KIT | Health

Formative Evaluation of the EU-Luxembourg-WHO Universal Health Coverage Partnership (UHC-P) 2011 - 2016

Royal Tropical Institute (KIT)
Mauritskade 63
1092 AD Amsterdam
www.kit.nl

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Abbreviations

AFRO	WHO African Regional Office
BBP	Basic Benefits Package
CBHI	Community Based Health Insurance
CSO	Civil Society Organisation
DFID	UK department for International Development
DP	Development Partner
DRC	Democratic Republic of Congo
EMRO	WHO Eastern Mediterranean Regional Office
EU	European Union
EURO	WHO European Regional Office
GAVI	Global Alliance for Vaccines and Immunization
HF	Health Financing
HI	Health Insurance
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IHP+	International Health Partnership
KIT	Royal Tropical Institute, Amsterdam
ILO	International Labour Organisation
JANS	Joint Assessment of National Health Strategies
LUX	The Grand Duchy of Luxembourg
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MoF	Ministry of Finance
MoH	Ministry of Health
MTEF	Mid-term expenditure framework
NCD	Non-communicable Diseases
NHP	National health plan

NHPSP	National Health policies, strategies and plans
NHSSP	National Health Sector Strategic Plan
OASIS	Organizational Assessment for Improving and Strengthening Health Financing
ODA	Official development assistance
P4H	Partners for Health
PHC	Primary Health Care
PNDS	Plan Nationale de développement Sanitaire
RBF	Results Based Finance
UHC	Universal Health Coverage
UHC2030	Intended successor to the IHP+ framework
UHC-P	European Union/Luxembourg/WHO Universal Health Coverage Partnership
UNFPA	United Nations Populations Fund
UNICEF	United Nations International Childrens' Emergency Fund
USAID	United States Agency for International Development
RMNCH	Reproductive, Maternal, Newborn and Child Health
SDG	Sustainable Development Goals
SEARO	WHO Southeast Asian Regional Office
SHA	System of Health Accounts
SWAps	Sector Wide Approach
TAd	Technical Advisor
TA	Technical Assistance
TOR	Terms of Reference
TWG	Technical Working Group
WB	World Bank
WHO	World Health Organisation
WHO CO	WHO country office
WHO HQ	WHO Headquarters in Geneva
WHO RO	WHO regional office
WPRO	WHO Western Pacific Regional Office

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Final editing of this report: Ingrid Zuleta, Olivier Onvlee, Jurrien Toonen

Correspondence: j.toonen@kit.nl

Executive Summary

This report provides the result of an evaluation of the Universal Health Coverage Partnership (UHC-P), a collaboration between the EU, Luxembourg and the WHO. As a *formative* evaluation, the focus is on lessons learnt, rather than on accountability. This review was carried out between March and September 2016 by KIT, the Royal Tropical Institute in Amsterdam, and mandated by WHO headquarters.

Methodology. For this study, an evaluation frame and instruments (Annex 3) were developed for data collection and data analysis, and agreed upon with WHO-HQ. This framework was used for a desk study on the global reports and all 20 country programs (roadmaps and annual reports), for a quantitative study on outputs of the UHC-P and for face-to-face interviews with key-stakeholders at all levels. An online survey was developed, but the response rate was too low for reporting purposes– except for interesting in-depth qualitative information on the country provided by those who did respond.

Individual face-to-face interviews and stakeholder workshops were held in 12 countries (Burkina Faso, Democratic Republic of Congo, Guinea, Mali, Mozambique, Liberia, Sierra Leone, Senegal, South Sudan, Sudan, Tunisia, and Vietnam). Skype interviews were held with stakeholders in another 5 countries (Cape Verde, Lao PDR, Republic of Moldova, Togo, and Timor-Leste). Unfortunately, the team was unable to reach enough stakeholders in three remaining countries (Chad, Niger, and Yemen). In these three countries the team relied on the countries' annual reports. Also, WHO officials were interviewed at Regional Offices (RO, in Cairo and Brazzaville) and Head Quarters (HQ, in Geneva).

Findings. The UHC-P has made significant contributions to national policies, strategies and plans towards Universal Health Coverage through supporting policy dialogue at central Ministry level by providing dedicated technical assistance in the 20 selected phase I & II countries between 2011 and2015. The partnership's activities were demand-driven by the various countries, and support focused on health financing, donor alignment, institutional capacity building and specific health sector themes. This support was provided by the WHO country offices, as well as by regional offices and headquarters.

In most countries, UHC-P support fostered policy dialogue on comprehensive national health policy, resulting in this policy becoming more oriented towards UHC. Also, the dialogue itself became more inclusive, which is important because continued commitment of all stakeholders is key. The UHC-P support helped governments to engage both national and international actors in policy dialogue, and improve their alignment with national health planning. The inclusion and engagement of other national ministries is an important achievement of the UHC-P. In many countries this took the form of NHPSP elaboration that provided the base for alignment of development partners, sometimes it included discussions to better define country COMPACTs.

The UHC-P support helped the MoHs in several countries to elaborate robust national health sector plans (NHPSP) as well as thematic strategies. The partnership's efforts helped MOH to **define their NHPSP with a more explicit focus on achieving UHC**. Moreover, the **UHC-P support was able to strengthen institutional policy making processes** and support the advancement of key health dossiers. At the same time the **MoHs' capacity was strengthened to claim its 'driver's seat'** of

planning processes involving development partners, other ministries and stakeholders. In the post-Ebola countries, the UHC-P funds enabled to WHO to take a leading role on recovery coordination and planning and was highly commended by stakeholders.

The partnership provided an evidence base for the policy dialogue process, by offering evidence on UHC experiences from other countries, case studies on health financing options, or organising situational analysis and annual review. The ability to provide **both technical assistance as well as seed funding helped the WHO to be convenor and facilitator of policy dialogue**. Moreover, training and capacity building activities further reinforced the policy dialogue process: costing health plans helped making choices in policy decisions and the support given to regional and district levels was important to make policies work beyond the paper version.

Even so, organising inter-sectoral dialogue sometimes proves to be a challenge. The translation of central health policies into implementation, both at central and decentralised level, remains a key challenge as well for many countries. Moreover, training and capacity building activities further reinforced the policy dialogue process: costing health plans helped making choices in policy decisions and the support given to regional and district levels was important to make policies work beyond the paper version.

Health financing (HF) remains a big challenge for most of the supported countries to define their UHC policies and strategies. Most countries demanded at least some form of support on this theme. The partnership supported countries by providing technical input for discussions, including situational analysis, technical support to HF-thematic working groups, HF-systems reviews and broader HF studies. Policy dialogue on health financing often proved to be challenging as it deals with politically sensitive issues in UHC like (re-)distribution and (re-)allocation of resources. Moreover, on occasion the MoH even requested support which does not align with evidence on what works to progress towards UHC. However, looking forward, demand for health financing expertise is likely to increase even more.

Provision of support to countries was first and foremost done via WHO offices at country level, with regional and HQ taking on a supporting and coordinating role. This set up allowed for learning at all levels, with intercountry partnership meetings providing a unique opportunity for all stakeholders to share experiences and insights. One of the major challenges the UHC-P faced during the implementation of the programme was the small pool of technical advisors qualified and available to take up the additional health system strengthening (HSS) advisory roles in the country offices. As these roles require senior candidates with a rather specific set of skills (thematic, language and more), potential candidates are not always easy to identify and recruit. But by creating a HR roster for the program the availability and quality of expertise needed was improved, and initial disbursement problems were overcome.

Looking forward, **the extension and expansion of the UHC partnership can only be encouraged**: WHO has the image of an independent technical agency; few other agencies are interested in supporting sector-wide policy development. UHC-P funding enables WHO to also add some seed financial support to the technical support. Nevertheless, there are some key questions that should be considered by the three partners with regards to both the sustainability of the support and how to maximize results in new countries. In this respect, the most **valuable lessons** are:

LESSONS LEARNT

- **The flexibility in planning and implementation of activities possible in the UHC-P program, allowed for prompt changes to the countries' roadmaps**.

  Roadmaps were sometimes ambitious for the crises encountered in the countries, limited timeframe of the programme and the complexity that policy dialogue entails. Moreover, the partnership was flexible enough to amend roadmaps as different needs arose – which became very clear in the case of the countries hit by Ebola.

- **The UHC-P shows that specifically allocated funds can help to meet mutual expectations between WHO, donors and beneficiaries of the policy process at ministerial level.**

  It is clear what the three parties involved can expect from another in this partnership – here: a certain degree of certainty that WHO's focus will be on country level – and here on health system strengthening (HSS) and health financing (HF). This is key in supporting countries towards UHC.

- **Support to HSS and HF require senior candidates with a rather specific set of skills (thematic, language and more), potential candidates are not always easy to identify and recruit.**

  By creating a HR roster for the program the availability and quality of these types of expertise needed has improved. In most WHO-Country Offices, Health Financing expertise is scarce. We would recommend to increase full-mode TA for UHC-P on both types of TA – health system strengthening and health financing for continued expertise on policy advice.

- **The three organisational levels of WHO have been well leveraged to provide high quality technical support to MoH** (*delegation of tasks and responsibilities*)

  Devolution of decision-making and resources (*transfer of competencies*) on the program could allow the CO level to be even more responsive to local needs.

- **The next few years of the UHC-P will likely concentrate more on implementation of the policies which have been developed in the policy dialogue processes of the past 4 years**

  All countries recommended to extend the activities of the UHC-P from policy dialogue to support in the implementation of the policies.

Introduction

The Universal Health Coverage Partnership (UHC-P) was formed by the European Union, Luxemburg and the World Health Organization (WHO), and represents a unique effort to promote Universal Health Coverage (UHC) at the national policy level. Through WHO headquarters (HQ), regional offices (RO), and country offices (CO) the partnership offered 20 countries tailor-made technical assistance. This technical support ranged from increasing monitoring and evaluation capacities in post-conflict Timor-Leste, facilitating the nationwide deliberations part of the societal dialogue on health in Tunisia, to the involvement in post-Ebola health systems planning in all three countries affected by the Ebola epidemic: Guinea, Liberia and Sierra Leone.

After three years of operations, the continuation and expansion of the partnership is at hand (phase III), thus there is a need for an evaluation of the partnership's work so far. The WHO has mandated the Royal Tropical Institute in Amsterdam (KIT) to conduct a *formative* evaluation of the partnership's phase I and II achievements and results, up to 2016. The aim of this evaluation was not simply to reflect the results achieved in the countries up to date, but also to identify key lessons learnt and recommendations for the successful continuation of the partnership.

The objectives of the evaluation, which were set out in the Terms of Reference of this consultation are:

Overall Objective:

To conduct an external evaluation of the UHC Partnership's results and achievements, also as per the programme's objectives and indicators and of its contribution in strengthening WHO's capacity to support Ministries of health (MoH) in the 20 countries.

Specific objectives:

I. To understand how the UHC Partnership succeeded in supporting the development and implementation of robust national health policies, strategies and plans and specifically health financing strategies, aiming at increasing coverage with needed health services, financial protection and health equity;

II. To identify how the UHC Partnership succeeded in increasing technical and institutional capacities, knowledge and information for health systems and services adaptation and related policy dialogue of country stakeholders;

III. To discover how the UHC Partnership succeeded in ensuring that international and national stakeholders are increasingly aligned around NHPSP and adhere to other effective development cooperation principles;

IV. To explore other tangible results that may be relevant and compliment this Partnership programme.

The focus of the evaluation was primarily on support provided to 20 countries, and how this was facilitated by the partnership. This included a thorough investigation into the main challenges and opportunities encountered in efforts to promote and develop policy dialogue for attaining UHC in the selected countries, with particular attention paid to the partnership's contribution. The evaluation centred on processes, and efforts were made to identify to what extent these results could be attributed to the UHC-Partnership support, specifically to the WHO's support in policy-making, capacity building and alignment of partners. As policy-making is a complex process influenced by several stakeholders a political economy lens was adopted to capture relations between various actors, and to better understand the UHC-P contribution within the larger policy making arena.

Understanding Universal Health Coverage (UHC)

UHC is most commonly defined as "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access"[i]. The WHO concept of UHC is "to ensure that everyone, everywhere, can access quality health services without facing financial hardship as a result".[1] Improving financial protection is a central focus of health financing policy aimed at enabling UHC. As visualised in the UHC cube (Figure 1), UHC requires work on three fronts: increasing the proportion of people who enjoy coverage (breadth); increasing the range of services included (depth); and increasing the proportion of costs covered for health (height).[2]

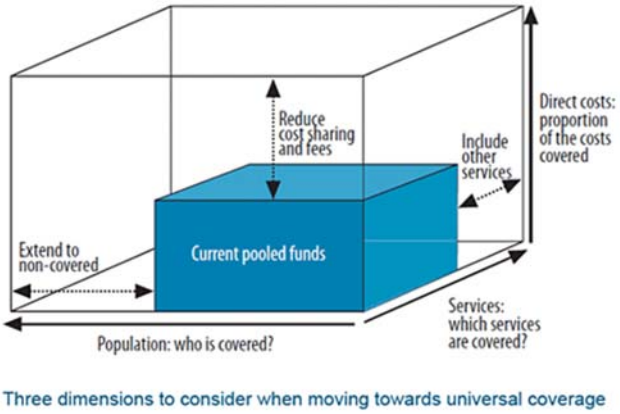

Figure 1: UHC Cube, WHO

When the UHC concept was first presented, it mainly focussed on financial access to care, as this was seen as the main obstacle to equitable access. Therefore, countries focussed on organising their health financing to improve financial access. Several countries introduced "free health care" policies to improve financial access for all. However, in practise many of these programmes are underfunded. In addition, many countries looked for ways to increase resources for the health sector, for instance through increasing the share of the national budget allocated to health, raising earmarked taxes, or installing "innovative" sources of financing for health. The organisation of funding is increasingly important as available resources are not always allocated in an equitable way, both geographically and towards vulnerable populations.

Over time, UHC became more specifically defined, such as by the first UHC monitoring report. Here, UHC means "all people receiving the health services they need, including health initiatives designed

[1] http://www.who.int/health_financing/en/
[2] World Health Organization. Sustainable health financing, universal coverage and social health insurance. World Health Assembly Resolution 58.33 (2005). http://www.who.int/health_financing/documents/cov-wharesolution5833/en/index.html

to promote better health (such as anti-tobacco policies), prevent illness (such as vaccinations), and to provide treatment, rehabilitation, and palliative care (such as end-of-life care) of sufficient quality to be effective while at the same time ensuring that the use of these services does not expose the user to financial hardship".[3] UHC therefore comprises three main components: quality of care, essential health service coverage and financial coverage, all three extended to the whole population.

Demand side issues are important too: offering high-quality health care that is *acceptable* for all, also referred to as "social-cultural accessibility". To reach UHC, services should be offered that meet the health wants, needs and demands of the population, and that respect cultural health views. Achieving equity, both in terms of social-economic factors and in terms of gender is of utmost importance in achieving UHC. Active targeting by means of allocating extra human- and financial resources is needed for vulnerable groups to ensure all can have access to healthcare.

To achieve UHC, changes in national health policies, strategies and systems are required, which can only be accomplished through sustained support of the different stakeholders involved. To facilitate the processes that should lead to universal health coverage, the Universal Health Coverage Partnership among EU, Luxembourg and WHO has been supporting the development of robust national health policies, strategies and plans, as well as national health financing strategies and plans – mainly through funding and facilitating, capacity building and bringing evidence to policy dialogue activities needed to stimulate reforms needed for the universal health coverage agenda in 20 countries across the globe.

[3] Tracking universal health coverage: First global monitoring report; Joint WHO/World Bank Group report, June 2015

Methodology

In order to capture the breadth of activities and topics covered in the participating countries, and to learn lessons from the unique experiences of various stakeholders involved throughout the process, the evaluation was organised in several phases and utilised various tools to collect data.

Preparatory phase

The preparatory phase of the evaluation focussed mainly on mapping the existing information on the UHC-P and its activities, as well as preparing the tools for the data collection phase. A theory of change of the partnerships was deducted from the UHC-P inception documents. In order to better demarcate the evaluation objectives and understand the dynamics of the programme, a desk review was conducted on the global characteristics of the UHC-P and its thematic and organisational change during the period of 2012-2015. As part of this process, the KIT evaluation team attended the 4th annual UHC-P intercountry meeting in Barcelona, where the evaluation was also introduced to all WHO and MOH stakeholders present.

In consultation with the WHO HQ, the KIT team developed an evaluation framework (see Annex 3) to cover the key thematic fields for policy dialogue as operationalised in the countries, as well as a focus on the mechanisms of the partnership, country context and other mediating factors. Based on this evaluation framework, four tools were developed to streamline the data collection process:

- Country Desk study frame: used for ordering information from the country roadmaps, self-reported findings in e.g. the annual report and key policy documents.
- Interview guides: semi-structured guides specified to global, regional and country level, as well as type of stakeholder (WHO, Development Partner (DP), MoH and other).
- Country Reporting frames: a frame to report and compile the merging findings from the interviews during country visits with those of the country desk studies
- Online survey: an online survey was developed to collect additional quantitative data on individual countries, effectiveness and perception of the UHC-P. The aim of the survey was to provide a more quantitative input into the evaluation process, as well as to enable stakeholders to anonymously voice concerns.

To prepare for the interviews in the 20 countries, a country desk review was completed for each of the UHC-P countries, using the provided country roadmaps and progress reports, as well as key policy documents that are publicly available.

Data collection phase

To cover the partnership's activities and processes in the 20 UHC-P countries, country evaluations either through an in-person visit by a KIT advisor or via Skype were planned for all the phase I and II countries. During country-visits, the WHO-CO was asked to organise an open meeting with key stakeholders. Furthermore, the aim was to interview approximately 4-6 key stakeholders individually, including but not limited to the WHO CO staff, MoH representatives and DPs. To identify the key stakeholders in each country, the COs were asked to share participant lists. All identified stakeholders received an invitation to the online survey, even if they could not be reached for interviews. All

responses to both the survey and interviews were handled as strictly confidential and are not quoted on this report.

Between May and July 2016, interviews were conducted in 12 countries (Burkina Faso, DRC, Guinea, Mali, Mozambique, Liberia, Sierra Leone, Senegal, South Sudan, Sudan, Tunisia, and Vietnam). Moreover, face-to-face interviews were carried out with key informants in WHO HQ in Geneva, EMRO in Cairo and AFRO in Brazzaville. Skype interviews were held with stakeholders in another 5 countries (Cape Verde, Lao PDR, Moldova, Togo, and Timor-Leste). Unfortunately, the team was unable to reach enough stakeholders in three remaining countries (Chad, Niger, and Yemen). Desk study findings from these countries were mostly used to inform this evaluation. A full description of the respondents can be found in Annex 4.

Data analysis phase

Once all country interviews were concluded, the advisor(s) responsible for the individual country studies compiled their findings in the country reporting frames. Care was given not to link individuals to the opinions they had expressed. Subsequently, the findings from the country reporting frames were necessary enriched by the findings of the country desk studies. Both sources were entered into the overall evaluation frame in Excel and analysed per theme. These findings were subject to discussions in workshops between the Amsterdam-based team and the African-based consultants to enrich the findings and their interpretation, and later with WHO-HQ to discuss gaps in the findings. A second draft was sent to different WHO-levels for comments, which were all taken into account in the writing of this report.

Limitations

Seeing as the evaluation encompassed all 20 countries involved in phase I-II of the partnership, as well as WHO regional and headquarters level, the evaluation team necessarily had to limit the scope of the review (as set out in the methodology) and the number of stakeholders it could interview.

Although care was given to form a comprehensive image of the partnerships' processes in all contexts, in some countries it turned out to be very difficult to reach out and meet with all stakeholders during the evaluation visits (Sudan and Vietnam). Where possible, we have tried to follow up with individuals via Skype. However, overall we believe that the number of people consulted for this evaluation has been substantial and represents a comfortable sample: 17 of the total of 20 countries, and 2 out of three RO involved.

Unfortunately, the findings from the quantitative online survey were not sufficiently numerous and diverse (only 33 respondents, representing 8 of the 20 countries) to be used for a representative quantitative analysis. However, the survey still proved to be a valuable addition as responses to open questions helped to clarify country specific findings.

Attribution of results of key health sector indicators linked to the progression towards Universal Health Coverage to UHC-P activities is not realistic from a statistical point of view. We may refer to contribution of results, but not to attribution of results. The partnership facilitated policy dialogue on policies linked to UHC. UHC represents a diverse mix of activities between the various countries within specific national policy environments which each encompass a vast and diverse number of programs, interventions and stakeholders. Therefore, it was a challenge to delimit in the UHC results of a country

the quantitative role of the UHC-P. However, quantitative data on a country's UHC results provided to be useful in providing a background for discussions with key stakeholders.

In this evaluation, we have briefly considered some of the financial characteristics of the UHC-P. However, it should be noted that this evaluation does not intend to be an accountability exercise and only limited financial data has been reviewed primarily with the aim to better understand the UHC-P processes.

Overall, the methodology of the study was mainly qualitative, and making use of quantitative indicators made it a mixed methods approach. As the goal of this evaluation is to be formative and to focus on lessons learned, the in-depth qualitative data collected provided enough information to the evaluation. A thorough description of the findings can be found on the next chapter and the lessons learned are summarized in the conclusion chapter.

Key Findings

The goals for the UHC-P evolved over the 3-year implementation period; the period covered by this formative evaluation refers to. The goals as they stand are:

- Objective I: To support the development and implementation of robust national health policies, strategies and plans to increase coverage with essential health services, financial risk protection and health equity;
- Objective II: To improve technical and institutional capacities, knowledge and information for health systems and services adaptation and related policy dialogue;
- Objective III: To ensure international and national stakeholders are increasingly aligned around NHPSP and adhere to other aid effectiveness principles.

This chapter discusses the various findings linked to the objectives above. It starts of by discussing overall experiences with supporting policy dialogue processes, before focussing on contributions to NHPSPs, HF and alignment of Development Partners. The chapter concludes by looking into partnership management. UHC-P contributions to capacity building are discussed in their thematic context, and as such are integrated within the other subsections.

UHC-P support to Policy Dialogue

KEY MESSAGES

- The role of WHO as *facilitator* of policy dialogue processes was highly appreciated in the interviewed countries.
- The policy dialogue process produced significant results with regards to improving the quality of national health planning – that facilitated changes towards UHC.
- Policy dialogue in- and of- itself clearly had value to foster inclusiveness within policy deliberation.
- In some countries, the leading role of WHO support to policy dialogue was more evident than in other countries, this depended on the importance of other concurrent development partners.
- The UHC-P activities were demand-driven and generally more inclusive than previous policy deliberation processes.
- In 'full mode' countries, the ability of the UHC-P TA to continuously follow up on the policy dialogue process was seen as a key success factor.

In general, the main focus of the UHC-P activities was stimulating policy dialogue on the national health plan and its financing, which was implemented in every country.

Overall, policy dialogue has been more widely used and improved in all partnership countries. Moreover, in most evaluated countries it was said that the dialogue had become **more inclusive** since UHC-P**.** Diverse stakeholders were involved in the policy dialogue sessions, including stakeholders from the MoH at national and local level, development agencies, the Ministry of Finance, local stakeholders, community members, civil society organizations, and in some cases members of parliament or cabinet. No doubt a result of the positive role of WHO as *facilitator* of the policy dialogue process, a key role description mentioned in almost all countries, the exception being Yemen due to the conflict crisis.

Inclusive Policy Dialogue

In countries, such as: Togo, South Sudan, and Tunisia a participatory approach was taken by involving all stakeholder in both attendance and decision-making of the development of specific policies. The case of Tunisia's Societal Dialogue presents an especially inclusive and comprehensive example of how consultations from the grassroots level can be used to identify key equity issues in the health system and result in a laudable set of policy recommendation in the form of the "Livre Blanc" (white paper). This type of citizen led initiative, sponsored by the WHO, gave considerable momentum to both the organizing committee and a voice to thousands in the country's population.

The role of WHO as facilitator of the policy dialogue process was mentioned in 16 of the 20 evaluated countries. Interviewees described the WHO country TAs' role as: instrumental, prominent, important, proactive and highly appreciated. Through the policy dialogue sessions the institutional capacity of the MoH on planning, results-based management, and training of key actors at decentralized level was increased.

The role of WHO TAs facilitating discussion such as steering committees or thematic working groups gave great platforms to foster policy dialogue. This

was especially seen in Burkina Faso, DRC, Guinea, Moldova, Mozambique, South Sudan, Sudan, Timor-Leste and Vietnam. Within these platforms regular meeting were held, which in most cases were used for preparing policy dialogue sessions providing issues for decision-making in the sector.

The UHC-P **seed funding** for activities provided for the hosting of policy dialogue activities, placed WHO in an unique position among other development partners as the broker of demand driven policy dialogue. In this sense, it often improved the visibility of the organization and even reshaped its role within health sector dialogue. Whereas funding for a comprehensive policy dialogue on the health sector as a whole is generally scarce in countries, as policy dialogue is often limited to narrowly defined health themes linked to a donor's interest, the UHC-P support for policy dialogue on the overall health sector was highly appreciated by most respondents.

Particularly in countries with a frail health system and limited capacity in the MoH, the policy dialogue activities were instrumental in achieving the elaboration of key documents and strategies. At the same time, this type of UHC-P support played a key role in strengthening the capacities of the MoH staff involved in the process. One key challenge mentioned by interviewees of a MoH was the difficulty in translating improved capacities in health policy and policy dialogue into **implementing** meaningful reforms or operationalization of activities.

Technical Assistance was an important element and an appreciated part of the UHC-P support to policy dialogue in countries – provided by WHO in different ways by HQ, RO and CO; but also by specific Technical Advisors (TAd). These TAds were so-called "full-mode" (long-term, living and working in the supported country) or "light-mode" (short term missions, according to specific demand). Where there was a full-mode TAd (like in Guinea), this was highly appreciated, while in other countries –like Sudan – there was a clear demand for full-mode TAds.

According to most of the interviewed stakeholders, the ability of the UHC-P 'full mode' TA to attend all meetings and closely follow up on new developments in the policy dialogue process was an important success factor. Not only could a 'full mode' TA provide input in the process itself, but often he/she could also identify potential roadblocks early on and closely manage the expectations of different national and international stakeholders. In the cases were "light mode" was in place, an alternative was to have a local institution that could guarantee follow-up in ongoing activities like thematic working groups. For example, in Sudan the draft HF strategy for UHC has been coordinated and developed by the Public Health Institute (PHI), mandated by the MOH and contracted by the WHO/CO. If continuity is seen as an important element of the policy dialogue process, then having a light mode programme in cooperation with a national institution may be an alternative to boost continuity too.

Discussion

Though the policy dialogue experience was a positive development, there is a need to address the sustainability of policy dialogue structures. These have significantly leaned on the partnership funding to kick-start the programme, but will need continued support and commitment from the governments themselves to truly institutionalise. It should be noted that true ***institutionalization*** *of these processes may take years. As mentioned by Dovlo D. et al in "Health policy dialogue: experiences from Africa", policy dialogue in general encounters difficulties with institutional change and internalization of*

culture of policy dialogue, challenges with new administrations and turnover key policymakers. Time for transition between administrations has proved to sometimes slow down the momentum of activities (e.g. Tunisia). The capitalization of policy dialogue experiences in the form of a briefing note ("Policy Dialogue: What It Is and How It Can Contribute to Evidence-Informed Decision-Making") represents a valuable addition to the knowledge available for actors both within and beyond the partnership.

Outsourcing the provision of TA to national institutes like to the PHI in Sudan did raise issues between the MOH and the WHO-CO: both questioned the management of the PHI –both on financial accountability as well as political accountability. A national institute like PHI may not be as independent as WHO, it may avoid treating political sensitive issues..

KEY MESSAGES

- The UHC-P strategy to work on NHPSP/ HF plans is highly relevant and appropriate to embark on meaningful reforms that may lead to UHC – and sustaining them.
- The UHC-P support has contributed to the strengthening of *comprehensive* national health policies, strategies, and plans and bringing a UHC-focus to them.
- UHC-P support also resulted in Monitoring and Evaluation plans strengthening Health information systems. But also more specific policies and plans, like for Human Resources for Health.
- After focusing on policy-making at central level and in some cases strategic planning at decentralised level, the need of support this strategic planning at decentralised level is more and more in vogue.
- The flexibility in the set-up of the UHC-P ensured that content of support of UHC-P were highly country-specific, and clearly demand-driven.

UHC-P support to the development and implementation of health policies, strategies and plans

Support to developing *National Health Policies Strategies and Plans* (NHPSP), with emphasis on UHC and harmonization within the health sector, has been a key focus of the partnership since its inception. In almost all countries there is a visible WHO contribution in at least one of the phases of the planning and implementation cycle. In the planning phase, where the National Health Sector Strategic Plan or similar 5-10 year plan (NHSSP) was about to come to a close (12 countries) or was not place, the WHO played an instrumental role in the consultations and policy dialogue sessions leading to the adoption of new NHPSPs.

The UHC-P support to the policy dialogue process produced significant **results** in the national health planning, such as drafts and approved documents of national health plans, Budgeting plans, health financing strategies, joint annual reviews, among others. The UHC-P contributed by performing situational analyses; drafting policy documents; engaging decentralised levels in the process of policy development; and costing and planning the implementation of the policies. This all facilitated policy makers in the countries to take informed policy decisions. For example, in the DRC's new NHPSP 2016-2020, the UHC focus has become much clearer, as it did in Senegal. Both countries also show a clear focus on vulnerable groups.

As the partnership supports both the poorest (Guinea, DRC, South Sudan) as well as higher middle income countries (Tunisia, Moldova), the needs to elaborate on NHPSPs vary in an important way both in the type of thematic support, as well as the level of involvement and capacity building. The **country-specific approach** of UHC-P allowed for adapting to these differences among countries. Hence the overall thematic focus of UHC-P support is rather broad as it is unique to each country.

UHC-P support was operationalised in the countries' roadmaps, within the offered thematic areas of the UHC-P for the NHPSP. In countries that were currently in the middle of NHPSP planning cycles, the attention seemed to shift towards the elaboration of **thematic strategies** in line with attention points as set out in NHPSPs. These thematic areas could all be very well explained as themes that are important for the road towards UHC. Very often this meant the elaboration of health financing strategies, which will be presented in a separate section below, but also included medications (Moldova); HRH (Sierra Leone, Sudan); NCD (Timor-Leste, Moldova); and RMNCH (Timor-Leste) to name the most common. The choice of which thematic strategies needed provision of support was demand driven, and based on MoH priorities. Again, this broad range of thematic choices allowed for tailor made programming in each country, and it was made possible by the flexible and comprehensive focus of the UHC-P. This should certainly be seen as a key strength and highlight of the programme.

Examples of support to NHPSP

In the DRC to the elaboration of the new PNDS 2016-2020; in South Sudan to the NHSSP 2015-2025 and the new CHW policy "the BOMA Health Initiative"; in Mali the new Programme on Social & Health Development 2014- 2018 (PRODESS); in Sudan the National Health Sector Strategic Plan 2012- 2016; in Guinea the Plan Nationale de Développement Sanitaire (PNDS) 2015-2024, in Burkina Faso revitalising the PNDS 2011-2020.

Examples of UHC-P contributions

In Vietnam: review of the 5-year National Health Sector Plan (NHSP for 2011-2015) and supporting the development of protocols and methodologies for the NHSP 2016-2020. In Liberia the restoration of essential health services and strategic investment plan (2015-2021). In Sierra Leone Health Sector Recovery Plan was costed.

In Timor-Leste, which had a 20 year vision (2011-2030) in place but no shorter term plans, WHO contributed to defining the operationalization of the plan, similarly in Senegal (of the PNDS 2009-2018).

Focussed was on making NHSSPs more concrete, both through costing exercises (like in e.g. Mali, DRC) of the plans and/or costing of annual operational plans (Sierra Leone, Liberia, Togo, and South Sudan).

Another contribution to robust national health policies was the partnership's support for the **joint annual health reviews** (JAHRs), which were consistently realised in most countries. More than simply a moment to review the results from the year before, the UHC-P support has tried to, in some countries, use the review as an opportunity to build a joint platform to promote reflection and policy dialogue. Moreover, the UHC-P also supported strengthening M&E structures necessary to conduct these reviews. In the DRC, the UHC-P made the case for introducing the improvement of M&E structures in the new NHSSP 2016-2020.

In a few countries, like Liberia, Burkina Faso, the DRC, Togo, South Sudan and Senegal, the partnership actively supported activities around national health policies at the **decentralised level**. This included both support for implementation of development of implementation strategies, operational planning, and capacity strengthening. At the lower administrative levels, capacity was often deemed to be low, and further support for planning and monitoring would certainly be of added value. For example, in Togo district health staff received substantial support for developing district operational action plans focusing on high impact interventions. In Burkina Faso, the WHO supported the training of MoH staff to better prepare regional health plans in line with the national priorities set out in the NHSSP. In the DRC, the important intermediate province level was strengthened by providing training and accompaniment of staff to improve the operationalisation of province level plans.

Building Capacity of the MoH

In Senegal, the decentralized units have a say in local health governance, and this is why the WHO focused on strengthening health management skills of newly elected local councillors by training over 100 of them on developing and implementing health plans. The idea was to get more tailor made solutions to local contexts. There was high interest in the training, and more are planned with efforts made to involve the private sector. Moreover, with help of the WHO the country has also joint annual health reviews at the intermediate regional level, at the same time creating a new platform for policy dialogue and sharing a participatory approach and involved MoH stakeholders at national and subnational level. Workshops on leadership and planning were given at both national and subnational levels. Experiences between district, regional, and national stakeholders – including DP.

The diversity of fragile contexts where the UHC-P is implementing its activities requires a high level of flexibility and rapid response to changing environments, such as epidemics and conflict. The support of the UHC-P in the **post-Ebola countries** was entirely reimagined to respond to the imminent need of new (short term) strategies and revised health plans for the restoration of the health system. The flexibility of the UHC-P allowed the WHO to take up a leading role and helped to restore the organisation's legitimacy and positioning in these countries. In South Sudan, another **fragile state**, the TA also helped develop a bottom-up planning. Whereas at the national level the focus was mostly on policy, at the subnational level the focus was on operationalization. WHO CO said that even though WHO headed the exercise, "the MoH did the work themselves and set the direction for 10 years".

Discussion

National health plans were of course in place in most countries before UHC-P. Only, these systems were not always working, often had no real scope, and they were most often highly fragmented. UHC-P built on these NHPSP, ***helped to revitalize*** *the policy dialogue process, and advocated for changes towards health system strengthening and towards universal health coverage as a scope. However, sustained support for the implementation of NHPSPs still remains a challenge in many countries. Another specific issue brought up in countries was about* ***support at central level vs Implementation level.***

A disconnect between central level policy making and implementation/operationalization of these policies at decentralized level remains a complex challenge in many countries. Both in terms of adequate and realistic planning, as well as communication, capacities at different levels and ownership of the interventions. Also, decentralisation does mean a lower concentration of human- and financial resources, as well as the executive (and legislative, in the case of devolution) powers to allocate resources for health. Certainly in West Africa, devolution has brought considerably more emphasis on local governments to organise and orchestrate health interventions– all in the name of UHC and SDG. Clearly, different forms of decentralisation pose new challenges to health policies, -financing and governance strategies in the countries, and the UHC-P is well placed to further expand on this subject.

UHC-P support did try to bridge this gap in a number of countries (like Sudan, Senegal and the DRC), but could arguably focus on this even more. There is widely expressed demand for support to decentralisation, both on how to deal with this at the central as well as decentralised level. It should be noted that this does not necessarily mean support for implementation, something which is not imagined as within the bounds of the programme (though demand is certainly there). Rather, policy dialogue activities and capacity strengthening activities could be of great added benefit, including support for decentralised policy development, capacity building for district reviews and strengthening governance. This may even imply support to local governments, who are more and more in charge of managing the health sector at their level (certainly in West Africa).

KEY MESSAGES

- Health Financing (HF) support is in demand by almost all the countries supported, as HF represents the most important challenge countries face on their road to UHC.
- The UHC-P has supported governments to clarify their vision on HF for UHC, mainly through policy dialogue, but also in technical support and training
- UHC may mean important but sensitive changes in health financing – for that reason WHO as an independent institution has added value in facilitating the HF policy dialogue
- UHC-P provided HF support by utilising existing WHO tools
- In most WHO-COs, HF and HSS expertise is scarce, therefore the provision of full-mode TA on these two areas from the UHC-P could be beneficial
- There is unmet demand from several countries to support progress towards UHC technically through their chosen UHC-strategy of health insurance in various forms

National Health Financing Strategies / Plans

Of the 20 countries, 17 chose Health financing as a key thematic strategy to be supported by the UHC-P. This priority can be associated with the many **HF challenges** that most of these countries face in their road to UHC- such as e.g.:

- Great majority of expenditure comes out of pocket;
- Inequitable funds transfer for operational level, aggravates health financing challenges;
- Inefficient use of external funds and of national funds;
- Fragmented system with poor coordination causing great inefficiency;
- Low financing of free health care policy and poor targeting process;
- Uneven and inefficient purchasing at all levels;
- Pricing mechanism for e.g. drugs is not clear;
- Weak and disjointed information system

The evaluation team found that countries in the road towards UHC most needed **policy dialogue** and technical support for developing their health financing strategies. Many countries struggle with how to raise (domestic) revenues, pool different types of health funding, and the purchasing of quality care with these funds, as well as the governance of these processes. The UHC-P has addressed these challenges in their support for various governments, and helped clarify and specify their vision of UHC. The support was given mainly through policy dialogue; situational analysis of health financing; update

of national health accounts; revision of health insurance law; and training in budgeting and costing of health plans, which all contributed to define HF policies.

Many respondents indicated that not only technical assistance, but also facilitation of policy dialogue on HF were high in demand. Many HF issues are highly politically sensitive, for example: developing criteria for allocating resources or pricing of drugs. Therefore, an independent institution like the WHO has added value as a facilitators in **policy dialogue**. In most countries, except for South Sudan and Yemen, respondents declared that UHC-P have contributed much to the development of the national HF strategy. Often, countries demanded support to clarify and specify their vision on UHC, and how to get there. For many, UHC provided a concrete target, but one that was difficult to achieve. The UHC-P helped clarify what it is about, how to define it in the country's context, and how to organize it.

Besides in-country dialogue, inter-country policy dialogue has proven to be important, too. For example, in 2013 a HF workshop was organized between UHC-P, P4H and ILO, Guinea, Niger, Chad, Gabon and Cameroon to reflect on their experiences in developing a health financing strategy. This has resulted in enthusiasm in the countries to work on national HF strategies.

Next, most countries asked for, and received, **technical support** for developing -Financing (HEF) strategies and plans. While at the start of UHC (before UHC-P) the focus was often on collecting more resources for health, , the UHC-P advocated for improvements in the way health system finances are organised. For example, issues like fiscal space analysis, pooling of financial resources (diminishing fragmentation, etc.), efficiency of disbursement channels and financial procedures received significant attention in various countries. More recently, purchasing of quality care has received increased attention.

Policy Dialogue

In Mozambique, UHC-P consensus workshops between DPs were organized, resulting in the formation of a health financing working group. With the recruitment of a national health economist, UHC-P took a strong coordinating role. The WHO-CO supported the design of the ToR, supported the consensus building process, set up a steering committee for the TWG.

In Senegal, UHC-P strongly influenced national HF strategy, which addresses an increase in health financing; several stakeholders attribute the subsequent increase in policy dialogue efforts to the UHC-P.

In the DRC, consensus workshops were organized for a policy dialogue on Financial Management Assessment, which influenced successful bilateral deliberation between MoH and GAVI.

The dialogue was institutionalized in Guinea through the UHC-P after Ebola, which strengthened the relations between MOH and MOF, which was important for estimating budget needs for the resilience of health systems after Ebola. It helped the three post-Ebola countries to estimate and express their budgetary needs, and then enter into the dialogue with the donor community from a driver's seat position (so, call it "alignment") on the demand for their contribution.

This support was coupled with providing **technical inputs** to HF policy development and training. UHC-P has mobilized the different stakeholders to participate in the policy dialogue and HF strategy development. Mali is a good example of how the UHC-P would provide this input: (i) carry out a situation analysis (ii) identification of possible funding sources; (iii) identification of possible 'innovative' financing mechanisms; and (iv) develop a case study for the possible implementation of an identified HF-policy intervention. In Mali, this resulted in a pilot for universal health insurance scheme.

Policy dialogue on HF often led to a specific HF-TWG (technical working group) was set up, which the WHO either leads or participates in. TWGs prepared technical (and political) input for decision-making on strategy development and policies. These groups are of high importance because they help to institutionalise dialogue and continuously involve all stakeholders involved in these processes. Moreover, the HF-TWGs observed within the evaluation generally work very well. TWG are a good entry point for additional policy support on various themes- e.g. in Vietnam on autonomy of providers, and benefit package; or in Togo searching for innovative financing mechanisms, or trying to involve private sector more, as in Liberia.

Multiple countries set out to conduct a **health financing system review** using the *OASIS* approach. Moreover, The UHC-P provided an ideal opportunity to utilise these pre-existing WHO tools, including technical support for national committees overseeing the process. The exercises often helped to integrate the committed funding of development partners effectively within the planning, thereby promoting alignment. A good example of this is the review of MoH budgets to kick-start review of the planning and budgeting in the post-Ebola countries (Liberia, Sierra Leone and Guinea). Here, input was provided on financial needs for resilience of health systems in these countries, which also helped to identify the gaps that could be funded by DPs.

Use of existing WHO tools

Support was provided to national health accounts (NHA) using the System of Health Accounts (SHA) framework, which was used to support data collection in Senegal.

The OASIS approach was used in Vietnam for a revision of the social health insurance implementation law, and analysis of governance of the Vietnam social security. Also, staff from WHO-CO and RO were trained in using the OASIS, making in-country expertise available.

In **Togo**, the study on innovative health financing, (2014), looked at the potential of new revenue raising mechanisms, exploring their institutional feasibility and simulating potential revenue. The study contributed to discussion of the question at an unprecedented policy level, all the way to the Presidency. The work ended up in focusing on increasing revenue generation for health through new taxes or increased rates, like plane ticket levy, mobile telecommunication taxes and alcohol tax.

HF Studies

HF studies were carried out to provide evidence in the policy dialogue. For example in Mozambique a study was carried out on out-of-pocket payments and catastrophic health expenditure. Another study (in 2015) analysed key trends in the Mozambican health sector, including strategic objectives for the next five years, with the view of identifying some initial innovative financing mechanisms. These studies often found their way to the HF-TWG, and into policy (like in the case of Togo, see box).

In the DRC, WHO facilitated a joint mission to design the financial management system improvement framework, leading to a Joint Funding arrangement which was completed and then presented to all health partners. All this helped to improve the financial underpinning of national health plans.

Of the HF activities agreed upon in the roadmaps **not all were carried out**. In Sudan, an exercise to develop criteria for allocation of resources and a new pricing policy were not executed. It was explained that these issues didn't any longer represent a priority for the country at the time. In the 2013 South Sudan roadmap there was a plan for establishing resource needs and resource allocation priorities through NHP costing and budgeting. This too was not realised, as "South Sudan does not take midterm expenditure frameworks", indicating, again, this was clearly currently not a priority for the country.

Interestingly, many countries, including Liberia, Mali, Senegal, Mali, Guinea, Sudan and Tunisia, included **Health Insurance (HI)** as a thematic priority in their UHC policy. Even though their strategies differed, the logic that underpinned this prioritisation was shared. HI can provide a defined benefit package reducing the problem of high user charges, based on a contributory approach, coupled with budget transfers from general government revenues to cover those population groups that do not contribute, and provided it contains an element of cross-financing between the poor and the rich that fosters solidary. Furthermore, it is a mechanism that is able to purchase services better than the patients themselves. Following this logic, HI with budget transfers to subsidize those unable to contribute themselves seem to serve increasing financial accessibility for the patient, and, by extension, promote UHC.

Examples of countries interested in embarking on health insurance

The UHC-vision of the Government of Sudan is to achieve universal health coverage (UHC) among all Sudanese population by 2020 through health insurance based on contributions and budget transfers.

Guinea is in search of setting up health insurance to increase financial accessibility – and pooling of funds. The main UHC-strategy foreseen is a mandatory health insurance scheme, based on deductions from salaries in the formal sector, and creation of "Mutuelles" (CBHI) for the informal sector.

Similar approach is taken in Mali, in Burkina Faso and Senegal to tackle especially catastrophic health expenditure. Health insurance in Senegal is highly fragmented leaving 80% of the informal sector out of HI.

The government in the DRC is mostly focusing on a Mutuelles inspired system to help improve financial protection of its population, though progress remains limited

Countries struggle with developing the different aspects of their proposed HF arrangement, including HI. DRC, Guinea, Sudan, and others express that there is a huge need for them in strengthening capacity in designing a health insurance policy and its implementation. In their technical assistance, WHO states that theory and practice suggest that Social HI for formal sector employees only or voluntary, *unsubsidised* "Mutuelles" or Community Based HI system are limited to accelerate progress towards UHC. In many cases, evidence reveals that vulnerable and poor populations remain most often excluded from voluntary CBHI coverage, even though in theory they should be fee-exempted. For these reasons, CBHI – *as a core pillar of a HF strategy* – is generally not recommended by WHO (and many others) as an effective mechanism to progress towards UHC by WHO. SHI (Social Health

Insurance) for the formal sector employees only, leads to inequity in access, and it is hence important to emphasize that budget transfers are needed to subsidize those unable to contribute themselves.

The key challenge countries are facing is how to **extend and improve coverage** for those outside the formal sector. Some countries are well on their way, like Sudan. The HF strategy in Sudan focuses on social protection, the MOF is increasing its contribution to support UHC, additional resources are mobilized through national demand-side organisations (ZAKAT and AWQAF) to fund PHC services for those without access. All this funding for the 202 UHC-vision is channelled through the national health insurance fund. Fragmentation may also be a key driver for change in HI structure. In the case of Tunisia, increased solidarity through defragmentation was the primary reason for the emergence of CNAM. The defragmentation is not yet complete: AMG and CNAM are still separate. The UHC-P support has addressed this issue through conducting several studies and is likely to stay engaged in this process.

Discussion

The organization of HF in countries needs reforms in order to "improve financial accessibility of health – for all", which is a key issue in UHC. Reform on health financing is most often incremental. Reforming HF in countries needs policy dialogue between stakeholders to agree on changes, as usually HF reforms mean sensitive issues like changes in allocation of scarce resources, meaning reforms in HF are inherently political. For that reason, HF, politics and politicians will have an important influence. Changes may come through pressure of certain stakeholders – e.g. civil society – but providing evidence to underpin decision-making will always prove to be necessary for stakeholders to agree on strategy objectives.

For example, potential ways to increase this fiscal space include: increasing contribution from e.g. local governments or demand-side organizations; introducing new additional sources of funding or "innovative sources of funding" (which can be earmarked) or by agreeing with MOH on efficiency gains. Providing evidence for e.g. assessing the feasibility of increasing fiscal space for health is then needed to inform decision-making between stakeholders. WHO is very well placed to do this, as an independent technical agency.

*HF policy dialogue quite complex, and technically not easy to **implement**. Because of this, countries are hesitant to pass over from policy objectives to implementing reforms. For example, changing (health) finance policies will have legal implications which need to be considered in existing laws and legislations. HF studies, like in Togo, have informed the debate: evidence is placed on the agenda in Togo and discussed, but designing and then implementing the reform will take time, especially as it is about the politically sensitive topic of redistribution of resources. One important role of WHO is to keep reform issues on the agenda of the policy dialogue, providing facilitation and technical support (evidence for policy options on e.g. "free care", policy briefs, etc.) to negotiation exercises when the reform moment is being prepared or arrives.*

*Our evaluation makes it clear that several of the 20 countries regard **health insurance** schemes (as a separate purchasing agency and as a collection mechanism for payroll deductions) as their preferred road towards UHC. For many contacted stakeholders within the WHO, voluntary small-scale CBHI and "traditional" SHI for the formal sector employees only, does not represent the preferred HF strategy for embarking on UHC. There are good reasons to support that opinion: indeed* 100% population

holding a HI card, does not necessarily mean "UHC". *On the other hand, HI may certainly be part of a solution – as it holds the potential such as pooling and strategic purchasing mechanisms of quality care as a provider payment mechanism. Even if contributions represent a smaller part of public funding, not serve as contributory systems to completely cover all spending on health, health insurance as a purchasing agency may still fulfil the strategic purchasing mechanism needed for a UHC policy.*

Sidestepping the technical debate on the merits of HI and RBF, the reality remains that several UHC-P countries (like Guinea, Sudan, Mali) have expressed a clear demand for technical assistance on HI systems from the partnership. As indicated by HQ, the WHO uses requests for support on CBHI as an invitation to open the debate with the MoH to explore on critical policy questions But if this doesn't change the policy decision, perhaps WHO should then intermediate to find expertise outside WHO to provide that type of support.

Alignment of international and national stakeholders to NHSSP

KEY MESSAGES

- UHC-P support has contributed to increased alignment of international and national stakeholders to national health policies, strategies, plans, and procedures.
- There are clear differences between countries in the degree of importance of the role WHO played in alignment and harmonisation.
- UHC-P has helped WHO to take the lead among the DPs to support the post-Ebola countries

In general, most evaluated countries have donor coordination mechanisms in place and these development partners align, at least a part of, their efforts around national health strategies. There are clear differences between the different countries in the extent of alignment of internal and external partners, and also clear differences in the role of WHO played in alignment and harmonization.

In the smaller, higher/middle income countries within the UHC-P, such as Moldova and Tunisia, markedly fewer **development agencies** are present, making it "easier" to come to coordination and alignment. Also, government capacity is already at a relatively high level in countries like Tunisia, Moldova, Vietnam, and Senegal, which can help to explain why the MoH in these countries are better equipped to take on a leadership role. In these countries, the health sector is funded mostly from domestic resources, which automatically puts the government more in a leading position. Nevertheless, this effectively meant that the TA provided through the partnership was able to work on other or more complex alignment issues, such as the inter-sectoral dialogue on the re-imagining of the health insurance system in Tunisia.

Strategies for partner alignment

In Timor-Leste, the elaboration of the partnership framework agreement, a code of conduct for cooperation with development partners in the country, helped strengthen the capacity of the MoH to take the lead in DP discussions.

In the DRC, the UHC-P funding was instrumental in coordinating development partner alignment via the Group Inter-Bailleurs Sante (GIBS – between DP) and revitalized key national and decentralized steering committees to improve alignment of DP.

In South Sudan, Mali, Guinea and Togo, the UHC-P was credited with boosting whose role in donor coordination, through the TA who played an active role in donor coordination mechanisms.

In some countries, such as DRC, Guinea and Senegal, the partnership helped to strengthen the alignment of different (internal and external) partners through support to the **Compact**. UHC-P support was not necessarily focussed on elaboration or negotiation of the compact itself, but more the support to alignment and adherence once it was negotiated. In Senegal, the UHC-P support was used to promote and raise awareness of the country compact, both at the national level as well as in the different regions during the regional reviews.

In Guinea, Sierra Leone and Liberia, the Ebola outbreak caused the countries to switch into humanitarian relief mode after almost a year of implementation of the UHC-P. In humanitarian relief mode, donor coordination mechanisms around UHC were given no priority in the first two years of implementation of the UHC-P activities. However, in the **post-Ebola period**, WHO has been very active in developing and supporting new initiatives to improve alignment. In Sierra Leone and Liberia new structures for aid alignment in the health sector have been set up with WHO's financial and technical support. In Guinea, the UHC-P supported the MOH in development and costing of a resilience plan to be funded by the DP community. In Sierra Leone, support was even extended to the district level, where WHO facilitated the channelling of funds from different donors in support of strengthening district capacities through District Ebola Response Committees.

Discussion

*The hallmark of a solid NHPSP is perhaps that it is **comprehensive both in scope as well as inclusion of all key actors' inputs**. Linking too much (or too little) to a specific program funded by an external development partner could bring in the risk of fragmentation of NHPSP. DPs have the opportunity to inscribe in the national health (financing) plans, and as the dialogue is inclusive: participate and contribute to it, instead of developing separate national plans for "their" programs, and align to it. Alignment of DP is like a pendulum: yes or no aligning over the years. This is based on what is expected from their country office by the DP headquarters - who every now and then change their ODA-policy. On the other hand, DPs often mistrust the National Government' capacity to develop its health policy plans and stick to it – inclusive development of NHP strengthens commitment of the DP.*

*Much of DP support comes through specific **priority (or "vertical") projects**. Too often, DP financial support is still off-national-budget, and in case it is on-national-budget, it creates another "budget line in the national budget" for vertical programs, instead of financing the existing national health plan (e.g. through general or sector budget support). Alignment has much to do with "trust" among stakeholders, and in the government effectively steering the health sector by systematically strengthening the capacity of the MoH to take a leadership role in dealing with partners and prioritizing the populations' needs. Often, only lip-service is paid to the Paris declaration, and the implementation of key agreements such as IHP+, and COMPACT is not always evident.*

*UHC-P could play a more pivotal role here. WHO-CO could be the natural lead in DP alignment. Currently, the IHP+ approach to support a COMPACT in countries is happening at mainly global level, and is an approach, not a program with (funded) activities. The link of IHP+ with UHC-P at country level is potentially an interesting approach to reinforce alignment. However, this link is not yet clearly developed at country level. However, the availability of seed funding changed the role of the CO from a "TA-only" to a "TA with funds", which makes the WHO-CO more **credible** for the DP in the sector as an actor that can take alignment around the NHPSP further. The UHC-P still has limited influence on DP to align to national health plans and HF strategies and plans. For example in Guinea, health financing is being organized around the NHPSP, which is still highly fragmented.*

Management of the Partnership

KEY MESSAGES

- The UHC-P provided the partners a unique opportunity to both realize their own strategic goals as well as strengthen the WHO country offices.
- For both EU and Luxembourg, the decision to earmark funds for UHC-P related WHO work, was also a way to also bring more country focus to WHO as an organisation
- There is a common agreement that the program is administratively (!) burdensome
- EU and Luxembourg delegations at country level should be involved more to be more efficient – but also to give legitimacy to the programme and create more visibility
- The Geneva office played a key role in both overall coordination, facilitation of knowledge exchange and principal point of contact for both the EU and Luxemburg.
- Both EMRO and AFRO believed that indeed the right countries were supported
- At country office level, strengthening of health systems (and then health financing) expertise is needed – probably best as "full-mode"

A key motivation of the funding partners was bringing more of a health systems focus to WHO country office level.

According to the EU, the idea to support WHO started from within the EU, which itself has rolled back its capacity in the field of health at both central and delegation level. Besides the value of WHO TA that is offered to countries, EU's aim of the institutional support was meant to strengthen the capacity of the WHO to operate at 'eye level' with the MoH's on health systems strengthening. For Luxemburg this aim was the same, as this strategy meant a general shift away from project based work towards demand driven, systems approach.

At the WHO, specifically within the health systems and innovations cluster in Geneva, there was a clear desire to strengthen the Health Systems Strengthening capabilities of various COs across the different regions. As many COs have limited resources (both human and financial) to support their host nations, health systems strengthening activities are sometimes not prioritised. HQ played a key role in developing the concept of this support and negotiated with EU (and later Lux) to realise increased support for the health systems activities in countries.

In terms of **communication** within the partnership, EU and Luxembourg have expressed their satisfaction: it is easy to contact the WHO HQ team, their first point of call. Generally, there is a swift follow up by HQ – with internal communications between the various levels of the WHO sometimes requiring a little more time. Overall, the EU and Luxembourg are happy with communication tools available, including the annual meeting, reporting and increased transparency and visibility offered by the website. The WHO, emphasizing the importance of the partnership relations, is very content with the central level involvement of the EU and Luxemburg, especially in terms of supporting the policy dialogue format and commitment to increased alignment of development partners.

Operation of the partnership at the global level (WHO Headquarters) was key

WHO-HQ helped to define the major characteristics of support in each country through inception missions, ensuring a design for long term technical support that was country oriented and flexible. It also provided short term backstopping – ensuring complementarity between policy, health financing and development aid aspects.

At a global level, the intercountry meetings were a unique opportunity for all stakeholders to come together to share experiences, discuss challenges and opportunities. In talks with stakeholders the intercountry meetings were generally very well received, and seen as a key learning moment by all actors involved in the partnership (from EU, to MoH representatives). These meetings certainly added value in terms of sharing and discussing an ever evolving and more comprehensive thematic frame in which the partnership operates, integrating more explicitly e.g. health financing, IHR and the SDGs during the three-year period. Meetings were deemed valuable both in terms of thematic expertise on UHC and sharing of key challenges with transnational application. The variety of country context (including the advent of health emergencies e.g.) enriched the dialogue.

Regional Offices are a key intermediary between the global programming and day to day activities

As the selected countries were predominantly from Africa, AFRO and EMRO were by far most involved in the coordination of the programme – SEARO, WPRO and EURO each supporting only one partnership country. AFRO and EMRO acknowledge that the experiences of other countries helped them to better formulate a context specific analysis of needs with regards to achieving UHC, therefore certainly putting forward a clearer vision on UHC.

Overall, the partnership was seen as an opportunity to further engage with current challenges around UHC in various country contexts, and provided a unique learning opportunity to distil common lessons learned and trends in different environments (see also the boxes on experiences from EMRO and AFRO). It was stated that most of the selected countries appeared to have considerable EU and Luxembourg strategic support to the health sector. In a sense, the UHC-P not only strengthened WHO capacity and MoH capacities, but also acted as catalyser for the effective use of existing activities of the EU and Luxembourg (and other DPs).

Regional office for Africa

13 out of a total of 20 countries participating in the UHC-P belonged to the AFRO region, making the Brazzaville office a key provider of backstopping and administration of the programme. AFRO expressed it was glad the programme was flexible enough to accommodate the changing needs of countries in a changing health context. From the initial focus on policy dialogue, to the increased awareness of health system resilience and IHR. The office feels like the experience in the Ebola countries, as well as the crisis situation in South Sudan, were quickly acted upon both in these countries themselves, as well as the lessons learned integrated within the larger UHC Partnership.

On an organisational level, the regional offices indicated that the partnership had strengthened their capacity to support countries. EMRO and AFRO indicated that they initially struggled with the management of the UHC-P activities: how to communicate in-house and in-countries, e.g. on monitoring and reporting on results, e.g. how to quantify the partnership results, if audit visits were needed how to organize the logistics, etc.

The **administrative burden** of the programme was reported to be high by both AFRO and EMRO. There are different reasons to be mentioned. It is partly due to the expansion of the number of countries and because of the changing nature of roadmaps as the UHC-P is relatively flexible. Besides the positive side of this – it also meant more work. Shifting of budgets and activities did not only take place within country roadmaps, but also between different countries. As some countries had serious issues with disbursement of all funds (especially in light of the delays with regards to TA, political instability) AFRO recalled some funds, to then re-assign these funds to another country.

Regional office for the Eastern Mediterranean

The countries selected in EMRO region proved to be an especially interesting case for UHC policy dialogue. Participating countries displaying rather varied levels of development and political stability. On the one hand, the case of Tunisia provided an insight into a country in the process of a democratic transition. This allowed for an ambitious experiment with grassroots societal dialogue (among other activities). On the other end of the spectrum, Yemen is going through continuing political crisis with limited government capacity in most of the country. Here, focusing the agenda on UHC in the face of urgent humanitarian concerns proved very challenging.

Lastly, stringent **reporting requirements** are to be mentioned. There is a common agreement that the program is administrative burdensome, because of the line budget items of the program, which provide less flexibility than other sources of WHO funding.

Country level

The existing relations between the WHO and the MoH clearly impacted both the legitimacy and effectivity of the actions. In countries where the WR was very supportive of the partnership and saw the value of the policy dialogue approach, the partnership often benefitted greatly from lobbying and **relation management efforts** by the WR. The WR could ensure the policy dialogue was addressed at various levels within the MoH, making it easier to gain a foothold. The contrary also happened where the relation between WR and the MOH were less friendly – issues raised mainly on the control over the UHC-P budget.

As noted by virtually all WHO country office staff, a key strength of the programme is its flexibility, both in terms of thematic areas within HSS that could be chosen, the nature of the activities that would be conducted, as well as with the possibilities to adapt the roadmap during the implementation period. Quick adaption of needs in crisis situations were realised through quick phone calls/emails with HQ and EU/LUX. Some (like stakeholders in the DRC, Tunisia) considered that the UHC-P intervention is one that few donors would sign up for, especially because of the inherently qualitative nature of activities and necessary flexibility.

Where they were involved, EU **delegations** in countries were very helpful – but were not much involved in UHC-P in all countries. Coordination between the UHC-P partners at country level (too) is especially relevant in countries focussing on donor alignment, as the EU tends to also play an important role in these discussions because of other portfolio commitments. Stakeholders in both EMRO and AFRO suggested that delegations could (and should) be involved more, not only for their input but also to give legitimacy to the programme and create more visibility. This, despite the fact that partnership funds often only constitute a relatively minor part of the delegation's portfolio in countries, and represent funding which is directly organised from Brussels, not the delegation. The EMRO office even articulated the possibility of organising annual visits by EU/Luxembourg.

Also this catalytic funding allowed complementarity between the IHP+ and the UHC-P. While IHP+ works at macro/global level, the UHC-P works at country level, this synergy can contribute to higher impact when establishing robust health policies in the long term.

There are issues to be mentioned on technical assistance providing support to health systems strengthening via the WHO Country Offices

Clearly, quality of support is very much individual TA dependent, but it is important to note that most countries were very positive about the TA that was provided. Still there were some structural issues mentioned. An important issue of discussion on the UHC-P was the human resource theme. First point of discussion was if TA at country level should be "Full-mode" or "light mode"; meaning that a permanent TA should be based at country level, or "light mode", where one or multiple advisors (either WHO staff or external consultants) perform short term missions.

In favour of the ***light mode*** was that presence of the TA is not too heavy, that TA could be better tailor-made to specific country needs, that this TA could be of higher quality, and that the TA could bring in experiences from other countries. On the other hand, a ***full-mode*** TA would be able to follow up swiftly and build the necessary relationships that are key for facilitating continuous processes. For a short term TA, it could be difficult to understand the context immediately, and act swiftly when need arises.

The evaluation team suggests the full-mode in all countries, because WHO Country Office staff numbers in health systems strengthening and UHC is quite limited: experience in CO is more disease control related. Also, there are frequently activities in the sector that are not directly UHC-P related but that are important for UHC: like sector-reviews, continued support for Technical Working Groups, etc. Here, a full-mode would be best placed to identify the needs for e.g. specific case studies and thematic reviews. As discussed above, the ability of a permanent TA to closely follow up on developments and ensure continuity in policy dialogue processes was considered an important asset by many stakeholders.

What is often needed at country office level is increasing expertise for **health system strengthening**, making WHO-CO less disease-control specific expertise. A strong and available TA in the area of UHC (HSS and HF) has been appreciated where available. This was specifically reported in Togo, Tunisia, Sudan, Guinea and Timor-Leste. Even so, in case full-mode TA were present, these are often "generic" health systems experts, that have broad experience, and so for that reason are not easy to find. On the other hand, in a few countries where comments were made about the quality of the expertise

offered by WHO, this was mostly about technical support in policy making, health systems strengthening, and more specifically: health financing. In Sudan, it was said that the support from CO in some cases didn't add value "they know about disease control, but not about HF; the quality of consultants is often not very good". In this case, the additional TA coming from EMRO and also from HQ was able to mitigate this, and their contributions to the draft HF strategy were highly appreciated.

In order to find the right placements for the different countries, the WHO HQ team and the EU made the choice to set up a dedicated **roster** of senior experts suitable to engage with a broad range of HSS related topics and adept at good interpersonal management – to ensure quality of the support. The time needed to set this up, and the difficulty to find candidates for some of the positions (especially francophone) from a relatively small global pool of potential candidates, helps to explain why the kick off of UHC-P in 2012 was somewhat slow. Moreover, as this kind of expertise is rarer than the usual WHO disease control expertise, rewarding for these experts is higher.

Overall, the countries deemed the **international** profile of the staff to be very useful as, unlike national officers, they had little pre-existing relationships with the MoH and were deemed more useful as a neutral convenor. However, the international advisor on the project needs a thematically broad focus and country specific knowledge (especially a good understanding of key actors and political economy context). Because of this, the regional offices and a number of CO offices stressed the importance of a more thorough induction of international staff.

Lessons Learnt

KEY MESSAGES

- UHC-P approach was demand-driven and country-led increasing the probability that results will be sustained
- The UHC-P funding for overall policy-making and planning was flexible and an important driver for changes in a coherent sector-wide way
- WHO contribution was important in terms of providing an evidence base for the policy dialogue process and providing UHC-P funds for organizing activities for a comprehensive and inclusive dialogue
- WHO has played an important role in keeping UHC on the agenda
- The collaboration at headquarters level between the three UHC-P partners is less visible than UHC-P at country level
- On the road to UHC, the political economy of a country plays an important role – WHO is accepted as an independent organisation
- UHC-P has supported WHO to focus more on Health system strengthening

In the previous chapter, this report set out to identify the successes of the UHC-P. This chapter tries to identify elements that my explain UHC these successes and formulate key lessons learned. A recurring challenge has been the attribution of result that were eventually found. In other words, in case of a success (or failure) in this complex field, to what extent can this be attributed to the UHC-P or WHO? For that reason, the evaluation team has tried to refrain from drawing strict conclusions based on more general health indicators, instead trying to identify key "contributions" made by UHC-P and/ or WHO that "probably" helped realise tangible results in countries – according to the interviewees.

In general, the UHC-P approach was demand-driven and country-owned.

The fact that UHC-P support has always been driven by the demand of the countries goes a long way in explaining the partnership's success. Already starting with the inception missions, joint development of roadmaps was a good strategic choice to foster ownership. Even though it was often WHO that brought up the idea of the opportunity, the set-up of roadmaps was always flexible and participatory. Leadership on establishing content and procedures were in the hands of the country. Roadmaps focusing most on fostering and facilitating "policy dialogue" around themes and issues brought up by thematic reviews, situational analysis, or joint sector reviews – sometimes even a review of the legal situation of UHC approach. The country specific approach allows for this great diversity in programming between countries.

Oftentimes, supporting inclusive planning processes for the development of national health plans had the positive side effect of strengthening the capacity of the MoH to take the leadership and align

internal and external partners. Importantly, fragmentation was reduced this way through early involvement of key stakeholders.

Providing an evidence base for the policy dialogue process proved to be an important contribution

In many countries, specific case studies and thematic reviews have helped to identify and clarify key challenges in the health sector. Studies on health financing reform were especially common. Existing WHO tools were often used, for example OneHealth and JANS, were used to develop , and national health strategic plans; SARA to develop situational analysis of health facilities, and OASIS were used to cost it or to develop a National Health Account. These analysis were used as a basis for dialogue between stakeholders on e.g. future health financing, provide the policy makers with an evidence for possible financing options, for MOH to better negotiate with the MoF. In the end, costing is a powerful instrument to underpin policy dialogue – as a tool for simulations, leading to interest at highest level (Presidents of Togo, Sudan, Mali, e.g.), but also for defining DP support (like in Guinea). However, the focus of UHC-P activities was much on participating in the policy dialogue to find consensus.

In essence, the UHC-P funds were seen by all as a catalyser.

Funds for comprehensive overall sector policy making and -planning are always limited. The UHC-P funding for overall policy-making and planning was an important driver for chance in a coherent sector-wide change. Also, bringing focus to the sector planning with UHC was a motivating factor in many countries: it brought mission & vision. The idea was that sustainability of the programme should not depend on UHC-P funding, but also on funding by other donors and, preferably, the Internal Generated Funds of the governments themselves. In reality, this did not always work out as planned, for a host of reasons. Perhaps most importantly, the changing of the guard at MoH level often caused delays in programming and commitments had to be reaffirmed.

Several stakeholders indicated that the perception of the WHO changed from an organisation able to supply "TA-only" to a "TA with funds". However, it was stated that there is a need to address the sustainability of policy dialogue structures: countries have significantly leaned on the partnership funding to kick-start policy dialogue platforms, but continued support and commitment from governments themselves is needed to truly institutionalise.

WHO was reported to have played an important role in keeping UHC on the agenda and radar of both MoH and development partners.

WHO's convening power, of both other development agencies and domestic or local actors is especially noted. WHO is often seen as an evidence-based pusher of the UHC agenda. WHO-CO is very well placed to be the natural ***technical*** *lead* in the aligned DP-group. WHO's mandate gives it a unique legitimacy as neutral facilitator both able to understand and coordinate with the government, as well as help align development partners.

WHR has always had privileged access to the Minister of Health, being his/her technical advisor. Before the UHC-P started, this direct line was often used for issues and themes of (endemic) disease control, but much less for policy-support and themes around health systems strengthening. This has changed with the UHC-P – but may represent a constraint too: that WHO-Rep may for that foster inclusive dialogue with different political agendas, while being the TA of the Minister. The case of Tunisia's societal dialogue, though certainly one of the most successful and comprehensive exercises

in inclusive policy dialogue, shows how diverging political agendas of an empowered civil society and newly elected administration can place the WHO in a more complex political position. Nevertheless, increased engagement in the political arena, if prudently managed, can significantly progress the UHC agenda, and ultimately the strengthening of the health system itself. Still, strong involvement of the WR is essential: at the end of the day WHO is a key player in country and can increase impact of programme, certainly also if we see the partnership as transformative for role of WHO in country. The varying self-image and ambition has an effect on the way WHO is seen from outside. WHO has viewed its own role differently across the different countries. This ranges from taking on a major role as the driver of the UHC agenda and related reforms in e.g. health financing, HMIS and quality of care in the country, or a 'knowledge hub' providing evidence for policy, to a mere facilitator "only" of dialogue on the issue and somewhere in between.

MoH-capacities and leadership were strengthened through the policy dialogue process

Institutional capacity development of MoH was mainly strengthened by the UHC-P through the policy dialogue sessions, developing a situational analysis and development of policy papers. This was most often carried out by consultants – though the interviewees judged that the technical quality of these consultants was not always beyond doubt. It was suggested (a.o. b y MOH in Sudan) that there is a need for a review of the criteria used for selecting the short term consultants. Here too it was suggested that an interesting alternative could be provided by a south-south exchange of expertise (e.g. the international UHC congress in Sudan had great impact) and visiting countries with successful UHC interventions. Nevertheless, it takes time for improved institutional capacities to translate policy dialogue into meaningful reforms, and then implement these

Besides building institutional capacities, there is also a clear need to build ***individual*** capacities in a more structural way in many UHC-P countries. In the end, the programme almost always hinges on the capacity (and willingness) of certain key stakeholders that are capable to taking the lead. This is certainly the case in the first years of the UHC-P intervention, before policy dialogue processes are truly institutionalised. Quite a few individuals were trained abroad funded by the UHC-P – for example in the field of results based planning, monitoring and evaluation, policy dialogue, health financing, or the organization of health districts in the context of decentralization. Nevertheless, individual capacity building – especially in low-capacity environments – should be approached carefully and in a coordinate way. Training of MoH 'champions' by multiple DPs will take key actors (e.g. through MPH programmes) out of the day-to-day running of the MoH – and does not contribute to the strengthening of departments. Here as well, the WHO could take a more coordinating role, without necessarily funding all trainings.

On the road to UHC, the political economy of a country plays an important role.

When talking about the positioning of WHO in the national policy dialogue arena, it is important to understand the playing field in terms of a political economy of health**,** where national and international stakeholders with different political agendas and constituencies vie for decision-making power and push for their optimal outcomes. The examples mentioned on Sudan and South Sudan, where politically sensitive roadmap activities (like "allocation criteria for health resources" and "pricing of drugs") were not carried out. This shows, again, that for adapting HF strategies, not only technical work is needed, but policy dialogue is key. In the end, changing HF strategies in a country to serve UHC goals is highly political, as it is about redistribution of resources. This can be either within

the national budget, meaning a higher proportion to health, or the redistribution of resources from rich to the poor to ensure "all" of the population have access to quality care. UHC 'favours' those who commonly don't have political access, such as the poor and vulnerable. WHO, as a UN institution (of which virtually all countries are a member), is better placed than bilateral donors (who have their political interests) and better placed than institutions such as the World Bank, as WHO is a technical institution.

Context matters: some countries need more support than others.

Where Government capacity was already at a relatively high level (e.g. Tunisia, Moldova, Vietnam, Senegal), governments were more capable of taking on a leadership role. As policy development processes are primarily dependant on the input and responsiveness of key national actors, and many countries experienced both politically difficult periods with little to no progress as well as periods of sustained momentum, the flexibility of funding allowed for a more tailor made support package responding to (unforeseen) political climates and transition. During politically difficult times, the UHC-P tends to focus more on 'a-political' topics, such as case studies and reviews, whereas in times of increased momentum extra support, in the form of consultants, in addition to the TA is often brought in. In several countries, the importance of **continuity** of WHO support (sometimes in the face of regime change, change of staff at development agencies and crises) was especially emphasised as an important success factor.

However, results between the different countries varied.

In some countries, WHO did not have a central leading role in health related matters, as in Vietnam and Mozambique. Sometimes it had significant influence within the MoH, but less authority with DPs and civil society organisations. WHO does not always actively take the lead on content matters. Where this is the case, the WHO is acknowledged more as a facilitator of the policy dialogue, rather than for its role as an alignment broker or 'knowledge organisation' in policy development. Although somewhat self-evident, it must be emphasised that much of the success of programme activities depends on the people who do the work, their relationships with national actors and the positioning within a broader national political arena.

One of the greatest challenges remaining: the disconnect between policy-making implementation.

When broken down, the policy dialogue cycle should normally largely reflect the following steps: (i) situational analysis, towards (ii) policy-dialogue; towards (iii) policy-development; towards (iv) policy decisions and validation of policies; towards (v) implementation and putting policies in practice.

UHC-P has put most of its work from (i) to (iii) – but then from (iii) to (iv) the process usually slows down – because this depends entirely on the country's decision-making. From (iv) to (v) policies often stay in the fridge for a long time. Instead of focussing on implementation, stakeholders in policy dialogue may head for developing new policies. This, of course depends mostly on national health authorities, but WHO/CO tends not to interfere in speeding-up the process. Reasons mentioned include: "it's the country's responsibility, WHO is neutral". Moreover, the WHO has been quite clear that the UHC-P does not cover implementation. Nevertheless, if the translation from policy to implementation remains a key barrier, one could imagine a more proactive role here for WHO and especially the WR, to use his/her position as the TA to the MOH to expedite the process. This would

also mean engaging with the different elements within the MoH that deal with implementation and early ensuring their buy-in in the process. This already started in e.g. Senegal and DRC, where more emphasis was given to the strengthening of the decentralised level.

The visibility of the WHO has certainly increased in many countries

Because of the UHC-P funding, WHO is better placed at the centre of the policy dialogue arena**.** Overall, it has enhanced the leadership role of the WHO as a major broker and advocate for improvement in health systems planning and management. Moreover, the UHC-P has improved the visibility of the WHO as key partner in the elaboration of NHPSPs, the provider of technical planning and management tools. In most countries, the UHC-P has been credited with contributing noticeably to a strengthened and trustworthy relationship between WHO and the MoH. It should be noted that this increased visibility is mostly to the benefit of the WHO, not necessarily the UHC-P. While most of the interviewees knew about WHO UHC-activities, few knew about the brand name UHC-P.

Still, in fragile countries (e.g. DRC, South Sudan, and to a lesser extent Mali), the UHC-P is reportedly ***less visible***, because there is greater donor competition in these countries. On the other hand, most often WHO-CO don't push for decisions or for a certain policy agenda, unlike other donor agencies. WHO is one among many big bi- and multilateral players with their own agendas, programmes and associated funding. Especially the World Bank is often very present, certainly in the field of HF. In other countries (e.g. Tunisia, Togo, Moldova), the working relationship between WHO and MoH appears to be more productive, because of fewer competing development players and closer contact with political administrations.

WHO now finds itself more in a position as a driver of policy dialogue at country level

Through the UHC-P, WHO finds itself in a far broader arena then before, where it acts in a more proactive role. WHO indeed became stronger in the strengthening of health systems, not only within endemic disease control. Its focus of attention returned to country level. This shift is especially notable where the MoH was reported to have shown appetite to reform: like in Tunisia, Guinea, Togo, and to some extent Senegal. Notably, the WHO took a more proactive role in West Africa to strengthen health systems after the Ebola outbreak. As several CO staff in the countries explained, this also helped to repair WHO' image that had been strongly criticized because of its late response to the Ebola outbreak.

UHC-P has supported WHO to focus more on Health system strengthening

Dealing with emergencies is one of WHO's most important mandated tasks, as infectious diseases like Ebola easily bypass borders, requiring an international approach. Often the WHO answer is *disease control*. Guinea, Sierra Leone and Liberia have switched back and forth between development, crisis and humanitarian and early recovery mode – because of the Ebola outbreak. This lowered at that time the attention to HSS and UHC, which are associated with more long-term planning, and consequently less visibility for the UHC-P during the outbreak. Health systems in the 3 countries were too weak to face the outbreak, so the first thing to do afterwards was to strengthen health systems again. Post-Ebola, WHO has been able to pick up a role towards greater donor coordination and HSS again. The global importance of **health system resilience** was quite well understood and acted upon by the partnership, and the WHO should be commended for integrating these learnings from the three countries within the larger programme.

MoH as WHO's principal partner in countries can sometimes be a challenge

Although experiences with facilitating policy dialogue on NHPSPs directly with the MoH have been mostly positive and constructive, Country offices both have a role as strategic advisers to the MOH, but also as conveners and facilitators in the overall health space. In practice, the former often prevails with the leadership in sector-wide health dossiers taking a bit of a back seat – which can be partly explained sometimes by the limited capacity at some COs. In practice, not all COs will be able to respond to initiatives launched by other ministries or other actors than in the health sector, such as the social protection strategy in the DRC. Moreover, the dual role of direct TA to the ministry of health and facilitator of policy dialogue with a broader stakeholder group can sometimes lead to complicated situations where official MoH policy diverges from other policy platforms UHC-P supports. This could for instance be seen in Tunisia where the recommendations from the societal dialogue strongly disagreed with the incoming government's agenda (though the situation was resolved later). Overall, a more comprehensive approach to sector wide issues, and coordination between different UN bodies, is key.

Conclusions

This report is on a **formative evaluation** – meaning that it focusses on lessons learned, as opposed to accountability of the implementing agency for results, or judging success in terms of value for money. The evaluation also focussed on the perception of both successes and less successful results, and to what extent these successes and failure can be attributed to the WHO or the UHC-P. As contributions of actors are difficult to ascribe in complex processes such as policy making, here the focus is the probability that results are the consequence of contributions made by UHC-P or the WHO. This formative evaluation shows that the UHC-P has permitted the WHO to achieve the objectives set out by the partnership: supporting the countries in developing their road towards universal health coverage.

The fact that **UHC-P support** has always been driven by the demand of the countries goes a long way in explaining the partnership's success. Joint development of roadmaps was a good strategic choice to foster ownership. Even though it was often WHO that brought up the idea of the opportunity, the set-up of roadmaps was always flexible and participatory. Leadership on establishing content and procedures were in the hands of the country, and focusing most on fostering and facilitating policy dialogue around themes and issues brought up by thematic reviews, situational analysis, or joint sector reviews – sometimes even a review of the legal situation of UHC approach. The country specific approach allows for this great diversity in programming between countries. Supporting inclusive planning processes of the national health plans were in themselves a useful mechanism to strengthen the capacity of the MoH to take the leadership and align internal and external partners. The partnership often benefitted greatly from lobbying and relation management efforts by the WR.

Apart from support to policy development, in many countries situational analysis, specific case studies and thematic reviews have helped to identify and clarify key challenges in the health sector, which would then be discussed with the MoH to inform the next round of policy elaboration. Studies on reform on health financing and health insurance were especially common. Existing WHO instruments (OASIS, JANS, SARA, etc.) proved to be of good value to countries to analyse the situation of their health system and what would be needed to embark on UHC. This also facilitated WHO country offices to become more health systems and health financing oriented – coming from a more disease control focus – though there is still quite some room for improvement.

The countries' roadmaps were often too ambitious for the limited timeframe of the programme and the complexity that policy dialogue entails. When roadmaps were redesigned whether due to change in political priorities, violent conflicts or epidemics, the activities were more realistic and tangible.

- Similar to the approach of the country activities to do situational analysis before the policy dialogue, as a recommendation the UHC-P can also do a situational analysis of the MoH' absorption capacity to ensure better support.
- Political economy studies can also be included in these situational analysis to know in advance the reasons why of the country's fragmented health/financial strategies, a mapping of the interests of the different stakeholders – and how to deal with that during the policy dialogue activities.

- At country level, there was also suggested that the development of an agenda for research (before all for operational research) can underpin policy-making.
- South-South visits between UHC-P countries was mentioned to be effective, like MOH in Guinea proposed to visit Rwanda where a national health insurance with budget transfers to subsidize the poor is already up and running for some time.

However, focus was most of all on **policy dialogue**, with WHO in a facilitator role to find consensus on "recommendations" developed by technical working groups – which contributed to the strengthening of *comprehensive* national health policies, strategies, and plans and bringing a UHC-focus to them. Importantly, fragmentation was reduced this way through early involvement of key stakeholders. UHC-support also resulted in Monitoring and Evaluation plans strengthening Health information systems. But also more specific policies and plans, like for Human Resources for Health. However, in some countries WHO was more in the lead of supporting policy dialogue than in other countries, much depending on the importance of concurrent input from other development partners. In 'full mode' countries (TA residing and working on UHC-P in the countries), the ability of the UHC-P TA to continuously follow up on the policy dialogue process was seen as a key success factor.

The policy dialogue process produced significant results in the **national health planning**. UHC-P support resulted in health policies becoming more UHC oriented. The importance of working on NHPSP/HF plans is that it is here where reforms are designed and where is embarked on meaningful UHC reforms. But results were not only in health policies and reforms. Besides supporting the defining of the policies and –plans, UHC-P support has also helped countries to have international and national stakeholders to align to national health policies, -strategies, -plans, and -procedures – as policy development has become more inclusive. Though there were clear differences in the importance of the role WHO played in alignment and harmonisation in the different countries. UHC-P has helped WHO to take leadership in DP support to defining the interventions of health system resilience in post-Ebola countries. This programme showed that WHO can have a key role in the Policy Making Agenda and Process of the countries developing robust health policies, especially through supporting the MoH position in the 'driver's seat'.

- This support can be done by advising MoH, which strategies show the best evidence, but it can improve by thinking along with the MoH on innovating strategies to improve health policies.
- All countries recommended extending the activities of the UHC-P from policy dialogue to support in the implementation of the policies.
- At country level, it was recommended to make a more clear link between UHC being one of the SDG, so different stakeholder may be more convinced on the importance of NHPSP

This formative evaluation also showed that discussions on UHC policies during policy dialogue activities brought more focus to NHPSP. Costing health plans helped making choices in policy decisions. **Health Financing** (HF) support is probably the highest priority in demand by countries supported, as they report that HF represents the most important challenge they face on their road to UHC. The UHC-P has supported governments to clarify and specify their vision of HF for UHC, mainly through situational analysis, policy dialogue, but also in technical support and training. Taking into account political economy insights is of utmost importance on the road to UHC, as UHC may mean important but sensitive changes in health financing – for that reason WHO as an independent institution has an added value in facilitating the HF policy dialogue. However, in most WHO-COs, HF

expertise is scarce. The case is made to increase full-mode TA for UHC-P on both types of TA – health system strengthening and health financing. We did observe that there is an unmet demand from several countries to support UHC through their chosen UHC-strategy: especially technical support on national health insurance with budget transfers arrangements, coupled with the question of expanding coverage to the informal sector and the poor – and results based financing. Voluntary CBHI as a core pillar of a HF strategy is not recommended by WHO based on technically (sound) arguments. However, this poses an interesting issue: UHC-P being so demand-driven, what should WHO do in case country's demand does not match with WHO strategic UHC-vision?

- Most technical support was required for HF, which required TA that was not always available in the CO (in terms of adequate expertise),
- Facilitation of intercountry workshops on HEF strategies were highly effective (e.g. UHC conference in Khartoum, Purchasing conference in Cairo and training course on UHC for francophone countries),
- MoH staff felt most learning was done through exchange of experiences. These South-to-South collaborations and learning opportunities have been highly appreciated by MoH staff across the studied countries

The **UHC-P itself** provided the partners a unique opportunity to both realize their own strategic goals as well as strengthen the WHO country offices. The partnership was managed efficiently by WHO-HQ. For both EU and Luxembourg, the decision to provide funds specifically for UHC/HSS related WHO work, worked well. It helped them realize their strategic objective: it brought more country focus to WHO as an organisation, and a stronger health system orientation at this level. It would help if the delegations of EU and Luxembourg at country level would be involved more for the UHC-P to be more efficient – but also to give legitimacy to the programme and create more visibility to it.

Also, one of the major challenges the UHC-P has faced during the implementation of the programme is the small pool of technical advisors available to fulfil the expectation of policy dialogue in country. These advisors need to be seasoned experts in health systems strengthening, able to foster political relations and have the willingness to work in countries with diverse contexts. These types of requirements are not easy to find, but by rostering HR in the program the availability and quality of expertise needed was improved.

- Nevertheless, for light-mode TA countries, the time spent on policy dialogue was not enough. Therefore, we recommend to reflect on the number of countries involved in the UHC-P, and perhaps only limit the program to full-mode TA
- The continued expertise on health systems strengthening, policy advice, relation management and HEF needs to be strengthened all over CO level.

Besides results in terms of support to UHC in countries, there are also results to be mentioned in terms of **effects on WHO** as an organisation. First of all, the visibility of the WHO has certainly increased in many countries. WHO, now finds itself more in a position as a driver of support to policy dialogue at country level. UHC-P has supported WHO to focus more on health system strengthening. Still, inter-