FINAL EVALUATION

The Rockefeller Foundation's Transforming Health Systems Initiative

March 2018

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A Health Surveillance Assistant records the results of a feverish child's rapid diagnostic test for malaria in a patient register.

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Acronyms

AfDB	African Development Bank
AeHIN	Asia eHealth Information Network
BMZ	German Federal Ministry for Economic Cooperation and Development
CBHI	Community-based health insurance
CCG	Country core group
CDC	Centers for Disease Control and Prevention
CHMI	Center for Health Market Innovations
CoE	Center of excellence
CRDM	Collaborative Requirements Development Methodology
DFID	UK Department for International Development
EMR	Electronic medical records
G8	Group of Eight (eight industrialized nations)
G20	Group of Twenty (19 of the world's largest economies and the European Union)
GIZ	German Society for International Cooperation
GoR	Government of Rwanda
HANSHEP	Harnessing Non-State Actors for Better Health for the Poor
HMU	Hanoi Medical University
HSPI	Health Strategy and Policy Institute
HSS	Health system strengthening
ICDDR, B	International Center for Diarrhoeal Disease Research, Bangladesh
ICT	Information and communications technology
IT	Information technology
IFC	International Finance Corporation
IHP	International Health Partnership
JLF	Joint Learning Fund
JLN	Joint Learning Network for Universal Health Coverage
LMIC	Low and middle income country

MDG	Millennium Development Goal
MEL	Monitoring, evaluation, and learning
mHELP	mHealth Expert Learning Network
MoH	Ministry of Health
MRS	Medical record system
NGO	Non-governmental organization
Norad	Norwegian Agency for Development Cooperation
OpenHIE	Open Health Information Exchange
PEPFAR	United States President's Emergency Plan for AIDS Relief
PHC	Primary health care
PLoS	Public Library of Science
R4D	Results for Development
RHEA	Rwanda Health Enterprise Architecture
SDG	Sustainable Development Goal
TB	Tuberculosis
THS	Transforming health systems
TI	Technical initiative
ToC	Theory of change
UHC	Universal health coverage
UN	United Nations
UN-ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

Preface

In the decade leading up to the 2008 economic crisis, health policy experts increasingly questioned the donor community's prevailing focus on interventions targeting specific diseases, such as HIV/AIDS, tuberculosis, and malaria. Though these disease-specific interventions produced major, measureable results, they did so at the cost of creating coordination, financial, and reporting challenges for recipient countries which already had overstretched health systems.

When The Rockefeller Foundation launched its Transforming Health Systems (THS) initiative in 2009, it committed itself to driving renewed attention to strengthening health systems as a whole. The Foundation believed that this was essential for meeting its overall commitment to equity – so that national health systems could provide quality care to everyone, rich and poor alike.

THS was ambitious and comprehensive in scope – aiming to build global acceptance for universal health coverage (UHC), create regional networks to promote learning and innovation, and develop country demonstration models of efficiency and effectiveness. Accomplishing these goals required a range of grant and non-grant activities focused on policy and advocacy, health financing, health system stewardship, and health information systems. Between 2008 and 2015, the Foundation made $115 million in grants to support work strengthening health systems at the global, regional, and national levels.

This final evaluation – conducted by the Foundation's monitoring and evaluation grantee, Mathematica Policy Research – assesses and documents the initiative in its entirety. It reviews the outcomes of the initiative's global advocacy, regional networks, and country-level investments, and its overall effectiveness and influence, as well as the Foundation's legacy for advancing UHC. By sharing this evaluation report, it is the Foundation's hope that others will join us in celebrating our successes, learning from our challenges, and building on this knowledge base to continue advancing Sustainable Development Goal 3 – health and wellbeing for all.

Veronica Olazabal
Director, Measurement, Evaluation and Organizational Performance
The Rockefeller Foundation

Mothers wait with their children outside a village health clinic, 30 km from Malawi's capital city, Lilongwe.

Executive Summary

The Rockefeller Foundation's Transforming Health Systems (THS) initiative (2008–2017) sought to catalyze health system strengthening (HSS) activities in low and middle income countries (LMICs) that support advancement toward universal health coverage (UHC). Conceptualized at a time of rising interest in and political will for UHC, the THS initiative was designed to take advantage of what The Rockefeller Foundation viewed as a "unique opportunity to drive a global movement to support UHC and to catalyze the strengthening of health systems that promote greater efficiency and effectiveness, and are more affordable and equitable" (The Rockefeller Foundation, 2009). THS was approved in 2007, with an initial budget of $100 million for grantmaking from 2008 to 2012. In 2013, the initiative received another allocation of $15 million for additional grantmaking until December 2015, with work continuing under THS through 2017.

THS's work spanned the global, regional, and country levels, and included complementary grant and non-grant activities. At the global level, the initiative focused on research and agenda-setting to support adoption of UHC as a policy goal among global and country actors. At the regional (Global South) level, it focused on creating and supporting networks that promote cross-learning, innovation, and collaboration to advance health system reform efforts in LMICs. At the country level, THS addressed key binding constraints to achieving UHC in four focus countries that the Foundation envisioned could serve as models for change (Bangladesh, Ghana, Rwanda, and Vietnam). In these countries and through its regional networks, THS's efforts focused on four key levers for advancing UHC: policy and advocacy, health financing, health system stewardship, and health information systems (also referred to as eHealth).

This report synthesizes findings from a five-year, multi-component summative evaluation of the THS initiative conducted by Mathematica Policy Research. The objectives of the evaluation were to assess: i) the effectiveness of the three core strategies – global advocacy, regional networks, and country-level investments in four focus countries – that were employed under THS to advance progress toward UHC in LMICs, ii) the overall effectiveness and influence of the initiative, and iii) the Foundation's legacy in the UHC arena. A key component of the evaluation was to document lessons learned from achievements and challenges to inform the development of future initiatives at the Foundation. The evaluation, which began in April 2013 and culminates in this summary report, included six in-depth case studies of THS's work at the global, regional, and country levels, as well as prospective data collection to monitor grantee progress under THS's consolidation grantmaking phase (2013–2015).

Overall, the evaluation found the THS initiative to be successful in its efforts to activate a global movement to accelerate progress toward UHC. The Foundation catalyzed and shaped the global UHC movement and, ultimately, influenced the inclusion of UHC in the Sustainable Development Goals (SDGs) of the post-2015 agenda. It also created enduring cross-learning platforms and tools to support country progress toward the SDGs' UHC targets. Although THS gained less traction in advancing UHC through its focus country investments, its success in making UHC a global development target and creating networks and coalitions to support UHC reform efforts in LMICs will likely have country-level impacts for years to come. Below we provide a summary of key achievements and learnings under THS.

Notable achievements

Global UHC advocacy

Global advocacy was central to THS's efforts to catalyze the UHC movement and, in turn, progress toward UHC at the global and country levels. A key objective of the THS advocacy strategy was to bring UHC to the forefront of the global health agenda in order to promote widespread adoption of UHC as a mechanism for improving health outcomes and a policy goal. To do so, The Rockefeller Foundation leveraged its legacy and convening power in the global health arena, and used a range of advocacy tools, to expand understanding, use, and operationalization of the UHC term among key global and country actors. Today, the Foundation is widely recognized as the thought leader behind the UHC movement among key actors in the UHC space. Its key contributions to the UHC movement are summarized below.

Championed a new policy concept and agenda to support health system strengthening in LMICs. Although policymakers had started to recognize the importance of well-functioning health systems by the early 2000s, "health system strengthening" was not gaining sufficient traction to influence policy. By providing a language and basis for dialogue on HSS that had broad appeal, THS paved the way for widespread adoption of the UHC term. In its efforts to disseminate and promote the UHC concept, THS helped to create a new policy space and agenda that brought together a broad range of partners working to improve health systems in LMICs. It also connected diverse members of the global health community under a common umbrella and goal.

Influenced the post-2015 agenda process and inclusion of UHC in the SDGs. By using a highly adaptive approach, and multiple vehicles and tools for policy influence and agenda-setting at the global and country levels, the Foundation was able to strengthen and shape the UHC movement and ultimately influence the post-2015 agenda process, culminating in the inclusion of UHC in the SDGs. Through strategic reflection and pivots at key junctures in the UHC movement, THS effectively responded to and leveraged changes in the UHC landscape and consolidated gains under the strategy. At the global and country levels, THS both created and harnessed momentum in support of UHC among key actors and institutions, and invested in strategic communications and coalition building to strengthen and sustain the UHC movement and commitment to UHC.

Played a defining role in key milestones that advanced the UHC movement. Several well-recognized milestones in the history of the UHC movement reflect the influence of THS's advocacy efforts. These include: i) the THS-supported *World Health Report 2010, Health Systems Financing: The Path to Universal Health Coverage*, recognized as the single most influential milestone in the UHC movement to date; ii) the United Nations General Assembly Resolution A/RES/67/81 (2012), which recommended inclusion of UHC in the post-2015 development agenda; and iii) public endorsements of UHC by WHO Director-General Margaret Chan, World Bank President Jim Kim, and prominent economists (via the Economists' Declaration on UHC). THS also organized and supported several strategic UHC-themed convenings around important global meetings and conferences which, in turn, helped to frame, inform, and increase UHC dialogue at pivotal points in the post-2015 agenda process.

Fostered new platforms, coalitions, and partnerships to build sustained momentum around UHC.
THS established and supported multiple global platforms to promote dialogue and evidence generation around UHC and HSS. These include i) the Global Symposium on Health Systems Research, an annual meeting of researchers, experts, policymakers, donors, and practitioners, and ii) the People's Health Assembly, a meeting held every five years by the People's Health Movement, a large global network of health activists, civil society organizations (CSOs), and academics. It also supported the formation of several new coalitions and partnerships that, in turn, support its advocacy efforts and advance UHC. These include the UHC Day coalition, a global coalition of 700 organizations that organize UHC Day, an annual rallying point for the UHC movement. One of the highest profile partnerships to emerge from THS is the International Health Partnership (IHP) for UHC 2030 (formerly IHP+), a partnership of governments, development agencies, and CSOs committed to supporting progress toward the SDG UHC target.

Gained a strong legacy in the UHC arena. The Rockefeller Foundation is widely recognized as the thought leader behind the UHC movement. Many experts and UHC actors hold the Foundation in high esteem for its influential role in catalyzing and advancing the UHC movement, and its visionary thought leadership in support of the UHC concept from its early days. Many noted that the Foundation's legacy in the global health arena, combined with the strong reputation of THS leaders, was critical for influencing leaders and decision-makers within the UN and other institutions, such as the World Health Organization (WHO), World Bank, and United Nations Children's Fund (UNICEF), to engage in the UHC movement. The Foundation's unique convening power was also cited as a critical factor in the UHC movement's success. However, many are not aware of the Foundation's specific contributions to pivotal events in the history of the UHC movement. This is in part because the Foundation has not publicized its role or successes in the UHC arena extensively, but instead has empowered global and country actors to be UHC champions and advance the UHC movement.

> *"Having a strong reputation changes the receptivity [of key leaders] and changes the legitimacy [of the issue]. [The Foundation's] reputation was formative for their credibility in this space."*
> *– Interviewee*

Regional networks for cross-learning and collaboration

A key cross-cutting strategy under the THS initiative was to establish networks that would catalyze learning, collaboration, and innovation around strategies for achieving UHC, and bring other donors on board to invest in critical HSS efforts. The Rockefeller Foundation has established several successful networks that bring diverse constellations of health sector stakeholders together to explore and

collaborate on new ideas and approaches. With the Foundation's strategic and technical guidance, financial support, and convening power, these networks have generated critical momentum around "orphan" issues in the HSS space, developed practical tools and resources, and used their learning to improve health policies, programs, and systems.

Formation of highly valued networks to address critical gaps in global knowledge generation and collaboration. As the Foundation engaged in efforts to build global momentum around UHC, it recognized early on that there were limited opportunities for policymakers, practitioners, donors, and others to learn about and collaborate around approaches to achieving UHC. To address this gap, the Foundation provided catalytic funding and support to grantee partners to launch networks that shared experiences and ideas, established knowledge platforms, and developed resources for policy and program development – thereby creating a strong enabling environment for movement toward UHC.

These networks focused on strategies for overcoming critical constraints to achieving UHC, drawing in particular on HSS tools and vehicles used in the Global North. For instance, an early priority for THS was to advance thinking on how to strengthen health systems by leveraging the private sector. To further knowledge and learning in this area, THS helped launch the Center for Health Market Innovations (CHMI), which has developed a web platform to catalog and disseminate information on innovative private health sector programs, and used this information to facilitate replication of effective practices and generate greater dialogue between public and private sector actors. At around the same time, the Foundation joined forces with other global health funders to form a donor collaborative focused on improving the performance of private sector actors in meeting the health care needs of the poor. Donors in the collaborative, known as the Harnessing Non-State Actors for Better Health for the Poor (HANSHEP) network, share knowledge and learning around the private health sector and co-finance promising initiatives.

The Foundation also looked to the fast growing eHealth domain to explore opportunities for health system improvement and identify and support promising solutions. One such strategy was the development of an open source electronic medical record (EMR) system platform that stakeholders in LMICs can use to develop their own customized systems. The Foundation provided seed funding to a loose collaboration of organizations working towards this goal, known as OpenMRS, to form a strong, sustainable institution and build out their community of practice. The Foundation also provided funding and support to grantee partners to establish the mHealth Alliance, which aimed to build the mHealth field through convenings, evidence generation, capacity-building support to NGOs, and more. The private sector and eHealth network efforts informed the creation of THS's flagship network – the Joint Learning Network (JLN) for Universal Health Coverage – that cuts across all work streams. The JLN connects practitioners from LMICs working towards UHC to facilitate knowledge sharing and tool development to advance UHC-oriented reforms.

Created greater attention to and consensus around the role of the private sector in health. HANSHEP gave donor representatives a platform to discuss this divisive topic – opinions had traditionally diverged on the extent to which the private sector should be leveraged in efforts to improve health

coverage. Key informants report that frequent discussion and cross-learning through HANSHEP helped destigmatize the issue, shined a light on unexplored opportunities and, ultimately, contributed to several donor representatives mainstreaming private sector engagement into their organizations' HSS efforts. CHMI's web platform of innovative private sector health programs supported this shift, acting as a useful resource for donors looking to work in this area and for service providers looking to learn from others. Overall, the platform has increased attention to and understanding of what the private sector has to offer – profiling over 1,300 innovative programs from 150 countries and receiving between 20,000 and 25,000 visitors each month.

Built lasting momentum around eHealth approaches to strengthening health systems. The Foundation's seminal conference – Making the eHealth Connection – held at its Bellagio Center in 2008, brought together representatives from 34 countries, 32 donor organizations, and 10 high-profile news and media outlets. The conference was a "tipping point" in the use of eHealth as a key HSS tool – generating transformative ideas and building a broad, cross-sectoral commitment to testing new approaches, building evidence, and changing policy. The mHealth Alliance was seeded at the conference and has continued this work, focusing in particular on the use of mobile phones and technology to strengthen health service delivery. The Alliance's mHealth summits, technical working groups, and other informal networking activities strengthened linkages among mHealth actors and, overall, gave greater shape and a larger profile to a relatively fragmented field.

Developed useful, practical tools and resources. Networks formed through THS have developed a range of tools and resources to help policymakers and practitioners embark on thoughtful, evidence-based reform of programs, policies, systems, and processes. These "global public goods" are grounded in an understanding of the context and designed to address practical challenges faced day to day in the health systems of LMICs. They include, for example, knowledge products summarizing prior experiences with reform, guidelines for assessments to inform reform efforts, open source tools for strengthening health information systems, and more.

Strengthened policies and programs through cross-learning and collaboration. Some networks have been successful in translating the momentum and learning they have generated, and the tools and resources they have developed, into tangible change in programs, policies, and systems. For example, policymakers and practitioners have drawn on JLN tools, to conduct costing studies and use results to inform the development of a national health protection scheme in India, and the reform of provider payment systems in Vietnam. The OpenMRS platform was piloted in Rwanda, which has since engaged in a national rollout of the OpenMRS EMR system for primary care. More broadly, as of 2015, 1,845 sites in 64 countries were reporting OpenMRS implementations.

Positioned networks for sustainability. The progress made by THS-supported networks – in fostering strong partnerships, generating useful resources, and motivating policy and programmatic action – has attracted support from other donors. CHMI, JLN, and the mHealth Alliance all eventually expanded their sources of funding, and CHMI and JLN have strong sustainability planning efforts underway to ensure their work continues beyond the life of the THS initiative.

Supporting country models for change

The Foundation selected four countries – Bangladesh, Ghana, Rwanda, and Vietnam – in which to develop, refine, and support pathways for achieving UHC, with the goal of developing models for change. In these countries, it invested in advocacy, evidence generation, policy development, and capacity-building activities. These activities increased understanding of UHC in these countries, contributed to building local capacity, and helped advance critical reform efforts.

Catalyzed and advanced nascent or slow-moving reform efforts. THS identified and tackled well-defined constraints to UHC reforms to facilitate achievement of concrete results within the initiative's lifespan. In Vietnam, THS propelled provider payment reforms forward by identifying and addressing a need for rigorous costing data collection and analysis. In Rwanda, the Foundation supported implementation of the country's new eHealth strategy, supporting the establishment of an eHealth secretariat within the Ministry of Health (MoH), the development of eHealth tools, and the roll-out of an OpenMRS EMR system for primary care. In Ghana, it supported government efforts to leverage the private sector to expand access to health services and enrollment in its national health insurance scheme. THS grants helped to strengthen the MoH's Private Sector Unit, develop a new private health sector policy, and improve accreditation processes for private providers.

Positioned countries for long-term progress on health system priorities through institutional capacity-building grants. THS contributed to building a strong pipeline of health sector officials committed to health system strengthening by establishing degree programs and founding centers of excellence at local academic institutions. However, these efforts were not designed to and did not produce immediate impacts on reform processes.

Increased understanding of UHC concept in focus countries. Through meetings, convenings, and production of a variety of reports and publications, THS strengthened awareness and understanding of UHC both within and beyond the health sector, and seeded nuanced dialogue around its core objectives and elements.

Challenges

Broad scope and siloed grantmaking. The THS initiative emerged out of The Rockefeller Foundation's efforts to develop four separate Advance Health initiatives focused on i) research and agenda-setting on UHC and HSS, ii) enhancing health system stewardship capacity, iii) harnessing the private sector, and iv) leveraging eHealth technology. In 2008, the Foundation decided to combine these four initiatives into one large initiative aimed at transforming health systems toward UHC. As a result, THS was expansive in scope, encompassing four largely independent work streams operating at multiple levels, all organized around a very broad and ambitious long-term goal. Ultimately, THS's four work streams were not brought together under an initiative-level theory of change or results framework that articulated how they would work together to strengthen health systems in support of UHC. In turn, grantmaking tended to be siloed and synergies across work streams and levels of intervention were difficult to identify and leverage, leading to some missed opportunities.

Abrupt shifts in strategy. Key informants felt that THS's private sector and eHealth investments, which were gaining traction at both the regional and country levels, were called to a halt too soon, which compromised opportunities for effecting long-term change. For example, THS's investments in Ghana were helping to develop capacity to expand the private sector's role in advancing UHC, but the decision to wind down private sector-focused grantmaking in 2011 led to some loss of momentum and persisting gaps in donor support for private sector efforts. A similar narrative emerged in the eHealth space. For example, once THS funding for eHealth came to a close, the mHealth Alliance found it difficult to raise funds for its thought leadership, evidence generation, and partnership-building activities – which were a critical part of its scope of work. The mHealth Alliance eventually wound down in 2013, for this reason as well as others – including its overly broad scope of work and the growing presence of other actors stepping into the role that the mHealth Alliance was created to fill.

Reliance on exploratory grantmaking in focus countries. The Foundation threw a wide net to identify promising short-term investment opportunities as it began grantmaking in its focus countries. However, at times, this exploratory approach was continued into the "execution" phase of country-level strategies, leading to disproportionate spending on scoping investments.

Limited traction at the country level. The Foundation had more limited success at the country level than at the global and regional levels – for several reasons. First, the Foundation had limited resources to invest at the country level, and these were spread relatively thin across THS's multiple work streams, which in turn diluted the Foundation's influence in focus countries. The Foundation was also constrained by its limited experience with country-level grantmaking and its lack of a local presence. Without country offices, THS staff found it challenging to establish relationships with all relevant government actors and to build collaborative partnerships with other donors in the country. Despite these constraints, THS did make significant contributions to reform efforts in some countries, helping to propel these efforts forward to advance UHC. However, this typically happened when a number of enabling factors aligned organically – such as when synergies emerged between the JLN's work and policy priorities in Vietnam and grew into a targeted country-level effort to guide provider payment reform.

Key learnings

Identify a well-respected leader to take the helm and a subject matter expert to guide the initiative. THS directors responsible for leading the initiative's global advocacy work and making it a success were well-known and respected in the global health arena, and possessed an historical perspective that enabled them to identify strategies and actors that could catalyze the UHC movement. Subject matter experts managing initiative components played a critical role in shaping the discourse in emerging fields such as eHealth, and providing needed technical guidance to grantees entering these fields.

Make big bets and bold moves, but ensure objectives are right-sized and aligned with comparative advantage. Initiative goals should be ambitious, but also feasible, and be closely aligned with Foundation strengths. For example, the Foundation had the legacy, leadership, and convening power to move the needle at the global and regional levels – bringing diverse actors together around

the policy goal of UHC and facilitating widespread collaboration around strategies for achieving that goal. By contrast, at the country level, the Foundation had limited experience and relatively sparse networks, which resulted in portfolios that did not always cohere to achieve common objectives and ultimately had uneven influence.

Invest in areas where finite funding can have outsized and enduring impacts, such as in global advocacy and network-based learning. Adoption of a multi-level, multi-pronged advocacy strategy was critical to THS's success in elevating UHC's status on the global agenda, and catalyzing action among global leaders, donors, and policymakers to propel long-term HSS efforts in LMICs. Learning networks are also a powerful vehicle for effecting change in the long term. The Foundation helped form five networks over the course of THS, four of which continue today to facilitate learning, collaboration, and innovation around approaches for strengthening health systems and advancing UHC.

Use theories of change to inform approach, and monitoring, evaluation, and learning (MEL) activities to guide strategy refinements. Initiative-wide theories of change, as well as results frameworks for specific initiative components, can help ensure the development of a cohesive portfolio of investments that are tied to well-defined, achievable goals. Theories of change and results frameworks can minimize the type of portfolio fragmentation the THS initiative experienced, and ensure that linkages across different grants and levels are identified and leveraged. They also provide an underlying framework for MEL activities, which are critical for tracking initiative progress and making timely and evidence-based refinements to strategy. Integrating MEL activities early on – and building decision points into the initiative strategic plan – can be particularly helpful in reining in lengthy exploratory grantmaking and expediting the process of identifying focus areas.

1

Introduction

The Transforming Health Systems (THS) initiative was one of The Rockefeller Foundation's largest global health initiatives. Aligned with the Foundation's mission to promote the well-being of humanity, THS aimed to improve the health status and financial resilience of poor and otherwise vulnerable populations through activities promoting improved health systems performance and the expansion of universal health coverage (UHC). THS was approved by the Foundation's Board of Trustees in 2007, with an initial budget of $100 million for grantmaking from 2008 to 2012. In 2013, the initiative received another allocation of $15 million for additional grantmaking until December 2015, with work continuing under THS through 2017.

The THS investment strategy focused on health system strengthening levers that have received less attention from the international community and contribute to the initiative's ultimate goal of UHC. The initiative defined UHC as "access for all to appropriate health services at an affordable cost," and aimed to increase the percentage of the global population benefiting from health coverage from 40 percent in 2009 to 60 percent in 2017 through increased health coverage in low and middle income countries (LMICs). To achieve this goal, THS's work spanned the global, regional, and country levels, and included complementary grant and non-grant activities. At the global level, THS focused on research and agenda-setting to support adoption of UHC as a policy goal among global and country actors. At the regional (Global South) level, it focused on catalyzing and supporting networks that promote cross-learning, innovation, and collaboration to advance health system reform efforts in LMICs. At the country level, the initiative addressed key binding constraints to achieving UHC in four focus countries that the Foundation envisioned could serve as models for change – Bangladesh, Ghana, Rwanda, and Vietnam. In these countries and through its regional networks, THS's efforts focused on four key levers for advancing UHC: policy and advocacy, health financing, health system stewardship, and health information systems (also referred to as eHealth).

This report synthesizes findings from a five-year, multi-component evaluation of the THS initiative conducted by Mathematica Policy Research. The objectives of the evaluation were to assess i) the effectiveness of the three core strategies – global advocacy, regional networks, and country-level investments – employed under THS to advance progress toward UHC in LMICs in four focus countries, ii) the overall effectiveness and influence of the initiative, and iii) the Foundation's legacy in the UHC arena. A key component of the evaluation was to document lessons learned from achievements and challenges to inform the development of future initiatives at the Foundation.

The evaluation, which began in April 2013 and culminates in this summary report, included six in-depth case studies of THS's work at the global, regional, and country levels, as well as prospective data collection to monitor grantee progress under THS's consolidation phase (2013–2015). The report is divided into 7 chapters. In the next chapter, we describe the THS initiative. In Chapter 3, we provide an overview of the evaluation. Chapters 4–6 summarize findings from our assessment of each of THS's three core intervention strategies at the global, regional, and country levels, respectively. Chapter 7 presents concluding findings on the overall effectiveness and influence of the initiative.

2

Description of the initiative

Conceptualization and rationale

The THS initiative was conceptualized in the context of a broader Foundation-wide effort to refine the Foundation's investment strategy to strengthen its impact. This effort, spearheaded by a new Foundation president in 2005, included a critical examination of the Foundation's role in the global health arena, an area in which the Foundation had a long history dating back to its first grants in the early 1900s. Public health and medical research were among the Foundation's first focus areas and included pioneering initiatives to eradicate preventable diseases such as malaria and yellow fever on an international scale, and to establish public health schools in a number of countries (including the first public health school in the U.S., at Johns Hopkins University, in 1918). The Foundation's robust public health programming continued into the twenty-first century, with an ongoing focus on important diseases of the day, later including HIV/AIDS and childhood diseases. However, by the early 2000s, a number of new and large foundations and donor initiatives had entered the global health landscape, with an overlapping focus on prevention, treatment, and/or elimination of specific diseases. These new actors included the

Bill & Melinda Gates Foundation, the Global Fund to Prevent AIDS, Malaria, and Tuberculosis (TB), and the United States President's Emergency Plan for AIDS Relief (PEPFAR), among others. In recognition of the important role these large actors were playing, The Rockefeller Foundation launched a strategic reflection process in the mid-2000s to reassess its comparative advantage and value-added within this new donor landscape.

The idea for the THS initiative emerged from this strategic reflection process. The Foundation sought to identify a strategic niche in global health that would leverage its legacy in public health, historic convening power, and heritage of building networks and institutions to address global problems, and also stand separate from the multitude of efforts being pursued by other foundations and global actors. In addition, the Foundation's refined health investment strategy needed to be aligned with a new strategic model adopted by the Foundation at this time, which focused on innovation and achieving impact within time-bound initiatives organized around four outcome areas: i) Revalue Ecosystems, ii) Advance Health, iii) Secure Livelihoods, and iv) Transform Cities. Global health work fell under the "Advance Health" outcome area. Under this new initiative approach, each new initiative was to be developed

based on targeted "searches" to identify emerging opportunities and innovative solutions.[1]

To inform searches in the Advance Health area, the Foundation first identified what it perceived to be a key gap in the global health landscape at that time: investment in health systems. Starting in the 1990s, donor support had shifted away from the "horizontal" systems-wide efforts to achieve universal access to primary care that followed the 1978 Alma Alta declaration, and became increasingly focused on "vertical" efforts focused on select diseases, including HIV/AIDS, TB, and malaria, among others. Although these vertical efforts had produced major results and measureable improvements in health status, by the late 1990s there was emerging evidence that their narrow focus on specific diseases had resulted in the neglect, and arguably the exacerbation, of fundamental weaknesses in health systems, thereby compromising access to basic primary care services (Hafner and Shiffman, 2012).

Highlighting this issue, the *World Health Report 2000* focused on health systems performance, arguing that a well-functioning health financing system was critical to improving population health and health equity. In particular, the report underscored the importance of reducing the burden of out-of-pocket payments for health services, harnessing the private sector to improve health systems performance, and strengthening country stewardship of the health system (WHO, 2000). Following this report, the need for UHC-oriented health system reforms became increasingly integrated into global and country discourse and agendas, leading to the landmark 2005 World Health Assembly (WHA) resolution on sustainable health financing, UHC, and social health insurance. In addition, by the mid-2000s, several

LMICs had taken significant steps to move their financing systems toward UHC, using various forms of prepayment and risk-pooling to improve access to health services and financial protection against illness.

Against this backdrop of rising interest in and political will for UHC, the THS initiative was conceived in 2008 to take advantage of what the Foundation viewed as a "unique opportunity to drive a global movement to support UHC and to catalyze the strengthening of health systems that promote greater efficiency and effectiveness and are more affordable and equitable" (The Rockefeller Foundation, 2009). To do so, it sought to reframe health system strengthening as a mechanism for achieving UHC, a term that was easier for non-health sector actors to understand, and was starting to gain support globally as a key mechanism for achieving progress toward the health-related Millennium Development Goals (MDGs). UHC implies full coverage of essential health services, and involves health system strengthening efforts to improve the quality, availability, and affordability of services linked to the MDGs, including essential maternal and child health services.

Search and development

Following the Foundation's new initiative model, THS was developed out of a series of "searches" to identify strategic opportunities and levers to advance the UHC agenda at the global and country levels. Drawing on the findings of the 2000 World Health Report, the search phase focused on exploring possible initiatives in five areas.

1. **Enhancing professional capacity for health system stewardship.** This search focused on identifying required competencies for and capacity gaps around health system planning and management in LMICs, an area aligned with the Foundation's history of building institutional pipelines of trained public health and medical professionals on an international scale.

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[1] Initiatives typically followed an "initiative pipeline" that included several distinct phases: i) a scan phase, in which a wide range of problem areas and opportunities were identified for consideration, using the criteria of dynamism, feasibility, and potential impact; ii) a search phase, in which a smaller set of problem areas were weighed against other potential options and the most promising were selected; iii) a development phase, in which the selected problem and solution is planned, tested, and modified as needed; and iv) an execution phase.

2. **Harnessing the role of the private sector in health.** The private sector accounts for the largest share of health service delivery in most developing countries, but was not being looked to as a possible solution lever by the global health community and policymakers in the mid-2000s. Drawing on the Foundation's successful public-private partnership efforts around vaccine development, this search explored possible approaches for integrating public and private health resources to foster mixed health systems that would be better equipped to achieve equitable access to quality services.

3. **Leveraging information and communications technology (ICT) to improve health systems performance.** This search explored how eHealth – use of ICT technologies in the health field – could be used to improve efficiency and quality in health service delivery in LMICs. Although eHealth technologies were emerging and becoming widely adopted in the Global North, few global convenings or collaborations had focused on their application to LMICs. This search focused primarily on the feasibility of building global eHealth partnerships to facilitate the development and adoption of eHealth solutions for the Global South. It was seen as leveraging the Foundation's heritage of developing and harnessing new technologies to achieve public health goals.

4. **Strengthening surveillance systems to track and respond to new diseases and outbreaks.** This search built on the Foundation's previous, large investments in disease surveillance programs in the Mekong Basin and East Africa. It focused on approaches to strengthening surveillance systems – as part of a broader health system strengthening agenda – rather than tracking specific diseases.

5. **Ensuring access to essential medical technologies and products.** This search area explored how supply chains within national health systems could be strengthened to improve access to new health technologies being offered through vertical donor-funded programs.

To further inform its thinking, in September 2007, The Rockefeller Foundation organized a two-day consultation meeting with key global health leaders, including the Secretary General of the United Nations (UN), and former U.S. President Jimmy Carter, at the Pocantico Center in New York. The objectives of the meeting, entitled "Meeting the Challenge of Health Systems," were to discuss and examine the role that The Rockefeller Foundation could play in these search areas, and to gain buy-in among global influencers for making health system strengthening and UHC central components of the global policy agenda.

Following the Pocantico meeting, the Foundation began to develop initiatives in four of the five search areas: i) enhancing health system stewardship capacity, ii) harnessing the private health sector, iii) leveraging eHealth technology, and iv) strengthening disease surveillance systems. In 2008, the Foundation decided to combine the first three initiatives into one, larger initiative, and to pursue disease surveillance separately, as it was found to be more aligned with a "vertical" disease-focused approach than a "horizontal" health system strengthening approach. In addition, recognizing the need for strategic advocacy to build global momentum around UHC, the Foundation added a "research and agenda-setting" work stream to the THS initiative.

Recognizing the ambitious scope of THS, the Foundation's board initially agreed to provide a budget of $150 million for the execution phase of the initiative. However, following the financial crisis, the board ended up approving an initial budget of $100 million for five years of grantmaking (2008–2012), which was increased to $115 million in 2013, to fund grantmaking through 2015.

Theory of change

Figure 1 shows the THS initiative's theory of change (ToC), which reflects strategy shifts adopted during a 2012 strategy review process spearheaded by a new

THS managing director. THS's ultimate goal, as shown in the highest-level outcome in the ToC diagram, was to improve health status and the distribution of health services among people worldwide. The Foundation believed that UHC was a necessary policy goal to that end, and that working to transform health systems in LMICs was a critical piece of the work needed to achieve UHC at a global level. Under the ToC, the two core outcomes for individuals within a transformed health system were: i) equitable access to quality care, and ii) improved resilience from financial shocks arising from health care needs.

At the beginning of the initiative, THS's intervention areas were organized around four strategic levers for transforming health systems toward UHC: i) fostering health systems research and agenda-setting at the global level, ii) harnessing the private sector as an important component of health systems, iii) enhancing health system capabilities in developing countries, and iv) promoting design and implementation of interoperable eHealth systems. During a 2012 strategy-refresh process, the initiative's strategy was revised and narrowed to align THS's work more directly with achievement of both dimensions of UHC – access to quality health care and financial protection against illness. This narrowing of THS's focus led to the decision

to wind down and eventually end THS's private health sector and eHealth work, which was seen as more distally related to UHC, except in the few cases where THS investments were having a direct impact on UHC reform processes in focus countries.

Figure 1 shows the four outcome areas, or work streams, around which THS investments were organized following the 2012 strategy review.

1. **UHC embraced as a global and country policy goal.** The Foundation's activities in this outcome area focus on adoption of UHC as a health policy goal at the global and country levels.

2. **Improved stewardship and management of mixed (public-private) systems that increase access to quality care and resilience.** Investments in this outcome area focus on improving government capacity to steward the overall health system, including its public and private components, and to use data to develop, plan, and manage implementation of policy reform efforts. This work stream includes efforts aimed at leveraging the private sector to improve health care financing and access (which formerly fell under an independent outcome area and were scaled back starting in 2012).

FIGURE 1. THS Theory of change
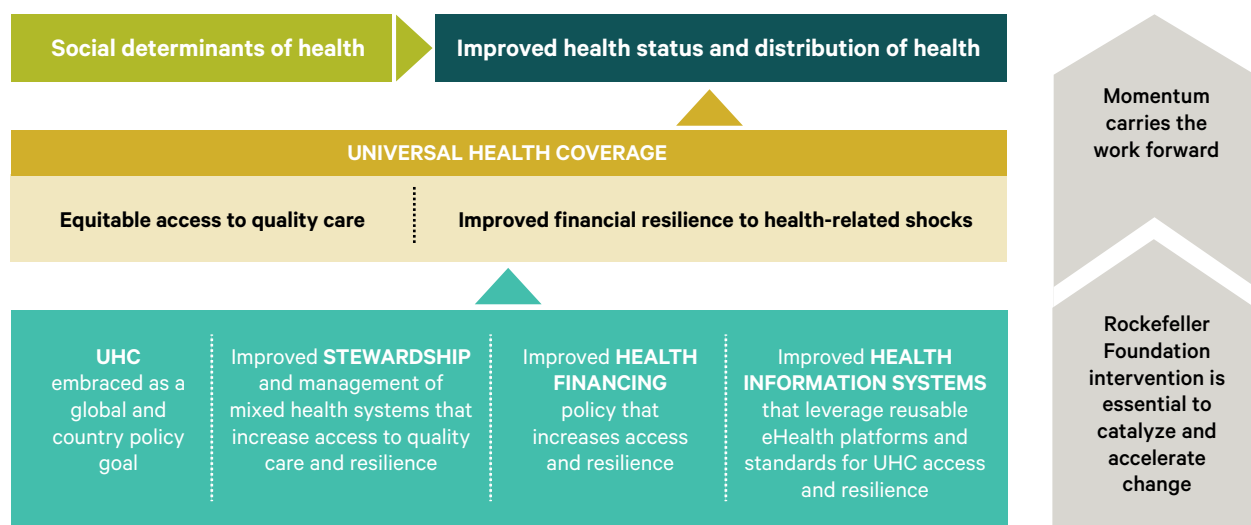
3. **Improved health financing policy that increases access and resilience.**

   This area focuses on strengthening health financing policy, including provider payment systems and mechanisms to reduce direct out-of-pocket payments for health services, including national health insurance and health service prepayment schemes. This has been a focus of THS's work since the initiative went into execution in 2009 (health financing activities fell under other work streams before the 2012 strategy refresh process).

4. **Improved health information systems that leverage reusable e-health platforms and standards for UHC.**

   Activities in this work stream promote the design and implementation of interoperable eHealth systems by supporting the development of eHealth tools and models that can be shared among countries, contributing to national eHealth policy and planning efforts, and strengthening government capacity to implement, use, and maintain eHealth systems.

Strategic approach

To influence change toward the four health system outcomes shown in Figure 1, THS's strategy involved mutually reinforcing activities at the global, regional (Global South), and country levels. A key assumption underlying THS's approach is that momentum, collaboration, and action is needed at all levels to support and advance health reform efforts in LMICs.

Figure 2 summarizes the focus of THS activities at each intervention level, and Figure 3 describes key activities at each level, by outcome area. At the global level, THS focused on bringing UHC to the forefront of the global health and development agenda, as a means of promoting widespread adoption of UHC as a policy goal and gaining support for UHC-oriented health reforms in LMICs. To do so, the Foundation invested in evidence generation and dissemination, meetings

and convenings, and a range of advocacy efforts to elevate awareness, understanding, and use of the UHC concept. To promote adoption of UHC as a measurable policy goal, it also supported the development of a measurement framework and indicators to track progress toward the various dimensions of UHC at the country level.

THS's work at the regional level focused on creating and contributing to collaborative networks that would be sustainable beyond the life of the initiative and propel health system reform efforts at the country level. Over the course of the initiative, THS developed networks to catalyze global support, innovation, and country action around the three technical health system levers on which the initiative focuses: i) health

FIGURE 2. Strategic approach*

**GLOBAL LEVEL
($34.0 million)**
Leverage The Rockefeller Foundation's legacy, influence, and convening power to elevate UHC on the **global agenda**

**REGIONAL LEVEL (GLOBAL SOUTH)
($31.1 million)**
Create **networks** to facilitate cross-learning, innovation and collaboration around health systems levers to achieve UHC

**COUNTRY LEVEL
($25.8 million)**
Advance **country reform** efforts in four countries that could serve as models for change

*Roughly $24 million of THS's $115 million grantmaking budget was allocated to activities that fell outside of its global, regional, and focus country portfolios (see text for more detail).
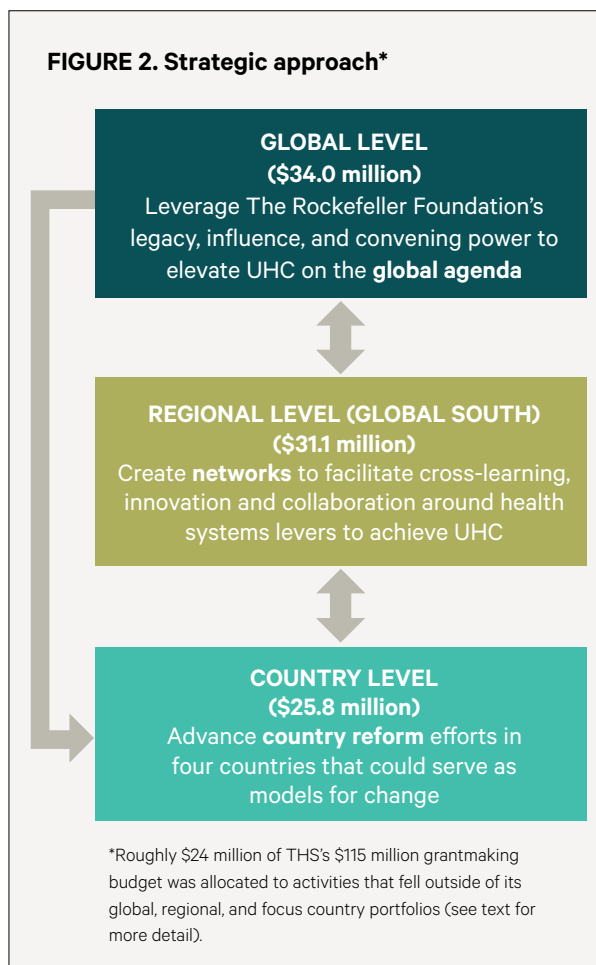
FIGURE 3. Funding and key activities by work stream and level

	UHC POLICY AND ADVOCACY	HEALTH SYSTEM STEWARDSHIP AND MANAGEMENT	HEALTH FINANCING	EHEALTH
Global activities	• Dissemination of information on the UHC concept • Building awareness of health systems transformations toward UHC in LMICs • UHC agenda-setting meetings and exercises around key global meetings • Development and use of UHC performance metrics • Advocacy for inclusion of UHC in regional and global resolutions			
Regional/ Network activities	• Momentum building around UHC through networks and partnerships (see right)	• Development of regional community-of-practice networks to facilitate joint learning among policymakers, practitioners, and donors on different aspects of health system strengthening (including strengthening the private sector, expanding health coverage, primary health care, health financing, and eHealth)	• Development of tools to strengthen health financing mechanisms, including prepayment and health insurance schemes, supporting provider payment reforms, costing expansions of health coverage	• Research and evidence generation on health financing • Technical support to facilitate provider payment reforms
Country-level activities	• Trainings, dialogues, and study tours to increase awareness and understanding of UHC concept • Development of strategic plans for achieving UHC	• Trainings at the ministerial, academic, and professional levels on data-driven health system management and planning • Creation of centers of excellence and academic programs to build a pipeline of health policy experts and practitioners • Private sector-focused evidence generation and policy development	• Research and evidence generation on health financing • Technical support to facilitate provider payment reforms	• Technical support to strengthen eHealth institutions and develop eHealth policy frameworks • Development of enterprise architectures and customized EMR systems • eHealth capacity building through creation of academic programs

system stewardship, ii) the private sector in health, and iii) eHealth. These networks brought together a constellation of actors, including donors, technical experts, policymakers, and practitioners, to share learning, capture knowledge, and develop solutions and practical tools to advance country reform efforts. Key networks created and supported under the THS initiative include:

- Center for Health Market Innovations (CHMI), which catalogs and shares information on innovative private sector approaches to improving health outcomes and fosters knowledge sharing among service providers
- Harnessing Non-State Actors for Better Health for the Poor (HANSHEP) network, a collaborative of donors who co-finance promising initiatives focused on the private health sector
- OpenMRS, a group of organizations developing an open source platform for electronic medical record (EMR) systems
- mHealth Alliance, which sought to strengthen the mHealth field through convenings, evidence generation, and technical assistance to policymakers and practitioners
- Joint Learning Network (JLN) for Universal Health Coverage, which connects country practitioners (mainly mid-level government technocrats) working toward UHC to facilitate knowledge sharing and tool development to advance UHC-oriented reforms.

These networks endured beyond the scope of their THS grants and most continue to be active today in bringing health sector stakeholders together, fostering idea- and experience sharing, and creating practical tools and resources.

At the country level, THS investments focused on advancing implementation of UHC-oriented reforms in four countries: Bangladesh, Ghana, Rwanda, and Vietnam. Based on the health systems context in these countries, the Foundation worked more or less intensively in each THS outcome area (policy and

advocacy, health system stewardship, health financing, and eHealth). Its investments focused on addressing key binding constraints within the national health system that are most important to overcome in order to advance toward UHC. Across all four focus countries, THS helped support health ministries and other actors in policy development, implementation, and regulation, and also invested in long-term capacity building efforts – establishing academic programs and centers of excellence – to strengthen the pipeline of health system experts and managers. However, within each country, THS focused on a specific "change lever" to catalyze health systems improvement. These strategic focus areas included:

- leveraging the private sector to support improvements in access to services and expand enrollment under Ghana's national health insurance program
- strengthening the stewardship, management, and implementation of eHealth systems and tools in Rwanda to increase efficiency and quality of health services and strengthen the national health pre-payment scheme
- facilitating evidence-based provider payment reforms under Vietnam's national health insurance program
- supporting advocacy for UHC and strengthening stewardship of mixed health systems in Bangladesh.

As shown in Figure 2, THS investments in its three primary intervention levels ranged from roughly $26 million at the country level to $34 million at the global level, and accounted for approximately 80 percent of THS's total grant expenditures. The remaining 20 percent, or $23 million, was used for a number of cross-level or discrete activities that fell outside of its core global, regional, and focus country portfolios, including select exploratory grantmaking and research efforts, monitoring and evaluation of THS, targeted activities in a small number of non-focus countries, and some conference activities.

Health Surveillance Assistant Esnat (far left) sits alongside volunteers from the local village health team.

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3

Evaluation approach

Evaluation objectives and scope

The summative evaluation of the THS initiative was a multi-component, multi-year evaluation effort conducted by Mathematica Policy Research from April 2013 to September 2017. The evaluation was conducted in consultation with the THS team and the Evaluation Office of The Rockefeller Foundation. The purpose of the evaluation was to assess i) the effectiveness of the three core strategies employed under THS to advance progress toward UHC in LMICs (global advocacy, regional networks, and country-level investments in four focus countries), ii) the overall effectiveness and influence of the initiative, and iii) the Foundation's legacy in the UHC arena. A key component of the evaluation was to document lessons learned from achievements and challenges under THS to inform the development of future initiatives at the Foundation.

The summative evaluation effort included several distinct evaluation activities that allowed for in-depth examination of THS's work at the global, regional, and country levels, as well as cross-cutting analysis of the initiative's overall effectiveness and influence. These activities included:

- retrospective case studies of THS's country-level investments in each of its four focus countries – Bangladesh, Ghana, Rwanda and Vietnam – conducted in 2014 (Sridharan *et al.*, 2014, Smith *et al.*, 2014a, Smith *et al.*, 2014b, and Sridharan *et al.*, 2015)
- retrospective case study of the JLN, conducted in 2016 (Sridharan and Smith, 2016)
- retrospective case study of THS's global UHC advocacy efforts, conducted in 2016–2017 (Sattar and Smith, 2017)
- collection and analysis of grantee monitoring data to inform and track THS grant investments during the initiative's consolidation grantmaking phase (2013–2015), which resulted in five semiannual monitoring reports
- collection and analysis of additional data to support cross-cutting and summative analyses of the initiative
- identification of lessons learned and promising practices under THS.

Together, these evaluation components cover, to varying extents, THS activities from 2008 to 2017, which span over 300 grants and include a range of non-grant activities. However, the evaluation focuses on the THS's global advocacy, regional networking, and focus country efforts, which account for roughly 80 percent of the THS initiative's grant investments.

The findings presented in this final evaluation report draw on and synthesize findings from all components of the summative evaluation.

Evaluation approach

We used a mixed methods approach to conduct the summative evaluation, including each of its individual components. Our approach was guided by the evaluation matrix for the overall summative evaluation (see Annex 1). As shown in the evaluation matrix, our mixed-methods approach to answering the research questions for the evaluation involved the use of a combination of data sources and methods to improve the rigor, depth, and generalizability of the findings. For some questions, we relied primarily on qualitative information obtained through document review, key informant interviews, and country site visits, whereas for others, we used quantitative data obtained from the Foundation's grants management database, an online survey, and/or grantee monitoring data. In most cases, the two types of data complemented each other such that the evaluation results benefited from the specificity and broad grantee/stakeholder base associated with quantitative methods, and the explanatory richness and contextual value of qualitative work. We used a variety of techniques to analyze the data collected, including tabulations of survey data, qualitative data coding and triangulation, and contribution analysis.

Data sources

The evaluation team collected data from three main sources to inform the case study.

Review of secondary data. The evaluation team reviewed and abstracted data from a range of secondary data sources, including The Rockefeller Foundation's documents and reports, grantee proposals and reports, financial data from the Foundation's grants management database, published and gray literature, country policy and program documents, and relevant websites, including the JLN website.

Key informant interviews. We conducted in-person and phone interviews with a total of 180 key informants, including current and former Foundation staff, THS grantees, representatives of donor or partner agencies, global health experts, and country-level policymakers and practitioners. In-person interviews were conducted at the Foundation's headquarters office in New York City, during country site visits to THS's four focus countries in 2014, and during the 2016 JLN global meeting in Kuala Lumpur, Malaysia.

Online survey. A web-based survey was developed using the SurveyMonkey platform to gather perspectives from a wide range of stakeholders on the UHC movement and the Foundation's role in it. These included THS grantees, external advisors to the Foundation, and other non-grantee informants with knowledge of the UHC landscape at the global and country levels. Of the 159 individuals who received the survey invitation, 58 responded for an overall response rate of 36 percent. Roughly one-half of all respondents had never received funding from the Foundation, and approximately one-third were current or former grantees. Other survey respondents included individuals from partner organizations (10 percent), external advisors to the Foundation (7 percent), and others (8 percent).

Data analysis

We used the following methods to analyze the information generated through the data sources described above to answer the research questions for the summative evaluation and its individual components.

Thematic framing. To identify cross-cutting trends and themes, we reviewed and assessed data from different sources together under key topics and subtopics aligned with the research questions and logic models developed for each study component. To support this review, we coded primary qualitative data using a coding scheme that mapped to the research questions and logic model. Once the data was coded, we examined it for key themes. As themes emerged,

the coding allowed us to organize data in different ways and compile both affirming and contradictory evidence.

Triangulation. Triangulation involves testing for consistency in results or findings across several data sources and methods of inquiry (Patton, 2002). It facilitates confirmation of themes or findings and the identification of important discrepancies across qualitative data, program monitoring data, and secondary data sources. It also reduces the potential for inaccuracies that arise from a largely retrospective review. By triangulating among the evaluation's data sources, we tested for the strength of and inconsistencies in findings identified through thematic framing. The availability of coded data allowed us to triangulate efficiently across all data sources and types.

Contribution analysis. Building on the triangulation process, contribution analysis aims to determine the strength of the evidence on the THS initiative's implementation and effects, focusing on the extent to which the project contributed to targeted outcomes shown in the logic model. The first step in contribution analysis involves compiling evidence on activities implemented, outputs and outcomes, and assumptions underlying the results chain shown in the logic model. The next step focuses on critically examining the strength of the evidence supporting the achievement of outputs and outcomes and linkages, giving considerable weight to stakeholder perspectives on the program's contribution or influence, as well as evidence of the influence of other factors on outcomes (Mayne, 2008). Contribution analysis complements triangulation by looking at activities and results in a broader context to identify where attribution is appropriate and robust, as well as any major shortcomings in initiative design, implementation, and achieved outcomes.

Identification of lessons learned and promising practices. Drawing on the findings from the above analyses, we highlighted lessons learned and best practices related to initiative design, grantmaking strategy and practices, and increasing overall effectiveness and influence.

4

Global UHC advocacy

Global advocacy was central to the THS initiative's efforts to catalyze and shape the UHC movement and advance progress toward UHC at the global and country level. A key objective of THS's global advocacy strategy was to bring UHC to the forefront of the global health agenda, to promote widespread adoption of UHC as a mechanism for improving health outcomes and as a policy goal. To do so, The Rockefeller Foundation sought to leverage its legacy and convening power in the global health arena to elevate understanding, use, and operationalization of the UHC term among key global and country actors.

Since THS was launched in 2008, UHC has risen to prominence as a measureable policy goal, culminating in the 2016 adoption of UHC as a health target in the Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development. As this chapter documents, The Rockefeller Foundation played a catalytic and well-recognized role in UHC's path to prominence on the global health agenda, supporting and shaping a number of key milestones in the UHC movement. It also invested in building coalitions and partnerships, as well as a measurement framework, to support and track country progress toward the SDGs' UHC target.

Over the course of its nine years of grantmaking, THS invested more than $32 million across 109 grants in

global advocacy activities, accounting for roughly one-third of all grant expenditures under THS. In addition to these grant investments, Foundation leadership and staff engaged in a range of non-grant activities to promote adoption of UHC as a policy framework and goal.

In this chapter, we begin by describing the key components and evolution of THS's advocacy strategy. We then provide a summary of key achievements and learnings emerging from its advocacy efforts.

At the time THS was launched, the UHC term was used only sparingly by a few international organizations, in part because of concern that the term would be interpreted as endorsing single-payer health insurance systems, but also because the term seemed vague to many health actors.

FIGURE 4. Conceptual framework for THS's global advocacy efforts

STRATEGY/ACTIVITIES	INTERMEDIATE OUTCOMES	LONG-TERM AND ULTIMATE OUTCOMES
A Generation and dissemination of information/evidence on UHC and country progress toward UHC	Increased coverage of UHC and progress toward UHC in the literature and mass media	Increased momentum toward advancement of UHC at the global level
B Promotion of UHC dialogue to increase awareness, understanding, and use of the UHC concept	UHC increasingly featured in global and regional policy discussions and conferences	Countries implement UHC-oriented reforms
C Identification of key global and regional actors to become champions for UHC	Endorsement of UHC as a policy goal by high-level international bodies and heads of state	UHC adopted as a Sustainable Development Goal (SDG)
D Mobilization of organizations and individuals to advocate for UHC at the country level	Adoption of UHC as an actionable policy framework and goal by global, regional, and country actors	
	Civil society organizations allocate resources to dedicated UHC advocacy	

KEY ACTORS IN THE UHC LANDSCAPE

Multinational and donor agencies • Thought leaders and influencers • Governments
International NGOs • Research and academic institutions • Civil society organizations

PHASE 1 2009–11
Definition and dissemination of the UHC concept
Initial focus on adoption among key global influencers. UN system identified as key vehicle to expand adoption at global and country levels.

PHASE 2 2012–14
Post-2015 development agenda
Identifying/supporting UHC champions within UN system who could influence post-2015 process and passage of UN resolution on UHC.

PHASE 3 2014–16
Strategic communications & coalition building
Focus on post-2015 agenda. Strategic communications to maintain constant "drumbeat" of focus on UHC. Convenings around key global meetings. Coalitions to support country progress toward UHC SDG target.

More information on THS's global advocacy work, achievements, and learnings can be found in Sattar and Smith (2017).

Overview of global advocacy strategy

Figure 4 presents the conceptual framework underlying THS's global advocacy strategy. As shown in the figure, the specific long-term objectives of THS's advocacy efforts were to i) build increased and sustainable momentum toward advancement of UHC at the global level and ii) ensure inclusion of UHC in the post-2015 development agenda (later known as the SDGs). Achievement of these objectives was considered critical for generating widespread commitment to and progress toward UHC at the country level. However, at the time THS was launched, the UHC term was used only sparingly by international organizations, in part because of concern that the term would be interpreted as endorsing single-payer health insurance systems, but also because the term seemed vague to many health actors. Therefore, to achieve these longer-term advocacy objectives, THS initially focused on increasing understanding and use of the UHC term among key global actors through strategic generation and dissemination of information and evidence on UHC (Box A) and promotion of dialogue around UHC (Box B). As the UHC concept became more widely understood and adopted, the focus of THS's advocacy efforts shifted

to gaining endorsements of UHC from key political and health institutions, and ensuring UHC's inclusion in the global development agenda (Box C). THS also invested in coalitions and local advocacy efforts to promote commitment to and progress toward UHC at the country level (Box D).

Below we decribe the evolution of THS's advocacy efforts, which reflects how the strategy adapted to changes in the UHC landscape. Additional detail on specific advocacy activities and outputs can be found in Annex 2.

- **Phase 1 (2009–2011): Definition and dissemination of the UHC concept.** For the first few years of the initiative, THS focused largely on generating evidence and disseminating information on UHC to increase awareness and understanding of the concept and its adoption by global influencers. To foster adoption, THS developed an economic argument for UHC, which it presented to global leaders, including The Elders, an independent group of highly influential global leaders working together to promote human rights. During this period, THS also identified the UN system as a key vehicle to advance adoption of UHC as a policy goal at the global and country levels. THS initially focused its UN advocacy efforts on achieving a UN resolution on UHC. To gain enough support to pass a UHC resolution, THS sought to shape and align UN delegates' messages on UHC. At this time, the Foundation also launched the JLN, which supported THS's global advocacy efforts by engaging global and country actors in dialogue around UHC policy reforms.

- **Phase 2 (2012–2014): Post-2015 development agenda.** In 2012, as the MDGs were nearing their expiration, the Foundation began to focus its advocacy efforts on ensuring that UHC would be included in the post-2015 development agenda. This meant ensuring that UHC was part of global conversations being facilitated by the UN on the post-2015 agenda, and featured in the inputs the

UN provided to its member states to support their participation in the post-2015 process. During this period, THS sought to identify and support UHC champions who could influence the post-2015 process, and support passage of a UN resolution on inclusion of UHC in the SDGs (which were agreed to in 2015 and adopted on January 1, 2016). Initially, it focused on gaining endorsements and support from major industrial countries, such as those in the G8, as well as influential global institutions, such as the World Bank.

"The Rockefeller Foundation hosted many different dialogues, invited member states to come in and participate, and laid out the rationale and evidence for why UHC is critical and should be an SDG target. They were useful for bringing in other stakeholders, civil society, and other voices."

– Interviewee

Once the UN resolution on UHC was passed, THS focused its advocacy efforts on UN member countries negotiating the SDGs' text on health, which included gaining the support of NGOs and thought leaders who could influence member states. To support its advocacy work during this phase, THS enlisted a communications firm to develop a multipronged communications strategy aimed at elevating UHC's prominence on the global stage. THS also invested in the development of a

framework for measuring progress towards UHC at the country level, an effort designed to make UHC a more concrete, actionable policy goal, and to increase its legitimacy as a policy goal within the SDG framework.

- **Phase 3 (2014–2016): Strategic communications and coalition building.** During Phase 3, THS intensified its strategic communications and coalition-building efforts to support its advocacy goals. It expanded its support of country UHC champions within the UN system through engagements with and technical support to mission offices, with a focus on countries that were members of influential coalitions such as the G8 and G20. It also secured formal endorsements of UHC by groups of influencers, including prominent economists and The Elders. To maintain a constant focus on UHC during SDG deliberations, THS facilitated the placement of op-eds and articles on UHC in prominent news outlets, supported the development and dissemination of policy briefs and research on UHC and country progress toward UHC, and organized or co-sponsored UHC-themed convenings around related global meetings.

During this phase, THS increasingly focused on civil society as an agenda-setting vehicle at the global and country levels. In 2014, THS supported a civil society meeting on UHC which brought together actors from over 23 countries and resulted in a civil society declaration on UHC. It also supported the formation of a coalition of 1,000 organizations from across the globe to campaign for and support UHC Day, an annual day (inaugurated in December 2014) commemorating the UN resolution on UHC. As it became clear in early 2015 that UHC would be included in the SDGs, THS looked toward the post-2015 period, devoting more resources to securing UHC commitments from collaboratives that could support country progress toward the SDG UHC target, such as the International Health Partnership (IHP+), a coalition of developing country governments and civil society organizations.

Notable achievements

The Foundation succeeded in championing a concept that was controversial at the time the THS initiative was launched, but responded to an unmet need for a unifying health sector objective. Although policymakers had begun to recognize the importance of well-functioning health systems in the early 2000s, "health system strengthening" was not gaining sufficient traction to influence global health policy. By providing a language and basis for dialogue on health system strengthening that had broad appeal, THS paved the way for widespread adoption of the UHC term. In its efforts to disseminate and promote the UHC concept, THS helped to create a policy space and agenda that brought together a broad range of partners working to improve health systems in LMICs. It also connected diverse members of the global health community under a common umbrella and goal.

Through its highly adaptive multi-component and multi-level advocacy strategy, THS was able to influence the post-2015 agenda process, culminating in the inclusion of UHC in the SDGs. By maintaining an adaptive and flexible approach to grantmaking, and using multiple vehicles for policy influence and agenda-setting at the global, regional, and country levels, The Rockefeller Foundation was able to strengthen and shape the UHC movement, and ultimately influence the SDG process. Through strategic reflection and pivots at key junctures in the UHC movement, THS effectively responded to and leveraged changes in the UHC landscape and consolidated gains under the strategy. At the global and country levels, THS both created and harnessed momentum in support of UHC among related actors and institutions, and invested in strategic communications and coalition building to strengthen and sustain the UHC movement and commitment to UHC. In addition, the Foundation worked to develop strong synergies between THS's advocacy efforts and other elements of the initiative's broader strategy to increase adoption of UHC as a policy framework, most notably, the JLN.

FIGURE 5. Influence of THS on the UHC movement

Select THS influence activities		Key milestones in the UHC movement

2015

THS organizes release of **Economists' Declaration on UHC** led by former Treasury Secretary Larry Summers in lead up to UNGA meeting on final SDGs.

• **UN adopts 2015 Sustainable Development Agenda**, including Goal 3 target: "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

2014

THS inaugurates **first annual UHC Day**, which is supported by growing coalition of over 700 NGOs.

• **UHC is included in the post-2015 development targets** proposed by the Open Working Group

THS supports strategic UHC-themed convenings around key global meetings and conferences, including at the sidelines of the **2014 UNGA, which launched key SDG deliberations**

• PLOS publishes special collection, *Monitoring Universal Health Coverage*, with 13 country case studies conducted by WHO and World Bank

2013

• **WHO/World Bank Ministerial Meeting on UHC** in Geneva with ministers of health and finance from 27 countries to discuss progress on UHC

WHO and World Bank receive support from THS to create a **framework for measuring and monitoring UHC** and release the first report on tracking UHC.

• World Bank President announces targets for UHC

2012

THS influences leaders of key global institutions to be vocal supporters of UHC. In high-profile speeches, **WHO Director-General Margaret Chan and World Bank President Jim Kim publicly endorsed UHC.**

• **UNGA Resolution A/RES/67/81 recommends inclusion of UHC in the post-2015 development agenda**

• Civil Society Call to Action on UHC released

• Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector

• Mexico City Political Declaration on UHC

THS staff and grantees guide and support the work of country champions for UHC within the UN system to assist passage of **UNGA Resolution A/RES/67/81.**

• Bangkok Statement on UHC

• The *Lancet* publishes special issue on UHC

2011

THS supports **First Global Symposium on Health Systems Research** in Montreaux, Switzerland, the only event of its kind at the time.

• **World Health Assembly approves resolution 64.9** on sustainable health financing structures and universal coverage

UHC Forward website launched to house evidence generated by THS grantees and staff and other actors in UHC landscape.

• G8 and G20 countries endorse UHC at summits in Deauville and Cannes, France

2010

• **Affordable Care Act signed into legislation** in the United States

THS supports the **World Health Report 2010,** widely recognized as the single most influential milestone in the UHC movement to date.

• World Health Report 2010 on *Health systems financing: The path to universal coverage* published

2009

THS staff and grantees submit article to *The Lancet*, "All for Universal Health Coverage", which **provides economic case for UHC.**

• ***The Lancet* publishes "All for UHC"**

2008

• **G8 commitment to strengthening health systems** in Toyako, Japan

THS played a defining role in key milestones and events that catalyzed and advanced the UHC movement. Several well-recognized milestones in the history of the UHC movement reflect the influence of THS's advocacy efforts, as illustrated in Figure 5. These include the following.

- **World Health Report 2010.** The THS-supported *World Health Report 2010, Health Systems Financing: The Path to Universal Health Coverage,* is recognized as the single most influential milestone in the UHC movement to date. Shortly after the World Health Organization (WHO) released the report, political leaders in Japan and Mexico, among other countries, and leaders of global institutions such as the World Bank, began using the term "UHC" and its WHO definition, which propelled acceptance and adoption of the term as a measureable policy goal.

- **UN resolution on UHC.** THS staff and grantees guided and supported the work of country champions for UHC within the UN system to support passage of UNGA Resolution A/RES/67/81 (2012), which recommended inclusion of UHC in the post-2015 development agenda, another prominent goal in the UHC movement. THS built relationships with well-placed country leaders willing to champion UHC within the UN arena, and provided strategic technical assistance to UN country missions, which key informants regarded as critical for facilitating the UN resolution process.

- **Public UHC endorsements.** Through the Foundation's grantmaking and direct outreach by staff, THS was able to enlist leaders of key global institutions and other public figures as vocal supporters of UHC, which helped legitimize and promote action around UHC as a policy goal. In several high-profile speeches, WHO Director-General Margaret Chan and World Bank President Jim Kim publicly endorsed UHC and the need for health system reform to advance country progress toward UHC. To increase the legitimacy of UHC as a policy goal, THS staff and grantees also generated endorsements for UHC from prominent figures

outside of the health arena, including the highly visible Economists' Declaration on UHC which was led by well-known economist Larry Summers.

- **UHC-themed convenings.** THS organized and supported several strategic UHC-themed convenings around important global meetings and conferences which, in turn, helped to frame, inform, and increase UHC dialogue at pivotal points in the post-2015 agenda process. For example, at the sidelines of the 2014 UN General Assembly (UNGA) meeting, which launched deliberations over the final language of the SDGs, THS organized a high-level panel discussion on the importance of UHC and how to achieve it, which served to influence and inform subsequent discussions around 2030 development goals.

Support for global platforms promoting dialogue around UHC and health system strengthening helped to bring UHC to the forefront of policy discussions. THS has created or supported multiple platforms that have brought together large groups of stakeholders to discuss health system strengthening issues and approaches. These have included: i) the People's Health Assembly, a global meeting held every five years by the People's Health Movement, a large global network of health activists, civil society organizations, and academic institutions, and ii) the Global Symposium on Health Systems Research, an annual meeting of researchers, experts, policymakers, donors, and practitioners.

Strategic use of media around UHC events helped amplify the UHC message in the post-2015 agenda process. THS grantees organized a number of successful social media campaigns around UHC-related global events and announcements leading up to the 2015 UN Sustainable Development Summit, including: i) the release of the June 2015 World Bank and WHO report, *Tracking Universal Health Coverage*, the first report to make a systematic assessment of countries' progress toward UHC using specific health coverage and financial protection indicators, ii) the release of the THS-initiated Economists' Declaration on UHC, which

"It is the combination of different [advocacy] strategies that has been most effective … and their success is in that variety even if all strategies were not equally impactful."

- Interviewee

elevated the profile of UHC and has been mentioned in speeches by several global leaders, including the WHO Director-General and World Bank President, and iii) the THS-supported UHC Day campaign, which is in its third year and has become the largest coalition working in the health sector, encompassing 739 organizations across 117 countries.

New partnerships to advance UHC have emerged out of THS-supported efforts led by countries and civil society organizations. One of the highest profile partnerships to emerge has been IHP for UHC 2030, announced in 2016 by WHO Director-General Margaret Chan. Formerly called IHP+, this partnership of governments, development agencies, and civil society organizations is committed to facilitating and supporting progress toward the SDG UHC target. THS helped guide the evolution of the IHP+ partnership into IHP for UHC 2030, in order to strengthen accountability for UHC at the country level.

Key learnings

Sustained investment in global advocacy over nearly a decade was critical to achieving THS's longer-term goals. THS global advocacy efforts spanned nine years, during which time THS achieved many of its targeted outputs and outcomes. Many key informants noted that movement-building and agenda-setting around a new policy concept are long-term endeavors, and that The Rockefeller Foundation's sustained support for the UHC movement was likely a factor in the movement's successes.

Adoption of a multi-level, multi-pronged advocacy strategy was key to THS's success in elevating UHC's status on the global agenda. The THS global advocacy strategy targeted key influencers while also striving to gain broad-based support from a range of stakeholders. It used multiple advocacy vehicles and tools, including research and dissemination, conferences and convenings, identification and support of UHC champions, and grassroots advocacy. Strategic use of these complementary advocacy approaches was critical in advancing the UHC movement – particularly in influencing the UN post-2015 deliberations – with each approach supporting the other. For example, THS investments in evidence generation and publications provided inputs for THS-supported convenings and for efforts to promote UHC dialogue and support UHC champions.

Certain components of the THS advocacy strategy were shown to be particularly effective. These included: i) securing and publicizing endorsements from groups of influential stakeholders, such as the Economists' Declaration on UHC, the Parliamentary Bellagio Statement, and the Civil Society Call to Action on UHC, and ii) undertaking non-grant activities, especially engagement of Foundation staff in one-on-one conversations with global health leaders and experts, which helped to both shape the THS initiative and further its goals.

Although an important milestone, the UNGA resolution may have missed an opportunity to generate stronger support for inclusion of UHC as a more prominent goal in the SDGs. The 2012

UNGA resolution on UHC, which endorsed UHC as a key policy goal and recommended its inclusion in the SDGs, has been hailed as a key milestone in the UHC movement. UHC champions involved in the UNGA resolution process continued to advocate for UHC after the resolution was passed, and engaged in tough negotiations around inclusion of UHC in the SDGs. Although these negotiations eventually led to the inclusion of UHC as a target under a broader health goal, some noted that the resolution could have done more to ease the negotiation process and pave the way for UHC to be included as an overall health goal. In particular, the resolution did not include language for setting up a task force or other type of body that could help institutionalize UHC as a key policy goal within the UN.

The limited engagement of champions from developing countries may have hindered promotion of UHC in the SDG negotiation process. THS engaged several countries to champion its efforts to secure a UNGA resolution on UHC and to include UHC in the SDGs. However, these were mainly wealthy and highly industrialized countries, with the exception of Thailand. Greater engagement of developing countries as UHC champions could have strengthened efforts to influence SDG deliberations. For example, the UN Group of 77, the largest intergovernmental organization of developing countries in the UN, had an influential role in the negotiation process leading to the SDGs, but was not a champion for UHC.

THS's global advocacy efforts offer several key learnings for future Foundation initiatives seeking to influence global and policy agendas.

A policy concept and, in turn, a policy goal need evidence, academic validation, and public endorsement by political and field leaders to gain wide acceptance. The publication of multiple articles on UHC in *The Lancet* and public endorsements of UHC by influential political and health actors provided legitimacy to the UHC concept, which was critical for increasing acceptance and adoption of UHC as a policy

goal. THS also took steps to ground UHC dialogue in research and evidence, which helped to identify and document evidence-based policy alternatives and country success stories that could be used as inputs for advocacy activities.

A global advocacy strategy should account for and address multiple channels of policy influence. In addition to efforts to gain buy-in and support from leaders of governmental and intergovernmental agencies, THS devoted significant resources to strengthening the capacity of organizations to advocate for the UHC movement and to generate policy analysis to support it. THS used the political connections of Foundation staff, a constant drumbeat of research and policy analysis on UHC, and support for influential organizations at the country and global levels to influence the SDG process. The combination of various approaches, rather than one singular effective approach, was the key to generating a critical mass of support for UHC.

Advocacy goals are more likely to be achieved when a strategy is flexible and responsive to changes in the global landscape and policy environment. The THS global advocacy strategy was responsive to changes in the UHC landscape, as well as achievements and learnings emerging from THS investments along the way. The Foundation's approach to grantmaking offered the flexibility needed to pivot THS's advocacy strategy, as well as to adjust grantmaking, including the number and size of grants awarded, to support achievement of targeted outcomes.

A policy movement requires institutionalization of its mission and vision in order to achieve sustainability. The UHC movement has been driven by many organizations and individuals working behind the scenes – without one unifying voice or leader. However, the Foundation is recognized by many as embodying the movement and for stewarding its progress when needed. To ensure that the end of the THS initiative does not result in stalled momentum, the Foundation influenced the evolution of the IHP for UHC 2030 coalition, as a

means of institutionalizing the global UHC movement and ensuring continued progress toward UHC at the country level. The JLN, a learning network to support countries' UHC-oriented reform efforts, was created and supported under THS and will likely also play a key role in sustaining momentum and advancing progress toward UHC in JLN member countries.

Learnings from THS's global advocacy efforts also offer insights into how the design of an initiative can affect achievement of policy influence.

Choose a leader who is well-known and respected in the field to take the helm. In order to influence discourse and agenda-setting at the highest levels, an initiative needs to have a leader with the experience, reputation, and connections necessary to: i) determine the Foundation's strategic positioning, ii) obtain the support of key influencers in the field, and iii) respond effectively to changes in the policy landscape.

Invest in exploratory grants to identify effective partners and build a broad base of support. Spreading grants across a large number of organizations can help mobilize a broad-based and diverse set of stakeholders around a policy issue, and facilitate identification of organizations that can effectively support achievement of the initiative's global influence goals. These organizations should represent different levels of influence and sectors in society, and include donors and global policymakers as well as country-level government agencies and civil society.

Invest in knowledge management and dissemination platforms to promote broader and deeper understanding of policy issues. Foundation initiatives, such as THS, often generate large volumes of research, evidence, and information on an issue area. These resources can and should be leveraged to support attainment of the initiative's goals. By creating a widely accessible clearinghouse or repository of information around a particular issue area, the initiative can reach a wider audience and provide important background and technical information to support policymakers and advocates. Such an effort may also help strengthen the Foundation's legacy in that issue area.

A Village Health Team, comprised of village elders and volunteer residents, works to ensure the needs of the village are met by locally-administered community health programs.

5

Regional (Global South) networks

A key cross-cutting strategy under the THS initiative was to establish networks that would catalyze learning, innovation, and collaboration around strategies for overcoming critical constraints to achieving UHC. As The Rockefeller Foundation was working to secure widespread global commitments to UHC, it recognized early on that policymakers and practitioners needed support with achieving this goal. To address this gap, the Foundation worked with grantee partners to design and launch networks of diverse health sector actors to share knowledge and ideas, and develop tools for policy and program development. The focus areas of these networks were aligned with priority work streams within THS, including the private sector, eHealth, and health system stewardship and management. The Foundation helped launch a knowledge-sharing platform around the private sector (CHMI), a collaborative of donors who co-finance promising private sector initiatives (HANSHEP), a group to strengthen EMR systems (OpenMRS), a network to strengthen the mHealth field (mHealth Alliance), and a flagship network cutting across all work streams that facilitates collaboration among government practitioners working on UHC reforms (JLN). It has also facilitated a variety of other informal networking activities.

The Foundation was a founding funder of these partnerships, providing catalytic funding to design and launch the networks and strategic guidance to formulate and refine network models. It also provided ongoing technical guidance on network learning activities and support with convening influential stakeholders to guide the network. A key goal for the Foundation was to ensure the sustainability of the networks – so that its short-term investments in these learning and innovation efforts could have long-term influence on health system reforms in LMICs. It built partnerships with other donors early on, sometimes even jointly launching the networks with them, and also provided significant funding for sustainability planning and conducted ongoing outreach to other funders.

Mathematica's assessment indicates that, overall, these networks were a successful vehicle for creating a strong enabling environment for health system strengthening and UHC achievement. They increased attention to and momentum around private sector and eHealth approaches in LMICs – two key levers for improving health system performance. They facilitated knowledge exchange and development of practical tools and resources – which, in turn, helped policymakers and practitioners improve programs, strengthen systems, and reform policies to advance UHC. Some felt these advancements were cut short to some extent in the eHealth space, which the Foundation stopped investing in around 2012. Progress also was hindered in some cases by the absence of a clear mission – some

networks adopted an overly broad scope of work, which led to uneven progress and lost momentum.

Most networks launched under THS have been able to sustain their work past their THS grants. For the most part, they have been successful in building a diversified pool of funding to support sustainability, though sourcing funds remains an ongoing challenge. Other funders that support THS networks include the Bill & Melinda Gates Foundation, the Vodafone Foundation, the UK Department for International Development (DFID), the U.S. Agency for International Development (USAID), PEPFAR, the Norwegian Agency for Development Cooperation (Norad), German Society for International Cooperation (GIZ), and private sector partners, such as Hewlett Packard and Johnson & Johnson. One network supported by THS, the mHealth Alliance, has been wound down – given lack of mission clarity and an enduring misalignment between the expectations of its members and what it received funding to do.

In this chapter, we provide a high-level overview of the networks launched under THS, and summarize key cross-cutting achievements, challenges, and learnings. Details on how each network was formed, and its current structure and activities, are provided in Annex 3 (private sector networks), Annex 4 (eHealth networks), and Annex 5 (JLN). More detail on the JLN is also available in Mathematica's in-depth case study report on the network (Sridharan and Smith, 2016).

Overview of networks supported by THS

THS's networks sought to bring focus to under-explored or neglected health system approaches to accelerate progress toward UHC. For instance, an early priority for THS was to advance thinking on how to strengthen health systems by leveraging the private sector, a controversial issue that the Foundation felt could benefit from a practical, evidence-based approach. To further knowledge and learning in this area, THS helped launch CHMI, which has developed a web platform to catalog and disseminate information on innovative private health sector programs, and facilitated knowledge sharing among service providers and greater dialogue between public and private sector actors. At around the same time, the Foundation joined forces with other global health funders to form a donor collaborative that focused on improving the performance of the private or non-state sector in providing health care to the poor. Donors in the collaborative, known as HANSHEP, share knowledge and learning around the private health sector and co-finance promising initiatives (Table 1).

THS also helped form several networks focused on eHealth, a growing field in the Global North that the Foundation felt LMICs could leverage for health system strengthening. It funded OpenMRS, a group of organizations developing an open source platform for EMR systems, and helped form the mHealth Alliance, which sought to strengthen the mHealth field through convenings, evidence generation, and technical assistance to policymakers and practitioners (Table 1). In the eHealth space, the Foundation sought to leverage public-private partnerships to support the development and integration of innovations and tools for health systems in LMICs. The mHealth Alliance, for example, received funding and support from bilateral agencies such as Norad and PEPFAR, private foundations such as The Rockefeller Foundation and Vodafone Foundation, and private partners such as Hewlett Packard and Johnson & Johnson.

The private sector and eHealth network efforts informed the creation of the JLN, THS's flagship network that cuts across all work streams. The JLN is a key innovation and central part of the Foundation's efforts to advance UHC under the THS initiative. Launched in 2010, it connects practitioners around the globe – mainly mid-level government technocrats – to share ideas and develop tools to support health system reforms and achievement of UHC (Table 1).

These networks are generally coordinated by one or more grantees and are also supported by a variety of other technical organizations and thought/strategic

TABLE 1. Overview of networks supported by THS

NETWORK	GOAL	KEY ACTIVITIES/STRATEGIES	KEY PARTNERS
Private sector			
CHMI $3,829,694 (2007-2014)	Provide information, analysis, and connections to service providers, researchers, donors, and policymakers with the goal of facilitating improvement and scale-up of innovative private health sector approaches	• Establish and run web platform to capture and share information and analysis on innovative private sector programs • Conduct research and analysis of cross-cutting themes in database • Create learning collaboratives for service providers • Link programs to funding opportunities • Conduct outreach to policymakers and foster public-private collaboration	• Coordinated by Results for Development (R4D) and multiple in-country partners • Funded by The Rockefeller Foundation, the Bill & Melinda Gates Foundation, and DFID • CHMI also partners with investors, innovation networks, and research/technical organizations
HANSHEP $926,424 (2007-2014)	Bring donors together to improve the performance of the private or non-state sector in providing health care to the poor	• Convene donors on quarterly basis to exchange ideas, make funding decisions, and learn more about private sector space • Co-fund promising initiatives, including knowledge-sharing platforms (e.g. CHMI), networks of non-state actors, efforts to promote public-private collaboration, market-shaping interventions, and scale-up of innovative service delivery approaches	• Coordinated by Secretariat run by MDY Legal • Donor members include The Rockefeller Foundation, African Development Bank (AfDB), Bill & Melinda Gates Foundation, IFC, DFID, USAID, and the World Bank • Country/non-funding members (who inform grantmaking) include the governments of Nigeria and Rwanda and Public Health Foundation of India
eHealth *			
OpenMRS $4,284,100 (2008-2016)	Improve health information systems in LMICs	• Work with network of developers, implementers, and users to develop an open source software platform that enables health sector stakeholders with no programming expertise to develop customized EMR systems • Build capacity of developers and other stakeholders through virtual and in-person meetings and site visits	• Coordinated by Regenstrief Institute and Partners in Health • Funded by The Rockefeller Foundation, with additional funding or other support provided by USAID, CDC, and NGO partners
mHealth Alliance $1,620,000 (2009-2012)	Facilitate innovation and collaboration in the mHealth sector and the widespread adoption of scalable mHealth solutions	• Organize annual summits for members, including multilateral agencies, governments, NGOs, academic institutions, and corporate members • Establish/run technical working groups focused on policy influence and capacity building • Generate evidence and develop tools • Create online research repository and networking platform (Health UnBound or "HUB") • Provide technical assistance to governments and implementing partners by establishing a mHealth Expert Learning Network (mHELP) • Implement innovative mHealth programs	• Coordinated by the UN Foundation • Funded by The Rockefeller Foundation, Hewlett Packard, PEPFAR, Johnson & Johnson, Norad, and Vodafone Foundation
Cross-cutting			
JLN $20,367,140 (2008-2017)	Connect practitioners around the globe to advance knowledge and learning about approaches to accelerate country progress toward UHC	• Establish technical initiatives that are facilitated by technical experts and include country practitioners, to facilitate knowledge exchange and development of tools to inform UHC-oriented reforms • (A new technical initiative on mixed health systems is being formed with CHMI's support) • Create flexible funding pool (Joint Learning Fund) for members to draw on for trainings, study tours, and other activities designed to address country-specific learning needs	• Managed by Network Coordinating Team, which includes R4D, ACCESS Health, and the World Bank • Funded by The Rockefeller Foundation, the Bill & Melinda Gates Foundation, and GIZ (with some funding for specific events from USAID) • (JLN also works with expert partner organizations that facilitate technical initiatives)

* As part of its eHealth work, THS also facilitated the establishment of the information technology (IT) track of the JLN and participated in Greentree's efforts to build donor consensus around best practices for designing and implementing ICT-enabled development programs. THS funding also contributed to the formation of the Asia eHealth Information Network (AeHIN), which supports eHealth-related policy development, capacity building, and learning. THS provided an $80,000 grant to WHO, a lead technical agency for AeHIN, for eHealth technical assistance to the Philippines. WHO drew on these funds to support several of AeHIN's initial activities.

partners (see Table 1: Key Partners). Over the course of their work, networks have developed varying structures for coordinating across these partners, and organizing and conducting their work (Annexes 3, 4, and 5 include figures describing how each network is structured).

Notable achievements

CHMI and HANSHEP have helped increase attention to and momentum around approaches for harnessing the private sector to improve health and health equity.

CHMI has helped increase availability of and access to information on innovations in the private health sector. CHMI's web platform catalogs over 1,300 innovative programs from 150 countries that have adopted a variety of strategies to expand delivery of high-quality, equitable care, including social franchising, licensing and accreditation, micro-health insurance, supply chain improvement, and mobile clinics and telemedicine. This information is used by a diverse set of stakeholders, including service providers and innovators, donors, government officials, researchers, and other actors in the private sector space. A 2015 internal assessment found that the website had been visited by almost 600,000 unique users, and that visits to the platform had grown over time and were averaging between 20,000 and 25,000 each month (Results for Development, 2015).

HANSHEP has contributed to donors becoming more open to investing in the private sector space. By frequently convening a core group of donors to discuss opportunities in the private health sector, and holding high-profile external meetings and symposia, HANSHEP has helped increase interest in and commitment to leveraging the private sector to improve health outcomes. First, donors appreciated the platform HANSHEP offered to discuss and explore a controversial issue – at the time the collaborative was formed, there was widespread disagreement about the extent to which the private sector should be leveraged to achieve universal and equitable health care. Key informants report that frequent discussions and cross-learning through HANSHEP helped destigmatize the issue, shined a light on unexplored opportunities, and, ultimately, contributed to several donor representatives mainstreaming private sector engagement into their organizations' health system strengthening efforts. HANSHEP also hosted high-profile convenings on the private health sector, such as the 2013 Private Sector in Health Symposium in Sydney, Australia, and the 2015 Advancing Partnerships for UHC workshop in Nairobi, Kenya, which helped raise the profile of the issue area and draw the attention of influential public and private sector stakeholders.

The Foundation increased momentum and collaboration around leveraging eHealth approaches for health system strengthening.

"When the group was convened at Bellagio, it was one of the first times someone had said global eHealth was a thing. The conference brought together people from across the world who hadn't worked together before to say we have common challenges and we have common solutions we want to work on."

– Interviewee

> *"That's how we built out the strategy. Based on our understanding of the challenges, we thought – How can we help governments have the organizational strengths to manage a more mature digital health strategy? How can we make sure there are people in the country who know about digital health and can help drive it forward? How can we help create products that they can take off the shelf and help deploy at low cost? (That's why we went with open source approaches.) How can we build up networks to allow information sharing in this space?"*
>
> *– THS staff*

The Making the eHealth Connection conference series organized by the Foundation enabled networking among eHealth actors, sparked ideas for new initiatives, and built global momentum around eHealth. The series was large and high profile. It included eight conferences on diverse eHealth topics and lasted over four weeks, with representatives attending from 34 countries, 32 donor organizations, and 10 prominent media outlets. It helped draw critical attention to opportunities in this emerging field and build a broad consensus on priorities and next steps. Conference participants signed a joint call to action, which called for engaging in evidence-based policy- and agenda-setting, forming collaborative networks, building capacity, developing reusable metrics and tools, and supporting country-level strategy development and implementation (The Rockefeller Foundation, 2010). The conference also enabled eHealth stakeholders to take critical first steps toward achieving these commitments – generating transformative ideas that have since grown into self-standing initiatives (Figure 6). The mHealth Alliance continued to facilitate networking and collaboration in this field – among eHealth actors focused on using mobile technologies to improve health care. It had almost 300 members by the time it was wound down in 2013, and its annual mHealth summits, which started with 500 attendees in 2009, grew to 4,500 attending in 2013.

Networks formed through THS have facilitated joint problem-solving and informed decision-making. HANSHEP donors have drawn on the input of non-funding country members to ensure their investments respond to country needs. For example, the government of Rwanda reported difficulties in engaging the private sector given its fragmented nature, which led HANSHEP to provide support to the nascent Rwanda Health Care Federation, an umbrella body that organized all private sector providers in the country. The JLN was also successful in promoting productive knowledge sharing. Participating practitioners frequently reach out to each other for input on changes they are considering to policies and processes. They also regularly exchange models or templates for programs, standards, and tools, which prevents them from having to "start from scratch" when developing new initiatives (Sridharan and Smith, 2016).

THS networks have produced a variety of practical tools and resources. Networks formed under THS have developed a range of tools and resources, or "global public goods," to help policymakers and practitioners embark on thoughtful, evidence-based reform of programs, policies, systems, and processes. These include knowledge products summarizing country experiences with reform, guidelines for assessments and studies to inform reform efforts, open source platforms, and databases of innovative programs and research repositories (Figure 7). Many networks have sought to ensure that these tools are practical, grounded in an understanding of country context, and designed to address challenges faced day to day in the health systems of LMICs. The JLN, which pairs technical experts with country practitioners to engage in a knowledge "co-creation" process, has been particularly successful in creating user-friendly resources.

Policymakers and practitioners have leveraged tools and resources generated by THS networks to strengthen programs and systems and reform policies to advance UHC.

CHMI has fostered program improvement by enabling collaboration and joint problem-solving among service providers. CHMI identifies organizations implementing similar service delivery models through its database and brings them together through learning collaboratives and exchanges to share information on common challenges and solutions that have worked on the ground. Participating service providers have replicated solutions that other organizations have tested and refined. For example, following their participation in CHMI's Primary Care Learning Collaborative, service providers adopted each other's practices, such as expanding patient follow-up to improve quality of care, offering discounts to increase patient in-flow, and integrating dental care as a key service (Brad Herbert Associates, 2015).

The OpenMRS platform has seen widespread use across the globe. The platform was piloted in Rwanda, which has since engaged in a national rollout of the OpenMRS EMR system for primary care (see Chapter 6: Focus country investments for more detail). More broadly, as of 2016, 1,845 sites in 64 countries were reporting OpenMRS implementations (OpenMRS, 2016).

CHMI

Web platform that includes profiles of innovative private sector programs, tools to help service providers adopt and adapt elements of successful programs, and research products exploring themes and trends across profiled programs

HANSHEP

HANSHEP funded CHMI and managed the Health Systems Hub, an online platform that synthesizes learnings from HANSHEP-funded programs

OpenMRS

Open source software platform and reference application to help health sector stakeholders build and strengthen EMR systems (with several add-on modules to facilitate customization)

mHealth Alliance

Library of resources, including policy papers, analytical frameworks, and landscape assessments produced by the mHealth Alliance, as well as links to mHealth applications, capacity-building workshops and courses, multimedia tools for health promotion, mHealth project inventories, and toolkits for leveraging mHealth technologies

JLN (selected resources)

- **Provider payment mechanisms.** Guide for assessing strengths and weaknesses of provider payment systems, manual for costing health services, and simulation model to assess various provider payment scenarios
- **Heath information technology.** Sample functional requirements for key business processes, open source tool for developing health data dictionaries, reference guide for developing eHealth standards frameworks
- **Primary health care.** Tool to assess alignment between health financing and primary health care (PHC) strategies, manual on engaging the private sector in PHC to achieve UHC

The mHealth Alliance helped advance country-level policy and programming around mHealth. The alliance engaged in advocacy and technical assistance at the country level, which contributed to Nigeria, Rwanda, South Africa, and others developing and implementing mHealth strategies (Seven Hills Advisors, 2014). This work was particularly successful in Nigeria, where the alliance helped the federal government develop a framework for leveraging ICT approaches to increase access to primary health care for women and children. This framework was adopted by the Nigerian parliament and is now policy.

Several JLN tools and resources have been used to inform UHC-oriented reforms. Tools developed by the JLN's provider payment mechanisms, health information technology (IT), and primary health care technical initiatives have been used to inform policy reform, guide policy implementation efforts, and develop needed IT infrastructure. For example, policymakers and practitioners have drawn on JLN tools to conduct costing studies and use results to develop a national health protection scheme (in India) and reform provider payment systems (in Vietnam). They have also drawn on tools developed by the JLN's IT technical initiative

to develop or rebuild the IT infrastructure for health insurance schemes (in Bangladesh and the Philippines) (Sridharan and Smith, 2016).

Most networks have attracted support from other donors and are positioned for sustainability. The Foundation was successful in leveraging partnerships with other donors to ensure that THS networks were sustainable ventures that would have a life beyond the initiative. Some networks, such as CHMI and the mHealth Alliance, were launched together with other funders. The Foundation also engaged in intensive outreach once THS networks were up and running to showcase the value of these collaborative partnerships to other donors and enlist their support (see Table 1 for a list of other donors funding THS networks).

Key challenges

Some networks lacked clear, well-defined goals and strategies, which diluted their overall influence.

HANSHEP lacked a strong strategic framework, which led to highly dispersed grantmaking and put limits on the collaborative's influence. At the root of this fragmentation were HANSHEP's broad objectives – when the group was launched, members opted for a loosely defined scope of work to allow time for exploring the field and identifying the group's comparative advantage. Unfortunately, a more concrete strategy did not emerge over time, likely due to the limited overlap between donors' institutional priorities, which ranged from leveraging the private sector for improved service delivery, to regulation and stewardship, to organizing the private sector for improved government engagement. Without a clear mission and strategy, the portfolio's influence was scattered, and at times duplicative. To concretize its approach, the group has recently devised a new "HANSHEP 2.0" construct with three distinct work streams: i) knowledge and learning, ii) an innovation challenge fund, and iii) agenda-setting.

Lack of mission clarity and reputational challenges muted the influence of the mHealth Alliance, and ultimately led to the decision to wind down the network. The alliance faced significant leadership and reputational challenges in its first three years. As a result, by 2010, few of its ambitious goals were achieved and perceptions of the alliance were poor. A change in structure and leadership in 2011 helped retrieve some lost ground, but the alliance continued to spread itself too thin across multiple activities. It also faced an enduring misalignment between what the mHealth community hoped it would do and what it received funding to do. Specifically, the mHealth community hoped it would play a convening and thought leadership role, but once The Rockefeller Foundation wound down its funding for eHealth, the alliance received funding mainly for implementing programs. These initiatives were quite successful, but most members felt the alliance should focus instead on knowledge sharing and coalition building to strengthen the overall mHealth sector. Due to this misalignment and the enduring negative impact of early reputational issues, and recognizing that other organizations were stepping into the role the mHealth Alliance was created to fill, the board and leadership of the alliance made the decision to wind down the network in 2013.

Some felt the Foundation wound down its investments in eHealth too early and may have missed opportunities for further influence. While the Foundation helped put eHealth on global and country agendas and build critical tools and capacity, some felt it withdrew too early from investments in the eHealth space. The Foundation's commitment to building communities of practice and facilitating the generation of global goods have been particularly missed. The mHealth Alliance, for example, was constrained in its ability to play the role of broker and convener once THS funding came to a close, and thereby missed the opportunity to sustain the momentum that came out of the 2008 Bellagio conference for building a strong mHealth sector.

Key learnings

Learning networks are a powerful vehicle for advancing a field and motivating action by policymakers and practitioners, especially with limited resources and time. In catalyzing and supporting learning networks, The Rockefeller Foundation has identified a strong niche for itself in the global health sector. The networks space receives relatively limited financial support – countries are not positioned to fund efforts that do not have tangible results for their population and donor funding for learning efforts is in relatively short supply. The networks space is also a strong match for the Foundation's strengths. In the case of THS, the Foundation's tolerance for risk has enabled investment in untested – but promising – learning models, and its in-house technical expertise and strategic insights have been critical in helping refine and strengthen these models. Finally, the Foundation's convening power has brought other donors on board once its networks have a clear structure and value proposition, and thereby ensured network sustainability. In this way, the Foundation has leveraged its finite funding to catalyze sustainable networks that are positioned to facilitate learning and build an enabling environment for country-level reforms in the long term.

A clear mission statement and well-defined goals can help networks build a closely knit, action-oriented membership that is focused on steadily moving the needle in its area of focus. Networks need a clear value proposition that members can align around to ensure they are moving steadily towards a common goal. Without a clear ToC, network activities can also become dispersed and disconnected from one another, thereby diffusing the network's overall influence. The JLN has a clear North Star – advancing UHC at the country level – that endows members with a sense of shared purpose and keeps bringing them back to network activities and initiatives. The clarity of its overarching mission has also helped ensure that individuals working in diverse technical areas, such as

health financing and eHealth, collaborate to advance their shared goals of strengthening health systems and advancing UHC. In contrast, HANSHEP has not been able to develop a strong unifying vision or focus. Therefore, although it has supported important and useful programs, these have not cohered to move the needle meaningfully on strengthening the private health sector.

Building a strong coordination function requires substantial time and resource investments; while it does not yield immediate, tangible outputs, it is critical to ensuring effective network operations in the long term. Grantees report that The Rockefeller Foundation is unique in its willingness to support the administration and coordination of learning networks. THS has recognized that networks need a strong governance function in order to be able to produce useful global goods, and facilitate meaningful action by network members with busy professional lives. It was with seed funding from THS that OpenMRS – until then a loose collaboration of organizations – was able to form an independent non-profit organization and hire full-time developers to oversee the design of its open source EMR platform. The Rockefeller Foundation also provided funding for the JLN's Network Coordinating Team, which has been critical to recruiting a strong membership, fostering country ownership, and coordinating across network units to get countries the support they need for UHC-oriented policy action. The Rockefeller Foundation's willingness to devote funds to network governance – which does not have tangible results – has also encouraged other donors to recognize the value of such investments. Once the Foundation provided initial funding for the JLN's Network Coordinating Team and HANSHEP's Secretariat, other donors eventually contributed funds as well.

Networks can ensure that collaborative learning efforts yield useful knowledge and tools by having a skilled technical facilitator work closely with a team of committed, insightful practitioners. The experiences of THS-supported learning networks show

> *"Networks don't self-form and self-maintain. You need a secretariat that wakes up every morning and continues to promote and engage the network."*
>
> *— Interviewee*

that collaborative learning does not happen unless it is carefully facilitated. Bringing bright minds together around issues of shared interest can build critical momentum, but if the collaborative process is not structured to develop and achieve common objectives, this momentum can quickly subside, or not lead to tangible change. For instance, the mHealth Alliance's working groups may have lost traction because the alliance missed the opportunity early on to play a "neutral broker" role and build a shared vision across group members (Seven Hills Advisors, 2014). Some of JLN's technical initiatives, by contrast, have been able to lead practitioners to identify challenges faced on the ground, share tested solutions, and jointly develop tools for policy reform that address common contextual constraints in LMICs. Their success is grounded in effective facilitation by technical experts who have both in-depth subject matter knowledge and the ability to listen to and learn from practitioners' experiences, elicit and synthesize lessons, and co-create useful knowledge products.

Networks need well-conceived strategies for building local ownership and participation; only this can ensure that network learning and tools are leveraged to effect real change in policies, programs, and systems. Networks can only produce relevant tools and resources, and coalesce groups around useful initiatives, when there is a high level of ownership among members and other local stakeholders. For example, in recognition of the need for greater member ownership, the JLN has formed country core groups (CCGs), which are comprised of staff at key government agencies working towards UHC and are responsible for organizing and facilitating country participation in the JLN. These groups have played a critical role in ensuring that countries are identifying and taking advantage of opportunities for learning through JLN's technical initiatives.

Networks need time and space to iteratively develop their models, but their work needs to be tied to at least a few benchmarks and milestones to ensure they identify their objectives and approach as soon as possible. Network stakeholders appreciated the flexible scope of work allowed by The Rockefeller Foundation, which enabled them to identify needs, and develop and iterate on strategies to address those needs. The JLN's CCGs, for instance, have become more effective over time, as the network has understood the factors limiting their effectiveness in overseeing country participation in the network, and installed strategies to address those obstacles (Sridharan and Smith, 2016). While it is important to ensure that networks have the creative space they need to refine their models, there is some risk to an unstructured design process. The mHealth Alliance spent the majority of its core funding in its first two years, but in that time had not clearly charted its path and, overall, had accomplished less than planned. Key informants feel that the alliance could have benefited from establishing and working towards some measures of success, such as membership size, establishment of working groups, level of activity among members, and member satisfaction.

Sourcing long-term funding is a critical challenge for networks focused on producing global public goods, and requires early planning and action. There is limited funding available for efforts to develop global public goods, especially those that prioritize iterative

learning without preset outputs and deliverables. To ensure adequate and long-term funding, networks must engage in relationship-building early on and recruit the support of diverse donor partners. The Rockefeller Foundation has been successful in building broad-based support for its networks by ensuring they are not too closely tied to its brand. This approach has enabled prominent donors with pre-existing priorities and agendas to come on board, thereby strengthening long-term network sustainability. Almost all THS networks have gone on to receive often substantial support from other donors.

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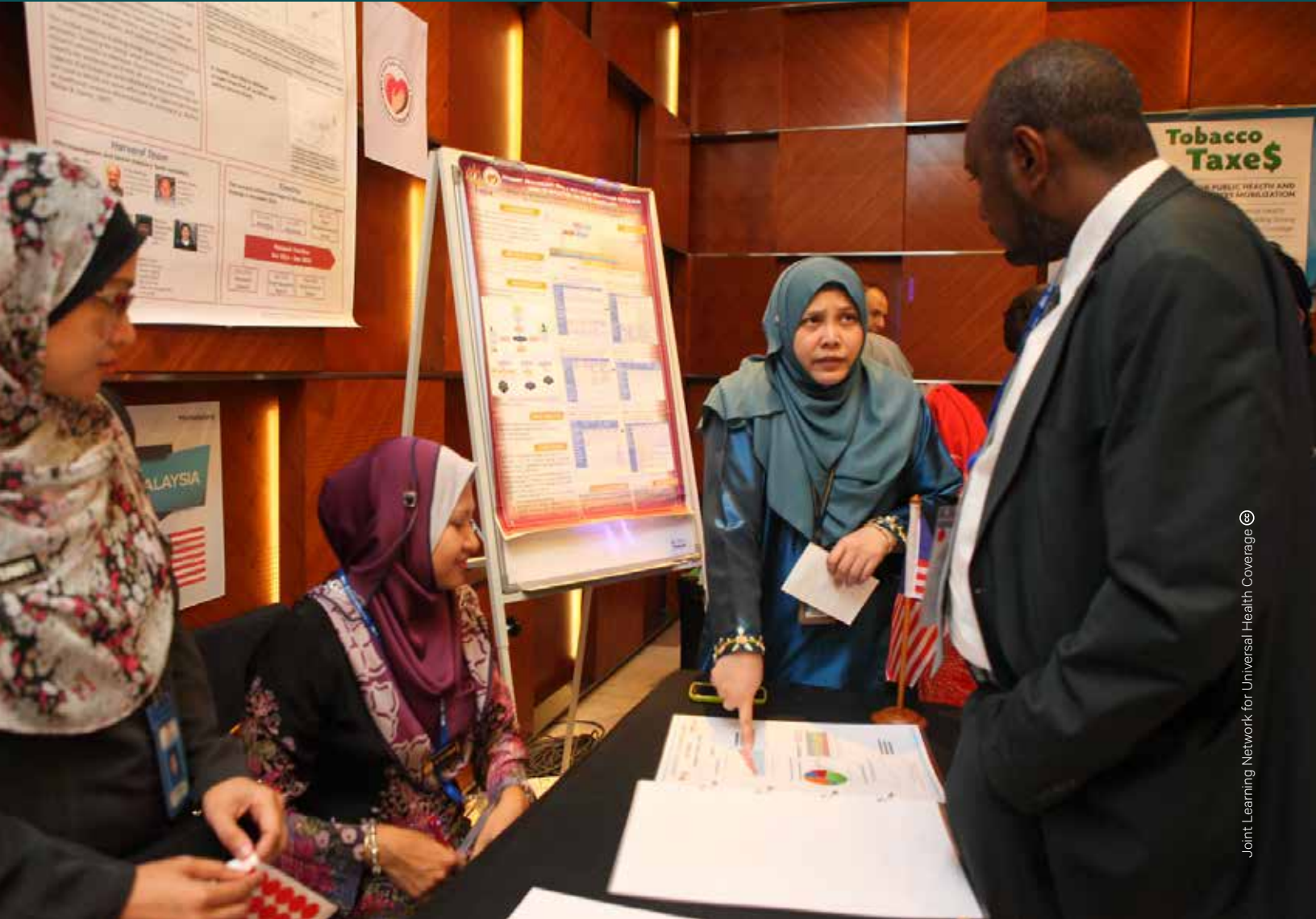
Focus country investments

THS complemented its efforts to build global momentum around UHC, and promote network-based learning around health system levers for UHC advancement, with targeted country-level investments that sought to test and iterate on models for achieving UHC. The Foundation selected four countries in which to develop and refine pathways for achieving UHC – Bangladesh, Ghana, Rwanda, and Vietnam. From 2008 to 2015, the Foundation issued around $25.8 million in grant funding to a mix of government agencies, and non-government and academic organizations in these countries to

engage in diverse activities that supported UHC advancement, including advocacy, evidence generation, policy development, and capacity building (Figure 8).

The Foundation typically began its country-level investments by supporting exploratory grantmaking in all four of THS's work streams, which helped identify policy constraints and capacity gaps on the pathway to UHC that could be addressed with finite short-term funding. Informed by these efforts, THS ultimately prioritized one work stream in each country

FIGURE 8. Country-level investments, by country and work stream

COUNTRY	DURATION OF INVESTMENT	# OF GRANTS	# OF GRANTEES	FUNDING	% OF TOTAL COUNTRY FUNDING
Bangladesh	01/2009 – 11/2016	26	15	$7,781,901	30%
Ghana	09/2009 – 01/2016	15	11	$4,065,345	16%
Rwanda	10/2009 – 12/2016	14	12	$6,752,761	26%
Vietnam	09/2009 – 06/2017	19	12	$7,197,562	28%
Total	**01/2009 – 06/2017**	**72***	**49***	**$25,797,569**	
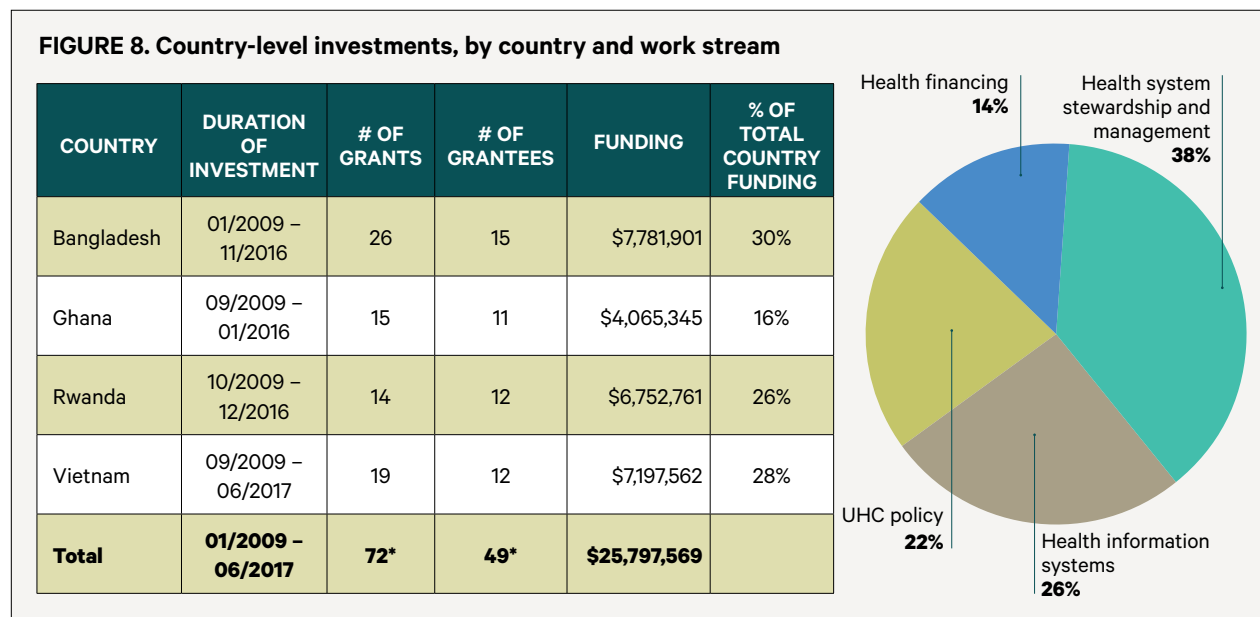
* Note that some grants/grantees are active in multiple focus countries.

– private health sector development in Ghana, eHealth in Rwanda, health financing in Vietnam, and UHC policy and advocacy in Bangladesh. THS grants built momentum and catalyzed policy action in several of these reform areas. The Foundation's investments helped to influence reform of the national social health insurance law in Vietnam, strengthen the eHealth infrastructure in Rwanda, and support the government's efforts to harness the private sector to expand health coverage in Ghana. While THS identified a priority work stream to support in each country, it also continued investing in other work streams. These investments, many of which had a capacity-building focus, did not yield immediate outputs, but contributed to building a pipeline of trained health professionals committed to improving health systems and advancing UHC.

While these were notable achievements, THS ultimately gained relatively narrow traction at the country level, for a variety of reasons. First, for most of its life cycle, the initiative was structured to prioritize investments in global and network activities, which limited the amount of resources and staff time available for country-level

investments and constrained what THS could achieve in each country. THS staff also had limited experience with country-level grantmaking and in some of the focus countries, which led to lengthy exploratory grantmaking. Additionally, within each country, investments were not brought together under – or guided by – country-specific ToC or results frameworks. Following the THS initiative's structure, investments were spread across THS work streams, without clear linkages between grant activities within and across work streams and changes in UHC-related outcomes. This led to some dispersed outcomes and missed opportunities for cross-grantee synergies and joint, country-level influence.

This chapter provides high-level background on how the THS focus countries were selected, and an overview of key steps in the THS country-level grantmaking strategy. It ends by summarizing cross-cutting achievements, challenges, and lessons learned. More information on THS's country-level work can be found in the individual case study reports on each focus country (Smith *et al.*, 2014a; Smith *et al.*, 2014b; Sridharan *et al.*, 2014a; Sridharan *et al.*, 2014b).

FIGURE 9. THS's strategy for country-level grantmaking
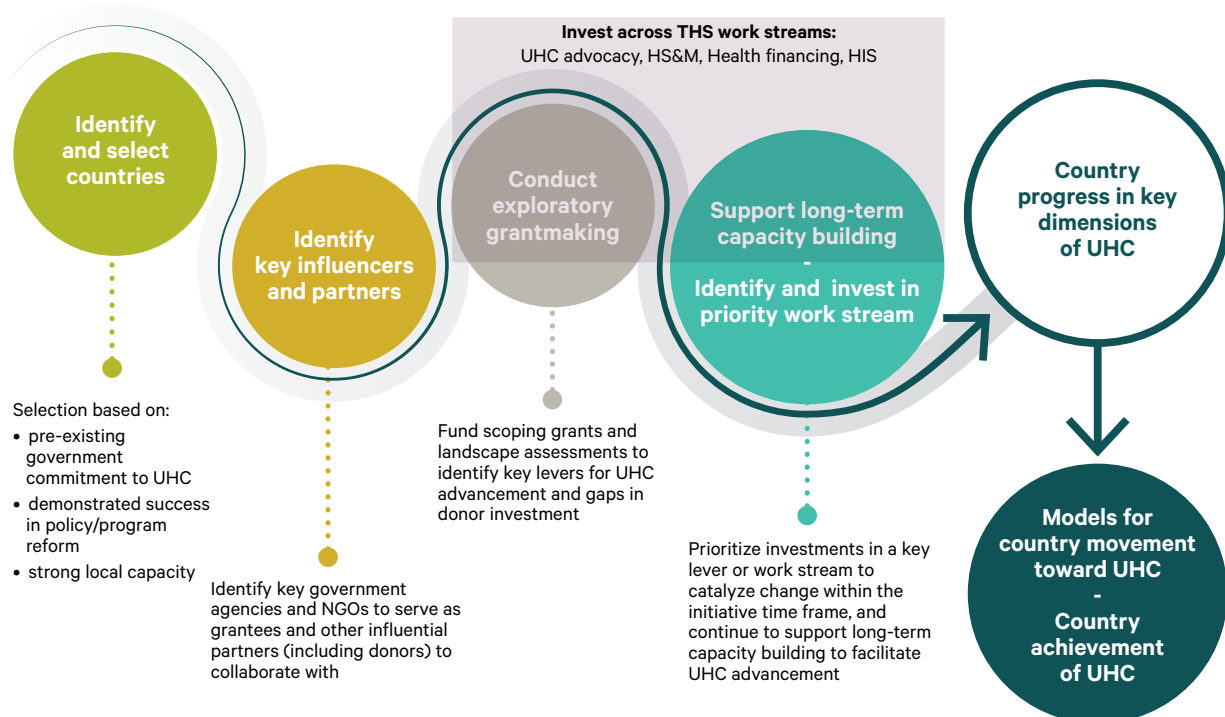
Background on THS's country-level grantmaking

Country selection

THS selected focus countries that had a strong, pre-existing commitment to UHC, seeking to leverage existing momentum, and fill gaps in the donor landscape, to catalyze focused UHC-oriented reform efforts. The governments of Ghana, Rwanda, and Vietnam had adopted UHC as a national policy goal, with key UHC objectives (access, financial protection, and equity) underpinning many health sector policy frameworks and planning efforts. These countries had also taken tangible steps to make this policy goal a reality, creating national health insurance schemes and engaging in reforms of key programs and systems to increase health system efficiency, expand coverage, and extend financial protection. THS was also guided in its selection by the presence of strong potential partners, including government agencies and NGOs that might serve as grantees, as well as other donors that could leverage and build on the Foundation's catalytic investments (Figure 9).

Bangladesh was selected as the fourth focus country to test a model for achieving UHC in an alternative context – one where government commitment to UHC was still uncertain and policy action relatively nascent. The Foundation felt that Bangladesh's strong NGO sector might compensate for these limitations, and could potentially be leveraged in efforts to expand coverage and improve equity. It also hoped to take advantage of THS staff's extensive network in the country to build momentum around UHC and promote focused action.

Country-level strategy

Figure 9 details the key steps in the THS country-level strategy. In each focus country, THS began by identifying partner organizations through the Foundation's existing networks and informal introductions at health sector conferences and meetings. It then issued exploratory grants to these organizations to better understand the

UHC landscape, hone in on high-impact opportunities, and identify critical gaps in donor funding. This initial grantmaking was conducted across all work streams, and investments were made in diverse activities, including advocacy, evidence generation, and trainings and technical assistance.

Through the work of these grantees, the Foundation grew its understanding of country needs and identified a priority work stream in which it could catalyze change within the initiative time frame. It also continued to fund activities in other work streams, with a view to building the long-term health system capacity needed to support advancement of UHC. Together, these investments were intended to facilitate meaningful progress on key aspects of UHC in the focus countries and propel them toward the ultimate goal of achieving UHC. It was hoped this process would yield tested, replicable models for advancing UHC. Table 2 provides a snapshot of THS investments in each country.

Notable achievements

THS's exploratory grantmaking approach was effective in uncovering short-term investment opportunities with potential for outsized impact. THS surmounted potentially large stumbling blocks – its limited health sector experience in the focus countries, and its finite budget and short timeframe for effecting change – by taking an investigative approach in its initial phase of grantmaking. Its landscaping studies and investments in multiple work streams allowed for the identification of critical policy constraints and capacity gaps on the pathway to UHC. These initial investments also shed light on which of these issues could be addressed with small, concentrated injections of short-term funding – a critical factor for a time- and resource-bound initiative. In Ghana, for example, investment in a World Bank-led private health sector assessment solidified THS's early focus on the private sector. It directly informed the main activities of the Foundation's first grant to the Ministry of Health (MoH), which sought to strengthen the ministry's capacity to

TABLE 2. Snapshot of country-level investments

	GHANA	RWANDA	VIETNAM	BANGLADESH
INVESTMENTS IN PRIORITY WORK STREAMS				
Lever	Private sector	eHealth	Health financing	UHC policy and advocacy
Main activities	• Support for World Bank private health sector assessment • Development of a private sector regulatory framework & institutional establishment manual • Technical support to strengthen the Private Sector Unit of the Ministry of Health (MoH) • Support for development of 2013 Private Health Sector Development Policy	• Establishment of an eHealth Secretariat within the MoH • Design and deployment of Rwanda Health Information Exchange architecture • Scale-up of OpenMRS EMR platform used in PIH facilities • Development & roll-out of District Health System Strengthening Tool	• Assessment of provider payments in Vietnam • Costing study to inform development of capitation formula • Simulation analysis to understand feasibility of different provider payment reform options • Support for designing capitation pilot and using results to inform policy reform	• Study tours to other countries to learn about their UHC/health insurance schemes • Trainings/dialogues on UHC for national and local government officials, medical professionals, NGOs, press, insurance firms, religious leaders, and others • Research on UHC and health financing
INVESTMENTS IN CAPACITY- AND MOMENTUM-BUILDING TO ADVANCE UHC				
Advocacy	• Meetings with government on public-private collaboration • National and regional conferences on UHC	• N/A	• Seminars on UHC for goverement staff & others • Development of national UHC "master plan"	• See "main activities" above
Evidence generation	• UHC landscape assessment and study on UHC reform impacts	• Research on community-based health insurance (CBHI)	• Evidence generation on health financing (see "main activities" above)	• The *Lancet* issue on Bangladesh health sector
Trainings/ Technical assistance	• Policy analysis trainings for MoH & partners • TA on priority-setting and quality improvement	• Trainings and study tours for policymakers and practitioners at centers of excellence (see "CoEs" below)	• Trainings on health system change for policymakers • TA on priority-setting and quality improvement	• Trainings on global health diplomacy • Trainings on specific health conditions for providers
Centers of excellence (CoEs)	• N/A	• Establishment of CoEs for eHealth and health system strengthening	• Formation of a center for health systems research at a local university	• Establishment of a UHC CoE at BRAC and ICDDR,B
Degree programs	• Development of a doctorate in public health program in health leadership in Africa	• Development of a curriculum for a masters program in health informatics	• Establishment of degrees/specializations in health economics and public health informatics	• Establishment of masters programs in public health and health informatics at local universities
OTHER INVESTMENTS (SELECTED ACTIVITIES)				
Other	• Implementation of HSS tool in facilities, creation of health informatics society, policy dialogues on human resources for health & maternity care	• Development of financing planning tool for CBHI schemes, and a plan for private health sector assessment	• Formation of civil society advocacy network, media/phone campaigns on insurance, family planning, tobacco use, WHA participation	• Micro-health insurance pilots, telemedicine program for community health workers, development of hospital accreditation standards

integrate private providers into the country's national health insurance scheme. Unfortunately, at times this exploratory grantmaking approach was continued into the "execution" phase of country-level strategies, which led to disproportionate spending on relatively scattered investments.

THS helped priority reform efforts gain traction by addressing key constraints to reform. THS focused investments in high-return gap areas to achieve concrete, sustainable results quickly. In Vietnam, THS identified data limitations that were impeding provider payment reform, which was a government priority, and, in turn, provided resources for rigorous data collection and analysis. These efforts strengthened awareness of the need for reform, increased technical knowledge about reform models, and shaped the design of a capitation pilot, which will influence reform of the national social health insurance law (Figure 10). In Rwanda, THS prioritized eHealth, with its grants developing critical new additions to the eHealth infrastructure, including a customized OpenMRS EMR system and the Rwandan Health Enterprise Architecture. It also tackled largely unaddressed gaps in the government's capacity to manage eHealth processes (Figure 11). In Ghana, THS focused on the private sector, a country priority, and in doing so, it identified and addressed a previously overlooked need – for improved government stewardship of the private sector. THS grants helped strengthen the MoH's Private Sector Unit, develop a new private sector health policy, and improve accreditation processes (Figure 12). THS was not able to gain traction in any key reform areas in Bangladesh, with funding spread evenly across different work streams for the duration of the Foundation's investment in the country (discussed further in Section 10).

Investments in trainings and technical assistance helped build government support for the initiative, overcome short-term capacity constraints, and make some contributions to reform. In response to needs identified during its exploratory phase, THS supported a variety of short-term capacity-building

FIGURE 11. Catalyzing eHealth innovation and reforms in Rwanda

Rwandan President Paul Kagame's attendance at the Rockefeller Foundation's "Making the eHealth Connection" conference series at the Bellagio Center in 2008 signaled the commitment of the Government of Rwanda (GoR) to building the country's eHealth infrastructure. Several of the ideas and initiatives that came out of the conference series have helped to inform and support THS's eHealth strategy in Rwanda, which focuses on supporting the GoR's strong eHealth vision and implementation of its nationwide eHealth strategic plan (2009-2014).

To help refine and execute GoR's ehealth vision, THS's eHealth investments in Rwanda concentrated on "support[ing] both the technology architecture and the talent needed to support it." The Foundation's first THS grant in Rwanda was awarded to the MoH in 2009 to establish an eHealth unit (with a full-time eHealth coordinator and multiple other staff) to build out its eHealth strategy. THS grant funding has also been used to establish an eHealth Center of Excellence to provide degree and certificate programs in health informatics and train eHealth professionals.

THS also supported efforts to pilot in Rwanda two key approaches that were conceived or gained traction at the Bellagio conference – the use of an open source software platform for developing customized EMR systems (OpenMRS) and the use of enterprise architecture to facilitate interoperability across different health information systems and improve continuity of care. THS grants supported the national roll-out of an OpenMRS EMR system for primary care and the implementation of the Rwanda Health Enterprise Architecture (RHEA) in one Rwandan district. Partners in Health continued to support roll-out and expansion of the OpenMRS EMR system after THS, and RHEA (now Rwanda Health Information Exchange) is being scaled up nationally with support from PEPFAR and USAID,

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FIGURE 12. Supporting private health sector development in Ghana

Ghana is one of the first countries in sub-Saharan Africa to successfully establish and implement a national health insurance scheme (NHIS). Despite significant increases in insurance coverage under the NHIS, ensuring equitable access to health services is a persistent problem in Ghana, and has discouraged enrollment in the scheme. MoH action to address this issue has included efforts to increase the participation of private providers in the NHIS. Under the scheme, accredited providers are reimbursed for services delivered to NHIS members. However, whereas accreditation is automatic for public sector facilities, private providers have to undergo an accreditation process to participate in the program. Many private providers are not accredited due to capacity and resource constraints within the MoH and NHIS. To guide its efforts to harness the private sector, the MoH developed its first Private Health Sector Policy in 2003, and the International Finance Corporation's (IFC) Health in Africa Initiative (HAI) began working in Ghana to support integration of the public and private health sector.

The Rockefeller Foundation saw the HAI work as an excellent opportunity to partner with IFC and leverage its work in the private sector to support UHC advancement in Ghana. In 2009, THS awarded a grant to IFC to support a comprehensive assessment of the private health sector. Published in 2011, the assessment identified several areas of action to support public-private collaboration in the health sector. Through a grant to the MoH, THS went on to fund three of these action items: i) building the capacity of the MoH Private Sector Unit; ii) developing a new private health sector development policy; and iii) establishing a platform for private sector actors to collaborate and interact with key players in the health system (the Private Health Sector Alliance of Ghana). In addition, the Foundation supported two grants to help strengthen accreditation of private facilities.

activities for health sector stakeholders, including high-level trainings on health system strengthening for senior policymakers, courses on planning and management for mid-level practitioners, the use of tools and assessments to guide planning efforts, and the development of broad health sector work plans. These investments often served as an indication of support for the country's overall health system strengthening efforts and a strong conduit for relationship building with the government. In some cases, however, they yielded useful contributions to reform. For instance, in Vietnam, the government has adopted a detailed framework for provincial health planning that was developed through a THS grant. In addition, a "road map" to UHC, developed as part of an MoH grant, is now the official plan for the roll-out of national health insurance. In another example, THS funds were used to develop a tool to strengthen financial management of Rwanda's community-based health insurance (CBHI) schemes. The tool has been used in each of Rwanda's 30 districts, and has facilitated documentation of CBHI funding sources and financial flows (which has strengthened the evidence base for CBHI decision-making and policies).

Institutional capacity-building grants laid the groundwork for long-term progress on health system priorities, but did not always yield immediate dividends. THS contributed to building a strong pipeline of health sector staff committed to health system strengthening by establishing degree programs and improving curricula in relevant fields, and founding centers of excellence (CoEs) at respected academic institutions (see Figure 6.6 for examples). Formed through institutions with powerful spheres of influence, these entities are strongly positioned to build local health system capacity in the long run. However, they were not designed to and did not produce immediate impacts on reform processes.

THS's research and agenda-setting activities amplified understanding of the UHC concept in the focus countries. UHC-focused awareness-building activities, particularly intensive in Bangladesh, included

FIGURE 13. Notable achievements in building long-term capacity for health system strengthening

THS contributed to building long-term health systems capacity by establishing and improving degree programs. THS funds have been used in all four focus countries to create new academic programs or specializations – in public health, health economics, and health informatics – which are intended to train future government officials and medical professionals. Some grantees have also been successful in improving and standardizing training at medical education institutions. For example, in Bangladesh, the Bangabandhu Sheikh Mujib Medical University developed a curriculum for its Master of Public Health degree that "emphasizes self-education and global vision" and aims to build core, need-based competencies. The curriculum was adopted by six other academic institutions and is now a requirement for anyone seeking to join a government institute as a public health specialist.

THS facilitated policy dialogue, evidence generation, and health system capacity building by establishing centers of excellence. For example, in Rwanda, a Center of Excellence in Health Systems Strengthening was established with THS funding at the National University of Rwanda School of Public Health. The Center develops original research and conducts meetings, trainings, and study tours for policymakers, practitioners, and researchers to debate and share best practices. It also collaborates closely with the MoH, thereby ensuring that its research and knowledge-building activities are linked with policies and practices in Rwanda. In Vietnam, the THS-funded Center for Health Systems Research at Hanoi Medical University has focused on capacity building. It conducts trainings on health research and evaluation methods, health economics, and costing analysis for academics, government officials, and NGO representatives. THS grantees in Vietnam have noted that these and other THS-funded education and training opportunities have helped their staff engage more meaningfully in policy dialogue and research on health systems, health financing, and health information systems.

a variety of conferences, meetings, and dialogues, and the production of reports, concept notes, and policy briefs. Through these activities, awareness of UHC stretched beyond health financing experts and other such "usual suspects" to other prominent health sector officials as well as non-health sector and non-government stakeholders. In some countries, understanding of UHC also grew deeper, with many recognizing that the concept encompassed more than the provision of universal health insurance coverage, and that equity in access to care was an integral component of UHC achievement.

Key challenges

THS country grant portfolios were spread across the initiative's four broad outcome areas and a wide range of activities, which ultimately limited the influence of country-level grantmaking. Country grant investments were spread across multiple work streams and activities and not well-positioned to achieve common UHC objectives – for several reasons. Exploratory grantmaking was often opportunistic, due to THS staff's limited experience with country-level grantmaking and in some of the focus countries. It was also lengthy, with some early grants lasting several years beyond the identification or emergence of a priority reform area. For example in Vietnam, even though a provider payment reform focus emerged in 2012, investments continued to be spread across other work streams and focus areas, including UHC advocacy and policy development, eHealth capacity building, and quality of care. In some cases, there was also fragmentation within focus areas. For instance, in Bangladesh, eHealth grants supported a government initiative to build a systems architecture to integrate its data collection systems, a dengue surveillance effort, and an ICT application for an NGO's community health workers to collect and analyze data on pregnant women and newborns. In light of THS's limited resources for country-level grantmaking, this fragmentation of grant investments across work streams and sometimes disparate

activities constrained and diluted the influence of THS's country-level portfolios.

Lack of a country presence constrained the Foundation's ability to build local partnerships and put limits on its overall in-country influence. Without a local presence, the Foundation found it challenging to move quickly in building out a portfolio and establishing relationships with critical health sector actors, which limited grantmaking effectiveness and sustainability. The absence of a local representative, combined with its relatively limited country experience, meant that the Foundation had to engage in extensive exploratory grantmaking. Lack of a country presence also meant the Foundation could not make inroads at some influential government institutions, particularly within the scope of a time-bound initiative. For example, in Vietnam, grantees felt the Foundation could have magnified its influence on the revision and operationalization of the social health insurance law (Figure 10) had it engaged more closely with the National Assembly, Ministry of Finance, and Ministry of Planning and Investment. However, this would likely have required intensive country-based outreach, which was difficult to do with no local office and a limited travel budget. Finally, the absence of a country presence hindered regular participation in dialogues and meetings among development partners. This constrained the Foundation's ability to build additional donor support for its country projects and ensure the sustainability of its gains.

The Foundation's decision to cease private health sector-related grantmaking, an area where THS was gaining traction in Ghana, may have limited THS's influence in the country. Following a 2012 review of the overall THS strategy, the decision was made to narrow the initiative's focus during its remaining years. As a result, grantmaking focused on the private sector ceased, with no further private health sector development grantmaking after 2011. This relatively abrupt change in strategy created some loss of momentum in grantmaking in Ghana (as THS officers had to quickly identify new areas for investment), and

resulted in missed opportunities for the Foundation to consolidate its influence in this outcome area. Case study respondents noted that traction around the role of the private sector had grown over the last five years in Ghana – culminating in the country's first private sector health summit – and that significant donor gaps remained.

THS was not able to significantly move the needle on UHC in Bangladesh. Given limited government commitment to UHC, disagreements among donors on health financing strategy, and the lack of a clear results framework across THS activities, the Foundation has not been able to effect meaningful change in UHC-related policies in Bangladesh. As mentioned, the Foundation selected Bangladesh as a focus country despite the absence of a strong national commitment to UHC, calculating that the strong NGO sector and THS staff's expansive in-country network would compensate for this limitation. Unfortunately, the NGOs selected as local champions were less effective than expected in promoting focused action on UHC. They were hindered by internal leadership and capacity constraints as well as a challenging policy environment, with frequent turnover among key government officials, limited collaboration between the health department and other relevant agencies, and uneven support from prominent donors for a nationwide health insurance scheme. These factors, combined with the fragmentation in THS's grant portfolio, limited the extent to which THS's country-level grantmaking was able to advance UHC in Bangladesh. However, over time, global momentum around UHC, combined with THS's global advocacy and regional networking efforts, may have influenced and strengthened Bangladesh's commitment to UHC. For example, Bangladesh is now a member of the JLN.

Key learnings

Time-bound initiatives can ensure tangible country-level impacts by working in countries with a strong national commitment to a policy goal, and supporting efforts to advance policy reform.

THS gained the most traction in focus countries, such as Vietnam and Rwanda, where the government had a meaningful pre-existing commitment to UHC and had engaged in ambitious health system reform efforts to achieve that goal. With existing momentum and capacity, these contexts are ideal for a strategic donor with finite funding such as The Rockefeller Foundation. In Vietnam and Rwanda, the Foundation identified well-defined constraints to reform that could be addressed through short-term grantmaking, and channeled funds to those gaps to catapult reform to the next phase.

Country portfolios require clear theories of change to maintain their focus, ensure a realistic scope, and achieve impact. The Foundation ensured that its grantmaking strategy in each country was aligned with THS's overall strategic framework. However, it did not develop country-specific strategic plans. Developing country-based results frameworks early on could have helped THS define clear, achievable target outcomes and build cohesive grant portfolios to achieve those goals.

Gauging organizational capacity and identifying strong local champions early on can help the Foundation drive country-level change. THS leveraged its exploratory grantmaking to understand which local partners had the needed influence, commitment, and capacity to undertake ambitious reform efforts. In Vietnam, for instance, the initiative had originally targeted a local research organization as a potential lead on evidence generation to support provider payment reform and quality improvement. However, it discovered ultimately that this institution's strengths lay in advocacy and networking, and therefore began working more closely with a local think tank that had more substantial manpower and research capacity. In Bangladesh, by contrast, a clear country champion did not emerge. THS had established a joint center of excellence across two prominent NGOs to conduct research and generate dialogue around UHC, but leadership gaps and interorganizational tensions prevented this center from playing the envisioned role.

Leveraging synergies between regional and country grantmaking can multiply the influence of a large, multi-level initiative. Some of THS's most concrete and promising achievements emerged when the initiative identified and capitalized on synergies between its regional and country-level investments. For example, the provider payment work in Vietnam was the outcome of the timely and organic alignment of several complementary trends. The MoH was displaying a strong interest in increasing the efficiency of its payment mechanisms, the JLN was working on supporting country partners on costing of health services and provider payment reform, and the Foundation had developed a relationship with Health Strategy and Policy Institute [HSPI]), a strong local partner that could contribute to policy reform. The Foundation capitalized on these synergies to advance reform efforts, pairing a technical expert from the JLN with HSPI to provide in-country technical assistance and help design a pilot to field test possible reform models. It is important that initiatives like THS play an active role in linking parallel streams of work in case such specific opportunities for collaboration do not emerge organically. For example, Ghana was a key leader in the JLN and drew extensively on network resources to strengthen the National Health Insurance Scheme. At the same time, the Foundation was investing through country-level grantmaking in public sector capacity-building activities. However, these highly related efforts

were not linked, which may have led to opportunities for change being missed.

Grantees need consistent oversight and support during the entire grant lifecycle to strengthen project results and ensure the sustainability of gains. Grantees reported that the Foundation tends to provide detailed and regular input during the proposal, planning, and start-up phases. They particularly appreciated the Foundation's deep subject matter expertise in eHealth, and noted that the technical guidance they received helped ensure the feasibility of their project plans. However, they felt they could have benefited from more feedback and technical assistance from the Foundation in subsequent project phases, and were particularly eager to receive more support with sustainability planning. The Foundation's small staff and lack of country offices put limits on how much donor outreach it could do to support sustainability efforts. However, it could likely have leveraged its reputation and convening power to a greater extent. For example, many grantees indicated that they would have benefited from additional opportunities to showcase their work to other development partners, which, in turn, could have helped them secure resources to sustain grant activities. Many grantees also felt that the influence and sustainability of their work could have benefitted from more purposeful linkages with other THS grantees to foster cross-learning and collaboration.

7

Summative findings

Overall, the summative evaluation found the THS initiative to be successful in its efforts to build an enduring global movement to catalyze progress toward UHC at the global and country levels. Below, we summarize key cross-cutting achievements, challenges, and leanings under the initiative.

Achievements

The Rockefeller Foundation played a catalytic and influential role in the global UHC movement and adoption of UHC as an SDG health target. The Foundation is widely recognized as the thought leader behind the UHC movement. It successfully championed the once-controversial UHC concept to rally widespread support for health system strengthening, ensure UHC was a focal area in the post-2015 agenda deliberations and eventually an SDG target, and galvanize country commitment to UHC in LMICs. Although THS gained limited traction in advancing UHC through its focus country investments, its success in making UHC a global development goal will likely have country-level impacts for years to come.

THS generated global public goods and enduring platforms to support country progress toward the SDG UHC target. Under THS, the Foundation created and supported successful and enduring networks that

brought global attention to health systems issues and solutions and fostered joint problem solving. These networks have brought diverse constellations of health sector stakeholders together to explore and collaborate on new ideas and approaches. With the Foundation's strategic and technical guidance, financial support, and convening power, these networks have generated critical momentum around "orphan" issues in the HSS space, developed practical tools and resources, and used their learning to improve health policies, programs, and systems. THS also created research platforms, advocacy coalitions, and partnerships that helped build momentum around the UHC SDG target and will support progress toward the target moving forward.

The Foundation's legacy in the global health arena, combined with the strong reputation of THS leaders, helped influence leaders and decision-makers in the UHC arena. The Foundation's legacy in the global health arena, combined with the reputation and connections of individual THS leaders, was critical to THS's success in influencing key institutions – such as WHO, the World Bank, UNICEF, and the UN Secretary-General's office – to engage actively in the UHC movement. The Foundation's reputation also facilitated its efforts to gain support and endorsements for UHC from key political leaders. One of the most effective elements of THS's movement-building strategy was its

leveraging of various intergovernmental platforms to promote UHC, including the G8, the Global Health and Foreign Policy group, and the African Union. By making connections with government officials participating in these platforms, THS was able to influence the health agenda and put UHC on the map.

"Having a strong reputation changes the receptivity [of key leaders] and changes the legitimacy [of the issue]. [The Foundation's] reputation was formative for their credibility in this space."

- Interviewee

The Foundation is widely recognized as the thought leader behind the UHC movement among key actors in the UHC space. Many experts hold the Foundation in high esteem for its influential role in advancing the UHC movement, and its visionary thought leadership supporting the UHC concept from its early days. Online survey data suggest that many perceive the Foundation's role in the UHC movement as its most notable contribution to global health (see Table 3). Almost 80 percent of survey respondents reported that The Rockefeller Foundation was one of the top-five influencers in the UHC movement. In contrast, only 50 percent of respondents selected the Foundation as a top-five influencer in the global health arena. The Foundation's unique and powerful convening power was highlighted by many experts as critical to the movement's success.

Although The Rockefeller Foundation is perceived to be a catalytic and influential player in the UHC movement, many UHC actors outside of the movement's inner circle are not aware of the Foundation's specific contributions or its role in pivotal events in the movement's history. For example, only 47 percent of survey respondents believed that the Foundation played an influential role in the 2012 UN resolution on UHC, and only 57 percent believed that the Foundation had an initial role in the inclusion of UHC in the SDGs. This is likely because the Foundation has not publicized its role or successes, but instead empowered global and country actors to be UHC champions.

While the Foundation's reputation in the global health arena was a key factor facilitating its global advocacy successes under THS, the Foundation has not invested in communications efforts to protect and potentially strengthen its reputation. In fact, some respondents

TABLE 3. Survey respondents' perceptions of key UHC movement and global health influencers

ORGANIZATION	TOP 5 INFLUENCER IN UHC MOVEMENT (%)	TOP 5 INFLUENCER IN GLOBAL HEALTH (%)
WHO	84	93
The Rockefeller Foundation	77	50
World Bank	74	65
Bill & Melinda Gates Foundation	46	73
Global Fund to Fight AIDS, Tuberculosis and Malaria	28	44
USAID	21	44
UNICEF	17	29

Source: Mathematica online survey

indicated that the Foundation's presence in the global health arena has diminished over time due to a reduction in the number of Foundation staff representing its health area. Moreover, the Foundation's website does not provide extensive information about UHC or the THS initiative, or access to the many research products and publications that have been generated under the THS initiative. A few blog posts by THS staff have focused on the Foundation's contributions, but the posts are not easily found when searching online for UHC information.

Challenges

Broad scope and siloed grantmaking. The THS initiative emerged out of the Foundation's efforts to develop four separate Advance Health initiatives focused on: i) research and agenda-setting on UHC and health system strengthening, ii) enhancing health system stewardship capacity, iii) harnessing the private sector, and iv) leveraging eHealth technology. In 2008, the Foundation decided to combine these four initiatives into one large initiative aimed at transforming health systems toward UHC. As a result, THS was very broad in scope, encompassing four largely independent work streams operating at multiple levels, all organized around a very broad and ambitious long-term goal. Ultimately, THS's four work streams were not brought together under an initiative-level ToC or results framework that articulated how they would work together to strengthen health systems in support of UHC. In turn, grantmaking was largely siloed by work stream, and synergies across work streams and levels of intervention were difficult to identify and leverage, which led to some missed opportunities. For example, Ghana, a leader in the JLN, drew extensively on network resources and learning to strengthen its National Health Insurance Scheme. However, this work was not linked closely to the public sector capacity-building activities supported by country-level grantmaking – leading to opportunities for change being missed.

Abrupt shifts in strategy. Key informants felt that THS's private sector and eHealth investments, which were gaining traction at both the regional and country levels, were called to a halt too soon, which compromised opportunities for effecting long-term change. For example, THS's early investments in Ghana were helping to develop momentum and capacity to expand the private sector's role in advancing UHC, but the decision to wind down grantmaking in the private sector space in 2011 led to some loss of momentum and persisting gaps in donor support for private sector efforts. A similar narrative emerged in the eHealth space. For example, while the mHealth Alliance was able to attract support from other donors once THS funding for eHealth came to a close, these new resources were mainly for designing and implementing programs. Without THS funding, the mHealth Alliance was not able to focus on its main goals of building a community and providing thought leadership and global public goods. (The mHealth Alliance was eventually wound down in 2013, for this reason as well as others – including an overly broad scope of work and the growing presence of other actors stepping into the role the mHealth Alliance was created to fill.)

Reliance on exploratory grantmaking in focus countries. The Foundation threw a wide net to identify promising short-term investment opportunities as it began grantmaking in its focus countries. However, at times, this exploratory approach was continued into the "execution" phase of country-level strategies, leading to disproportionate spending on relatively scattered investments.

Limited traction at the country level. The Foundation had more limited success at the country level than at the global and regional levels, for several reasons. First, the Foundation had only limited resources to invest at the country level, and these were spread relatively thinly across THS's four work streams and multiple activities. The high degree of fragmentation in country grant portfolios diluted the Foundation's overall influence in focus countries. The Foundation was also

constrained by its limited experience with country-level grantmaking and its lack of a local presence. Without country offices, THS staff found it challenging to establish relationships with all relevant government actors and engage in collaborative partnerships with other donors. Despite these constraints, THS did make significant contributions to reform efforts in some countries, helping to propel efforts forward to advance UHC. However, this typically happened when a number of enabling factors aligned organically, such as when synergies emerged between the JLN's work and policy priorities in Vietnam and grew into a targeted country-level effort to guide provider payment reform.

Key learnings

Identify a well-respected leader to take the helm and subject matter experts to guide the initiative. THS directors responsible for leading the initiative's global advocacy work and making it a success were well-known and respected in the global health arena, and possessed a historical perspective that enabled them to identify strategies and actors that could catalyze and advance the UHC movement. Subject matter experts managing initiative components played a critical role in shaping the discourse in emerging fields such as eHealth, and providing needed technical guidance to grantees entering these fields.

Make big bets and bold moves, but ensure objectives are right-sized and aligned with comparative advantage. Initiative goals should be ambitious, but also feasible and closely aligned with Foundation strengths. For example, the Foundation had the legacy, leadership, and convening power to move the needle at the global and regional levels – bringing diverse actors together around the policy goal of UHC and facilitating widespread collaboration around strategies for achieving that goal. By contrast, the Foundation had

limited experience and relatively sparse networks at the country level, which contributed to portfolios that did not always cohere to achieve common objectives and ultimately had uneven influence.

Invest in areas where finite funding can have outsized and enduring impacts, such as in global advocacy and network-based learning. Adoption of a multi-level, multi-pronged advocacy strategy was critical to THS's success in elevating UHC's status on the global agenda, and catalyzing support and action among global leaders, donors, and policymakers to propel long-term HSS efforts in LMICs. Learning networks are also a powerful vehicle for effecting change in the long term. The Foundation helped form five networks over the course of THS, four of which continue today to facilitate learning, collaboration, and innovation around approaches for strengthening health systems and advancing UHC.

Use theories of change to inform approach and monitoring, evaluation, and learning (MEL) activities to guide strategy refinements. Initiative-wide theories of change, as well as results frameworks for specific initiative components, can help ensure the development of a cohesive portfolio of investments that are tied to well-defined, achievable goals. Theories of change and results frameworks can minimize the type of portfolio fragmentation the THS initiative experienced, and ensure that linkages across different grants and levels are identified and leveraged. They also provide an underlying framework for MEL activities, which are critical for tracking initiative progress and making timely and evidence-based refinements to strategy. Integrating MEL activities early on – and building decision points into the initiative strategic plan – can be particularly helpful in reining in lengthy exploratory grantmaking and expediting the process of identifying focus areas.

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Annexes

Annex 1. Evaluation matrix for summative evaluation

DATA SOURCES	INTERVIEWS	INTERVIEWS		WEB SURVEY		SECONDARY SOURCES		
Research questions	Sub-questions	Phone	In-person	Grantee survey	External stakeholder survey	Program and monitoring data	Other secondary data	Case studies of THS focus countries
I. Design and evolution of the THS initiative								
1. To what extent (TWE) has THS been effective in developing a strategy based on clear program logic and evidence, and in creating a shared vision for programming with key stakeholders?	• How has the initiative's strategy evolved over time and TWE were strategy changes supported by experience and evidence? • TWE did THS's strategy address key issues and gaps in the global health landscape? • TWE has the initiative's strategy included clear, attainable, and measurable outcomes and indicators at each stage of its evolution? • TWE have external experts and stakeholders participated in and informed the initiative's initial strategy and its evolution? • What role has the Rockefeller Foundation's (RF) senior management team and board played in the design and execution of the initiative's strategy? • TWE is there a shared understanding of and support for the initiative's strategy among external stakeholders and grantees?	✓	✓	✓	✓	✓		
II. Effectiveness of key approaches under THS								
2. TWE were THS' global advocacy strategies and approaches effective in advancing the UHC movement?	• TWE was the RF/THS effective in advocating for and influencing a global movement toward UHC? • TWE was the foundation successful in its efforts to put UHC on the post-2015 agenda? • What was the foundation's role in the inclusion of UHC in the sdgs? • TWE did THS's global advocacy strategy effectively target and leverage actors and institutions at the global, regional, and country levels?	✓	✓	✓	✓	✓	✓	
3. TWE were THS' network strategies and approaches effective in facilitating the adoption and implementation of health policies and reforms to achieve UHC?	**NETWORKS** • TWE did RF-supported networks (for example, JLN, HANSHEP, and CHMI) advance country-level commitment to and progress toward UHC? • Are cross-learning platforms an effective vehicle for building capacity and facilitating change at the regional and country level?	✓	✓	✓	✓	✓	✓	✓

DATA SOURCES	INTERVIEWS	INTERVIEWS		WEB SURVEY		SECONDARY SOURCES		
Research questions	Sub-questions	Phone	In-person	Grantee survey	External stakeholder survey	Program and monitoring data	Other secondary data	Case studies of THS focus countries

	TOOLS
	• To what extent are THS-supported technical tools and approaches being adopted and used by countries, and referenced by experts and in the literature?
	• Specific tools to be examined include:
	  • JLN costing manual
	  • Guidebook for designing benefits packages
	  • IDSI guide to priority-setting
	  • Health technology assessment (HTA) guides
	  • WHO/World Bank UHC measurement framework
	  • eHealth/mHealth interoperability and enterprise architecture
		✓	✓	✓	✓	✓	✓	

	RESEARCH AND TECHNICAL ASSISTANCE • TWE did RF-supported research and technical assistance efforts aid countries' HSS and UHC efforts? • TWE has RF generated knowledge and technical thinking that has contributed to country-level health system strengthening in support of UHC achievement?	✓	✓	✓	✓	✓	✓	✓

4. TWE has the RF influenced UHC progress in its four focus countries and leveraged its country-level work to catalyze broader UHC advancement?	• TWE did THS advance country-level progress toward UHC in its four focus countries?
	• TWE did the initiative help to develop models for change?
	  • TWE is Ghana seen as a model for progress in expanding enrollment toward UHC?
	  • TWE is Rwanda seen as a model for advancing effective models of eHealth?
	  • TWE is Vietnam seen as a model for efficient provider payment systems that support UHC?
	  • In Bangladesh, TWE did UHC momentum develop into concrete policy outcomes and implementation?
	• To what extent did THS leverage its country-level work to influence broader UHC advancement at the global and regional level?
		✓	✓	✓	✓	✓	✓	✓

DATA SOURCES	INTERVIEWS	INTERVIEWS		WEB SURVEY		SECONDARY SOURCES		
Research questions	Sub-questions	Phone	In-person	Grantee survey	External stakeholder survey	Program and monitoring data	Other secondary data	Case studies of THS focus countries
III. OVERALL EFFECTIVENESS AND EFFICIENCY OF THE THS INITIATIVE								
5. To what extent has THS achieved its objectives?	• To what extent has THS achieved its stated objectives and planned outputs under the initiative's lifespan? • Has THS addressed key gaps or constraints in, and added value to, the UHC landscape at the global and country level? • Has the initiative increased the capacities of individuals, organizations, institutions, networks, and policies to advance UHC?	✓	✓	✓	✓	✓	✓	✓
6. TWE were THS resources used in an effective and efficient manner to achieve intended outcomes?	• TWE has THS grantmaking been consistent with the initiative's evolving strategy and objectives? • Does the THS grant portfolio represent a coherent and cohesive set of grants and activities that support achievement of the initiative's intended outcomes? • Were the grantees and partners selected appropriate for advancing progress toward targeted outcomes? • To what extent were there complementarities and synergies across investments/activities at the global, cross-country, and country level? • TWE did non-grant activities complement, leverage, and advance grantmaking efforts?	✓	✓	✓	✓	✓	✓	✓
7. TWE has the foundation demonstrated effective guidance, oversight, and management of the initiative?	• TWE and how did internal Foundation processes affect the initiative's approach, effectiveness, and efficiency? • What role did Foundation leadership and other internal stakeholders play in the design and execution of the initiative? • Has the THS initiative demonstrated good initiative development, management, and governance practices? • TWE have THS team members been involved in strategy discussions and decision making? • Have sufficient human resources and funds been allocated to THS to ensure a well-designed program strategy, effective implementation, and achievement of results?	✓	✓	✓	✓	✓		✓

DATA SOURCES	INTERVIEWS	INTERVIEWS		WEB SURVEY		SECONDARY SOURCES		
Research questions	**Sub-questions**	Phone	In-person	Grantee survey	External stakeholder survey	Program and monitoring data	Other secondary data	Case studies of THS focus countries
IV. Influence of the THS initiative on UHC achievement								
• 8. TWE did THS shape and advance the UHC movement and progress toward UHC?	• TWE has the initiative influenced (intended or unintended) changes that support the advancement of UHC at the global, regional, and country levels? • TWE has THS influenced external partners and other resources to advance the UHC agenda and health systems change?	✓	✓	✓	✓	✓	✓	✓
9. TWE are the achievements of THS likely to be sustained?	• What are the major factors influencing the sustainability of THS achievements? • TWE has the initiative developed sustainable institutional and financial support for health systems change in support of UHC? • TWE have grantees been able to continue work in the UHC arena after their THS grant has ended? • Which THS approaches show the most promise for sustainability?	✓	✓	✓	✓	✓	✓	✓
V. Rockefeller Foundation legacy								
10. TWE is RF recognized for its contributions to UHC advancement and hss?	• TWE do grantees and external stakeholders perceive RF to be an influential and catalytic partner in global and country efforts to achieve UHC? • TWE is RF credited for UHC progress in its four focus countries? • TWE is RF seen as a resource for innovative thinking and effective initiatives around global health issues?	✓	✓	✓	✓		✓	
Vi. Recommendations and lessons learned								
11. What lessons and recommendations does THS provide for other foundation initiatives and the broader field?	• What learnings emerging from THS's work have implications for future RF initiatives and approaches? • What lessons have been learned about strategies that can enhance grantmaking effectiveness? • What recommendations emerge from THS that can inform future RF work at the global, regional, and country levels?	✓	✓			✓		✓

Annex 2. UHC advocacy activities

GLOBAL ADVOCACY ACTIVITIES, BY STRATEGY COMPONENT

COMPONENT	ACTIVITIES	SELECTED OUTPUTS
Evidence generation and information dissemination on UHC	• Generating evidence, information, and stories on UHC that could be used for broad-based and targeted advocacy efforts • Broad-based efforts included dissemination in academic journals and traditional and social media outlets • Targeted efforts include securing endorsements of UHC and influencing dialogue at key global forums	• "All for UHC" article in The Lancet (2009) • WHO Report 2010: "Health Systems Financing, the Path to Universal Coverage" • The Lancet special series on i) UHC, ii) Southeast Asia and UHC, iii) Bangladesh and UHC, iv) Implementing UHC in Latin America and the Caribbean, and v) progress toward UHC in BRICS countries (2011-14) • Lancet article on "UHC in post-2015 framework" (2013) • WHO/World Bank Report on tracking UHC (2015)
Promotion of UHC dialogue	• Supporting convenings that brought together global leaders, policymakers, health ministers, researchers, and civil society to engage in dialogue around UHC • Hosting UHC-themed events around key global meetings, such as the UNGA and World Health Assembly (WHA) • Supporting conference attendance by key stakeholders, and documenting meeting proceedings and outcomes • Sponsoring regional convenings to deepen country-level support for UHC	• Bellagio global health expert meeting (2008) • Global Health Forum (2009) • Symposiums on Health Systems Research (2010-13) • UHC side event at 2010 WHA (2010) • Panel on progress toward UHC at UNGA (2011) • Prince Mahidol Award Conference in Bangkok (2012) • Third People's Health Assembly in Cape Town (2013) • Panel on UHC as post-2015 priority at UNGA week (2014) • UHC sessions at the WHA, the Roadmap Summit, and the Financing for Development Conference (2015)
Identification of and support for UHC champions	• Identifying champions who could influence dialogue and debate on UHC, and generate country support for UHC through the UN and other channels • Formally engaging champions through grants, direct outreach by the Foundation to leaders at key institutions such as the World Bank, and efforts to generate formal endorsements for UHC by groups of influencers • Gaining buy-in and enabling more vocal support for UHC from country leaders and country support for inclusion of UHC in the post-2015 agenda	• Development of global roster of UHC advocates (2010) • Establish and provide secretariat support for the Global Task Force for UHC (2010) • Advocacy and support for UNGA UHC resolution (2012) • Advocacy and support for embedding UHC within the post-2015 agenda (2013) • Joint NGO statement from the UN post-2015 health thematic consultation (2013) • The Bellagio Declaration on parliamentarians and UHC • Economists' Declaration on UHC (2015) • The Elders publicly endorse UHC (2016)
Country-level UHC advocacy	• Supporting institutions that influence and shape health policy at the country level, including civil society networks that could advocate for UHC • Supporting local advocacy campaigns in several Asian and African countries aimed at elevating UHC on the political agenda and gaining greater support for implementation of UHC-oriented reforms • Facilitating the formation of global civil society networks and coalitions, resulting in a civil society declaration on UHC and global UHC Day Campaign	• Creation of Vietnam Alliance for Health Equity (2009) • Creation of secretariat to assist India in developing a framework for UHC (2010) • Local support for UHC advocacy in five African countries, India, Indonesia, Myanmar, and Egypt (2011-13) • Development of regional UHC agenda for Americas (2013) • Civil society declaration on UHC (2014) • Inaugural UHC Day held to commemorate UNGA resolution on UHC (2014)

Annex 3. Networks focused on the private health sector

THS helped form two key networks to facilitate learning and collaboration around private health sector approaches – the Center for Health Market Innovations (CHMI) and the Harnessing Non-State Actors for Better Health for the Poor (HANSHEP) network. CHMI catalogs and shares information on innovative private health sector programs through a web platform, facilitates knowledge sharing on effective practices, and promotes public-private dialogue. HANSHEP is a collaborative of donors who share knowledge and learning around the private health sector and co-finance promising initiatives. Below, we describe how these networks were formed, how they evolved, and how they are structured today.

Center for Health Market Innovations

CHMI was formed to address critical gaps in the private health sector landscape perceived by The Rockefeller Foundation. Early in the development of its private sector strategy, around 2008, the Foundation commissioned 14 papers on different aspects of the private sector to inform its vision for this component of THS. The papers revealed that the Foundation's original plan for its private sector investments – to identify innovative private sector programs and support their work – was very similar to what other donors were already doing. The Foundation perceived a need, instead, for an apex function or vehicle to facilitate learning across these programs – a realization that led to the formation of CHMI. This multi-component initiative facilitates knowledge sharing around health market innovations with the goal of i) enhancing private sector capacity to launch and scale innovative programs, and ii) improving government stewardship of private sector actors. Coordinated by Results for Development (R4D), it was launched in 2010 with joint funding from both The Rockefeller and Bill and Melinda Gates Foundations, with The Rockefeller Foundation providing around $3.8 million from 2007 to 2014. CHMI is now also funded by DFID, through the HANSHEP donor network.
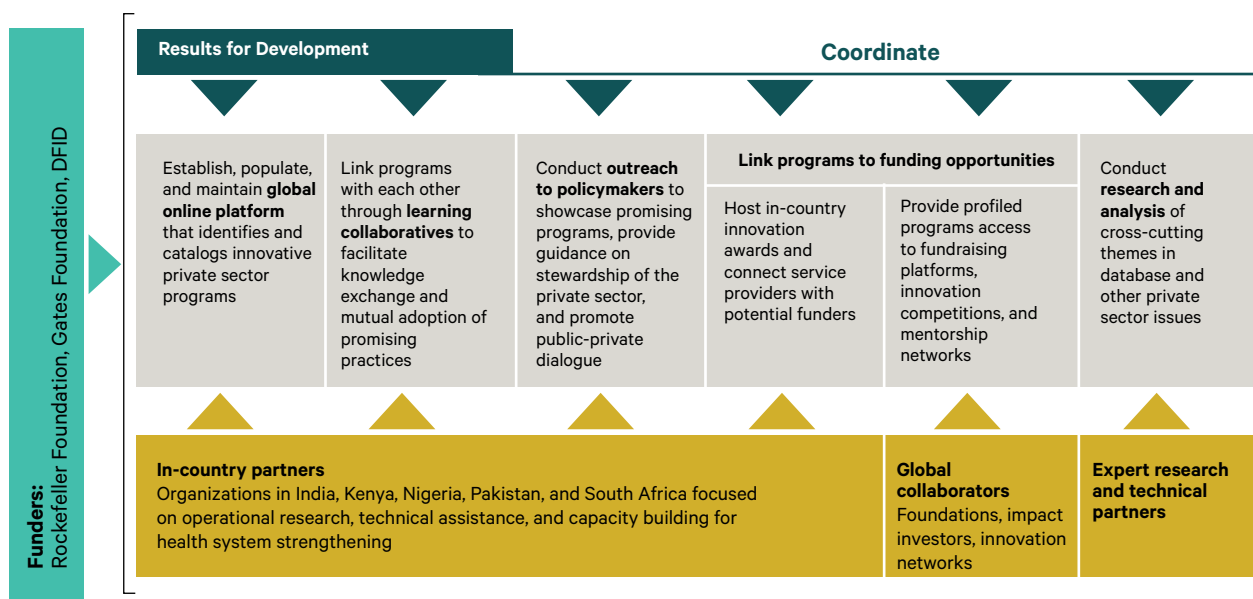
FIGURE 14. The CHMI model

Figure 14 describes the structure and key elements of CHMI. The first component of CHMI to be established was a global online platform that provides profiles of innovative private sector initiatives (this is still CHMI's central component). Profiled private sector programs adopt a variety of strategies to expand delivery of high-quality, equitable care, including social franchising, licensing and accreditation, micro-health insurance, supply chain improvement, and mobile clinics and telemedicine. Data on these programs is collected and summarized by both R4D and its in-country partners, which are prominent organizations in India, Kenya, Nigeria, Pakistan, and South Africa focused on operational research, technical assistance, and capacity building for health system strengthening. CHMI has two efforts underway to ensure the quality and completeness of this information (see Figure 15). These initiatives sought to encourage programs to move beyond reporting descriptive data and provide information on program effectiveness and lessons learned (which are critical for scale-up, replication, and funding decisions).

Over the years, CHMI has grown its scope of work to ensure that the knowledge cataloged by the web platform is influencing key programs and policies. For instance, R4D and the in-country partners now form learning collaboratives of like-minded service providers that facilitate knowledge exchange, joint problem solving, and eventually, adoption of promising solutions (see Figure 16 for details on two recent learning collaboratives/exchanges). In-country partners have also started to engage in more intensive outreach

FIGURE 15. Initiatives to improve quality of CHMI data

Reported Results

This initiative requests and collects data on program outcomes (e.g. availability and quality of services) from profiled service providers.

CHMI Plus

This incentive program offers ratings of "profile completeness", with corresponding benefits such as greater visibility on the website and nominations for innovation competitions, to encourage organizations to provide more comprehensive data on their work.

FIGURE 16. CHMI's learning initiatives

CHMI learning exchange

This initiative, launched in 2014, allows profiled organizations to apply for learning exchange grants. Grants are coordinated by a "lead partner" and include one or more "knowledge partners", who engage in peer learning exchange, conduct site visits to successful programs, and co-create solutions to common challenges. Thus far, five grants have been issued to 12 organizations, which have drawn on the each other's insights and experiences to improve drug supply models, strengthen operational processes, and enhance financial sustainability.

Primary care learning collaborative

CHMI brought together five organizations in Kenya, Burundi, and India that are using franchise models to provide primary health care. Drawing on the JLN's knowledge co-creation approach (described further below), R4D and in-country partners facilitated discussion and information exchange among these service providers on challenges of quality, sustainability, efficiency, and scale in delivering primary care in developing country contexts. Member organizations compiled their shared learnings in a knowledge product – *The Primary Care Innovator's Handbook: Voices from Leaders in the Field*. They also adopted each other's practices, such as expanding patient follow-up to improve quality of care, offering discounts to increase patient in-flow, and integrating dental care as a key service.

to government decision-makers. They showcase promising programs to policymakers, and in general, have assumed a "brokering" function, whereby they facilitate dialogue between public and private actors, and advise and guide government officials on how to respond to key trends in the private sector.

A key benefit that CHMI provides to service providers is access to funding opportunities. In-country partners host innovation awards and connect service providers with potential funders. CHMI also partners with foundations, impact investors, and innovation networks ("global collaborators"), which give programs access to fundraising platforms, innovation competitions, and mentorship opportunities. In addition to working with service providers to advance the field, CHMI also takes the "30,000 foot view" – identifying and addressing critical gaps in the broader literature on the private sector. CHMI's expert partners, which are research, technical, and learning organizations, conduct cross-cutting thematic analyses of programs in the database, and engage in independent research

around critical but overlooked aspects of the private sector (Figure 14).

HANSHEP network

HANSHEP also grew out of the Foundation's early efforts to understand and identify the gaps or pressure points in the private sector landscape. The review the Foundation commissioned to inform its private sector strategy gave the Foundation an out-of-the-box perspective on the long-brewing controversy around the role of the private sector in health. This debate, which was of long standing, had reached particular levels of intensity around the time the Foundation was developing its private sector strategy. In particular, while some organizations made the case that private sector solutions had a critical role to play in achieving universal and equitable health care, others argued this approach was not grounded in the evidence, and called instead for the scale-up and strengthening of public provision of health care. The Rockefeller Foundation, in
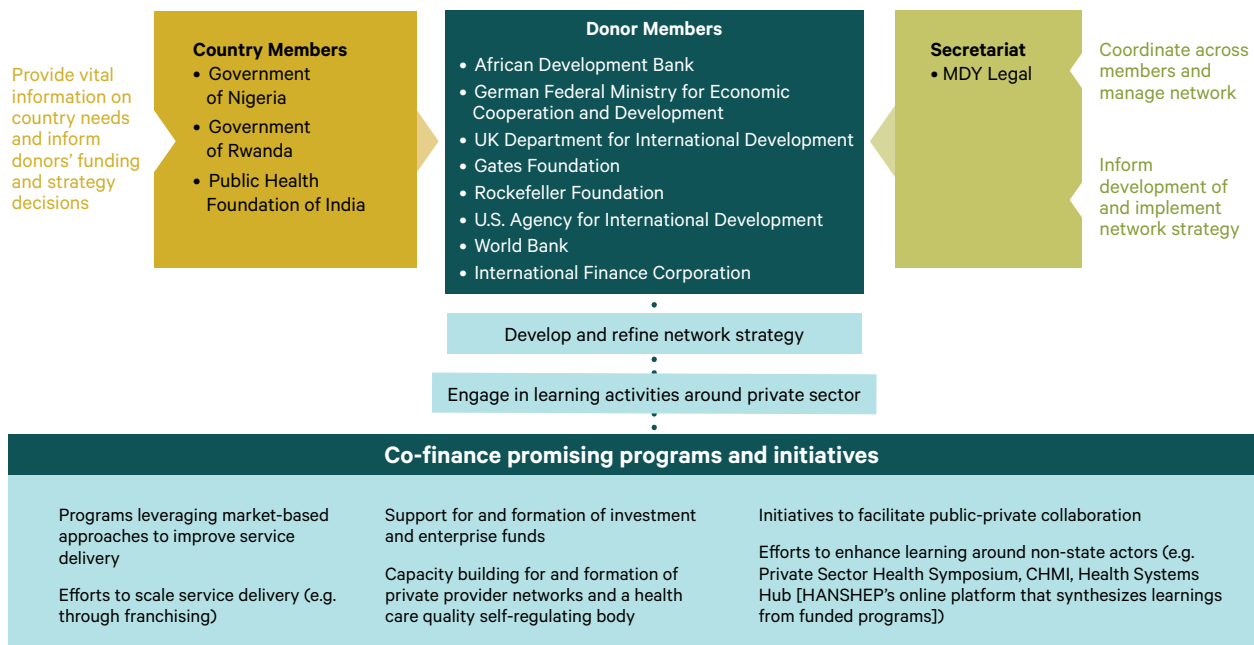
FIGURE 17. HANSHEP stakeholders and activities

Provide vital information on country needs and inform donors' funding and strategy decisions

Country Members
• Government of Nigeria
• Government of Rwanda
• Public Health Foundation of India

Donor Members
• African Development Bank
• German Federal Ministry for Economic Cooperation and Development
• UK Department for International Development
• Gates Foundation
• Rockefeller Foundation
• U.S. Agency for International Development
• World Bank
• International Finance Corporation

Secretariat
• MDY Legal

Coordinate across members and manage network

Inform development of and implement network strategy

Develop and refine network strategy

Engage in learning activities around private sector

Co-finance promising programs and initiatives

Programs leveraging market-based approaches to improve service delivery

Efforts to scale service delivery (e.g. through franchising)

Support for and formation of investment and enterprise funds

Capacity building for and formation of private provider networks and a health care quality self-regulating body

Initiatives to facilitate public-private collaboration

Efforts to enhance learning around non-state actors (e.g. Private Sector Health Symposium, CHMI, Health Systems Hub [HANSHEP's online platform that synthesizes learnings from funded programs])

sharing and learning around promising approaches and practices.

Figure 17 provides an overview of HANSHEP's structure and activities. The collaborative currently includes 11 members, including bilateral and multilateral agencies, private foundations, and government agencies or other organizations representing countries. Members meet on a quarterly basis to exchange ideas and information, make funding decisions, and jointly learn more about the private sector space. During the meetings, funders bring promising initiatives to each other's attention, and decide to co-fund programs that show potential (a HANSHEP program is one that is funded by at least two donors in the collaborative). Investment decisions are informed by local needs highlighted by the three country members (India, Nigeria, and Rwanda), and have yielded a diverse set of programs that support innovative service delivery mechanisms, foster public-private dialogue, and generate needed evidence. Quarterly meetings also serve as a platform for broader learning around mixed health systems – they frequently feature guest speakers and may entail visits to project sites. Management of the network is the responsibility of the Secretariat, run by MDY Legal, which coordinates across members to help develop and refine HANSHEP's strategy and priorities, implements the network strategy in consultation with the members, captures and disseminates learning from the funded programs, and is responsible for overall management of the network.

exploring the private sector space, developed a more practical view of this controversial topic. It recognized the reality that private health markets were already large and enduring in many developing countries, and focused, therefore, on exploring strategies to improve their stewardship by the government. This sentiment drew the attention of DFID, which was hoping to bring a group of donors together to address a key recommendation of the 2009 innovative health financing task force chaired by UK Prime Minister Gordon Brown – to increase government capacity to "secure better performance and investment" from non-state actors in the health sector. The Rockefeller Foundation's focus on improving integration of the private sector into the overarching health system strongly resonated with key players at DFID, and the two organizations, together with the Bill and Melinda Gates Foundation, joined forces to launch the HANSHEP network. HANSHEP facilitates multi-donor financing of programs that seek to harness the private sector to improve health outcomes, and enables information

The Rockefeller Foundation was the first HANSHEP chair, playing a critical role in bringing donors together initially to commit to a joint plan of action. Overall the Foundation provided just under $1 million to HANSHEP, funding the formation and initial operations of the Secretariat and co-financing four out of HANSHEP's 15 initiatives (Figure 18).

Annex 4. eHealth networks, partnerships, and alliances

In its effort to leverage new vehicles to strengthen health systems, THS looked not only to the private sector, but also to the fast growing eHealth domain. It recognized the transformative power of eHealth technologies – to make health systems more efficient, effective, and responsive by tackling deeply entrenched issues of data access, quality, and use. To explore the opportunities for health system improvement offered by emerging eHealth tools, and strengthen linkages between eHealth innovations germinating across the world, the Foundation sponsored what became a seminal conference series on eHealth at the Bellagio center in 2008. The "Making the eHealth Connection" series entailed eight conferences over four weeks that covered a diverse set of eHealth topics, including interoperability, eHealth capacity building, national eHealth policies, and telemedicine, among others. The rich and varied discussions at these conferences helped inform the development of THS's overarching eHealth strategy and seed two new collaborative networks, including OpenMRS and the mHealth Alliance, which the Foundation supported with seed funding and strategic guidance. As part of its eHealth work, THS also facilitated the establishment of the information technology track of the JLN (described further in the next section), supported the work of the Asia eHealth Information Network (AeHIN), and participated in Greentree's efforts to build donor consensus around best practices for designing and implementing ICT-enabled development programs.

OpenMRS

Led by the Regenstrief Institute and Partners in Health, OpenMRS is a network of developers, implementers, and users collaborating around building a software platform that enables health sector stakeholders with no programming expertise to develop customized electronic medical records (EMR) systems. OpenMRS was formed in 2004, but mainly as a collaboration among three organizations with no full-time staff. To allow this group to devote the time and effort needed to expand its suite of tools and grow its open source community, The Rockefeller Foundation provided seed funding to these organizations to form an independent non-profit organization. Initial as well as ongoing THS funding (of around $4.3 million from 2008 to 2016) helped OpenMRS identify and implement a strong organizational structure, strengthen its community of developers, implementers, and end-users, and enable joint development and refinement of an open source EMR system platform.[2]

Seed funding from THS supported management consulting and legal assistance, which allowed OpenMRS to formalize operations. It also supported the hiring of several full-time developers, which in turn significantly increased volunteer code contributions from its community, and helped OpenMRS develop new tools and engage in multiple releases of its platform. OpenMRS has also facilitated the piloting of the platform in real-world settings (for example, in Rwanda, which rolled out an OpenMRS system for primary care). Health sector stakeholders from across the globe have drawn on OpenMRS for their health information system needs; as of 2015, 1,845 sites in 64 countries were reporting OpenMRS implementations (OpenMRS 2016). OpenMRS also offered opportunities for collaboration and capacity building to its developers and other stakeholders, organizing virtual and in-person meetings as well as site visits to showcase how the OpenMRS platform is being customized and deployed.

mHealth Alliance

The mHealth Alliance (2008 – 2013), coordinated by the United Nations Foundation, aimed to build the

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2 OpenMRS has also received funding or other support from USAID, the Centers for Disease Control and Prevention (CDC), and NGO partners.

mHealth field through evidence generation, diverse convenings and events, technical assistance to countries on policy development, capacity-building support to NGOs, and implementation of mHealth programs. The idea for the mHealth Alliance came out of the 2008 conference series at the Bellagio Center, where stakeholders expressed the need for a neutral platform to facilitate learning and exchange among organizations with competing interests (such as mobile phone companies as well as NGOs with varying interests). To support this goal, and mobilize collective action on mHealth, The Rockefeller Foundation joined forces with the Vodafone Foundation to support the formation of the mHealth Alliance (The Rockefeller Foundation provided around $1.6 million to the alliance from 2009 to 2012). The alliance eventually received funding from several other donors, including Hewlett Packard, Johnson & Johnson, the Norwegian Agency for Development Cooperation (Norad), and the United States President's Emergency Plan for AIDS Relief (PEPFAR). Key activities of the alliance included:

Bringing mHealth stakeholders together through convenings and events: The mHealth Alliance brought together around 300 members, including multilateral agencies, governments, NGOs, academic institutions, and corporate members. These organizations came together in technical working groups to work on advancing country-level mHealth policy, building organizational capacity in mHealth, and advancing country-level policy on integrating mHealth into health services. The alliance also convened annual mHealth summits, which started with 500 attendees in 2008 and ended with about 4,500 people in 2013.

Development of tools and resources: The alliance developed an expansive library of resources, which included policy papers, analytical frameworks, and landscape assessments produced by the mHealth Alliance, and links to mHealth applications, capacity-building workshops and courses, multimedia tools for health promotion, mHealth project inventories, and toolkits for leveraging mHealth technologies.

mHealth capacity building: To build capacity in this field, the alliance formed the mHealth Expert Learning Network (mHELP), which provided technical assistance to governments and implementing partners as they developed and implemented mHealth solutions (mHELP was eventually spun off into an independent organization, known as Health Enabled, in South Africa). Another vehicle the alliance created for knowledge sharing and capacity building was Health UnBound or "HUB", an online research repository and networking platform.
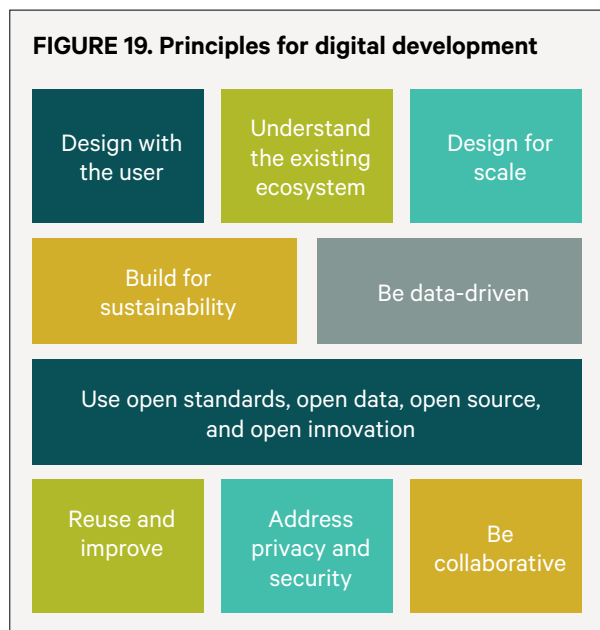
mHealth policy development: The alliance engaged in advocacy and technical assistance at the country level, which contributed to Nigeria, Rwanda, South Africa, and others developing and implementing mHealth strategies.

mHealth program implementation: The alliance implemented several on-the-ground mHealth programs – developing, testing, and refining promising mHealth intervention models. For example, the Foundation incubated the Mobile Alliance for Maternal Action, a global public-private partnership that tested the mobile phone-based delivery of MNCH information to pregnant women and new mothers.

The mHealth Alliance was wound down in 2013. This was partly a result of a misalignment between its goals and activities (while its membership hoped it would play a strong convening and thought leadership role, it received funding mainly for implementing programs once THS funding came to a close). Due to this misalignment and the enduring negative impact of early reputational issues, and recognizing that other organizations were stepping into the role the mHealth Alliance was created to fill, the board and leadership of the alliance made the decision to wind down the network in 2013.

Other eHealth networking and donor collaboration efforts

The Rockefeller Foundation's foundational investments in eHealth networking efforts helped draw support from other funders for this budding field. For example, THS funding contributed to the formation of AeHIN; WHO, a lead technical agency for AeHIN, used a portion of the THS funds it received for eHealth technical assistance to the Philippines to support several of AeHIN's initial activities. Starting with only seven members from six countries in 2011, AeHIN currently has more than 700 members from 25 countries, and receives funding and/or technical support from a variety of development partners, including the International Telecommunication Union, USAID, Norad, Asian Development Bank, World Bank, International Development Research Centre, and the UN Economic and Social Commission for Asia and the Pacific (UN-ESCAP). Over these years, AeHIN has grown into a highly influential body – supporting country development of eHealth policies, strategies, and governance structures, working with country partners to strengthen long-term eHealth capacity, facilitating cross-country learning on eHealth through in-person and virtual meetings, and developing resources to promote system interoperability (AeHIN, 2013).

FIGURE 19. Principles for digital development

Design with the user

Understand the existing ecosystem

Design for scale

Build for sustainability

Be data-driven

Use open standards, open data, open source, and open innovation

Reuse and improve

Address privacy and security

Be collaborative

The Rockefeller Foundation was also involved in early donor collaboration meetings organized by Greentree to establish the Principles for Digital Development, which have been endorsed by almost 75 organizations (Figure 19). The principles have informed program development, guided the development of trainings and other capacity-building efforts, been integrated into funders' procurement requirements, and influenced overarching organizational policies and strategies (Waugaman, 2016).

Annex 5. Joint Learning Network

The idea for the JLN emerged as THS was honing in on UHC advancement as its key goal and gaining early insights from its other recently launched networking efforts on how to foster meaningful collaboration between health sector actors. Around 2009, key discussions with global and country leaders revealed to the Foundation that countries engaged in UHC reforms had few platforms available to share experiences and exchange ideas and best practices. The Rockefeller Foundation set out to address this gap in 2010 by partnering with Results for Development (R4D) and ACCESS Health to launch the JLN, a country-led, global learning network that connects practitioners around the globe to advance knowledge and learning about approaches to accelerate country progress toward UHC. The JLN currently includes 27 member countries across Africa, Asia, Europe, and Latin America, which engage in multilateral workshops, country learning exchanges, and virtual dialogues to share experiences and develop tools to support the design and implementation of UHC-oriented reforms.

The JLN integrates functions similar to other THS-supported networks, including the facilitation of experience- and idea-sharing and the development of practical tools and resources. However, it has formalized several of these processes, developing a structured model for shared learning among practitioners, and establishing a strong governance structure to oversee and support technical efforts (Figure 20. The core learning vehicles under the JLN are technical initiatives, which facilitate cross-country knowledge sharing and resource development around key levers for reaching UHC objectives (see Figure 21 for details on this process). Technical initiatives focus on provider payment mechanisms, primary health care, population coverage, quality improvement, health financing innovations, and health information technology (which
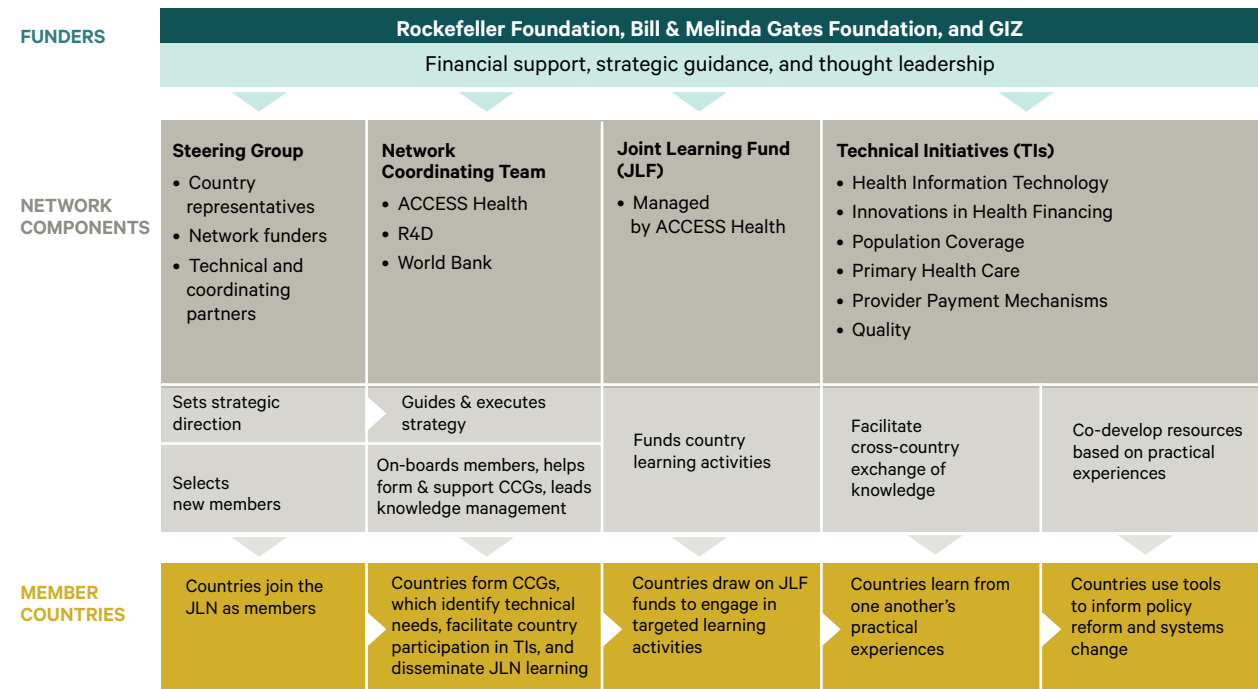
FIGURE 20. The JLN model

also falls under THS's eHealth portfolio). JLN is also in the process of developing a new technical initiative focused on mixed health systems with support from the Center for Health Market Innovations (CHMI), another learning platform supported by the Foundation (see Annex 3). To address more targeted technical needs, the JLN has also established technical collaboratives, which fall within or cut across technical initiatives. To address country-specific learning needs, the JLN has established a flexible funding pool, known as the "Joint Learning Fund" (JLF). Countries can draw on the JLF for study tours, trainings, and targeted support from technical initiatives. The JLN is managed by a Network Coordinating Team of technical partners, which implement the strategic direction set by a global Steering Group of member countries, technical partners, and network funders. At the country level,

country core groups (CCGs) comprised of staff at government agencies organize and facilitate country participation in the JLN.

Since 2010, The Rockefeller Foundation has provided over $20 million in grant funding to JLN partner organizations, which has supported the design, launch, and coordination of the network, as well as the facilitation of cross-country and country-specific learning activities. As a founding funder, the Foundation has also worked to strengthen the JLN's sustainability by building support for the network among other donors, including the Bill & Melinda Gates Foundation, the World Bank, and the German Society for International Cooperation (GIZ).

Health Surveillance Assistant Esnat (left) pricks a feverish child's finger in order to conduct a rapid diagnostic test for malaria at a local village health clinic in Malawi.

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