East African Community

Universal Health and HIV Coverage (UHHC)

Resource Mobilization Strategy 2018 - 2023

Preamble

During the last decade, global confidence in the ability of countries to provide quality health services to all has culminated in three important commitments to be attained by 2030: First is Sustainable Development Goal (SDG) 3.8, which aims to achieve Universal Health Coverage (UHC); second is the United Nations General Assembly Political Declaration on HIV and AIDS of June 2016, which resolved to fast track an end to the AIDS epidemic, and third is a reaffirmation of Member States' commitment to implementing the Agenda on Financing for Development.

Cognisant that the East African region bears an unequal disease burden, where nearly 1.5 million people die of preventable causes annually, dialogue among and within East African Community (EAC) Partner States has progressed towards ending AIDS and achieving Universal Health and HIV Coverage (UHHC). Achieving the latter implies access to high-quality, safe and affordable essential healthcare services, medicines and vaccines, in addition to financial risk protection. However, one of the major and longest standing barriers to UHHC in East Africa is a huge resource gap: In 2015, a sustainable financing analysis report on UHHC estimated the collective funding gap for East Africa to 2030 at a minimum of US$18 billion annually. Based on this analysis, an issue paper on sustainable financing proposed a EAC Framework of Action (EFoA) for all Partner States, which was adopted during the High-level Ministerial dialogue on Sustainable Financing for UHHC on 23 June 2016, when EAC ministers responsible for health and finance committed to implementing a number of actions. The 13th Sectoral Council of Ministers responsible for health noted the need for clear strategies to mobilise resources to support implementation of the EFoA on Sustainable Financing for Health and HIV, and approved terms of reference to develop a resource mobilisation strategy to support its implementation.

An analysis of Partner States' progress in implementing EFoA, other financing commitments and emerging best practices provides a solid contextual foundation for prioritising future resource mobilisation efforts. The strategies proposed here drew lessons from this analysis and were developed consultatively with stakeholders in the EAC region and individual Partner States. The strategy's six results-based programmes will be implemented through a mutual accountability and reporting framework guided by domesticated implementation plans that take into account each Partner State's context. The expected programme results include: Enhanced fiscal space for UHHC; sustainable UHHC financing mechanisms developed by each Partner State; improved efficiencies and financial investments in UHHC from less than 70% to at least 90% by 2023; increased UHHC funding through public private partnerships (PPPs); strengthened structures at national and regional level to support and enable UHHC policy, governance, regulation and resource mobilisation; and enhanced cross-sectoral collaboration for UHHC resource mobilisation.

The EAC is thankful to the Honourable Ministers responsible for health, finance, East African affairs and others; as well as permanent secretaries for their foresight and enduring support to this process. EAC acknowledges numerous contributors drawn from other government entities, civil society and private sector in all Partner States, development partners, technical support providers, and regional and global partners, in addition to members of the various EAC expert and technical working groups. The community is immensely grateful to the Swedish International Development Agency (Sida) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) for financial and technical support towards the realisation of this strategy.

ABBREVIATIONS AND ACRONYMS

501 (C) (3)	Registered organisations that are tax exempt in the United States
95-95-95 (90-90-90)	Diagnose 95% of all people living with HIV, provide antiretroviral therapy (ART) for 95% of those diagnosed, and achieve viral suppression in 95% of people on treatment (similar 90-90-90 targets apply for tuberculosis)
ARVs	Antiretroviral medicines
AU	African Union
BIF	Burundian Francs
BPHNS	Basic Package for Health and Nutrition Services
CAM	Carte d'Assistance Médicale
CBHI	Community-based Health Insurance (Rwanda)
CBHI	Community-based Health Initiative (Boma Health Initiative, South Sudan)
CIDA	Canadian International Development Agency
CRPA	Central Region Planning Authority
CSO	Civil society Organisation
DHIS 2	District Health Information System (2)
EAC	East African Community
EALA	East African Legislative Assembly
EFoA	East African Community Framework of Action
eLMIS	Electronic Logistical Management Information System
EU	European Union
EWG	Experts Working Group
FAPS	Fonds d'appui à la protection sociale
GDP	Gross Domestic Product
HMIS	Health Management Information System
HPF	Health pooled fund
HRIS	Human Resource Information System
HRTT	Health resources tracking tool
HSDP	Health Sector Development Plan
HSSP	Health Sector Strategic Plan
IFMIS	Integrated Financial Management Information System
IGAD	Intergovernmental Authority on Development
KFF	Kaiser Family Foundation
LMIS	Logistical Management Information System

MdS	Mutuelles de Santé
NAC	National AIDS Councils
NACC	National AIDS Control Council
NASA	National AIDS Spending Assessment
NCD	Non-communicable Disease
NGOs	Non-governmental organisation
NHA	National Health Accounts
NHIF	National Health Insurance Fund (Tanzania)
NHIF	National Hospital Insurance Fund (Kenya)
NHIS	National Health Insurance Scheme (Uganda)
OoP	Out-of-pocket Expenditure
PERs	Public expenditure reviews
PETS	Public expenditure tracking survey
PEPFAR	President's Emergency Fund for AIDS Relief
PHC	Primary healthcare
PPP	Public private partnership
QAID	Quality Assurance and Inspection Directorate
REMA	Rwanda Environmental Management Agency
RMNCAH	Reproductive, maternal, neonatal, child and adolescent health
SDG	Sustainable Development Goal
Sida	Swedish International Development Cooperation Agency
THE	Total health expenditure
TWG	Technical Working Group
UHC	Universal Health Coverage
UHHC	Universal Health and HIV Coverage
UK	United Kingdom
UNAIDS	Joint United Nations Programme on AIDS
UNGA	United Nations General Assembly
UNICEF	United Nations Childrens Fund
US	United States
WHO	World Health Organization

DEFINITIONS IN THIS STRATEGY

Economy	Delivering the best value/quality of services at the least possible cost or price.
Effectiveness	A measure of whether qualitative or quantitative results are attained.
Efficiency	A measure of productivity, including quantitative and qualitative results attained against the amount of resources invested, including financial costs.
Equity	Delivering services in a manner that does not cause, maintain or aggravate avoidable social, economic, demographic or geographical differences among groups of people.
HIV-specific social protection	Programmes that focus exclusively on HIV and people living with and directly affected by HIV. Under HIV-specific programmes, HIV services are provided for free and users encouraged to access them by the health, social development, finance, education, agriculture, governance, justice, law and other sectors.
Quality health services	Preventive, promotion, treatment, palliation and rehabilitative services that are effective.
Universal Health Coverage	Ensuring that all people and communities can access and use promotive, preventive, curative, rehabilitative and palliative health services when required, without exposing the user to financial strain or hardship (SDG 3, Target 8).
Universal Health and HIV Coverage	Ensuring that all people who require them have access to quality health and HIV-specific social protection services, including HIV prevention, treatment and mitigation, without exposure to financial strain or hardship (an amalgamation of SDG 3.8 with Goal 3.3, with emphasis on HIV specific social protection).
Value for Money	Ensuring that investments are efficient, economical, effective and equitable.

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Introduction and Rationale for this Resource Mobilisation Strategy

1.1 EAC background and commitments to universal healthcare and ending AIDS

The EAC is the regional intergovernmental organisation of the republics of Burundi, Kenya, Rwanda, South Sudan, United Republic of Tanzania and Uganda. The EAC is headquartered in Arusha, Tanzania. The EAC mandate on health is stipulated in sections (a) (b) and (e) of Article 118 of the EAC Treaty in which Partner States committed to: (a) Take joint action towards the prevention and control of communicable and non-communicable diseases, control pandemics and epidemics of communicable and vector-borne diseases such as HIV-AIDS, cholera, malaria, hepatitis and yellow fever that might endanger the health and welfare of the residents of the Partner States, and cooperate in facilitating mass immunisation and other public health community campaigns; (b) Promote the management of health delivery systems and better planning mechanisms to enhance efficiency of health care services within the Partner States; and (e) Harmonise national health policies and regulations, and promote the exchange of information on health issues to achieve quality health within the community.

At least 1.3 million East Africans were estimated to have died of preventable diseases in 2016, while five million others are living with HIV, making the region's arguably one of the highest disease burdens in the world, comparable only to southern Africa in terms of HIV prevalence and leading in the incidence of tropical and non-communicable diseases. Deaths related to AIDS and opportunistic infections account for between 18% and 30% of all deaths. Furthermore, the EAC region also faces huge resource gaps and constrained fiscal space, with an additional UHHC financing need of at least US$18 billion for the six countries annually.[1] [2]

Through the United Nations General Assembly Resolution 70/1 of September 2015, governments, including those of EAC Partner States, pledged to achieve UHC and end the HIV epidemic by 2030, among other goals. These were reaffirmed at the United Nations General Assembly in June 2016, where Member States committed to the 2030 Agenda for Sustainable Development, including the provision of UHC, resolved to fast track and end the AIDS epidemic by 2030 and to implement the Addis Ababa Action Agenda on Financing for Development.[3]

Building upon the EAC Vision 2050, which seeks to attain 100% access to health services, the 5th EAC Development Strategy 2016/17-2020/21 prioritises health (including HIV) as a cross-cutting objective and is aligned to these global, continental and regional goals. It aims to ensure a people-centered approach in the delivery of each of the EAC's health sector policy objectives, sub-sector strategic plans and operational frameworks.[4] In addition, the 36th Ordinary Meeting of the Council of Ministers of February 2018 considered nine health sector priorities, including one on expansion of health insurance coverage and social health protection. The foregoing and other global, regional and Partner State priorities have informed the content of this Resource Mobilisation Strategy.

1 WHO (2015); UNAIDS (2017); EAC (2015)

2 Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2016 (GBD 2016) Results. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2017. Available from http://ghdx.healthdata.org/gbd-results-tool.

3 UNGA Seventieth Session Agenda item 11: Implementation of the Declaration of Commitment on HIV/AIDS and the political declarations on HIV/AIDS; Addis Ababa Action Agenda of the Third International Conference on Financing for Development.

4 EAC Development Strategy 20616/17-2020/2 pages 17-19.

1.2 Rationale for the UHHC Resource Mobilisation Strategy

In 2015, the EAC mandated the development of a sustainable financing analysis report on UHHC for the region, which estimated that the UHC funding gap in East Africa until about 2030 could be at least US$18 Billion annually. Following this report, an Issue Paper on Sustainable Financing proposed an EFoA) for all Partner States. This framework was adopted during the High-level Ministerial dialogue on Sustainable Financing for UHHC held on 23 June 2016, during which EAC ministers of health and finance committed to:

- Adopting the recommended EFoA strategic activities, which called for reprioritisation of public spending towards meeting the 15% Abuja Declaration; tax regime efficiency to expand fiscal space and enable additional investments in health; and minimisation of costs through increasingly efficient service delivery.
- Conducting efficiency audits in the health sector to inform EAC policies on improved service delivery;
- Implementing mechanisms to strengthen health regulatory authorities for better-quality healthcare delivery in pursuit of UHC;
- Designing and implementing innovative financing mechanisms to ensure sustainable access and optimal use of quality healthcare services;
- Promoting the use of information communication technologies (ICTs), research and evidence on UHC financing investment cases that support advocacy;
- Promoting multisectoral synergies, including PPPs, to leverage additional health and HIV financing in the Partner States; and
- Sponsoring and convening the 1st EAC Summit on Investment in Health with the aim of attaining health-related SDGs by 2030 in all Partner States.

The 13th Sectoral Council of Ministers responsible for health noted the need for clear strategies to mobilise resources to support implementation of the EFoA on Sustainable Financing for Health and HIV and approved terms of reference to develop a resource mobilisation strategy to support its implementation (EAC/Health/SCM13/Decision 15). Subsequently, the EAC Secretariat performed country consultations in each of the EAC Partner States to analyse and report on the status of implementation of EFoA, to inform development of this EAC UHHC Resource Mobilisation Strategy 2018 – 2023.

Although national budgets and compulsory contributions through indirect taxes towards national and community health insurance schemes remain the preferred source of UHC financing, health and HIV financial landscape analyses conducted in 2017[5], reveal that no single individual financing source - not even government revenue - can sustain the nearly US$200 billion health sector financing gap facing EAC Partner States during the next ten years, as estimated in the EAC (2015) report on sustainable financing analysis of UHHC. The EAC health sector financing gap and disease burden are increasing, while external financing, the region's largest source of health sector financing, is decreasing, according to a UNAIDS and Kaiser Family Foundation (KFF) 2015 analysis of international assistance towards HIV, with adverse effects on the sector. In fact, the UNAIDS (2015) analysis and Global Fund (2016) replenishment outcomes already show a marked decline in bilateral and multilateral funding, averaging about US$1 billion between 2012 and 2015. These gaps remain large even if fiscal space is increased. Filling the gap in Burundi would cost a fifth of her gross domestic product (GDP), two-fifths of Uganda's budget, more than 26% of Tanzania's budget, 23% of Rwanda's and one-tenth of Kenya's budget at 2016 rates. South Sudan's needs would be higher, compounded by the need to rehabilitate about one third of her health infrastructure (at least 20% of health facilities) and rebuild human resources for health. It may be argued that short of prioritising UHHC as a development priority and strategically mobilising additional resources, Partner States may not meet EFoA goals.

5 *Validated Funding Landscapes for the Republics of Burundi, Kenya, South Sudan and Tanzania, towards the Global Fund Funding Requests for the March and May 2017 Application Windows.*

1.3 Objectives

General objective: To support implementation of the EFoA on Sustainable Financing for health and HIV and AIDS and innovative financing mechanisms.

Specific objectives of this resource mobilisation plan include:

- To guide Partner States' resource mobilisation efforts in support of UHHC financing needs within and outside of EFoA;
- To mobilise funding to support EAC UHHC strategic priorities;
- To guide EAC resource mobilisation planning and implementation in such a manner that it is sustainable, and benefits resource needs of Partner States;
- To promote value for money in sourcing and utilising funds.

1.4 Scope

This strategy follows an assessment of the implementation status of the EFoA, which was, in turn, informed by recommendations from the report on sustainable financing analysis of UHHC in the EAC. The assessment generated evidence to guide strategic regional and Partner State priorities, examined progress, prevailing financial landscape and challenges, highlighted best practices and weighed varying views regionally and globally on how best to finance UHHC in lower- and lower middle-income countries.

In addition, this strategy extends beyond foundational literature to propose resource mobilisation strategies for UHHC in Partner States' resource-constrained economic environments, drawing lessons from financing models in other regions, and recommending innovative resource mobilisation techniques and mechanisms for both Partner State and EAC Secretariat UHHC financing, coordination, management, monitoring and evaluation needs.

2 Contextual Analysis: Implementation Status of EFoA

Financing UHHC is an important commitment made by EAC Partner States. The EFoA was adopted during the High-level Ministerial Dialogue (by ministers of health and finance) on Sustainable Financing for UHHC on 23 June 2016. This section analyses regional and country-level progress and challenges in implementing EFoA, guided by the 26 actions under each of its four overarching frameworks and agreed timelines.

2.1 Commitment to increase national health budgets to cover resource requirements for UHC:

2.1.1 Commitments to increase national health budgets for UHHC:

Partner States committed to increasing national health budgets for UHHC. One of the benchmarks was the April 2001 African Union meeting where Member States pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. This pledge is popularly referred to as the Abuja Declaration. However, although government spending on health has increased slowly, it is still far from the aspirational 15% in EAC, characterised by less than 50% domestic financing of health (including HIV) budgets. By comparison, some African governments, including Lesotho, now fund 70% or more of their health budget and purchases over 70% of the ARV need, while South Africa spends more than US$1 000 per capita on health compared to less than US$200 in the EAC.[6][7][8]

Partner State	Implementation status of commitment to increase national health budgets for UHHC
Burundi	The Republic of Burundi committed to increasing her national health budget for UHHC. Despite fiscal challenges, the budget allocated to the Burundian Ministry of Public Health increased by 7% between 2016 and 2018: from 82 billion Burundian Francs (BIF) or US$44 million to BIF84 billion BIF (US$45 million). In 2018, the health sector budget further increased to BIF88 billion BIF (US$48 million). Corrections for increasing inflation and population pressures may have cancelled some of the real value of this increase. Burundi's Carte d'Assistance Médicale (CAM) medical assistance scheme, on which the country relies as a sustainable UHHC financing strategy is 80% government funded, while 20% of its costs are contributed by individuals. Support by the Burundi diaspora has advanced use of this scheme, especially by schools. A social protection fund (FAP) has been established and is awaiting necessary laws, financing and strategies to support its implementation.
Kenya	The health sector budget increased from US$58.9 billion (US$590 million) in 2016/17[9] to Kenyan Shilling (Ksh) 60.1 billion (US$600 million) in the 2017/18 financial year. This represented an increase of 2% between the 2016/17 and 2017/18 financial year budgets. Despite missing the 2017/18 revenue collection targets by US$840 million, treasury allocated an additional US$91 million for 2018/19. Government spending on health in 2016/17 decreased to 7.6% from 7.7% of the preceding year's budget, below the pre-devolution level of 7.8%, and is still far from the aspirational 15% Abuja Declaration target.[10] Health services are delivered under both national and 47 county governments. The latter finance the primary level, where most UHHC services are delivered. County governments maintained a gradual increase in health budgets, from 13.5% to 25.2% between 2013 and 2017. From 2015/16 to 2016/17, at least 33 of the 47 county governments increased allocations to health, bringing the total to Ksh92 billion (Us$920 million), up from the previous year's Ksh85 billion (US$850 million). While this indicates increased commitment to health by county governments, the allocation is still below pre-devolution levels. However, absorption rates by the counties is low, sometimes falling below 60%. The share of the county health budget allocated to recurrent expenditure increased from 72% in 2015/16 to 79% in 2016/17, above the recommended 70%.[11] Total spending on AIDS increased by 24%, from US$690 million in fiscal year 2013/14 to US$853 million in fiscal year 2015/16. Domestic financing by national and county (devolved) governments increased by 29% during the same period.

6 USAID (2016) Health Financing Profile for Uganda
7 USAID (2016) Health Insurance Profile for Rwanda.
8 World Bank (2015), UHC In Africa, a Framework for Action
9 The National Treasury
10 MOH (2017) National Health Accounts 2015/16
11 USAID Health Policy Project (2016) Kenya County Health Accounts

Partner State	Implementation status of commitment to increase national health budgets for UHHC
Rwanda	Along with other EAC Partner States, Rwanda committed to increasing her national health budget for UHHC. Indeed, between 2013 and 2018, the nominal health budget increased by 23%, from Rwandan Franc (FRW) 157.5 billion (US$177 million) in 2013/14 to FRW193.6 billion (US$218 million) in 2017/18. However, fiscal space has expanded, leading to an increase in the overall budget at a pace generally surpassing the increase in health sector investments. Key sectors benefitting from increased investments include infrastructure, finance, technology, tourism and general private enterprise. As a result, the health sector budget as a proportion of the national budget shows a declining trend, from 10.8% in 2014/15 to 9.2% in 2017/18 – below the 15% Abuja Declaration target adopted by the third Health Sector Strategic Plan (HSSP).[12]
South Sudan	South Sudan is committed to increasing her national health budget for UHHC. The nominal budget for health has increased from £1 billion US$100 million) in 2017/18 to £1.5 billion (US$150 million) in 2018/19.[13] A significant proportion of external funding remains unspent. Nominal government budget for health is still short of the 15% Abuja Declaration target, with domestic sources accounting for 2% of the health budget. The first National Health Accounts (NHA) was conducted in 2018 to determine the proportion of external funding to the health sector. Through health pooled funding, some partners have collectively funded essential health services in eight of the state's main regions to the tune of US$240 million and now updated to about US$133 million annually for the third phase, while the World Bank has supported the two remaining regions, using government, civil society and humanitarian agency health facilities, and mostly staff on government payroll. Other partners collectively provide tens of millions of dollars annually so support several cluster responses, ranging from non-communicable diseases (NCDs), new disease threats such as hepatitis, nutrition and others. The HIV programme is still heavily funded by external partners and South Sudan could benefit from sustainable and transition preparedness planning towards 2030.
Tanzania (mainland)	Tanzania mainland is committed to increasing her national health budget for UHHC. The heath sector was allocated 2.22 trillion Tanzania Shillings (Tsh) or US$958 million in the 2017/18 fiscal year. This represented a 34% nominal increase on 2016/17, or 28% increase when adjusted for inflation. The sector's proportional allocation of the total budget averaged for three years is estimated at around 10%. However, only about 57% of the budget for 2018 had actually been disbursed to the sector by the third quarter of the fiscal year[14], while a significant proportion of external funding remains unspent. HIV funding is heavily donor-dependent (77.4%) and could benefit from sustainability and transition planning.[15] Funding is externally sourced, while the government supports about 10% of HIV programme needs.
Tanzania (Zanzibar)	The Revolutionary Government of Zanzibar, consisting of the islands of Unguja and Pemba in Tanzania, increased the nominal budget for health by 27% from Tsh85 billion in 2016/17 (US$37 million) to Tsh108 billion (US$47 million) in 2018/19. A significant proportion of external funding remains unspent. At 7.7%, the nominal government budget for health falls short of the 15% Abuja Declaration target. The HIV programme is still heavily funded by external partners and Zanzibar could also benefit from sustainable and transition preparedness planning towards 2030.
Uganda	Uganda has committed to increasing her national health budget towards UHHC. The Government of Uganda increased her health budget from 1.8 trillion Uganda Shillings (UGX) or US$463 million to UGX2.3 trillion US$591 million) between 2017/18 and 2019/20, effectively increasing allocation to health from 6.3% to 7.3% of the budget. However, government spending on health has increased slowly and is still far from the aspirational 15%. Less than a fifth of total HIV spending is from government.

Contributions to UHHC by EAC governments is not necessarily premised on income, and mean HIV expenditure accounts for 0.3% of GDP, or less than 10% of the budgets. Only 15% of all HIV spending in the EAC is from government budgets and 13% is from the private sector, while donor dependency on HIV is more than twice that of health – at 72% compared to 35%.[16] As populations and disease burdens grow commensurately, donor contributions to health have been falling globally, by up to US$1 billion between 2013 and 2016.[17] [18]

12 UNICEF (2017) Rwanda Health Budget Brief (2017/18) Investing in Children in Rwanda.
13 National Budget
14 Parliamentary Social Services Committee Statement, April 2018
15 Funding Landscape Analysis, 2017
16 EAC (2015) Issue Paper on Sustainable Financing of Universal Health and HIV Coverage in EAC Partner States
17 Global Fund (2016) Pledges at Global Fund Replenishment Conference, 16-17 September, Montreal. Canada.
18 Kaiser Family Foundation & UNAIDS (2016) Financing the Response to HIV in Low and Middle-Income Countries: International Assistance from Donor Governments in 2015

2.1.2 Strategies to achieve UHHC and end AIDS by 2030:

Partner States have aligned their new health sector strategies to global visions to achieve UHHC and willingness to implement UHHC is evident in all the countries, while HIV strategies are gradually being aligned with the Global Vision to end AIDS by 2030.

Republic of Burundi

Burundi's Vision 2020 proposes the 90-90-90 targets, while the health sector development plan is aligned to UHHC goals. Burundi shares the Global Vision to end AIDS. The health sector extended the second National Health Development Plan (PNDSII) as a framework for strengthening the health system, with partners significantly contributing and committing to narrow the financing gap for HIV and the health system. Burundi's extended Health Sector Development Plan (PNDS II) already prioritises UHHC and HIV and is aligned to achieving UHC. Burundi's CAM seeks to increase coverage to the majority of the population. The partners jointly advocated with the Ministry of Public Health to align international aid towards these strategies.

CAM was launched in May 2012 and has since been adopted as Burundi's main health financing mechanism. The policy adopted by the Government of the Republic of Burundi pertaining to free healthcare of children younger than five and maternal healthcare (pregnant women) has provided a platform for scaling up UHHC. Private sector contributes through Mutuelles de Santé - MdS (PPP), while a health insurance and subsidy programme for people living with HIV is supported by development partners including USAID, the World Bank and local organisations (CNLS, SWA Burundi, RBP+). While revenue from premiums has been insufficient to fund basic items such as recurrent costs of outpatient drugs, women have reported some of CAM's advantages as elimination of cash payment at point of use, convenience and independence of health seeking without reliance on heads of households. Although CAM has faced challenges including inadequate quality of services, and uniform/undifferentiated pricing, experts in Burundi have proposed mandatory enrolment, developing a consolidated/health-pooled fund (HPF) to channel and harmonise all funds currently in different sectors into one social protection support fund (FARS), and adopting a progressive pricing system, among other promising proposals.

Republic of Kenya

Kenya has entrenched UHHC in the constitution[19] within health policy goals[20] and as a theme in the Kenya HSSP, while a specific strategic plan has been developed for UHC. In 2017, the Head of State prioritised UHC as one of the four development pillars, along with affordable housing, food security and manufacturing. Kenya has now set up UHHC coordination structures and is consultatively planning for UHHC at national and devolved (county) levels. Plans to transition HIV and AIDS support to Kenya's National Hospital Insurance Fund (NHIF) have been complicated by the huge disease burden, which has seen HIV treatment costs soar above those of EAC Partner States and equal the subnational health sector budgets even as donor contributions gradually stagnate.

Kenya's NHIF: Kenya's preferred channel for UHHC financing is the NHIF. The fund's previously basic benefits package has grown to include both outpatient and inpatient services, maternal care, reproductive health, dialysis, cancer treatment; rehabilitation for drug and substance abuse; all surgical procedures, including transplants; emergency road evacuation services, overseas treatment and radiology imaging services[21] All contributing informal and formal sector workers and their paying family members, as well as the elderly and expectant mothers, receive NHIF services. In April 2018, three million secondary school children were added to the NHIF benefits scheme through a government subsidy. Other subsidies include a medical cover for the elderly and people with disabilities, and the removal of user fees at public primary healthcare facilities[22] and the health insurance subsidy programme for households living in extreme poverty, which was supported by the World Bank and Japanese bilateral aid (covering poor households through community-based targeting of NHIF) and has now transitioned to the government.

19 Constitution of Kenya 2010
20 Kenya Health Policy 2014-2030
21 www.nhif.or.ke
22 Cabinet Secretary of Health (Minister) statement, March 18, 2018.

Republic of Rwanda:

The Government of Rwanda's Health Sector Policy is aimed at UHC (universal access to equitable and affordable quality health services for all Rwandans) and this is provided through compulsory health insurance and subsidised through the HPF and other channels of financing.

Rwanda's Community-Based Health Insurance (CBHI): Among EAC Partner States, Rwanda has advanced furthest in UHHC provision. The MdS/CBHI scheme emerges as one of the best practices not only in the region, but in Africa, meeting the needs of Rwandans outside of the formal sector, where access to and use of healthcare services had been historically low. Rolled out in 2003, the community-based MdS is complemented by the Military Medical Insurance and Rwanda Health Insurance Scheme. It benefits from public financial support (from Government of Rwanda, development partners, the private sector and other insurance providers) and allows the informal sector population access to the essential healthcare package. Rwanda's ambitious target is 100% population coverage. Still, quality of services under Mutuelles de Santé has remained a major concern. The state has partly addressed this though partnerships, including with private healthcare providers. For people with disabilities, it offers specialised services such as arthroplasty for knees, hips and shoulders; fractures, tendons and ligament repair; joint resurfacing, knee repair and reconstruction, and crutches, among other services. Membership/subscription fees comprise 61% to 70% of revenue sources, with government providing additional revenue. While the scheme is well received, criticism includes poor quality of services in some areas and relatively high out-of-pocket (OoP) expenditure. The Rwanda Social Security Board continuously updates the benefits package[23]

Extending coverage through mutual health organisations/MdS and enacting a law for compulsory health insurance for all, complemented by a subsidy programme differentiating between levels of vulnerability and socio-economic stratifications ('Ubudehe' categories) are among the best practices emanating from Rwanda. Others[24] include:

- Resource mobilisation mechanisms for the granting of microcredit to facilitate insurance subscription for qualifying individuals;
- Inclusion of support for people living with HIV, and other vulnerable groups in national insurance;
- Splitting of CBHI provider (Ministry of Health) and purchaser (MdS – under Rwanda Social Security Board, an institution under the Ministry of Finance and Economic Planning - MINECOFIN);
- Decentralisation and separation of functions between district mayors and the presidency, with the former signing performance-based contracts;
- A strong legal framework for the operation of health insurance in Rwanda;
- Human resource development and continuous capacity building for MdS management structures;
- Continuous upgrading of services provided to insurance subscribers;
- Additional resource mobilisation through government and partners into a pooled fund; including people living with HIV support through partners;
- Continuous community sensitisation and advocacy on the importance of insurance coverage;
- Political leadership and involvement of political and administrative authorities in expanding coverage;
- Synergy between health insurance and other health system mechanisms, including quality assurance and performance-based financing;
- Coverage is above 90% by 2018 and use of CBHI is at 84%.

Republic of South Sudan:

Access to UHHC is a major priority of South Sudan's Health Sector Development Plan (HSDP) 2017/18 - 2022/23 and eliminating AIDS is a key focus of the HIV/AIDS Strategic Plan 2017/18 - 2022/23, which is aligned to global commitments to end AIDS. South Sudan's subsidised health sector is in a position to achieve UHHC by 2030 if well financed.

South Sudan's Boma Health Initiative and Basic Package for Heath and Nutritional Services (BPHNS) delivers a thoughtfully designed essential mix of services (albeit with quality challenges) through a partnership of government, civil society, and international and

23 Rwanda Social Security Board - http://rssb.rw
24 Musango et al (2013), WHO

humanitarian partners provided at government and non-government health facilities and humanitarian health posts in all states of the country, extended to the primary level through a specific community based health initiative and a performance-based pooled funding mechanism. The Partner State's main challenges include sustainability, funding size and transition from heavy donor financing to government financing.

United Republic of Tanzania

Access to UHHC is a major priority of Tanzania's fourth HSSP, which is midway through implementation. The Partner State has aligned her strategic plan for HIV with global commitments to end AIDS and seeks to achieve 90-90-90 targets by 2020. The HIV strategy is gradually being aligned with the Global Vision to end AIDS by 2030.

Tanzania's NHIF and Community Health Fund (CHF) were established by government as part of heath sector reforms in the 1990s. Among other benefits, establishment of these schemes sought to make healthcare affordable and accessible to all Tanzanians, whether in rural or urban areas, informal or formal sectors. It was a necessary step towards universal coverage, which addressed some of the gaps and challenges emanating from tax financing deficits and limited access to services due to financial constraints of individuals and households. NHIF as a pre-payment mechanism began in 2001, initially offering healthcare to public employees, but evolved to include other formal sector groups, including private employees, students and members of parliament. To date, the fund covers 7% of the entire population, who access services in accredited health facilities spread all over the Partner State. On the other hand, CHF is a form of pre-payment scheme designed for the informal sector, which consists of about 80% of the entire population living in rural areas. The scheme uses a risk-sharing concept where members make a small regular contribution to offset the risk of paying a larger amount out of pocket should they fall sick. Membership of CHF is voluntary and each household in a district contributes the same membership fee, as agreed by a council based on socio-economic status of its community. CHF covers 25% of the entire population. Members are entitled to a basic package of curative health services throughout the year. Households that do not participate in the CHF/Tiba Kwa Kali (TIKA) urban health insurance scheme are required to pay user fees at health facilities. Towards UHHC, Tanzania is enacting a law to require mandatory health insurance for all citizens to increase enrolment on the health insurance scheme and contribution of the scheme to overall healthcare financing.

Similarly, Zanzibar's third HSSP (2013/14 – 2018/19) prioritises access to UHHC, while eliminating AIDS is a key focus of the HIV/AIDS Strategic Plan 2017 – 2022, which is aligned to global commitments to end AIDS. Zanzibar's free healthcare policy and subsidised HIV programme are a direct route to the achievement of UHHC.

The Revolutionary Government of Zanzibar provides and supports free healthcare for all, which is funded mainly through revenue from indirect taxes. To continuously improve quality and cross-border coverage (portability) with the mainland, some stakeholders have called for acceleration of NHIF coverage into Zanzibar.

Republic of Uganda has developed a UHC strategy draft focusing on systems strengthening, affordability, efficiency, access to essential meds and building sufficient capacity. The Partner State launched the Presidential Fast Track Initiative (for HIV), becoming the first to do so, and rolled it out in 82% of the districts. Uganda has taken the public health insurance and domestic financing route to financing UHHC by moving to enact a health insurance law that will lead to establishment of the National Health Insurance Scheme (NHIS), which has already been reviewed by the Ministry of Finance for its financial implications.

Uganda's NHIS: Uganda's NHIS is expected initially to cover 25% of Ugandans and reduce OoP expenditure. The NHIS Bill is currently at cabinet. Stakeholders recognise NHIS as a key method to sustainably finance UHHC. However, there is still an opportunity to thoroughly analyse and address challenges faced by the NHIS Bill, including private sector concerns, and learn from regional experiences.

2.1.3 Expansion of fiscal space (increase tax and other revenue) towards reducing the proportion of total health expenditure (THE) that is OoP expenditure to less than 20% in all Partner States:

Fostering UHHC as part of the economic growth agenda helps lower proportion of OoP health spending with time. Partner States committed to expanding fiscal space and reducing the proportion of total health spending that is OoP expenditure to less than 20%. However, OoP expenditure is above 30% for most Partner States.

The Republic of Burundi faced an economic contraction of -4.5% in 2015, and her economy did not grow (0%) in 2016, while donor resources were not forthcoming. This led to decreases in two main sources of revenue, including taxes and external sources, and limited fiscal space, with signs of recovery only just emerging in 2018. OoP expenditure is, therefore, thought to be high.

In Kenya, OoP expenditure is estimated to be stagnating. The last National Expenditure Tracking Survey (2015)[25] estimated OoP expenditure at 24%. OoP expenditure varies widely across the 47 counties, from single digit to about 50%. The National AIDS Spending Assessment (NASA) 2017 estimates household expenditure on health from 2012/13 to 2015/16 for HIV at US$2.3 billion for the first year and US$2.7 billion for the last year.[26] The average annual per capita spending for all outpatient and inpatient visits in 2013 was estimated at Ksh1.254 (US$12.5) and Ksh355 ($3.5) respectively. In 12 sampled counties, households controlled most THE through OoP spending, at 36% of THE in 2013/14, followed by county health departments and non-governmental organisations (NGOs), at 34% and 19% respectively. In 2014/15, county health departments managed 36% of THE, followed by households at 35% and NGOs at 16%.

Rwanda has been successful in both committing to expanding fiscal space and reducing OoP below the proposed threshold. Economic growth is averaging between 6% and 7% annually from 2017 and is forecasted to continue growing at more than 7% in 2019, while OoP payment rates as a share of THE fell from 25% in 2000 to 18% by 2013 (US$13 per capita) and was expected to decrease over time. In 2016, OoP was up to 26% by 2015.[27] The fourth HSSP of July 2018 to June 2024 aims to increase health insurance coverage to more than 95% and reduce the proportion of household expenditure on health as a share of total household income to less than 10% from more than 25% currently[28]

Experiencing a narrow tax base due to a small but growing private sector, a large but mostly untaxed informal sector and civil strife, the Government of South Sudan has stewarded significant partner support mainly towards the health sector. While there has been no recent study, OoP expenditure on health is assumed to be high (between 56% and 75%),[29] since while primary healthcare is free, secondary and tertiary healthcare is still payable. Disposable income has been constrained and the health sector is heavily donor-dependent. Still, some clients visit other countries for specialised healthcare, since quality remains a significant issue, and the Ministry of Finance has been paying up to an estimated US$14 million annually for civil servants' healthcare needs abroad.

In the United Republic of Tanzania, Government of Tanzania (mainland) has made efforts to increase complementary financing from health insurance and social protection. OoP expenditure reduced from 26% in 2005/6 to 21% in 2016/17 according to the NHA (2017). The Partner State has implemented a set of governance reforms leading to market correction and stabilising fiscal space. The situation is expected to improve in the medium term (two to three years).[30] Despite a narrow tax base due to a small but growing private sector, and a large but mostly untaxed informal sector, the Revolutionary Government of Zanzibar collects tax revenue relatively efficiently. OoP expenditure on health stood at 23% (World Health Organization (WHO), 2014). OoP spending on health now accounts for 30% of household expenditure in Zanzibar. Given the low public allocation to the health sector, lack of national health insurance and the high household expenditure on health, it is likely that health events could result in catastrophic spending and impoverishment. Further study is warranted to better understand the issue.

25 MOH, Population Council (2015)
26 NACC (2018) NASA 2017, page 32.
27 Trends in contribution per person are published by the EICV Report and the World Bank
28 MOH (2018) Health Sector Strategic Plan (http://www.moh.gov.rw/index.php?id=91or)
29 World Bank, NASA – prior to 2016
30 Considering changes in health sector budget, (PETS; PERS) from MOF.

In Uganda, OoP expenditure is still above 30%. Partly due to delayed establishment of national health insurance, Uganda has experienced narrow fiscal space and been unable to move towards compulsory sources of UHHC financing. Another challenge is inefficiencies in programme implementation, which consume up to 13% of THE, increasing dependency on external financing for the health budget.[31] The informal economy employs 80% of the population and contributes more than 50% of her GDP (Uganda Bureau of Statistics 2014) but contributes only 13% of GDP, compared to a 20% average in sub-Saharan Africa. Weakly implemented PPPs and untapped sources from capital investments are other missed opportunities. Compulsory sources from government and the private sector must be complemented by subsidies for the extremely poor and vulnerable. Innovative methods are required to include unbanked rural populations.

A World Bank study shows that people in higher-income countries still spend proportionately less out of pocket on health than their counterparts in low-income economies.

Table: Correlation between economic development levels and health expenditure patterns

Country income group	Government spending as % of GDP	Private/OoP spending as % of total health spending
Low	26%	59%
Middle	33%	45%
High	42%	30%

Source: World Bank, 2016

Indirect taxes within general tax revenues are a better, less visible source for public financing of UHHC, since they complement available revenue for health within the general budget but can be targeted at the rich and urban dwellers, or the top economic deciles. Narrow fiscal space has constrained additional funding from tax revenues and slowed the move towards compulsory sources. This underlines the importance of dialogue between the ministries of finance and health on the level of funding, budget process and other issues.

One way of ensuring sustainable UHHC financing is to ring-fence compulsory sources from government and individuals (meaning that government ensures access to quality healthcare through subsidies for those who cannot afford to pay and a recurrent minimum threshold of funding to the health sector, while individuals who can afford to pay a reasonable contribution out of pocket) followed by complementary private sources. Prevailing thinking[32] is that compulsory contributions to UHHC financing work better than voluntary contributions, the source of funding notwithstanding, especially if UHHC is placed high on the development agenda. However, it is difficult for EAC Partner States and other low- or lower middle-income economies to tax huge portions of their populations, a significant proportion of whom already live under extreme poverty, and this must be complemented by subsidies for the extremely poor and vulnerable. In addition, it is difficult to tax unbanked rural populations that are not connected to the financial 'grid'.

2.1.4 EAC Secretariat support to Partner States to develop investment cases for health and HIV to be used in advocacy for UHC financing:

Ongoing support has been provided by development partners and several technical support providers to assist countries to develop investment cases for health and HIV to be used in advocacy for UHHC financing. In 2018, the EAC undertook country consultations in each of the Partner States and ascertained technical support needs for the implementation of this Resource Mobilisation Strategy.

31 Health Sector Financing Strategy, February 2016.

32 WHO (2017) Public Financing for UHC: Towards Implementation – Presentation at the WHO Symposium on Health Financing for UHC, October-2 November 2017.

2.1.5 National dialogues by ministries responsible for health in Partner States on earmarked taxes to address UHHC financing; and to explore additional financing sources for health:

Ministries responsible for health in Partner States have conducted national dialogue, in varying forms, beyond earmarked taxes, to address UHHC financing. Earmarking is discouraged since it tends to lower total revenue. Each Partner State is exploring additional financing sources for health. This discussion began as far back as 2008 in some EAC countries, but EFoA had the effect of catalysing alignment and focused action. Some Partner States are ahead of EFoA timelines on a few actions. Factors driving national dialogue include:

- Existence of large health coverage gaps and high burden of disease;
- High cost of health services amid increasing amount of OoP expenditure for health;
- Resource mobilisation/proposal writing processes;
- Demand/pull factors from citizens/the electorate within countries;
- Prodding by development partner co-financing requirements - for instance 5% increase in government pre-financing commitments required by the Global Fund;[33]
- Political processes, especially demands by electorates have entrenched UHHC, particularly maternal, neonatal and child health into the agenda in Kenya;
- Decentralisation and devolution of health services in South Sudan and Kenya respectively, are driving some of the demand and generating ideas for UHHC financing;
- Cherry-picking aspects of SDG 3 and country-essential healthcare packages to implement under UHHC based on their current fiscal space and political economy considerations - not based on SDG 3, 3.8 or any standard.
- Burundi is progressing on national dialogue but there is a need to strongly integrate HIV into UHHC dialogue. The Ministry of Public Health and the National AIDS Control Programme (PNLS) have conducted national dialogue. CAM is working to increase universal health coverage among the general population, with emphasis on the informal sector.
- In Kenya, the Ministry of Health continues to conduct national dialogue on UHHC. Sources of HIV funding include government (budget allocations, counterpart financing, county government funds, sectoral finances); United Nations agencies (through technical assistance to the government and civil society organisations); President's Emergency Fund for AIDS Relief (PEPFAR - US Government, through commodity support and NGO/implementing partner grants); other bilaterals and multilaterals; and civil society (including private sector).

In Rwanda, the annual national dialogue (Umushyikirano) congregates the community, district, national level and the diaspora with the national leadership. It discusses all issues regarding national development, including CBHI/MdS. This dialogue is a constitutional provision. In addition, a high-level national retreat of leaders chaired by the Head of State convenes district and national leaders to discuss national priorities and challenges, including health.

Earmarking as a method for raising additional funding has been discouraged in South Sudan, since it tends to have a negative effect on fiscal space, in preference for revenue through indirect taxes and external partners to subsidise healthcare for all. Country dialogue to increase health sector financing has been held as part of resource mobilisation processes, and the state plans to increase the quality of health coverage to all. The Ministry of Health has been in discussions with the government (Ministry of Finance and legislature) to progressively increase financing to the health sector, and particularly HIV, which is very heavily donor funded. Civil society engagement in UHHC, which has previously been inadequate, is now planned.

Similarly, earmarking is discouraged in the United Republic of Tanzania. Country dialogue to increase public health sector funding has been held as part of resource mobilisation processes. On the issue of health insurance, dialogue is ongoing with a view to making the NHIF more sustainable. Zanzibar has preferred obligatory government-led financing (through indirect taxes) to subsidise healthcare for all using revenues. Country dialogue to increase health sector financing has been held as part of resource mobilisation processes; and the state plans to increase the quality of health coverage to all.

33 Global Fund Sustainability, Transition and Co-Financing Policy – "The STC Policy" (GF/B35/04) urges countries to progressively increase financing to cover UHC goals, co-finance Global Fund-supported programmes and progressively take up key costs of national disease plans.

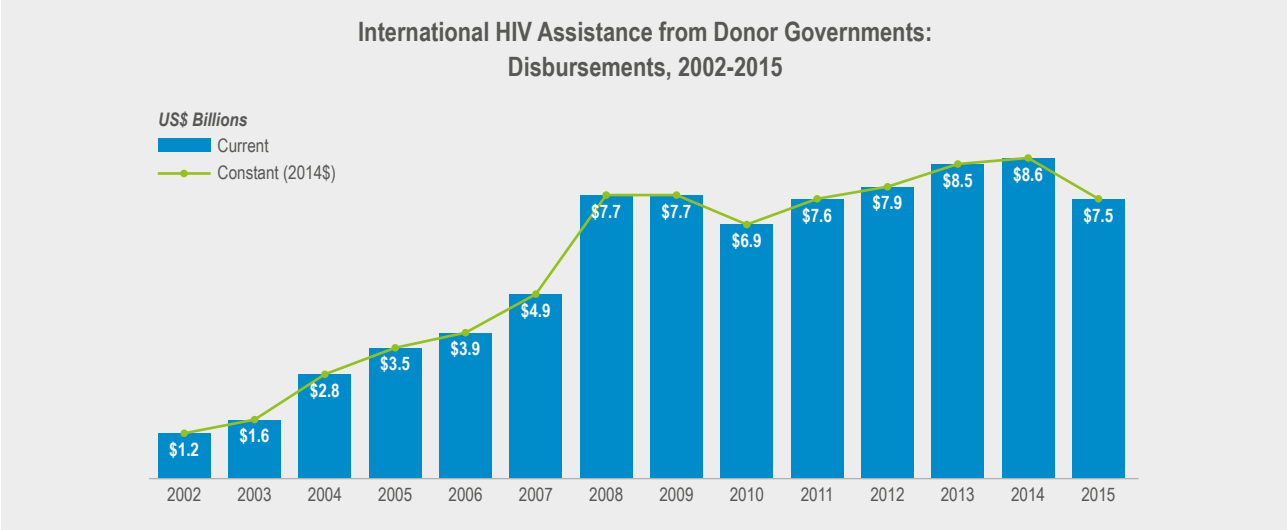
In Uganda, the Ministry of Health has conducted national dialogue, in varying forms, beyond earmarked taxes to address UHHC financing. Factors driving national dialogue include: Existence of large health coverage gaps and high burden of disease; high cost of health services amid increasing OoP expenditure; demand/pull factors from citizens/the electorate within countries, prodding by development partner co-financing requirements - for instance, 5% increase in government pre-financing commitments required by the Global Fund[34]; and demands by the electorate.

Rising demand for UHHC takes place against the challenge of increasing health sector financing gaps, increasing health service coverage and costs, and increasing disease burden amid expected decreases in external funding - the region's largest source of health sector financing. The 2016 ministerial high-level meeting dialogue, UNAIDS and KFF (2015) analysis of international assistance towards HIV in low- and middle-income countries, and the EAC (2015) Issue Paper on Sustainable Financing of UHHC in EAC forewarn of an expected decline in external funding in the coming years with adverse effects on the sector. The UNAIDS (2015) analysis and Global Fund (2016) replenishment outcomes show a marked decline in bilateral and multilateral funding, averaging about US$1 billion a year since 2015.

Current sources of financing for the health sector include predominantly domestic, external (bilateral and multilateral partners), OoP expenditure, private sector and PPPs. Health insurance is emerging as the preferred source for expanding UHHC in most Partner States.

While the majority of overall health expenditure is either from public or private sources, most HIV funding in East Africa originates from external sources and OoP expenditure. External sources fund on average between 75% and 90% of the HIV budget in EAC Partner States, with about 60% of financing provided by the US Government, about 20% by the Global Fund to fight AIDS, tuberculosis and malaria, and the other funding from bilateral (Canada, European Union, France, Germany, Japan, Sweden, Norway, United Kingdom and others) and multilateral partners, including the United Nations System. This calls for serious transition preparedness planning to gradually enhance the sustainability of financing for HIV in the region.

Stakeholders recognise that transition preparedness planning is a lengthy process that requires gradual implementation and have sought technical support from UNAIDS headquarters, WHO Afro and other partners to develop benefits packages, national master plans and human resource capacity, among others. Ministries, departments and agencies have been approached to popularise transition preparedness for better adoption and implementation, establish coordination structures and identify stewards. In 2018,



Source: UNAIDS Kaiser Family Foundation (2015)

34 Global Fund Sustainability, Transition and Co-Financing Policy – "The STC Policy" (GF/B35/04) urges countries to progressively increase financing to cover UHC goals, co-finance Global Fund supported programmes and progressively take up key costs of the national disease plans.

UNAIDS was asked by stakeholders to prepare and present a policy paper to the Council of Ministers responsible for health, to guide the EAC on the adoption and implementation of transition preparedness planning in the region.

2.1.6 EAC Secretariat facilitation of advocacy activities for increased investment in UHHC in the region:

The EAC Secretariat has facilitated advocacy activities for increased investment in UHHC in the region. In April 2017, the 35th EAC Council of Ministers included the 1st EAC Summit on Investment in Health in the agenda of the Summit of Heads of States. In February 2018, Uganda hosted the EAC Health and Infrastructure Summit, indicative of a series of positive developments, including the Heads of States Summit, and continuous hosting of the technical working group meetings, among them those of reproductive, maternal, neonatal, child and adolescent health (RMNCAH) and HIV/AIDS. To this end, the first EFoA objective of ensuring commitment to increase national health budgets to cover resource requirements for UHHC is broadly being met. The EAC Secretariat has facilitated sharing of best practices at regional level and promoted their adoption and scale up by the Partner States. Leaders committed to nine regional health sector investment priorities, which will guide Partner State health sector investments.

2.2 Commitment to develop and implement a cost-effective UHHC reference package in each of the Partner States

The joint communiqué of the ministers of health and finance from EAC Partner States following the high-level ministerial dialogue meeting on sustainable financing for UHHC for the EAC region made reference to SDG 3, whose Target 3.8 on achieving UHC requires continued concerted efforts by Partner States. Progress in SDG 3 has been measured against indicators in reproductive, maternal, newborn and child health; NCDs, mental health, infectious diseases, other health risks and sustainable financing. Lack of standardisation continues to negatively affect the region, but given the differences in disease burden and causes of disease at sub-national levels in all countries, efforts at standardisation should emphasise the assurance of quality service delivery, coverage, service availability and developing health systems that can take on the UHHC provision challenge. To illustrate, NCDs and diseases such as polio and guinea worm disease, long eradicated in the rest of the region through immunisation and other health measures, are still ravaging parts of South Sudan, with traces found among South Sudanese in northern Kenya and Ugandan districts - while all countries similar require health system support. Furthermore, Partner States face different policy challenges in UHHC provision.

2.2.1 Development of a regional reference package for UHHC to guide country specific processes:

Between September and October 2017, Partner States submitted sectoral investment priorities that were, in turn, considered by Partner State experts. The draft EAC regional priorities were considered by the 14th and 15th ordinary meetings of the Sectoral Council. In 2018, these priorities were further considered by the first, second and third extraordinary meetings of the Sectoral Council. In February 2018, the priorities were considered by the 36th ordinary meeting of the Council of Ministers. While the 'one-size-fits-all approach' is discouraged (WHO symposium 2017; World Bank), the disease burden is largely similar in all Partner States, except for South Sudan, where NCDs, cholera, polio and malnutrition are also prominent. The EAC has, to some extent, considered programmatic gap analysis and impact analysis on disease burden – to arrive at regional health sector investment priorities.

Criteria for EAC regional health sector priorities: To arrive at health sector investment priorities, the EAC considered the impact of investment area on attainment of EAC's regional integration and development aspirations (EAC Vision 2050) in terms of innovation, medical tourism, manufacturing, job creation and contribution to the GDP; African Union Agenda 2063 and the health-related SDGs, such as UHC. Other criteria included: Magnitude of the health issue, effectiveness and impact of the proposed intervention, cost feasibility and sustainability of the intervention, acceptability of the intervention to the Partner States, and impact of the intervention on fairness and equity and prioritisation of the intervention in the national development vision or plans. Other considerations included malaria control and elimination, elimination of HIV and AIDS, tuberculosis prevention and control, elimination of preventable maternal,

newborn and child deaths; prevention and control of NCDs (common cancers, renal complications, cardio-vascular complications, among others), and emerging and re-emerging diseases (especially of epidemic and pandemic potential).[35]

The following health sector priorities were proposed at the roundtable of EAC health sector Partners States, donors and investors held in Uganda on 21 February 2018.

- **Priority 1:** Expansion of access to specialised healthcare and cross-border health services.
- **Priority 2:** Strengthen the network of medical reference laboratories and the regional rapid response mechanism for health security threats.
- **Priority 3:** Expansion of capacity to produce a skilled and professional workforce for health in the region based on harmonised regional training, and practice standards and guidelines.
- **Priority 4:** Increase access to safe, efficacious and affordable medicines, vaccines and other health technologies focusing on malaria, tuberculosis, HIV/AIDS, NCDs and other high-burden conditions.
- **Priority 5:** Upgrading of health infrastructure and equipment in priority national and sub-national health facilities/hospitals.
- **Priority 6:** Establishment of strong primary and community health services as a basis for health promotion and diseases prevention and control.
- **Priority 7:** Expansion of health insurance coverage and social health protection.
- **Priority 8:** Improvement of quality of healthcare, health sector efficiency and health statistics.
- **Priority 9:** Strengthening of health research and development.

In addition, advocating for Partner States to stick to a minimum package guided by SDG 3 may be useful, since analysis of the disease burden shows the highest impact on reduction of mortality and morbidity would be achieved through the SDG 3 package.

Table: Annual disease burden in eastern Africa (2015)

Rank	Disease	Annual mortality	Rank	Disease	Mortality
1	Neonatal and child diseases (diarrheal diseases, malnutrition including kwashiorkor and marasmus, birth trauma, low birth weight, congenital anomalies)	344 821	7	Coronary heart disease	46 320
2	HIV/AIDS-related deaths	245 677	8	Violence (including sexual- and gender-based violence), falls and other Injuries	41 033
3	Influenza and pneumonia	225 259	9	Diabetes mellitus and kidney disease	38 213
4	Stroke	76 384	10	Tuberculosis	37 199
5	Malaria	71 469	11	Meningitis	37 131
6	Cancers (breast, cervical, prostrate, stomach, oesophagus, lung, oral, colon and rectum, liver, lymphoma, leukemia and others)	53 755 +	12	Maternal conditions	35 495

35 *Outcomes and recommendations of the 1st EAC Partner States, investors and partners roundtable on investing in health infrastructure, systems and research for the accelerated attainment of UHC and the Sustainable Development Goals, Uganda, February 21, 2018. Source: World Health Organization/World Bank Global Health Observatory (accessed 2015)*

2.2.2 Adopting/adapting a country-specific package of services for UHHC from the regional reference package:

By 2018, Partner States were already implementing adopted packages of UHHC as essential services, with mixed effects.

In Burundi, the health insurance scheme, CAM, already includes minimum packages, and is working to improve quality and increase coverage. It covers the majority of costs and works on the basis of continuously upgrading the minimum package for health.

The Kenya UHC health benefits panel has developed UHC packages and costed them. Complexities in standardisation across counties due to differences in disease burdens means that this national effort, while commendable, should also focus on building a resilient health system that can support UHHC scale-up in a quality-assured manner. NHIF has emerged as the major vehicle for channelling health sector financing (with several reforms being undertaken) while the Health Insurance Subsidy Programme for households living in extreme poverty is being supported by the government and several other sources.

Rwanda's HSSP and Vision 2050 prioritise UHHC, while the quality and efficiency of MdS/CBHI are continually being improved. Rwanda has been implementing an incremental UHHC health service package as part of CBHI/MdS, which is compulsory[36]

South Sudan HSDP and BPNHS and the Boma Health Initiative (five main packages) have encouraged the formation of partnerships to deliver quality health services. One such partnership steered by the Ministry of Health was the HPF, with five of the largest development partners, whose objectives included: To improve the access, use, and quality of primary healthcare (PHC) services and emergency obstetric and neonatal care (EmONC) services; to increase accountability and effectiveness by working with community mechanisms for improving health and health education, and to support the strengthening of key stewardship functions of the Ministry of Health, including planning, management, coordination, supervision and monitoring at all levels, in accordance with Ministry of Health guidelines and tools. Services provided through the Boma Health Initiative include health promotion, maternal and child health package, communicable diseases, NCDs and community health information system, the pooled fund supports delivery of nearly all basic services and RMNCAH, vaccinations, NCD, HIV care, malaria, tuberculosis, services and nutrition, disease outbreaks such as cholera, guinea worm, polio - among others, for the most part free of charge.

Mainland Tanzania's HSSP and its financing strategy prioritise UHHC. The government has established a minimum UHHC service package under NHIF and CHF, which is continually being improved. A draft UHC strategy was developed based on the national health policy. The Tanzania Essential Health Intervention Project stipulates the minimum benefits package, which is included in the HSSP. The Health Financing Strategy for this plan supports expansion of health insurance covering a defined package. The NHIF has a minimum benefits package, which will be continually improved. Zanzibar's HSSP aims to deliver cost-effective, quality primary healthcare services to all (100% coverage) by 2018 as defined in the Vision 2020[37]. This package is elaborated on in the new HIV/AIDS strategic plan, which aims to achieve the three 90s and end AIDS by 2030.

By 2018, Uganda was already implementing adopted packages of UHHC as essential services.

Questions remain: Is an EAC regional UHHC reference package the best way to go or should countries be free to define their intervention packages while the EAC focuses on the health systems? Given the lessons learnt, should the EAC advocate a minimum package of interventions based on global SDG guidelines or focus on the health system building blocks through which UHHC will be delivered?

2.2.3 Costing of country-specific package for UHHC

In Burundi, the costs of CAM (health insurance) have been calculated and proportionate contributions have been established, while cost estimates for both Burundi's health sector strategy and HIV strategic plan are available.

36 RSSB CBHI Service Package
37 Health Sector Strategic Plan 2013/14 -2018/19, page 102.

Kenya's UHHC strategy has been costed.[38] The government, through World Bank support, will be covering 100% of the cost for two years in four pilot counties using the 'NHIF super-cover package' (Isiolo, Machakos, Nyeri and Kisumu counties).

The costs of Rwanda's delivery of UHHC through MdS are continually collected and updated. CBHI consultative group takes place quarterly and annual reporting on CBHI includes a financial report. The entire HSSP IV (July 2018 to June 2024) is projected to cost RWF4 290 170.71 million (RWF4.29 trillion or US$4.8 billion) during the seven years. At the end of the period, the mean per capita cost would be RWF44 826.92 or US$60 per capita, up from RWF27 415.22 per capita in 2018 or US$36 per capita.[39]

In South Sudan, the Boma Health Initiative package has been costed, and is for the most part delivered under results-based financing strategies. The BPHNS is planned for review and subsequent costing.

Mainland Tanzania's HSSP 2015-2020 is costed. However, its costs vary slightly from those in the National Health Financing Strategy. Zanzibar's HSSP III (2013/14 - 2018/19) was costed using the one health tool as guided by WHO. Annually, all programmes and unit,s including HIV/AIDS, are required to develop and cost their plans of action as per the HSSP. In addition, the Ministry of Health supports district health management teams (DHMTs) to produce annual costed workplans based on the HSSP. Each year, all districts produce their costed comprehensive district health plans

Uganda developed a health financing strategy in 2016, which covers the period 2015/16 to 2024/25.

2.2.4 Implementation of the costed country-specific reference package for UHHC

While UHHC is at different stages of implementation, AIDS strategies have been prioritised and have obtained at least 60% of their required annual funding. The largest funding source for health remains external sources and OoP expenditure, while most HIV and AIDS funding in the region emanates from PEPFAR.

In Burundi, both the costed health sector strategy and CAM are being implemented, albeit with difficulty, most critical being inadequate fiscal space and health sector financing, quality issues, structure and pricing issues, and high transactional costs related to procurement and supply.

In Kenya, UHHC is at different stages of implementation, nationally and at the county level, with the most advanced county being Makueni. The Ministry of Health has begun piloting for UHHC scale-up in Isiolo, Kisumu, Machakos and Nyeri counties. Lessons from the pilot phase will inform UHHC scale-up nationally. In the other 43 counties, government will subsidise 10 000 households. The largest funding source for health remains governments and OoP expenditure, while most HIV and AIDS funding emanates from PEPFAR.

In Rwanda, the cost of services through MdS informs both the pricing/cost paid per person who is able to pay and the cost of subsidisation for the various categories. The health resource tracking tool (HRTT) provides OoP payments per person, while the CBHI report provides an analysis of cost recovery per category.

More than 90% of South Sudan's population receives basic health services through the HPF, World Bank, Global Fund and other Ministry of Health-led health programmes under the HSDP and CBHI.

In mainland Tanzania, the UHHC strategy is being implemented through the HSSP 2015-2025, which is midway through its term. About 32% of Tanzanians are covered by health insurance. An additional 28% are covered through social protection. The rest pay through OoP and other sources. Within Zanzibar, the UHHC strategy is implemented through the HSSP 2013/14-2018/19. Each year, the budget speech is prepared and submitted to the House of Representatives for discussion and approval. In this speech, financial

38 At about US$6 per person per month
39 MOH (2018) Health Sector Strategic Plan p 49 http://www.moh.gov.rw/index.php?id=91or

analysis of HIV/AIDS as one of the Ministry of Health development programmes is portrayed to obtain a clear picture on the progress in implementation status in financing, but also sector performance in general. This is also noted in the annual health sector performance report and annual health bulletins.

UHHC as a consolidated strategy is at its nascent stages of implementation in Uganda. The largest funding source for health remains domestic, external sources and OoP expenditure, while most HIV and AIDS funding in Uganda emanates from PEPFAR.

2.3 Exploration of innovative financing mechanisms to expand fiscal space for UHC and ending AIDS by 2030

2.3.1 Development and implementation of innovative financing mechanisms including (consumption taxes, resource taxes, sin taxes and others)

All Partner States are exploring innovative financing mechanisms to expand fiscal space. All implement innovative financing mechanisms, including consumption taxes, resource taxes, sin taxes, levies and 'Robin Hood' taxes. All countries have conducted fiscal space analyses within the last four years. Burundi, Rwanda, Tanzania and Uganda have opted for both national and community health insurance, while Kenya has focused on affordable national health insurance supplemented by county-level risk pooling in some counties, and financial health protection programmes aimed at reducing the burden of OoP expenditure among families and households. South Sudan and Zanzibar-Tanzania have adopted free healthcare packages, with the former covering primary healthcare and the latter covering up to secondary and tertiary healthcare.

Burundi is recovering from an economically difficult period. However, the country is exploring innovative financing mechanisms to expand fiscal space, including a variety of taxes. The current taxation policy, direction and system are yet to be established. A study on innovative financing for social protection (fonds d'appui à la protection sociale - FAPS) was conducted and validated, but there is as yet no law allowing its financing. The Partner State is looking into other innovative ways of financing it in the meantime, including through direct contributions from capital projects.

Kenya has implemented innovative financing mechanisms including consumption taxes, PPPs, capital project contributions and Robin Hood taxes. Kenya has conducted a fiscal space analysis and focused on affordable national health insurance, contributions of some counties, and financial health protection programmes aimed at reducing the burden of OoP expenditure among families and households.

Rwanda's HPF endeavours to direct funds and technical support more efficiently to areas where it is required, and allows for reprogramming of some donor support to avoid inefficiencies. Rwanda is exploring innovative mechanisms to expand fiscal space. The Partner State began by focusing on land and agriculture, and thereafter moved to sectors that increase velocity of money (hence taxes), such as ICT, finance and infrastructure. In 2018, the Rwanda Development Board increased its focus on tourism promotion and branding of Rwanda as a liquid investment destination through partnering with one of the leading English Premier League football teams. Some of the proceeds from tourism and trade tourism are expected to be reinvested into the national treasury, while a percentage is invested into local communities and as part of social protection/development.

South Sudan is exploring innovative financing mechanisms to expand UHHC coverage, relevant to the Partner State's context. These include implementation of the PPP framework where the private sector is increasingly involved in provision of equipment and filling systemic gaps at lower transactional and overall cost, while performance-based financing opens the service delivery platform to civil society, with stakeholders working towards the same health sector goals and objectives. The HPF has also successfully consolidated health sector financing towards the BPHNS and in general, the health sector strategy.

Mainland Tanzania has adopted results-based financing, which pays for performance under several projects.[40] Zanzibar is also studying several mechanisms, one of which is the Basket Fund, which directs financial contributions towards a unified set of priority interventions mainly at district level to be managed through DHMTs.

Uganda has faced significant tax/fiscal issues and has adopted new taxes. An even more sustainable approach is the introduction of a health insurance bill which seeks to establish the NHIS.

2.3.2 Development and implementation of a PPP policy framework for mobilising health sector resources:

By 2018, all Partner States had developed and were implementing a PPP policy framework for mobilising resources for health, at varying scope and scales. However, implementation of PPPs is still basic and cannot be compared to advanced health sector PPP models in industrialised economies such as Canada, South Korea or emerging economies such as South Africa and Turkey. Innovations in PPP include social impact bonds, long-term contracts for health equipment provision and maintenance, and human resource capacity building. PPP implementation in the region has tended to come at higher transactional and hidden costs to the taxpayer due to inadequate negotiation by the public sector, lack of fiduciary transactional advisory services, rigid public purchasing strategies and other systemic shortcomings.

The private sector in Burundi is comparatively less robust than that of her neighbours. However, the country is implementing a PPP policy to mobilise health sector resources. This is expected to grow in value as fiscal space expands.

Kenya is implementing a PPP policy framework to leverage resources for health. The Ministry of Health has implemented a multibillion-dollar leasing programme for medical equipment, which has enabled the government enhance provision of specialised health services in 98 hospitals across the country, including dialysis, theatre, intensive care units, MRI, advanced CT scans, ultrasound and mammography. Beyond construction of health facilities, the international private sector committed in 2016 to refresher/in-service training of up to 10 000 health workers, including radiologists, biomedical engineers and technicians on better health practices. PPP models are being implemented in several counties, for example, a Turkish private investor began constructing a hospital and staff housing project through the Ministry of Housing and Homa Bay county using a build-operate-transfer model. Another example is Isiolo county government leasing facilities to be managed by Phillips Corporation..

Rwanda has developed and is implementing a PPP policy framework for mobilising resources for health. However, the country has not yet optimally tapped the international private sector's capacity to increase the quality of services equitably and sustainably invest in the health sector, such as long-term infrastructure provision through the various PPP models.

South Sudan is implementing a PPP policy, including non-state actors comprising predominantly NGOs and the private for-profit sector: Civil society is a key service delivery partner in all states, while the private sector fills systemic health sector gaps. However, several challenges have triggered the need for joint and multisectoral resource mobilisation , investment and financing of the health system.

Mainland Tanzania is implementing a PPP policy framework for mobilising resources for health, including non-state actors comprising predominantly NGOs and the private for-profit sector. The HIV programme has implemented a partnership where viral load and other equipment has been placed in the facilities by the private sector, which also maintains them while the government purchases reagents and pays only when the equipment is functional. The Ministry of Health has implemented a large leasing programme for medical equipment, which has enabled the government to enhance provision of specialised health services in 200 hospitals across the country, providing dialysis and other services. Zanzibar is implementing a PPP policy, including non-state actors comprising predominantly NGOs and the private for-profit sector. However, the policy requires joint resource mobilisation, and investment and sustainable financing of the health system with the above sectors.

40 https://www.rbfhealth.org/country/tanzania

Uganda has developed and is implementing a PPP policy framework for mobilising resources for health, which requires expansion and revitalisation to reduce transactional and hidden costs to the taxpayer, rigid public purchasing strategies and other systemic shortcomings. It also requires restructuring public purchasing strategies to support increased UHHC financing.

Expansion and strengthening of PPP frameworks and restructuring public purchasing strategies to strengthen UHHC implementation and mobilise additional resources for health, remain a majorly untapped resource mobilisation strategy in the majority of EAC Partner States.

2.3.3 Partner States establish/strengthen mechanism to enforce integration of health and gender into environmental impact assessments (EIAs) for all capital projects:

While gender has not been incorporated into all EIAs for all capital projects, HIV has been integrated, and lessons from the World Bank Inter-governmental Authority on Development (IGAD) application of this policy in the construction of the northern corridor highway that crossed several countries have been implemented by individual Partner States.

In Burundi, health/HIV and gender have been integrated into capital projects and funds are channelled through treasury.

In Kenya, adoption of AIDS EIAs and similar resource mobilisation initiatives have paid off, increasing sectoral resources. By 2017, the urban roads sector alone was contributing US$21 million for HIV impact mitigation towards insurance of local communities against the disease-driving effects of development projects (NACC, 2018). NACC is seeking to raise funding from a percentage of engineers' costs from infrastructure projects, which would raise significant amounts of money.

In Rwanda, EIAs are conducted regularly, with gender and health, including HIV, integrated into the assessment. The Gender Monitoring Office under the Ministry of Gender and Family Promotion monitors aspects of EIA for gender sensitivity. The Rwanda Development Board (RDB) and the Rwanda Environmental Management Authority (REMA) are engaged in this monitoring process. Mining companies are mandatorily required to report under social responsibility obligations on the number of people supported to subscribe to CBHI/MdS. This requirement is not mandatory for other companies, which may spend on developmental causes other than CBHI/MdS.

In South Sudan, integration of gender and health into EIAs for all capital projects is a requirement monitored and enforced by the Office of the President (Monitoring and Evaluation Unit), Audit Chamber and Ministry of Health.

Integration of gender and health into EIAs for all capital projects is a requirement monitored and enforced by the National Environmental Management Council of mainland Tanzania. Some projects are implemented between TANROADS, TACAIDS and other organisations involved in impact mitigation and social protection. Still, there is a need to develop clear procedures and guidelines on the collection and channelling of these funds to health sector strategic priorities. In Zanzibar, integration of gender and health into EIAs for all capital projects is a requirement monitored and enforced by the Zanzibar Environmental Management Authority. Funds mobilised through such projects are channelled into various sectors, including health, through the exchequer/treasury system.

While gender has not been integrated into EIAs for all capital projects in Uganda, HIV has been. Raising funds through capital projects remains a major opportunity and requires the establishment of mechanisms for channelling and monitoring of use of finances.

2.3.4 Develop a mechanism to ensure use of resources allocated to health and HIV in capital projects:

This has been a challenge for most Partner States. While some prefer special purpose vehicles such as AIDS or health funds, others prefer the exchequer/treasury or the use of national health/hospital insurance schemes or funds. Engagement between the ministries of health and finance has been wanting in countries where the National AIDS Council (NAC) is structured under the Ministry of Health. Partner States could learn from successes in countries where the HIV sub-sector is managed from the chief political or administrative executive's office, which tend to attract increased domestic public spending on health.

In Burundi, the availability of mechanisms to channel such funding is unclear and may constitute a significant leakage to Burundi's UHHC financing. There are suggestions to direct such moneys to the social protection funds (FAPS).

Mechanisms to channel such financing are still unclear in Kenya. This has been a challenge for Kenya and most EAC Partner States, with the exception of Rwanda and Zanzibar, which prefer the treasury/exchequer. There is a need to legislate and formalise the financing channels to include treasury or NHIF, which will then provide the Ministry of Health, NACC and the countries financing to implement their UHHC strategies. Oversight roles for the use of such financing also need to be clearly defined.

In Rwanda, while the Gender Monitoring Office under the Ministry of Gender and Family Promotion monitors aspects of EIA for gender sensitivity and the RDB and REMA are engaged, the extent of their engagement in monitoring use of funds remains unclear, yet this portends a significant source of income.

Currently in South Sudan, proceeds from capital projects are channelled by contributing parties directly to projects. Various departments within the Ministry of Health play various mandated roles to ensure effective use of health sector funds. There is a need to channel such financing directly to a consolidated financing mechanism to increase impact and additionality to the health sector and HIV strategies.

In mainland Tanzania, this funding is channelled primarily through treasury. Tanzania is discussing the most efficient mechanism to ensure use of resources allocated to health in capital projects. This issue has proved challenging. In Zanzibar, funds are similarly transferred through treasury. Nationally, the Planning Commission through the Department of Monitoring and Evaluation reviews programmes and projects quarterly and annually to ensure that agreed indicators are met. The Department of External Finance under the Ministry of Finance monitors monthly the use of external financing to development projects. Within the Ministry of Health, the Department of Planning, Policy and Research coordinates all capital projects and links them??? to the Ministry of Finance. In terms of infrastructure, drugs and medical supplies, the directorate of the Chief Pharmacist Office, the Central Medical Store and the Procurement Management Unit (PMU) is responsible for procurement, storage and distribution of drugs in all health facilities. The electronic Logistic Management Information System (eLMIS) is used by all health facilities to request and report quarterly on the use of the drugs. Under this system, projects such as malaria and HIV/AIDS can monitor drug stock status and use in health facilities.

Operationalising such mechanisms has faced significant challenges in Uganda, which has preferred a special purpose vehicle, the AIDS Trust Fund and the NHIS. Evidence shows that such mechanisms perform better when managed at the executive political level. Implication of the Head of State in oversight of quality and consistency of service has been high, but financing challenges remain.

2.3.5 Development of a regional financing strategy for health and HIV by the EAC Secretariat

This EAC UHHC Resource Mobilisation Strategy 2018 - 2023 acts as a reference point for the EAC region and Partner States to mobilise resources and finance UHHC. The EAC has developed a UHHC priority investment package and brought together Partner States through the expert working group on health sector financing to review this strategy and agree on priorities.

2.3.6 Development and approval of national financing strategies for UHHC coverage by 2017

In June 2018, Partner States reviewed this Resource Mobilisation Strategy for debate, prioritisation and approval in their individual contexts beginning July 2018. Partner States were defining their national and sub-national UHHC packages by 2018, and had developed financing strategies for essential health packages and HIV. Rwanda was already providing UHHC by 2018, while the UHC strategy in Kenya was costed by mid-2018/19. Uganda and Burundi had also costed their health sector strategies.

Burundi had defined CAM packages and costed her health sector strategies. Several development partners have committed to co-financing these health sector strategies with the government.

Kenya had developed a national financing strategy by 2018. The resource mobilisation implementation plan currently under development will be harmonised with relevant interventions under the EAC UHHC Resource Mobilisation Strategy.

Rwanda relies on the CBHI and supporting structures for implementation of UHHC; and has developed a financing strategy.

South Sudan's updated HSDP was costed in 2018, with plans to develop a financing strategy. The HIV programme had drafted a HIV and AIDS National Resource Mobilisation Strategy by 2018 and made plans to operationalise it. The state reviewed various options for financing in this strategy and the regional strategy and developed a prioritised UHHC resource mobilisation implementation/workplan. Mainland Tanzania has drafted the health financing strategy, but this has not yet been formalised. Resource gaps to finance the full implementation of the plan are substantial. In Zanzibar, the Ministry of Health has supported the development of a long-term healthcare financing strategy within HSSP III. The state has reviewed various options for financing in this strategy and the regional strategy and began to develop a prioritised resource mobilisation implementation/workplan in 2018.

Uganda developed a financing strategy for her HSDP and an HIV resource mobilisation strategy by 2016. However, the package for UHHC, including thresholds for the number of people who would receive subsidies and the exact healthcare costs that would be covered, was still not clear. while funding gaps were still large for UHHC.

Huge resource gaps remain a general concern throughout the region. Monitoring implementation of the regional resource mobilisation strategy by all Partner States will be a critical contributor to sustained UHHC financing.

2.3.7 Full institutionalisation and implementation of resource tracking/monitoring/mapping:

Expenditure tracking, rigorous resource mapping and efficiency audits are performed in Partner States, albeit not consistently. These also need to be reviewed to include UHHC tracking modules. Expenditure tracking exercises are performed within the ministries of health, and national AIDS commissions, through NHAs, World Bank public expenditure tracking surveys (PETS), PERs and NASAs. The HPF stewarded by the Ministry of Health in South Sudan goes further to include value-for-money indicators as part of annual reporting processes.
In Burundi, expenditure tracking, rigorous resource mapping and efficiency audits are performed, albeit inconsistently, but stakeholders have committed to biennial audits and reporting under the UHHC Resource Mobilisation Strategy.

In Kenya, expenditure tracking and rigorous resource mapping are performed, but efficiency audits are not consistently performed at a national level - albeit more common at project level. Expenditure tracking exercises are performed by the Office of the Controller of Budget and by the Auditor General, Ministry of Health (including NACC) and others.

Rwanda has instituted an annual HRTT.

In South Sudan, value-for-money studies (effectiveness, efficiency, equity and economy) are performed through the HPF. Expenditure tracking exercises are performed within the Ministry of Finance, Ministry of Health and South Sudan AIDS Commission, through NHA (currently being implemented for the first time), World Bank PETS, PERs and NASA, although these are not consistently performed.
In mainland Tanzania, expenditure tracking exercises are performed within the ministries of health, and Tanzania Commission for AIDS, through NHA, World Bank PETS, PERs and NASA. These need to be reviewed to include the UHHC tracking module and value-for-money studies (effectiveness, efficiency, equity and economy). Arrangements are similar in Zanzibar, where expenditure tracking exercises are performed within the Ministry of Finance, Ministry of Health and Zanzibar AIDS Commission, through World Bank PETS, PERs and NASA, although these are not consistently performed.

In Uganda, expenditure tracking, rigorous resource mapping and efficiency audits are performed, although not consistently. These also need to be reviewed to include UHHC tracking modules. Expenditure tracking exercises are performed within the Ministry of Health, NAC and through NHA, PETS, NASA and others. Value-for-money (efficiency, equity, economy and effectiveness) audits are rare.

2.3.8 EAC Partner States adapting and implementing financing mechanisms (including health insurance) that improve access, quality and financial protection:

Health insurance schemes are at advanced stages in Burundi, Rwanda, Kenya and Tanzania mainland. South Sudan and Rwanda have also relied on HPFs to channel resources to a single health sector strategy. Uganda's NHIS bill has been tabled at Cabinet. South Sudan and Zanzibar-Tanzania have chosen to implement public subsidised free healthcare at different levels of the health system. Generally, however, public insurance is the preferred way forward, but the issue of portability of insurance cover across borders, while it has been achieved by the private sector and is being piloted between Kenya and Rwanda; is yet to be scaled up at intergovernmental level. Most private insurers in East and southern Africa operate seamlessly across the region and allow for air transfers of patients within and beyond the EAC. The public sector intends to extend cross-border services beginning with some priority populations.

CAM has been adopted as Burundi's main health financing mechanism. However, it has inherited some of its predecessors' challenges. While revenue from premiums has been insufficient to fund basic items such as recurrent costs of outpatient drugs, and women have reported elimination of cash payment at point of use, convenience, and independence of health seeking without reliance on heads of households as some of CAM's advantages. Previous challenges have included inadequate enrolment, low/unattractive quality of services and skewed membership towards households at higher risk that sought health services more than the average household (the scheme was voluntary and OoP-based.) Improvements could be achieved through encouraging higher enrolment; ensuring quality assured services by building capacity and bonding service providers to quality requirements, increasing medicines availability, enforcing higher prescription standards by health workers, and advancing policies requiring communes (local governments) to fund services at health centres. Besides low coverage, the scheme's level of acceptance by private sector facilities remains wanting. To subsidise the poor, the state has established a FAPS. To improve efficiency, the country plans to consolidate social protection/ development financing from different sectors into FAPS.

Kenya's preferred channel for UHC and HIV AIDS financing is the NHIF. The fund's previously basic benefits package has grown to include both outpatient and inpatient services, maternal care, reproductive health, dialysis, cancer treatment; rehabilitation for drug and substance abuse; all surgical procedures, including transplants; emergency road evacuation services, overseas treatment and radiology imaging services.[41] All contributing informal and formal sector workers and their paying family members, as well as the elderly, and expectant mothers, receive NHIF services. In April 2018, three million secondary school children were added to the NHIF benefits scheme through a government subsidy. Other subsidies include the health insurance subsidy programme for households living in extreme poverty, which was supported by the World Bank and Japanese bilateral aid (covering poor households through community-based targeting of NHIF) and has now transitioned to the government, a medical cover for the elderly and people with disabilities, and the removal of user fees at public primary healthcare facilities.[42]

Rwanda's health insurance scheme is advanced, with subscribers divided into four categories stratified mainly by socio-economic status. Category 1 subscribers are fully covered, while the medical scheme takes care of 85% of the bill for medical treatment and prescribed drugs. Patients cover the remaining 15% of the cost. Rwanda also relies on an HPF to channel resources to a single health sector strategy and to the social protection scheme. Portability of insurance cover across borders has been achieved by the private sector but is yet to be implemented at intergovernmental level. Reviewed against WHO UHC metrics.[43] Rwanda scores commendably well. At one point, the Partner State registered 96.15% health insurance coverage, with 1.07 health facility visits per capita, above the one visit recommended by WHO. About a quarter of the population, comprising indigent/vulnerable people, had been subsidised, at parity with the 24.1% living in extreme poverty, while only 10.8% of the targeted ≤40% had catastrophic health spending levels. Proper cost recovery was estimated at 82.55% by as early as 2012. Rwanda provides a vast amount of lessons for scaling up UHHC within the EAC.

The Government of South Sudan supports and finances free primary healthcare, with plans underway to mobilise additional funding from different sources to improve access and quality. A public sector health insurance scheme has not been set up. There is an

41 www.nhif.or.ke
42 Cabinet Secretary of Health (Minister) statement, March 18, 2018.
43 Ndayekwe et al, (2014), Pan African Medical Journal

informal insurance sector offered by the private sector to employees of the United Nations, NGOs, companies and other individuals who can pay. Stakeholders acknowledge the need to develop a national health insurance scheme, especially to fill gaps in financing secondary and tertiary healthcare, and have adopted the strategy, to begin advocacy nationally. By 2018, Tanzania's NHIF and CHF covered 7% and 25% of the entire population respectively, who accessed services in accredited health facilities spread all over the country. Towards UHC, Tanzania is in enacting a law to require mandatory health insurance for all citizens to increase enrolment and contribution of the health insurance scheme to healthcare financing. The CHF scheme uses the risk-sharing concept where members make a small regular contribution to offset the risk of paying a larger amount out of pocket should they fall sick. Membership of CHF is voluntary and each household within a district contributes the same amount of membership fee, as agreed by a council based on socio-economic status of its community. Non-participating households pay user fees at health facilities. The Revolutionary Government of Zanzibar supports and finances free healthcare for all, with plans underway to mobilise additional funding from different sources to improve access and quality. By 2018, there was no public health insurance established in Zanzibar. However, people were free to use the national health insurance (mainland Tanzania) or the private health insurance they preferred.

The public health insurance scheme was at its nascent stages in Uganda by 2018, awaiting enactment of a law to establish the NHIS. In the meantime, UHHC scale-up was being financed through domestic and external sources and OoP expenditure.

2.4 Prioritisation and implementation of measures to improve efficiency in the allocation and use of health resources

2.4.1 Finalisation of the development of EAC medicines manufacturing regulation, including a compulsory licensing framework:

This was expected by December 2018 and work was ongoing. However, it was not finalised by the December 2018 deadline.

2.4.2 Finalisation and development of EAC pooled-bulk procurement and generic substitution framework by December 2018:

Work on this was progressing in 2018 and technical assistance had already been sourced by the EAC Secretariat to develop it further.

2.4.3 Development of biennial national and regional essential medicines and health product indicative price lists by December 2017:

Individual Partner State essential medicines lists exist, and since most regimen are standardised, these can be pooled into a regional list. Most countries receiving Global Fund support already use WAMBO.org, which by default harmonises prices - it would be a good starting point to leverage. However, countries report higher prices for some maternal and child health, and HIV/tuberculosis medicines, equipment and commodities. In addition, all Partner States receive PEPFAR support, with the exception of South Sudan. The Partner State receives US Government support through the HPF, which negotiates and sets a ceiling on the budget for essential medicines. Regionally, this is work in progress that has received support from the Bill and Melinda Gates Foundation.

2.4.4 Development of EAC health worker remuneration and incentive guidelines/framework for equitable distribution of health workforce and the right skills mix:

Human resource remuneration standardisation plans have been developed at country level (Rwanda, Uganda, Kenya, Burundi, Tanzania) in the context of the WHO (2013)[44] guidance on human resources for health (HRH) and devolution of health services. These are very challenging areas since they involve partners such as PEPFAR's projects trading off quality and achievement for harmonised HRH remuneration and incentives. EAC countries receiving PEPFAR or Global Fund support have highly fluctuating payment structures for similar positions. Many countries have not succeeded in standardising pay structures beyond community-level incentives.

44 WHO (2013) CHW and UHC - A framework for harmonised support and joint commitment

This is a difficult area to harmonise across the region and even within countries. There is a need to agree on harmonising standards (training, licensing and practice), assisting countries to attain WHO thresholds for health-worker-to-population ratios.

In Burundi, HRH systems and financial management information systems are linked. It is, however, unclear to what extent the logistical information management system (LMIS), human resource information system (HRIS) and financial management information system (FMIS) are linked through the district health information system 2 (DHIS2), and the comprehensiveness of the data that can be accessed to assist in planning.

In Kenya, human resource remuneration standardisation plans have been developed at country level in the context of HRH and devolution of health services developed by WHO. However, it was unclear if this was done regionally as per (WHO 2013 guidance.[45]

In Rwanda, human resource remuneration standardisation plans have been developed in the context of HRH and devolution of health services. An investment priorities framework was developed in 2018 with clear tasks towards achieving this commitment. The Rwanda Structure for Health Facilities was gazetted in November 2016, and all sources of financing rely on the government system. To incentivise quality service providers Rwanda has developed a performance-based financing mechanism for the health sector.

In South Sudan, the public service scheme was developed and implementation was scheduled to recommence in 2018, after the ministry responsible for public service had reviewed it in consultation with other ministries.

In mainland Tanzania, the Health Workers Scheme of Service guides remuneration for service providers. For community health workers who were previously not included in the scheme of service, a recommendation was reached to merge them with medical attendants in a new cadre called health assistants, which would result in an upgrade of the scheme and an update of the training curriculum to include streams for facility and community/household-level health assistants. This recommendation was awaiting approval from the President's Office, Public Service Management and Good Governance by 2018. In Zanzibar, the Public Service Scheme had been developed and plans were underway to implement it, and for the ministry responsible for public service to review it in consultation with other ministries.

In Uganda, it has been challenging to harmonise HRH remuneration and incentives across donors and the government, standardise pay structures beyond community-level incentives and recruit the minimum number of health personnel required across several cadres.

Partner States have requested the development of a human resource manual to address the need for a minimum number, mix and level of remuneration for health personnel that each Member State must provide.

2.4.5 Prioritisation, harmonisation and linkage of HRH information systems in Partner State budgets to expand its coverage and integrate it with medicines logistics and financial management information systems:

This was progressing to various degrees by June 2018. HRH systems are linked through NHAs, results-based budgeting (RBB) - modelling/ one health and linked in DHIS 2. Most advanced systems are in South Sudan, Burundi and Rwanda.

Kenya had neither integrated the HRIS with the integrated financial management information system (IFMIS) nor cross-related them beyond the payroll, even within DHIS 2. This integration was underway at the Ministry of Health by 2018 and is planned for completion during this strategic plan period. Every health facility can currently complete information on the financing received. Integration is planned for DHIS2 with Ministry of Interior and NHIF information systems.

Rwanda has one of the most advanced health information systems linking the LMIS, HRIS/integrated payroll and personnel information system (IPPS), managed by the Ministry of Public Service and Labour and IFMIS. DHIS2 has the capacity to provide integrated data,

45 http://www.who.int/workforcealliance/knowledge/themes/incentives/en/

including electronic medical records, but financial information is managed through IFMIS. HRIS and IPPS inform salary payment. IPPS helps in management of public servants and their performance evaluation.

The South Sudan Ministry of Health (HMIS integrated information system model developed under the stewardship of the Ministry of Health through the HPF, had already integrated the HRIS, LMIS with signal/tracker medicines and the electronic payroll integrated with management dashboards into DHIS 2 by 2018. This offers valuable lessons for EAC Partner States.

In mainland Tanzania, the HRIS and LMIS are integrated into DHIS 2. However, these had not been cross-related with the IFMIS by 2018. In Zanzibar, the HRSI stores and updates the staffing situation but faces limitations including non-integration with other systems such as DHIS 2 and eLMIS. Efforts are ongoing to integrate these systems. By 2018, only the malaria programme had been integrated with eLMIS, when there is a need to integrate all the systems for effective planning and decision-making.

In Uganda, linkage and integration of the information system was progressing to various degrees by June 2018. HRH systems are linked through NHAs, RBB modelling/one health and linked in DHIS 2.

2.4.6 Adoption and implementation of national development cooperation frameworks for the health sector (involving both the public and private sectors, CSOs and international NGOs) to improve governance and accountability by December 2018, as per the accountability agenda:

This was ongoing to a great extent for HIV.

In Burundi, cooperation with civil society, including the private sector, is ongoing to a great extent for HIV. but the level and impact of involvement of CSOs in improving financial outcomes are unclear. The private sector in Burundi has not been adequately involved in health, even though it offers a comparative advantage in reaching the informal and mostly uninsured sector.

In Kenya, linkage of information system and introduction of unique identifiers will reduce fraud and duplication at service access level and improve data credibility.[46] To strengthen accountability across development partners, a comprehensive resource tracking tool is being developed that will capture sector-wide spending across expenditure categories for all. Merger/alignment of donor UHC and country UHC sub-committees began in Kenya by 2018.

Rwanda's CBHI/MdS and HPF structures have clear and often well-implemented cooperation frameworks, and management of the CBHI/MdS across administrative levels and sectors has been recognised by WHO as a best practice.
In South Sudan, multisectoral collaboration is included, with clustered implementation entrenched in development and disease strategic plans. Examples include cooperation agreements among government, civil society and development partners for pooling funds and implementing together, grant agreements, and formation of health, humanitarian and development clusters through which multisectoral partners coordinate service delivery, among others. HPF and subsequent coordination arrangements continue to lay the foundation for the Ministry of Health to transition from dependency on foreign aid in future. Outside of the HPF, the Global Fund has also supported HIV, tuberculosis and malaria response, and the health system. More than 40 of the world's largest NGOs, most of which are 501 (3) (c) organisations or large NGOs headquartered in other continents, have also mentored local NGOs, facility and district staff in the Partner State's massive health and humanitarian effort.

In mainland Tanzania, adoption of development corporation frameworks and the accountability agenda have progressed to a great extent through sector-wide approaches, results-based financing and others. In Zanzibar, the Ministry of Health Steering Committee was established to enhance coordination, harmonisation and commitment to support the ministry to implement the HSSP. It also provides strategic guidance on public financial management, including risk assessment, implementation, monitoring and evaluation of this plan in Zanzibar. In addition, the District Health Basket Steering Committee, which has been in existence for more than five years, meets quarterly to oversee use of Basket Fund resources.

46 To introduce accountability agenda data and complete based on progress in implementation of corporation agreements.

Uganda was advised to convert available multisectoral coordination structures into UHHC implementation and coordination structures, hence the donor UHC and country UHC sub-committees have been merged to meet the required cooperation and accountability agendas.

Partner States have been advised to avoid reinventing the wheel by converting available multisectoral coordination structures into UHHC implementation structures.

2.4.7 National and regional level efficiency studies informing strategies to minimise wastage in the health sector, including development of EAC regional indicators, annual monitoring of indicators and support of implementation in the Partner States:

Efficiency studies have been standardised, although not consistently at national level. Joint annual health sector reviews are performed to assess the implementation progress of annual plans. For example, South Sudan conducts value-for-money analyses under the '4 Es' and it is practically the most advanced since value for money is a health sector indicator reported annually - although it requires external technical support (heavily subsidised by UKaid, US Government, EU, CIDA and Sida), while the Ministry of Planning leads cost-benefit studies and value-for-money studies are integrated into the HPF evaluation plan.

Regional guidance on efficiency studies could benefit the health sector. Global efficiency studies have progressed mainly through development partners (US, UKaid, World Bank, UNICEF, UNDP, WHO, some civil society and private sector partners are current leaders) and the region could learn from their methodology. All partners had by June 2018 conducted national level efficiency studies to inform strategies to minimise wastage in aspects of the health sector, although few have been carried out in the last two years. These were, however, donor-driven, for example through Global Fund reprogramming or grant-making exercises or provided by partners. The monitoring and evaluation framework in this plan provides regional level indicators that could influence both national and annual monitoring of indicators.

The preceding analysis suggests that some regional and Partner State strategies for UHHC financing require rethinking. These include a move away from voluntary towards compulsory UHHC, from bureaucracy in public health procurement towards strategic purchases, and towards creating more flexible public financial management processes and structures; growing fiscal space for sustainable UHHC financing and continuing to expand coverage beyond the recorded into the unrecorded or informal economy to reduce significant fiscal leaks; stratifying poor and vulnerable populations further to better target UHHC subsidies for those who cannot afford healthcare, among other strategies and interventions prioritised in the following section.

3 Strategic Framework

The goal of the UHHC Resource Mobilisation Strategy is to guide mobilisation of resources adequate for EAC Partner States to meet the SDG 3 and its concomitant targets, as domesticated by EAC Partner States. Partner States can then implement the strategies most relevant to their context and develop Partner State-specific workplans to arrive at the main programme results. Below is a tabular representation of the expected outcomes from resource mobilisation interventions that would lead to the attainment of programme results and, in turn, the overall strategic results (goals).

STRATEGIC RESULTS (GOALS)	Adequate financing to meet shared goals of: o Reduced maternal and child mortality in EAC Partner States o Reduced disease-related deaths in EAC Partner States by 75% by 2023 o Reduced new HIV infections by 50% by 2023 o Universal health and HIV service coverage, including financial risk protection, access to safe quality essential health services, medicines and vaccines					
PROGRAMME RESULTS	Programme Result 1: Enhanced fiscal space for UHHC	Programme Result 2: Sustainable UHHC financing mechanisms developed by each Partner State	Programme Result 3: Improved efficiencies in health spending and financial investments in UHHC from less than 70% to 90% by 2023	Programme Result 4: Increased UHHC funding through PPPs	Programme Result 5: Strengthened structures at both national and regional level to support and enable UHHC policy, governance, regulation and resource mobilisation	Programme Result 6: Enhanced cross-sectoral collaboration for UHHC resource mobilisation
RESULT AREAS	Expanded financing from current sources Improved tax systems	Sustained UHHC financing Strengthened national health insurance and assurance schemes	Improved health system efficiencies Improved public financial management	Innovative sources of financing implemented by all sectors	Improved effectiveness and coordination of EAC UHHC RM processes	Enhanced cross-sectoral collaboration in UHHC financing and delivery
OUTCOME RESULTS	At least an additional 50% of the UHHC financing gap available by 2023 To be determined by Partner State and 50% for the EAC region)	UHHC support entrenched in national constitutions, development plans and health sector budgets and national schemes by 2023	Accelerated service delivery and efficiency savings increased by 50% by 2023	PPPs provide at least 30% of UHHC financing by 2023	At least 50% of US$3.4 billion budget raised to implement EAC regional investment priorities	Critical sectors contribute to UHHC (finance, legal, agriculture, education, industry, energy, labour, roads etc)
Prioritised resource mobilisation strategies and interventions						
Monitoring and Evaluation Framework						

A set of priority interventions and activities will be implemented under each strategy. In turn, the strategies will collectively contribute to the attainment of a set of result areas. These result areas will collectively contribute to the attainment of the six programme results that will contribute to achievement of the goal.

3.1 Resource mobilisation strategies

Strategic Result (Goal):

Adequate financing to meet the shared goals of:

1. Reduced maternal and child mortality in EAC Partner States
2. Reduced disease burden in EAC Partner States
3. Reduced disease-related deaths in EAC Partner States by 75% by 2023
4. Reduced new HIV infections by 50% by 2023
5. UHC, including financial risk protection, access to safe quality essential health services, medicines and vaccines.

Result Areas:

1. Result Areas 1: Enhanced fiscal space for UHHC
2. Result Areas 2: Sustainable UHHC financing mechanisms developed by each Partner State;
3. Result Areas 3: Improved efficiencies and financial investments in UHHC from less than 70% to 90% by 2023;
4. Result Areas 4: Increased UHHC funding through PPPs
5. Result Areas 5: Strengthened structures at both national and regional level to support and enable UHHC policy, governance, regulation and resource mobilisation
6. Result Areas 6: Enhanced cross-sectoral collaboration for UHHC resource mobilisation.

Below is a set of prioritised strategies, interventions and expected outcomes under each programme result.

PROGRAMME RESULT 1:
Enhanced fiscal space

RESULT AREA
Expanded financing from current sources

Health financing needs are increasing at a faster pace than the available resources. Fiscal space expansion will involve budget reallocation; increased domestic resource mobilisation, targeted channelling through UHHC financing mechanisms and improved efficiency of public and private health spending. This programme result focuses on increasing space for budget reallocation (including through attraction of increased external or private sector funding), domestic resource mobilisation and strengthening channels for UHHC financing, while avoiding strategies such as earmarking that, while impactful, have been shown to decrease revenue. Domestic resources are generated by economic growth, supported by an enabling environment at all levels. The EAC should continue to promote sound social, environmental and economic policies, including countercyclical fiscal policies,[47] adequate fiscal space, good governance at all levels, and democratic and transparent, responsive institutions.

UHHC should focus most on the poor and marginalised, to maximise the likelihood of having a high effect on economic growth, hence be sustained. Pro-poor interventions such as social protection, incentives and conditional vouchers have been shown to work well.

To meet the large funding gaps, much reform in UHHC service delivery and vast resources need to be allocated by government. This can be achieved fast enough only at political level. UHHC reform is a political and technical issue, hence the need to engage neutrally in policymaking at the political action stages to ensure its successful establishment and prioritisation.

EXPECTED OUTCOME
At least 50% of the health financing gap per Partner State, totalling US$9 billion for the EAC region is available annually by 2023.

Priority strategies and interventions

Strategy: Shift from voluntary to compulsory contributions to UHHC through framework development, financing mechanisms and increased budget allocations

For UHHC to succeed, the main domestic source of public funding must be general budget revenues, with indirect taxes often as a major source. There is need for focused engagement with the ministries of finance and to establish mechanisms for the ministries of health and finance to engage on funding, allocation and budget processes.

Interventions

1. Gradually expand integration of UHHC into EIAs for public and private capital projects and direct sectors to channel resultant financing through treasuries or the NHIS as the country situation requires.
2. Finalise development of differentiated service packages (people-centred, directed to priority populations and services).
3. Enhance legal and policy frameworks for all stakeholders to enable smooth transition from voluntary to compulsory government and employer contributions, as well as mandatory health insurance uptake by individuals.
4. Develop master information systems for all citizens, including one master identification system linking social assistance, health and economic data, public services and all others with health insurance information.

47 A 'countercyclical' fiscal policy involves moderating/reducing spending, raising taxes during a boom period and increasing spending and cutting taxes during recessions, while with a 'procyclical fiscal policy', governments increase spending and reduce taxes during economic booms, but reduce spending and increase taxes during recessions. The former stabilises and grows fiscal space.

5. Ensure that the shift to mandatory UHHC includes subsidisation for those who are unable to pay.
6. Develop guidelines for use of funds that have been channelled to the NHIS.

Strategy: Increase domestic contributions to UHHC

1. Progressively increase strategic government budgetary allocations to health sector, by at least 10% annually.
2. Engage parliaments (HIV and health committees in the legislature), policymakers and ministries of finance to ring-fence and gradually increase UHHC funding.
3. Engage civil society to advocate increased UHHC financing.

Strategy: Increase absolute value of external and private funding for UHHC (including from external partners, international foundations, private sector and civil society)

1. Increase external and private sector partnerships under UHHC coordinating structures and provide social, environmental protection and health insurance subsidies to extremely poor, vulnerable and marginalised populations, including women, orphans, the elderly and people living with HIV.
2. Strengthen capacity among Partner States and implementing partners for resource mobilisation and proposal writing to optimise funding from external sources, private sector and international foundations.
3. Revise and update health sector partnership/financing and development partner/development assistance/cooperation frameworks to prioritise UHHC financing.
4. Develop policies and strengthen regulatory frameworks to better align private sector incentives with public goals, including incentivising the private sector to adopt sustainable practices and ultimately attract domestic and international private business and finance from foreign direct investment.
5. Facilitate development of partnerships between the private sector in East Africa with multilateral, bilateral and other investment guarantee agencies and mechanisms to mitigate international private sector investment risk and accelerate international PPP in the health sector through guaranteed direct sector investments (World Bank's Multilateral Investment Guarantee Agency, China's SINOSURE, EU trade guarantee mechanisms, US Government's Overseas Private Investment Corporation).
6. Develop national and regional standing UHHC partnerships with foundations, private sector and civil society partners to jointly access a percentage of the US$10 trillion international private foundation financial base [US Chapter 501 (3) (C) registered organisations and other foundations and NGOs].
7. Shift from siloed to basket/consolidated or pooled funding for the health sector.
8. Engage additional partners to contribute to such funds where these exist (for example in Rwanda, South Sudan, Tanzania-Zanzibar)

Strategy: Support tax reform processes that increase revenue generation and collection[48]

1. Encourage adoption of progressive tax systems by EAC Partner States.
2. Encourage improved tax policy and more efficient tax collection. EAC Partner States should increase the amount of taxes collected by increasing the tax base and number of taxpayers, improving tax collection systems, creating more jobs and promoting efficient use of taxes.
3. The EAC to continue to assist Partner States to scale up international tax cooperation and inclusive cooperation and dialogue among national tax authorities on international tax matters.
4. Strengthen countries' capacity for contract negotiations for fair and transparent concession, revenue and royalty agreements, and monitoring and evaluation of contract implementation.
5. Expand online and mobile revenue collection, administration and follow up.
6. Expand tax base by requiring employees of international organisations and diaspora to pay tax.

48 In Burundi and Uganda, significant technical support is required by the Ministry of Finance to analyse and advise on the most appropriate changes in tax policy

PROGRAM RESULT 2:
Sustainable UHHC financing mechanisms developed by each Partner State

National and community health insurance and social protection schemes are emerging vehicles of choice to sustain investments in essential health service packages, and now UHC.

Rwanda's MdS/CBHI scheme, Tanzania's urban health insurance scheme, TIKA, and rural scheme CHF, Uganda's emerging NHIS, Kenya's NHIF, Burundi's CAM medical assistance scheme and South Sudan's HPF portend significant opportunities for UHHC treatment expansion. The schemes and fund (will) face similar challenges, including sustainability (HPF) and funding size, enrolment size, governance, management and quality assurance; staff availability, and revenue generation. There is a need to address these challenges and increase enrolment beyond 80% of populations in each Partner State. These should be complemented by integrated subsidy programmes from Partner States.

For continuity and sustainability, there is a need to pay more attention to the legal, political and community engagement processes in countries; engage neutrally and use opportunities such as elections and party processes to entrench UHHC into constitutions, and define bills of rights and budgetary laws and manifestos at parliamentary and political party level, which subsequently become government manifestos and development plans.

RESULT AREA
Sustained UHHC financing

EXPECTED OUTCOME
UHHC support entrenched in national constitutions, development plans, health sector budgets and national insurance schemes by 2023.

Priority strategies and interventions

Strategy: Strengthen and expand enrollment in NHIS

Interventions

1. Strengthen the legal, policy and regulatory framework to ensure sustained UHHC financing.
2. Strengthen governance, management, quality assurance, staff availability, revenue generation and increase enrolment beyond 80% of population in each Partner State.
3. Develop, cost and implement advocacy and communications sensitisation strategy and quality assurance strategy to significantly increase enrolment in national health schemes;
4. Integrate HIV and AIDS prevention, treatment and mitigation into national health schemes, subsidy programmes and insurance fund.
5. Develop voluntary mechanisms and adopt practices that protect scheme incomes from foreign exchange fluctuations, for example operating foreign currency accounts, spot or forward contracting as appropriate, and other measures

Strategy: Strengthen primary health and multisectoral service delivery and coordinating structures at primary level

1. Invest in primary healthcare services on governance, human resource, monitoring and evaluation, infrastructure, financing and commodities local governance systems, in partnership with civil society and non-state providers to expand and sustain UHHC coverage.
2. Roll out UHHC through strengthening community systems/structures.
3. Improve information collection and sharing for data use.
4. Improve interoperability of information systems.
5. Operational research to more granularly respond to challenges where they are found.
6. Capacity building of staff managing primary healthcare around financial leadership and management..
7. Invest to ensure and enforce quality assurance in health service delivery at primary level.
8. Assess systems and strengthen community systems, including information and monitoring and evaluation systems.
9. Strengthen community health insurance schemes and link them to national schemes.
10. Include provisions of PPP acts in all resource mobilisation strategies.

Strategy: Regularly monitor levels of financing for UHHC and address challenges in a timely manner

Institutionalise and routinely carry out resource tracking/monitoring/mapping to monitor levels of financing to UHHC in real time with annual reporting.

PROGRAM RESULT 3:
Improved efficiencies and financial investments in UHHC from less than 70% to 90% by 2023

Better public financial management and engagement are critical to the UHHC financing agenda. Despite high need, public, development partners and civil society systems currently spend only about 70% of available non-commodity funding in all EAC countries.[49] This is due to high transactional costs, delays in disbursement, accountability versus efficiency tradeoffs, and other causes and inefficiencies in service delivery. Public financial management reforms are being implemented in each Partner State and challenges addressed as they arise. In addition, the health sector in several Partner States is facing challenges related to allocative efficiency.

RESULT AREA
Improved public financial management

EXPECTED OUTCOME
Accelerated service delivery and efficient use of available resources increased by 50% by 2023

Priority strategies and interventions

Strategy: Strengthen and develop flexible and responsive public financial management and allocation systems

Interventions

1. Strengthen health ministry capacity to engage with ministries of finance and procurement management and oversight authorities, and negotiate for more responsive public financial management systems, more flexible accountability structures and other forms of procurement that lower the cost of public sector purchasing.
2. Develop capacity for more strategic allocation and use of general budget revenues at centralised and decentralised levels, with emphasis on departments responsible for accounts, finance and procurement and supply management.
3. Accelerate implementation of health financing reform (strengthen budgeting and management).
4. Improve monthly, quarterly and annual expenditure and absorption rates through strengthened financial management systems for all implementers.
5. Establish a pooled procurement mechanism to reduce transactional costs.

RESULT AREA
Improved health system efficiencies

Strategy: Improve efficiencies in the health system

Partner States will implement the following WHO recommendations adapted to their needs, to reduce inefficiencies and strengthen the health system, in specific building blocks that are problematic for most partners.

49 *Country Global Fund Programme Reviews, 2017*

SOURCE OF INEFFICIENCY	COMMON REASONS FOR INEFFICIENCY	PROPOSED INTERVENTIONS
1. HIGHER COST INPUTS CHOSEN OR INPUTS NOT ACHIEVING THEIR MAXIMUM POTENTIAL		
(i) Medicines - adopt generic drugs that have been approved	No generics policy, provider/patient perceptions that generics are poor quality, financial incentives to prescribe branded medicines, poor purchasing practices or corruption, lack of knowledge of international prices, high mark-ups or taxes on medicines	Update or develop generics policy and update essential medicines list for health facilities accompanied by quality controls, provision of information on generics Invoke favourable international trade rules as done by Rwanda to enhance affordability of ARVs
(ii) Irrational use of medicines, the wrong medicines or using them at the wrong time	Inadequate regulation/administration to control sub-standard medicines,-Inadequate knowledge by providers, demand or low adherence from patients	Fast track harmonisation of EAC regulatory bodies Reinforce government capacity to regulate medicines to ensure safety and quality, information exchange for providers and the population Establish regulatory bodies to ensure quality control, improved information sharing and management
2. INFRASTRUCTURE (e.g. HEALTH FACILITIES)		
	Too few facilities for the demand or maldistribution, patients choose higher-level facilities – over and under capacity coexist, poor management, financial incentives for high admission and long length of stay, poor referral system at all levels	Develop and implement referral guidelines Master plans for streamlining infrastructure, increased service delivery capacity and quality at lower levels of care Appropriate blending and use of payment methods Improved management capacity with appropriate incentives
(iii) EQUIPMENT that is purchased and cannot be repaired or is not used optimally	Donations of equipment that cannot be serviced locally or where supplies and maintenance are too expensive, poor procurement practices, corruption Lack of experts (biomedical engineers) who can conduct periodical maintenance, lack of preventive maintenance plan, lack of donation policy	Adoption of equipment management services and performance-based contracting whereby equipment services and maintenance remain the responsibility of the providers, while reagents and supplies provision remain the obligation of health facilities Recruit biomedical engineers Revisions of donations policies to regulate donations, e.g. refuse donations of new technology where domestic budgets will be strained to buy supplies and maintenance, improve donor practices, improve procurement practices and controls of corruption, build capacity of staff on equipment use and maintenance Develop preventive maintenance plan
3. HEALTH SERVICES		
(i) Unnecessary tests, procedures or underutilisation of these compared to need	Poor management and control (perhaps linked to insufficient management resources or inadequate information on patterns), financial incentives to over-service, defensive medicine	Improve management and availability and use of data, develop and update clinical guidelines that will be enforced
(ii) Medical errors and low-quality care	Inadequate provider knowledge, insufficient data collection or use of data by managers, no incentives for quality, poor infrastructure, low-quality (including hygiene), poor compliance with infection	Continuous training for providers, improved data availability and use (e.g. clinical audits), clinical guidelines, incentives for quality (contracting, provider monitoring, payment systems), Improved laboratory use and efficiency

SOURCE OF INEFFICIENCY	COMMON REASONS FOR INEFFICIENCY	PROPOSED INTERVENTIONS
4. PERSONNEL		
(i) Inappropriate mix between different cadres	Poor planning, inappropriate training intakes (can be linked to student demand), brain drain or lack of retention of some cadres, resistance by various cadres to less-skilled people taking more responsibility Incentives insufficient for some locations Non-application of retention strategies	Health workforce planning based on labour market assessment and links to training intakes HRH training and recruitment aligned with broader health system's objectives, strategies and incentives to recruit and retain key health workers in remote and underserved areas, skill-task matching, including task shifting Application of scheme of service by ministries of health to regulate training and enforcement of implementation of other strategic human resource practices
(ii) Demotivated workers with low productivity and poor quality of services (e.g. low visits per health workers per day, absenteeism)	Poor wages and incentive structures, poor management and supervision, poor working conditions, recruitment and promotion not based on merit	Salary and incentive structures in line with system objectives Regulation of dual practice Improved management, supervision and working conditions, multi-disciplinary teams Eliminate 'cronyism' in hiring and promotion (establish clear process for hiring, deploying and promotion of health personal)
5. INAPPROPRIATE MIX OF INPUTS: E.G. HEALTH WORKERS BUT NO MEDICINES OR OTHER MEDICAL PRODUCTS		
	Poor management or budgeting practices, inflexible contracts with workers	Improved management of inputs for service delivery Adopt budget practices providing greater flexibility of use of inputs

PROGRAM RESULT 4:
Increased UHHC funding from innovative sources

This programme result focuses on PPPs and related innovative financing initiatives that are sustainable. Partner States are implementing PPP policies to mobilise health sector resources and implement UHHC. These are expected to grow in value as fiscal space expands. They are still at a low scale compared to other regions, yet tend to cost the public more than the more competitive market rates. In scaling up UHHC, the EAC stands to benefit greatly from reviewing current frameworks and implementing more optimal PPP policies.

RESULT AREA:
Innovative sources of financing implemented and used by all sectors

EXPECTED OUTCOME
Innovative financing sources provide at least 30% of UHHC financing by 2023

Priority strategies and interventions

Strategy: Develop and implement innovative UHHC financing mechanisms aligned to both public and private sector impact goals

Interventions

1. Adopt hybrid public-private healthcare models and/or other PPPs such as paying for results or through public health insurance systems.
2. Partner with the private sector to transform primary care through the effective application of innovative service delivery, financing and business models such as PPPs that combine government funding with private income flows.
3. Partner with CSOs to fundraise for UHHC.
4. Harmonise public health policies with private sector and civil society goals through a focus on results and sustainability.
5. Update and define private sector standards through changes in PPP laws, policies and frameworks.
6. Establish fiduciary transaction advisory capacity at EAC level to support the capacity of Partner States to negotiate public procurements.
7. Build EAC Secretariat capacity to support the capacity of Partner States in PPPs design and implementation.
8. Introduce and use community health funds.

Strategy: Develop partnerships to approach foundations and multinational corporations

1. Convene regional annual UHHC financing conferences.
2. Deliberate efforts by both Partner States and the EAC to develop proposals and submit to foundations and multinational corporations (Partner States and the EAC should build capacity for proposal writing, negotiation and resource mobilisation in general).
3. Engage high-net-worth Individuals directly to fund substantive projects in the public and private sectors.

Strategy: Expand partnerships with emerging high-value industries

1. Develop or review policies to include emerging sectors in EIAs so that each sector budget contributes a minimum percentage of its budget to UHHC (in countries except where direct levies have been removed, such as Kenya).
2. Conduct social and environmental impact assessments, levy licensing and operational fees for capital projects in high-value industries. Introduce levies in high-risk environments, including recreational events.
3. Institute levies and taxes in industries such as betting, licensing and communication; levies on diaspora remittances and diaspora bonds for sale to emigrant citizens; levies on securities exchange transactions; sin taxes - levies on alcohol, and other inebriating or unhealthy substances, and seed funding for UHHC lotteries.
4. Partner with other ministries and sectors, including commerce, forestry, finance, agriculture, customs, gender, mining and petroleum, telecoms, revenue authority and private sector to mobilise resources for UHHC.

PROGRAM RESULT 5:
Strengthened structures at both EAC and national level to support and enable UHHC policy, governance, regulation and resource mobilisation

There is added value in enhancing collaboration between Partner States and with other regional bodies on the UHHC financing agenda. The EAC Secretariat could begin advancing the more sustainable best practices in UHHC financing and facilitate the scale-up of models for risk pooling.

The EAC can also build on efforts by other regional bodies, including the Great Lakes Initiative on AIDS (GLIA), Lake Victoria Basin Commission and exchange best practices beyond the region, including with the Southern Africa Development Community (SADC) and the AU and others.

Key issues in UHHC financing currently include transition from aid, the political economy of increasing public funding (WHO, 2017) and efficient private sector engagement. EAC Partner States require significant lead time to transition from aid since much of the health sector, including the HIV budget, is externally funded.

Some SADC Member State experiences offer good lessons on domestic resource mobilisation. These include resource mobilisation and operational structures between the ministries of health and finance in South Africa and Lesotho. Lesotho's health expenditure has met Abuja Declaration recommendations, while domestic share of health spending has risen to about 70%.

RESULT AREA:
Improved effectiveness and coordination of EAC UHHC resource mobilisation processes

EXPECTED OUTCOME:
At least 50% of US$3.4 billion budget raised to implement EAC regional investment priorities

Priority strategies and interventions

Strategy: Strengthen EAC Secretariat capacity to mobilise, manage and account for significant UHHC resources

1. Strengthen existing structures to better support and monitor UHHC resource mobilisation.
2. Leverage resources from EAC structures, including health sector experts working groups (EWGs), technical working groups (TWGs) and other regional bodies and multisectoral structures, including ECSA, IGAD, GLIA, SADC and the Economic Community of West African States (ECOWAS) to support and advocate increased UHHC financing.
3. Link UHHC committees in countries to the UHHC financing team at the EAC Secretariat and form a joint UHHC coordination platform.
4. Establish a strong regional coordination mechanism.
5. Adapt a regional resource mobilisation mechanism from existing and external EAC structures.
6. Assess risk and develop strong risk mitigation strategies as part of Partner State workplans drafted to implement the Resource Mobilisation Strategy.

Strategy: Promote local, regional, and global information exchange to accelerate UHHC adoption and financing

Organise UHHC investment summits, resource mobilisation and interregional benchmarking for EAC ministers responsible for health and finance and resource mobilisation committees on issues such as transition from aid, and learning from other ministries of health experiences in working with ministries of finance.

Strategy: Strengthen policy, regulation and governance of health professions, medicines and health technologies, service delivery/provision quality assurance systems and PPPs

1. The EAC should promote adherence to national and international health regulations for epidemics.
2. Roll out quality assurance of health service delivery under UHHC.
3. Provide regulatory and policy support to countries.
4. Strengthen regional and national capacity to coordinate flagship projects and effectively report to the council and summit.
5. Facilitate sharing of best practices at regional level through the EAC and promote their adoption and scale-up by the Partner States.

Strategy: Facilitate advocacy activities for increased investment in UHHC in the region

1. Advocate for ring-fencing or allocation of financing to scale up portability of health insurance across EAC Partner States.
2. Enhance cross-border availability of services for vulnerable and priority populations, young women and adolescents to access sexual reproductive health rights and HIV services;
3. Advocate increased reliance on evidence-informed approaches in countries.

PROGRAMME RESULT 6:
Enhanced cross-sectoral collaboration for UHHC resource mobilisation

Accelerating progress in UHHC requires collaboration through clear strategies and coordinating political leadership at the highest levels. Transition towards sustainable financing should be led by the political leadership, at or above ministerial level, even as programme managers continue to provide necessary technical guidance.

RESULT AREA:
Enhanced cross-sectoral collaboration in UHHC financing and delivery

EXPECTED OUTCOME
By 2023 all critical sectors contribute to UHHC

Strategy: Ensure inclusive multisectoral partnership to enhance UHHC resource mobilisation

Interventions

1. Establish UHHC coordinating mechanisms led by the Ministry of Health for UHHC financing and include development partner/ donor coordinating structures in UHHC structures.
2. Strengthen engagement between health and finance ministries to ensure more realistic health budgets and gradual transition from donor-funded health systems.
3. Orient and engage decentralised/sub-national governance and management structures in planning, differentiating, reviewing and costing the updated UHHC strategy.
4. Create platforms for direct cross-sectoral partnership between NGOs and private sector entities.
5. Integrate UHHC investment packages into local and international investment promotion activities.
6. Enhance multisectoral dialogue on UHHC financing.

Strategy: Develop policies that attract increased private sector investment into UHHC

1. Attract impact investors by combining health impact with financial returns on investment.
2. Expand private sector investment in primary healthcare through PPP as inclusion on health facility-community-private sector forums at all levels of service delivery.
3. Encourage the use of innovative technologies in service provision and data capture; automation and patient tracking to reduce costs and encourage budget reallocation.
4. Encourage private sector participation in equipping health facilities, training staff; providing technologies that guide or automate service delivery, quality, developing referral pathways and monitoring to further reduce costs.
5. Institute results/performance-based financing/incentives for health service providers and community-level health workers/ volunteers.

4 Operationalisation of the Plan

4.1 Coordination and partnerships

The implementation and coordination framework for the UHHC Resource Mobilisation Strategy is premised on principles defined in Article 7 of the Treaty Establishing the EAC, namely asymmetry, complementarity, subsidiarity and variable geometry. The principle of asymmetry foresees a variance in the implementation of measures, complementarity defines the extent to which economic variables support each other, subsidiarity emphasises multi-level participation of a wide range of participants, while the variable geometry requires flexibility, which allows for progression in cooperation among a sub-group of members, at different speeds and in a variety of areas. Engagement of the forum for national planning authorities and the central regional planning authority will be critical in advancing many of the strategies proposed, especially interventions relying on regional regulation, cooperation, coordination and policy.

Council of Ministers

The Council of Ministers is the central decision-making and governing organ of the EAC. Its membership includes ministers or cabinet secretaries from the Partner States whose dockets are responsible for regional cooperation. It meets twice a year and links the political decisions taken at the summits with functional operations of the community. Regulations, directives and decisions taken or given by the council are binding to the Partner States and to all other organs and institutions of the community other than the summit, the court and the assembly. The council elects a chairperson each year, on a rotational basis.

Coordinating Committee

Under the council, the Coordinating Committee is responsible for regional cooperation and coordinates the activities of the sectoral committees. It recommends to the council the establishment, composition and functions of sectoral committees. The Coordinating Committee comprises permanent/principal secretaries responsible for regional cooperation from the Partner States. Subject to any directions given by the council, the Coordinating Committee meets twice a year preceding the meetings of the council. It may in addition hold extraordinary meetings at the request of the chairperson of the Coordinating Committee.

Sectoral committees

Sectoral committees conceptualise programmes and monitor their implementation. The council establishes sectoral committees on recommendation of the Coordinating Committee. The sectoral committees meet as often as necessary for the proper discharge of their functions.

Forum for national planning authorities: All six Partner States have planning authorities that provide functions for planning, surveys, data collection and analysis, dissemination and production of regular economic reports. The forums for national planning authorities will ensure information exchange, harmonisation and consistency, and will be represented in the proposed EAC Joint Resource Mobilisation Committee to assist in implementing this plan.

Central Regional Planning Authority: As the implementation of the EAC's Vision 2050 and the global vision for UHHC and ending AIDS by 2030 progress, there is a need for increased joint planning. The Central Regional Planning Authority (CRPA) will ensure harmonised and efficient coordination of activities. The CRPA coordinates formulation of medium-term plans that would run for a phase of the implementation period.

Operationalisation of this strategy will be synchronised with EAC strategies and planning entities. It will be overseen by the EAC Secretariat. The EWG on Sustainable Financing will offer technical support.

The EAC Secretariat: The EAC Secretariat will support implementation of this strategy through functions outlined in Article 71 of the EAC Treaty.

Key stakeholders:

- Partner State's ministries responsible for health, EAC affairs and finance.
- Summit of the Heads of States, Council of Ministers and the Sectoral Council on Health.
- Development partners (Intergovernmental, multilateral, donors, philanthropic organisations) investors/private sector.
- CSOs and faith-based organisations.
- Academic and research institutions.
- Healthcare providers and implementing partners.
- Health regulatory authorities (professional training and practice, medicines, quality of healthcare).
- End-beneficiaries of health services.

4.2 Other EAC TWG on health

Other EAC TWGs on health include:

i) EAC TWG on Health Systems and Policy.
ii) EAC TWG on Health Professionals Regulation.
iii) EAC TWG on Disease Prevention and Control.
iv) EAC TWG Medicines, Food Safety and Health Technologies.
v) EAC TWG on HIV/AIDS, TB and STIs.
vi) EAC TWG on RMNCAH and Nutrition

4.3 Resource mobilisation and tracking roles for the EAC TWG on Health Systems and Policy

Most of the strategies proposed here fall within the scope of Article 118 of the EAC Treaty and EAC priorities emanate from the EAC Regional Health Sector Strategic Plan - RHSSP (2015-2020). To better operationalise UHHC resource mobilisation, guided by Article 6 of the EAC Treaty and specifically Article 71 on the functions of the EAC Secretariat, it is proposed that the EWG charged with financing UHHC (health systems and policy) take on the following roles, with external technical support and collaboration/representation from within existing EAC structures, including the forum for national planning authorities, ministries responsible for health and finance, national AIDS commissions, CSOs, development partners, technical partners and private sector representatives, and representatives of other complementing regional bodies:

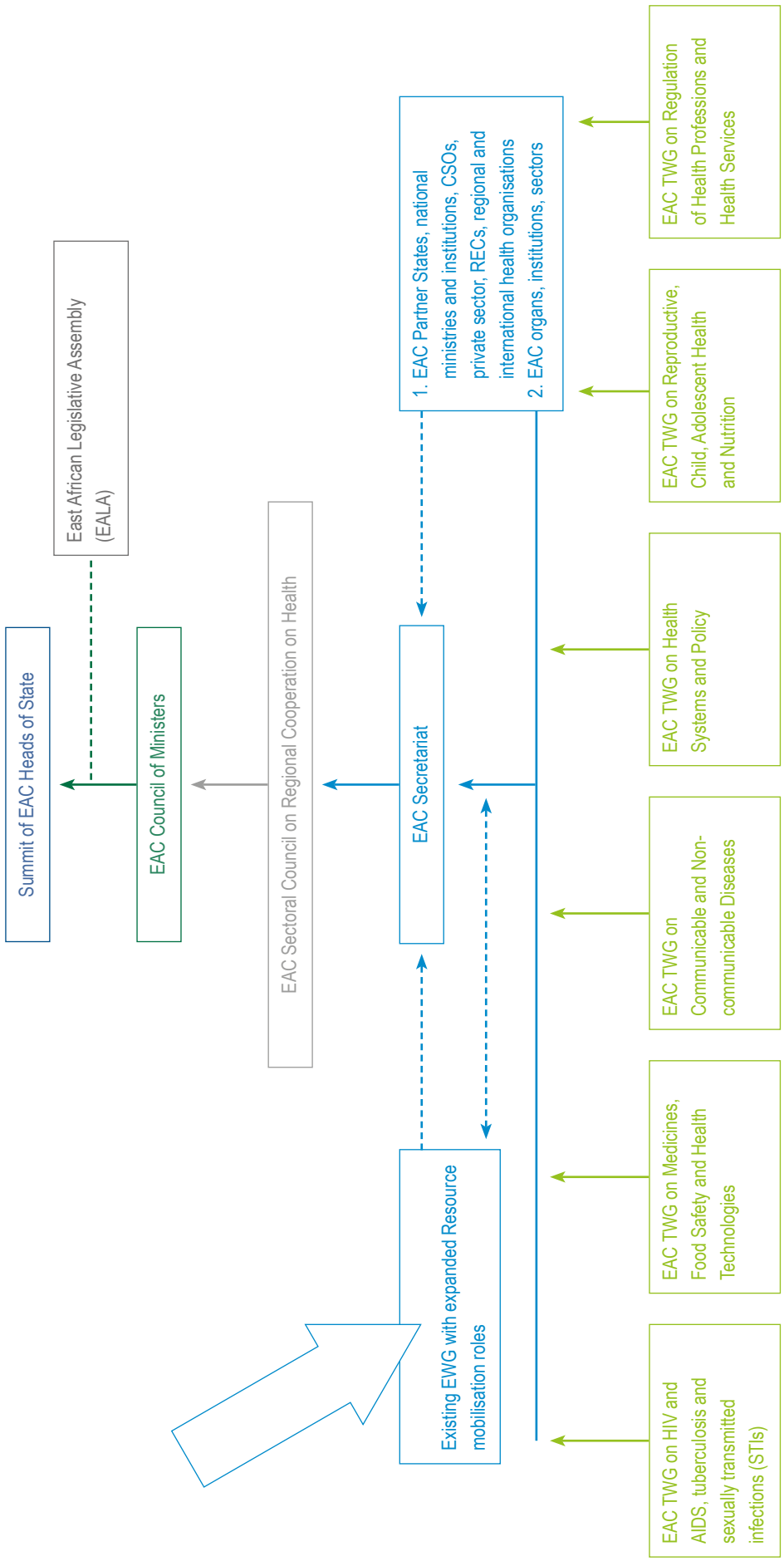
- Consolidate annual resource mapping and efficiency studies and update the EWG on Sustainable Financing, EAC Secretariat, Sectoral Council, EAC Council of Ministers and Heads of State Summit on UHHC financing progress and needs through the Secretariat.
- Jointly implement the EAC UHHC Resource Mobilisation Strategy.
- Provide technical advice to countries to select and operationalise priority interventions.
- Report to Partner States periodically on the status of resource mobilisation and the use of funds.
- Strengthen collaboration and cooperation among Partner States in resource mobilisation for high-impact and evidence-based interventions, for example by approaching development partners, and public and private domestic sources collectively for higher-impact fundraising.
- Promote dialogue on resource mobilisation, best practice, information and experience sharing among Partner States.

- Act as a regional forum for engagement in UHHC financing by ensuring participation of development partners, communities, CSOs, the private sector, United Nations agencies, high-net-worth individuals, foundations and other financial partners to actively participate in UHHC financing and coordinated response to HIV/AIDS in the EAC region.
- Consolidate and provide technical assistance to develop and review fiscal space expansion plans, investment cases and financing proposals; negotiations.
- The composition of this EWG will be drawn from the Health Systems and Policy EWG and aligned to the regional committee of experts on implementation of the EAC regional health sector investment priorities with membership drawn from Partner States' ministries responsible for health, EAC affairs, industry trade and investment, and finance as well as key development and collaborating partners, including CSOs and the private sector.

Other EAC TWGs on health: These were established by the EAC Council to formulate harmonised policies, coordinate their implementation and conduct advocacy. The EAC RHSSP supports implementation and coordination, and ensures that the regional and national management and accountability structure is fully operationalised. The TWGs will support implementation of EAC RHSSP (2015-2020) strategies and support the resource mobilisation strategy. Specifically, they will monitor and operationalise these strategies and develop guidelines and structures for the EAC Health Department, national ministries, county and other stakeholders. Stakeholders will include civil society, private sector and development partners' coordination, accountability and support structures mentioned in the EAC RHSSP (2015-2020);

- strengthen EAC resource mobilisation leadership and governance systems capacity for effective resource mobilisation, advocacy and legislative support of this plan, and support technical assistance processes.

EAC organisational structure and proposed situation of EWG



5 Monitoring and Evaluation

This section describes a framework and plan for monitoring and evaluating progress in implementing the EAC UHHC Resource Mobilisation Strategy. The monitoring and evaluation plan will be extended from the annual programmatic targets presented, to track interventions quarterly. Key activities will be monitored through quarterly workplan tracking measures by the EAC Secretariat and national stakeholders. The below programme results will be measured against targets for a limited number of carefully selected indicators.

Indicators

The indicators proposed for monitoring implementation of the Resource Mobilisation Strategy include:

PROGRAMME RESULT	INDICATOR
1. Enhanced fiscal space for UHHC	UHHC 2030 financing gap
2. Sustainable UHHC financing mechanisms developed by each Partner State	Proportion of population covered by health insurance schemes
3. Improved efficiencies in UHHC spending and financial investments	Health sector efficiency score/value-for-money score
4. Increased UHHC funding through PPPs	Proportion of UHHC financing contributed through PPPs
5. Strengthened national and regional structures to support and enable UHHC policy, governance, regulation and resource mobilisation	Proportion of EAC health sector investment priorities budget raised
6. Enhanced cross-sectoral collaboration for UHHC	Proportion of Partner States with effective multisectoral UHHC coordination mechanisms (in composition, functionality and productivity)

Tools

Tools for resource tracking will include those currently relied upon, including the open health initiative resource tracking tool currently used by Burundi and Rwanda.

Focal points for reporting

Partner State focal points for monitoring and evaluation will include the following:

PARTNER STATE	FOCAL POINT
Burundi	Ministry of Public Health, Policy and Planning Department and PNLS
Kenya	Ministry of Health Policy and Planning Department
Rwanda	Ministry of Health
South Sudan	Ministry of Health Department of Policy and Planning
Tanzania	Tanzania and Zanzibar Ministry of Health policy and planning departments, Tanzania AIDS Commission and Zanzibar AIDS Commission
Uganda	Ministry of Health Policy and Planning Department and NAC

Focal points will be responsible for integrating UHHC resource tracking indicators into DHIS 2 within the ministries of health information systems and other complementary systems, planning and conducting resource tracking and efficiency audits, collecting this data and sharing it with the EAC Secretariat, as agreed and in a timely manner.

5.1 Results matrix

Result Area	Indicator	Baseline (2018)	5-year Target (2022/23)	Means of Verification	Target 2019/20	Target 2020/21	Target 2021/22	Target 2022/23	Target 2023/24
1. Enhanced fiscal space for UHHC	UHHC 2030 financing gap	U$90 billion (US$18 billion per year)	UHHC financing gap narrowed to 50% by 2022/23 disaggregated by source of funding	DHIS; Partner State resource tracking reports	90%	80%	70%	60%	50%
					US$16.2 billion	US$14.4 billion	US$12.6 billion	US$10.8 billion	US$9 billion
2. Sustainable UHHC financing mechanisms developed by each Partner State	Proportion of population covered by health insurance schemes8	To be determined	At least 50% increase from baseline year	DHIS					
3. Improved efficiencies in UHHC spending and financial investments	Health sector efficiency score (value-for-money score out of 4: one each for economy, effectiveness; efficiency and equity)	<70%	Health sector efficiency score increased to 90%	DHIS	70%		80%		90%
4. Increased UHHC funding through PPPs	Proportion of UHHC financing contributed through PPPs	To be determined	30% increase in PPP contribution towards UHHC financing by 2023	DHIS	10%		20%		30%
5. Strengthened national and regional structures to support and enable UHHC policy, governance, regulation and resource mobilisation	Proportion of the EAC health sector investment priorities budget raised	0% of US$3.4 billion	50% of the US$3.4 billion	DHIS	10%	20%	30%	40%	50%
6. Enhanced cross-sectoral collaboration for UHHC	Proportion of Partner States with effective multisectoral UHHC coordination mechanisms (composition, functionality and outputs)	3	7	DHIS	4	6	7	7	7

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(Footnotes)

1 The National Treasury

2 MOH (2017) National Health Accounts 2015/16

3 USAID Health Policy Project (2016) Kenya County Health Accounts

4 UNICEF (2017) Rwanda Health Budget Brief (2017/18) Investing in Children in Rwanda

5 National Budget

6 Parliamentary Social Services Committee Statement, April 2018

7 Funding Landscape Analysis, 2017

8 May be replaced by utilisation rates of free public healthcare for South Sudan and Zanzibar, where public health insurance does not yet exist.