collection by local consultants in Guinea, Mali, Burkina Faso, Senegal, Vietnam and Lao PDR (Apr-May 2016, schedule and countries TBC).

• Video conference/telephone interviews by KIT in Moldova, Chad, Niger, Cape Verde, Yemen, Timor-Leste, and Togo (Apr-May 2016, schedule and countries TBC).

Operational research:

• Select target countries for realist research according to criteria list.

• Submit realist research methodology protocol to Ethics Review Board.

• Conduct research in four or five target countries during Phase I of the research (AFRO countries).

• Expand research in other countries and regions in Phase II of the research.

CSF communications team:

• Development of Phase 3 website and visibility enhancement strategy (Q2 2016), including a focus on the website's forum function (to actively facilitate dialogue and information sharing among partner countries) and a UHC-P newsletter.

• Website Country Roadmaps to be updated following review and approval of Phase 3 Roadmaps (Q2 2016).

• Develop success story articles following meeting interviews; design and implement new systems to support HQ-Country Office "story telling" engagement (Mar-Apr 2016).

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Annex A - Agenda

Annex A

4th Annual Technical Meeting
EU-Luxembourg-WHO Universal Health Coverage Partnership
1-3 March 2016

Hotel Alimara, Barcelona, Spain

PROVISIONAL AGENDA

DAY 1 - 1 March 2016

Day 1 morning – Chair: Ms Natacha Gomes, Luxembourg

07:15 – 08:15	Foyer	**Registration**
08:15 – 08:30	Plenary: Catalunya	**Administrative briefing** *Alberto Ramajo*
08:30 – 09:15	Plenary	**Welcome, opening remarks, agenda** *Matthias Reinicke, EU; Natacha Gomes, Luxembourg; Dela Dovlo, Gérard Schmets, Joe Kutzin, Dheepa Rajan, WHO*
09:15 – 10:45	Plenary	**The EU-Luxembourg-WHO partnership on Universal Health Coverage – background, global results, and lessons learnt** *Denis Porignon, Martin Ekeke, Juliet Nabyonga* ▪ After 4 years of Partnership experience, to set the scene in terms of what is successful, what is more difficult to achieve, and what is the overall context for implementation of activities in the coming 3 years ▪ To understand variations and similarities in Partnership activities across the 20 countries, and how to show results.
10:45 – 11:15		**Coffee**
11:15 – 12:30	Plenary	**Management, visibility, and evaluation** *Dheepa Rajan, Nejib Ababor, Frances Palen, Francis Gamba, WHO;* *Gary Goldman, CSF; Jurrien Toonen, KIT* ▪ Management: Inform participants of the results of the WHO management session on 29 February. ▪ Visibility: Discuss how countries use the UHC Partnership website, upcoming new features, and how to shape future communications and visibility work to meet countries' needs. ▪ Evaluation: Inform countries about the forthcoming independent external evaluation to be undertaken by The Royal Tropical Institute, The Netherlands (KIT), its rationale, methodology and timeline, and countries' role in the process.
12:30 – 14:00		**Lunch**

Day 1 afternoon - Chair: Naeema Al Gasseer, WR Sudan, EMRO

14:00 – 16:00	Plenary	**The International Health Regulations (IHR) and the Sustainable Development Goals (SDGs)** Introductory presentations followed by Q&A
	Breakout Rooms	**Parallel Working Groups** Introduction of Working Groups ❖ **Thematic WG 1 –The International Health Regulations (IHR) and the UHC Partnership** *Carmen Dolea* ▪ Provide an overview of the IHR and the renewed priority for all countries to be IHR-compliant in the wake of the Ebola outbreak ▪ Consider what countries need to do to achieve this, and how IHR can be incorporated into the national strategy and plan. How can the UHC Partnership support this process? **Parallel WGs - Discussion:**

		❖ **Thematic WG 2 - The Sustainable Development Goals (SDGs) and the UHC Partnership** *Kathy O'Neill, Denis Porignon* ▪ Provide an overview of the health-related SDGs, including goals and targets, and the proposed indicator monitoring framework ▪ Consider the implications of the SDG goals (both opportunities and challenges) for the health agenda at country level, and specifically the role of the UHC Partnership. **Parallel WGs - Discussion: From MDGs to SDGs - business as usual?**
16:20 – 16:40		**Coffee**
16:40 – 18:00	Plenary	**Working Group feedback and discussion** (45 minutes each for WG 1 & 2)

DAY 2: 2 March 2016

Day 2 morning – Chair: Anders Nordström, WR Sierra Leone, AFRO

08:15 – 08:30	Plenary	**Introduction to Day 2** *Denis Porignon*
08:30 – 10:30	Plenary Breakout Rooms	**Global Health Initiatives (GHIs) and IHP+, Integrated services and local health systems** Introductory presentations followed by Q&A **Parallel Working Groups** Introduction of Working Groups ❖ **Thematic WG 3 – Global Health Initiatives (GHIs) and IHP+** *Finn Schleimann, IHP+; Casey Downey, WHO HQ; Abdi Momin, WHO EMRO* ▪ inform/update countries on new policies and strategies of GHIs and IHP+ ▪ identify how these changes will affect countries, many of whom are members of IHP+ and UHC Partnership, as well as in receipt of major GHI funding **Parallel WGs - Discussion** ❖ **Thematic WG 4 – Integrated services and local health systems** *Martin Ekeke, Juliet Nabyonga, Tarcisse Elongo, Hernan Montenegro* ▪ Inform countries on the WHO global strategy on integrated people-centred care and services, its strategic directions and main activities ▪ Key aspects to focus on in order to achieve strengthening of local health systems **Parallel WGs - Discussion**
10:30 – 11:00		**Coffee**
11:00 – 12:30	Plenary	**Working Group feedback and discussion** (45 minutes each for WG 3 & 4)
12:30 – 14:00		**Lunch**

Day 2 afternoon – Chair: Martina Pellny, GIZ

14:00 – 15:10	Plenary	**Health Financing for UHC - Expanding coverage to people in the informal sector** *Joe Kutzin and Inke Mathauer, WHO HQ; Awad Mataria, EMRO* ▪ Update on key messages in health financing policy as a basis for country health financing strategy development dialogue ▪ Review and discuss options to expand coverage to the informal sector ▪ Discuss and share experience on how the UHC Partnership can facilitate the health financing policy dialogue to move towards UHC.
15:10 – 15:40		**Coffee**
15:40 – 17:10	Breakout Rooms	**Parallel Working Groups: Health Financing for UHC - Expanding coverage to people in the informal sector** Introduction to Working Groups: 1. HF strategy development processes: key issues and challenges 2. "New" revenue raising methods: what and how (presentation of 4 country study) 3. Pooling, purchasing and benefit package design and how this relates to expanding

		coverage to the people in the informal sector 4. Hurdles to accessing health care for people in the informal sector and how to overcome these.
17:10 - 18:00	Plenary	**Moderated panel discussion with a representative from each group**

DAY 3: 3 March 2016

Day 3 morning – Chair: Matthias Reinicke, EU

08:00 – 08:15	Plenary	**Introduction to Day 3** *Denis Porignon*
08:15 – 09:15	Plenary	**The role of institutions for advancing the UHC agenda** *Maryam Bigdeli and David Clarke* ▪ Introduction to the concept of institutions (governance, laws and regulation) ▪ The importance of institutions and institutional arrangements for: - improving and sustaining health system performance - effective health system stewardship at the national level - effective health system governance and service provision at the local level ▪ How to assess enabling and inhibiting factors for establishing institutions ▪ The use of country diagnostics ▪ Opportunities for incorporating work on strengthening institutions, including law and regulations, into a country's UHC Roadmap.
09:15-10:30	Breakout Rooms	**Working Groups: The role of institutions for advancing the UHC agenda** **There will be six breakout groups. Each group has the same tasks, to:** ➢ Provide feedback on how work on governance and regulation can be incorporated into UHC Roadmaps
10:30-11:00		**Coffee**
11:00-12:00	Plenary	**Working Groups feedback and discussion**
12:00-12:15		**Group photo**
12:15 – 13:15	Plenary	**Demonstrating results** *Emilie Robert, McGill University; Valéry Ridde, University of Montreal; Dheepa Rajan, WHO* ▪ Presentation of the operational research programme that WHO is undertaking in collaboration with Montreal and McGill Universities ▪ Explain the use of realist research to better assess the UHC Partnership's added value in countries: understand and be able to document the complex results the Partnership is achieving, and the impact of health policy and planning activities. ▪ Present pilot work undertaken in Togo on realist research within the framework of the UHC Partnership.
13:15 – 14:15		**Lunch**

Day 3 afternoon – Chair: Dela Dovlo, WHO AFRO

14:15 – 15:15	Breakout Rooms	**Parallel sessions:** 1. **The Global Strategy on Human Resources for Health: Workforce 2020** *Laurence Codjia* - How to translate the GSHRH into actions in countries, and the intersectoral action that will be needed for an effective health workforce labour market: - Proposed Discussion: o key HWF challenges priorities in your country o short/medium term actions needed in next 3 years, to include in roadmap o technical support that may be needed from WHO

		2. **How to improve access to quality-assured essential medicines and health products to reach SDG 3.8 and achieve UHC** *Gilles Forte* - Overview of current challenges and initiatives to strengthen pharmaceutical systems and improve access to quality medicines in 15 ACP countries through the EU/ACP/WHO Renewed Partnership - Update on key principles for improving access to essential medicines and health products, and how WHO could collaborate with countries. - Discussion 3. **SDG monitoring: towards a common agenda to strengthen Health Information Systems** *Kathy O'Neill, Eduardo Celades* - Overview of efforts to improve Health Measurement and Accountability in the post-2015 agenda, at global, regional and country level - Update on tools and resources available to monitor health sector progress and performance - Proposed discussion: o SDG monitoring needs and next steps o Standards and tools - how to create consensus at country level? o Implementing change - what is needed? o Bridging the gap between global and national level - role of regional networks , and how to link GHIs with in-country efforts.
15:15 – 15:30		**Coffee**
15:30 – 16:30	Plenary	**Finalization of 2016 Country Roadmaps** *Denis Porignon*
16:30 – 17:00	Plenary	**Way forward and closure of meeting** *Matthias Reinicke, EU; Natacha Gomes, Luxembourg; Dela Dovlo, AFRO; Denis Porignon, Gérard Schmets, Joe Kutzin, WHO*

Annex B -
List of participants

4th Annual Inter-Country Technical Meeting of the
EU/LUX-WHO Universal Health Coverage Partnership
Barcelona, Spain
1-3 March 2016
List of Participants

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