



Universal Health Coverage Partnership Annual Report 2018

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



World Health
Organization

Acknowledgement

We acknowledge the technical and financial support of the European Union, France, Grand Duchy of Luxembourg, Irish Aid, Japan and UK Aid.

Some donors have already taken up observer roles such as South Korea, Bill and Melinda Gates Foundation, Italy, Switzerland, Belgium, to name but a few, at the multi-donor coordination committee (MDCC) for UHC- Partnership.

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

This report covers the calendar year 2018.

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

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





Executive Summary

This Annual report 2018 looks back at a year in which the scope of work of the Universal Health Coverage Partnership (UHC-P)—in its efforts to drive global-level policy dialogue, build country capacities and develop patient-centred services at district level—developed by leaps and bounds.

In addition to expanding its collaboration with the EU, the Partnership continues to be supported by many governments: the Governments of Luxembourg, Japan and France, the UK Department for International Development and Irish Aid all support UHC-P, making it one of the most important and flexible funding streams in WHO. In recognition of these renewed and extended commitments, the multi-donor coordination committee (MDCC) was set up in 2018 to provide a platform for discussion and coordination on cross-cutting issues.

These new donor commitments in 2018 acted as a catalyst, almost doubling the number of supported countries from 36 in 2017 to 66 a year later: UHC-P support now extends across all WHO Regions.

The Astana Declaration on Primary Health Care, signed forty years after the watershed Alma-Ata Declaration in October 2018, along with the Global Action Plan for Healthy Lives and Well-Being, rekindled interest in PHC as a core element of universal health coverage in which, as WHO states, “no one should be left behind.” This reorientation overlaps with the major strategic shifts introduced in WHO’s own five-year General Programme of Work 2019-2023 which envisages 1 million more people benefiting from UHC within its “triple billion goal”.

The Joint Working Team for UHC, set up by WHO to harmonize work across the organization and at Country Offices, has an important role in aligning the UHC agenda with national priorities in supported countries at a time when the administrative workload is increasing. This alignment is in harmony with the on-going transformation of WHO and the implementation of its GPW13 (2019-2023). One of the new tools introduced in 2018 to facilitate this process was the “live monitoring” mechanism, which provides a quarterly forum for open dialogue about progress made and challenges faced between WHO’s technical and planning units, donors and partners. During the live monitoring, information on critical issues such as funding, distribution of resources, policy support and technical assistance can be exchanged promptly and transparently.

First year review of the monitoring mechanism suggests that most activities implemented were directly or indirectly related to primary health care. Country reports for 2018 show that the Partnership’s efforts have not only already bolstered PHC due to its interlinkage with UHC but that UHC country support plans are also starting to prioritize PHC.

Efforts are therefore ongoing, in liaison with Ministries of Health, to strengthen health systems across the board and to provide a more comprehensive package of services, notably to vulnerable and conflict-affected populations. By focusing on continuity of service provision and piloting new people-centred, community-based and integrated health care models, UHC-P efforts have helped reduce the long-standing and problematic gap between short-term humanitarian aid and longer-term development support.

These solid achievements, made with the consistent backing of all partners and stakeholders, afford a positive vision of what is possible through UHC-P’s continuous efforts, flexible mechanisms and ability to adapt to and integrate new donors and member countries.

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Abbreviations

ACP	African, Caribbean and Pacific Group of States	IVD	In vitro diagnostics
AFRO	WHO Regional Office Africa	JA(HR)	Joint annual (health) review
AMR	Antimicrobial resistance	JANS	Joint assessment of national strategies
AOP	Annual operational plan	JWT	Joint working team
ATM	Access to medicines	MCAI	Maternal and Child Health International
BHCPF	Basic Health Care Provision Fund	MDCC	Multi-donor coordination committee
CMAM	Community-based management of acute malnutrition	MDGs	Millennium Development Goal
CSEM	Civil society engagement mechanism	MDS	Model disability survey
CPSD	Cadre de partenariat pour la santé et développement	MESIWG	Monitoring and evaluation, supervision and information working group
CSO	Civil society organization	M&E	Monitoring and evaluation
CSP	Country support plan	MNH	Maternal and Newborn Health Care
DCP3	3rd edition of Disease Control Priorities	MoF	Ministry of Finance
DFID	UK Department for International Development	MoH	Ministry of Health
DHMT	District health management team	MOPHP	Ministry of Public Health and Population
DHS	District health strengthening	MSP	Minimum Service Package
DHIS2	District health information systems 2	MTC	Medicines and Therapeutic Committee
DRG	Diagnosis-related group	NCDs	Noncommunicable diseases
DQA	Data quality assessment	NHA	National health account
EHNP	Emergency Health and Nutrition Project	NHO	National health observatory
EPI	Expanded Programme on Immunization	NHFS	National health financing strategy
ERPM	Enterprise resource planning and management	NHI	National health insurance
EU	European Union	NHIF	National health insurance fund
EURO	WHO Regional Office Europe	NHP	National health policy
FCV	Fragile, conflict-affected and vulnerable	NHPSP	National health policies, strategies and plans
FP	Focal person	NHSU	National Health Service of Ukraine
GAVI	Global Alliance for Vaccines and Immunization	OPD	Outpatient department
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	OMRS	Overseas referral system
GMP	Good Manufacturing Practice	OOPS	Out-of-pocket spending
GP	General practitioner	PAHO	Pan American Health Organization
GPW	General Programme of Work	PEHS	Package of Essential Health Services
HBS	Household Budget Survey	PFM	Public Finance Management
HeRAMS	Health Resources Availability and Mapping System	PHC	Primary health care
HF	Health financing	PHS	Packages of Health Services
HiAP	Health in All Policies	PICs	Pacific island countries
HMI	Health market inquiry	PM-JAY	Pradhan Mantri Jan Arogya Yojana
HMIS	Health Management Information System	RMNCH	Reproductive, Maternal, Newborn and Child Health
HPG	Health partnership group	SARA	Service availability and readiness assessment
HRH	Human Resources for Health	SDG	Sustainable Development Goal
HSDP	Health sector development plan	SSHIS	State-supported health insurance scheme
HSR	Health sector reform	TA	Technical Assistant/Technical Adviser
HSS	Health system strengthening	UHC	Universal health coverage
HWC	Health and wellness centre	UHI	Universal health insurance
ICD	International Classification of Diseases	VMT	Visiting medical teams
IHIP	Integrated Health Information Platform	WCO	WHO Country Office
IHR	International Health Regulations	WHO	World Health Organization
IHP+	International health partnership	WHE	WHO Health Emergencies Programme
IMCI	Integrated Management of Childhood Illness		

1 Background and introduction

“Promote health, keep the world safe and serve the vulnerable”
WHO 13th General Programme of Work Mission Statement

It is estimated that 3.5 billion people lack access to essential health services worldwide. Even when accessible, services are often of poor quality and unsafe, as well as fragmented and inequitably distributed. They also often fail to address vital public health considerations such as the life course in its entirety, population-specific needs, the growing burden of noncommunicable diseases and the unfinished challenges of communicable diseases. Implementing robust strategies for primary health care is of critical importance to provide universal health coverage (UHC) to 1 billion more people.

UHC allows everyone to receive essential health services without suffering financial hardship. It is therefore a top priority for WHO and a target in the Sustainable Development Goals. Sustainable Development Goal target 3.8 focuses on achieving universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

In working towards Sustainable Development Goal target 3.8, WHO pursues the concept of effective coverage: seeing universal health coverage as an approach to achieve better health and ensuring that services are delivered and that they have their intended results.

UHC is at the top of the health agenda at global and country levels. Its importance is also acknowledged at global health conferences and development forums at all levels. Over the last few decades, health systems strengthening to achieve UHC has gained significant traction. It has triggered debates on complexities and “systems thinking” in various countries to come up with solutions for enhancing access to quality essential health services that are affordable for the general population, including poor and vulnerable groups. This is in line with the Sustainable Development Goals (SDGs), which promote a holistic approach and discourage health systems from promoting disease-specific vertical programmes. Programmes which include the entire range of services

from promoting healthy lifestyles, preventing diseases, and providing curative care to tackling social determinants of health should be embedded in a health system that is led and coordinated by the government. This implies that the role of Ministries of Health (MoH) is set to change in this century: rather than acting as traditional service providers they will become stewards of the health sector, convening the multitude of partners involved to find joint solutions for health priorities and identify actions to improve the health status of the population. In short, their new role will be to deliver the right to health to the citizens of their country.

The year 2018 was marked by the 40th anniversary of the Alma-Ata Declaration. The Astana Declaration on Primary Health Care (PHC), issued on 26 October 2018, reaffirmed that PHC is the cornerstone of a sustainable health system moving toward achieving universal health coverage (UHC) and other health-related SDGs. This has also been recognized in the Global Action Plan for Healthy Lives and Well-Being for All, which is a historic commitment to advance collective action across 11 leading global organizations, with the World Health Organization (WHO) at the helm, to accelerate and monitor progress towards the SDGs. As with many other initiatives, the final plan will be delivered in September 2019 at the United Nations General Assembly, at which there will be a high-level meeting on UHC. Other major events include the G7 and G20 summits, both of which have a health and UHC agenda and will provide further opportunities for promoting and adopting multi-stakeholder collaborative actions.

In a year in which UHC has attracted substantial attention as an issue in global health, it is critically important that global-level “policy dialogue” is informed by evidence-based country practices and lessons learned with regard to strategies that have worked well or less well on the path towards UHC. Conversely, global actions need to be scaled down and translated into national-level priorities. Policy dialogue is an important “steering wheel” for governments to drive evidence-informed decision-making and is also where the UHC Partnership plays a key role.



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UHC-P supports policy dialogue on the development and implementation of national health policies, strategies and plans, with a view to promoting UHC, people-centred care and Health in All Policies in various countries. It aims to function as a bridge to close the gap between global commitments and countrywide implementation at ground level.

Since its inception, the UHC Partnership (UHC-P or “the Partnership”) has undergone significant changes. In late 2011, WHO entered into a collaborative agreement with the European Union (EU), joined shortly thereafter by the Grand Duchy of Luxembourg. In 2017, Irish Aid joined UHC-P. One year later, Japan and France followed, and more donors have expressed their interest in joining UHC-P. Some donors have already taken up observer roles e.g. DFID, South Korea, Bill and Melinda Gates Foundation, Italy, Switzerland, Belgium, to name but a few attendees at the multi-donor coordination committee (MDCC) for UHC-P.

Thanks to new donor commitments, the number of countries increased from 36 in 2017 to 66 in 2018. Support is also provided to all WHO regions: Africa, Americas, Eastern Mediterranean, Europe, South-East Asia and Western Pacific. At the end of 2018, UHC-P has proven to be a notable success story in improving capacities at all WHO Regional Offices to offer strategic assistance to countries in relation to UHC-P management, e.g. follow-up on expenditure, resource allocation, reporting and live monitoring, etc.

In 2019, UHC-P enters a new phase of expansion. The European Union will increase its support through a more extensive collaboration programme with WHO under the title “Health Systems Strengthening for Universal Health Coverage Partnership.” This programme will continue supporting countries currently funded under UHC-P and provide additional focus on the African, Caribbean and Pacific Group of States (ACP). It will also support the strengthening of WHO regional structures and capitalize on existing synergies and harmonized approaches between WHO’s three levels. Luxembourg extended its contribution until end of 2021, allowing for longer-term technical assistance. France, Ireland and UK will continue their support in 2019, and WHO is under discussion with Japan for a possible extension from 2020 onwards. In addition, the United Kingdom shows clear interest in UHC-P activities, as do other observers such as the Bill & Melinda Gates Foundation, Belgium, South Korea, Spain, Italy and Switzerland.

As suggested above, these renewed and extended donor commitments have increased the number of supported countries and broadened the Partnership’s scope of work. This expansion is very timely since this working strategy stands in full alignment with WHO’s 13th General Programme of Work 2019–2023 (GPW13) adopted by Member States at the 71st World Health Assembly in May 2018. The GPW13 is pursuing a triple billion goal with the following components: 1 billion more people benefiting from UHC, 1 billion more people protected from health emergencies, and 1 billion more people enjoying better health and well-being. To meet the objectives and comprehensiveness of GPW13, 2018 was marked by an increasing emphasis being put on strengthening all aspects of the health system, including service delivery, human resources for health, information systems and access to medicines. In addition, greater attention has been given to other areas, such as noncommunicable diseases (NCDs), antimicrobial resistance (AMR), health security, migration and reproductive health. Following the major strategic shifts outlined in GPW13, the support provided to countries is more solidly anchored than ever in strong country ownership by upholding the principles set out by the International Health Partnership (IHP+) for effective development cooperation.

Moreover, health security and emergency preparedness issues have received substantial support through a strategic approach to close collaboration with countries, specifically those which are fragile, conflict-affected and vulnerable (FCV). UHC-P aims to provide joint support to accelerate progress on UHC in countries facing conflicts and protracted crises by: improving disease outbreak coordination at local level, ensuring continuity of service provision to affected populations and areas and strengthening primary health care at district level. This approach—the Humanitarian Development Nexus—also aims to reduce the gap between short-term humanitarian aid and the middle- and longer-term development objectives of health systems strengthening. It is an approach that encourages health professionals to keep in mind the long-term aspects of health system recovery and transition as well as their various developmental phases while working towards alleviating immediate issues in FCV countries. The current



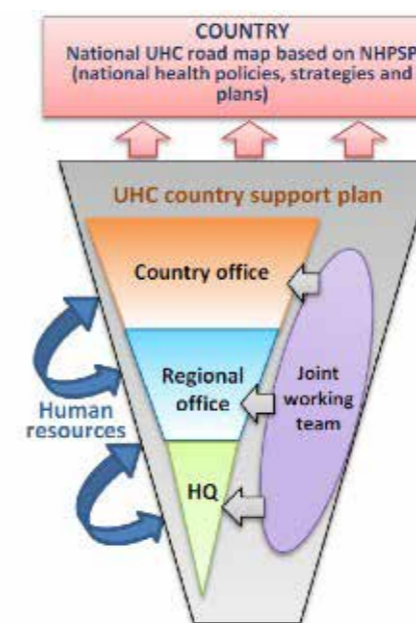
focus countries for implementing this approach are: Central African Republic, Nigeria, South Sudan and Yemen. Implementation support for the above four countries continues on the basis of national priorities, which is made possible by the flexible funding support within UHC-P. In addition, an 18-month piece of work reviewing health financing policy recommendations in FCAS was completed: this extensive synthesis of the evidence combined with a process of debate and discussion is the basis of new guidance on ensuring that health financing policy in FCAS makes health systems more, rather than less, resilient (link) and contributes to discussions around the Humanitarian Development Nexus.

The UHC-P model remains unchanged and reflects the Partnership’s key principles: convening and brokering stakeholders, adopting flexible funding modalities and maintaining a strong presence in countries by means of partnership-funded health systems advisers. Along with specific technical assistance, these advisers provide regular monitoring and transparent accountability. At present, 34 senior health systems advisers are in place while more are being recruited to boost capacity, provide technical expertise on UHC and encourage knowledge exchange between countries, regions and global levels. Despite the ongoing challenge of recruiting a sufficient number of adequately-qualified technical advisers (TAs), UHC-P has nonetheless boosted WHO’s and MOH’s impact in their key roles of convening stakeholders for critical countrywide policy dialogue, brokering discussions around health and related fields, and calling for multisectoral actions. UHC-P has also been able to include development partners within the framework of health sector coordination mechanisms. Furthermore, country-based health systems advisers have been able to respond more effectively to internal ad hoc requests including from the MoH, while developing trust, capacity and technical expertise locally. To pull together efforts and create synergies, country-based health systems advisers are backstopped by WHO regional offices as well as headquarters and remain in close contact with UHC-P partners’ local offices.

Joint Working Team

In order to foster coherence and synergies between different clusters, departments and units at HQ level and across the three levels of the organization, WHO senior management decided to establish a Joint Working Team for UHC (JWT).

JWT is presented in the GPW13¹ as an operational arm to support harmonization and alignment of efforts across various initiatives and coordinate different funding streams and allocations at the global level (see graphic below). JWT has been pivotal in facilitating horizontal and vertical collaboration between WHO’s divisions and departments as well as across the three levels of the organization. WHO UHC country support plans (CSPs) play a very similar role to the roadmaps previously developed in UHC-P-supported countries: they help the MoH, with WHO support, to agree on key UHC-related priorities and activities in line with national priorities. This allows enough flexibility for a shift in priorities due to circumstances, e.g. in the event of political instability, disease outbreak, war or other unforeseen situation. Activities can also be revised and updated according to countries’ needs and progress achieved. The table below lists the principles guiding the JWT’s work.



Principles

- Driven by the 13th GPW
- Bottom-up process
- Country ownership
- Tailored to country priorities
- Flexibility
- Results-oriented process
- Accountability

One of the tools developed by the JWT is the new “live monitoring” mechanism, which became operational in 2018. Its aim is to collect and disseminate information on country progress towards UHC. This initiative enables HQ discussion with WHO Regional Offices on a quarterly basis about activities and results achieved at country level. Live monitoring provides close follow-up of country support plans and is the reporting tool for highlighting activities and products that will be implemented at the national level. It serves as a forum for discussing progress and challenges on a quarterly basis among the three levels of WHO, as well as with relevant WHO technical units, planning units and donors and partners. This working method has encouraged transparency, boosted trust among experts and increased accountability between partners.

The figure below illustrates how live monitoring operates at the country level. The first iteration of the live monitoring mechanism took place in 2018. Based on the information collected, it was concluded that most of the 600 activities implemented with the US\$ 40 million allocated to the 66 countries are directly or indirectly related to primary health care.



1: WHO General Programme of Work 2019–2023, p. 20 - http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf

Multi-donor coordination committee (MDCC)

In recognition of the increased number of donors, the multi-donor coordination committee (MDCC) was set up in 2018 as a visible and transparent information exchange platform to enable discussion on cross-cutting issues and coordinate donor funding towards UHC.

The UHC multi-donor coordination committee is composed of donors who have expressed the desire to support WHO's efforts to implement UHC at the country level with non-earmarked, flexible, bottom-up funding, supporting WHO as one organization across its three levels. The MDCC is under the helm of the JWT at WHO. The multi-donor coordination committee (MDCC) organized two meetings in May and September 2018 to explore better methods for WHO-donor coordination. Discussion ranged across issues, such as: the JWT's roles and responsibilities, the UHC country support plans (CSPs), the web-based live monitoring system and joint reporting—all of which were endorsed by all donors at the MDCC meetings.

MDCC meetings and the new "live monitoring" tool also provide opportunities for UHC-P team members in WHO headquarters, as well as UHC regional focal points, to demonstrate results and milestones achieved through the implementation of the UHC CSPs. Outstanding results from selected countries, e.g. Sudan, have also been highlighted.

Participatory governance mechanisms

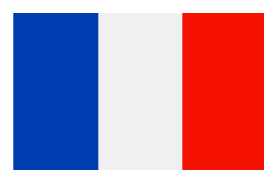
WHO's standard-setting work in participatory governance continued in 2018, with the UHC Partnership supporting case studies on participatory citizen platforms for health (in Iran, Tunisia and France) with the aim of allowing all Member States to share any cross-cutting lessons learned.

In 2019, both the MDCC and live monitoring mechanism, to which all donors are invited, will increase the circulation of information and enrich the understanding of activities implemented, results achieved and challenges faced at country level. Accountability and transparency will continue to be strengthened by means of this monitoring tool.

Multi-donor UHC coordination committee



U.K



France



EU



Ireland



Japan



Luxembourg

More money for WHO UHC country support, more flexibility

**Less transaction costs, less bureaucracy:
"one report", "one monitoring system", "one WHO indicators framework"**

More WHO accountability with well coordinated monitoring



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Measuring results: the realist research approach

It is widely recognized that it is not easy to measure short-term UHC results directly from a WHO technical assistance programme such as UHC-P. Most deliverables are disparate aspects of long-term strategies aiming at covering the population of each target country. There is a need to ensure that the different actions undertaken in each country contribute to UHC. WHO, in close collaboration with its partners, is therefore developing a theory-of-change or chain-of-results approach to assess the influence of UHC-P actions on UHC objectives in different countries.

In this context, the realist research approach offers a novel yet crucial way to make sense of programme outcomes, especially in view of the at times indirect link between UHC-P actions and the intended overall objective of improved health systems performance and better population health. The multi-country realistic research study launched in 2016 came to a close in 2018, with the final analysis report expected in 2019. The realist approach to qualitative

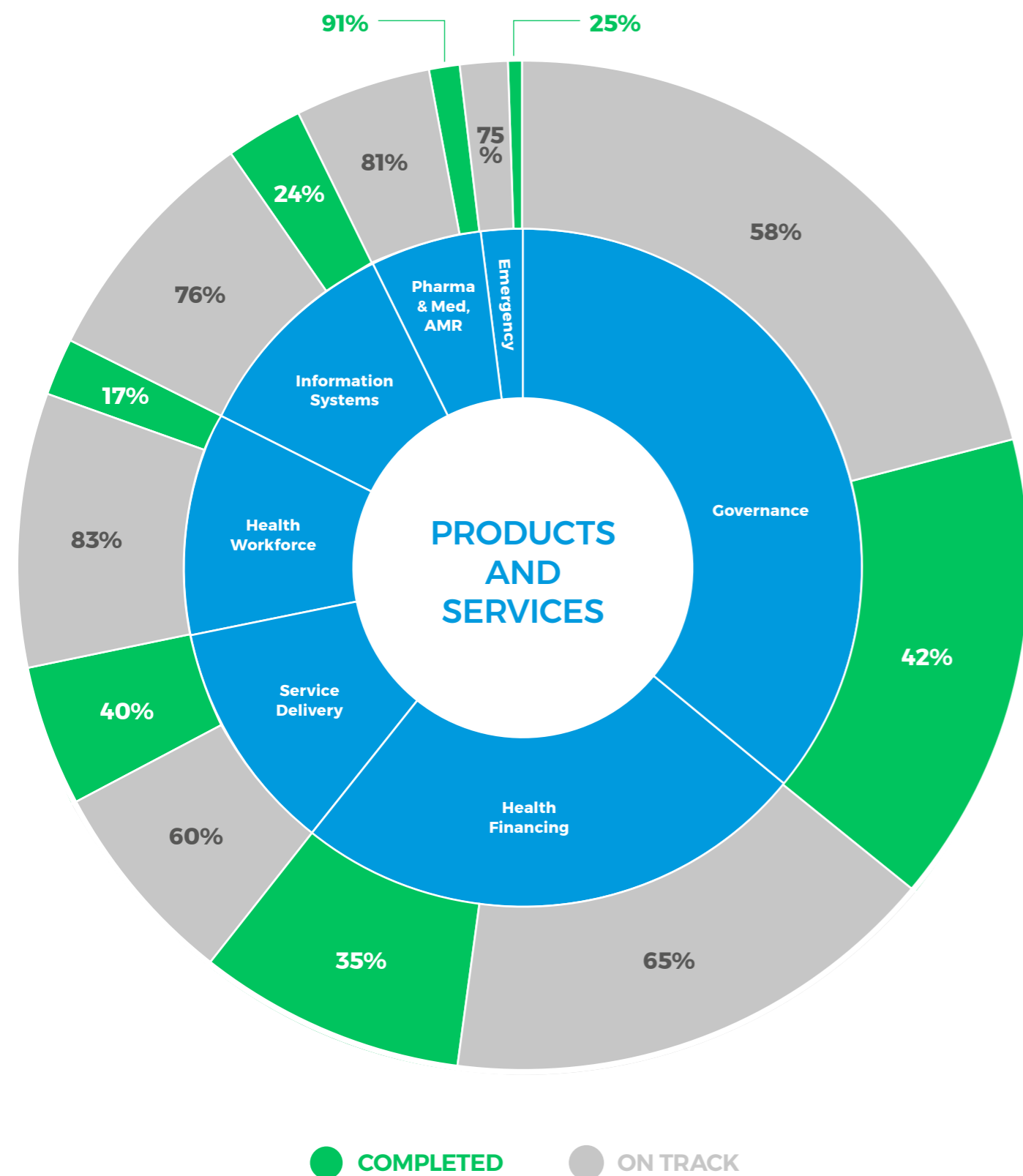
research entails distinguishing the mechanisms (trust, MoH empowerment, shared understanding of governance) which lie behind programme outcomes (alignment of stakeholders, regulatory framework, improved health sector governance, inclusion of actors, etc.). This is combined with an analysis of the contextual factors that may govern these not necessarily immediately-obvious mechanisms.

This study's target countries were Togo, Liberia, Democratic Republic of the Congo, Burkina Faso, Niger and Cabo Verde. The study makes it clear that where there is profound insecurity and poor government leadership, UHC-P support is fundamental. It also shows that to produce results, long-term continuity is needed especially in terms of ensuring political, financial and technical support from all partners and stakeholders. Far more detailed study results will be forthcoming in 2019, and several publications are in preparation to deepen our understanding of the intricacies of health policy dialogue.

UHC-P in a nutshell

Key thematic areas, in line with WHO's 13 GPW: Promote health, keep the world safe, serve the vulnerable

This Figure exemplifies the various areas of work as well as the overall implementation by area. It reflects the variety of actions undertaken in countries and illustrates the fact that some of them might have started late in the year or, most likely, are long term interventions implemented over a period of time that exceeds 1 year.



Countries enrolled in the UHC Partnership, by phases

The Figure below reflects the progression across the UHC-Partnership's 3 phases in terms of inclusion of benefiting countries.



The UHC Partnership's "From Whom To Whom?"

This map shows which country is supported by which donor. Thirty-five percent of the countries receive multiple donor support. This map also covers the countries supported by South Korea, however the report does not reflect all the activities supported by this donor.



Single Partner Support

Multi-Partner Support

- EU & Japan**
 - DRC • Georgia • Jordan • Kyrgyz Rep.
 - Lebanon • Moldova • Morocco • Philippines
 - Sudan • Timor-Leste • Ukraine
- EU & DFID**
 - Burkina Faso • Ethiopia • Sierra Leone • Zambia
- Japan & DFID**
 - Cambodia • Indonesia • Kenya • Nepal
 - Nigeria • Rwanda • Zimbabwe
- Japan & EU & DFID**
 - Afghanistan • Mongolia • Pakistan • Vietnam
- DFID & South Korea**
 - Myanmar
- DFID & South Korea & Lux**
 - Lao PDR
- South Korea & Irish Aid**
 - Tanzania
- France & DFID**
 - Mauritania

Japan

- Belize
- Benin
- CAR
- Dominica
- Egypt
- El Salvador
- Eritrea
- Greece
- Guyana
- Haiti
- India
- Madagascar
- Marshall Islands
- Micronesia
- Paraguay
- Solomon Islands
- Somalia
- Venezuela

European Union

- Burundi
- Chad
- Guinea Bissau
- Guinea
- Liberia
- South Africa
- South Sudan
- Tajikistan
- Togo
- Tunisia
- Yemen

DFID

- Bangladesh
- Cameroon
- Côte d'Ivoire
- Ghana
- Guatemala
- Honduras
- Malawi
- Sri Lanka
- Uganda

Luxembourg

- Cabo Verde
- Mali
- Niger
- Senegal

France

- Congo
- Iran
- Mauritius

Irish Aid

- Mozambique

South Korea

- Peru

UHC-P activities undertaken in 2018 in the 66 partner countries

Country	WHO Region	Income level	Governance	Financing	Service delivery	Health workforce	Health information systems	Medicines & other medical products	Noncommunicable diseases	Communicable diseases	MCH including immunization	Antimicrobial resistance	Health security
Afghanistan	EMRO	Low	■	■									■
Belize	PAHO	Upper middle	■	■		■		■					
Benin	AFRO	Low	■	■	■		■	■			■		
Burkina Faso	AFRO	Low	■	■		■	■	■					
Burundi	AFRO	Low	■	■			■						■
Cambodia	WPRO	Lower middle	■	■	■		■		■				
Cabo Verde	AFRO	Lower middle	■	■			■	■	■				
Central African Republic	AFRO	Low	■	■	■			■					■
Chad	AFRO	Low	■	■	■	■	■						
Congo	AFRO	Lower middle	■	■			■						
Democratic Republic of Congo	AFRO	Low	■	■	■		■						(■)
Dominica	PAHO	Upper middle	■		■			■					
Egypt	EMRO	Lower middle	■	■	■		■						
El Salvador	PAHO	Lower middle	■	■		■	■	■	■	■			
Eritrea	AFRO	Low	■	■	■	■	■	■					(■)
Ethiopia	AFRO	Low	■	■			■						
Georgia	EURO	Lower middle	■	■	■			■	■				
Greece	EURO	High		■	■								
Guinea	AFRO	Low	■	■		■	■						■
Guinea Bissau	AFRO	Low	■	■		■	■						
Guyana	PAHO	Upper middle	■	■	■	■	■	■					
Haiti	PAHO	Low	■	■			■						■
India	SEARO	Lower middle	■	■	■		■					■	
Indonesia	SEARO	Lower middle	■	■									
Iran	EMRO	Upper middle	■	■									
Jordan	EMRO	Lower middle	■	■	■		■		■				
Kenya	AFRO	Lower middle	■	■	■	■	■	■					
Kyrgyzstan	EURO	Lower middle	■	■	■		■	■	■	■			
Lao PDR	WPRO	Lower middle	■	■	■	■	■	■					
Lebanon	EMRO	Upper middle	■	■	■			■					
Liberia	AFRO	Low	■	■	■	■	■	■					
Madagascar	AFRO	Low		■	■	■		■			■		(■)
Mali	AFRO	Low	■	■		■	■						

Country	WHO Region	Income level	Governance	Financing	Service delivery	Health workforce	Health information systems	Medicines & other medical products	Noncommunicable diseases	Communicable diseases	MCH including immunization	Antimicrobial resistance	Health security
Marshall Islands	WPRO	Upper middle			■		■		■	■			
Mauritania	AFRO	Lower middle		■									
Mauritius	AFRO	Upper middle	■	■			■		■				
Micronesia	WPRO	Lower middle			■		■		■	■			
Moldova	EURO	Lower middle	■	■	■			■					
Mongolia	WPRO	Lower middle	■	■			■						
Morocco	EMRO	Lower middle	■	■	■	■							
Mozambique	AFRO	Low	■	■			■				■		
Nepal	SEARO	Low	■	■	■	■						■	
Niger	AFRO	Low	■	■			■						
Nigeria	AFRO	Lower middle	■	■	■	■	■	■				■	■
Pakistan	EMRO	Lower middle	■	■	■	■	■						
Paraguay	PAHO	Upper middle	■		■	■	■	■					
Philippines	WPRO	Lower middle	■	■	■		■						
Rwanda	AFRO	Low	■	■	■	■	■	■				■	
Senegal	AFRO	Low	■	■		■	■						■
Sierra Leone	AFRO	Low	■			■	■	■					
Solomon Islands	WPRO	Lower middle			■		■						
Somalia	EMRO	Low	■		■								■
South Africa	AFRO	Upper middle	■	■									
South Sudan	AFRO	Low	■	■			■						
Sudan	EMRO	Lower middle	■	■	■	■	■						■
Tajikistan	EURO	Lower middle	■	■			■						
Tanzania	AFRO	Low		■			■	■					
Timor-Leste	SEARO	Lower middle	■	■	■	■	■	■					
Togo	AFRO	Low	■	■			■						
Tunisia	EMRO	Lower middle	■	■			■		■				
Ukraine	EURO	Lower middle	■	■	■		■	■	■	■	■		
Venezuela	PAHO	Upper middle											■
Vietnam	WPRO	Lower middle	■	■	■		■		■			■	
Yemen	EMRO	Lower middle	■	■			■						■
Zambia	AFRO	Lower middle	■	■			■					■	■
Zimbabwe	AFRO	Low	■	■	■	■						■	(■)

2

Universal health coverage for one billion more people

The structure of this section follows GPW13 outcomes: its first part (2.1) deals with governance, service delivery and human resources, while its second and third parts (2.2 and 2.3) discuss health financing and medicines respectively.

2.1.: Access to services

This section relates to GPW13 outcome 1.1. and covers governance, coordination mechanisms, service delivery and human resources.

A. National health policies, strategies, and plans (NHPSP) remain a mainstay of good health sector governance for UHC

Since its inception, a key focus of this partnership has been on supporting countries in the development, implementation, monitoring and evaluation of national health policies, strategies and plans, centred around increasing coverage of essential health services, reducing financial hardship and moving towards health equity. This continues to be a major deliverable at country level as countries move through their policy and planning cycles. Indeed, the development process of the NHPSP often galvanises relevant actors in the health sector at country level to commit themselves more fully. This process also draws in new actors and partners from outside the health sector, demonstrating that health remains at the heart of development and prosperity. As in previous years, countries continue to make progress in developing these important strategic documents as a basis for health development and improved health outcomes.

In Cabo Verde, support was provided for the development and validation of the national health strategy 2017-2021 through inclusive policy dialogue, which also led to a monitoring and evaluation plan. The process of developing a new national health policy in **Mozambique** was supported by means of a reference group and provincial consultations. **Guinea-Bissau** shifted from an annual National Health Policy in 2017 to developing its third Health Sector Strategic Plan 2018-2022. WHO technical and financial support

guided the costing exercise using the One Health Tool after it was approved by the steering committee. In Kenya, UHC-P facilitated the completion of the draft **Kenya** Health Sector Strategic and Investment Plan (KHSSP) 2018-2023 and included recommendations made during the Joint Assessment of National Strategies (JANS) review of the draft plan. Counties were also supported to provide inputs to the KHSSP 2018-2023. Alignment of the KHSSP with the UHC agenda ensured a focus on priorities featuring health and devolution. Furthermore, UHC-P supported the development of the Kenya UHC Roadmap 2018-2022, which is currently being piloted in four counties (Kisumu, Machakos, Nyeri and Isiolo).

In Benin, Burundi and Senegal, support was provided to develop the National Strategic Plans 2018-2022, 2018-2023 and 2019-2022, respectively. The planning process in **Benin** was even longer term with the development of a new National Health Policy 2018-2030, as was also the case in **Nepal and Sudan** (2017-2030).

El Salvador conducted an evaluation of its recent health reforms by applying PAHO's framework for monitoring universal health. UHC-P strengthened efforts in **Democratic Republic of the Congo** to readjust the national health strategic plan (PNDS 2016-2020) in line with the UHC framework for action (WHO Regional Office for Africa) and the country development plan 2019-2022. This underlined the country's ambition to adopt UHC measures in spite of the Ebola epidemic, supported by all WHO levels and external partners.



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1 Kyrgyzstan: "Healthy Person - Prosperous Country" National Health Strategy

The UHC Partnership supported the development of the fourth health programme "Healthy Person - Prosperous Country" 2019-2030 led by the Ministry of Health (MoH) of Kyrgyzstan with coordinated "one voice" support from WHO on behalf of all development partners. By stimulating MoH's enthusiasm for strategy development, WHO helped to build up local expertise and MoH programme formulation capacity and encourage ownership and responsibility for implementation. The strategy's goal is to achieve universal health coverage (UHC) by 2030, strengthen primary health care, protect the health of the general population and ensure access to essential quality services without risk of financial hardship for citizens and communities. "Healthy Person - Prosperous Country" was approved by the Kyrgyz Government on 20 December 2018. These successful high-level stakeholder consultations and the strategic goal convinced the Kyrgyz Government to join the International Health Partnership UHC2030 and sign the UN Global Compact at the General Assembly in September 2018. The process has engendered a shift towards evidence-informed, outcome-orientated policies and has strengthened monitoring and evaluation procedures. This comprehensive and open policy dialogue exercise is expected to support intersectoral efforts towards achieving the Sustainable Development Goals (SDGs) in Kyrgyzstan.

The continued challenges in **South Sudan** did not stifle progress in the country. The Health Sector Strategic Plan for 2017-2022 was developed through national and subnational consultations and dialogue processes with various directorates of the Ministry of Health, technical working groups and relevant stakeholders.

Some countries such as **Jordan** have developed UHC policy briefs which have enabled them to conduct focused policy dialogue activities and thus gain further consensus on how to move towards UHC. The establishment of a policy support observatory in **Lebanon** helped foster multi-stakeholder policy dialogue and prepare an evidence-informed health policy for UHC.

In the current decade, the National Health Strategy of the Republic of **Tajikistan** 2010-2020 (NHS 2020) became a milestone in the development of the country's healthcare system and population health. To further the development of its forthcoming health policy 2020-2030, the Tajik Ministry of Health and Social Protection launched a new health policy development process, which includes an assessment of the current strategy's implementation and policy coherence. The draft national health policy in **Eritrea** underwent a multisectoral consultative process with stakeholders at an intensive workshop at which representatives of the relevant ministries, Ministry of Health staff and UN agencies were all present. Pressing issues were raised and feedback given to the steering committee.



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While national-level planning is crucial to confirm the goals a country wishes to adopt, regional - and district-level planning is just as vital.

B. UHC-P ensures bottom-up decentralized planning as a necessary complement to more top-down NHPSPs

While national-level planning is crucial to confirm the goals a country wishes to adopt, regional- and district-level planning is just as vital for the translation of national directives into operational guides and ensures that local-level planning and procedures outcomes feed back to the national level. This allows for more detailed actions and considers local settings and the various partners involved in delivering services at subnational levels.

In Greece, UHC-P supported activities to integrate services at the community level and pilot an integrated model of service provision in one region (Ioannina). Another region has expressed interest, and efforts are under way to develop an action plan that follows this initial approach. A national patient experience/user satisfaction survey has also been conducted in the network of community-based primary health care services. The evidence base generated will help further scale up of the primary health care model to extend the provision of quality services to the general population.

In Pakistan, the Baluchistan Health Policy and Strategy 2018-2023 was developed with UHC-P support. High-level policy dialogue also contributed to the development of strategic policies for the Punjab, Khyber Pakhtunkhwa and Sindh provinces.

In Niger, UHC-P assistance led to elaboration of the national hospital strategy and district health plans.

Cabo Verde validated its national strategic hospital plan and regional and health district plans. Continued UHC-P technical support in **Liberia** brought subnational plans in line with national priorities.

Support to Sierra Leone included the development of district health plans in Bonthe and Kambia. Capacity was further boosted through training programmes in leadership and management skills across all 14 districts for district health office staff. The national development plan is currently being drafted and will guide sector strategies to increase access to effective and high-quality essential health services.

In Togo, UHC-P provides ongoing support for the development and revision of annual district operational plans with a view to strengthening service delivery.

In Burundi, rapid evaluations were conducted in 17 health districts to improve UHC service delivery. These activities underscore the need to look beyond strategic planning at national level to guarantee that planning activities are adapted to the lower tiers of the health system, thereby guiding service delivery at the facility level. UHC Partnership resources supported policy dialogue processes to develop regional level operational plans in **Mali**, translating national directives for smoother implementation. Similar planning activities were conducted in Burkina Faso in the Boucle du Mouhoun region.

Guinea has updated its operational planning guidelines at the regional, prefectural and community levels in accordance with the UHC framework for action and SDGs. UHC-P supported the development of the community multisector Local Development Plans (PAO) 2018-2019. Planning guidelines were updated at regional, prefecture and community level, following the recommendations of the framework. To help put this into practice, assistance was provided for budget decentralization in 2018 and 2019. Furthermore, a common fund has been created in Nzérékoré district to support implementation of the district operational action plan, including the procurement of essential services.

In Guinea Bissau, WHO worked with relevant partners on “Terra Ranka,” the country’s strategic and operational plan for 2015-2020, aligning it with the SDGs. This exercise included reconfiguring all of the plan’s health sector indicators.

South Africa has made great strides in health systems strengthening with several initiatives at the national, provincial and district levels. WHO collaborated with the University of Pretoria to develop draft reports of 10 user case studies, best practices on health systems strengthening, and various health programmes at the national and provincial levels.

The launch of India’s UHC-orientated health scheme “Ayushman Bharat” in April 2018 aims to increase access to comprehensive primary health care through 150 000 upgraded health and wellness centres (HWC) by 2022. UHC-P provided technical support to operationalize the programme and produce HWC operational guidelines. The guidelines are widely available and inform district and PHC staff about the technical and governance aspects of the health and wellness centres, including their expanded public health functions (see box below).

In Mongolia, efforts were made in 2018 to improve the delivery of integrated, high-quality PHC services to disadvantaged populations in selected remote areas through a project expanding the use of mobile health technology for PHC/UHC at two sites. These efforts will continue at 14 sites in 2019. Recognizing the need to adopt new technologies, Guyana conducted a workshop to develop a national e-health strategy toolkit.

Following Hurricane Maria in Dominica in 2017, all health districts underwent an assessment of their health care delivery services. Results of this assessment—including key findings and recommendations—have been presented to the national health authorities. Once a decision is reached regarding these recommendations, health system priorities will be redefined and a national plan developed for their implementation

2 India: Rolling out health and wellness centres to provide comprehensive PHC

The launch of the government’s UHC flagship programme Ayushman Bharat in April 2018 will increase access to comprehensive primary health care through 150 000 upgraded health and wellness centres (HWC) by 2022. This programme has two components: the National Health Protection Scheme (which provides financial protection to 0.5 billion people) and the health and wellness centres themselves (which bring health services closer to people).

UHC-P provided technical support to operationalize the programme and develop the widely available HWC operational guidelines. These inform district and PHC staff about the technical and governance aspects of the centres, including their expanded public health functions. Other outputs included technical briefs on performance-based financing, which were developed through pooled international experience and policy options to inform HWC staff of decisions about performance-based incentives. State-level support to strengthen the health system was provided to roll-out HWCs in two states and three priority districts with poor health outcomes and persistent inequities with respect to their large tribal communities.

C. Ensuring and enabling a strong legal environment for UHC - an often-forgotten aspect of countries' UHC efforts

An important element of WHO's work in supporting countries is helping them establish a more enabling legal environment in which UHC can guarantee citizens' rights to health. With the support of the UHC Partnership, countries have begun addressing the legal infrastructure which underpins existing policies and strategies. Given that the legal environment in every country is different, these laws and public acts may differ in their expression while remaining true to the ultimate goal of UHC.

In the Philippines, support was provided to develop UHC laws that propose changes in local health systems governance while maintaining progress towards health service devolution. Support measures involved facilitation at public hearings and cross-party political debates. Technical assistance was also provided for discussions at the Senate and House of Representatives.

UHC-P provided technical support for the development, finalization and technical validation of the UHC law in **Chad**, resulting in a legal framework that expedites UHC activities. Support was provided to the various decision-making bodies including the Council of Ministers, which is chaired by the President of the Republic. The law is expected to be endorsed by Parliament in 2019. Its adoption by the National Assembly will enable most ongoing activities to be completed, including facility construction work, finance legislation integrating the UHC line item within the budget, and the recruitment and assignment of a minimum pool of technical staff to provide services.

In Ukraine, WHO is supporting the institutional adoption of a new public health legal framework by providing support and technical assistance for a draft public health law.

Both Eritrea and Nepal have also taken steps to introduce legislation on recent UHC actions in the health sector. In Eritrea, this has coincided with the development of the country's national health policy, ensuring future alignment.

Morocco has started a noteworthy policy dialogue with its parliamentarians to raise awareness of citizen involvement in health policy; this dialogue is encouraged and supported by WHO.

Several countries have also taken steps to introduce legislation specifically related to health insurance schemes. In **Egypt**, following enactment of the universal health insurance (UHI) law in late 2017, the government is being encouraged to make the law fully operational. This has included a review of existing laws and regulations to determine whether they are consistent with the UHI law. UHC-P has also helped draft policy documents to explore how much organizational reform and future adjustment of MoH roles would be required for UHI law's complete implementation.

South Africa's cabinet has voted to approve the country's draft national health insurance (NHI) bill and transform its

policy recommendations into legislation. UHC-P supported review of these documents, in particular the NHI bill with which WHO has been involved since its concept stage. Similar support has been provided in Mali for the development and adoption of the UHI law to sustain the country's health insurance scheme.

In Kenya, support was provided to obtain an expert report on the legal aspects of health financing. The UHC legal subcommittee has continued to identify the legal and regulatory reforms needed to allow for UHC implementation. These include fast-tracking the endorsement of the Health Act 2017, the development of several draft bills and the review of relevant existing laws. With a view to scaling up UHC, the cabinet secretary launched a Health Financing Reform Panel in February 2019 to provide advice on requisite health financing reforms. WHO has initiated informal discussions with major actors in this process to identify what kind of support is needed.

Following extensive consultations with and guidance from WHO, the health financing concept was approved by the Cabinet of Ministers of **Ukraine** in 2016, and Parliament passed a new health financing law along with a package of related by-laws in 2017. This array of documents has established a strong legal and political framework to implement new health financing arrangements starting in 2018, with ongoing support from UHC-P.

In Cabo Verde, support has been provided to revise laws on medical prescription and pharmaceutical regulations. Both were passed, and the country is now in the process of revising its basic health law; this will continue in 2019 with UHC-P support.

An important element of WHO's work in supporting countries is helping them establish a more enabling legal environment in which UHC can guarantee citizens' rights to health.



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D. UHC-P's strengthened coordination mechanism leads to more efficient partnerships including with civil society and the private sector

UHC-P strives for effective and coherent coordination with all its stakeholders in order to maximize the use of resources and expertise and reap the greatest benefits at country level. This section shows the ways in which UHC-P has made a greater commitment to stakeholder management by conducting reviews of existing structures, increasing the number of coordination meetings and improving the integration of private sector partners and civil society organizations.

Since signing the national compact in 2017, **Liberia** continues to implement it. Actions from the Health Sector Steering Committee have become more concrete and accountable thanks to timely quarterly reports. Joint assessments and reports, including a joint financial management assessment, have also been drafted and developed, and joint programme coordination units have been set up. Activities in **Niger**, **Jordan** and **Togo** have included developing and signing new national compacts, with Niger undertaking added efforts to include representatives from civil society and the private sector in national gatherings and meetings for health systems strengthening, partner coordination and UHC.

In **Sudan**, a roadmap was developed applying a "Health in All Policies" approach; it has been endorsed by the Cabinet and the national health coordination committee headed by the President. Twenty-two national ministers have subsequently signed commitments that oblige them to adopt the HiAP approach in their respective sectors.

Building on its experience of hosting large national forums, **South Africa** held a "Presidential Health Summit" specifically for UHC. The President of South Africa and several Ministers with portfolios related to the health sector engaged directly with stakeholders with the aim of accelerating UHC in the country. The key objectives of the Presidential Health Summit was to discuss challenges facing the health sector and to come to a consensus on a roadmap offering solutions for South Africa's progress towards UHC through implementing national health insurance (NHI). All stakeholders unanimously agreed on the need for NHI and a unified health system to achieve UHC in South Africa.

In **India**, meetings of the Health Partners Forum, chaired by WHO, helped to stimulate dialogue around UHC and the government's Ayushman Bharat programme; these discussions were useful in promoting combined efforts and avoiding duplication of partner initiatives.

Mozambique reviewed its policy dialogue structures and coordination mechanisms, which are hampered due to the many different partners active in the sector. UHC-P facilitated the process by providing technical support for the review and by coordinating the reference group of partners and MoH. This process will be completed in 2019.

South Sudan has also taken steps to revitalize its health sector coordination. The WHO Representative has been nominated as the platform co-convener and chair and

WHO contributed to the revised terms of reference. The cadre de partenariat pour la santé et développement (CPSD - Partnership Framework for Health and Development) was evaluated in **Burundi** at national and regional levels. Subsequent recommendations called for renewed efforts at policy dialogue between the authorities and partners. An implementation status review of UHC-orientated activities was also carried out in order to provide data for further mobilization of funds.

In **Chad**, **Timor-Leste**, **Mali** and **Democratic Republic of the Congo**, UHC-P continues to support the national health steering committees (or equivalent) in their routine meetings and activities. In **Chad**, the Partnership facilitated bi-monthly meetings between agency and mission heads which focused on resource mobilization for the joint UNDAF workplan. In Timor-Leste, a procedural manual has been drafted to clarify the roles and responsibilities of the steering committee and awaits validation. Policy dialogue helped decisions to be made at the platforms of the Programme on Social and Health Development (PRODESS) in **Mali**. The work of the coordinating bodies set up by technical and financial partners in the health sector was strengthened through increased focus on key areas of mutual interest and on the decision-making process under strong WHO leadership. The ultimate aim is to ensure that all actors are fully cooperating.

New relationships between MoH and WHO have been established in **Senegal**, buttressing WHO's role in the country. With the support of the Partnership, actors in the country increasingly recognize the need to commit to greater coordination, impetus and convergence when implementing programmes. A major benefit is improved health sector governance, and WHO is increasingly seen as a trusted partner for initiating policy dialogue and providing leadership and technical support.

In **Greece**, policy dialogue events organized at central and local level contributed to improved coordination and consensus building between all the stakeholders involved in primary health care (PHC) reform and other initiatives towards UHC. The MoH pledged to organize similar events in all regions countrywide, as well as regular yearly meetings of the entire primary health care network. Moreover, technical assistance on PHC financing and contracting—only initiated recently—has already raised awareness among health sector policy-makers on the crucial importance of their direct involvement in the budgeting process and on the need for close coordination and negotiation with the Ministry of Finance to ensure adequate funding for the sector. Once coordination has been established, it is likely to aid discussions on funding for future priority health programmes.

Madagascar has strengthened the manner in which its National Social Security Fund for Health is run and stepped up communication efforts for UHC implementation in the pilot district of Vatohandry. UHC-P also provided backing for reinforcement of the UHC management framework platform (cellule d'appui), which coordinates the application of the UHC agenda. This will allow a more harmonized approach to UHC in Madagascar, which with strong political commitment is currently in the early stages of moving towards UHC.

Eritrea, as part of its transformation agenda, has asked UN agencies to submit integrated annual plans. This ensures SDG coordination and further helps to achieve impact at country level. Multisectoral meetings with UN agencies and governmental bodies are also being held regularly to assess progress.

In **Burkina Faso**, coordination with partners in the field has vastly improved. UHC-P resources have also made it possible to build or strengthen partnerships in various sectors with other technical and financial partners including the World Bank, GFATM, GAVI and the EU Delegation. In addition, more pertinent and frequent dialogue mediated by the Partnership has encouraged actors from other relevant sectors to become involved, demonstrating that cross-sectoral policies can have consequences on both sides of the dialogue and thus contribute to the SDGs as a whole.

In **Lao People's Democratic Republic**, UHC-P offered to strengthen collaboration and coordination between partner activities. These efforts included midterm programme review with JICA and UNDP to allow greater integration of health sector recommendations in the National and Socioeconomic Development Plan, working with the World Bank, the Asian Development Bank and the Swiss Red Cross on the National Health Insurance benefit package and collaborating with GAVI on DHIS2.

Countries have also taken steps to explore how the private sector might contribute to health. In **Morocco**, an assessment is being carried out in the private sector on topics such as regulation, contracting, financing and competition between public and private providers. A national consultative commission to coordinate policy dialogue between public and private sectors is envisaged for 2019. At the same time, two MoH members from **Mali** received WHO support to undergo a training programme in public-private partnerships in Morocco to study the potential for PPPs in Mali. **Jordan** has also begun investigating different models of public-private partnerships in order to further improve health service delivery. In **Rwanda**, a market analysis of private sector engagement is under way to provide a basis for agreements.

Civil society engagement in **India** has been strengthened by WHO support for informal UHC discussions and a planned meeting between civil society organizations (CSOs) and The Elders, led by Gro Brundtland, during a mission to India in September 2019. CSOs shared their concerns about access to health care for the poor, including the difficulties experienced by those in the informal sector. In **Mauritius**, a CSO mapping exercise was conducted to pinpoint exactly which organizations are active in the different health fields.

With regards to South-South collaboration, the advantages of collaboration and joint learning processes across countries are illustrated by a number of examples. In **Sierra Leone**, continued technical support has been provided to the health systems strengthening (HSS) working group, via the offices of the Chief Medical Officer (CMO), Deputy CMO and the various directors of policy, planning, information, human resources for health and drug and medical supplies. Similar support has been provided to the health information

system working group, of which WHO is the co-chair, and the mechanisms of the health development partners' network.

Support has also been provided to the Ministry of Health to work in tandem with the **Ghana** health service through South-South Cooperation to provide eight master tutors in governance, leadership and management. The aim is to increase the capacity of the district health management teams' 97 staff members and that of district hospitals across 14 districts. Four staff members of the Ministry of Health were also trained to be future trainers. Seven participants from each district—a mix of district medical officers, medical superintendents, hospital matrons, district sisters, district pharmacists, HRH officers and finance officers—underwent a programme of classroom pedagogy, fieldwork, practicum, presentation and reporting skills. This activity is a good example of the benefits of peer learning between countries.

A similar activity was conducted in **Moldova**, where the institutional capacities of the national public health agency were reinforced by a study visit to Slovenia. The participants included policy-makers and senior managers.

An analysis was carried out in **Iran** as part of a joint MoH-WHO publication which assessed the Iranian health governance and financing system. This book, "Iran from PHC to UHC: the challenge of transformation," is due to be launched at the World Health Assembly in May 2019. In **Tunisia**, data collection was completed in 2018, and is currently being analysed.

In **France**, activities falling under the concept of health democracy (démocratie sanitaire) are being analysed conjointly with the Paris University of Applied Sciences (Sciences Po). This large-scale review includes analysis of mainly internal government documents, observation notes from the 2018 National Bioethics Consultation (Etats Généraux de la Bioéthique) and about 20 key informant interviews. The review contributes to the evidence-building process that informs how participatory governance is developed in UHC-P countries.

WHO also established a syllabus in partnership with Sciences Po on the topic of "deliberative democracy in health," which was piloted as a student course in autumn 2018. This work will be incorporated into training material for WHO and MoH staff on participatory health governance.

Finally, the UHC-P supported an official side-event at the 2018 World Health Assembly under the banner "People's voice and social participation: key roles and contributions to UHC." This type of event is an important advocacy tool to ensure that health governance remains an integral part of the UHC discourse.

E. Primary health care as an engine for UHC: a re-think about essential health service packages is increasingly becoming a focus as countries move towards UHC

UHC has three main dimensions: population, services and direct costs to the people. When these dimensions are fully extended, coverage provides services to a population which has not yet been reached, includes health services that were not yet generally accessible and reduces shared costs and fees while maintaining health services. Development of a package of essential health services therefore remains one of the major roles of the UHC Partnership (UHC-P).

Through technical and financial assistance, UHC-P support has enabled countries to develop essential health packages that address the most pressing needs of their populations including the most vulnerable, along with a more extensive set of services. **Chad, Cabo Verde, Democratic Republic of the Congo, Mongolia, Nepal, Lao People's Democratic Republic** and the **Philippines** have all successfully developed essential health packages.

In **Guinea and Benin**, UHC-P continued support was extended to national authorities to allow them to define their essential health packages, across the life course. Similarly, in **South Sudan**, the basic package of health and nutrition services was revised after its validation by stakeholders and awaits ministerial endorsement in 2019. WHO, through the UHC Partnership, was a key partner in redefining health service and human resource requirements for the essential health services package in **Timor-Leste**. In **Ukraine**, a new state-guaranteed benefit package is under development with UHC-P support.

Eritrea's ambition to reach its vulnerable populations is reflected by specific measures which have been integrated into its newly developed essential health package. In **Kenya**, a UHC advisory panel helped revise the essential health package. The panel provided advice on its design, affordability and responsiveness for UHC delivery. The package is being piloted in four counties prior to country-wide rollout.

Ethiopia has received support to develop a health financing policy, which includes revisions to the essential health service package (EHSP) together with related capacity building for staff from the Federal Ministry of Health (FMOH). The FMOH has developed a health financing strategy which is not yet fully enacted. As part of this process, WHO supported the EHSP revision process, focusing in particular on the inclusion of the cost-effectiveness of service interventions as a criterion in the revision process. By focusing public spending on a well-defined EHSP, efficiency and quality in spending is expected to improve, with enhanced transparency and clarity for the population regarding entitlements expected to increase access. Ensuring the EHSP's coherence with the other key strategy of scaling up CBHI and introducing SHI (in terms of policies on benefit entitlements, copays, provider payment mechanisms, etc.) is central to ensuring the best use of limited resources and maximizing progress to UHC.

Sri Lanka has received support for the development of an Essential Service Package (ESP) as part of comprehensive

reforms to reorganize the PHC service delivery model. The government is reorganizing its PHC system to improve effective coverage, equitable access and financial risk protection for the population. WHO is facilitating this PHC service delivery model reform, using a redefinition of the ESP as an entry point into the new 'clustering' system, which will serve as the base of the new PHC planning and management paradigm. ESP development is fundamental to this PHC reorganization, with system changes needed in terms of: laboratory service strengthening, availability of essential medicines and commodities, adequate and capable health workforce, referral pathways, electronic patient registry, supervision and monitoring of PHC services.

Further support to the PHC service delivery model reform process has been provided through a requested cross-programmatic efficiency analysis. The analysis had a focus on specific disease programs (e.g. HIV, TB, NCDs) with respect to the way they are governed and financed as well as how they deliver services and generate and use inputs. Such analysis is pertinent to the current reform context and can contribute to its success by identifying bottlenecks inhibiting the implementation of the PHC reorientation. Analysing the dynamic between curative and preventive sub-systems contributes to the overall ESP feasibility analysis. One objective is to incorporate HIV and TB interventions into the NCD-oriented system redesign. This contributes directly to ongoing service delivery model reforms and informs the reform process by providing evidence on current organizational structures (including funding flows) by assessing readiness to accommodate the necessary changes.

UHC has three main dimensions: population, services and direct costs to the people.

3 Greece: scaling up the PHC model

The newly created community based PHC services (TOMYs) are staffed with multidisciplinary teams (family doctors, nurses and social workers) and provide a comprehensive package of services, including disease prevention, health promotion, diagnosis, treatment, monitoring and care. They are expected to have a significant impact not only on tackling noncommunicable diseases and chronic conditions but also on addressing social and other determinants of health in the community.

UHC-P has supported the ongoing PHC reform by providing technical guidance on how to improve integrated care and develop a policy brief for better referral mechanisms at the community level. At the end of February 2019, 113 TOMYs were operating all over Greece, with over 300 000 registered beneficiaries and about 500 000 network visits.

A nationwide patient experience/user satisfaction survey was conducted in this PHC service network and solid evidence is currently being generated on satisfaction with TOMYs. This evidence is crucial for further improvements, the expansion of this PHC model, and for continuously increasing both the number and quality of services available to the population. Policy dialogue events organized at central and local levels have helped to improve coordination and build consensus between all the stakeholders involved in PHC reform and other UHC initiatives. Technical assistance on PHC financing and contracting has already raised awareness among health sector policy-makers about the importance of their direct involvement in the budget process and the need for close coordination and negotiations with the Ministry of Finance to ensure adequate funding for the health sector generally and for PHC in particular in order to vouchsafe the long-term sustainability of this newly created network of community-based PHC services.

Egypt, Jordan, Somalia and **Pakistan** are developing their respective UHC priority benefit packages following the recommendations of the third edition of the Disease Control Priorities publication (DCP3).² In **Egypt**, the UHC priority benefit package will be integrated into the service package provided by the new social health insurance scheme established by the law on universal health insurance (UHI). In **Jordan**, policy dialogue between the Ministry of Health and stakeholders is generating a consensus for upgrading the civil insurance funds' benefit package. **Pakistan** identified four intervention priority areas in its benefit package, including maternal and child health, communicable diseases, NCDs and intersectoral collaboration. **El Salvador** is discussing a draft implementation plan for a comprehensive health service benefit plan. Similarly, **Guyana** drafted and estimated the cost of a national plan to introduce an explicit package of essential health services (PEHS). WHO, with UHC-P support, is encouraging the MoH to identify priority activities and develop a monitoring and evaluation plan to ensure their implementation.

Pacific island countries (PICs) are also working to provide access to specialized yet essential health services for their populations. This feat is being accomplished through collective efforts by means of sub regional mechanisms and platforms for developing and strengthening policies to set up overseas medical referral systems (OMRS) and visiting medical teams (VMTs). The overarching goal is to build upon existing cooperative ventures between Pacific island countries in order to improve cost-benefit ratios, achieve savings and ultimately improve access to quality care as an integral part of UHC.

Some countries put more emphasis on the quality of health services. In **Burkina Faso**, the UHC Partnership supported the development and implementation of a national strategy for person-centered health care, which seeks to be high quality, safe and integrated. This ambition gives some idea of the interventions and processes which will be required for health care delivery. Support in **Cabo Verde** and **Niger** also led to the development of national strategic plans for hospitals. In terms of service delivery, these plans will require services to be provided at different levels of the health system.

The Partnership assisted in developing and introducing a national health care quality strategy in **Belarus**. This strategy, based on WHO methods for improving the quality of care and best available evidence, proposes introducing a series of regulatory and legislative procedures. It also envisages setting up the appropriate structural and functional components to enable a comprehensive system of health care quality governance. It was successfully introduced only due to the considerable efforts on behalf of WHO and the Belarus MoH to ensure policy dialogue and build consensus among key national stakeholders and policy-makers about the principal aspects of quality of care.

Finally, in **Paraguay**, it was the government which took the initiative to inaugurate the health service quality strategy with the introduction of a virtual campus offering a public course on quality in health care. A draft strategy document is ready and currently under review by the authorities.

2: <http://dcp-3.org/>

4 UHC-P as a showcase for PHC reform in the current context

A decade ago, WHO published the World Health Report 2008: "Primary Health Care - Now More Than Ever," which was dedicated to celebrating the 30th anniversary of the Declaration of Alma-Ata. In this report, WHO highlighted that the integration of PHC into national policy and health development programmes had been deepened and expanded to cover broader aspects of global health agendas over the past 30 years. The report suggested that health systems reforms should not rely solely on scientific evidence but also integrate the voices of the people in decision-making processes and be reactive to social change. Furthermore, the report stressed that the elaboration of PHC policy should go beyond top-down and command-and-control approaches and expand into inclusive and participatory dialogue with multiple stakeholders.

The World Health Report 2008 listed examples to show how the perceptions of the global health community had shifted with regards to PHC within three decades (Table 1). The left-hand column shows key features of traditional PHC efforts during its inception in the 1970s. The right-hand column describes the corresponding features of current PHC practices and policies, which put more emphasis on an equitable, people-centred and integrated PHC delivered through a multisectoral approach.

Although UHC-P was not established to focus solely on PHC, it was evident from the 2018 country reports that numerous UHC-P supported activities were in line with the concept of modernized PHC. For instance, Egypt and the Philippines legislated UHC laws aiming at comprehensive reform of their national health systems, which included institutionalizing the family practice model with a gatekeeping function for appropriate coordination of care. Benin, Burundi, Nepal, Senegal, Timor-Leste and Zambia developed national strategies to boost the numbers of qualified health professionals including PHC providers. Guinea partially devolved its health budget to its regional governments to speed up implementation of its multisectoral local development plans (PAOs) 2018–2019. In Greece, patient experiences of PHC were surveyed across the country so that the results could be reflected in the new integrated service delivery model. At the same time, the Greek MoH began a multi-stakeholder policy dialogue on PHC reform at national and regional levels. Pakistan extended the range of services in its benefit package to cover not only maternal and child health and selected communicable diseases but also NCDs and multisectoral interventions for health. Along with Tunisia, Morocco and Niger began efforts to involve civil society groups in health policy-making. For their part, Jordan, Mali, Morocco and Rwanda sought better regulation of private providers in the health sector.

The global PHC movement and UHC support efforts at global and country level will be accelerated following the adoption of the 2018 Astana Declaration on Primary Health Care.

Table 1 How experience has shifted the focus of the PHC movement

EARLY ATTEMPTS AT IMPLEMENTING PHC	CURRENT CONCERNS OF PHC REFORMS
Extended access to a basic package of health interventions and essential drugs for the rural poor	Transformation and regulation of existing health systems, aiming for universal access and social health protection
Main focus on mother and child health	Dealing with the health of everyone in the community
Focus on a small number of selected diseases, primarily infectious and acute	A comprehensive response to people's expectations and needs, spanning the range of risks and illnesses
Improvement of hygiene, water, sanitation and health education at village level	Promotion of healthier lifestyles and mitigation of the health effects of social and environmental hazards
Simple technology for volunteer, non-professional community health workers	Teams of health workers facilitating access to and appropriate use of technology and medicines
Participate to mobilise local resources and health-centre management through local health committees	Institutionalized participation of civil society in policy dialogue and accountability mechanisms
Government-funded and delivered services with a centralized top-down management	Pluralistic health systems operating in a globalized context
Management of growing scarcity and downsizing	Guiding the growth of resources for health towards Universal health coverage
Bilateral aid and technical assistance	Global solidarity and joint learning
Primary care as the antithesis of the hospital	Primary care as a coordinator of a comprehensive response at all levels
PHC is cheap and requires only a modest investment	PHC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives

(Reprinted from the World Health Report 2008: "Primary Health Care - Now More Than Ever" (p. xv). Geneva: World Health Organization; 2008)

F. UHC-P emphasises the importance of human resources for health strategies, studies and workforce capacity building as the backbone of efficient progress towards UHC

Efficient health service delivery requires countries to ensure that health personnel are adequately trained, motivated and allocated, and that they have the means to deliver quality and safe health care. In this endeavour, the development of **national human resources for health (HRH) strategies**, based on solid evidence, can serve as a guide for how human resources ought to be managed within the health sector. HRH capacity should be regularly developed, monitored and tested, and opportunities for peer learning provided so that knowledge and experiences can be shared.

Countries are taking steps to ensure that evidence guides the development of their HRH strategies. Whereas **Guinea, India** and **Burkina Faso** are currently conducting critical health labour market analyses to assess the situation and identify gaps in HRH (in terms of numbers, technical capacities and distribution, particularly in rural areas), **Sierra Leone** and **Rwanda** have already published their respective health labour market analyses. In **Morocco**, two reports on HRH analysis of the labour market and a job satisfaction survey in the health workforce have been finalized. In the latter case, WHO specifically helped to strengthen the ability of the national survey team to measure work satisfaction and sources of motivation among healthcare professionals. Recommendations to improve job satisfaction were adopted for implementation by national authorities. Furthermore, the **Indian nurse migration study** identified the “push” and “pull” factors which influence the migratory patterns underlying nurse recruitment in the state of Kerala, allowing for appropriate strategies to be planned to address these factors in line with the WHO code of conduct for health workforce migration.

Countries continued to make progress in the development of HRH strategies. This was the case in **Benin, Burundi, Zambia, Nepal, Senegal** and **Timor-Leste**, all of which have validated or produced near-final versions of their HRH strategies. In Timor-Leste, an intersectoral taskforce was established for this activity, highlighting the overarching nature of the HRH strategy. Developing such strategies also spurs related activities, as in **Benin**, where the country's HRH study on mobilizing qualified human resources emphasized the importance of having a sufficient number of qualified personnel within the general state budget's remit. The study also proposed some possible solutions to this issue involving cooperation with partners. In **Burkina Faso**, a study was conducted on efficiency in HRH management within a context of budgetary constraints. UHC-P also supported the development of a human resources investment plan.

In **Paraguay**, an HRH situation analysis was drawn up following three strategic workshops at which analysis findings were discussed. The study's conclusions will shape the development of a national HRH action plan. As part of its capacity-strengthening efforts, UHC-P is also supporting MoH efforts to relaunch its HRH observatory webpage as an information base to provide data for effective HRH planning.

Provincial HRH strategies have also been developed in the Sindh, Baluchistan, Khyber Pakhtunkhwa and Punjab provinces in **Pakistan** with the support of UHC-P in line with the national HRH vision 2018–2030. **Morocco**, using results obtained from the aforementioned reports, and **Sudan** are currently in the process of developing such strategies. **India** developed its HRH plan in selected priority districts with large tribal communities to have the tools to come up with creative HRH solutions to address critical gaps affecting hard-to-reach and geographically disadvantaged areas.

5 Belize: strengthening human resources for health in Belize

Belize's “Human Resources for Universal Health Strategic Plan 2019–2024” is a roadmap to ensure that health workers have the right personnel profiles and skills, are available where and when they are needed, and are motivated to provide quality care. The Belize plan draws attention to inequalities in the availability, distribution and quality of health workers and sets out five strategic objectives and activities that will be consolidated under Ministry of Health (MoH) leadership. They will focus on setting up a human resources unit within MoH as well as personnel training, skill sets, better employment and working conditions, standardized education and professional practices, and needs-based distribution of personnel among the general population for the goal of universal health.

The Pan American Health Organization organized a workshop, “Strengthening Human Resources for Health (HRH) Planning for the Implementation of Belize's HRH Strategic Plan,” which took place in Belize City from 26 to 28 February 2019. The goal of the initiative was to enhance the capacity of participants to develop effective health workforce strategies and interventions. Attendees included decision-makers and project managers involved in HRH from the Belize MoH, Ministry of Public Service, Ministry of Education, Ministry of Finance, Foreign Affairs, academia and related sectors. The focus of the workshop was to support the country's HRH strategic plan by helping participants gain a better understanding of their system and its opportunities and risks. The workshop resulted in a roadmap setting out specific steps for effective and efficient implementation of the national HRH Strategic Plan and identified innovations in resource mobilization and targeted communication strategies that would promote further health workforce investments in the move towards UHC. This initiative was part of PAHO's support to strengthen MoH management capacity in the development of HRH policies and plans able to define the strategic direction of HRH and to integrate it across other sectors.

6 Rwanda: scaling up capacity building at all levels to strengthen UHC

In 2018 and in cooperation with UHC-P and relevant stakeholders, Rwanda launched important capacity-building initiatives that focused on strengthening and expanding the health workforce in health financing and UHC, health management information systems (HMIS) and the international classification of diseases (ICD-11).

UHC-P facilitated training for over 40 people during the high-level consultative and learning workshop “Health Financing and UHC,” attended by government ministers, parliamentarians and representatives of partner institutions. A further 29 people from the Ministry of Health (MoH), Rwanda Social Security Board (RSSB), Medical Military Insurance, Ministry of Local Government and the School of Public Health (SPH) took part in a training-of-trainers workshop on health financing and UHC. A total of 121 private clinics and 150 private dispensaries were trained on the use of health management information systems (HMIS). Capacity building in the international classification of diseases (ICD-11) was also provided to over 40 master trainers with the goal of improving the quality of morbidity reporting. Further training sessions on data quality for data managers are planned. Two district health information systems (DHIS-2) academies on data use and data quality were supported in 2018. In cooperation with the MoH, UHC-P facilitated a DHIS-2 training for private health facilities. Training was also provided to 24 people from the MoH, Rwanda Biomedical Centre, School of Public Health and Rwanda Social Security Board (RSSB) on the One Health costing tool to boost the capacity for informed decisions in national strategic health planning. Rwanda also operationalized two health facilities, enabling them to provide essential health services to underserved populations, each reaching 6 000 to 7 000 people.

Capacity building for health workers in the health sector remains one of WHO's core functions and has been strengthened with UHC-P support. This not only includes frontline staff but also those in other roles such as administration, management, operations, policy, governance and analysis across various health sector-associated professions.

Capacity-building activities based on international evidence and best practices in improving health care quality have been carried out in **Belarus** to build up adequate capacity levels among key national stakeholders. A series of workshops and trainings organized by the WHO Country Office acquired sufficient momentum to create a network of national stakeholders to develop and implement policy on health care quality improvement. As a result of these various capacity- and consensus-building activities, national stakeholders are now better prepared to apply WHO approaches to health care quality management in the Belarusian context.

In **Jordan**, an online educational course for general practitioners (GPs) was launched to develop knowledge and skills related to the practice of family medicine. The first cohort of GPs graduated in 2018, and the 2019 cohort is currently in training.

In 2018, the **Rwandan** government made a substantial investment in capacity building at all levels of its health workforce. Numerous workshops and events were held on a range of topics including training in health financing and UHC, health management information systems (HMIS) and the international classification of diseases (ICD-11).

UHC has three main dimensions: population, services and direct costs to the people.

In India, a workshop was held to improve the capacity of state-level officials to make strategic purchases for the efficient use of available resources. A series of health systems research proposals were developed to analyse early feedback on implementation of the Pradhan Mantri Jan Arogya Yojana (PM-JAY) initiative and to guide its ongoing implementation while consolidating policies, guidelines and practices. The PM-JAY initiative aims to reduce the financial burden of catastrophic hospital episodes on poor and vulnerable groups and to ensure their access to quality health services, as well as to accelerate India's progress towards UHC and SDG3.

In Sierra Leone, 50 senior MoH officers and managers were trained at partnership-led workshops on strengthening health system capacity and management at central, district, hospital and community levels. The aim was to boost access to effective and quality health services with a focus on people-centred health care and efficiency gains

In Guinea, assistance was provided in drafting community health worker training curricula in cooperation with the Ministry of Technical Education ("rural pipeline").

In Eritrea, three cities hosted district health strengthening (DHS) orientation workshops with UHC-P support, which focused on district health priorities and aimed to cover about 100 district health staff.

In Moldova, a midterm review was conducted of the National Strategy for Human Resources for Health Development 2016–2025. The review was instrumental in allowing for national HRH management and planning capacities to be strengthened through a national delegation's participation at the European subregional meeting on health workforce accounts implementation and technical workshop of Support to the Health Workforce Planning Expert Network (SEPEN).

HRH capacity-building activities are being conducted in **Timor-Leste** on national health workforce accounts, in **Mongolia** on peer-to-peer support to address challenges in the health system at the annual healthcare managers' conference and in **Laos** on the licensing and registration of over 65% of health professionals in the public sector.

Partnership-supported countries have also been working on developing health workforce observatories to monitor and track the distribution of health personnel at different levels of the health system countrywide. This is the case in **Burkina Faso** and **Benin**. **Nigeria** took steps to advance its Health Workforce Registry in three priority states in the north-east of the country. Likewise, **Morocco** has drawn up a health workforce observatory model, which the country plans to implement in 2019.

7 Guinea: increasing access to primary health care in rural areas through the rural pipeline

After the Ebola outbreak of 2014, the government of Guinea decided to improve access to health services for populations living in rural and underserved areas through increased investment in human resources. This approach, also called the "rural pipeline," aims to strengthen coordination and governance mechanisms in the different regions, promote social responsibility among local actors in favour of a multisectoral and integrated community system, improve equitable access to health training for young persons and provide integrated community health services.

With the support of UHC-P, intersectoral meetings were organized at national, regional and community levels to determine health service needs and essential skills needed for PHC service delivery as well as to identify people who could be trained to deliver community health services. A new category of health professionals, "community health technicians," was created to respond to the need to provide epidemic information, prevention and surveillance in the community and to deliver primary health care especially in rural and underserved areas. Candidates for training will be recruited from rural areas and reassigned to their native communities on completion of training. UHC-P provided technical assistance in developing the training curricula for these community health technicians in collaboration with the Ministry of Technical Education and Ministry of Health. UHC-P also supported needs-assessment exercises for community health training of teachers and supervisors and community health schools functioning in four regions (Nzerekoré, Faranah, Labé and Boké). Capacity-building modules were developed for 75 teachers and 75 mentors. The content of training thus reflects the needs of the rural population and addresses the types of situations that community health workers are likely to face.

8 India: enhancing the role of midlevel health care providers

In 2018, UHC-P provided technical support to strengthen the health workforce as part of the progressive rolling out of health and wellness centres (HWCs) in India. Policies for stepping up the role of midlevel health care providers (MLHPs) were central to PHC reforms and involved the introduction of community health practitioners. A human resource for health (HRH) plan was developed in selected priority districts with large tribal communities, so that these districts would have the tools to come up with creative HRH solutions to address critical gaps affecting hard-to-reach areas. UHC-P guided the development of policy briefs for nurses and MLHP at the PHC level in terms of prescription options. UHC-P also contributed to a review of the legal implications by bringing a realistic and balanced perspective to the debate on the prescription of medicines by non-clinicians. Lastly, occupational categories relating to health were mapped using the International Standard Classification of Occupations (ISCO-08), the results of which fed into the Allied and Health Care Professions bill, offering a framework for the regulation and maintenance of educational and service standards in the healthcare and allied professions.

A health labour market analysis is currently being undertaken to address relevant policy questions relating to factors in the health workforce that are crucial for successful roll-out of the HWCs, and to improve health workforce recruitment and assignment, especially in rural and remote areas. Furthermore, a nurse migration study has identified the "push" and "pull" factors which influence the migratory patterns underlying nurse recruitment in the state of Kerala. The study resulted in planning appropriate strategies to address these factors in line with the WHO code of conduct for health worker migration.



2.2 Health Financing Strategies and Reforms

The following section deals with aspects of health financing (GPW13 outcome 1.2).



From a technical point of view, a health financing strategy is a high-level document developed at the national level to identify the major changes which need to be implemented in the medium- or long-term (5-10 years) with respect to the following key health financing functions: revenue raising, pooling, purchasing, benefit design and overall health financing architecture and governance. Policy changes identified by this strategy aim to address the root causes of barriers to UHC which are amenable to health financing reforms. It is a living document that sets out a vision but whose content may well evolve over time as new challenges emerge or decisions are made to pursue new directions.

WHO has used the UHC-P platform to provide health financing support aimed not only at contributing to the development, adjustment and updating of national health financing strategies, but also accompanying priority reform processes in health financing. DFID, a significant UHC-P observer in 2018, has strongly supported UHC-P health financing activities by providing complementary input. Work centred on UHC-P country policies and arrangements relating to the following key areas:

revenue raising to mobilise funds for health ("revenue raising");

- pooling of funds;
- purchasing of health services;
- policies on benefit design, entitlement and conditions for access;
- governance of the above functions and policies.

From a technical point of view, a health financing strategy is a high-level document developed at the national level to identify the major changes which need to be implemented in the medium- or long-term

WHO guiding principles in health financing

WHO has identified guiding principles that constitute a set of "signposts" for checking whether reform strategies (and, more importantly, their implementation) are creating an appropriately "incentivizing" environment and are thereby shifting in the right direction for the future development of health financing. The principles are organised along the four key health financing functions:

1) Revenue raising

- a. Move towards a predominant reliance on public/compulsory funding sources (i.e. some form of taxation).
- b. Increase predictability in the level of public (and external) funding over a period of years.
- c. Improve stability (i.e. regular budget execution) in the flow of public (and external) funds.

2) Pooling revenues

- a. Enhance the redistributive capacity of available prepaid funds.
- b. Enable explicit complementarity of different funding sources.
- c. Reduce fragmentation, duplication and overlap.
- d. Simplify financial flows.

3) Purchasing services

- a. Increase the extent to which the allocation of resources to providers is linked to population health needs, information on provider performance or a combination of both.
- b. Move away from the extremes of either rigid, input-based line item budgets or completely unmanaged fee-for-service reimbursement.
- c. Manage expenditure growth, e.g. by avoiding open-ended commitments in provider payment arrangements.
- d. Move towards a unified data platform on patient activity, even if there are multiple health financing/coverage schemes.

4) Benefit design and rationing mechanisms

- a. Clarify the population's legal entitlements and obligations (who is entitled to what services, and how much, if anything, users are meant to pay at the point-of-use).
- b. Raise the population's awareness of both their legal entitlements and their obligations as beneficiaries.
- c. Align promised benefits, or entitlements, with provider payment mechanisms.

The UHC-P has been decisive in supporting health financing strategies and strengthening health financing governance:

With regards to overall health financing governance, UHC-P support is structured around four main axes:

- support to develop a health financing vision;
- support to establish a health financing policy and regulatory framework;
- support to improve multiple stakeholder coordination and alignment;
- support to improve the health budgeting process and public financial management.

As outlined above, development of a National Health Financing Strategy (NHFS) is one of the key entry points used by WHO to spur policy dialogue on the topic of health financing in Member States. It aims for an agreed strategic vision for health financing and identification of the most appropriate policy options to achieve it. With the avowed intent of developing and strengthening their health financing environments, countries have continued to develop, revise and implement NHFS. UHC-P has made considerable efforts to contribute to develop new NHFS. In several countries, WHO has used the UHC-P platform to trigger and galvanize such development.

With UHC-P guidance, **Morocco** and **Pakistan** have embarked on the development process for their respective national health financing strategies, whereas drafts strategies for **Afghanistan** and **Mozambique** are undergoing consultations and will be finalized in 2019. **Sierra Leone** has progressed in developing its NHFS by conducting a health financing assessment and establishing a multisectoral national health financing steering committee and technical working group, which has also discussed issues related to the Sierra Leone Social Health Insurance Scheme (SLeSHI).

In **Togo**, UHC-P support spurred completion of the health financing strategy for UHC and the cost estimate for an action plan over a five-year implementation period. Similar support was also provided to the **Democratic Republic of the Congo**, **Guinea**, **Benin** and **Rwanda**, which developed and ratified their respective health financing strategic plans. In January 2019, a dissemination workshop on the Health Sector Strategic Plan (HSSP4) and other subsector strategic plans was held in **Rwanda** at which over 250 health sector stakeholders from government institutions, development partners, public and private providers and the School of Public Health took part.

Other countries have started projects to develop a health financing strategy which were scheduled to continue into 2019. In **South Sudan**, broad funding has been secured and a consensus reached on the appropriate methodology and approach for 2019. Similar preparations have taken place in **Niger**.

Another important element in the UHC-P agenda is to provide support to update existing NHFS. In **Burkina Faso**, the 2017 health financing strategy and operational plan for UHC was reviewed and updated with the support of WHO working with the World Bank, Global Fund and the EU, resulting in a revised implementation plan. Similar revisions also occurred in **Cabo Verde**, which also took the step of revising its exemptions policy for the poor and vulnerable conjointly with the Ministries of Family and Social Inclusion, Finance, Agriculture and Environment and Town Halls. High-level health financing policy dialogue is also being pursued and intensified in **Viet Nam**.

Support was provided by UHC-P to implement health financing strategies and to modify existing health financing architecture in partner countries. Following extensive consultations in **Ukraine** with WHO guidance, the health financing concept was approved by the Cabinet of Ministers. A new health financing law has been passed which establishes a strong legal and political framework for introducing new health financing arrangements. Similarly, **Kenya** has made leaps and bounds in consolidating the legal framework of its healthcare financing strategy with UHC-P support. Additional progress was made on advancing implementation of the Health Act 2017 and identifying necessary health financing reforms to enable UHC scale up.

In **Mongolia**, health care financing regulations were revised, developed and approved with the aim of moving towards strategic purchasing and increased PHC funding. This resulted in increased PHC funding of MNT 5.4 billion (approx. US\$ 2 million) in 2018.

Launched in September 2018 as part of the Ayushman Bharat, **India's** PM-JAY national financing scheme for the poor and vulnerable aims to cover 500 million people needing secondary- or tertiary-level hospital care. WHO provided support to develop the model and mechanisms for the new national financing scheme and PM-JAY roll-out.

9 Kenya: strengthening the legal framework for healthcare financing

In Kenya, UHC-P support was provided to obtain an expert report on the legal aspects of health financing. A legal consultant specializing in health care financing mapped out the legal landscape and provided a detailed analysis and report. The UHC legal subcommittee has continued to identify the legal and regulatory reforms needed to enable UHC to be implemented and scaled up. These include fast-tracking the introduction of the Health Act 2017, developing several bills and reviewing relevant existing laws. With a view to scaling up UHC, the cabinet secretary launched a Health Financing Reform Panel in February 2019 to provide advice on requisite health financing reforms. WHO has initiated discussions with the task force to identify what kind of support is needed.



Similarly, **South Africa** built on progress made on its National Health Insurance 2017. The country's cabinet approved the draft NHI bill, which will translate the NHI white paper's policy suggestions into legislation. UHC-P support was provided to review these documents, in particular the NHI bill with which WHO has been involved since its concept stage.

Nigeria established a Basic Health Care Provision Fund (BHCPF) in Edo State incorporating state-supported health insurance schemes (SSHIS) and plans a further roll-out in 2019. Outreach activities in **Madagascar**, encouraging enrolment of the poorest populations in the National Social Security Fund for Health in Vatomandry district, and in **Mali** were set up and supported through consultations between various stakeholders, including the Ministry of Health, civil society organizations, WHO and other technical partners.

In **Senegal**, **Morocco** and **Mongolia**, UHC-P also provided specific technical and policy support to initiate health financing reforms to step up progress towards UHC. For example, in Senegal the "health night," served as a resource mobilization and advocacy event.

Partnership guidance was provided to support needed changes in health financing governance arrangements in **Ukraine**. The country set up a new single purchasing agency, the National Health Service of Ukraine (NHSU). Professional licensing and regulatory standards for PHC providers were revised in line with WHO recommendations so that roles and capacities could be expanded. NHSU also introduced new contractual relationships with providers.

Improvements in the health budgeting process and public financial management rules are essential elements of the UHC agenda on health financing. **Greece** recently began work on financing and contracting aspects to enhance PHC. Health sector policy-makers were made aware of the importance of their direct involvement in the budget process. Close coordination and negotiation with the Ministry of Finance helped to obtain adequate funding for the health sector generally and for PHC in particular, and it further aims to ensure the long-term sustainability of the newly created network of community-based PHC services.

Revenue raising

More sustained efforts are being directed towards creating mechanisms to raise increased amounts of domestic revenue for healthcare with the support not only of WHO but of other key partners, as well. This strengthens the multi-donor approach while confirming and speeding up movement towards UHC. Various examples of these support activities are outlined below.

The pooling function and the different ways that countries organize this is critical for countries' progress towards universal health coverage

Following the development of **Chad's** health financing strategy, UHC-P supported the creation of a strategy document that made explicit the financing sources to be used for health services provided free-of-charge. In March 2019, the technical consultation committee (Comité national pour le secteur de la santé) commissioned a report on how to make the subsidy mechanism for the most vulnerable populations more effective to protect them from financial hardship. In **Niger**, with technical support from WHO, a study of the impact of the free healthcare policy on the organization, supply and access to health services was conducted.

UHC-P provided technical assistance to **Jordan's** MoH to encourage reform of the existing Civil Insurance Programme into a National Health Insurance Fund by the end of 2019.

Purchasing must be more strategic for countries to make progress towards UHC

In 2018, WHO responded to the increased demand for support to strengthen strategic purchasing in various countries. Activities involved:

- defining and designing benefits;
- improving coordination and alignment across multiple provider payment methods;
- improving governance of the health purchasing system.

In **Laos and Zambia**, UHC-P supported costing exercises and the implementation of essential service delivery packages linked to the the National Health Insurance (NHI) scheme's benefit packages. In **India**, UHC-P supported the costing of the PM-JAY benefit package in three states.

Morocco is in the process of developing its national health financing strategy with the goal of reforming the provider payment mechanism. It has produced a final situational analysis on strategic purchasing and is expanding service coverage to the informal sectors.

UHC-P provided technical assistance for integrating improved or new strategic purchasing mechanisms in **Georgia, Lao PDR, Tunisia, Morocco, Egypt, Sudan, Tajikistan** and **Ukraine** to increase efficiency and supply according to their specific needs. An important element of this is to support the introduction of new payment methods or optimization of existing payment methods in

partner countries. For example, reforming hospital payment mechanisms was a key policy priority to achieve efficiency gains in the **Georgian** health system: a newly introduced diagnosis-related group (DRG) payment system for hospitals was piloted by the Social Services Agency, replacing the previously used complex payment system. With the assistance of WHO, **Georgia** also drafted its strategy for strategic purchasing of health care services, which aims to optimize utilization of limited resources for all publicly funded health programmes under the Social Services Agency, including UHC-P.

UHC-P also provided policy advice on good governance of the health purchasing system. In **Tajikistan**, UHC-P supported the establishment of an Interministerial Expert Group under the State Budget Department of the Ministry of Finance to improve the efficient allocation of public funds and strategic purchasing. The Group provided support to both ministries in implementing the newly developed strategic plan for health financing reforms 2019–2021.

Sudan's MoH and National Health Insurance Fund (NHIF) developed a provider payment mechanism plan as well as a transition plan to split provider and purchasing functions by 2020.

10 Accelerating UHC in Egypt by means of the Universal Health Insurance law

Egypt recently passed a new compulsory Universal Health Insurance (UHI) law to accelerate progress towards Universal Health Coverage (UHC). The new law replaces several laws, ministerial decrees and other directives governing the current health insurance scheme that covers about 58% of the population so far. The new law aims to prescribe credible funding by introducing a variety of new revenue raising mechanisms that rely predominantly on domestic public sources. Other key changes relate to the pooling and purchasing arrangements, including revised cost-sharing mechanisms in order to improve financial protection of the population.

WHO supported the UHI process over several years and closely collaborated with various ministerial and UHI committees. Costing and actuarial studies were conducted to inform UHI financing, and substantial technical discussions, professional dialogues and capacity-building activities took place in its preparation phase. UHC-P provided capacity-building workshops so that national officials could update health accounts and financial risk protection indicators regularly within the national monitoring framework. Most recently, UHC-P undertook an extensive assessment and provided options to keep the UHI implementation plan abreast of key issues regarding strategic purchasing and relevant governance arrangements.

11 India: "PM-JAY" - Financial Protection Scheme

A hundred million people will benefit from the national financing scheme, PM-JAY, which was introduced in September 2018 to cover secondary- and tertiary-level hospital care for the poor and vulnerable. UHC-P provided support in developing the model and mechanisms of the new national financing scheme by sharing international experiences with social insurance schemes and helped in the rolling out of PM-JAY through enhanced policy dialogue. An analysis of claims made under existing financing mechanisms and costing of the PM-JAY benefit package was also conducted in 3 selected states to inform the administration about existing financing schemes and guide decisions concerning provider payment mechanisms.

UHC-P facilitated a workshop to strengthen the capacity of state-level officials on strategic purchasing for efficient use of available resources. A series of health systems research proposals was also developed to analyse early feedback on implementation of the PM-JAY initiative and to guide its ongoing implementation while consolidating policies, guidelines and practices. These activities were accompanied by efficiency and effectiveness reviews of insurance schemes (i.e. integration of multiple state insurance schemes, defining benefit packages, costing and feasibility of pilot introduction) in selected states with the aim of reducing administrative inefficiencies, increasing quality and ensuring sustainability. Lastly, a disaggregated analysis of health-related household expenditure across different income quintiles was conducted to generate information on out-of-pocket expenditure and catastrophic expenditure incurred by both hospitalization and outpatient health services.

Similarly, the Universal Health Insurance Law (UHI) in **Egypt** will bring major changes in the governance arrangements for strategic purchasing. A detailed assessment by WHO reviewed critical issues relating to strategic purchasing and governance that may arise once the new UHI Law comes into effect. In a high-level committee meeting moderated by UHC-P, the MoH discussed provider payment rules and regulations that will create a new contractual framework between purchasers and providers; these issues are currently undergoing consultation with stakeholders.

UHC-P has helped to build up purchasing capacities in its partner countries. The **Georgian** strategic purchasing strategy will aid national authorities in reshaping the Social Services Agency and increase its capacity as an active purchaser of health services, thereby maximizing the health and financial protection impact of public funds.

In **Sudan**, an assessment to strengthen governance of the National Health Insurance Fund (NHIF) was completed and the country started contractual negotiations to introduce the enterprise resource planning and management (ERPM) system for NHIF. Sudan also plans to strengthen its NHIF information technology infrastructure to replace the existing paper-based information system.

UHC-P supported capacity building exercises in **Mali**, focusing on advocacy and capacity-building activities for management of different health insurance schemes. In **Mongolia**, capacity building exercises were centred around the annual health insurance managers' meeting, health insurance regulations and the introduction of an e-prescription system to allow reimbursement of discounted medicines. These exercises increased the capacity of both countries' health insurance agencies. Likewise, **Guinea** conducted a diagnostic study on strategic purchasing with WHO support.

With regards to contracting, UHC-P provided technical input to **South Africa** for various health financing issues, such as advice to the independent inquiry into the private healthcare sector conducted by the Government's competition commission. WHO provided technical recommendations on "principles and suggestions for tariff determination of healthcare services" and "addressing regulatory gaps in health financing." These and previous suggestions were included in the provisional report of the Health Market Inquiry (HMI) released in June 2018, which made overarching recommendations for reducing healthcare costs and improving quality and transparency in the private healthcare sector through monitoring, regulatory control and strengthened policies.

Tracking efforts and results in health financing is essential to support decision making in health financing

Tracking expenditures in health is a critical exercise to monitor efforts in health financing

WHO has continued to intensify its efforts to produce quality information of spending on health to allow countries to keep track of financing trends in health. Under the UHC-P, WHO has assisted nearly all its partner countries in developing a System of Health Accounts (SHA). These exercises require time, technical expertise and resources—and wherever possible some level of institutional memory to build on past knowledge and experience. Countries in the Partnership are at different stages of production, institutionalization and use of SHA data for decision-making. Many countries within the Partnership include SHA activity in their roadmaps and recognize the need to maintain momentum and resources to be able to report on this activity.

In **Cabo Verde**, technical support was provided to produce health accounts for the financial years 2015–2017, along with financial assistance for data analysis. Similar support has been provided in **Democratic Republic of the Congo** (2016 and 2017), **Burkina Faso** (2017), **Liberia** (2016), **Nepal** (2018), **Niger** (2017), **Sierra Leone** (2014), **Senegal** (2017), **Sudan** (2016 ongoing into 2017), **South Sudan** (2016 and 2017), **Timor-Leste** (2017), **Tunisia** (2014–2016 ongoing into 2017) and **Togo** (2016). Most of these countries are in the final stages of SHA completion prior to dissemination of the reports.

Benin has undertaken steps to develop its health accounts for years 2016, 2017 and 2018. Like **Timor-Leste**, which held a partnership-led capacity-building workshop for members of the MoH, Ministry of Finance and other relevant line ministries, **Benin** has provided training exercises for focal-point departments and adapted collection tools. **Nigeria** has committed four States (Osun, Edo, Abia and Niger) to develop state-level health accounts. Measures such as personnel training, data collection, entry and mapping, validation and dissemination are being applied for expert review of health accounts for the financial year 2017.

In **Afghanistan**, the first draft of the SHA report for 2017 has been developed and is undergoing validation. Its key findings were presented to the MoH health accounts steering committee. In **Lao People's Democratic Republic**, the financial burden of out-of-pocket spending (OOPS) was analysed using expenditure and consumption survey (LECS 5) data in order to improve resource allocation in the health sector.

Tracking financial protection is key to evaluate efforts in health financing

WHO also supports member states in their efforts to monitor financial protection, a key performance indicator for the health financing strategy. Therefore, WHO carried out activities aimed at strengthening institutional capacities and processes to measure financial protection in health.

The UHC-P supported countries working to strengthen or expand financial protection by developing, updating or implementing various measures depending on their current health financing infrastructures.

WHO conducted a series of workshops to strengthen the capacity of **Egyptian** officials and researchers from the Central Agency for Public Mobilization and Statistics (CAPMAS), MoH, the health insurance organization (HIO) and Ministry of Social Solidarity (MOSS) to conduct regular financial risk protection indicator updates by themselves.

In **Mongolia**, analysis of the data from the “Catastrophic health expenditure and impoverishment in Mongolia” survey, conducted in 2013 and 2017 with the support of UHC-P, revealed that the poorest of the poor use mostly primary and secondary healthcare facilities while the richest members of the population were able to access advanced health services, including tertiary-level specialized centres, central hospitals and private institutions. There was, in other words, complete disparity of access to essential services for different income quintiles. The findings of such surveys thus provide an information base for new policies which aim to reduce inequities of access and ensure financial protection.

Development of the Health Financing Progress Matrix

Through 2018 WHO completed the initial conceptual development of the Health Financing Progress Matrix (HFPM), including an expert meeting (attended by DfID UK). This initiative grew out of discussions (with DfID following an external evaluation of the previous grant) of how to better measure progress in health financing at the outcome level. The HFPM will be used as the basis for all non-quantitative progress assessments by WHO for all internal and external reporting. It is also hoped that the HFPM will form the basis of joint stakeholder monitoring at the country level.

Application of the HFPM early concept took place in **Afghanistan, Myanmar, Peru and Tanzania** in summer 2018, and by the end of 2018 the HFPM had also been initiated in **Burkina Faso, Cambodia, Pakistan, Sri Lanka, Uganda and Zambia**, with **Guatemala, Honduras, Bangladesh, Comoros, Nepal, Cote d'Ivoire, Ghana and Mongolia** expected to begin application in the near future. All these countries are conducting baseline assessments with follow-up made not more than once a year; it is expected however that the baseline will take a partially retrospective view allowing some assessment of progress over the past 1-2 years.

Improving the institutional capacity for transparent decision-making

Countries also underlined other activities which had been undertaken or were in planning to increase the evidence base and allow for smooth progress towards UHC.

In **Burkina Faso**, studies were conducted on budget space efficiency and human resources management to identify where use of resources could be improved. Support was also provided for a workshop to analyse the country's budget



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WHO has continued to intensify its efforts to produce quality information of spending on health to allow countries to keep track of financing trends in health.

reforms over the past few years. Policy dialogue activities were conducted in **Liberia** to generate up-to-date evidence on health care financing options, including methods for generating domestic resources. **India** conducted reviews of insurance schemes in selected states in order to reduce administrative inefficiencies, increase quality and ensure sustainability. In **South Africa**, the effort to increase efficiency went further by means of a cross-programme efficiency analysis carried out in Kwa-Zulu Natal province. The analysis aimed to identify overlaps, duplications and misalignments in a number of the health programmes traditionally consuming the bulk of available resources. In **Democratic Republic of the Congo**, the results of a health accounts feasibility study are being finalized.

Countries have also taken steps to document practices and activities that demonstrate cross-cutting efforts in various domains, including health financing.

Some countries have made more comprehensive efforts to both share with and learn from other contexts. Extensive collaboration took place in **Liberia**, where WHO worked together with MoH, UNFPA and Maternal and Child Health International (MCAI) to tackle maternal and neonatal mortality through a task-sharing project in advanced obstetric and neonatal care. This has increased the number of trained professionals in this field, an outcome which has been widely documented and shared. Once **Zambia's** National Health Insurance Bill was drafted, WHO provided support to national authorities to develop a communication strategy for its widespread dissemination. WHO provided support to **Chad's** study on how different mutuelles (insurance agencies) can contribute to UHC in the country while also generating evidence for dialogue on health financing. Likewise, in **Democratic Republic of the Congo**, Partnership resources were used to finalize and validate the directive on base tariffs for certain services.

2.3 Medicines and other pharmaceutical products

The following section relates to medicines and other health products (GPW13 outcome 1.3).

Improved access to medicines and provision of authoritative guidance and standards on quality, safety and efficacy of health products

UHC-P assisted **Nigeria** in adopting a new national drug policy. In **Sierra Leone**, UHC-P extended support to the Directorate of Drugs and Medical Supplies (DDMS) to review and develop various strategic documents, resulting in the production of draft versions of the national medicines policy, national essential medicines list, standard treatment guidelines and treatment cards. The Partnership also facilitated the production of draft technical guidelines for establishing and running medicines and therapeutic committees (MTC) in five hospitals. The aim of these activities was to address the irrational use of medicines and responded to the need of DDMS to establish the National Medicines Supply Agency on an efficient basis.

Improved access to essential medicines, vaccines, diagnostics and devices for PHC

UHC-P provided technical advice for the development or review of essential medicines lists in various countries, including **Benin, Cabo Verde, India, Timor-Leste, Nepal, Guyana** and **Paraguay**.

Cabo Verde developed a national list of essential drugs along with an action plan for combating antimicrobial resistance with UHC-P guidance. A generic drug policy was also developed, accompanied by the introduction of a drug delivery strategy entailing a revision of the patient's financial contribution. In cooperation with the public university of Cabo Verde and the Order of Physicians, a strategic training plan in family and community medicine was also developed. **Benin** drew up its list of essential medicines for healthcare along with an inventory of generics. In cooperation with UHC-P, an operational guide for price monitoring of essential medicines is currently being drafted. In **India**, national guidelines to set up cost-free diagnostic and treatment schemes at state level are being finalized in order to improve access to medicines. With support from WHO and other partners, a subregional meeting to strengthen pharmacovigilance and post-marketing surveillance was held in 2018 in **Guyana**. Further work in strengthening the regulation systems is under way.

In **Georgia**, UHC-P provided training for GMP (good manufacturing practice) inspectors, thereby helping to strengthen the regulatory authorities: this is a prerequisite for securing access to quality medicines and health care services. Prompted by the results of a WHO assessment, **Ukraine** decided to extend its "affordable medicines" pilot programme into 2019 in order to make medicines more affordable and accessible for patients with noncommunicable diseases. State budget funds were allocated accordingly, and it is expected that the programme will be included in the NHSU's benefit package. Moldova has also conducted a survey on the affordability and availability of medicines.

Country and regional regulatory capacity strengthened, and supply of quality-assured and safe health products improved

As part of its reforms to improve governance and funding for UHC, **Senegal** organized a consultation meeting on improving the supply chain of medicines and health products. Training and capacity building are also being undertaken in **Rwanda** and **Timor-Leste**. A total of 80 **Rwandese** clinicians were trained on blood transfusion guidelines and best practices in the first quarter of 2019 and **Timor-Leste** is planning training for personnel at its National Agency for Medicines and Medical Equipment as well as for pharmacy technicians working in municipalities. Strengthening dossier and bioequivalence capacities of the regulatory agency in **Eritrea** is the aim of training in 2019. Three people from the regulatory agency will take part in a study visit to strengthen and develop their skills in quality management systems. An assessment of demand for and use of traditional medicines by the communities living in the Gash-Barka Region was undertaken, providing further input for evidence-based regulatory interventions. A second assessment is planned for the Debub Region. Guidelines and measures to increase the diagnosis and treatment of cervical cancer have also been developed. National capacities in pricing and medicine reimbursement policies were strengthened in **Moldova** through the participation of country representatives at the WHO Winter School on Pharmaceutical Pricing and Reimbursement Policies and the Third CIS Pharmaceutical Pricing and Reimbursement Network meeting.



In the WHO Regional Office for the Western Pacific, the **Pacific island countries (PICs)** division focused on upgrading the current regulatory systems for medicines in 12 PICs (**Cook Islands, Fiji, Federated States of Micronesia, Kiribati, Nauru, Niue, Palau, Papua New Guinea, Republic of the Marshall Islands, Tonga, Tuvalu** and **Vanuatu**). Based on the results of a study, an assessment paper outlined options for establishing sustainable systems with basic regulatory capacities that would meet public health needs in the Pacific region.

Focal points from **Sierra Leone, Ghana, Uganda** and **Nigeria** were trained in April 2018 during an AFRO Regional Workshop held in Lagos, Nigeria on Global Surveillance and Monitoring System (GSMS) for better prevention, detection, and response to substandard and falsified (SF) medical products. Moreover, requests for proposals were issued to conduct an insight study of a cross-section of the population in these four countries. The data generated through these insight studies will be used to implement awareness campaigns on SF medical products. An assessment of the National Medicine Quality control laboratory and access to field screening equipment for the detection of SF medical products is being carried out in **Nigeria** and **Myanmar** and was already completed in **Ghana, Sierra Leone** and **Uganda**.

The development of the first prototype of the notification system for monitoring medicines shortages is currently well underway, and countries will be brought on board once the first prototype is available. System testing and piloting is partially on track: **Tanzania, Uganda, Ghana** participated in a live system test conducted as a side event to a supply chain conference which also attracted the interest of future participant countries. The aforementioned countries submitted work plans on integrating and promoting the system's adoption at national level. Partners managing

supply chain initiatives in the participating countries and others in the region have been approached regarding the potential to develop automated uploads from their data systems into the final portal. This automation would require enhanced scope and funding to be created. Technical system testing at HQ level and the delivery of licenses for supporting software (MS CRM licences) encountered delays.

Sufficient information and strategies available to inform countries on medicines' pricing policies

In cooperation with DFID, a landscape analysis on the evolution of currently implemented pricing policies and price control measures was conducted in **Uganda, Tanzania** and **Ghana**.

The WHO Guideline Review Committee approved a proposal regarding the review of the WHO guideline on country pharmaceutical pricing policies

Addressing antimicrobial resistance (AMR) through strengthened surveillance systems, laboratory capacity, infection prevention and control, awareness-raising and evidence-based policies and practices

UHC-P support was provided to develop **Cabo Verde's** national list of essential drugs along with an action plan for combating antimicrobial resistance (AMR). UHC-P also supported the development of guidelines for registering medical devices and capacity building in **Eritrea**. There was multisectoral consensus on the national action plan for AMR, and assessment studies are currently being carried out. In **Indonesia**, support was provided to monitor the implementation of multisectoral national actions plans on AMR by means of multi-stakeholder coordination meetings.

3

One billion more people better protected from health emergencies

A central goal of GPW 13 is that essential health services and systems should be maintained and strengthened in fragile, conflict-affected and vulnerable settings. WHO's health systems strengthening (HSS) departments work in close partnership with the WHO Health Emergencies Programme (WHE) and global partners to identify and bolster the basic abilities of health systems to prevent, prepare for, detect, respond to and recover from health emergencies. This is a collaborative effort that takes place across the three levels of the organization, with some of the most important work being carried out in countries supported by UHC-P.

WHO therefore acts to ensure that emergency risk management for health (including implementation of international health regulations) is informed and supported by HSS and integrated into national health policies, strategies and plans (NHPSPs); provides active and timely HSS support in response to acute and protracted emergencies; and informs and supports the transition to recovery and development by effective institutional support for HSS.

A key feature of this collaboration is the strengthened focus on delivering support for UHC in challenging environments including fragile, conflict-affected and vulnerable (FCV) settings. This includes a joint operational approach to emergency response and systems strengthening from the assessment phase through development and implementation of basic service packages by Member States, to joint monitoring and acquiring knowledge from lessons learned by operationalizing UHC in FCV settings.

Continuity and agility of support is essential in emergency and crisis contexts. WHE and the UHC joint working team (JWT) therefore mobilize expertise from across all levels of the organization to provide efficient, timely, country-specific and coherent technical and operational support to drive UHC in FCV settings. As the driving force of this initiative, JWT/UHC-P has the task of coordinating a system of focal persons (FPs) to act as HSS counterparts in FCV countries: this system will be fully integrated into WHE operating models to ensure that in the longer term deep knowledge about health systems can be more usefully applied to emergency operations in FCV countries. Focal persons (FPs) are assigned to a single country, with a suggested 20% time commitment.



At the country level, WHO's approach to supporting UHC in FCV is based on five main areas of work which are adapted to the specific situation.

1. Joint analysis: provide together with health authorities and partners (humanitarian and development) analyses of different aspects of the system (e.g. public health risks, emergency/humanitarian needs, health systems and public health capacities, maps of health sector partners).

2. Estimate costs of an essential and/or minimum package of health services (PHS) which are adapted to morbidity and mortality patterns and the current environment, whereby development and costing of agreed essential and/or minimum PHS matches as closely as possible a country's existing PHS and the different contexts that often co-exist in the same country (stable, early recovery and humanitarian-focused geographies).

3. PHS implementation plan: develop an accelerated PHS implementation plan and supportive policies that are linked to the NHPSPs and national action plan for health security; capitalize on partner capacities for PHS service delivery; ensure appropriate coordination of humanitarian and development health; and foster close collaboration with other sectors, e.g. WASH, nutrition, protection.

4. Monitoring framework: set up a clear and comprehensive system (or improve the existing system) for monitoring the gradual expansion of PHS access and uptake and gradual improvement in service quality, allowing for course corrections and improvements when needed.

5. Knowledge agenda: build on lessons learned from working in FCV countries, document and evaluate experiences in liaison with governments and partners and collate lessons learned to hone WHO's approaches to supporting UHC in FCV countries, inform cross-regional and global exchanges and shared learning programmes.

A central goal of GPW 13 is that essential health services and systems should be maintained and strengthened in fragile, conflict-affected and vulnerable settings

Further to this fifth point, new guidance on health financing policy in FCV providers three overarching messages as follows:

- a) Safeguarding the financing of critical health system functions in fragile and conflict affected settings (FCAS) is a priority given the increased risks to population health security. These include population-based interventions such as disease surveillance, ensuring safe medication, water and sanitation systems, and other common goods. This message is as valid for external funders, as it is for national governments, given the increased reliance on external humanitarian and development funding in such settings.
- b) Health financing policy in FCAS should be guided by the health financing principles to avoid the development of schemes or sub-systems within FCAS inconsistent with UHC. Uncoordinated multiple, often external actors, can lead to the development of unsustainable interventions due to high cost or complexity, and fail to invest in the foundations of a resilient health system. In contrast, coordinated actions which use and support domestic systems where possible, or otherwise mirror those critical public functions, strengthen health system resilience. Examples include ensuring the pooling of funds, using a common pay scale for health workers salaries, and ensuring that funding for critical inputs required for service delivery takes priority.
- c) Cash and voucher assistance (CVA) can play a critical role in protecting human welfare in FCAS by supporting vulnerable households to meet both health and non-health needs. However, given the agreed interagency policy to suspend user fees for essential health care services in humanitarian and complex emergencies, unconditional or unrestricted cash transfers should not inadvertently contribute to a fee-charging culture for priority services, which would undermine progress towards universal health coverage. This can be achieved by ensuring that CVA modalities are viewed as complementary to support for the systems required to deliver essential health services.

This work is supported across the three levels of the organization by the JWT contact group on HSS for UHC in Emergency Preparedness, Response and Recovery. This contact group offers support through knowledge networking, which is facilitative and focuses on mapping, pooling and sharing knowledge resources from the numerous individual and collaborative initiatives already under way across the organization. It also provides helpful standard-setting HSS products and practical mechanisms for country support that have been developed to address gaps identified in the mapping process, such as the JWT/ UHC-P operational country support mechanisms: these have been adapted for the three emergency phases, and include UHC country support plans detailing the requisite activities, budgets, timeframes and expertise. It can also offer practical models and mechanisms for HSS support, including a roster for rapid deployment of HSS expert adapted to country needs and emergency context, including pre-deployment and longer-term approaches to capacity development.

12 Development of the minimum service package in Yemen

In Yemen, an ambitious, district-based systems approach to service delivery recovery and strengthening has been undertaken by WCO Yemen, EMRO and WHE, with massive financial support from humanitarian donors. Even with the planned appointment of senior HSS technical assistants (TA) to the Country Office, there will be an ongoing need for continuous HSS generalist and specialist support from across the organization.

In early 2016, the Yemen minimum service package (MSP) was defined as the strategy best suited to guide the restoration of basic health services in a country at war, while providing a model for post-conflict reconstruction of the health system. WHO and the Ministry of Public Health and Population (MoPHP) therefore launched a pilot which adopted the MSP approach in Bani Al Harith district in Sana'a city. Shortly thereafter, three technical partners (WHO, UNICEF and the World Bank) signed a tripartite agreement to commence implementation of the Emergency Health and Nutrition Project (EHNP) in order to scale up implementation of the MSP strategy in an additional 43 districts.

The beginning of 2018 marked another MSP scale-up in terms of geographic reach and inputs provided. Additional donors and partners joined the World Bank to implement MSP. By the end of the year, 135 total districts had been prioritized for MSP implementation, including the 43 districts where MSP implementation was ongoing at both the primary and secondary care level as part of EHNP. The additional districts were selected following a robust vulnerability analysis based on the Health Resources Availability Mapping System (HeRAMS) and other mechanisms able to identify and target vulnerable populations. The close of 2018 also saw an uptake in district hospital attendance, with a 1.4 fold increase in outpatient department (OPD) services compared to 2017. A similar upsurge was noted at the primary care level, with increased rates for community-based management of acute malnutrition (CMAM), integrated management of childhood illness (IMCI), maternal and newborn health care (MNH) and the expanded programme on immunization (EPI) services in the target facilities. The initiative also reactivated an additional

Progress to date includes joint health development and humanitarian response strategic planning for north-eastern **Nigeria**, legislation for pharmaceutical supply management in **Central African Republic**, joint UHC assessment in **South Sudan**, and support to the Afghanistan Ministry of Health on leadership in developing and completing its integrated package of essential health services. The list of items and interventions included in this package has already been agreed on, and it should be finalized in March 2019. WHO, with UHC-P support, also guided development of the national action plan for health security in collaboration with the National Public Health Laboratory, Diagnostic Directorate, IHR focal point and other relevant stakeholders. Under this plan, WHO facilitated a workshop to train personnel to investigate outbreaks.

In **Democratic Republic of the Congo**, health systems development work continues in the context of multiple emergencies: the UHC-P senior health policy adviser plays a key convening and leadership role in coordinating development cooperation and contributing to the humanitarian and emergency response. In the light of international health regulations (IHRs), DRC has developed

a multirisk plan to improve its capacities to address and manage different epidemics. In order to build up resilience in the country, efforts are being made to include emergency preparedness and response within routine national planning activities, as can be seen from the realignment of the national strategic plan.

Liberia has also strengthened the mechanism for coordinating stakeholders in its national public health emergency response, while adopting the IHRs and the One Health approach. In **Ukraine**, nationwide reforms to improve the quality of emergency care were initiated as a result of a WHO-lead survey. WHO also provided technical assistance for review of the concept paper on emergency medical services, which is now being put into action.

Yemen is operationalizing the humanitarian development nexus by rolling out a health systems strengthening approach to providing a basic package of services in close partnership with WHO, World Bank, UNICEF and the Health Cluster partners, with essential catalytic investments from the World Bank and key technical support provided by WHO with UHC-P support.



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Health information systems – a key pillar for a more efficient and improved implementation of the UHC agenda

Health information systems provide the opportunity to collect, store, manage, analyse and interpret health systems data for the purposes of monitoring and evaluation on the one hand and guiding policy formulation on the other. Different information collection activities have been undertaken with UHC-P support, all with a view to acquiring a better understanding of current situations in order to improve future actions.

In 2018, countries launched and expanded their use of national health observatories. Many made significant advances in introducing district health information systems and excelled in better data management through use of innovative technologies. At global level, DFID supported the modernisation process of the Global Health Observatory data infrastructure and front-end user interface resulting in a new GHO portal with improved access and visualizations. Moreover, the new portal has been designed to be used and tailored to regional use by being better aligned with Regional Observatories. EMRO and SEARO alignment is in progress and expected to be finalized in 2019.

UHC-P support was provided to set up national health observatories (NHOs) in **South Africa** and **Eritrea**. In the former, the NHO will monitor health trends, service coverage, public resource allocation and use and act as an archive for key health research data and evidence. The country is also seeking to establish baselines for UHC indicators which are lacking in current estimates due to insufficient data. UHC-P has been cooperating with statistics institutes to upgrade the measurement of health-related SDGs and fill the existing data gaps. In **Eritrea**, a prototype NHO was developed and launched at an advocacy meeting and training meetings. Eritrea agreed to use NHO dashboards for monitoring UHC and SDGs. In contrast, having designed its own format and decided on key indicators, **India** developed a national

SDG3 dashboard which will make it easier to analyse trends. This will be an important resource for different programmes, and civil society accountability mechanisms will also benefit from improved access to online public SDG/UHC data sources. District dashboards are also in place in **Indonesia** which can visualize data across different themes. This prototype also includes potential data monitoring indicators but the MoH has yet to decide on a final set of indicators. Nevertheless score-cards for SDG monitoring have been developed and shared with MoH as an offline tool, specifically for its M&E and Health Management Information System (HMIS) divisions. A prototype for a national health observatory in **Kenya** has been developed and plans are advanced to support implementation with co-funding from the World Bank. In **Tanzania**, a roadmap has been developed toward the development of a health observatory 2018-20 under guidance by UHC-P. Several additional countries have expressed interest in establishing national health observatories including **Uganda**, **Côte D'Ivoire**, and **Indonesia**, among others. It is evident that strong country stewardship and robust governance will be critical to drive the process of national health observatories forward. This cannot be addressed from a data perspective alone and will require closer cooperation with health systems governance and broader multi-sectoral stakeholders.

Sierra Leone is planning quarterly HMIS supportive supervision at national, district, health facility and community levels in order to conduct data quality assessments (DQA). UHC-P support provided technical assistance and helped to promote data use, resulting in two HMIS supportive supervision reports. The country also aims to produce revised national health care indicators as an output of at least three M&E, Supervision and Information Working Group (MESIWG) meetings at which related material in the literature will be collated. Stakeholder meetings and consultations with MoH and other government ministries, departments and agencies are to be held in support of this process. UHC-P support to strengthen the health

Health information systems provide the opportunity to collect, store, manage, analyse and interpret health systems data for the purposes of monitoring and evaluation.

information system in **Madagascar** is aimed at improving decision-making at central and regional levels through the extension of integrated epidemiological surveillance and epidemiological monitoring.

In **Egypt**, in line with the objective of the new UHI law to strengthen HIS, UHC-P assisted assimilation of the International Classification of Diseases 11th Revision (ICD-11) into the UHI information system. A standardized electronic health record system, which will eventually cover all public health facilities throughout Egypt, was also rolled out in Port Said Governorate. Likewise, **Lebanon** has started to develop a HMIS master plan with the aim of providing a nationwide electronic medical record system; its feasibility is currently being assessed.

UHC-P and other health sector partners supported the continuing production of **Mali's** statistical yearbook 2018. In Tunisia, WHO continued its efforts to build up the capacity of the "Institut National de Santé Publique" (INSP) and National Authority for Assessment and Accreditation in Healthcare (INEAS) to conduct data analyses. The Tunisia Health Examination Survey report was also published; it has been supported by WHO since data collection began in 2016.

Strengthening information systems allows decisions to be made on evidence. Different stages in the implementation process of the district health information system (DHIS2) platform can be observed in UHC-P partner countries. UHC-P provides technical support for ongoing implementation of the DHIS2 platform in **Mali**, **Cabo Verde**, **Nepal**, **Indonesia** and **Sudan**. In **Mali**, funding is complemented by other partners including USAID, UNICEF, Global Fund, UNFPA, Canada, The Netherlands and the Government. The implementation of DHIS2 in **Cabo Verde**, **Nepal**, **Sudan** and **Timor-Leste** is accompanied by training activities for health personnel. Sudan focuses on provinces, districts and municipalities, whereas **Timor-Leste** has made a point of assessing the interoperability of existing HIS systems.

Upscaling activities for DHIS2 platforms can be observed in **Senegal**, **Guinea**, **Cambodia** and the **Philippines**. As part of its support for reforms to improve governance and through UHC funding, **Senegal** facilitated a preparatory workshop on integrating community level data into the DHIS2 platform in the city of Thiès. UHC-P support helped to scale up use of the DHIS2 platform at district and community levels in **Guinea**. **India** rolled out an integrated health information platform (IHIP) for disease surveillance in seven states in order to generate real-time patient-based information about 33 infectious diseases and enable appropriate and effective public health responses to contain outbreaks and epidemics.

UHC-P facilitated the development of indicators to monitor UHC at primary care level (health centres and community) through health service delivery performance monitoring in **Cambodia** and supported the development of metrics to allow UHC monitoring in the **Philippines**. Likewise, the capacity to monitor SDGs at the national level was improved in **Mongolia** by means of regional and national workshops.

Capacity-building exercises on UHC monitoring were undertaken in **Tajikistan** to strengthen the evidence base for UHC. Technical support was provided to the country's statistics agency to update a health module questionnaire in the Household Budget Survey (HBS) and provide in-depth training for over 100 survey interviewers at national and regional levels on collecting health service use and household expenditure data within the routine HBS. Including this revised health module questionnaire in the routine HBS allows use and health expenditure data to be linked to detailed information on household consumption, including costs incurred by disability. It contains disability-related questions adopted from WHO's model disability survey (MDS). Tajikistan is the first country in the world to introduce MDS as a part of its HBS.

13 Mongolia: m-health can help achieving UHC in other countries

Mongolia is one of the most sparsely populated countries in the world. Going to hospital can be costly and time-consuming. In 2015, WHO helped the Government launch the m-Health initiative to bring screening for common diseases to people in their homes, starting with the most remote rural herder families and the most disadvantaged urban households—people who are often unable to afford health checks. UHC-P provided technical assistance and capacity building on the use of the cost-friendly mobile screening device. People in these communities can be tested for communicable and noncommunicable diseases including viral hepatitis, tuberculosis, HIV and other sexually transmitted infections. Other tests offered can check blood cholesterol levels, blood sugar for diabetes, measure blood pressure, screen electrocardiograms for heart problems and provide ultrasounds for pregnant women and chronic and acute internal diseases. Doctors and nurses from the nearest health centre go door-to-door, offering these mobile screening services.

The initiative—which is financially supported by the Korea Foundation for International Healthcare and the Community Chest of Korea—has been successful in detecting illnesses among Mongolia's remote and disadvantaged populations and ensuring people receive the care they need, when and where they need it, in line with the aims of universal health coverage. Over the course of a year, more than 14 000 people in three countryside locations and two subdistricts in the capital city of Ulaanbaatar received early screening, and thousands received timely medical care.

UHC-P is instrumental in achieving better UHC implementation results through strengthened monitoring and evaluation tools and stringent annual reviews of monitoring mechanisms

As part of the technical support it provides for devising national health plans (in **Benin, Cabo Verde, Kenya, Nigeria, Senegal** and **South Sudan**), WHO acts with senior staff at the Directorate of Planning, UNICEF, UNFPA, GAVI and the Global Fund, bilateral partners and civil society through health sector coordination committees to achieve consensus on national monitoring and evaluation (M&E) frameworks to monitor health plan implementation. The common M&E framework of the IHP+ for UHC 2030 Alliance and standard 100 UHC global indicators and elements of the UHC Framework of Actions for the WHO African Region were adapted to country contexts. Attention was also given to the GPW13 impact indicators. Topics of policy dialogue in the countries concerned included health programmes (in vitro diagnostics), access to medicines and reproductive, maternal, newborn and child health (RMNCH) and their funding partners (GAVI). Support to **Niger** included developing and validating the M&E guidelines in the National Health Plan 2017–2021. It was distributed to four out of the country's seven regions, with further roll-out expected in 2019.

In **Kenya**, M&E frameworks have been developed both for the country's health sector strategic plans and specifically for UHC. The UHC framework will guide all aspects of monitoring and evaluation relating to UHC implementation in the country, starting in four pilot counties. This complements the broader M&E framework in the national strategic plan and will ensure accurate, custom-made monitoring to review progress.

In **Morocco**, WHO supported development of the monitoring tool for tracking the progress of the National Health Policy and Action Plan 2025. The first draft of the monitoring report has been completed and is currently under validation by the MoH before it is rolled out. This activity is also currently in progress in **Guinea Bissau** where it will be finalized by mid-2019.

As part of the technical support it provides for devising national health plans, WHO acts with senior staff at the Directorate of Planning, UNICEF, UNFPA, GAVI and the Global Fund, bilateral partners and civil society.

WHO is providing guidance on evaluating **Ukraine's** regulations for sanitary protection, IHR implementation and disease surveillance. It has also reviewed the development strategy of a communicable diseases and laboratory network surveillance system through to 2020.

National annual health sector reviews were conducted in **Sierra Leone, Senegal, Democratic Republic of the Congo, Guinea, Burkina Faso, Indonesia, Timor-Leste, Sudan, Vietnam** and **Chad** through joint technical and financial support to the MoH, which led the review process in collaboration with partners. In **Guinea**, the review was conducted explicitly across national, regional, district and community levels. **Liberia** and **Senegal** pursued their annual reviews which highlighted improvements moving forward. In **Democratic Republic of the Congo**, the 2018 annual review was conducted with input from all levels of WHO. In **Sudan**, the annual health sector reviews have been institutionalized since 2017. A development partner forum has been set up in **Vietnam** to monitor progress towards UHC.

Through the support of the UHC-P, **Sierra Leone** published a report on its health sector review. UHC-P facilitated coordination and provided sufficient technical support to allow critical appraisal and analysis to be carried out prior to implementation of the national health policies and strategies, including the comprehensive national sector review.

In **Burkina Faso**, technical and financial support was provided for the annual health sector review which drew attention to issues based on the M&E plan of the national strategic plan. This process also helped to strengthen contributions made by other technical and financial partners in the country with regard to analysis, reporting and identifying solutions. Outcomes signalled that there was a need to improve policy dialogue and coordination structures.

A midterm review of the current national health plan was conducted in the **Democratic Republic of the Congo** to support the MoH and integrate some of the resulting recommendations. This complemented the alignment of the national health strategy to the National Development Plan (2019–2022) and the UHC Framework of Actions for the WHO African Region, which is mentioned above.

The health data collaboration (HDC) approach has been adopted by **Kenya, Malawi, Cameroon** and **Tanzania**, with evidence of greater alignment of investments in national data systems as a result. **Uganda** is preparing to launch country-level HDC activities.

As part of the alignment agenda, WHO has provided technical support to strengthen monitoring and evaluation of national health plans, including harmonization and alignment of core indicators, identification of key gaps and priority actions, and mapping and alignment of partner investments. WHO tools and standards for strengthening an integrated/harmonised approach to improving facility data have been introduced in multi-stakeholder national workshops (**Malawi, Zimbabwe, Tanzania, Pakistan, and Uganda**).

The HDC work (collective action) remains relevant and important, particularly within the context of the Global Action Plan (GAP) and the broader health systems collaborative work of the UHC2030. The links between the work of the HDC and the Data Acceleration of the GAP will need to be further discussed and aligned. Phase 2 of the HDC should take into account the focus on more resolutely coordinating international support behind national data platforms. Emphasis is being placed on holding individual partners to account for furthering the principles of alignment. The phase 2 workplan is expected to be completed by end Q3 2019.



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Service availability and readiness assessment (SARA) is rolled out and implemented in most UHC-P countries

UHC-P activities in several countries have also focused on monitoring and evaluation activities in support of the use of the service availability and readiness assessment (SARA). This is a systematic survey of health facilities which is designed to assess and monitor the service availability and readiness of the health sector and generate evidence to support the planning and managing of a health system. SARA produces a set of tracer indicators of service availability and readiness. Its objective is to generate reliable and regular information on service delivery (e.g. availability of key human and infrastructure resources), availability of basic equipment, basic amenities, essential medicines and diagnostic capacities, and on the readiness of health facilities to provide basic healthcare interventions relating to family planning, child health services, basic and comprehensive emergency obstetric care, HIV, TB, malaria and non-communicable diseases.

Burkina Faso disseminated the results of SARA in respect of the availability, operational capacity and quality of its health services. In Sierra Leone, SARA was conducted with UHC-P support for trainings sessions for district health teams on data management processes and analysis. Partnership resources were also used for quarterly supportive supervision in HMIS at national, district, health facility and community levels in order to conduct data quality assurance and promote data use. SARA data and dictionary will be available online by July 2019. **South Sudan** has made substantial efforts to implement SARA: preparations included technical and operational trainings of trainers as well as training for data collectors, data managers and field supervisors. All four modules of SARA+ (core SARA, cold chain inventory, quality of care and data quality review) were adapted and customized and the master facility list was drawn up. Data collection was well under way in 2018 and the report is expected in the first quarter of 2019. In **Liberia**, the Ministry of Health, with technical and financial support from WHO, the Global Fund and GAVI, conducted an integrated health facility survey, quality-of-care assessment and data quality review. A summary documents of findings and rapid sharing of reports with all stakeholders encouraged active policy dialogue. In **Guinea Bissau**, support was provided to the technical committee on developing an investment case for implementing SARA. This would allow plans to be put in place for holding the activity in 2019.

SARA has been conducted in **Benin**, enabling certain gaps in the availability of services to be spotted. This survey led the country to launch health service user satisfaction survey, which is currently under way and expected to provide further evidence on how the health service is perceived.

In **Kenya**, UHC-P provided support for the Kenya Health Facility Assessment Survey, which included carrying out the survey, developing an electronic data collection tool (CsPro), training research assistants, providing training of trainers and piloting data collection tools. Data collection has been concluded in all 47 counties with a 98% response rate at 2980 targeted health facilities. The next steps in support include data analysis and interpretation of results prior to their eventual dissemination.

While the above countries have focused on conducting SARA or its equivalent, small island states such as **Micronesia** and the **Marshall Islands** in the remote western Pacific have gone a step further: they used the health resources availability and mapping system (HeRAMS) survey in 2018 to assess primary health facilities, adapting the HeRAMS toolkit to collect and analyse data on the use of primary healthcare services. This survey enables use of Google Fusion tables with spatial mapping and provides assessments which include a complete mapping of services available at all dispensaries. Analysis of service gaps has pinpointed that there is a need to increase future investment in basic infrastructure (water and sanitation), provide training in basic primary healthcare topics and develop infection prevention and control practices across health facilities. WHO provided individual training for MoH/DHS officers on data collection and dataset management using the HeRAMS toolkit and conducted on-site visits with trained staff. Radio interviews were conducted with health facilities on distant islands.



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5 UHC-P in 2018 – Challenges encountered, and seven key lessons learned

Welcoming new partners and more countries and broadening the scope of UHC-P to include new technical areas has not changed UHC-P's core principles and values.

UHC-P continues to provide flexible funding to WHO Country Offices in response to needs and requests from individual countries and serves as WHO's main catalyst for initiating policy dialogue with Ministries of Health and other stakeholders. An upgraded UHC-P has further boosted WHO's credibility as a trusted partner for countries and MoHs.

Challenges

Despite the many successes UHC-P has achieved since its inception, the path of progress to UHC in partner countries has not been easy, and many obstacles and challenges have had to be overcome along the way. A few sticking points were mentioned in previous chapters which UHC-P had to take into account when planning ahead. It must be emphasized that the complexity of health systems differs from country to country and cannot be underestimated.

Depending on existing government structures and national development plans, implementing UHC activities, building up partnerships and guiding coordination all take time. Moreover, unforeseen changes in political administrations caused by crisis, political instability (as in **Guinea Bissau** and **Georgia**) or climate change, may stall the path of progress to UHC and demand flexible and patient solutions. For example, a bottleneck which slowed down the roll-out of the UHC-P agenda in **Nigeria** and **Mali** involved security challenges. **Nigeria** and **Senegal** also suffered delays due to national election campaigns, and **Ukraine's** upcoming national elections in 2019 may pose some challenges.

Moreover, as could be observed in several partner countries, mobilizing human resources for health was often an obstacle that impeded the smooth and timely implementation of UHC activities. It was often the case that either technical capacity was lacking or recruitment periods were very long. **Niger, Benin, Guinea Bissau, Liberia** and **Sierra Leone** experienced low MoH capacities. In **Nigeria** and **Mali**, high turnover of senior staff at federal level and prolonged

processes for engaging state health authorities hampered efforts to bridge the lack of capacity in the health workforce. **Niger** also had to deal with low capacities for using evidence in reviews and planning coupled with a late holdup in the 2018 funds. Limited funding for HSS in **Sierra Leone** and funding shortages in **Liberia** proved to be challenging for roll-out of the UHC-P agenda as planned.

UHC-P strives towards achieving complete UHC in partner countries and covers a wide range of starting points. Nevertheless, in spite of the astonishing efforts already made, it must be said that much more can be done. UHC-P and WHO therefore rely on sufficient numbers of technical advisers (TAs) being present in WCOs in order to provide targeted expertise that can address all the requisite technical aspects of UHC. Not all WCOs are currently adequately staffed. **Benin** and **Ukraine** WCOs, for instance, need greater TA capacities. **Georgia** has a small WCO and needs long-term external TA support in order to accelerate implementation of the UHC-P agenda; this is also the case with the **Uzbekistan** WCO. Continuing to mobilize human resources and build up capacity are therefore crucial elements which must be pursued.

Another challenge was building up partnerships at country level and including all relevant stakeholders in the respective countries. Despite UHC-P partners being on the ground, much effort was devoted not only to linking representatives from different entities (WHO Country Offices, EU Delegation counterparts, local Ministries, civil society organizations, etc.) but also to cultivating effective and regularly coordinated partnerships that had the same understanding of the UHC-P mission and its capacity to act. In some countries such as **Nigeria**, it proved a challenge to receive confirmation of the UHC-P focal point, and engagement with civil society and the private sector in Niger was difficult. In **Burkina Faso** there were difficulties regarding multisectoral engagement at national level, optimization of data use and incomplete information or insufficient knowledge to inform policy dialogue. These shortcomings are being addressed through



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measures which aim to create greater national ownership, engage other directorates and build up capacity at the subnational level. Liberia fostered MoH's ownership, which both improved structures for stakeholder dialogue and generated evidence to inform dialogue. In the case of **Cabo Verde, Mali** and **Senegal**, challenges were encountered in drawing up strategies to implement health plans. Cabo Verde also seeks to address its poor capacity in health information systems.

A critical gaze must also be cast at the UHC-P home base at headquarters. In spite of intensified efforts to establish better multisectoral coordination and communication across WHO departments, these relationships still need to be reinforced and strengthened. Speaking as one WHO and identifying synergistic activities could have a major technical and political impact. This point will be further developed in the lessons learned.

Lessons learned

Every year there are valuable lessons to be learned. This comprehensive review of the 2018 UHC-P country reports highlights seven key lessons which are discussed below.

Lesson 1. UHC-P is a successful vehicle for revitalizing PHC as a fundamental pillar of health systems

WHO emphasizes that primary health care is a core element of universal health coverage and that no one should be left behind. The global momentum to focus again on PHC and revive it was endorsed by Astana Declaration on Primary Health Care in October 2018 and the Global Action Plan for Healthy Lives and Well-Being. Both identified PHC as one of the key thematic areas to be accelerated to achieve the SDGs. As a co-founder with UNICEF of the concept of PHC 40 years ago, it is crucial for WHO to maintain a visible presence and contribute to the strengthening of PHC worldwide. Implementation of robust PHC strategies is of

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critical importance to provide universal health coverage to one billion more people. WHO will continue to coordinate support to countries, along with its partners, in order to ensure a comprehensive, coherent, balanced and flexible approach that is tailored to each country.

The 2018 country reports showed that UHC-P had not only already bolstered PHC in several countries due to its interlinkage with UHC but also that UHC country support plans had started to prioritize PHC. This was apparent in countries such as Egypt, Greece and Pakistan, which started piloting new people-centred, community-based and integrated health care models to deliver comprehensive PHC. Cabo Verde, Egypt and Jordan launched training programmes for general practitioners to upgrade their family practice capacities and Ukraine rolled out a new contractual framework to PHC providers based on a capitation formula.

In 2019, thanks to UHC-P's flexible structure and ability to adopt to trends and developments as they occur, WHO is even more committed to scaling up PHC by integrating PHC into its agenda and work activities.

Lesson 2. One planning – one pooling – one reporting: UHC-P improves its efficiency as the numbers of donors increase

By 2018, UHC-P had become one of the most significant funding streams in WHO. The number of countries benefiting from the flexible and responsible funding through the Partnership almost doubled within a year.

With two new donors joining the Partnership in 2018, UHC-P addressed the issue of its increased administrative workload and made considerable efforts to improve efficiency. Given the unique structure and flexible functioning of UHC-P, the Partnership was able to harmonize planning and reporting processes across all six donors. UHC-P therefore developed a new unified planning tool that registered the interests of every single donor and adapted work plans to the given development pace and health priorities of each UHC-P country. By working in this manner, stable and secured funding was guaranteed which enabled WCOs to focus on improving service delivery for results: their specific knowledge of the needs and geopolitical contexts of their respective host countries could be harnessed and thus maximized. In spite of different reporting timelines, UHC-P agreed with all donors to produce unified country reports as well as a global activity report (i.e. umbrella chapter).

In short, UHC-P's work methods and adaptable organization enables the integration of new donors and newly supported countries at any time, irrespective of the current status of their progress towards UHC.

Lesson 3. Beyond any other business: UHC-P technical expertise ensures UHC agendas are firmly integrated in high-level policy decision-making

Solid synergies established across flexible funding streams and UHC-P financial support channelled through the Partnership allows countries to prioritize UHC on their political agendas. Moreover, the Partnership provides additional capacity to support MoHs by strategically placing senior-level technical advisers (TA) with HSS expertise in WHO Country Offices. These advisers are specialized in providing longitudinal, coherent and contextualized assistance to strengthen health systems with the long-term goal of achieving UHC. In 2018, it became obvious that the technical advisers provided by UHC-P were instrumental in integrating high-level decision-making, diplomatic exposure and the technical agenda for HSS (e.g. in Guinea Bissau and Guinea). This in turn greatly benefited countrywide activities and cemented the pivotal role of the TA in advancing the UHC agenda.

From the beginning, UHC-P has recognized that in countries where technical advisers could not be appointed in a timely or sustainable manner, WHO Country Offices could not take on their supporting role to the MoH. It is therefore UHC-P's conclusion that in the future more attention must be paid to capacity needs especially in fragile and least developed countries in order to minimize technical and capacity gaps. New modalities must be developed, e.g. task forces or multidisciplinary teams of health systems experts who understand the technical needs and geographical challenges of these countries and are thus able to allow greater progress to be made towards achieving UHC.

Lesson 4. Ensuring unforced coherence: a critical element in striving for UHC

Besides flexibility and responsiveness, both essential functions of UHC-P, another strength is its capacity to ensure coherence in policy-making. While responding to ad hoc requests from MoHs even when there is a potential shift in priorities, HSS experts designated by the Partnership can continue their direct dialogue with the MoH. In 2018, inactive but important activities were revitalized in some countries so that progress towards UHC could be sustained from a longer-term perspective. Greater HSS continuity will result in a larger number of observable UHC-P outcomes.

Some outcomes derived from continued and efficient policy dialogue were clearly apparent in the 2018 country reports. For instance, Tunisia drafted its new national health policy based on its national development plan "Vision", which consolidated key findings from extensive and multiple discussions with citizens, civil society organizations, local representatives, health professionals and policymakers which were conducted in phase 2 of the Societal Dialogue for Health. UHC-P played a critical role in reviving the Societal Dialogue for Health after it had lain dormant due to changes in the Tunisian government administration following the national election in 2014. Similarly, Burkina Faso finalized its national strategy for the quality and safety of integrated people-centred health services, which UHC-P

had been supporting since 2015. Furthermore, UHC-P had been helping to develop legislation for the National Health Insurance bill in Zambia since 2016: it was finally approved by Parliament in 2018. In Sierra Leone, UHC-P continued to strengthen the capacity of the District Health Management Teams (DHMTs) following their establishment in 2015 soon after the outbreak of Ebola virus disease.

Lesson 5. The increased scope of UHC-P contributes to the GPW13 ambition: additional technical areas, health systems strengthening, health emergencies and disease-specific programmes

In 2018, WHO gave special emphasis to UHC as one of the three strategic priorities in its GPW13, thus increasing the expectation that UHC-P would make fast and efficient progress. UHC-P's mandate has thus successfully expanded beyond strengthening health systems to addressing health issues outside health systems. The scope of activities extends to broader global health agendas including health emergencies and disease-specific programmes. For instance, some countries such as Afghanistan, Democratic Republic of the Congo, Niger, Nigeria and Liberia conducted activities to address health emergencies or humanitarian crises. Other countries such as Egypt, Georgia, Lebanon, Morocco and Ukraine tackled the increasing burden of NCDs or mental illness by promoting prevention policies and programmes and redesigning benefit packages including NCDs. Lastly, Cabo Verde and Eritrea conducted activities to alleviate AMR.

WHO has engaged in various disease-specific programmes and life-course approaches, most of which have been carried out by departments other than health systems. However, in the past seven years, UHC-P has sought to step up and foster dialogue with programmes operating outside of the UHC and health systems cluster. UHC-P, under the banner of its Joint Working Team (JWT), has therefore started a series of meetings to catalyse cross-programmatic collaborations across different clusters and departments. In 2019, UHC-P will attempt to make the most of opportunities to harmonize activities across all clusters, departments and programmes and thereby contribute collaboratively to the triple billion goal of the GPW13.

Lesson 6. Spurring on health financing across UHC-P countries leads to faster progress

When looking at the lessons learned from the challenges and bottlenecks encountered and overcome in 2018, it must be kept in mind that existing mechanisms and actors on the ground do not operate in a political vacuum. While much of the strategic purchasing work is initially "technical", the environment in which these actors and UHC-P operate is influenced by sometimes stable, sometimes volatile political economies. As could be observed during 2018, UHC-P, with its convening power and facilitating role, has been pivotal in supporting the MoH to manage these group interests. Since UHC-P support resulted in a clarification of important aspects of governance, this made health financing structures less complex in many of its partner countries: the clearer the terms of reference for committees and commissions, the

clearer the responsibilities and division of labour, and the faster technical and institutional health financing capacity building. This is likely to be reinforced even more in 2019.

Another aspect addressed through more targeted activities was the strengthening of health information management systems (HIMS): this is required to provide full support for changes or necessary reforms in strategic purchasing, which is as intense as that of other health financing functions. Activities for 2019 underscore the need for the continued HIMS efforts in all partner countries. Finally, positive results were apparent for the health financing multisectoral dialogue supported by UHC-P. It is imperative to continue UHC-P activities which strengthen the role of the MoH in its dialogue with the Ministry of Finance over budgeting and public finance management issues.

Lesson 7. Spill-over effect: other WHO programmes in Africa join in spurring on UHC

UHC-P stands out due to its unique tailor-made action plans which are adapted to each partner country's regional development strategy and health policy priorities. One example of how UHC-P accelerates the implementation of regional agendas can be seen by looking at the UHC Flagship Programme in the WHO African Region (AFRO).

The UHC Flagship Programme in AFRO was established to accelerate the implementation of the Regional UHC Framework of Actions, endorsed in August 2017, by the Regional Committee for Africa. In late 2017, with the support of the UHC-P, the Regional Office for Africa led the first UHC scoping mission to Nigeria, followed by a mission to Swaziland. The results of these scoping missions are reflected in the development of country-specific UHC roadmaps, agreed between WHO and the MoH.³

Currently, UHC scoping missions are being undertaken systematically in the African Region. In 2018, missions were carried out in Eritrea, Mozambique, Zambia, Ghana, Benin, Togo, Ethiopia and Madagascar. South Sudan, Tanzania, Cameroon and other countries in the African Region are on the scoping missions list for 2019.

³ These UHC scoping missions consist of a technical team from the Regional Office, which visits a target country following extensive reviews of NHPSPs and related documents. Aside from dialogue with WCOs, meetings are held with the MoH and relevant stakeholders including civil society organizations and UN agencies. These scoping missions also entail field visits to health centres to explore the provision of essential services and PHC, and to identify how national directives are being implemented in the front line. The assessment proceeds following the UHC Framework of Actions.

6

Conclusion

UHC-P and WHO are proud of the results collated in this 2018 Annual report.

Despite challenges and bottlenecks, the achievements made with the support of all partners and stakeholders, as well as the authoritative credibility of WHO at country level, afford a positive vision of what is possible through continuous efforts and flexible mechanisms.

UHC and PHC are now at the forefront of the WHO mandate. Since it can plan ahead while maintaining these interlinked characteristics, UHC-P is an important vehicle for working towards achievement of the SDGs. UHC-P has maintained its key principles while adapting its operational structures to the needs and requirements of each of its partner countries and donors. Better alignment and harmonization with national development plans, fostered policy dialogue, support to countries either intending to prepare or already rolling out targeted health legislation, strengthening health governance and securing health financing systems and many more UHC related activities in all partner countries have shown constant progression with the tireless support of stakeholders.

A new financing extension until 2022 has not only enlarged UHC-P's geographical but also its technical scope. It is therefore envisaged that, in addition to health emergency actions, new activities in health security and NCDs will be integrated into the UHC-P agenda. This new development will allow UHC-P to make even more progress and accelerate the advent of UHC in partner countries. Enhanced mechanisms to ensure coherence, carefully nurtured policy dialogue, flexible funding streams and improved coordination are important instruments in moving forwards.



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