UNIVERSAL HEALTH COVERAGE IN FRAGILE STATES

A RADICAL RETHINK OF THE POLITICAL ECONOMY OF HEALTH
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Universal Health Coverage (UHC) is rapidly taking the stage as the ‘new’ sustainable development agenda for global health. It is supposed to succeed the UN Millennium Development Goals (MDGs) for health after 2015. Despite skepticism in certain corners and the fear that this post-2015 agenda will be little more than the global development industry resetting its rhetoric while continuing in the old footsteps, Cordaid considers UHC an opportunity to move beyond business as usual.

Cordaid commissioned this qualitative study to explore the potential of the UHC agenda in particular in the challenging environments of post-conflict countries or countries in transition; and focuses especially on the role of civil-society organizations (CSOs). The study comprises a literature survey and 77 interviews with a rich variety of key stakeholders in health and social policy circles in four countries: Afghanistan, Burundi, Rwanda and Zimbabwe. From the study, an exciting picture emerges of UHC being ‘a debate at a global crossroads’. UHC has this potential not only because it ties in with the UN policy debates, but more importantly because it calls for a deeper transformation in which the battle for gaining domestic control and working towards sustainability is particularly fierce. This appears to be more conspicuous in the context of the states studied here.

Cordaid is convinced that focusing policies on UHC has the potential to make a significant difference.

On the surface, many old concerns and agendas seem to be reiterated, such as ‘Health for All’ or earlier policies surrounding the MDGs. But for anyone taking a sharper look at the way in which the UHC debate currently takes shape in the health policy arenas of the countries we have examined, it is manifest that a new pride and transformative potential are emerging in which civil society can adopt new constructive roles. Cordaid is convinced that focusing policies on UHC has the potential to make a significant difference.

In the four countries in this study, UHC as it emerges as a policy agenda has found specific local resonance and translation and has clearly stimulated:

- A keener awareness of the crucial importance of political will.
- A deeper interest and pride in local ownership and context.
- A stronger drive towards more comprehensive approaches to domestic health financing and innovative forms of service delivery.
- A sharper focus on equitable and sustainable tax contributions.
- An acute call for turning to public health with vigour.
- A more focused appeal to see health as a human right.
- A greater awareness that local governance and accountability mechanisms must be improved.
- A more acute sense that community involvement, devolution and sharing of power are key to ownership and sustainability.

Cordaid is committed to align its efforts with the emerging local actions and with the novel ways of community and civil-society engagement.

This set of tendencies is transforming UHC from a merely technical program into a fundamentally political-economic one, affecting basic relationships in healthcare and potentially heralding a new health and development paradigm. For this, however, concerted efforts are needed. As a result of the many dialogues and discussions which took place during the production of this report, Cordaid as an international civil-society organization is committed to align its efforts for 2014-2020 strongly with the emerging local actions to take political ownership, strengthen good governance, design and implement integrated health financing and service delivery, and with the novel ways of community and civil-society engagement necessary to make such improvements stick.
Cordaid wishes to acknowledge the research team: the country consultants: Dr. Said Shamsul Islam and Dr. Ismail Hassanzai-Afghanistan; Dr. Longin Gashubije – Burundi; Dr. Laetitia Nyirazinyoye – Rwanda and Dr Sue Laver – Zimbabwe, Dr. Sven Neelsen (literature survey), Dr. Godelieve van Heteren (team coordinator), Marloes Huiskes, Frank van de Looij, Hilda van ‘t Riet, Jennie van de Weerd and Izabella Toth for their contributions. We are grateful to all the respondents who have contributed their time and expertise to this study.

We wish to thank John O’Kane and Hilde Bakker for their assistance in editing earlier drafts of the text.

We wish to express our special appreciation to Dr. Husnia Sadat and Dr. Salehi of the MoPH of Afghanistan; in Burundi to the Honorable Minister of Public Health and the Fight against AIDS of Burundi, Dr. Sabine Ntakarutimana, for facilitating the conduct of the study; the Honorable Senator Professor Samuel Ndayiragije, President of the Permanent Commission for Social, Youth and Culture, for facilitating various contacts; Professor Athanase Ndikumako, Vice-President of the Permanent Commission for Social Affairs, Youth and Culture for encouraging this study and for agreeing to answer our questions; and Mr. Venant Kagimbi, for his participation in data collection; in Rwanda: the Honorable Minister, Dr. Agnes Binagwaho, Minister of Health, to Mr. Pascal Bilindabagabo, co-investigator who facilitated contacts with key stakeholders and authorization from various institutions; Mrs. Aurelie Mutamuliza and Dr. Angele Musabyimana, research assistants from the National University of Rwanda who assisted in data collection and interview summaries, Prof. Jean Baptise Kakoma, and Dr. Jeanine Condo, Vice-Dean in charge of Research and consultancies who granted admission to a one-day workshop on UHC in Kigali, and subsequently allowed collaboration; and in Zimbabwe: to the Honorable Minister of Health and Child Welfare and the Permanent Secretary (PS) at the Ministry of Health and Child Welfare (which since has been renamed the Ministry of Health and Child Care (MoHCC)), who granted us permission to carry out the interviews.

This report is the result of an enthusiastic, collective effort, and constitutes the kind of collaboration Cordaid embraces and wishes to continue to support.
## Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>APGAR</td>
<td>A quick test performed on a baby at 1 and 5 minutes after birth.</td>
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<tr>
<td>BIF</td>
<td>Burundi Franc</td>
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<tr>
<td>BPHS</td>
<td>Basic Package of Health Services (Afghanistan)</td>
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<tr>
<td>CAM</td>
<td>Carte d'Assurance-Maladie</td>
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<tr>
<td>CBHI</td>
<td>Community-Based Health Insurance</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>CPIA</td>
<td>Country Policy and Institutional Assessment</td>
</tr>
<tr>
<td>CR</td>
<td>Contributory Regime (Colombia)</td>
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<tr>
<td>CSO</td>
<td>Civil-society organization</td>
</tr>
<tr>
<td>CTN</td>
<td>Cellule Technique Nationale (national PBF technical unit Burundi)</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>DMO</td>
<td>District Medical Office/Officer</td>
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<tr>
<td>DWMH</td>
<td>District Wide Mutual Health Insurance</td>
</tr>
<tr>
<td>EPMS</td>
<td>Essential Package of Hospital Services (Afghanistan)</td>
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<tr>
<td>G7+</td>
<td>Voluntary association of countries which are or have been affected by conflict and are now in transition to the next stage of development. Their main objectives are to share experiences, learn from one another, and advocate for reforms</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus infection / acquired immunodeficiency syndrome</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HTF</td>
<td>Health Transition Fund (Zimbabwe)</td>
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<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
</tr>
<tr>
<td>IRAI</td>
<td>International Development Assistance Resource Allocation Index</td>
</tr>
<tr>
<td>LMIC</td>
<td>Low and middle-income countries</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MoF</td>
<td>Ministry of Finance</td>
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<tr>
<td>MoHCW</td>
<td>Ministry of Health and Child Welfare (now: Ministry of Health and Child Care)</td>
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<tr>
<td>MoPH</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>MSPLS</td>
<td>Le Ministère de la Santé Publique et de la lutte contre le SIDA (Burundi)</td>
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<tr>
<td>NCD</td>
<td>Non-communicable disease</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>NHA</td>
<td>National Health Account</td>
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<tr>
<td>NHIS</td>
<td>National Health Insurance System</td>
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<tr>
<td>OOP</td>
<td>Out-of-pocket</td>
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<tr>
<td>OPD</td>
<td>Out-patient department</td>
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<tr>
<td>PBC</td>
<td>Performance-Based Contracting</td>
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<tr>
<td>PBF</td>
<td>Performance-Based Financing</td>
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<tr>
<td>PEPFAR</td>
<td>The U.S. President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PHC</td>
<td>Primary Healthcare</td>
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<tr>
<td>PNDS</td>
<td>Plan National de Développement Sanitaire</td>
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<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
</tr>
<tr>
<td>RBB</td>
<td>Results-Based Budgeting</td>
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<tr>
<td>RBF</td>
<td>Results-Based Financing</td>
</tr>
<tr>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<tr>
<td>SEHAT</td>
<td>System Enhancement for Action in Transition (Afghanistan)</td>
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<tr>
<td>SKY</td>
<td>Sokapheap Krousat Yeugn (large micro-insurance scheme Cambodia)</td>
</tr>
<tr>
<td>SR</td>
<td>Subsidized Regime (Colombia)</td>
</tr>
<tr>
<td>SSR</td>
<td>Semi-Subsidized Regime (Colombia)</td>
</tr>
<tr>
<td>TARSC</td>
<td>Training and Research Support Centre (Zimbabwe)</td>
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<tr>
<td>TG</td>
<td>Target Group</td>
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<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
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<tr>
<td>USAID</td>
<td>U.S. Agency for International Development</td>
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<tr>
<td>VAT</td>
<td>Value Added Tax</td>
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<td>WHO</td>
<td>World Health Organization</td>
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EXECUTIVE SUMMARY

Universal Health Coverage: definition and research

Universal Health Coverage (UHC) is widely emerging in debates in global health policy circles. WHO defines UHC as: ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. This definition points to the central dimensions of health coverage: Who is covered? Which services are covered? And how much financial protection do people have? The definition refers to the demand and the supply side of health systems – and it triggers debates and requires choices around equity, solidarity and good governance.

Until recently, many of the UHC debates addressed health coverage in middle-income countries and emerging economies. How the debates play out in fragile and transitional states is largely unknown. Therefore, Cordaid commissioned this qualitative study into perceived feasibility of pathways to UHC in fragile and transitional states. The aim of this study is to contribute to the global conversation on sustainable improvements in health, including attention for Universal Health Coverage as part of the global Sustainable Development Goals after 2015.

Cordaid supports more inclusive approaches in development, which for this research translated into a special focus on the role of civil society organisations (CSOs) in working towards UHC. This also influenced the research methods, as a substantial part of the research was an active, in-depth engagement with a wide array of people in Afghanistan, Burundi, Rwanda and Zimbabwe. A set of four research questions was leading throughout:

1. Stakeholder awareness: How do stakeholders understand the current UHC agenda and is UHC anything new for stakeholders in health in fragile and transitional states?
2. Specific pathways: Can we obtain a sharper understanding of the particular challenges and requirements for any pathways to UHC in fragile and transitional states?
3. Peace and state building: Is there evidence that UHC contributes to peace and state building?
4. Civil-society organizations: What should be their roles with respect to UHC?

The research consists of two main parts: a literature survey and an interview-based study. In the survey special attention was given to four countries that are known for their progress, in varying degrees, on the road to UHC: Thailand, Colombia, Ghana and Rwanda. In the interview-based study, a total of 77
interviews were conducted with 79 key figures from the health field in four countries that can either be considered fragile or transitional: Afghanistan, Burundi, Rwanda and Zimbabwe. The respondents came from ministries of Health and Finance, from local health policy, patients/consumer organisations, health insurance providers, implementers, academics, NGOs (including donors), MPs, policy advisors and policy/professional bodies.

**Literature survey**

The literature survey, in chapter 3, first analysed the globally accepted WHO conceptual framework as depicted in the WHO ‘UHC Cube’. This framework describes the three dimensions of UHC predominantly found in the literature: who is covered; which services are covered; which proportion of the costs is covered (financial protection). In this research, a twin indicator approach – where one looks at financial protection in combination with healthcare utilization - is used.

Looking at the four countries selected for the literature survey, both Thailand and Colombia are considered to have made major progress towards UHC in recent years, while Ghana and Rwanda are viewed as countries on the way to UHC. Thailand and Colombia show that the route towards achieving UHC can be very different, depending on local historical, socio-economic, institutional and political contexts. Policies can be tax-based or rely heavily on the private sectors; health care can be provided for free or through premium-based schemes. Pre-existing functioning structures and a healthy economy help to reach goals. Challenges that remain are: inequity in access and coverage; heterogeneity of benefit packages, financial sustainability and quality of care. Ghana and Rwanda made some progress, mainly in improving care access and financial protection. However, there are major challenges in areas similar to those in Thailand and Colombia: inequity, financial sustainability and quality of care. And in Ghana and Rwanda, inefficiencies in management and administration are added to these.

“**We can arrive at universal health coverage but it will demand a plurality of financial means, a lot of energy, strong will and technical skills, without forgetting to sensitize the population.**”

**Respondent, Burundi**

The literature survey then addressed the question of achieving UHC in fragile states. In this research, fragile states are defined by using the World Bank IRAI threshold. There are notable similarities and differences between the fragile states and the UHC achievers, but not all related to health financing. Fragile states face a lower life expectancy, a higher incidence of mental disorders and morbidity and mortality patterns differ substantially - some related to recent or ongoing armed conflict and subsequent breakdown of health services. The failure to provide health services is often also linked to the failure to raise sufficient funding. Health insurance in the form of premium-based schemes is uncommon in fragile states, due to incapacity in required management and administration. Government commitment to and spending on health is generally lower than in progressing or UHC states; donors often step in.

Three strategies are mentioned for moving towards UHC; these were reviewed in their applicability to fragile and transitional states. Firstly, there is (selective) free health care, the removal of user fees and specific targeting of the poor. Unfortunately, the effects of this strategy are not straightforward until now. Secondly, there are contributory schemes, both insurance premiums and taxes. This will be difficult to realize on a large scale in fragile states, as it requires extensive administrative and regulatory capacities and sustained political commitment. Lastly, there is deepening coverage: through results- and performance-based financing. This could, tentatively, provide valuable instruments to increase healthcare utilization and improve care quality in fragile states, but more research is needed.

Regarding the relationship between fragile states, health and statebuilding, more research is needed as well. However, four ways can be distinguished in which healthcare systems could relate to nation-building and stabilization: promoting social cohesion; restoring accountability and strengthening the social contract; restoring trust; and strengthening government capacity.

Chapter 4 presents the health policy situation of the four fragile or transitional countries selected for the interview part of the research.

**Afghanistan:** Since 2000, Afghanistan has deployed several policies on health financing and sustainability. In practice, the general population still pays 76% of the total health expenditure through out-of-pocket payments, despite user-fee exemptions. The further 24% is public healthcare funding, of which international donors provide 75% (and much of its healthcare provisions). Afghanistan offers two packages of healthcare, a basic package of health services (BPHS) and an essential package of hospital services (EPHS), but equity, access and financial protection remain problematic. Over the last years, the government is trying to develop a more diversified domestic financing mix, also to counteract the looming withdrawal of donors.

“(UHC IS) the government’s legal task, since access to health services is a human right, a basic right of people, as stipulated in the Constitution.”

**Respondent, Afghanistan**

**Burundi:** In Burundi contracting and Performance-Based Financing (PBF) are national policies for the health sector since 2010. At the same time, free healthcare was introduced and integrated with the PBF strategy. In 2012 the insurance scheme Carte d’Assurance-Maladie (CAM) was re-introduced. The combination of these strategies causes strains on the system. A government-led technical support unit, the CTN, has been a pivotal strategic asset in coordinating and integrating health financing and service delivery. Improvements in the utilization
and quality of health services, as well as in community participation and data management, have been realised. However, sustainability remains a challenge.

**Rwanda:** Over the last ten years, Rwanda has worked steadily towards introducing a health financing mix of PBF- and insurance schemes and the community-based health insurance (CBHI) programs known as Mutuelles. PBF has shown a positive impact on quality of health services. The various insurance schemes have shown gradual increase of financial coverage. The ultimate aim of the Rwandan government is to have a functional obligatory health insurance scheme for all citizens, using the CBHI as vehicle. At the moment, CBHI only offers access to public health facilities and their packages of health services, which differ per level of the health system. Concurrently, a system for the poor has been designed, Ubudehe, through which the poorest people are exempt from paying CBHI premiums. Challenges are mainly connected to financial management and the design of the PBF schemes.

**“We need to understand the needs of the villages; they need to contribute; they need to be informed in the best way.”**

*Respondent, Rwanda*

**Zimbabwe:** Due to the economic situation in the country, the Zimbabwean health system has come under strain. Private parties now account for most of the health financing, as the government's contribution declined to 18% in 2010. The official free health service is not free in practice, as 'community levies' can be charged, and many people refrain from seeking health care. In 2011 a World Bank-sponsored RBF program was piloted mainly targeting maternal and child health. This proved successful and the government subsequently introduced similar RBF interventions more widely. As a result, the HMIS has improved, accountability has increased and financing at various levels of the health system has been structured. Challenges remain in equity, management and in widening these services to attain a broader UHC. The government is showing increasing commitment and wants to tackle current issues, such as sustainable funding and financial harmonisation, equity, financial protection and access.

**Voices from the field**

The findings from the interviews are reflected in chapter 5. These findings are presented in a rich form, with many direct quotes to capture the detail, nuance and variety of opinions, knowledge and experiences of the respondents. The chapter shows that not all respondents were familiar with the term UHC as such, especially in Afghanistan, where some “heard the word UHC for the first time during the interviews”. Most however, did recognize debates and policies that fitted in with the UHC discourse, even though these were sometimes limited to government circles and “there has not been a significant trickle down of this agenda to other levels yet”. Only in Rwanda the term was widely known and used. The link with the ‘older’ agendas of Primary Health Care, Health for All and achieving MDGs was drawn and UHC was often perceived as the next phase in an ongoing global health agenda. However, added values of UHC were also identified: “three aspects are important: quality of services, equity of services and social financial protection.” Increased community involvement was also more often mentioned. Respondents of all countries agreed that for UHC to succeed it takes political will, better governance and leadership as well as long-term commitment. They see this reflected in the roles their governments take. In addition, most felt that donors should take a back seat in this process, while aligning their funds and policies with those of the national government. Generally, the dependency on donor funding was seen as untenable and undesirable and therefore the need to raise domestic funding was stressed by all. On how domestic funding should and could best be increased, experiences and opinions differed, but taxes and premiums featured often. Despite the fact that government commitment was considered essential, there was considerable anxiety about the current weakness of most governments at this stage.

Respondents mentioned UHC-like policies and structures that were already in place in their countries, and those that were needed. These varied in shape and effect, from Performance- or Results-Based Financing, to basic packages, free healthcare and health insurances. Some expressed they had “come to realize that UHC is not merely about health financing but even more about offering the services which people need”. Local contexts were seen to be determining. Many felt their current policies were fine, but “the problem lies in its implementation”. Coverage was considered a problem, as well as access to services especially in remote or unsafe areas; and user fee removal was perceived to be unsustainable. Countries were searching for a balance between reducing out-of-pocket payments and increasing community participation in payment for health care through various ways.

Besides financial sustainability, coverage and quality of care, other major issues were identified, such as equity, limited understanding of health insurance by many people, human resources in health, management of health systems and sustainability of insurance schemes. Except for Rwanda, most respondents believed the input of Parliament could be improved: “Parliament should be involved in policy formulation regarding UHC from the very beginning.”

**“Donors must be partners in this process and commit to priorities and stop coming up with non-priority ideas and parallel structures.”**

*Respondent, Zimbabwe*

Equity being at the heart of UHC is picked up in all countries. Mechanisms to improve coverage for the poor and marginalized are being implemented, but are not always greatly successful in practice. In Afghanistan, Rwanda and Zimbabwe respondents argue that health is actually a human right, which is embedded in the constitution. The UHC debate provides renewed emphasis to this: UHC is “the government’s legal task, since access to health services is a human right, a basic right of people, as stipulated in the Constitution”.
Communities should be involved much more, since “the real novelty in UHC is that it requires working much closer at community level.” Community involvement is key in providing the right services: “we need to understand the needs of the villages” and “there are currently health facilities which are underutilized… Community participation is very important for understanding the nature of this problem and for enhancing utilization of health services”. Furthermore, because taxes and premiums paid by the people are considered necessary contributions to health financing, communities have to be involved in how their money is being spent and “a willingness to pay will come if the quality of services improves.”

The impact of UHC on stability and nation-building was not easy to establish. Some respondents believed there was a link, as “improving healthcare makes a country stable”, therefore developing UHC would have “some effects” on stability. However, more respondents felt poverty was a stronger factor: “One reason for instability is hunger… self-sufficiency in food can be the basis for health and peace”. Equitable health care services and financing can work towards stability, however, through “building trust” and by creating social cohesion, others thought.

Finally, the changing roles of civil society were discussed. There is a strong conviction that UHC will never be reached without greater civic involvement: “The state cannot arrive at UHC on its own”. International organizations could “provide technical and financial assistance”. Civil-society organizations are therefore perceived as having a bigger role to play in promoting accountability. “They can raise the community voice, share it with government, or question the government as to why services are not equally provided. They can involve the media to do so.” Local CSOs, “as members of society, should be involved in all processes.” They could stimulate research and the use of good data, engage in lobby and advocacy and act as a watchdog.

Conclusions

the two general aims of this qualitative study were to understand and advance UHC in fragile and transitional states and to articulate the specific roles which civil-society organizations (CSOs) – from local to international – may play in the process. Based on the interviews and the literature survey, we come to the following conclusions:

1. Stakeholder awareness

Stakeholders in the countries in this study are generally aware of the UHC agenda, even if the term itself is not always widely used. It is not necessarily seen as something new, many elements of Primary Health Care and Health for all and even the MDCs are also seen as part of UHC. Nonetheless, UHC does appear to have added value. First of all, it requires a more holistic approach, in which equity and rights-based principles are central, accompanied by an integrated financial strategy. Secondly, UHC is clearly felt as a long-term objective and an opportunity to further an integrated national health system under country stewardship. And thirdly, community involvement is vital.

These basic reflections have consequences. Countries want to take the lead themselves, so the roles of many actors in the (international) health scene will have to change. National governments should lead the process, ensuring real political will towards UHC, accountability and good governance while designing and implementing domestic solutions and integrated strategies for health financing and service delivery.

The lead has clearly shifted from donors to governments. International donors and partners should pool their funds with the government and align to and support the government health policies. Communities need to be involved in the development of the health system, to ensure their needs are answered, to reach greater understanding and awareness in communities about the health system and its financial base, and to ensure they get value for money. Service providers have to make sure they provide equitable and sustainable health services and are accountable to the communities they serve.

2. Specific pathways and particular challenges and requirements

There is no ‘one size fits all’ pathway. Each country should make its own inventory of what is currently in place, both in services provided, inclusion of all people and health financing. Starting with their existing health systems and an assessment of what works and what does not (nationally and internationally, as possible examples of best practices), additional or improved instruments, strategies or interventions can be added, improved and scaled up. This can be done either simultaneously or one by one, depending on the possibilities within the country. Step-by-step learning and gradual introduction of new components will support progressive realization of UHC. This requires good data, which can be collected and analyzed properly and should serve as input for decision making.

In short, UHC requires combinations of instruments to ensure inclusion of all people, delivery of quality services and ensuring an appropriate and sufficient health financing system. The focus should be on a mix of instruments, which are locally designed and lead to a progressive realization by adding and improving instruments and thus effects over time.

Domestic funding is key! Sustained domestic funds for health require accountability and international funding should also facilitate accountability to the population. Eventually, domestic funding needs to be ensured for a sustainable health system. Community responsiveness is essential in this, because domestic funding will include contributions from the community, either through taxes or health insurance premiums. PBF can contribute greatly towards strengthening the system of service delivery (both in quantity, quality and separation of roles from Ministries to communities).
In countries where service delivery is very limited or mainly provided by international actors and/or where the legitimacy of government is still very fragile, certain early steps can be identified. These countries can use PBF to increase quantity and quality of service delivery, making sure not to exclude any groups in society. Community involvement can be realized in establishing basic service delivery packages (and thus answering to community needs). At the same time, there should be accountability from health facilities to the communities they serve (giving them value for money). Equally, there should be clear roles and responsibilities for stakeholders within the health system as the importance of accountability is increasing. Available funds (domestic and international) should be pooled to support an integrated health system. With health services available and of good quality, countries can work towards health financing, including pooling the contributions from the people themselves.

3. Peace and state building
In fragile, post-conflict and very low-income states, international involvement of both donor organizations and NGOs is large. This often undermines the legitimacy and the capacities of the local governments. Leadership in implementing UHC by national governments, including accountability to their people (rather than to the international actors), can increase the legitimacy of the government. International actors should be supporting this.

Although there is no documented causality between the impact of health services and peace and state building, increasing service delivery through state regulation, ensuring inclusion of all groups in society is likely to support stability. The reverse is certainly true: providing services to limited parts of the population only will lead to instability.

4. Civil-society organizations
At local level, community involvement is important, for example in identifying the health needs, verification of services provided and to hold stakeholders accountable for their part in the health system. Local NGOs or CBOs may represent the community at different levels. However, good representation of the variety of voices in society is a precondition.

International civil society should focus less on direct service delivery (only when it is not possible by local actors, e.g. in emergency situations). Handing over of these tasks must happen in a sustainable way. International NGOs should instead focus on facilitation and technical assistance at the explicit request of local stakeholders. Areas of interest can be capacity building and evidence based analysis and data; facilitating multi-stakeholder encounters and deliberations; and assisting domestic policy development and practical planning.

Furthermore, international civil society can support the countervailing powers within systems to promote equity, accountability and access. This can entail supporting representation of various voices from society; answering requests of local civil society for capacity development; and engagement in independent verification of results.

Universal Health Coverage in fragile states
The worldwide attention for Universal Health Coverage as part of the global Sustainable Development Goals after 2015 is very important, as the MDG health goals have not yet been achieved in many countries.

“UHC is a great opportunity to improve healthcare, but will only work if radical changes in donor behaviour occur!”

Simone Filippini, CEO, Cordaid

This report shows that for fragile and transitional states, the road to achieving UHC will be more complex, requiring an increased focus on community needs and national ownership in the design and implementation of health policies.

Therefore, the international community – funders and NGOs alike – have to ensure that the pathway to UHC in fragile and transitional states will be given the extra attention and tailored support that it needs, taking into account their particular challenges and requirements.

What does this mean for international NGOs like Cordaid?
International NGOs need to shift their focus combining service provision with facilitating national dialogues and community involvement to secure inclusive national health policy making. This will go hand in hand with better alignment and pooled funding methods so as to create more space for national ownership and accountability to the population. This is crucial to achieve sustainable domestic mobilization of funding.

“Ensuring community accountability in the pathway to UHC is crucial to Cordaid Healthcare.”

Remco van der Veen, Director Healthcare, Cordaid

The findings of this qualitative study inspire Cordaid to further its mission on building flourishing communities by:

- Focusing more on providing capacity development to local organizations and communities involved in policy dialogues,
- Supporting national governments through technical assistance in formulating better and more responsive policies for universal health coverage,
- Making the link with the international level by advocating for a rethink of existing approaches on universal health coverage in fragile and transitional countries,
- Capitalizing on the opportunities that the UHC discourse and activities provide for restoring state – civil society relations within countries.
1. INTRODUCTION: OBJECTIVES AND AIMS

Universal Health Coverage and the post-2015 agenda

UHC (Universal Health Coverage) has captured the attention of the global health policy world. With the deadline of the Millennium Development Goals (MDG’s) looming in 2015, but the targeted results including those relating to health and health care not being met – the international community is gearing up for the next phase: Sustainable Development Goals (SDG’s). A UN Open Working Group on SGD’s has been established, following the United Nations Conference on Sustainable Development (Rio+20).

In this context, a UN System Task Team has been established, a High-Level Panel of Eminent Persons has issued recommendations, and a set of 11 global thematic consultations and national consultations in 87 countries – facilitated by the United Nations Development Group – has been carried out (United Nations, 2013). Global agencies, notably WHO and the World Bank have devoted ample coverage to UHC with the intention of driving the agenda (WHO 2008, 2010, 2011, 2012, 2013, 2013b & 2014; World Bank, 2013 & 2013b). Increasingly, other international bodies (Brearly et al., 2013) and networks of civil-society organizations (CSOs) are following suit, such as the Action for Global Health (2013), the Global Network for Health Equity and Beyond 2015.

CSOs especially are keen to see the UHC agenda address the unfinished business of the international development agenda, and come to terms with the major gaps in equity, good quality services and general opportunities that so tragically persist in many parts of the world.

The WHO definition of UHC as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services (http://www.who.int/healthsystems/universal_health_coverage/en/) points to those gaps as it depicts the various dimensions of health coverage: Who is covered? What services are covered? And how much financial protection is there for citizens when they access the services? (WHO, 2010; WHO, 2013)

This definition encompasses much more than just health financing. It refers to the demand side of health systems (users, population and clients), seeking a system that enables people to access the services they need and guarantees that people do not suffer financial hardship when accessing health services. It refers to the supply side, the provision of quality health services, including the availability of medicines, technologies and motivated, well-trained human resources. It comprises treatment, but also early detection, prevention and health education mechanisms. And it provokes debates around equity, solidarity and good governance.

Until recently, many of the debates on Universal Health Coverage revolved around health coverage in middle-income countries, emerging economies and relatively stable environments. How the debates play out in lower-income settings and particularly how they affect fragile and transitional states has been much less explored. To what extent are the aims and methods of UHC applicable in more challenging circumstances? Which pathways are feasible and what modus operandi are required to turn UHC into a truly universal development agenda, meeting the needs of all, even in more deprived circumstances?

With these questions in mind, Cordaid commissioned this largely qualitative study around perceived pathways to UHC in fragile and transitional states. Cordaid wishes to help foster more inclusive operational scenarios for moving towards UHC in such situations. To attain that goal, it is crucial to articulate the specific role of CSOs in the new UHC endeavours much more prominently. The aim of this study is to contribute to the global conversation on sustainable improvements in health by engaging more in-depth with people in the field, in this case from Afghanistan, Burundi, Rwanda and Zimbabwe.

Research questions

the two general aims of this qualitative study are to understand and advance UHC in fragile and transitional states and to articulate the specific roles which civil-society organizations (CSOs) – from local to international – may play in the process. The following sets of questions are then of interest:

1. Stakeholder awareness: How do stakeholders understand the current UHC agenda and Is UHC anything new for stakeholders in health in fragile and transitional states?
2. Specific pathways: Can we obtain a sharper understanding of the particular challenges and requirements for any pathways to UHC in fragile and transitional states?
3. Peace and state building: Is there evidence that UHC contributes to peace and state building?
4. Civil-society organizations: What should be their roles with respect to UHC?

Outline of the report

Following this introduction, Chapter 2 introduces the study methodology. Chapter 3 renders the key findings of the literature survey, which focused on suggested strategies for and known impact of some ‘model’ UHC programs. Chapter 4 introduces the four countries where the interviews were conducted: Afghanistan, Burundi, Rwanda and Zimbabwe. This chapter focuses primarily on current indicators of health financing and service delivery, and highlights a number of challenges such as equity. Chapter 5 presents the results of the 77 interview sessions, involving 79 key stakeholders. Conclusions are drawn in Chapter 6.
2. METHODS

This study consists of two main parts: a literature study and interview-based qualitative research.

UHC Literature Survey
A targeted survey of the literature on UHC impact was carried out (for a summarized report see Chapter 3; for the full text of the essay, see Appendix A). The survey was confined predominantly to an assessment of evidence on the ‘impact’ of UHC agendas. It scrutinized the role of financial arrangements and looked into the relationship between UHC and state building processes in fragile and transitional states.

After defining fragile states (see chapter 3 for details) and compiling a list of fragile states, we conducted a survey of recent literature on the impacts of user fees, premium-based insurance, and results-based financing. Subsequently, we identified articles on countries on the fragile states list and combined the country names in the Google Scholar database with the keywords ‘user fees’, ‘health insurance’, ‘results-based financing’ and variations thereof.

The literature survey served as a point of departure for the design of the questionnaire, by picking up on the main pending issues regarding UHC.

UHC interviews
Four countries were selected for the interview part: Afghanistan, Burundi, Rwanda and Zimbabwe. Their selection was related to Cordaid’s prior engagement in assisting in health and health-systems strengthening in these countries. The countries represent environments with considerable challenges. They are in different stages of transition, after warfare and serious conflict. Specific discussions regarding Universal Health Coverage are ongoing in all four countries, albeit with varying degrees of intensity and stakeholder involvement.

In each of the four countries Cordaid recruited senior health-systems experts with in-depth knowledge of the local health systems, sufficient status to engage in dialogue with senior stakeholders and seasoned in undertaking qualitative research. For Afghanistan Dr. Said Shamsul Islam was selected, for Burundi Dr. Longin Gashubije was recruited, for Rwanda Dr. Laetitia Nyirazinyoye of the National School of Public Health assisted and from Zimbabwe senior public-health expert Dr. Sue Laver joined the team.

The consultants conducted between 17 and 23 interviews in their respective countries.
11 target groups (TG) of respondents for the interviews were defined. All target groups were identified as belonging to the broad group of ‘decision-makers in health policy and health systems strengthening’.

<table>
<thead>
<tr>
<th>TARGET GROUP</th>
<th>AFGHANISTAN</th>
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<th>RWANDA</th>
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<tr>
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A list of potential respondents per country was drawn up. Some of the persons selected belonged to more than one professional category. Each respondent is listed in a maximum of two categories with the exception of one Zimbabwean respondent who was listed in three. Of these respondents, six have preferred to remain anonymous. They are listed by their target-group code (TG), and their general areas of expertise. In some countries, no representatives of certain TGs were available during the interview months (o).

A questionnaire was drawn up for the semi-structured interviews. The form included instructions on explaining the protocol to respondents and on obtaining and checking informed consent. The questionnaire itself was divided into five headings (for the full Questionnaire in English, see Appendix B).

1. General information regarding the respondent, such as age, gender, professional background, position in the health system.
2. Familiarity and understanding of Universal Health Coverage as it is used in policy circles; assessing the respondent’s personal and professional relationship with the subject.
3. Extent to which Universal Health Coverage is a perceived theme in government policy; connections with the several dimensions of UHC that have been defined in the literature; people’s sense of the process of ‘moving towards UHC’ and of who and what drives this process; the involvement of politicians and the Parliament and the sense of whether UHC introduces novel debates in the health-policy discourse.
4. How the UHC practices impact on current practice of health financing and service delivery.
5. Assessment of the perceived relation between UHC and stability and the roles of CSOs. This section contains several of Cordaid’s key interest questions related to the link between UHC development and fragile or transitional state building. It also contains the questions regarding the specific potential of non-state agencies and the role of communities.

A total of 77 in-depth interviews with 79 respondents were carried out (in Zimbabwe two in-depth interview were held with two respondents together) (see Appendix C). Permission was sought and granted by the relevant authorities in the Ministries of Health of Rwanda, Burundi, Zimbabwe and Afghanistan. The interviews were recorded and transcribed. Feedback was organized through comments from the local consultants, a panel session at the 2013 Autumn meeting of the World Bank and IMF in Washington DC (a summary can be found in Annex D), and an internal review panel at Cordaid headquarters.
3. UHC LITERATURE SURVEY: KEY OBSERVATIONS

The full text of the literature survey, including all references, can be found in Appendix A; this chapter contains a summary and the key observations.

Outline: What technicians say about the impact of UHC

The survey analyzed the WHO conceptual framework and describes the different dimensions of UHC as predominantly found in the technical literature. It then focused on four countries often quoted as ‘UHC frontrunners or achievers’: Colombia, Ghana, Rwanda and Thailand. These are countries in different stages of development and with different institutional setups. We considered how the existing knowledge may apply in fragile states. We explain our use of the concept of ‘fragile states’ and outline the health challenges such states encounter. Lastly, we looked at three types of policy towards UHC as applied in fairly stable environments and often recommended as potential strategies for fragile and transitional states, i.e. (i) user fee removal and (ii) mandatory insurance schemes as demand-side interventions, and (iii) results/performance-based financing schemes as supply-side measures. We discussed the feasibility of such interventions for fragile states.

The main observations are summarized at the end of this chapter.

The WHO ‘UHC Cube’

Most deliberations around Universal Health Coverage start with reference to the WHO Cube (see Figure 3, WHO 2010). The three axes of this dynamic model refer to three essential dimensions of access.

The first dimension, the width of the cube, designates what share of the population is covered by the pooled health funds available. The second dimension, the depth of the cube, describes the share of health services made available by the pooled funds. The third dimension, the height of the cube, states the proportion of the total costs met, indicating the level of financial protection a healthcare system offers (WHO, 2010). Low financial protection is indicative of UHC not having been achieved. However, low out-of-pocket expenditure does not necessarily mirror a functioning healthcare system, as people may forgo needed care altogether because financial or geographical access barriers are too big. Thus, low out-of-pocket expenditure greatly gains in meaningfulness as an indicator for UHC if considered in combination with healthcare utilization. This twin indicator approach – impacts on financial protection and utilization – we used to assess health-policy reform towards UHC in this study.
Universal Health Coverage ‘achievers’

countries that have achieved UHC, have done so by many different pathways. What works well depends on the country context; there is no simple, universal recipe for UHC (World Bank, 2013; World Bank, 2013b). Below are some examples that highlight differences and discuss pathways.

Example One: Thailand’s National Health System

Thailand’s UHC reform began in early 2001, shortly after a new populist government had taken office and nationwide rollout was completed within a year. On the demand side, all Thais not already covered could now enroll in the ‘30 Baht Scheme’. The scheme’s benefit package is near comprehensive, including high-cost treatments, antiretroviral treatment and renal dialysis (http://jointlearningnetwork.org/content/universal-coverage-scheme). The fixed charge of 30 Baht (US$ 0.75) per service contact was abolished in 2006. To achieve a balance between effective coverage and control of healthcare spending, substantial changes were made in the financing and organization of the public healthcare system. The 30 Baht Scheme enabled Thailand to make rapid and substantial progress towards UHC. Health coverage jumped from 71% in 2001 to over 98% in 2011. More people sought ambulatory and inpatient treatment when sick (Limwattananon et al., 2013). Medical expenditure risks reduced largely across the board. Both infant mortality and labor force non-participation due to illness or disability reduced dramatically (Gruber et al., forthcoming; Wagstaff and Manachotphong, 2012).

The 30 Baht Scheme coincided with a rise in public healthcare expenditure per capita by almost 170 percent. Still, total health expenditure remains low. Rapid economic growth helped Thailand to finance the spending increase (Thai National Bank, 2013). In terms of UHC achievements, Colombia’s reform increased health insurance coverage from about 10% in 1990 to over 90% today. About half of the population is enrolled in the SR, SSR coverage is small at 2-3% and 40% are covered by the CR. Those enrolled in the SR have lower out-of-pocket expenditures (Panopoulou, 2001; Flórez et al., 2009) and catastrophic expenditure decreased at different thresholds for both SR and CR enrollees (Flórez et al., 2009). SR is associated with greater medical care use for women, children and the elderly (Trujillo et al., 2005), fewer reports of not seeking medical care for financial reasons (Giedion et al., 2009), better self-reported health, more preventive and curative outpatient care, and fewer hospitalizations (Caviria et al., 2007). It is also associated with increased birth weight and better APGAR scores (Camacho and Conover, 2008). SR enrollment is also associated with higher uptake of preventive childcare, which appears to positively influence child-health outcomes. Results for curative care utilization may be muted by the improvements in population health resulting from the increased use of prevention.

Where not otherwise indicated, the account of Colombia’s health system and its development is based on information from the Joint Learning Network for Universal Health Coverage (http://jointlearningnetwork.org/content/colombia), Giedion et al. (2013) and Soors et al. (2010).

Example Two: Colombia’s Social Health Insurance

Colombia embarked on major healthcare reform with the passing of Law 100 in 1993. Prior to the reform, more than half of healthcare spending was out-of-pocket and more than every second citizen reported to forgo needed care for financial reasons. Law 100 gave Colombians the choice between competing private and public insurers. The reform also unified healthcare financing in one single fund. The system knows three types of insurance arrangements. A contributory regime (CR) is open to anyone and in principle mandatory for formal sector employees and informal sector workers with a minimum income. A small percentage of the premium is used to cross-subsidize care under a subsidized regime (SR), catering to the poor. The near poor can purchase insurance under the Semi-Subsidized Regime (SSR). Finally, there is public care provision for individuals without insurance and treatments not included in insured benefit packages. Benefit packages differ between the three regimes.

In terms of UHC achievements, Colombia’s reform increased health insurance coverage from about 10% in 1990 to over 90% today. About half of the population is enrolled in the SR, SSR coverage is small at 2-3% and 40% are covered by the CR. Those enrolled in the SR have lower out-of-pocket expenditures (Panopoulou, 2001; Flórez et al., 2009) and catastrophic expenditure decreased at different thresholds for both SR and CR enrollees (Flórez et al., 2009). SR is associated with greater medical care use for women, children and the elderly (Trujillo et al., 2005), fewer reports of not seeking medical care for financial reasons (Giedion et al., 2009), better self-reported health, more preventive and curative outpatient care, and fewer hospitalizations (Caviria et al., 2007). It is also associated with increased birth weight and better APGAR scores (Camacho and Conover, 2008). SR enrollment is also associated with higher uptake of preventive childcare, which appears to positively influence child-health outcomes. Results for curative care utilization may be muted by the improvements in population health resulting from the increased use of prevention.

While there is no impact on outpatient spending, SR enrollment decreases mean inpatient spending by about one-third for those using inpatient services. Finally, SR enrollment is associated with reductions in the variability of inpatient spending as an indicator of lower financial risk (Miller et al., 2013). Colombia made substantial improvements in healthcare access particularly for the poor. Perhaps the biggest challenge to UHC remains the heterogeneity of benefit packages, as the country tries to weight higher equity against concerns of financial sustainability.

Countries showing progress to universal health coverage

Thailand and Colombia show that UHC is achievable under certain preconditions, including a functional provider network, sufficient tax-revenue, and the institutional structure and capacity to make efficient use of funds. These preconditions are rarely met in fragile states. Hence, we decided to zoom in
on two other country cases, Ghana and Rwanda. They have achieved progress towards UHC in the face of challenges that more closely resemble those met by most fragile states.

**Example Three: Ghana's National Health Insurance System**

Ghana introduced the National Health Insurance System (NHIS) in 2004. It builds on a ‘hub-satellite’ model, i.e. central authorities regulate and subsidize a nationwide network of District-Wide Mutual Health Insurances (DWMHI). The NHIS is a compulsory scheme by design, but in practice enrollment remains voluntary. Financing is primarily through a 2.5% health insurance levy on the national value added tax (VAT), accounting for about 70% of all financing. The NHIS benefit package includes essential medicines, preventive, outpatient and basic inpatient care but excludes most high-cost treatments. Care provision is through both public and accredited private facilities.

In terms of its contribution to UHC, recent government estimates speak of only 36% coverage rate. Furthermore, enrollment is inequitable, as affordability and information gaps hinder higher uptake among the poor (Sarpong et al., 2010). Robust evaluations of NHIS impacts on care utilization and financial protection are scarce. Insured pregnant women are more likely to receive care around birth and experience less birth complications (Mensah et al., 2010). Although a study by Nguyen et al. (2011) suggests that NHIS enrollment significantly reduces the likelihood of incurring catastrophic health expenditures, Witter and Garshong (2009) find that evidence on financial protection remains inconclusive.

While some success is reported in improving care access and financial protection in Ghana, large challenges remain. Besides inequitable enrollment, managerial and administrative inefficiencies, financial sustainability (Lagomarsino et al., 2012) and care quality are a concern.

**Example Four: Rwanda’s Mutuelles de Santé**

After the war had ended in 1994, the Rwandan government removed user fees to achieve rapid improvements in care access. In the absence of a strong supply-side, however, the policy remained ineffective and care quality compromised. The government in response reinstated user fees – with the predictable negative consequences for access equity. Rwanda then returned to its early, pre-war, experiences by rebuilding the system based on strong involvement in healthcare management and financing. Piloting of community based health insurance (CBHI) began in 1999 and implementation of a nationwide CBHI policy began in 2003.

The new CBHI system’s main building blocks are the Mutuelles de Santé. They function as local insurers for anyone not covered through formal sector schemes (that together insure only about 5% of Rwandans). In the system, the center provides essential medicines, preventive, outpatient and basic inpatient care but excludes most high-cost treatments. Care provision is through both public and accredited private facilities.

District-level Mutuelles are placed between the central level and the subdistrict Mutuelles. Each subdistrict has a Mutuelle, that decides on benefit packages, premiums and periodicity of subscriptions, within the boundaries of the national and district regulatory framework.

System financing is mainly through government funds from tax and donor contributions. A smaller part of funds comes from insurance contributions and copayments. To enable these payments community banks provide earmarked 15% interest loans.

Provider payment is by fee-for-service and/or needs-adjusted capitation, depending on the local Mutuelle’s arrangement. Since 2006, the provider payment mechanism includes Performance-Based Financing (PBF) elements.

The Mutuelles system started out with voluntary enrollment but health insurance is now officially compulsory. Every insured citizen is entitled to primary care at local public or private not-for-profit health centers. On top of this, Mutuelles membership insures a limited number of services at district hospitals and since 2006 select services in national hospitals.

By using a system of local responsibility for enrollment and making enrollment compulsory, Rwanda has achieved near universal insurance coverage, up from about 10% in 1999. Evaluations of the CBHI policy find higher use of modern health services, including assisted deliveries and increased financial protection among the insured (Sekabaraga et al., 2011; Hong et al., 2011).

In Rwanda, the insurance story is accompanied by the introduction of PBF. It is not possible to attribute all evidence of success in Rwanda’s health system to PBF, but some positive effects, especially around childbirth and with children, are found (Basinga et al., 2011). Still, there are potential side effects, such as gaming, neglect of non-incentivized activities, irrational behavior to fulfill requirements and falsification of documents (Kaik et al., 2010).

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3. **UHC LITERATURE SURVEY: KEY OBSERVATIONS**

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5 Subdistrict is the translation used here for secteur, the third level administrative subdivision in Rwanda. The Provinces of Rwanda are subdivided into districts. Each district is in turn divided into sectors.
3. UHC LITERATURE SURVEY: KEY OBSERVATIONS

UNIVERSAL HEALTH COVERAGE IN FRAGILE STATES

Allocation Index (IRAI), which considers as key elements: property rights and rule-based governance, the quality of budgetary and financial management, efficiency of revenue mobilization, quality of public administration, transparency, accountability, and corruption in the public sector (World Bank, 2011). The fragility 'threshold' is an IRAI score below 3.3.

We used the IRAI threshold as inclusion criterion for our analysis of recent fragile state healthcare reform impacts. We included all countries with a score below 3.3 at least for two years in the 2005-11 period. We added South Sudan and Somalia, for which no CPIAs are available, to the list. This resulted in a total of 38 states considered ‘fragile’. The survey showed health and health-system indicators for 33 states which qualified as fragile in 2011 by World Bank criteria and for which data were available. These were compared with the data from Rwanda and Ghana, and from Thailand and Colombia (all lists available in full survey text, see Appendix A).

Similarities and differences in health profiles of fragile states
There are notable similarities and differences in the health profile of fragile states compared to that of the UHC achievers. Life expectancy and death from non-communicable diseases are substantially lower in fragile states; maternal and child deaths are higher. The high rates of avoidable deaths in part mirror nutritional deficiencies and low rates of access to improved water sources and sanitation (see Table 3 in full survey text, Appendix A). Fragile states account for more than one third of global maternal deaths, half of under-5 deaths, and one third of the people living with HIV/AIDS; Malaria death rates are 13 times higher than in other developing countries. None of the fragile states had achieved a single health-related MDG by 2011 (Haar and Rubenstein, 2012).

Many fragile states experience armed conflict. The vast majority of conflict deaths occur in non-combatant populations like women and children due to the breakdown of health services. Health effects of health system disruptions under conflict are also long-lasting. An often neglected health issue in fragile and conflict affected fragile states are mental disorders (Kruk et al., 2010).

Despite its unquestionable success in improving care access and financial protection, challenges persist at all levels of the Mutuelles system in Rwanda. Uneven coverage and low managerial and administrative capacity still hamper the system’s effectiveness in places. The overall financial stability of the system is also under scrutiny. Contributions and copayments still prove insufficient to cover the Mutuelles’ expenses, even with a non-comprehensive benefit package. At the same time, subsidies from the center to overcome the financing gap remain highly donor-dependent.

Extending UHC to fragile states?

Defining ‘fragile states’
Various definitions of ‘fragile states’ exist. An often-cited definition comes from DFID (2005) stating “the government cannot or will not deliver core functions to the majority of its people, including the poor”. USAID (2005) distinguishes between ‘failing’, ‘failed’ and ‘recovering’ states. The World Bank considers a state fragile if it performs poorly in the Bank’s Country Policy and Institutional Assessment (CPIA) or if a UN and/or regional political and peacebuilding or peacekeeping mission took place over the past three years. The CPIA is based on the International Development Assistance Resource

A mother at Karirwe Clinic. Mtoko, Zimbabwe 2014.

Photo: Adriaan Backer

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states, large heterogeneity exists in healthcare spending, which in part reflects differences in country income levels. Health insurance in the form of premium-based schemes is uncommon in fragile states. This is unsurprising as many fragile states lack the capacity to meet the managerial and administrative requirements of a nationwide scheme. The biggest part of fragile states’ healthcare spending comes from out-of-pocket payments.

In fragile states governments are unable or express limited commitment to provide appropriate healthcare resources and services. Donors and international NGOs often step in as financiers and service providers (Kruk et al., 2010).

**Healthcare reform potential in fragile states through the UHC lens**

Three strategies were surveyed in their applicability to fragile states: extending coverage through free health care and user fee removal; extending coverage through insurance schemes; and deepening coverage through RBF/PBF.

**Free health care, the removal of user fees and targeting the poor**

The use of user fees has been contentious for many years. They were introduced or substantially increased in many LMICs in the 1980s and early 1990s as structural adjustment policies promoted by the World Bank (Akin et al., 1987). It assumed autonomy in spending at the lower levels of the health system, which in practice was often compromised. Critics were concerned that the fees would contribute very little to health financing and exacerbate financial inequities in access to needed care (McPake, 1993; Gilson and Mills, 1995).

Three decades later it is clear that their contribution to health sector resources is often marginal (McPake et al., 2011), and user fees reduce healthcare utilization (Lagarde and Palmer, 2011; McPake et al., 2011; Ponsar et al., 2011), especially among vulnerable groups – and so they worsen the already rampant socioeconomic inequalities in care access (Bornemisza et al., 2010).

Predictions on the effects of user fee removal on UHC are not unambiguous either. In fragile states it is often limited to specific services or population groups, which can be challenging to target (Ridde, 2008). Also, there is the danger of overburdening the health care facilities if no improvements are made on the supply-side (Gilson and McIntyre, 2005; Ridde et al., 2012). A number of fragile states have recently removed user fees for parts of their populations (such as the poor, or expectant and new mothers and children) or altogether (Witter, 2010). These interventions typically indicate large increases in care utilization and some improvement in financial protection. These increases may also be related to accompanying changes in (health care) systems.

**Premium-Based, Contributory Schemes**

Efforts to introduce contributory schemes in fragile states have focused on Community-Based Health Insurance (CBHI). CBHI schemes cover a large range of regulatory, ownership and management arrangements, benefit packages, enrollee cost-sharing provisions, and target populations. CBHI are characterized by (a) community-based social dynamics and risk pooling, where the schemes are organized by and for individuals who share common characteristics; (b) solidarity, where risk sharing is as inclusive as possible within a given community and membership premiums are independent of individual health risks; (c) participatory decision-making and management; (d) nonprofit character; and (e) voluntary affiliation (Soors et al., 2010).

CBHI is argued to bear potential as a tool for equitable access and better financial protection for underserved populations. It might instill awareness of the concepts of insurance, community participation and entitlement. Premiums and co-payments may raise scarce resources for healthcare and the implementation and administration of schemes may help build local management capacity. There is the danger of continued exclusion of the poor, due to admin costs, limited risk-pooling and required managerial skills (Soors et al., 2010; Spaan et al., 2012).

Robust CBHI impact estimates are hard to find. Some tentative results point to pro-rich membership and difficulties in (re-)enrollment (Atim, 1999). Enrollment rates may vary with episodes of violent conflict. Some schemes show some promise, with participation of the poor subsidized through an integrated health equity fund and care quality ensured through provider contracts and tests of patient satisfaction. Some descriptive evidence suggests utilization rates can be higher and financial protection more effective (Soors et al., 2010).

While heavily subsidized CBHI has substantively contributed to progress towards UHC in countries like China, Ghana and Rwanda (Spaan et al., 2012), these successes will be difficult to realize on a large scale in fragile states. The existing evidence indicates that CBHI requirements in terms of administrative and regulatory capacities, combined with the sustained political commitment which is needed, make it an unlikely candidate for quick progress towards UHC in fragile states.

**Deepening Coverage: Results- and Performance-Based Financing**

The above indicates that demand-side policies to improve healthcare access are bound to fail if not supported by a functional supply side (Razavi et al., 2009; Corter et al., 2013). Results-based financing (RBF) as an approach to improve care quality has thus gained traction in many fragile and transitional states over the last decade (Corter et al., 2013).

RBF is understood as “a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified” (Musgrove, 2011). There are five subtypes: performance-based contracting, performance-based financing, results-based budgeting, vouchers and health equity funds and conditional cash-transfers (Corter et al., 2013). Here we look at the applicability of the former three in the context of fragile states.

Under performance-based contracting (PBC), governments, donors, or health insurance agencies contract agencies or facilities to manage or provide healthcare. PBC is popular in particular in fragile states where public health providers are often defunct and the initial contract partners are often external agencies. Ideally, this is based on a competitive
bidding process – in fragile states, however, a sufficient number of capable providers may initially not be available (Witter, 2012). Under performance-based financing (PBF), governments or donors introduce performance elements into the reimbursement of public or private healthcare providers. Finally, under results-based budgeting (RBB), government financing of health authorities is conditioned not only on inputs but also on the achievement of desired outputs.

In the following, we summarize several known impacts of RBF reforms in fragile states on UHC dimensions and beyond (reviews by Eldridge and Palmer, 2009; Fretheim et al., 2012; and Corter et al., 2013). One impact study in Afghanistan found no difference in outcomes between PBC and PBF arrangements, but PBF facilities did have increased outpatient utilization compared to facilities without and were leading to more equitable healthcare access as the poor, women, and children under five show particularly large utilization increases (Arur et al, 2010). Studies in Cambodia also find positive effects of PBC in higher and more equitable primary care utilization and reduced out-of-pocket spending (Schwartz and Bhushan, 2004; Bloom et al., 2007; Soeters and Griffiths, 2009), but these effects cannot always be attributed to PBC or PBF alone (Eldridge and Palmer, 2009). Studies in Pakistan found increases in curative care utilization and increased community satisfaction with services, but no effects on uptake of preventive care and care quality (Ali, 2005; Loevinsohn et al., 2009). Effects found in Burundi included large increases in family planning services and assisted deliveries uptake and increases in care quality, while HIV/AIDS related activities and immunization dropped and out-of-pocket increased (Soeters et al., 2011a). A study in the Democratic Republic of the Congo found that a performance-based cash bonus to health workers did not increase utilization but improved perceived care quality and reduced out-of-pocket expenditure and corruption (Soeters et al., 2011b).

According to an expert panel at a conference on PBF and RBF schemes in Clermont Ferrand in 2011, the potential for over-reporting and data falsification are risks. Crowding out of certain activities and overlooking indicators are less of a problem when schemes include the whole spectrum of basic care provisions, which is PBF best practice. Experts felt that PBF can create conditions so that quality will follow, but it cannot enforce all dimensions of quality in its entirety (http://www.aedes.be/view/en/News_ClermontFerr.html).

Results- and Performance-Based Financing seem to provide valuable instruments to increase healthcare utilization and improve care quality in fragile states. Nevertheless, caution is advised as most estimates come from observational studies with bias risk that can lead to an overstatement of effects. Ireland et al. (2011) underscore that potential adverse effects have yet to be rigorously studied and suggest more research into the cost-effectiveness of RBF as it is to date unclear if the high administrative costs are justifiable against the quality and utilization gains achieved.

**Healthcare reform in fragile states and nation building**

Theoretically, health system development is an entry point to overcome state fragility as it is hypothesized that effective provision of basic services like health can lead to involvement and positive feedback between government and citizens, providing legitimacy, and potentially instating a platform for broader, longer-term development initiatives (Haar and Rubenstein, 2012). However, regarding the relationship between fragile states, health and nation building, the overwhelming conclusion is that much more empirical research is needed.

There are four ways in which healthcare systems can contribute to building and stabilizing a nation or state (Kruk et al., 2010):

1. **Promoting social cohesion.**

Healthcare systems can improve inclusion by providing equitable access to care and strengthen civil society through participatory health sector decision-making. Social inclusion and equity correlate with higher economic growth, opening a pathway for increased government legitimacy (Haar and Rubenstein, 2012). If conflict lines run across ethnic or regional rather than socioeconomic groups, a trade-off between higher equity and stabilization might exist (Waldman, 2006). If stabilization is priority, health system development efforts may focus on areas where opposition to the government is most widespread, rather than on the most vulnerable parts of the population (Rubenstein, 2011).

2. **Restoring accountability and strengthening the social contract.**

Healthcare systems reflect government values and capacity and as such are an important building block of government legitimacy (Freedman, 2005). To underscore this commitment, governments can embed access to healthcare as a basic right in new constitutions (Witter et al., 2011).

3. **Restoring Trust**

A functional and accountable healthcare system conveys trust – a scarce resource in fragile environments – on various levels, from the provider-patient interaction and the overall relationship between a health facility and the local community, to a citizenry’s general perception of the trustworthiness of government in fulfilling its obligations (Tibandebage and Mackintosh, 2005).

4. **Strengthening government capacity**

Building effective public health system capacity enables governments to fulfill basic functions that are paramount to legitimacy (Ohiorhenuan and Steward, 2008). There are indications that healthcare system development supports nation building (Kruk et al., 2010). Health system rehabilitation should engage the local government to improve program coordination, increase support for local government, and allow the government to take complete ownership of health service provision.
Expansion of UHC debate in the literature: beyond the technical to political will and civil-society and community involvement

Recently, debates in literature expanded beyond financial-technical considerations to the politics of implementation, ownership and multi-stakeholder engagement. Several agencies and civil-society alliances (CSO Forum, Action for Global Health) have begun to raise their voices for UHC to become truly transformative (see Appendix D). The UHC debate is placed squarely in the context of the right to health (Averill and Marriott, 2013). Health insurance schemes that reinforce inequality by prioritizing formally employed people and excluding those who cannot afford to pay premiums, are criticized. Some conclude that prioritizing general government spending for health to successfully scale-up health coverage, funding through progressive taxation and international aid is the key to achieving UHC – including urgent action on global tax evasion and avoidance, which is needed to ensure that countries can generate and retain more of their own resources for health (Averill and Marriott, 2013).

The Japan-World Bank Group Partnership Program for UHC has supported systematic analyses of health policies and programs in 11 countries. The 11-country study found that in principle UHC programs could improve the health and welfare of their citizens and promote inclusive and sustainable economic growth (World Bank, 2013b). The ongoing reforms in the countries studied—Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey and Vietnam—have yielded valuable insights into the common challenges and opportunities faced by countries at various stages on the path to UHC. The key policy messages from this multi-country study concur with several of Cordaid’s conclusions in the October 2013 panel. They highlight that successful UHC adoption and expansion requires at least strong political leadership and long-term commitment; equitable coverage; fiscal sustainability of UHC; scaling up the health workforce; and investing in a robust primary care system.

In summary: key observations from the literature survey

- For most developing countries, Universal Health Coverage (UHC) has long been an implicit policy goal. Today, despite conceptual uncertainty about its indicators, it is on its way to become the global target against which national health policies are assessed. It ranks high on the international health policy agenda.
- Generally, heterogeneity of schemes said to contribute to UHC abounds, and innovative mixes of approaches are emerging.
- There is limited transferability of successful models to fragile states, due to issues regarding administrative rigor, human and financial resource requirements and difficulties with simply copying the political drive and structures necessary for such large-scale reforms.
- Robust evidence on the impact of health reforms in fragile states is still sparse. However, some indications are emerging of the specific requirements and the caveats regarding various schemes.
- The evidence on contributory local health insurance schemes, especially voluntary ones, is not very encouraging. Several (fragile) states have experimented with them, but none have achieved substantial uptake, and enrollment is often inequitable. Maintaining equity and meeting its high administrative and regulatory requirements at both the central and local levels have proven considerable challenges.
- With respect to results-based financing (RBF) schemes, robust evidence to date suggests that RBF elements can improve care quality and utilization. However, much remains to be learned and the newly emerging work on equity and the sustainability in RBF still needs to be further assessed.
- The causal evidence case on the link between UHC efforts and state building has yet to be made. Importantly, researchers underline that quick fixes to defunct fragile state healthcare systems – like contracting out to international NGOs – may be successful in improving health outcomes in the short run, but face the risk of further delegitimizing national governments if their own ability to provide policies, financing and services is not concurrently developed.
- Where public providers are in short supply, adjustments can be achieved by contracting private providers. The combination with the introduction of performance-based reimbursement of all those concerned, proper autonomy and a proper separation of functions appears to function positively.
- Many other adjustments appear necessary for fragile states. Premiums and user fees are a huge challenge in many places. More donor money, a realignment of tax spending, or acceptance of the fact that healthcare access will continue to be rationed through income are suggestions made in the literature. Continuous funding is needed to respond to the utilization increases that follow user fee removal.
- The larger donors have officially committed themselves to greater coordination, but in practice fragmentation is still rampant.
- Much concerted research effort is still needed to produce further evidence on particular interventions in fragile-state contexts.
In this chapter we briefly sketch the health-policy scene in Afghanistan, Burundi, Rwanda and Zimbabwe, the four countries where our study was carried out. We outline a number of developments, notably in health financing, that form relevant background for the discussions on UHC in each of the countries.

**Afghanistan**

**General health-policy background**

The 2012 “Afghan Revenue Generation Strategic Framework” is the frontrunner of Afghanistan’s integrated health-financing thinking and reflects the current Ministry of Public Health’s (MoPH) strategic position on moving towards UHC. In practice, the general Afghan population bears 76% of the total health expenditure and the 24% that public healthcare funding provides is still largely taken care of by donor funding, accounting for 75% of that. But the search for a more diversified domestic financing mix is on. The government aims to adapt various international recommendations to the Afghan context. It tries to improve revenue collection, fight corruption and introduce value-added tax in 2014. Despite these measures, the domestic revenue at 11% of GDP remains below the 15-18% average of low-income countries. The administrative ability to collect additional fees is weak.

The capacity of the government to provide basic health services also remains challenged. Major donors have contributed to a basic package of health services, the expansion of midwifery programs, and the restructuring of the health delivery system. Given the potential withdrawal of donors after the 2014 elections, experts at the Ministry of Public Health (MoPH) agree that a more comprehensive, multi-year strategy to increase domestic revenue for health should be developed.

**Health financing, sources of funding, equity measures**

There are five basic healthcare financing instruments that could have an impact in the Afghan context: government funding, social health insurance, community-based health insurance, private health insurance and private out-of-pocket payment. However, the current ‘national health service’ delivers healthcare goods and services based on two packages: a basic package of health services (BPHS; operational in all 34 provinces) and an essential package of hospital services (EPHS; operational in almost 30 provinces). These packages were accompanied by official fee exemption aimed at equity and access. However, there is no operational ‘social health insurance’, ‘Community-Based Health Insurance’ (CBHI) or functional ‘private health insurance’. Households provide the lion’s share...
**Box 1: Afghanistan**

**General social indicators**
- Population: 27 million (CSO 2012-13).
- Per capita income: US$ 426.
- Natural and cultural barriers limit access to healthcare services, especially for women and children.
- Literacy rate: 12% for females; 39% for males; high discrepancies between rural and urban areas.
- Almost 9 million Afghans unable to meet their basic needs (36% of the population).

**Health-status indicators (Afghanistan Mortality Survey 2010)**
- Life expectancy at birth: 62/64 (m/f) years.
- Total Fertility Rate: 5.1.
- Under-5 mortality rate (Excluding the South Zone): 97/1,000 live births.
- Infant mortality rate (Excluding the South Zone): 77/1,000 live births.
- Maternal mortality rate: 327/100,000 live births.
- One in three women giving birth under the care of a skilled professional.
- Use of some method of family planning: 22%.
- Antenatal care: 68%.
- Institutional Delivery: 42%.
- Potentially 90% of children under five immunized by 2015.
- 52% of deaths among women between the ages of 15–59 is now due to non-communicable diseases. Among adult men, nearly 20% of mortality is due to road-traffic accidents.

**Health financing indicators (National Health Account, 2010)**
- Total health expenditure: US$ 1,044 million.
- Total government share of health expenditure: US$ 63.9 million.
- Total expenditure on health per capita: US$ 42.
- Government contribution to health as % of total government expenditure: 4%.
- Sources of Public Health Expenditure:
  - Central government 6%.
  - Private (external partners financing) 18%.
  - Private (OOP) 76%.

**Health service delivery indicators (National Health Account, 2010)**
- Services delivered through hospitals: 29%.
- Services delivered through outpatient care centers (clinics, district hospitals): 32%.
- NHA accounted for public expenditure on pharmaceuticals and medical equipment: 28%.

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**Current policy preoccupations and suggestions for the future**

A special working group at the Ministry of Public Health has proposed to levy taxes such as excise tax on tobacco, vehicles, fuel, and airline tickets. They wish to combine such interventions with the introduction of user fees for services outside the EPHS at the district and provincial level to generate revenue for hospitals and tertiary centers.

**Burundi**

**General health-policy background**

In recent years, Burundi has tried to marry several health-financing and service-delivery strategies (Basenya, 2009). In 2006 the country adopted contracting as a national policy for the health sector, as part of the National Health Policy 2005-2015 and the National Health Development Plan (PNDS 2006-2010). It also started pilots in Performance-Based Financing (PBF), first in three provinces, but this gradually expanded to national level from 2010 (Ministère de la Santé Publique et de la Lutte contre Sida, 2011). In addition, the government introduced selective free healthcare for children under-five and for pregnant women in a separate system. The attempts to combine these various strategies led to several strains on the system, such as reimbursement delays, overcharging, drug shortages, an enormous administrative burden and deteriorating staff motivation due to underpayment. Technical international experts then suggested the integration of PBF strategy and the free healthcare policy. A reduction of the payout period was achieved, private providers and donors became involved and effective verification systems around the payment of free care were established. The success of PBF was followed by the reintroduction and extension of an insurance scheme, the Carte d'Assurance-Maladie (CAM) in 2012. Unfortunately, as the CAM premiums are hardly covering the costs of care, the CAM system is compromising the PBF budget.

The national scale-up of PBF in Burundi received worldwide attention. Donors pooled funds. A technical support unit (CTN) was established at the Ministry of Public Health and the Fight against AIDS (MSPLS). It has been active in coordinating innovations in the health systems related to PBF. The CTN undertakes regular monitoring of the implementation of PBF to avoid possible perverse effects and has assisted in incorporating health-equity funds to protect the poorest in the system. It has developed into a pivotal strategic agency at central level.

External evaluations of Burundi’s health-system developments pointed out marked improvements in the utilization and quality of health services. Curative care for children under-five increased by 32%, and for pregnant women by 48%. The use of modern family-planning (FP) methods increased by 8.5%. The average quality score increased to 67%. In addition, PBF helped to stimulate public-private partnerships and strengthened relationships between partners. Community participation improved through grassroots-organizations’ involvement. The reliability of the health system’s data appeared to be improved through strategic purchasing in PBF. Efficiency and equity in health financing received an initial boost through provincial budget per capita and the introduction of equity bonuses for disadvantaged areas. Health personnel were more motivated and more available in remote areas. However, the evaluations...
also demonstrate the need for continuous intellectual investment and capacity building and further decentralized autonomy and quality assurance systems to be maintained (Musango L. et al., 2010).

Health financing, sources of funding, equity measures
Around 8.7% of GDP is allocated to health (2011). Almost half of the Burundian health budget is derived from external funding (2013). The PBF funding is to a large extent pooled and includes some equity mechanisms described above. In addition, the Ministry of National Solidarity receives 1.2% of the national budget of which around 1.4 billion BIF is allocated to healthcare for the vulnerable.

Current policy preoccupations and suggestions for the future
The majority of Burundi policy-stakeholders are most concerned with the financial sustainability of the health system after the political decision to expand the CAM. An integrated health-financing strategy is seen to be needed to bridge the various financial gaps and to prevent PBF allocated funds to be used to fill the gap around the CAM. An in-depth study to explore the feasibility of more integrated health-financing approaches has been commissioned.

Box 2: Burundi estimates (data vary between sources)

General social indicators (Sources: DHS, 2010; WHO, 2013)
- Population: 9.8 million.
  - Population density: 305 inhabitants/km².

Health-status indicators (DHS, 2010; MMEIG, 2012; WHO, 2013)
- Life expectancy at birth: 52/54 (m/f) years.
- Total fertility rate: 6.4.
- Under-5 mortality rate: estimates vary between 139 (ICME, 2012) and 104 per 1,000 live births (WHO, 2013).
- Maternal mortality rate: estimates vary between 800 (MMEIG, 2012) and 615 (WHO, 2013) per 100,000 live births for 2011.
- Stunting rate in children under-5: 58% (DHS, 2010).
- Rate of births assisted by trained personnel: 60%.
- Contraceptive prevalence: 18% (DHS, 2010).
- Immunization coverage rate: 87%.

Health-financing indicators
- Total expenditure on health as % of GDP (2011): 8.7.
- Total expenditure on health per capita (international $/2011): 52.
- 48% of Burundi’s health budget (80 billion BIF) is derived from external funding (2013) of which 17.9 billion is PBF, and 2.3 billion is allocated to the CAM.
- The Ministry of National Solidarity receives 1.2% of the national budget of which around 1.4 billion BIF is allocated to healthcare for the vulnerable.

Health service delivery indicators
- The PBF system: 510 health centers, 48 hospitals, 17 provincial health offices and 45 district health offices, plus one PBF Central Technical Support Unit (CTN) are operating under a PBF contract.
- The PBF payment of health facilities occurs on a monthly basis with a maximum of 45 working days processing time.
- The regulatory bodies are paid quarterly.
- There are 24 health-service indicators considered for PBF payment at primary level. They cover curative, preventive and promotional services and focus largely on the Millennium Development Goals: Maternal and Child Health, HIV/AIDS, malaria, and tuberculosis.
- The hospital level also encompasses 24 services for PBF payment.
- Services offered by provincial and district offices pertain to regulation, supervision, and quality assessment. At central level, the indicators pertain to regulation, supervision, policy development and quality standards.
Rwanda

General health-policy background
Rwanda has been seen as one of the few countries in Africa on its way to meeting several of the MDGs. Rwanda was amongst the first countries in Africa to embark on policies to develop integrated health financing (Government of Rwanda, 2009).

Health financing, sources of funding, equity measures
Over the last ten years, Rwanda has introduced performance-based financing schemes side by side with health insurance schemes. The community-based health insurance (CBHI) programs, known as ‘Mutuelles’, have been expanded. Gradually, financial coverage through these various insurance schemes has grown. The ultimate aim of the Rwandan government is to have a functional obligatory health insurance scheme for all citizens. Vehicle of such national health insurance would be the CBHI scheme. The current CBHI only offers access to public health facilities and their packages of health services. Private facilities are deemed unaffordable for CBHI coverage. Other insurance schemes give access to both private and public facilities without any gate-keeping system.

Different packages of activities have been defined at each of the levels of the health system in order to provide equitable and quality care across the country. The packages are: community package offered by Community Health Workers (CHWs); a primary health services package (at health center level) and packages at tertiary health services (the National referral hospital). The Mutuelles reimburse the package offered by health facilities, which includes all curative services and drugs from the national essential drug list. It also covers most health services and drugs delivered at district and referral hospitals when members are referred to them (MoH, 2013).

In addition, PBF focuses on purchasing public goods, preventive services (including community-based interventions) and quality of services at the primary, secondary (and tertiary) levels. Studies show a positive impact on health services delivery and health outcomes (Basinga et al., 2011).

Concurrently, a system – Ubudehe – has been designed to identify the poor. Six Ubudehe categories have been defined and are linked to differentiated levels of CBHI premiums. People in Ubudehe category 1 and 2 are considered very poor and government pays their CBHI premiums. Those in Ubudehe categories 3 and 4 pay less than half of those in Ubudehe categories 5 and 6. This way the CBHI enrollment has grown to 91% in 2010, with 95% OPD utilization. However, a slight drop in enrollment was registered for 2012.

Box 3: Rwanda

General social indicators (Census 2012 and MINECOFIN)
- Population: 10,537,222.
- Per capita income 2012: US $644
- Population below poverty line: 44.9%
- Population living in extreme poverty: 24.1%

Health-status indicators (UNDP, 2011; DHS, 2010)
- Life expectancy at birth: 56.7
- Total fertility rate: 4.6
- Under-5 mortality rate: 76/1,000 live births
- Infant mortality rate: 50/1,000 live births
- Maternal mortality rate: 476/100,000 live births
- HIV prevalence among adults: 3%
- Modern contraception: 45%

Health-financing indicators (MoH, 2013)
- 11.5% of the annual national budget allocated to health
- Annually 150 billion RwF spent on health
- Still 61% dependent on external contributions from donors for general sources for health.
- Public funding (including parastatal input): 21.1%.
- Private contributions: around 16.8%
- Out-of-pocket payments: officially estimated at 11% (coming down from 23% in 2006).

Health service delivery indicators (MoH, 2013)
- Human Resources density: 1 doctor per 17,240 inhabitants, 1 nurse per 1,294 inhabitants, 1 midwife per 66,749 inhabitants. This gives a workforce density of 0.85/1,000 population which is low compared to WHO standard of 2.3/1,000.
- A four-tier health system: 24/25 indicators: 14/15 core ones for general basic health package services (such as: curative consultations, immunization, family planning, etc.) and 10 HIV specific indicators related to voluntary counseling and testing, prevention of mother-to-child transmission, ARVs, and TB/HIV interventions.
- 14,837 communities with 45,011 community health workers.
- 469 health centers work with 8,279 generalist nurses.
- 42 district hospitals in the country count a total of 475 generalist physicians.
- Five tertiary referral hospitals have 150 specialists providing services. An additional three referral and four provincial hospitals are being planned.
4. FOUR COUNTRIES: FOUR HEALTH-POLICY SCENES

ZIMBABWE

General health-policy background
The Zimbabwean health system experienced tremendous shortages, due to the financial crisis and decline of all sectors of the economy in 2000, culminating in a 2007-8 meltdown that severely affected the country. Key health indicators declined, especially those for mother and child health.

A National Health Strategy for Zimbabwe, 2009-2013, was drawn up. Its main goal was to mobilize resources for the revitalizing of the health sector and to create a sustainable financial resource base. Over the last few years several efforts have led to many discussions in Zimbabwe's health policy circles about how to implement a solid national healthcare financing policy and strategy, create community health-financing mechanisms, put together essential packages of health services for the whole population and find equitable ways of financing them.

Health financing, sources of funding, equity measures
An average of 8% of total government spending is allocated to health (NHA, 2010). Private parties still account for most of the health financing. The government's contribution declined from 39% in 2001 to 18% in 2010. Many poor households have stopped seeking care from the conventional health system altogether. For a roadmap towards UHC, the current distribution of sources of financing is not considered ideal; more tax-based financing is needed. A stated 'free health service' system for children under five, pregnant women and people over 65 is variously interpreted with the imposition of 'community levies' in some settings, instead of 'user fees'.

RBF/PBF – In 2011 a World Bank-sponsored RBF program was introduced to accelerate the availability, accessibility and utilization of quality health services, in particular to boost the maternal and child-health indicators. The RBF program offers subsidies directly linked to performance at primary healthcare level in rural public and faith-based not-for-profit centers, and in hospitals at district level. By 2012 RBF interventions were functional in 18 districts. A mid-term review confirmed significant progress in terms of rollout, and registered the first positive effects of the RBF mechanism at the health-system level. The HMIS has improved, and the planning, management and stewardship of financial resources at decentralized levels have been strengthened. The program has increased accountability. At the same time, challenges remain: health managers cannot hire and fire; a range of private facilities are still excluded; and no equity bonuses have been used for vulnerable patients (http://www.rbfhealth.org/event/results-zimbabwe-and-financial-sustainability-rbf-africa).

Current policy preoccupations and suggestions for the future
At a national stakeholder meeting ‘On Domestic Health Financing for UHC’, organized by the MoHCW and the Training and Research Support Centre (TARSC) in Harare in August 2013, three clusters of policy issues were identified that are since organizing the policy consultations:

- Is public financing progressive and adequate to attain UHC? Have funds been pooled to allow for cross-subsidies? Can this lead to financial harmonization?
- Are the funds reaching those with the greatest health need? What degree of access to care do households have? How are resources distributed? What priorities should guide resource allocation? What areas and levels of services should be prioritized?
- Are there cost barriers to care? Is there financial protection? How are we tracking and reporting on equity in financing?

The answers are still pending. The new multi-donor Health Transition Fund (HTF) offers a golden opportunity for stronger alignment and strategic use of resources. The MoHCW is showing commitment to strengthen supervision, implementation and governance, and support advocacy and behavioural
change (Stakeholder meeting On Domestic Health Financing for UHC Harare, 16 August, 2013). It has commissioned various studies into determining, validating and costing an Essential Health Benefit Package and is subjecting it to stakeholder and policy review. It wishes to identify, analyze and review options for adequate equitable domestic health financing. It constituted a technical working group and top management team review to drive this agenda.

**In summary**
All four countries in this study are confronted with major challenges after or amidst political and economic crises. No ideal mix of health financing or model for service delivery has been identified as yet. External financial dependency is still substantial. But the policy-makers appear to be moving towards taking larger policy control. Accountability to the communities served is severely lacking, even though they contribute most of the costs of the health system. Furthermore, equity in service provision as well as quality of services provided remain issues of concern. Core teams of policy experts have been formed in order to move the system to greater coordination and integrated strategies, with explicit mechanisms for equity and experimenting with expanding service delivery.

### Box 4: Zimbabwe (estimates)

#### General social indicators
- Population (2012): 13,724,000
- Per capita income: no recent estimates available

#### Health-status indicators (WHO, Global Observatory, 2013)
- Life expectancy at birth (years m/f, 2011): 53/55
- Total fertility rate: 3.56 (WHO, 2012)
- Under-5 mortality rate (2012): 90/1,000 live births (WHO, 2013)
- Maternal mortality rate: 570 deaths/100,000 live births (NHA, 2010, but estimates vary considerably)

#### Health-financing indicators (Source: National Health Accounts 2010 Report, 2011)
- 8% of total government spending is allocated to health.
- Government contribution declined from 39% in 2001 to 18% in 2010 (NHA, 2011).
- 82% of health expenditure comes from private parties: employers with 21%, households with 39%, and donors with 19% and other private sector with 3%.
- The contribution by donors has increased from 4.2% in 2001 to 19% in 2010.

#### Health services delivery indicators (Source: National Health Accounts 2010 Report).
- Of the available funds, hospitals received 23.3% of the disbursements; nursing and residential care facilities received 0.3%.
- The administration of public health programs received 22.1%, general administration: 52.7%.
- Funds usage is weighted in favour of curative and administrative services with less for preventive services and minimal expenditure on research.
- In 2010, 17% of the population fell ill of whom 82% sought medical attention, while 18% stayed home. The 82% included 3% of persons who visited traditional/faith healers, while the remaining 79% sought help from conventional health facilities. The 18% who stayed home consisted of 5% of persons who self-medicated and 13% who did not seek any medical attention. 30% of the population visited rural health centers.
5. UHC INTERVIEWS: VOICES FROM THE FIELD

Outline
In this chapter we share the key findings from the 77 interviews conducted for this study. The chapter consists of seven sections, related to the research questions. We start by covering the general familiarity respondents conveyed with the term UHC. We then turn to how UHC policy themes and drivers are being perceived. A third section enters into the reflections respondents made regarding the impact of UHC on practical instruments of financial access and protection, service delivery and equity. A fourth section sums up how – upon deeper reflection – the ‘novelty’ of UHC is assessed. Then, the vital requirements and perceived challenges which respondents note regarding the implementation of any UHC agenda are addressed. The final two sections treat Cordaid’s two key concerns: whether respondents judge the UHC agenda to be a potential stabilizer and building block for nation building; and what contributions they think civil-society organizations (CSOs) should make in the face of the UHC agenda.

5.1 UHC: GENERAL FAMILIARITY
What understanding of the theme of UHC do the respondents express at first?

FAMILIARITY WITH THE TERM UHC
The respondents in the four countries demonstrate varying degrees of familiarity with the term UHC and UHC debates. In Afghanistan and in Burundi, the term UHC as such did not appear in much use beyond the inner circle of policy-makers and donors, to the extent that many respondents indicated they “heard the word UHC for the first time during the interviews”, while others came across it while they “attended one or two workshops given by donors”, or encountered it in policy documents. In Rwanda and Zimbabwe the term seemed better known, although in Zimbabwe UHC seems articulated most clearly at senior policy level and in agencies operating in the formal context of healthcare delivery: “There has not been a significant
trickle down of this agenda to other levels yet; it has not yet devolved or transitioned to district level parlance”. While in Rwanda it is “used in the country and discussed in different meetings, and it means that all Rwandans should have access to health services delivery in different hospitals and health centers”.

**DEFINING THE TERM**

In all countries concerted efforts are undertaken by central government to define the term and get on top of the agenda. A few respondents referred very explicitly to the WHO definition of UHC, especially those working within or closely with the relevant Ministries. Some respondents from Burundi and Zimbabwe connected the current UHC agenda to what came before: the Alma Ata Declaration, Health for all and Primary Health Care. Others emphasized that UHC is “broader in scope”, with all countries pointing out issues of financial protection and equity: “UHC means access to healthcare and services for everyone regardless of their income or their social status. This should be done in a way that avoids and prevents people from enduring financial hardship, and out-of-pocket payment. The philosophy of UHC is that everyone, i.e. the entire population, should have access to quality health services that they need; in brief, enhancing UHC is about equity in healthcare.” In Zimbabwe the role of community participation was highlighted as essential to the definition of UHC, as the term “universal” implies a recognition of the need for greater thrust to increase reach and coverage of the marginalized and to ensure greater and increased participation of the community in determining their own health outcomes. Therefore “the health delivery system should be an enabler in that process and not merely a provider of services.”

“The philosophy of UHC is that everyone, i.e. the entire population, should have access to quality health services that they need; in brief, enhancing UHC is about equity in healthcare.”

**Respondent, Rwanda**

Respondents from Afghanistan, Burundi and Rwanda agreed that some of UHC’s components were already being discussed and implemented. In Afghanistan “service provision is there, efforts are going on to have more qualified staff... separate policies for community nursing and midwifery are being developed... in the discussions, topics like maternal and child mortality, equitable access and coverage are in focus... and we have made some progress here”. Many Burundi respondents related UHC first and foremost with the rollout of the Carte d’Assurance-Maladie (CAM) and in Rwanda with Community-Based Health Insurance (CBHI), which meant “that all people, even the poor, should be covered by health insurance. But not only that... the population must have places where they can receive health services. So three aspects are important: quality of services, equity of services and social financial protection.”

**RESERVATIONS**

How issues of coverage are perceived is closely related to pre-existing contexts: debates, terms and policies, as are the current developments and the way forward for UHC. Some skepticism was expressed by Afghan, Burundi and Zimbabwean respondents about the true novelty of the term and agenda: “Sure, we need to discuss this. But we should see that the subject trickles down to the community, and that it develops; otherwise these goals will remain pure philosophy. We know about health MDGs, and other terms like poverty reduction indicators that contribute to health, but I do not know yet about any UHC indicators...We have not yet seen any discussions to relate or compare MDGs and UHC and I do not know which comes first”. Several respondents from Burundi felt the country “has not moved very much in relation to this subject since 1978”. In their view, UHC is a concept that should be cast primarily “as the overall struggle against poverty, not just confined to health”.

**5.2 UHC: POLICY THEMES AND DRIVERS**

Which dimensions of UHC (financial access, service delivery, quality, equity) do the respondents primarily refer to? Who in their view currently drives the UHC agenda? Who should take the lead? Are politicians and Parliament implicated in any way?

**DRIVERS**

In all four countries, respondents indicate that in principle any UHC agenda should be driven by government and should involve financial access and quality service delivery combined. In Afghanistan, Rwanda and Zimbabwe, respondents stated clearly that health is embedded in the Constitution and therefore UHC was: “the government’s legal task, since access to health services is a human right, a basic right of people, as stipulated in the Constitution”. All countries agreed that for UHC to succeed, it takes political will and leadership. They see this reflected in the role governments take, mainly through their ministries of health. In Rwanda this is seen as a major contributing factor to its progression, which has been going “very well, primarily because there has been political will and commitment at all levels”.

At the same time, most respondents acknowledge a large degree of dependency on private funding (external partners and out-of-pocket contributions) still to exist in the health care systems, both financially (50-70%) and in terms of directing service delivery. These dependencies are problematized: “Donors have their plans, UNICEF and WHO discuss access but only for specific services such as reproductive health”. Many felt: “Stakeholders should increase their involvement but work through the [Ministry] to understand gaps and clarify priorities.” However, some respondents from Afghanistan and Burundi worried that the leadership of their governments is still too weak and they were wary of the consequences if donors would shift to other roles too quickly: “We do not suggest changing the role of NGOs in the near future since the NGOs’ role as implementers is obvious, bearing in mind the current realities. If we compare contracting in (i.e. implementation by the MoPH) with contracting out (implementation by others), even in the secure provinces contracting in is currently not better than contracting out to NGOs. NGOs provide services even in remote and insecure areas”, was said in Afghanistan. The Burundian respondents see a better future for the country if it would align itself with the positions of the donors: “Let players launch health initiatives, let researchers evaluate the effectiveness of the different initiatives. If we and the donors pool our efforts, it will enable us to have an acceptable model on the basis of synthesis.” Such a ‘Burundian model’ of UHC could only be attained through leadership from the center which would have to be accompanied by the promotion of a clear view at district level with strong involvement of local stakeholders, including private parties and communities, proponents said.
In all four countries the need for taking greater control and designing domestic strategies is clearly expressed. This would not be easy, all agreed, as UHC was generally considered to be “a very difficult process, since a lot is at stake”. In Burundi, the objective of UHC was called “very ambitious, especially given the inequalities that still exist in the country between provinces, districts and even within communities”. Some felt that this led to the debate being restricted “because the country is poor; it is not possible to cover the entire population”. Others strongly objected to merely repeating that “Burundi is a poor country”. They remarked: “We have an active and working population (...) The 10-15% of the population that is really poor could be covered by the state”.

“(UHC is) the government’s legal task, since access to health services is a human right, a basic right of people, as stipulated in the Constitution.”

Respondent, Afghanistan

Regarding opinions on what needed to happen to move towards UHC, there was no single, clear strategy proposed by all respondents. Increasing domestic funding was key in Afghanistan: “Government should increase its contribution to health through increasing its income: either by user fees, health insurance, or using the private sector in some areas. It can motivate the private sector by incentivizing them”. In Zimbabwe respondents focused on: “reducing for Zimbabwe’s population the gap between the need for quality services and the actual use of those services, diminishing inequities in health and extending healthcare to those not covered by essential health benefits; reducing out-of-pocket spending and shifting to mandatory prepaid and pooled health spending, particularly through progressive forms of domestic health financing; and progressively widening the services provided to all, such as in relation to NCDs.” And in Burundi it was considered that: “if you say ‘universal coverage’ this also means that you really wish to avoid an evolution at several speeds in which persons who have the means can have themselves looked after while others do not even get a small part of the services. We can arrive at universal health coverage but it will demand a plurality of financial means, a lot of energy, strong will and technical skills, without forgetting to sensitize the population.” Here, respondents agreed that “there is no particular pattern yet in our country. One could consider Performance-Based Financing, but that is not yet a model per se. It does, however, visibly improve the quality of care... We could on the other hand have free healthcare and try to move from there to universal coverage... PBF and free healthcare together could be the basis for the debate on how to move towards UHC... In any case, in a country like ours, it would be better to have several models.”

HEALTH POLICIES AND HEALTH STRUCTURES

In most countries, respondents referred to health policies and health structures that are already used to work towards UHC. Here, the importance of preexisting infrastructure emerges clearly from the interviews. Some policies and structures were seen as working well, others as facing challenges. All countries pointed out certain health structures and laws that were helpful in achieving UHC, such as in Afghanistan: “We now have a healthcare financing department at the MoPH, staffed with young professionals who have master’s degrees and who have proposed taxes to increase government revenues, that will increase the government’s share in health financing, like tax on old cars or on tobacco, user fees, and the introduction of public/private partnerships in five hospitals, and improvements in coordinating the efficient use of resources, training of staff, sending technicians to places like India and Turkey and the creation of some services such as having standard Intensive Care Units.” Such structures also facilitate debates around UHC: “Each quarter, major issues are discussed in a steering committee. In this setting there have been discussions about the new System Enhancement for Action in Transition (SEHAT) project, which is all about quality, sustainability, capacity building, systems development and service delivery. All these discussions are highly relevant for UHC, even though they have not been discussed under the umbrella-term of UHC.”

Besides health structures, respondents from all countries also mentioned national health policies that can be seen as elements of UHC. In Afghanistan, the Basic Packages of Health Services (BPHS) and Essential Packages of Hospital Services (EPHS) were mentioned, together with the practice of contracting out, especially in remote and insecure areas, to reach greater access. In Burundi respondents referred to the “initial experiences with the CAM from which we can learn and derive improvements.” And: “We have the ‘Mutuelles’, which originally only covered the public sector; but they gradually expanded to include officials, private administrators and university students. We hope they will extend to other sectors... and contribute to achieving UHC.” However, more than half of their countrymen maintained that “there are not yet well-defined, coherent strategies to achieve UHC” and judged the initiatives to improve access to be still fragmented. In Zimbabwe, in the current policy debate the potential of a National Health Insurance Scheme has been reintroduced and the revision of the five-year National Strategy for Health could lead to a better health information system (HMIS). At the same time, respondents felt much is happening in provinces and districts with strong initiatives such as the Results-Based Financing program funded through the World Bank, which is already leading to a rethink of some key features of the system. However, according to some, efforts still remain “too piecemeal” and too confined to health-political circles. And finally in Rwanda, a policy on health insurance was firmly established years back and has been regularly updated. The country has improved financial access for the poor through the strengthening of Mutuelles de santé (CBHI) and the introduction of a socio-economic stratification mechanism (Ubudehe): “We have to ensure that
those who are the poorest should also be able to access that minimum package of health.” The government of Rwanda also supports public health insurance institutions, has encouraged public private partnerships (PPP), and has embraced Performance-Based Financing (PBF). With its reputation of being advanced in achieving UHC, respondents here felt that each country should have its own routing to UHC “because the geopolitical context and economic situations are different”. Some of Rwanda’s specific characteristics were identified as political leadership and commitment, a clear vision, strategy and implementation policy, CBHI complemented by public and private insurance, PBF, community commitment and involvement, donor funding and involvement of parliament.

As for challenges, the other countries all agreed that “there is no problem with the policies themselves, but the problems are in the implementation of the policies.” An example from Burundi: “We introduced free healthcare. This implies that consultation, care and drugs should be automatically available. But just visit the public hospitals and you will see that there are not enough drugs. Those who attend public hospitals and health centers should all be covered... but this is not the case.... In practice, it is another reality”. However, some felt that the problem in Burundi is less the supply-side than the demand-side: “My big concerns are not MDGs or UHC, but the current organization, logistics and investment capacity.... The government should guide the country into strategies, which are cheaper for the state and for the population.... I cannot imagine, for instance, how the country could continue to finance free healthcare. We must organize the population so it can meet the costs of healthcare by itself.” Major challenges in Zimbabwe are the political uncertainties and the state of its economy: “There is high unemployment, a low tax-base and in view of this a clearly urgent need to consider other than traditional forms of healthcare financing.” A number of respondents commented that: “Zimbabwe is rich in resources.... but accountability is lacking and taxes from certain sectors do not reach the tax office.” Existing incentive systems - even RBF - are not capable of fundamentally changing this allocation problem. “This is not just about philosophy and equity but also about maintaining the principles of reality. We need a wider discussion to get a ‘buy-in’ from certain sectors who attend public hospitals and health centers should all be covered... but this is not the case.... In practice, it is another reality”. 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LEARNING FROM OTHERS

There was a sense among most respondents that in reaching UHC, learning from others and using existing, successful examples was important. However, context-specific realities have to be taken into account. In Afghanistan, there was a bit of conflict among the respondents in assessing the importance of “foreign examples of best practices”, but most ended up favoring a mixed approach of domestic and international experience: “We cannot totally ignore other people’s experience and start from zero. For instance, the MoPH has looked at both the experience of other post-conflict countries and the context of our own country in developing the BPHS and EPHS.” In Burundi as well, respondents were open to learning for other countries’ experiences: “there are other countries in similar positions to ours which have attained UHC, such as Rwanda. That country is very advanced compared to other African countries. We have similarities and must adapt strategies. It will be difficult for Burundi to reach UHC with state funding alone.” In Zimbabwe, the experiences from Rwanda, Thailand and Ghana were seen to have potential relevance for the country.

“We can arrive at universal health coverage but it will demand a plurality of financial means, a lot of energy, strong will and technical skills, without forgetting to sensitize the population.”

Respondent, Burundi

ROLE OF PARLIAMENT

Most countries, with the exception of Rwanda, indicate that politicians and Parliaments are not so systematically and strategically involved in discussions around the future of their health systems, and that this should change: “Parliament should be involved in policy formulation regarding UHC from the very beginning,” respondents in Afghanistan said, and: “Parliament and MPs representing people from specific geographical areas can play a role in two directions. Now they often discuss the need for specific health facilities, supplies, equipment and certain people’s problems and demands to improve access. That role has been very obvious recently. But MPs could also be very supportive on aspects of healthcare financing. Public Health services are free according to the Constitution, so new financing mechanisms like taxation, insurance, or increase in the government’s health budget require the support of MPs. They could engage in advocacy with the Ministry of Finance, cabinet, and externally to allocate more funds, or at community level on issues like taxation. For example, people should know what the taxes they pay are used for.” A similar need was felt in Burundi,
where many were fairly critical of the input in the UHC debates by Parliament. It was currently not perceived as “aware of many technical issues” and did not “sufficiently focus the discussion on long-term goals”, or follow UHC developments in other countries and draw comparisons. One respondent stated: “Not only the debate on health coverage remains low-key but also that on health issues in general. This translates into low levels of health financing. Our Parliamentarians rarely discuss these matters in any depth; such debates are largely lacking.” By contrast, the role of the Parliament in Rwanda is deemed substantial. It has been actively involved “in voting bills and policies related to Insurance, in listening to people and follow up insurance policy implementation, revising laws, and promulgation”.

5.3 UHC: IMPACT ON THE PRACTICAL INSTRUMENTS OF FINANCIAL ACCESS, SERVICE DELIVERY AND EQUITY

How does the UHC agenda impact on current practices of health financing, service delivery and equity?

HEALTH FINANCING SITUATION AND COVERAGE

In all countries, the prevailing health-financing situation – amounting to huge donor dependency and limited domestic government funding to health – is increasingly perceived as unacceptable, such as in Afghanistan, where only “42% of the government budget is allocated to health, the cost per capita on health is US$ 42 of which US$ 32 (75%) is out-of-pocket. Of the remaining 25%, 90% is financed by donors and only 10% by government.” Respondents from Rwanda are equally concerned that their health system still largely depends on external support, but some pointed out that donors are “necessary”, others that they are “arriving with their own agendas”, which results in much donor funding being earmarked for specific purposes, like HIV/AIDS.

“(I) have come to realize that UHC is not merely about health financing but even more about offering the services which people need.”

Respondent, Rwanda

In all countries, the extensive donor dependency and insufficient domestic contributions affect issues like coverage and quality of care and equity in service delivery. For instance, “In 2011, 83% of the Burundians who received healthcare had to sell goods in order to pay it. 17% do not have access at all due to financial barriers.” “80-90% of the population is considered underserved (untreated and under-nourished).” In the same country coverage of care at hospital level too is deemed insufficient: with some hospitals refusing certain kinds of patients, and patients even ending up in prison for not paying their health bills. The non-payments cause “health facilities [to] currently run up a lot of debts”. The impact is considered disastrous: “One cannot talk about UHC if health facilities are not financially viable”.

The tight financial situation also aggravates challenges regarding human resources for health in remote, rural populations. In Afghanistan “there is a lack of female staff in some areas, due to security issues, which affects service delivery in remote areas. If we do not have female staff, few women will attend the health facilities for reproductive health services. Insecurity affects both access and quality.” Many here believe the challenges are caused by the specific circumstances of the country: “As citizen and health professional, I think that if we did not have the political and security challenges and if work were undertaken to improve MoPH effectiveness, we could achieve 50% more services delivered.” “We have good doctors, good nurses, and midwives. I think the system could work if we did not have corruption in the government and the MoPH.” Many note that in insecure environments with limited resources, quality of care rapidly diminishes. The UHC agenda will have an impact on that, they believe: “When we talk about UHC, we need to apply quality standards as well, which require resources. When we talk about hygiene we need to buy chlorine, gloves or use hand-wash solutions, or for a uniform we need money. To be self-reliant and sustainable we need to develop a policy, which can allow public hospitals to charge some fee. We could charge penalties on those families who disregard the environment, sanitation and then use this money to improve sanitation.”

LOCAL FINANCING MECHANISMS AND CHALLENGES

In all four countries, this worrisome situation triggers more organized efforts to search for a mix of local solutions. Various tax systems and their levying power, a range of insurance possibilities, and new modus operandi, such as Results- or Performance-Based Financing are all explored. In Afghanistan and Burundi, there are issues around user fees, albeit slightly different. In Afghanistan, “PBF officially works without charging user fees, since paying user fees is against the Constitution.” Many felt that the free public health service as enshrined in the Constitution, in practice blocks the option of user fees, which could otherwise have officially contributed to domestic funding streams. Meanwhile in Burundi: “It appears that some patients are holders of the CAM but are still forced to pay which brings about complaints”. Some here perceived the CAM as “poorly managed and without a clear orientation”, as its coverage rate is lower than expected and the number of adherents insufficient. Still, for others the CAM could become the “precursor of UHC”, if properly managed and combined with the other financial systems. Overall, respondents recommended a more integrated health-financing approach.

In Rwanda on the other hand, respondents were proud of some of the “innovative dimensions” of the current coverage systems: “Officially, almost all categories of the population, both in the formal and the informal sectors, are covered.” They noted how the health service
was accessible, that there has been a gradual improvement of financial management. However, most respondents acknowledge the considerable problems with the Ubudehe categories, such as access to healthcare. Access is also a problem for certain people working in the private sector, who may be uninsured, but not poor.

EQUITY AND EQUITY MECHANISMS

Generally, UHC enhances an emphasis on equity and developing equity mechanisms. This appears to be picked up in all countries. However, there are major challenges in reaching universal coverage, such as these in Afghanistan: “People living in [certain] provinces have difficulties in receiving care due to the very difficult geographical terrain. In addition, there are nomads who continually move around, and for whom we do not have a specific policy. They are very vulnerable.” And Zimbabwean respondents said that the majority of people are “not accessing services or access them too late”. Surveys are cited which show “that deliveries in some mother and child health facilities are low at 50% – the main barriers being user fees and infrastructure”. Since the informal sector is made up by 80% of the population, many have no health insurance coverage whatsoever. Service delivery to the poor remains a challenge as well in Afghanistan and Burundi, where it was stated that the policy “does not target the most vulnerable (...) certain categories remain outside the debate such as the elderly, the indigent, people with chronic diseases.” And it was concluded that: “Actually, most of the population – except for children and pregnant women – is not really covered.”

“One cannot talk about UHC if health facilities are not financially viable.”

Respondent, Burundi

Attempts to improve coverage for the poor and marginalized, are met with varying degrees of hope and skepticism. In Zimbabwe, the official ‘removal of user fees’ and free health-care, were largely dismissed: “In reality there is no such thing as free health”. In many places the loss of user fees has been compensated for by “community levies”. What would help is a coherent policy with a clear agenda, broad engagement and transparency and spokespersons felt that “only a national policy can bring change in the long term”. However, in Afghanistan there was hope that extending the BPHS to urban areas, would improve coverage to the urban poor. In remote rural areas, some saw a clear movement towards “innovative approaches beyond the classical BPHS”, which included public/private partnerships to improve access; the design of mobile health teams; the health sub-centers or increased responsibilities to community health workers and midwives and improving their capacity, as: “Capacity building is an important component of quality and hence of UHC”. Both these countries mentioned the use of RBF which was seen to foster “accountability, transparency, program-monitoring and tracking” and concluded: “Where we have RBF, access shows a positive trend.”

Even though in Rwanda coverage was still uneven, most respondents underscored the importance of several existing provisions for the poor, such as an integrated local development program, meant to eradicate poverty, stimulate rural growth and foster social protection, in addition to the CBHI. Here, due to the debates on UHC, respondents have “come to realize that UHC is not merely about health financing but even more about offering the services which people need”.

A further problem was signaled in Burundi: “The government sets up a model but it does not yet meet the demands, since population growth has not been brought under control. It requires proper management and awareness raising to use healthcare efficiently.” Some insurers added that capacity to check up on things will become a huge problem if insurance schemes are scaled-up nationally.

“(Surveys show) that deliveries in some mother-and-child health facilities are low at 50% - the main barriers being user fees and infrastructure.”

Respondent, Zimbabwe

AREAS OF CONCERN

In all four countries, efforts are made to tackle challenges to the developing health system. Policies around improving funding for the health sector are surrounded by a sense of urgency. In both Zimbabwe and Afghanistan, the focus is on harmonization and the necessary alignment of donors with the government: “There is a need for more equitable distribution of funds across programs: towards a common goal.” In Zimbabwe some spokespersons urged to put equity center-stage again: “Equity debates have always been present in Zimbabwe... Constitutional rights, a desire for equity, and fairness of access are deeply rooted in Zimbabwe. People relate to it. Most stakeholders, including the MedAid societies, and church organizations would be happy to modify their behaviour to maintain these values”. Other suggestions to make funding for health more accessible in this country included for earmarked funds to be “cascaded to where it is really needed most – i.e. beyond the central level”. Much policy attention at the Ministry of Health goes towards this. On raising taxes, some respondents cautioned against negative effects of taxes on alcohol and tobacco and warned against “the impoverishment and public health effects” of such taxes. “Raising taxes does not mean that people give up drinking and smoking behaviour – they will find cheaper alternatives.” In Afghanistan, some even suggested pilot projects involving insurance: “We have not experienced health insurance much in Afghanistan, but international experience shows it is a good thing. So it would be good to start somewhere...”

In Zimbabwe, Burundi and even Rwanda, despite its head start on health financing structures and services, respondents said they struggled with a number of clear challenges. An obvious challenge for both was funding, with the international crisis affecting funding and (in Burundi) budgets decreasing from year to year, while the population is growing more rapidly. This situation leads to more than 80% of people paying out-of-pocket, and some ending up in prison for not being able to pay their health bills. In Rwanda respondents mentioned the limited understanding of health insurance by many people and their low ability to pay. A second major challenge centered on a lack of (human and other) resources for health, with shortage of (specialized and trained) staff, distribution of staff and
physical resources over the country (urban vs rural) and brain-drain being problematic: “The government should retain all the young men and women who are now sent outside to study... they need to be brought back and given a proper salary based on the quality of their services.” Also, knowledge of and attitude towards delivering and claiming quality of care is reported lacking in both countries, despite ‘customer-care strategies’ are being propagated in Rwanda.

Some solutions that were suggested in Rwanda included easing people's ability to pay: for instance by income-generating activities and grouping villages together and having them pay together; using the ibimina mechanisms according to which everybody must contribute and differentiating payment mechanisms. Others focused on improving the human resources for health situation, by investing in training and capacity building and increasing motivation of staff; and on improving the quality of care.

5.4 UHC: ANYTHING NEW?

Upon further reflection: Does UHC introduce novel debates or new emphases in health? Do the current UHC agendas make any visible difference in practice? Are any new stakeholders needed?

TERM AND AGENDA

As indicated before, respondents in all countries perceive UHC as a relatively ‘new concept’, but based on old foundations. Progression “from the MDGs to UHC” is seen as a continuous path: “UHC is the background and foundation for achieving the MDGs. You cannot differentiate health from poverty. If we achieve UHC, we are going to be directly protected against infant mortality and maternal death. All the things we gain from UHC are also priority indicators for the MDGs.” However, the UHC agenda is viewed as “more comprehensive” and discussions on UHC have resulted in “developing new policies, new coordination mechanisms. The health circle has been widened”.

“We need to understand the needs of the villages; they need to contribute; they need to be informed in the best way.”

Respondent, Zimbabwe

Many respondents believed UHC to be “pivotal rather than peripheral” for future debates. These “should be innovative and visionary” and are expected to “sharpen the agenda” and “invigorate” certain themes and alliances. Already debates are shifting to (expansion of) health insurance coverage, equity and distribution, good governance, local solutions, greater community participation, greater local ownership and financial sustainability: “Donors will not stay forever. Having its own resources is important for UHC. To finance services through our own resources will be difficult in the near future, but not impossible if the government considers certain recommendations such as increasing its domestic revenue and allocation to health and insurance”, as a respondent from Afghanistan said. Here, the debates were also moving to “social determinants of health, since health is not related to the health system alone, but other sectors such as education, rural development, and agriculture are involved.” Therefore, across the board, respondents felt “it is not so much a question as to ‘whether’ we are going to develop UHC, but rather a question of ‘how’ we can further advance UHC”. Doing the groundwork was considered important to achieve UHC in Burundi: “We must start from our own situational analysis and analyze all socio-economic and demographic aspects: map all current financing streams, organize the informal sector that predominates in the economy, map what people can contribute according to their means and have the state organize and support this policy by using its partners, including hedge funds. We must combine strategies to achieve this coverage.”

Zimbabwean respondents cautioned that UHC must not be “the mere proliferation of ‘new terms’ and non-implementation”. “Its success will depend on who drive this process and what their agendas are – financial and otherwise. If narrow and technocratic, UHC risks becoming just another global program and that will turn out to be very limited. However, if it is driven by ‘communities of practices and their values’ and pushed by a public health agenda, it will make a big difference.”

COMMUNITY INVOLVEMENT

One element respondents from all countries identified as ‘new’ in the UHC agenda, was serious engagement of communities: “The real novelty in UHC is that it requires working much closer at community level”, hence: “people as key stakeholders”. This has not been the case so far, as a respondent from Rwanda described: “Previously, the population was not able to participate in any debate on health insurance. The debates were held at the ministerial level... the population was not aware of how they could best contribute to health insurance strategies. But today everybody is mobilized and must be involved in health insurance.” Several aspects of community involvement are mentioned: “We need to understand the needs of the villages; they need to contribute; they need to be informed in the best way”. In Afghanistan and Rwanda “to arrive at the best way to implement UHC” knowledge of the communities’ needs was believed to be critical: “There are currently health facilities which are underutilized. The best way to improve coverage is to provide health services in an integrated manner. Today, we are bringing vaccination services to household level, but they are not utilized. Community participation is very important for understanding the nature of this problem and for then enhancing utilization of health services and the uptake of UHC...Community participation should therefore be strengthened. Community awareness should be raised. Only then will they take ownership.” But communities also need to come to the party: “Afghan people have become used to free services... We feel they should play their role and contribute. The MoPH should create a policy to ensure people’s contribution.... In reality, despite our ‘free healthcare’, people do pay from their pockets. Let’s legalize this through a proper system. Like insurance or public/private partnerships.” This kind of community involvement was linked to poverty reduction in Rwanda: “We are going to mobilize the population to be involved in the insurance scheme. This is a process closely related to the economic development of our country. (. .) the number of people classified in Ubudehe

Respondent, Zimbabwe
categories 1 & 2 must decrease and everyone must be enabled to access real quality services delivery.”

In Zimbabwe and Burundi, acting with and within communities was said to require a focus on prevention: “It is imperative to devolve the delivery of healthcare, with a renewed emphasis on prevention at all levels. A new model of inclusion is required to embrace these ideals if healthcare is truly to devolve to decentralized levels and reach the marginalized.” As a result, shifts in approaches are occurring: “The thrust should be on prioritizing those issues that mitigate bad effects on health rather than merely responding to outcomes (such as cholera).”

**STAKEHOLDERS**

To make these agendas work, concerted efforts are required. Government should keep control, but all stakeholders need to work together. In Afghanistan and Rwanda, respondents felt there was a need for new stakeholders, notably the private sector. Some in Afghanistan wanted more: “We need new stakeholders on the research side to assess new models and their cost-effectiveness. We need new stakeholders with financial resources. The MoPH should motivate them and has to develop a long-term strategy. NGOs have played a good role but now the national budget has to improve.” Fortunately “new, non-conventional stakeholders” are seen to be getting involved, such as the Ministry of Women, Agriculture, Rural Development. “Several other sectors should also get involved, such as the Ministry of Power, and there should be coordination between the sectors.” On the other hand, Burundi respondents generally felt that integrating existing stakeholders more effectively into the UHC dialogues was a more promising strategy than introducing new stakeholders.

“**It is not so much a question as to ‘whether’ we are going to develop UHC, but rather a question of ‘how’ we can further advance UHC.”**

*Respondents, Rwanda*

**LOCAL PRIDE AND OWNERSHIP**

UHC constitutes a vital appeal to new local pride and a sense of ownership. Afghan respondents saw “lots of new initiatives emerging which have been locally generated.” On the whole, they felt “new models adapted to our context are good. In the past we had much need for external expertise; now this need is diminishing.” They pointed to a number of good, novel practices that sprung up in the country: “BPHS was an original idea in Africa, but the actual model was developed in Afghanistan, based on the local experience of NGOs and others working here. (...) Many examples from Afghanistan can be replicated in other countries. (...) Sure, Afghanistan is a different case from most countries. There had been total destruction of the system and infrastructure, so we needed to build from nothing; but this also offered the opportunity to build a system based on local experience. In 10 years we have developed documentation which can be used globally, and we have some good models...” However, simply transferring models would not work, as respondents had seen in their own country: “In Afghanistan, the Integrated Management of Childhood Illness (IMCI) strategy has been copied from elsewhere, but not adapted to our country’s situation. Working groups should take account of the field experience and adapt the IMCI according to the Afghan context.” The sentiment that “we should develop our own model” was shared in Zimbabwe: “Our approach to UHC should not be internationally driven – it should be more regionally driven and aligned with the role of the community. Loosely aligned with our local context... We have the infrastructure, legislation and strategies; now we need expertise to assist us in unlocking value – refocusing on PHC – in order to build on past experience, emphasize PHC approaches and involve other sectors ...to help us reach our objectives and come up with health policies that underpin health. This will add to stability.”

**5.5 UHC: REQUIREMENTS AND CHALLENGES**

What are the specific prerequisites for UHC? How hard are they to achieve? What are the perceived factors of success and failure? Are there specific pathways to UHC?

Respondents in all four countries observe that it is not easy to achieve Universal Health Coverage. Each country tries to introduce and implement policies their own way, with their own deep cultural resonances. Certain prerequisites are recognized by all, but dealt with in specific, national ways.

“**If all donors supported MoPH through the same funding mechanism it would help the MoPH to achieve its objectives much more easily.”**

*Respondent, Afghanistan*

**POLITICAL COMMITMENT**

In all countries, respondents agree that civic and political leadership, and long-term commitment are necessary to attain UHC: “Our politicians and law-makers should be familiar with the philosophy of UHC, if not the details. Political commitment, broad-based understanding and comparative analysis are of vital importance.” Important aspects of the required sound political support were seen to be: “Good governance and administration, reducing political interference in the work of professionals and educating people, especially women, about selecting good government” in Afghanistan. Indeed: “The encouragement of government and the encouragement of the people are the two key dimensions of implementing UHC.” Respondents from Rwanda were convinced their country had exactly these advantages on the road to UHC. There is a “high commitment and willingness... that may be different from other countries”. And Rwanda's
health system operates with “a clear vision, strategy and practices in order to achieve UHC”, which were the same elements identified by Burundi respondents as requirements for their country. Rwandan respondents went even so far as to suggest the best routing towards UHC: CBHI should be adopted “as one of the main pillars of UHC... complemented by public and private Insurance, with PBF as another pillar for Results-Based Financing”.

HEALTH AND OTHER SECTORS
As connected to that required political commitment, many saw the need to view UHC as an overriding priority, which should not have to compete with other priorities such as “building up the army or promoting agriculture.” Respondents from Afghanistan mentioned a push for proportionality, as a necessary precondition: “Develop sectors in a more integrated fashion”, and referred to the disproportional allocation of funding to the military. In that respect, many in Burundi pointed out the connection between health and other public sectors. They felt the agenda of UHC should be linked to that of productivity improvement of the population. The relationship of healthcare with other public sectors also needs some new thinking: “If agriculture and education do not develop simultaneously, it will be hard for people to have any prospects or resources for health”.

“...We need to assess how many people actually receive healthcare, who are currently paying the health services, what the quality of the health packages is and what geographical barriers exist.”

Respondent, Rwanda

STRUCTURES, MANAGEMENT AND ACCOUNTABILITY
A further requirement mentioned was the need for a proper organization of healthcare systems, financial structures and institutions of accountability. In all countries this was thought to be essential – and in need of improvement. Pooling of funds was stressed in Burundi and Afghanistan, in Afghanistan mainly relating to donor funding: “If all donors supported the MoPH through the same funding mechanism it would help the MoPH to achieve its objectives much more easily” and in Burundi to all private funding with the transformation of the existing health financing into a social security system, supported by applying PBF, in mind: “Things will not happen with the disparate Mutuelles Burundi has now. We must channel all relevant private initiatives to finance and promote health out of a common basket. We must put in place mechanisms to protect the poor. The state should not discourage but stimulate private funding.”

Rwandan respondents pointed to these critical prerequisites for UHC: “the country needs to have a sufficient number of well-trained and qualified health professionals as well as strategies for financing health services”. To guarantee “reliable funding” and promote access to “good quality services”, improvements should be made in the “management of public funds, the human resources for health and the mindset of members of the population regarding insurance”. In Zimbabwe, besides bolstering the health financing capacity, different ways of accessing financing were considered: “package the requests for funding to Ministry of Finance differently; or work towards an independent Commission with the power to allocate funds and act as an internal donor”. In terms of service delivery, many here felt efforts should be focused at primary level where new interest in public health should be fostered: “Equip health workers with a clear understanding of the need to deliver care to the most marginalized. Here, PBF can help.”

GOOD DATA
Another element that was frequently mentioned: good research and data to base strategies and policies on, including those for accountability: “Good decisions depend on good information, good plans, good implementation and good reviews. To carry out research, monitoring, and evaluation and to develop action plans, good data are essential.” Lack of accurate health statistics was referred to in Burundi and Rwanda: “We need to assess how many people actually receive healthcare, who are currently paying the health services, what the quality of the health packages is and what geographical and financial barriers exist.”

COMMUNITY INPUT
A stronger link with community ideas and needs is seen by all countries as adamant, as this was not the case yet, for instance in Burundi: “The population can already participate in financing the CAM, but up to now they have not acquired a sense of ownership of the program”. Besides ownership, accurately responding to people’s needs was equally important: “First accurate knowledge of people’s needs is required, then an assessment of the quality of available care, and finally, one must gather knowledge of the resources available to cater for the population’s needs.” In Zimbabwe it was felt the role of communities was thus far underestimated: “The community is literate and they want to participate. Most perceived healthcare issues can be dealt with at community level. This is the way to go. We need to get back to a ‘re-empowering PHC model’.” This is not simply viewed by respondents as a matter of ‘hard cash’, but instead “we need to build a concept of volunteerism working through past models of health promoters and Voluntary Health Workers. Communities need to be constantly reminded that it is their duty to volunteer...There is a reservoir of expertise on hand and we can do things at low cost as well.” With more people-centered approaches the “loss of an integrated health approach should be redeemed”.

“The population can already participate in financing the CAM, but up to now they have not acquired a sense of ownership of the program.”

Respondent, Burundi

MULTI-STAKEHOLDER INVOLVEMENT
A further prerequisite is truly multi-stakeholder involvement and communication strategies that support the regular exchange of ideas and best practices, for “the UHC policy to be shared with all stakeholders. Everybody should contribute”. Afghanistan looked towards a wide range of expertise: “We need brains and intellectuals to develop innovations and strong working groups with internal and external expertise to discuss creative innovations.” But in Burundi, Zimbabwe and Rwanda the role of communities was emphasized in this: “We need leadership by the people and for the people. All leadership levels need to be joined together in the implementation of the same program. UHC is achievable if we dare to speak out about our experiences, our mistakes, our efforts... We need to record them, share our knowledge and foster partnerships to achieve UHC.” Burundi and Zimbabwe agreed that this would
require decentralization of health management: “Involve local stakeholders (education, agriculture, administration). In the predominantly rural environment of Burundi, the district level should be focused on as the primary operational level of the MSPLS.” It would also require efforts to enable everyone to participate, as was expressed in Rwanda: “the government must work together with the population, and sustainable economic development in the health system must be implemented so that the whole population is able to partake of the health system. We can achieve this by fostering social harmony... and the government working in new ways with donors”. Different countries felt different stakeholders could play a role in dissemination of UHC: Afghanistan pointed towards engaging mullahs, Zimbabwe to NGO’s and in Rwanda “all people listen to the radio, so any message from the MoH reaches all Rwandans”.

SOLIDARITY

Lastly, a precondition already mentioned in a quote from Rwanda above, is solidarity. Rwanda has long lived with “a culture of mutualism”, but also in Burundi and Zimbabwe many felt strong coordination of interventions to stimulate solidarity, especially between related sectors such as health, education, and agriculture was needed and part of the culture. For the informal sector in particular solidarity is deemed necessary: to strengthen awareness and include vulnerable people, to promote solidarity between rich and poor. For this, existing solidarity mechanisms need to be extended and made compulsory, so the poorest people should “benefit more from state subsidies to be able to purchase the CAM”.

5.6 UHC: STABILIZER AND BUILDING BLOCK FOR STATEBUILDING?

What are the perceived links between UHC development and fragile or transitional state building. Does UHC through specific debates, policies and practices help to advance stability?

“If community satisfaction exists, basic needs like health are fulfilled; there is less agitation against the government.”

Respondent, Afghanistan

SOCIO-ECONOMIC AND SECURITY FACTORS

Reflecting on the possible links between UHC development and nation building, the respondents frequently mentioned the broader context of their countries where strong destabilizing socio-economic and security factors are still hampering progress. In Rwanda, Burundi and Afghanistan, many stated it to be obvious “that health is a necessity”, and in that sense “improving healthcare makes a country stable”. Some stated that “when people are healthy, they can work and become wealthy. When all people are wealthy, security is ensured.” “Health security contributes to financial security. A system in which vulnerable persons are identified and treated provides help. Everyone must therefore have access to service delivery and the poor should be protected financially.” In Rwanda many believed that UHC contributes to stability and consolidation, whereas in Burundi and Afghanistan many felt it would not have an immediate impact, but could potentially contribute in the long run. A majority in these two countries stressed that “poverty” is a more determinant factor in causing instability. Hence “creating jobs, education and job opportunities to improve the economy” would have a more important role to play. The Rwandan respondents also felt that the current institutional setup of their coverage is “gender sensitive and promotes security”.

Health can also work towards stability through “building trust”. Several respondents maintained: “People who come to trust the health sector (seen as linked to government)... will support the government and will refrain from conflicts.” In that sense: “Stability is linked with health. If community satisfaction exists, basic needs like health are fulfilled; there is less agitation against the government.” Similarly, respondents in all countries felt that if equity and community involvement are not further developed, these become stability hazards, as was expressed in Burundi: “If people come together and pool their funds into a mutual insurance, this will lead to social cohesion, if there is equitable access. Even if the population is poor, such solidarity among people will help to strengthen social cohesion and prevent instability.” However, in Afghanistan some saw things the other way: “It is the role of government to supply peace, security and justice, as well as to provide support and stability. If the government does not do this, the project (of health) cannot be implemented.”

Zimbabwean respondents deemed a direct link between health and security too simple; the issues being much more complex. They indicated that a positive relation between health coverage and security is surely thinkable, but “it all depends on leadership and engaging the right players with expertise, including finance experts”. The greater sensitivity to context and more local type solutions required by the UHC agenda, the stronger emphasis on governance and sustainability, and the advances possible in infrastructure, legality and strategic management of a country, could indeed “add to stability” - and stressed again: “But the relationship between these different factors is not a simple one.”

5.7 UHC: THE POTENTIAL AND CONTRIBUTIONS OF CIVIL-SOCIETY ORGANIZATIONS

The perceived specific potential of civil-society organizations to advance UHC.

CURRENT ROLE OF CSOS

In all four countries, the UHC agenda has triggered a fundamental debate about stakeholder responsibilities in health. Civil society organisations are viewed by most as essential and “obvious” in the development of UHC, if not right now, then definitely in the future. However, no country was completely satisfied with the current role of CSO in the health field, for various reasons. In Afghanistan the current work of NGOs is seen to be directed “more to implementation rather than to advocacy”. It was viewed that they: “can implement projects and use budgets correctly, and utilize their capacity suitably”, however “they could be utilizing their resources more appropriately”.

“They (CSOs) should contribute to the mobilization of the community around the importance of CBHI coverage and financing.”

Respondent, Rwanda
In Burundi “the level of training of civil society representatives and their lack of information is still a barrier to serious contributions from national civil-society organizations”, as the CSO sector focuses too much “on political aspects and human rights but seems to have involved itself very little as yet in universal health coverage”. In Rwanda, problems were identified more at local level: “There is a problem with these organizations, sometimes they do not respond to the root cause of a problem.”

And in Zimbabwe, several respondents noted an ambiguous situation vis-à-vis CSOs, both locally and internationally. They urge to “avoid playing the blame game – NGOs versus the Ministry of Health... all must be involved in the UHC approach”. However, it was clear many respondents from Zimbabwe were critical of “civil society”, which they equated with donors. “Donors must be partners in this process and commit to priorities and stop coming up with non-priority ideas and parallel structures. The problem is that donors employ highly paid individuals. They focus on single programs and take away our staff.” Some felt that the balance between local and international civil input is flawed and “a lot of money has been wasted on involving advice from outside”. “The mechanization of health is a massive industry. Donors need to examine more closely the motives behind their largesse – especially big foundations such as Elizabeth Glazier, the Clinton Foundation or PEPFAR – and focus more on visibility and sustainability.”

“Thelys (CSOs) can raise the community voice, share it with government, or question the government as to why services are not equally provided.”

Respondent, Afghanistan

NEW ROLE FOR CSOS
At the same time, there is a strong conviction that UHC will never be reached without greater civic involvement. CSOs and NGOs are seen as potential partners for government and community and as positive forces in determining the needs of people and raising awareness. Various new roles are emphasized. CSOs could assist in the mobilization of funds and resources and: “help to bring together key players: policy-makers, consumers, civil society and stakeholders to understand the concept in the same way and move forward with a common vision with understanding.”

For that, CSOs needed to be invited to attend policy forums, as respondents in Afghanistan pointed out: “Civil society, NGOs and private sector involvement in big policy forums like the Consultative Group for Health and Nutrition is very important, but it remains rather minimal today. The MoPH should take responsibility and invite such parties to the big policy forums. The coordinating mechanism of the NGOs could monitor these forums. In that way, there would be no need for new stakeholders, but the participation of some old ones can definitely improve.”

Many saw a role in mobilizing the community, raising awareness on UHC and “they should promote systems that foster equity, access, and human rights. They should contribute to the mobilization of the community around the importance of CBHI coverage and financing.”

Several of these Rwandan respondents saw it as a priority task for CSOs to “help in making people use services better”. Zimbabwean respondents agreed and added that community stakeholders could “demonstrate that communities are already engaged and this is showing results... illustrate the point with examples, for instance, of how local mining activities allocate money to health.” In Afghanistan national CSOs were seen to “work a lot in rural areas” and have therefore obtained greater community trust. From that, they are could play a bigger role in promoting accountability. “They can raise the community voice, share it with government, or question the government as to why services are not equally provided. They can involve the media to do so.” In addition, these groups could “work to reduce the stigmatization of certain groups like people with HIV, and to improve services. As far as these respondents are concerned, local CSOs, “as members of society, should be involved in all processes.”

“Donors must be partners in this process and commit to priorities and stop coming up with non-priority ideas and parallel structures.”

Respondent, Zimbabwe

NEW ROLES OF INTERNATIONAL NGOs
Regarding the role of international organizations, a wide variety of possibilities was mentioned. First of all, they could continue to “provide technical and financial assistance”, as “the main task of international organizations today is funding and capacity building”, respondents in Afghanistan felt. In addition, respondents in Burundi and Rwanda formulated a number of suggestions. Some related to communities: assess the population’s needs more effectively, reach out to specific disadvantaged groups, and transmit the voice of communities. Other suggestions indicated stimulating data use, evaluations, research and evidence-based decision-making, also to enhance real multi-stakeholder dialogues with the aim to find real local solutions. Further ideas were to experiment with innovative models and promote sustained strategies and good governance. And lastly it was considered important to participate in common forums and intensify the sharing of experiences and best practices.

So, with differences in detail, all respondents are united in their view that greater alignment of international agencies with local agendas is long overdue.
6. CONCLUSIONS

The two general aims of this qualitative study were to understand and advance UHC in fragile and transitional states and to articulate the specific roles which civil-society organizations (CSOs) – from local to international – may play in the process. Based on the interviews and the literature survey, we come to the following conclusions:

1. Stakeholder awareness

How do stakeholders understand the current UHC agenda and is UHC anything new for stakeholders in health in fragile and transitional states?

Stakeholders in the countries in this study are generally aware of the UHC agenda, even if the term itself is not always widely used. It is not necessarily seen as something new, many elements of Primary Health Care and Health for all and even the MDGs are also seen as part of UHC. Nonetheless, UHC does appear to have added value. First of all, it requires a more holistic approach, in which equity and rights-based principles are central, accompanied by an integrated financial strategy. Second, UHC is clearly felt as a long-term objective and an opportunity to further an integrated national health system under country stewardship. And thirdly, community involvement is vital.

These basic reflections have consequences. Countries want to take the lead themselves, so the roles of many actors in the (international) health scene will have to change. National governments should lead the process, ensuring real political will towards UHC, accountability and good governance while designing and implementing domestic solutions and integrated strategies for health financing and service delivery.

The lead has clearly shifted from donors to governments. International donors and partners should pool their funds with the government and align to and support the government health policies. Communities need to be involved in the development of the health system, to ensure their needs are answered, to reach greater understanding and awareness in communities about the health system and its financial base, and to ensure they get value for money. Service providers have to make sure they provide equitable and sustainable health services and are accountable to the communities they serve.

2. Specific pathways and particular challenges and requirements

Specific pathways: Can we obtain a sharper understanding of the particular challenges and requirements for any pathways to UHC in fragile and transitional states?

There is no ‘one size fits all’ pathway. Each country should make its own inventory of what is currently in place, both in services provided, inclusion of all people and health financing. Starting with their existing health systems and an assessment of what works and what does not (nationally and internationally, as possible examples of best practices), additional or improved instruments, strategies or interventions can be added, improved and scaled up. This can be done either simultaneously or one by one, depending on the possibilities within the country. Step-by-step learning and gradual introduction of new components will support progressive realization of UHC. This requires good data, which can be collected and analyzed properly and should serve as input for decisionmaking.

In short, UHC requires combinations of instruments to ensure inclusion of all people, delivery of quality services and ensuring an appropriate and sufficient health financing system. The focus should be on a mix of instruments, which are locally designed and lead to a progressive realization by adding and improving instruments and thus effects over time.

Domestic funding is key! Sustained domestic funds for health require accountability and international funding should also facilitate accountability to the population. Eventually, domestic funding needs to be ensured for a sustainable health system. Community responsiveness is essential in this, because domestic funding will include contributions from the community, either through taxes or health insurance premiums. PBF can contribute greatly towards strengthening the system of service delivery (both in quantity, quality and separation of roles from Ministries to communities).

In countries where service delivery is very limited or mainly provided by international actors and/or where the legitimacy of government is still very fragile, certain early steps can be identified. These countries can use PBF to increase quantity and quality of service delivery, making sure not to exclude any groups in society. Community involvement can be realized in establishing basic service delivery packages (and thus answering to community needs). At the same time, there should be accountability from health facilities to the communities they serve.
**Universal Health Coverage in fragile states**

The worldwide attention for Universal Health Coverage as part of the global Sustainable Development Goals after 2015 is very important, as the MDG health goals have not yet been achieved in many countries.

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**“UHC is a great opportunity to improve healthcare, but will only work if radical changes in donor behaviour occur!”**

Simone Filippini, CEO, Cordaid

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**What does this mean for international NGOs like Cordaid?**

International NGOs need to shift their focus combining service provision with facilitating national dialogues and community involvement to secure inclusive national health policy making. This will go hand in hand with better alignment and pooled funding methods so as to create more space for national ownership and accountability to the population. This is crucial to achieve sustainable domestic mobilization of funding.

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**“Ensuring community accountability in the pathway to UHC is crucial to Cordaid Healthcare.”**

Remco van der Veen, Director Healthcare, Cordaid

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The findings of this qualitative study inspire Cordaid to further its mission on building flourishing communities by:

- Focusing more on providing capacity development to local organizations and communities involved in policy dialogues,
- Supporting national governments through technical assistance in formulating better and more responsive policies for universal health coverage,
- Making the link with the international level by advocating for a rethink of existing approaches on universal health coverage in fragile and transitional countries,
- Capitalizing on the opportunities that the UHC discourse and activities provide for restoring state – civil society relations within countries.

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**3. Peace and state building**

*Is there evidence that UHC contributes to peace and state building?*

In fragile, post-conflict and very low-income states, international involvement of both donor organizations and NGOs is large. This often undermines the legitimacy and the capacities of the local governments. Leadership in implementing UHC by national governments, including accountability to their people (rather than to the international actors), can increase the legitimacy of the government. International actors should be supporting this. Although there is no documented causality between the impact of health services and peace and state building, increasing service delivery through state regulation, ensuring inclusion of all groups in society is likely to support stability. The reverse is certainly true: providing services to limited parts of the population only will lead to instability.

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**4. Civil-society organizations**

*What should be their roles with respect to UHC?*

At local level, community involvement is important, for example in identifying the health needs, verification of services provided and to hold stakeholders accountable for their part in the health system. Local NGOs or CBOs may represent the community at different levels. However, good representation of the variety of voices in society is a precondition.

International civil society should focus less on direct service delivery (only when it is not possible by local actors, e.g. in emergency situations). Handing over of these tasks must happen in a sustainable way. International NGOs should instead focus on facilitation and technical assistance at the explicit request of local stakeholders. Areas of interest can be capacity building and evidence based analysis and data; facilitating multi-stakeholder encounters and deliberations; and assisting domestic policy development and practical planning.

Furthermore, international civil society can support the countervailing powers within systems to promote equity, accountability and access. This can entail supporting representation of various voices from society; answering requests of local civil society for capacity development; and engagement in independent verification of results.

The two general aims of this qualitative study are to understand and advance UHC in fragile and transitional states and to articulate the specific roles which civil-society organizations (CSOs) – from local to international – may play in the process. The following sets of questions are then of interest:

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**serve (giving them value for money). Equally, there should be clear roles and responsibilities for stakeholders within the health system as the importance of accountability is increasing. Available funds (domestic and international) should be pooled to support an integrated health system. With health services available and of good quality, countries can work towards health financing, including pooling the contributions from the people themselves.**

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APPENDIX A: LITERATURE SURVEY
TOWARDS UNIVERSAL HEALTH COVERAGE IN FRAGILE STATES
A SURVEY OF IMPACT STUDIES

Sven Neelsen and Godelieve van Heteren

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Abbreviations

CBHI Community Based Health Insurance
CPIA Country Policy and Institutional Assessment
CR Contributory Regime
DFID Department for International Development
DWMHI District Wide Mutual Health Insurance
DRG Diagnosis-Related Groups
IRAI International Development Assistance Resource Allocation Index
LMIC Low and Middle-income countries
NHIS National Health Insurance System
OOP Out-of-pocket
PBC Performance-Based Contracting
PBF Performance-Based Financing
RBB Results-Based Budgeting
RBS Results-Based Financing
SR Subsidized Regime
SSR Semi-Subsidized Regime
UHC Universal Health Coverage
UN United Nations
WHO World Health Organization
1. INTRODUCTION

Universal Health Coverage (UHC) is being discussed as the new Sustainable Development Goal in health after the Millennium Development Goals ‘deadline’ of 2015. The WHO states that the goal of UHC is to ensure that ‘all people obtain the health services they need without suffering financial hardship when paying for them’. This definition clearly refers to both supply and demand-side elements, and does not merely focus on financial access to services but also on good quality.

Important development in the background is the New Deal for Engagement in Fragile States. The ‘New Deal’ involves the commitment of the G7+ group, 19 fragile states and a number of international organizations – Cordaid included – to strive for progress in fragile states. It proposes key peacebuilding and state-building goals, focuses on new ways of engaging, and identifies the kind of commitment necessary to build mutual trust and achieve better results in fragile states.

It is clear that a host of pressing issues surrounds the UHC debates. The debates therefore deserve careful scrutiny. Who sets the UHC agendas in various countries? Which real policies and policy innovations are being introduced on the basis of UHC? To what extent does the new emphasis on UHC introduce genuine innovation in terms of orientation and methodologies of health systems and financial strengthening? To what extent are the UHC dictums which are being propagated at the moment applicable to all contexts in a similar fashion; are there important differences to be considered? Which approaches, if any, may be most effective in fragile states? To what extent is equity – the supposed ‘heart of UHC’ - actually being promoted by the current UHC agendas? And which are the most important factors that may contribute to achieving UHC?

As an international NGO with a long track record in health systems strengthening, capacity-building and innovation, often in challenging situations, Cordaid has a strong commitment to carrying out solid knowledge building and evaluation while undertaking its practical and policy work. In this survey of the known impact of UHC programs, Cordaid wishes to contribute to the key issue of defining what UHC amounts to and whether UHC agendas have any viability and relevance in fragile and transitional states.

Amid the many larger studies which now appear showing the growing interest in UHC, Cordaid has commissioned a more concise literature survey which specifically focuses on the known impact of existing pathways to UHC, and the feasibility of such pathways in fragile and transitional states.

In Section 2, we will sketch the conceptual framework used to outline universal health coverage. This chapter also introduces healthcare reform towards UHC in four countries at different stages of development and with different institutional setups to achieve the common goal of UHC. Making well-informed health policies for fragile states should therefore be able to build on tests of the effectiveness of different approaches to achieve UHC in the fragile state context. In Section 3, we detail how we use the concept of fragile states and outline the health challenges they face. In Section 4, we provide a non-exhaustive overview of the evidence regarding three broad types of policies - which have been applied in more stable environments with more or less success: (i) user fee removal and (ii) contributory insurance schemes as demand-side interventions, and (iii) results/Performance-Based Financing schemes as supply-side measures. And we will discuss their feasibility particularly for fragile states.

2. UNIVERSAL HEALTH COVERAGE

Conceptual Framework

The World Health Organization (WHO) defines Universal Health Coverage (UHC) as a situation in which ‘all people obtain the health services they need without suffering financial hardship when paying for them’. This definition clearly refers to both supply and demand-side elements, and does not merely focus on financial access to services but also on good quality. The concept of UHC is visualized in a box diagram (Figure 1).

The first dimension, the width of the box, designates what share of the population is enrolled in programs that provide financial protection against excess out-of-pocket (OOP) healthcare expenditure. Such pre-paid programs can take a variety of forms, ranging from contributory social health-insurance schemes with risk pooling on the national or sub-national levels, to private commercial insurance, or to tax-financed national health systems (WHO, 2008).

The second dimension, the depth of the box, describes the share of health services effectively covered by the pre-paid program (WHO, 2008). A great variety of benefit packages exists both between and within countries. In low and middle-income countries (LMIC), healthcare coverage for public servants and formal private sector employees often comprises more generous benefit packages than programs for people in the informal sector, complicating any measurement of coverage depths on the national level. Especially for higher-level care, there is also uncertainty about what constitutes the UHC benefit package (Stuckler et al., 2010). Perhaps the most important complication in measuring coverage depth in fragile states is that effective benefit packages are often different from entitlements, as system underfunding and inefficiencies often only make a fraction of possible services accessible in practice. If benefits to which one is entitled are in practice not accessible, mass enrollment in pre-paid programs has little meaning for the achievement of UHC.

The third dimension of UHC, the height of the box, states the level of financial protection which a healthcare system offers, commonly measured by the out-of-pocket share in total health expenditure or the share of the population spending a ‘catastrophic’ share of total household expenditure on health (WHO, 2008). The financial protection dimension has the advantage of also capturing - to a degree - coverage depth.

APPENDIX A: LITERATURE SURVEY

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If there is mass enrollment in a program that only gives ineffective coverage, financial protection will still be low as people will resort to purchasing care out-of-pocket. Thus, a bad performance in terms of financial protection is indicative of UHC not having been achieved even if mass entitlement to generous health benefits is formally granted. However, a low share of out-of-pocket expenditure does not necessarily mirror a functioning healthcare system. It can also reflect that people forgo needed care altogether because of financial or geographical access barriers. Thus, low out-of-pocket expenditure greatly gains in meaningfulness as an indicator for UHC if considered in combination with healthcare utilization. This twin indicator approach – impacts on financial protection and utilization – we will use to assess health policy reform towards UHC in fragile states.

**FIGURE 1 THREE DIMENSIONS OF UNIVERSAL HEALTH COVERAGE**

![Diagram illustrating the three dimensions of universal health coverage: reduce cost-sharing and fees, include other services, direct costs proportion of the costs covered, extend to non-covered services, current pooled funds, population: who is covered?, services: which services are covered?](image)

**Source** WHO (2010)

**Universal Health Coverage Achievers**

The countries that have achieved UHC have done so by many different pathways, and differences exist at all levels of UHC systems. In terms of health financing, for instance, some countries use contributory, premium-based schemes while others rely exclusively on tax-funding – in fact, mixed financing arrangements are the most common. Provider reimbursement can also vary, through different combinations of fee-for-service, capitation or case-based payments, and can also include performance-based elements. With regards to the payer, some countries use a national single payer approach while others continue to operate with multiple sub-national risk-pools. Finally, healthcare and insurance can be exclusively provided by the public sector or also come from the private non-profit or commercial sectors. While some institutional elements have proven more efficient than others, the specific weighing of advantages and disadvantages depends on the country context and there certainly is no single or simple recipe for UHC across the world. In the following, we aim to exemplify the heterogeneity of approaches to UHC with the cases of Colombia and Thailand.

**Thailand’s National Health System**

Thailand aimed to achieve UHC in 2001 with an ambitious package of both demand- and supply-side reforms (Limwattananon et al., 2013). These steps were preceded by several decades of strategic health-system development, during which the country had built an evolved provider infrastructure and extended healthcare coverage to a substantial share of its population. On the eve of the UHC reform, 30% of Thailand’s population had no coverage, whereas about half of the population was enrolled in two welfare schemes: for children, the elderly, the poor and the near-poor. The rest was covered through either a scheme for public servants and their dependents; a scheme for formal private sector employees, or through private insurance. Despite widespread coverage, concerns existed about its effectiveness, especially for the two welfare schemes with annual budgets of only around US$ 13 per enrollee (Donaldson et al., 1999). Coverage heterogeneity not only existed between schemes but also among localities with persistent regional disparities in provider infrastructure and health outcomes (Wibulpolprasert, 2002). Ineffective targeting of indigents in the welfare programs added to the inequities in healthcare access (Kongsawat et al., 2000).

The UHC reform began in early 2001, shortly after a new populist government had taken office and nationwide rollout was completed within a year. On the demand side, all Thai not covered by public or formal private sector insurance could now enroll in the ‘30 Baht Scheme’. Its beneficiaries were entitled to free inpatient and ambulatory care and prescribed medicines at facilities within a local, mainly public, provider network. Initially operating on a budget of about US$ 18 per enrollee, the scheme’s benefit package is near comprehensive, including high-cost treatments such as chemotherapy and open-heart surgery. For the most part tax-financed, a fixed charge of 30 Baht (US$ 0.75) per service contact was levied on non-elderly, non-poor adults that constitute about half of the scheme’s beneficiaries. Partly due to continuing difficulties with targeting those exempt from this charge, it was abolished in 2006.

On top of the coverage extension, the reform made substantial changes in the financing and organization of the public healthcare system to achieve a balance between effective coverage and maintaining control of healthcare spending. Key supply-side measures were a capped global budget, gatekeeper control of access to specialist care, reliance on mainly public providers and generic medicines, a mix of capitation and DRG-based reimbursement for provider payment; and from 2006 onwards a single public payer organization.

The 30 Baht Scheme enabled Thailand to make rapid and substantial progress towards UHC. Benefiting from the political momentum and the absence of enrollment fees and premiums in the new scheme, health coverage jumped from 71% in 2001 to 95% in 2003, and by 2011 had risen to over 98%. Limwattananon et al. (2013) find that the reform reduced the

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7 Where not otherwise indicated, the following account of the Thai healthcare system and its development is based on Limwattananon et al. (2013).

8 Antiretroviral treatment and renal dialysis were initially excluded but became part of the benefit package in 2003 and 2008, respectively. Organ transplantation is one of the few essential treatments excluded until today.
likelihood of forgoing formal ambulatory treatment when sick by 11% and increased inpatient admissions by 18%. The increase in ambulatory care utilization was greatest for the poor and rural populations, while significant inpatient care effects were only found in the urban population. The latter likely reflects the persistence of geographical access barriers. The study also found large reductions in exposure to medical expenditure risks. Mean household medical expenditure appeared reduced by one-third, as did the probability of spending more than 10% of the household budget on healthcare. Spending at the very top of the distribution of medical expenditures (i.e. the 95th conditional quantile) even halved. In terms of health impacts, Cruber et al. (forthcoming) found very large reductions in infant mortality and Wagstaff and Manachotphong (2012) found reduced labor force nonparticipation due to illness or disability.

Despite the cost control measures put in place, the 30 Baht Scheme's rapid and massive extension of health coverage coincided with a rise in public healthcare spending. There was a sharp increase in the introduction year and expenditures continued to rise, but at a less rapid rate, in the post-reform period. Between 2001 and 2010, public health expenditure per capita increased by almost 170 percent, driving the doubling of total health expenditure over this period. In spite of this increase, total health expenditure remains low, having increased from 167 to 353 real purchasing power adjusted dollars. Rapid economic growth helped Thailand to finance the spending increase, as a percentage of GDP, total health expenditure increased by only 0.6 of a percentage point from 2001 to 2010 and public health expenditure increased by one percentage point (International Health Policy Program, 2011).

Challenges remain - Thailand continues to wrestle with ensuring access to tertiary care for the substantial proportion of the population still living in rural areas. Inequities also persist in the financing of the different health coverage schemes. Despite an over 70% increase in the 30 Baht Scheme's budget between 2001 and 2011, the financing gap compared to the public sector employee scheme is large and increasing. While there is no clear evidence to prove it, this gap may well reflect clinically significant differences in healthcare quality, potentially undermine support for the 30 Baht Scheme if it comes to be seen as a poor man's service that the slightly better off prefer to opt out of. The accelerating budget of the public employee scheme is also a major contributor to the mounting pressure on government health spending and makes financing reform a priority on the Thai healthcare policy agenda.

Colombia's Social Health Insurance

Our second example country in the category of UHC achievers, Colombia, embarked on major healthcare reform with the passing of Law 100 in 1993. Until then, the country had used a three-tier system with a contributory scheme for formal sector employees covering 15% of the population, private insurance covering another 15% and the rest of the population paying out-of-pocket and/or relying on free or subsidized care from government providers. While universal in principle, the system failed to protect Colombians from excess out-of-pocket expenditures. Prior to the 1993 reform, more than half of healthcare spending was out-of-pocket and more than every second citizen reported forgo needed care for financial reasons.

The 1993 law redesigned the Colombian healthcare system around the principle of managed competition, relying on both the private and public sectors. Colombians now had the right to choose between competing private and public insurers. Insurers, within government regulation, could individually contract with public and private provider networks, negotiating both payments and payment modes. The reform also unified healthcare financing in one single fund. Pooling insurance premiums and tax revenue subsidies, the fund finances the insurers on a risk-adjusted per enrollee basis. Provider reimbursement is in most cases on a per capita basis for preventive and outpatient care, and by fee-for-service for hospitalizations.

The system knows three types of insurance arrangements. A contributory regime (CR) is open to anyone and mandatory for formal sector employees and informal sector workers with a minimum income. Premiums amount to 12.5% of 40% of monthly wages and purchase enrollees a comprehensive benefit package. 1.5% of the 12.5% premium is used to cross-subsidize care under a subsidized regime (SR), catering to the poor and indigent that are identified by means testing. The cross-subsidy amounts to around 40% of the SR's total funding with the rest coming from government revenue. The near poor can purchase insurance under the Semi-Subsidized Regime (SSR). Finally, there is public care provision for individuals without insurance and treatments not included in insured benefit packages. Here, however, the uninsured and CR and SSR beneficiaries subject to income-dependent copayments. Benefit packages differ between the three regimes. The CR includes comprehensive inpatient and outpatient services and cash benefits for maternal and sick leave. Meanwhile, the two subsidized schemes cover only a limited number of inpatient services and no cash benefit for short-term disability.

In terms of its UHC achievements, Law 100 and its follow-up legislation increased health insurance coverage in Colombia from about 10% in 1990 to over 90% today. About half of the population is enrolled in the SR, SSR coverage is small at 2-3% and 40% are covered by the CR. Today's near universality is the results of a two-decade long effort. Rollout of the SR was purposefully staggered, starting with the most needy parts of the population and being extended as more funding became available. The CR, however, met problems in reaching its informal sector target population. In response, additional regulation was passed. Since 2003, any individual wishing to accumulate a formal pension would also have to make health insurance contributions. Moreover, the reported wage used to calculate health and pension contribution levels determined future pension payments, thus incentivizing truthful wage reporting/health insurance contributions. Also, since 2002, employers are fined if contracted free-lancers do not participate in the CR. Several papers have investigated impacts on financial...
Thailand with its essentially free healthcare system achieved high coverage levels much faster than Colombia’s premium-based schemes. A functional provider network, sufficient tax-revenue, and the institutional structure and capacity to make efficient use of funds are preconditions for Thailand’s achievements. These preconditions are rarely met in other low and middle-income countries and found even less common in fragile states with their often-compromised central steering capacity and lack of human resources at all health system levels.

In the following, we present two country cases – Ghana and Rwanda – that have achieved major progress towards UHC in recent years in the face of challenges that more closely resemble those often met by fragile states. Because of this higher resemblance, they might be more instructive to inform intermediate, feasible steps towards UHC.

Ghana’s National Health Insurance System

The history of Ghana’s healthcare system is typical for many African countries. Economic stagnation led its tax-financed public system into bankruptcy in the 1970s. Following World Bank/International Monetary Fund structural adjustment policies, the country began to rely heavily on user fees, with the goal to recover a share of recurring costs and to reinvest the newly won funds into quality improvements. Side effects of this ‘cash-and-carry’ system were serious: as in many other countries, the user fees drove up out-of-pocket expenditure and negatively impacted healthcare access, in particular for the poor for whom exemptions were barely enforceable. Since the early 1990s, the country attempted to reverse these negative trends but it took until 2004 to gather sufficient political momentum to introduce a new national policy - the National Health Insurance System (NHIS). Inspired by prior experience with local health insurance, the new system builds on a ‘hub-satellite’ model with a national fund and reinsurance, and central authorities – the hub – that regulate and subsidize a nationwide network of District-Wide Mutual Health Insurances (DWMHI) – the satellites. Each district has one DWMHI that, within the central regulatory framework, is granted managerial autonomy and is accountable to the district’s Community Health Insurance Committee that includes representatives of local civic society.12

The NHIS is a compulsory scheme by design but in practice enrollment remains voluntary. Financing is primarily through a 2.5% health insurance levy on the national value added tax (VAT), accounting for about 70% of all financing. Around a quarter of NHIS’s funds come from payroll-based formal sector employment contributions and around 5% from income-related premiums collected from informal sector workers. The informal sector contribution takes the form of an annual enrollment fee that is being collected by DWMHI employees visiting houses and market stalls if not paid by the enrollee via bank transfer or in cash to designated pharmacies/chemical shops. To accommodate that informal sector incomes vary and are often seasonal, informal sector premiums can be paid annually or by monthly installments. Various groups like the elderly, children and the indigent are exempt from the enrollment fee/premium payments.

Coun tries showing progress to Universal Health Coverage

Thailand and Colombia show that UHC is achievable through different policies – a tax-financed mainly public national health system in the former and a voluntary insurance scheme that relies heavily on the private sector in the latter. Unsurprisingly, Thailand with its essentially free healthcare system achieved

12 Where not otherwise indicated, the following account of Ghana’s health system and its development is based on information from the ‘Joint Learning Network for Universal Health Coverage’ website, http://jointlearningnetwork.org/content/ghana and Soors et al. (2010).
The NHIS benefit package includes essential medicines, preventive, outpatient and basic inpatient care but excludes most high-cost treatments. No copayments are charged for the covered services. To prevent cost explosion and overuse, access to specialist/tertiary care is subject to primary care provider referral.

Care provision is through both public and accredited private facilities with the latter mainly consisting of faith-based organizations that account for over 40% of health services provided in the country. The providers are reimbursed through the DWMHIs by a mix of DRGs and capitation payments.

In terms of its contribution to UHC, NHIS increased the share of health-insured Ghanaians but enrollment is still far from universal with 2008 estimates indicating a coverage rate of 61%. In addition to its rather sluggish pace, enrollment is also inequitable. Studies by Sarpong et al. (2010) and Witter and Garshong (2009), among others, find it to be positively associated with socioeconomic status with both affordability and information lags hindering higher uptake among the poor. In the Sarpong et al. study, an alarmingly low 21% of poor households were enrolled, compared to 60% in the highest socioeconomic cluster. The difficulties Ghana continues to face in (re-) enrollment mirror the typical struggles of extending a contributory scheme in a low-income and widely informal economy – in response, the country is now considering replacing annual re-enrollment fees with a one-time lifetime payment (Lagomarsino et al., 2012). Robust evaluations of NHIS impacts on care utilization and financial protection are scarce. Mensah et al. (2010), in a study employing propensity score matching to account for non-random selection into insurance membership, find that insured women are more likely to receive prenatal care, deliver at a health facility, have their deliveries attended by a trained health professional and experience less birth complications. They also find much larger payments accruing for uninsured compared to insured women with facility deliveries. Results by Nguyen et al. (2011) suggest that NHIS enrollment significantly reduces the likelihood of incurring catastrophic health expenditures, with particularly large protective effects among the poor. In Witter and Garshong’s (2009) study, evidence on financial protection, however, remains inconclusive.

While the few available impact studies indicate some success in improving care access and financial protection, large challenges on the way to UHC remain. In addition to inequitable enrollment, the system suffers from managerial and administrative inefficiencies. Financial sustainability is also a concern as spending exceeded the budget for the first time in 2010, calling for more effective financing mechanisms and spending (Lagomarsino et al., 2012). Enrollee payments so far contribute under 5% to the NHIS budget but their extension would likely exacerbate the already existent equity issues. Finally, care quality remains a major concern with a continually weak human resource base and a fragmented provider system.

Rwanda’s Mutuelles de Santé

Rwanda had experimented with community-based risk pooling for healthcare for three decades before the early 1990s civil war severely disrupted its health system. To achieve rapid improvements in care access after the war had ended, the first post-war government removed user fees. In the absence of a strong supply-side, however, the policy remained ineffective and care quality remained compromised. The government in response reinstated user fees – with the predictable negative consequences for access equity. After repeated failure, the Rwanda then turned back to its early experiences by rebuilding the system based on strong community involvement in healthcare management and financing. A joint effort with international donors, and forming part of a larger push towards more decentralization of government responsibility, CHBI piloting began in 1999. Evidence on impacts from the pilots on healthcare utilization and, to a lesser degree, financial protection were encouraging while enrolling the poor posed a challenge despite contributions being conditioned on socioeconomic status (Musango et al., 2004; Schneider and Hanson, 2006). Building on the experience gained, implementation of a nationwide CBHI policy began in 2003.

The new CBHI system’s main building block are the Mutuelles de Santé as local insurers for anyone not covered through formal sector schemes that together insure only about 5% of Rwandans. Similar to the Ghanaian NHIS, in Rwanda, the center provides strategic vision, regulation, capacity building, monitoring and the majority of funding and reinsurance while the local level commands a great degree of managerial autonomy. The districts (250,000-500,000 inhabitants) form the first level of health governance below the central authorities. Here, a district-level Mutuelle coordinates the funding of, reinsures and regulates the community level, or sector Mutuelles, and ensures care quality in the district level facilities. At the bottom level, each sector (about 50,000 inhabitants on average) has one of these Mutuelles, managed by elected officials based on a locally agreed-upon constitution and by-laws. Within the framework given from the central and district levels, the sector Mutuelles decide on benefit packages, premiums, periodicity of subscriptions, conventions on care and health services, service providers and health centre reimbursement modes. The sector level is also responsible for insurance enrollment and the collection of contributions, as well as monitoring and evaluation of local health and healthcare providers.

System financing is mainly through government funds from tax and donor contributions. A smaller part of funds comes from insurance contributions (about US$ 1.80 per family member) and copayments (10% of treatment costs for Mutuelles) levied from enrollees. To enable these payments in light of a rather strict exemption policy – only about 10% of Rwandan’s are freed from them due to poverty or having HIV/AIDS – community banks provide earmarked 15% interest loans.

Provider payment is by fee-for-service and/or needs-adjusted capitation, depending on the local Mutuelle’s arrangement.

Where not otherwise indicated, the following account of Rwanda’s health system and its development is based on information from the ‘Joint Learning Network for Universal Health Coverage’ website, http://www.jointlearningnetwork.org/content/rwanda and Soors et al. (2010).
Since 2006, the provider payment mechanism includes Performance-Based Financing (PBF) elements, rewarding providers for the quantity and quality of services delivered and managerial efficiency. Results monitoring is on a quarterly basis.

The Mutuelles system started out with voluntary enrollment but health insurance is now compulsory. Each Mutuelle is responsible for (re-)enrollment levels in its catchment area and premium contributions, incentivizing outreach activities at the community level via church services, radio broadcasts, etc. to reach hard-to-enroll groups like rural dwellers and the poor. As part of Mutuelles’ autonomy, there is some discretion over the insurance benefits. A centrally determined minimum package, however, is binding for all. Every insured citizen is entitled to comprehensive primary care at local public or private not-for-profit health centres. This includes maternal and reproductive health services, vaccinations, minor surgical operations, essential drugs, and basic laboratory testing. On top of this, Mutuelles membership insures a limited number of services at district hospitals (cesarean sections, treatments of all diseases afflicting children ages 0 to 5 years, certain surgical operations, medical imaging, and medicines) and since 2006 select services in national hospitals are insured if accessed upon health centre referral.

Using a system of local responsibility for enrollment and at a later point, making enrollment compulsory, Rwanda has now achieved near universal insurance coverage, up from about 10% in 1999. Evaluations of the CBHI policy find higher use of modern health services, including assisted deliveries and increased financial protection among the insured (Sekabaraga et al., 2011; Hong et al., 2011).

In Rwanda, the insurance developments are accompanied by the introduction of PBF. Impacts of the PBF elements, piloted since 2002 and introduced nationally since 2005, have been investigated in several observational studies. Meessen et al. (2006) employed a controlled before-after comparison and found health centre utilization, especially for maternal services going up. Similarly, Soeters et al.’s (2006) non-controlled before-after study found maternal health services uptake to more than double and out-of-pocket expenditures reduced by 62%. Rusa et al.’s (2009) quasi-interrupted time-series study also indicates utilization increased for services previously not incentivized and guideline compliance rising. However, causal interpretation of the observational evidence is limited by the fact that co-interventions like ‘secular’ increases in facility financing and managerial support often accompanied the PBF interventions. Therefore, the randomized controlled trial by Basinga et al. (2011) is of particular relevance. It found large and positive impacts of PBF on institutional deliveries (from 35 to 42% of births, i.e. an increase of 23%) and preventive care visits by children (ranging between 56 and 132%, depending on age group), better quality of prenatal care and increased immunization rates. Against the background of these encouraging results, Kalk et al. (2010) in a qualitative study, still warn against potential side effects as gaming, neglect of non-numerated activities, irrational behavior to fulfill requirements and falsification of documents.

Despite its unquestionable success in improving care access and financial protection, challenges persist at all levels of the Mutuelles system. At the center and local health authorities, low managerial and administrative capacity hamper system effectiveness. The inefficiencies contribute to the high administrative costs that typically occur in a not full-fledged decentralized system - administration consumes almost one third of Rwanda’s total healthcare expenditure. The overall financial stability of the system is also questionable. Contributions and co-payments still prove insufficient to cover the Mutuelles’ expenses, even with a non-comprehensive benefit package. At the same time, subsidies from the center to overcome the financing gap remain highly donor-dependent (Soors et al., 2010).

**3. FRAGILE STATES, THEIR HEALTH AND HEALTHCARE SYSTEM PROFILE**

**Fragile States**

Various definitions of fragile states exist, resulting in different country classifications. An often-cited definition comes from DFID (2005) by which a fragile state is one in which “the government cannot or will not deliver core functions to the majority of its people, including the poor”. These core functions comprise service entitlements, justice and security. USAID (2005) emphasizes the evolutionary character of fragility by distinguishing between “failing”, “failed” and “recovering” states. The World Bank considers a state fragile if it performs poorly in the Bank’s Country Policy and Institutional Assessment (CPIA) or if a UN and/or regional political and peacebuilding or peace-keeping mission took place over the past three years. The CPIA is based on the six-scale International Development Assistance Resource Allocation Index (IRAI), in which higher scores indicate better performance and which considers as key elements: property rights and rule-based governance, the quality of budgetary and financial management, efficiency of revenue mobilization, quality of public administration, transparency, accountability, and corruption in the public sector (World Bank, 2011). The fragility threshold is an IRAI score below 3.3.

We use the IRAI threshold as inclusion criterion for our literature survey on recent fragile state healthcare reform impacts, as we include all countries with a below score in at least two years in the 2005-11 period. If we also count South Sudan and Somalia for which no CPIAs are available, this method results in a total of 38 states considered fragile. Table 1 lists these countries, along with their IRAI scores for 2005-11. For the 33 states qualifying as fragile in 2011 by World Bank criteria and for which data were available, Tables 2-4 show health and health-system indicators. For comparative purposes, the tables also include data from Rwanda and Ghana, the two countries progressing to UHC and from Thailand and Colombia, the two UHC achievers.

**Health profile**

Despite some heterogeneity, similarities in the health profile of fragile states emerge from Table 2. The average citizen in fragile states has a life expectancy of 59 years as compared to 73.5 years across the two UHC achievers. The stark life
expectancy difference reflects in the mortality patterns. Non-communicable diseases cause 37% of deaths in fragile states compared to 68.5% in the UHC countries. Deaths from communicable disease and maternal and child deaths combined account for 55% of the fragile states’ death toll. Women in fragile states have a 0.39% chance of dying in childbirth, almost six times higher than women in UHC countries, and in fragile states neonatal, infant, and under-five mortality are three, five, and six times higher, respectively. The high rates of avoidable deaths in part mirror nutritional deficiencies as the chance of a citizen in fragile states to be undernourished has increased more than 2.5 times. Low rates of access to improved water

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>COUNTRIES WITH IRAI-SCORES BELOW 3.3 IN AT LEAST TWO YEARS OVER THE 2005-11 PERIOD</th>
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<tr>
<td>COUNTRY</td>
<td>IRAI-SCORE</td>
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<td>Afghanistan</td>
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<tr>
<td>Angola</td>
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<td>Burundi</td>
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<td>Cameroon</td>
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<td>Central African Republic</td>
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<td>Chad</td>
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<td>Comoros</td>
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<td>Congo, Dem. Rep.</td>
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<tr>
<td>Congo, Rep.</td>
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<td>Djibouti</td>
<td>3.1</td>
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<td>Eritrea</td>
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<td>Guinea</td>
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<td>Liberia</td>
<td>-</td>
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<td>Mauritania</td>
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<td>Nigeria</td>
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### Table 2: Life Expectancy, Undernourishment, Causes of Death, and Maternal and Child Mortality

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### UHC Progression Countries

| Ghana                      | 64                             | 5                                          | 53                             | 8                                       | 39                                  | 350                                           | 30                                          | 52                                          | 78                                          |
| Rwanda                     | 55                             | 29                                        | 63                             | 8                                       | 29                                  | 340                                           | 21                                          | 38                                          | 54                                          |

### UHC Countries

| Colombia                   | 74                             | 13                                        | 13                             | 21                                      | 66                                  | 92                                            | 11                                          | 15                                          | 18                                          |
| Thailand*                  | 73                             | 11                                        | 17                             | 12                                      | 71                                  | 54                                            | 10                                          | 14                                          | 17                                          |


**Notes:** Superscript numbers indicate data coming from years other than year indicated in first row: **1** indicate 2005, **2** indicate 2008, **3** indicate 2010 data, respectively. °data for Thailand from 2003, the first full year in which UHC was implemented. Thai undernourishment and maternal mortality data from 2005, cause of death data from 2008.
## Table 3: Access to Improved Water and Sanitation, Health Infrastructure and Preventive Care Use

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<th>Access to Improved Sanitation in % of Population, 2010</th>
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<th>Nurses and Midwives per 1,000 Population, 2010</th>
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**UHC progression countries**

| Ghana                                                  | 86                                                       | 14                                                     | 0.09                               | 1.05                                        | 0.9³                                   | 68                                                      | 91                                                      | 91                                                      |
| Rwanda                                                 | 65                                                       | 55                                                     | 0.06                               | 0.69                                        | 1.6³                                   | 69³                                                      | 97                                                      | 95                                                      |

**UHC countries**

| Colombia                                               | 97                                                       | 77                                                     | 1.56                               | 0.62                                        | 1.4³                                   | 99                                                      | 85                                                      | 88                                                      |
| Thailand³                                               | 94                                                       | 96                                                     | 0.28                               | 1.52                                        | 2.1³                                   | 97                                                      | 98                                                      | 96                                                      |


**Notes:** Superscript numbers indicate data coming from years other than year indicated in first row. 1, 2, 3, 4, 5, 6 indicate 2005, 2006, 2007, 2009, 2010, 2011 data, respectively; ³data for Thailand from 2003, the full year in which UHC was implemented, Thai midwife and nurse data from 2004, skilled birth attendance data from 2006, hospital bed data from 2010.
### Table 4: IRAI Score, GDP Per Capita and Selected Health Financing Indicators

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<td>-</td>
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<td>42</td>
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<td>57</td>
<td>83</td>
<td>6.8</td>
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</tbody>
</table>

**UHC progression countries**

| Ghana             | 3.9              | LM                   | 1,671                                       | 90                                            | 4.8                               | 29                                       | 66                                            | 11.9                                           | 14                                            |
| Rwanda            | 3.8              | L                    | 1,111                                       | 135                                           | 10.8                             | 21                                       | 49                                            | 23.8                                           | 46                                            |

**UHC countries**

| Colombia          | -                 | UM                   | 8,890                                       | 618                                           | 6.1                               | 17                                       | 68                                            | 18.5                                           | 0                                             |
| Thailand*         | -                 | LM                   | 6,206                                       | 206                                           | 3.6                               | 27                                       | 74                                            | 13.0                                           | 0                                             |


**Notes:** As for the income brackets, L indicates ‘lower income’, LM ‘lower middle income’ and UM ‘upper middle income’ countries, according to gross national income per capita - for details on the classification method, see [http://data.worldbank.org/about/country-classifications](http://data.worldbank.org/about/country-classifications); *data for Thailand from 2003, the first full year in which UHC was implemented.*
southern Africa, including Angola, gives cause for optimism, with a declining trend in fertility and infant mortality. However, many other fragile states face an ongoing challenge to meet the health needs of their populations. The failure to make progress in improving health outcomes is likely linked to weak health systems, inadequate health workforce, and limited financial resources allocated to health. The situation in fragile states is further exacerbated by conflict, which disproportionately affects vulnerable populations such as women and children. During times of conflict, health facilities often close and health workers are forced to flee, leaving populations without access to essential health services.

Healthcare infrastructure and services
Fragile states disease profiles often mirror an underdeveloped healthcare system or a system in disarray through a fragile situation (Haar and Rubenstein, 2012). The fragile states lack the capacity to meet the managerial and administrative requirements of a nationwide scheme. With government involvement in healthcare financing also lower in fragile states than progression and UHC countries, the majority of fragile states healthcare spending comes from out-of-pocket payments. For eleven of the 29 fragile states for which spending data is available, more than half of healthcare spending is out-of-pocket and for 20, the out-of-pocket share is above 30%.

With fragile states governments are unable or express limited commitment to provide both appropriate healthcare resources and services, donors/international NGOs often step in as both financiers and service providers (Kruk et al., 2010). 57% of the healthcare budget in Liberia, for instance, comes from external sources.

Healthcare financing
Table 4 indicates that the failure of many fragile states to make proper health services accessible to their populations is closely linked to the failure to raise sufficient financial resources for health and distribute them equitably so as to achieve broad protection against catastrophic healthcare spending. In 2011, per capita healthcare spending for the almost 500 million people living in the fragile states in our analysis was 91 international $, similar to the spending level of Ghana (90) but far below that of Rwanda (355). Within fragile states, large heterogeneity exists, with spending ranging from 17 international $ in Eritrea to 564 in Georgia. Thailand achieved massive improvements towards UHC while spending just 26 international $ per citizen on healthcare. However, while Thailand's low spending indicates that UHC may not be out of financial reach for lower- and middle-income fragile states, it is not representative for UHC elsewhere – healthcare spending in Colombia accrued to 618 international $ when the country approached UHC in 2011. The differences in per capita healthcare spending in part reflect differences in country income levels. Half of the fragile states are in the lower income bracket, the other half, with the exceptions of upper middle-income Angola and Libya, are lower middle-income countries. While a number of fragile states lag far behind in economic development, the gap to the two African progressing countries is not so large for many – in fact, in twelve fragile states, 2011 per capita GDP was higher than in Ghana and Rwanda. By contrast, GDP per capita in the two UHC countries far exceeds that of all fragile states except Libya and that of the two countries progressing to UHC.
4. RECENT HEALTHCARE REFORM IN FRAGILE STATES THROUGH THE UNIVERSAL COVERAGE LENS

Extending Coverage

Free Healthcare

The use of user fees has been contentious for many years. User fees for health services were introduced or substantially increased in many LMICs in the 1980s and early 1990s as part of structural adjustment policies promoted by the World Bank (Akin et al., 1987). At the time, policymakers hoped they would help mend dysfunctional healthcare systems by raising urgently needed resources for care quality improvements, and preventing health services overuse (Akin et al., 1987; Litvack and Bodart, 1993).

Concerns about this type of introduction of user fees were voiced early on. With large parts of the implementing countries’ populations impoverished, critics argued that the fees would contribute very little to health financing and exacerbate financial inequities in access to needed care (McPake, 1993; Gilson and Mills, 1995). Three decades after the great political push for user fees in LMICs, the scientific verdict is ever clearer. Their contribution to health sector resources is often marginal, typically amounting to less than 10% (McPake et al., 2011). At the same time, user fees reduce healthcare utilization – facility visits often halve after their introduction or increase (Lagarde and Palmer, 2011; McPake et al., 2011; Ponsar et al., 2011). Yet, no evidence has emerged that the reductions come from stifled frivolous demand, nor that overuse of free care is a relevant issue in LMICs (McPake et al., 2011). Rather, utilization reductions are often particularly large among vulnerable groups, and so worsen the already rampant socioeconomic inequities in care access (Bornemiszsa et al., 2010). South Sudan provides a particularly compelling case for the failure of such user fee regimes in fragile states. Piloting a user fee model aiming at care access (Bornemiszsa et al., 2010). At the time, policymakers hoped they would help mend dysfunctional healthcare systems by raising urgently needed resources for care quality improvements, and preventing health services overuse (Akin et al., 1987; Litvack and Bodart, 1993).

The evidence from non-controlled before-after studies of these interventions typically indicates large increases in care utilization and, where measured, some improvement in financial protection. Much caution however has to be applied for any causal interpretations of these trends as user fee removals are commonly accompanied by other health system and non-health system changes that can have ‘sectoral’ impacts on utilization and out-of-pocket spending. In the following, we present evidence from controlled before-after studies that are able to rule out a confounding of impact through trends that affect control and treatment groups alike.

Heavily donor backed and building on both public and contracted private providers, Afghanistan introduced a comprehensive basic health services package after ousted the Taliban regime. User fee charges varied regionally with no national policy in place. In 2005-7 the country piloted full user fee exemption for the package and free availability was introduced nationwide in 2008. Steinhardt et al.’s (2011) controlled before-after study finds curative care utilization up to quadrupling and no compromising of care quality that they assign to an accompanying step-up in provider funding. More recent studies however, indicate that the user fee removal in practice may not have been so complete as policy makers wished and some are even clamoring for their return (see chapter 5 of the Cordaid study).

In light of the pressing need to reduce high maternal and child mortality, some fragile states have initiated fee removal by exempting reproductive and child health services from user charges. Robust evidence is provided in a controlled before-after study on the effects of three different user fee schedules for children and pregnant women in Sudan (Abdu et al., 2004). Decreasing user fees by 25% and 75% led to a more than proportional increase in the number of pregnant women (52% and 130% respectively) and children (64% and 280% respectively) seen in health centres. Moreover, a similar but smaller impact was found for a decrease in fees of 50% (32% increase for children and 28% increase for women). Contrasting evidence on the impact of user fees comes from Cambodia, Akashi et al. (2004) find that the introduction of user fees in pilot hospitals increased antenatal care utilization and facility deliveries. The authors explain this finding with accompanying quality improvements and the high prevalence of informal payments in the Cambodian healthcare sector. It is argued that by replacing informal fees, the formal fee made delivery costs predictable and brought down overall payments for birth attendance.

Because of the administrative challenges of identifying indigent groups, few fragile states have implemented fee exemptions based on socioeconomic status in recent years. Cambodia and Afghanistan form two noteworthy exceptions.

Starting in 2000, the Cambodian Health Equity Funds identify their poor beneficiaries through third party actors that are typically international donors. The benefit package covers...
comprehensive acute care at project hospitals. The scheme not only removes all user fees for care, but also reimburses transport, food and other expenditures accruing around hospital stays. In addition, social workers assist beneficiaries during their hospital stay, helping to overcome additional access barriers like social stigmatization, and guaranteeing that no informal fees are charged, or that patients are referred to private clinics. The project showed impressive gains in hospital access for the poor but also underscored challenges in standardizing beneficiary identification models, organization and management procedures, benefit packages, funding, monitoring and evaluation across providers (Ir et al., 2010b). Moreover, despite their aim to keep the direct cost of hospitalization to minimum, financial access barriers for beneficiary households remained (Grundy et al., 2009). Pakistan’s Punjab and Sindh provinces have experimented with vouchers giving free access to maternal health services since 2008. The program had issues in effectively targeting the poor (Agha, 2011a) but the fee removal increased utilization in particular in the poorest wealth quintile (Agha, 2011b).

In Afghanistan, community-based targeting of very poor and female-headed households was piloted in 2005, before the nationwide introduction of the free basic healthcare package. Beneficiary households identified by community leaders received waiver cards that entitled them to a comprehensive benefits at no user charge. Steinhardt and Peter’s (2010) evaluation study finds higher rates of care seeking for recent illnesses for households receiving the waivers. Contrary to community leaders’ self-reporting of effective targeting, household data, however, revealed significant leakage and high levels of under-coverage occurred. Forty-two percent of cards were used by people in the wealthiest three quintiles, and only 19% of people in the poorest quintile received a card. Hence, while adding evidence on the effectiveness of user fee removals in raising healthcare utilization, the Afghan, Pakistani, and, to a degree, the Cambodian experience underscore that the high managerial and human resource requirements of exempting the poor may not be met in fragile states (Ranson et al., 2007).

In conclusion: the story around user fee removals or exemptions remains complicated and compromised.

**Premium-Based Schemes**

With its high managerial and administrative requirements, statutory national health insurance is virtually absent in most fragile states (Witter, 2012). Instead, efforts to introduce contributory schemes have focused on CBHI. Past and current CBHI schemes cover a large range of regulatory, ownership and management arrangements, benefit packages, enrollee cost-sharing provisions, and target populations. Against the background of this heterogeneity, Soors et al. (2010) attempt to summarize common features: CBHI are characterized by (a) community-based social dynamics and risk pooling, where the schemes are organized by and for individuals who share common characteristics (geographical, occupational, ethnic, religious, gender etc.); (b) solidarity, where risk sharing is as inclusive as possible within a given community and membership premiums are independent of individual health risks; (c) participatory decision-making and management; (d) nonprofit character; and (e) voluntary affiliation.

CBHI is argued to bear potential as a valid tool to achieve equitable access and better financial protection for underserved populations. Further potential is suspected in instilling an awareness for the concept of insurance and for community participation and entitlement in its members. Moreover, premiums and co-payments may raise scarce resources for healthcare and the implementation and administration of schemes may help build local management capacity. In terms of challenges, critics have warned that CBHI, by building on premiums and cost-sharing, bears the danger of continued exclusion of the poor. Administrative cost may also run high and the managerial skills required may be scarce at the local level. Moreover, risk pooling in small-scale schemes may often not be sufficient to uphold financial stability or insure a meaningful benefit package, especially if voluntary enrollment leads to adverse selection - i.e. enrollment concentrated among those with high healthcare needs (De Allegri et al., 2009).

We could only identify one small-scale study (Rao et al., 2009) applying a robust, quasi-experimental methodology to obtain CBHI impact estimates. The following account of CBHI effects in fragile states hence also includes weaker evidence from non-controlled studies. Cameroon has been experimenting with CBHI since the 1990s, but uptake remains marginal and a national umbrella organization and policy framework is missing. One early impact study from a Yaoundé scheme documents pro-rich membership and difficulties in re-enrollment (Atim, 1999). For the Democratic Republic of the Congo, CBHI enrollment also remains low despite a recent growth in activities. Evidence on CBHI impacts in the country focuses on the Bwamanda scheme, which was established already back in 1986. The scheme quickly achieved up to 65% enrollment of its target population, with enrollment rates varying with episodes of violent conflict in its catchment area. Insurance coverage is for hospital care and conditional on health centre referral. Ilunga et al. (1995) and Criel and Kegels (1999) document the scheme’s success in increasing equitable access to hospital care and improving financial protection, as well its effective management and high beneficiary satisfaction. These findings, are, however, most likely highly contextual. The scheme is part of an integrated development project managed by a Congolese NGO together with several donors since the 1960s. Already before the CBHI element was introduced, healthcare delivery in the project area was effective and a long-term relationship had been established between project leadership and the local population, creating an atmosphere of mutual trust in which membership conditions (premiums, copayments, etc.) could be extensively discussed and designed specifically in line with community needs.

In Cambodia and Lao, CBHI a decade after its introduction, still operates with a small number of schemes and marginal enrollment on the national level. Existing schemes, however, have shown some promise. The largest Cambodian scheme, SKY, is in operation since 1998 and in 2010 covered 61,000 individuals for private primary and referral care and transportation costs to providers. To ensure participation of the poor, around 30% of beneficiaries are subsidized through an integrated health equity fund. Care quality in the scheme is ensured

---

14 This account of theoretical predictions of CBHI effects as well as the list of studies mention in the discussion of the empirical evidence on impacts in fragile states is based on the reviews by Soors et al. (2010) and Spaan et al. (2012).
through provider contracts stipulating service requirements to be met, with regular tests of patient satisfaction. The extension of CBHI is backed by the central government’s commitment to a multi-tier approach to achieve UHC, building on statutory health insurance for the formal and contributory CBHI for the informal sector, with health equity funds assisting the poor in CBHI enrollment. Lao PDR has a similar vision towards achieving UHC that includes backing up CBHI with health equity funds for the poorest. Despite a similarly generous benefit package as in Cambodia, schemes in both countries struggle with reaching a substantial share of their target populations and re-enrollment (Soors et al., 2010). At the same time, descriptive evidence suggests utilization rates are higher and financial protection effective among Laotian members (ibid.).

For Afghanistan, Rao et al. (2009) report on a CBHI experiment prior to the nationwide user fee removal. They find increases in utilization but no impact on out-of-pocket expenditure, the scheme experiencing difficulties with re-enrollment and a cost recovery rate through premiums of 12%.

Burundi, Guinea, Mauritania, and Togo have also made attempts at introducing CBHI but none of the countries has achieved substantive enrollment rates and policy frameworks remain weak. No peer-reviewed impacts studies on UHC dimensions could be identified (Soors et al., 2010).

In summary, while CBHI has substantively contributed to progress towards UHC in countries like China, Ghana and Rwanda (Spaan et al., 2012), these successes will be difficult to realize on a large scale in fragile states. Rather, the existing dimensions could be identified in any of the fragile states under study. Conditional-cash transfer programs under which citizens receive a cash benefit upon using, typically preventive, health services were not formalized in many fragile and transitional states over the last decade.

Impact studies on PBC have been conducted in at least four fragile states. In Afghanistan, the BPHS program is implemented under Results-Based contracts with NGOs (PBC), and some public providers (PBF). The Performance-Based component can amount to 10% of annual budgets and is evaluated based on 29 indicators (the ‘Balanced Scorecard’) that include both health outputs like antenatal care and immunization coverage, and patient and health worker satisfaction (Peters et al., 2007). Arur et al. (2010) investigate the impacts using a before-after comparison with controls. They find no difference in outcomes between PBC and PBF arrangements, but that facilities with Performance-Based Financing have increased outpatient utilization compared to facilities without (29% to 41%).

Performance-Based Financing is also found to lead to more equitable healthcare access as the poor, women, and children under five show particularly large utilization increases.

In Cambodia, a 1999-2008 pilot used PBC with healthcare provision by international NGOs in two rural districts and contracted-in public facilities in three districts. Schwartz and Bhushan (2004) and Bloom et al. (2007) use a before-after comparison with controls to estimate impacts. PBC, they find, contributes to higher and more equitable primary care utilization and reduces out-of-pocket expenditure. There is, however, uncertainty if the impacts can be assigned to the PBC, as the treated facilities were subject to co-interventions like management support. Similarly, Soeters and Griffiths (2003) compare staff performance, primary care utilization and out-of-pocket spending over time without controls, also finding positive evidence compiled here mainly builds on the reviews by Eldridge and Palmer (2009), Fretheim et al. (2012) and Gorter et al. (2013).
associations with PBC that made 45% of health worker salaries conditional on punctuality and patient contacts, Eldridge and Palmer (2009) however, caution that due to the lack of controls, the study cannot distinguish potential PBC effects from those of ‘secular’ increases in health worker salaries, facility managerial support and the effects of contracting NGOs as providers independently of results-based financing elements. Moreover, the health outcome improvements identified in the study had no little linkage to the incentivized performance indicators.

Eichler et al. (2009) and Eichler et al (2007) analyze a Haitian program in operation from 1999 to 2011, where contracted NGO providers received health output and managerial indicator-based bonus payments. NGOs quarterly received 95% of their projected budgets unconditionally, with 5% conditional on achieving performance goals and another 5% possible for completion of all targets. The evaluations find large increases in immunization, skilled birth attendance, and oral re-hydration salt usage and a reduction in performance gaps between NGOs. Like in the Cambodian studies, however, co-interventions like technical assistance and capacity development and an overall facility budget increase impede identification of a pure PBC effect.

In Pakistan’s Punjab region, the government introduced PBC for basic healthcare provision with local NGOs in 2003. Ali (2005) and Loevinsohn et al. (2009), in a controlled before-after study find over 50% increases in curative care utilization and increased community satisfaction with services but no effects on uptake of preventive care and care quality.

In Burundi, the 2006 user fee removal for maternal and childcare was accompanied by the piloting of PBF. Soeters et al.’s (2011a) non-controlled before-after study finds large increases in family planning services (7 to 53%) and assisted deliveries uptake (16 to 82%) and increases in care quality, while HIV/AIDS related activities and immunization dropped and out-of-pocket increased. The pilot-projects where scaled up to the national level in 2011.

In the Democratic Republic of the Congo PBF pilots were started in 2000 and later programs have been scaled up. Facilities can autonomously set user fees while they reimburse rises in the number of patients they attract. Soeters et al. (2011b) controlled before-after study finds that a performance-based cash bonus to health workers that can amount to up to 30% of salaries does not increase utilization but improves perceived care quality and reduces out-of-pocket expenditure and corruption. Other fragile states are experimenting with RBB. Since 2008, Cambodia uses its midwifery incentive scheme to incentivize institutional deliveries with budgets conditioned on the number of life births. Ir et al. (2009) and Ir et al. (2010a) document positive impacts but the lack of controls and co-interventions limit the interpretability of their findings.

In summary, the available evidence indicates that Results- and Performance-Based Financing provide valuable Instruments to increase healthcare utilization and improve care quality in fragile states. Nevertheless, at least in the quantification of impacts, caution is advised as most estimates come from observational studies with bias risk that can lead to an overstatement of effects. In a first Cochrane review of the evidence from low and middle-income countries, Fretheim et al. (2012) cautioned that no general conclusion can yet be drawn on RBF impacts, which may be highly contextual and might not be very large. On a further cautionary note, Ireland et al. (2011) underscore that potential adverse effects – such as a biasing in service provision towards measurable services and target populations, gaming and fraud – have yet to be rigorously studied. Ireland et al. also suggest more research into the cost-effectiveness of RBF as it is to date unclear if the high administrative cost accruing at the provider and health authority levels are justifiable against the quality and utilization gains achieved. Finally, in the particular context of fragile states, Morgan (2010) notes that in fragile environments, poor performance may reflect circumstances rather than provider failure. Rewarding actors operating in more advantageous locations could then unintentionally exacerbate inequities.

Healthcare Reform in Fragile States and Nation-Building

In theory, health system development is an entry point to overcome state fragility as it is hypothesized that effective provision of health services can lead to involvement and positive feedback between government and civic society, potentially instating a platform for broader, longer-term development initiatives (Haar and Rubenstein, 2012).

More specifically, leaning on Kruk et al. (2010), functions of healthcare systems in nation building can be organized around at least four different aspects.

1. Promoting social cohesion: By providing equitable access to care and using progressive financing, socioeconomic tension as a source and consequence of conflict may be attenuated. Healthcare systems can not only improve inclusion by providing equitable access to care but also by strengthening civic society through participatory health sector decision making. Higher social inclusion and equity have in turn been shown to correlate with higher economic growth, opening a pathway for further increased government legitimacy (Haar and Rubenstein, 2012). If, however, conflict lines run across ethnic or regional rather than socioeconomic groups, a trade-off between higher equity and stabilization might exist (Waldman, 2006). Then, if stabilization is priority, health system development efforts may focus on areas where opposition to the government is most widespread, rather than on the most needy parts of the population. Such prioritization policies have been applied in the DRC, Afghanistan, and Mozambique (Rubenstein, 2011).

2. Restoring accountability and strengthening the social contract: Healthcare systems reflect government values and capacity and as such are an important building block of government legitimacy (Freedman, 2005). User fees, for instance, may communicate a government’s readiness to accept the exclusion of the extreme poor, whereas a financing system that employs cross-subsidization and stresses universal access can communicate commitment to solidarity and human rights (ibid). To underscore this commitment, governments can embed access to healthcare as a basic right in new constitutions, as happened recently in Nepal (Witter et al., 2011).
3. Restoring Trust: A functional and accountable healthcare system conveys trust – a scarce resource in fragile environments – on various levels, from the provider-patient interaction and the overall relationship between a health facility and the local community, to a citizenry’s general perception of the trustworthiness of government in fulfilling its obligations (Tibandebage and Mackintosh, 2005).

4. Strengthening government capacity: Building effective public health system capacity enables governments to fulfill basic functions that a paramount to legitimacy (Ohiorhenuan & Steward, 2008). Conversely, the broad reliance non non-governmental and even international agents in order to quickly achieve healthcare access improvements in fragile states bears the danger of not only leading to irreversible health system fragmentation but also of conveying public sector incapability to the population (Commims, 2010; Rubenstein, 2011). Also, a focus on easily quantified and quickly achievable health goals could bias health system development and thereby endanger sustainability (Zivetz, 2006).

If, as theory suggests, political stabilization is in fact enabled by health system development, this would be a crucial benefit as up to half of post-conflict states suffer from renewed conflict (Collier and Hoeffler, 2004). A causal linkage, however, has yet to be established, and empirical studies on the topic from fragile states are scarce. Kruk et al. (2010) summarize findings from Jones et al.’s (2006) review of post-conflict case studies from Germany and Japan after World War II, Somalia, Haiti, Kosovo, Iraq and Afghanistan. The review finds indications that healthcare system development supported nation building. Also, it is suggested that health system rehabilitation should engage the local government to improve program coordination, to increase support for the local government, and eventually to allow the government to take complete ownership of health service provision. Furthermore, the study points out the importance of emphasizing the government’s role in service provision to build public support for the Ministry of Health.

Waldman (2006), Eldon et al. (2008) report that in Sierra Leone, support for government appeared to shift with increasing and then decreasing availability of health services. In post-conflict Mozambique, the government emphasized healthcare system rehabilitation in opposition strongholds for which Vaux and Visman (2005) indicate positive effects on stabilization. For Afghanistan, healthcare waivers for the poor that employed community-based targeting mechanisms according to Steinhardt and Peters (2010) helped reinstate trust in local institutions. Much like for the Sierra Leonean and Mozambican studies, a high level of uncertainty about causality, however, remains.

5. CONCLUSIONS

- For most developing countries, Universal Health Coverage (UHC) – enabling universal access to quality health services that are both comprehensive and affordable – has long been an implicit policy goal. Today, despite conceptual uncertainty about its indicators, it is on its way to become the explicit measuring stick against which national health policies are assessed. It ranks high on the international health policy agenda.

- Generally, heterogeneity of schemes said to contribute to UHC abounds. This survey underscored some of this heterogeneity by discussing four country cases. Thailand with a massive centrally stirred reform that extended healthcare entitlements almost overnight for 80% of its population, Colombia that build on contributory social health insurance and more gradually progressed towards UHC, Ghana that combines national level risk pooling with local insurance provision, and Rwanda that relies on community-based health insurance schemes with strong local involvement. Developed and developing countries have used different policies to extend health coverage, and innovative mixes of approaches are emerging.

- There is limited stock-and-barrel transferability of successful models to fragile states. Countries like Thailand emerge as model cases, with rapid universal enrollment, large immediate improvements in healthcare utilization and financial protection, and successful healthcare spending control. However, these countries still face challenges, notably around equity. And the transferability of models such as the Thai one to a fragile-state context is likely to be limited, due to issues regarding the required administrative rigour, human and financial resource requirements and difficulties with simply copying the political drive and structures necessary for such large-scale reforms. These prove to be deeply rooted cultural phenomena. Thus, while an effectively organized, centrally governed public system with tax-funding in principle forms an efficient mode of advancing towards UHC, immediate progress in fragile states may require adjustments.

- Robust evidence on the impact of health reforms in fragile states is still sparse. However, as the literature survey demonstrates, some indications are emerging of the specific requirements and the caveats regarding various schemes, for instance about schemes not working given a level of administrative capacity which is not in place.

- The evidence, on contributory local health insurance schemes, especially voluntary ones, is not very encouraging. Several states have experimented with them, fragile states included, but none have achieved substantial uptake, and enrollment is often inequitable. Maintaining equity and meeting its high administrative and regulatory requirements at both the central and local levels have proven considerable challenges. It would be unfair to copy models, which are discredited in large parts of the world to ‘starters’ on the UHC market!
With respect to results-based financing (RBF) schemes, certain evidence to date suggests that RBF elements can improve care quality and utilization. However, much remains to be learned, however, and the newly emerging work on equity and the sustainability in RBF still needs to be further assessed by more research.

While many transmission channels are thinkable and discussed in theory, the causal evidence case on the link between UHC efforts and statebuilding has yet to be made. Importantly, researchers underlined that quick fixes to defunct fragile state healthcare systems – like contracting out to international NGOs – may be successful in improving health outcomes in the short run, but face the risk of further delegitimizing national governments if their own ability to provide policies, financing and services is not concurrently developed.

Where public providers are in short supply – as is commonly the case in fragile states – adjustments can be achieved by contracting private providers. Private provider contracting, as well as public provider payment in fragile states has been combined with performance-based reimbursement. If properly regulated for quality, they can help to alleviate the burden of e.g. executing health care in remote areas (see, for instance, the case of contracting out services in Afghanistan to private partners, or the case of many countries in which faith-based organizations provide much of the health services. Here, the combination with the introduction of performance-based reimbursement of all parties concerned, proper autonomy and a proper separation of function is found to function positively. In many countries, however, this set of preconditions is not in place and so some pilots yield little results.

Many other adjustments appear necessary. While an effectively organized, centrally governed public system with tax funding can form an efficient mode of advancing towards UHC to achieve immediate progress, fragile states may require substantial adjustments of such models. The limited amount of robust evidence on impacts of recent fragile state healthcare reforms tends to support the notion of specific requirements. Collecting any meaningful funding from the informal sector through premiums and user fees is too huge a challenge in many places. More donor money, a realignment of tax spending, or acceptance of the fact that healthcare access will continue to be rationed through income are suggestions made in the literature. Moreover, continuous funding is needed to warrant that providers can adequately respond to the utilization increases that can be expected after user fee removal. Somebody has to pay the bill!

The larger donors (bilateral and multilateral) have officially committed themselves to greater coordination, but in practice fragmentation is still rampant. The Paris agenda and Accra Declaration remain to a large extent paper exercises.

Much concerted research effort is therefore still needed, not least to produce further evidence on particular interventions in fragile-state contexts. Our review considered the role of

health system renovation for statebuilding. While many transmission channels are thinkable and discussed in theory, causal evidence on the link has yet to emerge. Importantly, scholars underlined that quick fixes to defunct fragile state healthcare systems – like contracting out to international NGOs may be successful in improving health outcomes in the short run, but bear the danger of further delegitimizing national governments if their own ability to provide policies, financing and services is not concurrently developed.

6. POST-SCRIPTUM

In late December 2013, we revisited the literature and observed an interesting shift in emphasis in the UHC arena. Where previously, many conversations had revolved around financing modes, the debate was seen to expand rapidly beyond financial-technical considerations. It turned more to the politics of implementation, ownership and multistakeholder engagement. On the one hand, the concerted efforts of WHO and the World Bank to frame the UHC agenda have led to an upgrading of existing documents, such as the country reports in the World Bank Unico project. They have stimulated consultation rounds coordinated by WHO and the World Bank on ‘monitoring and evaluating progress made in UHC’ (WHO, 2014). And they have facilitated the publication of a brochure with basic principles on health financing, country examples and guidelines to ‘Arguing for Universal Health Coverage’ to support advocacy (WHO, 2013b).

On the other hand, several agencies and civil-society alliances have begun to raise their voices for UHC to become more truly transformative. This call for a more paradigmatic shift was articulated sharply during a panel Cordaid hosted at the CSO Forum of the autumn meeting of the IMF/World Bank (see Conclusions report in Appendix E). It has also found expression in the UHC report by Oxfam International in October 2013 (Averill and Marriott, 2013). This report puts the UHC debate squarely in the context of the right to health. It criticizes some donors and developing country governments for promoting health insurance schemes that “exclude the majority of people and reinforce inequality” – by prioritizing people who are formally employed and excluding the most poor and marginalized who cannot afford to pay premiums, especially women. The report scrutinizes the various financial strategies and concludes that prioritizing general government spending for health to successfully scale-up health coverage, funding through progressive taxation and international aid is the key to achieving UHC. The authors estimate that improving tax collection in 52 developing countries could raise an additional $269bn – enough to double health budgets in these countries. They make a plea for urgent action on global tax evasion and avoidance, which is needed to ensure that countries can generate and retain more of their own resources for health (Averill and Marriott, 2013).

The presentations at the Global Conference on Universal Health Coverage (UHC) for Inclusive and Sustainable Growth, December 6-7, 2013 in Tokyo reiterated similar shifts in...
emphasis. The conference was organized under the Japan-World Bank Group Partnership Program for UHC, a Partnership Program that has supported systematic analyses of health policies and programs in 11 countries in order to respond to the growing demand from low- and middle-income countries for assistance in developing UHC policies and strategies. The 11-country study found that in principle UHC programs could improve the health and welfare of their citizens and promote inclusive and sustainable economic growth (World Bank, 2013b). The ongoing reforms in the countries studied—Bangladesh, Brazil, Ethiopia, France, Ghana, Indonesia, Japan, Peru, Thailand, Turkey and Vietnam—have yielded valuable insights into the common challenges and opportunities faced by countries at various stages on the path to UHC. The key policy messages from this multi-country study concur with several of Cordaid’s conclusions in the October 2013 panel. They highlight successful UHC adoption and expansion requires at least strong political leadership and long-term commitment; equitable coverage; fiscal sustainability of UHC; scaling up the health workforce; and investing in a robust primary care system.
APPENDIX B: QUESTIONNAIRE (ENGLISH)

General introduction
- Present a general introduction of purpose of the interview (see introduction document)
- Introduce the role of the interviewer
- Explain the timelines, the feedback mechanisms and requesting whether the person can be mentioned in the list of ‘persons interviewed’. Make clear that in the main body of the report nobody will be quoted without permission. Most information will be aggregated. There will be a list of persons interviewed in the back, but in general no information will be traceable to individual people unless permission has been explicitly granted for such quotes.
- We work with informed consent!

Interview sections
1. Note general information regarding the person interviewed
- Date of the interview:
- Name of the interviewer:
- Name of the person who is being interviewed:
- Target group:
- Contact information (Email/Phone):
- His/Her Titles:
- Age or age category: 15-25, 25-35 etc
- Occupation:
- Professional background (highlights):
- Current Role in the health system:
- Length of time in current position:
- Does the person wish to be mentioned in the list of persons interviewed and if so under which description: name, titles, professional affiliation
- Does the person wish to receive copies of the final report by mail, note down address?

2. General understanding: Universal Health Coverage is now widely used in policy circles
- Are you familiar with the term UHC? (this may not be the case with e.g. patients)
- Are you aware that this term is used in the country? (policy) circles in the country (general description, details will follow later in the interview)
- Have you followed/been engaged in the development of the UHC discussions and what has struck you as their main characteristics?

3. More detail: details Universal Health Coverage as thematic in policy (drivers, political involvement, new debates)
- Moving from your own perspective, is it your view that government is working on any UHC position for the country? If yes, ask for knowledge of documents/workshops and note them down.
- In the literature, several dimensions of UHC have been defined: such as (i) percentages of population coverage; (ii) depth, extent and quality of service delivery, (iii) degree and forms of financial coverage. Which of these dimensions do you feel are most prominent in the UHC debates in your country, if any?

4. In practice: Universal Health Coverage financial and service delivery dimensions in practice
- Can you sketch the financial health care situation in your country: e.g.:
- (Important: here, official documentation will often be available, so pose the first three questions in this section ONLY to officials or refer to official documentation)
  - How much budget is available publicly and privately for health?
  - By what mechanisms is healthcare being financed, who is paid and who is paying for it, how much Out-of- Pocket payment occurs currently?
  - Which services are ordered in the form of official packages (of PBF, Insurance or otherwise).
- How much dependency is there on donor funding, and which donors in particular are active in your country/ region/district and in the UHC debates?
- Which parts of the population are covered, and which groups experience challenges?
- What mechanisms exist to cater for the poor and do they work?
- In practice, what are the main challenges in financing for healthcare in your country? In your view should any new/ innovative mechanisms be developed to attain financial coverage, if any?

- Can you sketch briefly the service delivery situation in your country (who is catered for by whom) and what level of service is provided?
  - Which services are accessible for whom?
  - In practice, what are the major challenges in service delivery in your country?
  - Which (new) mechanisms in service delivery should be further developed to attain universal good service delivery, if any? Whose responsibility is that?
5. Do UHC agendas make any difference in fragile and transitional states and what are the roles of civil-society organizations?

- In practice, do you feel that the debates on Universal Health Coverage can make any difference in practice? If so, which differences are prominent in your view? What is really achievable? If not, why not?
- Where the MDG discussions prominent in your country and how do the new UHC debates compare in your view to what happened under the MDG agenda’s?
- Do you feel each country has its own specific routing to UHC, and if so, which should be the routing of your country? (Can we adapt or do you feel that we need anything special here?)
- How do you explain why UHC has not been achieved in most parts of the world and how does this question pertain to your country? What stops it from happening? What is really achievable/attainable? Bottlenecks/ challenges? Facilitators?
- What do you feel the (new) roles of stakeholders in health should be and which changes in their roles may be necessary? Should new stakeholders be involved? Who should motivate and monitor it?
- How do you see the role of civic society organizations, national or international, in advancing UHC?
- Do you feel pursuing a UHC agenda could contribute to stability and social consolidation in the country and if so, in what ways? If not, why not?
- What do we need to find out to equip us better to make realistic decisions with regard to UHC (practical research technical assistance)?
### APPENDIX C: LIST OF RESPONDENTS

<table>
<thead>
<tr>
<th>CODE</th>
<th>SURNAME</th>
<th>NAME</th>
<th>TG</th>
<th>AGE</th>
<th>M/F</th>
<th>OCCUPATION</th>
<th>DATE OF INTERVIEW</th>
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<td>A01</td>
<td>Miakhil</td>
<td>Dr. Khanagha</td>
<td>TG2</td>
<td>38</td>
<td>M</td>
<td>Prov. Public Health Director Urozgan</td>
<td>14-8-2013</td>
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<td>A02</td>
<td>Zameer</td>
<td>Dr. Fazel Mohammad</td>
<td>TG6</td>
<td>32</td>
<td>M</td>
<td>Health Projects Management EU Delegation Afghanistan</td>
<td>14-8-2013</td>
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<tr>
<td>A03</td>
<td>Siddiqi</td>
<td>Dr. Abdul Majeed</td>
<td>TG6</td>
<td>45</td>
<td>M</td>
<td>Head of mission of HealthNetTPO Afghanistan</td>
<td>15-8-2013</td>
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<tr>
<td>A04</td>
<td>Parsa</td>
<td>Victoria</td>
<td>TG10</td>
<td>Nm</td>
<td>F</td>
<td>Director of Afghan Midwife Association</td>
<td>15-8-2013</td>
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<tr>
<td>A05</td>
<td>Aini</td>
<td>Ashrafudin</td>
<td>TG6</td>
<td>45</td>
<td>M</td>
<td>Director General of AADA &amp; Chair Steering Comt Alliance Afgh Health NGOs</td>
<td>15-8-2013</td>
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<tr>
<td>A06</td>
<td>Zaheer</td>
<td>Dr. Hamayoon</td>
<td>TG2/TG5</td>
<td>43</td>
<td>M</td>
<td>Nangarhar Regional Director N. Prov</td>
<td>17-8-2013</td>
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<tr>
<td>A07</td>
<td>Khalid</td>
<td>Dr. Ibi Amin</td>
<td>TG1</td>
<td>55</td>
<td>M</td>
<td>Acting Director for Procurement MoPH</td>
<td>28-8-2013</td>
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<tr>
<td>A08</td>
<td>Hasani</td>
<td>Jamila</td>
<td>TG9/TG10</td>
<td>42</td>
<td>F</td>
<td>Trainer Afghan Women’s Resource Center</td>
<td>11-9-2013</td>
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<tr>
<td>A09</td>
<td>Anonymous</td>
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<td>TG6</td>
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<td>M</td>
<td>Health Program Manager</td>
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<td>Sharif</td>
<td>Dr. Asadullah</td>
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<td>14-9-2013</td>
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<td>Sarwari</td>
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<td>M</td>
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<td>Justine</td>
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<td>Chamkany</td>
<td>Dr. Mujibur-e-hamn</td>
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<td>M</td>
<td>Deputy Commissioner of Health, Labour and Youth Wolesi Jirga (Parl)</td>
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<td>Mirzad</td>
<td>Dr. Jawad</td>
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<td>Advisor policy and planning MoH</td>
<td>1-10-2013</td>
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<td>Hemiati</td>
<td>Cholam Sarvar</td>
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<td>M</td>
<td>Head of Department of Grants and Contracts Management Unit</td>
<td>5-10-2013</td>
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<td>A17</td>
<td>Saleh</td>
<td>Ahmad Shah</td>
<td>TG1</td>
<td>Na</td>
<td>M</td>
<td>Medical Officer in one of provinces</td>
<td>21-8-2013</td>
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<td>B01</td>
<td>Anonymous</td>
<td>Upon request</td>
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<td>M</td>
<td>Medical Officer in one of provinces</td>
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<td>Ngowenubusa</td>
<td>Dr. Melchior</td>
<td>TG2/TG5</td>
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<td>M</td>
<td>Chef du District Sanitaire de Kibumbu</td>
<td>26-8-2013</td>
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<td>B03</td>
<td>Ninihazwe</td>
<td>Mme Marlette</td>
<td>T8</td>
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<td>Directrice du departement de l'integr. Social au Ministere de la Solidarite Nationale etc.</td>
<td>26-8-2013</td>
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<td>B04</td>
<td>Twungubumwe</td>
<td>Dr. Novat</td>
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<td>Directeur des prestations a la Mutuelle</td>
<td>26-8-2013</td>
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<td>Rubeya</td>
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<td>Medical Director of supply and demand of healthcare</td>
<td>27-8-2013</td>
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<td>Nshimayezu</td>
<td>Dr. Maximilien</td>
<td>TG4</td>
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<td>DG Soc Cooperative Multisectorielle Coordonnateur Proj. Mutualite pour la Sante</td>
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<td>Uwineza</td>
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<td>Nduswmana</td>
<td>Dr. Stanislas</td>
<td>TG3/8</td>
<td>42</td>
<td>M</td>
<td>Advisor to 2nd Vice Presidency</td>
<td>28-8-2013</td>
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<td>M</td>
<td>Acting Director of Health Financing at the Ministry of Health</td>
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## Appendix C: List of Respondents

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The main conclusions drawn from the presentations and the debate were:

- There is no one-size-fits-all or single pathway to Universal Health Coverage.
- The UHC agenda is not new but demands more concerted effort: The political momentum which is generated by the international debates can be used as a positive stimulus to rally for better access, quality, and inclusion of marginalized people.
- It is adamant to go the extra mile and move the international health agenda beyond the circles of people who have become accustomed to setting the scene internationally.
- Communities, their needs and insights should be put much more center stage.
- It is crucial to cast UHC in a broader political, cultural and social frame and look much deeper into contexts.
- Political will and community engagement may be the most prominent factors in advancing UHC.
- The issue of local ownership enters a new phase. This applies just as much – maybe even more – to fragile states contexts as elsewhere. The UHC agenda if well managed could turn into the boost the international community needs to finally become inclusive.
- The UHC agenda should engage everybody interested in integrated health financing and management strategies.
- Transparency and good governance become more important under a new UHC agenda. This could foster stabilization of environments and states.
- Certain roles of CSOs become more pronounced under a new UHC agenda:
  - To help increase transparency, accountability and good governance.
  - To assist governments in particular kinds of technical assistance.
  - To assist communities to set the agenda, exchange, advocate, manage.
  - To opt radically for inclusion and resist forces of exclusion.
APPENDIX E: REFERENCES

References used in the report

Existing Evidence. UNICO Studies Series 25 (see also UNICO).

APPENDIX E: REFERENCES

- Thai National Health Accounts, International Health Policy Program. 2011.


Important networks and websites for UHC exchange and country studies


Rwanda

Zimbabwe
- DFID. 2011. The Department for International Development’s support to the health sector in Zimbabwe, Prepared by ICAI with assistance of KPMG LLP, Agulhas Applied Knowledge, Center of Evaluation for Global Action (CEGA) and the Swedish Institute for Public Administration (SIPU International); United Kingdom.

Four countries’ national strategy policy documents

Afghanistan

Burundi
- Cadre stratégique de croissance et de lutte contre la pauvreté CSLP II, see: http://www.bi.undp.org/content/burundi/fr/home/library/poverty/cslp-ii-2012-report/
- Health Indicators, see http://www.quandl.com/health/burundi-all-health-indicators
- Ministère de la Santé Publique et de la Lutte contre le Sida, general information. See: www.minisante.bi
ABOUT CORDAID

Cordaid is based in the Netherlands and has country offices in 11 countries. It has been fighting poverty and exclusion in the world’s most fragile societies and conflict-stricken areas for a century. It delivers innovative solutions to complex problems by emphasizing sustainability and performance in projects that tackle security and justice, health and economic opportunity. Cordaid is deeply rooted in the Dutch society with more than 300,000 private donors. Cordaid is a founding member of Caritas Internationalis and CIDSE.

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