



# Universal Health Coverage Partnership Annual Report 2019

In practice: bridging global commitments with  
country action to achieve universal health coverage



Universal Health Coverage Partnership annual report 2019. In practice: bridging global commitments with country action to achieve universal health coverage

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**World Health  
Organization**



**#UHCPartnership**

# Universal Health Coverage Partnership **Annual Report 2019**

In practice: bridging global commitments with  
country action to achieve universal health coverage



This report is dedicated to Pete Salama, the late Executive Director of WHO's Division of Universal Health Coverage across the Life Course.

*Thank you, Pete, for being such an inspiring leader.*

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**This report covers the calendar year 2019.**

It provides a synthesis of country activities and results achieved with the support of the UHC Partnership in all the participating countries. Country reports are accessible on the UHC Partnership website (<http://www.uhcpartnership.net/>).

This synthesis report is, by definition, not exhaustive. It presents a range of country examples related to the major areas of work. It reflects overall activities and results and provides details on how the UHC-P achieved sustainable buy-in of partners and stakeholders at the country level in the different countries concerned.



## Foreword

The year 2019 marked a historic opportunity for heads of state and governments at the global level to ensure that no one is left behind – that no one is denied access to the health services they need simply because they cannot access or afford them. On the occasion of the High-level Meeting on Universal Health Coverage at the United Nations General Assembly on 23 September 2019, it was very clear: States have made the political choice to commit to universal health coverage (UHC).

Several committed donors made this political choice in 2011 when they came together with the World Health Organization (WHO) to jointly develop the UHC Partnership; these donors were the European Union, France, Ireland, Japan, Luxembourg and the United Kingdom. More recent donors include Belgium, Germany and the Susan Thompson Buffett Foundation.

In 2019, to enable effective development cooperation in countries, the UHC Partnership provided support to 115 countries worldwide, representing an increase of 37 countries from 2018. It has created more than 100 technical expert positions (with progressive deployment in 2019 and 2020) to support country-led priorities, and has provided catalytic funds to strengthen health systems for UHC in the areas of governance, health products, workforce, financing, information and service delivery, with a growing focus on noncommunicable diseases (NCDs) and health security.

The success of the UHC Partnership has been linked to its innovative and agile approach since 2011 that continues to be its greatest strength in 2019 – a bottom-up process based on country needs and capacity, flexibility in terms of funding while adapting to changing priorities, systematic monitoring of implementation and results, continuity and sustainability of the efforts at national level, as well as a strong high-level governance, both internal and international, supported by world leaders' political commitments. Hence, in 2019, not only has the multi-donor coordination committee (MDCC) been reinforced to improve transparency and mutual accountability, but the High-level Steering Committee, which regularly gathers top-level management from WHO regional offices and headquarters, has also been set up. I would like to warmly thank here the long-standing and committed donors. Their trust in the UHC Partnership has

been a key factor for its success and has helped to lead countries towards unremitting progress and significant results. The UHC Partnership will continue to build on these unique strengths as it continues to expand and develop.

As part of this UHC Partnership Annual Report, you will find many examples of country results achieved in 2019 and presented along the lines of the WHO Thirteenth General Programme of Work 2019–2023 results framework and its “triple billion” goal: 1 billion more people benefiting from UHC, 1 billion more people better protected from health emergencies, 1 billion more people enjoying better health and well-being, as well as a fourth goal on health information. You will also find cross-cutting analyses on primary health care, health financing and NCDs.

These 2019 country achievements have been made possible thanks to the energy deployed by the Joint Working Team on UHC, an innovative WHO mechanism that smoothly brings together the three levels of our organization – country offices, regional offices and headquarters – on the UHC agenda.

I would like to pay special tribute to our late colleague, Dr Pete Salama, a strong supporter of the UHC Partnership and the Joint Working Team on UHC, and who deeply believed that by fostering a policy dialogue at country level based on robust evidence, we can collectively make the difference in improving access to health services and reducing financial hardship, even in fragile states; as many of you know, this mission was the passion and focus of Pete's entire career.

At the time I write this foreword we are facing the COVID-19 crisis, an eye-opener on the need, more than ever, to prepare and strengthen health systems. Together, thanks also to the flexibility of the UHC Partnership, we will be able to turn this tragedy into an opportunity for countries to engage in the needed health systems reforms to improve both health security and progress towards UHC.

**Zsuzsanna Jakab**  
Deputy Director-General, WHO



“

*The success of the UHC Partnership has been linked to its innovative and agile approach since 2011 that continues to be its greatest strength in 2019.*

**Zsuzsanna Jakab**  
**Deputy Director-General, WHO**

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Japan – Ministry of Health, Labour and Welfare

United Kingdom – Department for International Development

World Health Organization (WHO)



# Abbreviations

<b>ACP</b>	African, Caribbean and Pacific Group of States
<b>COVID-19</b>	coronavirus disease 2019
<b>CRVS</b>	civil registration and vital statistics
<b>DHIS</b>	District Health Information Systems
<b>DRG</b>	diagnosis-related group
<b>EAC</b>	East African Community
<b>GIZ</b>	Deutsche Gesellschaft für Internationale Zusammenarbeit
<b>GMP</b>	Good Manufacturing Practices
<b>GPW13</b>	WHO Thirteenth General Programme of Work
<b>HerAMS</b>	Health Resources Availability and Mapping System
<b>HMIS</b>	health management information system
<b>HRH</b>	human resources for health
<b>HRIS</b>	human resources information system
<b>HSEL</b>	Health Systems in Emergencies Lab
<b>HSS</b>	Health Systems Strengthening
<b>IAHO</b>	Integrated African Health Observatory
<b>ILO</b>	International Labour Organization
<b>IPCHS</b>	integrated people-centred health services
<b>JWT</b>	WHO UHC Joint Working Team
<b>LANACOME</b>	Laboratoire National de Contrôle de Qualité des Médicaments et d'Expertise
<b>MDCC</b>	multi-donor coordination committee
<b>MhGAP</b>	Mental Health Gap Action Programme
<b>MLHW</b>	mid-level health worker
<b>NCD</b>	noncommunicable disease
<b>NHA</b>	national health account
<b>NHSSP</b>	national health sector strategic plans
<b>NHSU</b>	National Health Service of Ukraine
<b>NMH</b>	NCD and Mental Health
<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>PAHO</b>	Pan American Health Organization
<b>PEN</b>	Package of Essential Noncommunicable Disease Interventions
<b>PHC</b>	primary health care
<b>PHC-ESP</b>	Primary Health Care Essential Service Package (Timor-Leste)
<b>PHCMI</b>	Primary Health Care Measurement and Improvement
<b>PhilHealth</b>	Philippine Health Insurance Corporation
<b>PMJAY</b>	Pradhan Mantri Jan Arogya Yojana (India)
<b>PSO</b>	Policy Support Observatory (Lebanon)
<b>SDG</b>	Sustainable Developing Goal
<b>SEARN</b>	South-East Asia Regulatory Network
<b>SIDS</b>	Small Island Developing States
<b>UHC</b>	universal health coverage
<b>UHC-P</b>	Universal Health Coverage Partnership
<b>UHC-PBP</b>	UHC Priority Benefits Package
<b>UNICEF</b>	United Nations Children's Fund
<b>WHO</b>	World Health Organization



## Executive summary

The UHC Partnership (UHC-P) Annual Report 2019 looks back at a year when the Partnership is entering into a new phase of expansion, working in 115 countries across six WHO regions and with the support of seven donors, including the expansion of European Union funding until 2022. The UHC-P channels donors' investments via WHO to ensure continuity between global commitments and country implementation for health systems strengthening, ensuring that nobody gets left behind. By combining policy dialogue and technical assistance, the UHC-P has provided tailored and bottom-up support for each country's roadmap towards UHC.

The year 2019 was also an important one for advancing UHC, which benefited from high-level political support from the United Nations General Assembly, which endorsed the Political Declaration following its High-level Meeting on UHC. WHO mirrored this additional focus on UHC with the establishment of the UHC Steering Committee to provide global guidance and alignment across all levels of the Organization, further increasing the visibility of the UHC-P.

This Annual Report 2019 outlines country-level and regional achievements in accordance with WHO's Thirteenth General Programme of Work 2019–2023 (GPW13). In terms of results, the focus of over two thirds of countries involved the first billion – achieving UHC, including its components such as health services, leadership and governance, and essential medicines. The second and third billion – addressing health emergencies and promoting healthier populations, respectively – remained a smaller focus in 2019; however, this should be increasing in 2020. As per GPW13's results framework, this report also includes elements related to a more effective and efficient WHO providing support at country level, and highlighting how the UHC-P is contributing to this overall strategic shift. This Annual Report demonstrates key country-level and regional examples (see Figs. 1 and 2), as well as a series of more detailed analyses on primary health care, health financing and NCDs. It should be noted, however, that the list of examples and outcomes is not exhaustive and is meant to highlight key achievements.

Moreover, underpinning the way in which the UHC-P operates (section 5), five key factors of success for the Partnership have been identified, embodying the strategic shifts occurring at WHO to ensure continuity between global commitments and country implementation, and providing leadership at the country level towards unremitting progress and significant results. These include:

- a bottom-up approach based on country needs and capacity;
- flexibility in terms of funding, as well as adapting to specific contexts and changing priorities;
- a strong and high-level internal governance of the UHC Partnership supported by world leaders' political commitments and a robust multi-donor coordination committee (MDCC) to improve transparency and mutual accountabilities;
- systematic monitoring of implementation and results, which ensures clear accountabilities; and
- continuity and sustainability of the efforts at national level, thanks to catalytic resources.

Fig. 1. 2019 Key milestones

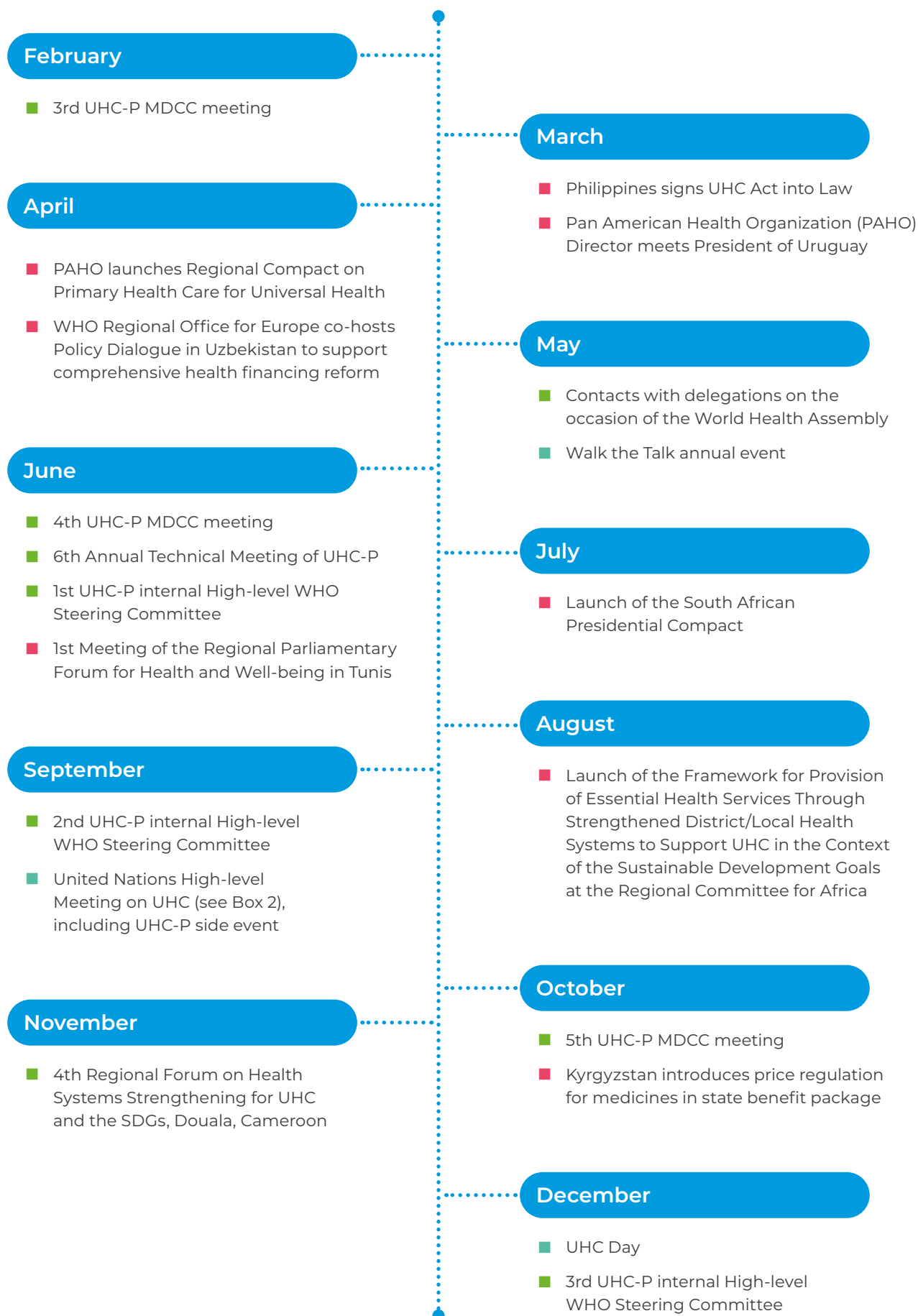


Fig. 2. Regional highlights, 2019

### WHO European Region

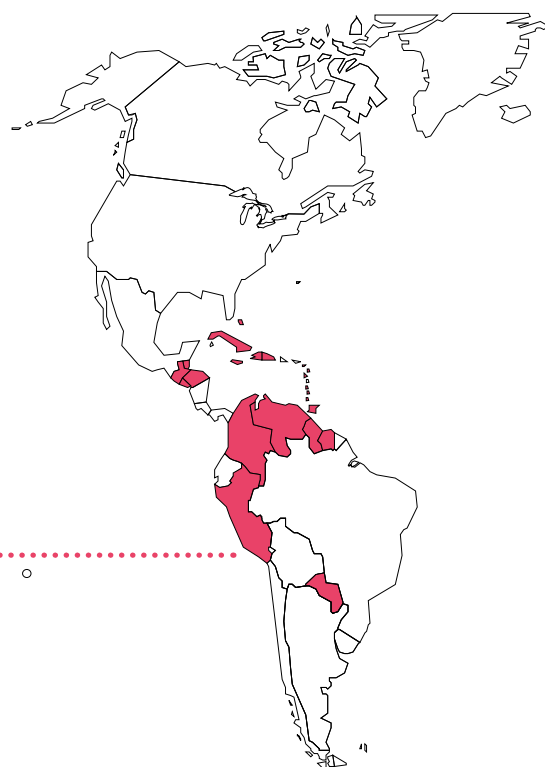
A key focus of the UHC-P in the European Region has been to realize its catalytic role in helping to coordinate and bring together stakeholders that have an impact at the country level. To this end, the WHO Regional Office for Europe ran 42 multidisciplinary technical assistance missions (see Box 35) related to the themes of the UHC-P to support impact on health financing, service delivery and human resources for health, and governance. These missions and dialogues have been key in securing the establishment of new laws to improve financial protection.

42 multidisciplinary technical assistance missions related to the themes of the UHC-P

Starting the year with 7 countries and quickly scaling to 22 countries

### WHO Region of the Americas

The WHO Region of the Americas recently joined the UHC-P, having started the year with seven countries and quickly scaling to 22 countries that will allow for medium-term funding to work on bigger issues of governance and financing at the country level and allow for seeing projects from inception to implementation. With catalytic funding, the Region was quickly able to leverage the flexibility of the UHC-P to support countries such as Paraguay with their national health sector reform that integrated the health of indigenous people (see Box 10), and to initiate work in fragile settings such as the Bolivarian Republic of Venezuela and Haiti.



### WHO African Region

The African Region benefited not only from the presence of technical expertise at the country level, but also from alignment of the UHC-P and the Regional UHC strategy, which covers 18 countries and is raising the profile of UHC amongst heads of state. A notable example of this is the launch of the Presidential Compact in South Africa (see Box 8).

UHC-P and the Regional UHC strategy covering 18 countries

Not Applicable

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Being home to 2 billion people, the WHO South-East Asia Region used the flexibility and capacity of the UHC-P as a channel to fill critical gaps and support intercountry work to achieve UHC. For example, the flexibility of the funding allowed the UCH-P to respond to country-level needs to develop essential services/benefits packages in Nepal and update the one for Timor-Leste (see Box 7). A key highlight from the Region is the roll-out of the Ayushman Bharat programme as a vehicle to effective health coverage in India, that involves the establishment of 150 000 Health & Wellness Centres to provide comprehensive primary care, and a new health insurance scheme that is covering over 500 million eligible people (see Box 23).

### WHO South-East Asia Region

Using flexibility and capacity of the UHC-P as a channel to fill critical gaps

Above-average increases in primary health-care budgets

Securing new political commitments

### WHO Eastern Mediterranean Region

The UHC-P has been building upon its success in supporting the Salalah Declaration<sup>1</sup> by securing new political commitments and engagement in 2019 (see Box 12). This spurred the creation of a regional parliamentary forum for UHC, and progress is being seen through such landmark legislation as the Universal Health Insurance Law in Egypt. As a region dealing with many health emergencies, important work continues to centre around integrating health systems strengthening for emergencies.

### WHO Western Pacific Region

The UHC-P has seen large movements in certain countries in the Western Pacific Region vis-à-vis health financing, with countries such as the Philippines passing a comprehensive UHC Act (see Box 11). Flexible support activities and funding in the Region allowed for the alignment of initiatives that resulted in tangible results, such as a near doubling of the capitated rates paid to primary health-care sites in Mongolia, in addition to above-average increases in primary health-care budgets.

1. Salalah Declaration signals countries' firm commitment to universal health coverage. In: WHO Regional Office for the Eastern Mediterranean [website]. Salalah: EMRO; 2018 (<http://www.emro.who.int/media/news/salalah-declaration-signals-countries-firm-commitment-to-universal-health-coverage.html>).

# Background and introduction

Universal health coverage (UHC) means that all people and communities – with no one left behind – receive the quality services they need, and are protected from health threats, without suffering financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. UHC is a political choice to be made by every nation.

## What is UHC?

Universal health coverage (UHC) means that all people and communities – with no one left behind – receive the quality services they need, and are protected from health threats, without suffering financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care (see Box 1). UHC has been adopted and supported by several World Health Assembly resolutions (WHA58.33, WHA64.8, WHA69.11, WHA71.1 and WHA72.13) and included as one of the three fundamental pillars of the new WHO Thirteenth General Programme of Work for 2019–2023 (GPW13).<sup>2</sup> UHC is a political choice to be made by every nation.

Treading the path towards UHC requires robust policies, political will and strong government capacity to steer the health sector. Policy dialogue can be an important “steering wheel” for governments to drive evidence-informed decision-making. Putting UHC into practice means brokering consensus amongst all relevant stakeholders on health priorities in order to jointly move towards set targets. Those priorities must then be spelled out in national health plans, charting out the country’s roadmap towards UHC.

There is ongoing work to finalize how WHO will measure progress on UHC, with several joint initiatives, such as the UHC Index and Sustainable Development Goal (SDG) target 3.8 of UHC for all by 2030. For the purposes of this Annual Report 2019, a focus has been put on organizing reporting in accordance with GPW13 and the corresponding results framework.

<sup>2</sup>. Thirteenth General Programme of Work 2019–2023. In: World Health Organization [website]. Geneva: WHO; 2019 (<https://www.who.int/about/what-we-do/thirteenth-general-programme-of-work-2019---2023>).

<sup>3</sup>. Universal Health Coverage Partnership [website]. Geneva: WHO; 2019 (<https://www.uhcpartnership.net/>).

<sup>4</sup>. Fact sheet: Universal health coverage (UHC). In: World Health Organization [website]. Geneva: WHO; 2019 ([https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))).

## What is the UHC partnership (UHC-P) and how does it support countries?

The Universal Health Coverage Partnership (UHC-P)<sup>3</sup> promotes UHC by supporting governments to strengthen health systems in governance; access to health products; workforce; financing; information and service delivery, with a special focus on noncommunicable diseases (NCDs) and health security. The UHC-P aims to ensure continuity between commitments at the global level and country implementation.

Since it started in 2011, the UHC-P has evolved into a significant and influential global partnership working in 115 countries across six WHO regions, with the support of seven donors (see Figs. 3 and 4).

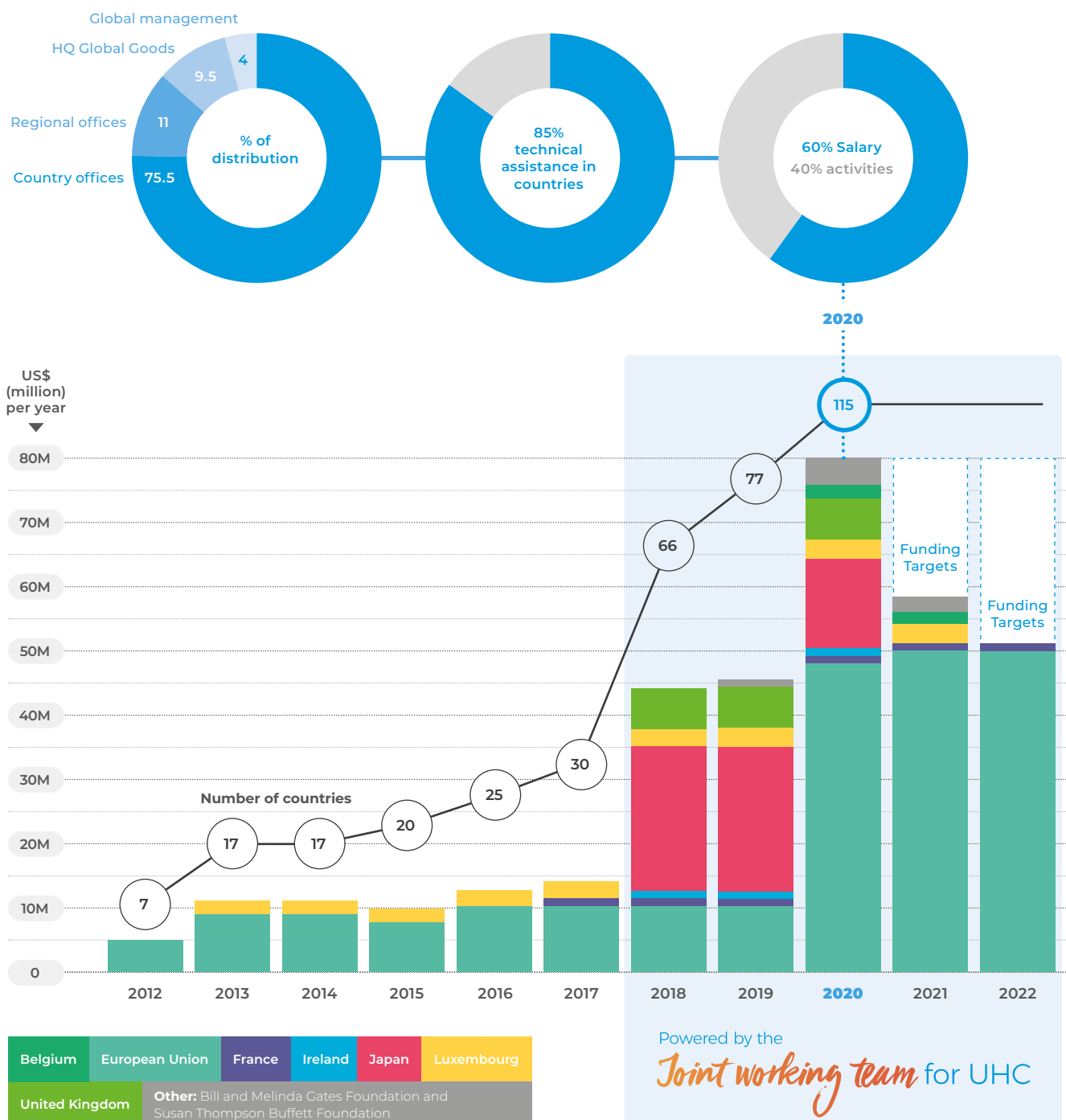
In 2019, the UHC-P entered into a new phase of expansion, with the European Union increasing its support through a more extensive collaboration programme with WHO under the title, “Health Systems Strengthening for Universal Health Coverage Partnership”, providing additional focus on the African, Caribbean and Pacific Group of States (ACP). Luxembourg extended its contribution until end of 2021, allowing for longer-term technical assistance. France, Ireland and the United Kingdom continued their support in 2019, and WHO is under discussion with Japan for an extension of support from 2020 onwards. In addition, the United Kingdom shows clear interest in UHC-P activities, as do other observers such as the Susan Thompson Buffett Foundation, United Nations Children’s Fund (UNICEF), Bill & Melinda Gates Foundation, Belgium, Germany, Italy, Republic of Korea, Spain and Switzerland.

Fig. 3 presents the evolution of financial support provided by an increasing number of donors. We expect additional contributions from other donors to complement ongoing commitments in 2021 and beyond.

## BOX 1: UHC at a glance<sup>4</sup>

- At least half of the world's population still does not have full coverage of essential health services.
- About 100 million people are still being pushed into extreme poverty (defined as living on US\$ 1.90 or less a day) because they have to pay for health care.
- Over 930 million people (around 12% of the world's population) spend at least 10% of their household budgets to pay for health care.
- All United Nations Member States have agreed to try to achieve UHC by 2030, as part of the SDGs.

**Fig. 3. UHC-P donor contributions 2012–2022, channelled through the Joint Working Team (JWT) on UHC since 2018**



## BOX 2: United Nations High-level Meeting on Universal Health Coverage

On 23 September 2019, the United Nations General Assembly held a High-level Meeting on UHC. This meeting, held under the theme “Universal Health Coverage: Moving Together to Build a Healthier World”, aimed to accelerate progress towards UHC, including financial protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all.

The political declaration recognized the need to “Revitalize and promote strong global partnerships with all relevant stakeholders to collaboratively support the efforts of Member States, as appropriate, to achieve universal health coverage and other health-related targets of the Sustainable Development Goals, including through technical support, capacity-building and strengthening advocacy.”<sup>5</sup>

The UHC Partnership organized a side event to illustrate how WHO is currently supporting strategic activities to help countries paving their way to UHC. Representatives from the **European Union, France, Ireland, Japan, Luxembourg** and the **United Kingdom** participated in this event and about 12 ministers of health from beneficiary countries expressed their needs to achieve the UHC goal.<sup>6</sup>

### UHC-P governing structure

Currently, the UHC-P donor investments are channelled through WHO to support work across all three levels of the organization (country, regional and headquarters) and activities at country level. UHC-P work is driven by a country-led, bottom-up approach and supported by a governance structure that – coupled with specific tools (see Box 3) and forums for knowledge exchange, such as the Annual Technical Meeting (see Box 4) – enables the UHC-P to be transparent and accountable to both donors and countries.

The UHC-P operates under the global multi-stakeholder platform of UHC2030 to promote collaborative working globally and in countries to enhance cooperation effectiveness. It benefits from the WHO-wide Joint Working Team (JWT) that brings coherence to all levels of WHO vis-à-vis UHC. The JWT has been established in the GPW13 and represents an operational arm overseeing the day-to-day management of WHO to guarantee harmonization, alignment and integration of efforts geared towards UHC implementation at country level (see Fig. 6). The WHO UHC JWT continues to ensure the coordination, monitoring and reporting of the UHC country, subregional and regional support plans.

In 2019, a new WHO internal governance structure, the UHC Partnership Steering Committee, was set up to augment the work of the multi-donor coordination committee (MDCC). Fig. 5 outlines the relationships between all of the UHC-P operational mechanisms.

Fig. 4. UHC-P by the numbers

7 donors



US\$ 155 million

disbursed to support country-level priorities to date; including **US\$ 51 million** in 2019.

Allocation of financial support to country support plans (approximately **60%** staffing versus **40%** activities).



115 countries in the 6 WHO regions

**38** new countries joined the partnership in 2019, of the **47** least developed countries, **all but one** (Bhutan) are part of the UHC-P.

See Fig. 7 for list of countries

See Fig. 10 in the Annex for all UHC-P activities mapped by country

114 health policy advisors globally

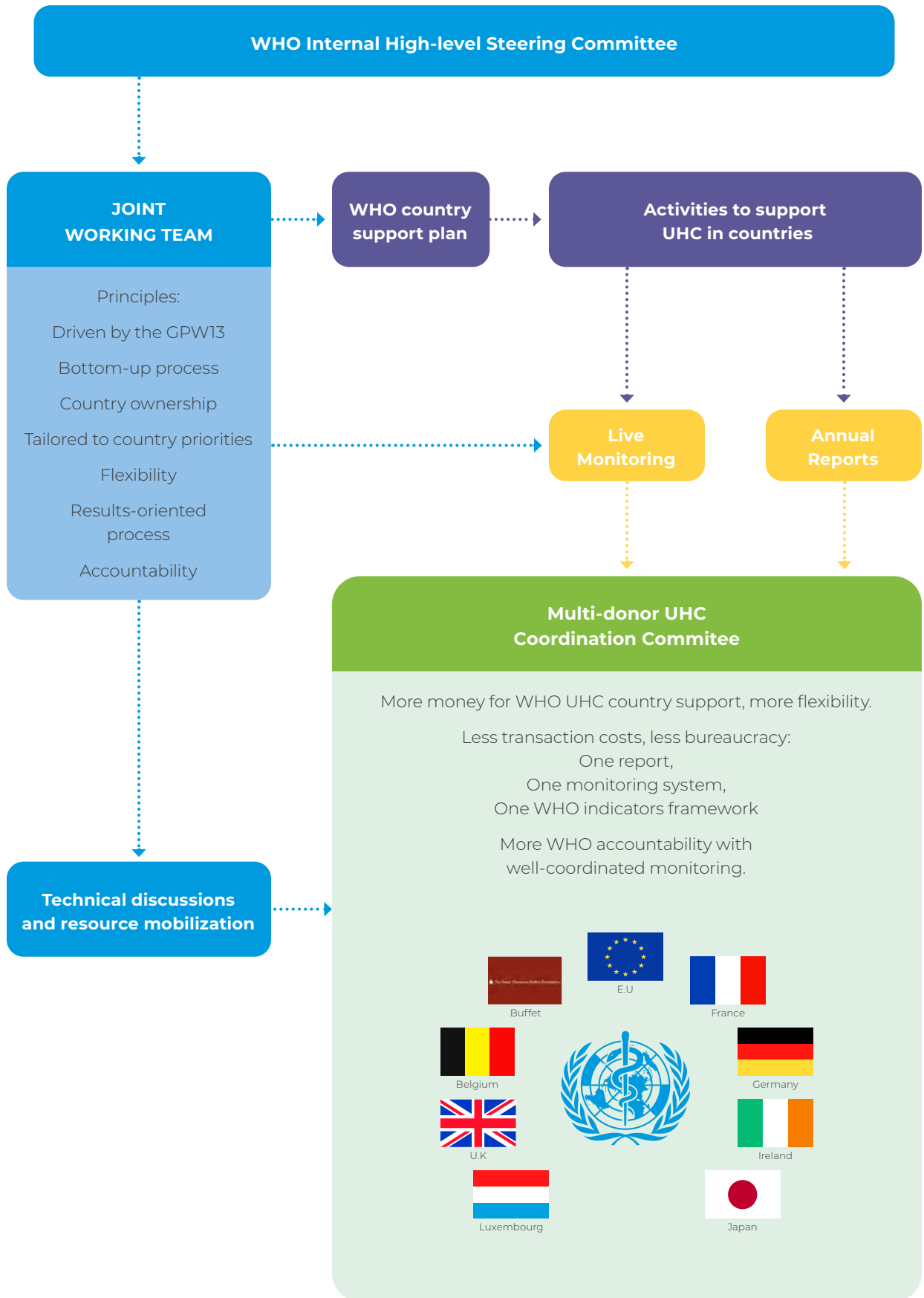
**36 country-level** health policy advisors in WHO country offices, with **57** under recruitment (to be deployed during the first semester of 2020).

**21 regional** health policy advisors based regionally.

5. Political Declaration 74/2 of the High-level Meeting on Universal Health Coverage. In: Seventy-fourth session of the United Nations General Assembly, New York, 10 October 2019 (<https://undocs.org/en/A/RES/74/2>).

6. “From political commitments to concrete actions: the way forward for UHC” a side event organized by the UHC Partnership at the UN High-level Meeting on UHC. In: Universal Health Coverage Partnership [website]; 2019 (<https://www.uhcpartnership.net/from-political-commitments-to-concrete-actions-the-way-forward-for-uhc-a-side-event-organized-by-the-uhc-partnership-at-the-un-high-level-meeting-on-uhc/>).

**Fig. 5. UHC-P operational mechanisms**



## UHC Partnership Steering Committee

In June 2019, under the guidance of the newly designated Deputy Director-General of WHO, Dr Zsuzsanna Jakab, a WHO internal High-level Steering Committee was put in place. This Committee comprises the Deputy Director-General, the Executive Director of the UHC Life Course Division, as well as all involved assistant directors-general and executive directors, as well as the director for programme and management of the six regional offices. In 2019, three meetings were held (in June, September and December) to exchange information on the UHC-P, on resource mobilization and allocation at the three levels of WHO, and to provide global guidance on how to best integrate WHO corporate efforts for optimal support to countries.

The main contribution of the Steering Committee to the UHC-P was improving alignment and coherence of WHO in the field and ensuring strong support from the senior management for implementation of managerial processes to ensure fast recruitment procedures and quick availability of funds at country and regional levels.

## Multi-donor coordination committee (MDCC)

The MDCC provides a visible and transparent mechanism to enable discussions and coordination with the donors on successes and challenges related to the implementation of major activities in the frame of the UHC-P. It met in February, June and October of 2019.

The overall objectives of the MDCC are:

- To improve coordination between WHO and donors, by providing a platform to regularly convene, streamline programmes, as well as harmonize and align approaches in order to build synergies and prevent duplication of work.
- To share information in a view to aligning donor investments based on aid effectiveness principles, i.e. one plan, one monitoring mechanism, one report, in line with the GPW13 and its priorities for countries.
- To identify priorities and gaps in the response in a view to informing future direction of programme-specific funds but also other investments in complementarity with other global initiatives.

The MDCC provides an opportunity to regularly share challenges and successes of WHO UHC country support plan implementation not only with the UHC-P donors, but with other stakeholders. Serving a catalytic role, the UHC-P allows stakeholders to come together to adapt and find solutions to address challenges and bottlenecks on progress towards UHC at country level.

### BOX 3: Live monitoring mechanism

Live monitoring of the WHO country support plans provides a unique opportunity for WHO and partners to actively engage in a regular dialogue on provision of support to Member States to deliver on their UHC goals. The objective of live monitoring is to review progress from the WHO country and regional offices on UHC-P-supported activities, lessons learned and updates on future technical work. Through this process, country intelligence on UHC progress and activities is collected and shared to mobilize and deploy support that is cross-cutting based on the current needs in the country.

### BOX 4: Annual Technical Meeting of the UHC-P<sup>7</sup>

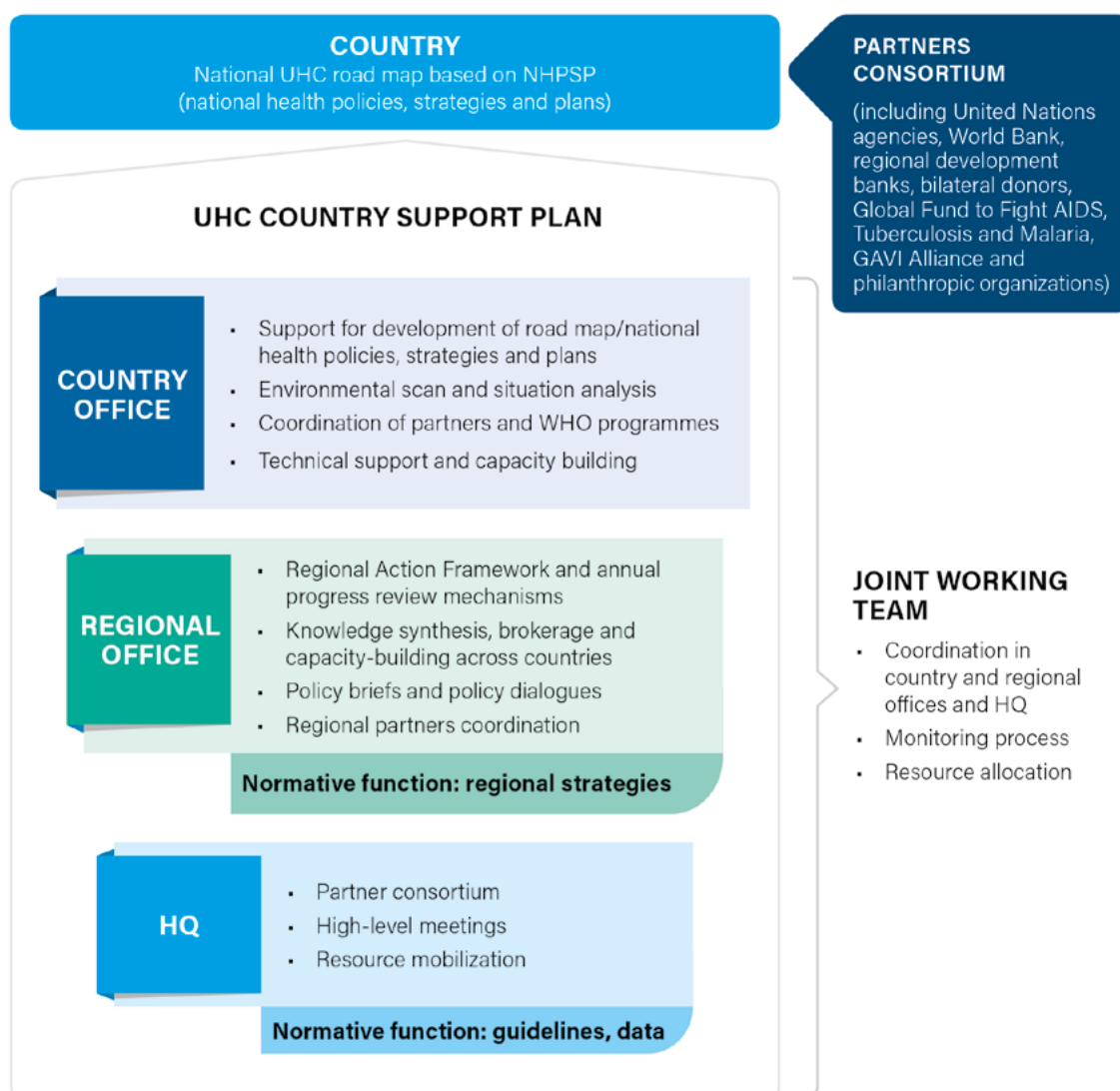
In 2019, countries, donors and WHO met to discuss key achievements and challenges on the path towards UHC and health-related SDGs. The overarching theme of the meeting was primary health care (PHC) as a foundation and key driver for achieving UHC. Amongst others, discussions focused on what strategies are better for reaching “the unreached” population in remote or crisis areas through a PHC-focused approach and effective coordination. The UHC-P organized policy lab sessions, enabling participants to understand what actions were taken by local governments to overcome challenges and bottlenecks faced by their health systems, with many of the issues and proposed solutions highlighted (see Deep Dive on Primary Health Care in the UHC Partnership).

<sup>7</sup> Reports. In: Universal Health Coverage Partnership [website]. Geneva: WHO; 2019 (<https://www.uhpartnership.net/reports/>).



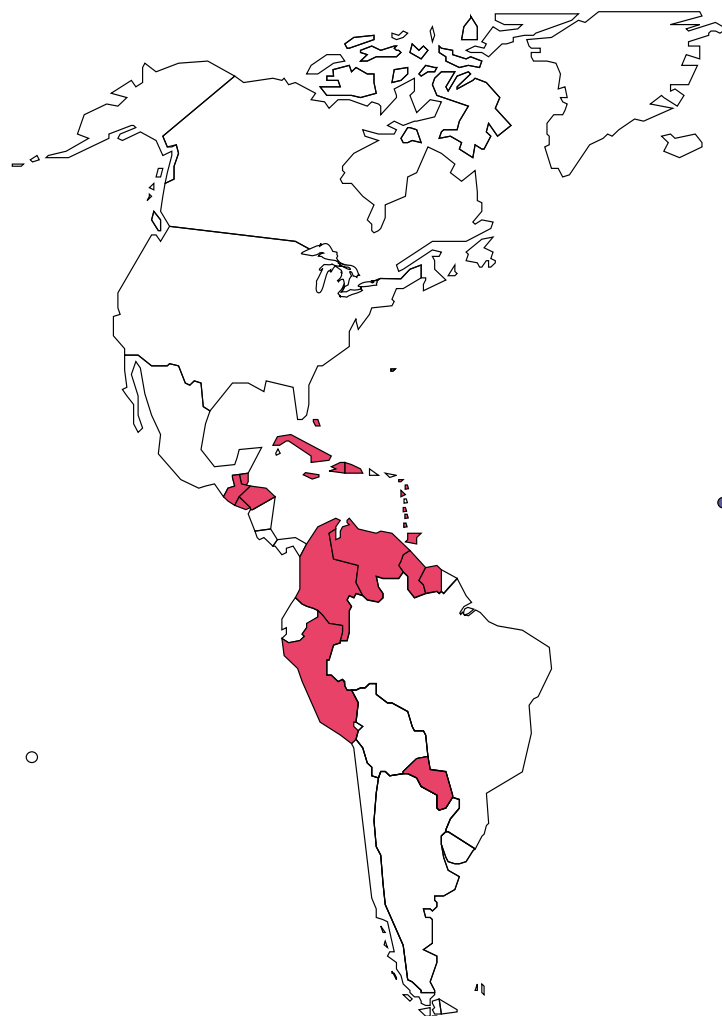
Children in Suriname. © PAHO/WHO.

Fig. 6. WHO Country Action Framework<sup>8</sup>



8. Thirteenth General Programme of Work 2019–2023. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/bitstream/handle/10665/324775/WHO-PRP-18.1-eng.pdf>).

**Fig. 7. Countries and areas enrolled in the UHC-P**



**WHO Region of the Americas**

- Antigua and Barbuda
- Bahamas
- Barbados
- Belize
- Colombia
- Cuba
- Dominica
- Dominican Republic
- El Salvador
- Grenada
- Guatemala
- Guyana
- Haiti
- Honduras
- Jamaica
- Paraguay
- Peru
- St. Kitts and Nevis
- St. Lucia
- St. Vincent and the Grenadines
- Suriname
- Trinidad and Tobago
- Venezuela (Bolivarian Republic of)

**WHO African Region**

- Angola
- Benin
- Botswana
- Burkina Faso
- Burundi
- Cabo Verde
- Cameroon
- Central African Republic
- Chad
- Comoros
- Congo
- Côte d'Ivoire
- Democratic Republic of the Congo
- Equatorial Guinea
- Eritrea
- Eswatini
- Ethiopia
- Gabon
- Gambia
- Ghana
- Guinea
- Guinea-Bissau
- Kenya
- Lesotho
- Liberia
- Madagascar
- Malawi
- Mali
- Mauritania
- Mauritius
- Mozambique
- Namibia
- Niger
- Nigeria
- Rwanda
- Sao Tome and Principe
- Senegal
- Seychelles
- Sierra Leone
- South Africa
- South Sudan
- Togo
- Uganda
- United Republic of Tanzania
- Zambia
- Zimbabwe

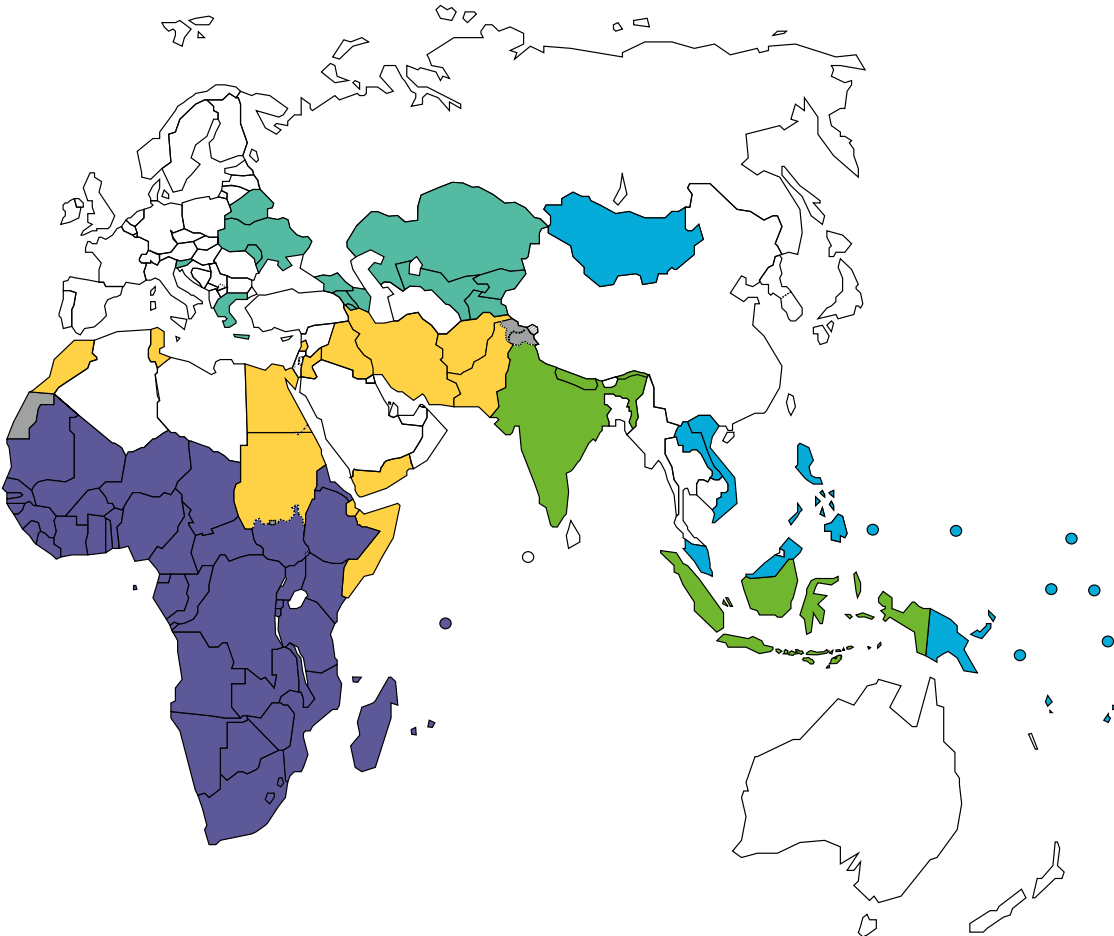


## WHO Eastern Mediterranean Region

- Afghanistan
- Djibouti
- Egypt
- Iran (Islamic Republic of)
- Iraq
- Jordan
- Lebanon
- Morocco
- Pakistan
- Somalia
- Sudan
- Tunisia
- Yemen

## WHO European Region

- Armenia
- Azerbaijan
- Belarus
- Georgia
- Greece
- Kazakhstan
- Kyrgyzstan
- Moldova
- Slovenia
- Tajikistan
- Ukraine
- Uzbekistan



## WHO South-East Asia Region

- India
- Indonesia
- Nepal
- Timor-Leste

## WHO Western Pacific Region

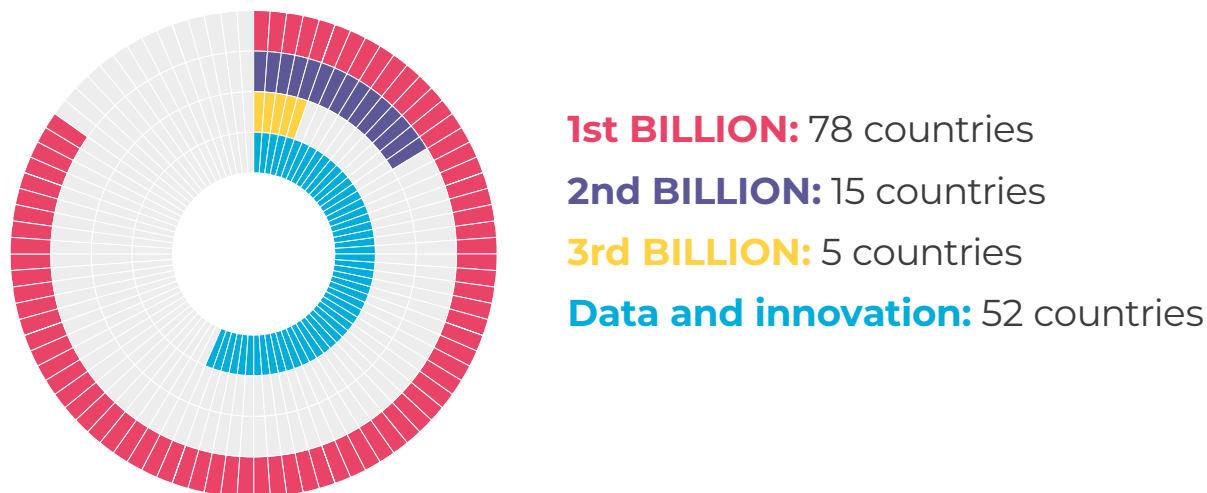
- Cook Islands
- Fiji
- Kiribati
- Lao People's Democratic Republic
- Malaysia
- Marshall Islands
- Micronesia (Federated States of)
- Mongolia
- Nauru
- Niue
- Palau
- Papua New Guinea
- Philippines
- Solomon Islands
- Tuvalu
- Vanuatu
- Viet Nam

■ Not Applicable

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.

**Fig. 8. UHC-P (key thematic areas; in line with WHO's GPW13)**

Figure 8 gives an overview of the activities implemented by the UHC-P in 2019 according to the submitted country and regional reports received in April 2020. A more detailed list of activities by country is provided in Fig. 10 in the Annex. Of note, due to a number of countries joining the UHC-P mid-year, not all member countries were required to submit annual reports, but instead provided an inception report.



## Which outputs are targeted through the UHC-P? The top 10 outputs

### Number of countries in GPW13 top 10 outputs implementation

51	<b>1.1.1</b> Countries enabled to provide high-quality, people-centred health services, based on primary health-care strategies and comprehensive essential service packages.	34	<b>1.1.5</b> Countries enabled to strengthen their health workforce.
50	<b>4.1.1</b> Countries enabled to strengthen health information and information systems for health, including at the subnational level, and to use this information to inform policy-making.	19	<b>1.3.1</b> Provision of authoritative guidance and standards on quality, safety and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists.
44	<b>1.2.1</b> Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage.	16	<b>1.2.3</b> Countries enabled to improve institutional capacity for transparent decision-making in priority setting and resource allocation and analysis of the impact of health in the national economy.
43	<b>1.1.4</b> Countries' health governance capacity strengthened for improved transparency, accountability, responsiveness and empowerment of communities.	15	<b>1.3.2</b> Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems.
38	<b>1.2.2</b> Countries enabled to produce and analyse information on financial risk protection, equity and health expenditures, and to use this information to track progress and inform decision-making.	10	<b>1.3.3</b> Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved.



## The WHO 3 billion strategic priorities

Since its inception in 2011, the UHC-P has been focused on strengthening health systems to make progress on UHC, which is one of the three core strategic priorities of WHO.

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The work of ensuring 1 billion more people benefit from UHC is interrelated with WHO's two other strategic priorities, addressing health emergencies and promoting healthier populations as part of the GPW13. Although the majority of the work being reported in this Annual Report at country level is via the UHC priority (section 1), increasingly this work is being recognized in the two other strategic priorities of WHO: Health Emergencies (section 2) and Healthier Populations (section 3).

The following sections of the report are organized for reporting purposes according to GPW13 along the triple billion (three strategic priorities: sections 1 to 3) and the corresponding outcomes. Linkages to outcomes include access to services (service delivery, leadership/governance and health workforce), health financing and access to essential medicines.

Section 4 focuses on health information systems. As per the GPW13 outcomes, section 5 reports on the ways in which WHO and the UHC-P are delivering on their work to provide more effective and efficient support to countries. Of note, as part of the country-level support provided by the UHC-P, there is concurrent and complementary work on various GPW13 outcomes and outputs. For an extensive list of UHC-P activities by country, see Fig. 10 in the Annex.

# 1. Universal health coverage – 1 billion more people benefiting from UHC

The UHC-P's work on UHC is fully aligned with SDG target 3.8, which focuses on achieving UHC, including financial protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all. Equity of access to health services is central to UHC, and by making the initial political choice countries are in fact committing to progressively break down these barriers and expand access to comprehensive services in order to meet the needs of the population. In this year's report, service delivery and primary health care (PHC) were a focus, as PHC is the strongest platform on which UHC is built (see Deep Dive on Primary Health Care in the UHC Partnership).

## 1.1 Access to services/improved access to quality essential health services

### Service delivery (GPW13 output 1.1.1)

The main challenge to making progress towards UHC comes from persistent barriers to accessing health services. The UHC-P's work helps to address these barriers, whether they are in terms of designing service packages to meet the health needs of the population or supporting access to vulnerable populations. For example, country-level actions have been supported by examples such as Compact 30.30.30 in the Region of the Americas, where commitments have been made to accelerate improving access to health services by reducing barriers (see Box 5).

### Developing essential health service packages

Developing and implementing essential health service packages are one of the keys to UHC. The UHC-P provides extensive strategic and technical support to assist countries in developing their own national packages of essential services, leveraging experiences from their peers. For example, the **European Region** launched an initiative, Meet the Reformers, to facilitate knowledge exchange between those implementing various reforms from benefit design to strengthening PHC. These exchanges helped to rapidly expand PHC coverage, such as in the case of **Ukraine** (see Box 20) and **Moldova** (see Box 6). Through technical and financial assistance, UHC-P support has enabled countries to develop essential

health packages that address the most pressing needs of their populations, including the most vulnerable, along with a more extensive set of services.

**In Afghanistan**, the UHC-P provided technical assistance for the implementation of an integrated package of essential health services, including NCD Best Buys,<sup>9</sup> which are a set of recommended interventions for the prevention and control of NCDs.

In the **South-East Asia Region**, WHO supported **Nepal's** Ministry of Health and Population in conducting feasibility and costing of the Basic Health Service Package, which was incorporated in Public Health Service Regulation (2019); and **Timor-Leste** with updating their Primary Health Care Essential Service Package (see Box 31).

<sup>9</sup> Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. Geneva: WHO; 2017 (<https://apps.who.int/iris/handle/10665/259232>).



### Shifting towards integrated people-centred health services (IPCHS)

Adopted in 2016, WHO's "Framework on integrated people-centred health services" (IPCHS)<sup>10</sup> calls for a fundamental shift in the way health services are funded, managed and delivered in a way that is coordinated around people's needs, respects their preferences, and are safe, effective, timely, affordable and of acceptable quality.

Within the **African Region**, IPCHS have been mainstreamed in the national health sector strategic plans (NHSSP) and UHC roadmaps of three countries – **Congo, Democratic Republic of the Congo** and **Guinea-Bissau** – and more awareness and capacity on IPCHS have been developed through the designated web platform, thereby facilitating implementation. In 2019, technical support was also provided to **Burkina Faso** in developing its national strategy on IPCHS, quality of care and patient safety. Moreover, re-engineering of PHC has been undertaken in **Sierra Leone**, where a PHC handbook has been developed that provides a framework for standardizing the PHC approach, service provision and monitoring, as well as the required system changes. **Burundi** organized a PHC National Conference to launch the implementation of the Astana Declaration at country level in September 2019.

**Chad** has developed a health map that includes geolocation of infrastructures, equipment, human resources for health (HRH), etc., to improve coordination and to guide investment plan development in the health sector.

IPCHS calls upon health systems to be more responsive to the needs of citizens and to meet them when and where they are. In the **Western Pacific Region**, this was demonstrated in the **Federated States of Micronesia** and the **Marshall Islands**, where the UHC-P was used to leverage a new model of care to bring PHC to remote populations, including purchasing a boat and leveraging biometric technology to track health information. Efforts to strengthen PHC for rural, remote and vulnerable populations were also a core tenet of UHC strategies.

10. Framework on integrated people-centred health services. In: World Health Organization [website]. Geneva: WHO; 2016 (<https://www.who.int/service-delivery/safety/areas/people-centred-care/framework/en/>).

11. WHO calls for urgent action to reduce patient harm in healthcare. In: World Health Organization [website]. Geneva: WHO; 2019 (<https://www.who.int/news-room/detail/13-09-2019-who-calls-for-urgent-action-to-reduce-patient-harm-in-healthcare>).

12. Ethiopia commemorates 1st World Patient Safety Day. In: World Health Organization Ethiopia Country Office [website]; 24 September 2019 (<https://www.afro.who.int/news/ethiopia-commemorates-1st-world-patient-safety-day>).

In **Cambodia**, this included an initiative focused on revitalizing PHC, "Accelerating towards UHC in Cambodia Initiative", which saw the roll-out of training on a new community health handbook, the development of minimum standards for private health facilities, and a primary care monitoring dashboard integrated into the health management information system (HMIS).

### Making quality of care and patient safety a priority

WHO defines quality of care as the extent to which health-care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred. Recognizing that 80% of harm is avoidable, WHO has created World Patient Safety Day.<sup>11</sup> In **Ethiopia**, it was co-organized by the National Patient Safety Technical Working Group.<sup>12</sup> Efforts to improve quality of care as part of the UHC-P's work in 2019 were far reaching, from focusing on and ensuring quality and safety in primary care, ambulatory and hospital settings, to a major focus on the access to medicines priority (see section 1.3).

Quality and patient safety is often accompanied by national-level regulations, such as in **Indonesia** where the UHC-P worked to develop a national guideline on monitoring and evaluating quality in hospitals. WHO played a convening role in bringing stakeholders together to assess the feasibility and develop the guidelines. Following initial development, Indonesia is examining expanding the quality framework to primary care centres.

Capacity-building for patient safety is also taking place in **Pakistan**, where the UHC-P has ongoing work supporting implementation of the Patient Safety Friendly Hospital Initiative in 38 hospitals across the country. Moreover, in **Kyrgyzstan**, the Government had prioritized building a quality-of-care management system for health service delivery, including PHC. The UHC-P was able to facilitate this work with the World Bank, KfW and the Swiss Agency for Development and Cooperation.

What countries are telling us



The issue of patient safety deserves due attention because it is among the foremost challenges of the health sector especially in developing countries. The best way to address this challenge is open discussion and learning from errors.

Dr Lia Tadesse, State Minister of Health, Ethiopia

## Box 5: Compact 30.30.30 PHC for Universal Health

The Compact 30.30.30<sup>13</sup> PHC for Universal Health is a call to action to intensify and accelerate the efforts in the **Region of the Americas** to achieve universal health and the SDGs by 2030.<sup>14</sup> It was launched in **Mexico City** in 2019 by the Director of the Pan American Health Organization (PAHO), Dr Carissa F. Etienne, in an event co-led by His Excellency Andrés López Obrador, President of Mexico, which drew representatives from 24 Member States, including 20 ministers of health.

The Compact reaffirms that health is a right and that “universal” means universal – that is, that all people have access to and coverage of comprehensive and quality health services and interventions to address the social determinants of health, without incurring financial hardship. This requires the commitment to transform health systems in the Americas, a concerted effort to transform health systems in the Region by:

- reducing by at least 30% barriers to access health services; and
- increasing public spending on health to at least 6% of gross domestic product, with at least 30% of these resources invested in the first level of care.

The new PHC 30-30-30 Compact for Universal Health is PAHO's immediate response to the 10 recommendations of the High-level Commission on Universal Health in the 21st Century, and a call to its Member States to accelerate the regional response to achieve health for all in line with the SDGs.

*“Applying these recommendations will catalyse the transformation we need to achieve Universal Health by 2030.”*

**Dr Carissa F. Etienne, Director, PAHO/WHO**

## Box 6: Moldova: WHO Package of Essential Noncommunicable Disease Interventions (PEN)

The WHO Package of Essential Noncommunicable Disease interventions (PEN)<sup>15</sup> for primary care in low-resource settings is a set of cost-effective interventions to enable the early detection of cardiovascular diseases, diabetes, chronic respiratory diseases and cancer. In 2019, as part of the UHC-P, Moldova prioritized evaluation of the roll-out of PEN protocols in piloted PHC institutions.

The project contributed to strengthening PHC based on WHO PEN protocols, which included improving health professionals' skills in early detection and condition management of major NCDs. Over 20 PHC facilities participated in the pilot, with 10 serving as the control. Over the duration of the project, a group of medical residents collected the baseline data that were analysed by the Steering Group and ultimately presented at a national conference.

Three health centres with the best results in PEN protocols implementation were selected to participate in a study tour to Finland to learn best practices on short interventions, especially of cardiovascular diseases. A team of 12 family doctors and nurses has improved their knowledge and capacities in PEN protocols implementation.



Using the MedMon app in a pharmacy in Moldova. © WHO/Igor Vrabie.

13. Compact 30.30.30 PHC for Universal Health. In: Pan American Health Organization [website]. Washington (DC): PAHO; 2019 ([https://www.paho.org/hq/index.php?option=com\\_content&view=article&id=15470](https://www.paho.org/hq/index.php?option=com_content&view=article&id=15470)).

14. PHC 30-30-30, PAHO's new Regional Compact on Primary Health Care for Universal Health. In: Washington (DC): PAHO; 11 April 2019 ([https://www.paho.org/hq/index.php?option=com\\_content&view=article&id=15078](https://www.paho.org/hq/index.php?option=com_content&view=article&id=15078)).

15. Tools for implementing WHO PEN (Package of essential noncommunicable disease interventions). In: World Health Organization [website]. Geneva: WHO ([https://www.who.int/ncds/management/pen\\_tools/en/](https://www.who.int/ncds/management/pen_tools/en/)).

## Leadership and governance (GPW13 output 1.1.4)

Effective governance is critical if countries are to move towards UHC. Governments' central role includes policy and planning; organization of the health system; and regulation of services, health financing, human resources and technologies. The work on governance is done ultimately to impact the delivery of services, such as the scale-up of access to PHC or NCD interventions.

### Mobilizing policy-makers for UHC

Across several countries and regions, the UHC-P is being recognized for convening and mobilizing policy-makers, such as in **Mongolia** and **Cabo Verde**, where significant new additional funding was allocated to UHC in 2019.

The road to UHC implies continued support to ensure responsiveness to changes in the political environment and to provide timely assistance to country-defined priorities when windows of opportunity emerge. This approach is leading countries to enact banner legislation, such as UHC acts that increase access to services while improving financial protection, as mentioned earlier, as well as also providing health systems strengthening to priority areas. In the Region of the Americas, PAHO's Director met with the President of **Paraguay** to discuss comprehensive reform of the health system in order to achieve UHC (see Box 10).

Due to the flexible support, the WHO Country Office in **Belize** was able to respond to the health needs of the country and adequately provide technical cooperation to bring in international experts, conduct assessment missions and deliver capacity-building. This work resulted in a situation assessment for cancer prevention and control that was conducted with broad stakeholder consultation to build the plan, as requested by the Ministry of Health. WHO supported the situation analysis and report; and the drafting of the national cancer plan is currently under development.

As part of the UHC-P's work to support progress towards UHC, WHO organized a multidisciplinary mission to the **Democratic Republic of the Congo** in 2019 to conduct a sectoral diagnosis following political changes and a health system disruption due to the ongoing Ebola epidemic. The country signalled its intent to invest much more in the way of addressing governance issues as it was identified as

a top priority, and UHC is one of the pillars of the President's programme. Based on the diagnosis, the mission provided support for the development of the UHC Strategic Plan and proposed the development of national, sectoral and provincial roadmaps to engage actions to improve availability of essential health services, and to introduce compulsory health insurance and medical assistance for certain categories of the population.

### Building transparent institutions

Under strengthening health system governance, a major focus is building transparent institutions, which requires sustained support that includes:

- institutional analysis and development;
- delivering policy dialogues for vision setting and consensus building;
- developing national and health system strategies;
- legal frameworks, including technical and political support; and
- communicating the plan and action at various levels.

This work has been a particular focus of the **European Region**, whether it is organizing a participatory process engaging actors across government, civil society and donors to develop the National Health Sector Development Strategy 2030 in **Moldova**, or maintaining a sustained effort to create a legislative framework to strengthen PHC in **Azerbaijan** (see Box 9). As part of its work with Moldova that was initiated with WHO support, a coordination process, governance mechanism and a national steering committee, including thematic working groups (human resources, public health, health financing, medicines, service delivery, information technology and communications), were agreed upon to assess the strategy and present options at a policy dialogue.

In the **Eastern Mediterranean Region** with the example of **Tunisia**, the "Societal Dialogue", implemented by the Ministry of Health proved to be a unique exercise in participatory democracy that helped to develop the new National Health Policy with a goal to move towards UHC in 2030. By bringing together technical experts, health professionals, policy-makers, elected representatives and citizens, the Societal Dialogue was able to put a major focus on the reduction of inequities in the policy, in part through institutionalizing universal entitlements.<sup>16</sup>

### Box 7: Timor-Leste: Updated programme on PHC rolled out

WHO provided support to revise the Primary Health Care Essential Service Package (PHC-ESP) in **Timor-Leste** that is re-orienting the model of health services towards integrated people-centred health services, while at the same time enabling reforms in upstream health policy processes. As part of a multi-phased approach, the Ministry of Health now has a revised benefit list following a systematic approach and rigorous consultation process. Through the service consumption forecasts, costing of the package and implementation feasibility assessment, the Government is now equipped with all the necessary tools to implement the PHC-ESP, which addresses the current epidemiological profile characterized by growing burden of NCDs, new public health policies and revised staffing standards, among others. Timor-Leste's flagship programme, Saúde na Família, comprising family-based domiciliary visits by multi-skilled teams, has been rolled out through policy, ministerial diploma and implementation arrangements, including digitization of health records of individuals, as well as family and household health statuses and determinants.

16. Towards a National Health Policy: Societal Dialogue in Tunisia goes strong. In: Universal Health Coverage Partnership [website]; 13 February 2019 (<https://www.uhcpartnership.net/towards-a-national-health-policy-societal-dialogue-in-tunisia-goes-strong/>).

## Box 8: South Africa: Presidential Health Compact

The Presidential Health Compact, a five-year roadmap for health systems strengthening reforms towards accelerating UHC in South Africa, was signed by President Cyril Ramaphosa in 2019.<sup>20</sup> The Compact outlines the roles of all key stakeholder groups in the implementation of critical tasks related to UHC and national health insurance in South Africa, such as updating quality improvement plans, developing an operational plan for human resources for health, improving public financial management, increasing access to essential medicines, upgrading infrastructure, and using information technology through public–private partnerships for scaling up initiatives to strengthen health systems.

*“Our mission is to reform health care, to make it better suited to the needs of an ever-growing population, which is part of a global movement towards equitable health care access that was given new impetus when the Sustainable Development Goals were adopted in 2015.”*

**Cyril Ramaphosa, President, South Africa**

*“The implementation of the compact is expected to contribute significantly towards improving the health-care system in the country, leading to many more South Africans having access to quality health services. We believe that it is the path to South Africa’s acceleration towards Universal Health Coverage, which will ensure that the country contributes to the Sustainable Development Goals, especially Goal 3 on Health, aimed at ensuring healthy lives and promoting well-being for all at all ages.”*

**Dr Brian Chirombo, Acting WHO Representative to South Africa**

### Supporting national health sector strategic plans (NHSSP)

Much of the work under the health system building block of governance has been centred around the building of national health strategies or NHSSP. As seen in the **Eastern Mediterranean Region** with the implementation of the Salalah Declaration on UHC (see Box 12) the UHC-P has helped to galvanize support regionally to put UHC on the agenda, including hosting a Regional Parliamentary Forum on Health and Well-being.<sup>17</sup> For example, in **Egypt**, the UHC-P provided technical assistance to implement the Universal Health Insurance Law and related institutional transformation. The result of all this work is a law which makes universal health insurance compulsory for Egyptians, while also securing credible funding, introducing new funding mechanisms, reforming pooling and purchasing arrangements, and redefining cost-sharing structures. Much like in the case of the Philippines (see Box 11) in the **Western Pacific Region** or in the **Ukraine** with the State Budget Law that included the Medical Guarantees Programme, the work is a result of the cumulation of sustained and flexible support that ranged from bringing together policy dialogues for developing systems of the future to providing pragmatic technical assistance to build national institutions.

In the **South-East Asia Region**, support was provided to **Timor-Leste** to ensure effective governance by supporting a comprehensive review of its NHSSP, including annual joint sector reviews, quarterly review meetings and support to conduct annual operational planning, which mirrors much of the work being done at country level across the entire UHC-P network. This work was coupled with advocacy and policy dialogues with parliamentarians that have further strengthened the visibility of UHC and priority placed on UHC. Health strategies have been re-enforced, ensuring they are leading to UHC, not only through direct support in developing specific strategies (health financing, pharmaceutical roadmap, human resource for health, and digital health roadmap), but also through enhancing knowledge of UHC among parliamentarians and university faculty and students.

### Building implementation capacity

To improve access to quality essential health services, which range from health promotion to prevention, treatment, rehabilitation and palliative care, there is considerable work to be done at the governance and financing levels to create the frameworks to ensure that nobody is left behind.

For example, in the **African Region**, beyond working to develop regional and national guidelines to inform the development and implementation of NHSSP, a large focus of UHC-P support has been provided to review, cost and implement these plans. Over 14 countries in the African Region have been using the OneHealth Tool<sup>18</sup> that provides planners with a single framework to link strategic objectives and targets of disease control and prevention programmes, with specific support for scenario analysis, costing, health impact analysis, budgeting and financing of strategies. This serves to improve their alignment to UHC aspirations, which are guided by the Region’s regional UHC strategy.<sup>19</sup> The number of countries that have developed UHC roadmaps has increased to 18 with contributions from more than 10 scoping missions that took place in 2019.

With many decentralized health systems, much of this work is also done in tandem at the district level, such as in **Sierra Leone** where a performance and assessment of the capacity gaps was undertaken to support planning, coordination and monitoring.

<sup>17</sup>. Meeting of the Regional Parliamentary Forum for Health and Well-being opens in Tunis, Tunisia. In: WHO Regional Office for the Eastern Mediterranean [website]; 25 June 2019 (<http://www.emro.who.int/media/news/first-meeting-of-the-regional-parliamentary-forum-for-health-and-well-being.html>).

<sup>18</sup>. OneHealth Tool. In: World Health Organization [website]. Geneva: WHO (<https://www.who.int/choice/onehealthtool/en/>).

<sup>19</sup>. Leave no one behind: Strengthening health systems for UHC and the SDGs in Africa. Brazzaville: WHO Regional Office for Africa; 2017 (<https://www.afro.who.int/publications/leave-no-one-behind-strengthening-health-systems-uhc-and-sdgs-africa>).

<sup>20</sup>. President Cyril Ramaphosa: Signing of Presidential Health Compact. Government of South Africa [website]; 25 July 2019 (<https://www.gov.za/speeches/president-cyril-ramaphosa-signing-presidential-health-compact-25-jul-2019-0000>).



## Box 9: Azerbaijan: Creating a framework for better PHC

Azerbaijan, with the roll-out of its mandatory health insurance, is aiming to improve population health outcomes via better public health and primary health-care services and improved financial protection. Following extensive advocacy by WHO, a Parliamentary Working Group was formed in order to draft changes in the national health legislation to create a legislative framework to strengthen PHC in Azerbaijan. Moreover, WHO co-hosted a policy dialogue in 2019, gathering high-level national policy-makers and international experts to advance the national dialogue on PHC strengthening. One of the main outcomes of the WHO technical assistance is a PHC demonstration project that coincides with the roll-out of mandatory health insurance. The goal of the project is to modernize and strengthen PHC services in Azerbaijan, focusing on NCD prevention, management and follow-up. This project will eventually yield evidence for scaling up an improved PHC model across the nation, improving health service quality and accessibility.

## Box 10: Paraguay: Health sector reform

In Paraguay, the UHC-P contributions had a high impact on the governance function of the Ministry of Public Health and Social Welfare through the reform that was ordered by presidential decree, including high-level meetings between the PAHO Director and the President.<sup>21</sup> The UHC-P supported the restructuring of the Ministry, the development of the Ministry's Organization and Management Manual, and the creation of the National Directorate of Quality and the National Directorate of Indigenous Health.

A high-level commission was created among the most important public providers, the Ministry of Public Health (covering 72% of the population) and the Social Welfare Institute (covering 22% of the population) to advance the integration of technical processes related to information, rules, procedures and costs monitoring between both institutions. The first high-level national meeting for health sector reform was held with the presence of the Minister of Health and the Government Cabinet Secretary, with technical support by PAHO.

PAHO has continued to accompany the Ministry of Public Health and Social Welfare through its process of reform of the health sector, including supporting the implementation and accompanying regulations for the Health Law of Indigenous Peoples. This involved support for integration of the Directorate of Health for Indigenous Peoples with the functions of services, surveillance and epidemiology, as well as on-the-ground support for integration of health service networks in the western region of Chaco, with impact on equity and intercultural health.

*“The National Development Plan 2030 and the National Health Policy are the guiding frameworks that will allow us to reach the goal of universal access and coverage.”*

**Dr Julio Mazzoleni, Minister of Health, Paraguay**

*“The challenge we have is also to install the health issue on the agenda of the other state powers, the legislative and the judicial. To speak of health is to speak of development and it is in everyone's interest.”*

**Dr Luis Roberto Escoto, PAHO/WHO Representative, Paraguay**



21. President of Paraguay and PAHO Director address the country's health priorities. In: Pan American Health Organization [website]; 12 March 2019 ([https://www.paho.org/hq/index.php?option=com\\_content&view=article&id=15019](https://www.paho.org/hq/index.php?option=com_content&view=article&id=15019)).



Photo source: Senate of the Republic of the Philippines.

### Box 11: Philippines: UHC Law

WHO's global drive for UHC came at an opportune time in the Philippines to advocate and inform the consultation and drafting process for the UHC Act in the Senate. The WHO Philippine Country Office, in close liaison with the WHO Regional Office for the Western Pacific, gently steered the process in the areas of people-centred integrated service delivery and health financing, drawing on experiences from other countries in the Region. Building on this historical work, the Philippines saw the UHC bill signed into law in 2019,<sup>22</sup> which automatically enrolls every Filipino citizen into the National Health Insurance Program, providing them access to the full continuum of health services, while protecting them from enduring financial hardship as a result.

WHO's role throughout was to provide evidence-based technical information upon which policy decisions should be based, in addition to providing technical assistance in framing the UHC bill so that it addressed bottlenecks in achieving UHC. One example of this was the issue of local government autonomy. The UHC Act contains provisions that consolidate local health systems and provide for the pooling of funding from the Department of Health, Philippine Health Insurance Corporation (PhilHealth), local government units and other sources, such as proceeds from the Philippine Amusement and Gaming Corporation. This was initially controversial, as local government units were skeptical about the potential effectiveness of the Act. WHO was able to share the experience of China, with its similar scale and devolved systems, to demonstrate that it was indeed possible and desirable to implement these reforms. This support was instrumental to the Government in order to pass such provisions, and WHO then continued to work with the Department of Health and PhilHealth as they enacted guidelines needed to implement and operationalize the Act.

Subsequently, WHO Philippines provided technical services and legal advice to the Department of Health and PhilHealth to ensure that all provisions of the consolidated draft Implementing Rules and Regulations of the Universal Health Care Act were written in clear and concise legal language while preserving technical recommendations and integrity.

In order to ensure alignment and common understanding among stakeholders of the undertakings needed to deliver UHC to the Filipino people, the UHC advanced implementation sites initiative required technical assistance to define the standardized process of translating the provisions of the UHC Act into long-term implementable strategies that will guide the day-to-day operations of the province- or city-wide health system. This was done through UHC-P funding and the WHO Philippines Country Office by the facilitation of a province-/city-wide health system visioning exercise and strategic planning.

*“By automatically enrolling our citizens into the National Health Insurance Program and expanding PhilHealth coverage to include free medical consultations and laboratory tests, the Universal Health Care Law that I signed today will guarantee equitable access to quality and affordable health-care services for all Filipinos.”*

**President Rodrigo Duterte, Philippines**

22. UHC Act in the Philippines: a new dawn for health care. In: World Health Organization [website]. Geneva: WHO; 2019 (<https://www.who.int/philippines/news/feature-stories/detail/uhc-act-in-the-philippines-a-new-dawn-for-health-care>).

## Box 12: Eastern Mediterranean Region: Implementing the Salah Declaration for UHC

The UHC-P has been instrumental over the years in supporting the Eastern Mediterranean Region in progressing towards UHC by gaining high-level political support, as well as working directly with nine countries. In line with GPW13, Vision 2023,<sup>23</sup> the Eastern Mediterranean Region has identified expanding UHC as a top strategic priority, following the Salah Declaration on UHC to ensure that at least 100 million more people benefit from UHC by 2023.<sup>24</sup> In 2019, this included hosting the first meeting of the Parliamentary Forum for Health and Well-being in the Eastern Mediterranean Region, as well as connecting regional and country-level initiatives.

Moreover, in line with the Salah Declaration, the Sixty-sixth session of the WHO Regional Committee for the Eastern Mediterranean held in 2019 endorsed resolutions for “Strengthening the nursing workforce to advance universal health coverage in the Eastern Mediterranean Region” and “Introducing the framework for action for the hospital sector in the Eastern Mediterranean Region”.<sup>25</sup>

Following the recommendation of the Salah Declaration, the Region developed the UHC-Priority Benefits Package (UHC-PBP) in 2019. This package at the national level is a set of publicly financed, evidence-informed, prioritized individual and population-based interventions, defined through a deliberative process, which accounts for people's health needs, countries' economic reality and societal preferences. The UHC-PBP consists of health services and programmes and intersectoral actions and fiscal policies. Health services and programmes include promotive, preventive, curative, rehabilitative and palliative interventions that respond to people's health needs. Intersectoral actions and fiscal policies relate to actions in other sectors with impact on health, such as the promotion of physical activity, subsidizing beneficial commodities or taxing harmful products.

Further to this, the Region prepared an operational guide for the development of UHC-PBP at the national level with 11 countries working towards implementation. **Afghanistan** revisited its 2005 package of services in 2019 and has a plan for its implementation in 2020. **Jordan** conducted a mapping exercise to understand the status of existing interventions. **Pakistan** defined the first batch of costed services for PHC.

*“Expanding coverage of essential health services to our people is likely to reduce inequality, but much more efforts beyond the health sector are also critical.”*

**Dr Zafar Mirza, State Minister for National Health Services, Regulations and Coordination, Pakistan**

*“The Ministry of Health is the focal point, but health concerns everyone. We focus on prevention rather than the curative which is also important; but we need to focus on primary health care.”*

**Bahar Idris Abu Garda, Federal Minister of Health, Sudan**



23. Vision 2023. In: Regional Office for the Eastern Mediterranean [website]. Cairo: EMRO (<http://www.emro.who.int/about-who/vision2023/vision-2023.html>).

24. Salah Declaration on UHC Coverage 2018: The road to universal health coverage in the Eastern Mediterranean Region. Salah: EMRO; 3–5 September 2018 ([http://www.emro.who.int/images/stories/health-topics/uhc/salalah\\_uhc\\_declaration\\_-\\_final.pdf](http://www.emro.who.int/images/stories/health-topics/uhc/salalah_uhc_declaration_-_final.pdf)).

25. Regional Committee for the Eastern Mediterranean resolution EM/RC66/R introducing the framework for action for the hospital sector in the Eastern Mediterranean Region. Cairo: EMRO; 2019 (<https://applications.emro.who.int/docs/RC66-R4-eng.pdf?ua=1&ua=1>).

## Health workforce (GPW13 output 1.1.5)

Providing health and social care in every system and in every country is labour intensive, while the delivery of safe and good-quality services in urban and rural settings calls for a fit-for-purpose, well-performing and equitably distributed health and social workforce.

### Human Resources for Health (HRH): Building a strategy

The Global Strategy on Human Resources for Health: Workforce 2030<sup>26</sup> is aimed at planners and policy-makers at the country level to bridge the coverage gap, including in availability, accessibility, acceptability and quality. Ensuring effective coverage of HRH has helped to provide a continued focus regionally, as well as at the country level with respect to building effective HRH strategies in 2019.

In the context of the **African Region's** framework for the implementation of the Global Strategy, 10 countries developed and/or reviewed their national HRH strategies as supported by the UHC-P. This helped to raise advocacy for financing health workforce to a higher level, generating South-South cooperation, including work on the rural pipeline initiated in Niger (see Box 15).

Mirroring this, special attention was paid to the linkages between national strategies and action plans and ensuring appropriate regulations are put in place for health professionals. In **Viet Nam**, the UHC-P supported establishment of the Health Professional Council, including the introduction of national licensing examinations. In **Nepal**, the strategy was linked to the development of professional registries, like in many other countries, and led to the definition of workload indicators for medical officers, nurses, midwives, auxiliary health workers and health assistants. Also, in **El Salvador**, agreements have been established with universities, training schools and legislators for a law to regulate the clinical practices of students of medicine and dentistry, and strategies have been established to continue advancing in the assignment of health professionals at the first level of care, to reduce gaps. The Management and Development Plan for Human Talent in Health in El Salvador, 2019–2023 by the Intersectoral Human Resources Commission was published in 2019.

### Strengthening management, planning and administration

One of the key activities for HRH undertaken by the UHC-P has been to ensure that appropriate health workforce accounts are in place, developing human resource information systems (HRIS), and ensuring appropriate regulation of health professionals. A good example of linkages between the health workforce and health information systems building blocks is the case of **Morocco**, where there is targeted work in project management and information systems that is supporting the creation of a national health human resources observatory.

In both the **South-East Asia** (see Box 13) and **African Regions**, there was a focus on expanding data collection for national health workforce accounts to ensure quality support to countries. In line with these efforts, capacity for health workforce planning and projection was built, and health worker workload assessments<sup>27</sup> were undertaken in **Benin, Burkina Faso, Liberia, Nigeria** and the **United Republic of Tanzania** to determine staffing norms and needs of health facilities. Moreover, activities to strengthen regional health workforce data and evidence for planning and advocacy in all the African Region countries demonstrate the critical nature of better, more robust evidence for realistic, objective and more credible planning for the health workforce.

In **Moldova**, the UHC-P provided support for building capacity for health workforce management and planning, including scaling up the new HRIS in alignment with the WHO minimum data set for a HRH registry. WHO experts provided support to the Ministry of Health, Labour and Social Protection via six country missions in 2019 to generate short- and medium-term interventions on HRH, which are also closely linked with the WHO European Region's work on ensuring HRH planning is linked to PHC transformation.

### Creative approaches to health workforce challenges

Due to the mismatch of supply and needs, the UHC-P is supporting innovation in delivery models for integrated people-centred health services (IPCHS) that help to optimize the role of health and social workers in providing multidisciplinary care across settings. This support ranges from initiatives like the rural pipeline across the **African Region** to developing targeted training for community health aides in **Dominica** or improving the retention of rural workers in the **South-East Asia Region**.

What countries are telling us



A more efficient and robust health workforce by 2024 is on the Ministry's agenda. A solid health system will ensure that all those persons involved in health care, whether directly or indirectly, are adequately resourced and trained. It will also ensure that they remain at the core of decision-making in the health sector. Any good and progressive health-care system must therefore take good care of the most valuable asset it has – its human resources.

Dr Ramon Figueroa, CEO, Ministry of Health, Belize

26. Global Strategy on Human Resources for Health: Workforce 2030. In: World Health Organization [website]. Geneva: WHO, 2016 (<https://www.who.int/hrh/resources/globstrathrh-2030/en/>).

27. Workload indicators of staffing need (WISN): User's manual. Geneva: World Health Organization; 2015 ([https://www.who.int/hrh/resources/wisn\\_user\\_manual/en/](https://www.who.int/hrh/resources/wisn_user_manual/en/)).

Leveraging the synergies with **India's** flagship UHC programme, Ayushman Bharat,<sup>28</sup> the national roll-out of comprehensive PHC in India through its Health and Wellness Centres, WHO provided support to districts with predominantly tribal populations to address critical human resource gaps in remote areas through better planning and by applying creative HRH solutions in geographically disadvantaged areas. This included looking at innovative solutions, such as use of telemedicine<sup>29</sup> and options for prescriptions by nurses being engaged as mid-level health-care workers (MLHWs) at the Health & Wellness Centres. Following an impact assessment and health labour market analysis, a plan was developed to rapidly train and deploy MLHWs to Health and Wellness Centres in three aspirational districts with large tribal communities in Chhattisgarh State. An ongoing comparative assessment of the training curriculum of the MLHWs in the two WHO focus states, Assam and Chhattisgarh, will offer further directions to strengthening the cadre. Working with nurses and midwives was also a focus of work in **Guyana** (see Box 14), where PAHO facilitated the development of a new bill and supported knowledge exchange.

Through technical cooperation for the development of **Belize's** National Human Resources for Universal Health Strategic Plan 2019–2024, the HRH Strategic Plan was officially launched by the Ministry of Health in February 2019.

What countries are telling us



The course was a great opportunity to achieve clarity on health, the community and what makes a community, how it functions and what can affect its functionality. Health is broad and has many areas which taught us that we have to adapt to different personalities and to different environments. The course has produced 27 qualified foot soldiers for their respective communities and by extension the primary health-care service in Dominica.

**Bertisha Bertrand, Graduate, Community Health Worker, Dominica**

### Box 13: South-East Asia Region: Improving retention of health workers in rural and remote areas

The inability to retain skilled health workers, especially in rural and remote areas, can be a major barrier to achieving UHC. In the South-East Asia Region, the UHC-P enabled in-depth country case studies on rural retention in six countries (**Bhutan, India, Indonesia, Myanmar, Sri Lanka and Thailand**). These showcased good practices and facilitated knowledge exchange across the Region. Key lessons learned were:

- A combination of interventions should be coordinated, sequenced and tailored to country-specific challenges.
- Education interventions and financial incentives have been most reported, but more policy attention should be given to new roles of other cadres such as mid-level health workers.
- Financial sustainability and taking a long-term view are critical to achieving rural workforce stability.



© WHO.

28. Ayushman Bharat. In: National Health Authority [website]. New Delhi: Government of India (<https://www.pmjay.gov.in/>).

29. With regard to telemedicine in Ayushman Bharat Health and Wellness Centres, see: <https://ab-hwc.nhp.gov.in/download/document/ecc507d177d4721fab41162b1f21271.pdf>; new guidance on telemedicine: <https://www.mohfw.gov.in/pdf/Telemedicine.pdf>; <https://esanjeevaniopd.in/>

### Box 14: Guyana: Empowering nurses and midwives

In 2019 the Guyana Nurses and Midwives amendment bill was presented by the Minister of Public Health to the National Assembly. The bill overall seeks to empower the Nurses and Midwives Council – for example, in enrolling, registering, certifying and licensing nursing personnel. This comes after PAHO supported the development of recommendations to update the bill following a stakeholder consultation.

Despite progress achieved during the last decade, Guyana continues to experience one of the highest maternal and infant mortality rates in **Latin America** and the **Caribbean**. In three regions of Guyana, capacity-building was carried out in 2019 for identifying maternal near-misses for zero maternal deaths from hemorrhage, for the use of non-pneumatic anti-shock garments, as well as sensitization and assessment for implementation of the electronic Perinatal Information System. South-South cooperation was facilitated when Ministry of Public Health and PAHO staff attended a study tour in **Nicaragua** with the objective of establishing maternal waiting homes, especially in the hinterland regions of Guyana. As part of this work, PAHO facilitated inter-country learning, with Nicaragua serving as one of the best practice examples for Guyana.



Scientific studies of molecular screening for malaria identification in Suriname. © PAHO/WHO.



Community members near Mainé Soroa in the Diffa region, watching a traditional youth wrestling tournament. Photo source: Communal Office of Youth of Diffa, October 2018.

### Box 15: Niger: Building a rural pipeline of health workers

Niger is setting a strong example for the world. A range of ministries and sectors are completely engaged and working together in new ways to strengthen the health workforce and improve socioeconomic development in general. They are taking into consideration important issues such as education, employment, finance, nutrition, mother and child health, and agriculture. As part of the UHC-P, political and technical staff have been collaborating in Niger to produce the “National Action Plan for Investment in Health and Social Sector Employment and Growth in Economic Health”.

One of the key projects is the rural pipeline, which is a systemic approach to inclusive community development to promote the resources of a region. Building on the earlier work by WHO, the International Labour Organization (ILO) and the Organisation for Economic Co-operation and Development (OECD) on regional health workforce investments, intersectoral work was undertaken both in Niger and across the African Region to create new jobs, build health facilities and improve UHC coverage in underserved areas. In the Diffa region in Niger, the rural pipeline project is expected to result in:

- 300 health graduates trained and recruited in health facilities in the Diffa region; and
- 12 mutual health associations to ensure UHC for populations in the 12 communes of Diffa.

*“We, the traditional leaders in the Diffa region – having actively participated in the amendment of the document of the Rural Pipeline Project – give our total approval to its ideals. We thank the high national authorities for the special attention they are giving our region.”*

**Mariama Chipkaou, Director, Promotion of Girls' Schooling, Niger**

*“The President of the Republic, His Excellency Mr Mahamadou Issoufou, congratulated us for having provided Niger with a real operational tool allowing significant progress towards the achievement of the SDGs, in particular towards the effectiveness of social protection, at the heart of which is universal health coverage. It also pays particular attention to the success of the Diffa Rural Pipeline Project.”*

**M. Mohamed Ben Omar, Minister of Employment, Labour and Social Protection, Niger**

# DEEP DIVE

## On Primary Health Care (PHC) in the UHC Partnership

PHC is the foundation and a key driver for achieving UHC

PHC has been widely acknowledged as the preferred pathway to UHC. PHC includes three components – namely, (i) multisectoral policy and action, (ii) engaged people and communities and (iii) primary care and essential public health functions at the core of integrated health services.<sup>30</sup> Many of the activities supported through the UHC-P highlight the contributions of PHC to spur countries on their journey towards UHC.

This section examines what and how PHC-focused activities supported through the UHC-P have enabled progression towards UHC in 2019 through the lens of the WHO PHC Operational Framework.<sup>31</sup> The PHC Operational Framework was developed at the request of Member States to guide PHC implementation. It includes four strategic and nine operational levers that can be actioned to drive progress towards PHC and ultimately, UHC. These levers align with some of the elements of the GPW13 (see page 13 of the above-mentioned WHO PHC Operational Framework).

Building on the many country-specific achievements presented above, we consider here in more depth how each lever was articulated to support PHC strengthening, which levers received ample attention, and which tended to receive less. We highlight ways in which further action on some of the levers might be needed to continue making progress on PHC towards UHC.

Action on strategic levers: The PHC Operational Framework's four strategic levers are: (i) political commitment and leadership, (ii) governance and policy frameworks, (iii) funding and allocation of resources and (iv) engagement of communities and other stakeholders. Activities aimed at improving or strengthening leadership, governance and financing account for a large proportion of activities supported through the UHC-P, as expected given its origins and mandate. While action on these strategic levers does not exclusively impact PHC, most enable aspects of PHC and set the foundations needed to build robust PHC-oriented health systems needed to achieve UHC. Notable examples of activities undertaken in these areas in 2019 are described extensively elsewhere in this report. In 2019, activities that related to the first two levers and impacted PHC included leadership governance to support Health in All Policy

in **Lao People's Democratic Republic**; multi-stakeholder and multisectoral policy dialogues in **Morocco**; **El Salvador's** National Policy for Comprehensive Care of Noncommunicable Diseases launched along with a multisectoral plan; the Expert Group on Health in **Kyrgyzstan**, as well as new PHC-focused legislation in **Azerbaijan** and **Kyrgyzstan**.

Health financing was also a frequent focus of support for the UHC-P and is considered extensively elsewhere in this report. Activities under the funding lever tended to fall under two main types of activities: those related to mandatory health insurance (in **Kyrgyzstan**, **Mongolia** and **Uzbekistan**) and the development or confirmation of benefit packages (in **Nepal**, **Pakistan** and **Sudan**). In general, the reports provided little information about the specific content of benefit packages, including the extent to which they included the type and scope of benefits central to PHC, such as comprehensive high-quality primary care and essential public health function from promotion, prevention, curative, rehabilitation to palliative care.

The fourth strategic lever – the engagement of communities – overlaps with the similarly worded component of PHC. While central to PHC as a concept, relatively few countries reported community engagement activities explicitly supported through the UHC-P compared to the other three strategic levers. WHO India engaged with community-based organizations on UHC and what it means for minority groups such as women in the informal sector, transgender people and people with HIV. It was an empowering experience both for front-line activists and WHO. Other examples include health dialogue with communities focusing specifically on gender balance in **Sudan** and engagement of youth and participatory planning in **Tunisia**.

Primary health care has been widely acknowledged as the preferred pathway to UHC.

<sup>30</sup> WHO, UNICEF. A vision for primary health care in the 21st century: towards universal health coverage and the sustainable development goals. Geneva: World Health Organization; 2018 (<https://apps.who.int/iris/handle/10665/328065>).

<sup>31</sup> Interim draft operational framework for primary health care. Geneva: World Health Organization; 2020 (<https://www.who.int/service-delivery/safety/Draft-Operational-Framework-PHC-FBI46.pdf>).



## Operationalizing PHC

In addition to the four strategic levers, the PHC Operational Framework includes nine operational levers. UHC-P activities related to the health workforce and to medicines and other products were most common in 2019. Activities related to quality and digital technology were next, and those related to models of care, purchasing mechanisms, engagement of private providers, physical infrastructure, research, monitoring and evaluation, and health facilities were less common, although no less important. As countries continue to progress in fully orienting their health systems along a PHC approach towards UHC, paying close attention to which levers are typically used and in what sequence they receive attention might reveal important key enablers and barriers to UHC implementation.

The UHC-P supported activities pertaining to the PHC workforce included macro-level interventions through policy, planning such as the development of a national health workforce strategy in **South Africa** and accountability mechanisms such as the development of a licensing examination in **Lao Democratic People's Republic** (see above). They also included activities at the meso/micro level especially in the form of training, including the training of family physicians and upskilling of general practitioners in the Eastern Mediterranean Region; multidisciplinary training (see Box 16); and strengthening front-line services in the **South-East Asia Region** (see Box 19), first responders (**Haiti**), managers (**Timor-Leste**) and community aides (**Dominica**). **Paraguay** reported a particularly comprehensive strategy explicitly focused on increasing primary care capacity through extensive recruitment as described above. Planned activities related to the measure of the workload and the development of health workforce registries were either not initiated or were not completed in a number of countries. Many UHC-P activities in 2019 set the stage for the development of a health workforce able to fully deliver on PHC. Efforts to support the more complex and crucial processes to recruit, train, deploy and retain the necessary health workforce will be needed if further progress is to be made.

Activities related to medicines and other products to improve health were also common, including efforts to develop and strengthen national formularies in **Belize, Haiti, Mozambique** and **Nepal**. Strengthening of regulations through subnational capacity-building (in **Georgia** and **India**) and guidelines for rational use of essential medicines (**Nigeria**) were also notable efforts in this area in 2019. A more detailed examination of

the formularies, of the related prescribing regulations, and of funding and coverage for medication would provide a better sense of the ability of the primary care sector to deliver the services needed safely and reliably.

With respect to the lever on models of care, efforts included progress on implementation of the IPCHS approach described earlier. In addition, **Kyrgyzstan** hosted a meeting to develop a master plan for health services delivery, **Viet Nam** began to progress on the adoption of a new model of care, Pakistan adopted a family practice approach and **Egypt** established a quality service model based on PHC and a comprehensive service package via the Family Health Model. A number of countries engaged in efforts focused on NCDs, including **Cambodia's** efforts to improve diabetes screening and treatment in 25 health centres (see Box 17). It is unclear from the reports reviewed how well countries are progressing in their ability to deliver comprehensive high-quality health care to effectively and efficiently address both communicable and noncommunicable diseases. As the world emerges from the coronavirus disease 2019 (COVID-19) pandemic, it also remains to be seen whether and how the types of interdisciplinary models of care central to PHC will be established and strengthened in order to impart resilience and adaptability to health systems.

Digital technologies were the focus of a number of UHC-P activities in 2019. These tended to include digital technology as a means to support progress on another lever, such as **India's** efforts to develop a national health resource repository with data on health resources in the public and private sector collected from all states except **West Bengal** to enable planning and accountability. Other examples are the development of a digital health library in the **Bolivarian Republic of Venezuela** and important efforts to digitize vital statistics in **Lao People's Democratic Republic**. **Mongolia** provided a rare example of the use of digital technology in the delivery of health services, specifically for ultrasound and point-of-care testing. Here too, the post COVID-19 era might prompt countries to orient some of their efforts to using the full potential of digital technology to maintain access to clinical services in times of quarantine and physical distancing.

Quality was the focus of some UHC-P activities in 2019 and included efforts at the macro level, such as the development of a National Strategy on Quality Services in **Burkina Faso**, the development of minimum service standards of health facilities in **Nepal** and piloting a few hospital and National Standards on Basic Safety and Performance in **Mongolia**.

# DEEP DIVE

## On Primary Health Care (PHC) in the UHC Partnership

PHC is the foundation and a key driver for achieving UHC

The development of care protocols in the **Bolivarian Republic of Venezuela** and efforts to strengthen radiological services in **Dominica** were more focused at the meso and micro levels. There appears to be room and an opportunity for a broader and more deliberate effort to establish robust quality processes to support access to high-quality comprehensive primary care services.

Regarding the engagement with the private sector, in 2019, **Jordan** conducted a comprehensive capacity assessment of the private health sector to achieve UHC and identified important challenges. **Cambodia, Mongolia** and **South Africa** all gave attention to the regulation of the private sector. Tackling the complex challenges related to the engagement of private providers and optimizing the opportunities they present to achieve UHC may deserve further attention from the UHC-P in the future. Similarly, purchasing and payment systems received limited attention, including from **India, Mongolia** and **Uzbekistan**, and may well deserve further attention in the future in order to enable the expected benefits of sustainable and strong PHC-oriented systems on health.

Also, few UHC-P activities focused on physical infrastructure. **Uzbekistan** conducted a reorganization of its health facilities and **Cambodia** provided training to improve the function of health centres with respect to waste management, water treatment and others. The organization of health facilities to deliver high-quality primary care while accommodating the model of care of choice will be important to achieve UHC.

There were very few activities related to PHC research and processes to enable systematic research that meets the needs of policy planners and that can guide service providers. Some countries reported assessment processes as research. **India** reported establishing a few Innovation and Learning Centres for Comprehensive PHC to test innovations and learning for scale-up. **Moldova** and **Paraguay** reported some limited research-related activities on specific topics. Overall, the establishment or strengthening of a comprehensive research or knowledge enterprise to guide PHC was mostly absent, indicating that countries are paying little attention to this important area.

Monitoring and evaluation were the focus of a range of activities that were presented under a range of levers, sometimes as the goal of policies and frameworks (see Box 18 for an example of a regional approach in the **Eastern Mediterranean**), sometimes as the goal of digital technologies, or as related to accountability, quality and planning. It is expected that the PHC monitoring and evaluation framework currently in development at WHO will provide much needed guidance in this area.

### Conclusion

PHC, including its crucial primary care services component, is essential to achieve UHC. UHC-P countries have demonstrated in 2019 the rich and diverse ways in which progress can be made on PHC for UHC. Review of the UHC-P reports indicates a concentration of efforts around the four strategic levers of the PHC Operational Framework, in part because this paves the way for actions related to the other nine levers. The health workforce, medicines and other products and – to a lesser extent, digital technologies – have also received significant attention, while others such as the engagement with the private sector would need deeper focus in the coming years. In the future, taking concrete action on all levers to support the delivery of the high-quality comprehensive health services required by the population will be important to reap the full benefits of UHC.



## Box 16: PHC workforce development focus across the multidisciplinary team

The UHC-P initiative has provided resources to train various professions that are depended upon for sustainable, equitable and locally relevant PHC.

- In **Cambodia** three training initiatives were developed for Village Health Support Group members.
- Community health workers were trained in **Dominica** to increase the capacity in community health centres.
- In **Timor-Leste** a collaborative health management, leadership training and mentorship programme was implemented with officials from the Ministry of Health, referral hospitals and other stakeholders.
- In **El Salvador** palliative care training was carried out across various sites and facilitated agreements were put in place at the national level.



© PAHO/WHO, Sebastian Ojeda, El Salvador.

Nurse taking woman's blood pressure. Cacaopera, El Salvador. 30 November 2011. © PAHO.

### Box 17: Cambodia: An example of community and stakeholder engagement

Through the support of the UHC-P, Cambodia has strengthened community health literacy and engagement via the development of a community health handbook that includes more than 20 topics, developed in collaboration with the WHO Cambodia Country Office. This required a coordinated approach to health education across all national programmes and departments. This is an example of multisectoral engagement to facilitate health education dissemination, demonstrating the ability of PHC to provide sustainable, holistic and equitable solutions.

### Box 18: Primary Health Care Measurement and Improvement Initiative (PHCMI): A regional collaboration for evidence-informed PHC reforms

The WHO Regional Office for the Eastern Mediterranean, UNICEF, Bill & Melinda Gates Foundation and World Organization of Family Doctors have collaboratively launched the PHCMI to build national capacity for assessment-based PHC improvement in the **Eastern Mediterranean Region**.

PHCMI is built on global goods from the Primary Health Care Performance Initiative (PHCPI), the PHC Operational Framework, preexisting regional efforts on the family practice approach, PHC quality indicators, and **Eastern Mediterranean Region** health system profiles. The results of this initiative are being driven through the following approaches:

- building regional and national capacity, in addition to awareness, for an enhanced assessment-based approach to PHC improvement;
- institutionalizing PHC measurement in existing health system performance assessments; and
- improving PHC performance and scaling-up of the family practice approach to help countries accelerate progress towards the achievement of UHC.

To start, the evaluation of the performance of health systems at the PHC level has been conducted along with identification of priority areas for improvement in 22 countries in the **Eastern Mediterranean Region**. The UHC-P contributed in the measurement phase of the initiative at the country level and will be assisting selected countries in the implementation phase in 2020–2021 through the PHC-intensified support programme. The initiative presents a successful regional collaboration among development partners and national governments for improving evidence-informed PHC reforms.

### Box 19: South-East Asia Region: Strengthening front-line services for UHC

In 2019, the South-East Asia Region hosted a regional consultation on strengthening front-line services for UHC by 2030 in **New Delhi**.<sup>32</sup> This is part of the Region's work to adapt front-line services to changing needs, including ensuring more integrated health services of adequate safety and quality; health workforce education and rural retention; and improved HRH data.

As part of the consultations, participants agreed to a series of recommendations around three thematic focus areas:

- organization, management and staffing of front-line health services to accelerate progress towards UHC;
- effective strategies to improve health service quality and safety; and
- monitoring trends in the performance of front-line health services.

The UHC-P is actively supporting experimentation with new ways to organize, manage and pay for front-line services, such as new models that incorporate ageing and NCDs, or that leverage strategic purchasing and procurement of medicines.

32. Strengthening frontline services for universal health coverage by 2030: regional consultation. New Delhi: WHO Regional Office for South-East Asia; 23–25 July 2019 (<https://apps.who.int/iris/handle/10665/328579>).

## 1.2 Reduced number of people suffering from financial hardship (GPW13 outcome 1.2)

Ensuring adequate health financing requires the strengthening of four functions at country level: revenue raising, pooling resources, purchasing health services, and benefit design and rationing mechanisms.<sup>33</sup>

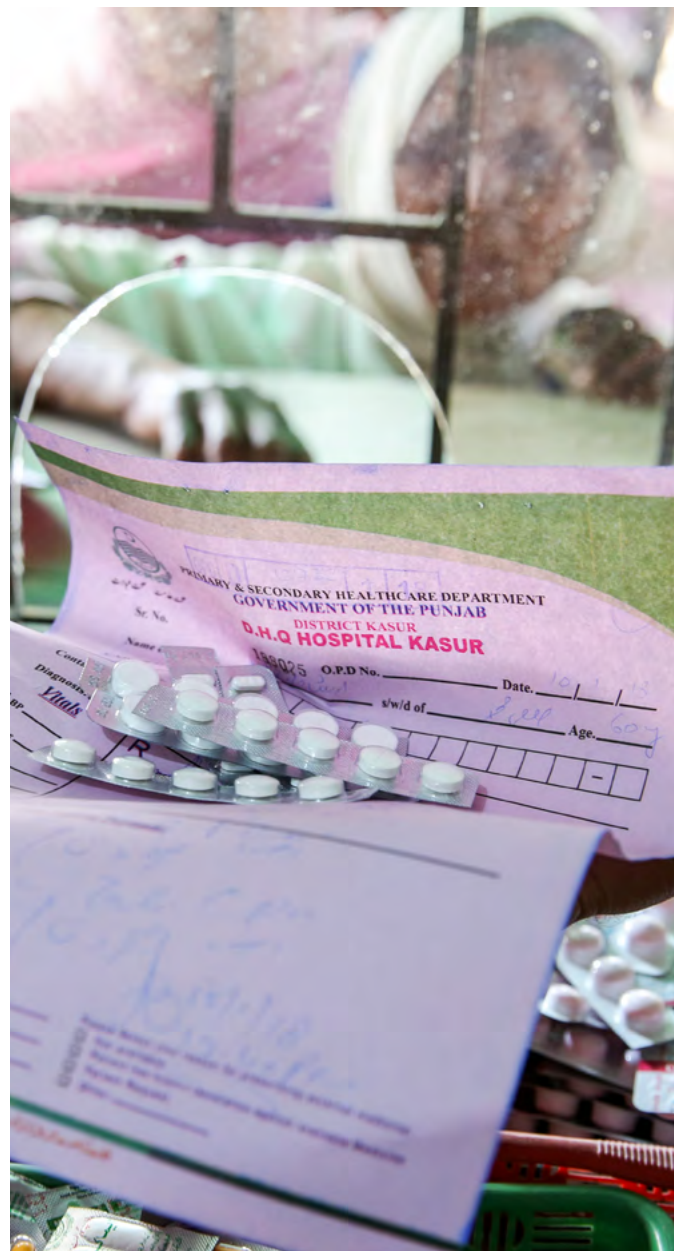
Countries can improve efficiency by supporting institutional development of pooling systems; by developing health service networks built on a strong first level of care; by developing the strategic purchasing function, including applying evidence-based and participatory methodologies in decision-making regarding the inclusion of medicines and health technologies in health systems; and developing performance-oriented provider payments systems and incentives mechanisms. To this end, WHO has used the UHC-P to provide health financing support aimed at not only contributing to the development, adjustment and updating of national health financing strategies, but also accompanying priority reform processes in health financing. In some countries, this health financing support was undertaken jointly with P4H, the Social Health Protection Network.<sup>34</sup> A special analytical section of this report goes into further depth about health financing (see Deep Dive on Health Financing in the UHC Partnership).

What countries are telling us



**A strategic approach to sustainable health financing is necessary; not just to secure increased financial resources for health, but to strengthen mechanisms for revenue generation, pooling resources and strategic purchasing in the health sector.**

**Bonifacio Maucoli des Reis, Vice Minister for Health Strategic Development, Ministry of Health, Timor-Leste**



A health worker gives free medicine to patients in district headquarters hospital (DHQ) Kasur, Punjab province, Pakistan. © WHO/Asad Zaidi.

## Health financing strategies to improve equitable access

The development of a national health financing strategy is one of the key entry points used by WHO to spur policy dialogue, and aims for an agreed strategic vision for health financing and identification of the most appropriate policy options to achieve it. The UHC-P has made considerable efforts in convening stakeholders, such as in **Morocco** for a National Health Financing Forum, which catalysed an opportunity for WHO to provide technical assistance for the development of a national health financing strategy (see Box 22). In the **European Region**, WHO co-hosted a policy dialogue with the Ministry of Health of **Uzbekistan** with over 100 participants, including partners such as UNICEF, the World Bank and the Asian Development Bank. The dialogue was organized to support comprehensive health financing reform, which aims at transforming the health financing policies and arrangements to put Uzbekistan on the path to UHC, through the introduction of a state health insurance fund, strategic purchasing mechanisms, and a single benefit package for the whole population.<sup>35</sup>

Beyond supporting a policy dialogue, the UHC-P regularly aids with the generation of evidence to inform the development of health financing strategies. Moreover, countries receive technical and policy advisory support for the process of implementing activities and reforms to improve financial protection. In a number of countries, this involved the development and advancement of robust national health insurance legislation, such as in **Egypt**, the **Philippines**, **South Africa**, **Uzbekistan** and **Zambia** in 2019. This was also the case in **Mali**, whose National Assembly had recently voted on a Universal Health Insurance Law, and to which the UHC-P provided support in 2019 to revise the accompanying health financing strategy and the universal health insurance care package.

**Timor-Leste** launched its first national Health Financing Strategy, which will enable a strategic approach to sustainable health financing not just to secure increased financial resources for health, but to strengthen mechanisms for revenue generation, pooling resources and strategic purchasing in the health sector to accelerate progress towards UHC. The Health Financing Strategy was launched at the Health Financing Forum, alongside the Health Financing Diagnostic Report.

In **Tajikistan**, a strategic plan for health financing reform has been developed with the overall goals of improving equity in access to health services and enhancing efficiency of the health sector through the introduction of new financing mechanisms.

33. Kutzin J, Witter S, Jowett M, Bayarsaikhan D. Developing a national health financing strategy: a reference guide. Geneva: World Health Organization; 2017 ([https://www.who.int/health\\_financing/tools/developing-health-financing-strategy/en/](https://www.who.int/health_financing/tools/developing-health-financing-strategy/en/)).

34. Link to francophone workshop in Senegal on health insurance (Laboratoire de partage d'expériences dans la mise en oeuvre de l'Assurance Maladie à vocation Universelle en Afrique de l'Ouest francophone) under Stories from the Field at: <https://www.uhcpartnership.net/>

35. Policy dialogue to support development of health financing strategy in Uzbekistan. In: WHO Regional Office for the European Region; 30 April 2019 ([www.euro.who.int/en/countries/uzbekistan/news/news/2019/4/policy-dialogue-to-support-development-of-health-financing-strategy-in-uzbekistan](http://www.euro.who.int/en/countries/uzbekistan/news/news/2019/4/policy-dialogue-to-support-development-of-health-financing-strategy-in-uzbekistan)).

36. Mathauer I, Dale E, Jowett M, Kutzin J. Purchasing health services for universal health coverage: How to make it more strategic? Geneva: WHO; 2019 (<https://apps.who.int/iris/handle/10665/311387>).

## Aligning strategic purchasing and benefits design with UHC goals

Strategic purchasing<sup>36</sup> for UHC seeks to link the transfer of funds to providers, at least in part, with information on aspects of their performance or the health needs of the population they serve. A core part of the country-defined priorities for the UHC-P has been strengthening resource allocation, strategic purchasing and benefits design for UHC. For example, **Ukraine** built, costed and implemented a benefits package based on PHC (see Box 20).

In the **European Region**, for instance, this work has been done collaboratively by analysing the alignment of strategic purchasing with health system goals, providing technical assistance, and building capacity and institutional support. In **Georgia**, the Social Services Agency developed a strategic purchasing strategy with WHO support, and it is being put forward to the Georgian Parliament. Support for the mandatory health insurance fund in **Kyrgyzstan** helped to strengthen the contracting mechanism for purchasing needed health services by volumes, types and quality. This support took the form of a two-day retreat for core staff and staff from the various regions, as well as working with the territorial units and hospitals to inform the strategic purchasing approach and case-based contracting.

What countries are telling us



With significant support of the UHC Partnership and the WHO Regional Office for Europe, we are committed to take tangible steps towards UHC by introducing DRG (diagnosis-related group)-based payment and a strategic purchasing system. This will ensure delivery of cost-effective, transparent and patient-oriented quality health services without people experiencing financial hardship.

**David Sergeenko, Minister of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs, Georgia**

## National health accounts: Tracking efforts and results to support decision-making

Through the health accounts<sup>37</sup> country platform, WHO provides countries with the framework, tools and technical support to institutionalize and set up a harmonized, integrated platform for annual and timely collection of health expenditure data. The creation of national health accounts (NHAs) has been prioritized by many countries, as the information is also used to develop policies that help protect citizens from catastrophic health bills, reduce inequities in health and make strides towards UHC.

This work mainly consists of capacity-building and technical assistance for countries to routinely produce NHAs. For example, in the **African Region**, training was undertaken with participants from 46 countries and subsequently, technical assistance was provided for 27 countries to develop NHAs. Given this support, **Eswatini** and **South Sudan** were able to produce their first-ever draft NHA reports. The enhanced capacity of countries contributes to better evidence for advocacy for more and better allocation of resources. Similar targeted support was provided in other regions, where countries such as **Afghanistan, Haiti, Lebanon** and **Tunisia** received support from WHO for health expenditure surveys and institutionalizing of health accounts.

With WHO's help in providing technical support to produce NHAs, countries like **Nepal** have been able to increase regular monitoring and to develop their NHAs annually, with plans in place to cover the subnational level in the coming years. Led by the Ministry of Health and Population, 2019 saw the establishment of a technical working group and steering committee to identify core areas of intervention in the health financing sector in which WHO, World Bank and the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) actively supported the process.

The **Western Pacific Region** provided technical assistance to many of the countries in the preparation and estimation of health expenditures in the Global Health Expenditure Database. The UHC-P was also used to conduct analyses in several countries on spending on PHC. For **Cambodia**, this evidence generated for the Ministry of Health provided the opportunity to convene institutions and partners to discuss a joint approach to expanding financial coverage, including revitalizing PHC.

What countries are telling us



I sincerely hope that this health financing strategy will ensure that Government health budgeting and expenditures remain compatible with the delivery of health services, both in quantity and quality, to the Timorese population. It is internationally recognized that a strong and resilient health system needs efficient and sustainable health financing.

**Simon Le Grand, Head of Cooperation of the European Union to Timor-Leste**

<sup>37</sup> Health accounts. In: World Health Organization [website]. Geneva: WHO ([https://www.who.int/health-topics/health-accounts/#tab=tab\\_1](https://www.who.int/health-topics/health-accounts/#tab=tab_1)).



## Box 20: Ukraine: Championing UHC through health financing reform

In 2015, the Government of Ukraine initiated massive reform of its entire health system, to move towards UHC and improve the health outcomes of the population. The Ministry of Health of Ukraine first focused on health financing reform and improving information systems. In 2017, the Parliament of Ukraine adopted a law on Government Financial Guarantees of Healthcare Services, which was developed and finalized by WHO. This law created a new framework for health financing which aims to reduce high out-of-pocket expenses for people who seek medical care.

The National Health Service of Ukraine (NSHU) was established to change the way funds are distributed, which was crucial to the country's UHC plans. The NSHU is a purchaser of health services from public (and eventually private) providers, and transfers money to health facilities on a per-capita basis.

Starting with primary health care, the NSHU implemented per-capita payments based on the number of enrolled patients, regardless of the number of visits or services used by the patient, and ensure that there are no out-of-pocket payments from patients. The share of public spending going to PHC has increased from 9.8% in 2016 to 14.9% in 2019 (with an expected 15.5% in 2020); the share of the population enrolled with PHC providers has also increased to 72%, with most of the population registering with a physician and reinforcing the commitment of the Government of Ukraine to provide financial protection and to deliver integrated patient-centred health services to each and every Ukrainian. By 2019, implementation of the first phase of PHC financing was practically completed and WHO continues to support implementation of the financing law, which is being extended to all levels and types of medical care.

*“It was critical to give patients a free choice of provider, to ensure competition among public and private providers, and to introduce eHealth instruments and transparency at each consecutive stage of the reform. These changes established a new social contract, which is the most important shift in the system. Under new rules a primary care physician has tripled his income not because of salary premium from the Government, but due to his or her hard work and support from the patients. This meritocracy is what really matters in the new transformed system.”*

**Pavlo Kovtonyk, Deputy, Ministry of Health, Ukraine**

*“Ukraine has been a champion of UHC in the WHO European Region since 2016 demonstrating steadfast political commitment, evidence-informed reform design, innovation, impressive speed of implementation and inspiring attention to communication.”*

**Melitta Jakab, Senior Health Economist, WHO Regional Office for the European Region**



# DEEP DIVE

## On health financing in the UHC Partnership

Over the past decade, the WHO Department in charge of Health Financing has progressively defined how health financing can support progress towards UHC. In a recent publication prepared for the United Nations General Assembly on UHC in September 2019, these lessons were synthesized “as a set of principles to guide health financing reforms, and reformers, at country level.”<sup>38</sup> These principles constitute a set of signposts for checking whether undertaken reforms (and, more importantly, their implementation) contribute to progress in health financing.

They are structured around four key axes:

### Revenue raising

- Move towards a health system that relies predominantly on compulsory funding sources.
- Increase multi-year predictability in the level of public funding likely to be available.
- Make the flow of public funds more stable.
- Promote pro-health tax and subsidy policies as a part of national fiscal policy.

### Pooling

- Reduce fragmentation in pooling, or mitigate its effects.
- To make pooling effective for UHC, ensure a large pool size, a diverse pool of health risks in the population and compulsory or automatic participation.
- Limit the role of voluntary health insurance.

### Purchasing

- Move towards more strategic purchasing of health services.
- To anticipate and mitigate the harmful effects of a single payment method, move towards explicitly mixed payment methods.
- Build or strengthen data systems on patient activity that are unified or interoperable across the health system.
- Give public providers at least some autonomy in managing their financial resources.
- Align payment arrangements with defined benefits.

### Political economy

- Incorporate political economy considerations into health financing design, adoption and implementation reform plans.

In 2019, WHO made extensive use of the UHC-P to disseminate and translate these key principles into practice and concrete actions. The organization used multiple modalities to support policy dialogue on formulation and implementation of health financing policies and arrangements; for example, technical assistance, capacity strengthening (including through peer learning and policy labs) and coordination with partners. WHO country offices, in close collaboration with WHO regional offices and headquarters, have helped national health authorities to steer the process and to define and implement coherent plans in health financing, in line with the above-listed principles.

Most of the WHO work in health financing has been around the definition of clear and coherent national health financing strategies. The organization also directly supported implementation through applied policy and operational research. The following three examples are illustrative of how WHO has adapted its support in health financing to Member States' needs and expectations, while using its unique position to softly push for the application of the above-mentioned principles; they also show how the UHC-P was instrumental to this, as it proved to be an effective modality to build a health financing policy process at country level (see Boxes 21, 22 and 23).

Most of the WHO work in health financing has been around the definition of clear and coherent national health financing strategies.

<sup>38</sup> Financing for universal health coverage: Dos and don'ts. Health Financing Guidance Note No. 9. Geneva: World Health Organization; 2019 (<https://p4h.world/en/node/8598>).



# DEEP DIVE

## On health financing in the UHC partnership

### Box 21: Uzbekistan: Better health through better coverage

Uzbekistan has been committed to moving towards UHC as part of its broader development agenda and path towards the SDGs. With WHO's support Uzbekistan developed a "Concept on health development of the Republic of Uzbekistan 2019–2025". The concept charts a new path for better health through better coverage, sets ambitious goals for the next six years and identifies major areas of the health system reform. The Government rapidly began to implement its vision after the concept was approved by a Presidential Decree on December 2018 and requested technical assistance and policy dialogue support from WHO in a wide range of areas.

#### Achievements in 2019

To implement the ambitious concept, the Government carefully considered the sequencing of policy issues and decided to begin with the transformation of health financing flows to catalyse changes in service delivery, particularly in primary health-care services. Under the leadership of the Ministry of Health, an inter-agency working group was established with the Ministry of Economy and the Ministry of Finance to develop a health financing strategy and implementation roadmap. WHO worked closely with the working group in developing a well-sequenced mission as well as virtual working sessions.

A high-level intersectoral policy dialogue on UHC was held in April 2019 with 100 key government participants and development partners. Key policy options were discussed and debated based on international experience, taking into account success stories from Europe and Asia. The policy dialogue has led to key policy decisions, including:

- designing a state-guaranteed benefit package with clear entitlements and obligations to access health services to improve financial protection and ensure utilization of health services relative to need;
- using general taxation as the source of funding to enable full population coverage;
- establishing a single national pooling and purchasing agency, the State Health Insurance Fund, to pool all budgetary resources; and
- introducing strategic purchasing mechanisms to boost quality improvements in service delivery and maximize equity and efficiency considerations in resource allocation.

Following the policy dialogue, the Ministry of Health continued further articulation of policies and implementation plans with technical assistance from WHO. Monthly multidisciplinary technical assistance missions took place, with additional virtual dialogue when needed. Four key technical areas were covered: governance and strategic planning, strategic purchasing, benefit package design; public–private partnerships; reorganization of primary health-care and hospital services; role of digital health in rolling out health insurance and reorganization of health services. Such support led to:

1. A health financing strategy and an implementation roadmap providing five-year strategic directions for the transformation of health financing policies and arrangements through the introduction of state health insurance.
2. A feasibility study on alternative revenue sources for the State Health Insurance Fund that convinced the Government that general taxation (as opposed to payroll taxes) offers the most effective way to support progress towards UHC in the country; it is consistent with the broader ongoing tax system reforms, and can be effectively complemented by additional revenue streams from sin taxes.

3. The preparation of a set of legislative documents necessary to the establishment of the State Health Insurance Fund, including operational details and its supervisory arrangements, the design process of the benefit package offered to the whole population, and formal approval of the health financing strategy and health financing reform roadmap.

4. The development of a pilot design concept note for testing the envisioned health financing and service delivery arrangements in Syrdarya Oblast (starting in 2021), along with an action plan for its implementation.

#### **Expected short-term/longer-term results**

The strategic directions in the health financing strategy are in line with international good practices and WHO recommendations, and will put Uzbekistan on the path to UHC.

The design of a universal state-guaranteed benefit package – with clear entitlements for recipients and obligations on health services – is set to guarantee fair service use while enhancing financial protection for all.

Through the establishment of a single national pooling and purchasing agency, the State Health Insurance Fund, the country will enhance its capacity to pool all budgetary resources directed to health under one roof and thereby improve its ability to distribute resources more fairly.

The establishment of strategic purchasing mechanisms and capacity will boost quality improvements in service delivery and maximize efficiency in resource allocation.

#### **Next major steps in 2020**

In 2020, Uzbekistan has embarked on a one-year preparation and start-up phase for the Syrdarya pilot, which includes the following milestones:

- Legislative package approved.
- State Health Insurance Fund established and begins to operate, including at the Syrdarya branch.
- Ensure pooling of funds at the State Health Insurance Fund central office and resolve technical issues between the Treasury and the Fund on budget flows and reporting.
- Fine-tune the payment and contracting mechanisms for different kinds of providers and levels of care.
- Design a state-guaranteed benefits package for the pilot (definition, fiscal impact, etc.).
- Establish a health information system to enable the envisioned reforms.

Although the Government has shown a firm commitment to take the reform agenda forward and has announced that the State Health Insurance Fund will be established by mid-May 2020, overall implementation is likely to be affected by the current COVID-19 crisis and some re-prioritization will most likely be needed in the next months.

# DEEP DIVE

## On health financing in the UHC Partnership

### **Box 22:** Morocco: A participatory and inclusive policy dialogue to define a health financing strategy

Several evaluations of the health financing system in Morocco pointed out a number of serious roadblocks on the way to UHC (e.g. low mandated pooled financing, high out-of-pocket payments, fragmentation in the health financing architecture, passive purchasing of services) and evaluators unanimously stressed the need for a comprehensive set of health financing reforms.

WHO advocated that addressing such challenges required more than a set of sporadic actions and scattered fixes. It received the go-ahead from the Government and its partners to initiate an inclusive and participatory process to identify and formulate a comprehensive national health financing strategy.

#### **Achievements in 2019**

The UHC-P platform was used to support such a system-wide dialogue through data production and synthesis, as well as facilitation of policy dialogue to guide political decisions for developing strategy and implementation of accompanying actions.

This support culminated with the organization of a Health Financing Conference under the patronage of His Majesty, King Mohamed VI, and with high-level support, including from the Prime Minister and other ministers. The Conference was attended by 250 health actors (including those from the Government, private sector, civil society, and including national and international experts). Such a participatory and inclusive approach allowed the identification of 38 strategic recommendations for the development of a new health financing strategy grouped around six strategic axes: (i) actions related to the mobilization of resources; (ii) pooling of resources; (iii) improvement of the purchasing function; (iv) ensuring the financial protection of vulnerable groups; (v) improving health financing governance; and (vi) multisectoral actions related to health financing, like the benefits package definition and Health in All Policies. The Conference created an opportunity to discuss longer-term orientations such as harmonization of the benefit packages across the different health financing regimes or progressive establishment of a single health financing pool. It also helped to strengthen existing collaborations and partnerships between the Ministry of Health, WHO and other partners (World Bank, European Union and Asian Development Bank) to translate these orientations into concrete plans.

Building upon its high-level visibility, the UHC-P supported a participatory process to further develop the health financing strategy, including organizing workshops with technical departments and decision-makers to validate the strategy. The final version of the strategy is expected to soon be approved by the Minister of Health.

### Expected short-term/longer-term results

Over the last two years, the WHO Morocco Country Office has found this approach of evidence generation and organization of policy dialogues leading to development of strategies to be very useful for supporting UHC reforms in the country.

The health financing strategy process was a learning opportunity to restructure further support to achieve more effectiveness. Two direct consequences can be mentioned:

First, based on the successful Health Financing Conference and subsequent proceedings, the Ministries of Health and Foreign Affairs, in collaboration with WHO, organized a side event on the Moroccan experience of health financing dialogue at the United Nations General Assembly in September 2019 in New York.

Second, Morocco has decided to take a similar approach to come up with a PHC strategy which, combined and aligned with the health financing strategy, constitutes the best approach to move towards UHC. The process was initiated in December 2019 through the organization of a national conference on PHC that gathered more than 450 participants under the patronage of His Royal Highness.

### Way forward in 2020

Several activities were planned with UHC-P support along with partners in 2020 for implementation of the strategy, such as supporting the development of health technology assessment processes, supporting evidence generation, strengthening capacities in health financing, and introducing a pay-for-performance component in the current payment system.

The development of the PHC strategy is to be continued, with the ultimate objective to align both strategies. Conducting these two processes back-to-back offers a great opportunity to ensure complementarity between the two strategies and to make health financing work for the delivery of quality, fairly distributed PHC services.

# DEEP DIVE

## On health financing in the UHC Partnership

### Box 23: India: Health financing and PHC-strengthening reforms in Chhattisgarh

In 2018, the Government of India engaged in a large-scale reform process through the introduction of its UHC flagship programme, Ayushman Bharat. This programme entails two major complementary components. The first is a national health insurance programme known as “Pradhan Mantri Jan Arogya Yojana” (PMJAY) that covers secondary- and tertiary-level inpatient care services at public and private hospitals for 40% of the population, namely the poor and most vulnerable. Second is the phased establishment of 150 000 government-owned Health and Wellness Centres, which will gradually expand the current service package – mostly focused on maternal and child health and key communicable disease services – to include common NCDs such as hypertension, diabetes and screening for common cancers, as well as mental health, dental care, eye care, geriatric care and palliative services for the entire population. The Health and Wellness Centres are expected to provide a platform for activities focused on disease prevention, health promotion and wellness to empower people to adopt healthier behaviours and to take control of their health.

Ayushman Bharat is a landmark programme in India's path towards UHC. PMJAY improves financial protection for the poor and vulnerable, and increases the Government's capacity to engage with the private sector in both the health insurance industry and the health-care delivery sector. Additionally, the Centres provide an unprecedented opportunity to enhance access to patient-centred comprehensive PHC delivered closer to communities. Firmly anchored in the WHO Country Office Country Cooperation Strategy is the objective of working towards this successful implementation.

#### Activities in 2019

While activities in 2018 focused on supporting the formulation of the programme, in 2019, WHO focused its support on its implementation. One of the key strategic directions the WHO India Country Office took upon the request of the Ministry of Health & Family Welfare was to support implementation of Ayushman Bharat in priority states that were selected for their relative social and economic vulnerability. More specifically, direct technical assistance was provided in aspirational districts of these states, identified by the Government of India as priority areas to ensure inclusive and sustainable growth. In Chhattisgarh, the Country Office collaboration with the State Government focused on two areas.

First, activities supported the process of harmonization across existing health financing schemes with the newly established PMJAY. WHO provided technical and financial support to assess the seven existing health financing schemes operations and to identify a blueprint for state authorities to harmonize key operational domains across these schemes. WHO also conducted two additional studies – a cost analysis of service delivery and a review of Rashtriya Swasthya Bima Yojana claims for the 2013–2017 period – that served to inform the State's decision to pilot a new contracting arrangement for the provision of low-cost, high-volume health-care services. These two studies were also used to inform the national-level discussion with the National Health Authority responsible for PMJAY implementation at the federal level, on provider payment mechanisms and rate setting.

Second, WHO supported roll-out of comprehensive PHC through the Health and Wellness Centres. Activities included adaptation and implementation of national guidelines at the state and district levels. Analytical work on HRH informed creative solutions to address critical workforce gaps in disadvantaged districts with a large tribal population. Further assessments using health labour market analysis are being conducted to inform HRH policies. Three district coordinators supported planning to rapidly upgrade existing health facilities to Health and Wellness Centres, developed protocols for reorganizing the services and oriented health workers. WHO's involvement supported re-orienting the PHC services towards a more people-centred approach.



Support from the UHC-P also helped the Country Office to expand its health system team with three public health officers who were posted in the aspirational districts in Chhattisgarh. This allowed the organization to provide support to the front lines to implement national policy decisions at the district level and establish a mechanism to monitor progress and challenges. For example, government front-line staff were able to flag policy implementation challenges around referral systems and health worker incentives to the central level, and propose solutions informed by field experience. WHO's presence at the state level also facilitated access to international good practices, influencing the policies put in place by the state authorities.

### Early achievements, longer-term anticipated results

While it is too early to identify the precise results of WHO's work, some key achievements are already apparent.

First, following the commissioned assessment by WHO, the State Government of Chhattisgarh took the decision to integrate all public health financing schemes operating in the State under a newly established scheme called "Dr. Khubchand Baghel Swasthya Sahayata Yojana". Defragmenting the health financing architecture is a key principle promoted by WHO to guide health financing reform. As such, it is a significant breakthrough as it holds many promises:

- This new financing scheme is expected to offer a standardized health benefit package for the whole population in the State. Such a move is expected to have positive impacts on access to secondary and tertiary care services.
- Going from multiple schemes to a single scheme and shifting its management scheme to the State Health Authority has improved redistributive capacity and administrative efficiency. We anticipate that this will increase service coverage and financial protection for vulnerable populations.
- Third, the single scheme has consolidated the health service purchasing power of the State authorities. WHO support has heightened awareness among state-level policy-makers of the potential for a sound provider payment mix to influence provider behaviour and service provision. The State is currently experimenting with new bulk contracting modalities for the provision of high-volume/low-cost services. If well designed, such purchasing instruments – i.e. provider payment mechanism, contracting – can help contain health expenditure and improve efficiency of health-care service delivery.

Second, locally tailored human resource solutions have addressed immediate workforce gaps. The use of an integrated approach to district planning and monitoring has facilitated piloting of hypertension management into PHC service delivery and working towards addressing communicable diseases such as malaria elimination.

Last, but not least, it is important to highlight that the three districts directly supported in Chhattisgarh have started to see improvements in health indicators and have moved upward in the state performance ranking list.

### Next steps

At the national level, WHO will continue to work with both the Ministry of Health & Family Welfare and the National Health Authority to support efforts to expand the Ayushman Bharat programme. The focus will remain on advocating for UHC, investing in evidence generation and strengthening engagement with civil society and the private sector. Early learning of state-level support will be used to stimulate cross-learning, identify good replicable practices and scale up WHO health systems support in other states.

## 1.3 Improved access to essential medicines, vaccines, diagnostics and devices for PHC (GPW13 outcome 1.3)

Access to medical products is one of the leadership priorities of the GPW13 and one of the indispensable pillars to strengthen national health systems – one of the building blocks to move towards UHC. Difficulties in accessing affordable and quality-assured medicines, vaccines and health products (including diagnostics and devices, as well as blood and blood products) lead to onerous out-of-pocket payments and to financial hardship.

### Strengthening regulatory capacity for safety

WHO and the UHC-P support countries in strengthening their regulatory capacity, further contributing to ensuring a safer supply chain of medicines and medical products (see Box 27). Technical guidance on best practices and harmonization are offered to national medicines regulatory authorities that are responsible for the regulation and control of medicines, vaccines, blood products (see Box 25) and medical devices. This work is also related to the updating of pharmaceutical legislation and political frameworks; an example is the technical assistance provided to Georgia for the revision of its Medical Products Law and to improve the governance structure in merging the country's National Drug Agency and the National Regulatory Agency. As a concrete outcome, this sustained work in the area of pharmaceuticals has contributed to the inclusion of **Georgia** in the WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce.

In Lebanon, country support is being provided to improve the quality of pharmaceutical products through the Good Manufacturing Practices (GMP) audit and to enhance the capacity of the Ministry of Public Health to monitor the pharmaceutical market through wider use of the barcoding system. Seven local pharmaceutical companies were audited for GMP by an external auditor recruited by WHO; this was coupled with training for Ministry of Public Health inspectors and quality control staff from the manufacturers.

The national GMP guidelines were also revised and recommendations for amendments presented to the Ministry. The GMP audit mission created important momentum among the local pharmaceutical manufacturers to improve the quality of their products for safety and better competitiveness in regional and international markets. It also opened a national dialogue on quality and safety and GMP between the Ministry and the Association of Pharmaceutical Manufacturers. As an immediate result, a roadmap for local production improvement and expansion has already been developed.

The UHC-P also fosters regional collaboration with respect to national policies and regulation practices, such as in the **African or South-East Asia Regions**. The South-East Asia Regulatory Network (SEARN), hosted by the WHO Regional Office for South-East Asia, has been working to develop and strengthen regulatory collaboration, convergence and reliance in the Region. The Network launched an information sharing platform<sup>39</sup> in 2019 and was busy scaling up the regional Initiative for Coordinated Antidotes Procurement (see Box 24).

A roadmap was established to better integrate the management of drugs and supplies, including using an information management system in **El Salvador**. PAHO recently completed an evaluation of its regulations and surveillance systems of medicines. This important progress in improving price market regulation had a great impact on the population in terms of accessing quality medicines at low prices, which is worthy of imitation by other countries.

39. Information Sharing Platform. In: South-East Asia Regulatory Network [website]. Manila: SEARN; 2019 (<https://searn-isp.org/SEARN/en/Home>).



An infant receives the pentavalent vaccine at the Greater Accra Regional Hospital. During the COVID-19 pandemic, WHO is supporting the Ghana Health Service in their efforts to continue providing essential medical services to the population. At the Greater Accra Regional Hospital, vaccinations continue to be offered along with other critical services for children, and care is provided to mothers before, during and after pregnancy. © WHO/Blink Media – Nana Kofi Acquah.

## Supporting access to essential medicines, vaccines and diagnostics

National lists of essential medicines guide the procurement and supply of medicines, underpin schemes for medicines reimbursement mechanisms, guide medicine donations, and orientate local medicine production. The UHC-P has been active in supporting several countries to develop or update their own essential medicines lists, such as in **Guyana** and **India**. By listing the most efficacious, safe and cost-effective medicines, essential medicines lists provide guidance for the use and availability of medicines. In India, the revision meant updated guidance was disseminated to the state level to reflect improved access to free diagnostic schemes.

Essential medicines are also frequently listed per level of care to ensure more equitable access (see Box 26). In **Mongolia**, the Government is working to improve people's access to discounted essential medicines, ensuring a 20–80% discount for 774 types of medicines, as well as introducing an e-prescribing system.

Guidance for more efficient procurement practices have been led by WHO headquarters and the Regional Office for Africa for the development of a pooled procurement mechanism in the Small Island Developing States (SIDS) – **Cabo Verde, Comoros, Mauritius, Sao Tome and Principe** and **Seychelles**. The focus was to ensure political commitment, country cooperation, strengthening planning capacities in the acquisition and use of supplies, and quality assurance procedures, while addressing the issues relative to expensive health products – including for NCDs – and leveraging the common contexts in the five countries. Collaboration has been strengthened with the East African Community (EAC) Secretariat and partners like the United States Agency for International Development to better structure the governance mechanism for the EAC pooled procurement mechanism, bringing together **Burundi, Kenya, Rwanda, South Sudan, Uganda** and **United Republic of Tanzania**. A roadmap has been revised and submitted to the EAC Health Ministers Council for approval, and will guide further implementation and concrete actions.

The collaboration is also continuous with key partners involved in international procurement (The Global Fund to Fight AIDS, Tuberculosis and Malaria; Unitaid; UNICEF; Joint United Nations Programme on HIV/AIDS; The U.S. President's Emergency Plan for AIDS Relief; Gavi, The Vaccine Alliance) to ensure better access to strategic and priority products. The coordination is assured at all three levels of WHO.

In **India**, a national guidance document for the implementation of free medicines and diagnostics schemes has equipped state governments to improve access to medical products.

In the **African Region**, medicine selection, pricing and reimbursement through insurance schemes were supported in **Ethiopia** and this has contributed to improved access to medicines for the insured population. Of note is **Ghana's** work to integrate traditional medicine into its national health system through the establishment of recognized herbalists working side by side with medical doctors in 40 health facilities at district level and regional hospitals.

National formularies serve as a complement to the national essential medicines lists, and provide detailed information for the appropriate selection, use, dosage, adverse drug reaction, contraindications and warnings, for medicines used to address or prevent diseases. In 2018, **Nepal** published a revised Nepalese National Formulary and launched its mobile app in 2019, which is expected to be a helpful tool to health professionals for information on medicines used in the country. Related to this work to improve access to quality medical products, WHO supported the Drug Regulatory Authority in development of an awareness campaign on the responsible use of antibiotics.

### What countries are telling us



We are all new to this important concept and we realize that more training is definitely needed to help improve our knowledge base, and to allow us to create a stronger network within the international Pharmacovigilance community. I was fortunate to be among those selected for a workshop in Tunis, led by WHO experts on setting up a national Pharmacovigilance Strategy. With expert input during the workshop, we were able to fine tune our 'yellow card' reporting scheme to better capture relevant information on adverse drug reactions.

Dr Hana Shtwei, Ministry of Health, Libya

## Box 24: South-East Asia Regulatory Network (SEARN)

SEARN hosted its third annual meeting in April 2019 for all 11 regulatory agencies in the South-East Asia Region. The work of SEARN is organized into five work streams, including:

- quality assurance and standards of medical products
- good regulatory practice
- vigilance for medical products
- information sharing platform
- medical devices and diagnostics.

As part of each stream, SEARN is undertaking collaborative activities, such as training or providing joint technical assistance. For example, as part of the work on good regulatory practices, the national regulatory authorities across the Region are looking at how they can jointly utilize WHO collaborative registration procedures for accelerated registration of priority health products.

## Box 25: Region of the Americas: Expanding access to safe blood

The Regional Action Plan for Universal Access to Safe Blood seeks to promote universal access to safe blood, based on unpaid voluntary altruistic donation, in a timely manner to help save lives and improve the health conditions of patients who need it, by integrating blood systems into the health system of the country. In 2019, PAHO organized a Caribbean-node meeting<sup>41</sup> to discuss progress of the Regional Action Plan with representatives of national blood programmes and services from countries and territories in the Caribbean, including **Belize, Dominica, Guyana** and **Haiti**. Following this meeting, **Dominica** assessed the laboratory and national blood services with a focus on hospital services where most of the resources and capacities reside. The assessment report made several recommendations for the strengthening of systems and procedures.

In **Peru**, PAHO has supported the development of blood bank strategies, particularly in remote and hard-to-reach areas such as Amazonas, as part of technical cooperation to Peru through the “Zero Maternal Deaths by Hemorrhage” initiative. The initiative seeks to strengthen health services, breaking down access barriers and training personnel to manage obstetric bleeding and ensure the availability of safe blood for transfusions and life-saving essential drugs.

*“The Caribbean countries and territories have high percentages of repeat volunteer donors, which is essential for guaranteeing safety, quality and availability of blood and blood products; however, challenges remain to achieve 100% repeat voluntary donation in many countries.”*

**James Fitzgerald, Director, Department of Health Systems and Services, PAHO/WHO**



41. Caribbean countries meet to discuss progress in the implementation of the Regional Action Plan for Universal Access to Safe Blood 2014–2019. In: Pan American Health Organization [website]. Washington (DC): PAHO; 19 March 2019 ([https://www.paho.org/hq/index.php?option=com\\_content&view=article&id=15045](https://www.paho.org/hq/index.php?option=com_content&view=article&id=15045)).

## Box 26: Kyrgyzstan: Improving access to essential quality medicines

In Kyrgyzstan, almost all citizens pay for medicines out of pocket and the state only pays for 10% of the cost. Essential medicines are amongst the most expensive in the world, with medicines being the second largest expenditure for most families after food. As such, improving access to quality essential medicines is a significant measure to strengthen the health system, and led to new laws on medicines to allow the state to regulate prices of essential medicines.

WHO supported the national authorities with the development of by-laws in different areas of medicines and medical devices, and continues to provide technical assistance to Kyrgyzstan to achieve internationally recognized quality standards on:

- the regulation of quality and circulation of medicines and medical devices;
- postmarketing control and monitoring of medicines and medical devices; and
- the transparency, predictability and accountability of the pharmaceutical sector.

As part of country-initiated work in 2019, the UHC-P is supporting improved financial protection through expanding access to medicines, including supporting the national scale-up of price regulation and the introduction of an e-prescription system. There is also ongoing collaboration to implement the Drug Regulatory Agency institutional strategy and capacity-building to increase access to essential medicines. The major highlight from 2019 was the introduction of price regulation mechanisms for medicines on the state-guaranteed benefit package. This is expected to increase the affordability of essential drugs for conditions managed in PHC settings and yield tangible reductions in financial hardship and unmet needs in many Kyrgyz households.

*“The Kyrgyz Government from now on can regulate the prices of medicines and medical devices to make them more affordable. This is an important step towards establishing equitable access to quality essential medicines for the Kyrgyz citizens. Technically and financially the World Health Organization helped a lot. Moreover, we have studied all the rules and practices that exist around the world and have developed our own drug pricing policy.”*

**Dr Kosmosbek Cholponbaev, Minister of Health, Kyrgyzstan**



## Box 27: Technical assistance deployment in UHC-P countries in the area of pharmaceuticals

Access to medical products is one of the leadership priorities of the GPW13 and one of the indispensable pillars to strengthen national health systems in order to reach UHC. Resources from the UHC-P allowed a larger deployment of technical assistance in many targeted countries and improved the coordination between different levels of WHO (countries, inter-country support teams, regions and headquarters).

The continuous presence of experts in the field of pharmaceuticals facilitated the coordination with regional economic communities like Communauté Economique Monétaire de l'Afrique Centrale (CEMAC), Organisation de Coordination pour la lutte contre les Endémies en Afrique Centrale, West African Health Organization, and with networks (i.e. Laboratoire National de Contrôle de Qualité des Médicaments et d'Expertise [LANACOME] network of Quality Control Labs in CEMAC Region), and further collaboration with international partners like the World Bank to develop common regional pharmaceutical policies and frameworks.

It also enabled the development of the harmonization of regulatory requirements in the regions and a wider use and monitoring of the global benchmarking tool to assess national regulatory functions. Technical assistance is also indispensable to contribute to building capacity in countries and areas, such as the selection of medical products (briefing on the use of new tools such as the electronic version of the WHO Model List of Essential Medicines) or quality assurance of medicines in the market (improving use of the WHO alert system to report on substandard and falsified products).

Ensuring the continuity and sustainability of the technical expertise in the field creates favourable conditions and opportunities for coordination with others on initiatives in priority countries, and to improve access to medical products for targeted groups of the population (for example, the Muskoka Initiative on Maternal, Newborn and Child Health, aims at improving health conditions for mothers, newborns and children in nine **sub-Saharan** countries).

At country level, WHO technical assistance is crucial to support national authorities' leadership in the establishment or development of national committees of pharmaceuticals, and to ease the coordination of main partners and stakeholders and enhance efficiency in the interventions. Technical expertise in very fragile and vulnerable states (such as the **Central African Republic**) allowed the development and implementation of a national roadmap to structure the pharmaceutical sector, including revision of the pharmaceutical legislation, policy framework, and supply chain and distribution mechanism for medical products.

## Strengthening supply chains and infrastructure

Ensuring appropriate access to affordable and quality-assured medicines, vaccines and health products requires a strong supply chain and infrastructure, including quality control laboratories.

In the **African Region**, the revised WHO guide for the stepwise laboratory improvement process towards accreditation<sup>40</sup> has now been made available, and a guideline document for the development of district and peripheral laboratory services to support UHC has been developed. Efforts to enhance access to high-quality health products and medical technologies have led to 30 African countries having national guidelines on the appropriate clinical use of blood and blood products, 16 countries establishing a national hemovigilance system, with five countries having accredited blood transfusion services. The average blood donation rate is 4.9 per 1000 population, and eight countries are collecting 10 units or more per 1000 population as recommended by WHO. Finally, 19 countries reached the target of 80–100% voluntary non-remunerated blood donations by the end of 2019.

40. WHO guide for the Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA). In: Regional Office for Africa [website]. Brazzaville: AFRO; 2015 (<https://www.afro.who.int/publications/who-guide-stepwise-laboratory-improvement-process-towards-accreditation-slipta-african>).

## 2. Addressing health emergencies – 1 billion more people better protected from health emergencies

“Universal Health Coverage is not just the best investment in healthier populations. It is also the best investment in health security. Strong health systems are better able to prevent, detect and mitigate outbreaks.”

Dr Tedros Adhanom Ghebreyesus, UHC Health a political choice, 11 June 2019

### 2.1 Reinforcing global health security

Every country is vulnerable to epidemics and emergencies. One of WHO's main goals is to strengthen the resilience of communities and countries through UHC as the foundation for health emergency management. Since 2005, WHO and its Member States have established a new version of the International Health Regulations (IHR)<sup>42</sup> in order to capitalize on the lessons learned after the response to the 2003 SARS epidemic. This agreement, in force to date, has been ratified by 196 countries, including all WHO Member States, to work together for global health security. It aims to strengthen international regulations in times of a Public Health Emergency of International Concern and basic health system functions in countries, such as early detection, risk assessment, information sharing, and rapid response to avoid illness, injury, death and economic losses on a large scale.

As such, health security is increasingly a focus of the UHC-P, as the world is only as safe as its most vulnerable setting. This has been a particular focus of the **WHO Regional Office for the Eastern Mediterranean Region**; over 62 million people across the Region account for half of all displaced people globally.<sup>43</sup> Therefore, the UHC-P has supported the establishment of the Health Systems in Emergencies Lab (see Box 28).

Additionally, countries such as **Lebanon** have also been leveraging the UHC-P to support the reinforcement of its Emergency Operation Centre at country level. This was initiated alongside the automation of the Early Warning and Response System, which is being rolled out to health

facilities. Moreover, many countries such as **Jordan** and **Sudan** received support to strengthen their local hospital emergency care systems.

In the **Federated States of Micronesia**, the Health Resources Availability Mapping System (HeRAMS)<sup>44</sup> and geographic information systems were developed to map out services, such as the 164 dispensaries, which were used by aid partners during the typhoon in 2019.

“Our region is unique in terms of emergencies and disasters, either manmade or natural. When it comes to health, we must act as one body to bring unity, regardless of differences of opinions and directions of Member States.”

**Dr Ahmed Al-Mandhari, Regional Director,  
WHO Regional Office for the Eastern Mediterranean Region**

<sup>42</sup>. Strengthening health security by implementing the International Health Regulations. In: World Health Organization [website]. Geneva: WHO; 2005 (<https://www.who.int/ihr/about/en/>).

<sup>43</sup>. Countries in crisis. In: WHO Regional Office for the Eastern Mediterranean [website]. Cairo: EMRO (<http://www.emro.who.int/eha/countries-in-crisis/index.html>).

<sup>44</sup>. Health Resources Availability Monitoring System (HeRAMS). In: World Health Organization [website]. Geneva: WHO (<https://www.who.int/hac/herams/en/>).



## Box 28: Eastern Mediterranean Region: Framework for action on health systems recovery

Through UHC-P support, the Department of Universal Health Coverage/Health Systems at the WHO Regional Office for the Eastern Mediterranean established the innovative “Health Systems in Emergencies Lab” (HSEL) as a new unit to improve the health systems resilience of the Eastern Mediterranean Region by integrating health systems strengthening and health emergency preparedness, response and recovery works. The HSEL is a shared institutional space dedicated to experimenting with new ideas, with a focus on fragile, conflict and violent settings and vulnerable populations, including refugees and migrants.

In 2019, HSEL – in collaboration with the Health Emergencies Department – developed A Framework for Action on Health Systems Recovery in Emergencies in the Eastern Mediterranean Region: Transforming challenges into opportunities to provide technical support to the countries that are gradually stepping out of crisis. The Framework will be implemented in two selected countries in 2020–2021. Furthermore, HSEL prepared A Guide for Implementing the Humanitarian-Development-Peace Nexus for Health in the Region and is supporting countries and areas facing protracted emergencies by operationalizing the guide; these places include **Afghanistan, Iraq, Libya, occupied Palestinian territory, including east Jerusalem, Somalia, Sudan, Syrian Arab Republic and Yemen.**

Furthermore, HSEL has supported country support missions on post-disaster needs assessment after floods in **Djibouti** and the **Islamic Republic of Iran.**



## 2.2 Delivering essential life-saving health services in fragile and vulnerable settings

In 2016, over 1.8 billion people, or 24% of the global population, were living in fragile and vulnerable settings, while the projections for 2030 anticipate this to grow to 2.3 billion people (28% of the global population) and to 3.3 billion people (34% of the global population) by 2050.<sup>45</sup> Fragile and vulnerable settings have the highest rates of epidemics, maternal and child mortality, food insecurity and malnutrition, sexual and gender-based violence and mental health disorders, as well as the lowest immunization rates.<sup>46</sup> During emergencies and protracted crises, individuals have an increased need for access to essential health services, and health systems may endure major dysfunctions due to the fragility of the situation.

In order to foster connections and effective coordination between the response to humanitarian crisis and early recovery development programmes, the World Humanitarian Summit identified in 2016 the strengthening of the humanitarian-development nexus as a top priority. The humanitarian-development nexus envisages that there is a continuation of long-running efforts in the humanitarian and development fields which allow – even in fragile and vulnerable contexts – the provision of emergency life-saving health services, while increasing the robustness and resilience of the health system. As a general rule, whenever and as much as possible, acute response interventions should utilize the already established system as the basis for managing the event. However, usual health system issues – such as low and inequitable coverage or dysfunctional referral services – are significant challenges to delivering emergency services. In these circumstances, the package of essential health care needs to be defined and adapted to the reality of the fragile environment and the capacities of the delivery platforms. Moving forward, it will be crucial for both strands of work to come together in the context of developing resilient, people-centred health systems and services.

As outlined by the United Nations Secretary-General's Report for the World Humanitarian Summit, a New Way

of Working<sup>47</sup> has since been put in practice to achieve collective outcomes that reduce risks and vulnerabilities, over multiple years, using the comparative advantage of a diverse range of actors. Under these circumstances, WHO has been named as the leading agency for the health sector. The Organization has developed a typical response based on the following axes: emergency service delivery, outbreak alert, response coordination and public health services as information, analysis and monitoring for decision-making. Inside WHO, the collaboration between the Department for Health Emergencies Preparedness and Response and the Division of UHC/Life Course has been reinforced to ensure a strong synergy between humanitarian and development programmes, with a special attention on health security and NCDs. This advanced cooperation is the first step in a long road and will be strengthened in the coming years, thanks to the support of the Susan Thompson Buffet Foundation.

**“ Oftentimes, patients don't realize the severity of their symptoms and don't seek care. But also, with a diagnosis, there is often no continuity of care for various reasons, including displacement, shortages in medicines and of medical staff. However, despite immense challenges and limited resources, WHO is investing in NCD care.”**

**Annette Heinzelmann, Emergency Lead, WHO**

Each year, the **African Region** is challenged by hundreds of outbreaks and other health emergencies, resulting in unacceptably high morbidity, mortality, disability and socioeconomic disruptions.<sup>48</sup> In this context, the UHC-P has been supporting ministries of health and humanitarian partners to deliver emergency health services while strengthening health systems, such as in **Nigeria** (see Box 29).

In **South Sudan**, the concept of the humanitarian-development nexus has been pursued. Health system stabilization and recovery efforts, supported by the UHC-P, at the three levels of WHO (country and regional offices, headquarters), have led to a consolidated system-building effort with both humanitarian and development elements integrated into a single set of priorities that the Government is championing. Moreover, in 2019, the Partnership supported a scoping mission to identify, with key stakeholders, priority interventions for achieving UHC, such as health services availability mapping and laboratory testing for detection of priority diseases. Given South Sudan's difficult history, there are unique challenges in its efforts towards moving to UHC. Amid the humanitarian crisis, many implementing partners stepped in to complement delivery and contracting of services, which led to a situation where health services are largely financed by and dependent upon multiple partners and out-of-pocket payments for health services. To move towards UHC, recent progress must be highlighted, such as the use of various service delivery models adapted for different contexts, the ongoing construction of health facilities, elaboration of the basic health and nutrition package of services, and significant donor funding to ensure the humanitarian response and health service delivery. Finally, in the framework of the UHC-P, the collaboration established between the Health Emergencies and UHC Life Course Divisions also allowed the opening of a technical assistance position for South Sudan in Emergency and Health Systems.

### Box 29: Nigeria: Humanitarian-development nexus

In order to foster connections and effective coordination between the response to the protracted humanitarian crisis and early recovery development programme, the humanitarian-development nexus<sup>49</sup> has been established in the three north-east priority states in Nigeria (**Borno, Adamawa and Yobe**) using the SDG 3.8 target for UHC as a collective outcome. Several mechanisms – such as joint assessment and planning, coordinated implementation, and joint monitoring and evaluation – have allowed humanitarian partners to seek opportunities for integration of their programme with flexibility in implementation and risk management. As a result, humanitarian and development actions have been jointly incorporated into the 2019 Annual Health Sector Operational Plans and the Humanitarian Response Plan.

The humanitarian-development nexus hopes to demonstrate that, even in unstable contexts, it is possible to provide emergency life-saving health services, while increasing the robustness and resilience in the health system and putting it in a better position to recover. Highlights include:

- An essential package of health services as well as infection prevention and control guidelines were developed for **Borno State** to ensure equitable availability of and access to safe and quality health services within the State, including for displaced populations.
- A preliminary assessment of the status of health infrastructure, which informed the identification, prioritization and rehabilitation of health facilities destroyed by the conflict, and which enhanced the availability of and access to primary health-care services – a total of 13 health facilities and training institutions were rehabilitated in the three states.
- The development of an HRH policy in **Borno State**; in addition, a health workforce registry was established for the three north-east states to foster planning and management of health workers, including redistribution to ensure equity and fairness in the health workforce coverage.

45. States of fragility 2018. Paris: Organisation for Economic Co-operation and Development; 2018 (<https://www.oecd.org/dac/states-of-fragility-2018-9789264302075-en.htm>).

46. Stronger collaboration, better health: global action plan for healthy lives and well-being for all: strengthening collaboration among multilateral organizations to accelerate country progress on the health-related Sustainable Development Goals. Geneva: World Health Organization; 2019 (<https://apps.who.int/iris/handle/10665/327841>).

47. The New Way of Working. In: Joint Steering Committee to Advance Humanitarian and Development Collaboration [website]. New York: UN; 2017 (<https://www.un.org/jsc/content/new-way-working>).

48. "Putting people first": the road to universal health coverage in Africa. Kigali: WHO Regional Office for Africa; 28 June 2017 (<https://www.afro.who.int/ahf/call-to-action>).

49. Humanitarian Development Nexus. In: United Nations Office for the Coordination of Humanitarian Affairs [website]. New York: UN (<https://www.unocha.org/fr/themes/humanitarian-development-nexus>).



Women at a clinic in Bauchi State, Nigeria. © WHO.

### 3.

## Promoting healthier populations – 1 billion more people enjoying better health and well-being

Although having “healthier populations” is a broad priority, WHO has committed to contributing to people enjoying better health and well-being through five platforms, including:

- improving human capital across the life course;
- accelerating action on preventing NCDs and promoting mental health;
- accelerating elimination and eradication of high-impact communicable diseases;
- tackling antimicrobial resistance; and
- addressing health effects of climate change in SIDS and other vulnerable states.

As many health systems are grappling with populations that are increasingly suffering from lifelong NCDs, the UHC-P is trying to intervene earlier to prevent or delay onset of these diseases. This means that increasing attention is being paid to addressing key determinants of health, taking multisectoral action to reduce risk factors, and ensuring Health in All Policies are promoted. As part of this approach, countries such as **Mauritius** (see Box 32) are looking at how to support NCDs as part of their national health strategy, and identifying bottlenecks. In the **Western Pacific Region**, the UHC-P facilitated work on health equity, with a special focus on adopting multisectoral approaches on the road to UHC (see Box 30).

Leveraging WHO's platform on acceleration of action to prevent NCDs, there was targeted work across the UHC-P to incorporate essential NCD interventions, particularly into PHC, such as in **Timor-Leste** (see Box 31). In the **Region of the Americas**, for example, in **Guyana** and **Suriname**, as part of a shift to address risk factors in PHC, training was provided on how to incorporate smoking cessation services. The UHC-P has played an important role in supporting pre-hospital services in Eastern **Ukraine**. Specifically, WHO supported the development of a community-based mental health service model and provision of mental health services in PHC. In close cooperation with the Ministry of Health, WHO introduced a new approach for the integration of mental health into primary care through the implementation of its Mental Health Gap Action Programme (mhGAP). It has also provided advanced trauma care training and supported mobile clinics.

### Box 30: Western Pacific Region: Strengthening governance for health equity

As part of its focus on strengthening governance for health equity in the Western Pacific Region, the UHC-P conducted a number of collaborative workshops with participants from **Cambodia**, **Mongolia** and **Viet Nam** to facilitate knowledge exchange and build capacity around monitoring and evaluation and practices to address health inequities in the Region.

During these collaborative workshops, **Cambodia** shared results from a secondary analysis on health inequalities, which portrayed disparities along dimensions such as wealth, education and residence. At the time of the workshop, Cambodia was in a key phase of planning for a five-year strategic health plan, which opened a window for health equity indicators to be included.

The team from **Mongolia** worked on strengthening their multisectoral action to address geographical barriers to accessing PHC through multisectoral work. Implementation of the chosen initiative has been successful and included participation from all three levels of government and multiple sectors in organized meetings.

During the workshops, the delegation from **Viet Nam** focused on healthy ageing as it is among the most rapidly ageing societies in the world. To strengthen governance for health equity, they identified key multisectoral stakeholders. Stakeholder mapping was vital during the implementation process, and new stakeholders appeared as they moved along. The delegation identified the following as challenges: developing a shared-concept definition of long-term care, ensuring accountability for different roles and responsibilities, and the lack of an annual reporting mechanism. To face these challenges, Viet Nam will be focusing on strengthening monitoring and evaluation, mobilizing resources, and advocating setting up of a multisectoral steering committee at the national government level.



Pharmacy at a health centre in Mondulkiri Province, Cambodia. ©WHO.

# DEEP DIVE

## On NCDs

### The UHC partnership as an avenue for NCD impact: first results for 2019 and expectations for 2020

The UHC-P empowers countries to deliver on prioritized interventions; described below are a few examples of how this has impacted NCDs. While each health system block delivers crucial benefits, the act of strengthening the health system is not an end in itself, but rather an avenue for improved delivery of NCD services to those who need it most. The UHC-P plays an integral role and could help drive innovative and equitable solutions for NCD programmes.

The Partnership has equipped countries like **Timor-Leste** with the necessary tools to develop and implement an essential services package which addresses the growing burden of NCDs through directives for NCD screening and management. Rigorous consultation, costing and feasibility assessments were undertaken as part of a comprehensive approach to adequately reflect core needs for NCD service delivery. **Belize** offers an example of further prioritizing the development of a national cancer plan through UHC-P support.

In the **Lao People's Democratic Republic**, UHC-P activities to improve the national benefit package were influential towards the expansion of services for people with diabetes and hypertension. Similarly, in **Cambodia**, access to hypertension and diabetes treatment services was improved at select health centres, and the Partnership supported NCD screening and management administered through mobile clinics in **Mauritius**.

Strengthening WHO PEN protocols to provide continuous medical education for PHC workers on early detection and treatment of NCDs, as demonstrated in **Moldova**, enables the workforce to effectively respond to the needs of the chronically ill. Future UHC-P support for countries can further extend pre-service curricula to include NCD training and intensify capacity for self-management of NCDs.

Availability of essential medicines to treat major NCDs is highlighted as a key target in the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020.<sup>50</sup> The UHC-P programme in **Lebanon** aided the provision of NCD medications and training on good prescription and medication management to health-care staff, reaching 92 000 patients of the most vulnerable host communities and Syrian refugees. “Being able to obtain my diabetes and hypertension medications almost for free has changed my life; I don’t have to worry about my health now,” said a 72-year-old widow attending a PHC centre in the outskirts of Beirut. Joint action to train the provider and connect the patient to life-saving treatment effectively bridges the gap of the NCD response. Further use of mobile technologies, portable diagnostic devices and rapid tests, as demonstrated in **Mongolia**, ensures the continuum and quality of critical NCD care.

The next phase of the UHC-P proves critical to catalyse action in strengthening health systems to deliver and scale up NCD “best buy” prevention and treatment services in countries as per programme objectives.

#### Box 31: Timor-Leste: Essential health services packages incorporate NCDs

The updated Primary Health Care Essential Service Package (PHC-ESP) in Timor-Leste addresses the current epidemiological profile characterized by growing burden of NCDs and their risk factors prevalent in the country. Multisectoral emphasis – and the need to engage with sectors beyond the health sector – is emphasized in the development of the PHC-ESP, as well as the ongoing high-level advocacy efforts around tobacco and alcohol legislations in the country.

Monthly Development Partners Health Coordination Group meetings, co-chaired by WHO and the European Union, have contributed to a coordinated and trusting development partnership in health. In a context such as Timor-Leste, the platform for engagement of diverse and multiple partners involving government, development partners, nongovernmental organizations, civil society and other stakeholders is critical to addressing NCDs and their risk factors. Such platforms ensure alignment and harmonization of policies and efforts, predictability of assistance, and reduction of administrative burden on both the Government and the partners.

50. Global action plan for the prevention and control of noncommunicable diseases 2013–2020. Geneva: WHO; 2013 (<https://www.who.int/nmh/publications/ncd-action-plan/en/>).

### Box 32: Mauritius: NCD management

Mauritius is strongly impacted by an increased prevalence of NCDs, representing 85% of morbidity and 81% of mortality in 2015. In the framework of the 2019–2023 National Health Strategy, several activities have been supported by the UHC-P to ensure an evidence-based and inclusive policy-making process in the country, especially in terms of NCDs and health financing.

First, an evaluation identified 15 key bottlenecks in the fight against NCDs and led to some recommendations that have been included in the National Health Strategy. Second, national health accounts have been established to monitor and analyse health system performances. Third, good practices and lessons learned have been shared with other countries on different challenges for monitoring and detecting NCDs. One best practice in this context was that of the prize-winning use of mobile clinics for nationwide screening and management of conditions, which will allow the country to move towards a healthier population. Finally, inspired by the French and Tunisian initiatives, a National Health Assembly has been created to institute an inclusive and participatory societal dialogue through all levels of the health system between different health actors and the population. The Partnership has provided fundamental technical assistance with a dedicated evaluation team that helps to decide which methodology should be used, facilitate technical exchanges and discussions between stakeholders, and deliver the final analysis. The support of the UHC-P has enabled communities, civil society organizations and government agencies to improve their capabilities to participate and express their opinions and needs regarding the health system, to ultimately improve the management of NCDs.



Development partners for health coordination group meeting, Timor-Leste. © WHO/Shobhan.

## 4.

# Health information systems – strengthened country capacity in data and innovation (GPW13 outcome 4.1)

The UHC-P collaborates with countries to improve their health information systems, analytical capacity and reporting for UHC, including developing comprehensive and efficient systems to monitor health risks and determinants; track health status and outcomes, including cause-specific mortality; and assess health system performance. Good governance and leadership of a health system requires reliable, timely information, such as whether people are getting the services they need and where resources are going. Information is used in a wide range of situations, such as developing national strategies and plans, monitoring progress against priorities, or responding to public health emergencies.

## 4.1 Developing systems to monitor and track UHC

### Vital statistics

A well-functioning civil registration and vital statistics (CRVS)<sup>51</sup> system registers all births and deaths, issues birth and death certificates, and compiles and disseminates vital statistics, including cause-of-death information. Thanks to the well-documented benefits of CRVS, it is one of the foundational information systems for which the UHC-P provided technical assistance and capacity-building, both in terms of developing CRVS action plans, such as in **Papua New Guinea**, or in filling critical gaps.

In **India** work was undertaken to compare methods for assigning verbal autopsy-based causes of death and recommend feasible and intermediate alternatives to medical certification of deaths to improve vital statistics. Whereas in the **Bolivarian Republic of Venezuela**, PAHO provided support in maintaining CRVS and information systems during its deepening emergency situation by ensuring the availability of birth and death certificates, which affects the calculation of indicators based on data obtained through these certificates, as well as the definition of health policies.

### Health information systems

Countries have a range of health information systems that are required to provide good-quality data. The UHC-P works with countries to provide tools and standards for the collection, analysis and use of health data.

With respect to health management information systems (HMIS), several countries were supported to use District Health Information Systems (DHIS) software, particularly in the **African** and **South-East Asia Regions**. For example, in **Nepal**, strengthening the HMIS and rolling it out across the country was done to improve reporting on UHC and health-related SDGs. This work has included the development of monitoring and evaluation guidelines, an eHealth roadmap, and a health facility registry. Capacity-building included the delivery of training on DHIS, as well as targeted sessions on collecting, reporting, analysing, visualizing and using the HMIS data for decision support at the district and municipality levels. A training of trainers on the HEAT+ equity monitoring tool was completed, while the Planning, Policy and Monitoring Division of the Ministry of Health and Population is taking steps to scale up training at provinces and subnational levels.

Beyond implementing or upgrading their HMIS, support was also provided to integrate various sources of data into national systems. In **Paraguay**, the UHC-P worked to support the integration of HIV/AIDS information systems into the integrated HMIS to support decision-making.

51. Civil registration and vital statistics (CRVS). In: World Health Organization [website]. Geneva: WHO ([https://www.who.int/healthinfo/civil\\_registration/en/](https://www.who.int/healthinfo/civil_registration/en/)).





Data collection, health and analysis, Khanh Vinh district hospital, Viet Nam. © WHO.

## 4.2 Information for more efficient and improved implementation of the UHC agenda

### Data to inform policy

The UHC-P supported many countries to produce comprehensive health situation and trend assessments in order to monitor the state of health, trends, inequities and determinants at the facility, subregional and national levels. For example, in **Lebanon** the Policy Support Observatory is supporting information use and evidence generation to promote better implementation (see Box 34).

Within the **African Region**, many courses and targeted training were delivered to address data gaps, knowledge of tools, as well as capacity to conduct system performance assessments. These included opportunities for countries to come together not only to learn from each other, but also to strengthen access, use and analysis of routine facility data through regional initiatives. The standards packages on which participants were trained will be accessible through the Integrated African Health Observatory (iAHO), in view of establishing interoperability between DHIS and the iAHO. Another capacity-building training conducted was one in **Uganda** on a Harmonized Health Facility Assessment tool, with participants from 11 countries, to provide them with an opportunity to track the quality of data that strengthens surveillance systems, as well as to generate strong evidence for good decision-making.

### Measuring progress on SDGs

In order to assess progress on the SDG Global Action Plan,<sup>52</sup> a number of countries as well as regions have put a particular focus on building data collection and reporting that also feeds into the Global Monitoring Report on UHC (see Box 33).

Many regions have been working towards improving the reliability of health data and indicators, such as the **South-East Asia Region**, which released its fourth annual publication on *Monitoring progress on UHC and the health-related SDGs in the South-East Asia Region* in 2019.<sup>53</sup> The update focused on the delivery of front-line health services, exploring issues such as low ambulatory service utilization, coverage for the urban poor, quality of care and PHC spending. Data were limited for many countries, but what was available was utilized to spur dialogue around service delivery issues underlying progress towards UHC. In the **African Region**, 11 WHO collaborating centres and 14 WHO African Regional Office partner institutions came together in **Congo** in 2019 to form communities of practice on the attainment of SDGs and of the UHC agenda. Another key area of focus for countries across the African Region is the development of country health profiles providing overviews of health system investments and performance, as well as of health sector performance. A specific tool will be used by countries for the elaboration of these profiles, based on feedback from Member States and academic institutions.

In terms of operationalizing the WHO impact framework as well as SDG indicators, **India**, with WHO support, created a national SDG health dashboard, as well as reviewed SDG 3 implementation in states, including UHC mapping. Regarding knowledge products, **Algeria** and **Mauritius** were supported in the documentation of best practices for progressing UHC and other health-related SDGs. The countries provided examples of how to overcome common implementation challenges.

52. Global action plan for healthy lives and well-being for all. In: World Health Organization [website]. Geneva: WHO (<https://www.who.int/sdg/global-action-plan>).

53. Monitoring progress on universal health coverage and the health-related sustainable development goals in the South-East Asia Region: 2019 update. New Delhi: WHO Regional Office for South-East Asia; 2019 (<https://apps.who.int/iris/handle/10665/326828>).

### 4.3 Leveraging the potential of digital health

In 2019, WHO was in the process of developing its digital health strategy, which aims to support and respond to the growing needs of countries to implement appropriate digital technologies in accordance with their health priorities, and to make progress towards UHC.

As such, several countries prioritized digital health, including five in the **African Region – Benin, Congo, Madagascar, Mauritania, Niger** – which were supported to plan, develop and work towards implementing eHealth strategies. Along these lines, a capacity-building workshop was convened in Benin with 13 francophone countries and **Malawi** to strengthen leadership in digital health and provide a roadmap for the deployment of various digital health solutions. Serving as an integrated platform for electronic health records, including a personal user/health-seeker module, and housing various information systems, a WHO African Region digital health platform is being developed, with plans for progressive roll-out to countries.

At the country level, however, many countries are seeking support for how to create an appropriate architecture and invest in digital health. For example, there is significant discussion in **Tunisia** on the need for digital solutions to many problems. As such, a study visit was organized to **Estonia**, a country which is a pioneer in its digital architecture, and it was an invaluable step in advocating for holistic thinking around digital health issues in **Tunisia**. The choice of including varied stakeholders – parliamentarians, high-level policy-makers, engineers – also allowed for collaboration on a variety of foundational areas for digital health, spanning from regulations and laws to adoption of national information technology standards. Follow-up work from the study visit has started and is expected to continue and lead to a more unified architecture for digital health.

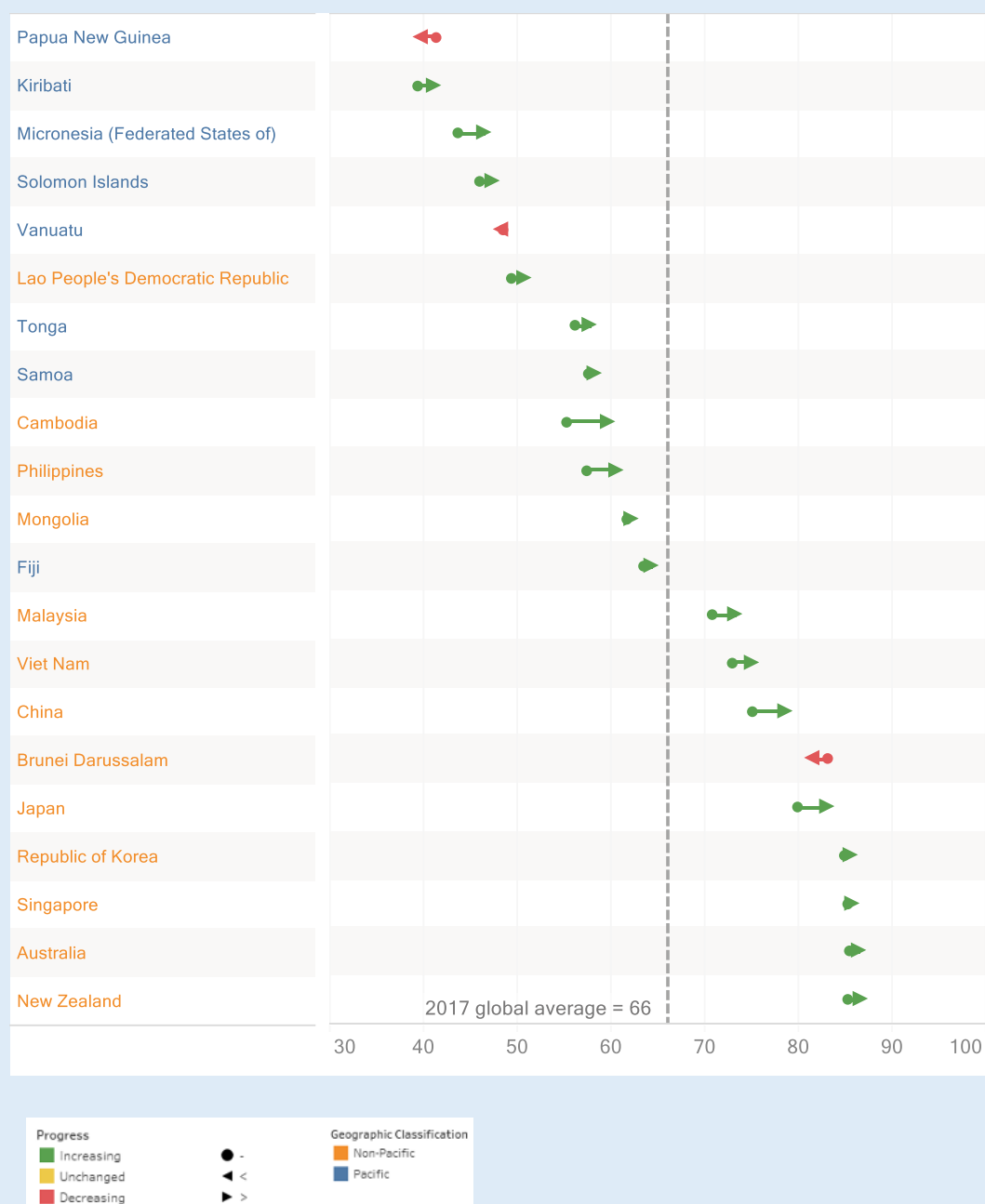
The UHC-P supported many countries to produce comprehensive health situation and trend assessments in order to monitor the state of health, trends, inequities and determinants at the facility, subregional and national levels.

### Box 33: Western Pacific Region: SDG gap monitoring

The UHC Service Coverage Index is the official measure for SDG 3.8.1 and was developed as part of a multi-year effort; subsequently WHO and the World Bank jointly published monitoring reports in 2017 and 2019 on both UHC indicators 3.8.1 (coverage of essential health services<sup>54</sup>) and 3.8.2 (catastrophic spending on health<sup>55</sup>).

As part of this work, WHO regional offices, such as the Western Pacific Regional Office, are contributing to data collection and reporting for the *Global monitoring report on financial protection in health 2019*, which is part of the SDG monitoring. It also contributed to the update of the global database on UHC in the UHC data portal.<sup>56</sup> Key highlights from the Region in 2019 include a steady improvement in UHC service coverage (see Fig. 9), particularly vis-à-vis infectious disease control and maternal and child health. However, it should be noted that only 12 countries had data on financial protection (SDG 3.8.2).

Fig. 9. Changes in UHC service coverage index from 2015 to 2017



54. Defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health; infectious diseases; NCDs; and service capacity and access, among the general and the most disadvantaged populations.

55. Proportion of population with large household expenditures on health as a share of total household expenditure or income.

56. The Global Health Observatory. In: World Health Organization [website]. Geneva: WHO (<https://www.who.int/data/gho/data/major-themes/universal-health-coverage-major>).

### Box 34: Lebanon: Policy Support Observatory sheds light

The Lebanese Health Strategic Plan 2016–2020 highlights health sector governance as one of the four strategic goals to make progress towards UHC. With over 15 years of civil war leaving Lebanon with a weakened health system, destroyed public health facilities, and a dispersed health workforce, there was a need to strengthen the health system with institutionalized sources of intelligence and evidence, collaborative decision-making and political consensus. The new Policy Support Observatory (PSO), hosted at the Ministry of Public Health and operated by the Faculty of Health Sciences at the American University of Beirut, supports health systems strengthening by creating a platform for systematic, open and transparent collaboration.

In collaboration with the stakeholders, WHO supported this vital work from early conceptualization of the PSO and now through to the implementation of several projects. Having joined the UHC-P in 2018, Lebanon has benefited in 2019 from the implementation of several PSO projects, including interventions to evaluate the electronic health record deployment strategy, plans for a national HMIS, introduction of the people-centred primary care approach in 30 PHC centres in the country, and improvement of quality monitoring of local pharmaceutical production through conducting GMP audits. Furthermore, the UHC-P enabled critical support for the expansion of mental health services and their integration with PHC/community-level centres, thus improving access for vulnerable populations.

In 2019, WHO collaborated with the American University of Beirut in operationalizing PSO, including support for staffing; recruitment of international experts to support development of a PSO plan of action; and drafting of proposals for supporting health systems strengthening at the PHC level, including mapping of nongovernmental organizations, and development of a provider survey and beneficiary perception survey.

*“WHO is committed to working with the Ministry of Public Health to make this initiative a success. Achieving universal health coverage requires countries to build a consensus not only on the scope of services to be covered, but also how they are financed, managed, and delivered. Lebanon’s Policy Support Observatory will help the Ministry of Health do all of that.”*

**Dr Tedros Adhanom, Director-General, WHO (during the launch event)**

*“This Observatory will facilitate communications with all parties and partners, especially citizens, to ensure the sustainability of cooperation, effectiveness and scientific policy, away from political influence or any other subjective effects.”*

**Ghassan Hasbani, former Minister of Health, current Deputy Prime Minister, Lebanon**



## 5.

# More effective and efficient UHC-P providing support to countries

As part of GPW13, one of the strategic shifts of WHO is to provide more effective and efficient support to countries, to drive measurable improvement. The UHC-P is supporting these fundamental changes in the way it works to deliver impact, to ensure that it aligns with the evolving WHO operating model.

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As part of WHO's commitment to putting countries squarely at the centre of its work, the UHC-P, with country-led prioritization, allows each respective ministry of health to define a roadmap comprising a set of activities to strengthen the national health system in order to make significant progress towards UHC. The support from the UHC-P forms part of the annual country support plans. This is further reinforced by supporting this work regionally and globally, as highlighted by the case in the WHO **European Region** (see Box 35).

The aim is to build country capacities and hence reinforce the leadership of ministries of health to build resilient and effective health systems in a sustainable manner. This will help to ensure continuity between global commitments and country implementation on the ground, hence serving as a country-level resource for UHC2030,<sup>57</sup> the global movement to build stronger health systems for UHC.

Much of this has been reflected in sections 1–4 above, with concrete examples of how:

- policy dialogues have been designed for countries' needs and contexts;
- strategic advice is tailored to strengthen health systems; and
- technical assistance is based on the notion of partnership with governments and other stakeholders.

As part of the development of this Annual Report, which included a virtual workshop attended by all WHO regional offices, a major focus was on identifying key factors of success and challenges and opportunities for how the UHC-P conducts its work, which are summarized in section 5.1. This commitment to improvement is also enhanced by initiatives, such as the external realist evaluation (see Box 37), that is providing insight as to how context at the country level can accelerate valuable interventions for UHC.

<sup>57</sup> Taking action for Universal Health Coverage. In: UHC2030 [website]. Geneva: WHO (<https://www.uhc2030.org/>).



Testing for COVID-19 at the Jawaharlal Nehru Hospital, Mauritius. Samples are sent to the Candos Virology Lab in Quatre Bornes and results are received in around two days. The programme was made possible with the support and guidance of the WHO team in Mauritius. © WHO/Blink Media – Gilliane Soupe.

## 5.1 Key factors for success

Underpinning the way that the UHC-P operates, five key factors for success have been identified, which embody the strategic shifts occurring at WHO in ensuring continuity between global commitments and country implementation, providing leadership at the country level towards unremitting progress and significant results.

Although these five key factors for success are mutually reinforcing, it is important to note that they are all built upon the foundational trust and long-standing commitment of the UHC-P's donors, who have created the environment for the successes outlined below. The UHC-P offered opportunities to donors to be active and engaged partners with WHO. A good example is the MDCC that provides transparency and helps foster alignment of donors for country-level impact. This iterative process capitalizes on the emergent nature of decision-making and provides a flexible funding tool to get resources when and where they are needed.

### **1: A bottom-up approach based on country needs and capacity**

The UHC-P supports engagement in policy dialogue, to coordinate and align plans across various levels of the health system, as well as between immediate humanitarian aid and long-term development concerns. As part of a bottom-up approach, the UHC-P has focused on ensuring that UHC reaches the poorest and most marginalized populations to improve health and mitigate financial hardship. In 2019, this has been seen in a number of cases, not only where new laws or programmes were adopted to extend benefits packages and financial protection, but also in terms of initiatives, such as the rural pipeline or humanitarian-development nexus that strengthen health services for the most vulnerable.

The alignment with WHO country support plans is crucial: country support plans help respective ministries of health, alongside all levels of WHO, to agree on key UHC-related priorities and activities that are in line with national priorities. This alignment has helped shape WHO's operating model to drive country, regional and global impact. For example, the UHC-P has deployed senior health systems' advisers (20 in 2019, with 60 under recruitment) in WHO country offices, in direct support of ministries of health. Backed up with WHO's expertise from regional offices and headquarters, these advisers support the national authorities upon request, both for ad-hoc requests and long-term projects, in a timely and tailored manner.



## 2: Flexibility in terms of funding as well as adapting to context and changing priorities

This has been a defining feature that has resonated with country-level partners, but also with WHO country offices, regional offices and headquarters, enabling more timely and relevant interventions.

This flexibility to pivot based on emerging priorities will be especially important to the UHC-P in 2020, with the rise of the global COVID-19 pandemic, as countries mount a response and strengthen essential health services.

The UHC-P has become one of the most flexible funding streams in WHO, and through careful attention to governance structures and a strong commitment to principles (including being country led), has been able to model a new way for WHO to support countries. This ranges from the collaborative nature of the country support plans to ensuring that new health system advisers are on the ground accelerating progress nationally and regionally.

## 3: A strong and high-level internal governance of the UHC-P supported by world leaders' political commitments and a robust multi-donor coordination committee to improve transparency and mutual accountability

High-level meetings and commitments, such as at the United Nations General Assembly, have provided opportune entry points to foster dialogue about UHC, both regionally and at the country level. There have been a number of initiatives up to the presidential and ministerial level, where UHC-P involvement was made possible via these entry points, which led to tangible results.

Moreover, within WHO, the establishment of governance structures such as the internal High-level UHC Steering Committee set up in 2019 – chaired by the Deputy Director-General with the participation of all the Directors of Programme Management of the WHO regional offices – has helped to align and mobilize all levels of the organization. The establishment of the MDCC in 2019 has also improved transparency and mutual accountability.

## 4: Systematic monitoring of implementation and results, which ensures clear accountabilities

Significant progress has been made ensuring that the UHC-P operates in a transparent manner by leveraging the complementary nature of the structures that have been put in place. Accountability, delivering and documenting results are a key factor of success of the UHC-P. Together with the meetings of the internal High-level Steering Committee (three in 2019) and the MDCC (three in 2019), and publication of the Stories From the Field<sup>58</sup> (more than 30 in 2019), the live monitoring sessions, which are undertaken for each region quarterly, have helped to facilitate knowledge exchange,

as well as provide a forum to share results achieved and challenges faced at the country level. They also provide additional accountability and transparency with respect to real-time tracking of funding. This not only feeds into decision-making at WHO and with donors, but has supported adaptability at the local level and learning across the Partnership. With a significant expansion of funding in 2019, a major focus was on the inception phase or onboarding of new countries, such as in the **Region of the Americas** (see Box 36). Without being able to leverage the processes, structures and learnings from other regions, the onboarding of 20 new countries would not have been possible.

## 5: Continuity and sustainability of the efforts at national level thanks to catalytic resources

In many cases, sustained support at country level was cited as a chief contributor to the success of the UHC-P. This took the form of being able to influence politically, and also follow through technically as new initiatives, laws or structures are put in place to accelerate UHC. Pragmatically, this means that at the country level, progress is not always steady – with one year showing tremendous gains but perhaps not as many the following year. Having sustained support, however, provides the UHC-P with the opportunity to mobilize quickly to capitalize on opportunities.

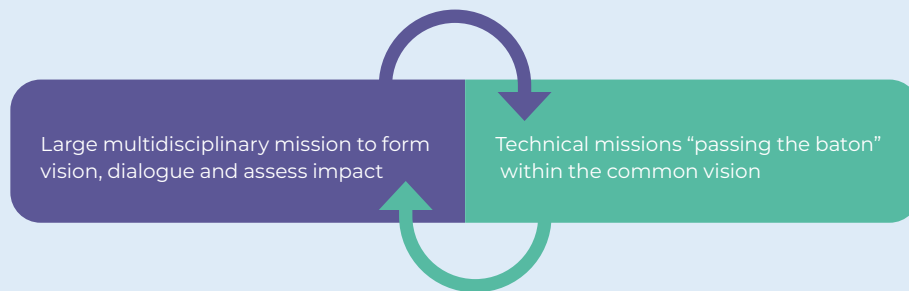
By facilitating alignment, the UHC-P has been able to generate high-level support for UHC, as well as supported the allocation of domestic resources by working with ministries of health and finance for UHC. This was the case in many countries which saw significant new resources allocated to UHC. Moreover, the UHC-P has provided an avenue to align resources, such as the PHC-intensified support programmes in conjunction with partners such as UNICEF to enhance equity.

**Underpinning the way that the UHC-P operates, five key factors for success have been identified.**

58. Reports. In: Universal Health Coverage Partnership [website]. Geneva: WHO; 2019 (<https://www.uhcupartnership.net/reports/>).

## Box 35: European Region: Multidisciplinary and agile missions

As part of WHO's vision to strategically reinforce country-level activities with regional cross-country activities, the European Region has been moving towards a new modality of country support that is multidisciplinary and agile. In 2019, the Regional Office supported over 42 technical assistance missions on core UHC-P themes, mobilizing expertise across different technical disciplines. For example, a multidisciplinary mission to **Azerbaijan** supported a high-level policy dialogue on PHC, creating the space for the Ministry of Health and the Health Insurance Agency to come together and discuss how to advance PHC reform in the context of the establishment of the new mandatory health insurance model. The technical inputs provided by experts from the Regional Office ranged from areas such as health financing, governance, service delivery and human resources for health to child and maternal care.



This modality was further reinforced by regional activities that strategically strengthened and complemented country activities, such as:

- Meet the reformers: A platform to share and learn from the experience on areas from benefit design to PHC performance monitoring from senior policy decision-makers who have been leading large transformation and reforms processes.
- Capacity-building: Strengthening of policy-makers' knowledge in key technical areas such as health financing and pharmaceutical pricing for country and regional impact.
- Impact frameworks: Support for analytical work on themes such as financial protection or NCD outcomes.

*"The multidisciplinary and agile approach – it's a game changer in the way [the WHO European Regional Office] provides technical assistance to countries. It's a modality that allows us to bring together key national stakeholders and policy-makers with the relevant technical experts to sustain the policy dialogue and advance the reform agenda in the country."*

**Gabriele Pastorino, Technical Officer, WHO Regional Office for Europe**



### **Box 36:** Region of the Americas: Onboarding over 20 new UHC-P countries

From 2018 to 2019, PAHO scaled up to more than 20 countries supported by the UHC-P, starting in 2018 with seven countries supported by funds from the Japanese Government for one year, and adding 16 Caribbean ACP countries and four non-ACP countries during 2019. Rapid planning according to country needs, flexibility in the use of funds, and leveraging existing partnerships and ongoing technical cooperation processes enabled 100% implementation of the Region's allocation of funding in the time frame. The same approach has been used to programme the Development Cooperation Instruments funds in four countries, aligning programming flexibly with the Compact 30.30.30: PHC for Universal Health.

Longer-term planning was required for the European Commission's ACP programme, which was the first to develop a regional roadmap in 2018. PAHO then began the development of four-year integrated regional, subregional and country workplans, culminating in the meeting in November 2019 opened by the Director of PAHO, Dr Carissa Etienne, and bringing together Health Systems Strengthening (HSS) and NCD and Mental Health (NMH) regional teams, the HSS and NMH advisors in each Caribbean ACP country, the Subregional Program Coordinator for the Caribbean, Communications and Visibility focal points and guests from UHC-P WHO.

Governance of the UHC-P in the Region of the Americas has been set up with a UHC-P Management Team in HSS in the Regional Office, led by the Director of HSS for the day-to-day and overall planning, coordination and monitoring of the project. Roles and responsibilities within implementing entities are defined in the UHC-P programme management arrangements.

## 5.2 Challenges and opportunities

### Funding

With recent scale-up of funding of over US\$ 50 million per year from seven donors, the UHC-P is starting to provide predictable medium-term funding, which allows for follow-through from initial policy dialogue to implementation. With over half of the world's population still without access to essential health services, there is a benefit to scaling up this work that is aligned with country-level priorities and that can allow for long-term planning to sustain changes on the path to UHC. Of note is the fact that the majority of earmarked resources are targeted for the African, Eastern Mediterranean, Western Pacific Regions and the Region of the Americas; as such, the MDCC and WHO should work jointly on improving resource availability for the European and South-East Asia Regions.

### Collaboration

The UHC-P has made significant strides in ensuring alignment and collaboration with donors and all levels of WHO to respond to country-level needs. This collaboration is an exemplar for how the UHC-P has been able to adapt to country contexts; however, these efforts can be further evaluated by formally establishing partnerships with external organizations. This is already being done in some regions and at country level, but there is more to be gained by formalizing these partnerships globally, which can mobilize resources for UHC at country level.

### Country-level support

A key link in the UHC-P is the interrelationship between all levels of WHO, which relies heavily on strong country offices, which are the face of the Partnership at country level and corresponding country support plans. Given that commitment to UHC is a political choice, country offices play a large role in ensuring that funding and activities are responsive to country-identified needs. As such, it is important for the UHC-P and the WHO regional offices to not only ensure that it remains top of mind for country offices, but that the country offices are supported to undertake high-level advocacy for UHC.

### Visibility

The UHC-P has made concerted efforts to raise the profile of UHC not only within WHO, but also across the world and with partners. As the UHC-P enters a mature state, having been operational since 2011, its work is being acknowledged for its impact. The UHC-P needs to continue to actively communicate this work in a way that demonstrates how results are achieved through sustained support for country-led priorities for UHC.

## Box 37: Realist evaluation: Ongoing external evaluation of the UHC-P

As part of the realist evaluation, researchers are trying to answer the following question: How, in what contexts, and triggering what mechanisms, does the UHC-P support policy dialogue for health planning and financing towards UHC?<sup>59</sup> The realist evaluation of the UHC-P was a qualitative embedded multi-centre case study in six African countries. Three types of policy dialogue processes which the UHC-P supported were examined: dialogue on health financing (**Burkina Faso** and **Democratic Republic of the Congo**), dialogue for health planning (**Cabo Verde**, **Niger** and **Togo**) and dialogue for aid coordination (**Liberia**). Below are the four main findings of the transversal analysis.

### The Partnership's ability to initiate and support dialogue (general system context)

Across countries, contextual factors clearly determined the extent to which the UHC-P was able to effectively support policy dialogue. In the study, the following factors were prominent: available resources, policy and legal frameworks, socioeconomic and cultural characteristics, political dynamics and power relations among policy dialogue participants. Where these factors were favourable, the UHC-P contributed to greater ministry of health ownership of the policy dialogue process, with broad buy-in of stakeholders.

### The Partnership's role in the initiation of the dialogue

Three factors seem to be pertinent for the UHC-P to initiate policy dialogue: (i) providing financial support; (ii) considering actors' needs and interests, and (iii) generating interest in multisectoral collaboration, keeping in mind potential interdependencies and conflicts of interest among actors.

### The Partnership's role in nurturing the dialogue

Through capacity-building initiatives, the UHC-P strengthens the capacities of ministries of health to apply policy dialogue as a collaborative governance tool. Once the dialogue was initiated, the UHC-P was a valued partner in the dialogue process itself. Its valued role involved facilitating data collection, providing content expertise, and paving the way towards mutual understanding among stakeholders.

### Dialogue dynamics

Despite the Partnership's support, local policy dynamics can prevent optimal UHC-P support and policy dialogue outcomes. These may lead to the interruption or weak institutionalization of policy dialogue processes. In particular, poor ministry of health ownership of the dialogue process was found to be a key barrier to participation due to the lack of stakeholder confidence in the capacity for joint action. This often led to missed opportunities for mobilization and collaboration with actors on the ground.

The presence of a full-time health systems expert in WHO country offices was found to counterbalance many of the above-mentioned challenges and helped to institutionalize policy dialogue processes.

In conclusion, the UHC-P is advised to foster three resources that have demonstrated their added value:

- international health systems experts who support health ministries and promote dialogue inclusivity and multisectoral collaboration;
- seed funding for activities such as stakeholder meetings which foster collaboration in policy processes; and
- financial support for activities that generate knowledge, nurture exchange, enhance stakeholders' competencies and create mutual understanding.

59. Robert E, Ridde V, Rajan D, Sam O, Grave M, Porignon D. Realist evaluation of the role of the Universal Health Coverage Partnership in strengthening policy dialogue for health planning and financing: a protocol. *BMJ Open*. 2019; 9:e022345 (<https://bmjopen.bmj.com/content/9/1/e022345>).

Robert E, Ridde V. Policy dialogue (dialogue sur les politiques): une synthèse exploratoire des écrits scientifiques. *Cahiers Realisme*. August 2018;16 (in French) (<https://www.uhcpartnership.net/wp-content/uploads/2018/09/Robert-Policy-Dialogue-Numero-16-Aout-2018.pdf>).

Robert E, Rajan D, Koch K, Muggleworth Weaver A, Porignon D, Ridde V. Policy dialogue as a collaborative tool for multistakeholder health governance: a scoping study. *BMJ Global Health*. 2020; 4:e002161 ([https://gh.bmj.com/content/4/Suppl\\_7/e002161](https://gh.bmj.com/content/4/Suppl_7/e002161)).

Robert E, Ridde V. Dealing with complexity and heterogeneity in a collaborative realist multiple case study in low- and middle-income countries. *SAGE Research Methods Cases*. 2020; doi:10.4135/9781529732306 (<https://methods.sagepub.com/case/complexity-heterogeneity-collaborative-realist-low-middle-income-countries>).

Robert E, Ridde V. Faire face à la complexité et à l'hétérogénéité dans une étude de cas multiple réaliste dans des pays à revenu faible et intermédiaire. 2020; hal-02517418 (in French) (<https://hal.archives-ouvertes.fr/hal-02517418/document>).

## 6. Conclusion and looking forward to 2020

The year 2019 has been a banner year for the UHC Partnership as it scaled up support to over 115 countries, with donors – such as the European Union – extending support until 2022.

With over 60 health systems advisers expected to be recruited in 2020, country and regional support is set to be significantly enhanced. As highlighted throughout the Annual Report, the UHC-P achieved key political and UHC milestones in a number of countries, and continues to provide on-the-ground support for progress on UHC in alignment with WHO's GPW13.

To date, the UHC-P has been mostly focused on the first billion of WHO's strategic plan – UHC. However, the challenge has been to realize the interconnection between UHC, health emergencies and healthier populations. This has been a gradual evolution, as progress is made on UHC and countries realize opportunities to align activities, such as the integration of NCDs, which has been an emerging theme in UHC-P support.

**2020 presents a key opportunity for the UHC-P as a model for flexibility and responsiveness to also focus on the second billion of health emergencies.**

The year 2019 has also been a key year in galvanizing support for UHC globally, and an important year in terms of onboarding new countries, as well as anticipating results that ranged from improving access to quality essential health services and essential medicines, to reducing the number of people experiencing financial hardship. This progress at country level, coupled with the recent strengthening of the Partnership via additional resourcing, positions the UHC-P well to support the integration of important areas into the UHC agenda in 2020.

This year, 2020, presents a key opportunity for the UHC-P as a model for flexibility and responsiveness to also focus on the second billion of health emergencies. Challenges are expected in 2020 with the COVID-19 pandemic and possible delays in UHC-P workplan implementation, but this also represents an opportunity for better integrating essential public health functions and International Health Regulations/Joint External Evaluation/National Action Plan for Health Security recommendations into national health strategies to improve both health security and progress towards UHC and better health.



A health worker in Ukraine. ©WHO/EURO.



A laboratory technologist in Suriname. © PAHO/WHO.

# Annex.

## UHC-P 2019 activities mapped to GPW13

Fig. 10. UHC-P 2019 activities mapped to GPW13

GPW13 OUTCOMES ▶	UNIVERSAL HEALTH COVERAGE															HEALTH EMERGENCIES		BETTER HEALTH AND WELL-BEING			MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES				
	1.1					1.2			1.3					2.1	2.3	3.1	3.2	3.3	4.1	4.2		4.3			
	1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.3.1	3.1.1	3.2.2	3.3.1	4.1.1	4.1.2	4.2.1	4.2.5	4.2.6	4.3.2	
Algeria																									
Angola																									
Benin	■				■	■	■	■	■																
Botswana																									
Burkina Faso	■			■	■	■	■																		
Burundi	■			■	■																				
Cabo Verde	■			■																					
Cameroon																									
Chad																									
Comoros																									
Congo	■			■																					
Côte d'Ivoire																									
Democratic Republic of the Congo	■			■		■	■																		
Equatorial Guinea	■			■																					
Eritrea	■			■																					
Eswatini	■			■	■	■	■																		
Ethiopia	■					■	■																		
Gabon																									
Gambia																									
Ghana				■	■	■	■	■																	
Guinea	■			■	■																				



## GPW13 OUTCOMES

- 1.1 Improved access to quality essential health services
- 1.2 Reduced number of people suffering financial hardships
- 1.3 Improved access to essential medicines, vaccines, diagnostics and devices for primary health care
- 2.1 Countries prepared for health emergencies
- 2.3 Health emergencies rapidly detected and responded to
- 3.1 Determinants of health addressed
- 3.2 Risk factors reduced through multisectoral action
- 3.3 Healthy settings and Health in All Policies promoted
- 4.1 Strengthened country capacity in data and innovation
- 4.2 Strengthened leadership, governance and advocacy for health
- 4.3 Resources management

GPW13 OUTCOMES ▶	UNIVERSAL HEALTH COVERAGE															HEALTH EMERGENCIES		BETTER HEALTH AND WELL-BEING			MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES					
	1.1					1.2			1.3					2.1	2.3	3.1	3.2	3.3	4.1	4.2		4.3				
	1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.3.1	3.1.1	3.2.2	3.3.1	4.1.1	4.1.2	4.2.1	4.2.5	4.2.6	4.3.2		
WHO African Region	Malawi	■			■		■																			
	Mali				■																					
	Mauritania				■		■												■							
	Mauritius	■			■						■									■						
	Mozambique	■			■		■	■	■		■									■						
	Namibia																			■						
	Niger					■	■													■						
	Nigeria	■			■	■	■	■	■		■		■	■	■					■						
	Rwanda	■				■	■													■						
	Sao Tome and Principe						■						■													
	Senegal	■		■	■	■	■		■											■						
	Seychelles							■					■							■						
	Sierra Leone	■			■	■	■	■	■	■		■	■							■						
	South Africa	■			■	■	■	■	■	■										■						
	South Sudan	■				■	■	■								■				■		■				
	Togo	■				■	■	■												■		■				
	Uganda						■	■												■		■				
	United Republic of Tanzania						■	■																		
Zambia	■			■	■	■	■		■		■						■		■							
Zimbabwe					■	■													■		■					

## GPW13 OUTCOMES

- 1.1 Improved access to quality essential health services
- 1.2 Reduced number of people suffering financial hardships
- 1.3 Improved access to essential medicines, vaccines, diagnostics and devices for primary health care
- 2.1 Countries prepared for health emergencies
- 2.3 Health emergencies rapidly detected and responded to
- 3.1 Determinants of health addressed
- 3.2 Risk factors reduced through multisectoral action
- 3.3 Healthy settings and Health in All Policies promoted
- 4.1 Strengthened country capacity in data and innovation
- 4.2 Strengthened leadership, governance and advocacy for health
- 4.3 Resources management

GPW13 OUTCOMES ▶	UNIVERSAL HEALTH COVERAGE															HEALTH EMERGENCIES		BETTER HEALTH AND WELL-BEING			MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES					
	1.1					1.2			1.3					2.1	2.3	3.1	3.2	3.3	4.1		4.2		4.3			
	1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.3.1	3.1.1	3.2.2	3.3.1	4.1.1	4.1.2	4.2.1	4.2.5	4.2.6	4.3.2		
WHO Eastern Mediterranean Region	Afghanistan	■			■	■			■					■												
	Djibouti														■											
	Egypt	■					■																			
	Iran (Islamic Republic of)														■											
	Iraq														■											
	Jordan	■			■		■								■											
	Lebanon	■			■		■		■	■					■				■	■						
	Libya														■											
	Morocco	■			■	■	■																			
	Pakistan	■					■																			
	occupied Palestinian territory, including east Jerusalem														■											
	Somalia	■			■										■											
	Sudan	■			■		■								■											
	Syrian Arab Republic														■											
	Tunisia				■	■	■													■						
Yemen														■												
WHO European Region	Azerbaijan	■	■		■	■	■												■						■	
	Georgia						■																			
	Kyrgyzstan				■		■	■		■									■			■				
	Moldova		■		■			■	■	■												■		■	■	
	Tajikistan				■		■	■																		
	Ukraine	■		■			■	■	■											■		■				
	Uzbekistan	■	■	■	■	■	■	■												■						

GPW13 OUTCOMES		UNIVERSAL HEALTH COVERAGE													HEALTH EMERGENCIES		BETTER HEALTH AND WELL-BEING			MORE EFFECTIVE AND EFFICIENT WHO PROVIDING BETTER SUPPORT TO COUNTRIES						
		1.1					1.2			1.3					2.1	2.3	3.1	3.2	3.3	4.1		4.2			4.3	
		1.1.1	1.1.2	1.1.3	1.1.4	1.1.5	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	2.1.1	2.3.1	3.1.1	3.2.2	3.3.1	4.1.1	4.1.2	4.2.1	4.2.5	4.2.6	4.3.2	
WHO Region of the Americas	Belize	■			■		■		■	■																
	Colombia	■			■																					
	Dominica	■			■				■	■																
	El Salvador	■			■		■		■	■																
	Guyana	■	■		■		■		■	■																
	Haiti		■				■		■	■																
	Honduras								■	■																
	Paraguay	■			■	■															■					
	Peru								■	■																
	Suriname																		■							
	Venezuela (Bolivarian Republic of)								■	■											■					
WHO South-East Asia Region	India					■	■														■					
	Indonesia					■																				
	Nepal	■						■													■					
	Timor-Leste	■				■		■													■					
WHO Western Pacific Region	Cambodia	■			■		■													■						
	Lao People's Democratic Republic	■		■	■	■	■	■		■		■	■				■				■					
	Mongolia	■					■		■																	
	Marshall Islands	■																								
	Micronesia (Federated States of)	■													■											
	Mongolia																	■								
	Papua New Guinea																				■					
	Philippines	■			■		■														■					
	Viet Nam	■			■		■	■	■												■	■				

## Activities table summary

NUMBER OF COUNTRIES ADDRESSING OUTCOMES AND OUTPUTS GLOBALLY AND BY REGIONS							GOAL, OUTCOME AND OUTPUT
WORLD WIDE	AFRO	EMRO	EURO	PAHO	SEARO	WPRO	
92	45	16	7	11	4	9	Number of countries with reported activities in 2019 (refers only to the 92 countries that developed operational activities in 2019. The remaining 19 countries focused in 2019 only on planning activities to be implemented in 2020)
<b>78</b>	<b>41</b>	<b>9</b>	<b>7</b>	<b>10</b>	<b>4</b>	<b>7</b>	<b>One billion more people benefiting from universal health coverage</b>
66	33	9	6	7	4	7	<b>1.1</b> Improved access to quality essential health services
51	25	8	3	6	2	7	<b>1.1.1</b> Countries enabled to provide high-quality, people-centred health services, based on primary health care strategies and comprehensive essential service packages
5	0	0	3	2	0	0	<b>1.1.2</b> Countries enabled to strengthen their health systems to deliver on condition- and disease-specific service coverage results
4	1	0	2	0	0	1	<b>1.1.3</b> Countries enabled to strengthen their health systems to address population-specific health needs and barriers to equity across the life course
43	21	7	5	6	0	4	<b>1.1.4</b> Countries' health governance capacity strengthened for improved transparency, accountability, responsiveness and empowerment of communities
30	20	3	2	1	3	1	<b>1.1.5</b> Countries enabled to strengthen their health workforce
61	34	8	7	4	3	5	<b>1.2</b> Reduced number of people suffering financial hardship
44	21	8	6	4	1	4	<b>1.2.1</b> Countries enabled to develop and implement equitable health financing strategies and reforms to sustain progress towards universal health coverage
38	28	0	5	0	2	3	<b>1.2.2</b> Countries enabled to produce and analyse information on financial protection, equity and health expenditures and to use this information to track progress and inform decision-making
28	13	2	3	9	0	1	<b>1.3</b> Improved access to essential medicines, vaccines, diagnostics and devices for primary health care
19	7	2	1	9	0	0	<b>1.3.1</b> Provision of authoritative guidance and standards on quality, safety and efficacy of health products, including through prequalification services, essential medicines and diagnostics lists
15	2	1	2	9	0	1	<b>1.3.2</b> Improved and more equitable access to health products through global market shaping and supporting countries to monitor and ensure efficient and transparent procurement and supply systems
10	8	0	2	0	0	0	<b>1.3.3</b> Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved
2	1	0	0	0	0	1	<b>1.3.4</b> Research and development agenda defined and research coordinated in line with public health priorities
2	1	0	0	0	0	1	<b>1.3.5</b> Countries enabled to address antimicrobial resistance through strengthened surveillance systems, laboratory capacity, infection prevention

**AFRO:** WHO Regional Office for Africa

**EMRO:** WHO Regional Office for the Eastern Mediterranean

**EURO:** WHO Regional Office for Europe

**PAHO:** Pan American Health Organization

**SEARO:** WHO Regional Office for South-East Asia

**WPRO:** WHO Regional Office for the Western Pacific

NUMBER OF COUNTRIES ADDRESSING OUTCOMES AND OUTPUTS GLOBALLY AND BY REGIONS							GOAL, OUTCOME AND OUTPUT
WORLD WIDE	AFRO	EMRO	EURO	PAHO	SEARO	WPRO	
15	2	12	0	0	0	1	<b>One billion more people better protected from health emergencies</b>
12	1	10	0	0	0	1	<b>2.1</b> Countries prepared for health emergencies
12	1	10	0	0	0	1	<b>2.1.1</b> All-hazards emergency preparedness capacities in countries assessed and reported
3	1	2	0	0	0	0	<b>2.3</b> Health emergencies rapidly detected and responded to
3	1	2	0	0	0	0	<b>2.3.1</b> Potential health emergencies rapidly detected, risks assessed and communicated
5	1	1	0	1	0	2	<b>One billion more people enjoying better health and well-being</b>
3	0	0	0	1	0	2	<b>3.1</b> Determinants of health addressed
3	0	0	0	1	0	2	<b>3.1.1</b> Countries enabled to address social determinants of health across the life course
1	1	0	0	0	0	0	<b>3.2</b> Risk factors reduced through multisectoral action
1	1	0	0	0	0	0	<b>3.2.2</b> Multisectoral determinants and risk factors addressed through engagement with public and private sectors, as well as civil society
1	0	1	0	0	0	0	<b>3.3</b> Healthy settings and Health in All Policies promoted
1	0	1	0	0	0	0	<b>3.3.1</b> Countries enabled to adopt, review and revise laws, regulations and policies to create an enabling environment for healthy cities and villages, housing, schools and workplaces
52	35	2	5	2	3	5	<b>More effective and efficient WHO providing better support to countries</b>
50	34	2	4	2	3	5	<b>4.1.</b> Strengthened country capacity in data and innovation
50	34	2	4	2	3	5	<b>4.1.1</b> Countries enabled to strengthen health information and information systems for health, including at the subnational level, and to use this information to inform policy-making
1	0	0	0	0	0	1	<b>4.1.2</b> WHO Impact Framework and triple billion targets, global and regional health trends, Sustainable Development Goal indicators, health inequalities and disaggregated data monitored
10	8	0	2	0	0	0	<b>4.2</b> Strengthened leadership, governance and advocacy for health
9	7	0	2	0	0	0	<b>4.2.1</b> Leadership, governance and external relations enhanced to implement GPW13 and drive impact in an aligned manner at the country level, on the basis of strategic communications and in accordance with the Sustainable Development Goals in the context of United Nations reform
2	1	0	1	0	0	0	<b>4.2.5</b> Cultural change fostered, and critical technical and administrative processes strengthened through a new operating model that optimizes organizational performance and enhances internal communications
1	0	0	1	0	0	0	<b>4.2.6</b> “Leave no one behind” approach focused on equity, gender and human rights progressively incorporated and monitored
2	0	0	2	0	0	0	<b>4.3</b> Resources management
2	0	0	2	0	0	0	<b>4.3.2</b> Effective and efficient management and development of human resources to attract, recruit and retain talent for successful programme delivery



A mother waits with her young child for polio vaccination in Ukraine. ©WHO/Alex Shpigunov.



**#UHCPartnership**

“The UHC-Partnership implements a people-centred approach in order to leave no one behind, in particular through the organization of a societal dialogue for health. Luxembourg’s development cooperation is fully aligned with this principle and puts people at the heart of its strategy.”

**Franz Fayot, Minister for Development Cooperation and Humanitarian Affairs, Luxembourg**

“As the political declaration reaffirms, Health is essential to all the goals and targets of the 2030 Agenda for Sustainable Development, which are integrated and indivisible. In this area of enhancing health and improving health care, each of our countries starts with its own context and history. But we face common challenges. And we share common principles.

The goal of Universal Health Coverage must guide our national and international efforts, to improve the health and well-being of our people. To ensure that human development translates into human flourishing. To ensure that no one is left behind, and that we reach out first to those who are furthest behind.”

**Simon Harris, Minister for Health, Ireland, statement at UHC High-level Meeting in New York in 2019**

“Japan is extremely grateful that the UHC Partnership is making significant contributions to accelerate UHC in many countries, leaving no one behind. In order to combat the pandemic of infectious diseases like COVID-19 which causes extensive impact, resilient health systems should be developed urgently through UHC to protect people’s lives in all countries. The Japanese Government will continue to support and collaborate with the UHC Partnership to achieve UHC globally.”

**Ministry of Health, Labour and Welfare, Japan**

“Aujourd’hui, plus que jamais, nous comprenons l’importance de penser la santé de manière ambitieuse et globale : par son mandat et son fonctionnement, le programme Partenariat-CSU propose une approche systémique et transversale, pour un renforcement durable des systèmes de santé. Il vise notamment à décloisonner les politiques et actions de santé publique, à travailler en synergie et permettra de fédérer les travaux de l’OMS dans un monde post-COVID.”

**Son Excellence Madame Stéphanie Seydoux, Ambassadrice pour la santé mondiale, France**



#UHCPartnership

[www.uhcpartnership.net](http://www.uhcpartnership.net)

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\*“Today more than ever, we understand the importance of considering health in a holistic and bold manner: through its mandate and way of working, the UHC Partnership proposes a systemic and cross-cutting approach for sustainable strengthening of health systems. It focuses on opening up public health policies and actions, working in a synergistic way. It will allow the coming together of WHO’s interventions in the post-COVID world.” – Her Excellency, Mrs Stéphanie Seydoux, Ambassador for Global Health, France.

