Year 5 Report (2016 activities)

Please see a reminder of Strategic Objectives (SO) and Expected Results (ER) at the end of the document

Country: TUNISIA

EU-Luxembourg-WHO UHC Partnership

Date: 24/01/2017 **Prepared by:** Benoit Mathivet, Health Policy Adviser, WHO CO in Tunisia

Reporting Period: year 2016

Main activities as planned in the Road Map.

Put here all activities as set in the roadmap and link them to SO I, SO II or SO III and to an expected result

*Please estimate **approximate percentage of achievement** for each roadmap activity.*
Please note which activities were undertaken with the technical support of WCO (potentially in collaboration with existing initiatives of UN agencies, NGOs etc.)

What are some concrete and visible outputs of Partnership activities?(ex: annual review report, key policy changes that may be under way as a result of the processes described; has there been or will there be any likely improvement in service delivery outputs?)
Please relate all undertaken activities to SO I, SO II or SO III, to an expected result (ER1-ER6) and report progress on the indicators as per the roadmap. This can be presented in a table format or in bullet points.

SO I

PHASE 1 of the societal dialogue for health (for the majority, achieved from 2012 to 2014 yet some updates needed to be brought in 2016):
- Activity 1 (ER1): Improve the policy dialogue capacity of the MoH (this is a continuous work, with past and current efforts done on the societal dialogue, it is possible to say that 100% the objective was reached)
- Activity 2 (ER1): Define methods and mechanisms of civil society participation (100%, initial modalities of the societal dialogue were amended in 2016)
- Activity 3 (ER1): Establish a comprehensive situation analysis of the health system (100% done from 2012 to 2014, and adequately updated since then through complementary studies)
- Activity 4 (ER1): Etats Généraux de la Santé (100% done in 2014)

PHASE 2 of the societal dialogue for health (postponed and now mostly planed pour 2017-18) :
- Activity 5 (ER1) : Develop a new national health strategy (initiated and on track 20% implemented)
- Activity 6 (ER1) : Establish strategic and regional plans (at national and regional level) (initiated and on track 20% implemented)

PHASE 3 of the societal dialogue for health (Planned for 2018)
- Activity 7 (ER2) : Monitoring and evaluation, then review of progresses, following a participatory approach (at national, regional and local levels alike)

SO II

Activity 8 (ER3): Develop national capacity to generate and/or synthetize evidence on health financing and better inform policy decision in this domain. (100% all objectives for the year in this field were attained)
Activity 9 (ER3): Analytical work for the institutional strengthening of the health financing system. (20% in development, work in 2016 mostly consisted in discussing previous work with new people in charge)
Activity 10 (ER3): Analytical work to explore feasible options/reforms. (80% NHA 2014 where produced and are more complete than ever).

Activity 11 (ER3): Participatory approach to determine a health financing reform within the broader framework of health systems reforms in Tunisia (10%, awaiting phase II of the societal dialogue in 2017).

SO III

Activity 1 (ER6): there were no specific activities planned in this field. Yet, the inclusive nature of all the work supported in SO I and SO II involved all development partners active in the sector. In addition, involvement of Tunisia in international partnerships such as IHP+ or P4H have started to be envisaged in 2016.

Main activities achieved and progress made:

SO1
As far as SO1, activities 1 & 2 are concerned, the main achievement of year 2016 was to **put the societal dialogue for health back on track** by reshaping the goals and modalities of work on phase II of the dialogue societal, in view of the moving political context (change of Minister of Health in September 2016) and of potentially new priorities for the development of the health sector.
This was done through the efforts of a small group of individuals already involved in the management and facilitation of phase I policy of the policy dialogue, whose work was facilitated thanks to the technical support of the UHC-P, through the WHO country office.

Main activities in 2016 consisted in:
- **Advocating together, in front of two consecutive Ministers of health, for the continuation of the dialogue societal as a key modality for the development operationalization and future**

successful implementation of the national health policy. These local efforts where reinforced by the technical and financial support provided by the UHC-P for the participation of high level Tunisian delegations at the 4th Global Symposium on Health Systems Research (Vancouver, November 2016) and at the WHO Meeting on health promotion (Shanghai November 2016). During both events, respectively, the Director General of Health and the Minister of Health were requested to present the exemplary Tunisian efforts in terms of citizens' involvement.

- **Drafting of a new roadmap for phase II of the policy dialogue**. A first draft of the roadmap was developed and in April 2016 and presented during a meeting of the "jury citoyens" of the societal dialogue in order to amend the document and obtain a consensus. 5 themes were retained as priorities: **the development of a national health strategy, development of proximity health services, governance and decentralization, health financing policy, and health in all policies**. This roadmap was consecutively presented for approval to the former and current Minister of Health. The agreement of the later should be concretized in february 2017 by the signature of an official MoH decision on "the Implementation of phase II of the dialogue societal en santé", describing objectives, roles and responsibilities of an updated set of actors.

As far as **SO1, activities 5 and 6 (ER1)** are concerned: **A five years plan for the health sector was developed by the MoH throughout 2016** as part of the broader, national development plan. This plan was based on a number of priorities highlighted in the "White book for a better health in Tunisia", yet the match was incomplete, and it was also very much geared toward investments, certainly due to the preparation of the Tunisia 2020 Conference of November 2016. Above all, although a national "tradition", the 5 year timeline is rather incompatible with setting up a full-blown strategic vision for the development a countries' health system. UHC-P support hence took several forms over to period to help promote a longer term, strategic vision:

- **An analysis of the degree of matching between the 5 years plan and the priorities of the White Book** was conducted in summer 2016 to serve as a basis for the phase II of the societal dialogue.
- The UHC-P supported 2 workshops in October 2016 for **the launch of the adaptation of the national 5 year plan in regional plans**, gathering regional directors of health, heads of public hospitals, the Minister of health and directors at national level. These will be followed in 2017 by regional workshops to help develop further and finalize these regional documents. This activity will be above all an opportunity to feed-back in the broader, longer term health sector strategy to be developed over the same period.
- A last means of putting health sector development into a longer term, more strategic phase was **the launch of the joint UN program on monitoring SDGs**, which is supported by WHO and which includes advocacy for UHC activities in the country, and should create a strong national impetus for adopting a longer term vision, and for monitoring progress as well. The UHC-P funded WHO Health System Advisor is deeply involved in this initiative.

Concerning **SO1, activity 7 (ER2)**, the participatory review of progress will obviously take place after the national plan is operationalized and the implementation starts. Yet, some crucial activities were supported in the course of 2016 to serve as a basis to a genuine monitoring and evaluation of future progresses of health reforms. This is especially the case of WHO support to the conduction and interpretation of **Tunisian Health Examination Survey, conducted in 2016 by the National Public Health Institute**. Although the bulk of the financial support comes from a separate WHO source of funding, the WHO Health System Advisor plays a continuous role of advising the INSP on the interpretation process. The results of the survey, which includes individual data on health status, access to health services,

financial protection etc… will serve as a baseline for the monitoring and evaluation of progresses towards the SDGs and represents a rich, updated source for follow-up studies, part of which will be supported by the UHC-P.

Another very valuable source of monitoring data comes from the continuous support provided by the UHC-P to MoH Department of Public Health Services**, for the development of the hospital performance dashboards**. This activity, conducted with the support of the University of Montreal, entered its second phase in 2016 and was scaled up from 17 to 37 facilities of various levels, throughout the country. It provides hospital directors with a robust framework to measure the performance of their facilities and take action at their level, will also represent, after a progressive scale-up, a consistent source of information for national level policy making. At facility level, this work on performance dashboards was complemented by the development of **quality collaboratives**, groups through which facilities executives and staff reflect on key issues affecting their performance, and also share their experience between facilities. The focus was so far put on working conditions and such issues as absenteeism. In some facilities like the National Institute of Nutrition, this led to tangible improvement on the organization of services and quality of care (see result chain in the dedicated section).

SO2

Coming to **SO2, activity 8 (ER3) – capacity building in health financing**, has been the main focus of UHC-P support in 2016. Members of the MoH in charge of health financing policy have been supported to attend an **international meeting on national health financing strategies** organized by EMRO in Cairo in May and where especially trained to conduct a causality tree exercise to explore the deep causes of a health financing issue. The exercise of Tunisia sought to explain the causes of persisting high level of out-of-pocket spending in spite of well-developed MHI and dedicated scheme for the most vulnerable. Potential issues of fragmentation and absence of strategic purchasing where identifies as main causes and feasible solutions proposed. In June 2016, the same team attended the **second Francophone Course on Health Financing and UHC** co-organized by WHO and the World Bank in Rabat and specifically focused on coverage of individuals living in the informal sector. Finally, a large delegation of members of the Tunisian MoH and of the Academia was supported to attend and present their work at the 2016 **Scientific conference of the African Health Economics Association** in Rabat in September. There, they presented a wide variety of studies and ongoing policy work, from cost-efficiency analysis, evaluation of the MHI scheme, and ongoing work on the national health strategy. In addition, and in order to reach a wider audience at national level, the INSP was supported to conduct its first course on health economics and health financing policy in October. This is an introduction course geared towards decision makers, administrators and practitioners, explaining the basics of health economics and WHO health system and health financing system frameworks and emphasizing upon health financing role in reaching UHC. The aim of UHC-P support to such activities is two-fold: on the one hand it improves leadership in health financing issues and create a critical mass of informed professionals (and even future potential experts), on the other hand, I raises the visibility of health financing activities at MoH and raises momentum for reforms.

As far as SO2, activities 9-10 (ER3) are concerned**, support to evidence generation in health financing** mostly consisted this year in speeding up and improving the calculation and interpretation of **national health accounts for year 2014** (third year of calculation using the new SHA2011 methodology). This was done through a very inclusive, interdisciplinary exercise, not only requesting raw data from sources as diverse as the MoD or Directorate of Essential Health services but also having everyone participating to

coding and calculation in a series of workshops. The main achievement this year was on **diseases coding**, which jumped from 20% to more than 75% of recorded expenditure, paving the way to richer interpretations.

A notable progress is to be noted as far as health financing policy is concerned. **One of the first decisions of the new Minister of Health was to advocate for explicit funding of the free access scheme for the most vulnerable**. The previous lack of funding for this scheme was highlighted by previous studies (both at national level and global level best practice reviews) as a reason for financial difficulties of public hospitals which resulted in poorer quality of services for all. This proposal was agreed with MoH and included in 2017 budget law. This is an encouraging first step: mechanisms are of course still to be implemented to ensure that this explicit funding will be used in a way promoting quality and efficiency. Yet it shows that the priorities of the White Book for a better health in Tunisia of 2014 are still alive, and that the work done on evidences and capacity building in HF is progressively paying off.

In addition, some **advocacy work was conducted on the determination of the package of care and on strengthening the role of proximity health services with an emphasis on prevention**. This was especially the case for domains which are dealt with in a very siloed, vertical way, such as mental health.

Please explain any changes in circumstances or programme implementation challenges encountered affecting the original plan:

Please provide information on activities eliminated, changed, added or postponed. Please list them and provide the reasons for each of them (obstacles encountered, remedial measures taken,…).

1. The main delays concerned phase II of the societal dialogue. It can mostly explained **by the tense political situation of the first half of 2016 which resulted in a change of government in September**. As indicated above the main mitigating measure has been to maintain support to the team of voluntaries in drafting key support documents to update the framework of phase II of the societal dialogue, and to advocate with the consecutive ministers to re-initiate the work. This paid-off early 2017.
2. As a result of these political changes, it has also taken more time to find a proper setting to move ahead with support to health financing reforms. To gain momentum, WHO proposed the constitution of an inter-ministerial reflection group on health financing reforms (MoH, MoSA & CNAM, MoF), which still has to be instated.

Proposed modifications to Programme Road Map resulting from changes above:

If the changes above have implications for future work, please attach the new roadmap to this report and confirm that the changes have been discussed with the MoH and EU delegation.

1. As indicated, phase II of the dialogue societal is now back on track and we expect swift implementation until 2017, followed by work on phase III dedicated to monitoring and evaluation.
2. We expect the inter-ministerial group on HF reforms to be instated in 2017 and planed support in the field will catch-up with original plans.

Lessons learned:

Please describe the principal lessons learned during the last 12 months of implementation of the UHC Partnership:

- As reflected by the recent regain of momentum of the societal dialogue, **continuous support to civil society is key for the perpetuation of institutional memory** in the country and for advocating for the government to hold the line drawn by previous participatory exercises such as the development of the White Book.
- The presence of a **resident WHO health policy advisor is a crucial asset** in case of government change, **to coach** the new ministerial team, make them aware of **previous policy options and of Tunisian commitments to global goals such as SDGs** etc. This coaching tasks is nevertheless difficult to quantify and hence neglected in the monitoring framework of the UHC-P as well as somewhat in WHO project management tools.
- In period of political uncertainty, it is important to assist the MoH both in **setting up a long term strategic vision and in achieving quick wins** able to reinforce their political credibility. Actually, the later can reinforce commitment of the Ministerial team to the former. The resident WHO advisor has a key role in identifying new opportunities to convey key messages on health system strengthening (like for instance the forthcoming conduction of a vertical functional review of the MoH). Yet it is important for the advisor to help keeping consistency between short-term measures often favored by the MoH in period of uncertainty and longer terms UHC goals, which can be challenging.

Road Map and timeline for 2017:

Please list here the work plan activities as well as the time-frame for those activities for the calendar year 2017. ***These activities should be related to objectives/ER and have clear timeline and indicators.***

1. (SO1, ER1): **technical support to the thematic workgroups of the societal dialogue (governance and decentralization, proximity services, social determinants of health) – Q1 to Q4 2017.**
2. (SO1, ER1): as part of the above: **support to the development of a national health strategy, and of related regional strategies (Q1-Q3 2017). Support to the MoH in the forthcoming MoH**

functional review to be conducted Q1-Q2 2017 as part of the conditionality for IMF support.

3. (SO1, ER2): continuation of the support **to generating evidence for decision-making, including follow-up studies exploiting the Tunisian Health Examination Survey (health status, access to services, financial protection – support expected Q1-Q2 2017), as well as a support to setting targets and filling information gaps for SDG monitoring throughout 2017.**
4. (SO2, ER3): Constitution and facilitation of the **inter-ministerial reflection group on health financing reforms (throughout 2017).**
5. (SO2, ER3): **Evidence generation for health financing policy to sustain the above:** among others calculation and interpretation of **year 2015 health accounts (Q1-Q4 2017)**, update of **catastrophic health expenditure measurements based on household budget survey 2015 (Q3 2017)**, assessment of institutional arrangement of the **purchasing function in the country (Q1-Q2 2017)**, assessment **PFM and health** in Tunisia (Q1-Q2 2017).

Visibility and communication

Please give a short overview of visibility and communication events that took place and attach evidence (scanned newspapers, pictures, brochure,…). Please describe how communication of programme results to the public has been ensured

1. The September 2016 training of journalists was relayed in the press (see, http://www.letemps.com.tn/article/99152/le-journaliste-aussi-un-r%C3%B4le-%C3%A0-y-jouer). An article on this training was also published on the UHC-P website.
2. A number of events supported by the UHC-P were covered on the very active Tunisian social media. This was for instance the case of the Kairouan workshop of May for the jury citoyens' consultation on the new phase II roadmap, as well as for the first meeting on development of regional strategies in October.
3. In 2017, it is forseen to publish **a report on the achievements of the 5 years of UHC-P in Tunisia**.

Impact assessment:

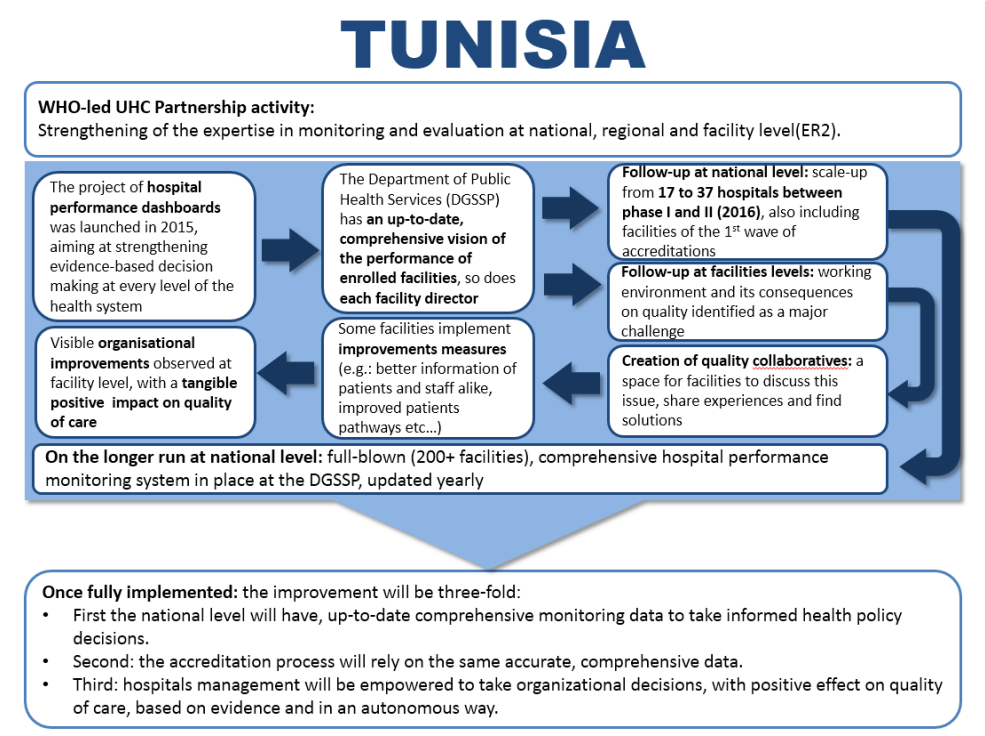
Please explain to which extent 1-3 country level activities have already contributed towards achieving the overall programme objectives. ***Carrying out activities as per the roadmap is good. We would like to go beyond the activities and try to relate them to potential contribution of the Partnership to broader results or impact: better services for the population, improved health status of the population or a specific target group, better equity, contribution to health in all policies, contribution to live saved, better access to care and services, improved financial risk protection, better coordination or involvement of the actors… The linkages might be direct (sometimes) or indirect (most of the time) but should be explained with as many details as possible to let an "external" reader understand the added value of the Partnership. If possible, those broader results should be supported by indicators.***

Where possible, please use short stories /field voices box / quotes (MoH, district level officials, health workers etc) / press releases to illustrate the impact and added value of the programme and WHO

action in the policy dialogue process.

1. *Result chain on improved performance monitoring at hospital level and impact on quality of care*

In some facilities enrolled in **the project of hospital performance monitoring and quality collaboratives** supported by the UHC-P, significant, **concrete changes were triggered in both the working environment of staff and the welcoming conditions of patients**. At the National Institute of Nutrition for instance, much staff and patient frustration came from the organization of consultations. Solutions were discussed as part of the quality collaborative exercise, then implemented in the form of a new patient pathways (including an electronic queuing system, a dedicated orientation staff, color codes for the various areas, and ample sitting areas). With the current progressive scale-up of the performance monitoring project; it is expected that such changes at facilities level will be more common, in addition to providing the central level (DGSSP) with a reliable way to monitor facilities under their responsibility. The most important result of this activity will most certainly be the empowerment of hospital management, now aware that they can take, **based on evidence they collected and in an autonomous way**, some organizational changes which have a direct impact on quality of care.



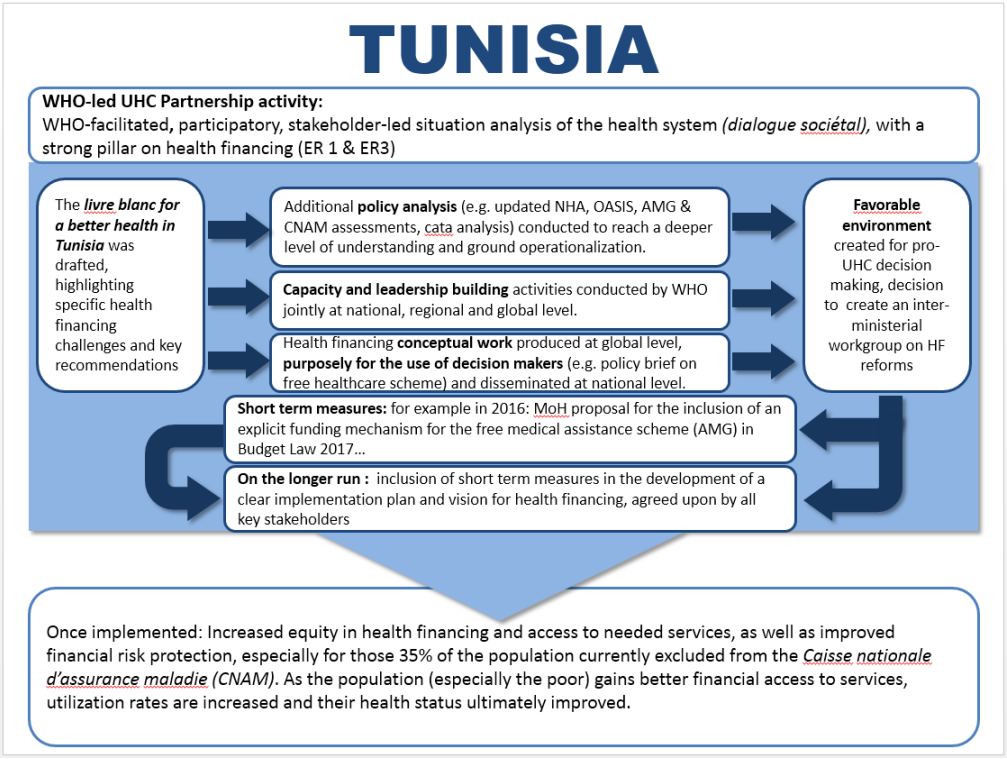
2. *Result chain on the progressive concretization of advice provided on health financing policy: explicit funding for AMG*

During the discussions of the 2017 budget law, the Minister of Health made the proposal to **introduce an explicit funding for the free medical insurance scheme (AMG),** which currently covers the need of more than 20% of the population, vulnerable not contributing to the MHI. This lack of explicit funding

was previously pointed-at as a **threat for the financial sustainability of hospitals** of the poorest localities, which in turns resulted **in poor quality of care delivered for AMG patients as well as for all**.

This is only a first step, which needs to be complemented by a lot of support measure to deliver its promises, but **it represents a first tangible move towards UHC in several years**. It comes at a time when a favorable environment for such decision has been created, through the production of a **critical mass of studies and policy documents and awareness and capacity of key decision makers at the MoH on UHC has been raised**(a lot thanks to the UHC-P).

This shows that progress in health policy does not necessarily take the shape of a long-mature, well-structured, full-blown health (financing) strategy. Positive punctual measures can arise almost spontaneously providing the environment is ready. They need to be taken as opportunities, but of course further require some support to be put to good use and integrated in a longer run, more structured picture.



Linking activities to overall Objectives:

Please see below list of overall programme monitoring indicators and select the ones which apply to your country Road Map. Please describe if this target has been met and how.

- National Monitoring & Evaluation framework indicators developed and used : **ongoing work on determining key indicators and identifying gaps in data available in preparation of an SDG monitoring framework… this not yet a full blown M&E framework.**
- Reduced share of direct out-of-pocket payments in total health expenditure by at least 10%... **OoP are stagnating between 37 and 38% of THE since 2012.**
- Fall in the incidence of financial catastrophe and impoverishment due to out-of-pocket payments evolution to be monitored closely… **There was only a baseline measurement in 2010 based on the household budget survey of that year and showing limited incidence of catastrophic health expenditure. It requires a follow up study on 2015 data to show the post-revolution trend.**
- NHPSP is in line with JANS attributes. **National 5 years plan has not yet been assessed, likely not to meet JANS attributes)**
- An agreed Health Financing (HF) strategy exists, linked to NHPSP, such that more rapid progress towards Universal Coverage (UC) is feasible. **There is no national health financing strategy at the moment, only chapter 5 of the white book as a reference for priorities.**
- Increase in utilization of outpatient health services, particularly among the poor, or a more equitable distribution of public spending on health. Not measured to date, **requires additional monitoring.**
- Inclusive National Policy Dialogue exists, with a roadmap defined, agreed and rolled out → **achieved and existing mechanism currently renewed.**
- Proportion of identified bottlenecks which have been analysed and addressed during annual reviews (address the consistency between situation analysis and follow-up in Annual Review reports) → **no annual review organised to date (no NHPSP)**
- Number of substantive policy changes achieved as a result of more effective and inclusive health sector reviews. **One this year main achievement this year: first concrete step towards implicit funding for the free medical assistance scheme.**
- Number of improved policy frameworks elaborated and implemented as a result of a truly representative multi-stakeholder consultation **Only one and beginning to age: the 2014 white book for a better health in Tunisia. Forthcoming in 2017-18: RMNCAH strategy and NCDs strategy.**
- Positive trend seen in stakeholders' alignment with NHPSP: **Good alignment, stable trend. Technical partners are limited in number and demonstrate a good level of coordination: WHO and the EU work hand in hand. In fact, potential misalignment and lack of coordination might come from the fact that the national strategy itself needs to be more explicitly shaped.**
- Existence and implementation of an IHP+ compact or equivalent at the country level – **No IHP+ compact, contacts where taken with IHP+ in the course of 2016 however.**
- Agreed or strengthened mutual accountability mechanisms such as joint annual reviews – **So far no joint annual reviews.**
- Positive trend in stakeholders overall performance on aid effectiveness performance scorecards, or equivalent – **Not implemented, somewhat weak relevance considering the current development partners scene.**

Reminding Strategic Objectives and Expected Results of the EU-Lux/WHO UHC Partnership

Strategic 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 coverage (UC), with a particular focus on the poor and vulnerable: ER 4. Countries receiving HF support will have implemented financing reforms to facilitate UC; 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.