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5th Annual Technical Meeting Report
Brussels, Belgium

A country-level resource for uhc2030

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2017

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THE GOVERNMENT
OF THE GRAND DUCHY OF LUXEMBOURG
Ministry of Foreign and European Affairs

Directorate for Development Cooperation
and Humanitarian Affairs

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

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EXECUTIVE SUMMARY

It was truly a high quality event, and we are very much looking to continue our close cooperation and further strengthen the UHC Partnership. - Matthias Reinicke, Health-sector Advisor, Directorate General International Cooperation and Development - EuropeAid, European Commission

We see the success and the results of this Partnership every day, but we need to communicate better to the outside world. - Natacha Gomes, Direction de la Coopération au Développement et de l'Action humanitaire, Ministère des Affaires étrangères et européennes, Grand-Duché du Luxembourg

Celebrating the fifth anniversary of the European Union, Luxembourg and WHO Universal Health Coverage Partnership (UHC-P), the 2017 technical meeting in Brussels was not only an opportunity to commend the achievements and share lessons learnt from the past years. It was also a time to innovate, to look ahead and discuss groundbreaking tools and actions to advance the UHC agenda. Moreover, it was an occasion to discuss the changing role of the ministry of health in a new global development context.

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

Recommendations that emerged from the discussions centred on the need to strengthen the ministries of health (MoH) with regard to their new roles in a changing global context and enhance coordination beyond the health sector to integrate UHC and Health in All policies. They involved a plea to continue to push for the International Health Partnership (IHP+)'s compliance by donor agencies at global level under the umbrella of UHC2030, and for the alignment of global health initiative (GHI) HSS windows at country level. They articulated the support to the MoH in identifying the best ways of working with all actors at country level in order to maximize the development impact; and to provide country offices with clear guidance on how to implement and monitor the health Sustainable Development Goals (SDGs).

The next steps will include developing guidance and capacity-building on SDG indicator development; increasing interaction and exchange platforms within and across regions to share and learn from evidence and best practices in the field of health financing reform and in particular on strategic purchasing reforms, advancing multi-country operational research to better demonstrate results and strengthening MoH capacities to monitor private sector contracts, manage PPPs and to lead a dialogue with the private sector.

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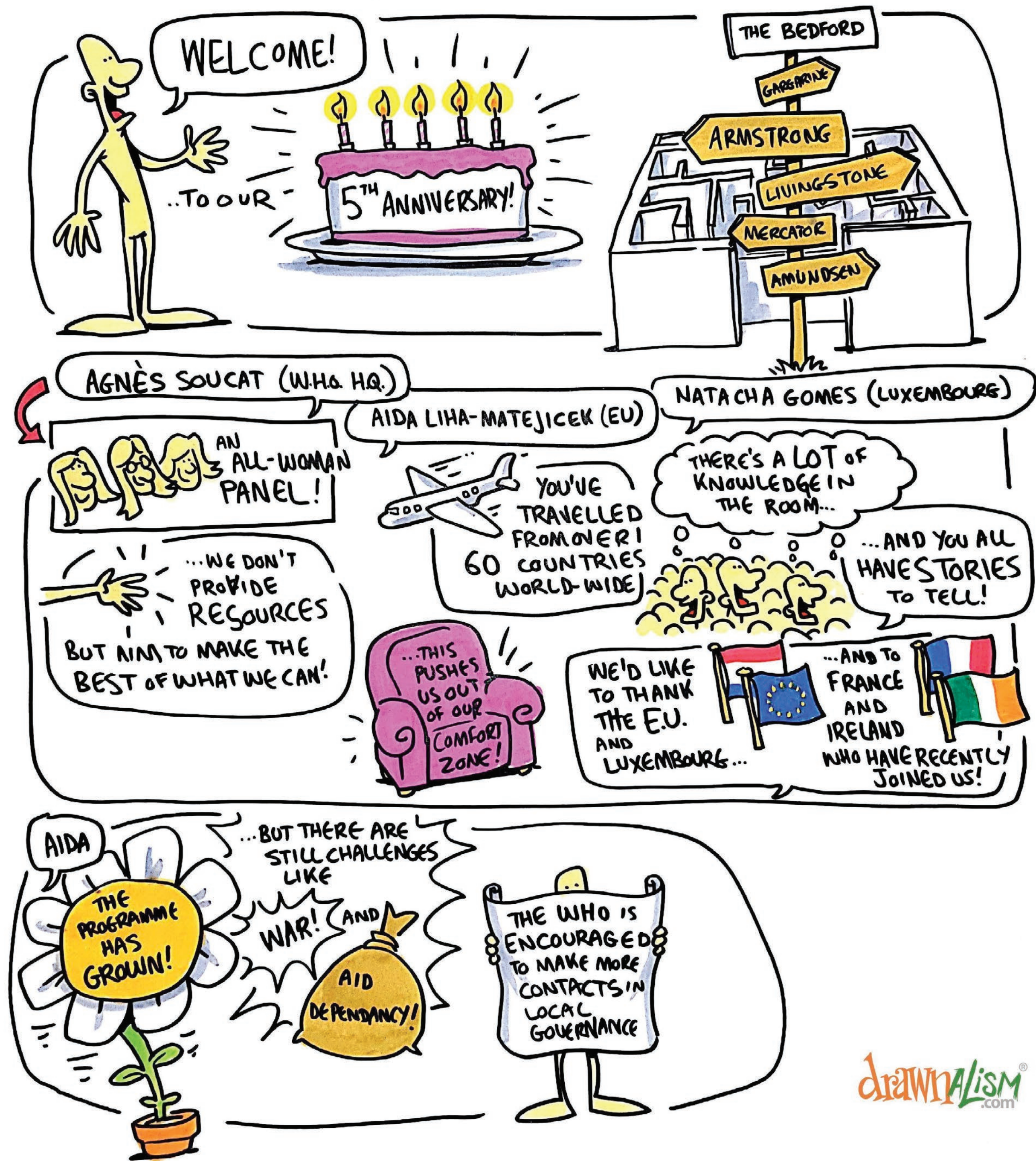

5TH ANNUAL INTER-COUNTRY TECHNICAL MEETING OF THE EU/LUX-WHO PARTNERSHIP, BRUSSELS 21-23 MARCH 2017

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INTRODUCTION

"Celebrate, share and innovate": this was the motto of this year's annual meeting of the European Union, Luxembourg and WHO Universal Health Coverage Partnership (UHC-P) in Brussels. On the occasion of the Partnership's fifth anniversary, many participants felt it was worth recalling "where we are coming from, share our rich experiences and find creative and innovative ways to move ahead together." Since its inception in 2011, the Partnership has successfully supported policy dialogue on National Health Policies, Strategies and Plans (NHPSP) within all of its partner countries.[1] Over five years, the UHC-Partnership has also significantly expanded, thematically and in its geographic scope: from seven to 28 partner countries. Today, UHC-P is broadly recognized as a comprehensive approach to UHC due to its three major pillars - health financing, IHP+ and NHPSP Policy Dialogue.

In his opening speech, Denis Porignon, Health Policy Expert at WHO HQ highlighted some of the UHC-P's chief successes, which involve:

- **the implementation of hundreds of different activities** in 14 areas of work, including UHC and health financing learning courses and a multitude of global products for HF advocacy and policy guidance, the development of country-specific material; the execution of many in-country support missions to launch and follow-up programme activities;
- **the much improved collaboration between all stakeholders** both at global and country level, as well as within WHO. To many in the programme, WHO had become a strong and recognized enabler of health policy dialogue;
- **the mobilization of 30 long-term technical assistants** over 5 years;
- **the development of 28 roadmaps** in collaboration with Ministries of Health;
- **the expenditure of on average around 400.000 USD per country per year**, with country allocations accounting for 70% of the UHC-P resources.

Denis Porignon stressed that as a country-led process the UHC-P aimed to build the capacities of Ministries of Health and WHO country offices regarding the development, negotiation, implementation, monitoring and evaluation of

[1] See documents at www.uhcpartnership.net

7 working sessions,

24 working groups

addressing over

14 key areas of work

robust and comprehensive NHPSP. Chief goals were to promote UHC, people-centred primary care, health-in-all-policies and the implementation of an Aid and Development Effectiveness agenda. This was relayed in discussions during this session through direct testimonies from countries such as Moldova, Tajikistan, Ukraine, Guinea, Tunisia, and Timor-Leste, that unanimously recognized the benefits of such a flexible and strategic approach.

Throughout, the programme has remained an important development policy priority of the European Union (EU) and the Grand Duchy of Luxembourg.[2] Under Phase 3 of the UHC-P, which started in January 2016, the EU and Luxembourg therefore continued their support to the programme. This enabled nine new countries to join the UHC-P, in addition to Georgia and the Kyrgyz Republic. Lesotho and the Congo are currently exploring the possibility of joining the programme and were welcomed as observers to the Brussels meeting. Potentially interested new donors to the programme, such as Germany, France, Japan, IrishAid and Belgium also participated in the meeting.

With an eye on future developments, the meeting placed explicit emphasis on innovation and the changing roles of Ministries of Health in the hugely dynamic context of global health and development today.

OBJECTIVES:

The objectives of the meeting followed the 5th anniversary motto and general aspirations:

Celebrate

to showcase country success stories

Share

to share experiences, and set up dialogues about challenges and constraints

Innovate

to envisage new ways and energies for MoHs, WHO Country Offices and partners to be at the centre of their country's health system agenda

PROGRAMME AND PARTICIPATION:

In order to reach these objectives, the agenda of the meeting was articulated around 7 carefully selected sessions, encompassing plenary introductions, 24 related working groups and feedback:

1. **Connecting UHC-P and the UHC 2030 agendas:** the transformation of IHP+ and opportunities for the UHC-P
2. **The changing role of the Ministry of Health I:** new roles, new energies, new forms of connection
3. **The changing role of the Ministry of Health II:** steering the health system towards a strong population focus
4. **Health financing and strategic purchasing** for Universal Health Coverage
5. **How to prepare the EU verification mission**, proper evaluation of the programme
6. **Effective development cooperation:** Alignment and Harmonization – Walking the talk, complemented by a special, additional session organized by the Global Fund and Gavi

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

7. **UHC: innovation and communication** in an age of changing policies, a social lab

The programme of the 5th annual meeting was highly participatory and used a shared format in most sessions. Participants were invited to discuss the changing roles of ministries of health in countries supported by the partnership and the drivers of this change. The idea was to start by learning from selected change agents – sharing the experiences of specific partnership countries in responding to these changes and challenges.

These sessions were kicked-off by putting the rich and diverse country experience presented by a number of high-level country change agents in the foreground. Country experiences were also highlighted in plenary feedback discussions and by inserting a range of country cases as significant examples in the working-groups (see Appendix C for some of the country cases thus shared). The plenary presentations were carefully chosen to stimulate dialogue and serve as inspirational starting points, while leaving ample time for the working-groups in which in-depth deliberations could take place. The quality of the debates was very high and the degree of interaction and participation much appreciated by the delegates who expressed their appreciation for this set-up in the evaluations.[3] The agenda was consciously constructed to allow partner countries to communicate the many lessons learnt during Phases 1 and 2 of the UHC-P and advance the programme in the current highly dynamic global health and development landscape.

The time for exchanges between participants during the meetings supported a range of reflections on the most effective ways ahead, on innovations and new joint ventures and on updates of the current roadmaps for each country.

180 participants:

2/3rds came from **31** partner countries (Ministries of Health and WHO Country Offices)

22 representatives from **10** development partner agencies

[3] 74 participants completed meeting evaluations. The overall rating note was 4.2 /5. The most highly-rated sessions were the plenary sessions on the changing role of the ministry and the plenary session on health financing. Other comments/ critiques (among others): Very informative and well-constructed meeting, topics well-chosen. Need for more time for discussion – less presentations and to reduce size of working groups – agenda too packed; invite more CSO representatives.

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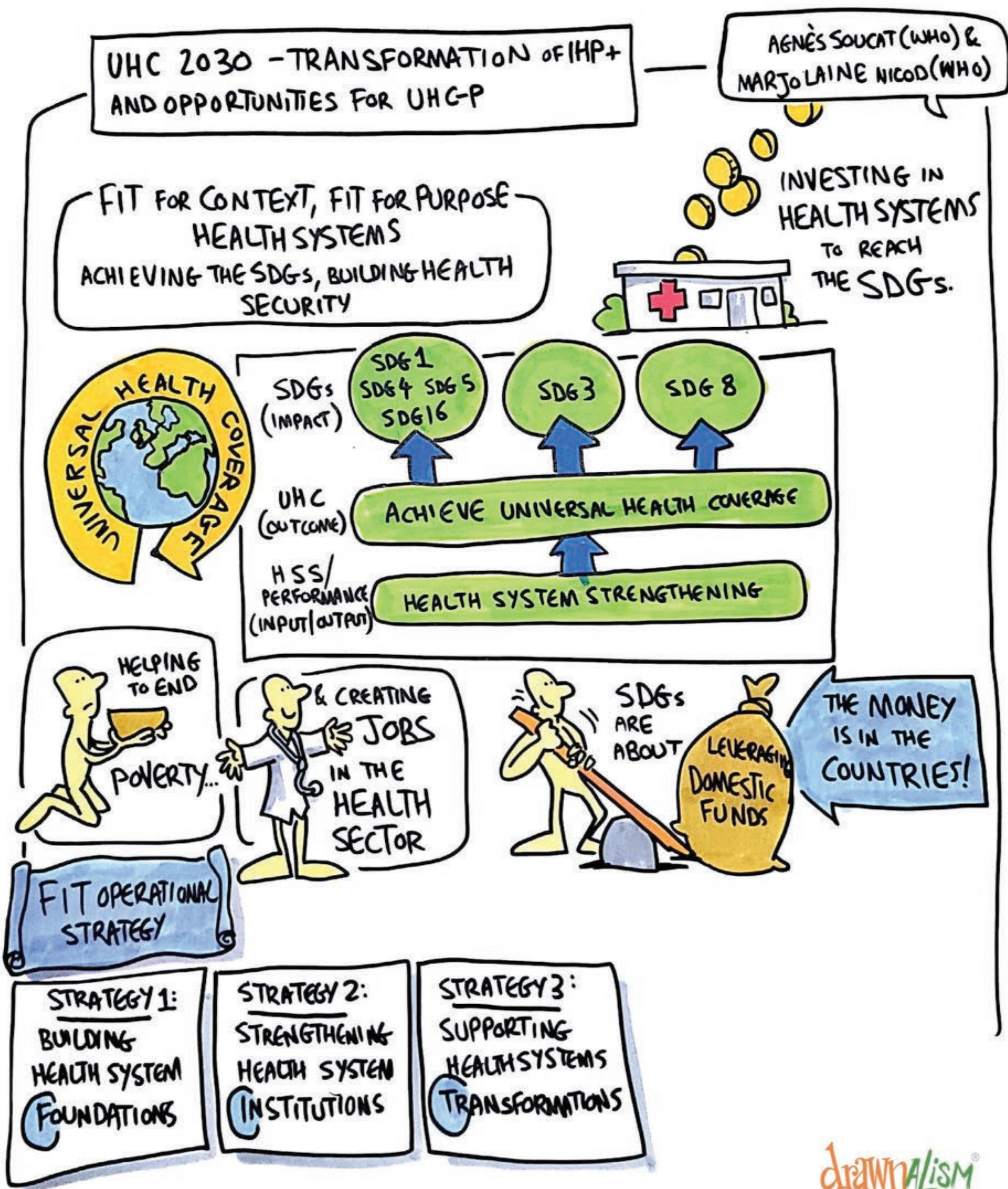

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MEETING PROCEEDINGS

1. UHC 2030: TRANSFORMATION OF IHP+ AND OPPORTUNITIES FOR UHC-P

Achieving the SDGs, Building Health Security & UHC 2030 - transformation of IHP+ and opportunities for UHC-P

Addressing the future of the collaboration within the UHC-P, Agnes Soucat of WHO and Marjolaine Nicod of the UHC2030 secretariat presented the current global dynamics of international collaboration on the road to UHC.

Agnes Soucat focused on the context of convergence in the wake of the adoption of the UN Sustainable Development Goals of which UHC is a vital target for health. She welcomed the emerging awareness of the key role which local health stakeholders need to play. A shift in the global focus is visible to countries' vital domestic agendas: in governance, in leveraging domestic health funding and in making financing and service delivery more aligned with the urgent needs of people and requirements for well-functioning health systems.

Agnes Soucat pointed at how 'domestic health financing' should not be equated with a continuation of the very high out-of-pocket (OOP) spending, which countries currently experience. To date, this OOP is still unacceptably high in fragile and low-income countries, where it may amount to 50% of total health expenditure on average. This indicates that domestic resources are not optimally distributed. But while the call to mobilize and reallocate domestic sources to finance HSS is strong, for the foreseeable future there remains a role for external assistance as well, to support countries in better management and efficiently using domestic resources.

Agnes Soucat presented the FIT strategy, a set of strategic approaches which WHO recently developed to support the thinking on how to make health systems reforms more "FIT for context and FIT for purpose". The FIT strategic approaches should answer the needs and match the degree of institutional development of a particular setting and country.

Firstly, one needs to build Health System Foundations: "A house needs a good foundation in order to stand on its own." This foundational work requires investing in 6 essential dimensions in which gaps frequently exist, i.e.: 1. Finances; 2. Pre-service education; 3. Supply chain, laboratories, stocks availability and management; 4. Health information systems, surveillance structures; 5. Local health governance systems; 6.Integrated services, Infrastructures & equipment. These foundations need to be in place for a health system to operate.
Secondly, one needs to deal with Strengthening Health System Institutions. This implies supporting institutions for Health Systems Strengthening, e.g. fostering managerial capacity, sustainability and accountability of institutions including, through decentralisation, citizens' voice mechanisms and health financing training etc.

> **We want to give opportunities for a range of actors to work better together, help them co-ordinate efforts on health system strengthening, facilitate efforts to advocate for policies that lead to equitable policy and use of resources, and create avenues for partners to share knowledge & power. UHC-Partners are frontier soldiers... and the global community is behind them.** - Agnes Soucat, Director of Health Systems for Governance and Financing, WHO

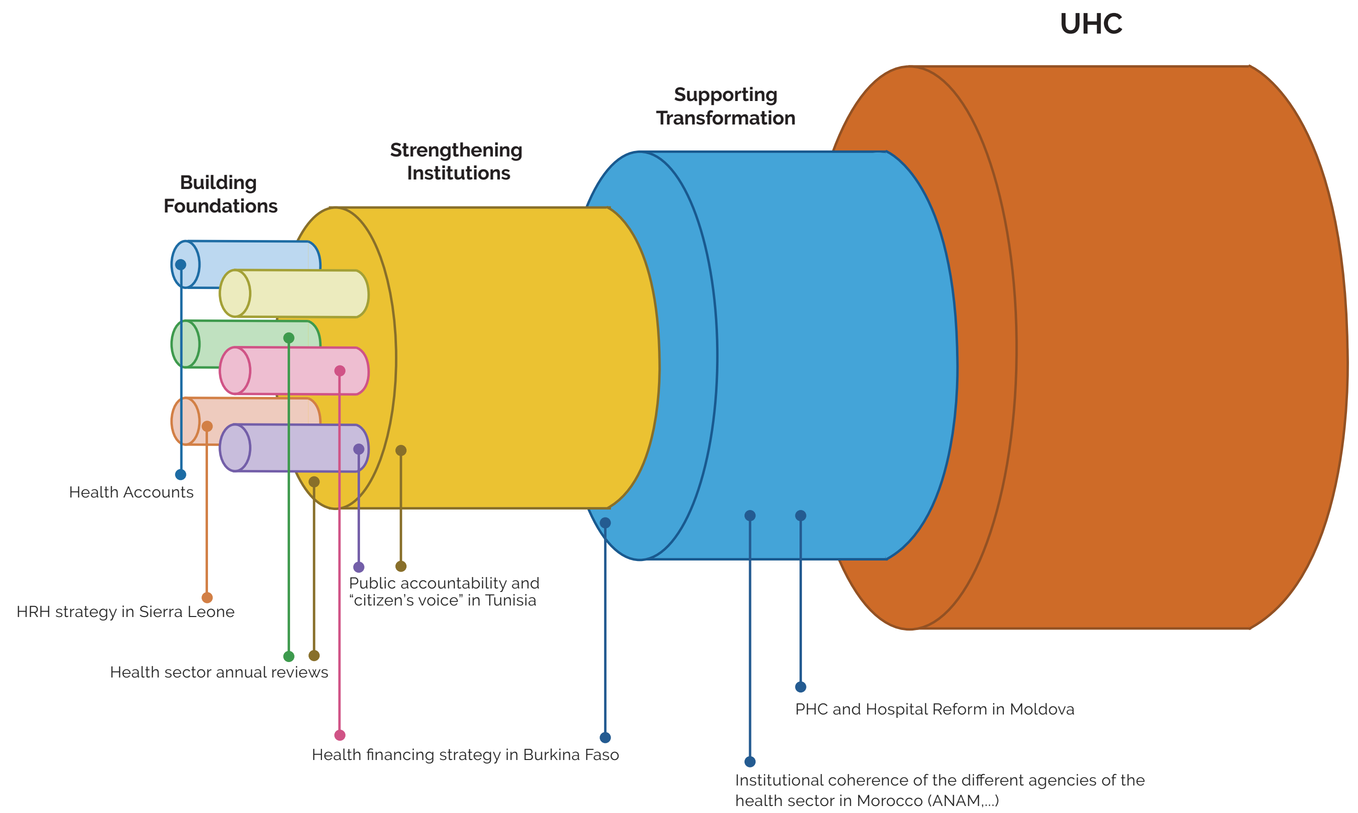
A third strategy pertains to Supporting Health System Transformations. Even if a health system possesses a strong foundation and robust institutions, an efficient strategy must be prepared to handle "transformations," for instance on how to deal with an ageing population or with the new data revolution.

The UHC-Partnership has de facto already tested the FIT approach. The picture on the next page illustrates how the UHC-P has helped making health systems "fit for context and fit for purpose" in partner countries.

The challenge, however, remains how best to coordinate the many stakeholders responsible for implementing these strategies. Marjolaine Nicod of the IHP+ / UHC2030 secretariat sketched how the establishment of the 'International Health Partnership for UHC 2030' may be the answer to this question as it aims to provide a single platform for all existing health alliances.

Marjolaine Nicod stressed the continuity of development and indicated that there will be many similarities between IHP+ and UHC2030. For instance, country leadership will remain key. And the 'seven behaviors' (the critical areas where international development partners need to change their behaviour in order to accelerate progress) will remain relevant for countries receiving aid. UHC2030, however, is supposed to expand the geographic scope of IHP+ as it aims to invite all countries to join in, as well as international organizations, CSOs, philanthropic organizations and the private sector. It will also broaden its mandate - from coordination towards the inclusion of advocacy and accountability as well. Countries can join UHC2030 by signing the UHC2030 Global Compact which is not legally binding, nor involves any mandatory financial contributions.

The presentations were followed by a lively sharing of experiences from the floor. One of the key challenges highlighted by participants from Morocco and Cabo Verde, was to involve all stakeholders periodically and thoroughly document indicators and activities towards UHC in the countries. Adding different health leaders to the network of stakeholders involved in UHC2030 will also be crucial in unifying and connecting different communities of practice.


UHC
Supporting Transformation
Strengthening Institutions
Building Foundations
Health Accounts
HRH strategy in Sierra Leone
Health sector annual reviews
Public accountability and "citizen's voice" in Tunisia
Health financing strategy in Burkina Faso
PHC and Hospital Reform in Moldova
Institutional coherence of the different agencies of the health sector in Morocco (ANAM,...)

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CHAIR: DJAMILA CABRAL WR/MOZAMBIQUE

THE CHANGING ROLE OF THE MINISTRY OF HEALTH: NEW ROLES, NEW ENERGIES, NEW FORMS OF CONNECTION

DR A. BELGHITI ALAOUI MD MPH
MoH MOROCCO

WE ARE IN A PHASE OF CHANGE

OUR DREAM IS TO HAVE BETTER HEALTH FOR OUR POPULATIONS!

FIRST WE WILL HEAR FROM OUR 'AGENTS OF CHANGE'

DR. BELGHITI

FIRST, I HAVE A STORY TO TELL YOU!

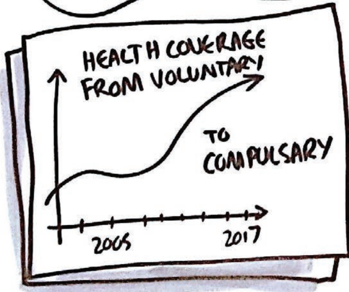
IS NOT THE SAME AS THE... MINISTER OF HEALTH

ACTOR

IN MOROCCO WE HAVE 8 CHANGES HAPPENING AT ONCE!

THE FIRST THING TO CHANGE MUST BE DIALOGUE

LEADERSHIP & GOVERNANCE
REFORMS
PROGRAMMES
SERVICES
PERFORMANCE



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2. THE CHANGING ROLE OF THE MINISTRY OF HEALTH: NEW ROLES, NEW ENERGIES, NEW FORMS OF CONNECTION

The purpose of this session was to discuss the changing roles of ministries of health in countries supported by the partnership and draw attention to the capacities and institutions required to support these changing roles.

The session was opened with two highly experienced and successful change agents: Abdelali Belghiti Alaoui, Secretary-General of the Ministry of Health of Morocco and Professor Tilek Meimanaliev of the MoH of the Kyrgyz Republic.

Abdelali Belghiti Alaoui underscored that the Ministry of Health is not the same as the Minister of Health: change is a collective process involving political leadership and technical implementation. Current transformation of ministries of health and health systems hinges on managing 5 key dynamics: Reforming the Ministry and the health system start by reviewing existing programmes. Subsequently, they involve setting up new services, revisiting governance structures and building the capacities needed for the reform process. Abdelali Belghiti Alaoui insisted on the importance of a multi-layered, multi-stakeholder dialogue within and beyond the health sector. He pointed out that it is essential to distinguish between the more political role of a Minister as an actor for change and the complex institutional landscape supporting health, whose reforms require time and careful strategic planning.

Tilek Meimanaliev from the MoH of the Kyrgyz Republic echoed these ideas, arguing on the basis of Kyrgyz's recent transformations that change is possible: "Imagine: In the Kyrgyz Republic, we have moved from a total health expenditure of USD 6 per capita in the year 2000 to USD 87 per capita in 2015 – My comment about this is: Yes, we can!" He stressed how such huge transformations require sustained efforts, constant reviewing and informed policy dialogue. In this context, reforming sector-specific institutions is equally as important as initiating and maintaining a high-level inter-sectorial dialogue, for example through a dedicated council.

Following the interventions of the two change agents, participants moved into working groups to discuss challenges faced by health ministries in three key areas: health system decentralization, private sector engagement and the specific challenges faced by health ministries in fragile states. Participants were invited to synthesize their lessons learned to guide the future work of the partnership and move from dialogue to action.

> **Ministries of Health are faced with a changing world and their roles need to change accordingly.** - A. Belghiti Alaoui, Secretary General of the Ministry of Health in Morocco

MoH's changing roles in fragile state contexts:

Does it make sense to talk about UHC in contexts in which health systems are - at least partially - dysfunctional due to a crisis or disaster? "Yes" was the clear answer from the participants, who even claimed that "health can act as a convener; a neutral ground in times of conflicts and in fragile states."

In 'States of Fragility 2016', the OECD has characterized fragility as "the combination of exposure to risk and insufficient coping capacity of the state, system and/or communities to manage, absorb or mitigate those risks". About one third of the UHC-P countries can be counted to this category.

Participants were reminded about the International Health Regulations (IHR), a key international framework designed to help address health challenges in contexts of fragility and transition. Adopted in 2005, these IHR constitute the only global, legally binding instrument of international law against the international spread of disease. They oblige signatory states to establish and operate National IHR Focal Points which should notify, within 24 hours, public health events of international concern (PHEIC) to WHO. The IHR not only obliges member states to develop eight core capacities at points of entry, across all sectors, related to legislation and policy, coordination, surveillance, response, preparedness, risk communications, human resources and laboratory tests. They also entitle them to receive technical support and advice from WHO. Meeting participants were invited to discuss how to best implement these regulations at country level and what role a Ministry of Health should take in this context.

The working group agreed that in principle the role of the Ministry of Health should not significantly change within a fragile state context. The Ministry should continue to provide overall guidance to the health sector on how to transition from emergency to recovery and post-recovery. The institution has a critical role to play in putting the right strategic framework and policies in place and in building communities' and health systems resilience.

However, this role may be diminished during crisis because of resource constraints, and because of other avenues of available resources. There will be many actors on the ground, which will affect MoH's leadership role. In this context it is important for donors to avoid undermining the ministry's legitimacy and instead work with the MoH to develop consultative roadmaps, bringing all actors together to discuss the way forward.

CONCLUSIONS & ACTIONS

- Health can be a bridging tool for peace – a convener. "Never waste a 'good' crisis!"
- In contexts of fragility and crises, the MoH should continue to provide the overall leadership and guidance to the health sector, including setting the health agenda, strategic planning, surveillance, diagnostics, outbreak response, essential services to vulnerable groups and monitoring services.
- WHO needs to support the MoH in building IHR core capacities, developing robust strategic plans that incorporate emergency response as well as development activities to ensure a continuum and harmonization of activities during the emergency, recovery and post-recovery phases.
- Involving the highest levels of government is crucial for successful IHR implementation and transparent communication with WHO must be an obligation.
- Partner support in fragile settings should reinforce and not replace the Ministry of Health: the MoH needs to be at the helm of the coordination in order to ensure coherence between multiple mechanisms.
- The UHC partnership has a critical role in bringing together all actors – both humanitarian and development - particularly at global levels.

Engaging the private sector:

UHC signifies that all individuals and communities receive the quality health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care. To achieve and sustain UHC and ensure access to services for all, the health systems of most countries need to mobilize both public and private stakeholders.

It was felt more private sector engagement had major implications for the roles played by ministries of health. As highlighted by presentations from the EMRO region, Georgia, South Africa and WHO HQ, the participants concluded that the question of private sector engagement raises the specific challenge for health ministries of how to engage effectively with the private sector while exercising their stewardship role in service of UHC and the right of Health for All. Concretely, it meant health ministries need to look at:

- Obtaining intelligence about the private sector and its activities
- Assessing the positive and negative aspects of healthcare delivery by private not-for-profit and private-for-profit providers
- Identifying appropriate strategies for productive engagement
- Developing regulatory frameworks designed to ensure private sector activities contribute to UHC objectives

The participants discussed the capacities and institutions needed to support the MoHs in engaging effectively and appropriately with the private sector. They considered the next steps regarding the UHC-P country roadmaps, the required institutions and capacities.

CONCLUSIONS & ACTIONS

- Countries should have clear strategic goals for their engagement with the private sector.
- The MoH should ensure that the national health plan and coherent policies are guiding the work of the private sector.
- Gathering data on private sector activity is important but challenging and the MoH may need support to map and assess the private sector and its activities.
- The MoH's role must be equipped to regulate the private sector, for example regarding licensing and accreditation of health services and health workers, setting standards for health worker education, setting standards for quality of technology, standards for medication, exercise hospital's infection controls – as well as pricing.
- The MoH may need support to develop appropriate norms and standards to regulate effectively and may need to create or strengthen existing institutions to make and implement these standards.
- Mechanisms to enforce such regulation also need to be strengthened.
- To that end, the MoH capacities to monitor private sector contracts, manage PPPs and to lead a dialogue with the private sector need to be enhanced.
- Decentralizing monitoring functions to sub-national levels may help which means that appropriate capacity needs to be built at the sub national level.
- More evidence needs to be gathered on where the private sector can make a difference to UHC - e.g. franchise system to reach out to rural areas; purchasing, health promotion and communication.
- More efforts are required to improve the quality of licensing of private providers by assessing how often it needs to be done and on the basis of which criteria, in order to make it meaningful.
- A tailored approach needs to be adopted for each of the different types of private sector actors at different levels of the health system.

Decentralisation:

In an increasingly complex public health environment, there is only so much that central governments can do on their own. They need to be able to rely on their sub-national structures for effective health systems management. However, decentralization is often a process that occurs outside of the health sector, with drivers that are political, fiscal or administrative. In several instances, decentralization is driven by donor requirements to increase local level decision-making capacity. Implementation of such reforms in the health sector might be rushed, without a clear idea of what needs to be decentralized, and without time and resources for building the necessary capacities in the field.

Examples of decentralisation processes in Burkina Faso and Ukraine highlighted the different shapes that these processes can take in each country. Albeit based on a new general law on decentralisation, the process in Burkina Faso was spearheaded by the health sector. The current division of responsibilities between the national, regional and local levels is still centred around the idea that essential planning processes are happening at the national level, while local and regional levels are tasked with implementing national-level policies and decisions, on the basis of annual plans they elaborate.

Ukraine explained that the country decided to engage in a lengthy decentralisation process upon request by its population. Following a consultation and in consideration of the importance of guaranteeing universal health coverage, the country opted for a single purchasing system with a fund mechanism concentrated at the central level. This decision implied new roles for local level governments, which needed to switch from their funder position to a manager one. Several challenges are still to be overcome for this complex process to be completed with success. Nonetheless, Ukraine highlighted that decentralization is about a good partnership between the different government levels (central, regional and local) and their balance in terms of capacity, financing and accountability.

Participants shared experiences on how very often people have an oversimplified understanding of decentralization when it starts. One needs to be very alert, however, in order to avoid fragmentation and safeguard guarantees for all. Local governments may lack capacity to generate resources, deal with HR, or formal systems of accountability, which in turn can lead to an inability to manage the decentralized affairs. Equity in access may thus remain jeopardized. Political tug of war may plague decentralization processes.

OVERALL REMARKS

- Decentralization is complex.
- Decentralization often implies a long process, which should be based on a strong mutual partnership between central and local levels in order to succeed.
- Learning from each other experiences is vital. The UHC-Partnership can have an important role of guaranteeing a broad exchange of practices between its members.
- Whatever process of decentralization is followed, a transfer of functions will necessarily have to go hand in hand with a transfer of resources in order to be effective – even if the pace of the resources transfer is more progressive in certain countries than in others.
- Participants agreed on the following set of competencies which should stay at central level versus those which could be delegated to sub-national levels **[see table on next page]**.

CENTRAL LEVEL	SUB-NATIONAL LEVEL
National sector policy and multi-annual strategic plan	Annual sector plans
Tertiary Care - Hospitals	“primary care” and “sub-national reference care”
Definition and expansion of health coverage schemes and essential services packages	Management of ESPs and schemes
Setting of norms and standards, licensing, accreditation and quality control criteria	Monitoring and oversight of standards
National resource mobilisation and equitable allocation	Local resource mobilisation and distribution
Central health information system Evidence for policy	Local data collection
International procurement - bulk purchases - of medicines	Management of stock-outs
Private sector regulation	Private-public partnerships at local level

CONCLUSIONS REGARDING SHIFTING ROLE OF MINISTRIES OF HEALTH IN DECENTRALIZED CONTEXTS

- A Ministry of Health in a decentralized context should identify clearly what to decentralize and what to leave at the centre. It should pool resources at central level for the benefit of UHC utilized by a single purchaser (launch the national executive agency). It should foster consensus on central versus local/decentralized functions.
- A Ministry of Health often needs strong capacity to define and assume the new roles.
- A Ministry of Health at central level would need to establish policy leadership and partnership coordination with the national government to identify national priorities. The capacity of MoH as policy regulator, in communication, in partnering with national purchasing agents and local governments, in establishing equity, needs to be strengthened.
- A Ministry of health at central level would also need to take a multi-sectoral approach and align across sectors.
- In certain areas, decentralization of health services would require civil service reform.
- A Ministry of Health at central level would need to align resources with responsibilities: governance, HR, finances; information and ensure good communication the across hierarchy.
- In a decentralized environment, the roles of local governments will also change. It will involve the management and payment for services from a single purchaser (this will eliminate conflict of interest). Local governments need to play a big role in public health. Local governments need to learn how to use local resources efficiently to address local priorities. Better information and evidence would be needed with E-health applications to establish a functional system for health and financial data/information.

CONCLUSIONS REGARDING CAPACITIES AND INSTITUTIONS REQUIRED

- Examine the areas to be decentralized and identify the areas of capacity needs.

- Strengthen capacities in a coordinated and harmonized manner under the leadership of the MoH (eg. HR, etc.).

  - *Readiness assessments for decentralization (for both central and local governments).*

  - *Enhance capacity of local levels: Technical Advisors at local councils.*

  - *Reinforce the capacity for public health functions.*

  - *Define the essential health benefit packages.*

- Provide adequate time and proper phasing of decentralization – do not rush.

- Adopt a learning process for decentralization, learn from doing and learn from other country experiences.

- Develop local capacities, especially related to management aspects. It is important not to rush into decentralization without developing capacities before.

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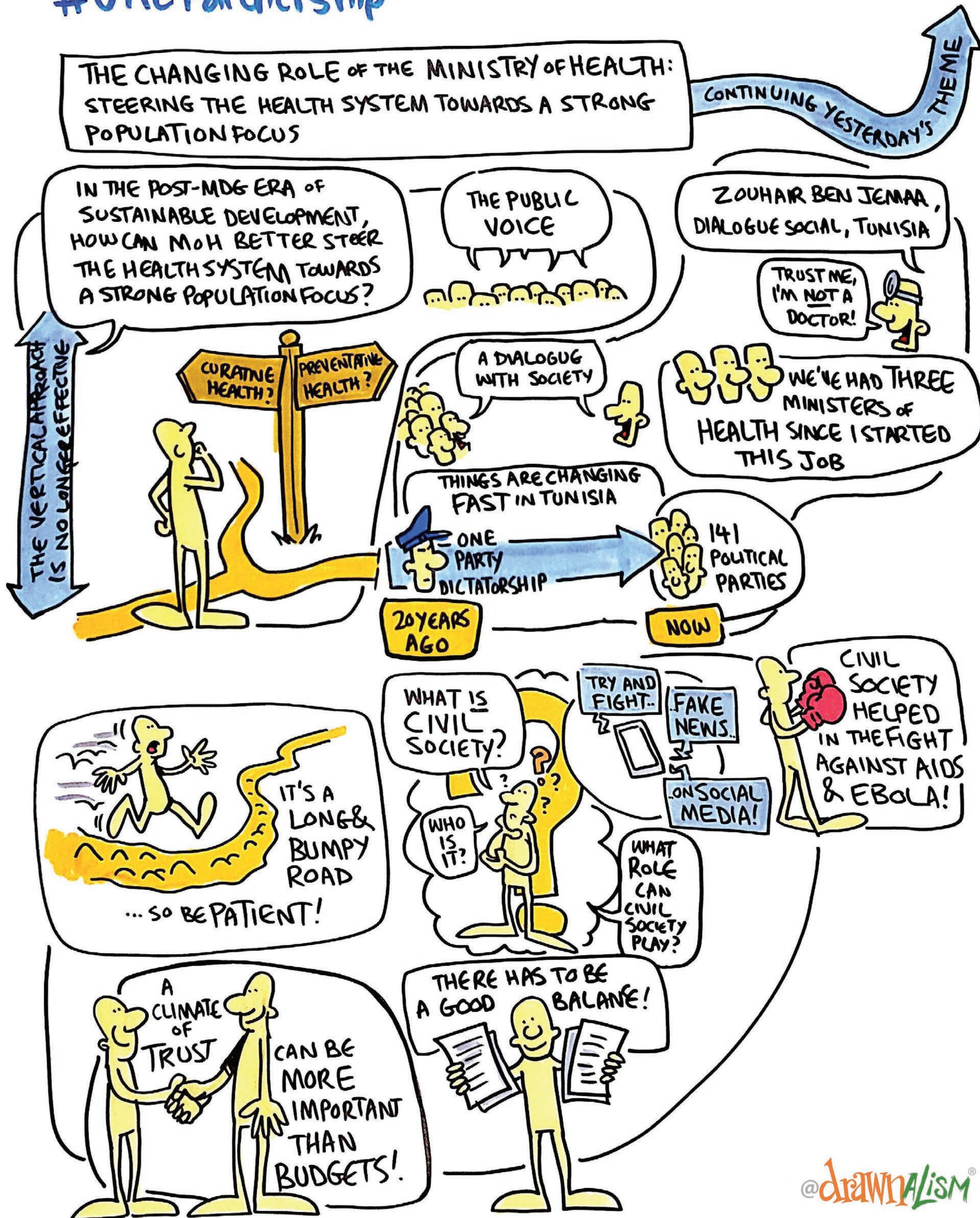

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3. THE CHANGING ROLE OF THE MINISTRY OF HEALTH 2: STEERING THE HEALTH SYSTEM TOWARDS A STRONG POPULATION FOCUS

"Some of the challenges we face today as an international community stem from the fact that we are coming out of the MDG era", says Dheepa Rajan, Technical Officer at WHO. She continued that the current Sustainable Development Goals (SDGs) represent "a much more holistic, multi-sectoral approach, in which all goals have to be addressed simultaneously. One cannot take a vertical approach and address one of these goals selectively.

For Ministries of Health, this shift from MDG- to SDG-thinking implies working increasingly with other sectors, as well as engaging with a broader range of stakeholders, to address all different aspects of societal health. Steering the health system towards a stronger population focus is essential in such a context. A person's basic needs and demands are by nature interlinked and cross-sectoral.

Following these assumptions, the working group discussions during this second session centred around understanding better how to consult the population as an integral part of health policy & planning. The idea was to try and articulate how Ministries of Health could be guided in SDG monitoring and assisted to adapt the monitoring process to the country context. And they underscored the importance health sector contributions to multi-sectoral efforts for health as part of UHC.

Making the population's voice truly heard in health policy & planning

The discussions echoed the broad recognition that the UHC-P has earned over the last years as a key alliance for strengthening civil society's role and citizens' participation in health policy making. UHC-P country examples of good practices in this area are numerous. Two cases were evoked to trigger an animated debate among participants, as described below:

COUNTRY EXAMPLE: TUNISIA'S "DIALOGUE SOCIÉTAL"

In the past few years, the societal dialogue carried out in Tunisia in the health sector has become an invaluable source of lessons learnt on making the population's voice heard. As narrated by Zouhair Ben Jemaa, spokesperson for the societal dialogue, it was an unprecedented, democratic process, supported by UHC-P-funded WHO experts, that started in 2013. It involved around 3400 citizens and health professionals in the election of a "citizens' jury". While deliberately being "locked-up on an island", as Ben Jemaa humorously put it, this elected jury drafted a declaration on citizens' demands for health, which was presented to – and warmly welcomed by - the head of state during the national health forum in September 2014. The declaration fed into a White Book on the Tunisian health sector, which will provide the foundation for the new national health sector development plan. This process of deliberation in the health sector also became a model for other sectors. As a result, in Tunisia "We don't do anything anymore without citizens. Nothing can be decided without civil society", said Ben Jemaa, adding that "Without WHO's support, we would have not been able to take this dialogue to this next level".

LEARNING FROM BEYOND THE UHC-P: THAILAND'S NATIONAL HEALTH ASSEMBLY

The UHC-P can also help members learn from experiences of non-member countries. The case of Thailand, for example, was presented at the annual meeting as a country which has a long-standing experience in implementing participatory processes in the health sector. In 2008, it established the National Health Assembly (NHA), an annual, 3-day multi-actor and multi-sector platform aimed at elaborating recommendations on how to

integrate health-in-all policies. 280 constituencies participated in the latest assembly in December 2016. Over the years, the NHA has led to increasingly concrete and actionable resolutions – 68 in total, across all sectors - and thus has increased the level of buy-in from the government. The NHA is now seen as a mechanism which contributes to more evidence-based policy-making. In addition, the NHA greatly fostered mutual understanding, respect, and capacity for consensus between members of what is seen as the "triangle that moves the mountain" – government, academia and civil society.

These and other country examples provided the ground for some heated debates. Key issues raised were how to ensure appropriate and legitimate representation of civil society in the policy dialogue; how to align requests from a societal dialogue with those of officially elected members of parliament and their committees. They touched on how to reconcile the population's request for an inclusive, but often lengthy dialogue on the one hand, and its demand for fast and visible progress on health reforms, on the other. "At one point, the MoH needs to take a step back from the dialogue and define its strategic way forward", one participant underscored, who also explained that "the population cannot wait for reforms – they are organizing themselves in associations in order to pressure the government". The financial costs of organizing and participating in a multi-stakeholder dialogue were also a source of lively discussions.

CONCLUSIONS AND ACTIONS

- Civil society buy-in provides more legitimacy and credibility to policy-making – but it is a long road to arrive at mutual understanding and consensus-orientation – so be patient!
- The role of the ministry should be to create the conditions for mutual trust between government and civil society and allow for a meaningful engagement of civil society, notably by creating follow-up mechanisms for population consultations.
- MoH should allow civil society to organize itself (bottom-up) and to prove their legitimacy and credibility to the government, by also ensuring a fruitful and collaborative relationship with elected representatives (parliament). Civil society must not be politically steered.
- Financial support (from donors or the government) can help consolidating the process but should not be the primary motive for participation.
- How to strike a balance between the need to hear the voice of the population and the need of the MoH to move forward should be a first point to agree upon with civil society – e.g. by jointly identifying those areas where citizens' approval is essential.
- Participation needs to be informed and evidence-based.

SDG Monitoring at country level

"Think globally, act locally" is the motto of the SDG Agenda 2030. This is easier said than done, some would say, especially when working towards an objective as complex and crosscutting as universal health coverage. Echoing this concern, some attendees of the UHC-P meeting claimed that not all SDG indicators were applicable to the national context, spurring the need for ministries of health to see how they can best be integrated within national frameworks. It was further pointed out that one of the lessons learnt from monitoring the MDGs was that focusing on the targets and attainments of the goals can lead to bypassing the more systemic (and slower) processes necessary for sustaining them.

A broadly shared view was that SDG 3-related indicators would necessarily need to capture both preventative and curative services. Moreover, as difficult as it may be, there should be a common monitoring platform for governments and external partners in order to coordinate health information systems in a more holistic manner.

Further, since monitoring the SDGs will be a multi-stakeholder process, there is a need to engage in SDG 'health' custodianship. For instance, WHO is the custodian agency for the assessment of several SDG indicators within the following goals: SDG 2 (one indicator on malnutrition), SDG 3 (eight indicators on health, four on health services, and three on health impacts from determinants), SDG 6 (six indicators on access to water and sanitation) SDG 7 (one indicator on access to modern energy), and SDG 11 (one indicator on air pollution in cities).

Finally, it can be expected that the focus on 'leaving no one behind' will ultimately lead to monitoring indicators using intersecting stratification with double, or even triple disaggregation. For instance, one may look at the Gini coefficient of a country by wealth quintiles for a country; and within each of these wealth quintiles, disaggregating by urban and rural areas.

CONCLUSIONS AND ACTIONS

- SDG 3-related indicators will need to capture both preventative and curative services, and thus encompass several sectors.
- Monitoring indicators will need to use intersecting stratification with double, or even triple disaggregation.
- UHC-P countries and constituencies need to consider engaging in SDG 'health' custodianship.

Working more intersectorally: practicalities and challenges

Scaling-up inter-sectoral work represents a major challenge for many health ministries because it is not their usual scope of influence, responsibility and effort. Grappling with a shortage of funds for urgently needed medical services, growing the financial pool for medical and basic prevention services is often a main focus. Health progress in the SDG era has nonetheless to proceed on two fronts: health promotion, where inter-sectoral work is key, and the expansion of access to health services and financial protection. Reaching UHC will not be possible without both.

Scaling-up inter-sectoral work to address the poverty-environment determinants of health is thus a key strategic and policy challenge. In 2012, 23% of all deaths worldwide were attributable to the environment.[4] Practically speaking, health can work with other sectors to combine the strengths of different ministries in addressing environmental health risks and promoting healthy settings, aligning social programmes, and improving the accountability.

During the annual meeting, participants discussed how improved inter-sectoral work is facilitated in countries, notably through the Health in All Policies approach, as well as practical ways and challenges to addressing the poverty/inequality-environment nexus.

As explained in a presentation from Sudan about the country's experience with integrating Health in All Policies (HIAP), it is "an approach to public policies across sectors that systematically takes into account the health implication of decision-making and seeks synergies to avoid harmful health impact, in order to improve population health and health equity".

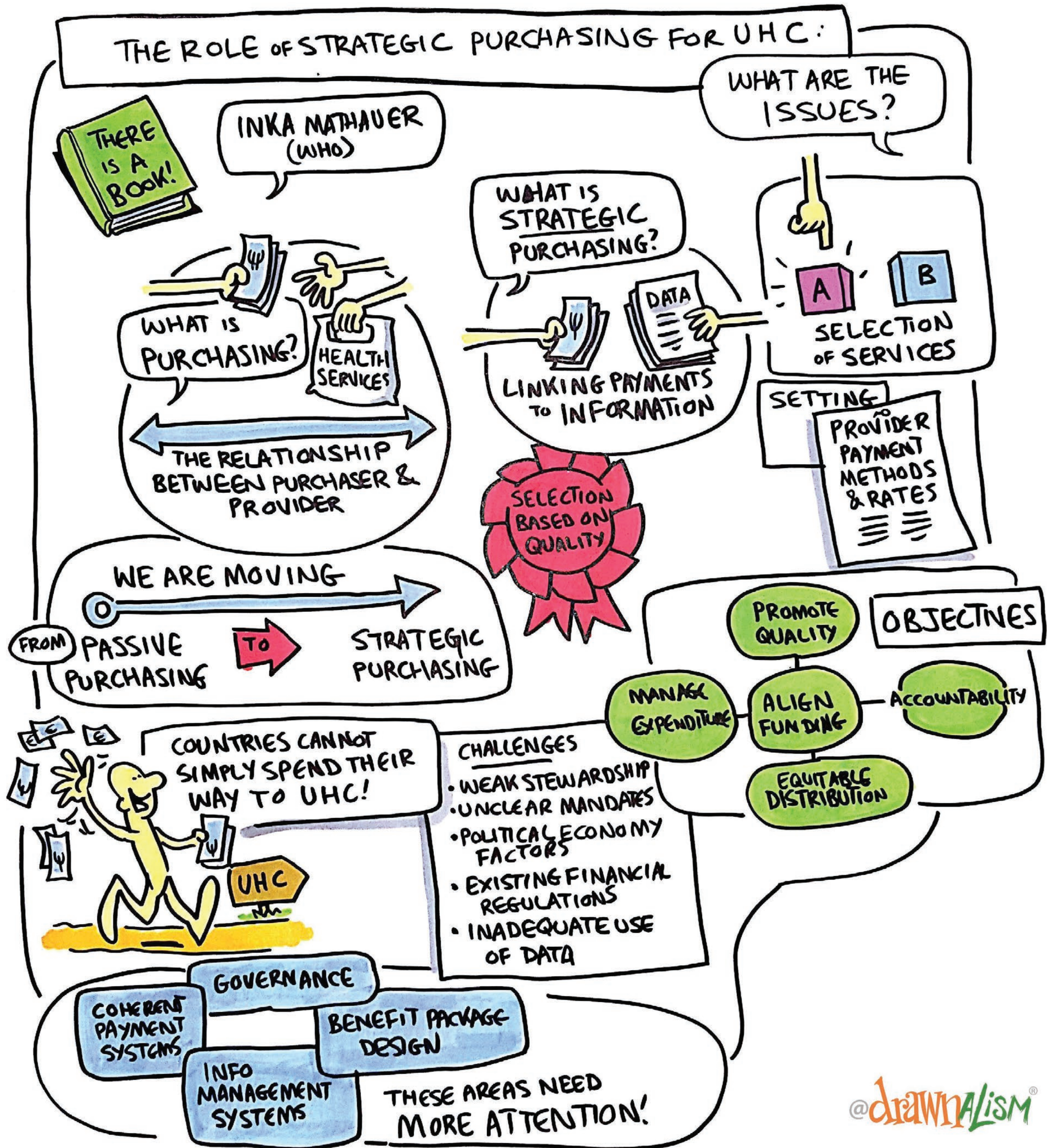
One overarching message which emerged from the working group discussions is that MoH needs to start the HiAP process with relationship-building around low-hanging fruits. "The Health sector can't do everything, but if you're going to sustain dialogue, you must have the capacity to work on at least some issues", as one participant put it, adding that "working on low hanging fruits is just the beginning and aims at building trust. Success is about relationship in this process".

[4] For Prüss-Üstün A, J Wolf, C Corvalan, R Bos, M Neira. Preventing disease through healthy environments: a global assessment of the burden of disease from environmental risks. World Health Organization, Geneva, 2016

CONCLUSIONS AND ACTIONS

Participants agreed on a number of steps to be taken to advance Health in All Policies at country level:

- Start from your own ministry: MoH needs to establish a dedicated team to coordinate issues around intersectoral work with the responsibility specifically to engage other sectors.
- Identify where the tough decisions are being taken in other sectors and try connecting with their highest levels in order to get the appropriate level of priority .
- Ensure buy in from other sectors – help others understand the win-win of working on health issues/determinants, listen to what other sectors want from the process and help them to get that if possible.
- Get the Ministry of Finance involved – make them a target for understanding the need – and find mechanisms to get local governments involved.
- Determine roles and responsibilities for each of these ministries and include monitoring and evaluation in the partnership.
- Establish mechanisms for a continuous dialogue by using existing structures, networks etc and repurposing them and taking part in initiatives of others.
- Document things you do (also through high level documents).



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4. HEALTH FINANCING AND STRATEGIC PURCHASING FOR UHC

This session aimed to show the relevance of strategic purchasing for universal health coverage (UHC), describe better what it implies and how to shift towards strategic purchasing with the aim to accelerate progress towards UHC. Strategic purchasing implies aligning funding and incentives with promised health services, to promote efficiency and to increase accountability. Countries "cannot simply spend their way to UHC" as funding flows and efficiency matter and effective health financing reforms and strategies need to be aligned with each other as well as with reforms related to service coverage and to the rest of the health system.

As previous UHC-P annual meetings had focused on discussing the first two core health financing functions - revenue raising and pooling – this year's health financing discussions were centred around strategic purchasing (SP). Strategic purchasing is about linking payment to information on provider performance and the health needs of the population. As outlined by Inke Mathauer, it refers to the allocation of resources on the basis of the following three questions and related assessment criteria:

When I was asked to chair this session about "strategic purchasing" I had to admit that I had never heard about it. Then I went to google and realized that whole books had been written on the issue [...] but what does this have to do with universal health coverage? - **Lucien Manga, WR Mali**

1. BENEFIT PACKAGE DESIGN: WHICH SERVICES WILL BE PURCHASED?

SP is not possible without a clearly thought-through, sensible benefit package (BP). Taking an informed decision on what is covered according to population needs and preferences, the BP focus should be on primary health care, health prevention and promotion, as well as on giving priority to generics. This should be coupled with appropriate cost-sharing mechanisms and effective referral systems.

2. RESOURCE ALLOCATION CRITERIA AND PROVIDER PAYMENT METHODS: HOW ARE PROVIDERS PAID AND AT WHAT RATES?

This is about moving away from 2 extremes: From line-item budgets towards more output-oriented payments on the hand, and from completely unmanaged fee-for-service payments to a system with reasonable ceiling and cost-limitation incentives, on the other.

3. SELECTION OF PROVIDERS: FROM WHICH TYPES/LEVELS OF PROVIDERS?

Key policy instruments to use here are: Accreditation, selective contracting and performance monitoring.

For countries, it is key is to move away progressively from "passive" purchasing methods, i.e. using norms and historical spending for resource allocation; little or no selection of providers, insufficient quality monitoring, whereby the purchaser is a quality and price taker. Instead, one should move to "strategic" purchasing with payment systems that create deliberate incentives for efficiency and quality, imply selective contracting and quality improvement and rewards. In this latter situation, the purchaser is more a quality and price maker.

To move towards more strategic purchasing, greater attention needs to be given to the following areas: 1) governance around the purchasing function (institutional setup of oversight, of accountability and decision-making); 2) alignment in mixed provider-payment systems to set coherent incentives and (funded) mandates for the providers; 3) benefit package design and alignment with provider payment and 4) setting up coherent

and unified information management systems. Three parallel group discussions were structured around these topics.

Governance for strategic purchasing

Country evidence points to the following success factors and pitfalls to strengthen governance for strategic purchasing:

> The purchaser should pursue a balanced set of objectives (health, financial protection, efficiency) and avoid over-reliance on financial objectives.

> Benefits need to be balanced with the fiscal envelope in the medium term and be predictable, it is critical to avoid unfunded mandates.

> Policy framework should be stable and consistent to avoid misalignments across reform areas.

> Governments need to strive for a balance between catalysing public finance reform and continued functioning: inconsistent incentive environments for providers need to be avoided.

> It is important to provide channels of transparent participation to ensure ownership and legitimacy and to avoid capture by specific interests .

> Last but not least, ambitions should be in line with capacity and system development.

Participants in this session voiced two related concerns: how to overcome fragmentation based on a multitude of piloted – and often donor-funded – schemes, and how to ensure scale-up could be executed once donor funding would end. The debate led to the conclusion that it is essential not to rush into adopting a particular purchasing model over others. Rather, countries needed to assess carefully which options would be best suitable for their context by adopting a coherent health financing vision on how to increase coverage. The group discussions also touched upon the following issues:

> Institutional legacies render many changes in governance arrangements difficult.

> There is need to define the governance roles of Ministries of Health (e.g. with respect to benefit package design, protocols and guidelines setting, oversight, policy and rule setting).

> Vision is needed on how to increase coverage, otherwise fragmented schemes will aggravate the governance situation.

> Health information management systems are critical for strategic purchasing reforms.

CONCLUSIONS AND ACTIONS

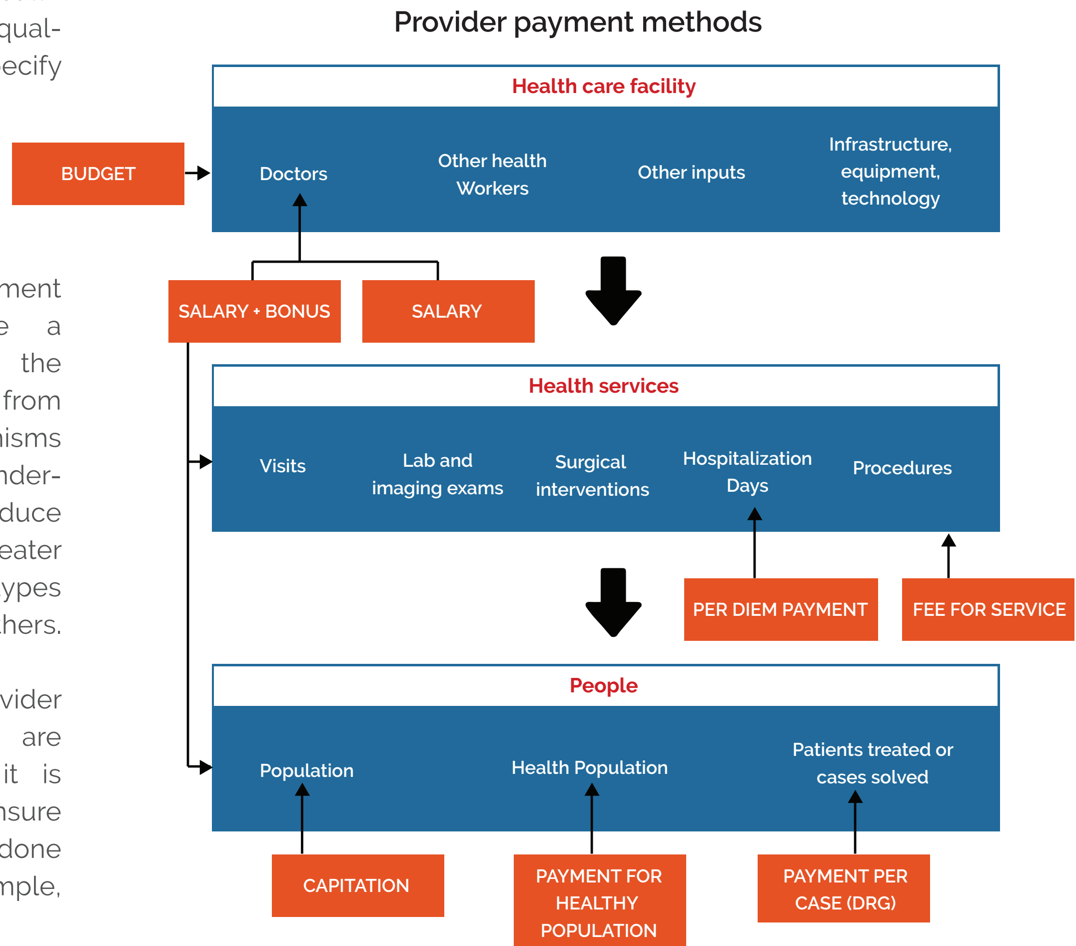
The Ministry of Health needs to adopt a coherent and country-tailored vision on how to increase coverage through strategic purchasing, by seeking the political buy-in from other government levels and sectors – notably the Ministry of Finance – for this vision. There is a need to move from scheme-based models to a system-based approach. Establishing a unified and coherent information system based on reliable data is a pre-requisite for effective purchasing.

Mixed Provider Payment Systems

One of the key challenges which participants in this session voiced is how to design purchasing methods that are effective and strategic. According to WHO, the starting point is to acknowledge that designing purchasing is "not happening in a vacuum". It is important to identify all the agencies that purchase health services in a given country - from the Ministry of Health and local governments to social health insurance funds, private insurance agencies, community-based health insurers, or others. Equally, one needs to specify what methods are already used to pay providers.

In most countries, provider payment systems constitute a combination. And the incentives arising from such mixed mechanisms are important to understand, as they may induce providers to pay greater attention to certain types of patients than to others.

Since mixed provider payment systems are often the reality, it is important to ensure that this 'mix' is done wisely. For example, when a facility is paid by several different payment mechanisms, it is crucial to look at who pays what in order to avoid double payment and payment gaps, or create perverse incentives. Moreover, it is important to look at whether the right payment level has been used and whether the selected mix keeps healthcare affordable for most.



CONCLUSIONS AND ACTIONS

The UHC-P should help countries make informed choices about context-adequate payment mechanisms as part of a mixed payment system, e.g. through peer-learning. A purchaser-provider split makes (strategic) purchasing more explicit (and hence visible), but whichever system is adopted, the key is to mix payment systems wisely, by ensuring clear and funded mandates, and a coherent set of incentives, tailored to the appropriate level within a health system is essential.

Voice, preference and demand: benefit package design, review and alignment with PPM

The dialogue around health financing has traditionally focused on the essential package of health services to be delivered, and most notably on its associated cost. Availability of funds, however, does not necessarily translate into effective service delivery. In fact, as was pointed out, HSS and UHC achievements vary significantly between countries with similar levels of health spending in the past few years. Participants were therefore challenged to identify jointly some innovative ways of making the benefit package design and implementation more effective. agencies, community-based health insurers, or others. Equally, one needs to specify what methods are already used to pay providers.

One key question discussed in the working group pertained to the various advantages and risks of explicit approaches to benefit design. The advantages of explicit benefit package design are that they:

- Ensure essential services covered
- Promote health objectives
- Meet user expectations and demands to know entitlements
- Facilitate common understanding between purchaser and provider
- Facilitate common understanding between provider and patient
- Reduce manipulation by providers
- Reinforce entitlements and protect the poor
- Work towards greater transparency
- Support fiscal responsibility
- Enable better planning and projections

However, there are also considerable hazards surrounding explicit benefit package design. There is a political risk of excluding critical services or population groups. It can be unpopular when such a benefit package reduces previously understood entitlements. Moreover, technically well-prepared decisions may be politicized and overturned through political discussions.

Further action points

- UHC-P to support increasing interaction and exchange platforms within and across regions to share and learn from evidence and best practices in the field of health financing reform and in particular on strategic purchasing reforms.
- WHO HQ to take the lead for drafting of policy briefing on strategic purchasing, including lessons learnt from different partnership countries as well as best practices from model countries that have progressed significantly towards UHC, aimed not only at guiding UHC-P member countries in their strategic purchasing policies, but also providing the group with a common voice and messaging around the issue for advocacy.
- Promote the inclusion of peer-learning activities on health financing and strategic purchasing in the UHC-P country roadmaps.

CONCLUSIONS AND ACTIONS

For transparent and participatory benefit package design and revision, countries have to ensure a legitimate process. The UHC-P can support this by providing guidance on some of the principles shaping this process. This needs to be based on a clear statement of goals, Use of contextualized evidence (regional, country), clear criteria of selection and decision rules, channels of citizen voice and involvement, explicit rules on modification, monitoring and evaluation.

5. HOW TO PREPARE FOR A EUROPEAN UNION VERIFICATION MISSION

The agreements the European Commission signs with International Organisations such as WHO include a verification clause with verification provisions and guidelines for on-the-spot verification missions by Commission services. Since these missions can also be carried out in Luxembourg-funded UHC-P countries, it was deemed important to use the opportunity of the annual meeting to inform all country participants about how best to prepare for a potential visit.

Verification missions involve a review of the system of accountability for the action put in place by the International Organisation and checks on the information supporting the implementation of the specific agreement concerned and the use of the EC funds. Below is a simple graph that details the four main steps of the process: Notification, Planning, Implementation, and Verification. Further details can be found in the presentation annexed to this report.

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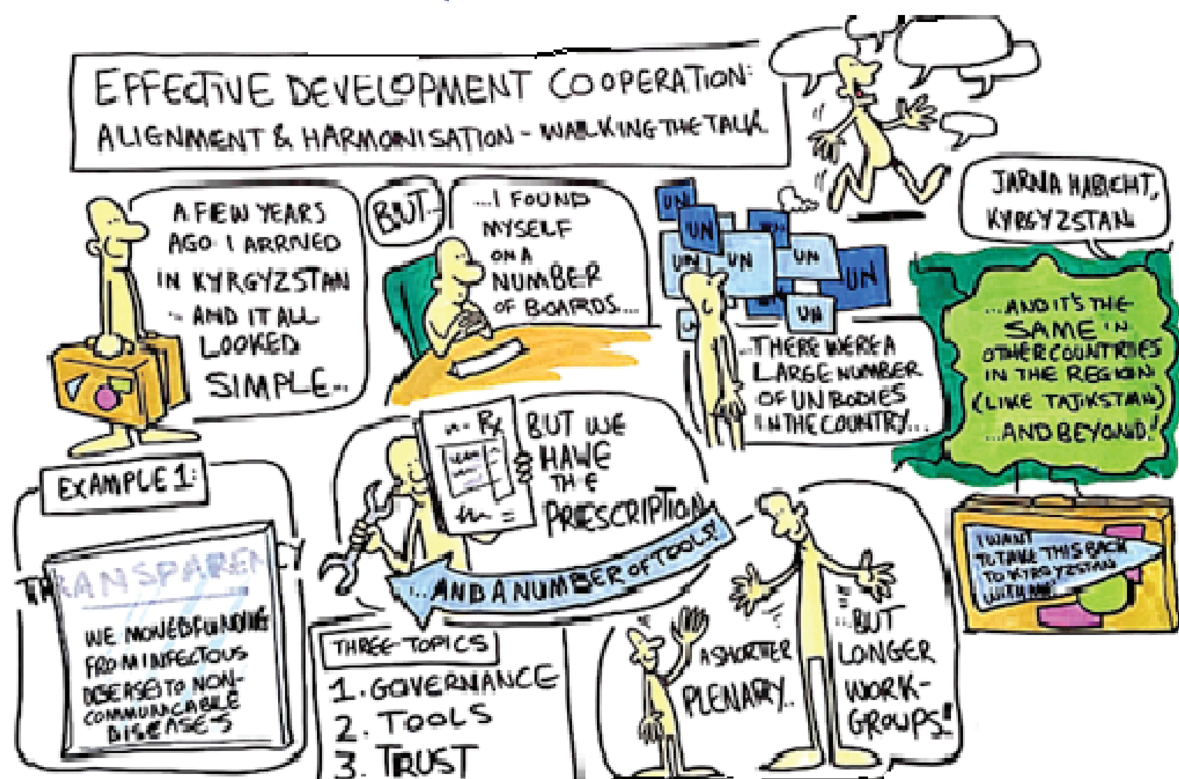

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6. EFFECTIVE DEVELOPMENT COOPERATION: WALKING THE TALK

The meeting revealed that in many countries good progress had been made with regard to development partner alignment and harmonization. The UHC-P helped countries 'walk the talk' – or putting coordination into practice: The Republic of Kyrgyzstan, for example, has one health plan and a sector-wide approach involving a coordinated donor group. That said, as highlighted by the head of WHO's country office, discordant voices within the health sector (e.g. Global Fund & Gavi's respective plans and strategies, agency-specific health projects with their own independent boards) have sometimes hindered progress.

Some differences in health sector strategies and contexts within Eastern European countries were highlighted. While Tajikistan, for instance, has adopted a health sector wide approach and Moldova benefits from a common health platform, health stakeholders in Georgia are not as keen on these forms of coordination.

The good news is, however that according to Jarno Habicht, Head of WHO Office, Kyrgyzstan, "collective knowledge will push countries forward" and that countries will be enticed to consider how to put the UHC2030 community into practice.

Aid effectiveness for UHC

What can ministries of health do to ensure that donors align to their policies and planning? This question spurred a heated debate among participants. One participant noted that each health stakeholder acts in accordance to his or her agency agenda, and that they are ultimately accountable to their funders. While some argued that any failure of the Partnership must be attributed to WHO, this was countered by others claiming that the Ministry of Health should take a leadership role from the start to ensure that donors align to national priorities.

A consensus was reached on the importance of involving all health stakeholders in consistent and periodic planning meetings in order to reach an honest and transparent dialogue. However, as stressed by some, having mechanisms in place may not necessarily lead to the expected results. As a first step, mutual trust needs to be established between country stakeholders and development partners. Planning documents such as Joint Annual Plans, Joint Financial Management Assessments, Joint Annual Reviews and similar joint approaches are just a means to an end. In order for a joint approach to work, a well-established review process needs to be in place, with a clear idea of what constitutes a successful output. The participants looked at whether a joint review process could be institutionalized.

The issue of competing priorities of different health partners was repeatedly brought up, with a consensus that WHO has played a key convening role in facilitating dialogue between the Ministry of Health and various stakeholders, as well as in providing leadership in planning and budgeting. Participants from both working groups touched upon the importance for partners to align on multiple levels: in planning and budget cycles, in Health Information Systems used, as well as in inventory management or purchasing techniques.

CONCLUSIONS AND ACTIONS

Participants listed 3 concrete actions to be taken forward within the UHC-P to strengthen harmonization and alignment between global health partners:

- Monitor in-country activities to ensure accountability
- Make clear the linkages between UHC-P and the IHP for UHC2030: UHC-P is the operational arm of the IHP for UHC2030 Secretariat.
- Ensure that the transition to UHC2030 reinforces the previous focus on the IHP+ 7 behaviours

Global Health Initiatives

Global Health Initiatives (GHI) have often been criticized by partner countries for their vertical way of working on specific diseases or issues and their lack of alignment and harmonisation. Beyond the main session on GHI, the annual meeting also provided an opportunity for GAVI and the Global Fund to rectify this image by presenting their latest efforts to reform their funding processes and mechanisms in an attempt to make them both more supportive of health systems strengthening and adaptable to different national contexts.

The Global Fund presented its 2017-2021 funding strategy, which includes, among its four overall objectives, the goal to build resilient and sustainable systems for health (RSSH). According to the GF spokesperson, more than 80% of RSSH investments are focused on health information systems, procurement and supply chain management, health workforce and service delivery. The Global Fund also explained how countries should proceed with regard to funding requests. They encouraged applicants to submit comprehensive and integrated funding requests including HIV, TB, malaria and RSSH components.

In a similar vein, GAVI presented its new vision for the Country Engagement Framework. This framework was clearly intended to enhance systemic alignment and was characterized by simplified and less burdensome processes, new templates and tools to allow for longer-term support and to integrate all types of Gavi support (PSR, budget template). It also involved new flexibilities for timing of process steps and alignment to country cycles, as well as the possibility to request support and guidance from Gavi in the application phase. More details can be found in Gavi's and the Global Fund's presentations annexed to this report.

Participants, however, still raised a number of critical questions, including: "When will Global Fund and Gavi start aligning their separate coordination mechanisms to existing national level mechanisms and cycles, notably around the benefit package design. When would they start harmonizing their procedures and elaborate common templates for health systems strengthening?"

The dialogue echoed references to a discussion which had indeed been launched 5 years ago, but which, according to Gavi, had been abandoned for organisation-internal reasons. Gavi confirmed that it had recently been taken up again and discussions are ongoing – a first coordination effort has been made with regard to carrying out joint country missions. Another step had been to try and align the funding request cycles between the 2 institutions to be able to be present HSS proposals at the same time on the basis of Gavi's new timing flexibility.

On the question from one participant on how both institutions would cooperate with the World Bank and the Global Financing Facility (GFF) in particular (given the Global Fund's increased focus on maternal health), the Global Fund's answer was that coordinating efforts had so far been limited to a regular exchange of information both at global and country level and to some cases joint missions with the Bank.

CONCLUSIONS AND ACTIONS

While participants welcomed GHI efforts of adjusting their individual procedures to the national context by involving all health partners as a first step in the right direction, GHI should work towards harmonizing their procedures and unifying their coordination mechanisms.

In the meantime, GHI should provide countries with additional guidance and TA support for assisting them with the funding request procedures.

Moreover, WHO should continue to have a key role in coordinating the dialogue between external and internal stakeholders to elaborate strong national planning documents, and find a consensus on financial management and procurement tools and processes. To this end, having a common and robust M&E framework between partners would be critical.

Understanding effective development cooperation through a realist research lens

When speaking about an outcome as broad as 'universal health coverage', the question of attribution - or how to measure the results and impact of a programme has been a recurrent challenge and the source of intensive discussion between WHO and the UHC-P's donors.

In 2016, WHO tasked researchers from Montreal, Canada to use innovative qualitative methods to answer to this very complex question, by conducting a "Realist research" study. This is a multi-layered social intervention aimed at understanding how the UHC-P contributes to strengthening health policy dialogue and planning towards UHC.

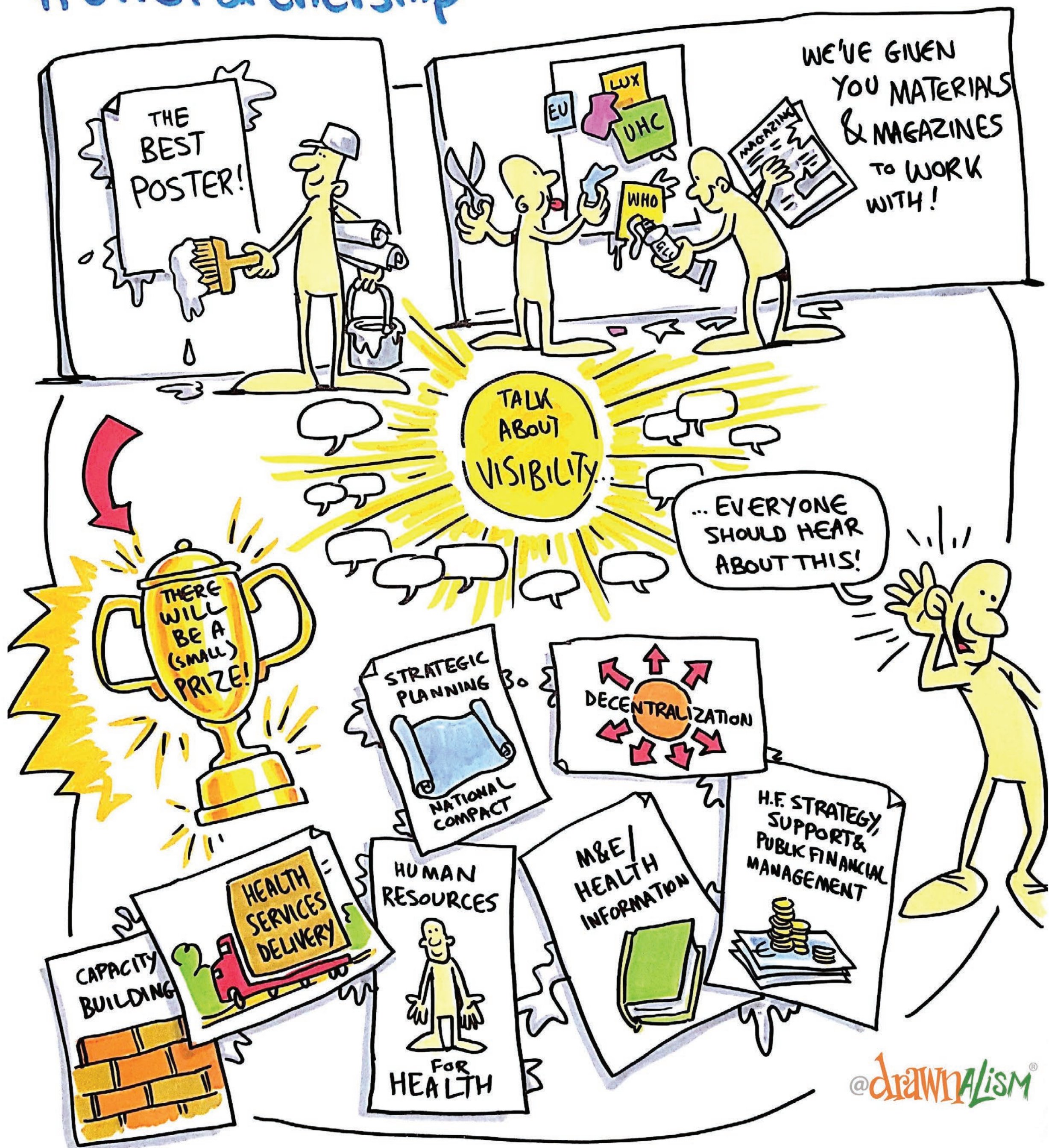
A realist approach to health policy and systems research aims to produce relevant and targeted evidence to understand the impact of health policies and interventions on health systems. In the context of the UHC-P, realistic research is meant to offer a qualitative explanation of how the UHC-P works across sampled countries; provide an explanation of challenges and successes of the UHC-P through in-depth understanding of contextual factors by uncovering hidden key ingredients (mechanisms), using lessons learnt and bringing about theoretical & methodological advancements.

To this end, six countries of the Partnership will be involved in a study: Burkina Faso, Cabo Verde, the Democratic Republic of the Congo, Liberia, Niger, and Togo. The researchers will conduct purposive sampling in each of these countries, taking into account criteria that include policy dialogue, Ministry of Health leadership and stability, as well as opportunities to participate in planned country-level policy dialogue events.

The study will either help validate or challenge the assumption that policy dialogue for health planning and financing leads to strengthened health systems and to the realization of universal health coverage.

Even by showing causation between policy dialogue and health systems improvement, successes will ultimately also depend on the national context and criteria including, but not limited to: the stability of the government, the leadership role of the ministry of health, the existence of robust policies, and opportunities for health stakeholders to participate in planning events.

This flagship piece of research is thus critical for the Partnership as it will not only feed into further country programming but also potentially encourage other donors to consider investing in this important health systems area of work.



5TH ANNUAL INTER-COUNTRY TECHNICAL MEETING OF THE EU/LUX-WHO PARTNERSHIP, BRUSSELS 21-23 MARCH 2017

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7. UHC INNOVATION AND COMMUNICATION IN AN AGE OF CHANGING POLICIES

At the end of this highly enriching 5th annual meeting, teams of participants were challenged to ‘flex their creative muscles’. They were invited to partake in the mini Social Lab ‘Innovate and Connect’ and design innovative UHC strategies for the future that would stress cross-country connection and new forms of UHC-partnership collaboration. The teams were split into competing groups and tasked to put their thoughts into a poster.

The twelve posters varied widely in both form and contents. For instance, while one team focused on decentralization as the critical ingredient towards achieving UHC, another focused on interconnected centralized health information systems and skill-exchange among stakeholders.

The two winning posters – one in English, one in French – were given an original drawing by cartoonist Alex Hughes.

#UHCPartnership

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8. CLOSING CEREMONY

At the well-attended closing ceremony, representatives of the EU, Luxembourg, and WHO expressed their appreciation and strong hopes for the future of the UHC-partnership.

Walter Seidel, Senior Policy Advisor at the European Commission said that the partnership had been instrumental in changing the way that the WHO operates at country level, from acting as a "servant to the Ministry of Health" to becoming "a facilitator and convener of sector policy dialogue." He also thanked all ministries of health for their attendance and vital contributions: "We know that health sector reform happens at the country-level because of you." Finally, he emphasized the need to show results and to craft messages to the Partnership constituents.

Anne-Laure Theis, speaking on behalf of Natacha Gomes for Luxembourg, reaffirmed her country's engagement towards the Partnership. On the WHO side, Gerard Schmets commented on how enriching it had been to hear from 29 countries, and echoed the request to attend the following Partnership meeting with even more evidence on the value of these forms of collaboration.

Finally, Alaoui Belghiti, PS of the Ministry of Health of Morocco, publicly announced that his country has offered to host the 6th Annual Meeting of the UHC Partnership in 2018.

See you in Marrakesh!

SUMMARY, CONCLUSION AND NEXT STEPS

1. What People Said About the UHC-P: Let's Celebrate!

The meeting was attended by a wide range of experienced participants from more than 30 countries. They showed their satisfaction and they expressed during these 3 days how the UHC-P is adding value to their daily work in their respective country. The following few quotes by participants illustrate that statement:

“ For the first time in history of the world, universal health coverage is an official policy as well as equity, as part of the Sustainable Development Goals. In this context the UHC-P is really working as a global catalyst to help countries moving in this direction.
- Dr. Zafar Mirza, HSS Director, EMRO

“ WHO has played a key convening role in facilitating dialogue between the Ministry of Health and various stakeholders, as well as in providing leadership in planning and budgeting.
- Final consensus among participants in annual meeting working group on aid effectiveness

“ UHC-P support enabled WHO to become a lead facilitator for joint programming between humanitarian and health system actors and in ensuring the transition from a humanitarian context.
- Akjemal Magtymova, Deputy Representative of WHO country office for Yemen

“ Without WHO's support, we would not have been able to take this dialogue to the next level.
- Zouhair Ben Jemaa, spokesperson for the societal dialogue in Tunisia

“ Imagine: In the Kyrgyz Republic, we have moved from a total health expenditure of USD 6 per capita in the year 2000 to USD 87 per capita in 2015 – My comment about this: Yes, we can!
- Prof. Tilek Meimanaliev from MoH Kyrgyz Republic

“ I have seen this Partnership being very effective and grow over the period of 4 years since 2013, where there has been enthusiastic policy dialogue, making sure that all partners and stakeholders are engaged in the development of real strategies and plans for UHC.
- Dr. Rajesh Pandav, WHO Representative in Timor Leste

“ The UHC-P is a very actual and unique platform for collaboration
- Comment received from participant in the evaluation of the meeting

In addition some quotes from participants on the meeting itself should encourage organizers and participants to strengthen their active participation in the yearly technical meeting of the UHC-P in the following years:

“ The annual meeting will improve the agenda of the UHC-Partnership

“ There was a lot of communication, participation, interaction - a “real” meeting that moved away from “only” presentations.

“ The Thematic programme was very informative, well-constructed, and topics well chosen.

THANKS AND CONGRATULATIONS TO ALL WHO ACTIVELY WORKED & SUPPORTED UHC-P'S HUNDREDS OF ACTIVITIES OVER THE LAST 5 YEARS!

2. ...But There is Still a Lot to be Done, so Let's Share and Innovate:

Many recommendations and action points are mentioned in the different sections of the present report. The most relevant are summarized below.

FROM A GLOBAL PERSPECTIVE:

> Make the message clearer regarding the linkages between UHC-P and the IHP for UHC2030.

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

> The UHC partnership has a critical role in bringing all actors – both humanitarian and development - together, particularly at global levels.

> Support countries in integrating IHR into country-level policy dialogue on national security.

> WHO HQ to take the lead for producing a policy brief on strategic purchasing, including lessons learnt from different partnership countries as well as best practices from model countries where UHC has been achieved.

> UHC-P to support setting up of interactive, regional health financing platforms in order to facilitate the exchange of information and best-practices between countries.

> Promote the inclusion of peer-learning activities on health financing and decentralisation, as well as other complex health system issues, in the UHC-P country roadmaps.

> Under the new UHC2030 umbrella, continue to push for 7 behaviours compliance, as well as harmonization at the level of donor/GHI agencies' HQ.

> Gather evidence on where the private sector can make a difference to UHC

> Advance the multi-country operational research to better demonstrate results.

FROM A COUNTRY PERSPECTIVE:

> The WCO to continue and foster the key role they play in coordinating the dialogue between external and internal stakeholders to elaborate strong national planning documents, and find a consensus on financial management and procurement tools and processes.

> HQ and ROs to support countries in advancing health policy dialogue across all sectors, in order to integrate UHC and health in all policies.

> Bring together GHIs and central- and local-level actors in order to promote an integrated, people-centred approach to service delivery.

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

> Ensure that the GHI's new HSS windows are aligned with countries' NHPSPs in the framework of UHC by taking a coordinator role with regard to funding requests.

> Continue to support MoH in building IHR core capacities, developing robust strategic plans that incorporate emergency response as well as development activities to ensure a continuum and harmonization of activities during the emergency, recovery and post-recovery phases.

> MoH capacities to effectively regulate the private sector (eg. with regard to licensing and accreditation) and manage related contracts and PPPs, as well as to lead a meaningful dialogue with the private sector.

> Support countries in elaborating SDG 3-related monitoring indicators which capture both preventative and curative services, and encourage countries and constituencies to engage in SDG 'health' custodianship.

> Consider joining UHC2030 by signing related global compact

And more specifically:

Many recommendations and action points are mentioned in the different sections of the present report. The most relevant are summarized below.

1. WITH REGARD TO THE MOH, THE PRIVATE SECTOR, THE CITIZENS AND THEIR CHANGING ROLES

> MoH needs to support local governments in changing their roles, e.g. in taking on the management and payment for services as a single purchaser and learning how to use local resources efficiently to address local priorities.

> MoH needs to establish a dedicated team to coordinate issues around intersectoral work with the responsibility specifically to engage other sectors.

> Develop strategies and establish mechanisms for a continuous dialogue with other sectors by using existing structures, networks and/or repurposing them and taking part in initiatives of others.

> Ensure buy-in from Ministry of Finance.

> The MoH should ensure that the national health plan and coherent policies are guiding the work of the private sector.

> With support from UHC-P, MoH should enhance its capacities to monitor private sector contracts, manage PPPs and to lead a dialogue with the private sector.

> MoH to create the conditions for mutual trust between government and civil society and allow for a meaningful engagement of civil society, notably by creating follow-up mechanisms for CSO consultations.

> MoH should allow civil society to organize itself (bottom-up) and to prove their legitimacy and credibility to the government

2. ON STRATEGIC PURCHASING FOR UHC...

> A shift to strategic purchasing is relevant in all countries, independent of its income-level and of the health financing architecture. Above all, shifting towards strategic purchasing can be incremental, while nonetheless being an important driver for system change.

> The Ministry of Health needs to adopt a coherent and country-tailored vision on how to increase coverage through strategic purchasing, by seeking the political buy-in from other government levels and sectors – notably the Ministry of Finance – for this vision.

> More attention needs to be placed on the governance around the purchasing function with the aim of aligning mixed provider payment systems that set coherent incentives for providers and ensuring transparent processes for evidence informed benefit package design.

> Equally critical is to focus on information management systems that play a critical role to shift towards strategic purchasing.

3. FOR DEVELOPMENT PARTNERS:

> Partner support in fragile settings should reinforce and not replace the Ministry of Health, who needs to continue being at the helm of coordination.

> Partners must align their country programmes on multiple levels: planning cycles, budget cycles, Health Information Systems used, as well as inventory management or purchasing techniques.

> GHI should work towards harmonizing their procedures and unifying their coordination mechanisms. In the meantime, GHI should provide countries with additional guidance and TA support for assisting them with the funding request procedures.

The next meeting will be held in Marrakesh (Morocco) in March 2018. As a follow up of the spirit of the Brussels meeting, it will be opened to more actors and will propose to engage them through innovative means like joint preparation workshops and providing more avenues to reflect how vivid universal health coverage is in countries.

ANNEX A – SOME (OF MANY) COUNTRY EXAMPLES

1. UHC 2030 - TRANSFORMATION OF IHP+ AND OPPORTUNITIES FOR UHC-P Achieving the SDGs, Building Health Security & UHC 2030 - transformation of IHP+ and opportunities for UHC-P

COUNTRY EXAMPLES

In **Guinea**, a new National Health Development Plan post-Ebola was developed through the UHC Partnership with close consultation of all health partners. These partners are now involved in all stages of health systems strategy: from the planning to the M&E.

In **Cabo Verde**, health forums in the country's nine islands organized by the Ministry of Health with the participation of civil society stakeholders led to a national-level forum.

In **Chad**, the national health policy was revised in 2015 and the development of a UHC strategy was initiated as a participatory process. Security issues due to the presence of Boko Haram, as well as demographic constraints (half of the country is desert), have led to a multiplicity of partners, making the conciliatory role of the Ministry and WHO critical.

2. THE CHANGING ROLE OF THE MINISTRY OF HEALTH: NEW ROLES, NEW ENERGIES, NEW FORMS OF CONNECTION

2.1 FRAGILITY

COUNTRY EXAMPLES

In the context of the Ebola outbreak, ministries of health in all three Ebola-affected UHC-P member countries (**Liberia, Guinea and Sierra Leone**) took the lead in elaborating, with support from the UHC-P, so-called recovery plans – short-term, emergency plans to address the crisis, but which were carefully designed to ultimately allow for a smooth transition to post-recovery and their integration into longer-term national health plans.

In **Yemen**, as a result of the war that started in 2015, WHO country office had to change the UHC-P roadmap and way of working, by minimizing its focus on 3 areas, namely the design and implementation of a an Essential Services Package (ESP); data collection from the field to help the humanitarian action response; and, most crucially, the elaboration of a concept for a post-recovery plan, the so-called "bridging framework". UHC-P support enabled WHO to become a lead facilitator for joint programming between humanitarian and health system actors and in ensuring the transition from a humanitarian context.

2.2 Private Sector

COUNTRY EXAMPLE: SOUTH AFRICA

In South Africa over half of all doctors work in the private sector due to higher fee levels, thus raising the issue of affordability. There was no regulation on the quality of private providers. In 2014, the country´s Competition Commission initiated an inquiry into the private healthcare sector because it had reason to believe that there are features of the sector that prevented, distorted or restricted competition. The Commission looked at issues such as the concentration of hospitals and medical schemes; price negotiation and levels; how consumers benefit from current private sector and the profitability of private hospitals.

2.3 Decentralization

COUNTRY EXAMPLES

Burkina Faso and Ukraine provided two different examples of how to go about decentralisation: Albeit based on a new law on decentralisation, the process in **Burkina Faso** was spearheaded by the health sector and the current division of responsibilities between the national, regional and local levels is still centred around the idea that essential planning processes are happening at the national level, while local and regional levels are tasked with implementing national-level policies and decisions, on the basis of annual plans they elaborate.

Ukraine explained the long process which was taken in the country in order to engage in a decentralization as demanded by the population. Following a consultation, the country decided to have a single purchasing system with a fund mechanism concentrated in the central level. This decision implied a new role of local level governments who needed to switch their funder position into a manager one. While challenges remain, Ukraine highlighted that decentralization is about good partnership between the different government levels (central, regional and local) and their balance in terms of capacity, financing and accountability.

3. THE CHANGING ROLE OF THE MINISTRY OF HEALTH: STEERING THE HEALTH SYSTEM TOWARDS A STRONG POPULATION FOCUS

3.1 MAKING THE POPULATION'S VOICE TRULY HEARD IN HEALTH POLICY & PLANNING

COUNTRY EXAMPLE: TUNISIA'S "DIALOGUE SOCIÉTAL"

The societal dialogue carried out in Tunisia in the health sector has, undoubtedly, become an invaluable source of lessons learnt in the past years for making the population's voice heard. As described by Zouhair Ben Jemaa, spokesperson for the societal dialogue, during the annual meeting, it was an unprecedented, democratic process, caringly supported by UHC-P-funded WHO experts, which started in 2013 by involving around 3400 citizens and health professionals in the election of a "citizens' jury". While deliberately being "locked upon on an island", as Ben Jemaa humorously put it, the elected jury came up with a white paper on citizens' demands for health, which was presented to and applauded by the head of state during the national health forum in September 2014. The paper is now to feed into the new national health development plan. This process also became a model for other sectors. As a result, in Tunisia, "We don't do anything anymore without citizens. Nothing can be decided without civil society", said Ben Jama, adding "Without WHO's support, we would have not been able to take this dialogue to the next level".

LEARNING FROM BEYOND THE UHC-P: THAILAND'S NATIONAL HEALTH ASSEMBLY.

The UHC-P can also help members learn from experiences of non-member countries. The case of Thailand, for example, was presented at the annual meeting as the country has a long-standing experience in implementing participatory processes in the health sector: In 2008, it established the National Health Assembly (NHA), an annual, 3-day multi-actor and multi-sector platform aimed at elaborating recommendations on how to integrate health in all policies. 280 constituencies participated in the latest assembly in December 2016. Over the years, the NHA has led to increasingly concrete and actionable resolutions – 68 in total, across all sectors - and thus increased the level of buy-in from the government: It is now seen as a mechanism which contributes to more evidence-based policy-making. In addition to that, the NHA helped improving internal coordination and the quality of interaction between members of what is seen as the "triangle that moves the mountain" – government, academia and civil society.

3.2 SDG MONITORING AT COUNTRY LEVEL

COUNTRY EXAMPLES

In December 2015, the **Kyrgyz Republic** created a coordination committee on SDG implementation. The Ministry of Health established working groups pertaining to SDG adaptation in health sector, eventually agreeing on a set of indicators with various stakeholders. WHO supported the monitoring of SDG 3.8.2 via a Kyrgyz Integrated Household Survey, providing data on OOPs of households by quintiles and types of health expenditures. Challenges for SDG monitoring have included a lack of political commitment, which may result in delays. A high turnover rate of health sector personnel as well as a need for regular interaction between different sectors have also led some to consider SDG monitoring as a "huge burden" that the sector is required to prioritize.

3.3 WORKING MORE INTERSECTORALLY: PRACTICALITIES AND CHALLENGES

COUNTRY EXAMPLES

Ukraine's current efforts towards adopting a HiAP approach are inspired by the Estonian experience: Estonia's national health plan 2009-2020 aims at addressing the cross-sector nature of health by structuring it around five cross-cutting themes. These themes are oriented towards overall human development and well-being with a strong focus on addressing health determinants. Estonia established a management committee (MC) which includes representatives from all relevant ministries who are responsible for following up on the MC's decisions within their respective areas, including the planning of resources in the state's budget and ministerial work plans.

In **Sudan**, a HiAP roadmap and action plan were developed on the basis of a workshop involving 80 senior level policymakers from 17 sectors. The roadmap, which included commitments from each of the participating line ministries, was signed at the highest levels of the government, thus placing a responsibility on all ministries to contribute towards its implementation, results monitoring and reporting.

Photo: HiAP workshop supported by UHC-P in Sudan

4. HEALTH FINANCING AND STRATEGIC PURCHASING FOR UHC

COUNTRY EXAMPLES

In **Ukraine**, the recent launch of reform on strategic purchasing 2017-2020, accompanied by UHC-P training and capacity-building, allowed for moving from the country's initially very passive purchasing scheme towards a single purchaser system (NHS – National Health Service), involving the purchase of services within a guaranteed benefit package, including new payment methods based on services quality control.

In **South Africa**, a single purchaser system was adopted in 2012 as part of efforts to move towards UHC and the country is now moving from a currently passive relation between purchaser and providers to a capitation model.

In **Rwanda,** a high degree of political buy-in – specifically from the highest levels of government and the Ministry of Finance - was cited as a key factor which helped the country advancing towards a successful, results-based financing model.

COUNTRY EXAMPLE: THE TUNISIAN PARADOX, A GOVERNANCE ISSUE

Despite the existence of voluntary health insurance covering 2/3 of the Tunisian, in addition to free health insurance for 20% of the population and a dense network of public health facilities, almost 40% of the country's health expenditures are still out of pocket. Several governance issues related to strategic purchasing were identified as being at the root of the problem, namely: a fee-for-service system with annual ceilings per affiliate which were not respected, implying additional costs for the user related to exceeding fees, especially in the private sector; allocations to hospitals deemed insufficient in light of usage; allocations to health centres often ill-adapted to the target population or risk leading to service discontinuity and loss of patient trust. To address these problems, the introduction of a capitation system is currently being considered by MoH. In the long-run, the transfer of health financing governance responsibilities to one unique entity, the National Health Insurance Fund, in charge of managing a single benefit package applying to both the public and the private sector, is seen as an option.

COUNTRY EXAMPLE: KYRGYZ REPUBLIC

It is important to remember that impressive results and health outcomes can be achieved over time, as pointed out by a speaker from the **Kyrgyz Republic:** "Imagine: In the Kyrgyz Republic, we have moved from a total health expenditure of USD 6 per capita in the year 2000 to USD 87 per capita in 2015 – My comment about this is: Yes, we can!"

5. EFFECTIVE DEVELOPMENT COOPERATION: ALIGNMENT AND HARMONIZATION – WALKING THE TALK

COUNTRY EXAMPLES

In **Yemen**, implementation of Joint Annual Plans is more problematic as there are two governances acting simultaneously since the coup in 2014-2015. This has made it difficult for government stakeholders to align on common planning documents.

In **South Sudan**, there is a chronic history of being dependent on partners because of the 20-year period of war and the subsequent low capacity of the MoH (which contributes less than 1% of funds towards the health sector). There, the Joint Annual Review was seen as a starting point to bring partners together, but this has since led to challenges of coordination and accountability.

In **Sierra Leone**, many partners left the country because of the civil war; and then once the county was declared Ebola-free. There were efforts to adopt a national compact for partners, but it was ultimately rejected.

COUNTRY EXAMPLES

In its funding proposal to the Global Fund, **Mozambique** successfully argued that constraints to improving HIV, Tuberculosis and Malaria outcomes included poor infrastructure, scarce human resources, cumbersome HR management procedures, weak laboratory and drug procurement/distribution systems, ineffective referral system and that part of the funding would hence need to be used to address these challenges.

Kenya argued that the most effective response to low tuberculosis detection was by improving the delivery of essential health services, including TB/HIV, at primary care facilities.

ANNEX B: MEETING AGENDA

5th Annual Inter-Country Technical Meeting | Celebrate - Share - Innovate
EU/LUX-WHO Universal Health Coverage Partnership
Venue: Bedford Hotel & Congress Centre (Brussels, Belgium) | 21-23 March 2017
Join our conversation: #UHCPartnership

Moderator: Godelieve van Heteren

DAY 1 | 21 March 2016

CELEBRATE:

Day 1 morning		Chair: Rajesh Pandav, WR/Timor-Leste
07:45 – 08:45	Foyer	**Registration**
08:45 – 09:00	Plenary	**Administrative briefing** Alberto Ramajo (WHO HQ)
09:00 – 09:30	Plenary	**Welcome, opening remarks, agenda** Agnès Soucat (WHO HQ), Aida Liha-Matejicek (EU), Natacha Gomes (Luxembourg)
09:30 – 10:30	Plenary	**The EU-Luxembourg-WHO Universal Health Coverage Partnership (UHC-P) – 5th Year Anniversary: Celebrate – Share - Innovate** Denis Porignon (WHO HQ)
10:30 – 11:00		**Coffee**
11:00 – 12:30	Plenary	**UHC 2030 - transformation of IHP+ and opportunities for UHC-P** Agnès Soucat (WHO HQ), Marjolaine Nicod (WHO HQ)
12:30 – 14:00		**Lunch**

SHARE:

Day 1 afternoon		Chair: Djamila Cabral, WR/Mozambique
14:00 – 15:00	Plenary	**The changing role of the Ministry of Health: new roles, new energies, new forms of connection** Introductory presentations followed by Q&A Change Agent: Dr Belghiti, MOH/Morocco Change Agent: Prof. Tilek Meimanaliev, Mandatory Health Insurance Fund, MOH/Kyrgyzstan
15:00 – 17:00	Breakout Rooms	**Parallel Working Groups** Introduction of Working Groups • **Thematic WG 1: Engaging and regulating the private sector** • **Thematic WG 2: Specificities of MoH's changing role in fragile state contexts** • **Thematic WG 3: Decentralisation** **Coffee in groups**
17:00 - 18:00	Plenary	**Plenary panel** **Working Group Feedback and Discussion**
19:00 – 20:00	Restaurant	**Welcome Reception – Food and Drinks served**

DAY 2 | 22 March 2016

SHARE:

Day 2 morning — Chair: Natacha Gomes, Luxembourg

Time	Venue	Session
08:15 – 08:30	Plenary	**Introduction to Day 2** Denis Porignon (WHO HQ)
08:30 – 09:15	Plenary	**The changing role of the Ministry of Health: steering the health system towards a strong population focus** Introductory presentations followed by Q&A Change Agent: Zouhair Ben Jemaa, Spokesperson, Dialogue Sociétal, MOH/Tunisia Change Agent: Rodica Scutelnic, State Secretary, MOH/Moldova
17:00 - 18:00	Breakout Rooms	**Parallel Working Groups** Introduction of Working Groups • **Thematic WG 1: Making the population's voice truly heard in health policy & planning** • **Thematic WG 2: SDG monitoring at country level** • **Thematic WG 3: Working more intersectorally -practicalities and challenges** **Coffee in groups**
19:00 – 20:00	Breakout Rooms	**Working Group Feedback and Discussion (rotating): Implications for MoH on the working group topics**
12:15-12:30	Plenary	**Overall feedback and close of session**
12:30-14:00		**Lunch**

SHARE:

Day 2 afternoon — Chair: Naeema Al Gasseer, WR/Sudan

Time	Venue	Session
14:00 – 16:15	Plenary	**Health financing and strategic purchasing for Universal Health Coverage** Introductory presentations followed by Q&A **Country Panel** Aquina Thulare, MOH/South Africa Katya Maynzyuk, Public Finance Advisor, MOH/Ukraine Tran Mai Oanh, Director, Health Strategy and Policy Institute, MOH/Vietnam Mohamed Mokdad, Director of Planning and Studies, MOH/Tunisia
	Breakout Rooms	**Parallel Working Groups** Introduction of Working Groups • **Thematic WG 1: Governance for strategic purchasing** • **Thematic WG 2: Mixed provider payment systems** • **Thematic WG 3: Benefit package design**
16:15 – 16:45		**Coffee**
16:45 – 17:30	Plenary	**Working Group Feedback and Discussion**

DAY 3 | 23 March 2016

Breakfast - Start off the day		
07:30 – 08:25	WCOs and MOHs Plenary Room	**Meet and Greet Breakfast** Discussion to inform participants and prepare the EU verification mission WHO HQ

SHARE:

Day 3 morning		Chair: Jarno Habicht, WR/Kyrgyzstan
08:30 – 08:40	Plenary	**Introduction to Day 3** Denis Porignon (WHO HQ)
08:40 – 10:15	Plenary	**Effective development cooperation: Alignment and Harmonization – Walking the talk** Introductory presentations followed by Q&A
10:15 - 12:00	Breakout Rooms	**Parallel Working Groups** Introduction of Working Groups • **Thematic WG 1: Aid effectiveness in light of the UHC2030 agenda** • **Thematic WG 2: Global Health Initiatives** • **Thematic WG 3: Understanding effective development cooperation through a realist research lens** **Coffee in groups**
12:00 – 12:30	Plenary	**Working Group Feedback and Discussion**
12:30-14:00		**Lunch**

INNOVATE:

Day 3 afternoon		Chair: Matthias Reinicke, EU
14:00 – 16:00	Plenary	**UHC: innovation and communication in an age of changing policies** A social lab
16:00 – 17:00	Plenary	**Way forward and closure of meeting**

ANNEX C: LIST OF PARTICIPANTS

5th Annual Inter-Country Technical Meeting of the EU/LUX-WHO Universal Health Coverage Partnership
Venue: Bedford Hotel & Congress Centre (Brussels, Belgium)
21-23 March 2017

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