ECSA HEALTH COMMUNITY

REPORT OF REGIONAL MEETING ON UNIVERSAL HEALTH COVERAGE

Meeting held 14th – 15th February 2013 at the Speke Resort Munyonyo, Kampala, Uganda

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List of Acronyms

Acronym	Definition
ACHEST	African Center for Health Systems and Social Transformation
AIDS	Acquired Immune Deficiency Syndrome
CHAM	Christian health Association of Malawi
CHF	Community Health Fund
CSOs	Civil Society Organizations
ECSA	Eastern, Central and Southern Africa
GDP	Gross domestic product
GGHE	General government expenditure on health
HIV	Human immunodeficiency virus
ICOBI	Integrated Community Based Initiative
IMR	Infant mortality rate
IST	WHO Inter-Country Support Team
M&E	Monitoring and Evaluation
MDGs	United National Millennium Development Goals
MFED	Ministry of Finance and Economic Development
MMR	Maternal mortality ratio
MoH	Ministry of Health
NHI	National Health Insurance
NhIF	National Hospital Insurance Fund-Kenya
NHIF	National Health Insurance Fund
NCDs	Non-communicable diseases
NGOs	Non-governmental Organizations
NMR	Neonatal mortality rate
OOP	Out-of-pocket
PPP	Private-Public Partnership
SACCOs	Savings And Credit Cooperatives
SHI	Social Health Insurance
HSSD	Health Systems and Services Development
TB	Tuberculosis
THE	Total health expenditure
U5MR	Under 5 mortality rate
UHC	Universal Health Coverage
WHO	World Health Organization

1.0 Introduction

1.2 Background to the meeting

East Central and Southern Africa (ECSA) Health Community and Rockefeller Foundation has partnered to support ECSA Health Community Member States to establish advocacy mechanisms for Universal Health Coverage (UHC); create learning and knowledge sharing platforms at regional level and; develop UHC monitoring framework for the ECSA region. The Secretariat facilitated the development of a regional monitoring and evaluation framework for UHC though a consultative process involving experts from the Ministries of Health.

The Secretariat is aware of member states commitments and that they are party to global and regional resolutions on access to and coverage with needed health services for the citizens. But for these to result into solid actions for attainment of UHC there is need for sustained multi-stakeholder dialogue, making available the required information including through appropriate fora for cross-country learning of best and promising practices on universal health care access and coverage.

The Secretariat therefore continues to catalyse these processes. This meeting, involving senior government officials, representatives from the private sector, civil society organizations and health development partners was meant to share practical experiences on implementation of interventions geared towards the achievement of UHC in the context of African Health Systems. In addition, this meeting was organized as a high level political advocacy where experts were to generate and make recommendations to the ECSA Health Ministers Conference on UHC. To this end, it was held as pre-60th Health Minister Conference meeting. The ECSA Health Ministers conference took place on the 16th and 17th February 2015 in Uganda.

1.3 Objectives of the meeting

The meeting was organized to provide a platform for exchange of experiences and best practices in the implementation of interventions and initiatives for enhancing UHC and generate recommendations for consideration by the 60th Health Ministers Conference regarding UHC agenda for the ECSA Health Community.

Specifically the meeting objectives included: -

- Sharing country level experiences in the implementation of interventions for UHC.
- Increasing awareness about UHC, particularly amongst stakeholders outside the health sector.

- Identifying areas for regional support for mainstreaming UHC agenda into regional and national processes.
- Making policy recommendations that inform ECSA Health Community Ministers' resolutions on UHC.

1.3 The Meeting Report

This meeting report is a procedural requirement at the Secretariat. It is also amongst the deliverables in the grant agreement between the Secretariat and the Rockefeller Foundation. But more than these, this report is a record of the meeting proceedings and contains recommendations that relevant stakeholders need to take note of and/or act on.

2.0 Proceedings of the meeting

2.1 Opening and welcome remarks

The opening remarks were given by Prof Yoswa Dambisya-the Director General ECSA Health Community, Ms. Muraguri Mwihaki from the Rockefellar Foundation, Dr Wondi Alemu - the WHO Country Representative Uganda and Dr Francis Runumi from the Ministry of Health Uganda.

Prof Dambisya noted that ECSA Health Community by virtue of the previous Ministerial resolutions is obliged to take the Universal Health Coverage agenda forward. Prof Dambisya observed that the case for Universal Health Coverage (UHC) has been made in various international commitments that most, if not all, ECSA Member states have endorsed. He also reminded the audience that issues that affect health as per the day's discussion were not new, but whereas they may seem obvious to the experts in healthcare practice, they may not be obvious to the majority of the population to whom the benefits of healthcare are intended. He urged participants to identify areas that would require specific actions and suggest recommendations on the next steps for UHC in the ECSA Health Community.

L-R: Dr. Francis Runumi, Ms. Mwihaki Muraguri, Prof Yoswa Dambisya, Dr. Wondi Alemu

Ms Muraguri noted that Rockefeller Foundation has been greatly involved in supporting health sector dating back from the 1920s with the development of yellow

fever vaccine. Ms. Muraguri highlighted the core areas of focus for the Foundation over the years as ;- overcoming emerging challenges and barriers to better nutrition and healthier lives; expanding opportunity and promoting inclusive markets in the changing global economy; promoting nature's capacity to sustain human well-being and meet growing demands; and catalysing equity and resilience in the world's most dynamic places. In the Health Sector, Rockefeller Foundation continues to support initiatives to improve the health status of poor and vulnerable populations through transforming health systems towards Universal Health Coverage.

Dr Wondi Alemu who made the remarks on behalf of the WHO Regional Director/AFRO observed that Universal Health Coverage remains central in achieving health goals in the post 2015 development agenda. He reminded participants that the UN General Assembly passed resolution 76/123 on UHC emphasizing responsibility of governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality healthcare services. Dr Alemu reaffirmed that regional approaches remain important especially in the global village with liberalization of movement and applauded ECSA Health Community Secretariat for the role it is playing in this area. He further noted that Countries in ECSA are at different in health financing with some countries health sector well financed and others inadequately financed, but all are in position to make steps towards UHC.

Dr Runumi making remarks on behalf of the Minister of Health Uganda observed that most of the countries in the region have similar health indicators. He noted that communicable diseases constitute the highest disease burden despite availability of proven interventions. He noted that the inadequate response in not for lack of knowledge but due to gaps in practical implementation mechanisms. He also noted existing rigidities towards health system reforms. He sighted the significant role the private sector plays and yet it has not been properly tapped to contribute to the overall mandate of the health sectors. He also noted the human resource challenges in Uganda. The country has not properly utilized the human resources the country produces. He said the country produces over 3000 health workers annually but only a fraction are absorbed in both the government and private sector.

He observed that health is a commodity and people need to take responsibility for their own health. He gave example of existing community initiatives savings and credit societies (SACCOs) that raise money for economic reasons for its members that can be supported so that they able to use part of their interests for their health. He noted these groups have not been reached and sensitized that their resources can provide them financial protection from

health care costs. He urged participants to share and advocate collectively and sensitize the politicians effectively if Universal Health Coverage is to be realized.

Dr. Walter Odoch-Manager HSSD at ECSA -HC

Dr Walter Odoch, Manager Health Systems and Services Development (HSSD) program at ECSA briefly described the background to the ECSA Health Community Secretariat support for UHC. He noted that these support is a directive by the ECSA Health Ministers through their resolutions on UHC and health financing. He noted that the Secretariat in consultation with the member states and financial support by the Rockefeller Foundation developed a monitoring framework for UHC in the ECSA Health Community that can be accessed online at http://www.ecsahc.org/downloads/. The Secretariat is also supporting advocacy at the country level through national symposium where stakeholders discuss best options for achieving UHC.

2.2 Universal Health Coverage- Global Perspective

Dr Benjamin Nganda, representing WHO Inter-country Support Team (IST) for Eastern and Southern Africa gave a background of how UHC reached the global agenda.

Dr Benjamin Nganda

- He noted that UHC was informed by the fact that MDGs have been a powerful tool that got the world's attention on development issues, but the way health was framed in the Millennium Development Goals (MDGs) left other critical issues out.
- He also noted that UHC frames health goal from a global rather than developing country perspective and makes it easier to position health in the context of sustainable development.
- He added that with UHC, its clear how health is a key development pillar, a right, and contributes to growth and development of economies.
- He further noted that UHC requires appropriate strategies, sufficient funding, reduced reliance on direct payment at point of care, improvement in efficiency and availability of quality health services. However all these require strong health systems that also link well with other sectors.

On the UHC from health development partners' perspective, Ms Muraguri from Rockefeller Foundation noted that Rockefeller Foundation does not work in isolation. The Foundation builds on regional and global partnerships and networks, leveraging on resources within countries along with other donor/funding agencies and uses its reputation and capacity to influence movements towards Universal Health Coverage at the local and global levels.

Ms. Mwihaki Muraguri

Ms Muraguri noted that Foundation works towards increasing equitable access to quality health care and improving financial resilience of individuals and communities from health-related shocks through; -

- Policy advocacy that influence the global health agenda towards a focus on UHC
- Supporting key countries in Africa and Asia to increase coverage
- Building regional communities of practice to share and learn from one another some of the best practices for expanding coverage with and access to needed health services.

2.3 Countries experiences and initiatives for improving access and coverage in the context of UHC

The member states shared their experiences through presentations and discussions, see annex 3 for the PowerPoint presentations. Below are some of the issues that arose from the presentations.

Zambia

As part of the government endeavors to increase access and coverage with the health care services a number of interventions guided by national policies and strategies are being implemented. Particular attention is being paid to how best to balance cost, quality, and access in a manner that is both sustainable and consistent with social values and political goals. Box 1 highlights some of these interventions.

Mr. Wesley Mwambazi- Principal Planner, MOH-Zambia

Box 1

- Removal of user fees at Primary Health Care (PHC) level
- Increased government allocation to Health by 300% over the last 5 years
- Construction of 650 Health Posts
- Upgrade and modernization of Hospitals
- Procured 160 Basic Life Support Ambulances, 5 Mini and 42 Advanced Life Support
- Training of more Health Workers (new Medical school & Training Institutions have been built)
- Salaried Community Health Workers (CHW)
- Process underway for instituting Social Health insurance; SHI Bill has been Drafted

Uganda:

Dr. Francis Runumi – Commissioner Planning, MOH-Uganda

Dr. Francis Runumi noted the existence of national policies and strategic plans that capture issues on UHC. He indicated that the as part of efforts to increase access with health care, there has been improvement and increase in health infrastructure, increase in number of health workers in the public sector (over 60% of approved posts filled) but still there is need for improvement in the skill mix and addressing health workers attrition rate from the public sector. He noted that the private sector power has not been fully harnessed, yet it remains a major player in the health sector. He noted the need for health stewards to appreciate where the private sector has comparative advantage and support them in order to optimize health service delivery. On health financing, he noted that the Ministry of Health has faced challenges with its proposed reforms that included introduction of national health insurance scheme. The Ministry has had to go back to the 'drawing board' several times and the Bill is yet to reach parliament. He noted that people are already paying for health, but what is lacking is how they can be supported such that they pay in a manner that is sustainable, equitable and they get quality health services. In relation to this he said there is inadequate support to community groups such as SACCOs' initiated health financial protection approaches. He noted that details of the issues he is discussing were also deliberated upon during a national symposium on UHC that was supported by ECSA Health Community in June 2014 (Report of the national symposium in Uganda is available at http://www.ecsahc.org/downloads/).

Malawi:

Dr. Dominic Nkhoma noted that the issue of sustainability in health care financing had dominated discussions in Malawi in the last many years. This is attributable to questions regarding how to reduce the donor component of health expenditure that remains significantly high. Even with the donor support the health spending per-capita remains low with resultant poor health outcomes such as high infant and maternal mortality. But the government is undertaking a number of initiatives and reforms to ensure a move towards UHC. See box 2.

Box 2

- Setting Up a Health Fund
- Introducing Purchaser/Provider Split, including creating Cost Centres and Hospital Autonomy
- Removal user-fees at targeted CHAM facilities through government subsidies
- Exploring Potential for a National Health Insurance (NHI) Scheme
- Private-Public Partnership (PPP) for some essential services non-core to the MOH
- Introduction National Identification System
- Improving access – Free at point of services health facility within 8km radius
- Focusing on social determinants of Health

Dr. Nkhoma noted some of the threats for accelerated move towards UHC as high population growth; Weak domestic financing of the health system coupled with high donor dependency especially for the HIV and AIDS, Malaria and TB programmes; high disease burden and ; low per capita incomes; poor nutrition, sanitation and education attainment

Zimbabwe:

Mr. Wenceslas Nyamayaro noted that the government of Zimbabwe is commitment to ensuing UHC achievement. He noted that UHC features in national policy documents and access to health service is a right in the 2013 Constitution of the Republic of Zimbabwe. He noted that the Public Health Act is being amended to bring the legal framework that will guide interventions for UHC. The government has undertaken innovative approaches to health financing, for example it introduced

Box 3

- Inadequate public spending on health e.g. no user fee policy that is not accompanied by proportional increase in public funding
- Determinants beyond health e.g. Structural Adjustment Programs, economic crisis, disease outbreaks, other competing sectors
- Limited coverage of health insurance (formal employed only)
- Donor funds largely managed outside the National Budget leading poor implementation coordination and non-alignment with the strategic ambitions of the government

the AIDS Levy Fund that resulted in improvement in HIV/AIDS service delivery. He notes some of the challenges to achieving UHC as outlined in box 3.

Swaziland:

Ms. Zandile Tshabalala noted that the government of the Kingdom of Swaziland continue to put efforts on moving towards UHC. It is targeted that by the year 2022, the all population of the Kingdom will be covered with the needed health services. There are still issues that need to be address in order to achieve that target. Major issues include lack of financial protection measure for all, sustainability of health financing and inefficiency in resources utilization. However she noted the existence of a health financing strategic document that is guiding how to tackle these constraints. The health financing strategic plan provides guidance for effective, equitable and sustainable health care financing mechanisms that will lead to mobilization of adequate resources for health, strengthen financial risk protection measures for all Swazi nationals especially for the poor and vulnerable and enhance efficiency in resource allocation and use.

Lesotho:

Dr. Piet McPherson noted that the Ministry of Health is undertaking measure to ensure universal health access. There is a program for hard to reach areas to ensure that all the population is able to access health services. The package for hard to reach areas include:-

- Improved accommodation for health workers (fully furnished, electricity, piped water)
- Monthly allowance
- Free mobile phone with airtime allowance
- Rotation after three years of continuous service

Performance based financing and use of mobile technology for health is also being used to enhance services delivery.

Kenya:

Mr. Elkana N. Ong'uti highlighted a number of interventions that the government has undertaken to improve access to and coverage with the needed health services such as;-

- Free maternity services in all public health facilities
- Free primary healthcare in all public primary healthcare facilities and waivers and exemptions in public hospitals
- Equipping major public hospitals
- Health insurance subsidies through NHIF

However there are challenges that still needs to be tackled including:-

- High direct Out of Pocket Expenditure
- Inefficiencies in allocation and utilization

- High external resource contribution
- Limited insurance/pre-payment, less than a quarter of the population is covered by pre-payment schemes

2.4 The role of National and Private Health Insurance Funds (schemes) in the achievement of UHC

The presentation by National Health Insurance Fund (NHIF) Tanzania highlighted the historical background to its establishment, progress in terms of health financing and increasing health coverage and some of the challenges. Mr Raphael Timothy Mwamoto, (Director Operations at NHIF) noted that there are two main health insurance schemes; the NHIF and the Community Health Fund (CHF) both established by Acts of Parliament but all are currently managed by the NHIF.

The NHIF and CHF provide health cover to 22.57% of the Tanzania 44.9 million people. Service providers include both public and private health care providers. NHIF also support infrastructure improvement of health facilitates through grants.

Some of the challenges noted include:

- Despite reduction in OOP from 47% after introduction of the schemes, it still remains high at 32.06%
- Coverage is voluntary making expansion difficult
- Access to quality health service provision especially in the rural area due to health system constraints
- Limited cross-subsidization between the two schemes
- Weak information system

The government of Tanzania is taking steps to address these challenges in the context of UHC. These include among others; -

- Development of a National health financing strategy that will lead to sustainable universal coverage health financing;
- Constructing medical centers of excellence;
- Utilization of e-technology for example health facilities being able to submit their claims on-line to the Fund;
- Undertaking a wide national awareness campaign on the importance of health for all and the need for pre-payment.
- Review of Health Insurance Regulatory framework

The presenter noted that national health insurance should be customized and localized using concept that are home grown. He added that problems might look similar but solutions should be derived using ideas from that country. He also emphasized that for the sake of solidarity and leading by examples, policy makers should consider being members and beneficiaries of these schemes.

Mr. Shadrack Owando gave a background to the establishments of the National Hospital Insurance Fund (NhIF) Kenya. He highlighted some of the strategic milestones reached by NhIF as increase in coverage with health care; internal restructuring to give NhIF a competitive advantage; Computerization and Decentralization of management of NhIF activities. He noted that despite the commitment to universal coverage, in practice effective access to healthcare and outcomes will depend strongly on economic and social conditions that is prevailing in the country. The population covered by NhIF is still less than 20% due to a number of constraints. But processes are being put in place so these are addressed. These include: - proposal to amend the NHIF Act 1998 in light of the current socioeconomic situation; aggressive marketing campaign and; enhancing strategic partnership

L-R: Profs Omaswa of ACHEST and Dambisya -DG ECSA and WHO CR-Dr Alemu and Dr Runumi –MoH Uganda sharing ideas on UHC during the meeting

Mr. Isaac Nzyoka, the General Manager UAP, a private health insurance provider in the region noted that the private sector players are not adequately involved in health sector processes in the region. He was happy that ECSA Health Community Secretariat has invited the private sector to be part of the UHC agenda in the region. He noted that as a commercial entity their interest will be driven by profit but there are roles they can play in the UHC agenda. He also observed that the private sector players look at existing opportunities and gaps and try to fill the gap. For example he noted that in Kenya, NhIF covers approximately 10% of the population with health insurance and other health insurance schemes cover perhaps less than 1%. Therefore there are about 30 million people in Kenya not covered and this present a business opportunity for the private sector. Mr. Nzyoka noted that UAP is conceptualizing how to have low cost premiums, that does not drive them out of business but can be afforded by many people. In this way they will be contributing to the objectives of UHC.

Axel Pellegrin, the Secretary General, Insurers' Association of Mauritius presented memo on the '*role of insurance industry in health care cover in Mauritius*'. He noted that even though the government ensure every citizen can access health services there is a role for the private sector. He gave example of how the government in working with the private health insurers, noting that once a household is benefiting from private health insurance through

government subsidy then they do not benefit form the public health services and this help to decongest public health facilities.

2.5 Panel Discussion – Perspectives from different actors; is UHC it everybody's concern?

The Panel discussion chaired by the Executive Director of ACHEST Prof. Francis Omaswa. The Panellist included Dr Stephen Assimwe of Integrated Community Based Initiative (ICOBI) representing the community health insurance organizations, Mr. Wesley Mwambazi from Ministry of Health Zambia planning unit, Mr. Vela Moyo from Zimbabwe Ministry of Finance and Economic Development (MFED), Mr Maziko Matemba from Malawi representing the Civil Society Organizations (CSOs)

Issues arising from the panel discussion included:

- Health sector stewards needs to build a case for health as an investment undertaking and should not assume the Ministry of Finance will just understand their situation. Resources will always be short thus a need for a clear prioritized need as a sector. The strategic and annual health sector work plans need to be costed.
- There is need for explicit involvement of CSO in the countries in the UHC agenda as they are best placed to undertake advocacy. But they should move away form the strategy on '*name and same*' to '*inform and inspire*'.
- WHO Country Offices was requested to enhance the level of support at the country level and should also support the CSOs in the countries so that they are more effective when they advocate for UHC.
- The level of support for community health insurance schemes was noted to be low across the member states, yet that are also contributing to UHC agenda and cold perhaps do better if they are well supported.
- Sharing of experiences at international level was also encouraged.

L-R: Dr. Stephen Assimwe (ICOBI), Mr Maziko Matemba (CSO-Malawi), Prof. Omaswa (ACHEST), Mr. Wesley Mwambazi (MOH-Zambia), Mr. Vela Moyo (MFED-Zimbabwe)

2.6 Key issues from the presentations and discussions

A number of issues arose from the two days deliberations and below is a summary of some of these issues.

Development and implementation of polices and programs needed for measurable move towards UHC requires ownership and/or explicit support by ***high level political*** leaders in the country. This will ensure national policies for all sectors are healthy public policies (health incorporated in all policies) and initiatives by the health stewards (Ministries of Health) to achieve UHC are fully supported.

It was also noted that ***communities*** most times have ***initiatives for social protections*** but more often than not, there is lack or limited support for these initiative by the health sector stewards. Examples were given of Savings And Credit Co-operatives (SACCOs) and other community groups that are not well-guided, for example through creating awareness that part of their savings can be used to provide financial protection for health for themselves. This was informed by the discussions that people are already paying for health, but through out-of-pocket at the point of care, which is generally discouraged due to its association with impoverishment, catastrophic spending and limiting health service access.

Addressing ***social determinant*** will be instrumental in achieving UHC in ECSA Health Community. This is because there will be reduced occurrence of diseases, that usually costs more to treat. Therefore addressing social determinant on health will result in cost savings in the long run and thus more people can be covered and depth of service coverage will increased using the freed up resources.

Inter-sectoral collaboration was identified as necessary for achievement of UHC because health sector alone is not in position to provide all the necessary ingredients for UHC. However it was also noted that there are certain activities that are implemented by the Ministries of Health that should ideally be led/implemented by other Ministries who have comparative advantages in undertaking them. Examples were given of construction of hospitals that could be better done by Ministries in-charge of Engineering/Infrastructure so that the Ministries of Health concentrate on their core mandates but just guide on the specification in light of the services to be provided in the infrastructure. The need to bring all stakeholders was noted as important in UHC. The Private Sector and CSOs need to be meaningfully engaged at all levels and stages in the move towards UHC.

It was noted that achieving UHC requires adequate resources. On the ***financial resources***, it was highlighted the differences in health system financing amongst ECSA member countries

which are generally dictated upon by specific political, economic and social context of each country. However it was clear that countries are using ***multiple approaches*** for mobilizing financial resources. For example, in most ECSA Member states public health spending is generally from ***government budgetary allocations***. Some member states are complementing this using the approach of National Health Insurance Schemes (NHIS) while others are in the process of developing such mechanisms. But even in countries implementing NHIS, still coverage is limited with only about 20% of the population covered in Tanzania as the highest amongst member states implementing NHIS. From the countries' experiences, public spending constitute only somewhere between 30-60% of total health spending and the rest of the spending are by individual households through out-of-pocket (OOP) at the point of care. The meeting agreed that this mechanism (OOP) of health spending should be reduced in line with WHO recommendation to countries that prepayment mechanisms in financing of health care are a better approach. The type of pre-payment mechanisms adopted whether tax-based, social health insurance and any other should be able to generate adequate resources to provide an agreed health benefit package to the all population irrespective of the income level of the member state.

On health benefit package, it was noted that most member states have ***essential health package*** defined according to the health system organization of each country. The challenge noted with most existing essential health packages in a number of member states is that they are too comprehensive and more often than not the budgetary allocation is inadequate to provide it. The experiences shared indicated that it is difficult for the beneficiaries (citizens) to get legal redress in case these packages are not provided. This is because the government may not have all the finances to provide it during certain periods as the budgetary allocation depends on the economic performance of the country and the priority of the government given the myriads of other services that governments also need to provide to their citizens. It was also noted that the lack of ***purchaser-provider*** split make efficiency saving difficult. Governments through Ministries of Health are usually the providers as well as the purchasers of health services. This interferes with monitoring and improvement in efficiency in the provision of health care. Therefore, proposals that member states looks at mechanisms to have provider-purchaser spit were made, with the government being the purchaser. Even where the services are currently provided government can adopt/adapt pseudo-market approaches and performance measured. In addition, there is need to ***re-define the essential health packages*** with the aim to have specific benefit package ***(depth of service coverage)*** to be provided to the all population ***(population coverage)*** by the service providers at all time without people paying for them at the point of care ***(financial protection).*** It was also noted that these changes, which are to be guided by the UHC principles, are likely to require ***review of national health and other related***

policies and strategic approaches in a number of ECSA member countries. The meeting also noted the role of private health insurers (commercial and community based health insurance) in the extension of health coverage to the population.

The Ministries of Health officials from almost all the member states noted the indifference by the Ministries of Finance in allocating ***adequate resources*** for health even though the governments are signatory to commitments such as the Abuja Declaration that urged countries to ensure 15% of the total government spending are on health. Ministries of Finance official noted that health stewards take it for granted that more monies should be allocated to health, oblivious of the pressures the Ministries of Finance face. For example without peace and security, can health services be provided? How do you pay health workers more than the persons involved in the production of the health workers? These are some of the tough questions posed by various quarters to the Ministries of Finance. In addition, it was noted that usually there is no explicit explanation of what level of outputs where got from the previous 'dollars' given the heath stewards. Therefore, the health stewards needs to ***prioritize*** their requests, have a ***costed essential health package,*** justify the need for more money in comparison to the other sectors, engage other sectors and present ***health as an investment case*** when soliciting for resources from the Ministry of Finance and other potential funders. Health investments also need to be ***smart investments***. The member states should for example explore the idea of having ***regional training centers of excellence so that each country does not have to make investments with huge capital outlays, yet it can train its personnel in certain areas from another member state at a lower cost.***

The challenge of inadequate human resources for health continue be faced by the member states and this is due to various reasons such as inadequate production, low absorptive capacity by governments of trained health workers into service, emigration, change in professions to other non-health areas with better opportunities and rewards, weak leadership and HRH planning, etc. These need to be addressed if we are to achieve UHC. Suggestions for countries to develop and implement ***innovative HRH management and retention approaches*** were made. For example Malawi has had program of fast-tracking promotion of certain health cadres, other countries facilitate the acquisition of vehicles and other personal properties for health workers, etc. as ways of retaining and motivating health workers.

A move towards UHC will also require very strong stewardship function of health systems. A strong ***governance and leadership*** by the Ministries of Health to rally all actors to support UHC achievement is necessary. WHO country offices were requested to support Ministries

of Health of ECSA member countries on the UHC agenda so that it remains high on the national political agenda. There is need to established national structures for UHC in the member states, this will also require that Ministries of Health engage with **high political offices** so that they are at the forefront on issues of UHC. The UHC structures at national level were seen as being instrumental for UHC advocacy, reviews of national policies to ensure they are healthy public polices and are in line with UHC principles and, ensure the necessary resources are mobilized to fund UHC initiatives.

Sharing of experiences and best practices at regional and international level will remain key for countries to learn from their peers and adopt/adapt best practices in their countries. Therefore, there is need for ECSA Health Community Secretariat to put in mechanisms that facilitate sharing of experiences in the region.

3.0 Meeting outcomes

The objectives of the meeting were to share country level experiences; get global and national perspectives on UHC from a cross-section of actors including WHO, health development partners, CSOs and the Private Sector and; increase awareness about UHC amongst non-health sector actors. These were generally achieved through presentations and discussions during the two days meeting.

The meeting was also meant to make policy recommendations for consideration by 60th ECSA Health Ministers' Conference; so that they can pass resolutions to guide the ECSA Health Community on issues relating to achievement of UHC. The meeting recommended to Health Ministers' Conference: -

a. To urge Member States to:

i. Set up multi-sectoral UHC structures such as national dialogue platform on UHC, which are spearheaded by high-level political offices.
ii. Develop policies and regulatory frameworks, which promote the participation of all stakeholders including the private sector and CSOs.
iii. Develop a roadmap for implementation of UHC.
iv. Build the case for investment in health which will ensure access to health care for all
v. Put deliberate efforts to support community initiatives including facilitating approaches that the communities have established to enable them access health services while being financially protected.
vi. In a consultative process review current essential health package with a view to re-define a realistic benefit package that is costed to facilitate advocacy and implementation of UHC and,

b. To direct the ECSA Health Community Secretariat to:

i. Support member states in the implementation of these resolutions
ii. Track, document and disseminate best practices on UHC
iii. Annually report on the progress of UHC to HMC
iv. Establish an expert committee on UHC

4.0 Closing remarks

The closing remarks were made by Prof Yoswa Damisya, the Director General (DG) of ECSA Health Community Secretariat and Dr Benjamin Nganda of WHO Inter-country Support Team for Eastern and Southern Africa. The DG thanked the participants for the open and transparent deliberations on issues that pertain to UHC in the region. He committed that the Secretariat will continue to support the member states on UHC initiatives and will engage with other partners in this endeavour. He noted that an Experts Committee on UHC in the region will be instrumental in providing technical guidance to the member states and to the Secretariat. On his part Dr. Nganda thanked ECSA Health Community Secretariat for spearheading issues of UHC in the region. He noted that WHO is at the forefront in engaging global partners so that UHC remain a key goal in the post-2015 development agenda.

Appendices

Appendix 1: List of meeting participants

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	Mr. Julius Ley Accountant
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Appendix 2: Meeting Programme

PROGRAM FOR THE REGIONAL MEETING ON UNIVERSAL HEALTH COVERAGE
14th and 15th FEBRUARY 2015, UGANDA

THEME: Universal Health Coverage
"Where are we & where are we are headed?"

VENUE: **Speke Resort, Munyonyo-Kampala Uganda**

DAY 1

Time	Activity	Session Chair
08:30 – 09:00	ARRIVAL / REGISTRATION	MOH-Uganda/ECSA
09:00 – 09:30	**Opening and Welcome remarks** DG ECSA Health Community Rockefeller Foundation WHO CR Official Opening by Hon. Minister of Health	PS- MOH-Uganda
09:30 – 9.50	**Overview of the Meeting** ○ Meeting Objectives ○ Overview of UHC & Current Regional perspective in ECSA Region- ***ECSA***	MOH-Uganda
09.50 - 10.50	**Universal Health Coverage- Global Perspective** ○ The position of UHC in the post-2015 development agenda: **Dr Benjamin M. Nganda-WHO/IST Eastern and Southern Africa** ○ The Role of development partners in supporting ECSA-HC member states in achieving UHC: **Dr. Mwihaki Muraguri-*Rockefeller Foundation***	MOH-Uganda
10.50-11.20	**HEALTH BREAK**	All
11:20 -13:15	**Countries experiences/initiatives for improving access and coverage in the context of UHC -*Ministries of Health*** ○ Zambia *(Mr. Mwambazi/ Dr Kayunga)* ○ Uganda *(Dr Francis Runumi)* ○ Malawi *(Dr Nkhoma/ Dr Ndindi)* ○ Zimbabwe *(Dr. Nyamayaro)* ○ Swaziland *(Ms. Tshabalala-Madlopha)* ○ Lesotho *(Dr. Mc Pherson/Mrs. Thoothe)* ***Discussion***	MOH-Mauritius
13:15-14.15	**HEALTH BREAK**	All
16:00-16:15	Day 1 closure-***ECSA***	

DAY 2

Time	Activity	Session Chair
08:00 -08:30	○ ARRIVAL / REGISTRATION	**MOH-Uganda/ECSA**
8:30-9:15	Recap and Draft Recommendations from day 1 proceeding	*ECSA*
09:15 – 10.15	**The role of National and Private Health Insurance Funds (schemes) in the achievement of UHC** ○ NHIF experience in increasing access and converge with health care: **Mr. Michael C. Mhando-*The NHIF-Tanzania*** ○ NHIF experience in increasing access and converge with health care: **Mr. Shadrack Owando, *The NHIF-Kenya*** ○ Private Health Insurance; breadth and depth of coverage- Kenya and Mauritius experience- **Mr Isaac Nzyoka**, *UAP-Kenya* and **Mr. Axel Pellegrin, *Private Insurers Ass. -Mauritius*** ○ Discussion	**MOH-Zimbabwe**
10:15-10.30	**HEALTH BREAK**	All
15:30-16:00	**Health Insurance Regulation in the ECSA-HC region** ○ Perspective form the National Insurance Regulatory Authorities- ***Tanzania IRA*** ○ ***Discussion***	**MOH-Zimbabwe**
09:15-11:15	**Panel Discussion – Perspectives from different actors; UHC is it everybody's concern?** ○ UHC principles; consideration in the planning process; **Mr. Wesley Mwabazi-*MOH-Zambia*** ○ The cost of UHC, Ministry of Finance perspective; **Mr. Vela Moyo *Ministry of Finance & Economic Dev't -Zimbabwe*** ○ The role of community health insurance schemes in UHC- **Dr Stephen Asiimwe *ICOBI*** ○ Role of CSO in the UHC agenda- **Mr. Matemba-*Malawi***	**Chair: ACHEST**
11:15 – 11:30	**HEALTH BREAK**	All
11.30-12.15	○ Key Issues and Recommendations for consideration by Health Ministers Conference - ***ECSA***	Lesotho
12:15 –12.15	**CLOSING CEREMONY**	All
	○ Closing Remarks from Representative Health Partners ○ Closing Remarks from Director General ECSA-Health Community	