

Document SC2. UHC2030 accountability strategy – initial scoping

UHC2030 Steering Committee meeting, Geneva, 15-16 June 2017

Table of Contents

1. Background – Purpose of the paper	2
2. UHC Accountability in the SDG context	3
3. UHC2030 role in the UHC accountability architecture: possible elements	4
4. Potential activities	8
5. Next steps	9
6. Annex 1. UHC2030 indicator framework.....	11
7. Annex 2. Background information on specific initiatives	14
8. Annex 3. Overview of examples of accountability relationships related to UHC	17

1. Background - Purpose of the paper

One of the four agreed objectives for UHC2030 is to facilitate accountability for progress on health system strengthening (HSS) towards universal health coverage (UHC) and through this to contribute to a more integrated approach to accountability for SDG3, and SDG 3.8 in particular, building on existing efforts contributing to accountability.

As part of the UHC2030 revised work plan for 2017, it was agreed **to develop a strategy for UHC2030 for delivery of this accountability objective**, specifying how the partnership can add value; identifying specific activities to strengthen monitoring, review and remedial actions at various levels of UHC; and ways of working to support implementation (e.g. role for a multi-stakeholder working group). It should be noted that such a strategy is not about accountability in relation to internal governance of UHC2030 (e.g. effectiveness of the partnership and its members in delivering on the mandate, lessons learning and knowledge sharing) which should rather be addressed as part of the preparation of work plan and associated reporting process.

The purpose of this paper is to stimulate initial discussion within the UHC2030 Steering Committee around some of the key questions related to carving out the role for UHC2030 in relation to overall architecture of accountability for UHC. An important guiding thread is how UHC2030, as a global partnership, can be helpful at the global level to influence change in countries.

The paper has been prepared by the Core Team, drawing on inputs from initial preparatory work which included desk review and interviews with a small number of informants (selected experts supporting accountability processes relevant for UHC). The paper aims to support the Steering Committee discussion which will guide the Core Team to draft a full strategy to be finalised for review by the SC by end 2017, identifying areas that may require more in depth consideration and further consultation of a wider range of partners.

2. UHC Accountability in the SDG context

Accountability for UHC rests with national governments. 193 countries have committed to UHC through the SDGs and a dedicated 2013 UN UHC resolution. Within these countries, a development continuum exists that varies by income, political system, expenditure on health and the pattern of health care provision and financing. Each country has its own specific accountability processes, which work to different degrees of effectiveness, including variation within the country. Every country has scope to improve policies and actions towards UHC but priorities depend on country context. Lessons on how to progress towards UHC can be learned both within and across countries.

Governments receive their mandate from citizens. Social accountability including the role of local authorities, civil society, private providers, citizen voice and the media therefore play a central role in holding Ministries of Health and government accountable.

Regional and global processes can play a role in supporting and advancing national accountability. Multiple connections exist between governments and regional/global organisations, as well as between national and international civil society organisations.

Development partner accountability processes exist also to support aid-recipient countries and should therefore be accountable to national authorities. Depending on the nature of the development partner (bilateral, multilateral, etc.), they are also accountable to their own political systems or management boards. Accountability on development effectiveness is distinct from accountability for UHC, but contributes to the latter in an indirect manner.

UHC is an important aspiration both in its own right and as a structural plank of the wider SDGs, underpinning other goals such as economic prosperity and lifelong learning.¹ UHC contributes to SDG3 health targets, alongside progress in other sectors like water and sanitation and factors that may be influenced by but are not under the direct control of health systems. UHC is also bounded by fiscal, demographic and technological pressures and opportunities that constantly evolve, requiring dynamic adjustment by health systems.

These cross-cutting priority-setting responsibilities underline the country level as the primary focus of SDG accountability, with national, regional and international monitoring and review mechanisms ultimately feeding into the UN High Level Political Forum (HLPF) as the apex body promoting and reviewing SDG progress.

¹ UHC2030, 2017, Healthy systems for universal health coverage – a joint vision for healthy lives

3. UHC2030 role in the UHC accountability architecture: possible elements

The 75 signatories to UHC2030 have agreed four main objectives for the partnership. This paper relates to how the 3rd objective should be enacted:

1. Contribute to improved coordination of HSS efforts for UHC at global level, including synergies with related technical networks
2. Strengthen multi-stakeholder policy dialogue and coordination of HSS efforts in countries, including adherence to IHP+ principles and behaviors in countries receiving external assistance
3. **Facilitate accountability for progress towards HSS and UHC that contributes to a more integrate approach to accountability for SDG3**
4. Build political momentum around a shared global vision of HSS for UHC and advocate for sufficient, appropriate and well-coordinated resource allocation to HSS.

A lot of work on accountability in the broader sphere of health, with some direct or indirect links to UHC, is already ongoing, at national, regional and global levels. WHO and WB have developed a framework for tracking global and country progress on UHC (Box 1)². The framework was applied for the first time in the first global monitoring report for UHC using a set of aggregate tracer indicators (Annex 1).

The first global monitoring report on UHC outlines three major challenges in tracking UHC; first sourcing reliable data on a broad set of health service coverage and financial protection indicators; second, disaggregating data to expose coverage inequities, third measuring effective coverage, which not only includes whether people receive the services they needs but also takes into account the quality of services provided and the ultimate impact on health.³

² WHO (2014) *Monitoring progress towards UHC at country and global levels: framework, measures and targets*. Geneva: WHO/HIS/HIA/14.

³ WHO and World Bank (2015) *Tracking universal health coverage: first global monitoring report*. Geneva: WHO.

Box 1. Goal, targets and illustrative indicators of UHC

Goal

Achieve UHC. All people obtain the good-quality essential health services that they need without enduring financial hardship.

Targets

- By 2030, all populations, independent of household income, expenditure or wealth, place of residence or gender, have at least 80% essential health services coverage.
- By 2030, everyone has 100% financial protection from out-of-pocket payments for health services.

Indicators

1. Health services coverage

1.1 Prevention

1.1.1 *Aggregate*: coverage with a set of tracer interventions for prevention services.

1.1.2 *Equity*: a measure of prevention service coverage as described above, stratified by wealth quintile, place of residence and gender.

1.2 Treatment

1.2.1 *Aggregate*: coverage with a set of tracer interventions for treatment services.

1.2.2 *Equity*: a measure of treatment service coverage as described above, stratified by wealth quintile, place of residence and gender.

2. Financial protection coverage

2.1 Impoverishing expenditure

2.1.1 *Aggregate*: fraction of the population protected against impoverishment by out-of-pocket health expenditures, comprising two types of household: families already below the poverty line on the basis of their consumption and who incur out-of-pocket health expenditures that push them deeper into poverty; and families for which out-of-pocket spending pushes them below the poverty line.

2.1.2 *Equity*: fraction of households protected against impoverishment or further impoverishment by out-of-pocket health expenditures, stratified by wealth quintile, place of residence and gender.

2.2 Catastrophic expenditure

2.2.1 *Aggregate*: fraction of households protected from incurring catastrophic out-of-pocket health expenditure.

2.2.2 *Equity*: fraction of households protected from incurring catastrophic out-of-pocket health expenditure stratified by wealth quintile, place of residence and gender.

Various efforts are also ongoing to address data challenges including through the Health Data Collaborative (HDC) (Box 2).

Box 2. Health Data Collaborative

If the SDGs are to be met, including all the health-related SDGs, it will require a new approach to the production and use of social, economic, and health data, including data on lifestyle and vital statistics.

The Health Data Collaborative (HDC) was formed in 2016 to support countries to implement the 2015 Measurement and Accountability for Results in Health Summit's Call to Action and

Health Measurement and Accountability Roadmap. The HDC is a joint effort by several global partners to work alongside countries to improve the availability, quality and use of data for local decision-making and tracking progress toward the health related SDGs.

HDC approach is crucial in helping countries improve their health information systems by:

- Supporting countries to improve their technical and institutional capacities to generate, analyze and use quality health data and vital statistics;
- Coordinating existing efforts and investments;
- Rationalizing global demand for data (by focusing on just 100 core indicators); and
- Harmonizing tools and guidance, which should improve the efficiency and effectiveness of partner support to countries

Despite the complex accountability architecture, there is emerging consensus over areas in which UHC2030 could add value. There exists a possible ‘accountability niche’ for UHC2030 that complements a range of efforts. Preliminary preparatory work points to three main areas where UHC2030 would likely add most value, and for which there seems to be strong demand:

1. **Bridging between technical and political fora** to help highlight emerging UHC problems and progress
2. A **‘network of networks’**, linking existing initiatives as an effective and agile learning
3. Acting as a **peer review platform**.

Accountability is grounded in the governance function of a country health system, and is as such reflected in the **cycle of priority setting action monitoring and review**. This is mirrored in accountability approaches of other partnerships: e.g. the EWEC model with its three-stage cycle around **monitor-review-remedial action** (Annex 2).

In countries the mandate for health system strengthening towards UHC is in most cases delegated to Government and MOH. They in turn exercise this by setting national plans, national health targets/national health priorities, system reform objectives, etc. (**the remedial /priority action part**) In recognition of the complexity of actors involved this needs to involve a broad range of stakeholders, other sectors, subsector and community levels, private actors and can in some cases be influenced by regional or even global level commitments.

For the **monitoring** part, at the system level many countries have some sort of processes of selecting a subset of indicators that are regularly assessed, sometimes within the framework of national plans and sometimes not. UHC objectives are closely associated with health system goals/outcomes and health system performance, while they do not represent a substitute for health system goals such as improved survival or healthy life expectancy.

For good stewardship of the health system a key action is **review** of a subset of indicators informing on progress on key system goals/outcomes. This can happen by assessments of national plans, regular review of the indicators, or dedicated health system performance analysis exercises done by countries. In some cases WHO and

other partners are helping with this. WPRO have focused on participatory development of a UHC assessment framework to help countries assess the system progress towards UHC and then determine priorities for improvement, whereas in SEARO the Regional office has helped compile profiles with data on progress on some of the key indicators for the use of policy makers.

Mechanisms for people's voice are central to accountability. A variety of mechanisms of voice and community empowerment in health service delivery convey the collective preferences of citizens including National Health Assemblies, community ownership, community management, and community and citizens monitoring and report cards.

At the global level, UHC2030 could play a role at the level of review and remedial action, in the following ways, aiming at soft accountability, based on peer review and exchange, rather than hard enforcement:

1. **To share country experience and lessons** focused on the tough, practical choices around expanding UHC through HSS.
2. To help share and **strengthen consensus on best practice principles** for moving towards UHC.
3. To act as an informal clearing-house and sounding-board, **to help coordinate** (with a light touch) **among other initiatives** targeting specific diseases, conditions or groups in need, and especially to help make these more coherent with broader systemic strengthening approaches and initiatives.
4. To act as a **nexus between existing data collection and analysis platforms** (such as the WHO UHC Data Portal and the Global Health Observatory) and policy makers to assist with the process of using data in policy decision making.

In terms of facilitating **country level accountability UHC2030** can add value indirectly by helping strengthen consensus on principles of good practice for UHC applicable at country level as well as sharing lessons on accountability processes. UHC2030 can also have a role in reinforcing principles of EDC that are updated for the SDG era in countries where external partners play a role. As a multi-stakeholder partnership, UHC2030 can help promote social accountability, working closely with the Civil Society Engagement Mechanism. Citizens' platforms are essential for the formulation and review of strong national health policies, strategies, and plans that enable progress towards UHC.

FOR STEERING COMMITTEE CONSIDERATION

Does the Steering Committee agree:

1. That the main locus for responsibility for UHC accountability rests with national governments, for their domestic actions?
2. That promoting EDC is not the major focus of UHC2030 work on UHC accountability but remains a significant complementary objective in low income countries and some lower-middle income countries, where external finance still plays a role?
3. That supporting 'social accountability' by strengthening civil society institutions and other non-state actors who play a central role in holding governments accountable is of central importance.

4. That UHC2030, at global level, should operate as a bridging for sharing lesson learning on UHC across countries, drawing on the work of other organisations, bridging coherent communication between technical and political discussion fora and strengthening political buy-in to best practice on UHC service delivery, financing and governance?

4. Potential activities

Having agreed its possible role, and established its accountability 'niche', UHC2030 needs to consider the kinds of activities it wants to engage in, and prioritise within a limited resource envelope. The focus should be practical, addressing issues through the lens of questions like: **what will this activity change in reality; what would it look like if we were doing it right; how will we know if we have done it?**

While considering possible activities, it is important to keep in mind important consideration. The focus of UHC 2030 work on accountability should be mostly focused towards data analysis, dissemination and use rather than new data collection, seeking to bridge political and technical agendas. Further UHC2030 will mostly seek to achieve its objectives by indirect work in countries rather than intensive direct country focus (Box 3).

Box 3. Considerations to keep in mind

The degree to which UHC2030 wants to collect dedicated/new data or to collate/analyse/use existing data. UHC2030 should carve out a niche in the area of data use in policy, rather than gathering any new data of its own. Major health actors including WHO and WB have established mandates in data collection, including for UHC. The only partial, and potentially contested exception, could for data on EDC, which is not currently collected elsewhere at the same level of detail. Even there, however, the first-best approach was thought to be to build on national survey instruments and processes.

The intensity of country focus. Encouraging decision makers through greater efficiency of information management and feedback loops is an intensive policy process. The IHP+ had a strong track record of developing and promoting practical tools for improving national planning and financial management systems. UHC2030 could build on this experience through transparent discussions of the utility of these tools and their impact on changing processes at national level. As for IHP, rather than testing and/or rolling out such tools with direct involvement in countries, UHC 2030 should become more of an intelligent 'curator' and discussion/dissemination hub for country experiences building on such tools, primarily supported by other actor's already present in-country. UHC2030 would also need to build on its direct links to other initiatives such as the Joint Learning Network (JLN) and the Health Data Collaborative (HDC), that provide support in specific technical areas.

Balance between technical versus political engagement. UHC accountability rests on both a political and technical process. UHC2030 partners already operate levers through existing political mechanisms, such as the World Health Assembly or the World Bank Spring Meetings, as well as the High Level Political Forum. Other levers exist regionally through WHO regional offices or bodies such as the African Union or ASEAN. At regional

and global levels, UHC2030 may have opportunities to add value by connecting up the different levels, and helping bridge between technical and political level, promoting peer review or traffic light mechanisms, as well as South-South learning opportunities. These 'soft' accountability mechanisms offer the potential for forward momentum. In order to support national political processes, UHC2030 should help **'make the bullets but not shoot them'**. These could for example include helping forge or broaden consensus on different best practices for UHC.

Table 1 contains a list of possible activities, by no means exhaustive, which emerged through preliminary preparatory work. Some would be a continuation of the kinds of things that the IHP+ did, while others would be new departures. Prioritising these activities should be led by an assessment of potential value added and transaction costs.

Table 1 Possible UHC2030 accountability activities

Help develop and help broaden consensus on good practice for moving towards UHC
Playing a role to bridge the gap between technical and political processes, for example by debates, review and communications around the WHO/World Bank UHC Monitoring Report
Establishing a central UHC knowledge platform, aiming to build on and ensure cohesion amongst the multiple other initiatives;
Providing regular opportunities for members for open, transparent information sharing on progress, achievements and challenges – 'soft' accountability through peer review
Supporting sharing of experience through dialogue between governments, local authority, CSOs and private sector stakeholders on progress towards UHC
Maintaining a focus on EDC in aid-dependent settings
Promoting synergies between key actors at different levels and platforms such as the WHA, the Spring Meetings or the AU, while avoiding raised transaction costs
Working to harmonise accountability work across related HSS and health finance initiatives e.g. with the Every Woman Every Child (EWEC) process and others.
Facilitate advocacy/other activities by civil society organisations (CSOs), including citizen's voice, professional organisations, and building on others work in this area,
Developing and operationalizing specialised tools, such as scorecards or benchmarks, for use by national and/or regional stakeholders

FOR STEERING COMMITTEE CONSIDERATION:

Which activities in Table 1 does the Steering Committee think are likely to deliver greatest return on investment for making progress on accountability for UHC?

5. Next steps

In developing the strategy, the core team would benefit from being guided by a **time bound advisory group**, drawing on the different expertise that exists among partners, including UHC2030 related initiatives (e.g. Health Data Collaborative, Health Systems Governance Collaborative, Joint Learning Network) and the Civil Society Engagement Mechanism, given their contribution to accountability related work. Consultations with countries are essential and should be envisaged, taking advantage of relevant regional or international gatherings taking place in the coming months, working in particular closely with WHO regional offices.

While further work is needed to develop the accountability strategy for UHC2030, it is proposed to maintain momentum and not miss important opportunities to influence. This includes **the preparation of an accountability report to review progress in coverage and financial protection**. This report will complement the 2nd annual UHC monitoring report and inform discussions at the UHC Forum 2017 that will take place in Tokyo, in December. WHO experts will provide the analysis while UHC2030 can facilitate some additional technical consultations that will help to frame key summary messages.

FOR STEERING COMMITTEE CONSIDERATION

Does the Steering Committee agree that the Core Team is tasked to develop a strategy for UHC2030 role in facilitating accountability for UHC within the SDG framework by end 2017, working with a group of experts?

Annex 1: UHC indicator framework⁴

Coverage indicators

Definitions of indicators of health intervention coverage for monitoring universal health coverage

Indicator	Primary data source	Numerator	Denominator	Equity measurements available for this report
Promotion/prevention				
Family planning coverage with modern methods	Household surveys	Sexually active women 15–49 years who are currently using a modern contraceptive method	Women 15–49 years of age who are sexually active and do not wish to become pregnant	Wealth, education, urban/rural residence
Antenatal care coverage	Household surveys, administrative records	At least 4 visits to any care provider during pregnancy	Live births	Wealth, education, urban/rural residence
Skilled birth attendance	Household surveys, administrative records	Live births attended by skilled health personnel (doctors, nurses or midwives)	Live births	Wealth, education, urban/rural residence
Diphtheria, tetanus and pertussis (DTP3) immunization coverage among 1-year-olds	Administrative records	1-year-old children who have received 3 doses of a vaccine containing diphtheria, tetanus and pertussis	1-year-old children	Wealth, education, urban/rural residence, sex
Prevalence of no tobacco smoking in the past 30 days among adults age ≥ 15 years	Household surveys	Adults 15 years and older who have not smoked tobacco in the past 30 days	Adults 15 years and older	Sex
Percentage of population using improved drinking water sources	Household surveys	Population living in a household with drinking water from: piped water into dwelling, plot or yard; public tap/stand pipe; tube well/borehole; protected dug well; protected spring; or rainwater collection	Total population	Wealth, urban/rural residence
Percentage of population using improved sanitation facilities	Household surveys	Population living in a household with: flush or pour-flush to piped sewer system, septic tank or pit latrine; ventilated improved pit latrine; pit latrine with slab; or composting toilet	Total population	Wealth, urban/rural residence
Preventive chemotherapy (PC) coverage against neglected tropical diseases (NTDs)	Administrative records	People requiring PC who have received PC (at least one NTD)	People requiring PC (at least one NTD)	None

⁴ WHO and World Bank (2015) *Tracking universal health coverage: first global monitoring report*. Geneva: WHO.

Indicator	Primary data source	Numerator	Denominator	Equity measurements available for this report
Treatment indicators				
Antiretroviral therapy coverage	Administrative records, household surveys including HIV test	People who are currently receiving antiretroviral combination therapy	People living with HIV	None
Tuberculosis treatment coverage	Administrative records	New cases of TB that have been diagnosed and completed treatment in a given year	New cases of TB in a given year	None
Hypertension coverage	Health examination surveys including blood pressure measurement	Adults 18 years and older currently taking antihypertensive medication	Adults 18 years and older taking medication for hypertension, with systolic blood pressure \geq 140 mmHg, or with diastolic blood pressure \geq 90 mmHg	Wealth, sex (not shown)
Diabetes coverage	Health examination surveys including blood glucose measurement	Adults 18 years and older currently taking medication for diabetes (insulin or glycaemic control pills)	Adults 18 years and older taking medication for diabetes or with fasting plasma glucose \geq 7.0 mmol/l	Sex (not shown)
Cataract surgical coverage	Health examination surveys including visual acuity and basic causes of vision impairment	Adults 50 years and older who have received bilateral cataract surgery or who have received unilateral cataract surgery with operable cataract and visual acuity $<$ 6/18 in the unoperated eye	Adults 50 years and older with bilateral operable cataract and visual acuity $<$ 6/18, who have received cataract surgery in both eyes, or who have received cataract surgery in one eye and have operable cataract with visual acuity $<$ 6/18 in the unoperated eye	Sex

Financial protection indicators

Definition of indicators of (lack of) financial protection

Concept	Lack of financial protection (LFP) indicators LFP headcount ratios = Numerator/total population	Financial protection (FP) indicators ¹ FP headcount ratios are rescaled versions of the lack of financial protection ones, i.e. FP ratios = 1 – LFP ratios
Catastrophic health expenditures		
Budget share approach	Number of people spending 25% or more of their total expenditure on out-of-pocket (OOP) health expenditures. ²	Share of the population spending less than 25% of their total expenditure on OOP
Capacity to pay based on subsistence needs (WHO approach)	Number of people spending 40% or more of their capacity to pay on OOP ^{3,4} Capacity to pay is defined as total expenditure net of expenses for basic necessities. Food is obviously one such basic necessity but not all food spending is non-discretionary. Hence a subsistence level of food expenditure is estimated as the average food expenditure per equivalent adults of households in the 45th–55th food budget share distribution. ⁵ When actual food spending falls below this amount, then capacity to pay is defined as total expenditures net of actual food spending. This also avoids estimating a negative level of capacity to pay. ⁵	Share of the population spending less than 40% of their non-subsistence expenditures on OOP
Capacity to pay based on food expenditure	Number of people spending 40% or more of their non-food expenditures on OOP? ²	Share of the population spending less than 40% of their non-food expenditure on OOP
Impoverishing health expenditures		
Absolute approach using the international poverty line	Number of people with expenditures net of OOP below an international poverty line but with expenses gross of OOP above such an international poverty line (e.g. US\$ 1.25 per capita per day). ²	<ul style="list-style-type: none"> • Share of the population not pushed into poverty, i.e. with expenditures net and gross of OOP above an international poverty line/level of subsistence food consumption/multiple poverty lines • Share of the population not further pushed, i.e. with expenses below an international poverty line/level of subsistence food consumption/multiple poverty lines and no OOP • Share of the population that are neither pushed nor further pushed into poverty
WHO approach using subsistence food expenditure	Number of people with expenditure net of OOP below levels corresponding to subsistence food expenditure but with expenses gross of OOP above subsistence levels of food. Subsistence food expenditure is estimated following the same approach used to identify catastrophic health expenditures in the WHO capacity to pay approach. ³ In other words, the incidence of catastrophic and impoverishing OOP expenditures is based on a function using the same benchmark.	
Absolute approach using different international poverty lines	Number of people with expenditures net of OOP below the international poverty line applied to the country according to its World Bank income group classification (US\$ 1.25 for low-income countries, US\$ 2.00 for lower-middle-income countries, US\$ 4.00 for upper-middle-income countries and US\$ 5.00 for high-income countries) but with expenses gross of OOP above its corresponding international poverty line. ⁶	

- 1 WHO and World Bank. Monitoring progress towards universal health coverage at country and global levels: framework, measures and targets. Geneva: World Health Organization and International Bank for Reconstruction and Development/The World Bank, 2014 (http://www.who.int/healthinfo/universal_health_coverage/en/, accessed 27 April 2015).
- 2 Wagstaff A, van Doorslaer E. Catastrophe and impoverishment in paying for health care: with applications to Vietnam 1993–98. *Health Econ.* 2003;12(11):321–34.
- 3 Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J, Murray C. Household catastrophic health expenditure: a multi-country analysis. *Lancet.* 2003;362(9378):111–7.
- 4 Distribution of health payments and catastrophic expenditures: methodology (discussion paper EIP/HSF/DP.05.2). Geneva: World Health Organization; 2004 (www.who.int/health/_dp_e_05_2-distribution_of_health_payments.pdf).
- 5 Wagstaff A. Measuring financial protection in health. In: Smith P, Mossialos E, Papanicolas I, Lathierman S, editors. Performance measurement for health system improvement: experiences, challenges and prospects. Cambridge: Cambridge University Press; 2009:114–37.
- 6 Flores G, O'Donnell O. Robust measurement of financial protection in health. Forthcoming HEC-DEEP, University of Lausanne.

Annex 2: Background information on specific initiatives

The IHP+ accountability framework, performance reports and Joint Assessments of National Health Strategies

The IHP+ has increasingly evolved in the direction of a cross-country learning platform, with a focus on broad health system strengthening (HSS, including health financing writ large). Its accountability framework is based on (1) a single country-level monitoring and evaluation platform and (2) mutual accountability between countries and development partners, based on periodic performance monitoring of the seven behaviours enshrined in the IHP+ Principles.

One additional tool, the JANS (IHP+ 2009, revised 2013), straddles the ‘what’ and the ‘how’ of HSS, by providing both a standardized planning guide and a systematic problem-solving agenda to which several partners can contribute, identifying further action and resource needs. JANS covers five areas, examining the soundness of: situation analysis and programming; the national strategy process; costs and budget framework for the strategy; implementation and management arrangements; and monitoring and evaluation mechanisms. JANS have been found (IHP Reviews, 2014 and 2016) to help strengthen national health strategies and build confidence in them, and to reduce transaction costs associated with multiple separate assessments. Their links to funding behaviour change by partners (in amount or predictability) are less clear.

This reflects the broad areas of strength and weakness already noted in the 2014 IHP+ Performance Report, mapping to four of the seven IHP+ principles:

- Partner country delivery on sector strategies, results and strengthened accountability systems: progress on the first two, stagnation on the third and on civil society engagement in policy and planning.
- Development partner alignment and participation in national accountability processes: progress in results frameworks and support to CSOs, stagnation in mutual assessment of progress.
- Partner countries improvement in health financing and financial management: progress in budget share and predictability, stagnation in public financial management.
- Performance of development partners on financing and financial management: stagnation (1/4 indicators) or decline (3/4) across the board.

The asymmetries here are quite marked, and point to the need for more realism perhaps in mutual expectations of the Partnership’s impact on future funding decisions made by development partners, while building on the relative success with national processes and funding mechanisms. These findings were also broadly validated by the recent Rapid Independent Review of IHP+⁵ which emphasised the three main areas in which IHP+ was found most useful: as an inclusive platform for

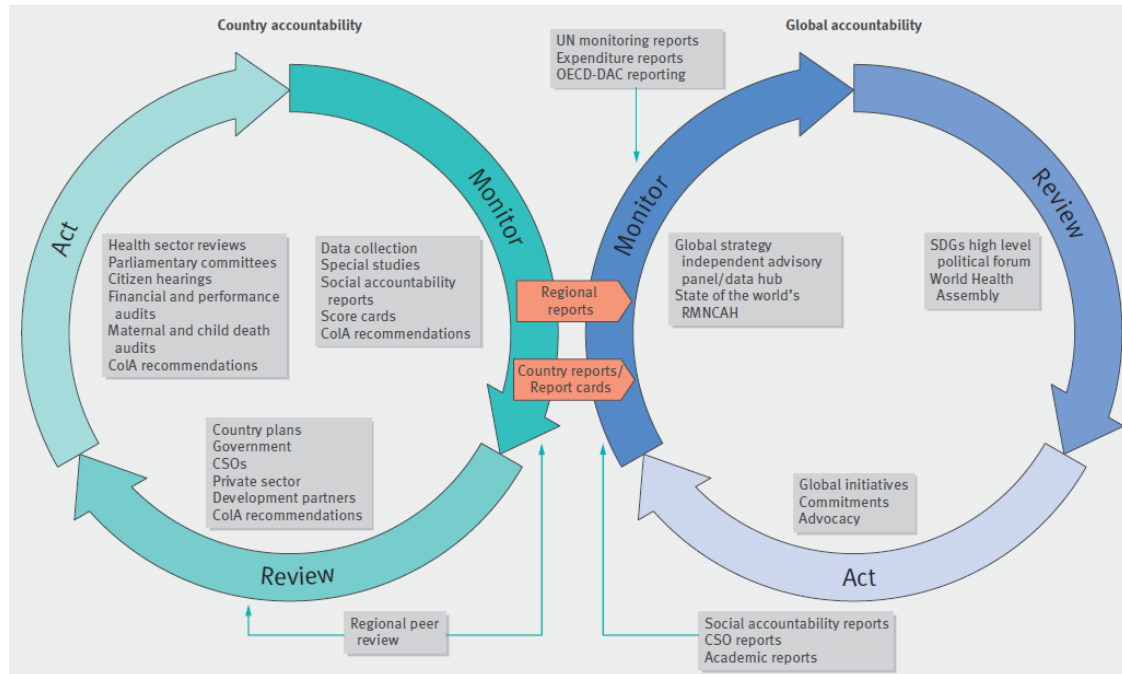
⁵https://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/About_IHP_/mg_t_arrangemts_docs/Core_Team/Rapid_Review_of_IHP_.Final_Report_16_DEC_2016_1.pdf

exchanges of views on HSS; as a way of keeping effective development cooperation on the national and international agenda; and for its practical tools, including JANS.

An example of a partnership framework n accountability: EWEC’s Unified Accountability Framework (UAF)

Examining experiences and structure of other health related partnership accountability frameworks can provide useful insights. The EWEC launched in 2010 is a movement of international and national actors on to address the major health challenges facing women, children and adolescents around the world. The movement puts into action the Global Strategy for Women’s, Children’s and Adolescents’ Health. The UAF has a three-stage accountability cycle of ‘Monitor-Review-Act’ operating both at national and at global levels (figure 1). This has recently been added to with a ‘remedy’ stage, more focused on underlying structural causes of health outcomes. The framework presents twin accountability cycles – national and global – that are linked, crucially, by country reports and scorecards, by peer reviews (regional in this schematic, but potentially also cross-regional) and by regional reports to global level. The peer review element looks important for UHC also, especially in the light of IHP+ experience.

Figure 1 Twin accountability cycles schematic of the Unified Accountability Framework for the UN Global Strategy for Women’s, Children’s and Adolescents’ Health⁶



Recognising that country contexts differ too much for a single ‘accountability blueprint’ to work, EWEC distilled instead a core set of accountability principles for the Global Strategy agreed in 2015:

⁶ Schweitzer, J. (2015) Accountability in the 2015 Global Strategy for Women’s, Children’s and Adolescents’ Health. *BMJ* 351: H4248.

- Adherence to human rights, including the rights of women, children and adolescents to receive quality and respectful services;
- The rights of communities and civil society to participate in monitoring, review and action; and
- The key roles and responsibilities of the different stakeholders in the health sector, from governments and international agencies, to the private sector, civil society and, above all, the women, children and adolescents who have the right to survive and thrive.

These core principles could be used as an example for inspiration to build upon for the broader target groups of UHC, applicable to UHC2030. Implementation of EWEC accountability processes (such as an annual multi-agency performance report, peer reviews, and supporting the work of the Independent Accountability Panel, which has been set up to provide an independent review of the Global Strategy) is the responsibility of the Partnership for Maternal, Neonatal and Child Health (PMNCH).

Rockefeller Foundation 2016 consultation recommendations on UHC accountability

With regard to UHC accountability overall, consultations undertaken on behalf of the Rockefeller Foundation⁷ identified the need to take stock from experience with relevant accountability initiatives in the MDG era, including how to leverage these experiences and efforts for health systems and UHC. This is partly being implemented through the present review, as concerns health initiatives in particular.

Other top-level Rockefeller consultation recommendations on UHC included: the need for country-specific consultations to identify gaps and opportunities to strengthen multi-stakeholder accountabilities for monitoring, review and action (as in the EWEC schematic presented above); securing reference to UHC accountability in intergovernmental resolutions such as the WHA resolutions on the SDGs; a better definition of 'non-compliance' in relation to UHC implementation; and exploration of the human rights and legislative mechanisms that can be leveraged for UHC accountability.

With specific regard to UHC 2030 accountability mechanisms, recommendations included: a clear commitment to the mandate to strengthen accountability, with sufficient human and financial resources to carry it out; inspiration from existing models of multi-stakeholder governance (such as the International Labour Organisation (ILO), Global Fund and PMNCH Boards) to inform the design of the Steering Committee; a consultative process leading to a CSO consortium under the umbrella of UHC 2030; and sufficient donor investment in operationalising the accountability framework at national level, including capacity strengthening of civil society, parliamentarians, media and other stakeholders.

The consultations also recommended that the mandate of the Independent Accountability Panel (as of now, established to serve the EWEC initiative only) be expanded to the whole of SDG 3 – including of course UHC, with appropriate redesign and resources.

⁷ Brearley, L. (2016) *Options for an Accountability Framework for universal health coverage*. New York: Consultation Report by Management Sciences for Health/Rockefeller Foundation.

Annex 3: Overview of examples of accountability relationships related to UHC

Accountability for UHC lies principally at the national level, and derives from government commitments to their citizens and commitments to the SDGs, under which UHC sits within SDG3 as target 3.8. However, many other actors are involved, operating across multiple levels and countries. This annex presents the findings of a mapping exercise undertaken to shed light on the institutional geography of accountability for UHC. The purpose is to identify gaps, overlaps and complementarities and set the scene for the discussion of the possible accountability role of UHC2030.

Rather than tabulating a comprehensive set of information on all the initiatives at every level, which would be large and unwieldy, a ‘mindmap’ approach has been taken to help visualise this picture (Figure 1 overleaf). The map is neither encyclopaedic nor directly derived from any theory of global governance. It is simply an attempt to represent the complex web of accountability relationships at national, regional and global levels in a visually accessible way. It should be noted, however, that not all the accountability lines contribute to UHC in the same degree: while they are linked, they may not be all fully relevant for an overall UHC accountability framework.

To the right of the mindmap, various institutions contributing to the SDGs are presented, with the UN SDG processes at the top and, under them, related national and regional institutions that could play a role in supporting implementation and accountability for SDG3. At the bottom right are a set of development partner accountability processes: High-level income countries would therefore have accountability for UHC deriving both from their own commitments to UHC for their domestic populations and any support they provide to aid recipient countries.

On the left side of the mindmap are three broad groups of initiatives: those that, in one way or another, form part of the UHC2030 family; those that form part of the family of organisations that together seek to deliver the UN Secretary General’s EWEC movement and its associated Global Strategy for Women’s, Children’s and Adolescents’ Health; and those that address associated specific health issues such as NCDs or health security. Some of these organisations could fit in more than one of these areas but for convenience has been placed where they appeared to concentrate most on.

Many additional relationships cut across this map: for example, many of the initiatives on the left have direct relationships with national or regional institutions on the right; likewise there are obviously multiple formal and informal connections between national, regional and global institutions. Furthermore, virtually all governments are represented on the governing bodies of all the international health-related agencies, and can hold their managements to account through those channels. The map recognises the importance of some of these connections but has left them out here for the sake of visual simplicity.

Figure 2 Map of accountability relationships related to UHC (to be provided during the meeting in a different format)

