DCP3 Disease Control Priorities

Country Translation Phase

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Reinforcing priority setting and design and delivery of health services packages for universal health coverage

A strategy for a new and sustainable technical cooperation model in low- and lower middle-income countries

The Disease Control Priorities 3 Country Translation Project - June 2023

Executive summary

This document outlines the reasoning and strategic directions for a viable and sustainable technical cooperation approach to priority-setting, and the design and delivery of essential health services to achieve universal health coverage (UHC). The proposed approach is based on primary health care (PHC) and builds upon the concept, evidence and experience accumulated by the Disease Control Priorities 3 (DCP3) Country Translation initiative.

UHC is an overarching target of the Sustainable Development Goals (SDGs) and a World Health Organization (WHO) key strategic priority. However, based on current progress, UHC will not be reached for at least a major proportion of the world's population by 2030. Of particular concern are low- and lower middle-income populations (LLMICs) and those in fragile and conflict-affected settings, whose health systems are poorly financed and suffer from severe resource and capacity constraints. For most of these countries, progress is impeded by three key factors: inadequate political will and weak leadership, insufficient public financing for health, and weak health systems.

Financial scarcity and weak health systems force LLMICs into difficult decisions and tough resource allocation choices. Obtaining greater value from available resources can only be achieved by directing focus toward their most effective and efficient use and by an unwavering resolve to strengthen health systems particularly at the PHC level. In this regard, evidence-informed prioritization and design and implementation of essential health service packages are critical for realizing UHC.

Planning and implementing such evidence-based policies requires critical national technical and institutional capacities, which many countries currently lack and are not enabled. As a consequence, there are increasing demands for technical collaboration in these areas. Addressing the gap between the demand for such collaboration and what is currently available is not the only challenge that LLMICs experience. The realities and effectiveness of existing technical assistance and how it is currently practised needs a general examination. Too often, technical support is fragmented and duplicative, and sometimes replaces rather than builds local capacity or institutionalization of basic skills. Short consultancies and brief visits by experts do not typically result in significant impact beyond the short term. Assessment of the desired outcomes of collaboration are frequently weak and rarely documented in full.

Capacity strengthening and expertise are particularly needed in the area of health financing, including assessment of existing fiscal space, the role of public financing relative to private financing and out-of-pocket payments, the role of public money in financing services outside the UHC package, and what should be funded as a priority by domestic financing. The DCP3 Country Translation initiative demonstrates that even in countries that are able to design an affordable package of health services, progressive increases in implementation costs along the UHC timeline require a parallel increase in health allocation, which may not be forthcoming. These circumstances require countries to be well equipped with the knowledge and good practice on how to make the case for increased domestic financing for health.

The approach adopted by DCP3 and the experience derived from the Country Translation initiative is unique in that it not only provides updated evidence for priority-setting and resource allocation, but it also presents a conceptual model and a strategic approach for UHC that covers its three primary dimensions: expanding population coverage; increasing the range of essential services; and reducing financial risk. By publicly financing the highest impact health interventions, the resulting range of essential services can be made accessible to all, and financial risk reduced.

Review of country experience shows that the key determinant of success in developing UHC packages is investing in an affordable and implementable package. The DCP3 review concluded with a set of key messages that are important in the progression from priority setting and package design to package implementation. The messages form an integral part of this strategy and are also documented in seven papers published by BMJ Global Health in January 2023.

There are important realities that underlie the need for a new conceptual model to reinforce technical guidance for LLMICs in priority setting, health financing and UHC package design and implementation. One of these realities is the pressing and increasing need to build national capacities to address the currently fragmented approach, which is not sustainable and does not always respond to country needs; the second is the DCP3 country experience, which provides a strategic approach to UHC, based on: (a) the use of evidence including on cost-effectiveness; (b) a robust process for prioritizing interventions; and (c) public financing of the highest impact services.

This document presents a novel technical cooperation model that outlines a viable programmatic and sustainable role for DCP3 and similar initiatives in support of LLMICs. We believe such a model has the potential of establishing a strong technical support platform that can be leveraged by countries to deliver on UHC commitments.

The proposed model has three key, highly coordinated, and inter-connected pillars, rooted at the country and regional levels. The centrality of country ownership, country needs and variation in country contexts is a vital element of this approach.

The first 'pillar' of the implementation plan is a consortium of technical institutions with the commitment, capability, and a clear role to provide technical assistance to LLMICs in the areas of: (a) priority setting and evidence-informed decision-making on resource allocation, particularly in the context of limited resources; and (b) development, revision and implementation of affordable UHC packages, with special emphasis on UHC financing and health system strengthening (HSS). The second pillar is a development partners' platform comprising a group of development agencies and donors with a priority and strategic focus on UHC, HSS and PHC and a mandate or interest to provide sustained support to LLMICs in these areas. These two pillars are supported by a convening mechanism that provides a light and flexible operational structure aiming to promote coordination, facilitate and sustain the initiative, and harmonize inputs and experiences. It promotes collaboration through effective linkages, exchange and support across LLMIC institutions, technical and development partners.

The three-pronged model incorporates the recognition and establishment of specialized regional hubs, dedicated to providing technical support and strengthening technical capacities in countries and an in-country institution-building process, by developing and enforcing in-country knowledge transfer centres, and groups in academia or nongovernmental organizations working closely with the government health sector in the priority areas of this model. The current strategy document outlines how these three pillars currently operate, the constraints and challenges encountered, and the role proposed for each pillar in establishing more effective technical collaboration with countries.

The proposed model describes a vision for a new kind of sustainable evidence-informed technical cooperation and capacity-driven model in countries demonstrating commitment and leadership to strengthen health systems and achieve UHC. We believe that the objectives of such technical cooperation are more likely to be achieved if certain prerequisites are met and some critical principles are observed. These principles, together with a set of strategic actions, are outlined in the strategy.

Introduction

This document outlines the reasoning and strategic directions for a viable and sustainable technical cooperation approach to priority-setting, and the design and delivery of essential health services to achieve universal health coverage (UHC). The proposed approach is based on primary health care (PHC) and builds upon the concept, evidence and experience accumulated by the Disease Control Priorities 3 (DCP3) Country Translation initiative. The model provides a sustainable framework for achieving better health outcomes in low- and middle-income countries (LMICs).

Achieving universal health coverage in low- and middle-income countries

UHC is an overarching target of the Sustainable Development Goals (SDGs) and a World Health Organization (WHO) key strategic priority. SDG target 3.8 aims to achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.[1] The WHO thirteenth *General Programme of Work 2019–2023*[2] focuses on 'triple billion' targets to achieve measurable impacts on people's health. One of the three targets is to ensure that one billion more people benefit from UHC during this period. To achieve this WHO target, it is essential to ensure that progress towards UHC is cost-effective and in line with countries' national priorities and contexts.[2] Primary health care (PHC) is a cornerstone of sustainable health systems that seek to attain UHC.[3] However, there are persistent financing and major service delivery challenges impeding equitable access to essential services in most LMICs. Progress towards the triple billion targets and health-related SDGs, including the UHC target, is off-track and was set back even further by the COVID-19 pandemic, which disrupted essential health services and compromised financial protection.[4] Almost all countries reported disruptions to essential, life-saving and critical services during the pandemic. For example, WHO reports that 25 million children missed out on routine immunisation and that there were glaring disparities in access to COVID-19 vaccines.[5] Based on the current pace, UHC will not be reached for at least a major proportion of the world's population by 2030,[6] and the current progress is far from sufficient to achieve the minimum of 80 for the UHC coverage index[1] required for the SDG 3.8 target by 2030.[7] The average index score in the WHO African Region is only 46,[6] and it has risen only slowly since 2000 in the Eastern Mediterranean Region, where almost a third of countries report levels below 50.[7,8]

[1] The UHC coverage index is measured on a scale from 0–100, based on 16 tracer indicators of health service coverage.

Of particular concern are fragile and conflict-affected settings, which often face a confluence of protracted crises and severe resource/capacity constraints that impede significant progress towards UHC. Most of the 37 fragile and conflict-affected settings[9] have very low scores on the UHC coverage index, as well as high rates of medical impoverishment from out-of-pocket (OOP) spending.[7] The countries and populations that are most likely to miss UHC targets are disproportionately among the poorest and most marginalised, and with 'business as usual' the current global challenges such as climate change, erosion of human rights, and a tightening macroeconomic environment make progress towards UHC even more brittle.

Factors hindering progress toward UHC

For many countries, there are three key impediments to UHC:

- inadequate political will and weak leadership
- insufficient public financing for health
- weak health systems

Political commitment and leadership at the country level are key to achieving UHC.[10–12] Although all countries endorsed the SDG goals and targets at the United Nations General Assembly in 2015, not all have made concrete commitments. The State of UHC Commitment Review also reports that when such commitments exist, they frequently lack clear targets on financial risk protection.[12] Leadership is also essential for the development of a clear vision and translating it into an effective and realistic roadmap. Only 11% of countries adopted a roadmap or strategy to achieve UHC, according to the review. A bold and transformational approach to institutionalising and sustaining PHC is central to achieving the SDGs and UHC.[13] Declared commitments are not enough. Strong and senior leadership at the government level is also needed to address the inertia and slow momentum, and the specific challenges that impede progress.[10,14–19]

The 2021 State of UHC Commitment Review suggests that while countries have made a wide range of commitments to UHC and set national targets for achieving them, insufficient dedicated resources mean that major gaps persist between policy, implementation and results.[12] While health spending as a percentage of gross domestic product is rising in high- and upper-middle-income countries, it is falling in LLMICs (Figure 1).[20,21] Even before the COVID-19 pandemic, financial hardship was trending in the wrong direction, with almost 1 billion people facing catastrophic health payments, defined as OOP health spending exceeding 10% of the household budget (Figure 2).[21]

Insufficient public financing for health – and the resulting combined dependence on development assistance for health and OOP payments for essential health services – are major contributing factors behind the slow progress. UHC can only be achieved through domestic financing. Weaknesses in related national capacities create a reliance on external technical cooperation and often threaten the achievement of UHC in many countries.[7]

Figure 1 Decreasing health spending in low-income and lower-middle income countries (Source: WHO Global Health Expenditure Database

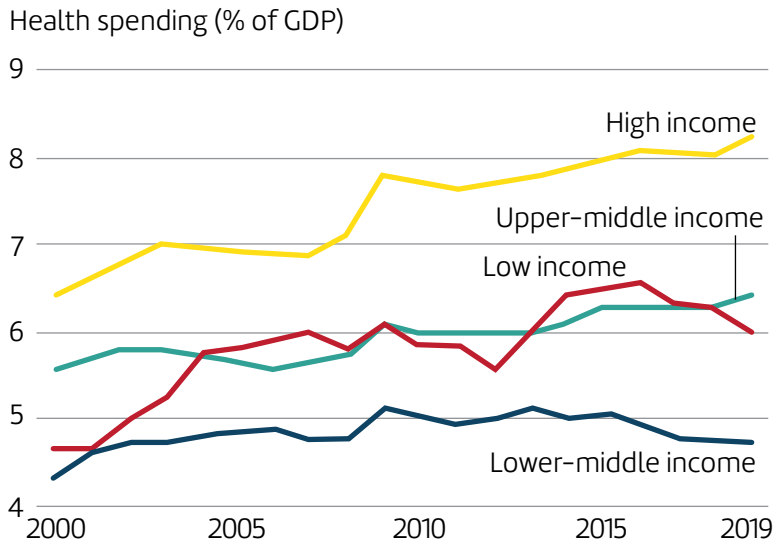
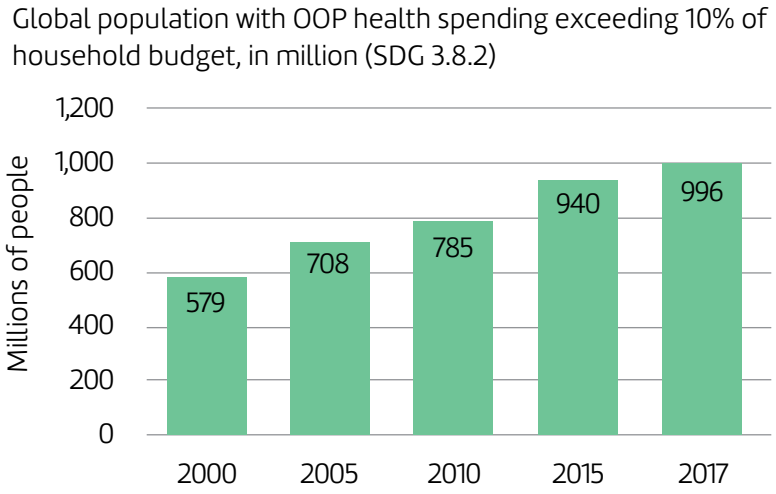


Figure 2 Trend in global rise in catastrophic health expenditure (Source: Global monitoring report on financial risk protection in health, WHO/World Bank, 2021)



Weak health systems are another major – but frequently ignored – impediment, which is overlooked and underestimated by countries. Designing UHC packages of services alone does not result in significant change. Health system strengthening and PHC reforms to improve access to high-quality and affordable health care are essential for UHC.[22] The DCP3 country review has highlighted the lack of engagement of the private sector and public–private partnerships as a major gap in implementing essential health services and to achieving UHC.[18] Countries need to redouble their efforts in addressing the gaps and improving access to, and delivery of, evidence-informed essential health services.

Demand for technical cooperation

Weak health systems and scarcity of resources allocated to health force many LLMICs into difficult decisions and resource allocation choices. Obtaining greater value from available resources can only be achieved by directing focus toward their most effective and efficient use. In this regard, evidence-informed prioritisation and design of essential health service packages are critical for realising UHC.

Planning and implementing such evidence-based policies requires critical national technical and institutional capacities and effective collaboration and networking among key institutions and stakeholders. This applies to the entire health system value chain but is particularly relevant to priority-setting, health economics, optimisation of resource allocation, and financing. But many health systems are not currently equipped nor enabled to carry out these critical elements of health policy development and health reform programmes without technical support and cooperation with external advisors and experienced centres.

Country surveys conducted regularly by WHO indicate that health system strengthening (HSS) and UHC are among the top reasons Member States seek related technical cooperation.[23] The demand for such assistance often exceeds the available capacity and resources in these areas. According to the 2021 WHO country presence report,[22] over two-thirds of its 147 country offices had some engagement in supportive roles related to national health policies and plans, but most WHO heads of country offices reported the need for expanding technical support on HSS and UHC. With growing demand from governments for technical assistance in priority-setting, health economics and financing, and optimisation of resource allocation, there would be a high return on expanded options for technical cooperation.

Addressing the gap between the demand for technical cooperation and what is currently available is not the only challenge experienced by LLMICs. Of equal importance is to manage the realities of existing technical collaboration with and within countries and how it is currently practised. Too often, technical support is fragmented and duplicative, and sometimes replaces rather than builds local capacity or institutionalisation of basic skills. Short consultancies and brief visits by experts do not typically result in significant impact beyond the short term. Approaches are often recommended by external experts without adequate engagement with or understanding of local authorities and institutions, or their

own dynamic relationships. There are many examples of development assistance projects that fail to achieve the desired outcome, but such experiences are rarely documented in full. Country leadership and in-country coordination are essential in determining the shape and impact of country cooperation. With good leadership, national policy-makers can work with WHO, the World Bank and other sources of technical cooperation to design technical assistance that is more effective in addressing gaps in expertise, determining the optimal allocation of resources in accordance with country needs and capacities, and in setting clear, measurable, and sustainable outcomes.

Experience from the DCP3 Country translation review indicates that sustained support and enduring national capacity building – including harnessing of local knowledge and hands-on experience – are essential. Rather than one-off training or presentations of external analyses, effective and lasting delivery mechanisms work alongside and in alignment with ministries of health and other country institutions to reinforce their roles, expertise, skills and interactions over a sustained period. Strengthening institutional capacity and coordination within LLMICs to generate, analyse, and use essential data for UHC-related policies lies at the heart of such collaboration, particularly in relation to health system assessment, priority-setting, prioritisation, and financing of essential health services.

Technical support and capacity strengthening in LMICs – areas of greatest need

Countries transforming health systems to reinforce PHC and achieve the UHC target will benefit from technical capacity across multiple steps: a) constructing a clear roadmap for sound evidence-informed processes for designing realistic and affordable UHC packages of essential health services; b) ensuring that the requirements for the transition to implementation are met; and c) adopting a realistic monitoring and evaluation scheme that assesses progress and outcomes.

Analyses of country experiences indicate that evidence-informed deliberative dialogue and decision-making processes effectively lead to the design of UHC packages that are affordable and represent good value for money.[11,14,24]

A large number of countries have developed health benefits packages, but only a small proportion have moved beyond design and planning to implementation.[25–27] This is typically because the selected packages were developed through evidence-informed process and without meaningful engagement of policy-makers and other national stakeholders, and – as a result – were not taken seriously. They may also turn out to be ultimately unaffordable or cannot be implemented because of health system gaps or contexts that were not considered, foreseen or addressed as part of the planning process.

Capacity strengthening and expertise are particularly needed in health financing, including assessment of existing fiscal space, the role of public financing relative to private financing,

the role of public money in financing services outside the UHC package, and what should be funded as a priority by domestic financing. The DCP3 Country Translation review[14–19] shows that even in countries that are able to design an affordable package of health services, progressive increases in implementation costs along the UHC timeline require a parallel increase in health allocation, which may not be forthcoming. These circumstances require countries to be well equipped with the knowledge and good practice on how to make an ongoing case for increased domestic financing for health.[10–11, 16]

Similarly, the transition from UHC planning and package design to implementation requires technical and institutional capacities for assessing health system gaps, and the willingness and the capability to establish an effective health service delivery model to tackle constraints that hinder package rollout, particularly at the PHC level.

Disease Control Priorities 3 as a source for country guidance

The Disease Control Priorities 3 (DCP3) conducted a comprehensive review of the efficacy and cost-effectiveness of priority health interventions across 21 health areas through a structured process of systematic appraisal of evidence, economic evaluation, and expert judgment to support decision-making on resource allocations, particularly in settings with limited funding.[28–30] The DCP3 evidence base has been re-oriented to support the achievement of UHC by providing the evidence, the concept, and model packages for prioritising essential health interventions using cost-effectiveness, financial risk, equity, and feasibility of implementation as key criteria. The DCP3 model packages provide country 'starting points' in the form of an essential UHC (EUHC) package of 218 interventions for lower middle-income countries and a high-priority package (HPP) of 108 interventions for low-income countries.

DCP3 has three major objectives that go beyond previous editions. First, DCP3 explicitly addresses the financial risk protection and poverty reduction objective of health systems. Second, DCP3 devotes systematic attention to disease prevention and the intersectoral determinants of health. Third, DCP3 is unique in that it not only provides updated evidence for priority-setting and resource allocation, but it also presents a conceptual model and a strategic approach for UHC that covers its three primary dimensions: expanding population coverage; increasing the range of essential services; and reducing financial risk. By publicly financing the highest-impact health interventions, the resulting range of essential services can be made accessible to all, and financial risk reduced.

In 2018, the DCP3 Country Translation project was established with a grant from the Bill & Melinda Gates Foundation (BMGF) to support focus countries in priority-setting and design of UHC packages of essential health services based on the DCP3 conceptual model and evidence.[30]

Several LLMICs have recently utilized the DCP3 evidence and model UHC packages[10–11, 14–19, 29] in an effort to accelerate progress toward UHC. These countries include Afghanistan, Ethiopia, Liberia, Pakistan, Somalia, Sudan, and Zanzibar (Tanzania). A critical review of these experiences has been conducted by a knowledge network of experts and health professionals as part of the DCP3 Country Translation project. A collection of papers has recently been published by the BMJ Global Health[,10,14–19,31] to summarise the experience gained by seven working groups and the conclusions of three meetings of the network organised in 2021–2022.

Other sources of evidence

The WHO UHC Compendium is another source of guidance that provides an approach to organizing and presenting information about health services and interventions. Launched in December 2020, it includes a database of health services and intersectoral interventions.[32] It also provides a structured architecture aimed at promoting linkages across health system levels within countries. However, the same challenges in responding to the increasing demand for technical support are also limiting the application of the Compendium and providing guidance on UHC packages of essential health services. The Compendium was also used as a supplementary reference alongside the DCP3 evidence in at least two of the seven focus countries mentioned above.

Review of country experience on priority setting and UHC packages of health services

Country experience[14–19,31] shows that the key determinant of success in developing UHC packages is investing in an implementable and affordable package. This requires sustained commitment from high-level government leaders, adequate engagement of national authorities, partners, and stakeholders, sustained resources, and institutionalisation of technical and managerial capacity. The pressing need for institutional strengthening has been evident during the country translation review.[14–19,31] There is limited value in investing in package development if the process does not lead to concrete government endorsement and implementation as an integral part of the UHC roadmap. Review of the country translation experience has also highlighted that the critical need to ensure affordability and feasibility of implementation has been underestimated in some countries during the package development processes. This is a key reason why health service packages remain aspirational rather than operational in many countries.

The review concluded with a set of key messages that are important in the progression from priority setting and package design to package implementation. These include the following:

- Setting or revising packages of essential health services must be country-owned and executed; in this respect, all focus countries included in the review require a higher level of technical support and sustained expertise, particularly in priority-setting, assessment

of health system gaps, including in financing, institution building and in strengthening the capacity of the workforce in implementing the highest priority services.

- Systematic guidance is seriously needed to improve the accuracy of costing methodologies, particularly regarding common health system costs and capacity constraints. To ensure policy relevance and confidence in results, costing needs to be reliable and linked to budgetary processes and national institutional cooperation, and it should facilitate financial planning and in-country budgetary decisions.
- Service delivery considerations must be integrated into package development, with special emphasis on assessing the downstream health system implementation gaps and the role of the private sector. Addressing the health system gaps and reinforcing strategic purchasing is critical for the transition from package design to effective implementation.
- Monitoring and evaluation plans need to be integrated into the package design from the start. While there is an international agreement on the global SDG indicators for UHC,[7] consensus is lacking on indicators for implementation of essential packages of health services (EPHS). Country stakeholders should jointly develop and adopt a monitoring system combining the 'core' UHC indicators (SDG 3.8.1 and 3.8.2), with other dynamic, country-specific indicators that reflect the current EPHS implementation and local needs.

Need for a new approach to sustainable technical cooperation

All LMICs are expected to double their efforts to reach UHC. As already highlighted, at least three important realities underlie the need for a new conceptual model that addresses existing limitations and provides a roadmap for reinforcing technical guidance based on available evidence.

- First, the need to build national capacities in the areas of priority setting, health technology assessment, health financing, and UHC package design and implementation. The technical support currently available is fragmented, often ineffective, and does not consistently respond to country needs.
- Second, the DCP3 country experience provides a strategic concept based on: (a) the public financing of the highest impact services; (b) the use of cost-effectiveness evidence; and (c) a robust process for prioritizing interventions. By prioritising the highest impact interventions and publicly financing the highest priority services, all the three key UHC dimensions will be addressed.
- Thirdly, the need for technical cooperation exceeds what is currently provided. Since their launch in December 2017, an increasing number of countries have used the DCP3 evidence and model packages but the number of countries requiring such technical assistance is considerably greater.

Technical institutions currently providing priority-setting and UHC package development support are limited in capacity and funding. Despite encouraging progress in DCP3 country translation in the focus countries and in WHO country collaboration, expanding support

to a larger number of LLMICs is impeded by the scarcity of external financial support and donor funding, and by the lack of effective cooperation among the relevant technical institutions and lack of effective engagement with development partners.

Initiatives to reinforce and sustain technical cooperation with LLMICs must build on existing international experience, use all available evidence, and leverage proven approaches from focus countries and other LLMICs using similar evidence in their UHC-reform initiatives.

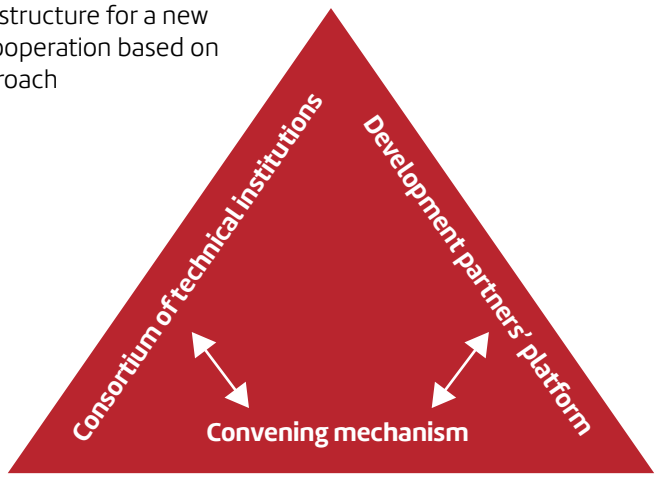
Conceptual framework for a new technical cooperation model

This document presents a novel technical cooperation model that outlines a viable programmatic and sustainable role for DCP3 and similar initiatives in support of LLMICs. We believe such a model has the potential of establishing a strong technical support platform that can be leveraged by countries to deliver on UHC commitments; it includes the required organizational and leadership structure and offers a roadmap for financial sustainability in collaboration with relevant partner organizations. The model would learn from and expand on WHO and the development partners' funded efforts in the countries that have used WHO technical guidance, the DCP3 evidence, and/or other relevant technical resources.

A three-pillar approach

Although a variety of options can potentially be considered to achieve these objectives, we propose, for critical appraisal, an option that has three key, highly coordinated, and inter-connected structures, rooted at the country and regional levels (Figure 3). The centrality of country ownership, country needs and variation in country contexts is a vital element of this approach.

Figure 3 A proposed structure for a new model of technical cooperation based on a three-pronged approach



Real-world implementation of the model requires balanced and flexible integration of the components presented in Figure 3, which takes account of the varied interactions between partners, multidisciplinary stakeholders, the heterogenous country contexts in which the model must operate, and the essential connections between the global, regional and country levels.

The first 'pillar' of the implementation plan is a **consortium of technical institutions** with the commitment, capability, and a clear role to provide technical assistance to LLMICs in the areas of: (a) priority setting and evidence-informed decision-making on resource allocation, particularly in the context of limited resources; and (b) development, revision and implementation of affordable UHC packages, with special emphasis on UHC financing and health system strengthening.

The second pillar is a **development partners' platform** consisting of a group of development agencies and donors with a priority and strategic focus on UHC, HSS and PHC and a mandate or interest to provide sustained support to LLMICs in these areas.

These two-pillars are supported by a **convening mechanism** that provides a light and flexible operational structure aiming to promote coordination, facilitate and sustain the initiative and harmonise inputs and experiences. It promotes collaboration through effective linkages, exchange and support across LLMIC institutions, technical and development partners (Figure 4).

This three-pronged model incorporates:

- **establishment of specialised regional hubs,** dedicated to providing technical support and strengthening technical capacities in countries, in coordination with WHO, the World Bank, and members of the global technical pillars; and
- **in-country institution-building,** by the development and enforcement of in-country knowledge transfer centres, and groups in academia or non-governmental organizations working closely with the government health sector in the priority areas of this model.

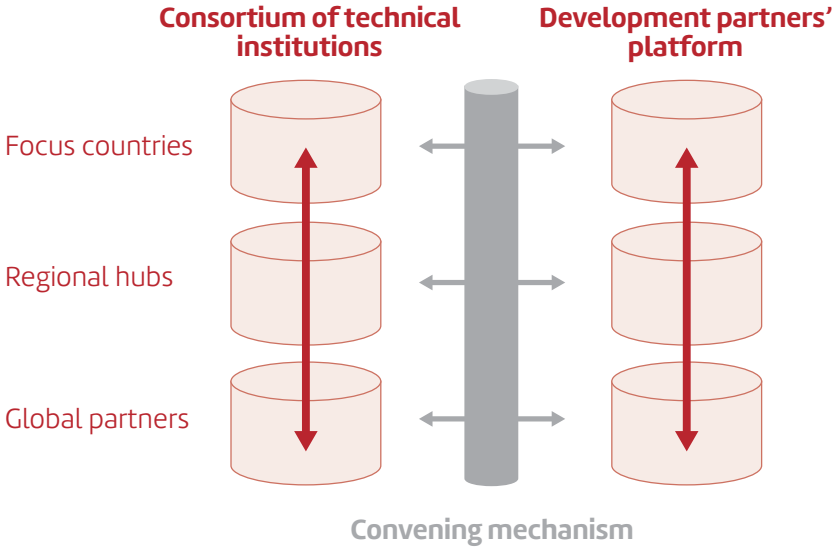


Figure 4 Implementation model traversing all operation levels

Current status, challenges, and proposed roles of the three pillars

Consortium of technical institutions

Current status

WHO is the main provider of in-country technical collaboration on HSS and UHC-related areas. Before and following the launch of the DCP3 initiative, some technical institutions, academia and non-governmental organizations have supported several countries in using available evidence and model packages to prioritise and expand essential health services, as part of UHC reforms. These include: University of Washington, London School of Hygiene and Tropical Medicine (LSHTM), Radboud University, Aga Khan University, Centre for Global Development, and University of Bergen are some examples. Others, such as the Center for the Evaluation of Value and Risk in Health (CEVR) in the Tufts Medical Centre, Health Intervention and Technology Assessment Program (HITAP), the International Decision Support Initiative (iDSI), IADB's CRITERIA, and University of York have also been collaborating with LLMICs in related areas, such as health technology assessment, cost-effectiveness analysis, decision-making and optimisation of resource allocation.

Current challenges

Cooperation and sharing of experience between these institutions is weak and they often typically operate in siloes. The emphasis on publications and grant competition motivates this working style in academic centres. Although some knowledge translation and dissemination initiatives exist, the engagement of national authorities varies and their impact on country work has not been adequately assessed. Many of these initiatives lack sustained funding and their continuity depends on the availability of grants or donor support, which are often limited and short-term. Moreover, there are no institutional models in place for ensuring programmatic and financial sustainability, and no serious attempts have been made to strengthen cooperation, joint work, and exchange of experience among these technical institutions.

Proposed role

The proposed Consortium will focus on improving cooperation, exchange of experience, and joint work in the areas of country support, and on training and development of analytical tools and other resources for technical guidance. The aim is to also create a coordinated and sustained approach to technical support in HSS and UHC-related areas, focusing on capacity building, knowledge transfer and impact evaluation. By leveraging the strengths and expertise of multiple institutions, the Consortium can enhance the effectiveness and efficiency of technical support. As a result, it will deliver targeted, cooperative support to more countries in need, ensuring that the overall impact of collaboration is more than the sum of its individual components. The consortium can have a critical contribution to harmonising technical cooperation with WHO and achieving a higher level of coordination and joint work.

Development partners' platform

Current status

BMGF has been the main source of support to country cooperation in priority setting, health technology assessment, and design of UHC packages. More recently, the Norwegian Agency for Development Cooperation (NORAD) has also provided support to one of the technical institutions working in these areas. Examples of other potential partners prioritising health system strengthening and primary health care include the World Bank, European Union (including through the Team Europe Initiatives), United States Agency for International Development (USAID), UK Foreign Commonwealth & Development Office (FCDO), French Development Agency (AFD), German Agency for International Cooperation (GIZ), Belgium Development Agency (Enabel), Regional Development Banks, Rockefeller Foundation, Mastercard Foundation, Global Fund, and GAVI.

Current challenges

The support provided to LLMICs is typically short to medium-term and limited to specific areas as opposed to a systematic approach that aligns with the priority needs outlined in this discussion paper and those identified by countries themselves. There is no consistent information on how the outcomes of development assistance projects in LLMICs are assessed and evaluated, and insufficient attention is given to minimising external costs and directing more resources towards country work and local capacity strengthening. Additionally, the lack of coordination within the development community often creates situations where more than one development partner provides funding to the same area without the minimum level of coordination, resulting in competition, duplication and repetition, rather than reinforcing the intended outcomes and impact. Country leadership is essential to the effective use of development funding. To maximise the impact of development assistance, there should be a stronger emphasis on local capacity building, instead of using the funding to implement activities that fall within the responsibility and accountability of national actors.

Proposed role

The proposed Platform aims to establish a more focused, longer-term, and sustainable support system with target countries, based on WHO guidance and the DCP3 concept and evidence. The platform will foster regular dialogue and stronger collaboration among bilateral and multilateral development partners, and will ensure that resources are directed towards areas of greatest need and potential impact. The platform will also serve as a mechanism for reinforcing the impact of development assistance on health system strengthening and other UHC-related policies by instituting metrics to assess outcomes of development assistance initiatives and projects. Similarly, the platform will play an important role in increasing the range of countries receiving effective technical cooperation.

The main challenge in establishing this platform is how to obtain the commitment of development partners to achieve a more coordinated approach to development assistance in

LLMICs in the priority areas of this discussion paper and to ensure more effective monitoring of their input in accelerating action on UHC.

Convening mechanism

Current status

Experience in countries suggests that interaction between technical institutions, supporting partners, and target countries is generally weak. There are only a few reported examples that demonstrate a high level of systematic coordination or productive dialogue between these three stakeholders, particularly in the areas of greatest needs addressed in this paper.

Proposed role

The Convening Mechanism will identify countries that are committed to investing in UHC, support national authorities in ensuring that technical cooperation meets national priorities and plans, and provide advice on preventing or addressing repetitions, competition and fragmentation of technical initiatives led by different external institutions or development partners. The mechanism could also make an important contribution in monitoring outcomes and impact of collaborations.

Successful technical cooperation requires full engagement of countries and a central role for governments. High-level policy-makers, particularly those with strong leadership, and support institutions – such as WHO regional offices and regional centres of excellence – will play an essential role in this initiative and in the operational model of the convening mechanism.

Given the role of WHO as the global normative agency in health that sets norms and standards and provides technical collaboration to Member States, and also considering its unparalleled convening power, it would normally be considered the natural body to guide such initiatives. We recognise, however, that for several reasons WHO may not be in a position to engage in a managing role, and in this case other options that ensure the highest level of technical cooperation and joint work with WHO will have to be considered.

Irrespective of the best option for mustering and administration of this strategic initiative, a key question is whether the Convening Mechanism should be principally financed to assume this role and whether it should also provide venues for information sharing and the provision of analytical resources.

Regional hubs

Acknowledging that regional bodies and structures are becoming increasingly important in global health cooperation, as seen in the launch of the Africa Centre of Disease Control and the African Medicines Agency, the proposed cooperation model includes support to the establishment and strengthening of one or more regional centres of excellence. These centres possess technical expertise in the priority areas and a legitimate role to offer,

upon request, technical advice and long-term support to institutions in LLMICs. Additionally, the regional hubs also provide technical training and support the institutionalisation of necessary skills and expertise in ministries of health and/or other national partner institutions. However, the success of regional centres depends on the level of their technical competence, sound management, and the level of support by countries and development partners.

In-country institution building

Institutional strengthening at the national level is a prerequisite for sustainability of effective technical cooperation. One of the operational approaches to achieve this is to encourage the establishment and reinforcement of knowledge translation platforms or consortia that work within and alongside ministries of health along the full extent of the health system value chain. Such an approach also creates a model for an institutionalised collaboration between ministry of health-led institutions, academia and research centres, where researchers and policy-makers work closely to generate knowledge for learning, as well as 'improving while implementing'. Expanded communities of practice are effective in supporting this kind of collaborative networking.

The interaction and alignment between policy-making and research and knowledge centres is essential for using available evidence to find solutions for addressing operational constraints and for tackling health systems gaps. Areas that specifically require urgent technical back-up and expertise-building include health economics, evidence-informed prioritisation of health services, health financing, and costing of health interventions. This model allows the institutionalisation of these skills through an implementation research approach that brings together researchers and policy-makers.

A review of existing experience and best practices will be needed to inform governments on capitalizing on national resources to achieve UHC. Experience in the DCP3 project in Pakistan demonstrates how capacity building in the group of technical staff of the planning unit of the Federal Ministry of Health enabled the development and costing of evidence-informed provincial packages of essential health services.[11]

Principles and strategic actions

The proposed conceptual model aims to provide a sustainable technical cooperation approach based on country experience to date, an extensive accumulated evidence base, and the good practices acquired during prioritisation and optimised resource allocation in focus countries. Lessons learned indicate that engagement and joint work between experts/researchers and policy-makers – and the resulting cooperation and mutual trust between the two communities – are important for success.[33,34]

We believe that the objectives of this technical cooperation model are more likely to be achieved if the following principles are pursued in working with countries:

1. High-level political commitment to the UHC goal is a prerequisite for impact. This technical cooperation model should accord priority to LLMICs that demonstrate a steadfast and senior commitment to UHC 2030, and provide a strategic plan for achieving that goal.

2. Technical cooperation should focus on strengthening PHC through priority setting and designing packages of essential health services delivered through PHC service delivery platforms. The experience in DCP3 pilot countries clearly demonstrates that informed and strategic leadership in the health sector recognises the central role of PHC in achieving UHC. Although prioritisation of health services in Liberia and Pakistan covered all health delivery platforms including tertiary care, the decision was to give priority to PHC interventions by endorsing a district-level UHC package for immediate rollout.[10–11,35]

3. The focus of technical cooperation must be on supporting country-led initiatives that strengthen their institutional capacity in the areas covered by this initiative. Institutionalising priority-setting, health technology assessment and design and implementation of UHC packages within the governance structure of ministries of health is important for long-term sustainability.

4. Technical cooperation must include a rigorous assessment of outcomes and the impact of technical cooperation on the UHC agenda, and a continuous process of appropriate course correction.

Considering these principles, we propose the following strategic actions as priorities for translating the conceptual framework into concrete next steps.

1. Development agencies with a mandate or priority focused on UHC and HSS to consider adopting a more collaborative approach by establishing a platform or similar coordination mechanism, designed to work with WHO, the World Bank and technical institutions to provide long-term cooperation in priority setting as well as design and implementation of UHC packages in target countries that meet the criteria mentioned above.

2. Future funding models to prioritise a focused and more rational use of grants, awards and loans by targeting them towards well-defined outcomes and impacts that demonstrate measurable progress towards UHC, avoiding investments that do not lead to concrete outcomes. Funding policies may also require matched domestic funding whenever possible.

3. Technical institutions or centres to work together by forming a cooperative consortium, with a light governance mechanism, to achieve the roles and functions described above. The consortium will reinforce and work jointly with regional hubs (where they exist) and use them as knowledge repositories to strengthen and harness long-term technical capacity in focus countries, including through South–South collaboration. To foster sustainable development and growth, funding support for projects must prioritise and demonstrate cooperation among technical institutions, regional hubs and partner organizations in focus countries.

4. A convening mechanism or council, with a light secretariat to support its function, to be established to harmonise inputs and experiences of all players in the technical cooperation model. The council should have a flexible operational model that facilitates and sustains the initiative. It should help to identify countries committed to investing in UHC, support national authorities in aligning technical support with national priorities, and provide advice on avoiding repetitions, competition and fragmentation of technical initiatives. The council should also provide curated venues for information sharing, productive dialogue and analytical resources.

5. Specialised regional hubs or centres of excellence to be encouraged and supported by development partners and regional organisations, including WHO, in order to offer technical advice and long-term support to counterpart institutions in focus countries. These hubs also offer training and institutionalise required skills and expertise in partner institutions and ministries of health.

Conclusions

This discussion paper describes a vision for a new kind of sustainable evidence-informed technical cooperation and capacity-driven model in countries demonstrating leadership to accelerate progress on UHC. The proposed strategy provides a common understanding of the current challenges and opportunities for strategic actions. To translate this vision into a feasible roadmap, there is a need to review other existing initiatives with similar elements in their design and conduct a rapid review of the success factors and challenges encountered.[36–37] Beyond examining these types of evidence-support initiatives, in-depth consultations with key stakeholders such as WHO, technical institutions concerned, country stakeholders, and development partners will be a critical next step.

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