UHC2030 Technical Working Group on Sustainability, Transition from Aid and Health System Strengthening

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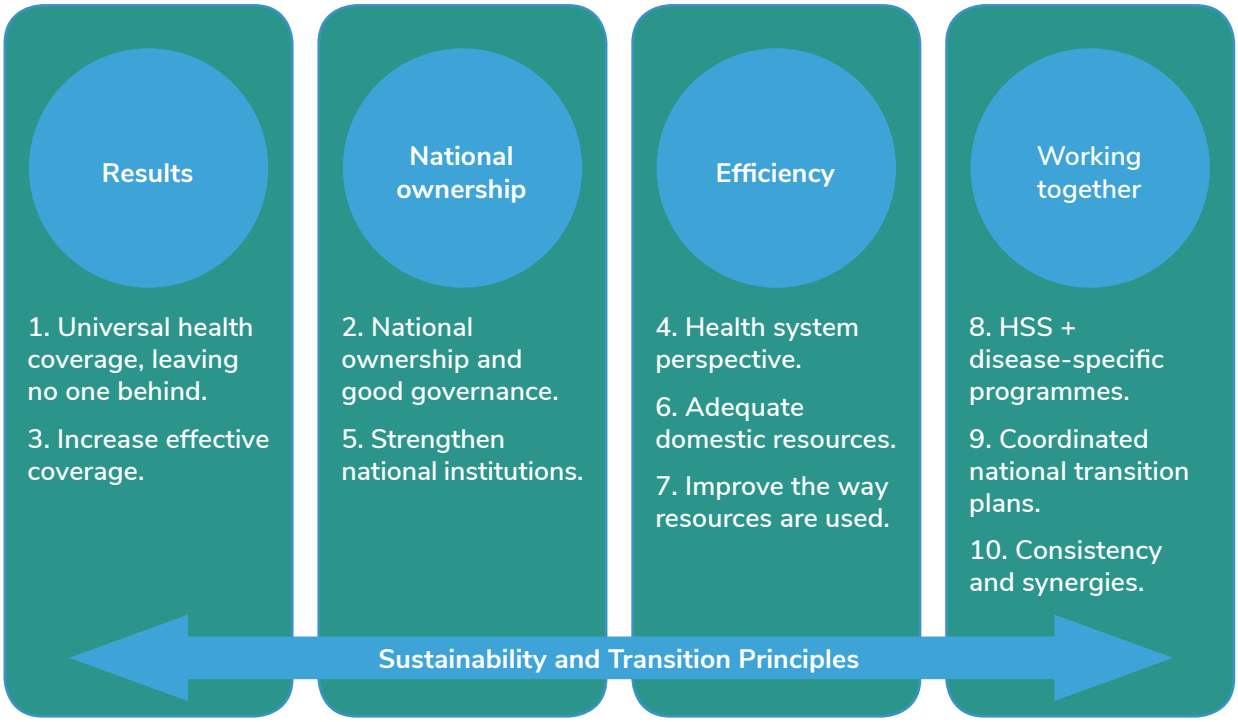

1. Executive summary

Introduction

In October 2018, the **UHC2030 statement on sustainability and transition from external funding** was launched following a comprehensive consultation process. The statement includes ten recommendations/principles directed at governments of countries experiencing transition from external funding and the broad range of development partners working in these contexts.

The third face-to-face meeting of the technical working group on sustainability and transition discussed the operational implications of the UHC2030 transition statement for different actors. The meeting gathered input for a collaborative agenda for improved outcomes and collaboration in contexts of transition from external funding. Securing agreement on the statement as a set of underlying principles for sustainability and transition was however the "easy *part*". The more difficult part is to find out if we really meant this, i.e. what are the operational implications, for government and key public and private actors in country, for development partners (DPs), for civil society and for academia. Further, within the transition agenda it is important to differentiate the political and technical issues as well as the country and donor/global agenda.

Transition carries the risk of a decline in effective coverage of priority interventions. Can we identify priorities for a transition reform and investment agenda? Within your country or agency, what is needed to reform health system policy and institutions, and what is the knowledge and advocacy agenda? What are the actions needed by development partners (not only donors)?

It is important to position the work of the UHC2030 TWG on sustainability and transition in the context of other global processes like the SDG action plan. The UHC2030 processes should contribute and align with the SDG action plan, including linking to the various "accelerators"; for example, the health finance accelerator and frontline services accelerator. The work of the sustainability and transition TWG is highly relevant and the transition statement has strong parallels with the focus in the health finance accelerator and others such as the PHC/frontline services accelerator.

Drafting an operational agenda

The table below summarizes some of the ideas from the TWG members from different constituencies – MOH, MOF, health programmes, civil society, academia, donors/GHI, and regional offices. The table includes both suggested and ongoing work undertaken by different actors.

UHC2030 sustainability and transition principles	Potential actions to operationalize the principles based on discussions	Actors*
1. Develop policies on transition within the context of universal health coverage leaving no one behind.	• Provide orientation to countries on the principles, translated to local contexts, at a time that fits the country planning cycle. • Provide orientation on transition principles in global meetings. • Target DAH in MIC to provide technical advice on system reform towards UHC. • Explore the involvement of HHA in operationalizing the transition principles. • Under different principles, define best practice by context as relevant/feasible. • Consider tabling the transition principles in the boards of GHI. • Present transition principles in the DAC for approval. • Build transition principles into the new EDC agenda. • Consider ways of working towards a WHA resolution adopting the principles. **Academia** • Consider a call for research/on operationalizing sustainability and transition principles.	
2. Promote national ownership and good governance for people-centred approaches and social accountability for effective transition policies.	Unpack different roles for CS in supporting UHC and develop an action plan to strengthen different parts. • Support a global-level CS platform (CSEM) on UHC. • Promote CS advocacy for UHC including budget advocacy. • Do CS work on policy analysis on UHC. • Empower professional associations for UHC, e.g. training. • Set up CS watchdog role on UHC implementation. • Review and summarize lessons and good practice on social contracting. • Review and summarize lessons on best practice for strengthening social accountability. • Develop an analysis on how CS can work to advocate and help operationalize the 10 principles globally and at country level. **Academia** • Research into the feasibility of developing an indicator framework to hold GVT accountable on UHC coverage for hard-to-reach populations that could later be used by CS. • Analysis of how subnational levels are consulted in transition processes with recommendations.	
3. Perceive sustainability as the ability of a health system to sustain or increase effective coverage of priority interventions and associated outcomes towards UHC.	• Strengthen national leadership for a vision and plan on progressing towards UHC. • Political will comes and goes. Developing systematic standards and scoring of HS trend/progress on UHC can act as a stabilizing factor to keep UHC reforms on track. • Consider linking transition-related DAH co-financing requirements to public allocations for health rather than programmes. • Build wording into the outcome documents of HLM.	

* Country, donors, GHI, academia, CS, multilaterals, disease programmes, HS programmes, etc.

UHC2030 sustainability and transition principles	Potential actions to operationalize the principles based on discussions	Actors*
4. Adopt the perspective of the health system in transition processes, including the other sectors that influence health, and move away from only focusing on specific individual health programmes.	• Develop a cross-programmatic priority/investment agenda and define actions under each area. • Start with a mapping of major global and feasible regional actors/coordination in selected cross-programme areas, e.g. procurement and supply, inter sector coordination, HMIS, PHC/SD, priority-setting processes, social contracting and hard-to-reach populations, PFM, HRH. • Review good practice principles for coordination models at sector level to ensure a focus on UHC – and examine in-country balance with other topic-specific coordination. • Explore feasibility to summarize/map available core cross-programmatic HS area best practice for UHC by subarea.	
5. Strengthen national institutions to ensure successful transitions.	• Advocate and fund efforts to anchor UHC reforms in building/strengthening institutions like HIF, payment certification agencies, others. • Build laws and regulations around GVT institutions for UHC and anchor good practice in those. • Support parastatal institutions on policy analysis aka Thailand and India. • Review TA models and examine alignment with UHC needs for developing capacities of institutions. • Increase DAH targeted for building skills, and capacity demand for policy analysis for UHC.	
6. Make the case for appropriate domestic resources for the health sector as a whole.	**Country** • Strengthen systems and processes for priority setting/strategic purchasing. • Set norms and standards for HRH. • Cost BBP. • Make population own BBP (CS support open consultations). • MTEF. • Resource mobilization policy linked with explicit results that funds will buy. • Link results to other sectors. **DPs** • Develop, disseminate and build consensus on good practice criteria on HF for UHC. • Define guidance and best practice for domestic RM for health. • Guidelines on BBP design and other HF processes (do they exist already?). • CS: Budget advocacy – targeting parliamentarian, media, professional associations, CS.	
7. Focus on transition as an opportunity for countries to enhance their use of resources.	• Consider developing normative guidance on assessing efficiency in HS cost of completed cases for disease/condition x or y. • Map existing normative guidance in cross-programmatic subareas?	

UHC2030 sustainability and transition principles	Potential actions to operationalize the principles based on discussions	Actors*
8. Ensure that health systems strengthening and disease-specific programmes work closely to identify barriers and actions needed in order to progress towards UHC.	• Link disease-specific funding into wider HS pools of DAH, e.g. MDTF as in Lao and Cambodia. • Develop policy papers on UHC and key disease priorities – articulated within the frame of UHC. • Country support: Joint scoping, planning and implementation of policy analysis on scaling up core intervention coverage and technical support as well as joint fundraising. • Consider developing case studies on different integration topics. • Joint training on UHC and different parts like HF.	
9. If you are a development agency, support well-coordinated national transition plans that adopt a UHC perspective.	• Consider tabling the transition principles in the boards of GHI. • Explore ways to strengthen input from PEPFAR/USAID in the TWG. • Consider tool mapping using T. principles lens to facilitate better coordinated approaches – not joint tool. • Build transition principles into EDC work for SDG era. • Consider targeted ways to increase T. principles buy-in from bilateral and multilateral donors. (EC) • Review ways of ensuring that all new DAH-supported work considers the transition principles).	
10. If you are a development agency operating at global and country levels, ensure consistency and synergies for coherent support to countries.	• Build global and regional platforms where countries can feed back on transition and EDC independent of DP. • Build consensus on using transition principles as a guide for accountability on transition processes. • Analyse better what did not work in the Paris agenda. Select topics as a group and analyse why they do not work. • Work to define the comparative advantage of different players at country level.	

2. Operationalizing the UHC2030 statement on sustainability and transition

Session 1: The UHC2030 statement on sustainability and transition from external funding – what are the technical and political implications?

Toomas Palu, Global Coordination, World Bank

It is important to position the work of the UHC2030 TWG on sustainability and transition in the context of other ongoing global processes including the SDG global action plan. This action plan was developed by 12 UN agencies under the leadership of WHO in response to a letter from the President of Ghana, the German Chancellor and the Prime Minister of Norway, aiming to better lever the reach expertise and experience of the global health community to make progress towards the SDGs. The action plan has three strategic approaches: (1) *Align*, which largely focuses on harmonizing and aligning better the different health actors and thereby improves efficiency; (2) *Accelerate*, which includes seven cross-cutting areas identified to accelerate progress, one

of which is on sustainable health finance (HF); and (3) *Account*, which focuses on improving monitoring and accountability for how health actors will work differently.

Within UHC2030 there are discussions on how the partnership and the processes already running may best contribute to the global processes including the SDG action plan; this includes optimal linking to the various "accelerators", for example the health finance accelerator, frontline services accelerator and fragility accelerator.

The work of the sustainability and transition TWG is highly relevant. The UHC2030 sustainability and transition statement has strong parallels with, for example, the focus on the HF accelerator – namely, the strong focus on placing work on transition within the context of UHC **(principle 1)**; the focus on increasing the priority for health through both a bottom-up approach **(principle 2)** complemented by incentivizing this via a global approach, for example using the human capital index, and reinforcing HS institutions to improve the effective coverage of priority interventions and outcomes **(principles 3, 4, 5)**; the emphasis on domestic resource mobilization **(principle 6)**; and improving the efficiency of how resources are used **(principle 7)**. There are also parallels with regard to the focus on improving collaboration and better aligning international partners to the objective of strengthening country systems for better outcomes, bridging the gap sometimes observed between global and country efforts **(principles 8, 9, 10)** as well as building on innovations in development assistance for health (DAH) models, for example the International Finance Facility for Immunization (IFFI).

Preparations are underway to develop the High-Level Meeting for Universal Health Coverage (HLM) political declaration on UHC in September. How can the work of this group best contribute strategically to this and the SDG action plan processes?

This meeting will be held back to back with a two-day meeting of the WB-led Multi Donor Trust Fund (MDTF) – a programme involving 12 countries mainly in South-East Asia to support strengthening of health systems to accelerate and sustain progress towards key health outputs and outcomes that contribute to UHC. The programme has four main pillars: (1) health financing and institutional assessments; (2) technical assistance and capacity building; (3) knowledge generation and exchange; and (4) implementation of HSS and integration activities. The two-day meeting following that of the TWG is one of the regular meetings convened as part of this programme (pillar 3). From the start there has been strong attention on health finance but there is evolving focus on ways to strengthen the models of service delivery. The programme aims for a practical country-driven approach. The GF and Gavi are both active partners and annual regional meetings are usually held in June.

Joe Kutzin, Coordinator Health Financing, WHO

Securing agreement on the statement as a set of underlying principles for sustainability and transition was the "easy part". The more difficult part is to find out if we really meant this, i.e. what are the operational implications for government and key public and private actors in country, for development partners (DPs), for civil society and for academia. Within transition processes it is important to differentiate the political and technical agenda as well as the country and donor/ global agenda.

UHC features prominently in the principles. UHC includes a focus on universality and equity and embeds all programmes and services within the overall health system. Transition from external funding can be seen as a political opportunity. From the perspective of the minister of health or minister of finance in response to transition there is a need to raise/allocate resources based on health needs and make the best use of the resources – directions that are relevant for all countries moving towards UHC regardless of transition context **(principle 1)**.

Transition provides an entry point to address health system inefficiencies and strengthen the institutions of the health system **(principles 5 and 7)**. In examining the efficiency, the unit of analysis should be the system rather than individual health or disease programmes. Progress should be assessed at the level of the population rather than for members of a particular insurance scheme or health programme **(principle 4)**.

Transition from external funding has brought a flurry of interest in financial sustainability. It is, however, important to be clear on what we are trying to sustain. Countries should aim to sustain or increase the effective coverage of priority interventions and associated outcomes towards UHC **(principle 3)**. Hence the aim should not be to sustain the HIV programme as such, but rather sustain or increase the effective coverage of interventions; for example, to prevent/treat and manage HIV. This calls for a joint reform or investment agenda for areas such as information systems, supply and procurement and PFM. What can be usefully consolidated without loss of accountability? Rather than different programmes presenting separate fiscal space analysis by disease or health priority, we should aim for a more comprehensive approach to securing adequate resources for the health sector as a whole **(principle 6)**.

Reducing external funding will in many cases greatly reduce funding for civil society including for activities such as key population outreach and advocacy. Can we find ways to strengthen political and technical advocacy and leadership for UHC and strengthen citizen voice for health **(principle 2)**? External funding is fungible. How does this affect how aid is channelled and the nature of agreements negotiated with government? The “external partner” is not (only) the programme manager – there is a need to connect the disease-specific dialogue with the overall sector dialogue **(principles 8, 9 and 10)**.

Transition also carries the risk of a decline in effective coverage of priority interventions. Can we identify priorities for a transition reform and investment agenda? Within your country or agency, what is needed to reform health system policy and institutions, and what is the knowledge and advocacy agenda? What are the actions needed by development partners (not only donors)?

Discussion

The transition principles are broad, making it difficult to pin down specific actions. Perhaps we can think about specific subtopics like information systems or supply chains and define specific indicators of progress that countries can work towards. This would need some contextualizing given the wide variety of country contexts.

The transition principles require contextualizing and a narrow focus on DAH may not be the right entry point for that discussion, but discussing transition overall within the context of UHC evolving service delivery (SD) model needs, the rise of NCDs and declining DAH is what many MICs are interested in.

Procurement and supply systems are critical areas. A large proportion of DAH goes to drugs and commodities. Globally, the landscape in this area is complex with some GF resources flowing through the global drug facility (GDF) and UNICEF handling procurement issues within the Gavi Alliance, in addition to other initiatives, making it unclear where countries interested in strengthening this area should turn.

Another key issue is the need to engage more actively with the US-based initiatives like PEPFAR; given its substantial role in many countries, it is essential to find ways of engaging better.

Transition should be seen as an opportunity. Programmes and GHI have valuable experiences to share; for example, working with hard-to-reach groups on HIV and reducing commodity prices of ARVs, Gavi has successfully helped shape vaccine markets. Civil society can be powerful catalysts of citizen engagement but there is a need to build capacity on UHC and make resources for this available.

For most of the principles, there are ongoing efforts. The problem is fragmentation. Can we think of ways of coming together to define some best practices and context-specific options?

Session 2: What do the principles imply in terms of different ways of working? Perspectives from constituencies.

H.E. Dr Youk Sambath, Ministry of Health, Cambodia

Principle 1: Develop policies on transition within the context of universal health coverage that include leaving no one behind. Cambodia is moving towards UHC. There are many actors in the Cambodian health sector. In addition to national actors there are more than 20 development partners and more than 100 NGOs, making for a complex environment for purchasing services. Development partners pool their support through the equity fund, a mechanism supported by the MOF. Through the health equity fund – now covering around 70% of health facilities – in 2018 new provider payment mechanisms were introduced, together with health facility grants using domestic resources. Health facilities have autonomy in managing the grants to improve efficiency in how services are delivered.

Further efforts, to strengthen performance, include the introduction of performance-related salary top-ups for civil servants. The MOH supported by the WB has set up a payment certification agency (PCA) which scores and verifies health centre activities with the aim of increasing coverage of selected priorities. Awards are calculated at the end of each calendar year. It is estimated that about 70% of the population is now covered by the above initiatives.

Niyazi Cakmak, Team lead, Vaccine Preventable Diseases and Immunization, WHO Europe

The statement is useful and reflects areas that are relevant and in many cases already worked on within immunization transition work in the European region. In 2010, when Gavi transition started in the region, initial efforts focused on the financial side of transition but it quickly became clear that programmatic sustainability was even more important including the need to strengthen institutional capacity of supply and procurement as well as information systems.

Principle 1: Develop policies on transition within the context of universal health coverage that include leaving no one behind. Equitable access is an important area in transition processes, addressing the pockets of lower coverage that often trail behind improvements in general immunization service coverage. Work focuses on tailoring immunization programmes to better address the demand side that often includes factors that are behavioural in nature.

Principle 7: Focus on transition as an opportunity for countries to improve the way they use resources. **Within WHO Europe's work on transition from immunization funding, the main focus has been on improving technical efficiency and several technical products have been developed, but there has been less focus on allocative efficiency. Within the latter, governance and institutional positioning of immunization programmes are areas where more work is needed in the European region.** Increases in efficiency have a positive correlation with mobilizing domestic resources. Work has included development of tools to help immunization staff make the case for immunization as a sector and national priority, helping forge the value case and key messages, and structure resource mobilization efforts.

Principle 8: Ensure that health systems strengthening and disease-specific programmes work closely to identify barriers and actions needed in order to progress towards UHC. Within the immunization area, WHO chairs the regional working group that regularly brings together the various actors involved in transitioning external immunization support, including WHO country and regional immunization staff with HS staff, UNICEF, the WB, the Gavi secretariat, and others involved in implementing activities related to country support to Gavi transition. The TWG works to ensure transition-related work on immunization is well coordinated, and that needs are identified and addressed in a coordinated manner. At country level, the immunization coordinating committee (ICC) plays this role under leadership of the government. **Collaboration between immunization and HS experts on transition work has improved in the region. Greater focus should be placed on cross-programmatic work on transition bringing major programmes (TB, HIV, immunization, etc.) together with those working on wider HS aspects under a UHC umbrella.**

Kuhat Thi Hai Oanh, Executive Director, Centre for Supportive Community Development

The statement is comprehensive and useful. We need to disseminate it more widely and find ways of translating the 10 principles into action in countries.

Principle 2: Promote national ownership and good governance for people-centred approaches and social accountability for effective transition policies. There are several important action areas for

civil society to operationalize this principle. Civil society needs to engage in policy development on transition; for HIV, for example – in many countries stigma in the general health service is high and civil society needs to follow the transition processes and safeguard and advocate the importance of addressing stigma as transition to general services takes place.

Civil society also needs to advocate for a transition policy that is placed in the context of UHC and takes a comprehensive evidence-informed approach focused on strengthening a people-centred, equitable health system that delivers on UHC. Civil society needs to support the MOH to advocate with parliament, the MOF and the cabinet for adequate domestic resources for the health sector.

Principle 8: Ensure that health systems strengthening and disease-specific programmes work closely to identify barriers and actions needed in order to progress towards UHC. Civil society is very fragmented by the disease/health topic: we need to define ways both at global and country level where civil society can come together under a UHC banner and build on the health system experience gained though working with various programmes.

Principle 5: Strengthen national institutions to ensure successful transitions. In many MICs, civil society has relied heavily on DP support. When DP support reduces, the community and citizen voice for health reduce. There is a need to find more durable ways to strengthen the determinants, systems and institutions of strong citizen engagement for health. The GF has piloted community engagement support, from which some lessons can be drawn. There is also a need to strengthen civil society platforms and institutions for UHC at global level.

Prof. Sara Bennett, Johns Hopkins School of Public Health

Below are personal reflections informed by recent evaluation work of the Gates Foundation-funded prevention programmes and work reviewing PEPFAR pilots of new geographical focus. For both, the focus is more on grass-roots observations than from a macro perspective.

Principle 1: Develop policies on transition within the context of universal health coverage that include leaving no one behind. Key populations like MSM/CSW are clearly at risk of being hit hard in transition processes in countries, but this also applies to populations with geographical access issues, for example people living in remote areas. There seems to be somewhat of a gap in the development of good markers/indicators that can be used to hold government accountable for progress on UHC in such contexts. **The development of such indicators – including the role of social contracting and civil society engagement more widely – could be a useful area for further research as a contribution to transition principle 1.**

Principle 8: Ensure that health systems strengthening and disease-specific programmes work closely to identify barriers and actions needed in order to progress towards UHC. Experience shows that both country policy-makers (e.g. Kenya and Uganda) and DPs have underestimated the implications of transition; for example, for HIV services in programmes with limited (e.g. few districts) geographical focus. Factoring in implications of decentralization – for example service delivery, and supply and distribution systems – has proved much more complex than anticipated. Some donors like USAID have temporarily postponed programme closure as a consequence. **Would the development of training programmes for different levels and contexts of service providers**

and health planners be of assistance here? Such trainings, if rolled out, could contribute to operationalizing principle 8.

Principle 2: Promote national ownership and good governance for people-centred approaches and social accountability for effective transition policies. A more general point is that involvement of subnational levels in transition processes is often insufficient. Negotiations take place at national level even in contexts of decentralized countries, leaving limited or no time for planning at subnational levels. **Could transition planning tools that better factor this in, for example institutional mappings, contribute to more advanced planning here? This could be part of operationalizing principle 2 on national ownership.**

Michael Borowitz, Chief Economist, Global Fund

Principle 6: Make the case for adequate domestic resources for the health sector as a whole. Expanding fiscal space including efficiency improvements is already part of GF policy, but operationalizing this can meet with challenges in transition contexts especially for drugs and other commodities where the GF is currently procuring these drugs through its pooled procurement mechanism (including the GDF for TB drugs housed at STOP-TB). In theory, governments can access these pooled procurement mechanisms with domestic funding, but there are often legal issues as well as financial issues like putting the money up-front. More importantly, domestic procurement and regulation of pharmaceuticals is often weak and this means governments could be buying drugs through their own domestic mechanism at much higher than GF prices (e.g. Belarus produces its own TB drugs). In addition, there may be issues of quality if there is not a good framework for regulation of pharmaceuticals, especially for domestic quality. The transition from GF-pooled procurement to domestic procurement is a critical transition issue where more coordinated work across development partners is needed.

More tailored work is therefore needed on specific transition challenges in health systems, mainly procurement and supply chain and public financial management including contracting with NGOs. It is important to take a more nuanced approach to these systems by understanding where the function lies, which may be outside the traditional partners for disease programmes. For example, at what level does the procurement take place (central versus local) – through the health insurance fund or through a general government procurement system (e.g. in Vietnam, the HIF procures the TB drugs)?

Principle 8: Ensure that health systems strengthening and disease-specific programmes work closely to identify barriers and actions needed in order to progress towards UHC. Integration can be a way of increasing fiscal space through efficiency as there may be economies of scale in integrating the three diseases to PHC. However, integration is not a panacea – we need to analyse what does and does not need to be integrated. The Integra study showed that integration of HIV/AIDS and family planning services led to a decrease in quality of family planning services. Generally, the case for wide HS integration is much stronger – for example, in TB and malaria as opposed to HIV – particularly in concentrated epidemics where the main focus is working with key populations that often are faced with stigma in the general health system.

For an institution like the GF, transition provides a political opportunity to work differently and gradually tailor its operational model. Engagement with the World Bank, for example in Lao, has enabled the GF to incorporate some disease-specific indicators into the new Results-Based Health Sector Loan. Harmonizing around the WB health sector loan may serve as a model for donor coordination by bringing together disease programmes like TB, malaria, and HIV/AIDS, immunization, and maternal and child health.

Joint training on health system strengthening and health finance can help catalyse more harmonized ways of working. This is happening with support from WHO already – both globally and at country level – across the three diseases as well as with the WB, for example in Lao.

Principle 7: Focus on transition as an opportunity to improve the way countries use resources. **The GF would like to see the development of standards for health system efficiency in countries.** Some work has already been carried out for this. Examples of outputs could include estimates of the cost to treat cases of HIV in a particular country.

Principle 2: Promote national ownership and good governance for people-centred approaches and social accountability for effective transition policies. National ownership has been a challenging issue for the GF. Conceptually, this should be represented by the CCM, but these will likely phase out as countries transition. Better understanding of how/if government systems will take on some of the roles of CCMs is needed, particularly engagement with civil society.

With regard to social accountability, civil society clearly has an important role to play. **There is a need to broaden the current disease-specific advocacy towards a wider HS/UHC focus, for example on improved models of service delivery. Equally, it is important to broaden the concept of engagement within the civil society term and not just rely on NGOs that provide services. Countries like Japan have emphasized how important professional associations such as the Japan Medical Association were in raising allocations to the sector, and in most OECD countries professional associations play an important advocacy role. There is very limited engagement with professional health societies as a key actor in civil society.**

Grace Kabaniha, Technical Advisor, WHO Regional Office, Africa

Principle 8: Ensure that health systems strengthening and disease-specific programmes work closely to identify barriers and actions needed in order to progress towards UHC. To operationalize this principle we need to find ways of fostering a shared understanding between those working on wider health system aspects and those working on more specific health or disease outcomes. **Dealing with the political economy can involve practical steps like joint scoping, planning and implementation of policy analysis and technical support as well as joint fundraising.** The cross-programmatic efficiency work is one entry point for this and often involves different partners under government leadership. One of the difficulties with DAH work is a tendency for rent seeking. Assessments have been carried out but there is resistance to some of the recommendations. We need to understand this resistance better and adjust the actions accordingly.

Principle 1: Develop policies on transition within the context of universal health coverage that include leaving no one behind. Globally, we are beginning to see a shift in the balance between work on disease-specific commissions towards a greater focus on mobilizing domestic funding for the health sector as a whole, but this shift has yet to trickle down to the country level. National Health Accounts (NHA) are there but disease-specific analysis is often being pushed strongly in countries. This links to the current separation in coordination mechanisms for the health sector broadly and disease-specific mechanisms, for example CCMs. **Reviewing coordination models at sector level is therefore also needed in order to translate this principle into action.**

Harmonization for Health in Africa (HHA) is a regional platform involving 16 organizations that also work on transition issues including streamlining PFM support to countries. **HHA would welcome a role in following up on operationalizing the 10 principles in the African region.**

3. Programme perspectives and a country lens

Session 3: Reflections from a meeting on programme perspectives on sustainability and transitions

Maria Skarphedinsdottir, UHC2030 Core Team

One of the recommendations at the previous meeting was to strengthen the input from service delivery, health and disease programmes as TWG discussions to date have had a strong HF focus. In response, a meeting was convened in December with Geneva-based health/disease programme representatives. Participants included WHO programmes on TB, HIV, malaria, NCDs, RMNCH, NTDs, polio, EPI and HF JWT (service delivery) as well as partnerships – UNAIDS, RBM, STB, GF and Gavi. **The aim of the meeting was to discuss the key HS challenges related to transition from external funding as seen by priority programmes and highlight areas for potential collaboration.**

A short background was given to the work of the group so far, placing the work on transition within the context of UHC, the importance of getting the sustainability question right and framing sustainability around the concept of sustaining or increasing effective coverage of quality priority interventions and outcomes for UHC, and how key concepts have been framed in the 10 UHC2030 principles.

A discussion followed on the HS barriers to scaling up effective coverage of priority outcomes, with some cross-cutting barriers/areas being apparent. The majority of the discussion focused on "efficiency" issues, for example which HS barriers are hampering increasing or sustaining the gains made so far by various programmes in expanding coverage. A smaller part focused on "harmonization and alignment", i.e. how DAH instruments and approaches can best be aligned to support UHC.

Transition-related "threats", i.e. the most pressing issues perceived to be threatening the sustained or scaled-up achievements made, were highlighted.

Table 1 Programme perspectives – priorities and threats related to transition from external funds	
TB	For transition from external funding the biggest threat we perceive relates to **drug supply systems**. MSF wrote an open letter to GF in 2016 highlighting the threats posed by transitions particularly related to the quality of and the supply chain for TB drugs. Once countries transition to domestic funds for TB, will governments continue to purchase quality drugs – how will the balance play out in relation to incentives to buy locally produced drugs, sometimes with weaker quality control standards? This can have huge implications on resistance development – **threatening advancement of multi-drug resistant TB (MDR-TB)**.
HIV	Transition can and has led to **resurgence in concentrated HIV epidemics** where key populations served by NGOs have a key role. In many countries there is **weak or no capacity for social contracting and priority in national resource allocation and policies is insufficient**. The major challenge will be the financing of community-based services that are often at a lower cost and effective. There are many different initiatives at community level – home-based care workers for HIV, community-based DOT workers, malaria extension workers, and PLHIV treatment supporters, to mention a few. **When funds become scarcer such structures are vulnerable. Prevention and community outreach is an area where resources are often cut first and there is the real threat that we may lose those community-based and outreach services needed to reach the vulnerable populations that are essential to reach UHC.**
Malaria	**While securing funding continues to be an issue, the efficient use of resources is even more important.** Currently we have parallel systems for planning and budgeting such as the CCMs while there is a clear need for better comprehensive sector planning for consistent ways to, for example, improve delivery models and data availability and use. Eroding the political commitment to eliminate malaria in the Asia-Pacific region. Many countries are well equipped to take over the current donor-supported programmes, but certain elements like **replacing the current DAH-supported procurement mechanisms** can be problematic particularly in small countries procuring small commodity orders. The malaria programmes share the concerns raised by other programmes about **difficulties in sustaining the current outreach for hard-to-reach populations being provided by civil society**. **There is a risk that political commitment to maintain vector control through effective coverage of indoor residual spraying (IRS) and LLIN will not be sustained at regional level.**
EPI	According to the Global Vaccine Action Plan (GVAP) 2018 report, the **global expenditures on routine immunization per live birth grew by 35% between 2010 and 2017**. In addition to **increased advocacy for additional domestic resources, it is a priority to improve efficiency**, through building institutional and human resource capacity, and strengthening management skills and ways of enforcing accountability. We have established collaboration, for example, on national health accounts (NHA) and have worked on tools to demonstrate the return on investments for immunization. We would like **broader collaboration on positioning immunization priorities and work within an overall framework on UHC**.

Table 1 (cont.) Programme perspectives – priorities and threats related to transition from external funds	
Polio	The Vaccine Preventable Disease (VPD) surveillance system is crucial for provision of reliable epidemiological data, immunization impact monitoring, outbreak prevention and informed decision-making on new vaccines. In many LICs and MICs, the current VPD surveillance system was built on the polio surveillance system with funding provided by the Global Polio Eradication Initiative (GPEI). **With polio approaching eradication, the GPEI funds will gradually dry up worldwide. This raises a sustainability challenge for countries. We are particularly concerned about sustaining the surveillance system and how this can be successfully integrated.**
NTDs	Barriers include the generally low profile and priority of NTDs both in countries and internationally despite them causing huge morbidity, challenges in effectively collaborating across sectors and sustaining community engagement, and having weak infrastructure and health systems including reliance on drug donations for several of the diseases. **In general, work on NTDs is reliant on interest from a selection of international partners and reduction in those would impact achievements substantially as work on NTDs is often not prioritized in countries.**

Table 2 Perspectives of health programmes that are less reliant on DAH	
NCDs	**The NCD agenda is huge, but has not received much attention from donors. The programmes are therefore fully reliant on domestic resources and systems.** **There are many HS barriers. Information systems are weak. Prevalence and coverage data is frequently absent – contrary to some other conditions where efforts have gone into strengthening surveillance and data systems. Budgets are also often skewed and NCDs are not prioritized proportional to the disease burden, perhaps in part as a result from an information bias.** **In order to respond to the high NCD burden, major investments are needed in both public health measures and models of service delivery – in particular, primary health care but also regional services as well as tertiary care – for example, for cancers.** NCDs are often chronic and alignment between PHC and other levels of service is important as is building services in a people-centric manner. Decentralization adds a layer of complexity and often partners like WHO are not always well geared to address this. Mechanisms to strengthen intersector work are essential to address commercial determinants of major NCDs. In many countries people are paying for services at the point of delivery and private sector providers are poorly regulated. The latter is an issue but priority must be given first to improving public sector data availability and use.
RMNCAH	The reproductive, mother, newborn, child and adolescent health (RMNCAH) area is a good indicator of the performance of the health system overall. The area benefits from external funding within the area of immunization (Gavi) and more recently the GFF are active. Overall, however, this area is one that relies mainly on domestic resources and systems. **For the future it is important to increase focus on equity in service access as well as advocating for and supporting more implementation research, through strengthened policy analysis capacity in countries. More focus is needed on innovations in service delivery including better integration of outreach and community services.**

Issues raised can broadly be divided into two categories: (1) issues related to health system barriers raised by programmes in relation to transition, outlining a "*cross programmatic health system/efficiency*" agenda; and (2) issues raised by participants that relate to how planning on transition happens in countries and ways of strengthening effective development coordination, and issues related to a "*coordination agenda*"

Table 3 Cross-programmatic health system/efficiency agenda

Priority area	Programmes identifying barrier	Related global coordination efforts/ platforms
Procurement and supply systems	TB, malaria, VPI, HIV	CGD Working Group on the Future of Global Health Procurement* Inter-Agency Pharmaceutical Coordination Group, Interagency Supply Chain Coordination Group * Does not cover immunization
Multisector ways of working	• NCDs: determinants of tobacco, alcohol and dietary policies • TB/HIV: work in prisons/other • Malaria: Vector control • NTDs: Vector control • All: migrants/cross border	SDG action plan determinants of health accelerator
Strengthen service delivery models/ PHC	All	Global Service Delivery Network (GSDN) Primary Health Care Performance Initiative (PHCPI) SDG action plan PHC accelerator, SDG community and CS accelerator (WHO and UNICEF)
Integration of community services	Polio, HIV	
Data and HMIS	All	Health Data Collaborative SDG action plan data and digital health accelerators
Social contracting	HIV, TB, malaria, polio, VPI, NTDs	UNDP/GF/OSF/UNAIDS/USAID coordination on social contracting

Table 3 Cross-programmatic health system/efficiency agenda (cont.)		
Priority area	**Programmes identifying barrier**	**Related global coordination efforts/ platforms**
Prioritization	All	SDG action plan health finance accelerator – (P4H secretariat) There are two main categories: firstly *what* to fund, focusing on questions about benefit design; and secondly *how* to purchase health services in a strategic way (strategic purchasing, including coherent provider payment methods and contracting). Health technology assessment (HTA) helps inform the decisions on the first part regarding benefit design. With respect to "what" to purchase (benefits design), numerous networks on HTA exist*, along with donor-funded networking activities**, representing different constituents such as professional agencies, individuals, industry and academia. MOHs have anecdotally reported confusion with regard to the contribution that the different networks have to support their advancement and avoiding duplication. In response, WHO will launch the Decide Health Decision Hub to provide a space for all networks to communicate and align to support country processes for resource allocation decisions. * Health Technology Assessment International (HTAi), International Network of Agencies for Health Technology Assessment (INAHTA), Health Technology Assessment Network of the Americas (RedETSA), EuroScan, EUnetHTA, HTAsiaLink, International Society for Pharmaceutical Outcomes Research (ISPOR). ** International Decision Support Initiative (iDSI), Disease Control Priorities (DCP).
Human resources for health	All	Global Health Workforce Network (GHWN) The five-year action plan for health employment and inclusive economic growth (ILO, WHO and OECD) Health worker mobility/migration: the health worker labour mobility platform established to coordinate efforts to maximize benefits from health worker mobility between source, destination countries and migrant health workers
Health financing	VPI, TB, HIV, malaria	P4H, WHO Montreux agenda, WB Multi-Donor Trust Fund SDG action plan health finance accelerator (WB and GF led P4H with secretariat)

In countries and globally there is misalignment of incentives to support a move to UHC. We should define ways of improving the coherence in incentives created by external support, how these are aligned with domestic policies, and incentives within an overall direction of the country moving towards UHC. Discussions highlighted the need for a more holistic approach to health financing discussions that embeds donor transition issues within the frame of overall health financing.

Work should address cross-cutting health system strengthening or efficiency issues within HS subareas to improve outcomes. For many of these there are platforms that work to coordinate, share good practice and, as appropriate, harmonize efforts. Notably, the cross-cutting HS issues/ barriers are to some extent similar for donor-supported programmes (e.g. HIV, TB) and for those programmes less reliant on external funds (e.g. NCDs), underlining that work on transition is in essence a UHC/health system strengthening agenda.

Work on transition should address issues related to how planning on transition happens in countries – coordination – that also relates to effective development coordination. The current donor-by-donor piecemeal approach is not effective and systemic issues will need to be better addressed. There should be work across the boards of the GF, Gavi and the WB to synchronize approaches better, align co-financing requirements and move away from the current approach of agreeing co-financing policies institution by institution. Similarly, in countries there is a need to move away from coordinating disease by disease and redefine the balance between vertical and horizontal efforts.

Notably, there can be **tension between an eradication/elimination agenda and moving towards UHC. There is also a need for better optics/frameworks that consider the progression of change in a spectrum from fragile to highly sophisticated complex health systems.**

We should define a transition investment and reform agenda that would allow us to jointly work on addressing selected cross-cutting elements that are hampering the scale-up of priority interventions in countries. This should extend to cross-cutting issues both inside and outside the sector.

Discussion

This should not be about defining a whole new health system framework but unpacking some cross-cutting areas where joint approaches may be of benefit. This will require some nuance as needs and contexts are different. The case for integration is stronger in some programme areas than others: for example for surveillance in the case of polio, or for aspects of the TB control, whereas for HIV – especially in concentrated epidemics – the case for broad-based integration may not be as strong.

Many countries are challenged by fragmentation in national systems. This is not only about integration per se, but about improving performance and addressing outstanding gaps in coverage. Tailored approaches are needed: selected programme elements may transition faster into national programmes while others, for example social contracting, require more time.

The four major NCDs – CVDs, DM, cancer and COPD – are diverse and require differentiated approaches, at the three levels of the system. The high prevalence rates of CVDs and associated risk factors like HT, for example, also have both operational and cost implications. In addition, the private sector is a big provider in many countries and particular issues arise from this related, for example, to efficiency, equity and accountability.

DAH has focused on particular programmes and in transitioning and moving to integrate these there is a risk that they will be left out from overall health system efforts, for example HF reforms to increase pooled public funding. It is difficult for programmes to address the wider governance, institutional and management issues alone. On the side of the donors, some – for example the GF, Gavi and the WB – are moving to harmonize efforts, but this really requires inputs from bilateral agencies that can influence GHI behaviour as well as address their own.

Session 4: Experiences from countries – challenges and action needed

Mark Blecher, Chief Director, Health National Treasury, South Africa

Principle 1: Develop policies on transition within the context of universal health coverage that include leaving no one behind. For South Africa as an UMIC, reference to donor partners is not helpful. South Africa is moving away from donor engagement. Transition is not so much a question of replacing DAH but of technical advice and peer learning to support development of cross-cutting global goods and addressing the political barriers in moving towards UHC.

South Africa has the world's highest HIV prevalence rates. By the time young women reach 25 years of age, almost one in every four (23%) have contracted HIV. Raising funds for drugs and services is less of an issue than implementing the right health financing, governance and service delivery models. Available resources for health are very unevenly distributed, with health resources roughly divided half–half between public and private sources. The private funding, however, covers only 15% of the population, resulting in a near fivefold per capita difference between those covered by the public system (4000 rand p.c.) and those covered by private insurance (20 000 rand p.c.).

UHC2030 should call for ways of supporting MICs to strengthen institutions and service delivery models that offer integrated quality services, for example institutions that develop and oversee quality standards for service delivery or integrated communicable disease management, or ways to undertake equity enhancing system reform. Governance is also important and engaging with civil society to improve citizen voice in health.

Global DAH should focus predominantly on fragile countries, whereas in MICs the main focus should be on technical advice for UHC reform.

Discussion

By some estimates, 50% of DAH[1] in the MDG was disease specific with limited funds available for wider UHC support. Keeping this division is a powerful incentive to maintain the status quo while greater targeting of resources for UHC broadly could help incentivize progress on UHC.

1 WHO Global Health Expenditure database, Public Spending on Health: A Closer Look at Global Trends.

Daniel Osei, Head of Budget, Ministry of Health, Ghana

Countries should strengthen national leadership for a vision on moving away from aid across sectors. For the health sector this should include actions towards strengthening a health system that delivers UHC to the population. It is noteworthy that discussions on the performance of the health system are often initiated in relation to discussions with donors. The performance of institutions is critical but grant agreements seldom have a strong focus on this.

Principle 2: Promote national ownership and good governance for people-centred approaches and social accountability for effective transition policies.

In 2018, the President of Ghana launched "*Ghana beyond aid*" outlining policies across sectors. This has been very helpful at the national level and should be translated into specific action in sectors. For the health sector these can, for example, include the obligation for any new externally funded work to have explicit plans for transitioning achievements into the wider HS at the end of the project.

There is a need for more targeted work on national institutions; for example, strengthening the systems and institutions for health policy analysis through building national think-tanks and para governmental institutions with a policy analysis and advisory role. Civil society should have a role in this, and not only focus on current activities like supporting service delivery, for example for hard-to-reach groups. Countries should develop mechanisms to fund such work from general tax revenues.

Strategies and incentives should be aligned from the start so that transition challenges are systematically addressed across the system with a focus on sustaining the results and achievements.

Discussion

Ghana has not included TB and HIV in the pooled health insurance funding – should we be thinking how to do this? Some misunderstandings exist on how to bring in the different priorities – there are overlapping polices. The policy states that services are free but in reality this is not the case. Donor-supported areas have been seen as separate. Ghana is currently reviewing the content of the BBP and malaria has been included given the high prevalence rate.

Regina Ombam, Deputy Director, HIV Investments, NACC, Kenya

Principle 3: Understand sustainability as a health system's ability to sustain or increase effective coverage of priority interventions and associated outcomes towards UHC. UHC is high on the political agenda in Kenya and a number of specific areas are being examined. Firstly, discussions are ongoing on ways to increase the allocations to health from the national budget, rationalize the financing by better integration of the off-budget funds, improve the predictability, transparency and complementarity of DAH, and adjust the budgeting structure to better align it to decentralized counties. A second major area includes reviewing the overall vision for the structure of the HS in Kenya, in particular improving service delivery efficiency by consolidating and integrating the service delivery models. A third area being worked on is developing the regulatory frame for institutionalizing heath care as an asset that is legally mandated. Fourthly, work is underway to

improve efficiency through greater use of advanced information and communication technology (ICT) drawing on private sector actors. Lastly, through a new framework for intersector cooperation there is a push for the health sector to step up collaboration with other sectors.

Important actions are needed to help operationalize the principles: political will can come and go, but developing systematic standards and scoring of HS performance can act as a stabilizing factor to keep reforms on track.

Discussion

Countries and partners should start transition planning early. Realistically, transition policies, processes and structures are already ongoing, and there may not be much space for operationalizing some of the principles underlining the importance of early planning in countries currently further away from transition. As political commitment for UHC is high in Kenya, on-the-ground partner support is focused on a selected number of counties where DAH-supported HIV and TB programmes are ongoing and less overall on UHC.

Sometimes global-level data can mask important fiscal context parameters. Allocations to the health sector may look low but only because a third of the budget is going towards debt payment.

For transition as an entry point for UHC, apart from HF we should increase the focus on HRH, service delivery models and the determinants of quality and equity.

Closing remarks

Midori de Habich, Co-chair of the technical working group

Transition from external funding, closely associated with a number of other changes and transitions, is best regarded as an opportunity. **UHC forms the basis for a country agenda and the statement, and the 10 principles should serve to align all actors behind this agenda.**

We all have a role to play in moving the collective agenda. We should increase engagement at the highest level with bilateral agencies and other donors of GHI, and use the principles to push for more flexibility and tailoring of approaches to country contexts as well as greater use of ongoing efforts to pool DAH in support of HS reforms. We should strengthen our efforts to work with US counterparts to involve them in this discussion given their substantial role in many countries.

There is a need to rethink and unpack the role of civil society in supporting transition in a UHC context. This should include policy analysis of UHC reforms and political comments and advocacy, for example on budgets; work with professional associations towards stronger capacity on social contracting; and developing the tools, skills and capacity for civil society to play a watchdog role and contribute to social accountability and citizens' voice for health.

There is a need to develop operational ways to catalyse greater synergies between those working on particular disease or health outcomes and those working on wider health system outcomes within the overall framework of increasing coverage of priority interventions and associated outcomes towards UHC.

We should define across the programme action agenda aligned to country efforts on UHC but address barriers in areas such as procurement and supply systems, intersector coordination, HMIS, PHC/SD, social contracting and the hard to reach, PFM and HRH. Numerous efforts are already underway, but tailored approaches are needed to build on ongoing work. We should also look for ways of articulating further the degree of health systems efficiency in delivering priority outcomes.

Finally, in doing the above we should look to learn from experience as much can be learned from examining barriers already encountered in previous work.

Annexe one: Participants at the third face-to-face meeting of the UHC2030 Technical Working Group on Sustainability and Transition from External Funding

28 January 2019

Centara Grand and Bangkok Convention Centre at Central World 23rd floor (Address: 999/99 Rama 1 Road, Pathumwan, Bangkok 10330, Thailand)

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Annexe two: Agenda of the third face-to-face meeting of the UHC2030 Technical Working Group on Sustainabilityand Transition from External Funding

28 January 2019

Centara Grand and Bangkok Convention Centre at Central World 23rd floor (Address: 999/99 Rama 1 Road, Pathumwan, Bangkok 10330, Thailand)

Objective: Build consensus on a collaborative agenda to operationalize the UHC2030 sustainability and transition principles.

08:45–09:00	Welcome coffee and registration
1. Operationalizing the UHC2030 statement on sustainability and transition from external funding	
09.00–09.15	Welcome: Midori de Habich, Co-chair of the UHC2030 technical working group
	Chair/Moderator: Midori de Habich Co-chair of the UHC2030 technical working group
09:15–09.40	The UHC2030 statement on sustainability and transition from external funding – what are the technical and political implications? • Toomas Palu, Advisor, Global Coordination, WB (context, SDG AP UHC) • Joe Kutzin, Health Finance Coordinator, WHO
09.40–09.50	*Discussion*
09.50–10.50	What do the principles imply in terms of different ways of working? Name three concrete changes that your "constituency" could take to operationalize one or more of the principles • Countries: H.E. Dr Youk Sambath, Cambodia • Health programmes: Niyayi Cakmak, Team Lead, Vaccine Preventable Infections, WHO Europe • Civil society actors: Khuat Thi Hai Oanh, Executive Director, Center for Supporting Community Development Initiatives • Academia: Prof. Sara Bennett, Johns Hopkins Bloomberg School of Public Health • Donors and GHI: Michael Borowitz, GF • HS programme: Grace Kabaniha, WHO AFRO
10.50–11.00	*Discussion*
11.00–11:20	**COFFEE BREAK**

2. Programme perspectives and a country lens	
	Chair/moderator: Sara Bennett
11:20–12.00	Reflections from a meeting in Geneva on programme perspectives on sustainability and transition • The outcome of 10 December meeting: Maria Skarphedinsdottir and Joe Kutzin • Commentary: – Tomas Palu, WB – Taskeen Khan, WHO NCD programme *Discussion*
12.00–13.00 13.00–13.30	Progress and challenges in countries: • South Africa: Mark Blecher, South African Treasury • Ghana: Daniel Osei, Ministry of Health, Ghana • Kenya: Regina Ombam, Deputy Director, HIV Investments NACC, Kenya *Discussion*
13:30–14:30	LUNCH in the World Restaurant on the 24th floor
3. Breakout sessions. The 10 principles: what action is needed and by whom?	
	Chair/Moderator: Somil Nagpal, WB
14:30–15.30	• Breakout sessions x 3 • Note takers/facilitators: Nertila Tavanxhi, Somil Nagpal, Maria Skarphedinsdottir
15.30–16.30	• Panel discussion
4. Feedback and implications for action	
16.30–17.00	Conclusions • Midori de Habich, Co-chair of the UHC2030 technical working group

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