

A close-up photograph of a man with a beard and a light-colored turban, wearing a dark jacket and a light-colored scarf. He is smiling and looking down at a baby he is holding. The baby is holding a yellow and green growth chart card. The background is blurred.

The UNICEF Health Systems Strengthening Approach

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Health Section Programme Division
UNICEF New York
November 2016

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Acronyms

CLTS	Community-led total sanitation
CSO	Civil society organization
DHSS	District health system strengthening
HSS	Health systems strengthening
ICCM	Integrated community case management
IRDS	Implementation research and delivery science
LMIC	Low and middle income countries
MDGs	Millennium Development Goals
MoRES	Monitoring of Results for Equity System
NCDs	Non-communicable diseases
NGO	Non-government organization
PHC	Primary health care
RMNCAHN	Reproductive, maternal, newborn, child and adolescent health and nutrition
SDGs	Sustainable Development Goals
UHC	Universal health coverage
WASH	Water, Sanitation and Hygiene

Acknowledgements

The document was written by David Hipgrave, Ngashi Ngongo, Gabriele Fontana, Kumanan Rasanathan and Mickey Chopra. Development of this document was led by the Health Systems Strengthening Unit in the Health Section, Programme Division at UNICEF New York headquarters. The content is based on a consultation held in Nairobi in May, 2015, with wide participation of colleagues from all Regional Offices, several Country Offices and other UNICEF Programme colleagues. Many others from the Health Section and other UNICEF Sections and Divisions also contributed.



1 Introduction

Since 1990, remarkable gains have been made in improving outcomes for children and women. The number of children dying before the age of five years has almost halved,¹ and similar progress has been made in maternal mortality.² A few easily preventable and treatable conditions are responsible for almost 60 per cent of the remaining child deaths,³ and 75 per cent of these deaths occur in only 20 countries.⁴ It has been particularly difficult to reduce child mortality during the perinatal period. Following the 2012 Washington call for a renewed commitment to child survival, a total of 178 countries have declared their intent to end preventable maternal and child deaths by 2030.¹

Persisting inequity in rates of child and maternal death between and within countries¹ underlines a number of challenges to further reducing preventable child and maternal mortality and ill health. Perhaps the most widespread are barriers to achieving universal coverage of life-saving interventions and basic care.³ Recent analysis suggests that the urban-rural divide remains very wide, and that there are also disparities between and within urban areas.^{5,6} Even for those with physical access to preventive and clinical health services, poor quality and the associated direct and indirect costs limit the impact and uptake of available services, and can lead to further illness and immiseration.¹

In addition to declining mortality, stunting (chronic undernutrition) among children below age five decreased from 40 per cent in 1990 to 25 per cent in 2013. However stunting continues to affect an estimated 161 million children globally. Moreover, wasting (acute undernutrition) affected 8 per cent of children under five (51 million) in 2013; 17 million were severely wasted.⁷ Undernutrition (including foetal growth restriction, stunting, wasting, and deficiencies of vitamin A and zinc) and suboptimum breastfeeding are collectively responsible for 45 per cent of deaths in children under five.⁸ In 2015, this would have resulted in over 2.65 million deaths.

Sustained improvement in child mortality and under-nutrition will depend on more than high impact interventions. As dramatically highlighted by the Ebola crisis in West Africa, fragile health systems in many low and middle income countries (LMIC) undermine progress. The 2016 Zika outbreak is another example of how broader developments such as frequent travel are also complicating and exacerbating the context. Changes in disease epidemiology and lifestyle are affecting health outcomes across the life cycle,⁹ with some predispositions to ill health acquired even before conception.¹⁰ Climate change is affecting the risk of certain diseases in different parts of the world,¹¹ and the demographic transition is affecting population distribution and creating new challenges. For example, in Africa, high fertility and the increasing number of fertile women will lead to a doubling of children there within the next 35 years, requiring massive expansion of related services. At the same time, ageing populations in all nations will also require improved health and social services.¹² Urbanization also presents new challenges,⁶ and the governance of health services is often weak and fragmented.¹³

Over the 2000s there were large increases in funds for development assistance in health, but these were largely for disease-specific programmes in poorer nations,¹⁴ have plateaued, and arguably did not significantly improve weak health systems in many LMIC.¹⁵ Input-level interventions have limited impact on the efficient and effective functioning of health systems,¹⁶ which is essential for the future achievement of universal health coverage (UHC),¹³ and on the flexibility required to ensure resilience to crises such as epidemics and natural disasters.¹⁷ In addition, many MIC have actually experienced a reduction in development assistance for health, making investing in health and health systems strengthening (HSS) in these countries even more crucial to sustaining progress.

Given this historic context and increasing attention to individual, national and global health security (broadly defined to include the establishment and *maintenance* of good health),¹⁸ governments, leading donors and development agencies are increasingly focusing on building robust, responsive and resilient health systems to meet the new challenges of the 21st century.¹⁹⁻²² This calls for an organization-wide, systematic realignment of UNICEF's approach in health and related sectors, considering health and development outcomes in all programmes and contexts, and with better linkages between the four explicitly health-related areas of programming (Health; Nutrition; Water, Sanitation and Hygiene [WASH] and HIV) and other programmes (Child Protection, Education, and Social Inclusion and Policy).

To this end, UNICEF has recently developed its "Strategy for Health: 2016-2030", with two overarching objectives: Ending preventable maternal, newborn and child deaths, and promoting the health and development of all children. Three approaches are proposed: (i) addressing inequities in health outcomes; (ii) promoting integrated, multi-sectoral policies and programmes to enhance child development and address immediate causes and underlying determinants of poor health outcomes, and (iii) HSS, including for emergency preparedness and responsiveness, and to ensure resilience. The Strategy calls for "vertical" programmes to address critical conditions and "horizontal" programmes to explicitly strengthen systems. The Strategy also emphasizes increasing integration of development and humanitarian efforts through risk-informed programming in all contexts.

HSS requires a different approach to vertical health programmes, which have traditionally sought to improve outcomes primarily by providing inputs. UNICEF has a long history of input-level support for the health sector, leading the child survival revolution in the 1980s through the expansion of high-impact interventions, strengthening supply systems and training human resources. This succeeded most obviously for vaccine-preventable diseases and vitamin A deficiency, and more recently for malaria through the use of treated bed-nets.³ UNICEF also supported the Bamako Initiative's focus on local accountability and cost recovery.²³ In the Millennium Development Goal (MDG) era, UNICEF supported the scaled-up provision of an expanded package of life-saving interventions,²⁴ accompanied by innovations in the delivery of services at community level.^{25, 26}

More recently, UNICEF has explicitly focused on equity and improving outcomes for the world's most vulnerable children, which (for child survival) can be more cost effective.²⁷ The Monitoring of Results for Equity System (MoRES) provides a framework for the design and monitoring of all UNICEF programmes, with an earlier²⁸ emphasis on six core determinants of health service coverage (related to the demand for, supply and quality of healthcare²⁹), which now also includes four "enabling environment" determinants.^{A, 30} For health, including the latter requires attention to broader performance drivers such as policies, financing, regulation, organizational structures and relationships between the health system and other sectors in order to motivate changes in behaviour and/or allow more effective use of resources to improve health outcomes.

A Supply-side determinants: 1. Availability of essential commodities; 2. Availability of human resources, and 3. Geographical accessibility.
Demand-side determinants: 1. Initial utilization by the target population, 2. Adequate and continuous utilization by the target population.
Effective or quality coverage: 1. Services meeting the required norms and standards to ensure impact.
Enabling environment: 1. Social norms; 2 Legislation, policies/strategies; 3. Budget/fiscal space and disbursement processes; and 4. Coordination, accountability and management.

UNICEF is the major child-focused global development agency. It has an extensive field programme and partnerships with governments and other development agencies at all levels, as well as policy experts and academia. As such, UNICEF is well-placed to contribute to the technical and policy discourse on HSS. Moreover, UNICEF's equity-focused and rights-based approach is underwritten by a growing portfolio of programmatic and technological innovations, particularly those focused on strengthening public and private sector accountability for health outcomes. Adopting a clear HSS approach will help UNICEF to: a) better deal with health system issues that limit equitable outcomes for children; b) focus on whether UNICEF support in a given country indeed strengthens its health system; c) further improve child and maternal health outcomes and ensure the sustainability of UNICEF-supported programmes; d) identify synergies with other development partners and sectors in addressing critical issues; and e) coherently communicate what UNICEF does in health to governments and partners in the context of the post-2015 agenda and efforts to achieve UHC.

The Sustainable Development Goals (SDGs) consideration of health as a foundation for social and economic development,²¹ individual and global health security, and indeed political security,¹⁸ merits this shift in UNICEF's approach from health system support to multi-sectoral HSS. The adoption of HSS in UNICEF's Strategy for Health, 2016-2030, also justifies this shift. UNICEF holds HSS as imperative to its mandate on promoting all children's rights to survival, growth and development, particularly those of the most vulnerable children in an evolving world.



2 UNICEF's vision and definition of, and approach to health systems serving children and women

2.1 Vision

UNICEF envisions health systems that reliably deliver integrated service packages for children, adolescents and reproductive age women, focusing on health, nutrition, WASH and HIV. A strong health system also facilitates child protection services and is linked to social protection and social welfare initiatives, as well as the education sector, particularly for alleviating poverty, improving health literacy, screening and promoting early child development (ECD). It pays special attention to services for girls and women and those with disabilities, and is a conduit for social and behaviour change communication. It collects and transmits data on the health, nutrition and development status of individuals and communities, and informs those responsible for developing and implementing social and economic policy. All these areas are necessary to ensure optimal child and adolescent survival and development, as well as national and global socio-economic development.³¹ Their integration is a key element of a strong health system.

UNICEF's vision: A health system that closes the gaps in access to quality services and in child health and nutrition outcomes, contributes to UHC and the SDGs, and is resilient.

The services provided and HSS strategies undertaken should cover all stages of the child life cycle, including the first three years of life, middle childhood, adolescence and women's years of fertility, especially before and during pregnancy. Strong health systems should also foster a progressive path towards UHC, one that favours the most disadvantaged. UNICEF has recently outlined its support for progressive universalism, along with a focus on service quality and the underlying determinants of health, in its approach to UHC (*Appendix 1*). Finally, strong health systems should be flexible, resilient to shocks and emergencies, and adaptable to new or unanticipated developments.

2.2 UNICEF's working definition of HSS and the related context

UNICEF defines HSS as *actions that establish sustained improvements in the provision, utilization, quality and efficiency of health services, including both preventive and curative care*, as well as the resilience of the system as a whole. In addition to improving services and producing equitable health, nutrition and development outcomes, these actions may influence key performance drivers such as policies, governance, financing, management, implementation capacity, behaviour and social norms.

UNICEF acknowledges existing global approaches to HSS, particularly WHO's six health system building blocks,^{B, 32} and the evolving context with regard to partnerships, particularly with governments, and areas of focus.^C

^B 1. Health services; 2. Health workforce; 3. Health information; 4. Medical products, vaccines and technologies; 5. Health financing; and 6. Leadership and governance.²¹

^C WHO is currently revisiting its HSS approach, with a focus on enhanced global partnerships, institution-building, improved domestic accountability and achieving UHC.

This includes the increasing attention to:³³ the availability and use of quality data;³⁴ increasing literacy on and awareness of human rights (especially those of women and girls);³⁵ engaging the private sector,³⁶ including as partners of social protection programmes,³⁷ and a global approach to governance and accountability, even in the context of increasingly decentralized systems.³¹ It also acknowledges the attention paid to and funds available for HSS through multilateral initiatives, such as the Global Fund and Gavi, and the explicitly stated interest of key partners^{20, 22} and leaders.^{19, 38}

2.3 UNICEF's overarching approach to HSS

UNICEF's HSS approach involves activities at all levels (section 3) and builds on its mandate, capacity and comparative advantages. Decisions on which activities to prioritize are made first with governments, as well as partners and stakeholders, guided by a results-based approach that applies at all levels of the health system.

This involves, first, a situation analysis to identify the main causes of mortality, morbidity and malnutrition affecting the most deprived children and women. Priority reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAHN) interventions with the potential to address such causes are then identified. The determinants of effective coverage of priority interventions are systematically analysed to identify bottlenecks on the supply side, on the demand side, on aspects linked to quality and on aspects linked to the broader enabling environment. These bottlenecks may exist at any level, which accordingly guides the scale and scope of actions required to deal with them. Since all programmes share the same health system platform to deliver services or interventions, this analysis may be applicable to many programmes.

Solutions to the bottlenecks identified are devised and strategies or interventions are modelled, costed and introduced. These solutions, or HSS actions, are based on the available evidence on their effectiveness, albeit often limited and highly sensitive to the context. For this reason, it is important to use local expertise in selecting the best actions to undertake. Operational research may be needed where evidence is lacking.

Implemented solutions are monitored frequently, with course correction as appropriate to maximize impact, and periodic evaluations are carried out to determine when it is possible to expand pilots if appropriate.

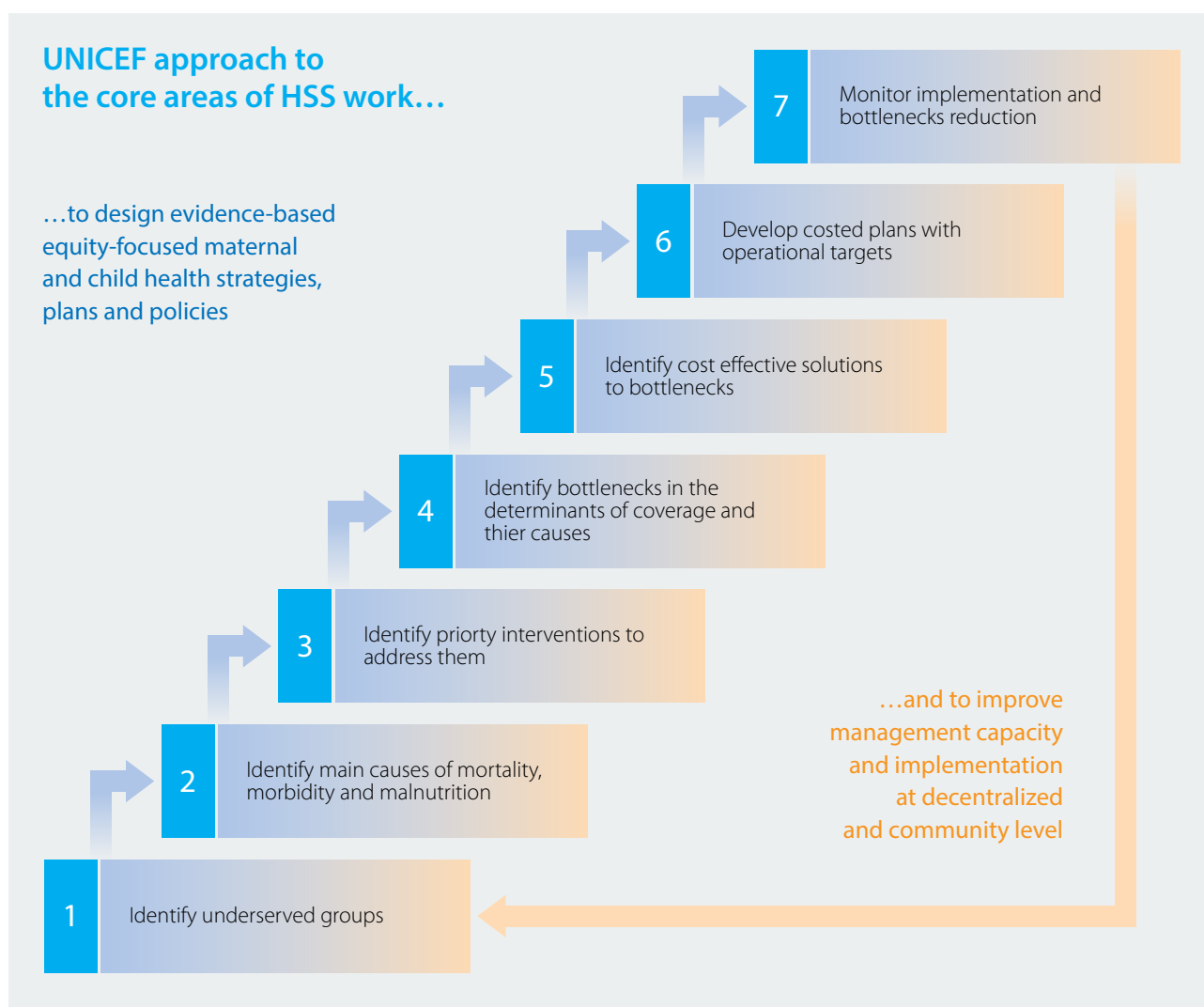
This approach is summarized in seven steps (*see Figure 1*),^D and can inform national plans, build efficiencies in the delivery of district health services, and strengthen community platforms that deliver services, promote healthy behaviours and empower communities for local accountability. Wherever possible, the approach uses data to underwrite decisions on priority actions in the different functional areas (such as the building blocks) of health systems. This evidence-based approach provides a linear way to assess the impact of HSS efforts on population health and to measure the reduction of identified bottlenecks and the resulting increase in effective coverage of priority interventions as intermediate results towards a strengthened system.

^D For more information see: http://www.unicef.org/health/files/DHSS_to_reach_UHC_121013.pdf

While shaped on general principles valid everywhere, the approach is highly customized to each country context. It requires the lead of the Ministry of Health, and benefits from the support of local and global partners to be effective and sustainable.

While the seven-step approach is applicable at all levels of the health system, it is also linked to the EQUIST (www.equist.info) and bottleneck analysis tools which are also being introduced or used. Appendix 2 provides background on the relationship between these important resources for UNICEF's work in HSS and also provides more information on EQUIST.

Figure 1 Seven-step approach to situation analysis and identification of priority actions in HSS



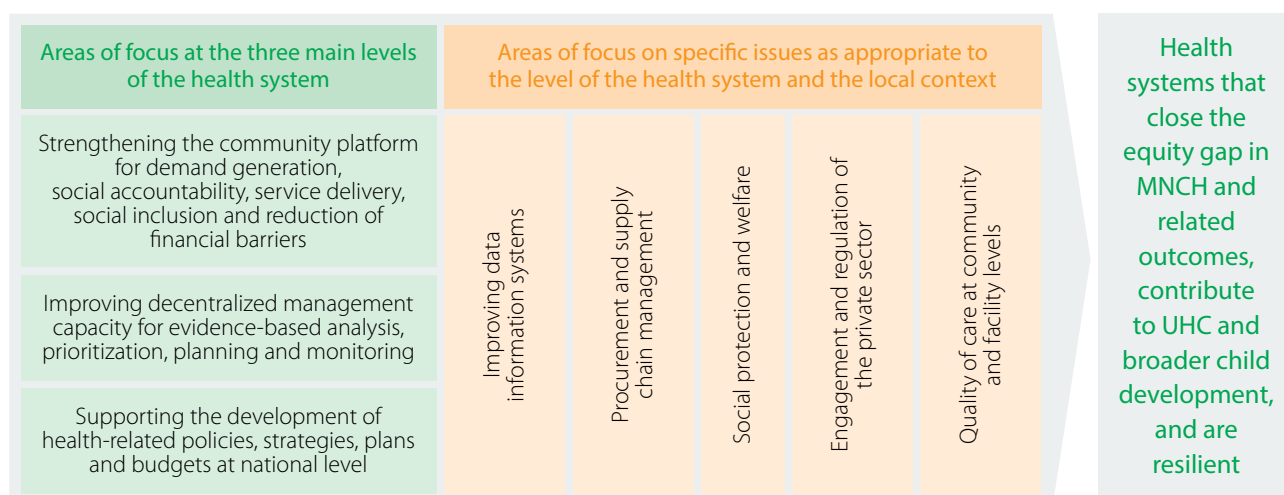


3 UNICEF's areas of focus and options for action in HSS

UNICEF's approach to HSS connects national and sub-national levels, focusing particularly on sub-national management capacity and community engagement based on sound national policy, plans and financing. Attention to these three levels facilitates the translation of policies and strategies into accessible, affordable and quality services for all, particularly the most deprived and vulnerable, or UHC. Priority is determined by local context, based on a sound and agreed situation analysis conducted by government and development partners, if any.

In addition, the approach includes five issue-specific areas of existing UNICEF capacity and perceived priority. Their relevance and UNICEF's activity vis-à-vis that of governments and partners will again vary according to local context and the level of the health system, as represented in Figure 2 and Box 1.

Figure 2 Schematic representation of UNICEF's system wide and issue-specific approach to HSS



The selection of these areas was informed by UNICEF's global experience and capacity, emerging evidence and innovations, and the need to ensure that health systems are resilient to emergencies and can accommodate local epidemiologic and demographic transitions. Further description of the core focus points in each of the eight areas are provided in the following sections and Boxes.

In each area, the extent of UNICEF's engagement vis-à-vis other agencies' will depend on local capacity, need and government priority. Appendix 3 provides options for monitoring and evaluating progress of work undertaken to support each area.

It is acknowledged that UNICEF has not included an explicit focus on strengthening human resources for health, which is known to be a major bottleneck in health service provision in LMICs. UNICEF notes the focus of other HSS partners on pre-service training of health personnel and will continue to support the training and capacity-building of health and related personnel as appropriate in each of the areas of focus. However, UNICEF does not recommend an overarching programme of activities on this issue for its own regional or country offices.

3 UNICEF's areas of focus and options for action in hss

The remainder of this section provides more detail, examples of work undertaken and options for action across country contexts. For consistency with UNICEF's Strategy for Health, and acknowledging the limits of categorizing countries by income per capita, this Approach uses "capacity", a product of country income and government effectiveness (*Table 1*). This should enable UNICEF and other partners to better prioritize and monitor their actions in HSS.

Box 1 Overview of UNICEF's priorities in HSS, across the health system and on specific issues

At the three main levels of the health system, UNICEF's HSS approach will focus on:

- 1 At community level: **creating demand for and ensuring the provision of essential and affordable health and related services** of appropriate quality, building on integrated community case management; **working to influence social norms or barriers** that deny the rights of children and women to access care, and related behaviours; **supporting initiatives to overcome financial barriers** to health service access; **improving the accountability of local health and community leaders** for the key determinants of health and for health outcomes; and **strengthening resilience and emergency response capacity**.
- 2 At district level: **improving health managers' capacity for evidence-based planning, budgeting, supervision and monitoring** of priority interventions for children and women; integration with community-based systems; **coordination with other sectors** (WASH, child protection, education etc.); and **efforts to formalize contingency planning and emergency response capacity**.
- 3 At national level: **contributing to evidence-based and equitable national strategic plans and policies for children's and women's health**, through strengthened use of evidence, equity analysis, costing and fiscal space analysis (in close collaboration with government and partners); **leveraging of national and international resources**; and **linking with UNICEF contributions in other sectors** (child protection and welfare, social inclusion and protection, education, C4D, WASH, HIV and nutrition).

Specific issues on which to focus, as appropriate to the level of the health system and the local context:

- 1 **Improving the collection, analysis and use of data and information** by strengthening the national health management, information, civil registration and vital statistics systems, and building on global tools and innovative technologies, including during health emergencies.
- 2 **Strengthening national and sub-national procurement, supply and distribution systems**, engaging with the public and private sectors, civil society and development partners, particularly in emergency prevention, preparedness and response.
- 3 **Contributing to the social protection system and plan for financing UHC** through the development of investment cases, fiscal space analysis and leveraging of resources (e.g., promoting insurance schemes focusing on the most vulnerable and prioritizing primary health care). Given the focus on a comprehensive and coordinated approach, linkages with social welfare services, early child development and adolescent engagement are also promoted.
- 4 **Supporting national and development partners to engage and regulate the private health sector** in provision of UHC and in monitoring and surveillance systems, and to ensure that private providers and organizations, and the private sector more generally, contribute to equitable and quality health outcomes for children and women.
- 5 **Working with partners to support governments improve the quality of health care**, especially community-level and maternal and newborn care, for example through the development and adaptation of standards, protocols and guidelines according to local contexts; capacity building of health and allied personnel, and ensuring institutional accountability.



Table 1 Programme Definition of country contexts according to “capacity”

Emergency	Fragile	Low Capacity	Medium Capacity	High Capacity
A situation that threatens the lives and well-being of large numbers of a population and requires extraordinary action to ensure their survival, care and protection.	Areas with post-conflict or prolonged crisis. Inability to meet the population's expectations or manage changes in expectations and capacity through the political process.	Insufficient fiscal resources; low functioning government and infrastructure.	Limited fiscal resources; medium functioning government and infrastructure. May struggle with persistent equity challenges among sub-populations.	Adequate fiscal resources; high functioning government and infrastructure. May struggle with persistent equity challenges among sub-populations.

3.1 Strengthen community-based health systems and community engagement

Communities are central to successful efforts to improve RMNCAHN. Lessons learned from various countries indicate that progress can be accelerated when communities are empowered to take action and civil society organizations (CSOs) hold policymakers, programme managers and health professionals accountable to local needs, particularly concerning children (e.g. community-led total sanitation [CLTS] in Bangladesh³⁹). In addition, communities play a critical role in promoting behaviour change and in delivering integrated packages of life-saving interventions within a wider service delivery system, which includes referral systems for serious illness. West Africa's Ebola outbreak showed that communities are the anchor of nations' resilience-building efforts. Strengthened community health services and engagement are a defining element of UNICEF's HSS efforts.

Ethiopia's Health Extension Programme

UNICEF supported the Government of Ethiopia to implement the Health Extension Programme (HEP) that employs over 34,000 Health Extension Workers. They provide a package of preventive, promotive and basic curative health and nutrition services in rural areas. UNICEF equipped over 20,000 such workers with essential commodities, enabling the government to coordinate and mobilize additional resources. The HEP has enabled national scale up of ICCM for the nation's predominantly rural population. It is one of the factors that helped Ethiopia to achieve the MDG target on under-five mortality three years ahead of schedule.

UNICEF and other agencies work with communities globally, in both development and humanitarian contexts, to support social accountability, service delivery, demand creation, data gathering and disease surveillance. UNICEF has supported: social and behaviour change communication; integrated community case management (ICCM) of childhood illness; the promotion of appropriate infant and young child feeding, and the prevention and management of malnutrition; the establishment of WASH interventions such as CLTS; the promotion of key family practices; HIV prevention, and a variety of social protection and welfare initiatives. In MICs and some

3 UNICEF's areas of focus and options for action in hss

LICs, and as recommended recently by WHO,⁴⁰ UNICEF has supported the transformation of primary health care (PHC) from traditional primary (clinical) care to a people-centred, community model that emphasizes health promotion, disease prevention, greater access to services through home visits and continuity of care.

A strong health system connotes the engagement of non-health sectors and programmes through health services at community level. Inter-sectoral linkages with child protection and education sectors can help identify and address developmental delay, disability, violence and neglect, especially affecting girls. UNICEF and other agencies' social inclusion and policy teams can also advocate for and support finance and welfare initiatives benefiting vulnerable households. Strong collaborations with CSOs and community leaders can facilitate piloting, and the engagement of policy makers and managers should help to create supportive policy environments.

Core HSS actions in this area	Contextualization and activity options, according to country capacity
Social accountability: Empower Community Based Organizations (CBOs), CSOs and community leaders to represent the most deprived, and facilitate community participation in policy formulation, budget allocation and programme implementation.	<ol style="list-style-type: none"> 1 In all settings, focus on strengthening the capacity of CBOs, CSOs and community leaders in social accountability, developing tools for community engagement (e.g., U-Report), promoting the creation of platforms/opportunities for community participation in policy design, and monitoring and establishing social accountability mechanisms. 2 In all settings, knowledge management and research activities to ensure options for community engagement and social accountability are reported and adapted for local uptake.
Demand creation and health promotion: Support the design of demand creation approaches; develop tools, approaches to and materials for health education and behaviour change, and also strengthen the implementation capacity of government and CSOs.	<ol style="list-style-type: none"> 1 In medium capacity countries with strong systems, focus primarily on emerging issues such as ECD, child care practices, adolescent health and prevention of NCDs. 2 In low capacity and fragile states, support adequate and timely care seeking through the adoption of a systems approach where possible (using examples from Ethiopia, Kenya, Nepal and elsewhere) and direct support through NGOs where the system does not reach. 3 In fragile states and emergency contexts, promote engagement of anthropologists and consider ethnological and political issues in the design of approaches to promote programmes and services.
Service delivery: Support development of policies and programmes, community health worker capacity, incentive schemes, systems initiatives, and inter-sectoral collaboration mechanisms between health, social protection, procurement and other services.	<ol style="list-style-type: none"> 1 In low capacity and fragile contexts, and also in deprived settings with medium capacity, engage in advocacy and provide technical assistance as required, supporting government ownership for sustainability, in partnership with other agencies. 2 In emergency settings, mobilize NGOs, provide essential commodities, and support community leaders, workers and volunteers to provide/maintain delivery of culturally sensitive basic social services, and promote healthy and safe behaviours.

3.2 Strengthen sub-national management capacity for service delivery in the health system

Implementation of good health policies is frequently stymied by weaknesses in sub-national leadership and management capacity, especially in newly decentralized contexts. Drawing upon UNICEF's and partner agencies' field presence and experience in providing direct assistance to governments, UNICEF has developed an approach for district HSS (DHSS) based on the seven-steps outlined above, to improve management capacity for evidence-based planning, frequent monitoring and prompt course correction at district and health facility levels.

UNICEF and DHSS

UNICEF uses a four-step approach to improve the capacity of sub-national management teams to achieve equitable RMNCAHN outcomes: 1. **Diagnose** the most deprived populations and systems bottlenecks; 2. **Intervene** with solutions to overcome bottlenecks; 3. **Verify** progress through timely monitoring; and 4. **Adjust** solutions as needed to optimize effectiveness and efficiency. UNICEF and partners have implemented this approach in 25 countries in Africa, the Middle East and Asia to support RMNCAHN and HIV programmes. It involved mainstreaming new data collection methods (e.g., lot quality assurance sampling – LQAS) and tools (e.g., DHIS2, mHealth, RapidPro, U-report) to augment data availability and quality; the institutionalization of quarterly performance reviews to improve management and performance, and the strengthening of social accountability through community and CSO involvement in programme planning, implementation and monitoring.

These efforts have led to better implementation of national policies and locally-developed solutions (often building efficiencies in the way services are provided) to close the gaps in children's and women's access to and uptake of quality services in a wide range of country contexts. This approach can also highlight the need for improved supervision and management of facilities and services, complementing the work led by other agencies such as WHO on clinical quality of care.

3 UNICEF's areas of focus and options for action in hss

Core HSS actions in this area	Contextualization and activity options, according to country capacity
Support the design of local planning processes and tools (e.g., district planning and budgeting guidance) through technical assistance and capacity building.	<ol style="list-style-type: none"> 1 In low and medium capacity contexts, provide technical assistance and advocacy to improve existing planning guidelines and tools. 2 In fragile states and post-emergency contexts, work with others to contribute to defining the architecture of the health system, with a view to improving resilience to future emergencies.
Build district management teams' capacity for evidence-based planning, budgeting, action, monitoring, (e.g., annual analysis) reporting, and course correction.	<ol style="list-style-type: none"> 1 In medium capacity contexts, provide technical support to model innovative approaches to planning and service delivery in selected most disadvantaged districts, including engaging with private sector; advocate for uptake by the Ministry of Health and translate into national policies and programmes. 2 In low capacity contexts, support the introduction and scale up of the four-step DHSS approach. 3 In fragile states and post-emergency contexts, provide technical assistance to build capacity and support direct implementation of priority programmes and services, in partnership with CSOs, non-government organizations (NGOs) and the private sector.
Support increased community participation in decision-making to improve social accountability in the management of district health services.	<ol style="list-style-type: none"> 1 In all settings, provide advocacy, capacity building and technical assistance, as appropriate, to improve community participation in health sector planning and monitoring, and social accountability. 2 In low capacity countries, develop partnerships with CSOs, private sector and social networks to support this work. 3 In fragile states and emergency contexts, promote engagement of anthropologists and consider ethnological and political issues in the design of programmes and services.

3.3 Develop national, equity-focused, RMNCAHN-related policies, strategies, planning, financing and approaches to budgeting

Across sectors, UNICEF works with national governments, partners and civil society to develop child-centred and equity-focused policies, plans and budgets. In the health sector, these efforts frequently influence national plans to prioritize child and maternal survival, address the main causes of illness and health disparities, and invest in evidence-based preventive and curative interventions.

However, the disparities in the achievement of the MDGs point to persisting national and sub-national challenges. While disease-specific programmes have been highly successful, underinvestment in cross-cutting HSS strategies has exposed limitations in such vertical programmes. First, while not yet universal, many have reached maximum coverage due to the weak systems they rely upon. Second, as seen in West Africa, vertical programmes often fail during health emergencies. Third, simple life-saving interventions targeting pneumonia and diarrhoea have been neglected while funding was directed to disease-specific programmes. Finally, the current discourse on the importance of social determinants of health emphasizes the need for a multi-sectoral approach to HSS, but there are few examples of such approaches to learn from. These challenges underscore the importance of adopting a broader, multi-sectoral approach to HSS that creates lasting change through equity- and child-sensitive policies and responsible regulation and financing. The Scaling Up Nutrition Initiative is one example of such an approach, involving a broad array of sectors (health, nutrition, WASH, agriculture, education and social protection) and partners. The UHC Alliance recently proposed by WHO might be modelled on this example.



3 UNICEF's areas of focus and options for action in hss

In Afghanistan: A shift from service delivery to HSS

In the post-Taliban period, UNICEF focused its support to the Government of Afghanistan on direct implementation to improve service delivery through supply procurement, training the health workforce, developing the infrastructure and providing cash support. More recently, UNICEF has shifted towards actions that build lasting changes towards UHC, in particular through strengthening partnerships and policies, through aid coordination and community engagement, and establishing mechanisms for financial risk protection and mutual accountability. The UNICEF Country Office is adapting its capacity and operations with this shift from service delivery and system support to HSS.

UNICEF has the advantage of working across sectors and collaborating with numerous agencies that contribute to health outcomes. It is developing its internal capacity, systemically integrating a strong focus on equity, building robust multi-sectoral monitoring and analytical approaches, and developing open-source tools (e.g., EQUIST) to effectively support its cross-sectoral engagement at policy and strategic levels.

Core HSS actions in this area	Contextualization and activity options, according to country capacity
Equity and bottleneck analysis to support the development of evidence-based policies, strategies, national plans, investment cases and budgets in health and related sectors, including in quality of care and new areas such as adolescent health, non-communicable diseases (NCDs), engagement of the private sector and social protection. Participation on and contribution to groups with influence on national health outcomes; leadership on the promotion of equitable RMNCAHN initiatives, especially those focusing on services at community level.	<ol style="list-style-type: none"> 1 In all settings, provide technical assistance for disaggregated data collection and equity-focused analysis of health outcomes and system bottlenecks at national and subnational levels; identification and prioritization of solutions and their translation into policies, strategies, plans, investment cases and budgets, with the support of EQUIST and other relevant tools. 2 In all settings, engage in dialogue with governments, private sector and development partners to support the development of policies, regulations and guidelines to achieve UHC, improve quality of care, improve adolescent health and introduce social protection for all, especially girls and the disabled; engage the education sector and in other ways ensure cross-sectoral alignment. 3 In fragile states and post-emergency contexts, strengthen the oversight, financing, coordination and management capacities of weak governments in health and related sectors (e.g., The Zimbabwe Health Transition Fund). Support efforts to achieve UHC and the protection of vulnerable communities.
Health financing: costing, financial and fiscal space analysis, budgeting and design of financing mechanisms to benefit children and women.	<ol style="list-style-type: none"> 1 In all countries, work with partners on technical assistance for public financial management, sub-national financial tracking, cost-benefit analysis, cost modelling and health financing mechanisms.
Policy advocacy on the enabling environment determinants of health outcomes for children and women.	<ol style="list-style-type: none"> 1 In all countries, support knowledge management and research to elucidate broader influences on the health and welfare of children and women. Engage in related policy advocacy and the development of national plans and strategy documents.





3.4 Data and information for action, accountability and learning

The collection, analysis and timely use of good quality data and information is critical for programme action, accountability, and learning – it is at the heart of HSS. In the health sector, there has been a major increase in data collection and knowledge dissemination but little improvement in data analysis and related action, especially at subnational level.⁴¹ As a result, substantive waste persists in health investments, and opportunities for learning are lost. Inclusion of this area of focus acknowledges UNICEF's position as the global leader on child-focused data and information, and the potential to influence and shape health information systems and related governance structures.

Using eHealth to improve data availability, quality and use in Lao PDR

In 2012 and 2013, UNICEF supported an equity and bottleneck analysis in Lao PDR that highlighted the need for more timely quality information to monitor the removal of bottlenecks and changes in equity of access. The analysis identified significant capacity gaps at the subnational level in data analysis and use of the information for programming. In response, UNICEF supported development of an eHealth strategy to strengthen health information systems by using information technology to integrate data from different sources, facilitating decision-making by policy-makers, managers, frontline staff and citizens. The eHealth strategy provided a unifying architecture to support the integration of managerial dashboards and the cold chain information system with the DHIS. Future developments include the integration of birth registration and the use of such technology in the capacity building of sub-national EPI and Nutrition programme managers.

UNICEF implements three-yearly Multiple Indicator Cluster Surveys and prepares the annual State of the World's Children Report.⁴ Numerous occasional or topic-specific reports provide more details on specific areas of focus.⁴²⁻⁴⁵ Increasingly, UNICEF partners with governments, development agencies and academia, to influence and shape health and other information systems related to the determinants of effective intervention coverage. The intention is for these systems to reflect the data needs of end users at national and sub-national levels and that the capacity to analyse and use this data is strengthened. The MoRES framework has also introduced a focus on tracking progress on reducing disparities across populations. Data collection methods (e.g., LQAS) have supported bottleneck analysis, data-driven planning and monitoring of results as part of UNICEF's support for DHSS. Several innovative tools are facilitating real-time data collection, timely performance reviews and social accountability (e.g., DHIS2, RapidPro, U-Report, geospatial mapping / geographic information systems, EQUIST, and national and sub-national score cards). In all instances, gender disaggregation of data is undertaken, and a focus on disability is included. Analysis and dissemination of this data and information is crucial to UNICEF's support for HSS and to underwrite multi-sectoral engagement.

3 UNICEF's areas of focus and options for action in hss

Core HSS actions in this area	Contextualization and activity options, according to country capacity
Shape information systems and support capacity development for data collection, analysis and use.	<ol style="list-style-type: none"> 1 In all settings, provide technical assistance and capacity building at national and sub-national levels to collect, analyse and use: <ul style="list-style-type: none"> • Survey data collected at facility and household level • Routine data and other information on the determinants of equitable and effective intervention coverage 2 In all settings, support the mapping of health assets, including the geolocation of front-line health facilities and health workers. 3 In all settings, support the adoption of innovative technologies and geographic information systems to strengthen data collection, analysis and use at all levels. 4 In all settings, identify and mobilize CSOs and community-based platforms to use data for social accountability at all levels. 5 In fragile states and post-emergency settings, provide direct implementation support through partners (e.g., CSOs) as a short term measure while restoring routine information systems.
Support community-based monitoring, surveillance and research. Develop indicators for monitoring community-based activities, establish mechanisms for community participation in monitoring and reporting, and implement a research agenda to generate and share knowledge.	<ol style="list-style-type: none"> 1 In all settings, advocate and provide technical assistance for the development of community-based monitoring and surveillance systems, linked to existing national information systems. 2 In low capacity and fragile contexts, support community-based monitoring and surveillance activities, mapping of community-based health assets (e.g., CHWs and health facilities) and strengthen connections with existing systems. 3 In all settings, support research activities that can underwrite new policies, strategies and interventions at national or local level.
Establish a global repository of HSS information, including routine data, surveys and country applications with interactive analysis capability.	<ol style="list-style-type: none"> 1 Establish EQUIST as an online HSS database with summary country profiles and updated country data, analysis and interactive options to visualize different outputs. 2 Link the global database to a sub-set of countries or individual country application(s).
Develop and implement a learning agenda for HSS.	<ol style="list-style-type: none"> 1 Agency-wide development and implementation of a joint learning agenda including research, evaluation, knowledge management and advocacy for HSS.

3.5 Comprehensive supply system strengthening

UNICEF's supply function has evolved considerably in the last decade, with a decreasing focus on direct service delivery, continued focus on procurement services, and an emerging focus on strengthening public sector supply chains, markets, innovations and managerial capacities. UNICEF is increasing its expertise in regulation, quantification, safe and reliable procurement, warehousing and inventory management of life-saving and other commodities. It is also strengthening cross-cutting, supply-related monitoring and data management, communication, and human and budget resources. These are all critical components of increasing access to safe health-related supplies and products.

Routine vaccine supply management systems: A switch from support to strengthening

UNICEF has scaled up its technical assistance to strengthen national capacities in adapting supply chain and logistics systems to the introduction of new vaccines. Periodic assessments pointed at health system-wide deficiencies. UNICEF and WHO accordingly developed a comprehensive Effective Vaccine Management framework that accounts for the interdependencies between health system determinants. Assessments in Kenya and Mozambique led UNICEF and WHO to advocate for investment in immunization supply system strengthening. This shifted funds for vaccines to funding broader HSS interventions, managing large budgets within a performance-based funding model, linking partners and sectors, introducing results-based implementation, and switching from training to capacity development.

UNICEF support for supply chain strengthening as an element of HSS/DHSS engages with both governments and the private sector. Most Country and Regional Offices function ably as conduits for health and related commodities procured with UNICEF support, but will increasingly scale up their capacity in other areas of supply function.

Core HSS actions in this area	Contextualization and activity options, according to country capacity
Ensure essential supplies through local standard setting, market analysis and quality assurance, especially for local or self-procured or locally produced goods (nutrition commodities, vaccines, cold chain, etc.).	<ol style="list-style-type: none"> 1 In medium capacity contexts, support the transition from UNICEF procurement to self-procurement, especially in the area of vaccines and nutrition commodities. 2 In low and medium capacity contexts, support work related to inspection, policy and market analysis with both public and private suppliers. 3 In fragile states, work with partners to maintain procurement standards and distribute essential supplies and commodities, especially for vulnerable communities.
Strengthen public and private sector supply chains (e.g., in tendering and inspection, manufacturing processes, audit standards, warehousing, personnel, transport, etc.).	<ol style="list-style-type: none"> 1 In all settings, provide technical assistance, training and convening of south-south exchange forums. 2 In all settings, especially in those of medium capacity, work with partners to enhance government capacity to regulate and supervise private supply chains. 3 In fragile states, work with partners to ensure availability of essential supplies and commodities, especially for vulnerable communities.
Fiscal space and national supply financing assessments (especially for major supply commitments such as vaccines, micronutrients, food or drugs).	<ol style="list-style-type: none"> 1 In medium capacity context, support tiered pricing, affordability of new vaccines and commodities, and private sector engagement on pricing and pooled procurement (south-south), particularly related to GAVI/Global Fund graduation. 2 In low capacity contexts, support transition to self-funding and introduce relevant tools. 3 In fragile and post-emergency countries, support governments to identify funding for essential supplies.
Preparedness for surge capacity.	<ol style="list-style-type: none"> 1 In medium capacity contexts, advocacy and technical support, pre-positioning and building resilience; transition from service delivery; strengthening of specific areas (cold chain, stock management, warehousing, etc.). 2 In low capacity and fragile contexts, partner with WFP and other agencies on real-time monitoring of supply availability and procurement activities.

3.6 Social protection

UNICEF promotes public financing for children through specific initiatives and general awareness-raising of the impact of public sector programmes on child and maternal health and development outcomes. With the World Bank, UNICEF supports cash transfer programmes in sub-Saharan Africa, and is increasingly engaging in discussions on reducing catastrophic health expenditure and introducing social welfare approaches at community level, including through the health sector. UNICEF has also supported several studies of financial flows in the health sector and fiscal space analyses to assess country capacity to increase domestic funding for social programmes.

UNICEF and PhilHealth in the Philippines

Based on district-level pilots of evidence-based planning and budgeting, UNICEF supported the national health insurer, PhilHealth, to develop and implement two equity-focused benefit packages: i) a PHC package and ii) a package for premature newborns. The former, launched in February 2015, benefits 34 million persons, which includes 11 million children and adolescents. An additional scheme to ensure the disabled have access to health services has been introduced in 2016. The Government is investing the fruits of recent economic growth and also a tobacco “sin tax” to address wide disparities in social services. The same evidence-based planning approach is now included in the training of new mayors across the nation, initially also with UNICEF support. These initiatives have the potential to reduce poverty among and improve the health of millions of families.

UNICEF's country-level work on social inclusion and protection supports HSS in three areas. First, within the health sector, UNICEF seeks to ensure **financial risk protection** for all children and works with specialist agencies to ensure that financing mechanisms and social insurance benefit packages prioritize the rights and interests of the most vulnerable children and women. Second, within **social welfare and protection systems**, UNICEF supports, monitors and evaluates the impact of welfare programmes on children, including their health consequences, aiming to influence the design and reform of related policies. Third, UNICEF works to build **social work systems** to facilitate their contribution to the health of children, especially that of girls. UNICEF convenes different sectors to contribute to social protection for children and their families, brokering and facilitating dialogue, disseminating evidence, and championing the rights of children.



3 UNICEF's areas of focus and options for action in hss

Core HSS actions in this area	Contextualization and activity options, according to country capacity
Health sector: assess vulnerabilities and financial access to care; prioritize resources for the most disadvantaged children; ensure families do not avoid or become impoverished due to the direct or indirect cost of healthcare; appraise current and proposed social health insurance programmes; support the design and implementation of RMNCAHN benefit packages.	<ol style="list-style-type: none"> 1 In all settings, but especially in medium capacity contexts, advocate for HSS-related public finance for children and women across health and other sectors. Support the assessment, design and implementation of health financing mechanisms that reduce financial barriers and risk of impoverishment to advance towards the achievement of UHC. 2 In fragile states and low capacity contexts, work with partners to develop linkages between social protection mechanisms and UHC.
Welfare sector: Monitor and evaluate the impact of welfare programmes, including their health consequences; influence, design, cost and pilot welfare schemes (including cash transfers) to increase access to social services, including health care, hygiene products and nutritious foods.	<ol style="list-style-type: none"> 1 In medium and low capacity contexts, undertake data, sociological and anthropologic analysis, documentation of good practices and lessons learned, evaluation of impact and gaps, and advocacy for changes to policy and implementation related to welfare programmes, to improve equitable health and development outcomes for children and women. 2 In medium and low capacity contexts, support demonstration projects related to assessing the impact of public financing for and integration of social welfare initiatives within the health sector. 3 In fragile states, focus on evidence gathering, assessing and mapping, partnership with other agencies including NGOs and CSOs, and advocacy.
Social work sector: Institution building in social work systems; capacity building of social workers to have a health-sensitive lens.	<ol style="list-style-type: none"> 1 In medium capacity contexts, focus on building related institutions and governance, including within the private sector. 2 In low capacity contexts emphasize strengthening community approaches. 3 In fragile states, partner with other agencies including NGOs and CSOs to identify and protect vulnerable children and women.

3.7 Private sector and CSO engagement

Engagement of private and non-state providers and entities, with an influence on RMNCAHN outcomes to support HSS and DHSS, is a major challenge for development partners in the health sector. In many LMICs, a large proportion of health services are provided by the private sector, and increases in total health expenditure in LMICs are predominantly driven by burgeoning out of pocket payments to private or non-state providers. Moreover, suppliers of health care equipment, drugs and related material; employers and corporations; insurers and health management organizations are all emerging major influences on the access of women and their children to quality health services. Communications, media and advertising agencies also increasingly influence health-related behaviours, and should be engaged in broader HSS and DHSS efforts.

UNICEF and the private sector

Multilateral agencies like UNICEF traditionally focus on the public sector, however they usually participate on coordination bodies where NGOs and non-state providers are represented. This provides opportunities for advocacy and policy dissemination. In Indonesia and China, UNICEF engaged with professional associations representing private providers, but with limited success due to these groups' commercial focus. Many UNICEF country offices, particularly in MICs, undertake local fund-raising with the corporate sector and can advocate for child-health focused industry policy and commercial activities, including through private sector advocacy groups. In addition, UNICEF's Supply, Programme and Partnerships Divisions have developed many partnerships with private entities, each vetted for appropriate activities and relationships.

The success of public-private partnerships will be a key influence on transnational governance on global public health and on child and maternal health, nutrition and development outcomes.³¹ Guiding and regulating these areas is difficult, particularly in the context of weak regulation and information systems, the political economy influence of individuals, corporations and professional associations, frequent inappropriate links between government and the private sector, and the general environment of weak governance in LMICs. UNICEF's potential activities across country typologies are tabulated in the following section, but as a new area this focus should also be the subject of detailed research and discussions with government and other development partners.

Core HSS actions in this area	Contextualization and activity options, according to country capacity
Support initiatives to strengthen provider regulation and maintenance of standards.	1 Engage with other actors to establish relevant regulatory frameworks at policy level in all settings; link them to best practices in medium capacity contexts and participate in designing and overseeing their introduction in low capacity and fragile contexts.
Support the inclusion of the private sector in efforts to achieve UHC, including through provision of health care in the workplace and through social marketing and franchising.	1 Support establishment of policy and stewardship mechanisms related to private providers and advocate on public goods and responsibilities in all settings; strengthen professional associations, especially in medium capacity contexts. Support and regulate social marketing of health services and commodities by private sector entities.
Engage private providers in data gathering and information management.	1 Work with partners to convene government and the private/non-state sector to encourage/ incentivize collection of quality data in all settings. Monitor and evaluate data in low capacity and fragile contexts; set standards on data quality in medium capacity contexts.
Partnerships with the private and non-state sectors to build health sector capacity.	1 In low capacity and fragile contexts, develop related policy and coordination mechanisms (on NGO and non-state providers). 2 In all settings, advocate and influence such providers on public goods and standards.
Promote corporate social responsibility in all sectors and participate in related knowledge management fora with other development partners.	1 Convene and advocate; support the establishment of means to monitor and document violations; develop/promote appropriate national policy according to capacity and need. 2 Work with other development and civil society partners to document or research related activities to inform future private sector support for public health and HSS.

3.8 Quality improvement

As access to health services has improved in many countries, poor service quality is becoming a key driver of unsatisfactory progress in RMNCAHN outcomes and a major cause for limitations in demand for services.⁴⁶ Quality of care has often been neglected in HSS efforts that have focused on improving access, which efforts are not sufficient to ensure effective coverage of essential RMNCAH services. Poor quality services often do more than undermine outcomes and public confidence – they may also be harmful. UNICEF works to improve service quality at the primary care level, with links and referrals between the different levels of national health systems. It also participates on groups of agencies that set global and national standards of care for children and women. It also works increasingly on empowering communities to demand such standards.

Moldova Perinatal Quality Improvement Initiative

Since 1998, UNICEF has advocated and provided technical assistance to the government of Moldova for the design and implementation of initiatives to improve the quality of perinatal health care. Over three phases (1998-2003; 2003-2009 and 2007-2014) the programme evolved through progressive stages of administrative restructuring, equipment provision, policy development and regulation, surveillance, auditing, monitoring and evaluation, clinical protocol development, quality improvement, planning, budgeting, and community mobilization. Finally, the system has supported the application of modern technologies for the care of premature newborns and the establishment of postnatal follow-up services. Collectively, these interventions contributed to the reduction of the nation's infant mortality rate by 50 per cent between 2000 and 2013.

Support to improve the quality of care in the context of HSS can focus on four broad areas (see Table).

3 UNICEF's areas of focus and options for action in hss

Core HSS actions in this area	Contextualization and activity options, according to country capacity
Adapt international service delivery standards and protocols related to RMNCAHN to local conditions.	<ol style="list-style-type: none"> 1 In all countries, advocate for and support development of national standards and protocols (especially for RMNCAHN) aligned with international standards; promote at least one mechanism (clinical audit, public consultation, etc.) to sustain RMNCAHN standards.
Contribute to the development of RMNCAHN-related policies, strategies and systems for quality improvement and sustainability at national and subnational levels.	<ol style="list-style-type: none"> 1 In all settings, participate in providing technical assistance for the development of policies, strategies and systems to reinforce the quality of care provided in the public and private sectors, including accreditation and incentive systems. 2 In low capacity and fragile contexts, partner with other agencies, especially NGOs and CSOs, to ensure application of best practices and the identification of support needed.
Build institutional accountability, involving the private sector, CSOs, patients groups, professional associations and NGOs, and increase the participation of communities themselves.	<ol style="list-style-type: none"> 1 In all settings, support the mapping of a quality improvement systems and initiatives linked to MoRES. 2 In all settings, advocate for and support stewardship by governments, CSOs, professional associations and academia through accreditation processes, maintenance of professional standards and quality improvement methods and mechanisms (such as those described above) in both the public and private health sectors.
Measure health service outcomes, quality and client satisfaction, and develop and support the use of tools and quality assurance methods, e.g., perinatal or maternal near-miss audits and tools for monitoring quality of care.	<ol style="list-style-type: none"> 1 In all settings, support integration of quality monitoring and improvement initiatives in DHSS management systems. 2 In medium and low capacity contexts, support mortality audits (perinatal, maternal newborn) and birth and perinatal death registration, moving towards universal registration. 3 In fragile and post-emergency countries and other contexts as needed, support perinatal and maternal death registration.





4 Complementarity and partnership opportunities

The HSS activities suggested are not unique to UNICEF, and in some areas UNICEF lacks the depth of experience required to lead on HSS, yet still sees important gaps. By definition, adopting a systems approach requires working collaboratively with partners and in related networks. In most countries, national governments appropriately take leadership in HSS, and UNICEF's primary objective is to support governments' capacity to do so. However, many development partners' work is crucial to HSS, including WHO, the World Bank, multilateral partnerships (e.g., Gavi and the Global Fund) and other UN agencies, bilateral partners, regional bodies, academia, and international and domestic CSOs and NGOs, as well as the private sector. In particular, as agencies with large pools of funding, the HSS focus of Gavi and the Global Fund is critical to future efforts in this area (*see Section 5*). UNICEF is an active participant in the International Health Partnership (IHP+) and its successor, the IHP for UHC 2030, the leading global forum for knowledge exchange and priority-setting on HSS for UHC.

UNICEF does not aim to replicate the work of others – for example, the normative functions of WHO, or the extensive knowledge and capacity in health financing of the World Bank. UNICEF's specific mandate is to protect the rights of children. However, our substantial involvement in health service delivery and community engagement, and at the same time our partnership with sub-national and national governments, will enable UNICEF's HSS work to augment and support other agency and government initiatives. UNICEF's specific focus on improving the RMNCAHN outcomes of the most vulnerable members of society, and our focus on strategies (social welfare and financing, strengthening data and supply systems, private sector engagement) also makes it essential to the broad achievement of these outcomes. Moreover, a HSS approach that includes non-health sectors establishes the potential for broader and long term gains in ECD, child protection, social protection, social welfare and education, which gains can impact social and economic development, as well as health-related indicators. Finally, there is a new global focus on implementation research and delivery science (IRDS), underlining the acknowledgement that whilst the interventions and strategies to improve child and maternal health outcomes are mostly known, their sustained uptake and implementation remains problematic in many countries. UNICEF, as an agency with substantive technical capacity and an extensive field presence, is an excellent partner for IRDS and related capacity building among national academics and public health institutes.

As the Ebola epidemic demonstrated, a neglected aspect of HSS to date is health system resilience, particularly at district and community levels. This calls for systems sufficiently adaptable to reconfigure resources in response to new threats, robust enough to withstand shocks, and equipped with monitoring and accountability systems that can detect and respond to new challenges.¹⁷ Building resilience requires, for example: strengthening and redeployment of the health workforce closest to where people live; knowledge of where health assets (including supplies and community-based personnel and facilities) are located; national integration of all health programmes and cadres; attention to social mobilization and health literacy (not only during emergencies); coordination of partner agencies and the establishment of common and agreed objectives and strategies; strong public-private partnerships; and improved coordination and governance across all levels of the health system. In addition, achieving health system resilience requires that all resources are pooled towards common ends. Existing UNICEF collaborations with WHO, the World Bank, UNFPA, UNAIDS, the Global Fund, GAVI, a number of academic groups and through other partnerships, our engagement in sector-wide approaches in several countries, and the Transition Fund model in Zimbabwe, provide examples which can be extended to jointly support national government efforts in HSS, including for resilience in unstable and fragile contexts.



5 Actions needed to move forward on HSS

The following are suggested action areas for UNICEF and partner agencies to consider in moving forward with HSS, both institutionally and in terms of programming. A more detailed Operational Guidance note for UNICEF Regional and Country Offices is included in Appendix 4. This includes guidance on the use of opportunities provided by Gavi, the Global Fund and the GFF, to ensure that the support of these entities moves beyond disease control or child survival to include sustained HSS.

5.1 Consultation and partnership development

Any major new approach for an organization or group of stakeholders requires a period of consultation, the establishment of buy-in and, ideally, the division of responsibility and accountability. A number of global, bilateral and other development partners and groups (in particular the IHP for UHC 2030) have issued documents outlining their priorities and approaches to HSS, and are convening meetings and discussions accordingly. Wherever possible, UNICEF should work with these partners and participate in these groups, or join governments or regional bodies to facilitate forward movement on HSS specifically for RMNCAHN. Where agreed and appropriate, UNICEF Headquarters, Regional and Country Offices may convene meetings of such partners.

UNICEF is already partnering on HSS with a number of agencies as outlined in Section 4. It participated in the high-level conference on Universal Health Coverage in the New Development Era: Toward Building Resilient and Sustainable Health Systems (Tokyo, December 2015), a WHO meeting on Health Systems Strengthening Initiatives and Priorities (Geneva, January 2016), the WHO-USAID-World Bank meeting on UHC Financing in April 2016, and follow-up meetings related to all these events. UNICEF is also an active member of the Steering Committee of the IHP for UHC 2030.

The cross-sectoral nature of HSS requires mechanisms for inter-sectoral collaboration within and outside the organization. In addition to partnership development, UNICEF will recommend HSS coordination mechanisms across agencies at all levels (e.g., matrix management), and accountability mechanisms to track progress in the implementation of HSS across sectors and agencies.

Local and regional partnership may be particularly important for promoting HSS in programmes of activity funded by the GFF, Gavi and the Global Fund. While the prioritization of HSS among the global leaders of these entities is clear, at country level this may not be translated by government or local agency partners into activities beyond their traditional disease control and RMNCAH focus. As an agency with an extensive field presence and significant technical capacity, UNICEF Offices should work with global counterparts to ensure an HSS focus is included in implementation, monitoring and evaluation of these entities' programmes at country level.

5.2 Communications activities

Communications strategies may be needed to ensure that government and development partners, the media and other interested parties understand and agree with the UNICEF approach to HSS. This document, a four-page Synopsis and UNICEF's Strategy for Health are the major sources of information for these partners. Related online sources have been referred to as footnotes and

references herein. Additional communications products are available and opportunities for advocacy related to this HSS Approach should be taken up with the support of Regional Offices and New York headquarters.

5.3 Capacity building

UNICEF is in the process of building its human resource capacity to participate in and convene groups working on the various components of HSS, and to undertake related activity. This will require both empowering existing staff in different sectors at Headquarters, Regional and Country level, building new capacity to engage on HSS with confidence, and integrating health and HSS in other UNICEF-supported programmes. To this end, the following activities will be carried out:

- Developing an organization-wide HSS course blending distance and face-to-face sessions, available to participants from across the agency's Departments and Divisions;
- Arranging training on HSS for UNICEF staff at all levels and across sectors (as undertaken previously on Child Rights and Social Protection);
- Re-profiling job descriptions to align competencies with HSS skills and expertise; and
- Supporting other agencies, along similar lines, as feasible and as needed.

5.4 Supporting country implementation

Where feasible and affordable, UNICEF Headquarters and Regional Offices will provide technical assistance for country-level HSS in partnership with other agencies. This will help mentor and build capacity and support quality assurance. The following actions are suggested:

- Mapping and supporting country application opportunities (e.g., Strategic Plans, GFF Investment Cases, National Health Plans, Gavi or Global Fund HSS applications, etc.) in partnership with the country and regional offices of WHO, the World Bank and other agencies or groups; and
- Developing and monitoring a plan for related technical assistance and quality assurance.

5.5 Knowledge generation and dissemination

There is limited evidence on the effectiveness of HSS strategies in different contexts. A new IRDS agenda is being developed within UNICEF and is viewed as a key component of its support for HSS. This should be considered at the commencement of all activities with HSS potential to the extent possible. Documenting and evaluating work on HSS is necessary to generate the knowledge needed to guide course correction and new priority areas. Suggested actions include:

- Careful selection of a set of milestones and indicators of progress on UNICEF-supported actions on HSS (Suggested indicators, drawn from UNICEF and global sources, are provided in Appendix 3);
- Support for IRDS activities at country level;
- Documentation and wide dissemination of UNICEF and partners' work on HSS, at meetings and through conference presentations, both online and in peer-reviewed literature; and
- Exchange of knowledge, experiences and information among countries during regional network meetings, webinars, etc.

5.6 Leveraging resources

The global context for HSS is increasingly influenced by concerns about health security and health emergencies. Moreover, there is growing recognition that the common pathway to progress in vertical disease programmes (e.g., the prevention, diagnosis and management of HIV, tuberculosis, NCDs, etc.) demands stronger health systems. These two major contextual influences provide an opportunity to leverage attention to and funding for the establishment of health systems that can deal with a wide variety of services, and which are also prepared for emergencies and are resilient. At all levels, UNICEF and its partners should encourage and participate in dialogue with both governments and donors to increase both the proportion of resources allocated to HSS, both public and private, as well as the related fiscal space. Disease control and child survival programmes, such as those funded by Gavi, the Global Fund and the GFF, should all consider their responsibilities to contribute to HSS in their programmes of supported activity at country level. Appropriate indicators of strengthened systems are needed to meet the needs of donors and governments seeking to verify the efficient and effective use of funds. Ideally, these indicators should be drawn from those used to assess progress on the SDGs or those proposed by WHO or other initiatives (Gavi, the Global Fund and the GFF) or agencies. Except in emergencies and the weakest contexts, HSS and health outcomes should be considered in fund-raising across all sectors.



6 Conclusion

Increasing recognition of the importance of robust and resilient health systems to meet new health challenges and achieve the SDGs has provided UNICEF with the incentive to define its HSS strategy, building on extensive experience gained over several decades. UNICEF's strategy is shifting from traditional input-based health system support to one that prioritizes interventions that generate lasting improvements in health systems, and accelerate and sustain gains for children. UNICEF's definition of health systems combines aspects of supply, demand, quality and the enabling environment, and takes equitable results for children as its starting point.

Engagement in HSS must respond to different scenarios in a variety of contexts, ranging from settings where UNICEF and other agencies continue their involvement in the provision of services, to settings where development partners' main role is advocacy, policy and institutional development, capacity building, and technical support. There are roles for many different sectoral programmes in HSS, each contributing to RMNCAHN and development outcomes, and to global, social and economic progress.

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Appendix 1 UNICEF Brief: Universal Health Coverage

MOVING TOWARDS UNIVERSAL HEALTH COVERAGE TO REALIZE THE RIGHT TO HEALTHCARE FOR EVERY CHILD

Executive summary

UNICEF strongly supports the progressive realization of universal health coverage (UHC), with special attention to the needs of children. The vision of UHC is that all people obtain the health services that they need. These services include promotive, preventive, curative and rehabilitative interventions that are of good quality and available at an affordable cost that does not impose suffering financial hardship.

For UHC to be equitable, its progressive realization must start with a focus on the hardest to reach – the poorest and most disadvantaged. These groups, which often include indigenous people, ethnic and sexual minorities, migrants, and people with disabilities, among others, are among the mostly likely to be excluded from health systems. Unless the poorest and most marginalized are prioritized in UHC efforts, new funding and expansion of health services can inadvertently increase disparities.

Expanding coverage and access to essential healthcare is necessary but not sufficient to realize UHC. It is also important to enhance service quality and utilization. Poor quality or socially inappropriate health services are often bypassed by communities. Poor quality health services, including substandard medicines and other commodities, may not only fail to address people's health needs; they may also cause harm and thereby deter future use of public services.

Actions to address the underlying determinants of health are just as important as healthcare services to give every child the chance to develop fully and have a healthy start to life, and must also be addressed in concert with moves towards UHC. These determinants include such diverse factors as poverty, nutrition, education, water and sanitation, climate vulnerability, discrimination, and political and social rights.

The progressive realization of UHC for children is a global imperative. The right to health care services for every child is enshrined in the United Nations Convention on the Rights of the Child. Many health systems currently fail to respond to the specific needs of the poorest and most marginalized children and families, in effect excluding them from essential interventions that can save or improve their lives.

In support of the progressive realization of UHC, UNICEF contributes to the expansion of health service coverage for women, newborns, children and adolescents – particularly for the poorest and most disadvantaged and in the countries in greatest need. UNICEF supports health system capacity development through staff training and deployment, resource mobilization, monitoring of health outcomes and health system performance, improving procurement systems and coordinating efforts across sectors. In some countries and settings, UNICEF also directly supports the provision of health-related services, including in health promotion, particularly in humanitarian and fragile contexts. In addition, UNICEF supports the expansion of social protection systems, including cash transfers and social support services, as a critical response to address the social and financial barriers to achieving UHC, particularly for poor and marginalized children. UNICEF will continue to expand this support to achieve UHC in the post-2015 era as a crucial contribution to ending preventable maternal, newborn and child deaths, promoting the health and development of all children, and achieving the broader Agenda 2030 for Sustainable Development.

Every child in every country has the right to healthcare

The right of children to health and healthcare is grounded in the ratification by countries of a number of international human rights treaties, in particular the United Nations Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights. Article 24 of the CRC recognizes “the right of every child to enjoyment of the highest attainable standard of health” and commits countries to “pursue full implementation of this right”. These treaties also embody principles of progressive realization of the right to health in all countries. The right to health impels the provision of essential healthcare for all people as well as appropriate action on underlying determinants of health, such as nutrition, education, water and sanitation, political and social rights, and protection from climate vulnerability and from discrimination.

Despite these commitments, millions of children and poor families are still missing out on essential quality healthcare that can save or improve their lives. This is the result of a combination of factors, including inadequate investment, financial barriers and discriminatory practices, and is reflected in still alarmingly high numbers of under-five, newborn and maternal deaths each year. In 2015, 5.9 million children died before the age of five worldwide, or more than 16,000 children every day. Of these deaths, 2.7 million occurred in the first 28 days of a child’s life – the neonatal period. Approximately 300,000 women also died in 2015 due to complications of pregnancy and delivery. Most of these deaths could have been prevented by the provision of good quality healthcare services, adequate nutrition, water and sanitation, and quality education for children and women.

These maternal, newborn and child deaths are concentrated among the poorest and most marginalized groups both regionally and within countries. For example, in both East Asia and the Pacific and South Asia, the under-five mortality rate in the poorest households is more than twice that of the richest.

One key cause of such health gaps is the inequitable distribution of, and access to, essential health services. In South Asia, for example, a pregnant woman from the richest quintile is almost four times more likely to have a skilled health attendant (doctor, nurse or midwife) at delivery than a pregnant woman from the poorest quintile. In sub-Saharan Africa, a child under five suffering from diarrhoea (from the richest quintile) is nearly twice as likely to receive oral rehydration treatment as a child from the poorest quintile.

In all countries, the lowest coverage of and access to essential reproductive, maternal, newborn and child health services occurs in the most marginalized groups – including the poorest households and regions, geographically-isolated populations, people with disabilities, residents of informal urban settlements, and groups who face discrimination such as indigenous peoples, ethnic minorities, sexual minorities, refugees, and undocumented migrants.

Equity starts with a focus on the hardest to reach

In their efforts to progressively realize universal health coverage (UHC), all countries must make choices about which health interventions they cover, for which parts of the population, and to what level governments cover the expense. How countries make these choices in pursuing UHC will determine how far and how quickly they improve health outcomes, reduce health inequities and realize the right of children to essential healthcare.

A key challenge for national UHC strategies is therefore to address and reduce inequities in access to and utilization of quality essential health services. More spending on health services does not necessarily improve health equity, particularly if attention is focused solely on improving national aggregates, without measuring progress for different groups within the country. For example, focusing most new health service investments on hospitals and health facilities in large urban centres is not an appropriate strategy if significant numbers of the most disadvantaged children live in rural areas.

The greatest health and equity gains are often found in community-based approaches managed at the district level. A 2010 study by UNICEF showed that such an equity-focused approach is also the most cost effective approach to achieve maternal and child health targets, such as MDG 4 and 5, and the more ambitious targets to end preventable child deaths recently adopted in the Sustainable Development Goals for the post-2015 era.

Accordingly, UNICEF advocates that actions towards UHC should first address the needs of those currently left behind. Using UHC to reduce disparities requires applying the concept of proportionate universalism, where policies and interventions are universal, but with scale and intensity proportionate to the level of disadvantage. This principle is widely accepted but can be challenging to put into practice because these populations often have the least political voice and face discrimination.

While there is an increasing need for comprehensive provision of health services, including for non-communicable diseases, the first measure of success for any national UHC strategy should be the provision of essential reproductive, maternal, newborn, child and adolescent health services for the poorest and most disadvantaged children and families.

Universal health coverage is about more than service availability

The existence of health services within a community does not necessarily imply that individuals and families obtain interventions and care that meet their health needs in a timely manner. Health services should be adapted to the particular needs of different populations. Systems must therefore go beyond access to address issues of acceptability, availability, quality, continuity, and the ability of communities to utilize services when they are needed. UHC should balance promotive, preventive, curative and rehabilitative interventions.

For example, immunization is an essential healthcare intervention for children. But vaccines will only provide the expected benefits if they are of good quality and potency, stored appropriately, dispensed at the requisite time and administered under sterile conditions. Immunization services need to be trusted by families, including those from marginalized groups, and must be available at a time and venue that is accessible. If health services are of poor quality or are not trusted by communities, they will not be utilized when needed. Poor quality health services, including substandard medicines and other commodities, may not only fail to address people's health needs, but also cause harm and deter future use of public services.

All children and their families should be able to afford health services

Removing the risk of people becoming impoverished through the cost of health care is an important contribution to eliminating poverty, given that 100 million people fall into poverty in this way each year. Poverty and disadvantage also prevent people from accessing and using health services due to direct and indirect costs, as well as social barriers. Addressing these barriers is critical to ensuring UHC.

UNICEF supports the removal of user fees, especially for the poorest, to help ensure that every family can access health care services for their children and that no family is driven into poverty because of the direct or indirect costs of quality health care. There is clear evidence that user fees reduce access to services and are an inefficient means of funding health services. However, removing user fees should be undertaken in the context of broad reform of the financing of health systems. Removing user fees without making alternative arrangements to pay health workers and purchase medical supplies, for example, can lead to adverse consequences such as mark-ups on commodities and demands for unofficial payments.

Prepayment schemes funded through public or private insurance can also provide an equitable and cost-effective path towards attaining UHC. Not all prepayment schemes are equally effective in reducing inequities however; voluntary health insurance schemes often exclude the poorest and most disadvantaged. Even where fees are low for participation in health insurance schemes, public or private, the poorest often still cannot afford these. Social protection programmes which subsidize or exempt populations from insurance contributions can help to ensure that the poorest benefit. Care also needs to be taken to ensure that taxation or social insurance schemes do not exclude those outside the formal sector, which often constitutes a majority of the population in low- and middle-income countries. Attention is also required for populations that are excluded to such an extent that they do not express demand for health services, and therefore can appear as not being affected by impoverishing health costs. Monitoring of UHC should explicitly include assessment of the coverage of the informal sector.

For many poor and disadvantaged children and families, overcoming financial barriers to healthcare is not only related to the direct costs of health services, although this is an important component. Other costs – including transportation to health services, medication, and the opportunity costs of parents' time – also stand in the way of realizing the right to healthcare for everyone. Measures that help address these costs, including social protection, are important to the achievement of UHC.

UNICEF considers that an equitable approach to health financing as part of the progressive realization of UHC will target new pooled resources towards marginalized groups first; prioritize financing of reproductive, maternal, newborn, child and adolescent health services; and adopt measures to avoid capture of these resources by groups who are relatively advantaged and have greater political visibility and influence.

Universal health coverage is necessary but not sufficient to achieve the right to health – action on underlying determinants is also vital

Even if UHC is achieved, health inequities will persist, as is seen even in the high-income countries that come closest to achieving that aim. The major drivers of health inequities lie beyond the purview of the health sector, in disparities that shape people's living conditions and their access to services, resources and power – the underlying determinants of health.

Allowing every child the chance to develop fully and have a healthy start to life requires just as much attention to education, nutrition, water and sanitation, climate vulnerability and adaptation, gender equality, preventing (and resolving) conflicts and disasters, eliminating poverty and discrimination, promoting early child development, and improving the built environment as it does to providing high quality and essential healthcare services. UHC is crucially important for health, but it cannot be the sole focus of efforts to improve health outcomes or reduce health inequities.

Furthermore, achievement of UHC itself requires actions in other sectors, such as social protection, civil registration, water and sanitation, transport, and energy. UHC should, at a minimum, include a consideration of factors governed by other sectors that influence the delivery and quality of health services, and the ability of people to access and afford them. UHC efforts should also consider actions within the health sector that can address underlying determinants, for example advocacy, education, improving the employment conditions of healthcare workers and reducing the environmental impact of the health sector.

Monitoring performance is key to building efficient and effective health systems

Progressive realization of UHC requires that all people are counted through improving civil registration and monitoring the number of people that are reached through expanding services or improving the quality of existing services, including measuring population coverage to quantify those unreached by specific interventions. UHC also requires assessment of the health outcomes achieved, and whether the poorest and most disadvantaged groups are being included.

Guidance for global and national monitoring of UHC is under development. It is crucial that such frameworks include the essential child interventions, including treatment for pneumonia, diarrhoea and malaria, and newborn care. Explicit targets for closing gaps within countries can highlight inequities and drive actions to reduce them.

Successful efforts towards UHC will also need better capacity in the governance of health systems. This includes the ability to know which data to collect, how to interpret it and how to act appropriately to implement changes with the large number of partners that make up health systems. Monitoring data should be fed back in a timely manner to managers at both national and district levels to make changes where required. Doing so will require significant investments to strengthen routine health information systems, including greater support from the global community, especially for low-income countries and fragile states.

UHC is conceived at the national level, but health services are delivered in communities. Much greater attention is required to building the capacity for planning, monitoring and implementation at decentralized levels, including training of district and municipal managers, supporting community delivery systems.

The role of UNICEF in supporting countries' efforts to move towards universal health coverage

UNICEF supports countries in their efforts to achieve UHC for children and their families. Progressive realization of this aim requires attention to all aspects of health systems, as well as to other sectors where actions are also necessary, such as energy and safe water supply for health care facilities and overall public financial capacity.

UNICEF has extensive experience and expertise in the delivery of health services, procurement of vaccines and other health commodities, training of health workers, advocacy for and mobilization of financial resources, surveying and monitoring health outcomes, innovative methods to measure health system performance, and coordinating efforts in other sectors essential to the aims of UHC. UNICEF is currently working in several countries to build the capacity for planning and prioritization of services, and monitoring health outcomes at sub-national levels, with disaggregation of data to uncover the impact on inequities. The organization also provides increasing support for implementation research to overcome obstacles in delivering health services for children.

Furthermore, because not everyone can afford to pay for medical supplies and services, UNICEF works to influence the global production and pricing of health products, such as vaccines and other medicines. Tiered pricing allows them to be supplied to the most disadvantaged populations at an affordable cost.

UNICEF also supports over 100 countries to expand and strengthen social protection systems, which are critical to helping families and children to overcome financial and social barriers that can stand in the way of UHC. Particularly in low- and middle-income countries, UNICEF supports governments to expand the number of children covered by cash transfer programmes, which evidence shows consistently to have positive impacts on increasing health care access and utilization. UNICEF support of social protection systems also includes strengthening social support services, which can help guarantee access to health services for vulnerable families. This work also strengthens links between social protection programmes in ways that address the multiple obstacles that disadvantaged children and families face, for example by automatically enrolling cash transfer programme participants into national and social health insurance programmes.

Recently, UNICEF has intensified its efforts to ensure that health care systems and interventions in low- and middle- income countries prioritize the poorest and most disadvantaged. UNICEF will continue to expand this support to achieve UHC in the post-2015 era as a crucial contribution to ending preventable maternal, newborn and child deaths, promoting the health and development of all children, and achieving the broader Agenda 2030 for Sustainable Development.

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Acknowledgements

This brief was written by Kumanan Rasanathan, Thomas O'Connell, Jennifer Yablonski, David Anthony and Nicholas Rees. Comments were sought and gratefully received during a UNICEF-wide consultation, including from Nicholas Alipui, Agbessi Amouzou, Raoul Bermejo, Sanjana Bhardwaj, Luisa Brumana, Mickey Chopra, Alejandro Grinspun, David Hipgrave, Colleta Kibassa, Holly Newby, Douglas Noble, Jeffrey O'Malley, Katy Scammell, Jean Servais, Henri Van Den Hombergh, Danzhen You, Alexandra Yuster and Willibald Zeck. Robert Marten (Rockefeller Foundation) provided additional comments.



Appendix 2 UNICEF's HSS tools at national, district and community levels, and overview of equist

The three main pillars of UNICEF's health system strengthening approach are a) supporting health policy and governance at national level; b) improving management and service delivery at district level; and c) promoting community systems for service delivery, adoption of healthy behaviours and accountability.

One common analytical framework is used at the three levels to identify priority actions and monitor their implementation and effectiveness. At the core of the framework is analysis of bottlenecks impeding effective coverage, based on the Tanahashi model and applied through a seven-step process (summarized in the right-hand panel in Figure 1 in the main document).

While applicable to any health situation, the approach aims to improve population health outcomes by increasing the quality and coverage of evidence-based interventions delivered or promoted through the health system, especially for the most disadvantaged women and children. To do so, systemic bottlenecks to the delivery of priority interventions are identified and tackled, and their reduction or resolution monitored over time. The approach focuses on the most disadvantaged populations as a cost-effective and equitable way to deal with illness and disease where their burden is the highest.

This methodology acknowledges that, for an individual or population to receive effective health services, each service must be available, accessible and affordable; the patient must be aware of and willing to use it; and must do so timely and regularly, when indicated. Finally, the service must be provided with sufficient quality to effectively prevent or treat the disease.

The seven-step, evidence-based approach and the bottleneck analysis methodology together provide a consistent set of guiding principles of UNICEF's activity in HSS. However, the specific strategies or types of support that UNICEF provides may vary dramatically at different levels of the system. For example, contrast the support provided to a government to develop a community health policy at the national level with that provided to a district manager to train, incentivize and monitor community health workers. Similarly, UNICEF may focus on improving supply chains and commodity forecasting at a national level while focusing more on improving quality of care and the use of those commodities at a district or facility level. The decision about what support to provide is based on the same seven-step, evidence-based approach, including careful bottleneck analysis at the relevant level of the health system.

When a national plan, policy or strategy is being developed, UNICEF may support the government and its partners in using this approach to develop or refine their content and budget. In decentralized countries, a strategic planning exercise may also happen at state, regional or provincial level, and the evidence gathered in this process may provide feedback to the national level. If strategic priorities have already been agreed upon, a prioritization exercise to define district and local priorities and system bottlenecks may be used to strengthen the implementation of national policies and plans at local level, through locally-contextualized strategies and operational work plans. Actual monitoring and fine-tuning of the strategies usually occurs at the facility or community level.

UNICEF has developed two tools to support the application of the seven-step evidence-based approach and bottleneck analysis methodology at different levels of the health system. The tools rest on the same principles and approaches: one is designed to support development of medium-long term strategies (EQUIST), while the other supports annual implementation and monitoring plans at local level.

EQUIST (the equitable lives saved tool) is a web-based tool that helps countries identify and compare healthcare priorities in terms of populations, diseases, interventions, and specific combinations of HSS strategies. It contains three modules: situation analysis, scenario development using bottleneck analysis, and cost and impact projections. EQUIST may technically be used at national or sub-national levels, where major strategic decisions and budget negotiations take place, but is less applicable at lower levels because of its reliance on evidence for the effectiveness of the different interventions available. A summary of EQUIST can be found in the section following.

The district Bottleneck Analysis Tool (D-BAT), has been developed to support prioritization, and operational work planning and monitoring at district and sub-district levels. Like EQUIST, the D-BAT's main module also walks users through a bottleneck analysis. The D-BAT contains modules for local data aggregation and review, the development of an operational work plan and budget, and routine programme monitoring.

UNICEF's national and district-level approaches to health systems strengthening can be employed separately, according to the needs of a country at a given point in time, but can also be applied in a sequential or iterative process, with complementing strengths. Similarly, EQUIST and D-BAT can be used side-by side to support the work in a conceptually and methodologically consistent way.

Neither EQUIST nor the BAT, however, is essential to conduct evidence-based planning or bottleneck analysis. While both can make the management, visualization, and analysis of data easier and less prone to human error, many countries have effectively developed and monitored health policies and HSS strategies using "low-tech" or "no-tech" alternatives. In other words, resistance to using one or both tools (for practical or political reasons) is not a reason to depart from UNICEF's HSS approach, and specifically evidence-based planning and bottleneck analysis methodologies. Similarly, users of either tool should be comfortable with the concepts and principles of evidence based planning and bottleneck analysis before using them; the tools are not intended to be didactic.

In conclusion, it is worth noting the conceptual consistency between UNICEF's national, district and community approach to HSS, and also the conceptual consistency between UNICEF's understanding of health systems and that of other organizations. For example, UNICEF is committed to universal health care but emphasizes that protecting society's most vulnerable sooner rather than later (and striving for efficiency and sustainability) is important. UNICEF's bottleneck analysis framework, consisting of six direct coverage determinants plus four enabling environment factors, is essentially a systematic way to identify priorities for HSS action within WHO's six health system building blocks.

UNICEF commends its HSS approach and guiding methodologies to its staff and partners. Learning materials are available, including a district HSS field guide and video tutorials. Once the concepts are clear, the interrelationships between work at different levels of the health system, and between EQUIST and D-BAT, should be intuitive.

EQUIST overview

What is EQUIST?

The Equitable Impact Sensitive Tool (EQUIST) was developed by UNICEF in partnership with the Community Systems Foundation (CSF), with funding from the Bill and Melinda Gates Foundation. It supports web-based strategic planning and prioritization of maternal, newborn and child health (MNCH) interventions and allocation of related resources in low and middle-income countries (LMICs). The explicit goal of EQUIST is to reduce health disparities between the most marginalized mothers and young children, and the better-off.

Policymakers often face difficult decisions about how to allocate scarce resources, balancing equity (eliminating inequality in health outcomes between groups), effectiveness (maximizing results for the country as a whole) and efficiency (making the most rational use of resources). It is often assumed that preferentially providing services for, or prioritizing the needs of the most deprived or vulnerable citizens is more expensive, and therefore less cost-effective and efficient than, for example, allocating resources evenly across the population or according to the needs of better-off citizens. However, the burden of disease and mortality is usually concentrated among the most disadvantaged populations, and in 2012, UNICEF modelling suggested that an equity-focused approach to health resource allocation is indeed cost-effective and efficient. EQUIST helps policy makers select strategies that balance the principles of equity, effectiveness and efficiency by leading them through a logical process to identify the most rational and cost-effective solutions for their context.

EQUIST is principally a tool that uses data and situation analysis to identify priorities in terms of populations, diseases, interventions and strategies. The priorities selected may reinforce the overall system and have positive effects on services other than those benefiting MNCH. Indeed, the principles applied by the tool can be used for any sector and at any level of the health system, subject to data availability, and can be adjusted to focus on specific aspects of the health system (such as primary care or malaria programmes), or the health system as a whole.

Such a prioritization exercise may be useful at the beginning of or halfway through a planning cycle, once annual funding windows are known, or when new opportunities arise. The exercise may also be part of a larger and more comprehensive national or regional planning process.

Theory of change

EQUIST is based on a simple seven-step theory of change, which also underpins UNICEF's general approach to health system strengthening. This theory of change assumes that investments in, and implementation of, equity-focused strategies that remove quantifiable health system bottlenecks will lead to improvements in the coverage of high-impact health interventions and improved health outcomes for target populations.

EQUIST uses data to help users visualize and select priority populations, and health and nutrition conditions; to both understand which interventions may resolve those conditions and which bottlenecks in the health system are presently constraining their delivery. It then helps the user address the causes of these bottlenecks, especially for the most disadvantaged, and estimates the impacts and cost effectiveness of the strategies. The process can then be repeated to compare alternative strategy options.

Data and evidence

EQUIST functions as a platform to connect multiple sources of evidence. The impact of interventions is calculated through a direct link to the Lives Saved Tool, or LiST, a widely recognized impact projection tool developed by the Johns Hopkins Bloomberg School of Public Health.

Data on intervention coverage, such as the coverage of family planning services or appropriate care seeking for pneumonia, has been pre-loaded in the tool, taken directly from the two most recent Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) for each country.

Data on health systems issues - in other words, bottlenecks – are more difficult to come by and usually need to be entered directly by experts in the country or the user him- or herself. UNICEF is in the process of ensuring that Service Availability and Readiness Assessments (SARA surveys), Service Provision Assessments (SPA surveys), Service Delivery Indicators surveys (WDI), and Emergency Obstetric and Neonatal Care (EmONC) assessments are also included. While EQUIST is pre-loaded with data on intervention coverage and different facets of the health system, all values can and should be revised and updated by national authorities and actual EQUIST users.

Data on the strategies to remove bottlenecks, and often strengthen health systems, are largely unavailable at the moment. As a temporary measure, EQUIST provides a list of fairly generic HSS strategies and allows the user to define their effect size based on local evidence, providing some benchmarks for reference. UNICEF is presently working with a consortium of organizations including USAID, the World Bank and sister UN agencies, with the support of Abt, John Hopkins University and Avenir Health, on a comprehensive review of the evidence for HSS strategies. Once complete (during 2016), the data will be incorporated into EQUIST.

Using EQUIST

The EQUIST website (www.equist.info) is partially open to the general public and partially restricted to registered users. Registration is open to all who are involved in country-level MNCH planning or HSS. UNICEF is hoping to make available an offline version of the tool as well, for use in areas with weak internet access.

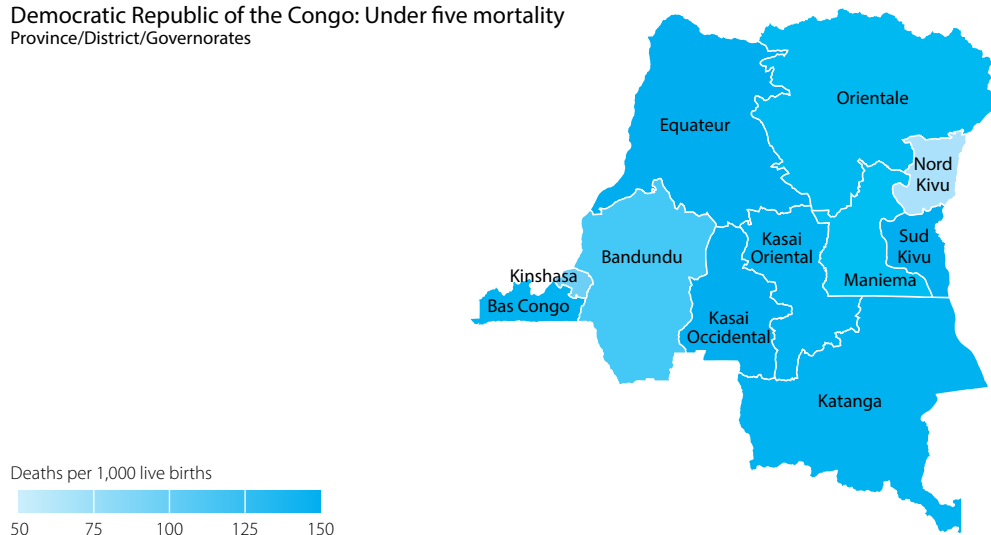
EQUIST's structure consists of three modules: situation analysis, scenario analysis and scenario comparison.

1 Situation analysis

The situation analysis module provides an overview of the health situation within a country, such as health and nutrition outcomes (under-five mortality, neonatal mortality, malnutrition, etc.), epidemiological components (under-five diarrhoea, pneumonia, etc.), and coverage of health interventions (WASH, antenatal care and skilled birth attendance). Data loaded onto the tool are from recognized sources including DHS, MICS, the UN Inter-agency Group for Child Mortality (IGME), and others. Currently, data from 60 countries has been loaded on the online tool, with data prior to and after 2010 to enable assessment of progress. An example of the mapping EQUIST can produce as part of this situation analysis is provided in Figure 1, using the example of under-five mortality in the Democratic Republic of the Congo (DRC).

Figure 3 Example of EQUIST situation analysis – under-five mortality by province in DRC

Democratic Republic of the Congo: Under five mortality
Province/District/Governorates



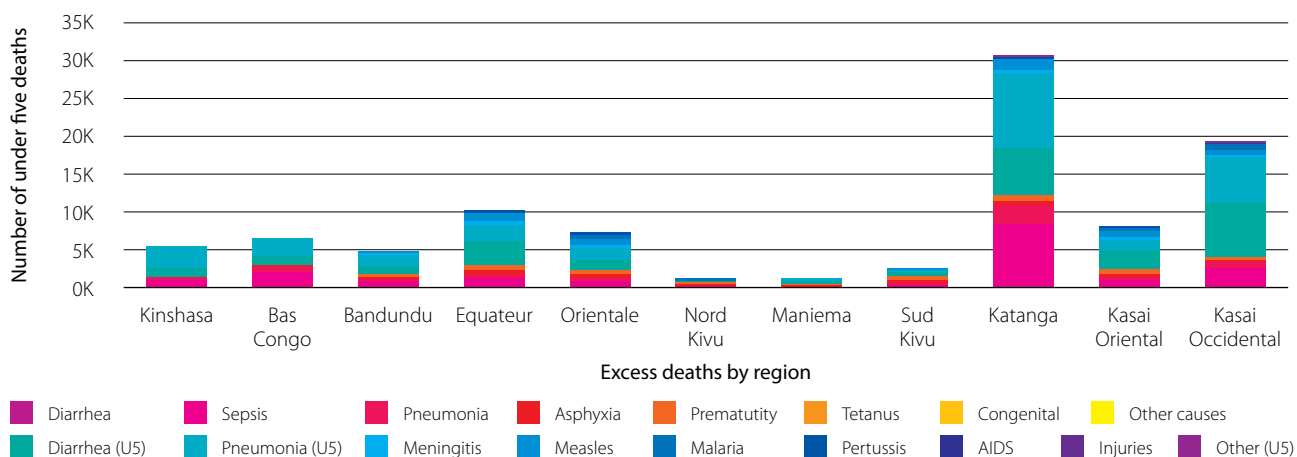
Source: IGME:2013 National data disaggregated based on DHS Subnational distribution – DHS: 2013, last updated 8 March 2016

Overall, the situation analysis module allows the user to visualize the most deprived populations in a country by geographic area and wealth quintile, using maps and bar charts. In EQUIST, the target population is always defined as the most vulnerable women, infants and children 0-5 years in a given geographic location.

Additionally, users can visualize the main causes of disease sub-nationally (equity frontiers). Figure 2 illustrates the main contributors to under-five mortality by province in DRC (diarrhoea, pneumonia and sepsis) in 2013.

Figure 4 Under-five mortality by cause, DRC, 2013

Democratic Republic of the Congo: Under five mortality – Equity frontier (2013)
Province/District/Governorates



Source: Estimated through LIST, last updated 28 March 2016

2 Scenario analysis

The scenario analysis module allows the user to go through the seven-step theory of change by creating a scenario, selecting target populations, epidemiological priorities for these populations and interventions to address these priorities. The impact and cost of the interventions will then be displayed at the end of this process and lives saved can be determined.

The initial three steps, informed by the situation analysis, include the selection of targeted populations, the identification of the most important health issues for these groups and the prioritization of interventions, currently with low coverage, that can address these issues for the targeted populations.

The next steps determine how to scale up these interventions. For example, after selecting epidemiological priorities and the interventions to be scaled up in order to address them, the user can identify critical bottlenecks for those interventions, as well as broader determinants such as public policies, finance, governance/management practices and social norms. EQUIST allows users to select causes of bottlenecks and interventions to address them. Users can also input context-specific strategies and adjust baseline coverage indicators and need, to define the effect size of the proposed strategy. Baseline coverage indicators in the bottleneck analysis mechanism serve only as benchmarks and are derived from previous DHS and MICS surveys. EQUIST calculates impacts using LiST.

The tool utilizes a modified version of the Tanahashi framework for bottleneck analysis. This framework uses information to assess “coverage determinants” (availability, accessibility, affordability, acceptability, initial utilization, adequate coverage and effective coverage) to identify the key bottlenecks that constrain effective coverage. In addition, two new approaches to analyse both country status and progress (equity frontiers and operational frontiers) have been introduced; these compare a country's performance with the “best performing countries”. Equity frontiers refer to improvements in early childhood opportunities that could be attained by the most disadvantaged children of a country if they had the same level of effective coverage of high impact health, nutrition and WASH interventions as children in the wealthiest quintile of the same country at baseline. Operational frontiers represent “best practice” approaches that serve as feasible benchmarks to high impact intervention coverage in the medium-term. Furthermore, the bottleneck analysis component allows the user to view the causes and severity of bottlenecks for each intervention, and identify or propose strategies to overcome them.

Figure 3 illustrates the bottleneck analysis component of EQUIST.

The EQUIST costing module draws upon LiST and the approach of its predecessor, marginal budgeting for bottlenecks. EQUIST is not designed as a tool for costing health programmes, but rather for comparing the costs of alternative strategies added into existing health systems. Other options are available for more detailed analysis of the cost of various health interventions/strategies, including the One Health tool which can be used in conjunction with priorities developed in EQUIST to develop and cost health plans.

Figure 5 EQUIST bottleneck and causal analysis**Bottlenecks and Causal Analysis for > Curative services view by determinant approach**

Determinant	Coverage of target population	Adjust baseline coverage determinant	Bottlenecks	Severity of Bottlenecks
Chart legend	0 20 40 60 80 100			No severity Severe bottleneck
Availability of commodities		100	Availability	
Geographical accessibility		40	Accessibility	
Financial affordability		29	Affordability	
Sociocultural acceptability		70	Acceptability	
Initial utilization			–	
Adequate coverage			Continuity	
Effective coverage			Quality	

3 Scenario comparison

Finally, the scenario comparison module can be used to simply compare the impacts of various user-created scenarios and identify the most cost-effective options for addressing bottlenecks and improving high impact intervention coverage rates. Users can specifically determine which interventions are more effective in terms of how many lives were saved per unit of financial expenditure. This could help users decide the most feasible actions to prioritize within certain contexts.

Conclusion

Operationally, UNICEF is supporting initial applications of EQUIST in a number of countries and documenting the process, results and added value. A plan has been developed to have EQUIST formally evaluated by third parties in several countries, and to establish regional technical support agencies in each UNICEF region, as well as a multi-agency committee to oversee its content, utility and utilization.

Although EQUIST focuses on MNCH, it may be adjusted to include adolescents. Other improvements will include an updated evidence base, including supply-related data and evidence for strategies, as well as an offline version of the tool. Considerable work is also ongoing to improve the user experience, specifically the visual simplicity and intuitiveness of EQUIST.



Appendix 3 Suggested indicators for monitoring progress on HSS initiatives

Introduction

The following table summarizes suggested indicators for each area in UNICEF's HSS Approach. It is derived from indicators for monitoring the Sustainable Development Goals (SDGs), the standard indicators used in Insight/UNICEF's Results Assessment Module (RAM), from WHO's Global Reference List of 100 Core Health Indicators (available at <http://www.who.int/healthinfo/indicators/2015/en/>), USAID and other sources. Some have been developed de novo. A list of indicators specifically on HSS taken from the WHO document is included after the table.

The table is structured to acknowledge that some activities are not specific to any of the five areas prioritized in the HSS Approach but are cross-cutting. There is some repetition, as some activities are conducted at each level of the health system hierarchy. Moreover, **some indicators are included specifically to suggest areas of potential activity, particularly in new areas of focus such as private sector engagement.**

The indicators are based on a premise that strong health systems should enable sustained, universal coverage of health interventions of agreed priority. **HSS-focused activities may target health systems issues (such as those suggested by the six building blocks) directly, or strengthen them indirectly through support for technical strengthening, or through vertical, disease- or population-specific programmes, as long as these are sustained by local authorities.** Health data is an example of an important foundation of the health system which may be improved directly (by improving the related information technology infrastructure) or indirectly (such as when a vertical programme like a national immunization programme streamlines its reporting system in ways that can be used by other programmes).

Accordingly, HSS can be monitored by tracking indicators pertaining to the health system in general, or by tracking those that focus on specific diseases, programmes or populations. However, **most of the indicators in the table below are specific to the areas of focus outlined in the HSS Approach.**

UNICEF Country Offices are recommended to monitor general and specific HSS indicators, **as appropriate to the local context and according to activities prioritized by government, UNICEF and partners.** Note, while the objective of these indicators is to report on country or regional progress, for the purposes of reporting UNICEF Country Office activities on the RAM, **it may be acceptable to report on these indicators only as they apply to UNICEF-supported sub-national geographic areas.**

An equity focus is maintained in the list of suggested indicators, and should be prioritized by UNICEF Country Office monitoring.

Cross-cutting activities and those pertaining to three health system levels	Suggested indicators for monitoring of cross-cutting activities, and activities pertaining to the five areas of UNICEF priority in HSS					
	Cross-cutting	Improving the collection, analysis and use of data and information	Strengthening national and sub-national procurement, supply and distribution systems	Contributing to the social protection system and plan for financing UHC	Engagement and regulation of the private health sector	Improve the quality of health care
Across all three levels: <ul style="list-style-type: none">communitysub-national/districtnational	<p>Financing: Proportion of total government spending allocated to the health sector (SDG, target 1.a.2)</p> <p>Services: Population with access to an agreed package of quality RMNCAHN services (defined locally; adapted from SDG 3.8.1)</p> <p>Equity: Proportion of health units, at any level, whose strategies or annual plans explicitly prioritize vulnerable populations of children and women</p>	<p>Health management information systems (HMIS): Proportion or number of facilities with real time monitoring (RTM) of local data, human resources for health (HRH) mapping, and meeting related International Health Regulation (IHR) guidelines (RAM)</p> <p>Data for management: Proportion of registered public health facilities or districts using local data for bottleneck analysis, annual programme planning, management, monitoring</p>	<p>Procurement and supplies management (PSM): Presence of a functional national logistics technical working group</p> <p>PSM: Country HRH strategy includes the supply chain workforce as a key component</p>	<p>Social budgeting/finance: Functioning of a social protection (SP) or social health insurance (SHI) scheme targeting the provision of RMNCAHN services for the poor or the informal sector</p> <p>Per cent of population participating in such SP or SHI schemes</p>	<p>HRH: Maintenance of an inventory of private providers (individuals; organizations; collectives) that could be engaged in improving RMNCAHN services and in the HMIS (RAM)</p> <p>HRH: A means of engagement or regulation/registration of private health providers is established or in development</p>	<p>Quality of care (QoC): Clinical RMNCAHN protocols based on local or global best practices have been disseminated</p> <p>Proportion of facilities applying QoC or clinical audit standards for RMNCAHN care</p> <p>Proportion of facilities offering in-service training or clinical supervision in RMNCAHN services</p>

Cross-cutting activities and those pertaining to three health system levels	Suggested indicators for monitoring of cross-cutting activities, and activities pertaining to the five areas of UNICEF priority in HSS				
	Cross-cutting	Improving the collection, analysis and use of data and information	Strengthening national and sub-national procurement, supply and distribution systems	Contributing to the social protection system and plan for financing UHC	Engagement and regulation of the private health sector
Community level: Strengthening community demand generation, service delivery, social inclusion, social accountability and reduction of financial barriers	Management: Per cent of registered primary healthcare units (PHUs) producing an Annual Community Health Plan (incl. RMNCAH) during the last two years (RAM) QoC: Per cent of PHUs with functioning WASH facilities (RAM) Equity: Local coverage of these tracer RMNCAH interventions: <ul style="list-style-type: none"> • full immunization • anti-retroviral Rx • Tb treatment • ITN usage • skilled birth attendance (SDG 3.8.1)	HMIS: Per cent of PHUs reporting locally-acquired administrative RMNCAH data, according to national standards (RAM). Per cent of PHUs with RTM of RMNCAH service and HRH mapping per local HMIS standards (RAM) Per cent of births and deaths of children notified to a civil authority, according to national standards (modified from SDG 16.9.1)	PSM: Percentage of storage points with full availability of a selected set of tracer RMNCAH commodities over a resupply period.	SP: Per cent of target population with financial protection against catastrophic/impoverishing out-of-pocket expenditure (modified from SDG 3.8.2)	HRH: Per cent of PHUs maintaining a register of private health providers (individual, organizations or collectives). HRH/QoC: Per cent of PHUs that include private providers in priority public health activities HMIS: Per cent of PHUs that report on the work of private providers per local standards
	Social accountability: Proportion of PHUs that have established active community health liaison (women's groups, Health Committee, etc.)				QoC: Establishment of a community platform for RMNCAH service delivery, according to national standards Per cent of PHUs with active supervision of CHWs according to national standards Per cent of villages served by community health workers with RMNCAH training according to local standards (RAM) Proportion of PHUs that meet basic RMNCAH service capacity standards, defined at national level (USAID) e.g., BEONC, CEONC

Cross-cutting activities and those pertaining to three health system levels	Suggested indicators for monitoring of cross-cutting activities, and activities pertaining to the five areas of UNICEF priority in HSS					
	Cross-cutting	Improving the collection, analysis and use of data and information	Strengthening national and sub-national procurement, supply and distribution systems	Contributing to the social protection system and plan for financing UHC	Engagement and regulation of the private health sector	Improve the quality of health care
Sub-national/District Improving decentralized management capacity for evidence-based analysis, prioritization, planning and monitoring	<p>Management: Per cent of districts that have prepared costed District RMNCAH Plans based on local data over the last two years (RAM) (record use of EQUIST)</p> <p>QoC: Proportion of district health facilities with functioning WASH facilities</p> <p>Equity: Coverage of listed tracer RMNCAH interventions (SDG 3.8.1)</p>	<p>HMIS: Per cent of districts with RTM of RMNCAH, planning, health service/HRH mapping and for meeting the IHRs (RAM)</p> <p>Per cent of children whose birth or death has been notified to a civil authority, according to national standards (SDG 16.9.1)</p>	<p>PSM: Proportion of districts monitoring the source of commodities sold by private providers</p> <p>Percentage of districts and lower or equivalent levels with electronic stock management systems in place</p> <p>Percentage of storage points with full availability of all or a selected set of tracer RMNCAH commodities over a resupply period</p>	<p>Social budgeting: Proportion of districts that established official SP or SHI schemes benefiting children and women</p> <p>Proportion of population in communities with an SP/SHI scheme protected against catastrophic/impoverishing out of-pocket expenditure (modified from SDG)</p>	<p>HRH: Per cent of districts that keep an inventory of private health providers (individual, organizations or collectives)</p> <p>Per cent of districts that engage private health providers in priority public health activities</p> <p>HMIS: Per cent of districts where private providers participate in routine reporting as defined nationally</p>	<p>QoC: Per cent of district health facilities providing RMNCAH services at the standards defined nationally (USAID)</p> <p>Management: Per cent of district health management teams monitoring RMNCAH programme quality, as defined nationally.</p>

Suggested indicators for monitoring of cross-cutting activities, and activities pertaining to the five areas of UNICEF priority in HSS						
Cross-cutting activities and those pertaining to three health system levels	Cross-cutting	Improving the collection, analysis and use of data and information	Strengthening national and sub-national procurement, supply and distribution systems	Contributing to the social protection system and plan for financing UHC	Engagement and regulation of the private health sector	Improve the quality of health care
National Support development of health related policies, strategies, plans and budgets at national level	Financing: National budget allocated for health (per agreed local standard) (RAM) IHRs: National Health Strategy/Plan with mainstreamed risk reduction/emergency preparedness (RAM) Health priority: National strategy on inclusion of health in all policies HRH: National strategies on engagement of the private sector in: (i) health services (ii) PSM, (iii) health literacy and communication and (iv) social accountability Access/QoC: National conduct of an equity analysis of maternal and child mortality, service access and bottlenecks, within the last 5 years (record use of EQUIST)	HMIS: Per cent of registered public health facilities submitting data in real time for the HMIS, annual planning, RMNCAH service/HRH mapping and for meeting the IHR guidelines (RAM) HMIS facilitates periodic reports on key RMNCAH outcomes with data disaggregated by age and sex at national and local level (RAM) HMIS generates annual reports of health facility and HRH distribution per national standards (RAM) Per cent of children whose birth or death has been notified to a civil authority, per national standards (SDG, 16.9.1)	PSM: Percentage of countries with an up-to-date national health sector supply chain strategy and implementation plan	Social budgeting: Proportion of the national population protected against catastrophic/impoverishing out of pocket health expenditure through participation in a SP/SHI scheme (modified from SDG)	QoC: Existence of a national audit programme for private facilities/providers HRH: Per cent of registered private providers/ facilities providing any RMNCAH services (e.g. antenatal care; EPI services) HMIS: Per cent of registered private providers reporting to the HMIS QoC: Per cent of registered private facilities/providers using drugs or vaccines procured unofficially Financing/SP: Per cent of registered private facilities/providers providing any services for which they receive payment (wholly or in part) by SHI or SP programmes	QoC: Proportion of registered facilities applying national RMNCAH service quality standards (if audited) National strategy for improving quality of care in RMNCAH across health and allied sectors
	Public financial management analysis or expenditure tracking survey within 5 years					

WHO HSS Indicators – taken from the Global Reference List of 100 Core Health Indicators

Quality of Care

- Perioperative mortality rate
- Obstetric and gynaecological admissions owing to abortion
- Institutional maternal mortality ratio
- Maternal death reviews
- Antiretroviral treatment retention rate
- TB treatment success rate
- Service-specific availability and readiness

Access

- Service utilization
- Health service access
- Hospital bed density
- Availability of essential medicines and commodities

Health workforce

- Health worker density and distribution
- Output training institutions

Health information

- Birth registration coverage;
- Death registration coverage
- Completeness of reporting by facilities

Health financing

- Total current expenditure on health (% of GDP)
- Current expenditure on health by general government and compulsory schemes (% of current expenditure on health)
- Out-of-pocket payment for health (% of current expenditure on health)
- Externally sourced funding (% of current expenditure on health)
- Total capital expenditure on health (% current + capital expenditure on health)
- Headcount ratio of catastrophic health expenditure
- Headcount ratio of impoverishing health expenditure

Health security

- International Health Regulations (IHR) core capacity index.





Appendix 4 Operational guidance on HSS for UNICEF regional and country offices

STEP 1 CONTEXTUALIZE

- Perform a desk review of the health situation in country, as well as current interventions and indicators of access, coverage, and equity of health services; where possible, use data/information from EQUIST, or GFF, Gavi or Global Fund applications.
- Determine the status of the Government's sectoral planning and policymaking cycles at national and subnational levels, and the current dialogue on plans for achieving universal health coverage (UHC).
- Become familiar with what other development partners are doing in the areas of HSS prioritized by UNICEF, and otherwise, at different levels of the health system (national, sub-national/district, community, etc.).
- Become familiar with the "UNICEF Approach to Health Systems Strengthening, a Resource Paper for the UNICEF Strategy for Health 2016-2030".
- Identify opportunities to introduce or reinforce HSS in local health sector/system management and UHC dialogue, and in GFF, Gavi or Global Fund proposals, and link these to opportunities to adjust or further develop UNICEF programmes.
- Identify actions in other sectors that might benefit the health system, and mechanisms to link them, both within UNICEF and related to activities undertaken by government or other stakeholders.

Country Programme Cycle



STEP 2 ASSESS, PRIORITIZE, DESIGN AND RESOURCE

- Use the seven-step approach outlined in the *UNICEF Approach* to revisit or update the situation analysis, child survival and/or development programmes (as appropriate), and partnerships. Reviewing assessments of priority populations, health conditions and interventions, evaluations of the health system's strengths, weaknesses and vulnerabilities, and check the status of the health sector plan, GFF Investment Case and Gavi or Global Fund activities. Use EQUIST (www.equist.info), the UNICEF guidelines on DHSS, and bottleneck analysis and tools used by other sectors (e.g., WASH-BAT, Education SEE, etc.) to complement your analysis or streamline this work. Seek regional or global assistance on this if needed.
- Select priority HSS focus areas and specific strategies based on your updated situation analysis, the typology of your country or sub-national region as defined in the *UNICEF Strategy for Health 2016-2030*, and develop the UNICEF scope of work.
- Contextualize the selected areas of focus vis-à-vis regional and global HSS initiatives and M&E frameworks, and GFF, Gavi and Global Fund activities. Consider how these global initiatives and related M&E can contribute meaningfully to country-level HSS. Define UNICEF's comparative advantages and prioritize HSS interventions where UNICEF can make a difference.
- Determine whether your HSS activities will comprise a new "project" or "programme", or be incorporated into existing work. Calculate the resource needs and mobilize funds. Assess opportunities for integrating with regional/global HSS initiatives. Always considering leveraging GFF, Gavi or Global Fund-supported activities for additional work on sustained, broader HSS.

STEP 3 IMPLEMENT, EVALUATE, PROMOTE AND DISSEMINATE

- Revisit your work-plan, Strategic Note, CPD, CPAP, etc. Seek to apply an HSS lens to these documents (with external support if needed) to achieve priority HSS goals such as UHC, local and national health security, and promote health sector resilience. Link HSS to your country's/region's risk-informed planning. Consider how HSS approaches can contribute to goals beyond health, and likewise, how multi-sectoral approaches might be more effective and framed as systems-strengthening. Advocate for an HSS lens to be explicitly applied to GFF, Gavi or Global Fund-supported activities.
- Consider the recommended indicators on UNICEF's work in HSS (Appendix 3 of the UNICEF "HSS Approach"). Select those you will report on and develop milestones for assessing progress according to related project or programme timelines. Include these in your country RAM reporting on HSS. Seek assistance on this from regional and global colleagues as needed.
- Strengthen visible participation in existing HSS partnerships, such as any local chapter of the IHP for UHC 2030, with multilaterals (e.g., GFF, Gavi, the Global Fund, local chapters of the H6), other UN agencies, bilaterals, regional bodies, academia, and domestic CSOs and NGOs. Advocate for the inclusion of HSS in policy-making beyond the health sector.





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November 2016