Global South Dialogues on Achieving Universal Health Coverage in Asia and Africa through Community-led Innovations

SUMMARY REPORT FROM GLOBAL SOUTH CONSULTATIONS
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Background

Over the past decades, Africa and Asia have witnessed impressive economic transformations with nations graduating from low-income to middle-income status. The growth is captivating global interest as the regions are displaying advancements in healthcare and innovation, and reinforcing the positive link between a vibrant and healthy community, and a nation's economy.

Many countries in Africa and Asia, including Rwanda, Uganda, Philippines and Indonesia have made significant progress in improving health coverage, however, key gaps remain. At least half of the world's population, most of whom are in Sub-Saharan Africa, South and Southeast Asia, still lack full coverage of essential health services. Africa and Asia alone account for 97% of the world's population impoverished by out-of-pocket health spending. [1,2]

In line with the Sustainable Development Goals (SDGs), governments are embracing Universal Health Coverage (UHC) to ensure that affordable healthcare reaches the last mile even in resource-constraint settings, and that medical costs do not deter families from accessing life-saving interventions. The government's commitment is vital for UHC but needs to be complemented by a multi-sectoral, or an 'all hands-on deck' approach that recognizes and leverages the role of various enablers and intermediaries. At the end of the day, the responsibility of UHC rests on a diverse set of players that influence a country's healthcare system—the government, private sector players, civil society organizations, technical experts, communities and the media.

Further, the expansion and disruptions in healthcare markets are impacting healthcare systems in Africa and Asia. An increase in the emergence of new players and technologies is creating opportunities for potential partnerships and warranting the need to explore the role of community-led innovations, the private sector and technology in advancing UHC.

Community-led Health Innovation

Community-led innovation is closely linked to collective action where local stakeholders identify a health priority and pioneer interventions to achieve a common goal, which will benefit others in their community. Community-led innovation also signals a break from the traditional groups that engage in health system strengthening – recognizing that health innovation is inter-sectoral encompassing a range of stakeholders, social economy actors and social innovation intermediaries, as well as the end-users.

Role of Technology and the Private Sector

Countries from around the world have developed different models for delivering healthcare. Some are fully public, some are mostly private, and others an intricate mix of both. As governments strive toward UHC, it will be essential to invite the private sector to join key conversations, build trust between the public and private sector, and ensure innovations and initiatives are supporting long-term health system goals. There is increasing interest among countries of the global south to see how regional partners are combining private and public providers; but what that system should look like, how it should be regulated and what the balance should be often remains unclear. It is important to see if the private sector can go beyond vertical health projects/services to championing government-led systems to achieve UHC. Companies, technology actors and non-state private providers can bring

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[1] WHO SEARO. (2018). Countries in WHO South-East Asia Region resolve to make essential medical products accessible, affordable to all. Available at: http://www.searo.who.int/mediacentre/releases/2018/1670/en/

[2] WHO. (2016). UHC in Africa: A Framework for Action. Available at: https://www.who.int/health_financing/documents/uhc-in-africa-a-framework-for-action.pdf

a unique set of skills and resources that can complement the public sector to improve access and outcomes particularly for vulnerable poor and rural communities.

National or Social Health Insurance schemes (SHI) are also attracting considerable attention in low- and middle-income countries in Asia and Africa as a means for improving healthcare utilization and protecting households against impoverishment from out-of-pocket expenditures.[3] Cognizant of coverage gaps in SHI models and the need to invest in primary health and outpatient care, many Asian and African countries are investing in low-cost technology based home grown innovations and their scale-up, to close the gap in healthcare delivery and access.

The focus on indigenous solutions and innovation is opening a window of opportunity for cross-regional learnings and partnerships. Collaborations are proving to make gains in expanding access to affordable, quality healthcare. For instance, *Figure 1* delves into how the Government of Thailand and the Government of Kenya have signed an agreement to share expertise and skills for the effective implementation of UHC in Kenya. Kenya's partnership provides insights and learnings for other nations interested in forming collaborations within the global south.

As a result, dialogues on achieving UHC through innovation are gaining momentum in Africa and Asia and

THAILAND-KENYA PARTNERSHIP

The President of Kenya, Uhuru Kenyatta, committed to address high out-of-pocket-expenditures and unequal access to healthcare services in the country, setting the goal of achieving UHC nationwide by 2022. In order to accelerate progress and attain this ambitious goal, Kenya has partnered with Thailand, which boasts of a highly successful UHC program. Between 2019 and 2021, Thailand will serve as an advisor and a technical partner to Kenya in its endeavour to implement UHC effectively. Till date, over 50 Kenyan officials have already been trained on evidence-based decision-making by the Ministry of Health, Thailand.

Figure 1. Thailand-Kenya Partnership on UHC implementation

warranting a place for global south perspectives at high-level platforms, to account for their unique contexts and their tailored approaches. This will be crucial as challenges of access to information, limited participation in decision-making forums, and limited ability to demand accountability from decision makers still remain, and will need to be addressed with a sense of urgency in the next years to achieve UHC.

Approach

Recognizing the evolving healthcare landscape in Asia and Africa, Amref Health Africa, the Public Health Foundation of India (PHFI) and Takeda Pharmaceuticals have organized a series of consultations in the past year that convened private sector players, government officials, technical experts, intermediaries and donor organizations, among others. The consultations examined the various actors and components that make up complex health ecosystems in the global south, serving as a platform that builds trust across sectors, and can reap significant dividends in accelerating UHC.

Four consultations, *as seen in Figure 2*, were organized to gather global south perspectives. The format included plenaries as well as deep-dive sessions to hold granular and engaging discussions on key priority areas. Specifically, the discussions delved into a) how Asian and African countries are adapting

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[3] Spaan, E., Mathijssen, J., Tromp, N., McBain, F., ten Have, A., & Baltussen, R. (2012). The impact of health insurance in Africa and Asia: a systematic review. Bulletin Of The World Health Organization, 90(9), 685-692. doi: 10.2471/blt.12.102301

health systems to achieve UHC; b) how health innovation is inter-sectoral and includes the roles of diverse stakeholders and social innovation intermediaries in scaling innovations for building health system capacity; c) how health innovations led by the private sector and non-state actors can be embedded in UHC models; d) how empowerment of communities can drive accountability; e) what kind of regulatory mechanisms need to be in place to best leverage the private sector and newer technology-driven solutions for UHC; and f) how regional partnerships, through knowledge-sharing, can accelerate UHC in countries.

Overview of four consultations

The first consultation '**Innovations for UHC- India-Africa Conclave'** was held in June 2018 in Bangalore, India. This meeting was organised by Public Health Foundation of India (PHFI), Amref Health Africa and the Institute of Development Studies (IDS), in collaboration with the Government of India's NITI Aayog and Government of Karnataka. The meeting brought together innovators, government officials, and public and private sector service providers. The discussions emphasised the need to consider three key issues in the journey towards transforming health systems in order to achieve UHC:

- The critical role of multi-stakeholder partnerships involving diverse disciplines and sectors.
- The importance of developing demand-focused innovations which meet the health needs on the ground.
- Changes in government regulation around innovative healthcare models and delivery.

The second meeting, '**Equitable Access to Healthcare in Asia and Africa,'** took place in September 2018. Amref Health Africa and UHC2030 hosted a high-level consultation along the sidelines of the UN General Assembly in New York. The meeting gathered prominent health leaders including health ministers, representatives of major foundations, non-government organizations (NGOs), UN agencies and private sector players to discuss the critical drivers of UHC in Africa and Asia. The convening showcased examples of progress towards the achievement of UHC in Africa and Asia, and shared some of the solutions, innovations and ideas that actualize the vision of UHC in the two continents by 2030. Key outcomes included:

- The identification of opportunity for the private sector to support governments as they make effort to implement technology by providing technical expertise, financing arrangements, or other supporting mechanisms.
- It is important to shift from the traditional model of healthcare delivery to community-focused models which are low-cost and encourage people to manage their own health.
- The need to strengthen social accountability through the empowerment of communities and increasing the effectiveness of social accountability tools.
- The importance of multi-stakeholder partnerships to ensure practical solutions to complex healthcare challenges.

The third meeting '**Leveraging Community-led Innovations for UHC',** was held at the Africa Health Agenda International Conference, or Africa Health 2019, in March 2019 in Kigali (Agenda can be found in *Annexure 3*). At this meeting, discussions examined the various factors in a complex health eco-systems within the global south and how locally-developed health innovations are helping to accelerate Universal Health Coverage (UHC). Specifically, the sessions focused on how to nations could strengthen their health systems through community-driven Initiatives and innovations, and emphasized on the role of community workers. The outcomes of this meeting were as follows:

- A consensus to have Africa and Asia learn from each other supported by the mobilization of domestic resources for UHC. The development of regional partnerships will support the achievement of UHC through knowledge sharing.

- The importance of integrating community health workers into the health system cannot be understated. The human resource gap can be closed by investing in community health programmes.
- Dialogue is required on the regulation of health technologies being developed to support the delivery of health.

The fourth meeting in the series '**Achieving UHC in Asia and Africa by Scaling community-led/local Innovations**,' occurred in Hanoi in May 2019 (Agenda can be found in *Annexure 3*). The sessions focused on the adaption of health systems in Asia to support UHC. Specifically, the discussions aimed to delve into the role of enablers such as the government and private players, and intermediary organizations, in an evolving healthcare environment. The Hanoi consultation built on Kigali discussions and explored:

- How Asian countries in the global south are adapting mixed health systems to achieve UHC.
- How health innovation (digital) is increasingly inter-sectoral and encompasses diverse stakeholders and social innovation intermediaries that are building health system capacity.
- How health innovations led by the private sector and non-state actors can be embedded in UHC models.
- What regulation and accountability mechanisms need to be in place to best leverage private sector for UHC.

The deliberations from the Kigali and Hanoi consultations have been captured in this report.

Continuous dialogue on UHC across Africa, Asia and role of private sector
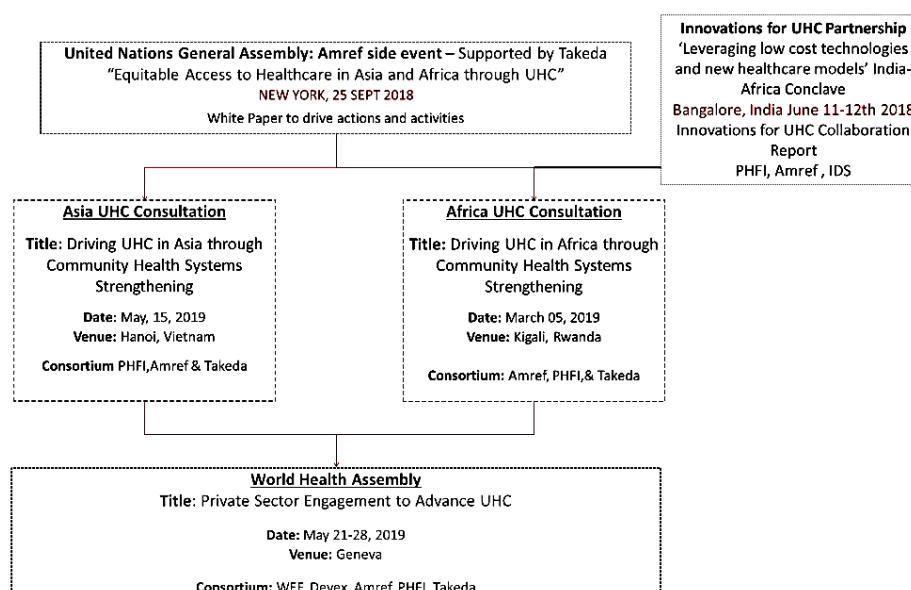

Figure 2. Timelines and details of the four consultations, leading up to WHA72

Methodology

As this report focuses on the discussions point raised at the Kigali and Hanoi consultations, this section aims to provide context around the session format, session objectives and the questions the session

strived to address, at the two consultations. The agendas for the two consultations can be found in *Annexure 3*.

KIGALI: SESSION FORMAT

The Kigali consultation included a panel discussion that was followed by a deep dive session. The 60 minute-long panel discussion featured speakers from across sectors, including development organizations and donor agencies, and revolved around driving UHC in Africa and Asia through community-led innovation.

Post the panel discussion, the meeting participants were broken into groups of three for the deep dive session. Each group was assigned one of three critical components of UHC, outlined below, for deliberation. Following the deep dive, each group synthesized recommendations on their topics.

1. Community health systems strengthening
2. Innovation
3. Financing

KIGALI: SESSION OBJECTIVES

Discussions in the panel and deep dive sessions were guided by the following set of objectives:

- Facilitate exchange of learnings and catalyse collaborations among actors/countries in the Global South around UHC
- Foster dialogue between policymakers, technical experts, the private sector, and community-level stakeholders about UHC implementation
- Identify innovative mechanisms to enhance community-focused interventions with the aim of accelerating UHC in Africa and Asia
- Discuss how emerging technologies and innovations can be leveraged to accelerate UHC in Africa and Asia, and how existing promising innovations can be supported to scale across geographies
- Highlight financing strategies that can be employed in Asia and Africa to achieve UHC
  - o Discuss both innovative and traditional financing mechanisms, such as public-private partnerships to co-fund healthcare, and strategic purchasing to get more value for money from existing resources, among other alternatives
- Document learnings and recommendations from participants, to be presented at the 2019 World Health Assembly

HANOI: SESSION FORMAT

The Hanoi consultation included two panel discussions that were 90 minutes each, as well as a deep dive session of around 2 hours, 30 minutes.

1. The panel discussions provided an opportunity for participants (government officials, private sector, multi-lateral organizations, and civil society) to broadly discuss the state of health systems in Asia and highlight the importance of community-led approaches and the role of various enablers and intermediaries.
2. The deep-dive session allowed for more granular discussions as the meeting participants were divided into three groups. Each group delved into one of the three critical components of UHS—community-led approaches, innovation and the role of enablers. The deep-dive encouraged a more participatory implementation oriented dialogue on regional exchange and opportunities. The session began with short presentations by spotlight speakers who introduced the groups to the three focus areas and provided their perspectives on the same.

HANOI: SESSION OBJECTIVES

Plenary I: Asia Perspective: Strengthening Health Systems Capacity for UHC, featured perspectives on countries' national health insurance schemes; explore how governance, leadership and political environment impact health system capacity in the region; and the instrumental role of the private sector.

Plenary II: Community-led Innovation, Scale & the Role of New Intermediaries, explored the underlying factors that drive scale and explore how new health intermediaries can contribute to scaling innovations. The specific objectives for the deep dive session were:

- Discuss the synergetic roles of the government, intermediaries and enablers in driving forth the UHC agenda in Asia, by focusing on the following areas:
    - o Financing/ National health insurance schemes
    - o Service delivery & Access
    - o Scaling Innovation at the Community/Local level
    - o Regulation /Accountability
- Explore underlying factors and key measures that contribute to the success in scaling innovations and community-led models
- Foster dialogues on how regulatory and accountability mechanisms can be strengthened to leverage and account for the growing private sector
- Identify innovative mechanisms to enhance community-focused interventions with the aim of accelerating UHC in Africa and Asia
- Discuss how emerging technologies and innovations can be leveraged to accelerate UHC in Africa and Asia

HANOI: SUGGESTED QUESTIONS FOR THE SESSIONS

Broadly, the panel discussion and dive deep session aimed to address the following questions to understand how UHC can be advanced in Africa and Asia through community-led innovation.

Overview topics
1. How are countries in Africa strengthening their health systems to achieve UHC?
2. How does governance, leadership and the political environment impact and influence health system capacity for UHC in Africa?
    a. Does the political environment around healthcare and UHC discourage private sector involvement?
3. How are citizens empowered to hold countries accountable for UHC? Any notable examples from countries in Africa or Asia?

Community health systems strengthening
4. How can UHC be realized through community-driven health system strengthening approaches?
5. Are there good examples of best practices in community-oriented models that can be adapted for other country-contexts?
6. How effective are community-based insurance models?

Learning from private and non-health sectors
7. How does the private sector view UHC in Africa? Does it align with their priorities?
8. How can the private sector enter into shared-value partnerships with the public sector to advance UHC policies? Examples include ensuring effective and efficient spending, and that regulatory rules are followed with the aim of improving health outcomes.
9. How can the private sector invest "downwards" to build the capacity of primary health systems?

10. What strategies are in place in Africa to strategically purchase services and products towards achievement of UHC?
11. As African economies grow and transition to middle-income status, how can donor organizations support governments in mobilizing resources, domestically?
12. How can technology and financial inclusion be instrumental in creating new forms of health financing, supported by the private sector?

Innovation and technology
13. How is the fourth industrial revolution impacting African health markets? What can the health sector learn from the non-health sector?
    a) Role of technology and new models of healthcare – supporting innovations in healthcare that benefit poor and vulnerable populations, including technology such as smart phone-based services, tiered pricing, pro-poor products, and beyond.
    b) Scaling up proven innovations.
14. What risks in innovation are governments taking or willing to take to progress UHC? Examples include:
    a) Bundling of technologies
    b) Biotechnology innovation in health systems strengthening and UHC
    c) Investing in health innovations
    d) Social Impact bonds
    e) Generating health funds from non-traditional sources – what is the experience from other sectors?
    f) New models of healthcare delivery
15. With digital technologies being harnessed for healthcare, how are countries addressing ethical, security and legal challenges around personal data and patient information?

Summary of discussions

The discussions held in Kigali and Hanoi were guided by the objectives and questions detailed above in the methodology section. Key points that emerged at the two consultations have been collated, summarized and contoured in this section under five thematic areas—community health systems strengthening, innovative financing models, role of government and social health insurance schemes, service delivery and access, and regulation and accountability.

Broadly, it was found that while some Asian nations including India and Myanmar are ahead of the curve on private sector engagement and innovation uptake, others are only beginning discussions on the same. The Kigali consultation shed light on the impressive strides nations have taken to leapfrog UHC through the use of technology—mobile healthcare platforms that increase access to medicines and quality of healthcare monitoring.

Community health systems strengthening
UHC calls for a fundamental shift from traditional models of healthcare delivery that focus on centralized curative measures, to decentralized models that also deliver preventive care, where individuals and the general public become the major players in solving their own health problems.

Community health systems and community health workers (CHWs), therefore, have come to play a central role in achieving UHC. Several countries are employing workers from the community level to bridge the gap between the population and the formal health system. These workers deliver services around people's homes and work-places, including in remote and hard-to-reach communities.

In Rwanda for example, approximately 45,000 community health workers provide health promotion activities as well as preventive and curative care to rural communities, and much of the country's progress in health outcomes can be attributed to their efforts. Further, the division in roles is clear among Rwandan health workers, such as those working in maternal and child healthcare, palliative care, chronic diseases and infectious diseases. The division in roles is reduces friction in the program's implementation machinery and makes it easier for people to know who to reach out to.

Ethiopia's Health Extension Programme deploys more than 38,000 salaried health extension workers, who provide services at fixed health posts as well as through home visits in their communities. These investments have paid off – Ethiopia has seen remarkable achievements in health outcomes since the launch of the programme, including drastic reductions in maternal and child deaths. Further, the Kigali consultation noted that Ethiopia is creating an integrated system where frontend health workers are supervising and cooperating with CHWs, rather than treating them as a separate workforce.

In Liberia, bold reforms were made to the national CHW program following the Ebola epidemic. In 2016, Liberia's Ministry of Health launched its revamped National Community Health Assistant (CHA) programme. CHAs are now paid, and their work is overseen by nurses or other clinic-based health professionals. As of March 2018, Liberia had hired and trained almost 3,000 CHAs, and many counties are already reporting improvements from their services.

In India, approximately 800,000 CHWs form the backbone of the nation's health system. These Accredited Social Health Activists, or ASHA workers, are paid an outcome-based remuneration according to the number of patients they serve and the specific targets they achieve. With ASHA workers belonging to the very communities they serve and an incentive structure that rewards performance and outcomes, their work has significantly contributed to improved health outcomes in India.

Despite the critical role of CHWs and their demonstrated impact in countries across Africa and Asia, few countries have introduced policies to formalize the role of CHWs, and most of them work on a voluntary basis or receive marginal pay. Further, the economic value of leveraging CHWs is well established. According to the World Health Organization (WHO), investing USD 1 in a community-based health workforce in sub-Saharan Africa can produce an economic return to society of USD 10.[4] Therefore, investing in health workers makes economic sense for a country. Discussions at the Kigali consultation noted the critical need to institutionalize their involvement through national policy frameworks for community health service. Discussants also highlighted that CHWs should be able to provide referrals to health facilities, who can follow up with CHWs if required.

It is also important to equip community health workers with easy-to-use technologies to improve quality of health services, to monitor and track performance, and to disseminate new information to the population. For instance, in Uganda, health workers use MTRAC—an SMS-based technology connecting hospitals to the national drug chain—to report on local medicine stocks using their mobile phones, saving time and transport costs.

Both the Kigali and Hanoi consultations stressed that community engagement is critical to strengthen health systems and impact health outcomes of populations. Enablers and intermediaries need to support communities to be empowered and equipped with information to challenge, demand and partake in decision-making processes that impact healthcare provided to them. Creating a formal space or platform for communities and governments to engage with one another can be a valuable driver in this regard. In Kigali, discussions cited the example of Tanzania, where facility governing

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[4] WHO. (2015). Strengthening Primary Health Care through Community Health Workers: Investment Case and Financing Recommendations. Available at: https://www.who.int/hrh/news/2015/CHW-Financing-FINAL-July-15-2015.pdf

committees include different community members, representatives from government, facility officials, etc. to govern implementation at the ground-level. Community representatives are supposed to elevate the communities' views, thereby involving the community in decision-making.

Finally, while we talk about communities being at the core of community health systems strengthening and UHC, it is critical to have the specific needs of the women and girls catered to. According to WHO, women and children from vulnerable communities disproportionally bear the brunt of preventable illnesses and death.[5] The Kigali discussions stressed that policy-making must ensure the health needs of women and girls are catered to and access for this group is improved.

Innovative Financing Models

Political commitment toward UHC is at an all-time high. Several governments across Asia and Africa including Kenya, Rwanda, Uganda, Indonesia, India and Philippines among others, have recognized the importance of delivering UHC to their populations and are ushering in important policy changes, in line with national commitments. Discussions at the Kigali and Hanoi convenings noted that these progressive policy reforms will have to be backed by sustainable financing in order to make UHC a reality. Governments across Asia and Africa are increasingly purchasing health services from the private sector. Such public-private partnerships can be seen as mutually beneficial as the government is able to tap into existing facilities in the private sector, while the private sector's capitation fees are compensated by the large volumes of beneficiaries.

"The private sector conversation is often on what you can supply or what you can do when people are very sick in the hospital. I don't hear enough of what we can be created or what can be done so private sector can have a more prominent role in prevention"

- H.E Governor Ndiritu Muriithi, Governor of Laikipia County, Kenya

Discussions at the Kigali and Hanoi consultations also highlighted that strategic purchasing will play a key role in ensuring that scarce funds are used where they matter most. In many African and Asian countries, public health spending is skewed toward hospital-based curative services that favor the wealthier and urban populations. However, investments toward preventive and promotive care are essential to reach the masses and halt illnesses from aggravating and requiring specialty or curative care. An emergent finding from the Hanoi consultation was that private sector partners need to look beyond Corporate Social Responsibility (CSR). Private sectors can add great value to UHC efforts by supporting the government with the strengthening of preventive and promotive services.

In order to ensure that everyone has equitable access to affordable, quality health services within scarce resources, it is critical to adopt a process of active decision making about which health services to procure, from whom and how to go about paying for them in a cost-effective manner. The government procuring a diverse set of healthcare services on behalf of both the public and the private sector, can leverage its buying power to incentivize delivery of quality services in an equitable manner. Countries that have recognized the power of the government as the "strategic purchaser" – such as Chile, Ghana, Rwanda and Thailand – are re-shaping the delivery of their health services. In these countries, the government pays for services that are often provided by both public and private health providers. These nations have been most successful in expanding access to health services with limited investments.

For example, in Ghana, a "gatekeeper system" was enforced by the National Health Insurance System (NHIS) to reduce unnecessary burden on tertiary care. When patients sought service from tertiary

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[5] WHO. PMNCH. (2013). Women's empowerment and gender equality promoting women's empowerment for better health outcomes for women and children. Available at: https://www.who.int/pmnch/knowledge/publications/strategybriefs/sb_gender.pdf

providers without a referral from primary or secondary providers, they had to pay more money out of pocket to access those services. Under the gatekeeper system, patients were encouraged to seek care for common illnesses and injuries at primary healthcare facilities instead.

At the Hanoi consultation, discussions were raised on the use of mixed financing models to challenge the belief that UHC should be financed solely by the government. The mixed model involves an innovative multi-sectoral blend for health financing, including the private sector, philanthropies, religious organizations and local community resources. For instance, a speaker expressed that the expenditure of health as a percentage of GDP in Indonesia is flattening at around 3.2%. This stagnation is creating an opportunity for innovative health financing models that are supported by the private sector.

Another key discussion point from the Hanoi consultation was on performance-based financing (PBF) or pay-for-performance (P4P), which is a form of incentive where health providers are, at least partially, funded on the basis of their performance to meet targets or undertake specific actions. It is defined as fee-for-service-conditional-on-quality.[6] Participants quoted country examples from Philippines where payments linked to performance are being prioritized to strengthen governance structures. Further, studies have shown that linking financing with performance can produce better outcomes—it can play a role in increasing efficiency of health workers and therefore contribute to positive effects on health services utilization. PBF improves communication between purchasers and providers as they need to come to a consensus on health services and their indicators.

Role of government and social health insurance schemes

For populations belonging to the lower economic strata, healthcare costs pose a lingering threat to the household's income and financial stability. High medical expenses borne out of patient's pockets drive families into poverty and deter people from seeking healthcare services. Governments across Asia and Africa have recognized social health insurance as a tool to provide financial protection to vulnerable and economically weaker populations, and to enhance access to healthcare services. However, effective implementation and the role of public and private providers remains an area that requires greater deliberations.

"We need to cover more [people] but also strengthen public health systems - if public system continues to play its role, private sector cannot increase their price. If we want the poor to be happy we need to retain the role of public health systems."

- Dr. P. Umanath
Managing Director, Tamil Nadu Medical Services Corporation, India

The discussants at the Hanoi consultation exchanged country experiences on the implementation of social health insurance schemes and emphasized the key role political will plays in ensuring health for all. For example, in Asia, countries including the Philippines, Indonesia and India, among others, have made strong headway to scale up access to health insurance as a means of driving UHC. However, it was noted that while social health insurance is critical for UHC, the focus cannot be redirected from primary healthcare and healthcare system strengthening, as they do not substitute for one another.

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[6] WHO. Health Financing. Performance-based financing. Available at: https://www.who.int/health_financing/topics/performance-based-financing/en/

Earlier this year, the Philippines made a significant commitment to improving access to high quality and affordable health services – a UHC bill was passed to law, setting a policy environment that prioritizes health. The UHC Act is the first of its kind in the Western Pacific region and seeks to ensure the automatic enrolment of all Filipino citizens into the National Health Insurance Program. Further, this monumental step facilitates major reforms to the healthcare system like consolidating financial flows, institutionalizing health technology assessment and improving governance. The program strives to integrate all services from primary care level and tertiary level along with the healthcare delivery system in all 81 provinces. In geographically isolated areas that lack government presence, the program seeks to leverage private players to fill the healthcare service delivery gap. According to discussion held at the Hanoi consultation, the program currently covers 98% of the Filipino population. For the remaining 2%, an existing government scheme allows patients to avail coverage at the point of service based on an assessment on the individual's finances.

> **"We are looking at the law to further improve efforts. Even if we are 98% covered, this law institutionalises and gives legal cover to achieve 100% cover of population."**
>
> *- Dr. Shirley Domingo,*
> *Vice President, Corporate Affairs Group,*
> *PhilHealth, Philippines*

The national social insurance program requires high investments to incorporate all services under the system. As per the law, UHC implementation is to be financed by one unified health fund that pools in resources from across departments, from different corporations and through various sin taxes. However, while there are serval funding sources, a large challenge lies in integrating the private sector into the unified fund approach.

While this commendable step positions the Philippines on the path to UHC, there are challenges to ensuring effective implementation. These include operationalizing the automatic enrolment of all citizens, and managing the heightened expectations of citizens since the enactment of the UHC law.

India paved its own pathway to UHC in 2017 by launching a national scheme, *Ayushman Bharat*. The initiative strives to move from India's fragmented approach of health service delivery to a comprehensive need-based healthcare service. *Ayushman Bharat* comprises two components to strengthen India's healthcare system—the transformation of health and wellness centres for primary and secondary care, and a national health insurance scheme, the *Pradhan Mantri Jan Arogya Yojana (PM-JAY)* to cater to tertiary care. PM-JAY aims to provide financial protection (*Swasthya Suraksha*) to economically weaker families.The scheme is co-financed by the national and state governments (60:40) and gives flexibility to states to choose their model of implementation such as bidding a private insurance company, establishing a government trust fund or through a mixed model for strategic purchasing.

Prior to the launch of PM-JAY, there was minimal engagement with the private sector for social health insurance. As per Indian government officials at the Hanoi consultation, only 34% of Indians were protected by an insurance scheme before 2018, and of those, 80% were covered by government schemes.[7] The predecessor to PM-JAY, *Rashtriya Swasthya Bima Yojana* (RSBY) scheme, covered a population of 36 million with a health cover of ~USD 430 per year and empanelled around 5,900 by its sixth year. The PM-JAY has set its goal to provide around 500 million beneficiaries with a health cover

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[7] Government of India. Ministry of Health & Family Welfare. Directorate General of Health Services National Health Profile 2018 13th Issue. Available at: https://cdn.downtoearth.org.in/pdf/NHP-2018.pdf

of ~USD 7,000 per family.[8] Today, 15,000 hospitals have been empanelled under PM-JAY, of which 50% are from the private sector, increasing private sector engagement.[9]

Indonesia has seen a reform in its healthcare landscape with the introduction of *Jaminan Kesehatan Nasional* (JKN) in 2014.[10] Before JKN, social insurance schemes were available for Indonesians but they were all highly fragmented—the wealthier had private insurance schemes, the poorer were provided basic state provision, while others were supported by NGOs through mixed-models. JKN was implemented to close the gap in coverage, as well as integrate participants and schemes under *BPJS Kesehatan*, the "single-payer" entity that administers JKN.[11] Today, JKN covers 83% of the nation's population and is targeting to reach the poor and indigenous in remote areas.[12] Indonesian policymakers at the Hanoi consultation expressed that the benefits under the premium are expansive and generous, which puts the government in a difficult position in terms of balancing the finances. Despite having an emergent private healthcare sector, the JKN is yet to fully capitalize on their presence and their resources. While Indonesia has room for private health insurers and technology innovators in strengthening the healthcare system and improving implementation of JKN, greater dialogues between the private sector and the government are needed to agree on collaborations and regulatory mechanisms that are grounded on mutual benefits.

Regulation and accountability

The traditional healthcare market is experiencing non-traditional disruptions owing to the influx of new innovations and emerging players. While this growing market is providing nations the opportunity to capacitate healthcare systems to meet the demands of UHC, a concern lies in maintaining a balance between the public and private sector, regulating partnerships and ensuring accountability for both existing and emerging stakeholders. With new enablers entering the market, it also widens the gap on the role of government, private sector and intermediaries. Further, governments are facing a challenge in pacing their regulations and standards with rapidly evolving technological advancements such as telemedicine and other mobile applications that manage large population datasets which can include sensitive individual information.

Discussions at the Kigali and Hanoi convenings highlighted public and private sector views on the barriers encountered in scaling-up innovations, as well as the role of intermediaries in shaping the future of healthcare systems. There was strong consensus that multi-sectoral forums need to be created to arrive at regulations both the government and private sector find practical and feasible. In this regard, intermediaries such as civil society organizations, NGOs, academia and technical forums, can play an instrumental role in hosting knowledge-sharing platforms that convene various enablers of healthcare and in bridging trust between governments and private sector players.

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[8] Chikermane, G., and Kurian, (2018). Can PMJAY fix India's healthcare system? Crossing five hurdles on the path to universal health coverage. Available at: https://www.orfonline.org/research/can-pmjay-fix-india-healthcare-system-crossing-five-hurdles-path-universal-health-coverage-44940/

9 Economic Times. (2019). Ayushman Bharat: 50% of empanelled hospitals are from private sector, says CEO. Available at: //economictimes.indiatimes.com/articleshow/68703794.cms?from=mdr&utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

[10] WHO Indonesia. Universal Health Coverage and Health Care Financing Indonesia. Accessed at http://www.searo.who.int/indonesia/topics/hs-uhc/en/

[11] Office of the Vice President the Republic of Indonesia. National Team for the Acceleration of Poverty Reduction. (2015). Available at: http://www.tnp2k.go.id/images/uploads/downloads/FINAL_JKN_road%20to%20national%20health%20insurance.pdf

[12] Data was cited by an Indonesian government official presenting at the Hanoi consultation.

> **"The technology capabilities are ahead of the regulation at the moment."**
>
> **"Regulation at moment envisages sitting in front of doctor, getting a piece of paper, going to pharmacy."**
>
> *- Deborah Gildea, head of Novartis Social Business Asia*

Private sector participants in Hanoi echoed the sentiment that existing regulatory processes are lagging and act as bulwarks to introducing technologies into the markets. The lack of a platform to hold dialogues between the government and private sector further aggravates the issue and often leaves private players demoralized to enter the healthcare market. A UHC legislation can be instrumental in laying out mandates for the government and private sector and providing clarity on roles from the start. This in turn would ease the regulatory processes. For instance, the current UHC law in the Philippines mandates that all benefits are assessed for their feasibility before roll-out.

Discussants at the convenings suggested that fast-track regulatory processes should be considered and implemented for health technologies, similar to drugs and medicines. Technology is universal, and thus, so are many of its problems and solutions. In this regard, nations belonging to the same regional groupings such as the Association of Southeast Asian Nations (ASEAN) could adhere to the harmonization of standards—once approved in an ASEAN nation, the others could follow suite instead of duplicating efforts by establishing their own regulations frameworks. Further, at the sub-national level, states and provinces should not be required to set their own regulations and standards.

In a growing market, governments must account for trade-offs between new and competing technologies while simultaneously ensuring the safety and clinical effectiveness of the technology before introducing it into their healthcare system. The discussions in Hanoi noted that governments face a challenge in choosing amongst a plethora of innovations that populate the health markets in regards to quality, cost and scalability. For instance, while a proposed technology may boast of certain advancements, it may not be viable for scale-up given its premium. Health Technology Assessments (HTAs) were recommended as a potential solution to explore as they look into a technology's safety and clinical effectiveness, along with cost-effectiveness and acceptability. Further it was suggested that along with safety regulation, price regulation needs to be prioritized so that price points are not decided based on profitability, but their necessity.

Further, information and technology (IT) solutions are being recognized as a cornerstone for UHC across Asia and Africa. IT support is being leveraged to monitor the quality of data, improve regulations and fasten procedures, assess investments, and avoid frauds. Technological improvements and improved data management in supply chain can also help main standards and avoid stock-outs. Data transparency and involvement of the final beneficiaries – the general population – can help improve accountability from the government and elected leaders.

Service delivery and access
UHC cannot be attained through the efforts of governments alone, particularly in developing countries, due to the constraint of limited resources. Engagement with the private sector is imperative to reach the last mile and to bridge the healthcare service delivery gap, particularly in geographically isolated areas. While some countries like India and Myanmar are ahead of the curve on innovation uptake and private sector engagement, others such as Indonesia and Malaysia are recognizing the benefits of private sector inclusion and increasing interest around the same.

For instance, ensuring access to affordable healthcare services to the booming population of 1.34 billion in India is unfathomable without support from the private sector. Therefore, India's national social health insurance scheme (PM-JAY) has empaneled private providers and is leveraging private

insurance companies to cater to the large demand for health services. Hospitals interested in empanelment apply on the government's web portal and are then assessed by the State Empanelment Committee (SEC) on their eligibility against the empanelment guidelines.[13] India's public-private partnership (PPP) model is mutually beneficial, as while the private sector has to lower its margins, the sheer volume of consumers provided by the government raises its profits. In turn, governments are able to tap into existing resources, expertise and infrastructure provided by the private sector.

Similarly, the Government of Myanmar has recognized the need to partner with private sector players to ease implementation and fill up gaps in resources. As mobile usage in Myanmar is increasing, the government is shifting toward technology-centered approaches to build capacity and provide care at the grassroots level. Mobile tablets are being used to disseminate knowledge and run healthcare initiatives such as diabetes care and safe motherhood apps. While the first phase of the project relies solely on the government, partners will support the project's expansion through the provision of additional mobile tablets.

The thriving private sector in Indonesia is witnessing the rise in start-ups such as *Atoma Medical* and *Sehati TeleCTG* that leverage mobile technology to disseminate information and services to those without opportunities or access. *TeleCTG* is used by community midwives who are connected through the app with medical practitioners at call centers. By empowering midwives, the primary providers of maternal and child healthcare in Indonesia, *TeleCTG* is providing access to obstetric services for patients without access to specialists in remote areas. *Atoma Medical* leverages social media platforms including WhatsApp and Facebook to share medical information with consumers and reach the masses.

Novartis Foundation, a large private sector player, is partnering with intermediary and global non-profit organization, PATH, and the Government of Vietnam to launch a blood pressure management program in Vietnam, specifically in Ho Chi Minh City. The effort aims to combat the rise of chronic diseases in urban areas by focusing on prevention, maximizing opportunities for screening, diagnosis and early treatment in the communities, and by empowering patients to assume a greater role in the management of their own health.[14] Through the initiative, local entrepreneurs including hair dressers and nail bars are being encouraged to add high blood pressure screening to their businesses. Discussants expressed the need to develop and adapt such set-ups that focus on promotive and preventive health, especially in resource-limited areas.

Engaging with the community to empower individuals to manage their condition is not unique to Vietnam. Novartis has applied a similar approach in Ghana through their Community-based Hypertension Improvement Project (ComHIP), which makes blood pressure screening services more accessible in the community.

Technological innovations are also helping countries manage their resources better by connecting different enablers in the healthcare system. For instance, in Uganda, tens of thousands of government health workers use MTRAC—an SMS-based technology connecting hospitals to the national drug chain—to report on local medicine stocks using their mobile phones, thus, saving time and transport costs.

Technology has benefits in service delivery as it supports automated reporting, synchronization of data at point of care with the central database and enables tracking of data. Indonesia for instance,

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[13] Government of India. National Health Agency. Guidelines on Process of Empanelment for Hospital. AYUSHMAN BHARAT – PRADHAN MANTRI JAN AROGYA YOJANA (AB PM-JAY). Available at: https://www.pmjay.gov.in/sites/default/files/2019-04/NHA_Guidelines_on_Process_of_Empanelment_for_Hospital_Revised_0.pdf
[14] Novartis. (2016). Fighting high blood pressure in Vietnam. Available at: https://www.novartis.com/news/fighting-high-blood-pressure-vietnam

has a large database that serves as the backbone for UHC as a robust and comprehensive IT structure allows nations to understand their consumers, and identify and target vulnerable populations. Further, in the Hanoi consultation, it was mentioned that developed countries are using predictive health management to build forecasting models focused on preventive care.

While local funding remains a challenge for private sector players in healthcare, advocacy based on evidence and cost-efficiency analysis, plays a large role in ensuring budgetary allocation for programs in coming years.

Key recommendations

The discussions in Kigali were centered on the strengthening of health systems through community-led interventions, whilst the discussions in Hanoi delved into the role of various actors—particularly the private sector and the government, and collaborations in furthering UHC.

Based on the summary of discussions above, key recommendations have been drawn and crafted under five key thematic areas—Community Health Systems Strengthening, Financing/Social Health, Regulation and Accountability and Service Delivery and Access. These set of messages can be tailored to account for country contexts, and allow nations with commonalities in governance and healthcare system structures, disease burden, geographies and financing, to be paired for regional learnings.

Community health systems strengthening

- **Integrating community health workers into the formal health system:** There is currently a huge gap between the number of professional health staff and the population, especially in Asia and Africa. It is critical that the role of community health workers are institutionalized and integrated into the formal health system through legislative policies. Further, governments must ensure fair employment conditions including fair remuneration and adopting a rights-based approach. For instance, Ethiopia is spearheading efforts in Africa by implementing an integrated system where front-end health workers are supervising and working closely with CHWs.
- **Tailoring approaches to cultural norms:** It is important to maintain high quality of care while we look to expand services through community health workers. While designing training modules for community health workers, it is important to keep in mind cultural norms and preferences, and adopt a selection criteria to train them with relevant competency for certification.
- **Leveraging easy-to-use technologies for community health workers**: Equipping health workers with easy-to-use technologies can be instrumental in improving quality of health services, monitoring and tracking performance, and disseminating up-to-date information to the general public. For instance, tens of thousands of government health workers in Uganda use MTRAC—an SMS-based technology connecting hospitals to the national drug chain—to report data on local medicine stocks.
- **Employing a bottom-up approach:** Joint planning and implementation should be based in community voices. There is a need to involve communities in decision-making, planning, and situational analysis as meaningful involvement at the hyper-local level has a spillover effect that strengthens the broader intervention. The involvement must be facilitated by the government and be structured on a formal platform that ensures community voices are heard.

Financing/social health insurance schemes

- **Increasing domestic funding toward healthcare:** With nations transitioning to middle-income status, governments must assume greater responsibly in domestically financing and strengthening their healthcare systems. In settings with limited resources, partnerships with the private sector can be instrumental in filling financing gaps and ensuring effective implementation of UHC. Further, financing for quality primary healthcare will be critical to drive UHC as this cornerstone

ensures comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout an individual's life course.

- **Catalyzing policy reforms through legislative action:** As seen in the Philippines, enacting a law on UHC and right to health can mobilize support from across the health and allied sectors for the adequate financing and effective implementation of healthcare schemes. Such a law can also institutionalize definitive roles for all players, including allied departments and other healthcare enablers.

- **Introducing strategic purchasing of services:** In limited resource settings, countries need to closely examine the health needs of the population; understand how disease burden varies across regions; identify and procure appropriate services; design a service delivery model that is customized to these needs; and focus on prioritizing resources toward cost-efficient services. Additionally, many African and Asian nations finance their health services through a mix of innovative financing mechanisms, such as private sector funds, donor support, national health budgets, religious institutions, etc. This mix implies that the government is not the sole decision maker and purchasing power is scattered among diverse stakeholders.

- **Incentivizing innovation:** Governments have a critical role to play in creating an enabling environment for innovation in healthcare. By working with intermediary organizations that are focused on innovation, the government can support innovations at different stages, from ideation and testing of concept, to early stage product development, and commercialization of the innovation. Critical tax reforms and supportive regulatory policies can further incentivize innovation.

Regulation and accountability

- **Fast-tracking regulatory processes to uptake technology advancements:** Technology is universal, and therefore, so are many of its problems and solutions. In this regard, nations belonging to the same regional groupings could adhere to common technology harmonization of standards instead of establishing their own regulations frameworks. For instance, nations belonging to a regional grouping such as ASEAN, can adhere to a universal harmonization of standards for technology and innovation. As a result, nations can quickly adopt technologies and avoid a lag in time due to the duplication of assessment efforts.

- **Identifying inter-sectoral linkages at the community level:** Healthcare cannot be seen as an isolated issue. Determinants of health such as drinking water, sanitation, food security, housing, etc., play a critical role in improving health outcomes in a population. Moreover, communities are complex with various actors such as private providers and civil society. Governments must have an 'Action Plan' or a forum that converges different government ministries and private bodies on a regular basis, to continuously take stock of the progress made on furthering UHC, align priorities, and discuss the challenges faced by each actor in advancing UHC.

- **Dispersing accountability across sectors:** The government must not be the sole enabler that is holding accountability. Private sectors entering the healthcare market and desiring regulatory frameworks to be more flexible, need to assume a stronger role in accountability to ensure quality of care.

- **Creating multi-sectoral regional forums:** There was strong consensus that multi-sectoral regional forums need to be created to arrive at regulation and accountability that both the government and private sector find practical and feasible. In this regard, intermediaries, can play an instrumental role in hosting knowledge-sharing platforms that convene various enablers of healthcare and in bridging trust between governments and private sector players. Developing common regulatory guidelines across regions was considered as part of regional collaboration for future health systems.

- **Enhancing accountability through technology:** On one side, demand needs to be created by involving communities and the beneficiaries through communication technologies, which can drive accountability from elected leaders and government authorities. On the supply side,

improved data management can drive accountability – for instance by having technological checks and balances throughout the supply chain of drugs and diagnostic equipment. Further, technology platforms and data management must be integrated across health programs to have one dataset for better policy planning and implementation.

Service delivery and access

- **Leveraging existing resources in the private sector:** The private sector has a vital role to play in advancing UHC as it can support the government address healthcare gaps and strengthen health systems by sharing its resources, expertise and technologies. Private sector players can help deliver healthcare to isolated populations and remote areas through innovations. India, for instance, is empanelling private sector hospitals under its national health protection scheme, PM-JAY, to tap into the resources available in the private sector.

- **Encouraging the use of technology across programs:** There is a need to diversify from the traditional model of in-person, patient health provider consultation to virtual or digital interaction enabled through mobile technology. Market disruptions are opening an opportunity to leverage technology and data management, and to reach the previously unreached with information and services. Further, leveraging of social media platforms such as Facebook, Twitter and WhatsApp can help disseminate information to the masses and reduce costs to already digitally- connected users. For example, *Atoma Medical* in Indonesia utilizes this digital medium to reach the general public with heath information and services. Additionally, the collection of data through technology can be instrumental in supporting programs by monitoring quality, analysing investments, avoiding frauds, and mapping vulnerable populations and health trends.

- **Engaging local businesses and innovators to increase access to preventive and promotive healthcare:** At the ground level, entrepreneurs can be incentivized to support the focus on promotive and preventive healthcare. For instance, as more African and Asian nations are facing the double burden of disease—with non-communicable diseases and infectious diseases gripping populations, blood pressure and diabetes screening can be installed in local businesses such as nail bars, parlours, grocery stores and hair dressers, to reach people in geographically-isolated areas. Vietnam and Ghana have already begun to employ this mode of engagement.

Future directions for research and policy

Discussants at the Hanoi consultation expressed keen interest in furthering dialogues on global south collaborations to achieve UHC through the scale-up of community-led innovations. The following research and policy focus areas were mentioned as critical discussion points for future deliberations.

- Solutions space across countries (exchange learnings)
- Country experiences with health seeking behaviour at tertiary level
- Looking beyond the health sector for learnings
- A consumer perspective and how to bring healthcare close to them and educate them- engage consumer companies?
- Support systems needed to achieve UHC (for e.g. drugs and medicine, health human resources)
- Private sector resources for health financing
- Specific earmarking of funds or mechanism to support preventive and promotive care (Action: framework for financing preventive services)
- Innovative processes for procurement
- Timely reimbursement of workers (to handle the resources we have now)
- Role of communities and how to ensure they are considered for based on their needs

Priority topics for future research

- Impact of health promotion on health outcomes

- Comparative studies to determine how financing models impact sustainable UHC and service delivery
- Feasibility of gap financing as incentive to investment in preventive care
- Use of sin taxes to increase revenue
- Effect of home based screening interventions in managing chronic disease (blood pressure)
- Constraints of follow-ups when patients are diagnosed with chronic diseases (cancer)- usually patient lost in follow up
- Service delivery incentives for private sector to invest (Indonesia has ageing population that needs special care- may need home service delivery)
- UHC financing- what models ca be developed to support collaborations
- Potential impact of investing in primary care (long term investment)
- Granularity in nations' experiences

Annexure 1

The output framework based on discussion points raised at the Kigali and Hanoi consultations on 'Achieving UHC in Asia and Africa by Scaling Community/Locally driven Innovation'

PROPOSED STRATEGIES ACROSS SECTORS		
Broad areas covered included the themes below as well as cross-cutting areas that emerged from discussions:		
Financing/ National health insurance schemes	**Service delivery & access**	**Regulation/accountability & scaling innovation**
• Contracting private sector providers for secondary and tertiary care • Political will to ensure adequate investments toward all levels of healthcare (primary care and insurance for secondary and tertiary care) • Improved data collection to identify vulnerable population • Decentralized and flexible financing structures for federal systems in certain countries • Philanthropies, religious groups, corporates to provide supplementary financing • Alternative financing e.g., separate taxes from various sectors (tobacco, gambling) • Invest in community health programs to close the human resource gap in healthcare	• Shared value propositions for public private partnerships to improve access while ensuring affordable costs • Innovation in information technologies and database management to target delivery of healthcare and improve information access • Philanthropies and corporate social responsibilities to provide risk capital and bridge gaps • Incentivizing private sector to create innovative interventions for the primary care level • Home-service delivery and telemedicine to provide last mile access to healthcare • Technology platforms to connect and empower each level of healthcare providers • CHWs to be integrated into the formal health system	• Fast-track mechanism for scaling innovations – harmonization of standards across regions and countries • Adequate technical expertise to evaluate health technologies – forum of government, medical institutes and research organizations • Data transparency and consumer education to drive accountability and encourage citizen participation and monitoring • Regional regulatory and accountability frameworks • Technology tools to empower consumers to provide feedback on healthcare services
Cross cutting areas		
• Legislative enactments can strengthen UHC strategies and future efforts • Innovative information technologies and data management systems can regulate and monitor quality, and conduct future assessments • Performance-based financing can ensure quality and affordability of healthcare • Inter-sectoral convenings/knowledge sharing platforms can accelerate the scale up of innovation for UHC		
CREATING AN ENABLING ENVIRONMENT FOR HEALTH INNOVATION: ASIA LEARNING CASE: PHILIPPINES		
• Enacting a law on UHC has vaulted the nation's policy environment to prioritize healthcare and steered a path for other leaders striving to achieve UHC in their respective nations		

- The social health insurance scheme gathers financial support from various sources, departments and sectors, including the private sector, casino companies, sin taxes, and the health department, among others, for a unified fund created for UHC
- Even the 2% populace lacking benefits from the social health insurance scheme can avail coverage through other government schemes at point of service
- In geographically isolated areas that lack government presence, the program seeks to leverage private players to fill the healthcare service delivery gap

COMMUNITY HEALTH SYSTEMS STRENGTHENING: AFRICA LEARNING CASE: RWANDA

- High level political leadership and commitment translating to critical policy reforms and financial prioritization
- Introduced legislations to outline support for Community Health Service
- Empowering communities to design solutions and set priorities, depending on local contexts

ENABLERS	Private Sector	Innovation and Technology	Intermediaries (NGO's)	Government
What	- Partner with government through mutually beneficial collaboration to improve access and ensure quality - Involvement in preventive and promotive healthcare - Develop private sector engagement advocacy model and tools to engage government - Document and Showcase costing models for UHC running across the continuum of care (preventive promotive curative rehabilitative and palliative aspects	- Creating innovations in line with country priorities and address existing gaps - Innovations in IT and data management to drive accountability	- Build trust between public and private sectors - Knowledge sharing platform to avoid duplication and synergize efforts - Document innovative public-private partnership models that highlight elements of shared value	- Political will and legislative action to strengthen UHC efforts - Incentivize private providers and technology developers to support government priorities - Create fast track mechanisms for new innovations – harmonization between countries - Partner with countries (with similar governance structures and health systems) to share and gather learnings - Develop inter-sectoral partnerships
Who	World Bank Marie Stopes International R4D PATH JICA Frost and Sullivan International Medical University, Malaysia		World Health Organization Rwanda School of Public health, University of Rwanda Care international Africa Palliative Care Association ABT Associates Dalberg Advisors Network for Adolescents and Youth of Africa	
Where	Indonesia India Malaysia		Kenya Uganda Tanzania	

	Philippines Myanmar Vietnam	Senegal Ghana
Learning	Indonesia	Kenya
	Philippines	
	Vietnam	Rwanda
	India	

Annexure 2

List of attendees from Kigali consultation

Panellists:

1. Chioma Nwachukwu, Senior Manager, Advocacy and Public Policy, Gavi (Moderator)
2. Dr. Jean Kagubare, Deputy Director, Global Primary Health Care Systems, Bill & Melinda Gates Foundation
3. Dr. Giorgio Cometto, Coordinator, Human Resources for Health Policies, Norms & Standards, World Health Organization
4. Dr. Koffi Houngbedji, SDGs Advisor, Public Health Specialist, The Sustainable Development Goals Center for Africa
5. Dr. Priya Balasubramaniam, Senior Public Health Scientist, Public Health Foundation of India; Director, PHFI-RNE Universal Health Initiative (Discussant*)*

Breakout Group Discussion Leaders:

1. Dr. Ernest Nyamato, Director, Ipas Alliance
2. Dr. Frasia Karua, General Manager, Amref Enterprises Ltd.
3. Magnus Conteh, Executive Director, Community Health Academy at Last Mile Health

Participants:

1. Akinyi Oongo, Program Coordinator, Trust for Indigenous Culture and Health-Kenya
2. Alexandra Burrough, Managing Director, Live Well (Zambia)
3. Angela Muchiru, Human Resources Director, Amref Health Africa
4. Ben Nortey, Founder and CEO, MINT Innovations
5. Beverly Nkirote Mutwiri, Network for Adolescent and Youth of Africa (NAYA – Kenya); Young Leader, Women Deliver
6. Carolyne Ndolo, Country Manager East Africa, IQVIA
7. Chimwemwe Zindondo, Member, Youth Hub Malawi
8. Chloe Lanzara, Program Officer, Results for Development (R4D)
9. Chrisanthus Okutoyi, Grants Management Professional, Amref Health Africa
10. Courtney Tolmie, Senior Program Director, Results for Development (R4D)
11. Deman Mohamud, Consultant, IQVIA
12. Diane Muhongerwa, Health Economist, WHO
13. Dr. Emmanuel Luyirika, Executive Director, African Palliative Care Association
14. Erastus Maina, Program Manager, Safe Surgery 2020

15. Erick Mundia, Policy Associate, Ipas
16. Esther Kamau, Amref Health Africa
17. Evelyne Mulunji, Chief Officer - Public Health, Ministry of Health, Kenya
18. Faith Abala, Sustainable Environment Development Watch (SUSWATCH KENYA)
19. George Hayes, Regional Advocacy Advisor – Asia, Marie Stopes International
20. Gerald Bloom, Health Economist and Research Fellow, Institute of Development Studies
21. Gershim Asiki, Associate Research Scientist, Africa Population and Health Research Center (APHRC)
22. Dr. Githinji Gitahi, Group CEO, Amref Health Africa
23. Jean Butera, Former Chief of Party, Health Financing and Governance Project, Abt Associates
24. Jenelle Williams, Director of Programs, Global Health Action
25. Jimmy Yuga, Maternal, New born and Child Health Specialist, Health Pooled Fund (Ministry of Health, Government of South Sudan)
26. Joseph Wangombe, Professor of Health Economics, University of Nairobi
27. Kiama Kaara, Senior Advisor to the Governor, County Government of Laikipia, Kenya
28. Lenganji Nanyangwe, 50/50, IAS, AGAG, Director, Southern African AIDS Trust (SAT), Zambia
29. Maisoon Chowdhury, Program Associate, Primary Health Care Performance Initiative (PHCPI)
30. Meshack Mbinda, Research and Development Lead, Amref Health Africa
31. Ngozi Akwataghibe, CEO, ENAULD Health Research and Services; Associate, Royal Tropical Institute, The Netherlands; Consultant, Liberia Health Sector Performance Evaluation, Ministry of Health, Liberia
32. Niamh Fitzgerald, Manager, Global Health Strategies
33. Nidhi Dubey, Senior Vice President, Global Health Strategies
34. Patrick Igunza Nagide, M&E and Research Officer, Amref Health Africa
35. Peter Otieno, Operations/Delivery Lead, Amref Enterprise Ltd.
36. Princess Osita-Oleribe, Director, Centre for Family Health Initiative
37. Rachel Ambalu, Project Manager, Amref Health Africa
38. Raman Sankar, Manager, Global Health Strategies
39. Sheenan Mbau, Youth Country Coordinator, Center for the Study of Adolescence
40. Simon Berry, Co-founder and CEO, ColaLife
41. Sofiat Akinola, Project Specialist, Global Health and Healthcare, World Economic Forum
42. Sophia Mutoni, Health Technical Advisor, VSO International – Rwanda
43. Stuart Knight, Global Strategic Alliance and Business Development, IQVIA
44. Stuart Nyakatswau, Co-Founder - WASTiNNOVA
45. Dr. Uchenna Nwokenna, Acting Program Director: Regional Action through Data (RAD), BroadReach Healthcare
46. Zaddock Okeno, Programme coordinator – HENNET, Amref Health Africa

List of attendees from Hanoi Consultation

Panellists:
Plenary I: Asia perspective: Strengthening health systems capacity towards UHC

1. Dr. Wangari Ng'ang'a, UHC Technical Adviser, Executive Office of the President, Kenya (Moderator)
2. Le Van Kham, Director, Health Insurance Department, Ministry of Health, Vietnam
3. Dr. Maya Rusady, Director for Health Services, BPJS, Indonesia
4. Dr. Mohd Safiee bin Ismail, Senior Principal Assistant Director, Ministry of Health, Malaysia
5. Dr. P. Umanath, Managing Director, Tamil Nadu Medical Services Corporation, India
6. Dr. Rohit Jha, Deputy Director, National Health Authority, Government of India
7. Dr. Shirley Lourdes Domingo, Vice-President, Corporate Affairs Group, PhilHealth, Philippines

Plenary II: Community-led innovation, scale & the role of new intermediaries

1. Rhenu Bhuller, Partner – Transformational Health, Frost & Sullivan (Moderator)
2. Anda Sapardan, COO and Co-founder, Sehati TeleCTG
3. Dr. Aye Aye Sein, Deputy Director General of Administration, Department of Public Health, Ministry of Health and Sports (MOHS) (technology, innovation e health and health systems), Government of Myanmar
4. Deborah Gildea, Head of Novartis Social Business, Asia at Novartis
5. Dr. Gregorius Bimantoro, CEO and Co-founder, Atoma Medical
6. Dr. Le Thi Thu Hien, Program Director, PATH, Vietnam
7. Prof. Safurah Bt Ja'afar, Associate Professor of Community Medicine, International Medical University

Deep dive spotlight speakers:

1. Dr. Atikah Adyas, MDM, Health Human Resource Body, Ministry of Health, Indonesia
2. Dr. Laksono Trisnantoro, Professor in Health Policy and Administration, Director, Centre for Health Service Management, Faculty of Medicine Universitas Gadjah Mada Indonesia
3. Mohammad Ameel, Senior Consultant, Healthcare Technologies (Medical Devices) at National Health Systems Resource Centre

Participants:

1. Dr. Abraham Auzan, Co-Founder, Sehati TeleCTG
2. Alena Koshcheeva, Social Marketing and Communications Manager, Novartis Social Business Asia
3. Alexandra Rupp, Manager Employer Management, Communications, External Affairs, Novartis
4. Anh Le Tuan, Head of GA, PA & Communications, Novartis
5. Anika Heavener, Executive Director, Enterprise Digital Health, Partners HealthCare / HMS
6. Dr. Ari Waluyo, CEO, Sehati TeleCTG
7. Dr. Beatrice Wanyara Gatumia, UHC Lead, Amref Enterprise Limited
8. Dr. Bui Van Truong, Director, Community for Healthy Heart
9. Cicely Thomas, Program Director, R4D
10. Dr. David B. Duong, Deputy Director, Program in Global Primary Care and Social Change, Harvard Medical School
11. Dessislava Dimitrova, Practice Lead, Health Systems Transformation, World Economic Forum
12. Desta Lakew, Director of Partnerships for Africa, Amref Health Africa
13. Dinh Thi Nhuan, Access & Quality Director, Marie Stopes
14. Dr. Donald Mogoi, Chief Officer Health, Laikipia County Government
15. Erica Young, Chief of Staff, Group President's Office, Fullerton Health
16. Dr. Frasia Karua, General Manager, Amref Enterprises Ltd.
17. Hương Kiều, Health Program Manager, Centre for Supporting Community Development Initiatives
18. Huong Thuy Nguyen, Head of Public Affairs and Market Access, Takeda Vietnam
19. Justin Wood, Head of Regional Agenda - Asia Pacific, Member of the Executive Committee, World Economic Forum
20. Kiama Kaara, Senior Advisor to the Governor, County Government of Laikipia, Kenya
21. Dr. Khuất Thị Hải Oanh, Executive Director, Centre for Supporting Community Development Initiatives
22. Dr. Kristian R Olson, Director, Consortium for Affordable Medical Technologies (CAMTech), Associate Professor, Harvard Medical School
23. Louise Cotrel-Gibbons, PATH, Mekong Regional Business Development and Communications Coordinator
24. Mai Phạm, Health Program Assistant, Centre for Supporting Community Development Initiatives
25. H.E. Governor Ndiritu Muriithi, Governor, Laikipia County, Kenya
26. Dr. Priya Balasubramaniam, Senior Public Health Scientist & Director, PHFI-RNE Universal Health Coverage Initiative, Public Health Foundation of India
27. Raman Sankar, Manager, Global Health Strategies, India
28. Dr. Ramesh Govindaraj, Lead Health Specialist, World Bank
29. Ria Basu, Manager, Global Health Strategies, India
30. Roeland Roelofs, Country President, Novartis –Vietnam -The Representative Office of Novartis Pharma Services AG
31. Roli Shrivastava, Program Associate, Global Health Strategies, India

32. Sandra Butler, Senior Manager of Global Business Strategy, Consortium for Affordable Medical Technologies (CAMTech)
33. Sang Minh Le, Health Specialist, World Bank
34. Sofiat Akinola, Project Specialist, Global Health and Healthcare, World Economic Forum
35. Sumita Palanisamy, COO, Cygen group (M) Sdn Bhd
36. Sze-Yunn Pang, Head Population Health Management, Philips ASEAN & Pacific
37. Thuy Nguyen, Project Lead, Asia Pacific World Economic Forum
38. Tiaji Salaam-Blyther, Specialist in Global Health, Congressional Research Service
39. Van Tran Ha Khanh, Novartis VietNam
40. Viet Ha Pham, Program Officer, Vaccines Delivery, Clinton Health Access Foundation, Vietnam
41. Wilson Wakaham, MCA, Laikipia Assembly, Kenya

Annexure 3

Time	Run of Show
	Panel Discussion
10:00AM-10:05AM	**Opening remarks (5 minutes)** *Dr. Githinji Gitahi, CEO, Amref Health Africa*
10:05AM-10:45AM	**Panel discussion** (40 minutes) **Moderator:** *Chioma Nwachukwu, Senior Manager, Advocacy and Public Policy, Gavi* o *Dr. Giorgio Cometto, Coordinator, Human Resources for Health Policies, Norms & Standards, World Health Organization* o *Dr. Koffi Houngbedji, SDGs Advisor, Public Health Specialist, The Sustainable Development Goals Center for Africa* o *Dr. Jean Kagubare, Deputy Director, Global Primary Health Care Systems, Bill & Melinda Gates Foundation (BMGF)* o *Priya Balasubramaniam, Senior Public Health Scientist, Public Health Foundation of India*
	Deep-dive Session
10:45AM-11:40AM	**Small group sessions (55 minutes)** The meeting participants will be broken up into three groups, led by two moderators, to deliberate on three critical components of UHC, outlined below. The moderators will ask the participants the recommended questions below and engage in active discussion and debate on these topics. Following the deep dive, each group will synthesize recommendations on their topics. **Moderator:** *Dr. Frasia Karua,* General Manager, Amref Enterprises Limited 1. **Community health systems strengthening** **Group Facilitator:** *Magnus Conteh, Executive Director, Community Health Academy, Last Mile Health*

	2. **Innovation** **Group Facilitator:** *Erick Mundia, Ipas* 3. **Financing** **Group Facilitator:** *Dr. Frasia Karua, General Manager, Amref Enterprises Limited*
11:40AM-11:45AM	**Closing remarks (5 minutes)**
**Closed Working Group Session**	
11:45AM-12:30PM	**Working Group Session** (45 minutes) Following the closing remarks, a select group of high-level participants, experts and thought leaders were requested to stay behind for a closed door working group session. The group deliberated on the topics discussed during the breakout sessions, to arrive at a set of actions and recommendations for advancing UHC in Africa through community-led innovation as well as opportunities for increasing dialogue between countries in the global south. Recommendations emerging from this meeting will be collated into an outline for a white paper to be presented at the World Health Assembly in May 2019.

HANOI: AGENDA | MAY 15, 2019

**Achieving UHC in Asia and Africa by Scaling Community/Locally driven Innovation**		
Time	**Topic**	**Person(s)**
9:00-9:15	**Welcome remarks & setting context**	Amref Health Africa/ PHFI Dr. Frasia Karua /Dr. Priya Balasubramaniam
9:15-9:30	**Opening remarks**	**Mr. Justin Wood,** *Head, Asia and the Pacific, World Economic Forum*

9:30-11:00	PANEL- 1 **Asia perspective: strengthening health systems capacity for UHC** *How has governance, leadership and political environment impact health system capacity in Asia? How is the private sector contributing?*	**Moderator: Dr. Wangari Ng'ang'a,** *UHC Technical Adviser, Executive Office of the President, Kenya* **Panellists:** ○ **Mr. Rohit Deo Jha,** *Deputy Director National Health Authority-Ayushman Bharat- Government of India* ○ **Dr. Shirley Lourdes Domingo,** *Vice-President, Corporate Affairs Group, PhilHealth, Philippines* ○ **Dr. Maya Rusady,** *Director for Health Services, Badan Penyelenggara Jaminan Sosial (BPJS)* ○ **Dr. Le Van Kham,** *Director, Health Insurance Department, Ministry of Health, Vietnam* ○ **Dr. Mohd Safiee bin Ismail***, Senior Principal Assistant Director, Ministry of Health, Malaysia* <u>**State/Provincial Perspective:**</u> ○ **Dr. P. Umanath,** *Managing Director, Tamil Nadu Medical Services Corporation, India*
11:00-11:15	**Nutrition and Networking**	
11:15- 12:45	PANEL 2 **Community-led Innovation, Scale & the role of new intermediaries** *What are underlying factors that drive scale?* *How have new health intermediaries (such as non-state development sector institutions) contributed to scaling innovations?*	**Moderator: Ms. Rhenu Bhuller,** *Partner – Transformational Health, Frost & Sullivan* **Panellists:** ○ **Dr. Gregorius Bimantoro,** *CEO and Founder, Atoma Medical* ○ **Ms. Anda Sapardan,** *COO and Co-founder, TeleCTG International* ○ **Ms. Deborah Gildea,** *Head (Asia), Novartis Social Business* ○ **Ms. Aye Aye Sein,** *Deputy Director General of Administration, Department of Public Health, Ministry of Health and Sports (MoHS), Myanmar* ○ **Dr. Mushtaque Chowdhury,** *Vice-Chairperson, BRAC, Bangladesh* <u>**Local perspectives on partnerships and scale:**</u> ○ **Prof. Safurah Bt Ja'afar,** *Associate Professor of Community Medicine, International Medical University, Malaysia*

		o **Dr. Le Thi Thu Hien,** *Program Director, PATH*
12:45-13:00	**Summary and context setting for Deep Dive**	
13:00-14:00	**Lunch Break**	
14:00-16:30	**Deep Dive** Leveraging Community driven innovations for UHC. The role of enablers (technology, private sector, government, local communities) Building Regulation and Accountability Mechanisms	
	Invited Participant Stakeholders Country representatives, regional private sector innovators, community representatives, regional development implementing organizations	
14:00-14:20	**Deep Dive Session format, Kigali framework overview and introductions**	Amref/ PHFI – Facilitate Dr. Priya Balasubramaniam, Dr. Desta Lakew, Dr. Frasia Karua Individuals share name and expertise. Break out in to 4 enabler groups with questions around 4 focus areas
14:20-15:45	**Identify country priorities, enablers and challenges that feed into the Kigali framework**	**Spotlight speakers:** o **Dr. Atikah Adyas,** *MDM, Health Human Resource Body, Ministry of Health, Indonesia* o **Dr. Laksono Trisnantoro,** *Professor in Health Policy and Administration, Director, Centre for Health Service Management, Faculty of Medicine Universitas Gadjah Mada Indonesia* o **Mr. Mohammad Ameel,** *Senior Consultant, Healthcare Technologies (Medical Devices) at National Health Systems Resource Centre, India* As 4 break-out groups
15:45-16:30	**Talk solutions for regional sharing** Synergies for Asia and Africa- opportunities for regional collaboration	Facilitators from each group pick one person from each groups to share points from their questions Open discussion on feasibility of solutions and next steps

	Identify key-measures of success in scaling innovations and community led models Pick 2-3 countries and partners that can move forward this agenda right now	
16:30-16:45	**Summary, Next steps and it's a wrap!**	